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An Exploration of the Use of Complementary Approaches to End-of-Life Care: the Perspectives and Work of Hospice Palliative Buddhist Chaplains in Taiwan

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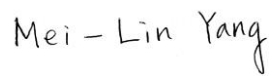
Declaration

I hereby declare that

1. This project has been composed by myself and that the research on which it reports is my own work.
2. The work presented within this thesis is my own unless otherwise stated.
3. This work has not been submitted for any other degree or professional qualification.



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Abstract

This study was motivated by the researcher's experience of working in end-of-life care and by the literature review which revealed a gap in the knowledge and understanding of the role of religious methods as complementary approaches in managing the experience of living with a life-limiting illness in Taiwan. Trans-cultural issues are extremely important to end-of-life care. In Taiwan, patients approaching death have used religious methods as complementary approaches to manage the experience of living with a life-limiting illness, and religious belief systems shape patients' understandings of what is happening. Current literature coupled with the experience of palliative care personnel identified that some patients with religious persuasions were refusing western medical treatments when they recognised that they were in the end stage of disease because they believed that these treatments could not control death and rebirth. However, few studies have discussed this experience and its meaning.

Buddhist chaplains, as providers of supportive palliative care services through therapeutic care, have presented their understanding of the way that people move towards death and dying in Buddhist temples, universities, and in public speeches, but not often in hospitals. Buddhist chaplains' life experience and interpretations influence the thinking processes and decision-making of many of those they come in contact with, especially those who share the Buddhist faith. However, few studies have demonstrated the way in which patients have made use of religious methods as complementary approaches from the perspective of hospice palliative Buddhist chaplains.

The perspectives and work of hospice palliative Buddhist chaplains regarding "hospice palliative care" and patients' use of religious methods as complementary approaches in end-of-life care in Taiwan were explored. The research questions were: (1) How do the Buddhist chaplains define "hospice palliative care"? (2) How do Buddhist chaplains use Buddhist religious methods as complementary approaches in clinical end-of-life care? (3) What are the experiences of Buddhist chaplains regarding the patients' use of Buddhist religious methods as complementary approaches in clinical end-of-life care? (4) What are the opinions of Buddhist

chaplains regarding patients' use of Buddhist religious methods as complementary approaches in clinical end-of-life care?

Charmaz's (2006) constructivist grounded theory method was adopted. Data collection used triangulation and included demographic questionnaires, semi-structured face-to-face interviews, field notes, and written memos. Purposive sampling was used to recruit participants with rich working experiences in clinical end-of-life care. Twenty female and two male Buddhist chaplains aged between 33 and 67 years old participated. Charmaz's (2006) constructivist grounded theory, which included comparative method, and three analytical phases (initial coding, focused coding and theoretical coding) informed the data analysis.

The findings demonstrate that Buddhist concepts of death, the process of dying, and the ethics and tools of the Buddhist religion formed the basis of the practice of the chaplains who regarded compassionate care and Mahayana Buddhism as the main content of Buddha's teachings. All participants used aspects of Buddhist philosophy to define "hospice palliative care".

The final theoretical framework emerged from the data to provide a structure to interpret "the dynamic process of compassionate care". Compassionate care is a multifaceted, dynamic phenomenon practised by the chaplains. Mahayana Buddhism provides the specific tools through which they interacted with patients creating a sacred relationship that allowed patients to understand their context and cope with their end-of-life experiences.

The thesis concluded that Buddhist chaplains' understanding of compassionate care was influenced by their educational background, hospice training courses, and Buddha's teachings to enable them to play important roles in end-of-life care in Taiwan.

Recommendations are made for future studies to test the theoretical framework regarding "the dynamic process of compassionate care" with different professional staff such as nurses, psychologists and mental health physicians. The findings are also relevant for future government policy concerning the financial cost of end-of-life care which is currently provided by Buddhist chaplains from a Charity rather than by Taiwanese National Health Insurance. Finally it recommends that the

findings inform the future education of medical and nursing students and staff in hospice end-of-life care in Taiwan.

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Glossary

The following terms are Buddhist religious specific terms, therefore, explaining those terms based on a Buddhist dictionary is a necessary step in presenting the thesis.

Attachment	執著	Attachments are what keep us turning on the wheel of rebirth. Being enlightened is nothing other than severing all our attachments. We can become attached to people, things, experiential states, and our own thoughts and preconceptions. In Buddhist teachings attachments are usually divided into general categories: attachments to self and attachments to dharmas.(Epstein, p.11)
Amita-Buddha	阿彌陀佛	Amita-Buddha, his pure land to the West and the means to rebirth therein. The large Amitabha Sutra explains the causal affinities resulting in the Pure Land of Ultimate Bliss. (Epstein, p.3)
Bodhisattva	菩薩	A Bodhisattva is someone who has resolved to become a Buddha and who is cultivating the Path to becoming a Buddha. Usually the term Bodhisattva is reserved for those who have reached some level of enlightenment. (Epstein, p.23)
Buddha	佛	Buddha means “the awakened or enlightened one” It is a title which is applied to those who have reached perfect enlightenment. (Epstein, p.31)
Buddha-nature	佛性	The Buddha-nature is the innate, inherent potential to become a Buddha that resides in the mind of every living being. (Epstein, p.33)
Faith	信	Faith is necessary in whatever it is one does. What kind of faith? One needs to have faith that one certainly can become a Buddha. One has to believe

		that there is no difference between the Buddha and oneself. The lack of difference between Buddha and oneself is in one's Buddha-nature.
Karma	業力	Karma is a Sanskrit term that refers to that which is made by the activity of body, speech, or mind. (Epstein, p.117)
Mantra	呪,陀羅尼	Mantras are phrases of sound whose primary meaning or meanings is not cognitive, but on a spiritual level that transcends ordinary linguistic understanding. (Epstein, p.138)
Taking refuge	皈依	Taking refuge with the Three Jewels is the way one becomes a Buddhist and enters the path to the ending of suffering that comes with full and proper enlightenment. (Epstein, p.168)
Three Jewels	三寶	The Three Jewels are (1) the Buddha, (2) the Dharma, and (3) the Sangha. The Three Jewels are Buddhism's greatest treasures.(Epstein, p.168)
Transfer of merit	功德回向	Transfer of merit means transferring one's own merit to others so that they may benefit from it. The practice of transference of merit is a natural and logical development of a fundamental principle of the Path of the Bodhisattva. (Epstein,p.206)

Chapter 1 Introduction

Introduction

The following thesis is a constructivist grounded theory investigation into the perspectives and work of hospice palliative chaplains who use religious approaches for end-of-life care in Taiwan. As religious approaches are not part of professional medical service in Taiwan, these religious approaches are regarded as "complementary" when Taiwanese people are sick or have bad luck. This introductory chapter begins with the rationale for the study and then outlines the structure of the thesis.

The study is based on clinical end-of-life patients' stories and the gap identified through the literature reviews with regard to complementary approaches to hospice palliative care in Taiwan. Palliative cancer patients and/or their families seek non-clinical, complementary approaches for dealing with death and dying from religious staff or chaplains in Taiwan, but few studies have explored this issue in detail. From the above phenomenon, trans-cultural considerations within the healthcare system are extremely important to end-of-life care. I summarise the literature on hospice and palliation to provide a background context to this study.

Definition of hospice palliative care

According to Doyle et al (1998), the founder of hospice care, Dr. Cicely Saunders, described how originally hospices welcomed pilgrims and only later became associated with illness because Christians cared not only for strangers but also for the sick (Doyle et al 1998, p.vi). Mechelen et al (2012) explored the definition of hospice palliative care by conducting a systematic review. They found that it is a holistic interdisciplinary approach that focuses on supporting the quality of end-of-life care. Lzumi et al (2012) thought that the current terms relating to end-of-life care included terminal care, hospice care, and palliative care.

The World Health Organization (WHO, 2016) defined palliative care as follows:

> "Palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early assessment and treatment of pain and other problems, physical, psychological and spiritual".(World Health Organization 2016, p.1)

The World Health Organization (WHO) (2016) added that hospice palliative care is a form of holistic care not only for patients at the end of life but also for their families. That is, physical, psychological and spiritual care is an important service provided by hospice palliative staff. Interdisciplinary team members are expected to cooperate with each other and to audit the quality of care offered in order to ensure that the standard of holistic care is met. Doyle et al (1998) stated that hospice palliative interdisciplinary teams who share the goal of improving patients' quality of life are best equipped to provide a nurturing environment for patients and their families.

The holistic care service in hospice care : the physical aspect

Tsai et al (2006) conducted longitudinal research to explore the physical symptom patterns of advanced cancer patients in a palliative care unit; they found that weakness, fatigue, anorexia, pain, and depression were the most common symptoms of patients who were admitted to the palliative care unit. Jordhoy et al (2007) suggested that physical decline is experienced by all palliative care patients and affects most aspects of life. Langlois (2013) noted that reducing suffering and helping patients to control their symptoms are the key components of palliative care.

The holistic care service in hospice care: the emotional aspect

Sekelja et al (2010) suggest that cancer patients' caregivers are a vulnerable population because they have unmet informational, emotional and practical needs, particularly during the end-of-life phase of care. Skarupski et al (2009) compared the emotional adaptation of family caregivers of different races and found that black caregivers suffered fewer depressive symptoms than whites. However, Taiwanese people are neither black nor white, and few studies have compared Taiwanese people with those of other ethnicities. Grande et al (2004) conducted a Random Controlled Trial (RCT) to explore caregivers' bereavement outcomes from hospice homecare in the UK, and found that inadequate terminal support and high symptom severity were related to worse bereavement responses for the caregivers.

According to a study by Sakagnchi et al (2004) in Japan, training in bereavement services is available, but the findings were limited because questionnaires were sent out only to Head Nurses rather than to all palliative care staffs. Davis (2011)

conducted literature reviews to explore the role of district nurses (DNs) in end-of-life care; she found that DNs should have responsibility for providing bereavement care, but that there is a lack of clear guidance on bereavement care as well as inequalities in current practice in the UK. McGrath et al (2010) conducted a literature review in Australia to explore caregivers' experiences of bereavement and found that general practitioners (GPs) play an important role in bereavement care in end-of-life care at home care.

The holistic care service in hospice care: the spiritual aspect

Kuin et al (2006) assert that spiritual needs should be integrated into palliative care, although they fail to define spiritual needs clearly. Their research focused on the Netherlands where they found that the discussion of spiritual issues is mainly influenced by consultants from all healthcare disciplines. Lo and Chou (2003) conducted many literature reviews, and they agreed that spiritual beliefs and religious rituals may help palliative patients to find meaning and comfort in the USA.

Spiritual need and spiritual care is not only an issues for patients

Sinclair et al (2006) conducted qualitative one-to-one interviews as well as focus group interviews and found that the culture of palliative care fosters spiritual reflection for health care professionals. Leuven and Belgium (2011) noted that religion and spirituality influence the ethical choices and compassion related to end-of-life care. Breitbart (2008) pointed out that compassion is an important

element of all palliative care clinical interaction; additionally, compassion may be defined by the following practices: hospitality, presence, and listening.

Puchalski (2007) noted how the founder of hospice care, Dame Cicely Saunders, developed the hospice movement based on the bio-psycho-social-spiritual model of care. The four dimensions of this model are important for the care of patients. Callahan (2009) argues that the need for spiritual care increases in hospice palliative care as patients struggle to accept the dying process. This need was further explored by Trinkus et al (2011) who identified the relationship between spirituality and complementary therapies within advanced cancer patients; their study found that spiritual faith was associated with the increased use of complementary approaches. Williams et al (2004), who studied the roles, responsibilities and stresses of chaplains in the UK, found that spiritual care is an integral part of palliative care, however most of such care is not provided by clinical staff but by chaplains. This was not because clinical staff did not understand the importance of spiritual care, indeed a study conducted by Balboni et al (2013) as a survey-based study, found that patients, nurses, and physicians viewed spiritual care as an important component of end-of-life care but that spiritual care was infrequent due to a lack of training. Other such as Cockell and Mcsherry (2012) explored the role of spiritual care in nursing, and found that nurse managers should have training in spiritual care and its planning and delivery.

<u>The hospice movement outside Taiwan</u>

Regarding the global spread of hospice palliative care, Clark and Seymour (1999, p.62) explained that the founder of the hospice movement Dr. Cicely Saunders had established a remarkably detailed agenda for hospice care in the UK. It was, they suggested, like a stone being dropped into a pond, creating ripples which eventually spread around the world. Pennell et al (2001, p.517) stated that hospice and palliative care had been a worldwide movement since the 1960s. In the United States of America, Cassin (2007, p.45) noted that the modern hospice movement there was influenced by the work of Elizabeth Kübler-Ross in the 1960s who recorded how people faced terminal illness and this influenced the rise of the hospice movement in the USA. Maddocks (1997, p.195) describing how the movement extended throughout the UK, North America and Australia from the early 1970s noted that the western ethical values of truth-telling and individual autonomy on which the modern hospice movement depended were very different from those in Asian countries.

Glass et al (2010) investigated the development of hospices in a number of Asian countries, such as Japan, South Korea, and Taiwan, and found that people's experiences of the hospice services influenced their adoption of hospice care. Significantly, they also found that greater financial support for hospice and palliative care from the government and insurance programs increased the availability and use of these services. However, there is little data on comparisons between the influence of financial support and government insurance programmes among various Asian countries.

Building palliative care within national health systems

Lynch et al (2010) identified barriers to the development of palliative care in Western Europe, including a lack of palliative care education and training programs; a lack of awareness and recognition of palliative care; a limited knowledge of analgesics; limited funding; a lack of coordination amongst services; and uneven palliative care coverage. Philip et al (2010) argue that the demand for palliative care services has increased because of the rapidly aging population in Australia.

Regarding education in end-of-life care, Gibbins et al (2009) suggest that in the UK, teaching about palliative care, death, and dying should begin at the undergraduate level. In Norway, Landmark et al (2004) found that the students attending a postgraduate education program in palliative care, reported a statistically significant increase in competence throughout the course. Shandgren et al (2006) used grounded theory to interview 16 nurses, and concluded that the nurses should be given the opportunity to increase their palliative care training and to attend continuous nursing education courses.

Regarding community palliative care in developed countries, Ingleton (2000) surveyed the opinions of local GPs and DNs about a community-based palliative care service in the UK; they found that promoting and integrating the service in the community was successful because the primary health care team was able to help the patients to remain at home. Funk et al (2009) explored the experiences of palliative family caregivers in Canada and found that the family caregivers thought that competent professional services were important.

The hospice movement in Taiwan

The concept of hospice palliative care was introduced in Taiwan in 1983 (Chen et al,2001). In Taiwan, hospice and palliative services are primarily provided for patients with end-stage cancer (Hospice Foundation of Taiwan, 2011). Cancer has been the leading cause of death in Taiwan since 1982 with more than 30,000 people dying from cancer every year (The Executive Yuan Department of Health Taiwan Republic of China 2009).

According to Chen et al (2001), it is the religious foundations in Taiwan which have promoted hospice palliative care. For example, the Catholic Sanipax Social-Medical Service and Education Foundation established a home care centre for terminal cancer patients in 1983. Additionally, Christians founded the first hospice ward at the Christian Mackay Hospital in 1990. Subsequently, a group of Buddhist doctors and nurses established the Buddhist Lotus Hospice Care Foundation. According to the vision of that organization, hospice palliative training courses should be offered for Buddhist chaplains. Buddhist chaplains did not work in hospitals until the National Taiwan University hospice palliative care ward was founded in 1995. The Foundation encourages and supports Buddhist chaplains to be involved in hospice services as much as possible (Buddhist Lotus Hospice Care Foundation 2011).

Taiwan's cultural history

According to Giger and Davidhizar (1995, p.3), Leininger founded the field of trans-cultural nursing, trans-cultural nursing theory was established in the mid-1960s, and the Trans-cultural Nursing Society was founded in 1974. Leininger (1970, p.51)

suggested that nurses should understand the particular cultural context in order to help patients, families and social groups because culture influences how people solve problems. In fact, all of the participants in my current study encountered specifically Taiwanese-cultural patients and their families. Therefore, trans-cultural issues should be discussed in this thesis, and the specific culture in Taiwan will be examined in the following paragraphs. I will discuss the transcultural issue in Chapter 9.

According to the Tourist Bureau of Taiwan, Republic of China (2014), the most important aspect of Taiwan's cultural history was played by different waves of Han Chinese who brought with them traditional customs from China and created new ones in Taiwan. Those Han Chinese who migrated to Taiwan over the centuries are southern Fujianese from Fujian province China; and those who came to Taiwan in the late 1940s are Chinese from various provinces in China because of the civil war between the Chinese Communist Political Party led by Mr. Mao Zedong and the KMT (Kuomintang) Political Party led by Mr. Chiang Kai-Shek.

According to government statistical data from the Republic of China Yearbook 2012 compiled by the Taiwanese government (2012), Taoism and Buddhism are the religions with the largest numbers of adherents; their temples accounted for most of the 15,310 places of worship registered with local governments at the end of 2011. Thus, as Buddhism is an important component in the life of many Taiwanese, clinically experienced Buddhist chaplains have an important influence on end-of-life care in Taiwan. In Tzeng and Yin's (2006) evidence-based data, Buddhist or Taoist

monks and nuns play an important role when Taiwanese people are sick or suffer bad fortune. This was particularly seen during the Severe Acute Respiratory Syndrome (SARS) outbreak in Taiwan in 2003 as during that epidemic many Taiwanese people, including government officials, visited temples to worship the gods of Taiwanese folk religion. Religious rituals exist and are important in Taiwan especially when Taiwanese people are sick or suffer bad luck. However, few studies have explored these religious complementary approaches rather than medical clinical approaches in end-of-life care in Taiwan. It is this that forms the basis of my study for this PhD thesis.

Wang (2008) believed that Chinese Buddhism in Taiwan was influenced by the Japanese colonial period (1895-1945) and the period of the Kuomintang (KMT), after 1949. According to Wang (2008), in Chinese Buddhist history, monastic Buddhism (the practice of meditation and chanting sutra) seems to have become the dominant tradition; the Chinese Buddhist movement in modern Taiwan seems to be seeking genuinely novel spiritual ends and/or means of its attainment. Masel et al (2012) suggested that palliative care could benefit from Buddhist insights in the form of compassionate care and relating death to life, as compassionate care and the issue of death and life are an important aspect of Buddhism globally. However, few studies focus on Buddhist death in palliative care in Taiwan.

According to Lu et al (2008), when the KMT state retreated to Taiwan in 1949, it applied martial law which restricted free speech, free assembly and religious freedom. With the democratization of Taiwan in the 1980s, the KMT state began to deregulate

religious affairs and the Buddhist organizations became significantly influential. For instance: Hu and Leamaster (2013) explored longitudinal trends in religious groups after deregulation in Taiwan from 1990 to 2009; their findings revealed an increase in the proportion of Buddhists who are formal converts. According to Clart and Jones (2003), the social and cultural changes were associated with modernization, urbanization, and globalization, all of which have had important effects on religious practice in Taiwan. That is, Buddhist religious practices for end-of-life patients are very common in Taiwan.

According to Kate (2003), a striking facet of religion in Taiwan is that economic growth and technological development have not resulted in a decline in religious practices. Religion continues to play an integral part in individual, family and community life, and temple cults in particular have retained their importance as sites for daily worship, community service and massive festivals. According to Clart and Jones (2004, p.196), the Buddhist population grew from 800,000 in 1983 to 4.9 million in 1995, a six-fold increase against an overall population increase of about 2 percent and while the proportion of men ordained as monks has decreased in Taiwan, nuns and lay Buddhists have taken on greater leadership responsibilities. Chen (2009) suggested that since Buddhists make up between 70-80% of the population of Taiwan, the training of Buddhist chaplains should be encouraged in order to offer good quality services in end-of-life care.

Buddhism is divided into the two great schools of Mahayana and Hinayana Buddhism (McGovern 1997, p.1). Mahayana Buddhism was introduced into China

in the first century A.D and was firmly established by the fourth century (McGovern 1997, p.24). According to McCormick (2013), Southern Buddhism follows the Theravada texts and is practised in Sri Lanka, Myanmar (Burma), Thailand, Laos, and Cambodia, while Eastern Buddhism is stronger in the Mahayana tradition, which emphasizes compassion (*karuna*). It is more prevalent in China, Taiwan, Vietnam, and Japan. According to Robert (2012), reciting the name of Amita Buddha for the dying patient before and after his/her death is the key to help the deceased to enter the Western Pure Land or Heaven. Friends and family are directed not to touch, move, or disturb the body in any way for a period of 12-24 hours, and not to cry, talk, or smoke in the presence of it, as this could distract the deceased from his journey and mire him in suffering (Robert , 2012).

According to Watts (2012), the Buddhist understanding of death and the subsequent practices developed for dying and the moment of death have been its hallmarks since it originated in India 2,500 years ago; that is, caring for end-of-life patients and their families could date back to the time of the Buddha. Barham (2003) explored Buddhist approaches for dying persons in Australia and found that Buddhists believed that they will be re-born, depending on "Karmic forces", and that death means a new cycle of reincarnation. Although Barham (2003) does not describe whether his participants were Mahayana or Hinayana Buddhists, the Buddha's teaching is the same in both cases. That is, the philosophy of Karmic forces, rebirth and deeds are the same in Buddhism worldwide. According to Kempton (2012), "Karma", translated from its Sanskrit root, simply means " action" - anything we say, do, or even think. Tu (2012) considers that the Buddha spoke of "death-proximate

Karma", which can lead us to a better or worse reality after we die. Liao (2010) explored the attitude towards death of five Buddhist chaplains in Taiwan and found that they regarded death as a natural process of life: life is a ceaseless cycle of rebirths; and therefore death could be regarded as an opportunity to cease the rebirth.

The hospice movement originated in the Christian culture. However, Buddhist beliefs differ significantly from Christian ones, and when hospice palliative services spread to Taiwan, cultural conflicts arose in the medical services, especially due to the influence of the Buddhists' attitudes towards sickness and death influencing their decision-making in medical therapy or medical service. The most notable difference is in what Gytso (1992) describes as the cycle of uncontrolled death and rebirth pervaded by suffering which is called "Samsara". Buddhists believe in the concept of "Karma" and the idea that an individual's life is determined by his/her previous life (Topmiller 2000).

<u>The culture and religion in Taiwan differ from those in Western society</u>

According to Tu (1996), Taiwan is not immune to religious fundamentalism. For instance, God, Buddha and the "Goddess of Mercy" (Guan-Yin Bodhisattva) are sufficiently efficacious to take care of the total well-being of humans, while local spirits ensure good fortune with regard to birth, health, marriage, exams, business, elections, travel and burials. As Leininger (1970, p.ix) comments, we must learn not only about cultural similarities and differences, but also how cultural factors influence the health and illness of people in a society.

Glass et al (2010) conducted cross-cultural comparison in Japan, South Korea, and Taiwan, and found that beliefs related to death and the place of dying in traditional cultures influence whether or not Taiwanese patients choose hospice palliative care, because dying at home has a significant meaning for Chinese people in Taiwan, metaphorically 'enabling the fallen leaf to return to its root'. Payne et al (2005) explored Chinese cultural perspectives on end-of-life care in the literature and found that Chinese people give priority to family-centred decision-making.

Cheng and Chan (2006) agreed that the family has been central to the social organization of Chinese societies for thousands of years. Krishna (2011) considers that the concept of filial piety and the position of the family were important factors in decision-making in the Chinese community. Shi (2008) notes how Confucius described filial piety as the foundation of all virtues, the source of teaching, the guidance of Heaven, and the principle of the earth. Patricia et al (2004) agreed that the influence of culture on ethical decision-making is well documented. Chater and Tsai (2009) explored palliative care in a multicultural society in Australia, and found that the families were always involved in important personal decisions about things such as job choice, marriage and medical care in Chinese traditional culture. Although Chater and Tsai's (2009) studies were carried out in Australia, Chinese traditional culture also existed in Taiwan.

Crawley (2005) asserts that culture shapes the framework for understanding health, illness, death, dying, grief, and bereavement. Cuevas and Stone (2007, p.1) note that Buddhism has been concerned with death and dying since its origin in India. As

mentioned earlier, Buddhism has influenced both Chinese and Taiwanese cultures deeply, due to their historical links. In Taiwan, people use religious methods as complementary approaches when they are ill or suffer bad luck, specifically in the end-of-life stage.

Todd and Baldwin (2006) suggest that the culture of an individual has a profound effect on how he/she deals with health and illness. For instance: Huang (2012, p.226) provided several evidence-based examples in Taiwan that the Buddhist chaplains refused western medical treatment because they wanted to have a peaceful death and avoid aggressive medical interventions as far as possible. Although Huang (2012) only interviewed four Buddhist chaplains in Taiwan, they had rich experiences both in Buddhist temples and hospice care units, so the participants could reflect the reality of the Buddhist chaplains' attitude. As a senior nurse by occupation I fully understand why many Buddhists refuse western medical treatments, as found in Huang's research. According to my past clinical experience in hospitals, certain Buddhist patients or chaplains shun western medical treatment when they know that their disease has reached the end stage because they believe that it cannot control death and rebirth.

Chen et al (2001) indicated that Chinese philosophies and religions strongly influence the Chinese mode of living and thinking on health and health care; nurses must combine cultural information with clinical assessments of their patients in order to provide culturally-sensitive care. Hsiao et al (2004) studied the subjective experiences of Chinese inpatients in Taiwan and found that traditional Chinese

cultural values - those emphasizing the importance of maintaining harmonious interpersonal relationships - influenced this group's expression of negative emotions and motivation regarding interpersonal learning.

Taiwan's health care system

The healthcare system differs from those of Western-type societies. According to Taiwanese government statistics:

> "The foundation for early medical development in Taiwan was laid mostly during the period when Japanese colonized Taiwan from 1895-1945. Unfortunately, Taiwan's medical facilities were seriously influenced during the Second World War, in around 1945. The National Health Insurance (NHI) program in Taiwan launched in 1995." (National Health Insurance 2016, p.1)

According to the National Health Insurance (NHI) Bureau in the Department of Health, Taiwan covers 36,192km^2, the total population is 23,162,000, those aged under 15 years old equal 15.65% of the population, those aged over 65 years old equal 10.74%, the crude birth rate is 7.2‰, the average male life expectancy is 76.2 years, the average female life expectancy is 82.7 years, and the NHI coverage rate is 99.6%. See Table 1.1: Key Public Health Data for Taiwan (2014).

Table 1.1: Key Public Health Data for Taiwan (2014)

Land Area	36,192km^2
Total Population	23,162,000
Under 15	15.65%
Over 65	10.74%
Crude birth rate	7.2‰
Average life expectancy	For males it is 76.2 For females it is 82.7
NHI coverage rate	99.6%

(Source: Bureau of National Health Insurance, Department of Health, Executive Yuan; Taiwan Public Health Report 2014)

Liu and Yang (2007) explored the utilization of national health insurance to cover palliative care in Taiwan, and found that the total expenditure on palliative care for cancer patients increased from NT$214 million in 2001 to NT$283 million in 2004. Its use appeared lower for palliative care for cancer patients in Taiwan compared with other countries and was concentrated in medical centres. According to Shih et al (2008), in Taiwan, the decision to use complementary approaches that are covered by insurance or not differs according to socio-demographics, behavioural factors and health requirements.

1.1 Study rationale

As a senior nurse in Taiwan, I have accumulated numerous stories regarding my patients, such as the following:

> "Mr. Lin (male, a pseudonym) was suffering from renal cancer with multiple-organ metastasis and died at a relatively young age in a hospice palliative care unit. At that time, he was a senior physician with a professional physician's licence in Taiwan; he tried many kinds of complementary approaches to treat his disease. He fully understood that these were clinical trials rather than scientific, evidence-based therapies. Additionally, he drank 'Dai-Bai (Great Compassion) Water' daily because his parents visited a Buddhist temple and obtained 'Holy' water from Buddhist chaplains at a Buddhist temple rather than in the hospice palliative care unit. Mr. Lin's parents hoped that Mr. Lin would be free from sin and suffering. Mr. Lin's parents, relatives and Buddhist friends wished that Mr. Lin might avoid 'bad Karma', and were eager for a miracle to happen for him. His parents prayed to Guan-Yin Bodhisattva and recited the 'Great Compassion Mantra' in order to make the Holy water 'Di-Bai (Great Compassion) Water' more effective. Mr. Lin told me that he tried these approaches because he wanted to be a good son and maintain his parents' hope. One day, he discussed with the hospice palliative Buddhist chaplain his 'Dai-Bai (Great Compassion) Water' therapy and the issue of his death. He said that he had had a mysterious experience and predicted his leaving day. He thought he should say thank you to his parents. After this conversation with the Buddhist chaplain, he felt peaceful at the end of his life and died on the Mid-Autumn Festival several years ago. After Mr. Lin passed away, his parents told us that they had learnt that their son, Mr. Lin, is studying Buddhism in Amita-Buddha's world, and living in Buddha's world very well now, and so please do not worry about him."

This story is an example of the use of and belief in complementary approaches to end-of-life care in Taiwan. Religious resources for medical purposes are an important part of Taiwanese folk therapies. Many Taiwanese ask Buddhist or Taoist monks and nuns to offer folk therapies which they regard as important forms of complementary approaches to end-of-life care. Therefore, Buddhist or Taoist monks

and nuns play an important role when Taiwanese people are sick or suffer bad fortune. Dworkin (2001) argued that complementary therapies stand between medical science and organized religion; therefore, they stand between what is known and what is unknown. Gau et al (2012) investigated the use of complementary therapies for patients with traumatic brain injuries in Taiwan, and found that the most frequently used complementary approach was traditional Chinese Medicine (37, 58.8%), followed by folk and religious therapies (30, 46.9%) and dietary supplements (30, 46.9%), although they did not explore the reasons for the use of complementary therapies. Chen et al (2009) thought that "Holy" water, or what is often known as "Dai-Bai (Great Compassion) Water" was one of the twelve most popular religious folk remedies in Taiwan.

According to Epstein (2003), the Great Compassion Mantra is one of the most widely used and most efficacious of all Buddhist mantras. Chen et al (2009) explained that the purpose of this "Holy" water, "Dai-Bai (Great Compassion) Water", is to let the sick bathe in or drink water that has been blessed in Taiwan. According to Li (2004), Guan-Yin Bodhisattva Belief is a prevalent folk religion in Taiwan; after World War II, Buddhism publications frequently published stories about Guan-Yin Bodhisattva inspirations, which were even edited into volumes of Guan-Yin Bodhisattva Inspiration Collections for circulation by Buddhist organizations. More information about these publications will be presented in Appendix 12: The Guan-Yin Bodhisattva Inspiration Collections in Taiwan. The detailed outline of this book about Guan-Yin Bodhisattva Inspiration Collections is also presented in Appendix 12.

According to Whilford and Olver (2011), the definition of a complementary approach is broad. Traditionally the understanding of complementary medicine, as captured by Fennell et al (2009) includes a wide range of activities, products and approaches including acupuncture, herbs, massage, yoga, vitamins, psychology, psychiatry, exercise, folk remedies, meditation, chiro-practice, prayer, aromatherapy, and sleep/rest. That is, "folk remedies" and "prayer" are forms of Complementary Medicine from the perspective of lay people based on Fennell et al's (2009) research.

According to the National Center for Complementary and Alternative Medicine (NCCAM) (2013) in the USA:

> "Complementary" generally refers to using a non-mainstream approach "together with" conventional medicine; "alternative" refers to using a non-mainstream approach "in place of" conventional medicine; true alternative medicine is not common, most people use non-mainstream approaches along with conventional treatments." (National Center for Complementary and Alternative Medicine 2013, p.1)

Although the definition of the NCCAM does not explore complementary and alternative medicine specifically in Taiwan, the case of Mr. Lin illustrates how many non-mainstream anti-cancer approaches can be used together with the mainstream ones. That is, Mr. Lin used complementary therapies rather than alternative therapies during his illness. Some of his complementary therapies are religious resources, for instance, "Holy (Great Compassion) Water" and religious blessings by Buddhist monks or nuns.

According to Yang et al (2008), the types of complementary therapies used by patients with cancer in Taiwan differ from those used in Western countries. For example in the case of Mr. Lin noted above, he drank "Dai-Bai (Great Compassion) Water" daily during his illness because his parents wanted to cure his disease and free him from "bad Karma".

Brown (2013) suggested that complementary medicine providers make religious or spiritual assumptions; these assumptions include Hinduism, Buddhism, and Taoism (Daoism) in Asian countries, or the metaphysical spiritual traditions developed in Europe and North American countries. Taylor (2005) suggested that prayer, distance healing, faith or spiritual healing, meditation, yoga, *tai chi*, and *qi gong* are classified as mind/body complementary therapies (CTs); these CTs reflect a religious tradition or involve spiritual beliefs or practices. According to Ulrich et al (2011), some forms of CAM (Complementary and Alternative Medicine) may function as a form of spiritual practice. Ellison et al (2012) explored spiritual and religious identities to predict the use of CAM in the USA and found that prayer, meditation, and spiritual healing are considered CAM and are well-received within most Christian circles.

Hsiao et al (2010) explored the spiritual needs of Taiwanese patients with advanced cancer. They interviewed thirty-three participants, twenty-nine of whom had different religious affiliations, who reported having alleviated physical pain and achieved a peaceful mind through meditation, prayer, reading the scriptures and reciting the name of God/gods; these gods are associated with the Buddhist, Taoist

and folk religions. According to Tippens et al (2009), complementary approaches employ prayer, occurring particularly in specific racial and ethnic groups.

Liang et al (2002) surveyed patients using folk medicine in Taiwan; the data revealed that 90% of the participants had used folk religion. Huang and Liao (1998) argued that children are exposed to various folk medicines in Taiwan because of their parents' misguided beliefs. Wood and Finlay (2011) found that parents are more likely to seek out complementary therapies as the severity of their child's illness increases. Chen (2000) explored temple-based folk medicine in Taiwan; the data revealed that it was predominantly middle-aged or elderly people who believed in the medical advice provided by the folk religious temples.

In the USA, Kübler-Ross (1969) found that most dying patients made a bargain with God. Furthermore, the chaplain was often the first person to hear of the patient's concerns. In my clinical experience in Taiwan, some patients found complementary approaches from their religious organizations. They believed that their religious gods or goddesses would give them hope for a better future and they denied the bad news provided by their physicians. A number of Buddhist patients or chaplains forego western medical therapies when they know that their disease is in the end stage because they think that western medical therapies cannot delay death and rebirth. For instance, according to Smith-Stoner (2003), Buddhists believe that the mind must be as alert as possible at the time of death. Many Buddhists refuse pain medication or limit its use; that is, a Buddhist patient may wish to abstain from or limit the use of drugs that can cause drowsiness, such as pain-relieving drugs. Keown (2005) also

found that some Buddhists may be unwilling to take pain-relieving drugs or strong sedatives and even those who are not in a terminal condition may prefer to remain as alert as possible, rather than take analgesics that would impair their mental or sensory capacity. However, few studies discuss their experiences and their meaning.

Lo (2010) believed that various cultural perspectives on the priorities regarding issues of life and death lead to different preferences and styles for end-of-life decision-making. Peng et al (2012) explored cultural practices and end-of-life decision-making in infant deaths in Taiwan, and found that various cultural issues affected both the grieving process of the families and the dying process of their infants. Although Peng et al's (2012) study only focused on neonatal intensive care units using retrospective chart review in Taiwan, cultural issues are important factors regarding end-of-life decision-making. Evans et al (2012) notes that cultural competency is increasingly recommended in policy and practice to improve end-of-life care. According to Weissman et al (2004), health providers need to be culturally competent, for example by being aware of and accepting the cultural differences between themselves and individual patients.

In this current study, exploring the clinical professional staffs' experiences and viewpoints is useful for developing the most appropriate hospice model in Taiwan. Specifically, to explore humans' experiences and perceptions it is crucial to avoid repeating mistakes and to develop interventions in a specific cultural society.

Previously, Buddhist chaplains presented their wisdom at Buddhist temples, academic universities, and in public speeches, rather than within hospitals. Buddhist chaplains' life experiences and interpretative meanings influence the thinking process and decisions of other Buddhists. As mentioned in an earlier section, on the hospice movement in Taiwan, Buddhist chaplains did not work in hospitals until the National Taiwan University hospice palliative care ward was opened in 1995. The Foundation encourages and supports Buddhist chaplains to be involved in hospice services as much as possible (Buddhist Lotus Hospice Care Foundation 2011).

Regarding Buddhism in Taiwan, hospice palliative medical team members deeply respect Buddhist chaplains' viewpoints, particularly regarding psychological or spiritual interventions. Bhikkkhuni et al (2001) stated that hospice palliative care Buddhist chaplains not only assist the patients and their relatives but also support the team members.

By searching databases, I found that relevant research regarding hospice care Buddhist chaplains is limited. Some research focuses on the role of hospice palliative Buddhist chaplains, which includes applying Buddhist sutras in clinical hospice palliative settings. For example, Bhikkkhuni et al (2004) applied the Buddhist Impermanence Sutra, Bhikkkhuni et al (2005) applied the Buddhist Lotus Sutra, and Bhikkkhuni et al (2002) applied the Buddhist Heart Sutra in palliative care. In conclusion, these Buddhist chaplains lead the people in hospices to read different Buddhist sutras.

Therefore, the motivation for this study is based on clinical stories and the apparent gap in the literature on the effect of specific cultural and religious issues on end-of-life care in Taiwan. The purpose of this study is to explore the perspective and work of hospice palliative buddhist chaplains in Taiwan. Chapter 2 will discuss theoretical perspectives of various issues in end-of-life care from literature reviews. The purpose of the literature review in Chapter 2 is to support this current research's background and research questions.

1.2 The structure of this thesis

This thesis is divided into ten chapters which aim to contribute a new understanding of the specific cultural and religious phenomena and Taiwanese Buddhist chaplains' approaches used in end-of-life care in Taiwan.

This current chapter, Chapter 1 focuses on the study's rationale; that is, the reasons why I conducted this current study with specific reference to Taiwan. The background to this study includes trans-cultural issues, and specific religious methods are regarded as complementary approaches in Taiwan when Taiwanese people are sick or experience bad luck.

Chapter 2 focuses on the literature review. I present a single review question in my thesis to explore the role of spiritual/religious caregivers in hospice palliative care settings. In particular I wished to ask the question:" What is the role of religious caregivers in psychosocial care in hospice settings with specific reference to

Buddhist chaplains in Taiwan?" I identified two dominant themes in my literature review related to the perspectives of psychosocial care in hospice settings and the role of religious caregiving in particular chaplains and more specifically Buddhist chaplains at the end of life in Taiwan. Finally, research questions are outlined at the end of this chapter.

Chapter 3 focuses on the research methodology, including methods of data collection and data analysis. Charmaz's (2006) constructivist grounded theory was adopted in this thesis. A step-by-step analysis is described in this chapter.

Chapter 4 is mainly focused on the participants' demographic characteristics and personal information. These data are related to the participants' approaches to end-of-life care for patients and their families. Therefore, in this chapter the participants' data is introduced, which include the participants' demographic characteristics, such as gender, age, educational level, religious faith, and the context of their training courses. The participants' personal information includes their major school of Buddhism, Buddhist faith, their attitudes toward different religious faiths, participants' thoughts about their role in end-of-life care, and the relationship between Buddhist chaplains and nurses.

Chapters 5 to 7 offer a full account of themes in this study. Three main themes emerged from applying Charmaz's (2006) constructivist grounded theory analysis of the interview data. The main themes include compassionate care, the dying process, and Mahayana Buddhism in end-of-life care. The main themes together with the

participants' interpretive examples are also presented. These findings are from the second stage of the data analysis, based on Charmaz's (2006) "focus coding". The relationship maps between the themes are also presented in these chapters. Following these findings, the third stage of the data analysis is "theoretical coding". In this current study, I conducted "theoretical coding" and so the final theoretical framework which was developed is presented in the next chapter (Chapter 8). The detailed discussions are presented in the following two chapters - Chapter 9: Discussion and Chapter 10: Conclusions and Recommendations.

Chapter 8 focuses on the final version of the theoretical framework. I analyzed all participants' data, and the final version of the theoretical framework was developed. In this chapter, the theoretical framework is presented diagrammatically (see Figure 8.1), to show "the dynamic process of compassionate care".

Chapter 9 focuses on the discussion of the findings. There are several reflections on the relevant issues to this current study. The purpose of these reflections is to help me to compare the relationships between the findings and the literature. The following discussions are included: the Buddhist chaplains' role, patients' safety in end-of-life care in Taiwan, Buddhist chaplains' training courses, my role in this study, and my belief and research process.

Finally Chapter 10 presents the conclusions and recommendations of this study. The conclusions include the key findings of the study, its contribution to knowledge, its methodological limitations, and the recommendations for policy and practice.

Finally, recommendations for future research, and recommendations for education are presented.

Summary

This chapter has demonstrated the rationale for this thesis, and the reasons why the research questions are so important. The outline chapter of the thesis is presented in Section 1.2 of this chapter. In summary, Chapter 1 is the background to this thesis, Chapter 2 is the relevant literature review to support the research questions of this thesis, and Chapter 3 outlines the thesis methodology. Chapters 4 to 7 describe the major findings of this study. Chapter 8 focuses on the final version of the theoretical framework. Chapter 9 presents a discussion of the study findings and Chapter 10 presents the conclusions and recommendations.

Chapter 2 Literature Review

Introduction

In Chapter 1, I presented the study's rationale and purpose which are to explore the perspectives and work (role) of hospice palliative Buddhist chaplains in Taiwan. This chapter reviews the relevant empirical literature on the role of religious caregivers in psychosocial care in hospice settings with specific reference to Buddhist chaplains in Taiwan. I present the literature review question, the search strategy including the search terms, inclusion, and exclusion criteria, the PRISMA(Preferred Reporting Items for Systematic Reviews and Meta-Analysis) review process and flow diagram (Moher et al 2009), synthesis of the study, and overview of the literature. The final section summarises the challenges which this review raises, highlighting current knowledge gaps, research questions, and the value of conducting my study.

Literature review question

Buddhist chaplains in Taiwan offer psychosocial care in hospice settings as illustrated by the story of Mr Lin recorded in Chapter 1. This story shows the importance to a patient of a good death and of supportive emotional care enabled by the Buddhist chaplains. Within South East Asia there is a paucity of literature to support this assumption which is why I wanted to explore this issue further in order to find the gaps in the literature to develop further study. In particular I wished to

ask the question: “What is the role of religious caregivers in psychosocial care in hospice settings with specific reference to Buddhist chaplains in Taiwan?” By interrogating the literature I sought to highlight the gaps and generate my research questions.

Search Strategy

I searched the following databases using ProQuest Library, which combines nine databases, including Linguistics and Language Behavior Abstracts (LLBA),MEDLINE®, New York Times, ProQuest AP Science, ProQuest Dissertations & Theses A&I, ProQuest Medical Library, ProQuest Nursing & Allied Health Source, ProQuest Research Library, and The Washington Post. The ProQuest Library is a very useful database because it also includes MEDLINE, CINAL, and PUBMED and enabled me to access PhD and Masters’ theses from the USA and Canada.

As my study was related to the Social Sciences within the context of South East Asia, an additional database, CEPS (Chinese Electronic Periodicals Service) was also checked. The CEPS database is the most appropriate Chinese database which focuses on the Social Sciences in Health and includes published papers from both Taiwan and China. The search terms I used were the Chinese characters “安寧療護” and “宗教師”. “安寧療護” which refers to hospice, and “宗教師” to “chaplain”.

Search terms

I used the Boolean operators AND/OR to search for relevant papers. I searched the following search terms: “psychosocial care”, “hospice care”, “palliative care”, “end-of-life care”, “chaplaincy service” and “Buddhism”. The results of the literature search and review are presented in the following sections.

Inclusion criteria

Inclusion criteria were records published in English and Chinese languages and between the years 1990-2016. I set the time frame from 1990 because that was the year when the first hospice ward in Taiwan was set up at the Christian Mackay Hospital. The inclusion criteria enabled me to capture the most recent literature and academic discussions related to psychosocial care in hospice and end-of-life care to ensure a good death, caregivers, different religious approaches, and chaplains’ roles. As Buddhism is the recognized national religion in Taiwan and as Buddhist chaplains started working in a hospice palliative care ward at the National Taiwan University hospital in 1995, I specifically focused my search on Buddhism, Buddhist chaplains and their role in psychosocial care to support a good death at the end of life in hospice settings in Taiwan. The type of study design included qualitative and quantitative research methodologies, data collection methods and analysis.

Exclusion criteria

Exclusion criteria were: literature not in English or Chinese language; non-academic papers; abstracts of conference papers and posters. I also excluded papers

which lacked empirically-based data and Editors' letters without information on research design.

Review strategy : PRISMA Flow Diagram

I present the results of the literature search in the PRISMA flow diagram (Figure 2.1) below. I record the original number of records I found in the ProQuest Library databases and explain why I then excluded a number of records at a later stage. The PRISMA Flow Diagram also shows the CEPS database that I accessed, the records I found and rejected at each stage and the reasons why. I used the Boolean operators AND/OR to combine the search terms during the entire review process.

I used the key words: "psychosocial care", "hospice care", "palliative care", "end-of-life care", "chaplaincy service", and "Buddhism" to search relevant records in the ProQuest Library. I found 411 records which included the total database of journals and theses and non-scholarly papers from 1990-2016. I reduced this number to 371 papers by limiting my search to scholarly records.

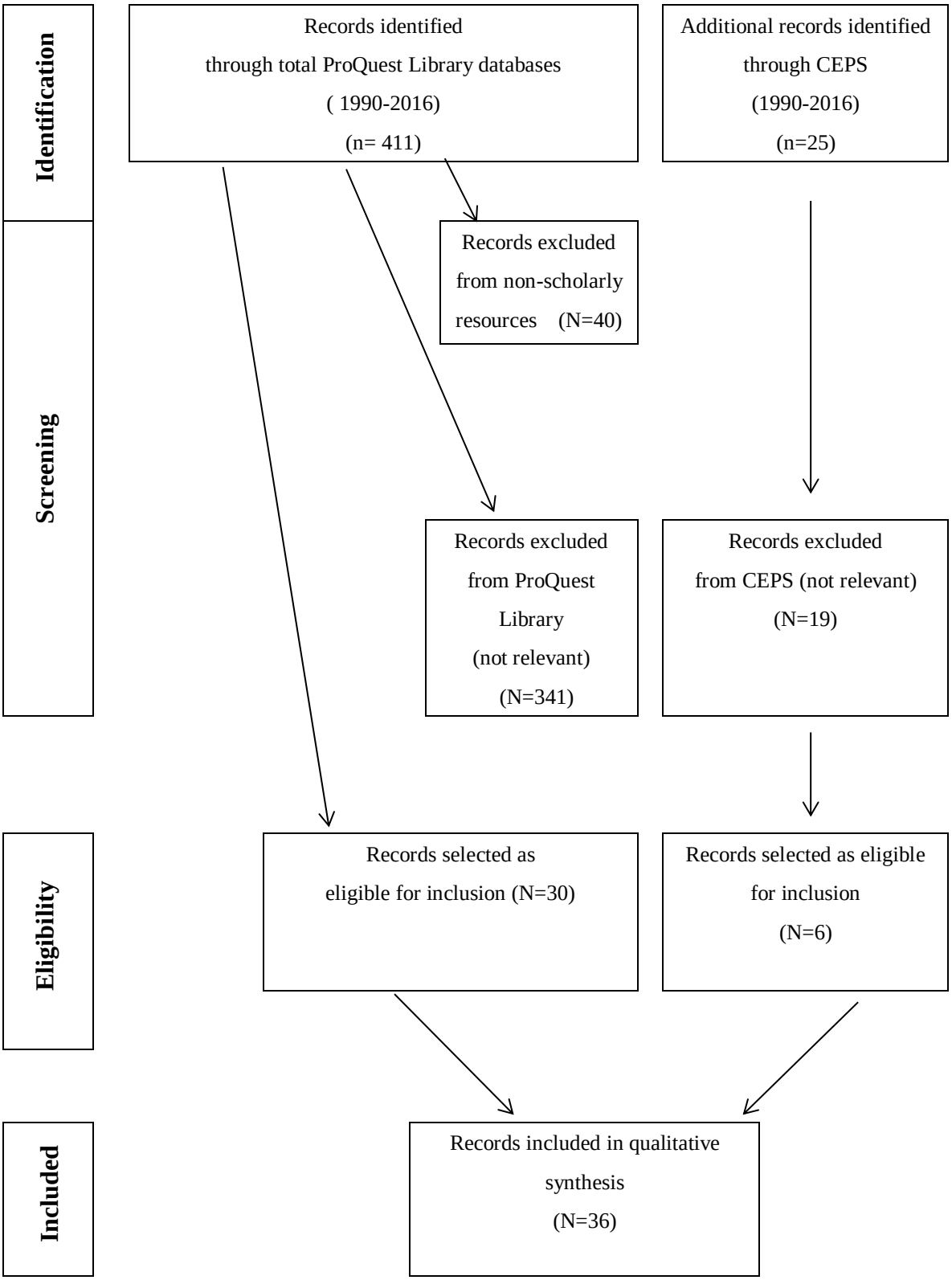
I only used the Boolean operator "AND" at this stage with all the search terms "psychosocial care", "hospice care", "palliative care", "end-of-life care", "chaplaincy service" and "Buddhism" because I wanted to access the most relevant papers and theses.

I read the abstracts of all papers and the full text of the 411 papers from the ProQuest Library and the 25 Chinese language papers from CEPS very carefully

from the perspectives of methodology, findings, strengths, and weaknesses in each study in order to assess and synthesize the studies in relation to my literature review question and to inform my research questions.

From the CEPS database, of the 25 papers that I read only six were related to my thesis. If the subjects were not about chaplains or if the issues being discussed were not related to the chaplaincy service and Buddhism then I excluded them as not relevant.

Figure 2.1 PRISMA diagram for this review



Note: CEPS=Chinese Electronic Periodicals Service. This is a database focused on Social Science in Health, which includes papers published in Taiwan and China.

As Figure 2.1 illustrates, the first stage of the PRISMA process is the identification stage. I obtained records through the ProQuest Library databases (1990-2016). The number of records identified was 411 papers. In addition I obtained 25 records from the CEPS database. The total number of papers therefore in this first stage was 436 records.

The second and third stages of PRISMA involve screening for academic rigour and eligibility. In the second stage I reviewed 411 English language papers from the ProQuest Library together with 25 Chinese language papers from the CEPS database i.e. a total of 436 papers. I excluded 40 non-scholarly papers from the ProQuest Library. I was therefore left with 371 papers and theses from that Library.

During the third stage I read very carefully the abstract or full text of the 371 ProQuest records and 25 CEPS records, a total of 396 records. I used my reading to further focus on the key components of my literature review question: "What is the role of religious caregivers in psychosocial care in hospice settings with specific reference to Buddhist chaplains in Taiwan?". I rejected 341 records from the ProQuest library database and 19 records from the CEPS database. I was therefore

left with 30 records from the ProQuest library and six records from CEPS giving a total of 36 records for in-depth review.

Presentation of synthesis

The fourth and final stage of the PRISMA process involves "Synthesizing" the included records. I conducted an in-depth review to set out the key characteristics of the themes in the literature related to the key components of my review question on the role of religious care givers in psychosocial care in hospice settings to ensure end of life support with particular reference to Buddhist chaplains in Taiwan. I selected 36 papers and theses to address my literature review question which I present below.

Overview of the literature

I identified two dominant themes from the results of my literature review which are related to the perspectives of psychosocial care in hospice settings and the role of religious caregiving in particular chaplains and more specifically Buddhist chaplains at the end of life in Taiwan. The presentation of my review focuses therefore on "psychosocial aspects of end-of-life care" and "the role of religious caregivers in hospices" with specific reference to Buddhist chaplains in Taiwan. A summary of the literature pertaining to each of these themes in terms of study aims, methodology, study population, country of study and key results are presented in Sections 2.1 and 2.2, Tables 2.1 and 2.2 below.

I undertook further appraisal of the studies from the perspectives of the following questions, which included: Are the studies clearly focused? Are the methodology and methods appropriate and valid? Are the results important and how are they applicable to my study? What are the strengths and limitations of the research? Are the findings valid and reliable? Does the research provide new evidence and broaden our understanding of the field?

I now present further appraisal of the studies in each section.

2.1 Psychosocial care perspectives in hospice and other healthcare settings (with a focus on a good death, palliative, end-of-life and emotional aspects of care)

In this theme I explore the psychosocial aspects of palliative and end of life care in hospice and other health care settings. Literature cited in Chapter 1 (Puchalski 2007, Mechelen et al 2012, World Health Organisation 2016) and other authors (Onyeka 2010, Legg 2011) describe palliative and end of life care as concerned with the psychological and emotional well-being of patients, their families and carers. Ensuring a "good death" is also considered an integral part of psychosocial care in hospice palliative care. Brown et al (2006) described how a "good death" in end-of-life care includes minimal suffering, no artificial prolongation of life, involvement of family, resolution of conflict and attention to spiritual issues. For Rokach (2005) the palliative care view of dying is that it is a 'normal' process that must be neither hastened nor postponed.

<u>Ensuring a good death in end-of-life care</u>

I explored the ways in which a good death is interpreted in non-western cultures. Miyashita et al (2008) conducted a questionnaire survey to explore the factors related to a "good death" in Japan. A total of 344 questionnaires were sent to bereaved family members of cancer patients and 165 responses were obtained and analyzed (48% response rate). These participants thought that a good death included "environmental comfort", " physical and psychological comfort ", " being respected as an individual " and dying a "natural death". The study showed that aggressive treatments were considered barriers to the attainment of a good death; however, the survey's limitations were that it only explored the views of bereaved families rather than patients. We can see the important viewpoints of a good death in hospices from the perspectives of the family in Miyashita et al's (2008) study.

Leung et al (2010) used the "Good Death Scale" (GDS) to explore good deaths and quality of life in a palliative care unit in Taiwan. The study assessed quality of death at admission and retrospectively 2 days before death. Using this research tool demonstrated that to achieve a "good death" there needed to be awareness, acceptance, propriety, timeliness and comfort, and quality of life from the dimensions of physical, psychological, social support, and spirituality. The contributions of Leung et al's (2010) study is that it suggests that patients with terminal cancer can have a good quality of life and that they can experience a good death even with short survival. A good death is related to a good quality of life in end-stage patients rather than length of survival; however, the limitations of this study was that it was conducted only in one setting in one geographical area in

Taiwan, the total sample was 281 patients, and it is not clear from the methodology whether or not the sample was randomized.

Cheng et al (2008) used the "Good Death Score" to investigate the good death status of elderly patients with terminal cancer in Taiwan. The assessment form used to measure a good death consisted of three parts including demographic characteristics, the use of the GDS, and audit scale for good death services. Reliability and validity of these two scales were established in Taiwanese palliative care units. The participants in Cheng et al's (2008) study were 366 patients, aged 65 or older. Randomized sampling was not used, the participants being selected during one period of hospice care in a Medical Center Hospital in Taiwan. The researchers concluded from their participants' responses that while death is inevitable for all humans, the concept of a good death varies across cultures, geography, religions, and generations.

Tang et al (2004) conducted a retrospective cohort study to explore how healthcare use at EOL (end-of-life) varies by age among adult Taiwanese cancer patients, and used administrative data among 203,743 Taiwanese patients who died from cancer during 2001–2006, who were categorized by age as : 18–64, 65–74, 75–84, and $\geq$ 85 years. Tang et al (2004) used multivariate logistic regression and the generalized estimating equation (GEE) method to examine the impact of age on each quality indicator of EOL. They found that elderly Taiwanese cancer patients at EOL received less chemotherapy, less aggressive management of health crises associated with the dying process, and fewer life-extending treatments, but they were more

likely to receive hospice care in their last year and to achieve the culturally highly valued goal of dying at home; they also noted that death and dying are inevitable events in a human's life. The contributions of Tang et al's (2004) study was that they used appropriate statistical analysis, such as multivariate logistic regression and the GEE method, to find out how age impacted on the different quality indicators of EOL.

Chao (1997) conducted hermeneutic qualitative research to interview 20 Chinese cancer patients regarding the issue of a good death and also used hermeneutic analysis data to develop a conceptual framework of the dying process in Taiwan. The results in Chao's (1997) study revealed that three themes: physical peace, psychological peace, and spiritual peace, were highly related to a good death. Chao's (1997) conceptual framework of the dying process was different from that proposed by Kübler-Ross (1969). This is not surprising since the participants were Taiwanese Chinese in Chao's study. Thus, the participants presented the wisdom of a specific culture about the definition of a good death. However, the number of participants in Chao's study was only 20, which is a limitation. Although studies about a good death in Taiwan exist, the results of these studies were not consistent and the methodologies that only focused on qualitative research was a further limitation. That is, there are still gaps in the literature to define the specifics of a "good death" in Taiwan. These gaps in the literature encouraged me to explore them further in my PhD study and to ask my participants questions regarding their definition of hospice care.

Nakashima (2003) conducted 100 narrative literatures in different countries to investigate various holistic perspectives of dying. She concluded that the view of death and dying in Buddhist philosophy can offer insights into a deeper level of healing of heart and mind, for instance it offers the possibility of becoming comfortable with death and dying. The contributions of Nakashima's doctoral thesis in the USA is its presentation of the complexity of the different religious philosophies and views of death and dying.

Clear definitions of Buddhist hospice palliative care are not consistenly available in current literature which leads to the importance of the first research question in my study which is "How do Buddhist chaplains define 'hospice palliative care'?"

Emotional aspects of end-of-life care

I now present my literature findings on the emotional aspects of end-of-life care. Baile et al (2011) in the USA explored psychosocial issues in, and emotional responses to palliative care from both patients' and their physicians' perspectives. The researchers used a questionnaire which was a self-administered checklist. One hundred and thirty seven patients identified their concerns and these were compared with their physicians' identification of patients' concerns. The study used purposive sampling. Patients completed the Concerns Checklist, Hospital Anxiety and Depression Scale, and Cancer Behavior Inventory at the beginning of their hospital visit. The researchers analysed the correlation between the total number of patients' concerns and their levels of anxiety, mood disturbance, and self-efficacy. They found that patients with more concerns also had higher levels of anxiety and

depression symptoms. The strength of Baile et al's (2011) study is that it explored the importance of psychosocial issues from both patients' and physicians' perspectives but the limitation of this study is that it was restricted to the population attending the outpatient symptom control and palliative care (SPC) clinics rather than hospices. The other limitation is that it is a type of purposive quantitative research rather than randomized quantitative research. I can see the contributions of Baile et al's study to help me to explore further the findings from my participants about the emotional aspects of end-of-life care which affected patients and physicians differently.

Sacks and Nelson (2007) used a grounded theory approach with the interview questions and comparative analysis to explore the views of 18 patients with chronic illness in the USA. In Sacks and Nelson's (2007) study, the grounded theory interviews began with a semi-structured schedule of questions to ensure that the research questions were being addressed. During interviews, participants' experiences were used to guide the interview process by allowing the participants' answers to guide the next question. They found that suffering is a complex, dynamic experience that includes physical, social, spiritual and emotional domains; they suggested that establishing and supporting trust and developing relationships are important when caring for someone who is suffering. The strength of this study is that they used a well-designed grounded theory study to construct a clear theoretical framework, namely the "Dynamic Nature of Trust in the Individual's Nonphysical Suffering Experience", but they did not say whether it could be applied to all end-of-life care. The limitations of Sacks and Nelson's (2007) study are that it was

undertaken in the USA and with patients who were suffering from chronic illness rather than at the end of life. However they showed how suffering is a complex, dynamic experience that includes physical, social, spiritual and emotional domains, which helped me to develop a theoretical framework applicable to Taiwan.

Sekelja et al (2010) used a randomized controlled trial (RCT) to interview thirty bereaved carers of patients with metastatic cancer in Australia. They wanted to explore bereaved carers' experiences and they found that cancer patients' caregivers were a vulnerable population because they had unmet information, emotional and practical needs, particularly during the end-of-life phase of care. The strength of Sekelja et al's (2010) study was their RCT sampling design and they used the Interpretive Phenomenological Analysis (IPA) methodology to analyse their data and produce robust findings. Five major themes were identified: meaning of palliative care, timing of palliative care, valued aspects of palliative care, preparation for the patient's death and the role of palliative care in preparing for and after the patient's death which made an important contribution to understanding the emotional support required during end-of-life care for patients' carers.

Skarupski et al (2009) conducted telephone interviews to compare the emotional adaptation of family caregivers of different races in the USA. They recruited 396 caregivers from the Rush Alzheimer's Disease Center in Chicago, Illinois USA. The analysis for this report is based on data from 307 caregivers who were interviewed quarterly over approximately four years from 1999–2002, an average of nine observations per person. Palliative care is often an unrecognized need for people and

their caregivers in the later stages of Alzheimer's disease. In their study, Skarupski et al (2009) used as their unit of theoretical analysis not the participant but the incident, story, or example provided. They found that black caregivers suffered fewer depressive symptoms than white caregivers. However, as noted already,Taiwanese people are neither black nor white, and few studies have compared Taiwanese people with those of other ethnicities. The gaps in Skarupski et al's (2009) study therefore supported my intention to focus on Taiwanese people's experiences of palliative caregiving through incidents and stories.

Grande et al (2004) conducted a RCT to investigate the impact of hospice at home (HAH) on caregiver bereavement outcomes in the UK. The participants in Grande et al's (2004) study were ninety-six informal carers of patients referred to HAH. The participants were surveyed six weeks post-bereavement about the quality of terminal care and were asked to complete measurements of bereavement outcome and general health in their own time, following the interview. The measurements were mailed back to the researchers in a prepaid envelope. The researchers used quantitative statistical analytic methods to analysis these data. They found that inadequate terminal support and high symptom severity were related to worse bereavement responses for the caregivers. The contributions of Grande et al's (2004) study were that adequate terminal support for patients and carers was very important. Although Grande et al's (2004) study was conducted in the UK rather than in Taiwan, their contributions prompted me to develop an understanding of the appropriate terminal care in Taiwan and also encouraged me to conduct my PhD thesis.

Hirai et al (2003) conducted a questionnaire study in Japan which contained three scenarios representing terminally ill cancer patients with uncertainty-related anxiety, guilt feelings, and dependency-related meaninglessness. The questionnarire was mailed to 701 Japanese psychiatrists, 118 psychologists, and 372 palliative care nurses. A total of 456 responses were obtained, a response rate of only 38%. Psychosocial interventions were classified into six subcategories which were recommended by the study and which included religious approaches. Hirai et al (2003) concluded that to effectively alleviate existential suffering in terminally ill patients, integrated care by an interdisciplinary team is necessary.The contributions of Hirai et al's (2003) findings regarding an interdisciplinary team being necessary in hospices was one of the influential factors which helped me to develop my study for a PhD thesis.

To summarize, the literature from several countries both outwith and within Taiwan shows that psychosocial care in hospices and other health care settings is an important component of palliative and end-of-life care to ensure a good death and emotional support for both patients and caregivers.

Table 2.1: Studies related to psychosocial care perspectives in hospice and other healthcare settings (with a focus on a good death, palliative, end-of-life and emotional aspects of care)

Author(s) (Years)	Study Aims	Methodology and methods of data collection and analysis	Study population	Country	Key results
Miyashita et al (2008)	Explore the factors related to a "good death"	Questionnaire survey 344 questionnaires sent to bereaved family members, 165 responses were analyzed (48%)	165 bereaved family members of cancer patients	Japan	A good death includes "environmental comfort", " physical and psychological comfort ", " being respected as an individual " and a " natural death".
Leung et al (2010)	Explore good deaths and quality of life in a palliative care unit	The research tool of "Good Death Score" Patient demography, cancer sites, Eastern Cooperative Oncology Group (ECOG) status were collected at admission. Quality of life, including physical and psychological	281 non-randomized patients with terminal cancer	Taiwan	A good death is related to good quality of life in end-stage patients rather than length of survival.

		symptoms, social support, and spirituality was assessed daily after admission. Quality of death was assessed by a Good Death Scale (GDS) at admission and retrospectively for 2 days before death.			
Cheng et al (2008)	Investigate the good death status	"Good Death Score" to investigate the good death status An assessment form of "Good Death Score"consisting of three parts was used for all of the subjects. On this form, the researchers recorded demographic characteristics, good death scale and audit scale for good death	366 elderly patients with terminal cancer in Taiwan.	Taiwan	Death is inevitable for all humans, the concept of a good death varies across cultures, geography, religions, and generations.

		services. Reliability and validity of these two scales have been established in Taiwanese palliative care units.			
Tang et al (2004)	Explore how healthcare use at EOL varies by age among adult Taiwanese cancer patients	Retrospective cohort study using administrative data among 203,743 Taiwanese cancer patients who died from cancer during 2001–2006. The impact of age on each quality indicator of EOL care was analizised by multivariate logistic regression using the generalized estimating equation (GEE) method.	203,743 Taiwanese cancer patients who died from cancer during 2001–2006	Taiwan	They found that elderly Taiwanese cancer patients at EOL received less chemotherapy, less aggressive management of health crises associated with the dying process, and fewer life-extending treatments, but they were more likely to receive hospice care in their last year and to achieve the culturally highly valued goal of dying at home; they also noted that death and dying are inevitable events in a human's life.
Chao (1997)	The issue of a good death in Taiwan	Hermeneutic qualitative research Interview to collect	20 Chinese cancer patients	Taiwan	Three themes of physical peace, psychological peace, and spiritual peace being highly related to a good death. Developed conceptual framework of the

		data and use Hermeneutic analysis data to develop conceptual framework of the dying process.			dying process.
Nakashima (2003)	Various religious philosophies and views of death	Narrative Literature Reviews Conducted 100 narrative literatures in different countries for her doctoral thesis to see various holistic perspectives of dying.	100 narrative literatures in different countries	USA	Various religious philosophies and views of death, including Buddhist philosophy and view of death and dying
Baile et al (2011)	Explore the psychological issues	Questionnaire Purposive sampling methodology Patients completed the Concerns Checklist, Hospital Anxiety and Depression Scale, and Cancer Behavior Inventory at the beginning of their visit.	137 patients themselves identifying concerns and their physicians' identifying patients' concerns	USA	Patients with more concerns also had higher levels of anxiety and depression symptoms.

		The researchers analysed the correlation between the total number of patients' concerns and their levels of anxiety, mood disturbance, and self-efficacy.			
Sacks and Nelson (2007)	Explore the suffering of patients with chronic illness	Grounded theory study Interviews began with a semi-structured schedule of questions to ensure that the research questions were being addressed. Constant comparative analysis, the interview questions changed after each interview was	18 patients with chronic illness	USA	Suffering is a complex, dynamic experience that includes physical, social, spiritual and emotional domains. They conducted a well-designed grounded theory study to construct a clear theoretical framework, namely the "Dynamic Nature of Trust in the Individual's Nonphysical Suffering Experience".

		evaluated. They conducted a well-designed grounded theory study to construct a clear theoretical framework, namely the "Dynamic Nature of Trust in the Individual's Nonphysical Suffering Experience"			
Sekelja et al (2010)	Explore bereaved carers' experience	Randomized controlled trial (RCT) to interview Interpretive Phenomenological Analysis	Thirty bereaved carers of patients with metastatic cancer	Australia	Cancer patients' caregivers are a vulnerable population because they have unmet informational, emotional and practical needs, particularly during the end-of-life phase of care. Five major themes were identified: meaning of palliative care, timing of palliative care, valued aspects of palliative care, preparation for the patient's death and the role of palliative care in preparing for and after the patient's death.
Skarupski et al (2009)	Compared the emotional adaptation of family	Interviewed via phone 396 caregivers were	307 family caregivers of different races 396 caregivers were	USA	Black caregivers suffered fewer depressive symptoms than white.

	caregivers of different races	recruited from the Rush Alzheimer's Disease Center in Chicago, Illinois, as part of a longitudinal study of persons with AD. The analyses for this report are based on data from 307 caregivers who were interviewed quarterly over approximately four years from 1999–2002, an average of nine observations per person. The unit of theoretical analysis is not the participant but the incident, story, or example provided.	recruited from the Rush Alzheimer's Disease Center in Chicago, Illinois, as part of a longitudinal study of persons with Alzheimer's Disease.		
Grande et al (2004)	Explore caregivers' bereavement outcomes	Random Controlled Trial (RCT) Ninety-six informal	Ninety-six informal carers of patients referred to HAH(hospice at home)	UK	Inadequate terminal support and high symptom severity were related to worse bereavement responses for the caregivers

	from hospice homecare	carers of patients referred to HAH, the participants were surveyed six weeks post-bereavement about quality of terminal care; the participants were asked to complete measures of bereavement outcome and general health, in their own time, following the interview. The measures were mailed back to the researcher in a prepaid envelope; the researchers used quantitative statisical analytic methods to analyse these data.			
Hirai et al (2003)	Explore the underlying structure of psychosocial interventions	Survey questionnaire study A questionnaire with three scenarios representing	Total of 456 responses were obtained (response rate 38%)	Japan	Psychosocial interventions were classified into six subcategories, and religious approaches especially were included in psychosocial interventions in this study.

		terminally ill cancer patients with uncertainty-related anxiety, guilt feelings, and dependency-related meaninglessness was mailed to 701 Japanese psychiatrists, 118 psychologists, and 372 palliative care nurses.			

In the following section, Section 2.2, I present the literature on the role of religious caregivers including chaplains in hospices and other health care settings in order to explore more specifically the work(role) of Buddhist chaplains.

2.2 The role of religious caregivers including Buddhist and non-Buddhist chaplains in hospice and other health care settings in Taiwan and other countries

In this theme I explore the role of religious caregivers in healthcare settings in general and hospices in particular. This includes the perceptions of patients and families on the chaplain's role in general hospital settings including psychosocial care but also on the role of volunteers in religious caregiving. I then consider the specific role of the chaplain in psychosocial and end-of-life care from a Buddhist and non-Buddhist perspective both in Taiwan and other countries.

Perceptions of the role of chaplains and other religious caregivers in psychosocial care in hospice and other healthcare settings

Liu et al (2008) surveyed patients' and their families' perceptions of hospital chaplains in Taiwan. The researchers sent 300 questionnaires to both patients and their families. This questionnaire was created by the researchers and applied to interviewees, requesting evaluation of their personal needs for chaplaincy services and whether the position of a professional chaplain was adequate for the hospital. There were 227 respondents in the sample with a 75.67% response rate. They found that 92.71% of the respondents required a chaplaincy service, specifically to meet their psychosocial and emotional needs. The strength of Liu et al's (2008) study was that the response rate was 75.67%; and it also revealed that a chaplaincy service was very important in hospices as borne out by 92.71% of respondents who said they required a chaplaincy service. Although the respondents in Liu et al's (2008) study were referring to Christian chaplains rather than Buddhist chaplains, the findings were important both in revealing the importance of chaplaincy services in this study

and the gaps which supported me to focus my study specifically on Buddhist chaplains.

Ng et al (2005) conducted qualitative research to interview three types of religious chaplains: a total of three chaplains on hospice wards in Taiwan participated. The researchers used content analysis methods to analyse the content of the interview data and found that those religious chaplains defined their role as providing spiritual care of a psychosocial aspect; additionally, that the involvement of religion should be recognized positively. The limitation of Ng et al's(2005) study was that it was a very small sample, with only three participants but it took place at a time when it was rare to find chaplains working in hospitals in Taiwan. It was a valuable study therefore because it was undertaken when the total number of hospital chaplains in Taiwan was very small and their role was just developing.

Liu (2012) conducted a qualitative pilot study to explore the contributions of religious volunteers with six long-term care residents. In this study, in-depth interviews focused on patients' perspectives on the contributions of religious volunteers and non-religious volunteers and were conducted between January and March 2009 in different regions in Taiwan. Thematic analysis was used to analyze the data. Liu found that religious volunteers lack the professional training and competence to attend to patients' religious needs because they could not offer in-depth spiritual and religious services. Although the sample size of Liu's (2012) pilot study was very small and chaplains in hospitals in Taiwan were in the minority at the time, Liu (2012) found that qualified chaplains were not available, and that inadequate religious services performed by religious volunteers were still better than no such care at all. The contributions of this study showed that there are insufficient numbers of qualified chaplains in Taiwan and that religious care is important but there are insufficient numbers of qualified chaplains in Taiwan to give that care.

The literature advocates that chaplains of all religions should be integrated into interdisciplinary health care teams; however, few studies have explored in detail the content of a Buddhist chaplaincy service.

Religious chaplains' role in psychosocial care in end-of-life care

Tenzek (2012) conducted qualitative research carrying out in-depth interviews with forty-one chaplains for her doctoral thesis in the USA. She found that the chaplains have multiple roles in providing spiritual care at end-of-life (EOL). The strength of Tenzek's (2012) study is that the researcher undertook two different rounds of data collection and the sample size was sufficient to ensure the quality of this study.

Fisher (2013) explored the development of Buddhist chaplaincy work in North America. He conducted narrative literature reviews to show different types of chaplaincy, such as healthcare chaplaincy, military chaplaincy, prison chaplaincy, campus chaplaincy, law enforcement and other first responder chaplaincies. Fisher (2013) did not mention which key terms were used to search these literatures and failed to show the process of searching, including not mentioning the number of papers included and excluded. Although I can appreciate the need for different types of chaplains, only healthcare chaplains were directly relevant to my study. The contribution of the literature reviews was that they compared different chaplaincy roles in different situations. Spiritual care and counselling offered by properly trained and certified workers were very important for healthcare chaplains working in hospitals.

Nolan (2011) used a grounded theory study to explore 19 palliative care chaplains in counselling dying people in the UK. He identified four important moments in the chaplain–patient relationship, each moment being a discernable development in the chaplain's being-with the patient: 'evocative presence', 'accompanying presence', 'comforting presence'; and 'hopeful presence'. As Nolan's (2011) study used grounded theory, he represented the four moments as a theory of the 'chaplain as hopeful presence'. The strength of this study is that there is a clear theoretical framework to show the chaplain as a 'hopeful presence'.

Gumminger (2008) conducted qualitative research to interview 45 hospice chaplains for her doctoral thesis in the USA. The majority of the participants took part in interviews about their communication practices; two participants kept records of

their conversations with patients and their families over a two-week period. Gumminger found that there were communication challenges for the hospice chaplains which included entering established family systems, discussing traditionally private or taboo subjects, and helping people to prepare for dying.

Kianpour (2010) used a qualitative research approach to undertake in-depth interviews with 21 hospital chaplains in end-of-life care units in Canada, and found that they not only performed religious rituals but also provided emotional support and spiritual care, and thus, they needed to manage their work-related emotions in order to protect their own mental health. Kianpour (2010) used qualitative research with an in-depth interview approach to collect data but failed to mention clearly which type of qualitative research had been adopted. However, the contribution of this study was to show that emotional management is important both for the chaplains and the patients.

Lamport (2007) conducted qualitative research in the USA to explore the process of chaplains' work in end-of-life care. Although Lamport (2007) did not present very clearly which type of qualitative research was used and also failed to mention details about the study samples, the findings show that meeting the chaplain in person increased the patient's and /or family's inclination to welcome the chaplain visiting again.

Wilson (2014) conducted descriptive quantitative survey research to explore the chaplains' level of grief and compassion fatigue in the USA. She found that the chaplains' grief responses may lead to compassion fatigue. Wilson did not present the sample size but she presented various factors related to chaplains' grief and their compassion or compassion fatigue. However, Wilson's study was only conducted in the USA rather than in Taiwan, where there are limited literatures that explore the relationship between the chaplains' grief and their compassion fatigue. Her insights were very important for my study.

Liu and Wu (2008) conducted a narrative literature review to present the development and the important roles of Christian chaplains in hospitals in different countries. Although they did not mention the search terms and the process of searching the literatures, they pointed out the current situation regarding the importance of chaplains in hospitals in Taiwan. Liu and Wu's study showed that the contribution of the Christian chaplaincy system in Taiwan included spiritual care that benefits patients, their families, the health care team, the organization and the community; that is, chaplains can provide high-quality spiritual care and help the health care teams to achieve the goal of holistic health care by collaborating with the physicians, nurses and other staff. However, this study (Liu and Wu, 2008) explored only the role of Christian chaplains, and did not include Buddhist chaplains. This gap encouraged me to develop my study related to Buddhist chaplains for my PhD thesis.

Huang (2012) explored four clinical Buddhist chaplains' religious practice in palliative care units, and found that compassion was developed from the field of hospice care. Although there were only four participants in this phenomenological qualitative study, it revealed the details of the Buddhist chaplains' daily religious practice.

Chen et al (2003) used a questionnaire of "Good Death Index" to explore 187 terminal cancer patients on a palliative care ward in Taiwan. The "Good Death Index" was assessed after the patient's death by team members using a 4 point Likert scale. They found that the clinical Buddhist chaplains' care enhanced end-of-life patients' good deaths. Howerever, this study was conducted in only one palliative care ward in Taiwan and failed to present how many palliative care wards exist in Taiwan; that is, it was hard to explain all Buddhist chaplains' role in hospices in Taiwan. The gaps in this literature revealed by Chen et al (2003)'s study supported me in developing my in-depth study about Buddhist chaplains' roles in hospice settings in Taiwan.

Bhikkhuni et al (2004) conducted quantitative research to explore the impact of belief cognition on end-stage cancer patients and their caregivers, and found that it further confirms the importance and necessity of the professional care provided by religious

chaplains. The total number of participants in Bhikkhuni et al's study was 20, but this study failed to mention the response rate to the questionnaire, so it is hard to judge the results in terms of the validity of the quantitative research findings. Although the number of participants in Bhikkhuni et al's study was small in terms of quantitative research, which was one of the limitations, the contributions and the gaps revealed by their study supported me in developing my PhD thesis to show that Buddhist chaplains' role was important in hospices.

Bhikkkhuni et al (2001) conducted retrospective research to investigate the role of clinical Buddhist chaplains in a palliative care unit in Taiwan, using questionnaires to survey 116 palliative care patients. The contributions of this study were in showing that Buddhist chaplains provided a vital service in enabling the patients and their relatives to face death, in supporting the medical staff, and in consulting the patients and their relatives on religious ceremony arrangements.

Ho (2003) used grounded theory methods to explore the Buddhist chaplains' role in local hospice teams and found that they clearly played a role in providing indirect care for the patient, assisting the family, and supporting the team, in order to facilitate a good death. Ho (2003) only used grounded theory open coding to develop her thesis; that is, she did not conduct second and third phase grounded theory analysis and it is unclear whether or not she applied classic or constructivist grounded theory in her study. She does not mention whether any person declined to participate in her study, so we do not know whether there were any patients or their families who had a negative attitude towards the Buddhist chaplains.

Hu (2006) used hermeneutic phenomenology to conduct field observations and interview three clinical Buddhist chaplains as well as to observe the interaction between terminal patients and clinical Buddhist chaplains. As this is qualitative research, the result cannot be generalized to other hospitals, but it supports the view that the role of clinical Buddhist chaplains is positive in hospice palliative care in Taiwan. The contributions of Hu's (2006) study encouraged me to develop my study further for a doctoral thesis as I thought there were valuable issues beyond Hu's

(2006) study that should be explored regarding Buddhist chaplains' viewpoints and work.

Smith-Penniman (2006) interviewed three clinical Buddhist chaplains in the USA and revealed that Buddhist approaches in pastoral care include mindfulness as a way out of suffering. The findings also present how clergy can engage with the individual, the congregation, and the larger community.

Sanou (2013) conducted a phenomenological study to explore meditation prayer for her doctoral thesis in the USA; this study used a mixed, purposive sampling design to select a total of 15 students, of whom a final sample of 13 responded to the research questions. Although the sample size in Sanou's study was small, the participants offered real and rich experiences, and evidence of trustworthiness was also clearly mentioned in this study. Sanou's (2013) study found that mindful meditation through the use of prayer can serve as a possible standard medical model in those times of pain, crisis or suffering. The contributions of this study are that the findings can be used to inform leadership for health care institutions on faith-based care of suffering. They may also guide leadership in conventional health care in developing a possible faith-based model and in integrating meditation-prayer as a complement to alleviate suffering. Sanou's (2013) study showed that Buddhist approaches regarding mindful meditation was a useful method to alleviate suffering, and this result prompted me to develop futher explorations for my PhD thesis.

Parameshwaran (2015) conducted practical applications of the mindfulness theoretical model to record chaplains' and patients' clinical interactions in Indian. The qualitative findings from the verbatim data are systematically analyzed by using neuro-physiological principles. The purpose of Parameshwaran's study was to explore the chaplain's spiritual care process based on neuro-physiological principles of mindfulness and interpersonal empathy. Parameshwaran found that the chaplain's deep listening skill to experience patients' pain and suffering, and awareness of his emotion/memories, may be a form of psychological therapy in which the chaplain's approach includes inter- personal and intra-personal mindfulness. The contributions

of Parameshwaran's study are in showing the importance of chaplains' approaches to spiritual care and this prompted me to develop futher explorations for my PhD thesis.

To sum up, there are possible Buddhist approaches to psychosocial and end-of-life care as shown from the above literature in different countries, such as Smith-Penniman's (2006) study in the USA, Sanou's (2013) study in the USA and Parameshwaran's (2015) study in India. However, there is a limited literature discussing Taiwanese Buddhist approaches to end-of-life care. I will now present Taiwanese Buddhist approaches in the following section.

Taiwanese Buddhist chaplains' approaches to psychosocial care in end-of-life care

There were three papers which discussed Taiwanese Buddhist approaches of psychosocial care in end-of-life care. These studies were conducted by different groups of clinical Buddhist chaplains in different years in Taiwan (Bhikkhuni refers to a female Buddhist nun in the Chinese language). These papers were published in Chinese with full texts and only the abstracts in English.

Bhikkhuni et al (2002) conducted a retrospective study using case studies of Buddhist chaplains' diaries in clinical interations with the patients. They explored the Buddhist Heart Sutra in the spiritual care of palliative cancer patients in Taiwan through the above methods. They found four major principles, which included suffering, causes of suffering, cessation of suffering, and the path leading to the cessation of suffering. The strength of Bhikkhuni et al's (2002) study was the use of information-rich diaries to record the Buddhist chaplains' interactions in hospices. However, the limitation of this study was the small number of participants- only three Buddhist chaplains in the same hospice unit in Taiwan. The gaps prompted me to develop my study in order to obtain more empirical data and to make further research contributions.

Bhikkhuni et al (2004) also conducted a retrospective study and used case studies with Buddhist chaplains' diaries in clinical interations with the patients to explore the Buddhist Sutra of impermanence to palliative care. They found that when patients understand impermanence and accept death as a natural life course, they can break

away from physical and emotional pain. The strength of Bhikkhuni et al's (2004) study was that it generated rich data based on diaries to record the Buddhist chaplains' interactions in hospices. However, the limitation of this study was that the number of Buddhist chaplains participating was only three in the same hospice unit in Taiwan. The gap prompted me to develop my study in order to obtain more empirical data and to make new contributions to future study.

Bhikkhuni et al (2005) conducted a retrospective study and used case studies of Buddhist chaplains' diaries in clinical interations with the patients to explore the application of the Buddhist Lotus Sutra to end-of-life cancer patients to overcome their fear of death in Taiwan. They found that the patients needed to be inspired by a firm religious belief; otherwise, it is hard to generalize the results to other patients without a religious belief. The strength of Bhikkhuni et al's (2005) study for me was that through Buddhist chaplains' information-rich diaries of clinical interactions with patients in hospices, I was able to see the process of Buddhist Lotus Sutra applied in hospices. The limitation of this study was that the number of case studies was only four, but this gap in the literature supported me to develop my study for PhD thesis.

In summary, Taiwanese Buddhist chaplains guided palliative care patients using different methods, such as sharing the Buddha's teachings, taking refuge in Triple Gem, reciting the Buddha's name, meditation, and repentance. From the literature review, it was shown that Buddhist chaplains guided the patients based on their(patients') clinical needs, but it is hard to apply these methods to people without a Buddhist faith. Although there were some studies about Buddhist chaplains' role in Taiwan, the results of these studies were not consistent and the methodologies limited. The literature reviews reveal there are still gaps in understanding the role of Buddhist chaplains in end-of-life care in Taiwan.

From the above literature, it is evident that some empirical data exist to show that Taiwanese Buddhist chaplains' approaches are related to Buddhist Sutra. The Buddhist chaplains use these Buddhist approaches to offer psychosocial care in end-of-life care. However, only three studies were found and the findings were

inconsistent as to which Buddhist Sutra is the best psychosocial approach to complement end-of-life care. There is a need therefore to develop empirical studies about Taiwanese Buddhist chaplains' approaches through research. This gap in the literature leads to Research Question 2: How do Buddhist chaplains use Buddhist religious methods as complementary approaches in clinical end-of-life care?

There is some literature regarding the religious chaplains' role in end-of-life care. Tzeng and Yin (2006) conducted quantitative research using a cross-sectional survey design to explore the provision of religious care within the Taiwanese health care system. The target population in Tzeng and Yin's (2006) study was nursing executives currently working in the 477 hospitals in Taiwan, and the data collection period was February to April 2005. They used quantitative analysis of the data and found that most hospitals have difficulty considering the religious and spiritual needs of patients. They also found that Buddhist or Taoist monks and nuns appear to deliver an important role when Taiwanese people are sick or suffer bad fortune, by offering psychosocial care. Although the overall response rate was only 47.6%., they found important results which showed that there were difficulties over providing adequate resources of clergy and chaplains in Taiwan. They categorized these difficulties on a continuum of 'no resources', 'resources provided through collaboration with agencies' and 'resources provided through patients or family members' own resources'. The limitations in Taiwanese society of a shortage of Buddhist chaplaincy services and the contributions made by the study to show the important roles of Buddhist chaplains, encouraged me to develop my PhD thesis.

I now summarize these studies from the aspects of study aim, methodology,methods of data collection and analysis, study population, country of study and key results in Table 2.2 below related to the role of religious caregivers in hospices and the chaplains' role in psychosocial, palliative and end-of-life care.

Table 2.2: Studies related to the role of religious caregivers including Buddhist and non- Buddhist chaplains in hospice and other health care settings in Taiwan and other countries

Author(s) (Years)	Study Aims	Methodology Methods of data collection and analysis	Study population	Country	Key results
Liu et al (2008)	Explore the need of chaplaincy services in hospital	Survey A questionnaire was created by the researchers and applied to interviewees, requesting evaluation of their personal needs for chaplaincy services.	Patients' and their families' perceptions of hospital chaplains. The researchers sent 300 questionnaires to both patients and their families. There were 227 respondents (a response rate of 75.67%).	Taiwan	92.71% of the respondents required a chaplaincy service, specifically to meet their psychological and emotional needs.
Ng et al (2005)	Religious chaplains defined their role	Interview Qualitative research and content analysis of data	Three types of religious chaplains and three chaplains as participants	Taiwan	Those religious chaplains defined their role as providing spiritual care.
Liu (2012)	Explore the contributions of religious	In-depth interviews In-depth interviews	Religious volunteers with six long-term care residents	Taiwan	Religious volunteers lack professional training and competence to attend to patients'

	volunteers	focused on patients' perspectives on the contributions of religious volunteers and non-religious volunteers were conducted between January and March 2009 in different regions in Taiwan. Data were gathered via a series of face-to-face semi-structured interviews			religious needs, and they may not afford in-depth spiritual and religious services. The contributions of this study show that there are not enough qualified chaplains in Taiwan.
Tenzek (2012)	Explore chaplains' role	Qualitative research Two different rounds of data collection and sufficient sample size ensured the study's quality.	41 chaplains in the USA	USA	The chaplains have multiple roles in providing spiritual care at end-of-life (EOL).
Fisher (2013)	Explore different types of chaplaincy	Narrative literature reviews. Did not mention	Literature reviews No mention of the number of	USA	Different roles of chaplaincy in different situations, spiritual care and counselling offered by properly

		how to use key terms to search these literatures and failed to show the process of searching, including not mentioning the number of inclusion and exclusion papers.	inclusion and exclusion papers		trained and certified workers were very important for healthcare chaplaincy working in hospitals.
Nolan (2011)	Explore palliative care chaplains in counselling dying people	Grounded theory study to explore 19 palliative care chaplains in counselling dying people in the UK. There is a clear theoretical framework to show the chaplain as a 'hopeful presence'.	19 palliative care chaplains	UK	Identified four organic moments in the chaplain–patient relationship, each moment being a discernable development in the chaplain's being-with the patient: 'evocative presence', 'accompanying presence', comforting presence'; and 'hopeful presence'
Gumminger (2008)	Explore chaplains' role and their challenges	Interview The majority of the participants took part in	45 hospice chaplains	USA	There were communication challenges for the hospice chaplains which included entering established family systems, discussing traditionally private or taboo

		interviews about their communication practices; two participants kept records of their conversations with patients and their families over a two-week period.			subjects, and helping people to prepare for an event that the chaplains had not yet experienced themselves.
Kianpour (2010)	Explore chaplains' role	Qualitative research approach to undertake in-depth interviews with 21 hospital chaplains in end-of-life care units. Failed to mention clearly which type of qualitative research.	21 hospital chaplains	Canada	They not only perform religious rituals but also provide emotional support and spiritual care, and thus, they should manage their work-related emotions in order to protect their own mental health.
Lamport (2007)	Explore the process of chaplains' work in end-of-life care	Qualitative research Did not present very clearly which type of qualitative	Chaplains The number of chaplains was not very clear	USA	Meeting the chaplain in person increased the patient's and /or family's inclination to welcome the chaplain visiting again.

		research and also failed to mention the sample size.			
Wilson (2014)	Explore the chaplains' level of grief and compasssion fatigue	Quantitative research Descriptive quantitative survey research	Chaplains Did not present the number of chaplains.	USA,	The chaplain's grief responses may lead to compassion fatigue.
Liu and Wu (2008)	Explore the role of Christian chaplains	Literature reviews Narrative literature review to present the development and the important roles of Christian chaplains in hospitals in different countries. The researchers did not mention the search terms and the process of searching the literature to identify the relevant papers was not very clear.	The topic is related to Christian chaplaincy but the participants were not chaplains. How many papers were reviewed was not very clear.	Taiwan	Chaplains can provide high-quality spiritual care and help the health care teams to achieve the goal of holistic health care by collaborating with the physicians, nurses and other staff.

Huang (2012)	Explore clinical Buddhist chaplains' religious practice in palliative care	Phenomenological qualitative study In-depth Interview Phenomenological data analysis	Four clinical Buddhist chaplains' religious practice	Taiwan	Compassion was developed from the field of hospice care.
Chen et al (2003)	Explore Clinical Buddhist Chaplain's Care Enhanced the Good Death Index	Questionnaire study Questionnaire of "Good Death Index" to explore 187 terminal cancer patients' experience on a palliative care ward in Taiwan. The "Good Death Index" was assessed after the patient's death by team members using a 4 point Likert scale	187 terminal cancer patients on a palliative care ward in Taiwan	Taiwan	The clinical Buddhist chaplains' care enhanced end-of-life patients' good deaths.
Bhikkhuni et al (2004)	Explore the impact of belief cognition on	Questionnaire research to explore the impact of belief cognition on	20 Cancer patients and their caregivers in Taiwan	Taiwan	It further confirms the importance and necessity of the professional care provided by religious chaplains.

	end-stage cancer patients and their caregivers	end-stage cancer patients and their caregivers.			
Bhikkhuni et al (2001)	Investigated the role of clinical Buddhist chaplains in a palliative care unit	Questionnaire Retrospective research to investigate the role of clinical Buddhist chaplains in a palliative care unit in Taiwan. The researchers used questionnaires to survey 116 palliative patients in a hospice unit in Taiwan.	116 hospitalized patients in Taiwan	Taiwan	The Buddhsit chaplains provided a vital service in enabling the patients and their relatives to face death, in supporting the medical staff, and in consulting the patients and their relatives on the religious ceremony arrangements.
Ho (2003)	Explored the Buddhist chaplains' role in local hospice teams	Grounded theory Ho (2003) only used grounded theory open coding to develop her thesis; that is, she did not conduct second and third phase grounded	4 patients or their families	Taiwan	The Buddhsit chaplains clearly played a role in providing indirect care for the patient, assisting the family, and supporting the team, in order to facilitate a good death.

		theory analysis and it is unclear whether or not she applied classic or constructivist grounded theory in her study.			
Hu (2006)	Explored the Buddhist chaplains' role	Hermeneutic phenomenology Field observations and interview Hermeneutic phenomenology was used to conduct field observations and interview three clinical Buddhist chaplains as well as to observe the interaction between terminal patients and the clinical Buddhist chaplains.	Three clinical Buddhist chaplains in Taiwan	Taiwan	The research supports the view that the role of clinical Buddhist chaplains is positive in hospice palliative care in Taiwan.
Smith-Penniman (2006)	Explored the Buddhist chaplains' role	Interview The researcher interviewed three	Three clinical Buddhist chaplains in USA	USA	Buddhist approaches in pastoral care included mindfulness as a way out of suffering. The findings also present how clergy can engage with

		clinical Buddhist chaplains in the USA.			the individual, the congregation, and the larger community.
Sanou (2013)	Explore meditation prayer	Qualitative research Phenomenological study A mixed, purposive sampling design The researcher conducted phenomenological study to explore meditation prayer for her doctoral thesis; this study was a mixed, purposive sampling design was used.	15 students were selected, of whom a final sample of 13 responded to the research questions	USA	Mindful meditation through the use of prayer can serve as a possible standard medical model in those times of pain, crisis or suffering
Parameshw-aran (2015)	Develop a conceptualized understanding of chaplain's spiritual care process	Qualitative research Practical application of this theoretical model is illustrated	The number of chaplains and their patients in the sample was not very clear	India	Chaplains' deep listening skill to experience patients' pain and suffering, awareness of his/her emotion/memories and their overall approach may be a form of psychological therapy which includes inter- and intra-personal

		using a carefully recorded clinical interaction, verbatim, between chaplain and his patient. Qualitative findings from the verbatim data were systematically analysed.			mindfulness.
Bhikkhuni et al (2002)	Explored the Buddhist chaplains' role and use of the Buddhist Heart Sutra in the spiritual care of palliative cancer patients	Qualitative research Retrospective study using case study and Buddhist chaplains' diaries in clinical interations with the patients. Content analysis of case study and diaries.	Three Buddhist Chaplains	Taiwan	The researchers found the four major principles of the Buddhist Heart Sutra were applied, which include suffering, causes of suffering, cessation of suffering, and path leading to the cessation of suffering.
Bhikkhuni et al (2004)	Explored the Buddhist chaplains' role	Qualitative research Retrospective study using case study	Three Buddhist Chaplains' clinical experiences	Taiwan	When patients understand impermanence and accept death as a natural life course, they can break away from physical and emotional pain.

		and Buddhist chaplains' diaries in clinical interations with the patients.			
Bhikkhuni et al (2005)	Explored the Buddhist chaplains' role	Qualitative research. Retrospective study using case study and Buddhist chaplains' diaries in clinical interations with the patients.	Two Buddhist Chaplains' clinical experience in hospices	Taiwan	The patients needed to be inspired by a firm religious belief; otherwise, it is hard to generalize the results to other patients without a religious belief.
Tzeng and Yin (2006)	An assessment of Taiwanese hospitals reveals variation in the policies and environment supporting religious practices	A survey of nursing executives. Cross-sectional survey design and a quantitative research approach. The data collection period was February to April 2005.	Nursing executives currently working in the 477 hospitals in Taiwan	Taiwan	The study showed differences between religious service provision in hospitals with and without a hospice ward. Most hospitals in Taiwan have difficulty considering the religious and spiritual needs of patients. The important results were that the difficulties over resources of clergy and chaplains in Taiwan include: no resources, resources provided through collaboration with agencies, and resources provided through patients or family

					members’ own resources.

There were nine studies describing Taiwanese Buddhist chaplains' care in hospices, However it is hard to find the Buddhist chaplains' own definitions of hospice care in these studies. This gap in the literature led me to develop Research Question 1: "How do the Buddhist chaplains define 'hospice palliative care'?"

The limitations of the research on Buddhist chaplains' role and their use of religious methods to provide psychosocial care to complement end-of-life care of patients leads into Research Questions 3 and 4, which are: "What are the experiences of Buddhist chaplains regarding the patients' use of Buddhist religious methods as complementary approaches in clinical end-of-life care?" and "What are the opinions of Buddhist chaplains regarding patients' use of Buddhist religious methods as complementary approaches in clinical end-of-life care?"

From the above literature review, it appears that Buddhist chaplains play an important role in end-of-life care in Taiwan and that they use religious methods as complementary approaches to achieve it. These questions derived from the literature form the basis for the research questions of this current study.

2.3 Literature gaps and research questions

In summary, there are some clear gaps apparent in the litertature reviews, which support the research questions of this study and support the value of conducting my research. The gaps in the literature include the following :

1. The literature review shows that psychosocial care in hospices is important in several countries both outwith and within Taiwan. There were several studies describing Taiwanese Buddhist chaplains' psychosocial care in hospices. However, few studies identified Buddhist chaplains' own definitions of hospice care. This gap lead me to develop Research Question 1: How do Buddhist chaplains define "hospice palliative care"?
2. Although there were studies about ensuring a good death at the end-of-life in hospice care in Taiwan, the results were not consistent and the methodologies were limited.

3. I have presented nine studies about Buddhist chaplains' role in Taiwan. However, the results of these studies were not consistent and the methodologies were limited, pointing to gaps in the literature in Taiwan.

4. There are three empirical studies presented to show that Taiwanese Buddhist chaplains' approaches are related to the Buddhist Sutra in end-of-life care, but these studies do not have consistent findings about the ways in which Buddhist Sutra are used and which are regarded as most effective. It is necessary therefore to generate more empirical data through research based on Taiwanese Buddhist chaplains' approaches. This gap in the literature leads into Research Question 2: How do Buddhist chaplains use Buddhist religious methods as complementary approaches in clinical end-of-life care?

5. These limitations of the research on Buddhist chaplains' role in the use of religious methods for end-of-life patients lead into Research Questions 3 and 4: "What are the experiences of Buddhist chaplains regarding the patients' use of Buddhist religious methods and psychosocial aspects as complementary approaches in clinical end-of-life patients' care?" and "What are the opinions of Buddhist chaplains regarding patients' use of Buddhist religious methods as complementary approaches in clinical end-of-life care?"

2.4 Summary

Hospice palliative care is an approach that improves the quality of life of patients and their families. Although Taiwan has developed hospice structures within hospital settings the development of modern hospice palliative care in Taiwan is different from that in Western countries.

Religious approaches are not identified by the Health Sector in Taiwan as part of the professional medical service, yet when Taiwanese people face ill health or misfortune they ask Buddhist or Taoist monks and nuns to offer religious approaches and they regard religious methods as an important form of care that complements medical care approaches in Taiwan. Therefore, Buddhist or Taoist monks and nuns play an important role when Taiwanese people are ill or suffer bad fortune. They offer what can be understood as a particular form of complementary medical care. In this chapter, I undertook a review of the literature to understand the role of religious caregivers in psychosocial care in hospices. The process of the literature search is presented in a "PRISMA Flow Diagram" (Figure 2.1) and the synthesis of the studies in Sections 2.1 and 2.2 and Tables 2.1 and 2.2.

The literature review sought to position the role of Buddhist hospice work in the context of complementary medicine. As noted in Chapter 1, according to Whilford and Olver (2011), the definition of a complementary approach is broad. Traditionally the understanding of complementary medicine, as captured by Fennell et al (2009) includes a wide range of activities, products and approaches including acupuncture, herbs, massage, yoga, vitamins, psychology, psychiatry, exercise, folk remedies, meditation, chiro-practice, prayer, aromatherapy, and sleep/rest. That is, "folk remedies", " mediatation" and "prayer" are forms of Complementary Medicine from the perspective of lay people based on Fennell et al's (2009) viewpoint and encompass Buddhist religious methods which are regarded as a form of "complementary" approaches to end-of-life care specific to Taiwan. Few studies explored Buddhist chaplains' role in Taiwan; additionally, the findings were not always consistent and the methodologies used in these studies were limited.

I identified several gaps in the literature, which I have presented above, to support my research questions. I answer them by using the appropriate research methodology and methods which I describe in detail in the next chapter, Chapter 3.

Chapter 3 Research Methodology and Methods

Introduction

This chapter outlines the methodology of this research and the research process. It begins by presenting the philosophy behind the research methodology chosen for this study, and explains why this methodology was selected. The results of the exploratory interview are presented in Section 3.1.1. The purpose of this exploratory interview was to confirm the interview questions for this study. Thereafter, this chapter explains how the methodology is employed, including the study design, sample and setting, ethical considerations, data management, and rigour. I explain the rationale for using Charmaz's (2006) constructivist grounded theory. The chapter also details the procedure whereby the data were collected and analysed. The study procedure of this current study is presented in Figure 3.1. The detailed content is presented in different chapters of this thesis.

Figure 3.1 The study procedure

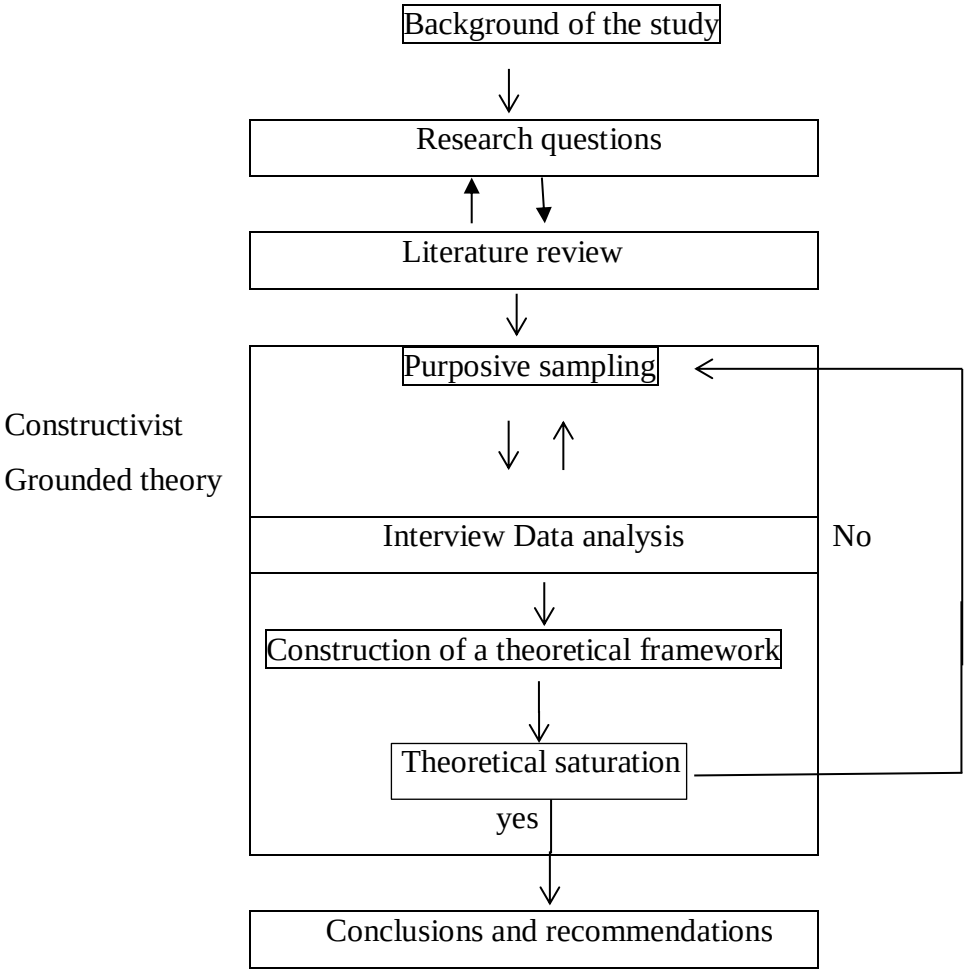


Figure 3.1 displays the study procedure for the thesis in the form of the flow of the research process. According to Hernadez and Andrews (2012), Charmaz developed research questions after a preliminary literature review. Therefore, I did a literature review to confirm the research questions. That is, the literature review was developed to determine the gap between the literature review and the clinical phenomenon; the above gap is the background of this study in Taiwan, and then to define the research purpose of the study and to select the most appropriate research approaches for it, I did purposive sampling and analysis. Finally, the contributions of the study are outlined, together with the conclusions and recommendations for future research. The literature review and research questions were presented in Chapter 2, and the main findings are presented from chapters 4 to 7. The theoretical framework is

shown in Chapter 8, the discussion is shown in Chapter 9, and the conclusions and recommendations in Chapter 10. This chapter focuses on the research methodology and methods.

The philosophy behind the research methodology

Barbour (2008, p.21) discussed the main qualitative traditions, which should include their origins, usages, and epistemological and ontological underpinning. Koro-Ljungberg (2004) stated that the epistemology that informs the research method, that is the epistemological assumption, forms and shapes the methods employed. Porta and Keating (2008, p.2) agree that clarity with regard to the epistemological assumptions is important when conducting research.

Alcoff (1998, p.viii) states that epistemology in the context of western philosophy is often thought to have begun with Plato. According to Barbour (2008, p.20), 'epistemology' refers to theories of knowledge, how we come to know the world, and our ideas about the nature of evidence and knowledge, whereas 'ontology' refers to our view on what constitutes the social world and how we can approach its examination. Ritchie et al (2003, p.22) explained that epistemology is concerned with the nature of knowledge and how it can be acquired; one of the main epistemological stances is positivism, which holds that natural sciences methods are appropriate for social enquiry. According to Andrew (2012), social construction accepts that there is an objective reality; it therefore adopts an epistemological rather than an ontological perspective.

Broom (2005) indicated that qualitative methods offer a potentially powerful approach to uncovering complex experiences in order to increase our knowledge of important processes. Strauss (1987) stated that this grounded theory approach to qualitative analysis was developed by Glaser and Strauss in the early 1960s, during a field observational study of hospital staff's management of dying patients. Charmaz (2006, p.4) noted how Glaser and Strauss's research team observed how deaths occurred in a variety of hospital settings, and examined how and when professionals and their terminally-ill patients knew that death was imminent and how they handled

the news. Charmaz (1997) applied constructivist grounded theory to identify the dilemmas of chronically ill men; the death issue after a life-threatening crisis was also explored in this study. Stiel et al (2010) explored the use of grounded theory in palliative care; they found that grounded theory (GT) allowed a systematic understanding of patients' experiences and attitudes, as well as a careful, in-depth exploration of this vulnerable population.

Cannaerts et al (2011) used a grounded theory approach underpinned by a symbolic interaction framework to explore the concepts of palliative care. Eight patients, nine relatives and twenty-four caregivers were involved in their study. The data revealed that palliative care requires each caregiver to have both expertise and a well-developed caring attitude. Although the sample size in Cannaerts et al's (2011) grounded theory research was relatively small, the data revealed important issues related to palliative care.

Blumer (1967) believed that society entails a symbolic interaction; for instance, human interaction is mediated by the use of symbols, interpretation, or ascertaining the meaning of one another's actions. Oliver (2012) agreed that symbolic interaction reflects clinical thinking and practical solutions. Andrew (2012) thought that social construction had been instrumental in remodeling grounded theory. According to Hall et al (2013), the philosophical foundations of grounded theory derive from symbolic interaction.

Neal (2009) compared Glaser and Strauss's (1967) classic grounded theory and Charmaz's (2006) constructivist grounded theory, and found that the former saw grounded theory as achieving 'middle range' theories, whereas the latter saw constructivist grounded theory as: "a close fit with data, usefulness, conceptual density, durability over time, modifiability, and explanatory power." Hunter et al (2011) compared three types of grounded theory, assuming that Charmaz's approach seeks to bring about mutual understanding through collaboration between researchers and participants. Charmaz (2006, p.2) thought that constructivist grounded theory methods help researchers to view their data in fresh ways and to explore their ideas

about them through early analytic writing; by adopting grounded theory methods, researchers can direct, manage, and streamline their data collection, as well as construct an original analysis of their data.

Rationale for using Charmaz's (2006) constructivist grounded theory

Timmermans and Tavory (2012) noted that grounded theory has become a leading approach promising the construction of novel theories and construction of theoretical ideas based on empirical data. According to LaRossa (2005), among the different qualitative approaches, the results of grounded theory will produce theory development over other qualitative research. I chose the grounded theory approach over other competing qualitative research methods to conduct this study as my educational background is nursing, I fully understand that theory development is an important issue in social science. For instance: McCurry et al (2009) noted that knowledge is built upon theories which together with their philosophical base and disciplinary goals, are guiding frameworks for practice.

I adopted Charmaz's (2006) constructivist grounded theory rather than the classic grounded theory as my research approach for several reasons, that will be outlined in the following section.

Hernadez and Andrews (2012) compared constructivist and classic grounded theory. A research problem is developed through a preliminary review of the literature in Charmaz's (2006) constructivist grounded theory; however, in the classic grounded theory the researcher decides to study an area with "no" preconceptions (personal, professional, or literature-based). In this study, I chose to undertake a literature review in the early stages of the research to develop the research aims and research questions because I wished to ensure that my research proposal was original. Therefore, Charmaz's (2006) constructivist grounded theory is more appropriate than the classic grounded theory for my study.

Charmaz (2006, p.23) thought that grounded theory methods preserve an open-ended approach to studying the empirical world, yet add rigour to ethnographic research by building systematic checks into both the data collection and data analysis. This current study is not ethnographic research, as the background is cultural issues in hospice palliative care in Taiwan, but it is very similar to the cultural exploration undertaken in ethnographic research. Therefore, Charmaz's (2006) constructivist grounded theory may be suitable for my data collection and data analysis.

Charmaz (2006, p.130) suggests that constructivist grounded theory depends on the researcher's view and lies squarely in the interpretive tradition. A constructivist approach leads researchers to explore and interpret implicit statements or actions (Charmaz 2006, p.146). Mills et al (2006) thought that Charmaz strove to maintain the participants' presence throughout the research with an emphasis on keeping the researcher close to the participants; on the other hand, Strauss and Corbin's (1998) focus is on the provision of tools to use in the process. The obvious differences between constructivist grounded theory and classical grounded theory is the construction of knowledge. This approach was applied to my study because the participants were healthy Buddhist chaplains rather than vulnerable palliative care patients; additionally, the main job of the Buddhist chaplains was to interpret and explain the role of Buddhism; that is, the participants also constructed the knowledge about the Buddhist religious approaches. All of the participants in this study had been working in the field of end-of-life care for several years and had very rich clinical experience in this area; they also constructed their knowledge based on rich viewpoints regarding a good quality end-of-life care model which is specific to Taiwanese culture. The role of Buddhist chaplains is to teach Buddhism in Taiwanese society. They also interpret and construct Buddhist knowledge based on Buddha's teachings. When they work in clinical hospice care, they will have their own experiences and viewpoints connected with Buddha's teachings.

During the whole research process, I and each participant discussed and constructed the knowledge which contributed to the research findings individually during each interview. I ensured that the participants agreed about the constructed knowledge

which contributed to the understanding of religious complementary approaches in hospice palliative care in Taiwan. For the above reasons, Charmaz's (2006) constructivist grounded theory is more appropriate than Glaser and Strauss's (1967) classic grounded theory for this current study because I and the participants had more flexible space in which to construct more appropriate knowledge in a clinical setting in a specific culture; namely, Buddhist culture in Taiwan.

I developed a theoretical framework in the final stage, constructed from the data following the interactions between me and the twenty-two Buddhist participants. During the twenty-two interviews, each participant supplied me with data about his/her experiences and viewpoints. These data met Charmaz's (2006, p.130) criteria about sharing experiences and relationships with the participants. Charmaz's (2006) constructivist grounded theory was an appropriate research approach for this current study because I aimed to understand the Buddhist chaplains' perspectives and work.

3.1 Study Design

In this current study, I choose a qualitative research approach which was Charmaz's (2006) constructivist grounded theory. During the process, Buddhist religious approaches also support participants' dignity; in this study, participants tell the clinical stories and hospice patients' and their families' life review. The purpose of Charmaz's (2006) constructivist grounded theory is to develop a theoretical framework. I use the approach of the participants' story-telling to support the evidence-based data.

I identified qualitative methods, specifically Charmaz's (2006) constructivist grounded theory, underpinned by symbolic interactionism as the research approach for the research questions; for example, exploring experiences, perceptions, beliefs, and meanings. Newell and Burnard (2006, p.21) noted that qualitative approaches are primarily suited to studies of individual experience, whereas quantitative approaches are primarily suited to epidemiological studies of large groups. The current study employs the qualitative research method because the study involves experiences. Another reason for choosing the grounded theory method over other qualitative

research was because I am attempting to generate a feasible theoretical framework for a specific Buddhist society in Taiwan. I applied in-depth semi-structured interviews, asking questions like: How do you define hospice palliative care? What is your role in hospice palliative care? What are your opinions of the use of Buddhist religious methods as complementary approaches in hospice palliative care? Can you tell me any stories about your hospice palliative care patients' use of Buddhist religious methods as complementary approaches? Can you tell me about your experiences regarding your hospice palliative care patients' use of Buddhist religious methods as complementary approaches? For example: why do they use Buddhist religious methods as complementary approaches? For which kinds of disease (symptoms) do they use Buddhist religious methods as complementary approaches? Can you tell me your view about hospice palliative patients' use of Buddhist religious methods as complementary approaches? Is there anything else you would like to discuss or raise? Do you have any questions? (See Appendix 3: Examples of written questionnaire and interview topic guides). Audio-taped records, field notes, memos, and reflectivity were also adopted as research methods in this current study.

Story-telling approach

Bailey and Tilley (2002) proposed storytelling and the interpretation of meaning in qualitative research, arguing that qualitative researchers who analyse the stories identified in interview data recognize the primacy of stories as meaning-making strategies, and how patients' stories provide access to subjective reality, that is, their truth and the meanings of their experience. In this study, I employed semi-structured interviews to elicit the participants' clinical stories about end-of-life care. For instance, one of the semi-structured interview guidelines was : could you tell me the story regarding your hospice palliative care patients using Buddhist religious methods as complementary approaches? All of the participants talked about their rich experiences and several clinical stories in this current study. The findings of the story-telling by participants will be presented from Chapters 5 to 8.

I also conducted an exploratory interview to determine whether the interview questions were appropriate and whether adjustments to the interview protocol were necessary.

3.1.1 The exploratory interview

Nunes et al (2010) suggest that the exploratory/ pilot interview in grounded theory is used to produce different insights about the context, change the focus, guide the improvement of these data collection instruments and inform the theoretical sampling. Following Nunes et al (2010), I thought it necessary to find relevant persons with whom to conduct an exploratory interview before commencing the formal field work.

I contacted the Dean of a palliative care unit, Dr. Hung (a male, pseudonym) who is a professional physician. The unit is outside Taipei, in central Taiwan. The dean's view was that Buddhist chaplains play a very important role in palliative care and so he recruited chaplains to help him to care for his terminal patients. Dr. Hung also encouraged Buddhist chaplains to attend palliative hospice training courses. Currently, the two chaplains at the palliative unit have completed the four-stage courses and an internship at a specific hospital. Dr. Hung told me that the Buddhist chaplains play an important role with the aspects of psychological and spiritual care in end-of-life care.

Dr. Hung also discussed my interview guide with me. He thought that it was appropriate to use with him and other physicians. He could answer me face-to-face or via E-mail. However, he was afraid that the interview guide might be somewhat difficult for the chaplains to understand; for example, he knew about the two chaplains' educational background because he was involved in their recruitment, training and caring experiences in the palliative care units. The Buddhist chaplains were not always medical or nursing students; so he thought that the term "Complementary and Alternative Therapies (CATs)" may be difficult for them because these areas are so multiple and complicated. He suggested that the definition of Complementary Therapies should be specific and clear; for instance, the

biological therapies are interesting topics of Complementary Therapies for medical professionals but maybe difficult topics for non- medical persons.

Dr. Hung suggested that there are many religious therapies that belong to complementary approaches. If we focused on Buddhist religious methods, then Dr. Hung was certain that the Buddhist chaplains could tell me about many valuable clinical experiences. According to Dr. Hung, he and the Buddhist chaplains had many good experiences regarding the application of Buddhist religious methods to the end-of-life patients and their families.

In the light of Dr. Hung's suggestions, I modified the research questions and interview guidelines; I then selected several participants for the exploratory/pilot interview to ensure that the modified interview guideline was clear. As I mentioned earlier, I purposely chose two participants from this group to participate in a exploratory interview, that would help me to determine whether the interview questions were appropriate or whether adjustments to the interview protocol were necessary. They were able clearly to understand my rewritten research questions.

The original research questions were: What are the experiences of Buddhist chaplains regarding hospice palliative patients' use of complementary and alternative therapies (CATs) in Taiwan? What do the Buddhist chaplains believe about hospice palliative patients' use of CATs in Taiwan? What is the belief of Buddhist chaplains regarding hospice palliative patients using CATs in Taiwan? What are the meanings of Buddhist chaplains regarding hospice palliative patients using CATs in Taiwan?

My revised research questions were as follows: How do Buddhist chaplains define "hospice palliative care"? How do Buddhist chaplains use Buddhist religious methods as complementary approaches in clinical end-of-life care? What are the experiences of Buddhist chaplains regarding the patients' use of Buddhist religious methods as complementary approaches in clinical end-of-life care? What are the opinions of Buddhist chaplains regarding patients' use of Buddhist religious methods as complementary approaches in clinical end-of-life care?

The relevant literature to support my research methodology is explained in more detail in the following sections:

In-depth Interviews in Qualitative Research and Constructivist Grounded Theory

Asksey and Knight (1999) noted that qualitative interviews enable the in-depth understanding and examination of meanings. Rubin et al (1995) proposed that before each interview, researchers should prepare several main questions to direct the discussion that are sufficiently open-ended to encourage the interviewees to express their own opinions and experiences, but narrow enough to prevent the interviewees from diverging too far from the topic. Bogdan and Taylor (1975) argued that interviews should be long enough to cover the topics adequately, but not so long that the researcher and the participant become fatigued.

Regarding the interview location, Rubin et al (1995) indicated that the participants could choose a convenient time and location. Bogdan and Taylor (1975) argued that the researcher must create a free, open atmosphere. According to Charmaz (2006, p.29), grounded theory interviewing differs greatly from in-depth interviewing because the range of interview topics is narrowed down to gather specific data to develop theoretical frameworks.

Pilot and Beck (2003) indicated that audio-taped interviews and field notes are major sources of data in qualitative studies, and that most researchers transcribe their tapes for analysis. Verbatim transcription is a critical step in preparing for the data analysis, and researchers must ensure that the transcriptions are accurate, that they validly reflect the totality of the interview experience, and that they facilitate analysis.

Researcher's Role in Qualitative Method and Constructivist Grounded Theory

Pilot and Beck (2003, p.434) stated that the researcher's role with regard to the qualitative method is to act as a data collection tool as well as the creator of the analytic process. Therefore, the researcher's qualifications, experience and reflexivity are important in establishing confidence in the data. Similarly, Finlay (2003, p.5)

believed that the qualitative researcher is a central figure who actively constructs the collection, selection and interpretation of data; that is, the researcher's education and experience are essential for this project. Reinharz (1997, p.3) indicated that the vast majority of fieldwork literature concerns the researcher's role in the field rather than the research itself; he proposed a framework to explain how the self actually serves as the field work tool.

In this study, I am a senior registered and trained nurse with working and internship experience in end-of-life care. In addition, I have attended several communication courses, and so may be able to create an atmosphere in which the participants feel comfortable enough to speak freely and openly. For example, I can pay attention, be reflective, and avoid making interruptions during the interview process.

Field Notes and Memos in Qualitative Research and Constructivist Grounded Theory

According to Goodall (2000, p.87), the aim of field notes is to write what is unsaid, what is unspoken. Glaser and Strauss (1967) believed that writing memos in grounded theory is often useful, as well as writing code and making a copy of the field notes. According to Chenitz and Swanson (1986, p.8), memos are the written capsules of the analysis and serve to store the ideas generated about the data; moreover, through memo sorting and resorting, researchers begin to organize the ideas into written form.

Birks et al (2008) explained that memos in qualitative research can help to clarify one's thoughts on a research topic and provide subjective perspectives on the research area and the development of the study design. According to Charmaz (2006, p.261), memo writing is the intermediate step between coding and the first draft of the completed analysis; this step helps to spark researchers' thinking and encourages them to examine their data and codes in new ways. She explained that writing memos on the codes from the start helps to clarify what is happening in the field and that memo-writing relies on treating some codes as conceptual categories to analyse in grounded theory (Charmaz 2006, p.91). Later, Charmaz (2012, p.9) explained that

memo-writing is the intermediate step between coding and writing the first draft of the manuscript.

I wrote personal memos that documented my thoughts, feelings and ideas about how the theoretical framework was developing and how the interviews were conducted. That is, my personal communication in this study played an important role.

Reflexivity in Qualitative Research and Constructivist Grounded Theory

Bott (2010) indicated that self-reflexivity in research processes has become an increasingly important area for qualitative research in recent years. Howatson-Jones (2010, p.79) stated that reflexivity can be defined as reflecting on the specifics of circumstances and how we might be implicated in those conditions.

According to Dowling (2006), the role of reflexivity in the varied qualitative methodologies is significant. Cutcliffe (2003) believed that qualitative research is a reflective process. Oerton (2004) chose a self-reflective diary to record the fieldwork experience, which became a layered account of chronological occurrences, vague and striking recollections, ponderous impressions, introspective emotions and dream-like images. Clearly, reflexivity is a critical research method based on these arguments.

According to Pillow (2003, p.178), reflexivity is often understood as involving an ongoing self-awareness during the research process. Gray (2008) indicated that research reflexivity is predominantly understood as the researcher's engagement with her/his own positioning in relation to the world s/he is researching, and/or the self-conscious writing up of research as itself an act of representation. Etherington (2007) believed that reflective research encourages researchers to display in their writing and conversations the interactions between themselves and their participants.

Mauthner and Doucet (2003) indicated that reflexivity during the data analysis stage also means examining the ontological and epistemological assumptions built into particular methods of data analysis by those who both develop and use them. Neil (2006) believed that although reflexivity may be only another framework for data

analysis, it has the advantage of facilitating the inclusion of records of the interpersonal element in research relationships, enabling its impact to be explored through constant comparative analysis.

Hernadez and Andrews (2012) believed that the researcher is viewed as a "reflective participant in data collection and analysis" in constructivist grounded theory. According to Charmaz (2006, p.131), constructivist grounded theories take a reflective stance toward the research process and products. Charmaz considers how theories evolve, which involves reflecting on the earlier point that both researchers and research participants interpret meanings and actions; that is, constructivism fosters researchers' reflexivity about their own interpretations as well as those of their research participants.

Triangulation of the sources of data in the current study

Barusch et al (2011) assert that triangulation is a strategy for establishing credibility, when multiple data, methods, analysis, or theories are involved. Originally, it referred to collecting data from multiple sources, for example, using interviews, observation, documents and video recordings as data sources for a single study.

In this current study, data were collected using triangular approaches, which included semi-structured audio-taped interviews, field notes and memos. Audio-taped records were used to ensure the accuracy of the interview data as well as to record the exact words, tones, and emphasis conveyed by the participants. During the data collection phase, I continuously made reflective notes and kept a self-reflective diary about the interview process. A list of the data sources is shown below in Table 3.1:

Table 3.1: The list of data sources

Data Source	Content
Participants' interviews	Semi-structured with audio-taped interviews Participants' demographic data and biographical data
Researcher's notes	Field notes Memos Reflective notes

3.2 Sample and setting

Purposive sampling was applied in this study. The participants were volunteers who could speak Mandarin or Taiwanese, and were willing to participate in this study. Each interview lasted from one to three hours.

I used the following process to recruit the hospice palliative care Buddhist chaplains in Taiwan:

3.2.1 Recruitment process

Firstly, I contacted the leader of the Buddhist Lotus Hospice Care Foundation to explain the purpose and procedure of my research. I then sent the "Research Protocol" to the research committee of the Buddhist Lotus Hospice Care Foundation. I summarised the main content and research process of my study in the " Research Protocol". The main content of this research protocol includes: protocol title, abstract, background and significance of preliminary studies, study aims, study design, study procedures, safety monitoring plan, analysis plan, and references lists. Please see Appendix 5-1 Research Protocol.

Secondly, I contacted the hospice palliative care Buddhist chaplains by E-mail after receiving approval from the ethics committee of the University of Edinburgh and from the Buddhist Lotus Hospice Care Foundation (see Section 3.3 below).

Finally, I sent the written invitation, consent form, and explanation form to explain the study to the hospice palliative care Buddhist chaplains in order to recruit them based on inclusion and exclusion criteria to ensure that all participants met the purposive sampling requirements and that they were willing to participate in the study. The written invitation, consent form, and explanation form are in Appendix 1 and Appendix 2 of the thesis.

3.2.2 The inclusion characteristics of potential participants

1.Participants were Buddhist chaplains who had experience of using Buddhist religious methods as complementary approaches for their patients in Taiwan.
2. Participants offered services to end-of-life patients and patients' relatives.
3. Participants were Chinese/ Taiwanese.
4. Participants could speak Mandarin or Taiwanese dialects of Chinese.
5. Participants were aged between 20 and 70 years old.
6. Participants considered themselves to be mentally healthy.
7. Participants did not have any history of mental disorder or disease.
8. Participants did not have any criminal history in any country.
9. Participants were volunteers and willing to participate in my study.

3.2.3 The exclusion characteristics of potential participants

1. Individuals who failed to meet any of the inclusion criteria mentioned above.
2. Individuals who declined to be interviewed.

In this current study, I found that the participants had rich experiences of end-of-life care that enabled me to develop an appropriate theoretical framework. I also describe the meaning of the themes, present the variations within the themes and define the

relationships among the themes through purposive sampling from Chapters 5 to 7. Through the approach of purposive sampling, the emerging theoretical framework will be presented in Chapter 8.

Sampling in grounded theory research

Charmaz (2006, p.96) suggested that theoretical sampling means seeking pertinent data to develop the emerging theory. Draucker et al (2007) stated that theoretical sampling is a hallmark of the grounded theory methodology because it is guided by emerging theory; additionally, data collection and data analysis occur simultaneously in theoretical sampling. However, according to Emmel (2013, p.48), researchers are always faced with the practical problem of a limit on resources, and sampling is done for strategic reasons, for instance: particular kinds of research questions. Devers and Frankel (2000) noted that qualitative research most often uses purposive rather than random sampling to collect data. Teddlie and Yu (2007, p.80) compared mixed method sampling in the USA; they defined purposive sampling techniques as having been referred to as non-probability sampling or purposeful sampling or qualitative sampling. They further explained that purposive sampling techniques are primarily used in qualitative studies and may be defined as selecting units (e.g., individuals, group of individuals, institutions) based on specific purposes associated with answering a research study's questions (Teddlie and Yu 2007, p.77).

Byant and Charmaz (2007, p.237) noted that purposive sampling is also used in grounded theory research, for instance, critical consideration of purposeful selection of participants depends on the need of the study, that is, sampling schemes change dynamically with the development of research in grounded theory. In my current study, I found that the participants had rich experiences of end-of-life care that enabled me to develop an appropriate theoretical framework.

At the beginning, I thought of using theoretical sampling to collect data because the main purpose of theoretical sampling is to develop a theory or theoretical framework to present a clearer research result. Later, I got the greatest support from the Buddhist Lotus Hospice Care Foundation to collect all clinical palliative Buddhist chaplains'

data in Taiwan. This useful supportive resource from the Buddhist Lotus Hospice Care Foundation allowed me rethink the sampling strategy. It may be that purposive sampling is better than theoretical sampling in this current study for meeting both research questions and the development of the theoretical framework. Therefore, I decided to use purposive sampling to conduct this study based on the above reasons and the literature reviews of sampling in grounded theory and qualitative research.

Sample size in grounded theory research

According to Ritchie et al (2003, p.84), qualitative samples for a single study involving individual interviews are often less than 50 participants; if the sample is much larger than 50 participants, then it becomes difficult to manage the data collection and analysis. Stern (1985, p.154) believed that the number of participants in grounded theory is unknown prior to the study. Charmaz (2006, p.113) suggested that the themes are "saturated" if there are no new theoretical insights or properties. In this current study, I chose Charmaz's (2006) constructivist grounded theory because the theoretical framework which emerges is considered more important than the total number of participants.

3.3 Ethical approval process and considerations

Ethical approval process

The study proposal was sent to the Research Ethics Committee of the University of Edinburgh. I received the ethical committee's approval from the University of Edinburgh prior to the data collection (see Appendix 4). The Study Protocol was also sent to the Buddhist Lotus Hospice Care Foundation as my participants are supported by this Buddhist organization. Additional institutional review board (IRB) approval was obtained from the Buddhist Lotus Hospice Care Foundation (see Appendix 5-2). The study protocol is appended in Appendix5-1.

Ethical considerations

I provided the participants with a consent form and an explanation before the face-to-face interviews commenced. All of the participants were given written and

oral information before the interview, including information on the study design, assurance of anonymity, confidentiality, and information about their right to withdraw from the study. For instance: the participants understood that the data would be gathered through interviews and observations. When possible, the interviews would be audio-taped. I would also keep notes of the conversations and of observations made by the participants. I would listen to the tapes to gain information, but individual confidentiality would be maintained. The findings of this study would be used in a final paper and may be published; however, the participants would not be identified. The detailed informed consent statement is shown in Appendix 1 and the explanation sheet is shown in Appendix 2. Moreover, the participants were volunteers and were free to terminate the interview process at any time as well as to withhold embarrassing or private information from me.

The participants could use pseudonyms to describe their clinical stories and experiences. If they did not wish to be audio-taped, I could take notes during the interview and write a summary after completion. To protect both the participants' and their patients' privacy, all of the names attached to transcripts and used in my study were pseudonyms. All of the participants were fully informed about the purpose of the research and assured that their anonymity and confidentiality would be maintained. Any identifying information within the interviews (e.g. participants, patients, families, or health care professionals' names/ locations) was removed from the transcripts. The audio transcriptions were created and rechecked repeatedly by me based on the ethical considerations.

The recordings were transferred to audio files, which were stored on a password-protected computer. Only I (the researcher) had the password to access the data. The recordings were then transcribed verbatim by myself. When the final version of the thesis was finished, all recordings and audio files would be destroyed after five years in Taiwan and after ten years in the UK. The participants were assured that all of the audio-taped records and any data related to them would be destroyed, and in addition that the data would be used for academic purposes only.

I adopted the following additional ethical rule: I did not tell any of the chaplains or co-workers or staff members in the Buddhist Lotus Hospice Care Foundation about the chaplains' opinions, due to ethical considerations and to encourage the participants' independent thoughts.

Data collection took place from June to September 2012, after ethical approvals had been obtained. The data collection included a demographic form for each participant, semi-structured face-to-face interviews, interview notes, and the researcher's written memos. The detailed information is presented in Appendix 3.The demographic form included theses questions: (1) What day was your birthday? (2) What day did you become a monk (a nun)? (3) What day did you become a formal Buddhist chaplain? (4) How long have you been a monk (a nun)? (5) How long have you been a hospice Buddhist chaplain? (6) What is your educational background in non-Buddhism? (7) What is your educational background in Buddhism? (8) What is your major area of Buddhism? (9) What are your hobbies? (10) Where is your temple? (11) What is your position in your temple? (12) Have you received hospice training courses? (13) How long have you received hospice training courses for? (14) Which hospital are you working in now? (15) How many years are you working at this hospice unit in this hospital?

The interview topic guide included: (1) Could you tell me "How do you define hospice palliative care?" (2) Could you tell me "What is your role in hospice palliative care?" (3) Could you tell me "What are your opinions of the use of Buddhist religious methods as complementary approaches in hospice palliative care?" (4) Could you tell me any story about your hospice palliative care patients' use of Buddhist religious methods as complementary approaches? (5) Could you tell me about your experiences regarding your hospice palliative care patients' use of Buddhist religious methods as complementary approaches? For example: why do they use Buddhist religious methods as complementary approaches? For which kinds of disease (symptoms) do they use Buddhist religious methods as complementary approaches? (6) Could you tell me your view about hospice palliative patients' use of Buddhist

religious methods as complementary approaches? Is there something else you would like to discuss or raise? Do you have any questions for me?

3.4 Data management

This section will describe the data management which consisted of two parts: the data collection and the data analysis. Marie and Higginbottom (2004) suggest that the goal of grounded theory is theory generation; they agree that data gathering and analysis must occur concurrently in grounded theory. In my research, I carried out the data collection and data analysis at the same time. I applied in-depth, semi-structured interviews, audio-taped recordings, field notes, memos and reflexivity until data saturation was achieved. During this process of data management, I used the computer software package "NVivo10" to store and organise the data. The following procedures were applied during the data collection.

Different stages of data collection

1. In-depth interviews were conducted in a location upon which the participant and I agreed. This allowed the participants to be comfortable and more relaxed and enabled me to ensure that the place was suitable for recording the interview.

2. After the first participant's interview, I transcribed the audio-taped recordings into written texts and wrote up my own field notes, memos and reflective notes as soon as possible in order to avoid memory bias. The audio-taped recordings were transcribed in Chinese for further data analysis.

3. When I finished the first participant's interview and analysis, I decided to collect the next participant's interview and analysis. I repeated the above procedure in the same way as I had used in the first participant's interview, transcription and analysis.

4. After I had finished the above steps 1 to 3 involving purposive sampling and analysis of each interview one by one, all the transcriptions were carefully read and analysed again and again.

Charmaz (2006, p.3) suggests that researchers should write preliminary analytical notes about their codes, comparisons and any other ideas about the data that occur to them, because it is through studying data, comparing them, and writing memos, that researchers define the ideas that best fit and interpret the data as tentative analytical themes.

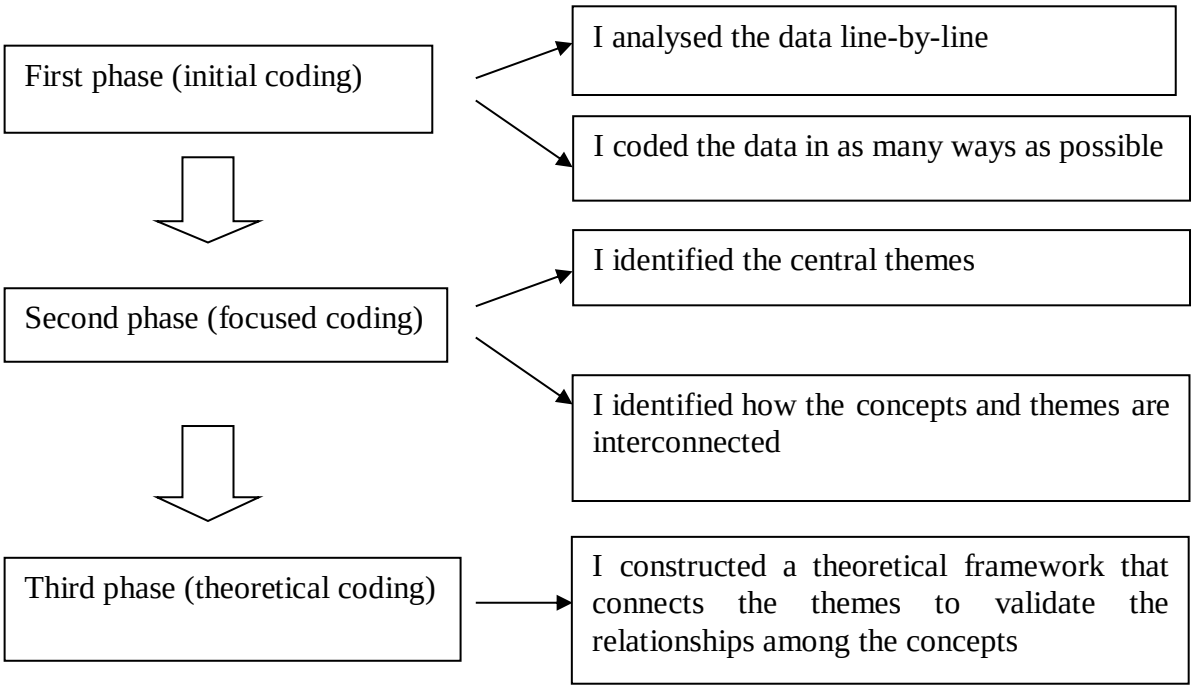
The step-by-step analysis

I analysed the written texts and later on discussed them with a qualitative expert in order to reduce the risk of my bias. To protect the participants' privacy and to achieve reliability of the data, another data analyst checked the written transcriptions independently. I chose Charmaz's (2006) constructivist grounded theory guidelines to manage the data including the initial coding, focused coding, early memo writing using focused codes, advanced memo writing and theoretical coding. Charmaz's (2006) constructivist grounded theory includes three analytical phases: initial coding, focused coding and theoretical coding.

Charmaz (2006, p.49) reminded researchers to make the codes fit the data rather than forcing the data to fit the codes. Therefore, a coder should remain open, stay close to the data, be simple, precise, and short, preserve actions, compare data with data, and move quickly through the data. Later, Charmaz (2012, p.5) proposed that the unit of coding needs to fit the purpose of the study and that codes rely on the interaction between researchers and their data.

The relationships between the step-by-step coding phases are presented in Figure 3.2:

Figure 3.2: Step-by- step analysis in this study



The step-by-step coding for this study was undertaken as follows:

1. First phase: the data analysis begins with the initial coding of the data. This initial step is used to discover, name, and categorize the data. I began the process of breaking down the interviews. Charmaz (2006, p.50) proposed that the first two guidelines for initial coding in grounded theory are word-by-word coding and line-by-line coding. Word-by-word analysis forces researchers to attend to the images, meanings, structure and flow of words, and how they affect the sense that the researcher made of them, as well as their specific content. Line-by-line coding works particularly well with detailed data about fundamental empirical problems or processes, whether these data consist of interviews, observations, documents, or ethnographies or autobiographies. I analysed the data line-by-line, coding them in as many ways as possible.

An example of line-by-line coding and the subsequent focused coding is presented in Figure 3.3. In fact, I used the original Chinese transcripts for the line-by-line coding and focused coding. The importance of the original Chinese transcripts will be

explained in the following section, Section 3.5 Rigour in qualitative research and grounded theory: “translation and back translation”.

Because the original Chinese version of the transcript was so important for the first phase of analysis (initial analysis and line-by-line coding), I also present a Chinese version of a transcript, initial analysis, line-by-line coding, and focused coding in Appendix 7.

Figure 3.3 Example of Initial Line-by-Line and Focused Coding

English translation of the interview transcript	Line-by-Line Coding	Focused Coding
When I first visited her, she told me she was very tired and could not talk to me for long because she felt physical fatigue. I told her it didn't matter, if you do not want to talk, you can end our conversation at any time. She told me she had cervical cancer and so was in great pain. She had had chemotherapy and radiotherapy, and also aromatherapy, and she felt comfortable after she had aromatherapy. I asked her what her life goal was. She told me she only wanted to have a healthy body and have someone love her and then get married and have their children. She told me that her goal was so simple. I said, "Your life goal was less simple until you get this cancer." I think her life goal became simple after she got this disease. I gave her an example of, a car. If a car is not running properly, what should we do? Drive it on the road or get a new one? I used this example to refer to her physical body. This patient was aware that her physical situation was poor, but she hoped to live longer than this. She asked me what she could do when death	Having physical effect Having compassionate attitude Patient's disease Having physical symptoms Having the skill of listening Guiding patient to do life reviews Having compassionate	Compassionate care Compassionate care Compassionate care Compassionate care

came. I advised her to recite the Buddha's name. I encouraged her to listen to the music of the recitation of the Buddha name. It's like learning to drive. At first, you may not be able to drive very well, just as you also can't recite the Buddha's name very well. You do not need to feel frustrated as you have only recited for an hour, you can't be good for another 23 hours. But you need to practise reciting the Buddha name continuously. This will calm you down and relieve your pain. She followed my advice and practised reciting the Buddha's name. She told me she felt bored sometimes. I told her that was normal; practising and practising would calm her down. Later, she felt better and calmer.	attitude Having the issues of death Using the approach of recitation of Buddha's name Having compassionate attitude to encourage the patient Offering emotional care	 Dying process Mahayana Buddhism

2. Second phase: the second step in the analysis is focused coding, a process used to identify the themes and subthemes. According to Charmaz (2006, p.57), with "focused coding" as the second major phase of coding, researchers can begin to synthesize and explain larger segments of data, having established some strong analytic directions through the initial line-by-line coding.

Charmaz (2006, p.61) did not use Strauss and Corbin's "axial coding" but she developed subthemes to show the links between subthemes and themes. I will present these themes in Chapters 5 to 7. Charmaz (2006, p.60) developed "focused coding" by comparing different parts of the data. The identification of the similarities and differences between and within categories enabled me to develop and refine the

categories as well as to identify concepts. I applied this step to identify how the concepts and themes interconnected. Detailed themes about this interconnectedness between the concepts and themes are also presented in Chapters 5 to 7.

3. Third phase: the third step in the data analysis is theoretical coding. Charmaz (2006, p.63) suggests that "theoretical coding" is followed by "focused coding". I applied this process to construct a theoretical framework that connects the themes and presents the relationships between the concepts. The detailed theoretical framework is presented in Chapter 8.

Constant comparative method

Glaser and Strauss (1967, p.105) indicated that the constant comparative method consists of four stages: (1) comparing incidents applicable to each theme, (2) integrating themes, and their properties, (3) delimiting the theory, and (4) writing the theory. Charmaz (2006, p.178) agreed that her constructivist grounded theory approaches also use constant comparative methods; for instance, making constant comparisons between the data, codes and themes. In this study, I used the constant comparative method when I finished the purposive sampling and analysis.

Computer assisted analysis

Bringer et al (2004) stated that a range of computer- assisted qualitative data analysis packages were available on the market. For example, "Nvivo10" is a user-friendly program that enables users to organize data, add detailed memos to documents or coding, run complex searches of the text and coding, and create links between the data. Pilot and Beck (2003, p.578) argued that computer programs offer numerous advantages when organizing qualitative data, but that some people prefer manual indexing because it allows them to get closer to the data. Personally, I agree with Pilot and Beck (2003, p.578) that manual methods help us to get closer to the data. I decided to abandon the use of "Nivo10" for line- by-line coding, because I found it difficult to recheck the "line-by-line" coding. I preferred to use "manual methods" rather than "Nvivo10" to help me to access the data.

However, twenty-two participant interviews comprised a huge data set. After I finished the "line-by-line" coding, I found the same coding existing for different participants, which suggested that I should organize the initial coding. Therefore, Microsoft Word and the software of "Nvivo10" were used to support the analysis and manage the interview data. I used Nvivo10 to re-sort the materials and codes (See Appendix 8). The interview data were stored on the software of Nivo10, and the raw data comprised both the original traditional Chinese transcripts and their English interpretations.

During the data analysis, I added all of the interview transcriptions to Nvivo10 and treated the research questions to thematic analysis. I found the answers to the research questions in this way. Nvivo10 proved a very useful tool to me as it enabled me to store and search the viewpoints of different participants in response to the same research questions.

3.5 Rigour in qualitative research and grounded theory

As mentioned earlier, I applied Charmaz's (2006) constructivist grounded theory together with participants' story-telling. Therefore, rigour in qualitative research and grounded theory should be considered in this current study. Charmaz (2006, p.182) proposed criteria for grounded theory, including credibility , originality, resonance, and usefulness.

The literature about rigour in qualitative research and grounded theory

Burns and Grove (1997, p.70) state that rigour in qualitative research is associated with openness, a scrupulous adherence to a philosophical perspective, thoroughness in collecting data, and consideration of all data during the subjective theory development phase. Bucker (2005) stated that researchers inevitably influence the data generation and analysis in qualitative research and must have an awareness of how to account for and make efforts to balance this influence.

McCabe and Holmes (2009) believed that qualitative researchers typically employ reflexivity to control the effects of researcher bias and its influence on the research process. Similarly, Dowling (2006) agreed that reflexivity is a concept that is central to qualitative research in general, where it is viewed as a means of adding credibility.

Translation and back-translation

In this current study, most of the participants could not speak English; however, my thesis is written in English. Therefore, the issue of translation and back-translation should be considered. Hammersley (2010) asserts that an accurate, strict transcription is very important in any qualitative research and notes that transcripts usually involve at least some description: who is talking, how they are speaking (seriously, ironically, jokingly, sarcastically, etc.), non-verbal behaviour, and contextual information. Elizabeth et al (2007) agreed that data collection, transcription and analysis were best undertaken in the first language of the respondents, and by using native researchers in trans-cultural research. Charmaz (2006, p.46) notes that language plays a crucial role in how and what we code, and that our codes arise from the language, meaning, and perspective through which we learn about the empirical world. Coding should inspire us to examine hidden assumptions in our own use of language as well as that of our participants.

Chen and Boore (2009) proposed translation and back-translation in qualitative nursing research, recommending: verbatim transcription of the content in the "original" language, and then analysis of "original" language content; two bilingual translators to translate the "emerged" concepts and themes, and back translation. In contrast, Temple and Young (2004) thought that, if researchers are objective, it makes little difference if they carry out the translation or if someone else does it, because the result will be same. In my study, the audio-taped recordings were transcribed in Chinese (the original language) for further data analysis. All translations of the "emerged" concepts and themes were translated by me, then validated by two bi-lingual experts who were proficient in both Chinese and English.

The rigour of this study

I succeeded in establishing good relationships with the respondents, and so was able to obtain more in-depth information from them than otherwise might have been the case. I remained open to all possibilities during the data gathering and analysis process in order to minimize personal bias. The development of the analysis is systematically recorded to provide an audit trail. This is conducted through the documentation of interview schedules, transcripts and chronological versions of the coding.

I adopted Charmaz's (2006, p.182) criteria of credibility, originality, resonance, and usefulness to set up the quality of the data. Credibility was established by using the participants' first language in the analysis, and also by keeping the raw data, written memos, and interview field notes, which provided an audit trail for the study. I interviewed my participants in our mutual first language, namely, Mandarin or its dialects. Originality was ensured through purposive sampling and using constant comparative methods of data analysis, as well as referring to the literature related to the social processes that emerged. Resonance was also addressed by confirming the theoretical processes with the participants when possible, and by providing descriptions of the theory that were grounded in the data. Finally, the "usefulness" of the emerging theoretical framework contributes new knowledge. A breakdown of the criteria for the rigour of this study is presented in Table 3.2 below.

Table 3.2: The rigour in this current study

Charmaz's (2006) criteria for rigour	In this current study
Credibility	Using the participants' first language Keeping the raw data Creating written memos Keeping interview field notes
Originality	Purposive sampling Using constant comparative methods
Resonance	Confirming the theoretical processes with the participants Providing descriptions of the theory that were grounded in the participants' data
Usefulness	The emerging theoretical framework is from the participants

Summary

This chapter has described the research methodology. The approaches include Charmaz's (2006) constructivist grounded theory. The perspective and work of the clinical Buddhist chaplains in end-of-life care were investigated in Taiwan. In this chapter, triangulation of the sources of data is adopted in order to enhance the rigour of this research. In the following four chapters, Chapters 4 to 8, I will present the findings of this research, which include Chapter 4: Participants' Characteristics. Chapters 5 to 7 present the main themes in this study, and Chapter 8 is The Theoretical Framework.

Chapter 4 Participants' Characteristics

Introduction

In this chapter, the participants' demographic data are presented alongside their major school of Buddhism, their Buddhist faith, attitudes toward different religious faiths, their understanding of their role in end-of-life care, and their relationship as Buddhist chaplains with nurses. These data are from the interviews with participants and participants' answers to the demographic questionnaire (see Appendix 3 Examples of interview topic guides- traditional Chinese version and English version). Sections 4.1 and 4.2.1 present the data from participants' answers to the demographic questionnaire; sections 4.2.2 to 4.2.5 present the data from the interviews with participants.

I sent out invitations to all of the palliative care Buddhist chaplains in June 2012, after I had obtained ethical approval from the Buddhist Lotus Hospice Care Foundation and the University of Edinburgh. However, I interviewed two participants initially because I only recruited two respondents. I analysed these two participants' interview transcripts. I was very concerned that I would generate sample bias. I decided that I needed to undertake advanced purposive sampling to generate a better theoretical framework. Therefore, I sent out the email invitations again, then called the clinical hospice Buddhist chaplains' mobile phone numbers. Five Buddhist chaplains very firmly declined to be interviewed. One was very busy at the time, another was a very new chaplain who had seldom visited palliative care units, so could not offer any information regarding my research questions. Eventually, I undertook 22 participant interviews and with further relevant persons for the exploratory/pilot interview. The result of the exploratory/pilot interview has been presented in Chapter 3. This chapter focuses on the results of the 22 participants' characteristics.

4.1 Participants' demographic data

Twenty-two Buddhist chaplains participated in this study and are identified by pseudonyms to ensure their anonymity. They were aged between 33 and 67 years old; most of them were in their forties; all of the participants were born after the Japanese colonial period (from 1895 to 1945); therefore, all of their elementary education had been Chinese rather than Japanese education. In fact, they majored in Chinese Mahayana Buddhism rather than Japanese Mahayana Buddhism. Twenty participants were female (Buddhist nuns) and two participants were male (Buddhist monks).It was noted in Chapter One that according to Clart and Jones (2003, p.196), the Buddhist population grew from 800,000 in 1983 to 4.9 million in 1995, a six-fold increase, against an overall population increase of about 2% and while the proportion of men ordained as monks has decreased in Taiwan, nuns and lay Buddhists have taken on greater leadership responsibilities.[1] In this study, the number of female participants (Buddhist nuns) is more than that of male participants (Buddhist monks). All of the participants were Chinese. I described in Chapter One how according to the Taiwanese governmental organization, the Tourist Bureau of Taiwan, Republic of China (2014), the most important aspect of Taiwan's cultural history was played by different waves of Han Chinese who brought with them traditional customs from China and created new ones in Taiwan. All were Buddhists, but all of them also respected other religious faiths. Eight participants had a Bachelor's degree, eight participants had a Master's, two participants had a PhD degree, two participants are current PhD students, and two participants without a Bachelor degree had obtained a senior high school education (see Table 4.1).

People in Taiwan attend senior high school from the ages of 16 to 19 years old. In other words, all of the participants had attained a high educational level. Two participants had been senior nurses previously. Most of them had not been medical or nursing students before. A brief overview of the participants' demographics is presented in Table 4.1.

[1] See Clart P and Jones CB (2003) Religion in modern Taiwan: Tradition and Innovation in a Changing Society. USA : University of Hawai Press

Table 4.1: Demographic data about the participants

Participant Number	age	Gender F: Female M: Male	Ethnic group	Education	Medical student or nursing student before
Participant 1	56	F(nun)	Chinese	Senior high school	Yes
Participant 2	44	F(nun)	Chinese	Master's degree	No
Participant 3	41	F(nun)	Chinese	Master's degree	No
Participant 4	48	F(nun)	Chinese	Bachelor's degree	No
Participant 5	48	F(nun)	Chinese	Bachelor's degree	No
Participant 6	67	F(nun)	Chinese	Master's degree	No
Participant 7	48	F(nun)	Chinese	PhD degree	Yes
Participant 8	47	F(nun)	Chinese	PhD degree	No
Participant 9	47	M(monk)	Chinese	Bachelor's degree	No
Participant 10	54	F(nun)	Chinese	Bachelor's degree	No
Participant 11	54	F(nun)	Chinese	Bachelor's degree	No
Participant 12	44	F(nun)	Chinese	Current PhD student	Yes
Participant 13	48	F(nun)	Chinese	Master's degree	No
Participant 14	60	F(nun)	Chinese	Master's degree	No
Participant 15	50	M(monk)	Chinese	Senior high school	No
Participant 16	46	F(nun)	Chinese	Master's degree	No
Participant 17	49	F(nun)	Chinese	Bachelor's degree	Yes
Participant 18	56	F(nun)	Chinese	Bachelor's degree	No
Participant 19	46	F(nun)	Chinese	Master's degree	No
Participant 20	47	F(nun)	Chinese	Master's degree	No
Participant 21	33	F(nun)	Chinese	Current PhD student	No
Participant 22	56	F(nun)	Chinese	Bachelor's degree	No

4.2 Participants' personal information

In the following sections, Sections 4.2.1 to 4.2.5, I shall describe the participants' more personal information including their major school of Buddhism, Buddhist faith, attitude toward different religious faiths, participants' understanding of their role in end-of-life care, and the relationship between the Buddhist chaplains and the nurses. Those data are from the participants' written answers to the demographic questionnaires and the interviews with participants.

4.2.1 Participants' major school of Buddhism

Twenty-one participants who majored in Chinese Buddhism focus on the Pure Land or Zen (Chan) School. Only one participant had majored in Tibetan Buddhism, although this participant applied the approaches of Chinese Buddhism in hospital clinical palliative units; that is, all of the participants were familiar with the Pure Land School of Mahayana Chinese Buddhism and they all employed the recitation of Buddha's (or Bodhisattvas') name in clinical palliative care units. Nineteen participants had attended a hospice training course run by the Buddhism Lotus Hospice Care Foundation. Three participants attended hospice training from other organizations, such as two participants attended hospice training from the Taiwanese Government's National Health Department (see Table 4.2).

When I was a nurse in hospital, the Buddhist medical staffs thought that hospice care was very important for all people; they were devoted to founding a Buddhist Lotus Hospice Care Foundation. According to documentary data by the Buddhist Lotus Hospice Care Foundation, this foundation was established in 1994. The foundation started to offer continuing education for all volunteers and medical staffs. In 2000, the foundation started to train Buddhist chaplains; they set up special curricula for the Buddhist chaplains; such as 4-stage training courses. So far, they have finished several publications in Taiwan, including academic research and non-academic research; these are good teaching materials for the public in Taiwan.

Table 4.2 : Personal information about the participants

Participant Number	Age	School of Buddhism (monastic places)	Type of training in hospice care	Additional documents received from the participant
Participant 1	56	Pure Land School of Chinese Buddhism	Four-stage palliative training courses run by the Buddhist Lotus Hospice Care Foundation	One written document to answer the research questions
Participant 2	44	Pure Land School of Chinese Buddhism	Four-stage palliative training courses run by the Buddhist Lotus Hospice Care Foundation	
Participant 3	41	Pure Land School of Chinese Buddhism	Three-stage palliative training courses run by the Buddhist Lotus Hospice Care Foundation	
Participant 4	48	Zen (Chan) School of Chinese Buddhism	Four-stage palliative training courses run by the Buddhist Lotus Hospice Care Foundation	
Participant 5	48	Pure Land School of Chinese Buddhism	Four-stage palliative training courses run by the Buddhist Lotus Hospice Care Foundation	The participant's master's thesis
Participant 6	67	Pure Land School of Chinese Buddhism	Four-stage palliative training courses run by the Buddhist Lotus Hospice Care	

			Foundation	
Participant 7	48	Pure Land School of Chinese Buddhism	Training course run by the Taiwanese Government Health Department	Two stories about caring experiences written by the participant
Participant 8	47	Pure Land School of Chinese Buddhism	Four-stage palliative training courses run by the Buddhist Lotus Hospice Care Foundation	
Participant 9	47	Pure Land School of Chinese Buddhism	Training course run by the Taiwanese Government Health Department	
Participant 10	54	Pure Land School of Chinese Buddhism	Four-stage palliative training courses run by the Buddhist Lotus Hospice Care Foundation	Three diaries about the interaction between the chaplain and the patients
Participant 11	54	Pure Land School of Chinese Buddhism	One-stage palliative training courses run by the Buddhist Lotus Hospice Care Foundation	Three diaries about the interaction between the chaplain and the patients
Participant 12	44	Pure Land School of Chinese Buddhism	Four-stage palliative training courses run by the Buddhist Lotus Hospice Care Foundation	Three diaries about the interaction between the chaplain and the patients
Participant 13	48	Pure Land School of Chinese Buddhism	Four-stage palliative training courses run by the Buddhist Lotus Hospice Care Foundation	

Participant 14	60	Pure Land School of Chinese Buddhism	Four-stage palliative training courses run by the Buddhist Lotus Hospice Care Foundation	
Participant 15	50	Tibetan Buddhism	Four-stage palliative training courses run by the Buddhist Lotus Hospice Care Foundation	
Participant 16	46	Pure Land School of Chinese Buddhism	One-stage palliative training courses run by the Buddhist Lotus Hospice Care Foundation	
Participant 17	49	Pure Land School of Chinese Buddhism	Four-stage palliative training courses run by the Buddhist Lotus Hospice Care Foundation	
Participant 18	56	Zen (Chan) School of Chinese Buddhism	Four-stage palliative training courses run by the Buddhist Lotus Hospice Care Foundation	
Participant 19	46	Pure Land School of Chinese Buddhism	Four-stage palliative training courses run by the Buddhist Lotus Hospice Care Foundation	
Participant 20	47	Zen (Chan) School of Chinese Buddhism	Other training courses run by another organization	
Participant 21	33	Pure Land School of	Four-stage palliative	

		Chinese Buddhism	training courses run by the Buddhist Lotus Hospice Care Foundation	
Participant 22	56	Pure Land School of Chinese Buddhism	Four-stage palliative training courses run by the Buddhist Lotus Hospice Care Foundation	

4.2.2 Participants' Buddhist faith

From sections 4.2.2 to 4.2.5, the data is from interviews with participants. In this section, I outline the participants' religious faith, the reasons why the participants became Buddhist monks and nuns, and the participants' religious knowledge of Buddhism.

All participants were familiar with the approaches of Guan-Yin Bodhisattva and used them in their daily monastic practice at Buddhist temples and in their clinical end-of-life care.

<u>The reasons why the participants became Buddhist monks or nuns</u>

Although none of the participants were asked why they had chosen to become Buddhist monks and nuns, some participants talked about their Buddhist faith and why they had become life-long Buddhist monks or nuns. Two monks said that they believed they had also been monks in their previous life; one (Participant 9) majored in Chinese Buddhism and the other (Participant 15) majored in Tibetan Buddhism.

Participant 4 stated that she decided to become a nun because her mother passed away before she was 30 years old. She thought that it is useful for her deceased mother in another world, as the merits of nuns could transfer to the relatives who have died. She said:

> "I was sad at that time and wanted to know where my mother would go after the death. I was very concerned about my mother's future. Therefore, I decided to become a nun and became deeply involved in Buddhism. I thought it would help my mother in another world because I focused on Buddhism, and the merits of these behaviours could benefit my mother in another world." (Participant 4)

During the interview, Participant 4 stated her belief about previous life, this life, and the next life in Buddhism. Participant 6 become a nun because her aunt was a Buddhist nun; Participant 14 became a nun as her father benefitted from "Dai-Bai (Great Compassion) Water". She prayed to Guan-yin Bodhisattva to obtain this Holy water "Dai-Bai (Great Compassion) Water", and she wanted to be a nun forever if her father became better.

Taking Refuge

Taking refuge is an important Buddhist ritual, and through it a person will become a formal Buddhist. According to Epstein (2003), taking refuge with the Three Jewels[2] is the way to become a Buddhist and enter the path to the ending of suffering that comes with full and proper enlightenment (see Glossary of terms used in this thesis)[3]. Participant 12 recalled that she used to follow the ritual of taking refuge when she was training to be a nurse at the Medical University about 20 years previously. She stated:

> "To be honest, I did not realize the real meaning of taking refuge in Buddhism at that time; I just followed my schoolmates to attend the ritual of taking refuge in a Buddhist temple. I read more Buddhism later; I understand the spirit of Buddhism. I decided to become a Buddhist nun about 6 years ago." (Participant 12)

Participants' understanding of their Buddhist faith

The concept of a previous life is a special concept in Buddhism. Believing in a previous life shaped participants' understanding of their current life; for example, Participant 12 spoke of how we experience different fortunes in this life based on our

[2] The Three Jewels are (1) the Buddha, (2) the Dharma, and (3) the Sangha. The Three Jewels are Buddhism's greatest treasures. (Epstein, p.202)

[3] Taking refuge with the Three Jewels is the way one becomes a Buddhist and enters the path to the ending of suffering that comes with full and proper enlightenment. (Epstein, p.168)

behaviour in previous lives. There was a view among the participants that those who had studied Buddhism in a previous life before they were born into this current life, were able to understand Buddhism very quickly in this life.

Karma is a very important concept in Buddhism (see Glossary of terms used in this thesis)[4]. Participant 14 described "Karma" as follows:

> "The patients have their Karma, so it will influence the result. The chaplain can play an important role in supporting them to have good Karma and avoid bad Karma as far as possible; for instance: Buddhist chaplains can remind their patients to engage in positive thinking because it is good for their next life." (Participant 14)

Another participant, Participant 22, explained why there are different Karmas:

> "In fact, Karma influences our fortune; it comes from each person him/herself, not from the God or the Buddha. That is, we can create our own Karma. Most people misunderstand Karma and the results of disease. I thought that it is important for patients to have a better next life. Please do not recall the evil things that patients have done because it is useless and will not help the patient to have a better next life." (Participant 22)

4.2.3 The Buddhist chaplains' attitude toward different religious faith(s)

All the Buddhist chaplains were resolute that they did not need to change the patients' or their families' religion and they thought that it was important to respect the patients' faith. Participant 17 explained how she cared for a patient from another faith:

> "I had a young Christian patient. His parents were Christian chaplains. When I interacted with the patient and his parents, I did not use professional Buddhist terms to communicate with them; I only used the spirit of the Buddha's teachings to help them. The Christian parents were so nice; they could accept me helping their sick son. Actually, they thought the methods I employed did not conflict with Christian teaching. I told the patient that, when you face death, you need to go to the light place and avoid the dark place as much as you can. Because the light place is your God's place, the dark place may be hell, and it is not good for you." (Participant 17)

[4] Please see Glossary of terms used in this thesis. Karma is a Sanskrit term that refers to that which is made by the activity of body, speech, or mind. (Epstein, p.117)

It was the spirit of the Buddhist Heart Sutra which Participant 17 applied with this Christian patient. According to Participant 17's past experiences, many families found that the spirit of Buddhist Heart Sutra was a useful approach no matter whether or not they were Buddhists.

Participant 14 described another situation about caring for a Roman Catholic patient and his family:

> "I had another patient; he had rectal cancer with the advanced distal organs involved, such as his lymph gland and neck. On that day, I entered his room; his older brother took care of his colostomy with a massive stool. The patient told me that the smell was bad because his colostomy was full. The patient wanted me to go away because he thought he smelled bad. I told him that the smell is familiar to me because I passed stool every morning myself. The patient laughed and allowed me to stay in his room. He started chatting with me. At that moment, the nurse entered the room and told me that the patient was Roman Catholic rather than a Buddhist and had told the nurses that he did "not" want a Buddhist chaplain to visit him. I apologized to the nurse because I did not know the patient had told the nurses that he did not want a Buddhist chaplain to visit him. I continued that my teacher had told me that Mary went to the West to help Americans; Guan-Yin Bodhisattva went to Asian countries to help Asian people. The patient allowed me to stay in his room because he agreed with what I said. The patient chatted with me continuously." (Participant 14)

Participant 16 explained that some patients changed their religious faith towards the end of their lives:

> "I think we should respect patients' decisions about their religious faith. One of my friends was suffering from terminal cancer; she was a Buddhist before, but she received a Roman Christian religious ceremony as she thought this would maintain her hope." (Participant 16)

4.2.4 Participants' understanding of their role in end-of-life care

This study sought to understand the role that chaplains believed they fulfill in relation to hospice palliative care.

<u>Compassionate support for patients, their families, and hospice team members</u>

All participants believed that their role in hospice care was to support patients, their families, and the hospice team members. Each participant saw themselves as a

hospice team member and was involved in palliative care team members' meetings. The Buddhist chaplains have a good relationship with palliative care nurses. Participant 1 described the role as follows:

> "I think the role of Buddhist chaplains includes listening to patients and their families, consultant of Buddhist ceremony, offering bereavement care to the family after the patients die, the acting as a spiritual guide to the patients and their families, supporting the hospice team members." (Participant 1)

Participant 8 described how she focused on the psychological aspect more than the religious aspect when she spent time in palliative care units. Participant 6 thought that the role of Buddhist chaplains was to help patients to feel calm. This participant had previously been the senior Head of a School, and had a rich experience of education; she explained that many medical students and nurses appeared to like discussing their stressful experiences in hospital with her.

Some participants thought that spiritual care was an important task of Buddhist chaplains. They identified the skills required of a chaplain to best serve their patient population. Listening skills were seen as important when dealing with patients' emotional and spiritual aspects. Participants believed that it was important for nurses to learn how to spend time with and listen to patients as this would foster mutual understanding. But they also recognized that in the busy wards, many nurses did not have the time to do this. The participants described how many people in society feel lonely; therefore an important role of the chaplains was to offer spiritual care.

<u>The factors influencing their role</u>

Participants believed that the physician's attitude towards chaplains is important for Buddhist chaplains' role. Participant 8 explained how she seldom visited the palliative care units because the physician in charge did not see the Buddhist chaplain as a professional staff member. Another Participant (15) explained,

> "I found that some physicians thought the Buddhist chaplains should guide the patients to learn Buddhist religious methods, I did not agree with it. I thought it is very important that we should notice different patients' or their families' level. I did not force any patients to recite the Buddha's name. If we guide the patients too much, I am afraid it will put too much pressure on them. We cannot deny

> that we have had a previous life; some people studied Buddhism very hard in a previous life; therefore, the people who have studied Buddhism before in their previous life, they could understand Buddhism very quickly in this life. It is impossible for everyone to accept the philosophy of Buddhism. We should respect the patients' and their families' religious faith." (Participant 15)

Another key factor identified as determining their role was the way in which the family of the patient interacted with the chaplain. Some families contacted the Buddhist chaplain after the patient died. Participant 12 explained why caring for the families particularly after patients' death was important:

> "Some families contact us; I spend a long time talking to them. Some families don't wish to talk to us after the patient dies because they are suffering. If the families have contact with us, we do not reject them. But it is important that we should not have the issue of money, for instance, some families give us money for some purpose, but I do not think this was a good idea. I will tell the families how to cope with the death of a patient. I think we should not have a monetary interchange between the chaplain and the families." (Participant 12)

4.2.5 The relationship between the Buddhist chaplains and the nurses

Buddhist chaplains play an important role for nurses. During field work, I observed that the nurses consult and transfer patients to the Buddhist chaplains very often. According to my field notes, during the interviews with participants, Participant 5 stated that when a senior nurse had a problem, she would consult chaplains. Participant 5 used Buddhist religious approaches and encouraged this nurse to engage in positive thinking. The original field note was as follows:

> "I interviewed this Buddhist chaplain in the palliative care unit in the hospital. During the interview, the senior nurse wished to consult her and ask some questions, and said she did not mind if I was also in the room. She asked about two matters: one was that she had had the same dream every night recently, and the other was her special ability and feeling. She saw someone (she thought it was a ghost, not human, not Buddha, and not Bodhisattvas) around the patients; then the patients would die within two days. She spoke to the Buddhist chaplain because she did not know whether she should tell the patients' families. She had several experiences related to different patients when she saw the "special ghosts" and felt a strange coldness. In fact, the weather in Taiwan is hot and the air conditioning in the hospital keeps it quite warm, but this senior nurse always felt a strange coldness when she sees a ghost around the patients. The interaction between the nurse and this Buddhist chaplain lasted about 40 minutes." (See Appendix 6:Field Notes)

Participant 19 explained how co-operative nurses referred patients to her. The nurses did the first evaluation of the end-of-life patients and found that the chaplain could offer better care than other team members. In this situation, the nurses will introduce the chaplains to those patients or their families. Participant 19 also described how several palliative care nurses sought support from the chaplain. One of the areas that chaplains found themselves frequently consulted about was the existence of ghosts. Participant 19 explained that she responded to this question with the following:

> "I don't think it is a very important issue; it isn't good to investigate ghosts. Actually, we could live with any creature peacefully in the same world if we retain a merciful attitude." (Participant 19)

As a palliative care Buddhist nun and a lecturer at a nursing college, Participant 19 recognised that nurses found palliative care units very stressful and because of this they sought her help. Therefore, she offered courses for nurses and nursing students on "stress management and relaxation".

Summary

Chapters Four to Eight present the findings of this study. In this chapter, Chapter 4, the participants' demographic data, and personal information related to their major school of Buddhism, Buddhist faith, their understanding of their role in end-of-life care, and their relationship with the nurses have been outlined. The findings of this chapter are from participants' interviews and written demographic questionnaires. For instance: most Buddhist chaplains in this study majored in Mahayana Buddhism, their roles were focus on using Mahayana Buddhist religious methods to offer spiritual/ psychosocial care. The Chapter 4 is the beginning of the findings in this thesis. The following chapters, Chapters 5 to 7, will present the themes which are arising from Charmaz's (2006) constructivist grounded theory data analysis.

Chapter 5 Compassionate Care

Introduction

Chapters 5 to 7 present the three main themes in this study. As mentioned in Chapter 3, the second phase analysis involves "focused coding", a process used to identify the central themes. Charmaz (2006, p.57) regarded "focused coding" as the second major phase of coding. Once the researcher has established some strong analytical direction through the initial line-by-line coding, he/she can begin the "focused coding" in order to synthesize and explain larger segments of the data. I present the relationship map about the themes and subthemes in Figures 5.1.

In this current study, the three themes emerged from the grounded theory's second phase analysis of the interview data. The three main themes include offering compassionate care, having the experiences of patients' dying process, and applying Mahayana Buddhism in end-of-life care. I present each of the three main themes in Chapters 5, 6 and 7 respectively. The main themes in this current study are the same as the spirit of "focused coding", as mentioned above in Chapter 3 (Charmaz 2006). That is, these themes are the detailed examples of the "focused coding".

All of the participants told me several clinical stories to explain Buddhist chaplains' perspectives and work in the end-of-life care. Some of the clinical stories, using pseudonyms, will be presented in this chapter in order to illustrate the detailed process of Buddhist chaplains' work about compassionate care in the end-of-life care. The detailed content of offering compassionate care at the end of life is presented in Section 5.1, and the relationship map in Figure 5.1. The relevant reflections about compassionate care will be presented in Section 5.2.

5.1 Offering compassionate care in the end-of-life care

All of the Buddhist chaplains believed that they offered compassionate care to patients, patients' families, and the palliative care team members with the intention of

relieving anxiety and enabling patients to experience a good death. Two subthemes emerged within compassionate care as practised by the chaplains, namely, listening and accompanying.

The relationship map for compassionate care is shown in Figure 5.1. Some summary examples of the ways in which the chaplains offered compassionate care are as follows:

Participant 1 commented:

> "The patient's physical health was deteriorating. I supported her to overcome her death anxiety. I applied a compassionate attitude and method to support this patient. I explained the Buddhist concept of death to the patient and hoped that she could accept that she will pass away. I listened to what the patient said and understood her feelings. I told her "Everyone dies. It's a natural process. Letting go is very important, whatever happens."(Participant 1)

Participant 2 spoke of how they (chaplains) applied the skills of compassion to assist patients and their families to feel peaceful at the end of the patient's life. The stories were recorded:

> "There was an old couple, an aged husband (the grandfather) and his aged wife (the grandmother). They were about 83 years old. Their children lived in the USA, and the couple used to live there with their children. The grandfather felt very homesick because of lifestyle and language barrier. When he broke his leg, the couple decided to return to their homeland.
>
> Unfortunately, when they arrived back in Taiwan, the grandfather suffered from head-neck cancer. He had an operation, which left him unable to speak any longer. His consciousness was very clear, so he could accept his disease, but his wife felt a strong sense of attachment to him. She said that they had never argued with each other and had always had a good relationship since they got married 60 years ago. I think it is difficult to achieve, as even good friends argue sometimes, but they never argued and had a good relationship for 60 years.
>
> Because the grandmother felt a strong attachment, she told her husband: 'I hope you will stay with me even if you're unconscious in the future.' I think that the key reason why the old man could not die was because his wife said this. The patient had several bouts of severe mass bleeding from which he nearly died, as it is impossible to stop mass bleeding when the cancer is close to several large arteries, but he survived this serious, dangerous physical situation. For example, his blood pressure was too low, and he lost half his face because of the cancer.

We could see the patient's main arteries and blood vessels very clearly, which meant that he could bleed profusely at any time. His wife could no longer accept the situation, and their children needed to return to the USA for their job. In front of his children, the patient wrote something to ask their children 'If I died, your mother?' I think the patient was very worried about his wife if he died.

The patient's wife could not 'let go' and prayed to Guan-Yin Bodhisattva daily. She recited Guan-Yin Bodhisattva's name with great sincerity. One day, she asked me: 'Master, could you pray to Guan-Yin Bodhisattva for me? I want my husband to continue living with me', but later she could no longer accept her husband's mass bleeding, so she came to find me again and said: I want to "let go". Please would you pray to Guan-Yin Bodhisattva for me? I want my husband to have a peaceful death; I don't want him suffering in order to remain alive." I advised her to tell her husband that she blessed him, would like to let go and hoped he'd have a peaceful death and a better next life"

I told her that, since she'd told her husband that she wanted him to continue living, I thought he worried what would happen to her if he died; he did not know how she'd cope or if their children would look after her, so she could inform him that she'd manage fine alone. She replied 'Master, I know what to say to my husband'. After our conversation, she spoke to the patient, who died very peacefully the next day in his sleep, without any bleeding or suffering. His wife bowed to me and thanked me very formally.

I think that, even though the patient had studied the Buddhist sutras in depth previously, he was worried about his wife and so could not die peacefully. After I applied the skill of compassionate conversation, his wife was able to surrender her strong sense of attachment, and the patient was able to die peacefully. I tell the patients and their families very often that, if we can deal with the issues of this life, forgive and thank others and let everything go well, we will have a peaceful death." (Participant 2)

Participant 3 assisted the palliative care nurses to offer compassionate care; the end-of-life patient's families are referred by the nurses. The clinical story is as follows:

"The nurse called for my help because she had other patients and told me that she needed to deal with the emergencies; for example, she needed to alleviate the patients' physical suffering, so she had no time to deal with a relative's emotions. I promised the nurse that I'd visit the family member, who was the patient's granddaughter. I spent over an hour listening to and supporting this patient's family. She felt guilty and thought that she was not a good granddaughter, so her relative's disease got worse. I applied the compassionate skill and gave the family compassionate support. Finally, the granddaughter agreed with what I said and stopping feeling guilty. In fact, the patient and his granddaughter were not Buddhists, but they accepted me; therefore, I could give the family compassionate support." (Participant 3)

The emotion of attachment[5] is seen in the end-of-life patients and families. Participant 4 also encountered a patient with a strong sense of attachment. She described how she helped him and his wife as follows:

> "A young patient had oral cancer. His wife was very beautiful and his child was very young. We thought that he was close to death, so his wife helped him to put on special clothes in order to face death, but the patient would not die and continued living for about a week. I chatted to him and discovered that he was very worried about his wife. Because she was so young and so beautiful, he thought that she would remarry after he died. After learning about the patient's concern, I rang his wife to discuss it with her. I told her: 'He is very concerned about you, so he cannot let go. I think you should discuss this with your husband', and I suggested that she should recite the Buddhist sutra of ground Bodhisattva. His wife accepted my suggestion and recited the Buddhist sutra for this patient." (Participant 4)

False reassurance is not appropriate in end-of-life care. Participant 8 described the importance of applying compassionate skills but without giving patients or their family members false reassurance:

> "If the patients made unreasonable complaints, we'd listen to what they said. I think that the skill of listening is supportive for them. I think that reciting the Buddha's name is useful for them; for instance, it distracts them from their anxiety and helps them to concentrate on the Buddha's name. I was careful to warn them that the recitation of the Buddha's name could not make everything OK, and did not give them too much of a guarantee. I think it is impossible to guarantee everything. I think that the patients' inner force was important. Someone with a very strong faith will have a strong atmosphere." (Participant 8)

<u>Listening and accompanying is very important in end-of-life care</u>

Participant 11 described spending a whole afternoon listening to and spending time to accompany with an end-of-life patient:

> "The physician's mother was an end-of-life patient. Unfortunately, this physician could not soothe his mother's emotions; therefore, he drove to my temple and begged me to visit his mother. When I met her on the hospital ward, I think I was very lucky because the patient did not refuse to see me even though the patient never met me. I spent the whole afternoon with her, listening

[5] See the Glossary of terms used in this thesis. Attachments are what keep us turning on the wheel of rebirth. Being enlightened is nothing other than severing all our attachments. We can become attached to people, things, experiential states, and our own thoughts and preconceptions. In Buddhist teachings attachments are usually divided into general categories: attachments to self and attachments to dharmas.(Epstein,2003, p.11)

> to her talk for four to five hours. She was 90 years old and very good at Japanese language and dialect (Min-Nan language). She could not speak Mandarin because she'd been born during the Japanese colonial period (from 1895-1945). In fact, I cannot speak Japanese because it was no longer the official language in Taiwan after 1945. Therefore, the patient taught me a 'Japanese song', and was very happy that I spent such a long time listening to her. After my visit, the physician thanked me deeply and bowed to me because I had alleviated his concerns." (Participant 11)

The attitude of respect is important. Participant 12 described how Buddhist chaplains should respect patients or their families' views rather than forcing everyone to accept a religious service as follows:

> "Some relatives have contact with us, and I will spend a long time speaking to them. Some relatives want to talk to us after a patient dies because they are suffering. If the relatives contact us, we don't refuse it but it is important that money isn't an issue; for instance, some relatives give us money for some purpose. I think this is a bad idea. I will tell them how they can assist the dying patient. I think that there should not be a trader relationship between the chaplain and the families." (Participant 12)

Figure 5.1 The relationship map for “offering compassionate care"

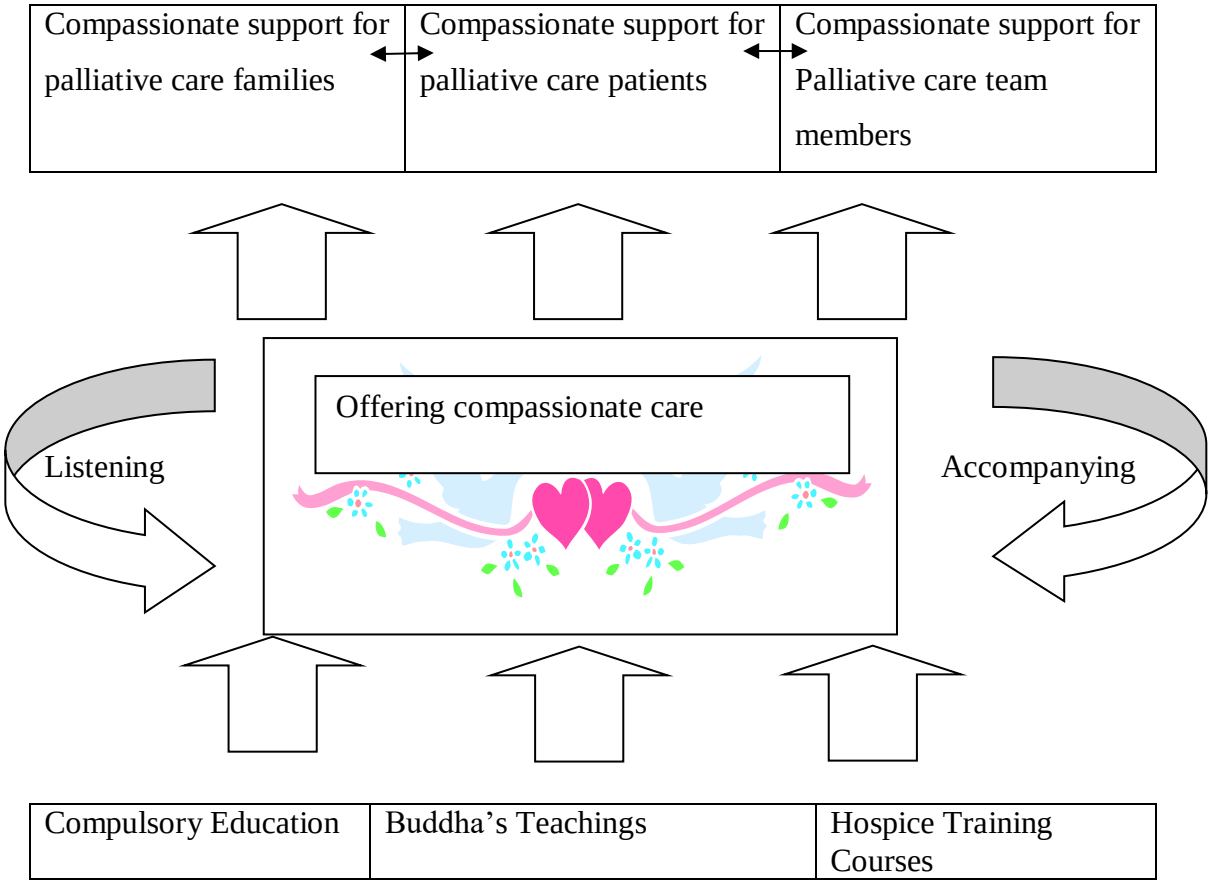


Figure 5.1 illustrates that listening and accompanying are the two main skills in compassionate care. Compassionate care is influenced by the participants’ compulsory education, Buddha’s teaching, and hospice training courses. Buddhist chaplains offer compassionate care for palliative care patients, families, and palliative care team members.

Compassionate care is a multifaceted, dynamic phenomenon which was time-consuming to give: the chaplains on average spent more than an hour in each intervention with patients and their families. The act of giving compassionate care was shaped by the Buddhist chaplains' basic education, hospice training courses, and the Buddha's teachings.

5.1.1 Compassionate support for palliative care patients

The "compassionate support to palliative patients" was linked in to the theoretical framework of the dynamic process of compassionate care. All participants offered compassionate support to palliative patients to deal with their anxiety and other emotional suffering during the dying process. All of the participants spent at least an hour listening to and sitting with patients. In this chapter, I present further evidence from the data to show how participants support the emotions of patients at the end of life.

Participant 4 had a relative who had died in a hospice palliative care unit. She started to attend hospice care training courses because of this end-of-life relative. She described the detailed process about the training course and how she used compassionate skills in a clinical end-of-life care:

> "Because of my experience with my father who was at end-of-life stage, I thought that ill patients need emotional care, so I decided to learn about hospice care. I think I could offer Buddhist religious therapy to patients. I think that hospice care enables patients to feel comfortable and free from any burden. I think that I play an important role in end-of-life care; first of all, I should not feel I am in a respectable position, because this is hospital rather than a temple. When I was less than 30 years old, my mother passed away. This caused me great suffering because she raised me but I would not have any chance to reward her. When I was able to be a filial daughter, my mother passed away. I did not know where my mother was after her death; therefore, I decided to become a nun. When I cared for my first patient at some National Hospital, I felt that that patient was similar to my mother; she reminded me of my deceased mother. I cared for this patient like my family and I thought about how to offer better care to them." (Participant 4)

All of my participants thought that they were able to help the patients or their families to decrease the level of anxiety and uncertainty. Here is an example from Participant 11:

> "We applied the religious method as a kind of psychological care and emotional care. If the pain killer medication is useless for the patients, we should explore the psychological and spiritual aspects of the patients. If the patients have the faith of Buddhist religious methods, the patients' anxiety decreased significantly and then the dosage of medications decreased, the dosage of oxygen decreased significantly." (Participant 11)

Participant 13 thought that the Buddhist chaplains are patients' friends rather than their teachers, even though Buddhist chaplains teach Buddhism in temples or universities. The role of a good friend is to help the patients and their families to express their emotions. She roamed around the hospice palliative care units in hospitals and let the patients and their families know that the Buddhist chaplain could help people in the hospital. This was because some people misunderstood the Buddhist chaplains' role thinking that they only attended funeral ceremonies.

Participant 13 told me the following:

> "Some people thought that the Buddhist chaplains were related to funeral ceremonies, so they had a fear of death when they saw the Buddhist chaplains. I was working at a hospital, and some patients and their families declined to see us for several reasons. We (the chaplains) roamed about the wards. When they see us every day, however, they do not die; they accept us. For instance, if we chat with a patient, the patient in the next bed will overhear our chatting, and the other patients will see that the chaplain has a good relationship with that patient, and so will not be afraid of the Buddhist chaplains. If I exhibit a kindly attitude, the patients and their families accept me. We start to chat with the family. When the family accepts you, it is good for the patient to accept you. I thought that we used skillful psychology, but it is not always helpful in every situation. Therefore, I thought adjusting different approaches are necessary. I met one family member, who cried loudly when they saw me. I put my hand on her shoulder and told her that I could see her suffering. Her husband was sick. She needed to support her husband and her mother-in-law. I let her cry because I thought it was a kind of emotional expression. At that time, we had a short conversation; I told her we will always be friends. If she wanted to talk to me, she could find me to have a chat or share something. She did not need to treat us as a chaplain/teacher, but as a good friend. I thought that I could spend time with her if she needed emotional support." (Participant 13)

Participant 17 had another patient who was a Buddhist. She was putting too much pressure on herself and feeling very anxious. Participant 17 used compassionate skills to calm this patient and described the process as follows:

> "I had a patient, who was a university lecturer. She had had good experience with meditation in the past; she had liver cancer. When she met me for the first time, she told me that she had little time left because her disease was very serious. Actually, I found that she put herself under a lot of pressure. For instance, she could meditate for a long time before she got liver cancer; unfortunately, she complained that her concentration was deteriorating. She was very worried about her physical condition and did not tolerate her medication well after she got the disease. I told her that I understood her situation. I knew that she used to meditate in a seated position before. Actually, there are many ways to meditate, for instance, breathe meditation, or reciting the Buddha's name is also a kind of meditation. If the religious methods put people under pressure, I think they are doing them incorrectly. The patient accepted my advice and modified her practices to reach the goal. That is, she stopped putting pressure on herself. I also told her that we did not need to do the same thing as in the temple because this is a hospital. Her health was poor, so all we had to do was to keep the spirit of Buddha teachings. The religious approaches are flexible." (Participant 17)

Obviously, terminal patients' physical condition is poor and fatal symptoms could occur at any time. These problems not only distress patients but also their families and nurses. Participant 19 gave an example to explain how she offered compassionate care to support the nurses' emotions together with end-of-life patients' emotions in the end-of-life care unit. She stated:

> "I had a patient, who could suffer a massive bleed at any time, which made the nurses and her family feel very stressed. Actually, the patient was suffering because of her family's anxiety. I spent a lot of time listening to what she said. I tried to understand her emotions and deal with her relationship with her family. I found that she told me more information than she told others. Therefore, I could help her to deal with her distress." (Participant 19)

Some end-of-life patients are very young; unfortunately, their life expectancy is very short when they are transferred to a hospice care unit by non-palliative physicians. These patients may be very angry about their disease. Participant 1 shared the following clinical story to illustrate how she applied compassionate skills in clinical end-of-life care units:

> "I met an end-of-life breast cancer patient. Her doctor had told her that she only had two weeks to live. The patient was very angry because she thought she was very young and she should not die so young. Unfortunately, she had a serious disease. She could not accept her disease. I used compassionate skills to listen to her. Then, I guided her to imagine the merciful face of Guan-Yin Bodhisattvas." (Participant 1)

Some participants have the experiences of patients using folk medicine. These participants have a compassionate attitude to deal with this issue in order to prevent the patients suffering from some harmful effect. For instance: Participants 10 and 21 met patients using folk medicine. The original words of Participant 10 and 21 as follows:

> "I had some patients who used folk medicine, they asked me not to talk to the physician about this. In this situation, I reported it to the Head of Nurses because I trust the nurses' professional knowledge; that is, I believe the nurses can judge whether the folk medicine is safe or harmful for the patients." (Participant 10)

> "I met many patients who spent a lot of money to buy the folk medicine, the patients would rather believe in uncertain complementary therapies that are sold by others because the patients denied what the medical doctor said. I found these issues were very common no matter I was a nurse before or a Buddhist nun now. I gave the patients advice not to trust the uncertain complementary therapies." (Participant 21)

5.1.2 Compassionate support for palliative families

The Buddhist chaplains offer compassionate support to end-of-life patients' families when patients are dying and after their death.

Participant 1 described the role of Buddhist chaplains in hospice care as follows:

> "I think that the role of Buddhist chaplains includes listening to patients and their families, presiding at Buddhist ceremonies, offering bereavement care to the palliative family after patients die, guiding the spiritual care of the patients and their families, and supporting the hospice team members." (Participant 1)

Participant 12 thought that the family was the key factor in palliative care units because of the Chinese, family-centred culture existing in Taiwan. Some families contacted her after the patients died. Participant 12 did not reject the patients' families,

even though the patient had died. She thought that it was a good opportunity to support the bereaved family. The skills of listening and spending time with the families are very important as the following clinical stories illustrate:

> "Some families contact us. I spend a lot of time talking to them. Some families don't want to talk to us after the patients die because they will remember their suffering. If the families contact us, we will not reject them, but it is important that money isn't an issue; for instance, some families give us money for some purpose, but I don't think this is a good idea. I will tell the families how to help the deceased patient. I think that money should not be exchanged between the chaplain and the families." (Participant 12)

As some participants had been palliative family members themselves they understood the families' emotions and applied compassionate skills to clinical hospice care. Participant 13 described her interactions with palliative families as follows:

> "I cared for my mother when she was dying. I thought that she had a good death. As I had had this experience, I could care for patients and their families with compassion. I care for the families a lot; for instance, I check that they are wearing enough clothes to protect themselves. Did they leave the hospital to ease their stress? I remembered when I was a palliative relative before; the nurses gave me good advice. I remember I also put myself under a lot of pressure. I reflected on how I went to buy food for myself and my family; I thought that it was a good way to ease the pressure. As I had been a palliative relative before, I could give families good advice on how to ease the pressure." (Participant 13)

Participant 20 noticed how culture influences emotional expression. She commented:

> "I think that different people have different emotional expressions. For instance, they express anger towards their family; actually, they love each other rather than hate each other." (Participant 20)

Participant 16 thought that the bereavement care provided for families is insufficient in Taiwan, and that the Buddhist chaplain could support the palliative families with bereavement care after a patient dies. Participant 16 analysed the reasons for this as follows:

> "I think that the bereavement care is insufficient for the palliative family after the patients die. Some families do not attend the bereavement meetings which are offered by the hospice care unit. In my opinion, the families were not ready

to discuss their bereavement; thus, they were absent in the meetings." (Participant 16)

Some families were very worried about where the patient would go after death. The Buddhist chaplains used compassionate skills to support these families. Participant 17 thought that Buddhism could support these worried families, and commented as follows:

"I think I had compassionate attitude to fully understand the families' emotion. I used the approach of taking refuge to help the anxious family. There was a patient's family. She was a single mother because she had divorced her husband many years previously. She lived just with her daughter; unfortunately, her daughter was terminally ill; the mother was very worried that she would never see her daughter again. I listened to what the worried mother said, and advised her to perform the ceremony of taking refuge[6] with her daughter. She accepted my advice; it was a useful method to help this family. I also taught the mother to recite the Buddha's name to help her sick daughter to have a better next life. The mother recited the Buddha's name ardently for her sick daughter. I applied this method to help the mother to overcome her suffering and anxiety during her daughter's sickness and after she died." (Participant 17)

Participant 5 spent more than an hour supporting a bereaved family after a patient died. She applied compassionate skills, such as listening and spending time with the family, as follows:

"I thought I would care for the family after the patient died. I had known them for more than three years. I had written her story in my notebook. I thought that I could play an important role in assisting her emotional expression. I shared similar experiences to this family. During this whole process, I listened to her talk about her suffering. I had visited her at home once after her husband died. She had no children; only a cat. I thought that I was so lucky to be able to listen to her. I understood that she felt guilty, like other families. For instance, she felt that she had not offered the best quality of care, so her husband did not have a perfect death. I thought that she had seldom cared for other dying patients; therefore, she did not know the dying signs. Even though she worked at a hospital, she seldom saw dying patients. She said that her husband saw Amita-Buddha[7] twice. She saw her husband was having a seizure, so she thought he was sick. That was the key reason why she felt that she had not

[6] See Glossary of terms used in the thesis. Taking refuge with the Three Jewels is the way one becomes a Buddhist and enters the path to the ending of suffering that comes with full and proper enlightenment.

[7] See Glossary of terms used in the thesis. Amita-Buddha, his pure land to the West and the means to rebirth therein. The large Amitabha Sutra explains the causal affinities resulting in the Pure Land of Ultimate Bliss. (Epstein, p.3)

provided the best quality of care. That day, as I listened to her, I realized what she was thinking. I told her, 'You cared for your husband very well'." (Participant 5)

5.1.3 Compassionate support for palliative team members

The Buddhist chaplains supported the palliative team members in adopting positive thinking.

Participant 17 related several clinical stories about how she had supported the medical team members in hospitals. She thought that this was a very important task because, if the medical team members had enough support, they could offer high quality care to the palliative patients and their families; otherwise, it was very difficult to offer good quality care if the nurses did not get enough support. Participant 17 thought that the Buddhist chaplains supported the team members; for example, she found a junior nurse crying as a patient was dying and spent time listening to her. Finally, the nurse felt better.

The original interaction between Participant 17 and this junior nurse was as follows:

"I met a junior nurse involved in hospice care in the hospital. When a patient was dying, she was crying outside the ward. I asked her, 'What happened?' She told me that her patient was dying, and she was suffering very much as she couldn't do anything for him. I asked her, 'What did you do for the patient during his illness?' She replied 'I did many nursing interventions for this patient before, but I can't do anything more for this patient.' I asked her 'Do you feel that this patient was in pain?' She replied 'No.' I guided this crying nurse to think in positive way. For instance, I told her: 'As I know, this patient's wish came true, as he saw his first grandson, who was born during his sickness. Under your care, his discomfort has been alleviated, so his death will be very peaceful. This is your contribution.' The nurse replied 'Is that my contribution?' I replied earnestly, 'Of course. Yes. It is your contribution that has enabled the patient to have a peaceful death. I don't think you should be crying now. You should go to the patient and thank him because you have learned good skills that will enable you to care for other patients also. This patient is a good teacher for you. You should thank him rather than cry about his death.' The nurse accepted my advice, went to the dying patient and talked to him. She would suffer less when he died." (Participant 17)

In this story, Participant 17 gave the nurse help to see her important role as a contributor to patients' good death and better next life. Participant 17 related several clinical stories about compassionate support to team members.[8] She thought that Buddhist chaplains should support hospice team members. One of her stories is as follows:

> "I think it is a very important task because if the team members had enough support, they could offer high quality for the palliative patients and their family; otherwise, it is very difficult to have a good quality of care if the nurses did not get good support. I thought the Buddhist chaplains gave the team members support, for example, a junior nurse was crying when the patients were dying. I found this junior nurse was crying, so I spent time listening to what the nurse said. Finally, the nurse felt better when the patient was dying." (Participant 17)

Participant 19 is a palliative care Buddhist nun and a lecturer at a nursing college. Her educational background is not nursing, but her students are all nursing students. She thought that attitude is very important, and knew that some nurses feel stressed in palliative care units. Some nurses seek support from her. She offered courses for nurses and nursing students in "stress management and relaxation." Participant 19 gave me an example of how her experience helped the nurses and nursing students. She described one patient who could suffer from mass bleeding at any time. It caused the nurses and the family a lot of stress. She described this to the researcher as follows:

> "Actually, I know that nurses also feel anxious about death. I had a patient recently who could suffer from mass bleeding at any time. We had several meetings about this. I was invited to the hospice ward, and we discussed it together. The patient's tumours were at multiple sites within great blood vessels, that is, there was a high risk that she would suffer from mass bleeding. The nurses on the hospice ward were very fearful and stressed." (Participant 19)

Participants 19 and 20 thought that the chaplains should have a compassionate attitude to support the nurses rather than to put pressure on them. Participant 20 commented:

> "I think it's unnecessary to put a lot of pressure on nurses. In my view, they are wonderful; for example, they spend all their time undertaking physical care.

[8] This is a summarized interpretation. I have presented Participant 17's various clinical stories in Chapters 4, 5 and this chapter.

> We shouldn't expect them to offer too much emotional care because they work very hard. I think the nurses are wonderful in Taiwan." (Participant 20)

Some participants had experience of nurses describing specific experiences to them related to when they cared for dying patients. For instance, the Head Nurse wanted Participant 6 to help her to avoid having nightmares. She described this as follows:

> "I met a Head Nurse, who told me that she dreamed very often about a patient who had died; she was very frightened. I said to her, 'Ask yourself, did I do my best when I cared for that patient. If you did your best, the dream means that your patient wants to thank you. Don't worry that the patient's disease wasn't cured, because you did your best to care for him'." (Participant 6)

Participant 6 has another story about support for palliative team members. She said that:

> "I think the role of the Buddhist chaplain is to give the patients' the spirit of calming down; I treated the medical students who interned in hospital and the nurses or other team members as the next (younger) generation. I was a senior Head of School before, I had rich experiences in education; therefore, many medical students and nurses would like to speak with me regarding their stressful emotions in hospitals. I had very good relationships with the team members." (Participant 6)

Some Buddhist chaplains thought that setting up good relationships is an important factor with regard to supporting hospice team members. Participant 15 commented:

> "I thought that the good relationship helped me to support the hospice team members." (Participant 15)

Participant 21 stated:

> "I had a very good relationship with the nurses. For instance, they referred patients to me. I found the palliative nurses to be wonderful. They cooperated with me; they were my good friends. That is the key reason why I could play an important role in hospice care units, such as supporting hospice patients, their families, and cooperating with the hospice team members." (Participant 21)

Participant 8 thought that hospice palliative care involves team work, and that cooperation between the team members is very important in hospice palliative care units.

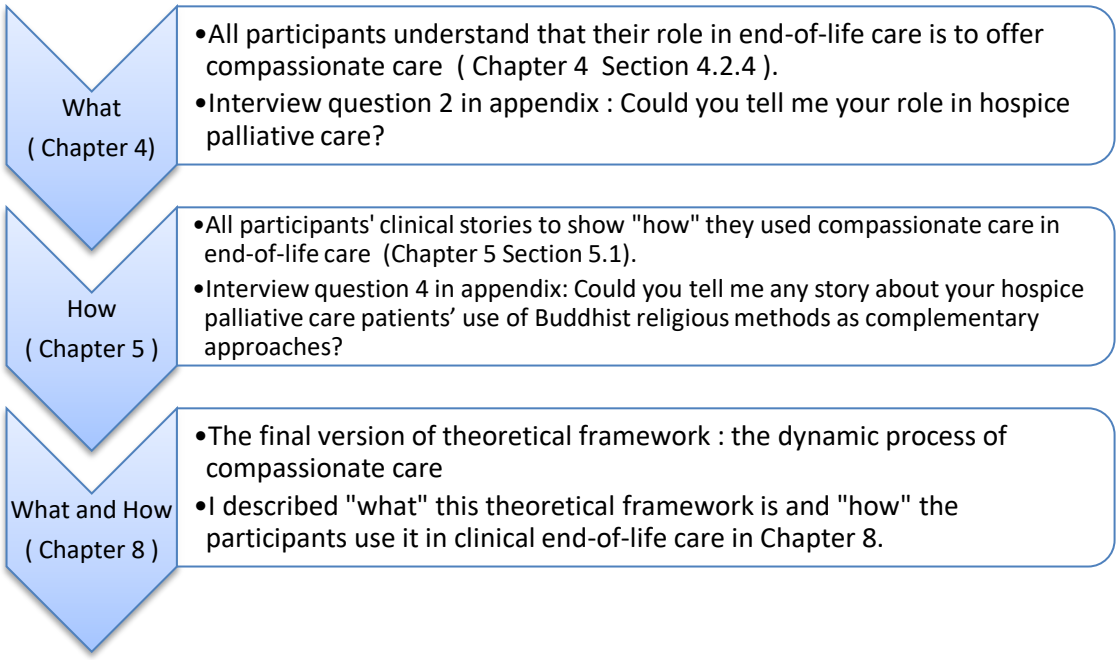
Several of them thought that nurses are very important for them, for instance, the nurses referred the palliative patients or their families to Buddhist chaplains. So Participants also support the nurses. Participant 19 said:

> "I have 8 cooperative nurses who will refer the patients to me. I appreciate the nurses doing the first evaluation for me. I have met several palliative nurses asking whether the ghosts existed in the world. I answered the nurses that it is not a very important issue; curiosity is not very good reason for nurses to try to explore the ghosts. Actually, we could live with any creatures peacefully in the same world if we kept a merciful attitude." (Participant 19)

5.2 Reflections on the theme: compassionate care

In this section, I present further reflections on compassionate care. I present a map of the relationship between this section and previous chapters in Figure 5.2 and I also explain the detailed relationship in the paragraph following Figure 5.2.

Figure 5.2 Map to show the relationship of different chapters to the findings on Compassionate Care



The purpose of this paragraph is to explain the detailed relationships about compassionate care in relevant chapters of this thesis. That is, this is the written explanation about Figure 5.2. As outlined in Chapter 4, all participants' understood that their role in end-of-life care was to offer compassionate care. Chapter 5 Section 5.1 presented the participants' compassionate care in the end-of-life care through their sharing of clinical stories. The purpose of Chapter 8 will be to present the dynamic process of compassionate care in end-of-life care, which is the final version of the theoretical framework.

Therefore, I shall reflect on three issues in the following section: Firstly why is compassionate care so important in end-of-life care? Secondly the clinical stories relating to the Buddhist chaplains' and my own compassionate care, and thirdly how compassionate care is best offered in end-of-life care in the future in terms of participants' and my own clinical stories. The above three aspects will be presented in the following Sections 5.2.1 to 5.2.3.

5.2.1 Why is compassionate care so important in end-of-life care?

There are several reasons to show why compassionate care is important in end-of-life care. In my own past clinical nursing experience in hospitals, I found that dying patients and their families frequently had complicated social issues during the period of the patients' illness and after the patients' death, and it was necessary for nurses to show compassionate care in order to support patients and their families.

I now explore the importance of compassionate care from the perspective of relevant literature. Mok et al (2010) explored healthcare professionals' perceptions of existential distress in advanced cancer patients and found three types of existential distress including the anticipation of negative meaningful activities, and of relationships, and having regrets. Baile et al (2011) explored patients' most important concerns in end-of-life care and found that patients with more concerns had higher levels of anxiety and depressive symptoms. Holtslander (2008) believed that bereaved caregivers are at high risk of distressing symptoms, including depression and sleeplessness, related to a range of complex variables such as age, gender, social support, resources, and their experiences during caregiving. Grande et al (2004) conducted a randomized controlled trial in order to explore the caregivers' bereavement outcome at a hospice homecare and it revealed that inadequate terminal illness support and high symptom severity were related to a worse experience of bereavement for caregivers. In Taiwan, Chiu et al (2010) explored caregivers' grief experiences after their relatives died of cancer, and recommended that clinical professionals should pay particular attention to caregivers.

From the perspective of this study regarding the importance of compassionate care, all participants identified that death anxiety and death fearfulness existed in human society. For example, Participant 13 met patients who did not ever turn off the light or their television because of their death anxiety. She described how patients were very afraid that ghosts would come to the hospital to find them and then they would die soon. These patients believed that the ghosts would appear in the night, as is a common belief in Taiwanese culture. Participant 13 told me that she discussed with

the patients some of these anxiety-provoking issues. The patients expressed very intense emotional feelings with this Buddhist chaplain. The original words of Participant 13 are as follows:

> "I encountered some patients who wouldn't turn off the light or the television because of their death anxiety. For example, they felt very afraid that ghosts would come to the hospital to find them and that they would die soon. The patients believed that ghosts would appear in the night based on Taiwanese culture. I discussed their fears with them, and they described their feelings to me in detail." (Participant 13)

According to the past experience of Participant 16, patients at the terminal-stage often experienced feelings of loneliness, and the Buddhist chaplain recognised that there was a specific role that chaplains could play which was that of accompaniment. Participant 16 said:

> "I thought patients at the terminal-stage often experienced feelings of loneliness. The role of the Buddhist chaplain is to spend time with patients." (Participant 16)

Lee et al (2009) described how healthcare teams actively provided compassionate care to those in the last phases of incurable disease. The authors of this paper were clinical hospice nurses in Taiwan; however, they did not investigate the perspectives of other clinical nurses or health care teams in Taiwan.

According to Betcher (2010), end-of-life patients expect nurses to communicate compassionately with them about their prognoses, treatment options, and goals. Curtis et al (2012) argued that compassionate practice is expected of Registered Nurses (RNs) around the world. Stajduhar et al (2009) did a secondary analysis of data from a large qualitative study on cancer care communication, and found the following key elements to be critically important: respecting the importance of time, demonstrating caring, acknowledging fear, and balancing hope and honesty in the provision of information.

5.2.2 The clinical stories related to compassionate care in hospitals

My previous occupation as a senior nurse in a hospital has given me a valuable insight into the issues raised by my research findings. I had numerous experiences regarding the emotional suffering of dying patients' and their families and I believed that it was very important that nurses should offer compassionate care. However the time limitation did not allow me or other nurses to offer much emotional care because we needed firstly to manage patients' physical problems. As described already, all of the participants in this study recorded offering compassionate care in end-of-life care. However, Participant 20 suggested that it was important not to put too much pressure on the nurses. She recognised the value of nurses' care, describing them as "wonderful" but recognizing that offering physical care in clinical settings occupied significant amounts of the nurses' time. Therefore, chaplains and others should not expect nurses in Taiwan to offer too much emotional care because of their heavy workload. Participant 19 spoke of the stress that nurses were under when working in palliative care units such that some nurses sought support from the Buddhist chaplain. Participant 19 offered courses for nurses and nursing students on stress management and relaxation. Participant 17 thought that the Buddhist chaplains had a role in giving the team members support, for example when a junior nurse was upset and crying when a patient was dying. Participant 17 described a particular case whereby she had offered a supportive role to a junior nurse, listening to the nurse sharing her emotions until the nurse was able to cope with the imminent death of her patients. Their original words are as follows:

> "I think that it is unnecessary to put a lot of pressure on the nurses. They are wonderful, as far as I can see; for example, physical care takes up all of their time. We shouldn't expect them to offer a lot of emotional care because they have so many tasks to do in Taiwan." (Participant 20)

> "Actually, I know that nurses also suffer from death anxiety. I had a patient recently who could suffer mass bleeding at any time. We had several meetings about this. I was invited to the hospice ward, and we discussed it. The patient's tumours were at multiple sites with great vessels, which meant that she was at high risk of mass bleeding. The nurses on the hospice ward were very fearful and stressed. The patient did not have a very good relationship with her family. I discussed with this patient some issues and her family's attitude. I guided her to think positively." (Participant 19)

> "I think that the Buddhist chaplains support the team members; for example, I met a junior nurse who was crying because a patient was dying. I found her

> crying outside the dying patient's ward; therefore, I spent a long time listening to her. Finally, the nurse felt better about the patient dying after I talked with her." (Participant 17)

When I interviewed Participant 3, Participant 3 did not judge whether the nurses' emotional care is enough or not enough in hospital but did tell me an important clinical story. The story was that one day, a patient's granddaughter gave the patient a banana; unfortunately, because the patient was so weak he almost choked and his physical situation became increasingly worse. The granddaughter began to cry on the ward. The Ward Nurse called Participant 3 for help as she recognised the importance of dealing with this emotional incident and did not have the time to care for the family's emotions herself.[9]

Participant 3 promised the nurse that she would visit the family of the patient's granddaughter. She recalled that she had spent more than one hour listening to what the family said and giving them her support. The granddaughter had guilty feelings because she thought that she was not a good person, and so her grandfather's disease was getting worse and worse. The chaplain used her skills of compassionate care to give the family compassionate support. Finally, the granddaughter was able to engage with what the chaplain said and ceased having guilty feelings. In fact, the patient and his granddaughter were not Buddhists but they did not refuse the Buddhist chaplain's offer to meet with them. In this situation, the nurse understood the importance of being able to offer emotional support to the family, but she had important and emergency nursing tasks to carry out on the ward, and so she asked the chaplain to do this. The Buddhist chaplains therefore carry out an important role as the nurses' valued assistants in providing emotional support.[10]

Participant 6 thought that ward team members cooperating together was very important in order to offer compassionate care and she also identified the importance of all workers carrying out their specific roles. She went on to say that physical care

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[9] This is a summarized interpretation. I presented the original words of Participant 3 in this Chapter in the previous Section 5.1.

[10] This is a summarized interpretation. I presented the original words of Participant 3 in this Chapter in the previous Section 5.1.

by the nurses was more important than the nurses' ability to give emotional care as this was what they had been trained to do. Additionally, Buddhist chaplains were trained and skilled to offer more compassionate care for the patients. Nevertheless she thought that the nurses were wonderful in palliative care units. She said as follows:

> "I think the nurses offering physical care is more important than emotional care. The role of Buddhist chaplains is to offer emotional care." (Participant 6)

Reflecting further on the literature, a study conducted by Huang (2012) in Taiwan interviewing Buddhist chaplains revealed that the chaplains believed that their role was to develop compassionate care within the field of end-of-life care. Although there were only four participants in this study, the finding are useful.[11] They revealed that a compassionate attitude is an important monastic practice for Buddhist chaplains based on "Buddha teaching (education)".

In terms of nursing education, Curtis et al (2012, p.792) explored student nurses' socialization in compassionate practice. One of the important findings was that the reduced time that the RN (Registered Nurses) had for being with patients left the students expressing concerns about their own future and the possibilities of professional dissatisfaction with not having sufficient time to care compassionately. Although Curtis et al (2012) used Glaser's grounded theory rather than Charmaz's (2006) constructivist grounded theory to conduct their research, one of their findings was similar to the finding of my study about participants saying that nurses have not enough time to offer compassionate care or emotional care.

Compassion fatigue and stress management in end-of-life care

When I was a nurse in non-palliative care units, I asked my co-workers, who were also nurses, to join in palliative care; they declined my invitation and said that they could not face the issues of death and dying every day. They explained that they had strong

[11] Please see previous Chapter 1. Although Huang (2012) only interviewed four Buddhist chaplains in Taiwan, they had rich experiences both in Buddhist temples and hospice care units, so the participants may reflect the reality of the Buddhist chaplains' attitude. For example, I am also a senior nurse, and I fully understand why many Buddhists refuse western medical treatments, as found in Huang's (2012) research.

emotions of anxiety about death and it was stressful for them to work at end-of-life units because they did not have good stress management. They thought that it was difficult for them to overcome this anxiety and that they really did not have good education about dealing with death when they were nursing students. Recently in the UK and US, the topics of compassion fatigue, burn out and poor stress management have been discussed, but there is a limited literature regarding compassion fatigue among Buddhist chaplains. Gallagher (2013) described how burnout was more likely to result from the stresses of the clinician's interactions with his or her environment; whereas compassion fatigue results more often from the relationship between clinician and patient. In my study, several participants talked about their stress management skills and they gave me their clinical stories to show how they dealt with emotional burdens. All the participants believed that they managed stress well. They described coping strategies such as praying to Buddha, reciting Buddha's (Bodhisattva's) name and doing mindfulness.

In this current study, some participants spoke of mindfulness as an effective way of managing their emotions; moreover, they practised mindfulness meditation very often and thought that that was a good approach to relieve a person's stress. Cook (2010, p.18) believed that the state of mindfulness cultivated in formal meditation practice should ideally develop and become a continuous state of mind in all activity. Sanou (2013) conducted qualitative research to explored meditation prayer, and she found that mindful meditation through the use of prayer serves as a possible standard medical model in those times of pain crisis or suffering. As noted in Chapter 2, in Sanou's study a mixed, purposeful sampling design was used to select a total of 15 students, a final sample of 13 responded to the research questions, that is, the sample size is small.

According to Baer (2011), empirical evidence suggests that mindfulness-based treatments provide clinically meaningful improvement for people suffering from many problems, including depression, anxiety, pain, and stress. Aiken (2006) interviewed six mindfulness participants in the USA. In his study, participants explained that mindfulness contributes to a therapist's ability to achieve a felt sense of the client's

inner experience; to communicate their awareness of that felt sense; to be more present to the pain and suffering of the client; and to help clients become better able to be present to and give language to their bodily feelings and sensations.

Chen et al (2012) conducted experimental research into meditation in mainland China. Their data revealed that a brief mindfulness meditation programme was beneficial for Chinese nursing students in reducing their anxiety symptoms and lowering their systolic blood pressure. In Chen et al's (2012) study in China, the randomized controlled trial was used to present the effects of brief mindfulness. Although Chen et al's (2012) research was conducted in China rather in Taiwan, the majority ethnic group in Taiwan are Chinese.[12] In my current study, the participants only applied mindfulness meditation to themselves; they had not used this Buddhist religious approach about mindfulness for their end-of-life patients or the patients' families.

Alkema et al (2008) investigated the relationship between self-care, compassion fatigue, burn out and compassion satisfaction among hospice care professionals in the USA. The results revealed that self-care strategies related to lower levels of burnout and compassion fatigue and higher levels of compassion satisfaction. Kianpour (2010) interviewed 21 hospital chaplains in Canada, and he found that hospital chaplains not only perform religious ritual but also provide emotional support, and spiritual care, thus, they should manage their work-related emotions in order to protect their own mental health. Although the sample size of 21 hospital chaplains in Canada is not a big sample, we can see the important role of a hospital chaplaincy in Kianpour's (2010) study. Wilson (2014) explored the level of the grief and compassion fatigue in clergy men and women in the USA, and found that clergy's grief response may lead to compassion fatigue. In my study, none of the Buddhist chaplains spoke of compassion fatigue and this may reflect the social and cultural differences that exist between Western and Eastern societies.

[12] I have noted the brief historial development of Taiwan in previous Chapter 1. This data support that the majority ethnic group in Taiwan are Chinese.

In my study, participants described how there were challenges rather than compassion fatigue in end-of-life care. They had strong faith and good experiences to help them to deal with many challenges in hospice care. My participants used the approaches about praying to Buddha (Bodhisattvas) or they taught the patients and their families to pray to Buddha (Bodhisattvas) in order to deal with the challenges in end-of-life care. Nursing education seldom teaches nursing students to use tools of faith such as praying to Buddha (Bodhisattvas) or to other deities. I reflect on my own nursing experience when I was so stressed about a nursing career in hospitals when I was a first-year junior registered nurse. I used the approaches of praying to Buddha and recitation of Great Compassion Mantra in front of Buddha and Bodhisattvas to help me to relieve the stress. After I had recited the "Great Compassion Mantra", I was sure that that was a good way for me to deal with my emotional burden in the clinical nursing setting in hospital; however, it is not always an appropriate approach for all nurses because different nurses have different faiths, including non-religious and religious methods. It was my feeling of compassion that encouraged me to recite this Buddhist Great Compassion Mantra because I really wanted my patients to be free from any suffering.

Participant 4 applied the approach of praying to Buddha in order to relax. In addition, she thought that mindfulness was an important way of managing stress. She explained:

> "I think doing mindfulness is very important; I told myself I have done my best. Basically, I don't suffer too much as I manage stress very well. I appreciate many Buddhists support me, I see my emotions were managed very well. I told myself everything will be going well." (Participant 4)

Reflecting on my own experience, I agree with Participant 4's viewpoint that mindfulness is an important approach to managing emotions because mindfulness is also an important topic of training in nursing education. However, praying to Buddha or God is not always mentioned in nursing education. Smith-Penniman (2006) interviewed 3 clinical Buddhist chaplains in the USA and revealed that Buddhist approaches in pastoral care included mindfulness, as a way out of suffering. The findings also present how clergy can engage with the individual, the congregation,

and the larger community.Williams et al (2005) explored dying, death and medical education from the perspective of medical students and the findings revealed that the students identified the need for coping strategies when confronting the dying patient; they found that writing exercises can help students to reflect on their emotions and feelings and these writing exercises also allow educators to see curricular elements of death and dying.

The emotion of "attachment" in end-of-life care

All participants had come across the emotion of "attachment" in end of life care. Participant 12 thought that human sentiments had very strong emotions of "attachment" in this world; for instance, Participant 12 was working in a hospital as a nurse at that time, but she was very anxious when her father suffered from disease and it was not easy for her to give up the emotion of "attachment". Participant 8 spoke about how "it is very difficult to give up the emotion of "attachment". Some Buddhists with stronger "attachment" find that it is an obstacle to achieving a good death at the end of life. The original words of Participants 12 and 8 are as follows:

> "I think human sentiments have very strong emotions of 'attachment'. When I was working in a hospital as a nurse, my father suffered from disease, I was very anxious about it. I think I have strong emotions of 'attachment', because I am very concerned about my father and his disease." (Participant 12)

> "I think it is very difficult to give up the emotion of 'attachment'. Some Buddhists with stronger emotion of 'attachment', it is an obstacle to achieve a good death at the end of life."(Participant 8)

"Attachment" is not always related to whether or not the person has a religious faith. For instance: Participant 7 said that patients from higher socio-economic groups, such as professors, lawyers and physicians, have strong "attachment" emotions, so it is very difficult for them to achieve a good death because they struggle with "letting go". She spoke of an experience of caring several years previously for a Buddhist nun who required palliative care: unfortunately, the nun did not have a peaceful mind at the end of her life because she was not able to give up the emotion of "attachment". Participant 7 said:

> "I think that when the patient is in the social stage, assisted recitation of Buddha's name is very useful; however, if the patient is in the inner-mode stage, any religious or spiritual intervention is useless for the patient. Actually, the emotion of "attachment" is very difficult to give up; for instance, if the patient or we are the rich man or we had good reputation in the society, it is very difficult to give up this money or reputation; therefore, a good death is more difficult to reach." (Participant 7)

Participant 17 also described witnessing the strong emotion of "attachment" between a patient and her single-parent mother. In this situation, Participant 17 applied the ritual of taking refuge for the patient and her family and told me that this had been helpful for the patient and her family because they believed that they would meet in Amita-Buddha's world after they had completed the ritual.

Participant 17 and other Buddhist chaplains often used the approach of taking refuge with their patients and their families. She thought that taking refuge would provide hope for the patient and her mother. After the patient died, Participant 17 visited the patient's mother who told the Buddhist chaplain that it had been a good way to help her and her daughter: the mother said that she believed that the recitation of Buddha's name would help her to meet her dead daughter again in the future. The mother had trusted the Buddhist chaplain when the chaplain had said that recitation of Amita-Buddha could send blessings to her dying daughter. The dying patient and her mother had not been Buddhists before they stayed in palliative care units, but they accepted the Buddhist chaplain's advice to join in the ritual of taking refuge in order to become Buddhists together. The end-of-life patient's mother thought that it had been a useful way of relieving her emotion of attachment.

In Taiwan, there are many family tombs which provide places where families can meet their ancestors. This is not confined to any one religion, but has been a characteristic of Chinese culture in Taiwan since the Chinese migrated from mainland China to Taiwan from the 17th century onwards. However, I have found little literature about whether it is related to the emotion of "attachment" and whether no matter how we live or die, we would like to meet with our families again. Most people in Taiwan believe family tombs to be a symbol of a family-centred culture based on oral history. Significantly, unmarried daughters and divorced daughters-in-law are not

permitted to enter into the family tombs; therefore, the dying daughter and her single-parent mother (who had divorced her husband when her daughter was a child) in Participant 17's story would not be able to meet up at their family tombs. However, they believed strongly that they could be permitted to meet in Amita-Buddha's (Pure-Land) world because Buddha and Bodhisattvas are extremely merciful. Participant 17 related this story as follows :

> "I think I had compassionate attitude to fully understand the families' emotion. I used the approach of taking refuge to help the anxious family. There was a patient's family. She was a single mother because she had divorced her husband many years previously. She lived just with her daughter; unfortunately, her daughter was terminally ill; the mother was very worried that she would never see her daughter again. I listened to what the worried mother said, and advised her to perform the ceremony of taking refuge[13] with her daughter. She accepted my advice; it was a useful method to help this family. I also taught the mother to recite the Buddha's name to help her sick daughter to have a better next life. The mother recited the Buddha's name ardently for her sick daughter. I applied this method to help the mother to overcome her suffering and anxiety during her daughter's sickness and after she died." (Participant 17)

According to the Buddhism dictionary by Epstein (2003, p.161), a pure land is a land in which Buddha and other pure beings live. The best known of the pure lands described by the Buddha is the Land of Ultimate Bliss of Amitabha Buddha in the West. Omvedt (2003, p. 184) describes how the family-orientated culture of Confucianism in Chinese culture was in conflict with the universalistic ethics of Buddhism, but the differences were not so great, and the rationality of Confucianism proved something of a bridge. According to Hui and Leung (2012, p.147), Confucianism-Buddhism-Daoism has an immense influence on the Chinese conception of good death and hospice care in Taiwan. I agree with Hui and Leung's (2012, p.147) viewpoints from the perspective of my nursing career.

Participants 8, 12, and 17 said that the emotion of "attachment" is related to a "good death" in end-of-life care. Participant 17 did not define the emotion of "attachment" as good or bad, and she did not mention the emotion of attachment as it relates to the

[13] See Glossary of terms used in the thesis. Taking refuge with the Three Jewels is the way one becomes a Buddhist and enters the path to the ending of suffering that comes with full and proper enlightenment.

matter of rebirth. Participant 10 explained the reasons why we will rebirth again and again: for instance, when we do not enlighten our Buddha nature, although it is not easy for most people to find their Buddha nature themselves. Everyone has his/her own Buddha nature and we will die and rebirth again until we find our Buddha nature ourselves and we do not "attach" our "emotion". As Epstein describes:

> "Attachments are what keep us turning the wheel of rebirth, becoming enlightened is nothing other than severing all our attachments. What is meant by "attachment" is the investing of mental or emotional energy in an "object". We can become attached to people, things, experiential states, and our own thoughts and preconceptions. In Buddhist teachings, attachments are usually divided into two general categories: attachments to self and attachments to dharmas." (Epstein 2003, p.11)

On the other hand, Participant 17 taught the dying patient and her mother to recite Amita-Buddha's name in order to deal with the emotion of "attachment". Participant 5 also encouraged her father to recite Amita-Buddha's name to deal with the emotion of "attachment" to the family.[14] For my part, recitation of Amita-Buddha's name and Guan-Yin Bodhisattvas helped me to alleviate the suffering of homesickness, just as Participant 10 encouraged the patients to focus on the recitation of the Buddha's name rather than focus on their sufferings. More importantly, I also believe that recitation of Amita-Buddha's name and Guan-Yin Bodhisattvas will bring blessings to my families no matter where they are.

All participants had met with end-of-life patients and their families who were experiencing emotional suffering, including the period of the patients' illness and the bereavement after the patients died. When I interviewed the clinical Buddhist chaplains, Participant 17's viewpoints were as follows: "Enlightening the patients' inner force is very important because it is the key factor in which the patients can overcome any discomfort physical suffering.[15]

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[14] This is a summarized interpretation. The detailed process and participants' words will be present in Chapter 7.

[15] This is a summarized interpretation. The detailed process and participants' words will be present in Chapter 8.

To sum up, from the perspective of the literature review and participants' clinical stories, end-of-life patients and their families had strong emotions, such as suffering, bereavement, and the emotion of attachment. Therefore, compassionate care is important in end-of-life care in helping patients and their families to deal with these strong emotions. In the following section, I present how we should offer compassionate care in the future.

5.2.3 How do we offer compassionate care in palliative care in the future?

Not all of the patients and their families had accepted religious approaches, so how do we offer compassionate care for non-religious clients in palliative care in the future? In this section, the following approaches from my participants may be applicable to future practice. In previous Section 5.1, I described how participants used compassionate skills, which included listening and accompaniment. In this section, I further discuss and raise some suggestions, such as the skill of listening and the skill of accompaniment.

<u>The skill of listening</u>

The skill of listening is the first step for participants to offer appropriate compassionate care. According to Sacks and Nelson (2007), supporting trust is important when caring for a suffering individual. All participants in this study agreed that when the patients or their families trust them, they can help the patients or their families. Participant 10 thought spiritual care a very important task for Buddhist chaplains. Listening is an important step in getting to understand patients' emotional and spiritual aspects. We should learn how to accompany the patients and listen to the patients. When you accompany patients, you understand them and they also understand you.

Regarding the skill of listening, all participants said that they usually spend more than one hour listening to what the patient or their families said. Participant 11 reported that once she had spent a whole afternoon doing so. I presented several

participants' clinical stories in Section 5.1 of this chapter to show how they are listening with accompaniment to those end-of-life patients and their families.[16]

All participants not only use the skill of listening but also use the skill of accompaniment. I will present reflections on the skill of accompaniment in the following section.

The skill of accompaniment

Participant 16 thought that the skill of accompaniment with the patients is very important so that you can listen to the patients' emotions. Additionally, Participant 16 thought that mindfulness was very important for the Buddhist chaplain because positive mindfulness can bring positive emotions for the patients and Buddhist chaplains. Participant 19 spent a lot of time doing accompaniment and listening to what the patient said, seeing it as a good way to understand the emotional effects on patients and their families. Participant 19 also tried to deal with the relationships between the patients and their families.

All participants came across some patients or their families who declined to meet them, which is an obstacle for Buddhist chaplains offering emotional care. Nurses are not religious staff and therefore, nurses seldom met patients who declined to see them because of religion.

Breitbart (2008) asserts that compassion is an important element of all palliative care clinical interaction; additionally, compassion may be defined by the following practices: hospitality, presence, and listening. Edwards (1998, p.11) suggests that the great value of compassion in Buddhism is that we can work on ourselves to increase our compassion and reduce our selfishness and thus begin to act for the benefit of other; in the process, we will experience freedom from greed, fear, hatred and delusion. Omvedt (2003, p. 109) believes that the development of the doctrine of Bodhisattvas, filled with universal compassion was also connected with the notion of the transfer of

[16] This is a summarized interpretation. The participants' detailed clinical stories are presented in this Chapter's Section 5.1

merit. McGrath (1998) in a study of Karuna Hospice Service (KHS) which is a community-based, Buddhist organization in Brisbane, Australia, collected comments (language/texts) about KHS from 15 participants who are doctors, nurses and administrators, and the data revealed that a major ingredient in the services' success was in achieving an excellent reputation for compassionate work with the dying. Although McGrath (1998) did not develop the theoretical framework of compassionate work, through the words of the participants she showed how the service was a compassionate one. She noted that KHS is a Buddhist organization and that its name, Kuruna, is the Sanskrit for compassion, compassion being the practical expression of wisdom. Keown (2005) believed that compassion is an important Buddhist moral value; that is, particularly linked to the concept of the Bodhisattva's compassion.

Summary

To sum up, this chapter's main focus has been on the reflections about compassionate care between literature and participants' data. Compassionate skills are very important for all participants in end-of-life care. I also shared some personal reflections based on my previous nursing experience in Taiwan and my own viewpoints about compassionate care. I undertook reflections from the aspects of religion and nursing. I summarized the participants' story-telling about compassionate care. For instance: Buddhist chaplains used the skill of Life Review and the attitude of respect to encourage end-of-life patients and patients' families to review life stories. All Buddhist chaplains offered compassionate care during their interactions with end-of-life patients, families and hospice palliative team members. This is the first main theme of my study. I will present the second theme, the dying process, in the next Chapter 6.

Chapter 6 The Dying Process

Introduction

Chapters 5 to 7 present the three main themes in this study. I have presented the first theme ‘compassionate care’ in the Chapter 5. Now I shall present the second theme, having experience of patients’ dying process, in this Chapter 6.

6.1 Having experience of patients’ dying process

The second theme is “having experience of patients’ dying process”. It has two subthemes : “meeting the ghosts” and “meeting Buddha or Bodhisattva”.

The dying process is a complicated physiological process. However, the participants in this current study are Buddhist chaplains; therefore, this section will focus on the perspectives and work of the Buddhist chaplains regarding the dying process of end-of-life patients.

All of the Buddhist chaplains had rich experiences regarding the dying process of end-of-life patients. They thought that it was common for the patients or their families to say that the patients had seen ghosts in the hospital. The Buddhist chaplains thought that they should not challenge what the patients said, even though they could not see ghosts themselves.

All of the participants used their Buddhist religious approaches to deal with the issues. Generally, the recitation of Amita-Buddha’s name or Guan-Yin Bodhisattva’s name was commonly used in clinical settings. All of the Buddhist chaplains thought that a compassionate attitude was the most important tool for dealing with unexplained problems. A further discussion of the dying process will be presented in Section 6.2.

A detailed outline of the participants’ experiences of patients’ dying process is presented in Table 6.1. The relationship map of their experiences of patients’ dying

process is presented in Figure 6.1. Some examples of "having the experiences of patients' dying process in end-of-life care" follow, divided into two subthemes: meeting the ghosts and meeting Buddha or Bodhisattva.

6.1.1 Meeting the ghosts

Participant 2 explained that being able to manage this reported phenomenon was an essential role for chaplains in end-of-life care. In Buddhist belief, dying with a peaceful, undisturbed mind is an important goal, but persons disturbed by ghosts at the end-of-life have reduced abilities to die peacefully. She expressed her personal opinions as follows:

> "I think we should focus on whether the patients feel peaceful more than the professional terms. I have encountered different effects in patients as signs that they are in their final 48 hours of life; for instance: anxiety, seeing the ghost(s) in the hospital, and so on. Some patients show signs of "delirium" during their last 48 hours; for example, they sometimes see something that we cannot." (Participant 2)

Participant 3 described working with a patient who was very distressed and spoke of seeing many mice on the ward. She explained what happened:

> "We could recite the Buddhist sutra of 'Ground Bodhisattvas' for the patient, because this dying process is written very clearly in this Buddhist sutra. I and other monks and nuns in my temple recite this sutra of 'Ground Bodhisattvas' in the temple for the patient. I think that the best way is to recite the Buddha's and Bodhisattvas' names in order to offer blessing to the patient." (Participant 3)

After they recited the Buddhist sutra, Buddha's and Bodhisattva's name, Participant 3 found that the patient's delirium symptoms had reduced and she was no longer visualizing mice on the ward.

Participant 6 explained the dying process from the perspective of Buddhism as follows:

> "I think that, when patients see ghosts, this means that they will die soon because these ghosts are very similar to their next life. In my opinion, it is a good way to deal with important issues; for instance, reciting the Buddha name or Buddhist sutras at the end of life. In my experience, these approaches are

> very useful for both the patients and the ghosts. I was a senior Head of School here. I had a student who was always disturbed by the ghosts. The student's teacher couldn't deal with this problem because the doctor can't deal with the student's ghosts' interruptions. The student's teacher and his patient asked me to help them because I was the Head of School and also a senior Buddhist nun. I thought it was useless to deny that the student had seen ghosts. I taught the student and his parent to pray to the Guan-Yin Bodhisattvas and tell the ghosts that they will do many good things for them and help them to find a wonderful place. His parent and the student did this every day. A month later, the ghosts had disappeared forever, and the student never saw them again." (Participant 6)

Participant 7 also described dealing with patients who said that they saw ghosts. She explained that some families were anxious that their loved one was seeing ghosts while other families interpreted this as a delusional state brought about by the patient's illness. In this situation, the relatives would often say that the patient has seen a ghost. Some felt anxious about this and thought that it might indicate that the patient had a troubled conscience.

> "I think the patients review their life. They talk and interact with people we can't see, so their relatives call these people ghosts. I find that some women who had an abortion at a young age see their baby's ghost at the end of life. I think they feel guilty because they killed their baby (abortion); I don't think that baby ghosts come to palliative care units to visit terminal patients." (Participant 7)

Participant 11 had had several end-of-life patients, who had seen ghosts in the hospital, and she taught them to recite the name of Amita-Buddha or Guan-Yin Bodhisattvas; in addition, she told them that ghosts are definitely afraid of Amita-Buddha and Guan-Yin Bodhisattvas, so this helped to ease the patients' anxiety. Participant 11 commented:

> "I don't think we need to worry about whether it harms the ghosts when the patients say the ghosts disappear after the patients recite the name of Amita-Buddha or Guan-Yin Bodhisattvas, mainly because Amita-Buddha and Guan-Yin Bodhisattvas are extremely merciful, so when patients follow the suggestion to recite the name of Amita-Buddha or Guan-Yin Bodhisattvas, the patients will quickly calm down and the ghosts will disappear finally. In fact, whether the ghosts are in the hospital is not very important; enlightening the patients' merciful nature is more important than finding ghosts." (Participant 11)

Participant 13 described how some patients refused to turn off lights and television:

> "I encountered some patients who wouldn't turn off the light or the television because of their death anxiety. For example, they felt very afraid that ghosts would come to the hospital to find them and that they would die soon. The patients believed that ghosts would appear in the night based on Taiwanese culture. I discussed their fears with them, and they described their feelings to me in detail." (Participant 13)

Participant 15 thought that patients' dying signs are very common in end-of-life care, and that patients could see "people" whom no one else could see. The relatives thought that the patients saw "ghosts" in the hospital. Participant 15 commented:

> "I don't think we need to worry too much about it if patients feel alright when they see "ghosts" in hospital. If the patients are very anxious or fearful when they see the people (ghosts) in the hospital, we can deal with this in several ways, including medical approaches and Buddhist religious approaches." (Participant 15)

Participant 19, who had rich experience of patients' dying processes, commented:

> "I have a lot of experience of patients' dying process. For instance, they often see 'people' whom we can't see. The relatives say that there are a lot of 'ghosts' in hospitals because they believe what the patients say. I don't think we need to challenge what the patients and their relatives say. We should evaluate the patients' conscious level by asking questions." (Participant 19)

Participant 20 had a lot of experiences of patients' dying processes and she thought that it was closely related to patients' Karma from the perspective of Buddhism. She provided the following clinical examples to support her opinions:

> "I think that Karma influences cancer patients' dying process. One patient saw many horrible ghosts every day, which terrified her. Generally, the patients' relatives' recitation of sutras or the Buddha's name helps the patients. I've another way of dealing with ghosts, which is to prepare food for them. Although this is a very popular religious method in Buddhist temples, it is difficult to apply it in hospitals. Actually, reciting a Buddhist sutra or the Buddha's name is a good method to use in hospitals, although preparing food for ghosts is less feasible there." (Participant 20)

Participant 21 also encountered patients who saw things and people that no one else could see. She believes that that there are six worlds and so considered the ghosts one of these six worlds. She commented:

> "I encountered some patients who saw things and people that we cannot see. I believe that there are six worlds, so ghosts are one of these six worlds. Buddha

could see bacteria before the microscope was invented. I believe that some Buddhist monks and nuns can see ghosts when they meditate because their brain waves are very stable. Therefore, they have a special ability; for instance, they can see ghosts and tell people's fortune. I think that this is why we don't need to challenge patients who say they see ghosts in hospitals." (Participant 21)

Participant 22 also thought that ghosts exist based on Buddha's teaching. She described an end-of-life patient at her Buddhist temple as follows:

"I believe that ghosts exist, based on Buddha's teaching because Buddha said that there are six worlds in the realm and ghosts form one of these. We don't need to challenge patients who say they see ghosts. Instead, I encourage them to recite the Buddha's name to help both the patient and the ghosts. For instance, I encourage them to inform the ghosts that they will live in the 'Pure land' (Amita-Buddha's world) together. I remember another nun's mother who lived in our Buddhist temple when she was at the end of her life. This patient saw many ghosts in the Buddhist temple, not only in the hospital. I think that if a patient sees a ghost, it means that death is not far off for them. I believe that a patient can see the ghost from the perspective of Buddhism." (Participant 22)

6.1.2 Meeting Buddha or Bodhisattvas

Participant 5 had very special experiences of patients' dying processes, as she believed that they go to the Amita-Buddha's world after death. She commented:

" I and my family believe strongly that my father definitely is in Amita-Buddha's world (the Pure Land) now. My father said he had seen the Amita-Buddha and two Bodhisattvas come here and pour 'Dai-Bai (Great Compassion) Water' for him, and that Amita-Buddha gave him a very beautiful lotus to welcome him. When my father saw Amita-Buddha was entering the ward, he felt very calm and no suffering. He said he'd seen Amita-Buddha several times." (Participant 5)

Participant 6 shared several clinical stories, one of which was about a palliative patient seeing Amita-Buddha in hospital:

"The patient's wife told me that her husband saw Amita-Buddha standing by the window and sending special gifts to people. I told her that we didn't need to challenge this, just listen and encourage the patient to follow Amita-Buddha." (Participant 6)

Participant 14 also described a patient who claimed to have seen Amita-Buddha:

"One of my patients said he saw Amita-Buddha entering the palliative care ward. Unfortunately, his siblings called to the patient because they noticed that he'd stopped breathing, so Amita-Buddha disappeared and the patient awoke." (Participant 14)

Figure 6.1 The relationship map of experience of patients' dying process

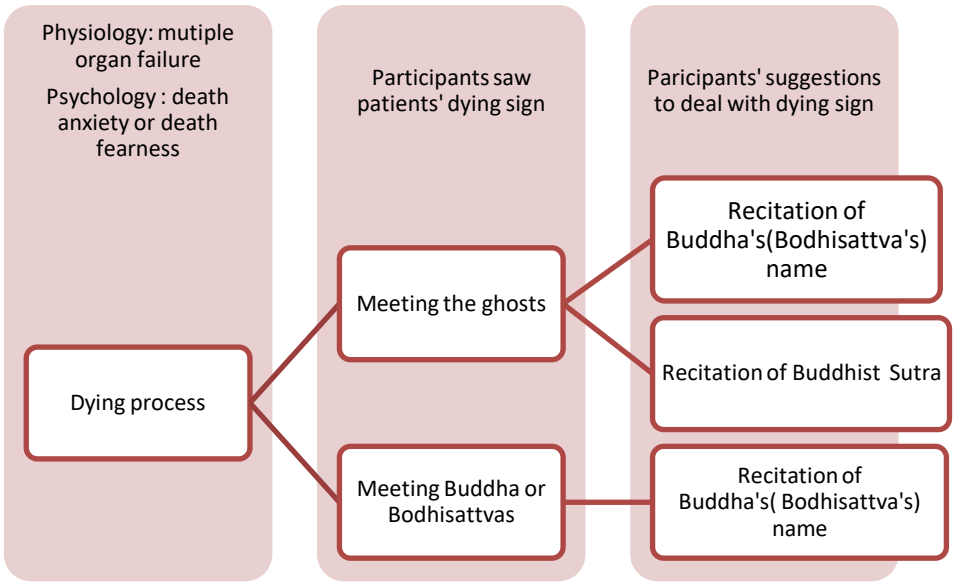


Figure 6.1 illustrates how participants deal with end-of-life patients' dying signs including patients meeting the ghosts and meeting Buddha or Bodhisattvas. Actually, participants thought that the reasons for these phenomena are multiple organ failure from the perspective of physiology, and death anxiety or death fear from the perspective of psychology. Participants suggested and used different ways to engage in the end-of-life care including recitation of Buddha's name (or Bodhisattva's name), and Buddhist sutra in order to help patients to face these phenomena of the dying process.

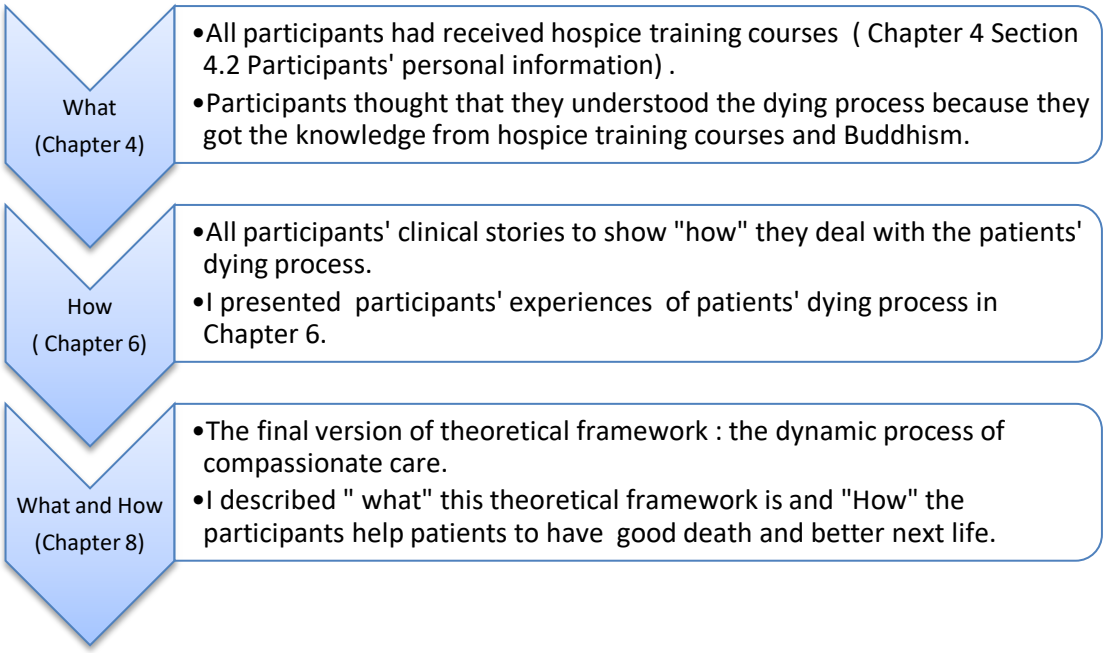
6.2 Reflections on the theme: dying process

In this section, I discuss participants' data and my nursing experience and also make comparisons with the literature reviews. The summarized findings are that all participants (Buddhist chaplains) had experiences regarding the dying process of the palliative patients. They thought that it was common for patients to say that they saw ghosts in the hospitals. The Buddhist chaplains thought that we should not deny what the patients said. Loy (2003, p.7) suggests that even if we choose to ignore all religious claims about an afterlife, we must at least consider the growing literature of personal accounts of near-death experiences. The summarized participants' information related to these reflections is that all participants had received hospice training

courses and they thought that they understood the dying process because they obtained the knowledge from hospice training courses and Buddhism.[17] This section is related to Chapters 4, 6, and 8. I show the relationship map about this section and previous chapters in Figure 6.2 and I also explain the detailed relationship in the next paragraph followed by Figure 6.2.

[17] This section shows a summarized participants' personal information. The detailed information has been presented in Chapter 4 Section 4.2 Participants' personal information and Table 4.2.

Figure 6.2 Map to show the relationship of different chapters to the findings on the dying process



The purpose of this paragraph is to explain the detailed relationship of the different aspects of the findings to the dying process in relevant chapters of this thesis. That is, this is my written explanation of Figure 6.2. In Chapter 4, I described how all participants had attended hospice training courses.[18] Participants thought that they understood the dying process because they obtained the knowledge from hospice training courses and Buddhism. Chapter 6 gave participants' experiences of patients' dying process through participants' clinical stories. The purpose of Chapter 8 is to present the theoretical framework. I describe "what" the theoretical framework is and "how" the participants help patients to have a good death and better next life.[19]

My nursing experiences of patients' dying process

Reflecting on my nursing experiences in hospital in the past, I also had numerous experiences regarding the dying process of patients similar to my research participants. Clark and Philomena (1995, p.49) state that nurses may often have to care for a dying

[18] Please see Chapter 4 Section 4.2 Participants' personal information and Table 4.2.
[19] This is a summarized interpretation. The detailed explanation is presented in Chapter 8 A good death and better next life.

patient who is confused and it is not always easy to establish the cause. They believed that assessment involving all staff and the patient and family was essential. Indeed confusion is very distressing not only for the patient but also for the family and other relatives. During the process of data collection in my study, I met a Buddhist chaplain at a Buddhist organization who did not participate in my study, but who gave me important information regarding my research questions. For example, he told me that he had had several experiences where different families asked him to deal with "ghosts" in the hospital because the dying patients had seen ghosts in hospital and the patients were very anxious and could not sleep. The families hoped that the monks or nuns could help them to deal with the ghosts. Generally, he used "Da-Bai (Great Compassion) Water" and recitation of Buddha's name or Bodhisattva's name to help the patients and their families. This Buddhist chaplain talked to the families and requested them not to take any action to harm the ghosts seen by the patients. He said that "Da-Bai (Great Compassion) Water" and Buddha's name or Bodhisattva's name were very good for both the ghosts and humans.

Buddhist chaplains' approaches to deal with patients' dying process

Participant 11 also had met patients who had seen people who had passed away many years before. When the end-of-life patients reported seeing dead people, the doctors and nurses could not see them (the ghosts). Participant 11 thought that there were two different approaches to deal with this problem; one is the medical approach and the other is the religious approach. Participant 11 thought that we do not need to deny what the patients say when they are experiencing delirium. We can encourage the patients to say more about the ghosts in the hospital. For instance: What is the gender of these ghosts? How about the faces of these ghosts? Are they beautiful? If the patients can answer these questions very clearly, you can encourage them to recite Amita-Buddha's name or Guan-Yin Bodhisattva's name. According to Participant 11's experiences, the patients always followed her suggestions to recite Amita-Buddha's name or Guan-Yin Bodhisattva's name because the patients were afraid that the ghosts would do something to harm them. Participant 11 had several experiences of patients talking about ghosts in the hospitals. The patients would calm

down after they had recited Amita-Buddha's name or Guan-Yin Bodhisattva's name. Participant 11 did not judge whether seeing ghosts is related to death anxiety, whereas Participant 4 did think that some patients saw the ghosts because they might have death anxiety. Sometimes, however, seeing ghosts did not always arouse a patient's anxiety. Participant 2 had met many patients who saw ghosts in hospital and she thought that we do not need to deal with it if the patients were peaceful. If the patients were very anxious when they saw the ghosts then we should do something for the patients. It depends on the emotional effects on the individual patient. The original words of Participant 11, 4 and 2 are as follows:

> "I don't think we need to worry about whether it harms the ghosts when the patients say the ghosts disappear after the patients recite the name of Amita-Buddha or Guan-Yin Bodhisattvas, mainly because Amita-Buddha and Guan-Yin Bodhisattvas are extremely merciful, so when patients follow the suggestion to recite the name of Amita-Buddha or Guan-Yin Bodhisattvas, the patients will quickly calm down and the ghosts will disappear finally. In fact, whether the ghosts are in the hospital is not very important; enlightening the patients' merciful nature is more important than finding ghosts." (Participant 11)

> "I thought we do not need to deny that what the patients saw were the ghosts. I thought recitation of Buddha's name is very useful tool for the patients to overcome seeing ghosts. In my opinion, some patients saw the ghosts because maybe they had death anxiety." (Participant 4)

> "I think we should focus on whether the patients feel peaceful more than on the professional terms. I have encountered different effects in patients as signs that they are in their final 48 hours of life; for instance: anxiety, seeing a ghost in the hospital, and so on. Some patients show signs of 'delirium' during their last 48 hours; for example, they sometimes see something that we cannot." (Participant 2)

Participant 20 described another way of dealing with ghosts namely preparing food for them. That is "*shishi* (施食)", a ritual of food bestowal. It is difficult to carry out in a hospital, but recitation of Buddhist sutra or Buddha's name is a good way in hospital where it is not possible to prepare food for ghosts.

Delirium during the dying process from the perspective of literature review

Barnes et al (2010) conducted retrospective palliative care research in England to find that the terminally ill patients have multiple risk factors for developing delirium.

Although the sample size in Barnes et al's (2010) survey was 61 consecutive referrals made to the team in 2006, they found words that could be used to describe the condition, such as confused, muddled, agitated and restless. In my study, all Buddhist chaplains had met end-of-life patients with delirium. The chaplains said that some palliative families thought that there were ghosts around the patients and did not know that seeing ghosts was a symptom of delirium. Buddhist chaplains knew that this was "delirium" based on their hospice training courses. According to the American Psychiatric Association (1999), delirium is primarily a disturbance of consciousness, attention, cognition, and perception but can also affect sleep psychomotor activity, and emotion. Leonard et al (2008) stated that delirium is often used interchangeably with terms such as "cognitive failure" "terminal restlessness" or "terminal agitation", that delirium in terminal patients can be divided into reversible and irreversible delirium, and that the length of time that the delirium lasts is related to age, severity of cognitive impairment and evidence of organ failure.

My nursing experiences of patients' delirium in the end-of-life stage

Reflecting on previous work, I also had many experiences of patients with delirium in hospitals; these patients could see something (some "people") that we could not see. Honestly, I had no way of proving whether the families thought that those "people" that the patients saw were ghosts; I only recognised that this is patients' delirium and that it is a very common issue in hospitals. All participants in my study said that they applied the skill of compassionate care when the patients had delirium. Some Buddhist chaplains thought that it was wrong for the families to deny what the patients said when in the stage of delirium. According to a study in the USA by Cohen and Pace (2009), in which they interviewed 37 caregivers and 34 patients, delirium in advanced cancer leads to distress in patients and family caregivers, and caregivers themselves also need emotional support and education about how to help delirious patients.

The indications of end-of-life symptoms

Alonso-Babarro et al (2010) reviewed the patients' medical charts in hospitals in Spain; the most common indications for palliative sedation were delirium (62%) and

dyspnoea (14%). In my study, some participants knew about medical interventions to treat patients' delirium, but they were not physicians, and they applied compassionate care to deal with patients' problems. All participants talked about the reasons for delirium from the perspective of Buddhism. From the perspective of medical science, Coggins and Curtiss (2013) thought that delirium was highly prevalent in palliative care; it is multi-factorial and may be related to infection, disease progression, metabolic state or medication toxicity. Hosie et al (2012) conducted a systematic review regarding delirium prevalence, incidence, and implications in palliative care inpatient settings; they found that there is limited consensus on assessment measures or knowledge of implications of delirium screening for inpatients and families; therefore, they suggested that further research is required to develop standard methods of delirium screening, assessment, and management that are acceptable to inpatients and families. In my study, all of the participants knew that delirium is very common in end-of-life patients but they did not have standard methods of delirium screening. Some participants explained the reasons for delirium in end-of-life patients from the perspectives of both Buddhism and medicine.

For my part I never saw the ghosts but perhaps, I could not distinguish who were ghosts during the ritual of *shishi(施食)* even though I had attended the rituals many times. However, the ritual of *shishi* certainly enlightened my compassion. Although this ritual was impossible to test scientifically as to whether the ghosts had got the food and drink, it was true that the ritual helped me to have more compassion as I really did hope that all sentient beings were free from the suffering of hunger for ever. I knew that the attitude of compassion was very important in my nursing career, although there was no direct evidence to refer to the religious ritual that will help persons to cultivate the characteristic of compassion. However, I could not deny that the purpose of the Buddhist rituals was to help persons to enlighten their "Buddha (Bodhisattvas) Nature" which included the spirit of compassion. Stevenson (2001, p. 31) describes how Chinese Buddhism typically classifies the "*shuilu*(水陸法會)" as a rite of food bestowal (*shishi*), with most contemporary performances of the "*shuilu*" in Hong Kong, Singapore, Taiwan (Republic of China), and the People's Republic of China.

When I was working on night duty as a nurse at a hospital, there was one night when after I had turned off the light in a 3-bed patient room, one of these patients asked me not to turn off the light because there were many ghosts in hospitals. She was unhappy that the nurse had turned off the light. This patient's disease was not serious and she would be discharged from this hospital a few days later. I was born in Taiwan, so I knew this patient's reaction was special to Taiwanese culture that no matter whether a person was at the end-of-life or not, they believed there were more ghosts within the hospital than outside. Participant 13 thought that some patients did not turn off the lights or the television because of their death anxiety. For example: the patients said that they were very afraid that the ghosts would come to the hospital to find them and then they would die soon. The patients believed that the ghosts would appear in the night, as is the belief in Taiwanese culture. Participant 13 said that she discussed these issues with the patients and the patients shared very detailed emotional feelings with the Buddhist chaplains. However, it was almost impossible to test how many ghosts there were supposed to be in hospitals. Participant 13 said:

> "I encountered some patients who wouldn't turn off the light or the television because of their death anxiety. For example, they felt very afraid that ghosts would come to the hospital to find them and that they would die soon. The patients believed that ghosts would appear in the night based on Taiwanese culture. I discussed their fears with them, and they described their feelings to me in detail." (Participant 13)

Participant 22 mentioned that the patients saw many ghosts in a Buddhist temple not only in a hospital. Participant 22 thought that if the patient saw the ghosts, it meant that the length of this patient's life was not too long, and that the patients would die soon. She explained to me why the patient could see the ghosts from the perspectives of Buddhism. Participant 22 said:

> "I believe that ghosts exist, based on Buddha's teaching because Buddha said that there are six worlds in the realm and ghosts form one of these. We don't need to challenge patients who say they see ghosts. Instead, I encourage them to recite the Buddha's name to help both the patient and the ghosts. For instance, I encourage them to inform the ghosts that they will live in the 'Pure land' (Amita-Buddha's world) together. I remember another nun's mother who lived in our Buddhist temple when she was at the end-of-life stage. This patient saw many ghosts in the Buddhist temple, not only in the hospital. I think that, if a

patient sees a ghost, it means that death is not far off for them. I believe that a patient can see the ghost from the perspective of Buddhism." (Participant 22)

In fact, not all palliative patients saw ghosts at the end of life; for instance, as I have presented in this Chapter in Section 6.1 already, Participant 5 said that she and her family believed strongly that her father would definitely be in Amita-Buddha's world (Pure Land) after his death in hospital. She said that her father saw the Amita-Buddha and two Bodhisattvas come to the hospital and pour "Dai-Bai (Great Compassion) Water" for him. Her father had said that Aminta-Buddha gave him a very beautiful lotus to welcome him. When he saw the Aminta-Buddha come into the ward, he felt very comforted and had no suffering. Her father had told them that he had witnessed Amita-Buddha several times.[20] Karetzky (2005, p.4) states that the Western Paradise of Amitabha (*Amitofu* 阿彌陀佛 in Chinese) is a land of everlasting bliss. The faithful need to sincerely recite this Buddha's name in order to be allowed entrance, but nine levels of welcome discriminate great souls from inveterate sinners. Foulk (2001, p.19) describes how the Song-dynasty painting 'Amitabha with Two Attending Bodhisattvas', in the collection of the Cleveland Museum of Art, for example, invokes the meditative and devotional practice of Buddha mindfulness (*nianfo* 念佛), for the six characters "Nanmo Amituofo"(Amitabha Buddha) are written above the figures ten times over, as if for repetitive recitation.

Gomes (1996, p.8) thought that much of Mahayana Buddhist literature was devoted to these two issues: the manner in which human beings attain the perfection of Buddhas and Bodhisattvas, and the manner in which Buddhas and Bodhisattvas assist other beings in their quest for liberation from suffering. Loy (2003, p.4) thought that Mahayana Buddhism developed a pantheon of celestial Bodhisattvas devoted to helping us, as well as the promise of a Pure Land accessible to those who appeal to Amitabha Buddha. Epstein (2003, p.23) explained that "Bodhisattva" is a Sanskrit word; a "Bodhisattva" is someone who had resolved to become a Buddha and who was cultivating the Path to become a Buddha; usually the term of "Bodhisattva" was reserved for those who had reached some level of enlightenment. Omvedt (2003, p.

[20] This is a summarized interpretation. The detailed process of this whole story is this Chapter previous Section 6.1.

110) believed that a major contribution of Mahayana was the emphasis on compassion that was involved with the figure of the Bodhisattva who rejected *nirvana* itself in order to save the world.

The above clinical stories from my own past clinical experiences and from Buddhist chaplains are very difficult to measure scientifically. Participant 20 told me that many people believe in ghosts in hospital more than in other places. Participant 21 had met some patients who had seen something that we could not see. She said "it is true that there are six worlds; therefore, the ghosts are one of these six worlds. In Buddha's era, Buddha could see bacteria without a microscope 2500 years ago. At that time, people could not see bacteria before the invention of the microscope." Participant 21 believed that some Buddhist monks and nuns could see ghosts when they were in meditation, their brain waves were very stable, and they had special ability, for instance, seeing some ghosts and being able to predict the person's fortune in the future. The original words of Participants 20 and 21 are as follows:

> "I know that many people believe in ghosts in hospital more than in other places; however, it is very difficult to measure the number of ghosts by scientific methods." (Participant 20)

> "I encountered some patients who saw things and people that we cannot see. I believe that there are six worlds, so ghosts are one of these six worlds. Buddha could see bacteria before the microscope was invented. I believe that some Buddhist monks and nuns can see ghosts when they meditate because their brain waves are very stable. Therefore, they have a special ability; for instance, they can see ghosts and tell people's fortune. I think that this is why we don't need to challenge patients who say they see ghosts in hospitals." (Participant 21)

To sum up, the dying process is complicated and the symptoms of dying include physical, psychological and spiritual aspects. Some problems are caused by multiple organ failure in dying patients, but some symptoms cannot be treated because we cannot remain alive for ever. In my past experience, nursing the soul is a challenging job for nurses; however, Buddhist chaplains are experts in this area. Some questions from dying patients are very difficult for other team members to deal with. For instance: What is a good death? What is eternal life? Where will I go after I die? Kraft (1992, p.6) believed that people could be reborn as animals, and that animals could be reborn as humans, therefore, one's past or future relatives might turn up in the most

unlikely places based on the doctrine of Karma in Buddhism. According to Mullin (1998, p. 33), Karma has three principal types: positive, negative and meditative; these are the three roots of samsaric evolution. Negative Karma results in rebirth in one of the three lower realms; positive Karma produces rebirth in the human, demigod or sensual god worlds; and meditative Karma brings rebirth in the higher heavens of form and formlessness. Keown (2005) suggests that Buddhism is acknowledged as the religion that has the most to say about death and the afterlife in many Asian cultures; that is, Buddhists tend to be psychologically prepared to accept impending death with calmness and dignity. Lee et al (2013) explored "good death" in Singapore from the perspectives of both the dying person and the family; they found five major themes which included preparation for death, good family and social relationships, comfort and physical care, moments at or near death, and spiritual well-being.

The above questions regarding, "What is a good death? What is eternal life? Where will I go after I die?" are difficult to answer for medical staffs because the medical staffs cannot give science-based evidence to support the answers. However, Buddhist chaplains could answer these questions very well. Participant 6 told me of meeting many patients who had death anxiety, and their questions were the same as I had met in my previous work. Participant 6 found that some patients who had strong faith in any religion were sure that they would go to their religious place after they died. Moscrop (1995, p.5) suggests that death in European history is seen as only a gateway to eternal life, with its Christian roots as a major influence. Connor et al (1995, p.179) notes that for Christians, the dead are no longer dead but living in Christ and that the Christian chaplains in hospice care were to be available to anyone who wished to "talk things over". Cuevas and Stone (2007, p.6) asserted that "rebirth is caused by the deceased's craving for existence: the nature of his rebirth is determined by his personally created Karma". Because Cuevas and Stone disagree with the philosophy of the significance of Christian roots, they do not mention the role of Buddhist chaplains in hospice care. Hsu et al (2009) agreed that death is a taboo and that Chinese families will not discuss issues of death and dying for fear of invoking bad luck. Participant 17 thought that the culture in Taiwan was different from that in the West; for instance, many Taiwanese refused to stay in hospice care units, they did not

want to talk about death issues, and they regarded death as taboo. Participant 17 took her grandmother and mother as examples to explain that the death issue is taboo in her family. Bostock (1991, p.8) states that most of us, including the doctors we so readily condemn, are frightened of death - our own death. The original words of Participants 6 and 17 are as follows:

> "I think that, when patients see a ghost, this means that they will die soon because these ghosts are very similar to their next life. In my opinion, it is a good way to deal with important issues; for instance, reciting the Buddha's name or Buddhist sutras at the end-of-life." (Participant 6)

> " I think that the culture in Taiwan is different from that in the West; for instance, many Taiwanese refused to stay in hospice care units; they do not want to talk about death issues and regarded death as taboo, such as my grandmother and mother do regard death as taboo." (Participant 17)

Summary

This chapter has focused on my study's second theme, the dying process. I presented participants' experences and stories in end-of-life care. I also made reflections from the perspectives of participants' opinions and my own nursing experiences. Some questions regarding the dying process are difficult to answer from the perspective of medical doctors or nurses; however, it is easier to find those answers from the Mahayana Buddhism. All participants used the approaches of Mahayana Buddhist religious methods to deal with patients' dying process. Generally, the recitation of Amita-Buddha's name or Guan-Yin Bodhisattva's name was commonly used in clinical settings. I will present the third theme about Mahayana Buddhism and further reflections (discussions) in the following Chapter 7.

Chapter 7 Mahayana Buddhism

Introduction

Chapters 5 to 7 present the main three themes in this study. I have presented the themes of offering compassionate care and of having the experience of the patients' dying process, in previous Chapters 5 and 6. I now present the third theme of applying Mahayana Buddhism in end-of-life care in this Chapter 7.

7.1 Applying Mahayana Buddhism in end-of-life care

All participants used the approaches of Mahayana Buddhism in end-of-life care. There are several subthemes in this theme. I will now present a summary of the main components of the findings related to this theme in the following sections (7.1.1-7.1.6). The relationship map of those participants' approaches of Mahayana Buddhism is shown in Figure 7.1. Further discussions (reflections) regarding these approaches of Mahayana Buddhism will be presented in Section 7.2.

All of the Buddhist chaplains thought that it was unnecessary to change the patients' or their families' religion and that it was very important to respect the patients' faith. It is unnecessary to force patients "always" to see the Buddhist chaplain. If the patients or their families did not reject the Buddhist chaplains, they were happy to visit them and support them as much as possible. Generally, all of the participants applied "Chinese" Buddhism with palliative care patients rather than "Japanese" or "Tibetan" Buddhism. It is worth noting that Participant 15 practised "Tibetan Buddhism" in his monastic place (a temple), but used "Chinese Buddhism" in end-of-life care.

All of the Buddhist chaplains applied the Pure-Land School of Mahayana Chinese Buddhism in their hospice care, that is, the recitation of Buddha's (or Bodhisattvas's) name in clinical palliative care units. Two schools of Mahayana Chinese Buddhism were applied in palliative care units: the "Zen" (Chan) and "Pure Land" schools. In Taiwan, the Amita-Buddha world is more popular than other Buddha worlds, and the

"Pure-Land" school is more popular than the "Zen School". Although there are eight schools in "Chinese Buddhism", only two of these were popular in Taiwan.

All of the participants described the detailed process and final results of their clinical stories about end-of-life care. Generally speaking, these Buddhist religious approaches include the approaches of Guan-Yin Bodhisattvas, the Buddhist ritual of taking refuge, the recitation of Buddha's (Bodhisattvas) name or Sutra, the Buddhist ritual of Confession, breath meditation, and the growth of good Karma. A summary of the participants' clinical stories is presented below.

7.1.1 The approaches of Guan-Yin Bodhisattva

As noted in Chapter One, according to Li (2004), Guan-Yin Bodhisattva Belief is a prevalent folk religion in Taiwan. After World War II, Buddhism publications frequently published stories about Guan-Yin Bodhisattva inspirations, which were subsequently edited into Guan-Yin Bodhisattva Inspiration Collections for circulation by Buddhist organisations (see Appendix 12)[21]. Chapter 4 shows that all of the participants are well versed in the Guan-Yin Bodhisattva approaches in their daily monastic practice at the Buddhist temples. Therefore, they also used the Guan-Yin Bodhisattva approaches in their clinical end-of-life care. Participant 1 commented:

> "I prefer the religious approaches that are closely-related to Guan-Yin Bodhisattvas to help patients and their families. For example, I recite the Dai-Bai (Great Compassion) Mantra for my patients, and imagine that the Buddha and Guan-Yin Bodhisattvas definitely give great blessings to palliative patients and all people in the world." (Participant 1)

Participant 6 described applying the Guan-Yin Bodhisattva approach to guide patients to perform the Buddhist ritual of confession:

> "I thought that I should guide patients to use a method familiar to them. I applied the Guan-Yin Bodhisattva approach to guide patients to confess and thank everyone. The image of Guan-Yin Bodhisattva is the Zen (Chan) school

[21] This is a summarized interpretation. The detailed information is presented in Chapter 1 and Appendix 12.

> of Buddhism. Recitation of the Buddha's name is very useful for patients. It is the approach of the 'Pure-Land' school of Buddhism." (Participant 6)

In fact, all of the participants applied Mahayana Chinese Buddhism in palliative care units in Taiwan as well as the Guan-Yin Bodhisattva approach. Some of the participants thought that patients rejected the recitation of Amita-Buddha's name but were happy to recite the name of Guan-Yin Bodhisattvas. For instance, Participant 11 commented:

> "I think that some patients reject the recitation of Amita-Buddha's name as they have severe death anxiety. I applied the recitation of Guan-Yin Bodhisattva's name and found that patients were very happy to recite it." (Participant 11)

Participant 12 stated that the patients in military hospitals are different from the patients in general hospitals in Taiwan. Generally, these patients had had rich experience of the Civil War between Taiwan and China. The patients at the military hospital were retired military soldiers and were born in mainland China rather than in Taiwan, and their families were also in mainland China. In 1949, the government of the Republic of China (R.O.C) lost the Civil War in mainland China, so these people followed the failed government to Taiwan. It was illegal for people to communicate with people in mainland China from 1949 to 1992.[22] These patients believe in "military war" rather than any religion. Participant 12 said that it was very difficult to discuss religion with them as they do not have any religious faith, but they can accept Guan-Yin Bodhisattva in that hospital because it is part of Chinese culture, and they allowed Participant 12 to give them "prayer beads" (see appendix 13) as gifts. She described her interaction with end-of-life patients who were retired military soldiers as follows:

> "I work in a military hospital; most of them don't have any religious faith. They told me that their life has been warfare, so religion is useless, although, when I

[22] See Chapter 1 about the important Civil War between China and Taiwan. According to the Taiwanese governmental organization, the Tourist Bureau of Taiwan, Republic of China (2014), the most important aspect of Taiwan's cultural history was played by different waves of Han Chinese who brought with them traditional customs from China and created new ones in Taiwan. Those Han Chinese who immigrated to Taiwan over the centuries are southern Fujianese; those who came to Taiwan in the late 1940s because of the civil war between Chinese Communist Political Party led by Mr Mao Zedong and the KMT (Kuomintang) Political Party led by Mr Chiang Kai-shek, in 1949.

> mentioned Guan-Yin Bodhisattva, they could accept it because it is Chinese culture." (Participant 12)

In Taiwan, only five or six Buddhist approaches are applied in palliative care units. The recitation of Amita-Buddha's or Guan-Yin Bodhisattva's name was the most common approach, followed by the Buddhist chaplains or nurses giving patients a picture of Amita-Buddha or Guan-Yin Bodhisattva to look at. This was because, firstly, the Buddhist chaplains received hospice training course from the Buddhist Lotus Hospice Care Foundation, and also because their religion is Mahayana Chinese Buddhism rather than Hinayana Buddhism. The Pure Land faith is very common in Taiwan. In fact, the Guan-Yin Bodhisattva faith is more common than the Amita-Buddha faith because the former also exists within other folk religions in Taiwan. People believe that Guan-Yin Bodhisattva will give them great blessings. When they have death anxiety or hope that death will not come soon, they will recite Guan-Yin Bodhisattva's name.

Holy (Great Compassion) Water in Taiwan

All participants had experiences where palliative patients or their families asked Buddhist chaplains to offer "Dai-Bai (Great Compassion) Water". Participant 20 believed that the effect of "Dai-Bai (Great Compassion) Water" was good for the ghosts and the patients; the effect of this water depended on their faith. Participant 20 said as follow:

> "I think the effect of 'Dai-Bai (Great Compassion) Water' was good for the ghosts and the patients; the effect of this water depended on their faith." (Participant 20)

Participant 14 said that an unexplained situation had happened to her father, and she also used "Dai-Bai (Great Compassion) Water" for herself and some patients or their families in the end-of-life care. Participant 14 said:

> "My father suffered from liver cancer. I pray to Guan-Yin Bodhisattvas for something and got the 'Dai-Bai (Great Compassion) Water', it is very effective, so I decided to be a Buddhist nun forever. I would like to help others by Buddhist religious methods. I think that this is a special gift for my families that I decided to be a Buddhist nun. I think that recitation of Buddha name is very useful for the patients; I also think 'Dai-Bai (Great Compassion) Water' is very

useful in the end-of-life care as this approach is related to merciful 'Guan-Yin Bodhisattvas'" (Participant 14)

Participant 11 holds different viewpoints from other Buddhists regarding "Dai-Bai (Great Compassion) Water". Participant 11 commented:

> "I think we ourselves are 'Dai-Bai (Great Compassion) Water' because our physical body was composed of 70% water and therefore, it is not necessary to find 'outer' 'Dai-Bai (Great Compassion) Water' in different places." (Participant 11)

Participant 12 had met patients and their families who drank "Dai-Bai (Great Compassion) Water" both when she was a nurse before and now that she is a Buddhist chaplain. Participant 12 said:

> "I knew the water was very common everywhere in Taiwan, but it was impossible for people to drink this water and be free from death. Based on Buddha's teachings, death is a natural process, and it is impossible to cure every disease. Rebirth will happen if you have not been enlightened. She thought that many people had misunderstood Buddha's teachings." (Participant 12)

Participant 21 talked about the Taiwanese special culture about "Dai-Bai (Great Compassion) Water" and other folk religious approaches, and said:

> "I also applied 'Dai-Bai (Great Compassion) Water' to myself rather than to the patients. I remember the great earthquake in Taiwan on 21st September 2000. The folk religion was used after the great earthquake in Taiwan, and it was useful for the Taiwanese; however, the Western psychology was useless at that time, we should think different methods were applied in different cultures. If we believe 'Dai-Bai' water is useful, the water will be useful. I do not dis-agree that the 'Dai-Bai (Great Compassion) Water' is used in hospital, but it is not permitted in some hospitals." (Participant 21)

Participant 6 talk about "inner" force and "outer" force about "Dai-Bai (Great Compassion) Water". Participant 6 commented:

> "Buddha's teaching was focused on "inner" force rather than "outer" force; the "outer" force is like finding 'Dai-Bai (Great Compassion) Water' in Buddhist temples or getting it from any other person; the 'inner force' refers to patients enlightening their Buddha nature to make the 'Dai-Bai (Great Compassion) Water', it is a good opportunity to discuss the death issue when the patients or their family want to seek some complementary approaches, such as 'Dai-Bai (Great Compassion) Water' or some religious blessings in Buddhist temples and other religious temples. For instance, when patients or their families would like to find 'outer' water; we can guide them to enlighten their inner force to face the

> death issue peacefully as much as we can. It was not permitted in my hospital to offer the water to the patients. As I know, the 'Dai-Bai (Great Compassion) Water' was applied in hospitals depending on different policies."(Participant 6)

7.1.2 The Buddhist ritual of taking refuge

Taking refuge is an important Buddhist religious ritual. All of the Buddhist chaplains had applied this approach in Buddhist temples, and told me the following clinical stories about it. Participant 17 shared her experience as follows:

> "I think that the relatives are very worried about where the patient will go after death. In this situation, the Buddhist ritual of taking refuge is a good way to help the patients and their families. I have clinical stories about offering bereavement care to the palliative care family after the patients dies. I visited a family after a patient died, who were reciting the Buddha's name very hard. This approach helped the bereaved family to relieve the patient's suffering." (Participant 17)

Some participants had special experiences that differed from their experiences at the Buddhist temples. For instance, Participant 14 told me several stories and thought that the Buddhist ritual of taking refuge was a good way to deal with the problem of patients seeing ghosts at the end-of-life. She commented:

> "Some patients saw ghosts that we couldn't see but the effect of the ghosts was very significant; for example, the patients panicked. We just saw the patient fighting others but we couldn't see the 'people'. I talked to the ghosts and asked them to calm down; I'd do something good for them. Fifteen minutes later, the patient had calmed down and felt better. I think that the Buddhist ritual of taking refuge is good for both the patients and the ghosts." (Participant 14)

In the Buddhist temples, people can follow the Buddhist ritual of taking refuge by themselves, but end-of-life patients differ from healthy persons. For instance, Participant 20 applied taking refuge to a patient and hoped that it would ease his anxiety. The patient was very weak, so his wife helped him to finish the ceremony of taking refuge. Two days later, after taking refuge, the patient died peacefully. Participant 20 said:

> "According to my past experience, death anxiety is very common in hospice patients; guilt feeling also exists in hospice patients. I think that bad Karma resulted in the patents' sufferings. I think that the Buddhist ritual of taking refuge is a very good method for the patients. This method can relieve the

anxiety of the patients. The patient died peacefully, after taking refuge, two days later." (Participant 20)

7.1.3 The recitation of Buddha's (Bodhisattva's) name or Sutra

All of the Buddhist chaplains used the approach of reciting the Buddha's (Bodhisattva's) name or Sutra. That is, they all recited the name of Amita-Buddha and Guan-Yin Bodhisattvas, and encouraged their patients to nurture a desire to go to the Pure Land (Amita-Buddha world) in the future.

Participant 3 encountered a patient who wished to die on a special day, which posed a considerable problem for the medical staff. Participant 3 applied the approach of Mahayana Buddhism to deal with this problem. The original story was as follows:

> "I encountered a patient who wished to die on a special day; the Buddha's birthday. The nurse told me that this was a problem because they can't control the day of the death, so she asked me to help. I went to the patient's room and listened to what she had to say. I understand that she wished to die on this particular day because she thought it was Buddha's birthday and so it would be good for her to die on that day. I told her: 'Every day is a good day based on Buddha's teaching. We don't need to become attached to dying on a specific day. We should just think that this is Amita-Buddha's business rather than our business; all we have to do is to recite the Buddha's name very hard.' After this, I taught her to use the prayer beads and how to calculate the number of recitations of Buddha's name. I took my special bag to her room, which contained a lot of pictures of Buddha. I gave her a picture of Amita-Buddha and told her how Amita-Buddha welcomes everyone to His world (the Pure Land). I gave the patient an assignment to recite the Buddhist sutra of Amita-Buddha, including reading the Sutra, reciting Buddha's name, and giving the merit of reciting Buddha's name to everyone. She followed my advice and did the assignment every day. I visited her again another day. She was still weak but she told me that she did the assignment every day. I told her that was good. Next time I went to the ward was the day after Buddha's birthday, the day when the patient had wanted to die. I asked the nurse when the patient had died, and she told me: 'She died on Buddha's birthday. Her wish came true'. The patient's daughter thanked me, and said: 'Master, you are excellent. You enabled my mother to die on the special day.' I replied: 'Your mother was excellent. She died on the day she wanted. As I know, only excellent monks can achieve this wish, so your mother was excellent. We believe that your mother is in Amita-Buddha's world because she had a good death.' For this reason, the daughter felt less pain about her mother's death. Actually, I was somewhat worried that the patient wouldn't die on the special day, so I told her very

> honestly: 'Every day is a good day based on the Buddha's teaching.'" (Participant 3)

Participant 1 applied the recitation of Amita-Buddha's name to an aged patient, reminding her of the meaning of the Pure-Land of Amita-Buddha, where there is no suffering. The aged patient accepted this view and calmed down, so she was able to concentrate on reciting the Buddha's name, which helped her to overcome her death anxiety and death fear. The original words of Participant 1 are as follows:

> "I applied the recitation of Amita-Buddha's name on the old patient; for instance, I reminded the patient of the meaning of Pure-Land of Amita-Buddha, there is not any suffering in this Amita-Buddha's world. The old patient could accept this viewpoint and her emotion calmed down and then she could concentrate on the recitation of Buddha's name, this method helped the old patient to overcome the death anxiety and death fear." (Participant 1)

Participant 7 had a special viewpoint; for example, if the patients were at the special stage, it was useful to apply any religious approach, such as reciting the Buddha's name. However, if the patients were not at the special stage, any religious method or spiritual intervention was useless to them. Participant 7 commented as follows:

> "I think that, if the patients are at the special stage, assisting them to recite the Buddha's name is very useful, however, if they are at some stage, any religion or spiritual intervention is useless to them. In fact, the emotion of 'attachment' is very difficult to give up; for instance, if the patients or we are rich or we have a good reputation in society, it is very difficult to give up this money or reputation; therefore, a good death is more difficult to achieve." (Participant 7)

There is little research on why participant 7's viewpoint is different. It is true that Participants 7 and 12 had different PhD careers; for instance, Participant 7's opinions originated from her PhD supervisor at university, and Participants 7 and 12 had different academic supervisors and studied different PhD courses at different universities. Participant 12 commented as follows:

> "I think that the recitation of Buddha name is the most useful method in palliative care units. I know that breath meditation was applied in palliative care units; however, I think that it is not easy for some patients. The method of Zen (Chan) school in Buddhism is very difficult for the patients because many patients were not monks or nuns previously. I think that the picture of Buddha is very important in the palliative care units in hospital. I sent a patient the prayer beads as a gift; it is a great blessing to the patients and their families. Sometimes, the patients reject the Buddhist chaplains but they do not reject the Buddhist

volunteers. I think that we should respect the patients' faith, we should not force them to receive our religion." (Participant 12)

7.1.4 The Buddhist ritual of Confession

Participant 2 thought that the approaches of confession and reading Buddhist sutras were useful for patients:

> "I think that confession is a useful method for helping patients. Reading Buddhist sutras is a very good method to employ in palliative care units. The families read the sutras for the patients. Although the patient was deteriorating, if the family keeps reading the Buddhist sutra, this supports both the families and the patients." (Participant 2)

Participant 17 described the approach that she believed made a difference to reassuring patients and bringing them to a state of calm before death. She recognized that the process of confession was an important tool, especially the components of forgiving others and forgiving yourself. However, she explained that confessions should be treated very carefully because confession can exacerbate guilty feelings and have a negative rather than a positive effect on enabling patients to become peaceful and able to think positively towards the end of life. She related one story of a patient who felt guilty because she had raised chickens and sold them at the market, after which the chickens were killed in the market. Participant 17 described how her role in this case was to alleviate the patient's guilt to allow the patient to become calm. She commented as follows:

> "I think the process of confession is an important tool, especially the components of forgiving others and forgiving yourself. However, the confessions should be treated very carefully as confession." (Participant 17)

Participant 20 also applied the Buddhist ritual of confession. However, end-of-life patients in hospitals are different from healthy persons; therefore, she did not apply the traditional ceremony of confession. She commented as follows:

> "I told the patient that you will be forgiven, no matter what you've done. It is impossible to apply some religious methods in hospitals but it is possible to apply these methods in Buddhist temples." (Participant 20)

7.1.5 Breath meditation

There are examples of the Buddhist chaplains applying "breath meditation" with clinical palliative care patients with significantly effective results. Participant 4 commented:

> "I applied breath meditation with one patient; she was short of breath so she felt serious and air hungry. The physicians have tried Western medication and medical interventions, but their prescriptions had not had the anticipated effect. I tried to teach the patient to relax, imagine the Buddha or Bodhisattvas standing in front of her, then adjust the speed of her breathing. Several minutes later, the approach alleviated the patient's discomfort. In fact, breath meditation is applied by most Buddhist monks and nuns in the Buddhist temples. It is a very useful tool for anxious people." (Participant 4)

Participant 1 applied the "breath meditation" approach combined with "guiding the patient to imagine something". She described this as follows:

> "I held the patient's hand gently and said 'Don't think about anything; just watch your breath'. I guided this patient to do breath meditation. I found that the patient's shortness of breath and anxiety eased. I asked her: 'Did you prefer to go to the coast or climb a mountain before you developed this disease?' She replied: 'I preferred to climb a mountain'. I asked her: 'Which mountain did you like to climb?' She replied: 'I liked to climb to the top of Mount Yang-Ming', so I guided this patient to imagine climbing Mount Yang-Ming. I told her: 'OK, let's relax totally, and imagine you're lying on soft grass on Mount Yang-Ming. The sun's shining down on you very warmly and gently. The wind ruffles your body lightly. Imagine that you can smell the wonderful smell of the plants and grass'. I guided this patient to have a good image, then started to repeat 'the great compassion mantra' for her." (Participant 1)

Participant 17 thought that the breathing meditation method was a kind of Buddhist religious approach but that it also was applied to all patients because everyone can breathe like this, not just Buddhists. Participant 17 applied the Buddhist religious method of concentration and relaxation to help patients because she was a nurse before she became a chaplain. She explained the medical mechanism of this Buddhist religious method very clearly and guiding patients to do breathing meditation is easy for her, based on her past experience in hospital palliative care units. She said as follows:

> "I think that breathing meditation methods is a kind of Buddhist religious method, but it is also applied to all patients because everyone can breathe not only Buddhists can breathe. I apply the Buddhist religious method regarding concentration and relaxation to help patients because I was a nurse before;

therefore, I can explain the medical mechanism of this Buddhist religious method very clearly. Guiding the patient to do breathing meditation is not very difficult based on my past experience in palliative care unit in hospital." (Participant 17)

7.1.6 The growth of good Karma

Karma is an important concept of Buddhism.[23] Several participants mentioned the role of Karma in end-of-life care. Participant 14 thought that patients' Karma will influence their future; the results depend on themselves. The chaplain could play an important role in helping them to have good Karma and avoid bad Karma as far as possible. The Buddhist chaplains could remind the patients to think positively, because this benefits the patients' next life. Participant 14 stated:

> "I think that patients have Karma and this will influence the result in this life. The Karma of the patients' result depends on themselves. The chaplain can play an important role in helping them to have good Karma and avoid bad Karma as far as possible. The Buddhist chaplains can remind the patients to think as positively as they can because it is good for the patients' next life. I agree with Professor Chen that a Buddhist chaplain's role is similar to that of a midwife who welcomes a new baby into the world. We hope that the patients will have a better next life. We mention the patient's good actions as much as possible because this method will bring the patient good Karma." (Participant 14)

Participant 2 thought that we can imagine the picture of Buddha and remind patients about their good actions (behaviour) in this life to benefit their next life. She shared several stories with the researcher, including one about a patient who was almost 100 years old. The chaplain conducted a life review and reminded the patient about her good actions in this life. I have cited the detailed whole story of Participant 2 previously in Chapter 5.

Participant 22 explained to the researcher why people have different Karma. In fact, Karma influences our fortune. She thought that Karma depends on each individual rather than on God or Buddha. That is, we can create our own Karma from the

[23] See Glossary of terms used in this thesis. Karma is a Sanskrit term that refers to that which is made by the activity of body, speech, or mind. (Epstein 2003, p.117)

perspective of Buddhism. Most people misunderstand Karma and the results of disease. Participant 22 stated:

> "I think that Karma influences our fortune; it depends on each individual rather than on God or Buddha from the perspectives of Buddhism. That is, we can create our own Karma. Most people misunderstand Karma and the results of disease. For instance, a risk environment will result in cancer; unhealthy habits in this life will result in disease; if you don't manage stress well, your immune system will be destroyed and you will suffer from some disease." (Participant 22)

Participant 22 also applied life reviews in the same way as other Buddhist chaplains' approaches, and she encouraged patients to recall their good behaviour in this life. She was sure that this method was what Buddha taught, which was written in the Buddhist sutras, and also applies to non-Buddhists. She thought that it was important for patients to have a better next life, and not to mention any bad behaviour by patients because it is pointless and will not help them to have a better next life.

Fitchett et al (2015) conducted a systematic review to explore the role of diginity, and they found that Chochinov proposed Diginity Therapy (DT) as a psychotherapeutic intervention for people facing serious illness. It has a heightened importance in the end-of-life care, and has some similarities with Life Review.

In my current study, no participants mentioned Diginity Therapy, but most of them use the skill of Life Review, such as establishing relationship, sharing words of love, and so on, such as the stories of Participants 2, 14, 17, and 22. They combined Buddhist religious philosophy and Life Review to help end-of-life patients to have good Karma in order to have a better next life.

Some participants mentioned that faith and Karma are important factors for people. To summarise, the patient's faith is a key factor. If patients do not believe in any religion, it is useless to apply Buddhist religious methods. If a patient can accept Buddhist religious approaches, this will help them to achieve a good death.

Figure 7.1 The relationship map of religious approaches of Mahayana Buddhism

Figure 7.1 illustrates how the Buddhist chaplains described the different ways that they engaged in the end-of-life care, which included the approach of Guan-Yin Bodhisattvas, the Buddhist ritual of taking refuge, the recitation of Buddha's (Bodhisattva's) name, the Buddhist ritual of confession, breath meditation, and the growth of good Karma. All of these approaches belong to Mahayana Buddhism.

In this section I have summarized the main components of the third theme: "Applying Mahayana Buddhism". I shall now present further discussions (reflections) in the following section.

7.2 Reflections on the theme: Mahayana Buddhism

In this section, I present the reflections from the perspective of the participants' data and literature review. The summarized findings are that Mahayana Buddhism has a complicated historical development from India to China and then to Taiwan. As mentioned in Chapter 1, according to McGovern (1997, p.1), Buddhism is divided

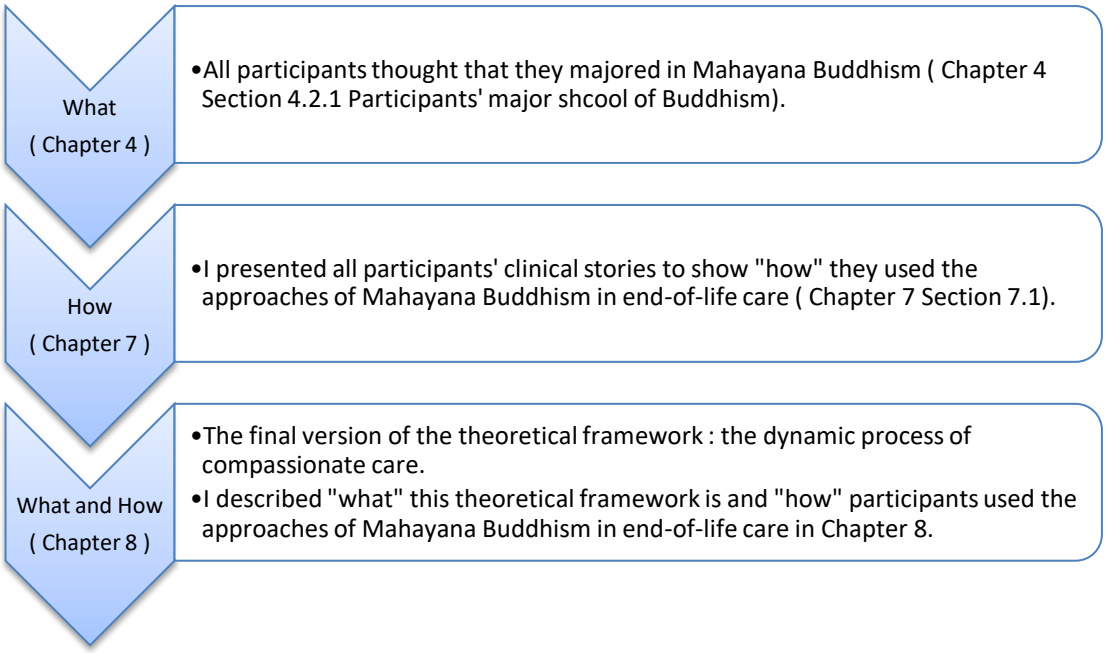
into the two great schools of Mahayana and Hinayana Buddhism. He stated that Mahayana Buddhism was introduced into China in the first century A.D and was firmly established by the fourth century (1997, p.24). According to Watts (2012), the Buddhist understanding of death and the subsequent practices developed for dying and the moment of death have been its hallmarks since it originated in India 2,500 years ago; that is, caring for end-of-life patients and their families could date back to the time of the Buddha.

The religious approaches belonging to Mahayana Buddhism are very broad in China. However, all participants only used some approaches of Mahayana Buddhism in Taiwan. The approaches that all participants used were presented in this Chapter in Section 7.1.[24] The participants' information considered in these reflections shows that the major school of almost all participants' is Chinese Buddhism, with a focus on the Pure Land School or Zen (Chan) school. Only one of the participants majored in Tibetan Buddhism but he used the approaches of Chinese Buddhism in clinical palliative units in hospital. That is, all of the participants were familiar with the Pure Land School of Mahayana Chinese Buddhism and they all applied the recitation of Buddha's (or Bodhisattva's) name in clinical palliative units.[25] This section is related to Chapters 4, 7, and 8. I show the relationship map pertaining to this section and the relevant chapters in Figure 7.2 below and I also explain the detailed relationship in the paragraph which follows Figure 7.2.

[24] Please see in this Chapter previous Section 7.1 and Figure 7.1 The relationship map of those approaches to Mahayana Buddhism.

[25] This section shows summarized participants' information, the detailed information has been presented in Chapter 4 Section 4.2.1 and Table 4.2.

Figure 7.2 Map to show the relationship of different chapters to the findings on Mahayana Buddhism



The purpose of this paragraph is to explain the detailed relationship of Mahayana Buddhism to relevant chapters of this thesis. That is, this is the written explanation about Figure 7.2.[26] Chapter 7 presented all participants' clinical stories in order to show "how" they used the approaches of Mahayana Buddhism in end-of-life care.[27] The purpose of Chapter 8 is to present the theoretical framework. I described "what" the theoretical framework is and "how" the participants used the approaches of Mahayana Buddhism in end-of-life care. They thought that Mahayana Buddhism is the Buddha's teachings.[28]

Actually, Buddhism has spread throughout the world; the literature review about the development of Buddhism has been mentioned in Chapters 1 and 2. However, some of my research participants said that Buddhism in Taiwan is different from elsewhere for complicated reasons. Participant 21 commented:

[26] Please see Chapter 4 Section 4.2.1 Participants' major school of Buddhism.
[27] This is a summarized interpretation. The detailed explanation is presented in this Chapter Section 7.1 Applying Mahayana Buddhism in end-of-life care.
[28] This is a summarized interpretation. The detailed explanations are presented in Chapter 8.

> "I think that Buddhism spread to mainland China, so the methods and meaning of the Buddha's teachings changed a little at that time in ancient mainland China because Chinese culture was different from Indian culture. I know that there were many approaches in the 'Pure Land School' of Buddhism; however, we prefer just one method in Taiwan. In my opinion, the other methods of the 'Pure Land School' of Buddhism are also very wonderful methods, so we should rethink this issue." (Participant 21)

Cheng (2007, p37) states that mainstream Buddhism in Taiwan during the early period was not orthodox Chinese Buddhism by the time of the Japanese colonial administration in 1919. However, since Buddhist discourse in post-war Taiwan had for a long time been dominated by the quasi-authority Buddhist organisation, it is the monastic form of Chinese Buddhism. Participant 22 mentioned that one of her patients believed in "Japanese Buddhism", and she encouraged this patient to apply "Japanese" Buddhism but the patient did not get the benefits from this religion at the end of life. Finally, Participant 22 and her patient gave up the method of Japanese Buddhism and adopted that of Chinese Buddhism to help the patient to have a peaceful death. From this clinical story, Participant 22 said that "no matter how we apply Chinese Buddhism, Japanese Buddhism, or other religions, the religious faith is important to help people." The original story given to me by Participant 22 was as follows:

> "I had a patient, the patient and his wife believed in 'Japanese Buddhism', I encouraged the patient to apply 'Japanese' Buddhism but the patient did not get the benefits from this religion at the end of his life. The patient's wife said they had many friends in Japanese Buddhist society in Taiwan. These people will help the patient and his family when the patient is dying. I think the Buddhist model in Japanese Buddhism in Taiwan is not perfect, but I should respect the patient's religion, therefore, I encouraged them to use their methods to face the death issues." (Participant 22)

<u>The approaches of Guan-Yin Bodhisattvas</u>

The approaches of Guan-Yin Bodhisattvas from the perspective of Mahayana Buddhism are examined. For instance: Karetzky (2005, p.1) states that the Guan-Yin Bodhisattva has played a uniquely important role in Asian religious life. At first the Guan-Yin Bodhisattva was an attendant to the Buddha of the Western Paradise, who guides the soul in death to the Land of Eternal Bliss. According to Karetzky (2005, p.4), the Western Paradise of Amitabha (Amitofu in Chinese) is a land of everlasting bliss, and the faithful need to sincerely say this Buddha's name to be allowed entrance,

but nine levels of welcome discriminate great souls from inveterate sinners. McGilloway and Myco (1985, p.29) agree that the Mahayana Buddhism believes that there are many Buddha and it has a doctrine of heaven and hell with salvation by faith and grace. Yu (2001, p.3) notes historical and cultural connections with Guan-Yin Bodhisattva in China because of the example of wisdom or meditators and the "Goddess of Mercy" who is particularly kind to women.

Yu (2001, p.x) mentions her own personal story in her publication:

> "This happened in the predawn hours by the banks of the Yangtze River in Wuhan, after the war had ended. We had been waiting for three months in order to secure seats in a boat that would take us back home. Finally, our chance came and the whole family was camped by the riverbank, waiting to get on board. Suddenly, my grandmother insisted that we not board the ship because she had a vision of Guan-Yin Bodhisattva standing in the middle of the river and gesturing with her right hand for my grandfather to stay away. My grandmother immediately knew that Guan-Yin Bodhisattva was telling her that the ship was not safe. Soon after leaving port, the ship ran into mines planted by the retreating Japanese army. It sank. If we had been on board, what chance would we have had of surviving the shipwreck when none of us could swim and the children were so very young (my brother was five and sister two)? This question had haunted me ever since." Yu (2001, p.x)

This above story is about an event in mainland China near the end of World War II. Interestingly, it was well-known that the statues of Guan-Yin Bodhisattvas in Long-Shan temple survived the bombing by the Allied aircraft on 8 June, 1945 (also near the end of World War II). In Taiwan, many Taiwanese believed that Guan-Yin Bodhisattvas protected them during these war periods because before 8 June, 1945 some Taiwanese saw and heard Guan-Yin Bodhisattvas say to them that some places would be dangerous on the day of 8 June 1945, so please tell people do not go to these places. According to Li (2004), after World War II in Taiwan, Buddhism publications frequently published stories of Guan-Yin Bodhisattva inspirations. The styles of inspiration collections include inspirational events, Guan-Yin Bodhisattva stories, relevant scriptures and hymns, and introductions to various approaches of studies. The contents generally contain stories testifying Guan-Yin Bodhisattva's mercy bestowed to relieve the characters of the stories from illness, flood, robbery, war, and

entrapment, as well as answers to prayers for rain, children, evil exorcism, life prolongation, and rebirth.

Participant 21 applied the approach of Guan-Yin Bodhisattvas on the patients and their families. One of her patients did not believe in any religion or any hospice team member but did accept the concept of Guan-Yin Bodhisattvas. It was a good start to help the patient. Participant 21 is an international PhD student now and she has finished her internship in palliative care units in Taiwan. She can speak Mandarin and my dialect (Min-Nan language) very well. The Guan-Yin Bodhisattva was not only common in Taiwan but was also known in Participant 21's home country. Additionally, Participant 21 thought that recitation of Buddha's name or Bodhisattva's name is the best emotional support. Although Participant 21 thought that finishing the 4-stage hospice training courses from the Buddhist Lotus Hospice Care Foundation was very wonderful and very useful for her, she would like to develop the hospice care in Malaysia in the future. She thought that there were many methods in the "Pure Land School" of Buddhism; however, we just prefer one method of "Pure Land School" in Taiwan. Participant 21 thought that other methods of "Pure Land School" in Buddhism, which are not popular in Taiwan, are also wonderful methods, and that we should rethink this issue. She said as follows:

> "I think that the Buddhism was widespread in mainland China, the method and meaning of Buddha teaching has changed a little at that time in ancient mainland China because Chinese culture was different from Indian culture. I think that there are many methods in 'Pure land school' of Buddhism; however, we just prefer one method in Taiwan. Other methods of 'Pure Land School' in Buddhism are also very wonderful methods, we should rethink this issue. I also applied 'Dai-Bai (Great Compassion) Water' on myself. I remember the great earthquake in Taiwan on 21th September 2000. The folk religion was useful for the people in Taiwan; however, the western psychology was useless at that time, we should think different methods in different cultures. If we believe that 'Dai-Bai Water' is useful, the water will be greatly useful. I think that the Buddhist ritual of taking refuge is useful for the patient. This ceremony will make patient's emotion calm down based on my past experience. I think that Buddha teaching is to teach us how to live and die well. After Buddha's death, Buddhism had changed a lot, Buddhism was also to be changed in different countries. I do not apply the approach of preparing food for ghosts; I think that this approach is not appropriate in hospital. I apply the approach of Guan-Yin Bodhisattva on the patients and their families. The patients accept the concept of Guan-Yin Bodhisattva. It is a good start to help the patients." (Participant 21)

The approach of the Zen school in end-of-life care

Faure (1993, p.3) states that Zen is the Japanese pronunciation of the Chinese character Chan (itself the transcription of the Sanskrit dhyana), and that Japanese Zen developed out of the Chinese tradition known as Chan Buddhism. There is undeniably continuity between Chan and Zen, and most scholars consider the two terms interchangeable. However, there are many historical, cultural and doctrinal differences as well, and these differences are not merely superficial: they would surely affect the "essence" of Zen.

Some participants applied breath meditation in end-of-life care to help the patients, such as Participants 12 and 17. Epstein (2003, p.139) states that meditation was used in the context of Buddhist teachings to indicate the controlling and directing of one's mind inwards in the quest for enlightenment. Kristeller (2005, p.128) explains that he had re-engaged with Buddhism, with his own contemplative practice, and with the purpose and value of meditation as a powerful tool for growth. The intention of study participants regarding the breath meditation was to alleviate the patients' anxiety; they did not mention enlightening the patients and their families. Participant 17 applied the Buddhist religious method of concentration and relaxation to help patients because this chaplain previously had been a nurse. She explained the medical mechanism of this Buddhist religious method very clearly, for instance, guiding the patient to do breathing meditation was not difficult for her because of her past experience in palliative care units in hospital. Participant 17 said:

> "I think that breathing meditation method is a kind of Buddhist religious method, but it is also applied to all patients because everyone can breathe not only Buddhists can breathe. I apply the Buddhist religious method regarding concentration and relaxation to help patients because I was a nurse before; therefore, I can explain the medical mechanism of this Buddhist religious method very clearly. Guiding the patient to do breathing meditation is not very difficult based on my past experience in palliative care unit in hospital." (Participant 17)

Participants 12 and 17 had been senior nurses; but Participant 12 held a different attitude from Participant 17 towards breath meditation in palliative care: Participant 12 thought that the recitation of Buddha's name was the most useful approach in

palliative care units. She knew that breath meditation was used in palliative care units; but it was not easy for some patients. Additionally, Participant 12 thought that the methods of the Zen (Chan) school in Buddhism were very difficult for the patients because many patients had not been monks or nuns. I have presented the original words of Participant 12 about this opinion in Section 7.1. above.

Regarding the approach of Zen (Chan) school in Buddhism, Participant 18 had been neither a medical student nor doctor but she used the approach of "Pure-Land" very often, and sometimes she used the approach of Zen (Chan) school with the patients; Participant 18 told of an occasion when a patient was short of breath, the participant applied breath meditation and it was a useful method for this patient. Actually, Participant 18 is good at the Zen (Chan) school in Buddhism and Zen (Chan) school is her daily monastic practice. Participant 18 said as follows:

> "I think that the recitation of Buddha's name is the main approache on palliative care units; generally, I apply the recitation of Buddhist name to help patients and their families. I had an experience of a patient who was short of breath, I applied breath meditation on this patient. I think that some sutras are too long for the patients; but the recitation of Buddha's name is very appropriate for all the patients because the Amita-Buddha name is very short, it is very easy to read it and it allows the people to calm down." (Participant 18)

In a previous section, I described how several participants thought that good Karma influences good death, good fortune, and a better next life.[29] Omvedt (2003, p. 278) asserts that Mahayana Buddhism overcomes Karmic determination by allowing for the transfer of merit.[30] The example of this is "Pure Land" Buddhism in which Amita-Buddha achieved the power to give every believer rebirth in a Pure Land of delight and glory from which he/she will then attain enlightenment. In the example of the single-parent mother who trusted Participant 17 described above in previous Chapter 5 Section 5.1, the meaning of what Participant 17 said is very similar to Omvedt in that she did recitations of Amita-Buddha's name to transfer the merit to her dead daughter. Epstein (2003, p.206) explained that the practice of transferring of

[29] This is a summarized interpretation. The detailed clinical stories were presented in this Chapter Section 7.1.6 The growth of good Karma.

[30] See Glossary of terms used in this thesis. Transfer of merit means transferring one's own merit to others so that they may benefit from it. The practice of transference of merit is a natural and logical development of a fundamental principle of the Path of the Bodhisattva. (Epstein,p.206)

merit is a natural and logical development of a fundamental principle of the Path of the Bodhisattva: one uses the benefits of Karmic accruing to oneself to benefit others; transfer of merit means transferring one's own merit to others.

Perhaps the Buddha teachings in Mahayana Buddhism are somewhat different from other religious viewpoints; for instance, the Bible says "God created the world and all creatures"; however, Buddha states that your mind and Karma decided your world; that is, we were not created by any God or Buddha. Omvedt (2003, p. 59) states that Buddha's teaching radically refused to express his thoughts about the origin of the world, embodied most famously in the metaphor of the arrow; for example, if a man is wounded, we don't bother asking about the origin of the arrow, our goal is to heal the wound. I suggest that Participant 17's opinions regarding "enlightening the patients' inner force" is very important and based on the Buddha teachings. Epstein (2003, p.74) describes how all enlightened beings have the following in common: they have seen through the illusion of self, and they have achieved permanent release from the cycle of rebirth. Venerable Master Hsuan Hua (2003, p.3) believed that the Buddha is the greatly enlightened one, his great enlightenment is an awakening to all things, without a particle of confusion, and Buddha has ended Karma and transcended emotions.

To sum up, the contributions of Mahayana Buddhism in Taiwan played an important role in helping people to have a peaceful death in end-of-life care as Taiwanese Buddhists believe in the cycle of rebirth and Karma.

Summary

Chapters 5 to 7 present the three themes in this study. The three main themes emerged from the grounded theory's second phase analysis of the interview data.This chapter focus on the third theme, Mahayana Buddhism. All Buddhist chaplains used Mahayana Buddhist religious methods during the process of end-of-life care. Following these findings, the third stage of the data analysis is the "theoretical coding". In this current study, I undertook "theoretical coding" therefore, the emerging theoretical framework is presented in the next chapter, Chapter 8. Detailed discussions will be presented in Chapter 9.

Chapter 8 The Theoretical Framework

Introduction

This thesis explores the way in which Buddhist chaplains understand and engage with patients requiring end-of-life care and how their particular understandings about death and dying, their roles in the end-of-life care, the way in which they offer care, and the tools that they use especially those derived from Mahayana Buddhism all combine to create a support network for patients, families, and medical team members. The Buddhist chaplains saw compassionate care as part of Mahayana Buddhism and as fundamental to Buddha's teachings.

A theoretical framework emerged from this study. 150 codes were generated during the initial coding. I use these 150 codes to develop subthemes and themes. Please see the coding tree in Appendix 7. In Chapters 5 to 7, I described the themes and subthemes derived from the current study, and the links between them. I developed the themes and subthemes following Charmaz's grounded theory approach (2006). The third step in the data analysis is theoretical coding. As noted in Chapter 3, Charmaz (2006, p.63) regarded "theoretical coding" as a sophisticated level of coding that follows the codes that the researcher selected during the "focused coding". I applied this process to construct a theoretical framework that connects the themes and to validate the relationships between the themes and subthemes.

Based on Charmaz's methodology, I made reflective notes and kept a self-reflective diary on the interview process, which I also analyzed. The final theoretical framework was developed from the constant comparisons from the various data sets. To sum up, the theoretical framework (see Figure 8.1) was developed based on "all" of the participants' data, which is from their interviews and story-telling.

8.1 The theoretical framework

I named the theoretical framework “the dynamic process of compassionate care” (see Figure 8.1). It includes the concepts of compassionate support for palliative patients, palliative families, and palliative team members and of Mahayana Buddhism which provides the tool to enable Buddhist chaplains to implement compassionate care and to understand the ways in which they care.

All the participants drew on their rich experiences of clinical end-of-life care to describe their application of the compassionate skills developed through Mahayana Buddhism in clinical end-of-life care.

Compassionate care is a multifaceted, dynamic phenomenon which was time-consuming to give: the chaplains on average spent more than an hour in each intervention with patients and their families. The act of giving compassionate care was shaped by the Buddhist chaplains’ basic education, hospice training courses, and the Buddha’s teachings. The first theme is “compassionate care”. I have presented the content of compassionate care in Chapter 5. The relationship map for compassionate care has been shown in Figure 5.1. The second theme is “the dying process”. I have presented the content of the the dying process in Chapter 6. The relationship map for the dying process has been shown in Figure 6.1. The third theme is “Mahayana Buddhism”.

The participants identified that Mahayana Buddhist religious approaches, if accepted by the patients, had the potential to be useful tools for giving compassionate care. I have presented the theme about “Mahayana Buddhism in this Study” in Chapter 7. The relationship map of those participants’ approaches of Mahayana Buddhism has been shown in Figure 7.1. All Buddhist chaplains in this study used the tool of recitation of the Buddha’s name in their clinical interactions and the Mahayana philosophy’s ideal goal of a good death and a better next life became a determinant of how they engaged with patients. All Buddhist chaplains in this study met the end-of-life patients’ dying process, which is the second theme in this study. All participants had experiences of dealing with the dying process.

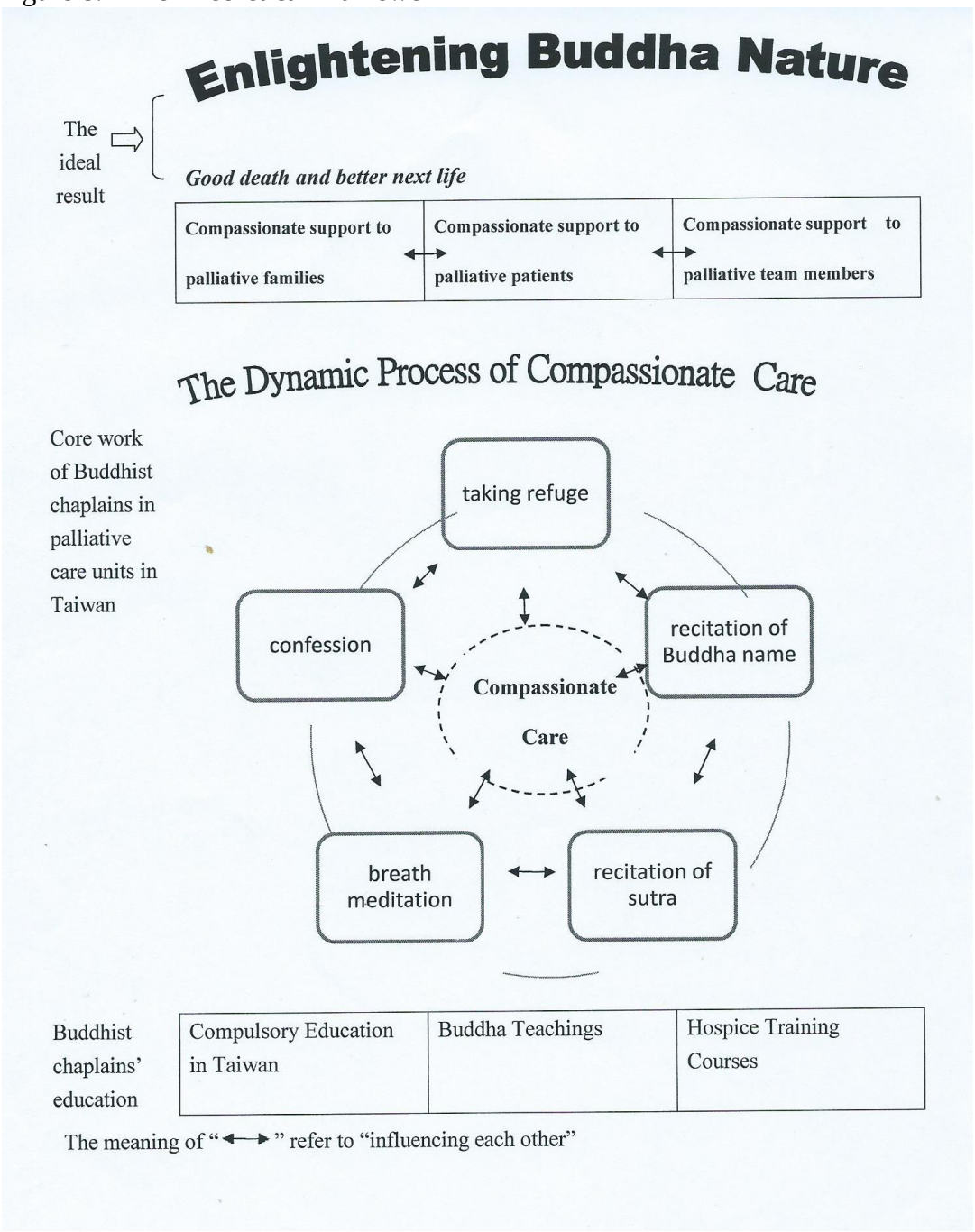
A number of chaplains identified that establishing good relationships was a very important part in end-of-life care. Participant 8 stated:

> "I thought that setting up a good relationship with the patients and their families is very important. It is a very flexible approach which depends on meeting different patients and their families." (Participant 8)

The whole process was "dynamic" rather than "static" as the Buddhist chaplains "adjusted" their methods to suit different stages for different patients. The Buddhist chaplains "adjusted" their methods for each person through conversing with the patients, families and palliative team staff. Therefore, a "dynamic" process is needed in order to choose the best approach for different individuals. I presented the dynamic process of compassionate care in previous Chapter 5. I also drew the relationship about compassionate care in previous Figure 5.1.

Figure 8.1 below illustrates the theoretical framework. In particular, chaplains used approaches derived from Mahayana Buddhism which created a support network for patients, families, and medical team members. In Chapter 7, I discussed and explained the various approaches related to Mahayana Buddhism in end-of-life care in Taiwan. I also drew the relationship among the different components of Taiwanese Mahayana Buddhism in previous Figure 7.1.

Figure 8.1 The Theoretical Framework



8.2 Enlightening the "Buddha nature"

All participants believed that the journey towards enlightening end-of-life patients' "Buddha nature" was the "ideal" destination for the process of coming to terms with death and accepting dying; however, in their professional role within the hospital setting they spoke clearly about ensuring that they did not force anyone to reach their own pastoral goal of enlightening the Buddha nature. Participants were able to identify that the act of offering compassionate care was much more important than enlightening the "Buddha nature". All participants thought that compassionate care was important to help the end-of-life patients and their families to enlighten their own "Buddha nature". In other words, compassionate care leads to enlightenment.

The "Buddha's nature" is an important abstract concept in Buddhism[31]; Buddhists believes that everyone has a "Buddha nature", and regardless of the school of Buddhism adopted, (e.g. "Zen school" or "Pure-Land school") all approaches help to enlighten our "Buddha nature". The chaplains spoke of how each person has a different "Karma" because each has a different career trajectory both from the past within previous lives as well as the person's current life.[32] The Karmic differences means that not everyone has the same capacity for achieving an "enlightened Buddha nature", and Buddhist chaplains can only do their best to enlighten end-of-life patients' "Buddha nature".

Participant 17 thought that the inner force is part of our Buddha nature. She stated:

> "I thought that the inner force is very important because it is a key factor in enabling patients to overcome any physical suffering. I've read a lot of academic papers, and this topic seldom features in western academic journals. I thought that enlightening the patient's inner force is because of the Buddha's teachings." (Participant 17)

Participant 17 explained that enlightening the patient's inner force based on the Buddha's teachings was appropriate as the inner force was believed to be part of the

[31] See Glossary of terms used in this thesis. The Buddha-nature is the innate, inherent potential to become a Buddha that resides in the mind of every living being (Epstein 2003, p.33).
[32] See Glossary of terms used in this thesis. Karma is a Sanskrit term that refers to that which is made by the activity of body, speech, or mind (Epstein 2003, p.117).

Buddha's nature, as well as a key factor in enabling patients to overcome any physical suffering.

Other participants also explored this "inner force" which complemented the "Buddha nature". Participant 6 commented:

> "I think that enhancing the patients' inner force is very important; it is very difficult to describe it in words. I thought compassionate skills, such as, listening, is the first step towards evaluating patients' distress and enhancing their inner force." (Participant 6)

To summarise, though chaplains believed that enlightening the "Buddha nature" was an "ideal" destination during the whole process of dying, they did not proselytize their patients but instead adopted a compassionate attitude to whole person care.

Based on their Buddhist belief system, every participant believed that everyone has a "Buddha nature". This concept is challenging to translate into English, but is significant as it shaped the way that Buddhists adopted and applied their principles of care. Participant 7 described the Buddha nature as a form of "inner force" that is closely connected to the process of dying and how to have good death. She commented:

> "I thought that what is very useful to patients is their own inner force rather than outer forces; that is, patients should have their own force to enter into peaceful death." (Participant 7)

In the following section, I develop Participant 7's perspectives on "how to have a good death" further by drawing on the data from other participants.

8.3 A good death and better next life

For all participants, a good death and calm emotions at the time of death were the goal of their end-of-life care practices and underpinned their philosophy. According to Buddhist beliefs, the chaplains believed that the patients had experienced a previous life before being born into this life and that all patients would have a next life after they die. All participants hoped that their patients would have a better next

life, and therefore felt a measure of responsibility to ensure that the patients were able to die peacefully to facilitate this movement towards a new and better life. The connection between a good death and a better next life is one of immense importance in the role of chaplaincy.

Participant 19 spoke of dying well as very important for everyone, and that a good death is related to a better next life. She commented:

> "I hope we have a better next life, rather than prolong this life; actually, it is impossible to prolong it. The recitation of Amita-Buddha's name is good for both this life and the next life." (Participant 19)

The participants involved various mechanisms to enable a good death. Participant 22 spoke of the value of reminding patients about their good actions in this life, recognizing that regardless of whether the patient was a Buddhist or not, this positive reflective practice was beneficial for everyone, because if a patient remembers their good actions, they are more likely to feel at peace.

Participant 2 described how a peaceful mind was very important for the patient and their families. She explained that chaplains can play an important role in enabling patients to have a peaceful mind by calming them and their families. She noted:

> "In fact, it should be said that when the chaplain appears on the hospice ward, the patients feel calmer. It is not important to say very much. I think the Buddhist chaplains' accompanying and support will help the patients and their families to feel calm." (Participant 2)

Participant 3 helped patients to have a good death, as the following example of her compassionate conversation with a dying patient illustrates:

> "I remember one patient who was in a poor physical situation but he could not die. The nurse asked me to talk to him and help him to have a good death. I promised I'd do this. I told the patient 'Your body is like a broken TV. We can no longer watch TV programmes on this broken machine. We could go to the Amita-Buddha world (Pure Land) to find a good, wonderful body. I thought that no one would want to keep broken equipment in their house forever. Please give up your sense of attachment, and let everything go well. We could recite the Buddha's name together for you and you could also ask your family to do so.'

> After I said this to the patient, we recited the Buddha's name together. Less than 2 minutes later, the patient died peacefully." (Participant 3)

Participant 6 used her skills in compassionate conversation to help patients to reduce any feelings of guilt or fear, as these negative emotions would reduce the patients' opportunities of moving to a better life after their death. Participant 6 gave the following account:

> "I met many families and their relatives who said that patients suffered from disease because of bad Karma. I thought that this was unhelpful for the patient and their families. We know that there is the force of Karma from the perspective of Buddhism, but talking about bad Karma brings suffering to the patient. I guided the patient to have good Karma rather than push them to have bad Karma. I thought we should establish a good relationship first, and then discuss some things that are good for the patients' good death and better next life." (Participant 6)

Participant 18 commented:

> "I think we just do our best. It's impossible for me to guarantee that all patients will have a good death at the end of their life." (Participant 18)

Managing the tension between the Buddhist chaplains' belief systems about the effects of a difficult death on the outcomes of the next life for a patient, with the recognition that the chaplains' role was not to proselytize but to provide comfort provided an interesting challenge and helped to frame the work of the chaplains. As Participant 18 said:

> "I met some people who rejected the Buddhist chaplains; for instance, some people do not believe in Buddhism. With these, we just say 'hello' very politely. The most important thing is that we should respect the patients' religion and faith. We hope that all patients will have a good death, but some reject the Buddhist chaplains' help. We cannot do anything for them. All we have to do is imagine we are giving them great blessings." (Participant 18)

This very beautiful imagery of "giving great blessings" in the midst of non-belief demonstrates the role that the chaplains saw for themselves. One participant also saw that the patients had great compassion and were themselves good teachers from whom she "gained many experiences" (Participant 19).

8.4 The Buddha's Teachings

As described in Chapter 4, all participants had been Buddhist monks or nuns for more than 10 years, and applied Buddhist religious methods, including taking refuge, the recitation of Amita-Buddha, confession, meditation, a special conversation with the patient at the end of life, and Buddhist chanting assistance (see Chapter 7).[33] Some participants preferred the methods closely related to Guan-Yin Bodhisattva. For example, Participant 1 recited the Dai-Bai (Great Compassion) Mantra to her palliative patients and imagined Buddha and Guan-Yin Bodhisattva definitely blessing them and everyone in the whole Dharma World. All of the participants applied "Dai-Bai (Great Compassion) Water" to themselves, but not always to the patients, for several reasons. Participant 12 commented:

> "I think that 'Dai-Bai (Great Compassion) Water' is very common in Taiwan, but it is impossible for people to drink this water to free them from death. Based on the Buddha's teaching, death is a natural process. It is impossible to cure any disease for ever; rebirth will happen even if you are not enlightened. I think that many people misunderstand the Buddha's teachings." (Participant 12)

It is a controversial issue about "Dai-Bai (Great Compassion) Water'. Participant 12 thought that it was impossible to drink Dai-Bai (Great Compassion) water to avoid death. Similarly, Participant 19 hoped that people would have a better next life rather than prolonging this one because it was impossible to prolong one's life. All of the participants thought that the recitation of Amita-Buddha's name was good for both this life and the next life. Participant 19 shared several stories about working in palliative care units. She also saw that patients had a lot of compassion during the dying process. She thought that they were good teachers for her and for the hospice palliative team; she gained a lot of experience from dying patients and their families. She commented:

> "Some patients think that we can give them blessings. I tell them that I can't give them blessings because I am not Buddha, but I can help them. They regard us as having a special ability to prolong their life; actually, when they saw us they felt happy, they will calm down, and feel less anxious about dying. I think I taught them how to calm their emotions. It is important for them to have a peaceful death; because a peaceful death is good for their next life." (Participant 19)

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[33] This is only a summarized interpretation. The detailed information was presented in Chapter 7. The detailed participants' personal information was presented in Chapter 4 Section 4.2.2.

The participants thought that reciting the Buddha's name is very useful for patients. The Buddhist chaplains spending time with the patients, was also considered important.

The concept of Karma in Buddhism[34]

Some participants described Karma as a very important factor; we can change our Karma if we do good things. Although Karma influences our next life, we can also do good things in order to have good Karma at the end of this life.

Participant 17 thought that, when nurses conduct a life-review with palliative patients, they should focus on the good things the patients have done as much as possible because it is a key factor in a patient having a good death and a better next life. Participant 17 stated:

> "When we conduct a life-review with palliative patients, we should focus on the good things they have done as much as possible, because it is the key factor in a patient having a good death and better rebirth place, such as Amita-Buddha Pure Land, in the next life." (Participant 17)

Participant 17 thought that she used simple terms to explain the Buddha's teaching because it is a form of compassionate attitude to understand the patients' and their families' educational level. Generally, she would evaluate a patient's past lifestyle and hobbies. She comments:

> "I think we should not use too difficult Buddhism terms in hospitals, this method is different from the courses at the Buddhist University." (Participant 17)

The Buddhist chaplains thought that compassionate care and Mahayana Buddhism are Buddha's teachings. The process of compassionate care has been presented in Chapter 5. Mahayana Buddhism that was practised by all the participants is described in Chapter 7.[35]

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[34] See Glossary of terms used in this thesis. Karma is a Sanskrit term that refers to that which is made by the activity of body, speech, or mind. (Epstein, p.117)

[35] This is only a summarized interpretation, the detailed information were presented in Chapter 7. The whole dynamic process of compassionate care was presented in this Chapter 5.

8.5 Hospice Training Courses

This section shows participants' original words about the hospice training courses. The further discussions (reflections) will be presented in the next Chapter 9. The participants' written questionnaires show that most of the participants have completed 4-stage hospice training courses run by the Buddhist Lotus Hospice Care Foundation[36]. I have presented "Participants' Characteristics" in Chapter 4. The leader of the Buddhist Lotus Hospice Care Foundation also gave me the detailed training curriculum design of the Buddhist chaplains, including the training in the physical, psychological, sociological, spiritual, and emotional aspects of hospice palliative care.

Three participants received hospice training from other organizations, two of them from the National Health Department of the Taiwanese government (the Republic of China). Some participants thought that some Buddhists did not provide good interventions for palliative patients, and so the hospice training courses are very important.

Participant 14 stated:

> "I think that the training courses are very important for the Buddhist chaplains and other hospice team members. I attended hospice training courses run by the Buddhist Lotus Hospice Care Foundation. I think that I didn't know how to communicate with patients before I attended the training courses." (Participant 14)

Participant 19 found that some Buddhists did not use appropriate methods for the end-of-life patients; therefore, she thought that hospice training courses were very important in clinical end-of-life care. Participant 19's words were as follows:

> "I thought that some Buddhists did not provide very good interventions for palliative patients, so the hospice training courses are very important. I also met some Buddhist groups who did not undertake any good interventions for palliative patients because they did not understand the palliative patients' physical situation." (Participant 19)

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[36] Please see Appendix 3 Examples of interview topic guides (There are written questionnaire and interview topic guides in both Chinese and English)

I asked Participant 18: “How can you work in hospice care for so long?” She replied that the hospice training courses were important for her to work with the end-of-life patients and their families:

> “I think the training courses are very important for me; for example, I did not attend training courses ten years ago, and some people invited me to visit end-of-life patients. I was afraid because I didn’t know how to talk to the patients at that time. Nowadays, I know how to do this and how to communicate with the end-of-life patients as I have completed a 4-stage training course run by the Buddhist Lotus Hospice Care Foundation.” (Participant 18)

Participant 22 commented:

> “I think that the training courses were very useful for the Buddhist chaplains. Without these, I could not know how to communicate with the patients and their families. Actually, the Taiwanese government required more than 20 hours of continuous training a year for medical staffs and any religious chaplains in hospitals.” (Participant 22)

One of the participants was born outside Taiwan; she thought that hospice training courses are very useful. She said:

> “I think the four–stage hospice training courses from Buddhist Lotus Hospice Care Foundation are very wonderful and very useful for me, I would like to develop the hospice care in my country in the future.” (Participant 21)

To sum up, the participants’ clinical stories presented above showed that the hospice training courses are very important for participants working in clinical end-of-life care. It seems that it is necessary that the training in the physical, psychological, sociological, spiritual, and emotional aspects of hospice palliative care, are mostly provided by courses run by the Buddhist Lotus Foundation and some by the National Health Department of the Taiwanese Government.

Summary

In this chapter, I present the final theoretical framework based on the participants’ data. The final theoretical framework to emerge focused on “dynamic compassionate care” in the end-of-life care. 150 codes were generated during the initial coding. I use these 150 codes to develop subthemes and themes. A theoretical framework emerged from this study. The chaplains used religious approaches derived from Mahayana

Buddhism which created a support network for patients, families, and medical team members. These Mahayana Buddhist religious methods were regarded as complementary approaches as they were a chaplaincy service rather than a medical service at hospitals in Taiwan. All Buddhist chaplains in this study met the end-of-life patients' dying process, which is the second theme in this study. All participants had the experiences of dealing with the dying process. Compassionate care is a multifaceted, dynamic phenomenon which was time-consuming to give: the chaplains on average spent more than an hour in each intervention with patients and their families. All participants used compassionate care with Mahayana Buddhist spirit to deal with the relevant issues during the end-of-life patients' dying process.

I will introduce further discussions in the next chapter (Chapter 9). I discuss relevant topics about patients' safety identified in Chapter 1 from the literature and the findings on complementary approaches in Taiwan, which show that 'patients' safety' is related to participants' complementary approaches and the dynamic process of compassionate care in end-of-life. In this chapter I have mentioned again one of the participants' approaches about "Dai-Bai (Great compassion) Water" which is a controversial issue in the consideration of patients' safety.

Conclusions and recommendations from my findings will then be presented in the final chapter (Chapter 10).

Chapter 9 Discussion

Introduction

This chapter provides analytical reflections and key issues identified from my research findings. In Chapter 3 I explained that I used several triangular approaches to enhance the methodological rigour of this study, and that one of these approaches included my keeping of reflective notes and an up to date self-reflective diary.[37] Thus, one of the aims of this chapter is to present excerpts from my reflective notes and self-reflective diary. A second aim is to analyse the literature review with the intention of presenting the position and new findings of this thesis in order to make an original contribution to knowledge.[38]

Macbeth (2001) suggests that reflexivity has two general inflections in the literature. Firstly, positional reflexivity leads the analyst to examine place, biography, self, and how they shape the analytical exercise. Secondly, textual reflexivity leads the analyst to examine and disrupt textual representation. I pointed out that trans-cultural issues should be discussed in this thesis. As mentioned in Chapter 1, Leininger (1970, p.51) suggested that nurses should understand the particular cultural context in order to help patients, families and social groups because culture influences how people solve problems. Those gaps were the reason why I embarked on this study.[39]

Charmaz (2006, p.168) noted that the literature review in constructivist grounded theory can help us to find the position of our study and clarify its contribution. Based on Charmaz's (2006) perspective, I did comparisons and reflections between the literature review and participants' data for further discussions; it is helpful for me to present the position and new findings of this thesis in order to make an original

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[37] Please see Chapter 3 Section 3.5 Rigour in qualitative research and grounded theory and one part of Section 3.1.1 Triangulation of the sources of data in this current study.

[38] This is based on Charmaz's (2006) viewpoint. Charmaz (2006, p.168) suggests that the literature review in constructivist grounded theory can help us to find the position of our study and clarify its contribution.

[39] This is a summarized interpretation. The detailed research rationale (background) is explained and supported in Chapter 1 and 2.

contribution to knowledge. In my study, all participants' story-telling shows specific Taiwanese Buddhist culture in end-of-life care in Taiwan. All participants said respect and compassion are important elements in end-of-life care. This seems one of the important contributions of my study.

In this chapter, Section 9.1 focuses on the reflections about Buddhist chaplains' understandings of their role. In Chapters 1 and 2, I cited common clinical stories and several literature reviews to show how people used folk religious approaches when they were experiencing bad luck or sickness, and how Taiwanese people asked religious staffs to offer these approaches without scientifically effective evidence. All participants also had ethical issues about the tension between offering compassionate care and patients' safety.[40] Therefore, I shall analyse the issues of patients' safety in end-of-life care in Taiwan in Section 9.2 below. Section 9.4 focuses on reflections on Buddhist chaplain training courses as some participants said that the hospice training courses were good for them to learn how to perform with respect and compassion. In Chapter 3, I described the researcher's role in the use of qualitative methods and constructivist grounded theory.[41] Therefore, further discussions will be presented in several sections of this chapter: Section 9.4 Reflections on my role; Section 9.5 Reflections on my belief, and Section 9.6 Reflections on the research process.

9.1 Reflections on participants' understanding of their role in end-of-life care

The purpose of this section is to reflect on participants' understandings of their role in end-of-life care. That is, I discuss the experience and work of Taiwanese Buddhist chaplains in end-of-life care. I analysed them from the perspectives of literature reviews and participants' viewpoints. This will help me to present the contributions which this thesis makes to new knowledge. For instance: my participants are Buddhist chaplains, they used the approaches of Mahayana Buddhism; and these approaches are significantly different from those described in Western literature reviews.

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[40] This is a summarized interpretation. The detailed information was presented in Chapters 1 and 2.
[41] Please see Chapter 3 part of Section 3.1.1 Researcher's role in qualitative method and constructivist grounded theory.

As noted, one of the interview questions was: Could you tell me about your role in hospice palliative care? All participants answered this question and the detailed findings were presented in Chapter 4. To sum up, all participants believed that they used the approaches of Mahayana Buddhism to offer compassionate care in end-of-life care because compassion and Mahayana Buddhism are integral to Buddha teachings. They thought that they practised Buddha teachings not only in temples but also in end-of-life care.

Piderman et al (2013) explored patients' expectations of hospital chaplains in the USA, and found that the reasons why patients want to see chaplains included: to listen to me, to remind me of God's care and presence, to be with me in times of anxiety and uncertainty, to counsel me regarding moral/ ethical concerns or decisions, to pray and /or read scripture or sacred texts with me, for a religious ritual or sacrament, and to offer support to family/friends. In my study, because my participants were Buddhist chaplains rather than patients or their families, it is not possible to know the perspective of patients. However, all of my participants thought that they were able to help the patients or their families to decrease their levels of anxiety and uncertainty.

Interdisciplinary collaboration in end-of-life care

In Chapter 5 I presented how participants thought that they offered compassionate support for palliative team members and also practised interdisciplinary collaboration in end-of-life care.[42] I analysed this further from the perspectives of the literature review and participants' descriptions of their work.

According to Wittenberg-Lyles et al (2008), their research in the USA revealed that chaplains play an important role in fostering interdisciplinary collaboration within the hospice team by providing individual self-care, providing day-to-day encouragement, and serving as the team's conflict manager. In my study, all my participants thought that their role in hospice care was to support the patients, their family, and hospice

[42] This is a summarized interpretation. The detailed process about participants' roles and their work are presented in Chapters 5, 7 and 8.

team members. Perhaps my participants supported hospice team members fostering interdisciplinary collaboration within the hospice team, as described by Wittenberg-Lyles et al. It cannot be denied that my participants played an important role in offering compassionate care to hospice team members. Several examples and the original data have been presented in previous Chapter 5.

Ho (2003) interviewed eight Buddhist chaplains, one nurse, one Head of Nurses, and one palliative family to explore the role of Buddhist chaplains in palliative care units in Taiwan. The data in Ho's study revealed that the role and function of Buddhist chaplains included direct care of the patients, assistance for families, and support for the team in order to facilitate a good death. Although the sample size in Ho's study is small and not all participants are Buddhist chaplains, the findings show that a good death is a very important issue from the perspective of these eight Buddhist chaplains, one nurse, one Head of Nurses and one palliative family.

Ekedahl and Wengstrom (2008) in a study carried out in Sweden compared the coping processes of nurses and hospital chaplains in multidisciplinary healthcare teams. The data revealed that the nurses need to be able to help the patient 'do good' and the hospital chaplains need to be available to meet the patient.

Reflecting on the coping process of nurses and hospital chaplains in Taiwan, Participant 17 thought that the Buddhist chaplains gave the team members support; for example, a junior nurse was crying when the patients was dying, and so Participant 17 spent time listening to what the nurse said. Finally, the nurse felt better when the patient was dying. Participant 3 thought that she had been working in hospice care units regularly for 10 years because she was able to manage her emotions very well. She concentrated on listening to the patients, their families and medical staff. She did her best to support them when she was in the hospital. When she went to a Buddhist temple, she did not carry negative emotions or suffering with her from the hospital. She thought that she should concentrate on reciting Amita-Buddha's name or the Buddhist sutra in the Buddhist temple. She could perform this every day and have blessings for her patients or their families. Participant 19 knew that some nurses were

very stressed in palliative care units. Some nurses sought support from her. She offered some courses for nurses and nursing students regarding stress management and relaxation. Regarding the role of participants, several of them thought that nurses referred the palliative patients or their families to Buddhist chaplains. For instance: Participant 19 said the nurses referred the patients or the families to them. I have presented the detailed original words of Participant 19 in previous Chapter 5.

Galek et al (2007) explored the role of religion and spirituality in the healthcare setting; in their study in the USA, participants rated the importance of referring patients to chaplains for four different areas of need: pain/depression, anxiety/anger, treatment issues, and loss/death/meaning. The results of this study revealed significant differences in referral patterns for type of hospital, professional discipline, the hospital's religious affiliation, and self-reported spirituality. Ando et al (2010) explored the value of religious care for the relief of psycho-existential suffering in Japanese cancer patients; they sent a questionnaire to 592 bereaved family members of palliative patients, and 378 families responded. The findings revealed that families of patients who received religious care generally evaluated this care to be very useful or useful. As this was a quantitative study, there was no deep exploration of participants' experiences or the process of religious care.

Some participants thought that they played a role of consultant in the hospice team. I have presented the examples and original words of Participants 5, 6 and 19 in previous Chapter 5. However the role of consultant is influenced by the physicians' attitude very much, and therefore I shall discuss the chaplains' role in relation to the physicians' attitude in end-of-life care in the next section.

<u>The chaplains' role in relation to the physicians' attitude to end-of-life care</u>

In Chapter 4 Section 4.2.4 I mentioned that participants thought that the factors which influenced their role included the physicians' attitudes.[43] The purpose of this

e [43] This is a summarized interpretation. I presented the detail of several participants' views about physicians' attitudes and their importance in end-of-life care in Chapter 4 Section 4.2.2.

section is to analyse the participants' role in relation to physicians' attitudes from the perspective of literature review and participants' viewpoints.

Lewis (1998) examined the nurse's role identity and suggested that peer collaboration on tasks may enhance logical reasoning skills to reduce mental conflicts. In my study, the Buddhist chaplains presented the fact that they cooperated with health team professionals and some Buddhist chaplains got respect from health team professors; however, some physicians did not think that they should cooperate with Buddhist chaplains. Several Buddhist chaplains thought that the physicians giving the patients the detailed progress of their disease was important for the chaplains' interaction with the palliative patients and their families because the role of Buddhist chaplains was not to tell the truth of the disease as they were not medical staff. That is, Buddhist chaplains thought that the physicians should do the truth-telling about the disease; when the physicians did not tell the truth to the patients, it was very difficult for Buddhist chaplains to break bad news because the patients would deny their life-limiting disease and would like to maintain their hope; the patients could not accept that everyone would die someday.

Some participants thought that the physicians' attitudes were a very important factor in their role. For example Participant 8 seldom had gone to the palliative care unit recently because apparently the physicians did not think that the Buddhist chaplain was a professional member of staff. Fitchett et al (2011) explored the role of professional chaplains in the USA from the perspective of physicians and chaplains. The physicians and chaplains agreed that chaplains address patients' and families' spiritual suffering, improve family-team communication, and provide rituals valued by patients, families, and staff. In another research study in the USA, Flannelly et al (2005) investigated the roles and functions of hospital chaplains and the results revealed that the physicians tended to rate the importance of most chaplains' roles lower than did other disciplines.

In my study, Participant 15 thought that a physician's education regarding hospice care is not enough; it is also related to the chaplains' role and patients' quality of life.

Sullivan et al (2003) conducted a national survey in the USA, and the participants included 1,455 students, 296 residents, and 287 faculties with a random sample of 62 accredited U.S medical schools. The data revealed that medical schools do not support adequate end-of-life care and moreover medical students and residents felt unprepared to provide good care for the dying. Liu (2012) thought that the role of religion and professional chaplains with regard to improving health had not been commonly accepted until recently in Taiwan. In my study, Buddhist chaplains did not offer medical interventions to improve health as they thought that they did not play the role of physicians or nurses even though some Buddhist chaplains previously had been senior nurses. They did not offer any medical interventions after they became Buddhist chaplains.

The truth-telling about illness in end-of-life care is an important issue, but there are different viewpoints about it. For instance, Chiu et al (2000) investigated ethical dilemmas in palliative care in Taiwan, and the data revealed that places of care and truth-telling were the commonest ethical dilemmas assessed by health care workers; however, the results did not clearly show the role of responsibility in truth-telling in palliative care in Taiwan. Reflecting on my previous nursing career, the physicians took the responsibility for truth-telling in clinical settings, although it was difficult to break bad news to the patients. Generally, the physicians give the bad news to the patients' families rather than to the patients as our culture is different from that of Western society. Windsor et al (2008) agreed that the communication of bad news, such as a complication or a poor prognosis for the disease was particularly difficult when dealing with Asian patients because Asian family members often ask health professionals to communicate with a member of the family rather than with the patient. In another Asian society, Patricia et al (2004) investigated the disclosure of information about a serious diagnosis in Japan, and the result revealed the emphasis on the importance of the "family bond" and the North American emphasis on the "patient's right to know".

Spiritual care in end-of-life care

In Chapter 4 Section 4.2.4 I noted that some participants thought that spiritual care was an important task of Buddhist chaplains. Participants identified listening skills as important when dealing with patients' emotional and spiritual aspects. The purpose of the following section is to analyse spiritual care further from the literature reviews and participants' viewpoints.

Kelley (2009, p.286) believed that a chaplain is a person to provide spiritual advice; the original sentence is as follows:

> "A chaplain is one who provides spiritual care through compassionate presence, and active listening to your end of life struggle; they help you to bear it. A chaplain is skilled in serving humanity; some have experience, others have certification, and many have Masters in Divinity. A chaplain is in touch with spirituality without distinction of race, sexual orientation, and difference in theology. Chaplain is a person who follows the patients need, it is patients that teach us, and we learn how to intercede. Chaplain can be counted as a friend; a friend is with you, from the beginning to the end. Chaplain is not the co-signer of death but rather a concerned, involved soul who is with you until you take your last breath." (Kelley 2009, p.286)

Kelley (2009, p.286) notes that many chaplains have degrees in Divinity rather than in Buddhism; in my study, several participants believed that Buddhist chaplains offered spiritual care in palliative care in Taiwan. Although some participants say that their role is to offer spiritual care in hospice care, they did not define spirituality. Wynne (2013) states that spirituality and religion are often confused or considered to be the same thing, but while they complement each other, they are separate elements: whereas religion tends to focus on beliefs, ethics, rituals and traditions, spirituality is intangible and subjective, meaning different things to different people. Nichols (2013) suggests that spiritual support (both religious and non-religious) is a vital factor in well-being and quality of life at the end of life.

Egan et al (2011) point out that spirituality is increasingly important in healthcare provision but that definitions of spirituality remain controversial, despite their importance for consistency in research and practice. Egan et al conducted a mixed method study of hospice care in New Zealand and proposed three general definitional categories: (1) religious approaches; (2) humanist/existential approaches; and (3)

summative/inclusive approaches. Mok et al (2009) explored the meaning of spirituality and spiritual care among Hong Kong Chinese terminally ill patients and found that if healthcare professionals can provide a compassionate and loving environment that facilitates acceptance and hope, then the spiritual life of patients is enhanced. According to Rossiter-Thornton (2002), most health care practitioners, perhaps feeling unprepared and untrained for addressing spiritual issues, are reluctant to introduce the concept of prayer into their practice.

McClung et al (2006) agreed that chaplains were trained extensively to provide spiritual care to patients, families, and staff as they assisted in meeting the organisation's mission to provide patient-centred care. Michalon (2001) suggests that Buddha's message is beginning to appeal to Western therapeutic communities and has already infiltrated many areas of medicine, palliative care, psychology, and psychiatry. Padmasiri (1979, p.1) suggests that the analysis of psychological phenomena as the discourses of the Buddha offers significant insights into the nature of consciousness and the psychology of human behaviour, because the discourses of the Buddhas are very good at the use of psychological terminology as well as psychological analysis. Although it is somewhat difficult to judge whether nurses would like to seek psychological therapy from Buddhist chaplains, nevertheless it is true that they regarded Buddhist chaplains as psychological consultants.

Diginity Therapy in end-of-life care

In my current study, no participants mentioned Diginity Therapy, but all participants use the skill of Life Review, such as establishing a relationship, sharing words of love, and so on. They combined Buddhist religious philosophy and Life Review to help end-of-life patients to have good Karma in order to have a better next life. Fitchett et al (2015) conducted a systematic review to explore the role of diginity, and found that Chochinov proposed Diginity Therapy (DT) as a psychotherapeutic intervention for people facing serious illness, it has a heightened importance in the end-of-life care, and DT (Diginity Therapy) has some similarities with Life Review. Li et al (2014) explored theoretical and cultural issues with diginity therapy in Taiwan, and thought

that over half of end-of-life patients' experience psychological-spiritual suffering and that diginity therapy might be helpful in improving this situation, but modification should be made to diginity therapy to ensure that it is culturally congruent with Taiwanese patients' beliefs.

Respect and Empthy in end-of-life care

According to Baldacchino (2015), the literature defines spiritual care as recognizing, respecting and meeting patients' spiritual needs, facilitating participation in religious rituals, communicating through listening and talking with clients, and being with the patient by caring, supporting and showing empathy. Liu (2013) conducted a literature review through the Chinese database CEPS in order to explore religious volunteers and volunteer service users in end-of-life care in Taiwan, and found that most of the studies approached the issue from a medical perspective and rarely mentioned the function of religious beliefs by chaplains (most of them are Buddhist chaplains) who provide spiritual care through teaching religious beliefs (e.g. life is impermanent, Karma principle). In my study, my participants offering Buddhist religious approaches are very similar to Liu's (2013) findings. The new contributions to knowledge in my study is that all participants mentioned that respecting end-of-life patients' religious belief is a very important attitude to have. When they offer a Buddhist chaplaincy service in end-of-life care, the Buddhist chaplains spend a lot of time actively listening and accompanying to express their respect and empathy in end-of-life care.

To sum up, all participants understand that their role in end-of-life care includes emotional and spiritual care and that they play the role of psychological consultants. They also use the approaches of compassionate care and Mahayana Buddhism in end-of-life care. No participants had professional registered licenses as psychological consultants and most of them did not have a medical license but they discussed sensitive relevant death issues with end-of-life patients and their families. When participants work in end-of-life care, it is important for them to know whether their approaches are safe for the patients which I present in the reflections on patients' safety in the following section.

9.2 Reflections on "patients' safety" in end-of-life care in Taiwan

The purpose of this section is to reflect on patients' safety in end-of-life care in Taiwan. In Chapter 8 I mentioned participants' approaches about "Dai-Bai (Great Compassion) Water" which is a controversial issue for the consideration of patients' safety. In Chapters 1 I noted that religious approaches are very common in Taiwan. I reflected on patients' safety for several reasons. For instance: participants used some approaches whose effects are difficult to test scientifically. We only know the outcomes from the participants' subjective experiences rather than scientific experimental results. I think that it is necessary to do reflections on patients' safety in end-of-life care in Taiwan in order to present the contributions made by this thesis. I do this from the perspective of literature reviews and participants' data in the following sections.

As I noted earlier, the majority of participants when I interviewed them had not previously been medical or nursing students. However they worked with team members, end-of-life patients and their families very closely. The history of clinical palliative Buddhist chaplain training courses is about 10 years old, although it never happened that there were dangerous results for patients after communications with palliative Buddhist chaplains. Participant 16 cared for her father in a "general hospital", the nurse there asked her to talk to one of the other patients who would like to commit suicide. The nurses thought that Participant 16 could help the patients and prevent them from seeking suicide even though the nurse knew that Participant 16 did not work in this hospital. Clearly, Buddhist chaplains aim to prevent the patients from self-harmful actions rather than encouraging people to commit suicide.

All participants had experiences where palliative patients or their families asked Buddhist chaplains to offer "Dai-Bai (Great Compassion) Water" or any religious blessings for them; this phenomenon is related to "patients' safety" in palliative care units in Taiwan as it is difficult to test those above approaches by scientific monitoring. The relevant issues of "patients' safety" should be considered in end-of-life care in Taiwan. The examples are as follows:

Holy (Great Compassion) Water in Taiwan

All participants used "Dai-Bai (Great Compassion) Water" for humans and for ghosts. Participant 20 believed that the effect of "Dai-Bai (Great Compassion) Water" was good for the ghosts and the patients; the effect of this water depended on their faith. Perhaps faith was more important than science for the dying patients and their families. This is an interpretation summary; the original words of Participant 20 were presented in previous Chapter 7.

How can one test the effect of "Dai-Bai (Great Compassion) Water"? In this current study, Participant 14 talked to me about the fact that "Dai-Bai (Great Compassion) Water" is the key factor for why she decided to become a Buddhist nun. The story is as follows: when her father suffered from liver cancer, Participant 14 was not a Buddhist or a Buddhist nun at that time. She described how and where she got the "Dai-Bai (Great Compassion) Water" for her father. She thought that the effect of the water was wonderful for her sick father. Participant 14 thought that concentration and a great compassionate attitude are the main key factors regarding the effect of "Dai-Bai (Great Compassion) Water"; it was very difficult to test it by scientific methods as to why the water had such a wonderful effect. Participant 14 prayed to Guan-Yin Bodhisattva and decided to be a Buddhist nun forever because the "Dai-Bai (Great Compassion) Water" helped her father. This is interpretation summary, and the original words of Participant 14 have been presented in previous Chapter 7.

Moor and Sanders (2006, p.1) remind us to think about the following questions: "Do all humans think in the same way?" "What is the relationship between culture and thought?" Participant 11 held different viewpoints from other Buddhists regarding "Dai-Bai (Great Compassion) Water". Although she did not deny its effects, she thought that its meaning was "great compassion and mercy" in Chinese, when we have enlightened our great compassion and mercy in the same way as Buddha (or Bodhisattvas). We ourselves are "Dai-Bai (Great Compassion) Water" because our physical body is composed of 70% water and therefore, it is not necessary to find "outer" "Dai-Bai (Great Compassion) Water" in different places. This is a

summarized interpretation summary, and the original words of Participant 11 have been presented in previous Chapter 7.

Participant 12 was previously a senior nurse and she had met patients and their families who drank "Dai-Bai (Great Compassion) Water" when she was a nurse. She said that "the water was very common everywhere in Taiwan, but it was impossible for people to drink this water and be free from death. Based on Buddha's teachings, death is a natural process, and it is impossible to cure every disease. Rebirth will happen if you have not been enlightened". She thought that many people had misunderstood Buddha's teachings. This is an interpretation summary, and the original words of Participant 12 were presented in previous Chapter 7.

On the other hand, Participant 6 said that it is a good opportunity to discuss the death issue when the patients or their family want to seek some complementary approaches, such as "Dai-Bai (Great Compassion) Water" or some religious blessings in Buddhist temples and other religious temples. For instance, when patients or their families would like to find "outer" water, we can guide them to enlighten their inner force to face the death issue peacefully as much as we can. Participant 6 also said that the Buddha's teaching was focused on "inner" force rather than "outer" force; the "outer" force is like finding "Dai-Bai (Great Compassion) Water" in Buddhist temples or getting it from any other person; the "inner force" refers to patients enlightening their Buddha nature to make the "Dai-Bai (Great Compassion) Water". This is a summarized interpretation and the original words of Participant 6 were presented in previous Chapter 7.

Participant 6 did not know what Participants 14 and 11 had said to me, but she agreed that both outer "Dai-Bai (Great Compassion) Water" and inner "Dai-Bai (Great Compassion) Water" were helpful for the patients and their families. In terms of Buddhist education, she enlightened the patients' and their families' Buddha nature, that is their inner force, when the patients applied any religious products, such as "Dai-Bai (Great Compassion) Water" and any religious symbolism. Yin et al (2004) thought that religious symbols were the medium by which dying patients could search

for spirituality; therefore, they suggested that clinical staff should establish a safe environment that was respectful, listening, receptive, and sharing in order to let the dying patients freely use religious symbols, express their will, and feel supported.

The application of "Dai-Bai (Great Compassion) Water" is a common religious method as a complementary approach during the dying process of patients in Taiwan [44]. All Buddhist chaplains knew that the "Dai-Bai (Great Compassion) Water" was related to the "Great Compassion Mantra". According to Epstein (2003, p.108), the Great Compassion Mantra is one of the most widely used and most efficacious of all Buddhist mantras, and it is a Dharma taught by Bodhisattva. All participants knew how to make "Dai-Bai (Great Compassion) Water" by themselves; generally, they would not offer it to the patients automatically. Participant 18 said that if the families asked her to make "Dai-Bai (Great Compassion) Water" for them then she would, because it might let the families have peaceful emotions; otherwise she would not offer it to the patients or their families.

Participant 6 knew that it was not permitted in her hospital to offer the water to the patients. She knew that the "Dai-Bai (Great Compassion) Water" was used in hospitals depending on different policies. However, few quasi-experiments or experimental research designs could answer the reality of the "Dai-Bai (Great Compassion) Water". Participant 11's viewpoint was different from Participant 14's and was as follows: everyone had his own "Buddha nature". These are interpretations and further discussions (reflections) based on the original words of Participants 6, 11 and 14 presented previously in Chapter 7. According to Epstein (2003, p.33), when the Buddha Sakyamuni first realised Buddha nature, he proclaimed:

> "How amazing ! How amazing ! How amazing ! All living beings have the Buddha-nature; all can become Buddha. Only because of their polluted thinking and attachments do they fail to realise this to obtain certification. The

[44] Please see Chapter 1. Chen et al (2009) thought that "Holy" water, or what is often known as "Dai-Bai (Great Compassion) Water" is one of the twelve most popular religious folk remedies in Taiwan.

> Buddha-nature is the innate, inherent potential to become a Buddha that resides in the mind of every living being." (Epstein 2003, p.33)

Generally, my participants did not use this water for the end-of-life patients for several complicated reasons, but all of them applied this water on themselves or other Buddhists. Although they did not mention patients' safety, the uncertain physical situations of end-of-life patients also existed in Taiwan. As Participant 21 noted, "Dai-Bai (Great Compassion) Water" was very common in Taiwan, but it was impossible for people to drink this water and be free from death. This is a summarized interpretation based on the original words of Participant 21 which were presented in previous Chapter 7.

In Chapter 1, I mentioned that folk medicine is common in Taiwan, and that Taiwanese people asked religious members of staff including Buddhist monks and nuns to offer folk medicine. Therefore it is necessary to take care of relevant issues about patients' safety in end-of-life care. Buddhist chaplains also met the issue of patients' safety when they offered compassionate care. In the following section, I will reflect on folk medicine in Taiwan.

Folk medicine in Taiwan

All participants had met end-of-life patients or their families using folk medicine because folk medicine is common in Taiwan. I mentioned several studies in Chapter 1 showing that folk medicines are common in Taiwan.

Participant 10 met some patients who used folk medicines; these patients talked to Participant 10 and asked her not to talk to the physician about this. In this situation, because the patients asked her not to talk to the physicians, she reported it to the Head of Nurses. She trusted the nurses to know whether this folk medicine was harmful for the patients. This is a summarized interpretation based on the original words of Participant 10 which were presented in previous Chapter 5.

Participant 21 was previously a senior nurse, and she gave advice to patients who did not trust certain commercial products; however, the patients would rather believe in

untested complementary therapies that were sold by others because the patients denied what the medical doctor said. Participant 21 found that these issues were very common and that no matter whether she was a nurse as before or a Buddhist nun now, it was useless to give these people advice. In her opinion, when we do not cure our death anxiety, it is easy for us to be cheated by complementary therapies. This is a summarized interpretation based on the original words of Participant 21 were presented previously in Chapter 5.

My own experience was of many patients trying folk medicine which was not prescribed by the physician, and these patients did not want their physician to know. Participant 21 thought that this situation was related to "death anxiety". Although there are few studies to support the relationship between "death anxiety" and complementary therapies, nevertheless it cannot be denied that ensuring "patients' safety" is an important issue no matter what the patient receives with regards to which kinds of treatments.

9.3 Reflections on Buddhist chaplains' training courses

The purpose of this section is to reflect upon Buddhist chaplains' training courses. All participants had received hospice training courses.[45] In Chapter 8 I presented participants' data about their training courses. Several Buddhist chaplains mentioned that hospice training courses are important for them in order to communicate with end-of-life patients and their families.[46] I did further reflection on hospice training courses from the perspective of participants' data and literature review. This helps me to present the unique contributions of this thesis here while thinking about the future in Chapter 10.

Participant 22 said that the Taiwanese government requires clinical chaplains and medical doctors/nurses to receive more than 20 hours continuing education every

[45] Please see Chapter 4 Section 4.2 and Table 4.2

[46] This is only a summarized interpretation. The detailed information was presented previously Chapter 8 These data in Chapter 8 also show how the hospice training courses are useful for the participants. For instance: participants said: this training course help them to have compassionate communication with end-of-life patients and their families.

year. This is a summarized interpretation based on the original words of Participant 22 presented previously in Chapter 8. Reilly and Ring (2004) propose an end-of-life curriculum for physician training programs; this would include self-awareness about death, communicating bad news, guidance with paper work and legal issues, the stages of grief, the patient's perspective on dying in a hospice unit, and physicians' well-being. Wasner et al (2005) explored the effects of spiritual care training for palliative care professionals, comparing participants' self-assessment before and after training, as well as six months later. The findings revealed increased self-perceived compassion for the dying, compassion for oneself, and satisfaction with work. According to Egnew and Schaad (2009), perceptions of the teaching about suffering at the medical school level are quite variable with significant curricular gaps in student instruction about suffering and its relief.

In this current study, almost all participants agreed that the palliative training courses from the Buddhist Lotus Hospice Care Foundation are very useful for them; for instance, they attained knowledge. Ury et al (2002) explored palliative care curriculum development using systematic reviews; they found that most are developed by national organizations and cannot meet the individual needs of different institutions. In this study, almost all participants attended hospice training courses from the Buddhist Lotus Hospice Care Foundation, which is not a national organisation in Taiwan; two of the participants who received the hospice training course from the National Health Department, such as Participants 7 and 9, did not mention the palliative curriculum of national organisations. Participant 20 attended a palliative training course at a Buddhist organization. She did not mention a hospice training course, but this participant suggested to me that the personality of hospice staff is very important. This is a summarized interpretation. In Chapter 4, I previously presented the original data of Participants 7, 9, and 20 about Hospice training courses.

Gibbin et al (2009) suggest that teaching about palliative care, death, and dying should begin at undergraduate level. All of my participants received hospice training courses from the Buddhist Lotus Hospice Care Foundation or National Health Department rather than from the curriculum development in Universities. Although most of them

did not give the detailed reasons as to why they received hospice training courses as this was not one of my research questions, some of them mentioned that they were unable to finish the fourth-stage training courses as they had important tasks in their Buddhist temple. A further explanation was that some leaders of Buddhist temples did not permit Buddhist monks or nuns to work in hospitals.

Newsome (2010) explored a mindfulness course for students in the helping professions. The participants enrolled in a one to three credit course on mindfulness that included six weekly sessions of mindfulness training. The participants' perceived stress significantly decreased, their mindfulness significantly increased and their self-compassion significantly increased between pre-intervention and post-intervention.

Participant 18 thought that the training courses had been very important for her; for example, she said that when she had not yet been trained she was afraid because she did not know what to say to the patients. She said that she knew how to do it now because she had finished the 4-stage training courses from the Buddhist Lotus Hospice Care Foundation. Participant 21 thought that the four-stage hospice training courses from the Buddhist Lotus Hospice Care Foundation were wonderful and very useful for her; she wanted to develop the hospice care in her own country in the future. This is a summarized interpretation of the original words of Participants 18 and 21 which have been presented previously in Chapter 8.

Rushton et al (2009) also found that health care professionals had reported a lack of skills in the psychosocial and spiritual aspects of caring for dying people, and high levels of moral distress, grief, and burnout. Therefore, they developed a contemplative end-of-life training programme to provide opportunities and methods for cultivating the stability of the mind and emotions. In my study, participants thought that hospice training courses from the Buddhist Lotus Hospice Care Foundation were very useful for them for their work in hospice palliative care units; however, they did not mention their curricular needs and expectations. They simply said that the curriculum helped them to communicate with terminally ill patients and their families. In fact, all

participants cultivated the stability of their minds and emotions in daily life based on Buddha teachings, not only for working at hospice units in hospitals.

Lynn and Goldstein (2003) state that avoiding commonplace errors and unwarranted sufferings is essential in treating fatal chronic illness, and assert that failure to treat symptoms adequately at the end of life is a serious medical error. In my study, it is not possible to evaluate medical errors because my participants were not medical staff, but all participants reported experiences regarding palliative patients who had symptoms of distress. Several participants had applied a specific Buddhist religious approach to alleviate patients' symptoms of suffering. For example, in Chapter 7, I presented the original words of Participant 17. Participant 17 used the Buddhist religious approach regarding concentration and relaxation to help patients because she was able to explain the medical mechanism of this Buddhist religious method very clearly. From the perspective of patients' safety, all participants' approaches were not harmful for patients or their families so far, although some approaches could not be tested by scientific means.

To sum up, I discussed the participants' training courses from the perspective of participants' data and literature review. Because of the training courses run by the Buddhist Lotus Hospice Care Foundation or other National Health Departments, the participants were able to play their roles in end-of-life care. The paticipants obtained the skill of compassionate care, respect, life review, and ethical consideration from the training courses. Therefore, all participants followed the ethical rules; for instance: they noticed patients' safety and they would not give unsafe interventions. In the next section I analyse my role as the researcher.

9.4 Reflections on my role in this study

In this section, I reflect on my role throughout the whole research process, including the relationship between the participants and the researcher. In Chapter 3, I explored the researcher's role when using a qualitative method and constructivist grounded

theory.[47] The purpose of this section is to show that I was able to collect rich data from participants because I had good strong relationships with Buddhist chaplains as I am a Buddhist and also have knowledge of Buddhism.

Birks and Mills (2011, p.49) describe how positioning the researcher in a grounded theory study is important, and how "developing reflexive practice" and "establishing relationships between the researcher and participants" are two main strategies to support the researcher's adopted position. In Chapter 3 I explored some of the literature on the role of the researcher in grounded theory, including Pilot and Beck (2003, p.434), Finlay (2003, p.5), and Reinharz (1997, p.3).[48] Based on Birks and Mills's (2011, p.4) viewpoints and previous literature reviews, I reflected on my role (position) in this study.

Morse (1989, p.101) reminds us that the task of the researcher is to be understood and accepted by the participants. I was a senior nurse in hospital before my doctoral training and attended hospice palliative intensive training courses several years ago. I got a nursing Master's degree in Taipei Medical University in Taiwan in 1999 and had both working and internship experience in hospice palliative care. In addition, I have taken several communication courses and this may have helped me to use skills to create an atmosphere that made the participants feel comfortable enough to talk freely and openly. For example, I was able to pay attention, be reflective, and avoid making interruptions during the interview process. I attended and received the ritual of taking refuge and received a Buddhist name in a Buddhist temple in 1989 and so I am a Buddhist. I obtained my Buddhism Master's degree in Hua-Fang Buddhism University in Taiwan in March 2009. I completed 16 Buddhism courses (total 576-hour courses) and a Buddhism thesis. I think I was able to establish a good relationship with hospice palliative Buddhist chaplains due to the fact that I had

[47] Please see Chapter 3 one part of Section 3.1.1 Researcher's role in qualitative method and constructivist Grounded theory.

[48] This is only a summarized interpretation; the detailed relevant literatures were presented in Chapter 3 Section 3.1.1 Researcher's role in qualitative research and grounded theory. I presented Birks and Mills's (2011, p.4) viewpoints here rather than in Chapter 3. Other relevant literature about the role of the researcher was presented in Chapter 3.

knowledge of palliative hospices and Buddhism. I understood Buddhism languages, which helped me to communicate with the Buddhist chaplains.

All participants knew that I was at the time a nursing teacher in a nursing college and a PhD student in Nursing Studies. They also knew that I was a volunteer in the Buddhist Lotus Hospice Care Foundation as they received two invitation letters to participate in the study: one was from the Buddhist Lotus Hospice Care Foundation, and the other was from the researcher myself.

The relationship between the participants and myself as the researcher in Buddhist society was similar to the teachers (Buddhist chaplains) and a student (the researcher) because Buddhist chaplains were a kind of teacher, who taught Buddhism. I bowed to the participants at the beginning of each interview and applied very polite ways and language during the whole interview and after the interviews as I am a Buddhist. Overall, I felt that my research subjects were friendly and welcomed my research. Morse (1989, p.89) thought that carrying out fieldwork in one's own culture had several advantages, but it was essential to make the researcher's role clear; for instance, one was acting as a researcher and not as a participant.

My job was a senior nurse before and I am an academic lecturer in a nursing college now; when I interviewed Buddhist chaplains about their work and perceptions, I was stimulated to reflect on the nursing work and nursing education on hospice palliative care. Therefore, there are many sections discussing the work of nurses and Buddhist chaplains, and the curriculum between nursing education and hospice training courses of the Buddhist Lotus Hospice Care Foundation in this thesis. The nurses were educated to fulfill a role of cooperation with the interdisciplinary medical professionals, including physicians, pharmacists, nutritionists, psychologists, and social workers. In general hospitals, chaplains seldom work with medical professionals or there may be no chaplain working at a hospital. However, in the hospice palliative care service, chaplains play an important role because some matters are very difficult for medical professionals to deal with, such as the issue of rebirth and patients' death anxiety. All participants in my study had received hospice

training from the Buddhist Lotus Hospice Care Foundation or the National Health Department and therefore were educated to work with hospice medical professionals. Their compassionate attitude was able to set good relationships with hospice team members, patients and families.

The language relationship between participants and myself as the researcher was that we shared the same first language. We could all speak Mandarin very well because Mandarin is an official language in Taiwan now. Although Participant 21 is an international PhD student in Taiwan, she can speak Mandarin and the same dialect as myself because her ancestors originated from mainland China as did those of the other participants and myself. Elizabeth et al (2007) agreed that data collection, transcription and analysis were best undertaken in the first language of the respondents, and that native researchers should be employed in transcultural research.

From the perspective of observation in qualitative research, I only observed the interview environment and my participants' (Buddhist chaplains) body language during the data collection. I did not get involved in the interactions between patients and Buddhist chaplains because of objective and ethical considerations. For example, if I had deliberately observed their interactions, some patients or their relatives might not have felt free to talk much with the Buddhist chaplains. However Participant 2 invited palliative patients' families to attend a small group discussion meeting in the hospital, which I also attended. During the hour-long meeting, I saw the interaction between Participant 2 and the palliative patients' families in the Buddhist association. Personally, Participant 2 was very good at dealing with the families' emotional effects, her consultancy skills were wonderful and she could enable the family to get a peaceful mood[49].

Loy (2003, p.74) reminded us that all Buddhists are expected to follow the five basic precepts: to avoid killing, stealing, lying, sexual misconduct, and intoxicating drugs. Based on the five basic precepts, all Buddhist chaplains do not lie. Although I did not

[49] Please see Appendix 6 Field Note.

observe the interaction between patients and Buddhist chaplains, all participants described the clinical stories in palliative care units using pseudonyms to me.

9.5 Reflections on my own belief

The purpose of this section is to reflect upon my belief in order to enhance the rigiour of this study. My belief as a Buddhist is that we have a previous life not only based on Buddha's teachings but in my case also based on some unexplained phenomena that happened to me. For instance, when I was 20 years old, I heard the "Sanskrit pronunciation" of Da- Bai (Great Compassion) mantra twice and then I was able to recite the whole Da- Bai (Great Compassion) mantra precisely without any readable paper or any direction. Actually, the Da- Bai (Great Compassion) mantra is a very long one, and I did not learn the Sanskrit language until I was 20 years old. Another unexplained phenomenon was that when I read the Buddhist Amita-Buddha sutra for the first time, I had a special feeling of familiarity with it. I believed strongly that I had learned Da- Bai (Great Compassion) mantra and Buddhist Amita-Buddha sutra in my previous life.

In Taiwan, we have the culture of ancestor-worship, we prepare delicious food for the dead ancestors and we burn paper-money for them. This is very important for us; however, some religions dis-agreed with this culture in Taiwan, and think that our dead ancestors are evil spirits. This is a very severe cultural conflict in Taiwan. Many of the older Taiwanese generations rejected some religions as they did not want their children to go to churches as they were very afraid that if their children believed in these religions they would become hungry and poor ghosts after they died. I cannot judge cultural conflicts in Taiwan: I was born into an "ancestor-worship" family, and I also believe that "ancestor-worship" is necessary in our society. As mentioned in several sections above in this study, Chater and Tsai (2009) agreed that in Chinese traditional culture, the families were always involved in important personal decisions, such as job selection, marriage arrangements and medical decision-making. Reflecting on myself, my parents and important relatives also played an important role in the decision-making during my career. According to Smart (2000), Buddha is not strictly treated as divine, as a God, Buddhism does not believe in a creator God;

it does not deny the gods. Reflecting on myself, I could not know a creator God, but I also do not deny the gods.

When I was a senior nurse in hospitals, I had numerous experiences regarding the patients' dying process. The patients said that they saw some people come to the hospital; however, I could not see who the patients saw. I remember clearly that when I was a child, my grandfather's mother saw many people who had died several years before and after she saw the dead people in this village she herself died two days later. What is the reality of these unexplained real stories? Some people believe that there are ghosts in this world. Actually, I do not know this. In my country, Guan-Yin Bodhisattvas is very popular both in Buddhism and Taoism. In fact, the Da- Bai (Great Compassion) mantra which I could recite in Sanskrit pronunciation is closely related to Guan-Yin Bodhisattvas. When Participant 1 and other Buddhist chaplains mentioned that the recitation of Guan-Yin Bodhisattvas name was very useful for the patients and their families based on their past experiences in hospital and in temples, I agreed with this strongly. I knew how to make "Da-Bai (Great Compassion) Water" before I conducted the research as I could recite the Da-Bai (Great Compassion) mantra precisely. I am also a Buddhist and have rich knowledge in Buddhism as I had earned a Master's degree in Buddhism.

I am not very sure whether my Buddhist background is a kind of researcher's bias or whether it ensures that the results of this study are more reliable. Therefore, I found another person, who was definitely not a Buddhist, to check the content of my interviews with Buddhist chaplains. I discussed with this academic person because she had completed training courses about various qualitative studies and had been involved in qualitative research projects.[50] During the data analysis I discussed with this qualitative researcher expert to ensure the rigour of the study and also to make sure of the final version of the emerging theoretical framework. After we discussed our data analysis, we agreed that the "dynamic process of compassionate care" is more than "emotional care" and fits with all participants' data as all participants not only played the role of providing "emotional care" but also used the "dynamic

[50] I wrote this qualitative expert's name in the acknowledgements section of this thesis.

process of compassionate care" to reach the goal of Buddha's teaching and let the dying patients have a peaceful mind and good death.

9.6 Reflections on the research process

The purpose of this section is to reflect on the whole research process. It is different from Chapters 1 and 2 in that I present the reasons why I changed the sampling goal, for instance: the participants were changed from palliative patients to the clinical palliative Buddhist chaplains.

Complementary approaches are very common when patients suffer from incurable diseases in Taiwan. In my culture, the complementary approaches were very special; for example, many kinds of different religious methods were adopted by patients and their families. The cultural meanings of the use of complementary approaches were different from that of Western society.[51] At the beginning, I planned my study to be about end-of-life patients rather than clinical Buddhist chaplains. However, the end-of-life patients are vulnerable people physically and emotionally and so it was difficult to interview them for ethical reasons. Another difficulty is that I was a full-time PhD student at the University of Edinburgh, and could not play the role of clinical nurse in Taiwan when I studied in Edinburgh. To be honest, hospice palliative patients are a vulnerable group even if I excluded patients with acute symptoms. However, based on my clinical experiences in hospice palliative care unites, chronic fatigue was very common and often happened to hospice palliative cancer patients. If I interviewed hospice palliative patients for perhaps 30 to 60 minutes, it is a long time for the patients. Thus, interviewing the vulnerable end-of-life patients was going to be difficult for me.

From my past clinical nursing experiences in hospitals, the religious staff played an important role when people suffer from disease or meet misfortune in Taiwan. Therefore, I changed my potential participants from palliative patients into clinical

[51] This is a summarized interpretation. I have presented the background of this study and the literature review about complementary approaches in Taiwan when Taiwanese are sick or bad luck.

palliative Buddhist chaplains. I conducted a pilot study at the beginning, and after that I modified the interview guide because most of participants had not been medical or nursing students previously. After I had modified the interview guide, all participants were able to answer my research questions and that enabled me to develop the final version of the theoretical framework (see Figure 8.1). I myself was also an integral part of the study as I wrote reflective diaries and field notes during the whole process of the research based on Charmaz's (2006) constructivist grounded theory.

Summary

This chapter focuses on analytical reflections which I compare with the literature; there are some similarities and differences between the findings and the literature which have been shown through my reflections. The similarities between literatures and the findings of this study include that Taiwanese very often used the folk and religious approaches to face their serious diseases, for instance: Holy Water or blessings from religious staffs or religious symboms. The differences from the literature which I have found are important contributions to knowledge. For example: the new contributions in the aspect of knowledge in my study are that all participants use the approaches of Mahayana Buddhism which is different from those end-of-life approaches most commonly found in Western Society. All participants mentioned that respecting end-of-life patients' religious belief is a very important attitude to adopt when they offer Buddhist chaplaincy service in end-of-life care. They spend a lot of time actively listening and accompanying to express their respect and empathy in end-of-life care. All participants thought that their compassionate care meant following Buddha's teachings rather than the theoretical and technical content of nursing education. They used the dynamic process of compassionate care in end-of-life care. Hospice training courses are necessary for them to work with the end-of-life patients and their families. In the following Chapter 10, conclusions and recommendations will be presented.

Chapter 10 Conclusions and Recommendations

Introduction

This final chapter is focused on conclusions and recommendations. The chapter considers the key findings of this study, the contributions to knowledge, methodological issues, and recommendations for future policy, practice, education and research.

10.1 The findings of this study

This study provided an in-depth exploration of the way in which Buddhist chaplains applied their understanding of Buddhist principles and practices to develop a dynamic process of compassionate care which complemented the medical services which patients received within the hospice setting.

All participants had been engaged in Buddhist monastic practices for over 10 years. A compassionate attitude is the dominant motif within Buddha's teachings. Therefore the practice of compassionate, emotional, spiritual care in end-of-life care enabled the chaplains to practise Buddha's teachings during the process of interactions with patients, families and professionals in hospice palliative care units in hospitals.

Though Buddhism is a mainstream religion in Taiwan, not all people in Taiwan practise Buddhism. Chaplains reflected on how their practice required them to be respectful of other religions, recognizing that the core aim of Buddhism was to seek a peaceful mind to enable a peaceful death, which was more important than the rituals or the religious frameworks articulated by specific religious teachings. The tension for the chaplains between facilitating the enlightening of "Buddha nature", as an important task within the life journey, and recognizing the complexities of the different Karmic stages at which different patients were situated, dominated their day to day activities. The chaplains, sensitized to the multiple perspectives of the hospice

wards, spoke of how the tools or methods of achieving what they believed to be a good death were less relevant than the process itself, the enlightenment of a person's "Buddha nature".

As compassion is at the heart of end-of-life care, the articulation of compassion identified through the chaplains' interactions with patients provides a new way of engagement that has important messages for the delivery of palliative care. Buddhism, as Bournemouth (1998, p.12) wrote, is a two-thousand-year-old master class in understanding the nature and true power of compassion. All 22 Buddhist chaplains within this study practised compassionate care in their hospice work because they believed that it was a natural outcome of their belief system, all owing to the Buddha's teachings

10.2 Contributions to knowledge

There are some contributions from this thesis. One of my important contributions to knowledge is an understanding of the "dying process" and the specific role of Taiwanese Mahayana Buddhist chaplains in end-of-life care. My other unique contribution to knowledge is to provide insight into how religious approaches are regarded as common "complementary" approaches in Taiwan. This particular understanding about religious methods as complementary approaches in Taiwan differs from much of the western literature on complementary therapies. The Buddhist chaplains play an important role in enhancing spiritual and psychosocial caring skills in end-of-life care in this study. They used the skill of Life Review to lead the end-of-life patient to have good Karma in order to have a good death and better next life. This contribution is of particular significance to hospice palliative care. I will present the following materials to support the contributions to knowledge in my thesis as follows.

A review of current literature coupled with the experience of palliative care personnel identified that some patients with religious persuasions were refusing western medical treatments when they recognised that they were in the end stage of disease because they believed these treatments could not control death and rebirth.

Buddhist chaplains' life experience and interpretations influence the thinking processes and decision-making of many of those they come in contact with, especially, but not exclusively patients who share the Buddhist faith. However, few studies have discussed the experience of patients who use religious methods as complementary approaches from the perspective of hospice palliative Buddhist chaplains working in medical or hospital contexts. The thesis addresses this gap by demonstrating how Buddhist chaplains understand death and dying through the lens of their Buddhist beliefs and techniques which play an important role and form the basis of their practice in end-of-life care.

The Buddhist chaplains regarded compassionate care and Mahayana Buddhism as the main content of Buddha's teachings. All participants used aspects of Buddhist philosophy in end-of-life care to define "hospice palliative care". The final theoretical framework to emerge from the data provided a structure for interpreting "the dynamic process of compassionate care". Compassionate care is a multifaceted, dynamic phenomenon practised by the chaplains and displayed in their interactions with patients. Mahayana Buddhism provides the specific tools for these interactions creating a sacred relationship that allowed patients to understand their context and cope with their end-of-life experiences. Furthermore, the Buddhist chaplains' understanding of compassionate care was influenced by their educational background, hospice training courses, and Buddha teachings. Participants used the skill of Life Review to support their compassionate care, including establishing relationships, and sharing words of love. They developed this skill of Life Review and compassionate care from the hospice training courses. They combined Buddhist religious philosophy and Life Review with their intent to help end-of-life patients to have good Karma in order to have a better next life.

It is hoped that this study will help palliative care professionals to understand the experiences of hospice palliative Buddhist chaplains. The findings will also help other Buddhists and non-Buddhists to deal with end-of-life care better. There are many clinical examples in this thesis about end-of-life care that will be helpful for setting National Health Policy and education for end-of-life care. The findings also

have implications for hospice palliative team members in caring for Buddhist patients or their Buddhist families.

10.3 Methodological issues: strengths and limitations of this study

Charmaz's (2006) constructivist grounded theory method was chosen for the study because they was deemed appropriate for the purposes of the research objectives and the nature of the research questions. Data collection used triangulation and included demographic questionnaires, semi-structured face-to-face interviews, field notes, and written memos. Purposive sampling was used to recruit participants with rich working experiences in clinical end-of-life care. Twenty female and two male Buddhist chaplains aged between 33 and 67 years old participated. Charmaz's (2006) constructivist grounded theory, which included comparative method, and three analytical phases (initial coding, focused coding and theoretical coding) informed the data analysis. As discussed in Chapter 3, Section 3.5, rigour in qualitative research is achieved by credibility, originality, resonance, and usefulness to set up the quality of the data (Charmaz 2006, p.182).

A number of study limitations should be considered when interpreting the findings since they are shaped by Taiwan's history and therefore may not be directly transferable to other cultures/countries.

The participants were end-of-life care Buddhist chaplains, who cared for Buddhists and non-Buddhists in Taiwan where the majority of the population are of Chinese descent and preserve Chinese culture. The findings of this study can be applied to Taiwanese culture, but may be less easily applicable to other ethnic groups and cultures.

Furthermore, not all Buddhist chaplains agreed to be interviewed. The researcher set out to interview all 27 hospice palliative Buddhist chaplains at the Buddhist Lotus Hospice Care Foundation in order to avoid sampling bias, but based on the ethical considerations and the participants being volunteers, I had to respect the chaplains' decisions about whether or not to participate. The number of participants in this

study was 22, and the reasons for why five participants declined to be interviewed were that each had departed from working in the clinical hospice palliative care in hospitals.

In this study I only interviewed clinical Buddhist chaplains. Some of the chaplains spoke of the importance of collecting information on physicians' attitudes and they had important relationships with nurses in the end-of-life care, but I did not interview other team members, such as physicians or nurses, to obtain their perspectives. Walshe et al (2011) noted that observation in "natural" settings allows the explanation of social process and phenomena. In my study, I did not directly observe interactions between participants and end-of-life patients. Howerver, I wrote field notes, research diaries, and used reflexivity to illustrate my own observations in "natural" settings. I presented some examples such as Participants 1 and 5's role in palliative settings from my fieldnotes (see Appendix 6).

Although all participants and I believe that "Buddha nature" exists in everyone's mind, nevertheless "Buddha nature" is an abstract concept and impossible to test by scientific methods. As constructivism is a qualitative research approach rather than an experimental research design, it does not set out to 'test' ethical and religious considerations. For instance, all participants talking about religious faith was a very important factor when they applied Buddhist religious methods both in hospitals and in temples, however, it is challenging to measure the effects of religious faith on their practice. It could be argued however that in-depth narratives are more appropriate to capture these type of data.

10.4 Recommendations for future policy and practice

Hospice palliative care is an essential component of the Taiwanese National Medical Service. All people will die, and the majority will need some form of care as they face death. The emerging theoretical framework of the "dynamic process of compassionate care" provides a new way of interpreting the complexities of complementary care systems within a medical system of care. The "dynamic" process is also appropriate in clinical nursing care.

All participants in my study offered compassionate care in hospice care and they usually spent more than one hour listening to what the patients and their families said. Unfortunately, health professionals such as doctors and nurses may not have enough time to listen to emotional suffering, as it is not included in National Health Insurance costs. Although time is costly and difficult to find in overstretched wards. Buddhist chaplains believe that it is important for nurses to learn how to spend time with and listen to patients, as this, they believe, will foster mutual understanding. But they also recognized that in busy wards many nurses do not have the time to do this because it is not covered by National Health Insurance costs.

Curtis et al (2012) state that compassionate practice is expected of Registered Nurses (RNs) around the world even though it remains a contested concept. Martin (2008) suggests that compassion is a vital part of good nursing care. There is a limited evidence-base within the literature to compare compassionate practice between nursing education and Buddha's education. Michalec et al (2013) believe that the impact of burnout and compassion fatigue will influence professional nurses' well-being and willingness to remain in the profession; there is limited literature regarding burnout and compassion fatigue in Buddhist chaplains, and further studies exploring this relationship could prove valuable for a better understanding of burnout within the health workforce.

It is recommended therefore that future government policy concerning the financial cost of end-of-life care which is currently provided by Buddhist chaplains from a Charitable Foundation rather than Taiwanese National Health Insurance should be increased in order to improve resources.

10.5 Recommendations for future education

Several participants thought that hospice training courses were very important and very useful for them. Hospice curricular design is a key factor for all health care professional team members, not just the Buddhist chaplains. Recommendations for future education suggest that appropriate hospice training courses should be

developed for different levels of trainees in end-of-life care in Taiwan including medical and nursing students and clinical medical and nursing staff.

10.6 Recommendation for future research

As noted above the current study did not include experimental or control groups. It was a qualitative research study. Therefore, it is suggested that future research could be undertaken using an experimental research design to test the theoretical framework regarding " the dynamic process of compassionate care" and the effects of complementary methods applied by Buddhist chaplains, such as the approaches of Mahayana Buddhism.

Secondly, the researcher developed a theoretical framework based on the Buddhist chaplains' experience of end-life-care and did not test whether it matched professional medical and nursing staff's experiences and viewpoints since the purposes of grounded theory is focused on "developing" mid-range theory (in classic grounded theory) or a theoretical framework (in constructivist grounded theory) rather than theory testing. Therefore, it is recommended that this framework be tested by quantitative research methods in the future.

Thirdly, this study only focused on Buddhist chaplains; therefore, in a future study, it would be valuable to include health professionals, such as physicians and nurses recognizing that physicians' and nurses' attitudes are important to Buddhist chaplains' work in end-of-life care. It also needs to be considered whether to test the theoretical framework of "the dynamic process of compassionate care" with different professional groups such as nurses, psychologists and mental health physicians.

Finally, all participants had rich clinical experiences in hospice care; however, almost all of their clinical stories were focused on patients with cancer because the hospice programme began with caring for terminal-stage cancer patients. Only Participant 21 talked about a patient suffering from a life-limiting neurological degenerative disease. With the support of the Taiwanese government, caring for non-cancer hospice patients will be important in the future because of the increase in all long term conditions. It is

increasing probable that in future, Buddhist chaplains will have more experiences of caring for non- cancer hospice patients and their families.

Summary

The purpose of this study was to explore the religious complementary approaches that were applied in the end-of-life care of patients in palliative hospice units in hospitals from the perspectives and work of hospice Buddhist chaplains.

The findings of this study developed an in-depth framework of "the dynamic process of compassionate care" from participants' interview data and relevant data sets. Constructivist grounded theory described how the participants used Mahayana Buddhist religious approaches in practising the dynamic process of compassionate care in end-of-life care.

Implications and recommendations have been proposed for future policy, practice, education, and research in the final sections of this thesis.

Appendices

Appendix 1: Informed consent statement

Study title: An Exploration of the Use of Complementary Approaches to End-of-Life Care: the Perspectives and Work of Hospice Palliative Buddhist Chaplains in Taiwan

I understand that the researcher is conducting a study regarding "An Exploration of the Use of Complementary Approaches to End-of-Life Care: the Perspectives and Work of Hospice Palliative Buddhist Chaplains in Taiwan".

Furthermore, I understand that the data for this study will be gathered through interviews and observations. When possible, the interviews will be audio-taped. The researcher will also keep notes of the conversations and of observations that she makes. The researcher will listen to the tapes to gain information, but individual confidentiality will be maintained. The findings of this study will be used in a final paper and may be published; however, I understand that I will not be identified.

I,_____, hereby agree to be a part of the study, An Exploration of the Use of Complementary Approaches to End-of-Life Care: the Perspectives and Work of Hospice Palliative Buddhist Chaplains in Taiwan.

I know that participation in this study is my decision, the personal risks are minimal and that I may withdraw at any time. My participation in this study is voluntary and no payment will be given to me for my involvement. I know that I will not incur any costs for my participation. If I withdraw from the study, my situation will not be affected.

I have been given the opportunity to ask questions regarding the study and all such questions have been answered. I have been provided with the researcher's phone number and Email account, and I may call at any time after the study begins to ask questions on the study. I give my consent freely to take part in this study based on the facts noted in this letter. I understand that I will be provided with a copy of the explanation and of this consent form.

Name of Participant _____

Signature of Participant _____ Date _____

Name of Researcher _____

Signature of Researcher _____ Date _____

Informed consent statement (Traditional Chinese version)

敬愛的法師，您好:

我是英國愛丁堡大學(The University of Edinburgh, UK)護理研究博士生楊美玲，目前正著手博士論文研究，研究主題為：「探討另類輔助療法（民俗宗教療法）的使用—從安寧緩和療護佛教宗教師觀點」，本研究之動機主要是基於末學過去的臨床護理經驗,安寧療護訓練課程,及文獻學上的缺乏。在台灣,有許多癌症病患(或其家屬)會自行尋求另類輔助療法(民俗宗教療法)，目前相關之研究多偏向從病患或家屬或醫療人員的角度探討，甚少從宗教師的觀點探討，根據目前研究及臨床經驗顯示:佛教臨床宗教師在安寧緩和療護有重要之影響力，包括:支持病患，家屬及支持醫療團隊..等等，基於上述之理由，實有必要進一步深入探討佛教臨床宗教師之經驗及理念。而在佛教法門中，亦有念佛法門及其他相關法門應用於臨終關懷上，有鑑於法師在佛學上的學養及安寧療護的經驗，透過您寶貴實務經驗的整理，有利於日後推動病患善終之重要參考。在此誠摯邀請您參與研究。

您若願意參與此研究，將會有１至２次會談，每次時間是依您所願談的內容多寡而定。為了完整而真實的記錄訪談內容，訪談過程中將會採取錄音的方式輔助，研究或訪談中若您不想繼續，可隨時終止或退出本研究，亦不會對您有任何影響。非常謝謝您的協助與支持。訪談過程將錄音並謄寫為文字稿，研究過程與資料將經過您的同意才引用，研究撰寫的過程中也邀請您一同參與您個人資料內容的檢核與討論；且為保護您的隱私，所有資料一律匿名而以編號處理。

為尊重您的意願，若願意協助研究，請先填具同意書，謝謝您！

英國愛丁堡大學護理研究
博士生 楊美玲 敬邀
E-mail:mailingtw@gmail.com

Appendix 2: Explanation to participants

Study title: An Exploration of the Use of Complementary Approaches to End-of-Life Care: the Perspectives and Work of Hospice Palliative Buddhist Chaplains in Taiwan

My name is Mei-Lin Yang. I am a doctoral student in the University of Edinburgh. I am also a registered nurse in Taiwan. As part of my doctoral study, I am conducting research on hospice palliative care. I am inviting you to participate in this study.

Your participation would involve answering questions and sharing your experience of your patients using complementary approaches. It will take approximately one to two hours of your valuable time to complete the interview. All the information provided will be used for research purposes only. You will be asked about your experiences and perceptions. Your answers will help me learn about the experiences of using complementary approaches in end-of-life care in Taiwan. The study findings may suggest approaches to improve patients' care.

If you agree, I would like to tape record our discussions. I will also make notes of our informal conversations. If you feel uncomfortable at any point during the interviews or conversations, please inform me, so that we can discuss it and can decide if you want to continue. You are free to ask any questions now or in the future. I will be available if you would like more information on this study.

All of our discussions, including your name and address, will remain confidential. Your name will be deleted from all records as soon as data collection is complete. Information that you and other participants provide will be analysed by qualitative research methods.

You are welcome to contact me if you have any questions about any part of this study. I very much appreciate your participation. Your information is very valuable. If you are willing to participate, there is a consent form I will ask you to sign.

You can reach me by calling my mobile phone or E-mail me, which you can find below.

My mobile phone number: (886)939300509

My E-mail account:mailingtw@gmail.com

Thank you for your time and cooperation

Sincerely yours

Explanation to participants (Traditional Chinese version)

研究同意書

本人(受訪者)同意參與訪談，將與研究者(英國愛丁堡大學護理研究博士生楊美玲)進行 1 到 2 次會談，每次依我所願意談的內容多寡而定。
訪談過程中，受訪者知道有錄音的方式輔助研究，可隨時終止訪談錄音，且知道錄音資料將由研究者轉換成文字稿，以利研究者整理分析。
研究過程與資料將經過受訪者同意才引用，研究論文撰寫的過程中也邀請受訪者一同參與受訪者個人資料及訪談內容的檢核與討論。
為保障受訪者的隱私，所有資料一律匿名而以編號處理。

受訪者:

研究者:

日期:

Appendix 3: Examples of Written Questionnaire and Interview Topic Guides

Study title: An Exploration of the Use of Complementary Approaches to End-of-Life Care: the Perspectives and Work of Hospice Palliative Buddhist Chaplains in Taiwan

I. Written Questionnaire - Basic Demographic Information

1. What day was your birthday?
2. What day did you become a monk (a nun)?
3. What day did you become a formal Buddhist chaplain?
4. How long have you been a monk (a nun)?
5. How long have you been a hospice Buddhist chaplain?
6. What is your educational background in non-Buddhism?
7. What is your educational background in Buddhism?
8. What is your major area of Buddhism?
9. What are your hobbies?
10. Where is your temple?
11. What is your position in your temple?
12. Have you received hospice training courses?
13. How long have you received hospice training courses for?
14. Which hospital are you working in now?
15. How many years are you working at this hospice unit in this hospital?

II. Interview topic guide

1. Could you tell me “How do you define hospice palliative care?”
2. Could you tell me “What is your role in hospice palliative care?”
3. Could you tell me “What are your opinions of the use of Buddhist religious methods as complementary approaches in hospice palliative care?”
4. Could you tell me any story about your hospice palliative care patients’ use of Buddhist religious methods as complementary approaches?
5. Could you tell me about your experiences regarding your hospice palliative care patients’ use of Buddhist religious methods as complementary approaches? For example: why do they use Buddhist religious methods as complementary approaches? For which kinds of disease (symptoms) do they use Buddhist religious methods as complementary approaches?
6. Could you tell me your view about hospice palliative patients’ use of Buddhist religious methods as complementary approaches?

*Summary

*Is there something else you would like to discuss or raise?

*Do you have any questions for me?

Examples of Written Questionnaire and Interview Topic Guides (Traditional Chinese Version)

I.訪談大綱(書面問卷) Written Questionnaire

I.基本資料

出生日期:　　年　　月　　日

剃度日期:　　年　　月　　日

受具足戒日期:　　年　　月　　日

出家幾年:　　年　　月

從事安寧療護宗教師的年資:　　年　　月

世學最高學歷(畢業學校與科系):

佛學最高學歷:

研究領域或專修法門:

請列舉您的興趣、專長:

目前常住(名稱):

常住擔任執事的狀況:

您有接受醫院臨床的受訓:　有　　無

受訓多久:

其他曾參加過安寧療護等相關訓練課程:

您目前服務的醫院:

該院成立緩和病房的時間有:

病房床數:

平均佔床率:

您平均一星期在病房的時間有:　　天或　　小時

您覺得目前宗教師在醫療團隊的地位? 如果以五點量表看，最高是 5 分，最低是 1 分，您認為在那一點?為什麼?

II.訪談指引 Interview Topic Guides

1.請問您對安寧療護的定義是什麼?

2.請問您在安寧療護的角色?例如:都做那些事?

3.請問您對佛教法門的定義及包含範圍?

4.可否告訴我您病人在安寧病房中使用佛教法門的故事?(包括使用的法門種類?過程?及最後結果?)

5.請問他們為何使用佛教法門?通常是何種疾病或何種症狀或何種因緣使用佛教法門?

6.您對安寧緩和療護病人使用佛教法門的看法?

除此之外，是否還有想要和我分享的故事及經驗?

Appendix 4: Research ethics team permission from the University of Edinburgh

The University of Edinburgh
College of Humanities and Social Science

SCHOOL OF HEALTH IN SOCIAL SCIENCE

APPROVAL BY SUBJECT AREA RESEARCH ETHICS TEAM/ CO-ORDINATOR (LEVEL 2)

Research Ethics Committee Number:	N/A
Name/s of Researcher/s:	Mei-Lin Yang
Proposed Title of Research:	An Exploration of Use of Complementary and Alternative Therapies (CATs): the Perspectives of the Hospice Palliative Buddhist Chaplains in Taiwan
Funding Body (if appropriate):	Taiwanese Government
General Comments:	
Outcome: (please tick box)	**Approved** ✓ **Approved with Conditions (see attached)** ☐ **Not Approved** ☐
If approved with conditions, name of person to oversee these:	

The above research proposal has been approved by the subject area research ethics team/co-ordinator.

Signed: . *(Dr Ethel Quayle)*

Date: 17th May 2012

Appendix 5-1: The Study Protocol submitted to the Buddhist Lotus Hospice Care Foundation

Title	Content
Protocol Title:	An Exploration of the Use of Complementary Approaches to End-of-Life Care: the Perspectives and Work of Hospice Palliative Buddhist Chaplains in Taiwan
	Protocol Version: 2012 version Protocol Date: 11th May 2012 Principal Investigator: Mei-Lin Yang Research Team: No, just only one Principal Investigator
Abstract	This study is motivated by the researcher's experience of working in end-of-life care and by the literature review which reveals a gap in the knowledge and understanding of the role of complementary religious approaches in managing the experience of living with a life-limiting illness in Taiwan. The research questions are : (1) How do the Buddhist chaplains define "hospice palliative care"? (2) How do Buddhist chaplains use Buddhist religious methods as complementary approaches in clinical end-of-life care? (3) What are the experiences of Buddhist chaplains regarding the patients' use of Buddhist religious methods as complementary approaches in clinical end-of-life care? (4) What are the opinions of Buddhist chaplains regarding patients' use of Buddhist religious methods as complementary approaches in clinical end-of-life care?
Background and Significance/Preliminary Studies	Tzeng and Yin's (2006) evidence-based data, show Buddhist or Taoist monks and nuns play an important role when Taiwanese people are sick or suffer bad fortune, such as during the Severe Acute Respiratory Syndrome (SARS) outbreak in Taiwan in 2003; during that epidemic many Taiwanese people, including government officials, visited temples to worship the gods of the Taiwanese folk religion. That is, it is clear that religious rituals exist in Taiwan when Taiwanese people are sick or suffer bad luck. However, few studies explore the religious complementary approaches in end-of-life care in Taiwan. These evidence-based data

	and the previous literature limitations are my study background for this PhD thesis.
Study Aims	(1) How do the Buddhist chaplains define "hospice palliative care"? (2) How do Buddhist chaplains use Buddhist religious methods as complementary approaches in clinical end-of-life care? (3) What are the experiences of Buddhist chaplains regarding the patients' use of Buddhist religious methods as complementary approaches in clinical end-of-life care? (4) What are the opinions of Buddhist chaplains regarding patients' use of Buddhist religious methods as complementary approaches in clinical end-of-life care?
Administrative Organization	Purposive sampling is applied in this study. The participants are volunteers who can speak Mandarin or Taiwanese, and are willing to participate in this study. Each interview lasts from one to three hours. I will analyse the written texts and later on discusse them with another qualitative expert in order to reduce the risk of researcher's bias. To protect the participants' privacy and to achieve reliability of the data, another data analyst will check the written transcriptions independently. I choose Charmaz's (2006) constructivist grounded theory guidelines to manage the data including the initial coding, focused coding, early memo writing using focused codes, advanced memo writing and theoretical coding. Charmaz's (2006) constructivist grounded theory includes three analytical phases: initial coding, focused coding and theoretical coding.
Study Design	In this current study, I choose a research approach which was Charmaz's (2006) constructivist grounded theory. During the process, Buddhist religious approaches also support participants' dignity; in this study, participants tell the clinical stories and hospice patients' and their families' life review. The perspective and work of the clinical Buddhist

	chaplains in end-of-life care will be investigated in Taiwan. Triangulation of the data sources is adopted in order to enhance the rigour of this qualitative research. It recommends that the findings inform the future education of medical and nursing students and staff in hospice end-of-life care in Taiwan.
Study Procedures	Firstly, I will contact the leader of the Buddhist Lotus Hospice Care Foundation to explain the purpose and procedure of my research. I will then send the "Research Protocol" to the research committee of the Buddhist Lotus Hospice Care Foundation. Secondly, I will contact the hospice palliative care Buddhist chaplains by E-mail after receiving approval from the ethics committee of the University of Edinburgh and from the Buddhist Lotus Hospice Care Foundation. Finally, I will send the written invitation, consent form, and explanation form to explain the study to the hospice palliative care Buddhist chaplains in order to recruit them based on inclusion and exclusion criteria to ensure that all participants meet the purposive sampling requirements and they are willing to participate in the study. The inclusion characteristics of potential participants 1.Participants are Buddhist chaplains who have experience of using Buddhist religious methods as complementary approaches for their patients in Taiwan. 2. Participants offer services to end-of-life patients or their relatives. 3. Participants are Chinese or Taiwanese. 4. Participants can speak Mandarin or Taiwanese dialects of Chinese. 5. Participants are aged between 20 and 70 years old. 6. Participants consider themselves to be mentally healthy. 7. Participants do not have any history of mental

	disorder or disease. 8. Participants do not have any criminal history in any country. 9. Participants are volunteers and willing to participate in my study. The exclusion characteristics of potential participants 1. Individuals who fail to meet any of the inclusion criteria mentioned above. 2. Individuals who decline to be interviewed.
Safety Monitoring Plan	I will provide the participants with a consent form and an explanation before the face-to-face interviews commenced. All of the participants are given written and oral information before the interview, including information on the study design, assurance of anonymity, confidentiality, and information about their right to withdraw from the study. For instance: The participants understand that the data for this study will be gathered through interviews and observations. When possible, the interviews will be audio-taped. I will also keep notes of the conversations and of observations that I make. I will listen to the tapes to gain information, but individual confidentiality will be maintained. The findings of this study will be used in a final paper and may be published; however, the participants will not be identified.
Analysis Plan	The Step-by-step analysis I will analyse the written texts and later on discuss them with another qualitative expert in order to reduce the risk of researcher bias. To protect the participants' privacy and to achieve reliability of the data, another data analyst will check the written transcriptions independently. I choose Charmaz's (2006) constructivist grounded theory guidelines to manage the data including the initial coding, focused coding, early memo writing using focused codes, advanced memo writing and theoretical coding. Charmaz's (2006) constructivist grounded theory includes three analytical phases: initial coding, focused coding and theoretical coding.

Literature Cited	Charmaz K (2006) Constructing Grounded Theory: A practical guide through qualitative analysis. USA: Sage. Yin YL, Su CY, and Tsai CH (2004) The meaning of religious symbols in palliative nursing care. *Taiwan Journal of Hospice Palliative Care* 9(1): 65-74.

Appendix 5-2: IRB from Buddhist Lotus Hospice Care Foundation

佛教蓮花基金會 *Buddhist Lotus Hospice Care Foundation*

同意研究訪談證明書

查 楊美玲（YANG, MEI-LIN）君 之研究案：「探討另類輔助療法的使用—從台灣安寧緩和療護佛教宗教師觀點 **An Exploration of Use of Complementary and Alternative Therapies(CATs):the Perspectives of the Hospice Palliative Buddhist Chaplains in Taiwan**」業經本會評估，具可行性及價值性，本會同意該君訪談安寧療護佛教宗教師及給予研究案執行之協助，特此證明。

佛教蓮花基金會
Buddhist Lotus Hospice Care Foundation
董事長 President
陳榮基 Rong-Chi CHEN
2012 年 5 月 27 日

This certificate to Yang, Mei-Lin

Research Title：
An Exploration of Use of Complementary and Alternative Therapies (CATs): the Perspectives of the Hospice Palliative Buddhist Chaplains in Taiwan」
Research Investigator:
YANG, MEI-LIN（PhD student in the University of Edinburgh）

We agree that this study is feasible and valuable. We are glad to support Mei-Lin to interview Buddhist Chaplains.

佛教蓮花基金會
Buddhist Lotus Hospice Care Foundation
董事長 President
陳榮基 Rong-Chi CHEN
27th, May, 2012

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Appendix 6: Field Notes

Examples of the researcher's field notes

Appendix 6.1: Example of field notes: Take Participant 1 for example

I met Participant 1 face-to-face in the palliative training course regarding aromatherapy on 16th and 17th June. The leader of the Buddhist Lotus Hospice Care Foundation, Miss Chen, arranged for me and this chaplain to be in the same team. Miss Chen specially introduced me and my research to this chaplain. During the coffee break, this chaplain answered the palliative nurses' phone and talked to different nurses. Generally, this chaplain talked to me and other palliative care team members almost in our dialects (Min-Nan language) rather than in Mandarin. I fully understand what this chaplain said because she did not speak another dialect (Ha-Ka language) during these two days. This chaplain has a good relationship with the palliative nurses. She also attended many palliative training courses, for example, aromatherapy, the course on the prevention of suicide, the course on anti-depression, the courses on faith culture and spiritual care, bereavement care, communication in hospital, death education, and so on.

Reflection on the observation of this field note (Participant 1)
Aromatherapy is very popularly used in palliative care in Taiwan. Aromatherapy is a form of CATs. Generally speaking, the nurses applied aromatherapy in palliative care units without any physicians' prescriptions, that is to say, it is not supported by National Health Insurance in Taiwan. The fee for aromatherapy materials comes from the donations. The fee of these aromatherapy materials is not very cheap for the poor. This Buddhist chaplain had many experiences regarding aromatherapy, she knows her role in palliative care is not to apply aromatherapy to her patients.

Appendix 6.2: Example of field notes: Take Participant 2 for example

Participant 2 is the leader of Buddhist association in Taipei. She has been spending a lot of time in palliative care since 10 years ago. When I invited her as my participant in my project, she was very happy to promise this for me. She answered me she got master degree in the college of Buddhism. She had been trained to conduct academic research at that time. She also finished 4-stage palliative training courses. She remembered she wrote several assignments regarding the 'interaction between herself, her patients and their families'. She also used Buddhist practice in clinical palliative care and had good results. She is the leader of this study group and also a consultant of palliative care.

Reflection on the observation of this field note (Participant 2)

Participant 2 is the leader of this palliative small group discussion meeting. This palliative small group discussion meeting will take place every second Friday afternoon from 13th July to 28th December this year. That is to say, we will enjoy 12 different movies (films) during this period; these movies were made in the USA or in Japan. There are Chinese translation characteristics on the screen. We can see different culture in the end of life from the movies.

Participant 2 invited palliative patients' families to attend the small group discussion meeting. Therefore, there were several palliative families that Participant 2 cared for in hospital. During one-hour discussion, I saw the interaction between Participant 2 and the palliative patients' families in the Buddhist association. Personally, Participant 2 is very good at dealing with the families' emotional effect, her consultant skills are very wonderful and she can let the family get peaceful mood. She also applied Buddhist meditation guide on 27th July, I felt much comfort; other members also thought these were very wonderful experiences.

Appendix 6.3: Example of field note: Take Participant 5 for example

I interviewed this chaplain at a palliative care unit in hospital. During the process of interview, the senior nurse would like to consult this Buddhist chaplain about some questions; she said she does not mind that I am also in the room. She raised two questions: one is that she had the same dream every night recently. The other question is that she had special ability and feeling. She saw someone (she thought they are ghosts not human not Buddha not Bodhisattvas) around the patients; then the patients die soon, less than two days later. She (the senior nurse) talked to the Buddhist chaplain because she did not know whether she should talk to the patients' family. She had several experiences with different patients. When she saw the "special ghosts" she felt special chillness, in fact, the weather in Taiwan is hot and air conditioning in hospital is not cold, but she feels special chillness when she saw the ghost around the patients. The interaction between the nurse and this Buddhist chaplain lasted about 40 minutes.

Reflection on the observation of this field note (Participant 5)

Although I am not sure what the senior nurse said because I have no special ability to see the ghosts, I can see that the relationship between the Buddhist chaplain and the team member is very good. Several team members went to find the Buddhist chaplain. When they knew I was interviewing the Buddhist chaplain for my thesis, they were friendly to me. For instance : they said to me that they will make an appointment at other time, they thought I was outside this city and it was not convenient for me to come in this hospital. They were the staffs in this hospital; they said that it is easy for them to make an appointment with the Buddhist chaplain.

The senior nurse told me about the process of setting up this palliative unit. The senior nurse told me they appreciated the Buddhist chaplains who support them and the role of Buddhist chaplains is very important in this unit.

Appendix 7: Coding Books, Coding Tree and Translation-back-Translation

Appendix 7.1 Example of translation and back-translation

The following example of translation and back-translation is about participants' stories and is followed by an important large section related to "Focused Coding"

Original Chinese from the participants	English in the thesis	Back translation from another translator
那個病人是直腸癌,可是因為他轉移到淋巴,在脖子這邊有更大的瘤,所以他是這樣子歪著,那我剛進去的時候,他是一個男眾,48 歲,他的哥哥在幫他清人工肛門,然後我剛好靠近他,他就說那個很臭,就是說你走遠一點,我根本不知道他是天主教徒,我就說什麼東西很臭,那個味道師父很熟悉啊,結果他就有一點在笑,我就說我每天早上也都是一樣這樣子,然後他就很開心,然後他就你一言我一語,然後他哥哥在幫他清,然後我就問他這是什麼東西,然後他就告訴我這是什麼東西,然後就聊起	"I had another patient; he had rectal cancer with the advanced distal organs involved, such as his lymph gland and neck. On that day, I entered his room; his older brother took care of his colostomy with a massive stool. The patient told me that the smell bad because his colostomy was full. The patient wanted me to go away because he thought he smelled bad. I told him that the smell is familiar to me because I passed stool every morning myself. The patient laughed and allowed me to stay in his room. He started chatting with me. At that moment, the nurse entered the room	"我有另一個病人，他有直腸癌病轉移到其他器官，例如淋巴腺和頸部。那一天我進入他的病房他的哥哥正在處理他的造廔口和大量的糞便。病人跟我說不好聞因為他的造廔袋滿了。那位病人要我離開因為他認為他聞起來很臭。我跟他說我對那個味道很熟悉因為我每天早上排便。那個病人笑了並且允許我待在他的房間。在那時，護理人員進來並跟我說病人是天主教徒非佛教徒；他不要佛教師父去拜訪他。我向護理人員道歉因為我不知道病人曾經告訴過護理人員他不要佛教師父去拜訪他。我繼續我的老師跟我說瑪莉去西方

天來了，聊起天來,剛好護理師就進來了,護理師,其實是要告訴我那個是天主教徒,她就直接跟王先生說,你不要師父嗎,她來不及告訴我,我就已經進去了,然後她就跟我說,王先生是天主教徒,我說對不起,我說我不知道,然後我就說我們師父說的聖母瑪利亞就是觀世音菩薩的化身,他們是一樣的,他們是不同的化身,瑪利亞是去渡西方人,觀世音菩薩就來渡化我們東方人,他就很有興趣,然後他就沒有叫我走,我在裏面就跟他聊起天來，聊起天來以後就幾乎每天都會進進出出跟他聊起天來(參與者 14)	and told me that the patient was Roman Catholic rather than a Buddhist and had told the nurses that he did "not" want a Buddhist chaplain to visit him. I apologized to the nurse because I did not know the patient had told the nurses that he did not want a Buddhist chaplain to visit him. I continued that my teacher had told me that Mary went to the West to help Americans; Guan-Yin Bodhisattva went to Asian countries to help Asian people. The patient allowed me to stay in his room because he agreed with what I said. The patient chatted with me continuously." (Participant 14)	幫助美國人；觀音菩薩去亞洲國家幫助亞洲人。那個病人允許我留在他的房間因為他同意我說的。那位病人繼續和我聊天。" (參與者14)
這個叫做業,什麼叫做業,業就是你的行為造作出來的,我們稱為業行,比如說這個病人是肝癌,我就說你是不是常常熬夜,或是是說你是壓力太重,這個就會講到他的點了,因	"In fact, Karma influences our fortune; it comes from each person him/herself, not from the God or the Buddha. That is, we can create our own Karma. Most people misunderstand Karma and	事實上，業力影響我們的未來；他是來自每個人自己的業力，不是來自上帝或是佛。也就是說我們可以創造自己的業力。大部分的人誤解業力和疾病的結果。我認為讓病人有

為在醫學來講也好,在業的觀點來講,這個都是相關係的,所以一講到這個他才會恍然大悟,去找到的,原來就是我自做的. 我就是這樣子跟他開示,請病人想過去的善事,請不要回憶病人曾經做過不好的事因為那是沒有用的也將不會幫助病人有較好的來生。(參與者 22)	the results of disease. I thought that it is important for patients to have a better next life. Please do not recall the evil things that patients have done because it is useless and will not help the patient to have a better next life." (Participant 22)	比較好的來生這是重要的。 請不要回憶病人曾經做過不好的事因為那是沒有用的也將不會幫助病人有較好的來生。"(參與者 22)
我也跟基督教青年講過這樣的話,他的父母親是虔誠的基督教徒,而且是在做佈教的工作,他們在旁邊聽了也非常地認同,但是我不是用佛教語言,那是他們唯一的一個男孩子,他們非常地不捨,這對父母是虔誠的基督徒,而且他們也都去做佈道佈教的工作,我告訴病人你要帶著這份祝福,我用他們了解的語言去告訴他們這個佛法的道理,就是如此,他們就可以接受,在這當中他們也會得到	"I had a young Christian patient. His parents were Christian chaplains. When I interacted with the patient and his parents, I did not use professional Buddhist terms to communicate with them; I only used the spirit of the Buddha's teachings to help them. The Christian parents were so nice; they could accept me helping their sick son. Actually, they thought the methods I employed did not conflict with Christian teaching. I told the patient that, when you face death, you need to	"我有一個年輕的基督徒病人。他的父母也是傳教士。當我和病人及他的父母互動，我沒有用專業的佛教詞彙與他們溝通；我只有用佛教的精神去幫助他們。那位基督徒病人的父母很好；他們能夠接受我幫助他們生病的兒子。真實的，他們認為我用的方法沒有與他們的教義衝突。我跟病人說，當你面對死亡時，必須去光亮的地方，盡量避免去黑暗的地方。因為光亮的地方是你的神的地方，黑

安定的能量,這也是事實,也沒有違背他們的教義,不需要那麼多的專業名相,不必受限於那此名相,但是你要告訴他的是重點,這世界上所有的宗教都有共通性,當生命在轉換的過程當中很重要的,就是要把握到光,我說你要把握到光,世界上的宗教雖然有不同的儀式和信仰的對象,但是都有共通點,就是在生死這個過程當中,這個轉換的過程當中,都有一個共通點就是要往光的方向,這個光是個非常美妙的地方 ,也是我們所信仰的神的地方(參與者 17)	go to the light place and avoid the dark place as much as you can. Because the light place is your God's place, the dark place may be hell, and it is not good for you." (Participant 17)	暗的地方可能是地獄，那對你不好。"(參與者 17)

Appendix 7.2 Example of transcript, initial analysis and coding book

Original Chinese transcript	English translation of the interviews transcript	Line-by-Line Coding	Focused Coding
第一次看她的時候,她說她很累啊,她沒有辦法跟我談話,我說沒有關係,我說我說沒有關係我跟你談話,如果你可以終止,你不想談你也可以跟我講,我們不一定要談,她跟我講因為子宮頸癌,她很痛,做了化療及放療,有用芳療補助她,因為她很痛,她用了之後就覺得很舒服,她跟我談話,就可以談很久,我問她說人生最大的目標,她說她只想一個健康的身體,有人愛她,然後結婚生子,我的目標就這麼簡單,我問她這是你在生病之前就有的目標嗎?我想你在還沒生病之前目標應該不是這麼簡單吧,那是因為你生病之後,	When I first visited her, she told me she was very tired and could not talk to me for long because she felt physical fatigue. I told her it didn't matter, if you do not want to talk, you can end our conversation at any time. She told me she had cervical cancer and so was in great pain. She had had chemotherapy and	Having physical effect Having compassionate attitude Patient's disease Having physical symptoms Having the skill of listening	Compassionate care Compassionate care

才會變得這麼簡單的想法吧,可是這個想法雖然很簡單,可是不容易做到,我跟她談一些事,我跟她講這個車子如果壞掉了,這些零件要是壞掉要怎麼辦? 你沒辦法上路,換一部新車,還是繼續開呢? 她告訴我說如果可以開當然繼續開,如果不能開就一定要換一部新的車,我用這樣來比喻她的身體,病人可以接受了,她還是希望能繼續活下去	radiotherapy, and also aromatherapy, and she felt comfortable after she had aromatherapy. I asked her what her life goal was. She told me she only wanted to have a healthy body and have someone love her and then get married and have their children. She told me that her goal was so simple. I said, "Your life goal was less simple until you get this cancer." I think her life goal became simple after she got this disease. I gave her an example	Guiding patient to do life reviews Having compassionate attitude Having the issues of death	Compassionate care Compassionate care Dying process
她問我要怎麼做,她因為整個人都攤在床上,所以我先讓她聽念佛法門,我用念佛法門給她,我告訴她說,她可以先聽,讓念佛這個佛號的,讓自己能....			

地聽,當然念一念心情還是會複雜起來我說這個部份,,你一定要突破,沒有突破你會掛礙,就像剛學開車一樣,一定有地方倒車,不好,那你如果不好不想發,就永遠學不好.就不會倒車,再過幾圈你一定要學會,那你下去就會很順利,就是你會覺得好像無聊了,你只要持續,那個無聊的念頭就會沒有了,就會突破,所以她就念佛法門,我也知道這個生病的人,....我也跟她講這個要很長一段時間,那你會想到很短的時間就有功效,就會想我都已經念那麼多佛,怎麼還是這樣,我說你 24 小時裏面, 你用多少時間來念佛,你 24 小時還挺空,可是你用 1 小時來念佛,你卻希望你其他 23 小時都是好的,那是不可能的	of a car. If a car is not running properly, what should we do? Drive it on the road or get a new one? I used this example to refer to her physical body. This patient was aware that her physical situation was poor, but she hoped to live longer than this. She asked me what she could do when death came. I advised her to recite the Buddha's name. I encouraged her to listen to the music of the recitation of the Buddha	Using the approach of recitation of Buddha name Having compassionate attitude to encourage the patient Offering emotional care	Mahayana Buddihism

	name. It's like learning to drive. At first, you may not be able to drive very well, just as you also can't recite the Buddha's name very well. You do not need to feel frustrated as you have only recited for an hour, you can't be good for another 23 hours. But you need to practise reciting the Buddha's name continuously. This will calm you down and relieve your pain. She followed my advice and practise		

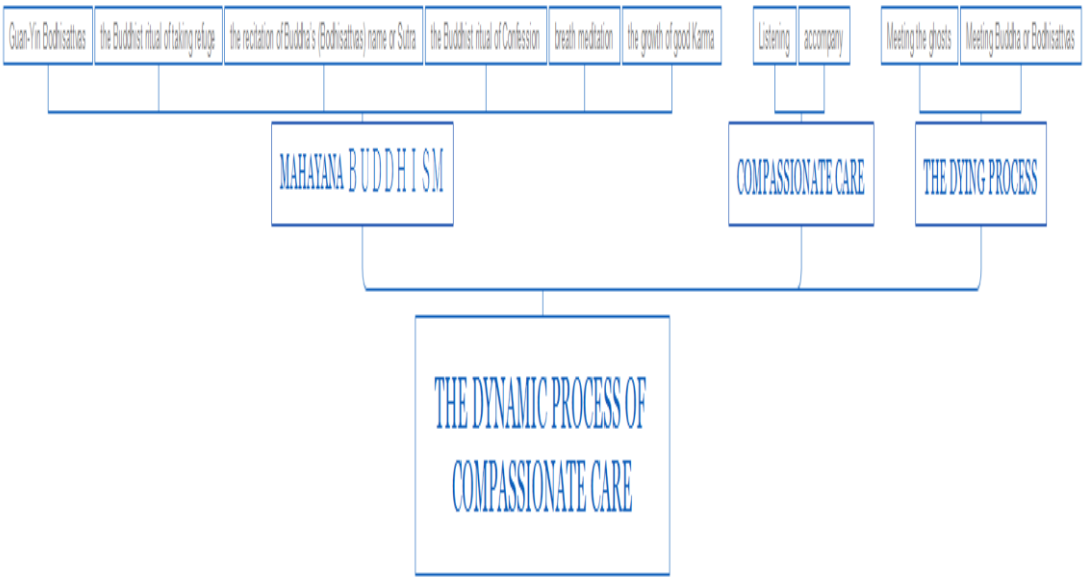
	reciting the Buddha's name. She told me she felt bored sometimes. I told her that was normal; practising and practising would calm her down. Later, she felt better and calmer.		

Appendix 7.3 Example of Coding Book

No	Initial coding name	definition	Focused coding
1	Offering compassionate care to patients	The chaplain offered emotional care to the palliative patients	Compassionate care
2	Offering compassionate care to families	The chaplain offered emotional care to the palliative patients' families	Compassionate care
3	Offering compassionate care to team members	The chaplain offered emotional care to the palliative team members	Compassionate care
4	Doing recitation of Buddha's name 念佛	Recitation of the Buddha's name refers to mindful recitation, whether aloud or silently, of the name of a particular Buddha, usually the Buddha Amitabha	Mahayana Buddhism
5	Doing recitation of sutra 念經	Recitation of sutra refers to mindful recitation, whether aloud or silently, of the content of sutra	Mahayana Buddhism
6	Doing breath meditation 數息法門		Mahayana Buddhism
7	Imagine of Buddha picture		Mahayana Buddhism
8	Taking refuge皈依		Mahayana Buddhism
9	Enlightening inner force 啟發內在力		Mahayana Buddhism

	量		
10	Enlightening the Buddha nature 啟發佛性	The Buddha-nature is the innate, inherent potential to become a Buddha that resides in the mind of every living being.	Mahayana Buddhism
11	Being influenced by karma 受業力影響		Mahayana Buddhism

Coding Tree


Guan-Yin Bodhisattvas
the Buddhist ritual of taking refuge
the recitation of Buddha's (Bodhisattvas) name or Sutra
the Buddhist ritual of Confession
breath meditation
the growth of good Karma
Listening
accompany
Meeting the ghosts
Meeting Buddha or Bodhisattvas
MAHAYANA BUDDHISM
COMPASSIONATE CARE
THE DYING PROCESS
THE DYNAMIC PROCESS OF COMPASSIONATE CARE

Appendix 8: Compassionate Care

Participant Number	Participants' clinical stories
Participant 1	The patient's physical health was deteriorating. I helped her to overcome her death anxiety. I applied a compassionate attitude and approach to support this patient. I explained the Buddhist concept of death to the patient and hoped that she could accept that she would pass away. I listened to what she said and understood her feelings. I told her 'Everyone will die. It's a natural process. Letting go is very important whatever happens.'
Participant 2	There was an old couple, an aged husband (the grandfather) and his aged wife (the grandmother). They were about 83 years old. Their children lived in the USA, and the couple used to live there with their children. The grandfather felt very homesick due to the different lifestyle and language barrier. When he fell and broke his leg, the couple decided to return to their homeland. Unfortunately, when they arrived back in Taiwan, the grandfather suffered from head/neck cancer. He had an operation, which left him unable to speak any longer. His consciousness was very clear, so he could accept his disease, but his wife felt a strong sense of attachment to him. She said that they had never argued with each other and had always had a good relationship since they got married 60 years ago. I think it is difficult to achieve, as even good friends argue sometimes, but they never argued and had a good relationship for 60s years. Because the grandmother felt a strong attachment, she told her husband: "I hope you will stay with me even if you're unconscious in the future." I think that the key reason why the old man could not die was because his wife said this. The patient had several bouts of severe mass bleeding from which he nearly died, as its impossible to stop mass bleeding when the cancer is close to several large arteries, but he survived this serious, dangerous physical situation. For example, his blood pressure was too low, and he lost half his face because of the cancer. We could see the patient's main arteries and blood vessels very clearly, which meant that he could bleed profusely at any time. His wife could no longer accept the situation, and their children needed to return to the USA for their job. In front of his children, the patient wrote something to ask their children "If I died, what about your mother?" I think the patient was very worried about his wife if he died. The patient's wife could not "let go" and prayed to Guan-Yin Bodhisattva daily. She recited Guan-Yin Bodhisattva's name with

	great sincerity. One day, she asked me: "Master, could you pray to Guan-Yin Bodhisattva for me? I want my husband to continue living with me", but later she could no longer accept her husband's mass bleeding, so she came to find me again and said: "I want to 'let go'. Please would you pray to Guan-Yin Bodhisattva for me? I want my husband to have a peaceful death; I don't want him suffering in order to remain alive." I advised her to tell her husband that she blessed him, would like to let go and hoped he'd have a peaceful death and a better next life." I told her that, since she'd told her husband that she wanted him to continue living, I thought he was worried what would happen to her if he died; he did not know how she'd cope or if their children would look after her, so she could inform him that she'd manage fine alone. She replied "Master, I know what to say to my husband". After our conversation, she spoke to the patient, who died very peacefully the next day in his sleep, without any bleeding or suffering. His wife bowed to me and thanked me very formally." I think that, even though the patient had studied the Buddhist sutras in depth previously, he was worried about his wife and so could not die peacefully. After I applied the skill of compassionate conversation, his wife was able to surrender her strong sense of attachment, and the patient was able to die peacefully. I tell the patients and their families very often that, if we can deal with the issues of this life, forgive and thank others and let everything go well, we will have a peaceful death.
Participant 3	The nurse called for my help because she had other patients and told me that she needed to deal with the emergencies; for example, she needed to alleviate the patients' physical suffering, so she had no time to deal with a relative's emotions. I promised her that I'd visit the family member, who was the patient's granddaughter. I spent over an hour listening to and supporting her. She felt guilty and thought that she was not a good granddaughter, so her relative's disease got worse. I applied the compassionate skill and gave the family compassionate support. Finally, the granddaughter agreed with what I said and stopping feeling guilty. In fact, the patient and his granddaughter were not Buddhists, but they accepted me; therefore, I could give the family compassionate support.
Participant 4	A young patient had oral cancer. His wife was very beautiful and his child was very young. We thought that he was close to death, so his wife helped him to put on special clothes in order to face death, but the patient would not die and continued living for about a week. I chatted to him and discovered that he was very worried about his wife. Because she was so young and so beautiful, he thought that she would remarry after he died. After learning about the patient's concern, I rang his wife to discuss it with her. I told her: "He is very concerned about you, so he can't let go. I think you should discuss

	this with your husband," and I suggested that she should recite the Buddhist sutra of ground Bodhisattva. His wife accepted my suggestion and recited the Buddhist sutra for this patient.
Participant 5	I have cared for the relatives after a patient dies. I have a clinical story about this. During the process, I listened to her talking about her many sufferings. I visited her at home once after her husband died. She had no children; only a cat. I thought that I was very lucky to be able to listen to her. I understood that she felt guilty, like other relatives. For instance, she felt that she had not offered the best quality of care, so her husband did not die perfectly. I thought that she had rarely cared for other dying patients; so she did not know the signs that someone is dying. Even though she worked in a hospital, she seldom saw patients dying. She said that her husband saw Amita-Buddha twice. She saw her husband having a seizure, so she knew he was unwell. That is the key reason why she felt that she had not offered the best quality of care. That day, as I listened to her, I realized what she was thinking, so I told her "You cared for your husband very well."
Participant 6	I tell the patients that, if we recite the Guan-Yin Bodhisattva, we will have a heart of compassion. We make confession. We hope that all patients and others can ease their sufferings, it will soon disappear. If you have greater compassion; your suffering will disappear quicker.
Participant 7	I thought that what was very useful for the patient was his/ her own inner force rather than our force; that is, the patient should have his/her own force to go to the sea of death. If we place too many stones in the way, it is a Karmic force, it influences his dying process. If there aren't any stones, he will go to the sea of death very smoothly.
Participant 8	I thought that the patients and their families will accept the physician's advice; therefore, we should ask the physician or nurses to discuss it with them. If the patients made unreasonable complaints, we'd listen to what they said. I think that the skill of listening is supportive for them. I think that reciting the Buddha's name is useful for them; for instance: it distracts them from their anxiety and helps them to concentrate on the Buddha's name. I was careful to warn them that the recitation of the Buddha's name could not make everything OK, and did not give them too many guarantees. I think it is impossible to give false guarantee. I think that the patients' inner force was important. Someone with a very strong faith will have a strong atmosphere.
Participant 9	I thought that the patient's daily life is more important than the fact that they practised Buddhism every day. For instance, I asked the patients how they were sleeping because their sleeping pattern is related to their emotions. Based on my past experiences in palliative care units, some patients cannot sleep very well because they feel anxious about dying or were suffering with them. I thought that we could evaluate their sleep pattern to explore some emotional aspects of issues of the end-of-life patients.

	I thought that the skills of listening and compassion are very important for learning about the patients' concerns. Please do not put too much pressure on the patients or their families. Do not judge why the patients or their families do not accept any religion. The role of Buddhist chaplain is to support rather than to teach Buddhism in hospitals.
Participant 10	When the patient rejects you, you need to remain involved. In this situation, spending time with and listening to patients is very important because it is the first step in establishing a good relationship. I thought that spending time together is very important because everyone feels lonely. In fact, you don't want to make friends or tell someone something, you only want an emotional resource; that is, you want someone to share your emotions with. When a chaplain spends time with and listens to the patients, they will start to talk to you.
Participant 11	The doctor's mother was an end-of-life patient. Unfortunately, this doctor could not soothe his mother's emotions; therefore, he drove to my temple and begged me to visit his mother. When I met her on the hospital ward, I think I was very lucky because the patient did not refuse to see me even though the patient never met me. I spent the whole afternoon with her; listening to her talk for four to five hours. She was 90 years old and very good at Japanese language and dialect (Min-Nan language). She could not speak Mandarin because she'd been born during the Japanese colonial period (from 1895-1945). In fact, I cannot speak Japanese because it was no longer the official language in Taiwan after 1945. Therefore, the patient taught me a "Japanese song", and was very happy that I spent such a long time listening to her. After my visit, the physician thanked me deeply and bowed to me because I had alleviated his concerns.
Participant 12	Some relatives have contact with us, and I will spend a long time speaking to them; some relatives want to talk to us after a patient dies because they are suffering. If the relatives contact us, we don't refuse it but it is important that money isn't an issue; for instance, some relatives give us money for some purpose. I think this is a bad idea. I will tell them how they can assist the dying patient. I think that there should not be a trade relationship between the chaplain and the families.
Participant 13	Some people think that Buddhist chaplains are related to the funeral ceremony, so they suffered death anxiety when they saw a Buddhist chaplain. I express kindness, so that the patients and their families will accept me. We start to chat with the relatives and when they accept; it is a good thing. I think that we apply a psychological method, but it is not always useful for everyone. I met one relative who saw me and cried loudly. I touched her shoulder and told her that I knew she was suffering. Your husband was ill. You needed to support your husband and your mother-in-law. I understand your sufferings. We are the hospice team, and each one of us is here to

	support you also. As I said this, she cried; I let her cry because I thought it was a kind of emotional expression. You don't need to treat us as chaplains (teachers); you can treat us as good friends. I can spend time with you if you need any emotional support.
Participant 14	I have another patient; he suffered from rectal cancer that had spread to his distal organs, such as the lymphoma and neck. That day, I entered his room; his older brother cared for his colostomy which had a mass stool. The patient told me that the smell was bad because his colostomy bag was full. He wanted me to leave him because he thought he smelled bad. I told him that I am very familiar with this smell because I pass a stool every morning. The patient laughed and allowed me to stay in his room. He started chatting to me. His older brother cared for the patient's colostomy. I asked what it was. At that moment, the nurse entered the room and told me that the patient was a Roman Catholic rather than a Buddhist, and that he had told her that he didn't want a Buddhist chaplain to visit him. I apologised to the nurse and told her that I didn't know that the patient had told her that he didn't want a Buddhist chaplain to visit him. I said that my teacher had told me that Mary went to the West to help Americans, while Guan-Yin Bodhisattva went to Asia to help Asians. When the patient heard me tell the nurse this, he allowed me to stay in his room because he agreed with what I said. The patient chatted with me continuously.
Participant 15	I work at two hospitals; one is in Ke-lung, the other is in Taipei county. I met many young nurses. They asked me about their issues. I thought that I could help them; for instance, by answering their emotional questions, calming them down. It is helpful for them to work in a hospital. I think we are family. I regard patients as my teachers because they teach us many things. Although each has individual monastic practice methods, the team members can give me different feedback. Some physicians think that the Buddhist chaplains should guide the patients, but I disagree. I think that it is very important that we should depend on different patients or their families' level. I did not force the patient to recite the Buddha's name. I applied Buddhist religious methods.
Participant 16	I had a patient who, although she had no symptoms of delirium, her vision had deteriorated. She was uncomfortable in all positions. Her younger brother couldn't massage her very well. I went there and massaged her. This method was very useful for her. I think that the role of the Buddhist chaplain is to spend time with patients. I think that our mind is also very important because our mind will influence our world.
Participant 17	I think that the Buddhist chaplains support the team members; for example, I met a junior nurse who was crying because a patient was dying. I found her crying outside the dying patient's ward; therefore, I spent a long time listening to her. Finally, the nurse felt better about

	the patient dying after I talked with her. I think that the families are very worried about where the patients will go after death. In this situation, taking refuge is a good way to help the patients and their families. I have clinical stories regarding offering bereavement care to the palliative family after the patient dies. One of these stories is as follows: a patient was short of breath; the physician visited him but he refused to see the physician and asked to see the chaplain because the chaplain could teach him how to do breath meditation and relieve his discomfort.
Participant 18	I think that the Buddhist chaplain's role in hospice care is different from the role in the temple. There are many ceremonies in Buddhist temples, but these are not always appropriate in hospital. I think that the Buddhist chaplains should be very kind and easy-going. I have a good relationship with the team members; they respect me as a Buddhist nun. Sometime, they consult me about psychological matters; for instance, when they encounter difficulties, they discuss these with me. They tell me that they are happy to chat with me and that it is easy for them to find appropriate answers from me.
Participant 19	Actually, I know that nurses also suffer from death anxiety. I had a patient recently who could suffer mass bleeding at any time. We had several meetings about this. I was invited to the hospice ward, and we discussed it. The patient's tumours were at multiple sites with great vessels, which meant that she was at high risk of mass bleeding. The nurses on the hospice ward were very fearful and stressed. The patient did not have a very good relationship with her family. I discussed with this patient some issues and her family's attitude. I guided her to think positively.
Participant 20	I think that the Buddhist ritual of taking refuge is a very good approach for patients, as it can relieve their anxiety. I have a clinical story: the doctor suggested that a patient should undergo amputation, but the result was very uncertain so the patient was very anxious and fearful at that time. The patient's wife invited me to visit him, and I applied the Buddhist ritual of taking refuge with this patient, which helped to relieve his anxiety. The patient was very weak so his wife helped him to complete the ceremony of taking refuge. Two days later, the patient died peacefully after undergoing the Buddhist ritual of taking refuge. I think that teaching the family is a very important task in Taiwan. After patients die, we should do more for them because their next life is also important. I encourage patients' families to recite the Buddha's name as much as 20,000 times a day. I think that it is unnecessary to put a lot of pressure on the nurses. They are wonderful, as far as I can see; for example, physical care takes up all of their time. We shouldn't expect them to offer a lot of emotional care because they have so many tasks to do in Taiwan.

Participant 21	I have a very good relationship with the nurses. For instance, they refer patients to the Buddhist chaplain. I think that the palliative nurses are wonderful. They cooperate with me and offered me lots of delicious food; they're good friends. In Taiwan, palliative Buddhist chaplains play an important role in palliative units. I applied the life review approach with this patient. She was born in mainland China and had lived in Taiwan for a long time. Her patients were in mainland China, but she was in Taiwan. It was illegal in Taiwan to communicate with those in mainland China from 1949 to 1992, even though the Chinese people are their relatives, so the patient did not have a good relationship with her family in mainland China due to the sensitive political issues. I helped the patient and her families to express the emotion of love and then the patient died peacefully.
Participant 22	I had a patient who believed in "Japanese Buddhism". I encouraged the patients to apply "Japanese" Buddhism but they did not get the benefits from this religion at the end of life. Generally, I apply Chinese Buddhism approaches in palliative care units, but it depends on the individual. Because this patient believed in Japanese Buddhism, I thought that we didn't need to change the patient's faith. Therefore, I tried to apply the method of "Japanese" Buddhism to help this patient.

Appendix 9: Patients' dying process

Participant Number	Participants' clinical stories
Participant 1	Participant 1 had the experiences that many end-of-life patients saw the "people" (the ghosts) or something in hospitals that we could not see. Participant 1 thought we do not need to deny what the patients said even though we were not able to see the ghost ourselves. Participant 1 said she had a friend, who is a nurse could see the ghosts in the world. Participant 1 was very sure this nurse with special ability was a very healthy person and Participant 1 worked with her very often.
Participant 2	I think we should focus on whether the patients feel peaceful more than on the professional terms. I have encountered different effects in patients as signs that they are in their final 48 hours of life; for instance: anxiety, seeing a ghost in the hospital, and so on. Some patients show signs of "delirium" during their last 48 hours; for example, they sometimes see something that we cannot.
Participant 3	I met a patient who saw a lot of mice on the hospital ward; actually, this was impossible because the hospital was very clean, and none of the patient's relatives or the medical staff saw any mice. Therefore, it appears that the patient was delirious at the end of life. The patient's families asked me how to deal with this, and I advised them as follows: "We could recite the Buddhist sutra of ground Bodhisattvas for the patient, because this dying process is written very clearly in this Buddhist sutra. I and other monks and nuns in my temple recite this sutra of ground Bodhisattvas in the temple for the patient. I think that the best way is to recite the Buddha's and Bodhisattvas' names in order to offer blessing to the patient."
Participant 4	I thought we do not need to deny that what the patients saw were the ghosts. I thought recitation of Buddha name is very useful tool for the patients to overcome seeing ghosts. In my opinion, some patients saw the ghosts because maybe they had death anxiety.
Participant 5	I and my family believe strongly that my father definitely is in Amita-Buddha's world (the Pure Land) now. My father said he had seen the Amita-Buddha and two Bodhisattvas come here and pour Dai-Bai (Great Compassion) water for him, and that Amita-Buddha gave him a very beautiful lotus to welcome him. When my father saw Amita-Buddha entered the ward, he felt very calm and no suffering. He said he'd seen Amita-Buddha several times.
Participant 6	I think that, when patients see a ghost, this means that they will die soon because these ghosts are very similar to their next life. In my opinion, it is a good way to deal with important issues; for instance, reciting the Buddha's name or Buddhist sutras at the end

	of life. In my experience, these approaches are very useful for both the patients and the ghosts. I was a senior Head of School here. I had a student who was always disturbed by the ghosts. The student's teacher couldn't deal with this problem because the physician can't deal with the student's ghosts' interruptions. The student's teacher and his patient asked me to help them because I was the Head of School and also a senior Buddhist nun. I thought it was useless to deny that the student had seen ghosts. I taught the student and his parent to pray to the Guan-Yin Bodhisattvas and tell the ghosts that they will do many good things for them and help them to find a wonderful place. His parent and the student did this every day. A month later, the ghosts had disappeared forever, and the student never saw them again.
Participant 7	I think the patients review their life. They talk and interacted with people we can't see, so their relative families call these people ghosts. I find that some women who had an abortion at a young age see their baby's ghost at the end of life. I think they feel guilty because they killed their baby (abortion); I don't think that babies' ghosts come to palliative care units to visit terminal patients.
Participant 8	The patients do not sleep at night because the patients see the ghosts in the hospital. The patients see something or somebody we cannot see, we do not need to deny the patients.
Participant 9	Some patients cannot sleep well because they meet some people (ghosts) in the night time, the reasons may be the patients had death anxiety or suffering. We can evaluate the patients' sleeping patterns to explore some emotional aspect issues of the palliative patients.
Participant 10	The patients' families are very important because the families also are very anxious and the families influence the patients' emotional state. The patients' families think many ghosts are around the patients, so their families suffering from serious diseases. The patients' families went to the folk temple to seek complementary approaches or asked the Buddhist chaplains or other religious chaplains to give them blessings.
Participant 11	I don't think we need to worry about whether it harms the ghosts when the patients say the ghosts disappear after the patients recite the name of Amita-Buddha or Guan-Yin Bodhisattvas, mainly because Amita-Buddha and Guan-Yin Bodhisattvas are extremely merciful, so when patients follow the suggestion to recite the name of Amita-Buddha or Guan-Yin Bodhisattvas, the patients will quickly calm down and the ghosts will disappear finally. In fact, whether the ghosts are in the hospital is not very important; enlightening the patients' merciful nature is more important than finding ghosts.
Participant 12	I thought when the patients saw the ghost that means his physical situation is not good.
Participant 13	I encountered some patients who wouldn't turn off the light or the television because of their death anxiety. For example, they felt

	very afraid that ghosts would come to the hospital to find them and that they would die soon. The patients believed that ghosts would appear in the night based on Taiwanese culture. I discussed their fears with them, and they described their feelings to me in detail.
Participant 14	One of my patients said he saw Amita- Buddha entering the palliative ward. Unfortunately, his siblings called to the patient because they noticed that he'd stopped breathing, so Amita-Buddha disappeared and the patient awoke.
Participant 15	I don't think we need to worry too much about if patients feel alright when they see "ghosts" in hospital. If the patients are very anxious or fearful when they see the people (ghosts) in the hospital, we can deal with this in several ways, including medical approaches and Buddhist religious approaches.
Participant 16	I think that dying signs at the end-of-life are very common; for instance, some patients see ghosts. I agree that ghosts exist. I think that patients see a ghost, God, an angel, or Buddha entering the hospital. We do not need to challenge this. It is a natural process. Therefore, we do not need to challenge some unexplained situations.
Participant 17	I have several clinical stories about patients' dying process. One is about a patient who saw Amita-Buddha enter the hospital and she felt very comfortable. The patient was certain that she saw Amita-Buddha in the hospital and told me,the chaplain, that she will definitely go to Amita-Buddha world (Pure-Land) after death.
Participant 18	I had many experiences of terminal patients seeing "ghosts" in hospitals. We do not deny the reality of this even though we cannot see them. Let the patient and their family calm down.
Participant 19	I have a lot of experience of patients' dying process. For instance, they often see "people" whom we can't see. The relatives say that there are a lot of "ghosts" in hospitals because they believe what the patients say. I don't think we need to challenge what the patients and their relatives say. We should evaluate the patients' consciousness level by asking questions. Don't interrupt the patients, even if they are not fully conscious.
Participant 20	I think that Karma influences cancer patients' dying process. One patient saw many horrible ghosts every day, which terrified her. Generally, the patients' relatives' recitation of sutras or the Buddha's name helps the patients. I've another way of dealing with ghosts, which is to prepare food for them. Although this is a very popular religious method in Buddhist temples, it is difficult to apply it in hospitals. Actually, reciting a Buddhist sutra or the Buddha's name is a good method to use in hospitals, although preparing food for ghosts is less feasible there.
Participant 21	I encountered some patients who saw things and people that we cannot see. I believe that there are six worlds, so ghosts are one of these six worlds. Buddha could see bacteria before the microscope was invented. I believe that some Buddhist monks and nuns can see ghosts when they meditate because their brain waves are very

	stable. Therefore, they have a special ability; for instance, they can see ghosts and tell people's fortune. I think that this is why we don't need to challenge patients who say they see ghosts in hospitals.
Participant 22	I believe that ghosts exist, based on Buddha's teaching because Buddha said that there are six worlds in the realm and ghosts form one of these. We don't need to challenge patients who say they see ghosts. Instead, I encourage them to recite the Buddha's name to help both the patient and the ghosts. For instance, I encourage them to inform the ghosts that they will live in the "Pure land" (Amita-Buddha's world) together. I remember another nun's mother who lived in our Buddhist temple when she was at the end-of-life stage. This patient saw many ghosts in the Buddhist temple, not only in the hospital. I think that, if a patient sees a ghost, it means that death is not far off for them. I believe that a patient can see the ghost from the perspective of Buddhism.

Appendix 10: Mahayana Chinese Buddhism

Participant No	Participants' clinical stories
Participant 1	I applied the skill of compassion and listening and guided the patient, who was a terminal-stage "young" breast cancer patient, to imagine the merciful face of Guan-Yin Bodhisattvas, I also was reciting the Dai-Bai Mantra and imagining Buddhahood and Guan-Yin Bodhisattvas definitely giving great blessing to the end-of-life patients and all people in the world. I guided the patient to apply the breath meditation in order to alleviate shortness of breath; this method could let the patient calm down and feel better. Generally, I preferred that the approaches are highly related to Guan-Yin Bodhisattvas. For example, I did recitation of Dai-Bai (Great Compassion) Mantra for my patients I applied the recitation of Amita-Buddha's name on the old patient; for instance, I reminded the patient of the meaning of Pure-Land of Amita-Buddha, there is not any suffering in this Amita-Buddha's world. The old patient could accept this viewpoint and her emotion calmed down and then she could concentrate on the recitation of Buddha's name, this method helped the old patient to overcome the death anxiety and death fear.
Participant 2	I think that the recitation of Buddha name is the most useful method in palliative care units. I think that the family is very important role in hospice care; the families can offer support for the patients. Additionally, I think that the patients have good death; the families will have peaceful emotions after the patients' death. I have many stories about the patients' doing the recitation of Buddha's name. I think that we can imagine the picture of Buddha and remind the patients that they had good actions (behaviour) in this life. This method can help the patients in the next life. I think that the ritual of confession is a useful method to help patients. Reading Buddhist sutras are very good methods in palliative care units. The families read the sutras for the patients. Although the patient is worse and worse, but the families repeat reading the Buddhist sutra, this method supports the families and the patients. I think that the feeling of "attachment" is very difficult to give up; however, the "attachment" will influence the patient's peaceful death. The patient's wife prayed to Guan- Yin Bodhisattvas and asked me to pray to Guan- Yin Bodhisattvas together. After discussion, the families give up the feeling of "attachment" then they chose the peaceful death for the patient.
Participant 3	Generally speaking, these Buddhist religious approaches include

	taking refuge, confession, reading Buddhist sutra with the patients, reciting the name of Amita-Buddha, and encouraging them how to pray to Amita-Buddha in order to go to Amita-Buddha's world after death. This world is an extremely happy place, there is not any suffering in this place, which is significantly differ from our world. I met a patient who saw many mice in the ward in this hospital; actually, it is impossible to see mice in the hospital because the quality of this hospital is very good, and another reason is that all families and medical did not see the mouse; in fact, the patients was delirium at the end of life. The patients' families ask me how to deal with it, I answered the families we could recite the Buddhist sutra of ground Bodhisattvas for the patient, because these situations were written very clearly in this sutra. I and my colleagues recite this sutra of ground Bodhisattvas at temple for the patient. And then the families said that the patients' delirium symptoms were sorted out. The dying sign was written in Buddhist sutra of ground Bodhisattvas very clearly; therefore, we could recite the Buddha and Bodhisattvas name in order to offer blessing to the patients.
Participant 4	I applied breath meditation with one patient; she was short of breath so she felt unhappy and air hungry. The physicians have tried Western medication and medical interventions, but their prescriptions had not had the anticipated effect. I tried to teach the patient to relax, imagine the Buddha or Bodhisattvas standing in front of her, then adjust the speed of her breathing. Several minutes later, the approach alleviated the patient's discomfort. In fact, breath meditation is applied by most Buddhist monks and nuns in the Buddhist temples. It is very useful tool for anxious people.
Participant 5	I applied several Buddhist religious methods on my father. For example, life reviews, recitation of Amita-Buddha name, and seeing the pictures of Amita-Buddha or other Bodhisattvas. I and my family believe strongly my father definitely is in Amita-Buddha's world (Pure Land) now. Because my father saw the Amita-Buddha and two Bodhisattvas come here and poured Dai-Bai (Great Compassion) water for him. My father said that Amita-Buddha gave him a very beautiful lotus to welcome him. When my father saw the Amita-Buddha come into the ward, he felt very comforted and had no suffering. Generally, I applied the recitation of Amita-Buddha or Bodhisattvas name in end-of-life care.
Participant 6	I think that we should guide the patients about their familiar approaches. I apply the approaches of Guan-Yin Bodhisattvas and guided the patient to confess and say thanks to everyone. I think that recitation of Buddha name is very useful for the patients. It is the approach of "Pure-Land" school in Buddhism. I think that there are many forms of Buddhism in Taiwan, some Buddhist focus on the recitation of Buddha name, I think that the meanings of the methods are very important. The recitation of Buddha name is a very good way to help the patients; however, we

	should respect patients' feeling; for instance, this method helps this patient; but the other patients disagree with it. Some Buddhist musical instruments are not always very appropriate in hospital; they can be applied in Buddhist temple not in hospital. Actually, the policy in hospital is different from that in Buddhist temple.
Participant 7	I think that when the patient is in the social stage, assisted recitation of Buddha's name is very useful; however, if the patient is in the inner-mode stage, any religion or spiritual intervention is useless for the patient. Actually, the emotion of "attachment" is very difficult to give up; for instance, if the patient or we are the rich man or we had good reputation in the society, it is very difficult to give up these money or reputation; therefore, a good death is more difficult to reach.
Participant 8	I remembered that the patients' recitation of Buddha's name is very common in the palliative care unit in National Taiwan University Hospital. I think that we should respect the patient's mind. I think that seeing the picture of Buddha is an important method for the patient, taking refuge is also important, but I do not focus very much on this because we should respect the patients' independence of mind.
Participant 9	I did not major in Tibetan Buddhism; I prefer the merciful attitude both in Chinese Buddhism and Tibetan Buddhism. I do not agree with the religious ritual in Tibetan Buddhism because Tibetan Buddhism is not our culture and burning food for ghosts in Tibetan Buddhism is not Buddha's teaching. Generally, I apply the recitation of Buddha's name or Bodhisattvas' name in end-of-life care.
Participant 10	I think that concentration is very important in Zen (Chan) school; recitation of Sutra or Buddha name can also help us to cultivate our concentrations. Recitation of Buddha's name is to enlighten our Buddha nature, so it is very good for us and for the patients and their families. I have read a Tibetan death book, but I do not agree with Tibetan Buddhism; therefore, I do not apply the approach of Tibetan Buddhism on the patients.
Participant 11	I apply recitation of Amita-Buddha and Guan-Yin Bodhisattvas, and encourage the patients to have the desire to go to Pure Land (Amita-Buddha world) in the future.
Participant 12	I think that the recitation of Buddha name is the most useful method in palliative care units. I know that breath meditation was applied in palliative care units; however, I think that it is not easy for some patients. The method of Zen (Chan) school in Buddhism is very difficult for the patients because many patients were not monks or nuns previously. I think that the picture of Buddha is very important in the palliative care units in hospital. I sent a patient the prayer beads as a gift; it is a great blessing to the patients and their families. Sometimes, the patients reject the Buddhist chaplains but they do not reject the Buddhist volunteers. I think that we should respect the

	patients' faith, we should not force them to receive our religion.
Participant 13	I think that if we could apply the Buddha teaching in our daily life, our wisdom will be better and better. The picture of Buddha or Guan-Yin Bodhisattvas is very useful for the patients because it can calm down the patients' emotion.
Participant 14	I pray to Guan-Yin Bodhisattvas for something, and it is very effective, so I decided to be a Buddhist nun forever. I would like to help others by Buddhist religious methods. I think that this is a special gift for my families that I decided to be a Buddhist nun. I think that recitation of Buddha's name is very useful for the patients. I think that taking refuge is a good way to deal with the problem of the patients seeing the ghosts. I had an experience as follows. The patients met the ghosts we could not see but the effect of the ghosts was very significant; for example, the patients could not calm down, we just saw the patient fighting with others but we could not see the "people". I talked to the ghosts and wanted the ghosts to calm down; I would do something good for them. 15 minutes later, the patient calmed down and felt better. I think that taking refuge is good for the patients and the ghosts. I think that the patients have their Karma, so it will influence the future of the patient. I can play an important role in supporting them to have good Karma and avoid bad Karma as much as possible. The Buddhist chaplains can remind the patients about positive mindful thinking process because it is good for the patients' next life. I think that the "prayer beads" is also a good way to help people to recite the Buddha's name many times.
Participant 15	I think that the Tibet Buddhist monk is the best for me. That is why I learned Tibetan Buddhism. Personally, I think that Chinese Buddhism is more appropriate for palliative patients in Taiwan. In fact, I apply the approaches of "Chinese Buddhism" in palliative care units. I have learned Tibetan Buddhism; therefore, I knew the reasons why the approaches of Tibetan Buddhism cannot be applied in hospital.
Participant 16	I think that although there are 8 schools in Chinese Buddhism, however, only two schools are popular in Taiwan. One is "Zen school"; the other is "Pure Land" school. Even though there are so many approaches in Buddhism, only five to six methods were applied in palliative care units. I think that the patients did recitation Amita-Buddha's name; it was useful for them to get peaceful death.
Participant 17	I think that the most common Buddhist religious approaches are recitation Amita-Buddha's name. How many times of recitations is enough for patients depends on different patients because fatigue is very common in the end-of-life patient. I think that breathing meditation methods is a kind of Buddhist religious methods, but it is also applied to all patients because everyone can breathe not only Buddhists can breathe. I apply the Buddhist religious method regarding concentration and

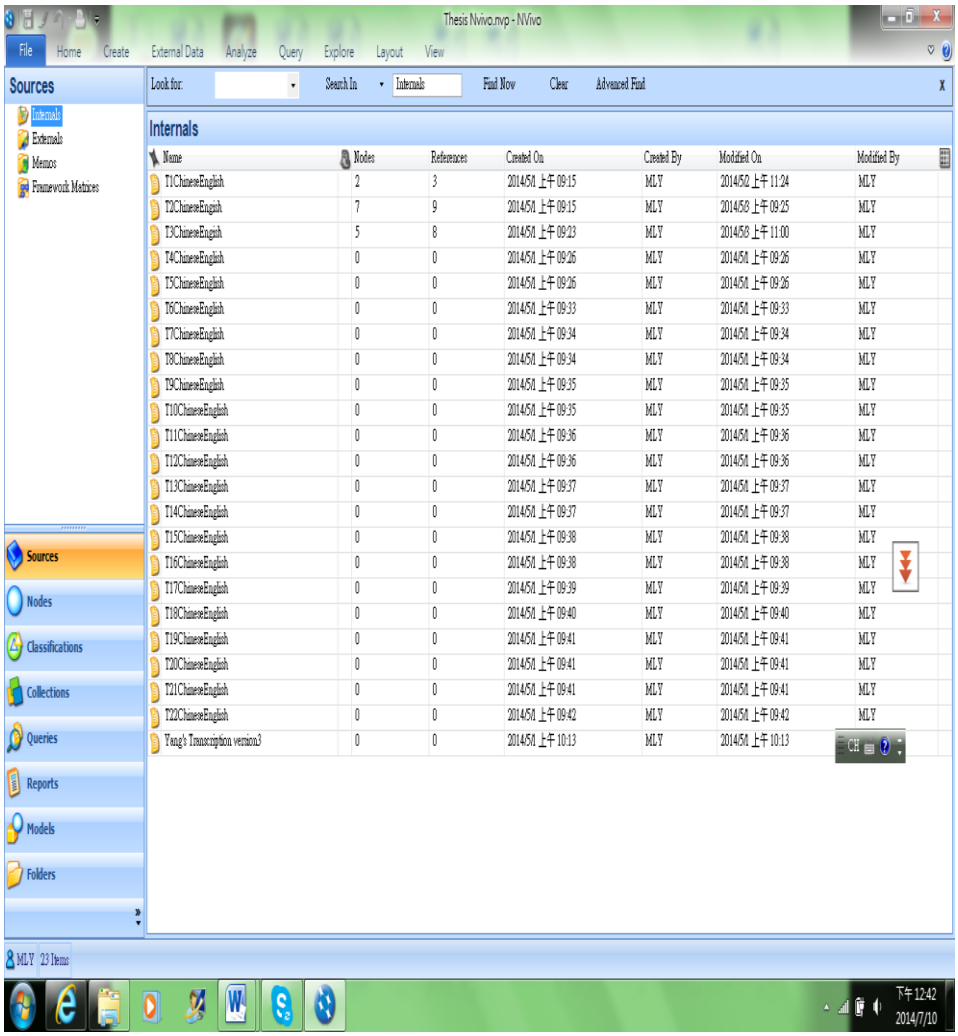
	relaxation to help patients because I was a nurse before; therefore, I can explain the medical mechanism of this Buddhist religious method very clearly. Guiding the patient to do breathing meditation is not very difficult based on my past experience in palliative care unit in hospital. I apply the spirit of Buddhist Heart Sutra on the Christian patients. The patient and his family are all Christians, the patient's parents are Christian priests, who are teaching Bible in the church. The patient and his parents accept the philosophy of Buddhist Heart Sutra. In this situation, we do not need to use professional Buddhist terms, we just keep the meaning of Buddha teaching. According to my past experiences, many Christian families agreed and accepted it. It is a very useful method for non-Buddhists, especially for Christians. I think that the families are very worried about where the patient will go after the death. In this situation, taking refuge is a good way to help patients and their families.
Participant 18	I think that the recitation of Buddha's name is the main approach on palliative care units; generally, I apply the recitation of Buddha's name to help patients and their families. I had an experience of a patient who was shortness of breath, I applied breath meditation on this patient. I think that some sutras are too long for the patients; but the recitation of Buddha's name is very appropriate for all the patients because the Amita- Buddha name is very short, it is very easy to read it and it allows the people to calm down.
Participant 19	Generally, I apply the rituals of "taking refuge" "confession" and "recitation of Amita-Buddha name". I also have met some patients or their families who hope to have a blessing from Buddhist chaplains. I think that that it is impossible for the chaplain to prolong the length of the patient's life. Because death is normal process, if everyone cannot die, it is a terrible issue in this society. I think that "Dai-Bai (Great Compassion) Water" from Buddhist temple is not harmful for the patients; however, some water from folk temple is uncertain, for example: some religious water will influence the effect of medicine. We should notify the physician. I think that "Tibetan Buddhism" is not appropriate for Taiwanese. Generally, I apply "Chinese" Buddhism on the palliative patients. I think that that recitation of Amita-Buddha can help people to relieve their suffering, including pain and other symptoms. It is also a good way to help nurses to deal with some unexplained situations, for example, some ghosts have interrupted some nurses and some physicians.
Participant 20	My Buddhist organization is Chan (Zen) school of Buddhism. It was different from other Buddhist temples in Taiwan. For instance, almost all the Buddhist temples are "Pure-Land" school of Buddhism in Taiwan. The Buddhist chaplains have received the training of meditations; therefore, the Buddhist chaplains can

	understand what the patients are thinking. It is difficult for nurses to do this because the nurses have not had the experiences of Zen (Chan) school in Buddhism. According to my past experience, death anxiety is very common in hospice patients; guilt feeling is also existing in hospice patients. I think that bad Karma resulted in the patents' sufferings. I think that the Buddhist ritual of taking refuge is a very good method for the patients. This method could relieve the anxiety of the patients. I also apply the Buddhist ritual of confession. However, the end-of-life patients in hospitals are different from the healthy persons; therefore, I do not apply the traditional ceremony of confession. I tell the patient that you will be forgiven whatever you did. Another way to deal with ghosts is that of preparing food for the ghosts, this method is difficult to be applied in hospital. Recitation of Buddhist sutra or Buddha's name is good way in hospital, but preparing food for ghosts cannot be applied in hospital.
Participant 21	I think that the Buddhism was widespread in mainland China, the method and meaning of Buddha teaching has changed a little at that time in ancient mainland China because Chinese culture was different from Indian culture. I think that there are many methods in "Pure land school" of Buddhism; however, we just prefer one method in Taiwan. Other methods of "Pure Land School" in Buddhism are also very wonderful methods, we should rethink this issue. I also applied "Dai-Bai" (Great Compassion) Water" on myself. I remember the great earthquake in Taiwan on 21th September 2000. The folk religion was useful for the people in Taiwan; however, the western psychology was useless at that time, we should think different methods in different cultures. If we believe that "Dai-Bai Water" is useful, the water will be greatly useful. I think that the Buddhist ritual of taking refuge is useful for the patient. This ceremony will bring patient's emotion calm down based on my past experience. I think that Buddha teaching is to teach us how to live and die well. After Buddha death, Buddhism had changed a lot, Buddhism was also changed in different countries. I do not apply the approach of preparing food for ghosts; I think that this approach is not appropriate in hospital. I apply the approach of Guan-Yin Bodhisattvas on the patients and their families. The patients accept the concept of Guan-Yin Bodhisattvas. It is a good start to help the patients.
Participant 22	I think that four kinds of Buddhist approaches are applied in hospice care in Taiwan, for example: Zen(Chan) method, taking refuge, confession, and reminder of the patients' good action in this life. I think that to remind the patients of their good actions in this life is very good for all people, not just for Buddhists, and because we remind patients about their good action, they will have peaceful emotions, and then they will have a better next life. I apply the approach of the Buddhist ritual of taking refuge in

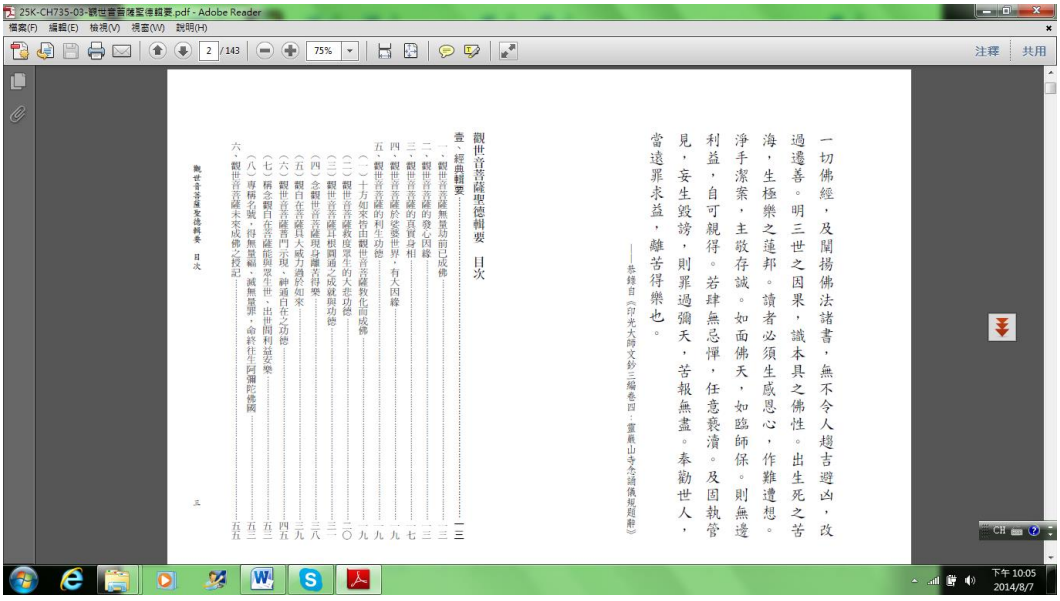
	palliative care units in hospitals. I think that the Karma influences our fortune; it is from everyone himself (herself) not from the God or the Buddha. That is, we can create our Karma. Most of people misunderstand the Karma and the results of disease. I apply life reviews and encourage the patients to remember their good behaviour in this life. I can be sure this method was Buddha teaching, which was written in Buddhist sutras, it is also applied for non-Buddhists. I think that it is important for the patients to have a better next life. Please do not talk about the evil behaviour that the patients have done because it is useless and it is not good for the patients in getting a better next life. I and my co-workers (other nuns in the same Buddhist temple) have many experiences regarding the patients doing recitation of Buddha's name; the people got good death in the end of life. I think that the breath meditation can help the patients to calm down and relieve the shortness of breath; it is a good method for the patients. When the patient focuses on the Buddha's name, it is also useful for helping the patients to calm down. I also have met some people who wanted the blessing from the Buddhist chaplains, I thought it is OK to do this; generally, I will recite the sutra or Buddha's name to bless the patients. I think that Karma will influence the patients' future; some people would like to die as soon as possible and ask the Buddhist chaplains if they can help them to die soon. In this situation, I encourage the patients to recite the Buddha's name to have good Karma and then the patients can die the day they expected. Generally, the patients can accept the viewpoint from my viewpoint.

Appendix 11: Data in Nvivo 10

The interview data was stored in Nvivo10. I stored each participants' interview data in the software of Nvivo 10 as follows:



The Guan-Yin Bodhisattva Inspiration Collections in Taiwan



Appendix 13: Prayer Beads

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