What End of Life Care Needs Now:
An Emerging Praxis of the Sacred and Subtle

Abstract
Conscious Dying Institute (CDI) is paving a new path in the realm of end of life (EOL) care; one emerging from awareness, humanity, dignity, caring consciousness, and a return to the sacred. The purpose herein is to discuss the emerging theoretical perspectives of CDI and to address their implications for broadening the scope of nursing and EOL care. In educating nurses about their own authentic selves, they return to their personal-professional purpose, awaken to a heightened awareness of needs for self and other, and influence a global shift in how EOL care is viewed, addressed, and delivered.

Introduction
(*Given the number of acronyms used throughout this article, a translation key is provided in Table 1 to more readily assist the reader. Acronyms are listed in the order they appear.)

Conscious Dying Institute (CDI) is paving a new path in the realm of end of life (EOL) care; one emerging from awareness, humanity, dignity, caring consciousness, and a return to the sacred. CDI is training the next wave health care workers to become Sacred Passage Doulas (SPDs), spiritually-grounded and emotionally-awakened transdisciplinary care providers, who are ushering in this innovation of transformative teaching-learning to individuals and systems and providing authentic caring connections, compassionate communication, and comforting healing education for patients, families, communities, and foremost, for themselves. CDI’s mission is to, “… restore death and dying to its natural place in the sacred circle of life by creating a new wisdom-based culture of healing caregivers and professionals… who elevate the experience of end of life care,” and their programs, “[restore] emotional integrity and spiritual
sanctity to relationships and [increase] life satisfaction for all involved”, 1. The purpose herein is to discuss the emerging theoretical perspectives of CDI regarding the Conscious Dying Principles and Practices© (CDPs), provide in-depth exploration of the Subtle Energy Realms© (SERs), and to address their implications for broadening the scope of nursing and EOL care. Conscious Dying work requires an invested interest in both the emotional-spiritual development of the nurse providing care and the environment that is co-created between nurse and patient, thereby identifying a much needed area for further education and qualitative research in integrating a more subtle and sacred praxis.

CDI implements a transformational, experiential education method for healthcare workers to ensure SPDs are guided in both personal development and the knowledge needed to influence system-wide EOL care evolution, 2. In this way, SPDs are led to embrace their own confusions and fears regarding death, and their impressions, lived experiences, and perceptions of the dying processes, while working to translate this very personal, individualized journey to the health system at large. Conscious Dying work employs a human caring science paradigm, 3, furthering the humanitarian and relational worldview of organizations such as Watson Caring Science Institute (WCSI), and is similarly rooted in a transpersonal ontology; extending beyond the ego-self of the individual and cultivating a focus on the spirit-to-spirit connections between human beings, an exploration of the inner life world, and the broader dimensions and metaphysical implications of the spiritual-cosmic-universal, 4. The nurse providing EOL care is in a prime position to adopt and implement Conscious Dying work and to share the information gleaned at unit and system-wide levels. Prior to exploring the qualities and characteristics of the CDPs and SERs, the healing role and intentionality of the nurse caring for the end-of-life patient
deserves further reflection and attention in order to ensure the integrity of this sacred EOL theory.

**The Nurse as Healing Instrument**

**Exploring an Emerging Archetype**

The nurse as healer is a universally recognized professional archetype that extends beyond clinical specialty, culture, gender, credentials, or disciplinary worldview, and is one of the core ethical tenets foundational to nursing practice, as espoused by Nightingale, 5. The nurse as healer becomes an embodiment of the divine feminine/sacred masculine, guiding and actualizing the journey of human caring toward the realm of the subtle, the yin, the receptive, and the energetic-existential, 6. “Healing” in this sense becomes detached from the medical model vice of quantitative physiological data and returns to its originally intended meaning and purpose, representative of the interpersonal, more qualitative, and humanely dynamic immeasurables of sacredness, such as the lived and expressed experience of wholeness, mental-emotional-spiritual alignment, and the concept of health as expanding consciousness, 7,8. It is in being, becoming, and facilitating healing that nursing creates and manifests a societal-global contribution of unique character and delineates for itself a legacy both separate and distinct from the practice of medicine, 9.

The nurse as healer maintains and demonstrates certain traits and characteristics, compiled by McElligott (2010), which integrates the work of leading healing practitioners and theoreticians; these traits and characteristics include, “empathy, respect, love, gratitude, acceptance, self-care, presence, mindfulness, compassion, awareness, trust, intentionality, and energy” 10(p253). Furthermore, McElligott (2010) provides an operational definition of healing as, “… the personal experience of transcending suffering and transforming to wholeness
resulting in serenity, interconnectedness, and a new sense of meaning” 10(p258). Other philosophical perspectives describe healing as, “… [an] awakening to one’s authentic Nature, awareness of integralty, and unfolding of integral human-universe patterning” 11(p7); “A lifelong journey… seeking harmony in one’s own life and in family, community, and global relations” 12(p54); “… grasping our interconnectedness with all that is… through a shift in consciousness that can be evolutionary or revolutionary… as we discover and co-create meaning and care and are cared for” 13(pE45). In this way, the nurse as healer embraces and humanizes these traits of empathy, respect, love, etc. to awaken a sense of interconnectedness, harmony, and balance for both self and other; guiding the conceptual toward a mutual lived experience for both nurse and patient.

In addition to the theoretical-practical definitions of healing as integral to the nursing role, the nurse as healer, herein referred to as the primary healing instrument, demonstrates skills and competencies that lead both self and other toward the wholeness, integralty, and co-creation of caring partnerships reflective of progressive healing; these include the ability to shift consciousness into a healing state, employ a transpersonal worldview of unity and oneness, and hold a sacred space for another, 14. Attention to the physical settings, ensuring aesthetics, cleanliness, and beauty, all contribute necessary aspects to the healing milieu and, yet, when one’s practice evolves to include healing consciousness, intentionality, energy, and awareness to create a healing environment at all levels, from gross to subtle, the nurse as healer archetype is subsumed by a broader, nonphysical, and more refined complexity of nurse as healing, 15, or nurse as guide for evolving human-centered care. Ultimately, Conscious Dying views the nurse as primary healing instrument (NPHI); a doula who births and guides the sacred passage of
another. In this realm of self-other caring, the nurse goes beyond fulfilling the competencies or skills associative of healing and is in becoming with the essence of healing itself.

Within the Conscious Dying framework, the NPHI becomes finely attuned to the lifesong and energetic alterations of the patient’s living-dying experience. In this evolving metaphor, the nurse finds themselves malleable, open, and available to the fluctuating needs of the patient at both the physical and energetic-spiritual levels. The NPHI allows for the EOL journey to venture into the subtle realms and embodies comfort, validation, witness, and presence throughout the experience of the one dying.

Thus, the foundational healing aspect of this work is referred to as evolving human-centered care. The principles, practices, and realms discussed throughout promote an environment of openness and embracing the unknown in the healing-learning journey. More so, these subtle ideals move the healer past the provision of “patient-centered care” toward the actualization of fully conscious and evolving “human-centered” care; extending beyond “patient” as label or separation to “human” as partner and fellow being. The CDPs and SERs lead the NPHI toward realizing the sacredness of evolving human-centered care, which may be defined herein as compassionate and empathic care that responds, attends, and conforms to the human as a living, breathing, evolving experience; human as a fluctuating phenomenological being of engagement; human as history, as story, and as narrative; human as presence, emergence, and possibility; human as fellow sojourner; human as caring-healing; and human as LOVE.

Evolving human-centered care rooted in an ontology of Conscious Dying surrenders goal-setting and outcomes-driven, bureaucratically-constrained management at EOL, and seeks to employ a moment-to-moment caregiving priority; one that allows for full self-expression at
each moment, and for all that is potentiated within that moment, which may guide both the healer and the healing toward a sense of wholeness and mental-emotional-spiritual integration.

Evolving human-centered care is based upon the idea that healing is possible at any time and may take many forms. Human connection and caring become defining characteristics of the role of the healer and the currency with which another is engaged. Understanding the implications of evolving human-centered care for both self and system is essential in the context of conscious dying work and education.

**Holistic and Integrative Approaches for Healing of Self & System**

Holistic and integrative approaches to care are inherent qualities of the NPHI, and yet deserve additional exploration, as they are the fundamental and requisite factors indicative of healing and healing relationships. Holistic nursing is defined as, “All nursing practice that has healing the whole person as its goal and honors relationship-centered care and the interconnectedness of self, others, nature, and spirituality…”, 16(p3). Furthermore, integrative nursing proposes that human beings are whole systems inseparable from their environment who maintain an inherent capacity for health and wellbeing, recognizes the inherent healing power of nature, is based on person-centered relationships and utilizes a broad range of therapeutic modalities to support healing processes, and focuses on the wellbeing of both caregivers and receivers alike, 17.

During the EOL experiences, the NPHI acknowledges and honors all cultural-specific, indigenous folk remedies, values, norms, beliefs, and practices of the patient in modeling a holistic-integrative approach to healing, 18. By honoring the richness and inherent values of cultural diversity, the NPHI brings healing wisdom to the cross-cultural barriers that hinder healthcare availability and EOL services to socio-economically deprived populations. Some of
these obstacles include mistrust of the system, dissatisfaction with services, ethno-centralism, and lack of access, 19. As a healer, the SPD seeks to bring effective communication and authentic presence to another, regardless of cultural differences, which illuminates the universality of death and dying and unveils a shared social meaning between human beings of diverse backgrounds, 20. If the nurse is to heal, their paradigm must be broad enough to encompass the various components of self, other, nature, relationships, spirituality, environments, and modalities presupposed by holistic and integrative nursing that will allow for a conscious, transculturally relevant, and authentically present NPHI-patient interface.

In order to be truly human-centered, the NPHI must cultivate and honor the flexibility required to meet the person under their care where they are, as they are, with the feelings and perceptions they are experiencing. This is particularly relevant in the death and dying processes at EOL. It requires self-knowledge and self-dependability on behalf of the nurse to venture into the unknown, and to be with another’s fear, grappling, resistance, and suffering in order to assist with their healing journey toward acceptance; indeed, it requires formidable courage to be with the vulnerability of another in the hopes of fostering a healing connection, 21.

According to Keegan and Drick (2013), 22, deepening one’s relationship with and to the conversations surrounding EOL care assists the nurse to:

- Confront their own feelings of death, dying, life, living, and all that emerges in between
- Create a vision for what they want and how they want it at EOL
- Reach a state of honesty with their individual readiness and resistance to death.

In this way, the NPHI becomes a wisdom keeper of death’s true purpose - a knower of death - their own and another’s. Their way of knowing becomes subtly attuned to the vicissitudes of one who is encountering death and dying, as well as the emotional inquiries, wounds, and strengths
that make themselves known at this time, 23. The ongoing relationship with death and dying, and its influence on the quality and satisfaction of life and living, plays a pivotal and unquestionable role in the developmental practice, research, and education of the discipline and directly impacts the quality of human caring that is delivered to those in need of nursing care, 24.

The NPHI is invested in the budding consciousness and integrity of the “evolving Self;” a Self that is not separate from the people and the environment in which “health care” is currently practiced. The NPHI is a change agent within the collective organizational structure that determines the quality and dignity of EOL care. Within this framework, EOL care is no longer viewed as “end” care, but rather, death is engaged as a rite of passage, an evolutionary moment in the lives of all involved in care at the end of physical reality. The NPHI caring for families and patients facing death holds and honors a sacred approach and philosophy of death as a transformational moment of life; a non-medical event that often takes place inside our medical systems. Careful assessments of both self and system are necessary to assure the integration of this work occurs at individual, unit, and institutional levels in nurturing-healing ways.

Self-reflection is essential to ensure that one is cared for and fully self-expressed, grounded in their capacity as a healing instrument, and able to support colleagues in the ongoing implementation of this work, 25. Systems awareness and needs assessments provide vital information for developing spiritually-supportive care environments, optimize physical and energetic settings for Conscious Dying intentionality, and further the dialogue of the role and implications of sacred EOL care delivery throughout modern health care infrastructures, 26.

**Conscious Dying**

Conscious Dying concerns itself with the fragility and vulnerability of human beings facing EOL as we know it. Conscious Dying asks NPHIs to be the ones embracing the truth that,
though death is often “managed” in medical systems, death itself, like birth, is not a medical event. Death is not the opposite of life. Death is the opposite of birth. Death and dying deserve to be held in such a way that the human being can face death and experience it as a rite of passage.

Conscious Dying calls NPHIs to stand firmly with another who needs strength to face their earthly impermanence while their friends, family members, and clinicians may be all working toward extending life to the exclusion of quality. It can, and perhaps should, be assumed that the NPHI will be practicing Conscious Dying care in systems whose frameworks view death as a medical event to be overcome and whose priority is life over death at all costs.

This work is that of the human spirit; procuring and protecting spaces of safety for the patient’s expressive freedom at EOL and exploring the many subtle, energetic, and spiritual evolutionary dimensions possible for both nurse and patient throughout the processes of death and dying, 27. Estes (2011) provides a structured approach for the moral-ethical-spiritual foundation of Conscious Dying work: guiding points, known as the Conscious Dying Principles and Practices© (CDPs) (seen in Table 2), that root the SPD in a considerate, open-minded, and empathic mental-emotional-spiritual approach to EOL care, 27. There are powerful connections to be made between these principles/practices and Watson’s Caritas Processes™, 28, (seen in Table 3) - the altruistic value system of human caring science; an extant nursing theory arising from the basic human need to be cared for and cared about. Conscious dying engages this human caring framework in articulating caregiver priorities at EOL and builds its educational pillars upon the transpersonal and unitary ontology of human caring science. One can readily observe the connections between the CDPs that promote self-care, emotional and spiritual support, and honoring others’ beliefs, and the moral/ethical values espoused by Watson’s Caritas Processes™.
Conscious Dying Education, through the CDPs and SERs, supports the creation of a nurse healer who becomes a true SPD – an end of life doula – who becomes confident in initiating relevant conversations regarding death and dying, emphasizing the importance of human-to-human connection during EOL, and stewarding in an experience of caring-healing consciousness. As a conscious steward of death, the SPD is present for the evolving needs of the patient and the intricacies of the five stages of death and dying: denial and isolation, anger, bargaining, depression, and acceptance, 29. The SPD allows for the experience of many healing intangibles, such as forgiveness, which is often confronted at EOL as the patient has the potential to move through forgiving self, other, body, God, parents, and world, and begins to align with intimate self-actualization through surrender of the ego-mind and reconnection to the source of unconditional love within, 30-32.

Conscious Dying calls SPDs to provide presence in a way that goes beyond a “dignified” death;” to imagine that how one dies is the last great legacy and goes beyond the thought and sense of “dignity.” It asks those providing care at EOL to consider: If I am a clinician, how can I serve beyond “Do No Harm”? Beyond medical-curative care? What would I want for myself and my loved ones? And further, what if how we die is the highest expression of our earthly journey? A best practice, if you will, of who we truly are? These reflections lead the SPD into the realms of subtle consciousness.

**Subtle Energy Realms©**

“Death is an especially valuable time for transformation and healing. Some people say that the veil between the subtle realm and our physical reality is so thin that with awareness and preparation, we can enter it along with the one who is passing… If we are open, we can feel this enhanced, subtle energy field in the presence of the dying one…” 27(p16).
The SERs shown in Table 4, supports EOL education, research, and practice that prepares NPHIs to attend to the fluctuating life transitions of the patient. They symbolize an emergence of consciousness and a shift in how NPHIs, as evolving human beings and SPDs, attend to self and other amidst the processes of death and dying. The SERs are distinct from the CDPs. Rather than principles, they are really stages or phases within the dying process that appear - or not - as the human being turns more and more inward toward the realm of spirit and invisibility; the mystery, reaching through the material realm, through the veil, into the spiritual-energetic realms we cannot physically see. Naming these subtle energies is really naming the realms/phases that are inherent in the transition from form to formlessness, a way humans can name, observe, honor, and validate this movement and perceive with the dying person their transition, how they really begin to exit while visiting the other realms before they die. They are guideposts that help the NPHI to learn and bear witness to the transition of form to spirit.

By understanding that these SERs are possible, the intentionality and purpose of the NPHI is nourished, reminding one of a sense of duty to evolving human-centered care and serving as a reconnection to individual concerns, worries, fears, anxieties, and views on the processes of death and dying. The template is laid for the NPHI to explore and expand their worldview regarding both giving and receiving care, as well as reestablishing integrity and reaching toward the “beyond dignity” goals in the care of all human beings at all stages of living and dying.

The CDPs, as discussed earlier, are guidelines of care during the period while the person/patient is still mostly merged with form; they are the foundation and pillars of Conscious Dying work. At a certain point, the NPHI is invited to notice when form begins to decrease in priority of care, as it may at any moment. The NPHI is always attending to spirit, but the SERs
assist in pointing toward the pristine EOL portal, where form is simply hosting the spirit’s movement to other realms; a space the NPHI can recognize, support, become connected to, and influenced by if he or she is aware of it.

Each SER below is accompanied by a question or questions from Estes (2011); self and community-oriented introspections that led to the development and continued emergence of this work and guide the reader to further a personal journey with the subtle energies that open and become more available during EOL transitions.

1. **Acknowledge mysteries.**

   “Is there something inherent during the dying process that can transform our experience of ordinary reality, [into] something subtle and mysterious that is available to everyone?” 27(p14-15). The mystery inherent in death and dying was addressed by Moody (1975) in a way that brought insight and curiosity to the near-death experience, with profiles of patients who had described peace and painlessness, out-of-body experiences, meeting people of light, and undergoing a life review, 33. The ability to acknowledge events that the nurse may or may not believe in begins with changing the consciousness around death and dying, from one of resistance and doubt to one of acceptance and reverence, 34. In fact, Estes (2011) reminds the SPD, “It doesn’t matter whether you believe in these things or not. What matters is how you use this information to tap into these subtle energies to become fully human, fully conscious and present, integrated with all the elements, visible and invisible.” 27(p15). The ultimate goal in communing with the mysterious is to be of maximum service and the utmost availability to those experiencing a host of physical-metaphysical crises at EOL, 27.

2. **Be open to miracles.**
Perhaps opening to miracles asks us to shift our inquiry from, “Do miracles really happen…?” 27(p15) to, “What miracles are happening now?” Even the possibility of considering that one’s dying is their ultimate healing - the surrender to death as a healing event - would be a miracle. Recognizing and honoring the subtlety of miracles emerges from honing the intentionality to heal and being authentically present with the vulnerability of another human being, 35. Miracles are often simple in nature and result in a shift in perception; they are resultant of the love one expresses in the world and represent a humble change in “how we experience the experience” 36(p65). The tenth Caritas Process™ directly addresses the openness and sense of compassion necessary to acknowledge the miraculous in the form of healing, spiritual growth, or mental-emotional peace, 15,26. Being open to miracles is not the same as searching or hoping for them. Being open to miracles is not the same as refusing death’s time and way. It is a way of being that allows the experience to be as it is without the need to fix, alter, or provide evidence. It is a process of bearing witness to a healing event that may appear beyond the NPHIs sensibilities, beyond what the patient, the family, the staff define or expect for healing to look like. The miracle may happen after the physical death has occurred, or during the dying time as family members relax, surrender, and realize the importance of their love and sharing what is most important.

3. Acknowledge unexplainable events.

“Is subtle energy simply a myth within our religions?” 27(p15). Consider the paradox of living today where, perhaps, it is “easier” to believe unexplainable events written about in Biblical times. And yet, science continues to find “evidence” about how the subtle energy of human thinking is so powerful as to effect change in both self and others. Anything the rational, analytical mind can’t justify it tends to negate. The ability to acknowledge unexplainable events
in the dying processes of the patient simply means reserving judgment, releasing the need to have the situation be different, and trusting the wisdom of the dying one, 37. The NPHI should understand that the person being cared for can always hear the NPHI’s voice and feel the NPHI’s presence and energy; “… attitude and emotional state are always being translated” 37. If the unexplainable happens then the need to explain is what must be surrendered; blaming medication, confusion, or agitation does not change the mental-emotional reality of the patient. If anything, it invalidates their subjectivity. A doula concerned with providing sacred guidance at EOL can always assume that the patient, regardless of traditional clinical assessment outcomes, is a fully thinking, feeling, and experiencing human being, and is self-realized in the knowledge of their own truth, without exception. Learning to validate, rather than refute or explain, to acknowledge the patient’s experience with curiosity and positive regard, are essential cornerstones of Conscious Dying care.

4. Be aware of nearing death portals.

What are “nearing death portals”? And, “How can we learn to access them to enhance our wholeness, our interconnectedness, and our caring, healing ability?” 27(p16). A nearing death portal can be felt and witnessed as a vortex, window, or an opening in one’s earthly embodiment, where they experience a transpersonal caring-healing moment within the unitary field of consciousness; the idea that all beings, in both this life and the next, are interconnected, interwoven, and related. How does the NPHI recognize a nearing death portal? A feeling of “otherworldliness” may appear in which the normal sense of time and space shifts to an experience of “time stands still” or “no separation” between self and other.
While bearing witness to the dying processes of another, the NPHI is made privy to the subtleties of spiritual evolution and the simplicity of nature’s life-death cycles and experiences. In this fragile space, the one dying becomes a vessel - a portal of the transpersonal - and presents those around them with a chance to know the universal connections between the physical and spiritual dimensions, 27. The one being cared for at EOL offers a vulnerable and sacred opportunity to experience a unitary field of consciousness. These portals and subtle energy access points become opportunities for NPHIs to transform limited belief patterns and separatist egoic structures that prevent humanity from realizing the greater unified consciousness of “one mind” 38.

5. Allow for the return of the ancestors.

“If this subtle reality exists, are its inherent features within us or outside of us?” 27(p.15). The great lineage of humanity is revealed in dying and through availing oneself to the possibility and sacred experience of “going home” during the dying time. The NPHIs “knowing of other” is clarified within the life history of the person who is passing and is realized through looking to know another’s inner life world. The NPHI may begin to experience a receptiveness to and discovery of the history of the dying one’s subconscious, the lineage from which they came, and their spiritual connection to all that is. This information becomes available to them in waves of dreams and visualizations and the transference of consciousness from a body-physical orientation toward a spiritual-metaphysical one, 39. Within the view and perception of the dying person, the ancestors may arrive to reassure, to embrace, and to reclaim; it is a comfort and a privilege to witness this welcoming of their return and can be held as an honor, even a comfort to us that the human being has welcoming love even before the spirit departs.

6. Validate the presence of departed loved ones.
“Why do people laugh or freeze up when a dying person talks about seeing God, or a dead relative, or an angel?” 27(p15). Witnessing and validating the patient’s journey and inner world during this time is like watching and supporting a dream. The NPHI can feel confident that whatever the one dying is “dreaming” about includes the ancestors, the total history of their life, and the important encounters with friends and family who are now reappearing to them in the resolution and conclusion of this earthly life. There is comfort to be found in the possibility that there are others coming in now to take care and support the patient in ways and times when the NPHI’s care is done.

When the dying one sees family members and friends who have passed before them, there is a tendency in the medical community to create excuses or explanation. However, the spiritual comfort and preparation these encounters provide should be honored as crucial to the mental-emotional-spiritual wellbeing of the patient. Just as traditional nursing education regarding pain suggests, “Pain is whatever the patient says it is,” so should be the respect and consideration given to the heightened sensibilities and sensitivities of the dying one; it is simply whatever the patient says it is. Validating the visitation of departed loved ones provides comfort and acknowledgement of the person being cared for. Additionally, these experiences allow NPHIs the freedom to discuss their own spiritual and existential anxieties and apprehensions and offer the opportunity for hope, meaning, and connection between NPHI and the one being attended to at EOL, 40.

7. Honor the waiting in between.

The waiting in between in dying time is the same as the waiting in between in labor as the child being born is awaited. There is labor in both dying and birth. Throughout both these bookend experiences of life, those attending to the laborer wait, remain authentically present, and
do what is necessary to support and ease suffering while surrendering to and trusting the body’s inherent wisdom. The NPHI waits, not knowing when the (sometimes) painful process of breathing/birthing into new life will be complete. “How would this [learned presence] impact [NPHIs] and their ability to serve the sick and the dying if they were introduced to [this concept] and allowed to express their own understanding of [it]?” 27(p.15).

The anxious discomfort of the NPHI during the physical-nonphysical transition of another may symbolize their personal unexplored quandaries regarding death and their untapped emotional existential suffering. Introspective and existential education that includes learning to be with intense emotions is essential in order to improve confidence in caring for this population, decrease feelings of powerlessness in communication, increase a sense of value while caring for a dying patient, cultivate enhanced awareness, and foster self-reflection abilities, 41. This time in between is the precise series of moments when healing may occur for both patient and NPHI. The NPHI must continue to cultivate spiritual care competencies of being intentionally present, maintaining whole-person care, surrendering the need to fix or adjust or ask for unnecessary increases in pain medication, embracing silence, minimizing interruptions, honoring the other as embodied spirit, exploring the meanings behind the stories heard, listening with all of the senses, avoiding premature judgments, letting conversation flow as dictated by the patient, and reconnecting to breath as mindfulness, 42.

NPHIs are called to be fully present during the labor or death… in moments while the breath is still or cresting… during periods of what may feel like suffering… amidst moments when the patient is expressing their last voice. This last voice, whether expressed silently or aloud, can be hard to hear for all who are waiting in between the dying one’s aliveness and passage out of the body.
8. Protect the time of crossing over.

“What if a traditional, clinical education included training in how to validate and support the experiences of those who speak of traveling back and forth between this life and the next?” 27(p15). How does the NPHI honor the time of crossing over as a time when the person has just taken the first step into a journey beyond the physical realm that requires “protection”? Protecting this time may include keeping watch over the body, prayerful contemplative silence, or keeping the body safe while assuring that other staff are not rushing to provide after death “care” (which is oftentimes less about care than about “getting the body out” so another patient can have the bed). Protecting this time means supporting the family to stay with their own discomfort and to model the sacredness of the passage. Protecting this time also involves allowing all involved to be fully embodied in the moment; to permit grief its time to appear and express; to demonstrate how to be with self and other; to model how to feel sadness for one’s loss; to maintain a strong connection to the person’s journey; and to continue with a stance of sacred care and protection for the dying one even after the last breath.

The NPHI acknowledges that a peaceful death, one empowered with silence and serenity and a respect for the privacy and individual journey of the human being, is a human right that helps determine the wellbeing and spiritual unfolding of the person, 43. This is the time for nurses to embrace their role as advocate, and to ensure collaborative partnerships with patients and families that contribute an ethical obligation to maximize the quality of life and avoidance of unnecessary suffering for those nearing EOL, 44, 45. This advocacy speaks to the physical protection of this sacred period - avoiding noxious stimuli, oversedation, and noise pollution - as well as mental-emotional-spiritual protection - clearing the space of negativity or conflicting agendas and promoting peaceful presence - creating a healing environment at all levels.
9. Imagine breaking into light.

“Are we all attracted to it, like the moth to a flame, or do we turn away from this invisible, altered reality?” 27(p15). The NPHI guides the one dying through to physiological death and beyond, assisting them in claiming their spiritual birthright of Self-realization and transcendence. Revered spiritual teachers have taught that death is merely a gateway for an immortal consciousness to evolve and mature:

Death does not end your personality and self-consciousness. It merely opens the door to a higher form… Death is not extinction of personality. It is merely the cessation of an important individuality… Death is not the end of life. It is an aspect of life… It is necessary for your evolution. Death is not the opposite of life. It is only a phase of life.

Life flows on ceaselessly… The physical sheath only is thrown, but life persists” 46(p121).

There have been countless near-death experience chronicles that describe the divine and loving light of Source consciousness that welcomes and embraces the dying one, 47, 48. As the NPHI doulas the dying process for the patient, they become a responsible part of the living-dying continuum and are accountable for its integrity. Tending to the dying of another is more than clinical priorities and tasks; it is the gift of helping another understand their human place in the universality of nature; it is bearing witness to the entirety of the process and honoring its inherent wisdom for life and living; it is providing a healing presence and intentionality as the dying embrace, merge with, and break into light.

Nursing Implications

Knowledge of the SERs nourish the intentionality and purpose of the NPHI, reminding one of a sense of duty to evolving human-centered care and serving as a reconnection to
individual perspectives on the processes of death and dying. The template provides the NPHI the opportunities to explore and expand their paradigm of EOL care, reestablish dignity for all involved in the dying process, and ensure system-wide recognition of a subtle and sacred passage. In this way, the CDPs and SERs extend beyond ways of doing, and mature in their highest sense as ways of being-knowing. While they lead the NPHI to examine the interventions and tasks being imparted in the clinical setting, their underlying raison d'être is to awaken a deeper consciousness and attention to the NPHI’s mode and method of being and what intuitive structures one is calling on to know another human.

Further theoretical development is necessary to establish how the SERs can be identified, assessed, and evaluated in the clinical milieu. Additionally, research is needed to translate the potential impact of the conscious dying framework to individual outcomes for both nurse and patient/family, as well as system-wide implications for those institutional infrastructures that promote a sacred environment for death and dying. Some variables that may be considered for such research include:

- Job satisfaction for nurses providing care at EOL
- Nurses’ experience of moral distress while providing EOL care
- Observed pain/distress for patients transitioning at EOL
- Use of narcotics and sedation in response to observed patient behavior and experience during the dying process
- Family-nurse, family-institution, family-patient relationships during EOL processes.

**Conclusion**

The Conscious Dying Institute (CDI) is at the precipice of a new and innovative worldview of EOL care. In raising the consciousness of SPDs and NPHIs, the hope is that
transformation will be supported throughout the infrastructures of modern health care for death and dying that unfolds beyond dignity and with respect, compassion, and the transpersonal implications of human caring partnerships intact. In educating NPHIs about their own authentic selves - the part of their being that is essential and timeless - they return to their personal-professional purpose, awaken to a heightened awareness of needs for self and other, and influence a global shift in how EOL care is viewed, addressed, and delivered. CDI echoes the mutually shared need for humanity, sensitivity, and openness throughout the living-dying care continuum and reminds NPHIs of their vital role in providing sacred passage guidance. CDI serves as healing evidence that, as spiritual teacher Ram Dass reminds, “We’re all just walking each other home” 49.
References


