religions

MDPI

Article

A Buddhist Biography Project: Story-Telling, Spiritual Connection, and Intergenerational Exchange

Catherine Dhavernas [1,*] and Carmel Williams [2]

[1] Department of French Studies, Queen's University, Kingston, ON K7L 3N6, Canada
[2] Karuna Hospice Services, Windsor, QLD 4030, Australia; williams@griffith.edu.au
* Correspondence: dhaverna@queensu.ca

Abstract: This descriptive article discusses the development, delivery, and impact of the "Biography Project". The project is a research and teaching initiative focused on both enhancing the quality of life of older persons, and providing university students across diverse degree programs the opportunity to learn about and engage first-hand with the challenges that confront older adults living in residential aged care. In accounting for the project and its objectives, the article explores the Buddhist values that underpin the project's approach to teaching, and the important role of spirituality in training students to engage older people in telling the stories of their lives.

Keywords: life narrative; biography; Buddhism; aged care

Citation: Dhavernas, Catherine, and Carmel Williams. 2022. A Buddhist Biography Project: Story-Telling, Spiritual Connection, and Intergenerational Exchange. *Religions* 13: 576. https://doi.org/10.3390/rel13070576

Academic Editor: Jane Kuepfer

Received: 3 May 2022
Accepted: 27 May 2022
Published: 22 June 2022

1. Introduction

The search for one's life's meaning grows as we age. Until we encounter our progressive mortality in real and meaningful ways, either through our own health issues or those of peers and loved ones, we tend not to reflect on ageing's relationship to life until it confronts us in ways that are impossible to ignore (Johnson 2018). In order to provide aged care residents with an opportunity to reflect on the meaning of their lives, the "Biography Project" began in 2019 in Brisbane, Queensland, Australia through a collaboration between Griffith University and the biography service unit of Karuna Hospice Services, a Buddhist palliative care provider, to record, transcribe, and publish biographies of aged care residents. To provide access to residents, the authors collaborated with a national non-profit aged care provider that was keen to see the program extend across their several care facilities.

The project design team is diverse. It includes one co-author who is a medical humanist specialising in literary theory and critical philosophy, and one who is a medical educator and clinician whose work as the undergraduate medical program director at Griffith University contributed to discipline-specific learning outcomes that also connected to the Australian Medical Association's strategic guidelines for medical education. Indeed, the association, in its submission to the recent Australian Royal Commission on Aged Care Quality and Safety, recognised residential aged care facilities as "fertile ground for teaching and vital for educating the next generation of doctors about caring for older people as part of routine medical practice". The Royal Commission further recommended an increase in education and training for doctors in the holistic care of older people, and further declared that such education must begin in students' early medical studies (Australian Medical Association 2019). Against the backdrop of medical education's limited engagement with residential aged care, research has found that aged care placements improve medical students' attitudes to working with older people (Annear et al. 2016), and that their exposure to a humanities education correlates with positive personal qualities, including empathy, self-efficacy, and communication skills (Mangione et al. 2018). Other team members include a medical sociologist whose work on grief, memory, and death literacy bridged the gap between palliative and aged care, whereas the other co-author's hospice palliative care expertise in the biography method was central to the project's

development. Last, the partner aged care provider's director of the mission organised and aligned the diversionary therapists, care staff, and volunteer coordinators who facilitated the meetings between students and residents. The project has received ethics approvals, updated regularly, from Griffith University and the partner aged care provider, and all participants, students, and residents signed consent forms to engage in the process, and to contribute to any research outcomes. Since 2019, 26 students have participated in the program: 12 from medical science and bioscience programs, and the rest from liberal arts and social science programs.

Two main objectives have guided the design of this Buddhist-based biography project. The first was to contribute in whatever small way the team could to improving the quality of care provided to older adults. The second was to spark student interest in the area of aged care, a field that is marginalised, underfunded, and of little interest to those training to be physicians. To be effective, the designers decided to expose students to the realities individuals face at the end of life, to have students engage first-hand with the challenges with which older adults are confronted, to introduce students to practices of care that extend beyond the physiological side of illness, and to address the socio-spiritual and existential dimensions of pain and suffering. The team chose to confront students with end-of-life issues because they entail some of the most significant challenges we will all have to face, and that are rarely, if at all, talked about, not even by medical practitioners in whose care people facing the end of life are often placed. The team, therefore, saw a need to start preparing carers, and young people in general, to meet the challenges of aging issues in competent and caring ways that take their cues from a foundational Buddhist approach.

2. Karuna Hospice Services and the Buddhist Approach

In 1992, Karuna Hospice Services was founded in Brisbane, Australia by a physiotherapist who was also a Tibetan Buddhist monk. Pende Hawter worked with people diagnosed with palliative conditions, and saw a need to provide comfort and guidance in the familiar and reassuring surrounds of their own home. With the help of a small but dedicated team of like-minded health care professionals, Hawter established a not-for-profit home hospice service that offered information and holistic care. He called the service Karuna, which means compassion in Sanskrit. In serving the community, Karuna follows the inspirational ideals and examples set by His Holiness the Dalai Lama, whose lifelong mission is to serve others with universal compassion and kindness.

As such, all staff and volunteers at Karuna, who may or may not be of Buddhist faith, are trained to honour a number of core Buddhist values that translate into the embodiment of respect, kindness and compassion, being fully present, as well as working to promote dignity, calm, comfort, reassurance, understanding, and acceptance in the other. It involves an attitude rarely encountered, valued, or facilitated by medical education or in the medical profession where the emphasis tends to be placed on fixing physiological problems rather than tending to the comprehensive socio-spiritual and existential needs of the whole individual (Puchalski et al. 2014). That Buddhists view life as suffering, which situates aging and dying within a frame of reference wholly removed from Western norms in which health tends to be construed as a state that requires treatment and remedy to restore its idealised perfection. For Buddhists, health is about a balance that rests on the unity of the person's mind and spirit (Ozawa-De Silva and Ozawa-De Silva 2011). For Buddhist practitioners, being healed is altogether different from being cured because one can be both healthy and dying, owing to death's inevitability (Balboni et al. 2014).

The key to providing holistic care to Karuna's clients was the development of a strong palliative care volunteer workforce, which later expanded to provide a client biography service, and the training of staff and volunteers in Buddhist principles and values has been critical to the success Karuna has had over the last 30 years. A Buddhist nun on staff would hold a short, calm, abiding meditation session with carers and volunteers focusing on the breath. The aim of such a practice was to integrate Buddhist principles and values each morning to allow the team to commence their day from a grounded, mindful place.

Carers could then set their intention to try to benefit not only Karuna's clients and families in their work with them that day, but also their work colleagues. This regular practice familiarised staff with a simple tool they could use during the day when confronted with circumstances that were challenging. For home-based volunteers, from the first day of their eight-day training, a similar routine was begun. Volunteers were introduced to the meditative principle that a calm mind and setting one's intention can provide essential support needed in their work with clients and family members, as well as provide them with "something they can do" in circumstances that are often beyond anyone's control.

Such preparation supported volunteers to develop a willingness to "be present" in the face of challenge and suffering without needing to flee or feeling they had to change or fix anything. The state of being calm that the volunteers brought with them could provide the dying person they were visiting the chance to either be silent themselves or to share feelings and stories that may not otherwise have emerged in the sometimes chaotic and busy home environment. Although underpinned by Buddhist principles, the practices were shared through a secular approach that could be appreciated by people of any faith or none. Volunteer-led weekly meditation sessions were also offered to the families of clients and to the general public to extend Buddhist practices and approaches to mindfulness and compassion. Again, such practices provided those who attended with "something they could do" to alleviate theirs or their loved one's fears and suffering. Families were also offered the opportunity for one of the Buddhist nuns to visit, to share these practices, or speak openly with them about preparing for death and specifically responding to that person's individual spiritual needs.

3. Religion and Spirituality in Medicine

For decades, research has probed the impact of such religious and spiritual approaches on biomedicine, particularly in palliative care, mental health care, and organ donation, to collapse the division between medicine and faith, and to create a new foundation for patient-centered care (Yeary et al. 2020). Though there is significant overlap in how religion and spirituality are defined (Chinnaiyan et al. 2021), for the purposes of this article, spirituality will be the key concept because the Buddhist approach that informs the Biography Project is intended to allow for the more individualised and self-determined space that spirituality affords, as opposed to the more formal and organised aspects of religion. Vachon et al. (2009) conducted a concept analysis to help develop an inclusive and comprehensive definition of spirituality that could be used to guide clinical practice and research initiatives. They summarised spirituality "as a developmental and conscious process, characterised by two movements of transcendence, either deep within the self or beyond the self. " (Vachon et al. 2009, p. 56) Transcendence within the self, still considered within the narrow limits of the ego, is understood as a sense of connection to the feelings, thoughts, and awareness of the inner self that arise from a search for meaning. In a recent volume on aging and spirituality, American writer and gerontologist Robert Atchley writes that spirituality enables one to experience an unmediated existence that is grounded in a sense of being and belonging within the finitude of life that can only be perceived as one ages. Death becomes an inevitable context in which one exists, and which prompts searches for bigger answers to the riddles of our existence (Atchley 2018).

Research questions about consistent definitions, methodologies, and clinical efficacy have challenged subjective approaches to the subject, and underpin everything between doubt and disbelief about how faith relates to medical care and patient well-being (Sloan et al. 1999; Plante 2016; Steinhauser and Balboni 2017). However, there is no consensus in the research field on the relationship between religion, spirituality, and medicine. Against scores of studies that can find no credible evidence that faith improves health, several other studies have shown that patients, physicians, and families have benefitted from a spiritual or religious approach to care (Kessler et al. 2013; Puchalski et al. 2014; Plante 2016). Studies have confirmed the importance of spirituality in healing, and suggest that people with regular spiritual practices tend to live longer, have a more positive outlook on life,

and better quality of life, and that different forms of spiritual practice, such as prayer and meditation, can play an important role in pain management, substance abuse, and recovery (Puchalski 2001; Puchalski et al. 2014; Kopel and Habermas 2019). One recent survey of the literature found that a patient's religious or spiritual outlook had beneficial effects on cardiovascular and neuroendocrine function, better lipid profiles, lower levels of stress, and improved immune responses (Yeary et al. 2020).

One of the values that stands out in recent explorations of spirituality in medicine is the connective relationships and personal connections that a spiritual approach to care affords (Puchalski et al. 2014; Ventres and Dharamsi 2013; Essary et al. 2020). As one team of researchers put it, "[spiritual care] training led to an increase in self-perceived compassion for the dying but also compassion for self, an increase in attitudes to family and work colleagues and the decrease of work stress. These benefits were preserved over six months." (Wagner et al. 2005) Personal connection is the key ground where Karuna's approach works because it dissolves the Cartesian alienation of self, body, and environment, and puts the individual in a continuum of being. Such a shift replaces the medical gaze that sees a person as a disease object with a compassionate relationship with a whole person who cannot be "cured" because they are where they are supposed as they travel the path to the end of their life (Ozawa-De Silva and Ozawa-De Silva 2011).

4. The Biography Project's Buddhist Foundation

The Biography Project fits within the broader concept of narrative medicine because it uses peoples' stories to enable better care, but its Buddhist inflections open the project to wider possibilities. Indeed, one research team has concluded that "narrative medicine and mindfulness interventions create meaningful connections with patients, improve the delivery of patient-centered care, and enhance the health of the caregivers." (Essary et al. 2020). Building Karuna's Buddhist values into a biography project that focused on aged care residents rather than palliative care patients involved three core mindfulness practices that believers and non-believers alike could learn and apply. First, is the importance of setting a motivation of kindness, as mentioned in the practices above, combined with a wish to be of benefit to others in all our interactions. It is one of the key steps Karuna encourages in all volunteers in the commencement of any activity or work task. Bringing deliberate attention to one's intention can not only give one's work a "bigger purpose", but it can be a way of focusing one's mind and leaving the usual distractions of daily life aside for a while to be fully present for others. Christine Longaker cites the importance of such an approach in her personal and professional work in hospice care: "One invaluable gift that came from my husband's death was that I could now help families understand how they could use this time of dying well and thereby alleviate much of the unnecessary suffering of dying and death." (Longaker 2011).

Second, is an understanding of the preciousness of this life, including the importance of being able to rejoice and find meaning in the life one has lived. Sharing life stories with a kind observer can help people to come to terms with regrets they may have, and to see their life as a whole. Such a perspective can improve the meaning and quality of life, so that people have a greater chance to ultimately die in peace (Bernard et al. 2020).

Third, to have an understanding, at a personal level, that life and all other things are impermanent has proven beneficial to staff and volunteers in their support of people approaching the end of life. To get to know that we will all die, and endeavoring to come to terms with this, at a deep level, forms an invaluable contribution to working with the aging and dying. This notion is introduced to volunteers, staff, and families through such reflections as a "death awareness" meditation. During such practice, one imagines oneself dying and losing not only one's life, but one's relationships, jobs, past history, and even the identity one has constructed for oneself. These reflections, especially when undertaken regularly, help people to "let go" of some of the fixed ideas they take with them every day, and to realise that, at any time, it could be ourselves in the position of the person we are visiting. Most importantly, it can allow a carer to be more at ease if conversations

about dying are broached by that person. Rather than trying to shut the conversation down by saying such things as, "There's no need to worry about that now" or "We'll get the nurses to talk to you about that," carers can be fully present to their queries, and through such presence, support people to come to an understanding of what the situation means to them and their loved ones. As DeLeo concluded "Accompanying the dying, whatever our role, challenges us to be authentically and compassionately present and ultimately, to look into the mirror of death ourselves and face the uncomfortable truth of our own mortality." (DeLeo 2019)

Learnings from Karuna's thirty years of experience working with the dying and supporting the integration of such Buddhist principles, through education and experience, has developed in staff, volunteers, and biographers, a confidence and a "way of being" that more readily facilitates compassionate listening and unconditional regard in all our human interactions.

Not surprisingly, a recent upsurge of studies in the role of spirituality in later old age suggests that as people age and approach the end of their lives, the need to find meaning in one's existence becomes increasingly important, yet very few physicians or carers are equipped to deal with the types of interrogations that people facing the end of their lives inevitably come to confront. Indeed, how does someone trained in redressing physiological dysfunctions that occur in the body begin to address these challenging existential dilemmas? In fact, when asked about it, many physicians admit to being paralysed (Puchalski 2001). A significant challenge physicians and carers face thus consists in helping people find meaning and acceptance in the midst of suffering and chronic illness at the end of life.

Although it is difficult to know what to say in confrontations with aging and dying—because there are no real answers—people long for their physicians, their families, and their friends to sit with them and to support them in their struggles. True healing requires some form of answer or, at the very least, a capacity to sit, listen, and engage with these sorts of questions to allow the person asking them to find their own responses (Puchalski 2001). The Biography Project works towards this objective by training students to address, engage, and respond to some of the more confronting situations facing older adults, and by having students take part in programs and activities that are designed to help residents find meaning and value in who they are, and what their life comprises.

5. Biography Project Training

Karuna's approach to palliative care prepares students to enter aged care facilities where residents' advanced age, loneliness, and isolation can cause existential distress in addition to physical pain and suffering. In such situations, physical pain is often accompanied by fear, and, specifically, the fear of death, which can manifest as spiritual suffering and which, in turn, can affect coping, acceptance, and wellbeing. Palliative care specialist Hisayuki Murata contends that "spiritual pain" at the end of life is linked to a sense of "extinction of the being and meaning of the self." (Murata 2003) When aged care residents suffer from the physical aspects of ageing, the spiritual pain they may experience often stems from an inability to engage with some of life's most challenging questions: wondering what will happen to them when and after they die; whether and how their family will survive their loss; whether and how they will be missed or remembered; whether or not there is a God or higher being, and, if so, whether or not such a being will be there for them; and how their life mattered. On a more practical level, people might want to know whether or not they will have time to finish their life's work, or how they can find meaning and purpose at the end. Within the framework of the Biography Project, the theoretical components of students' training allow them to explore and engage different issues related to the challenges of aging through peer discussions, readings, films, roleplays, and written assignments. For example, Atul Gawande's *Being Mortal* (Gawande 2015) provides students with an overview of what it means to grow old and to face the end of life. The book also explores key limitations within current forms of aged care and a range of alternative approaches aimed at enhancing the quality of life of older persons. After

reading the text, students critically engage and reflect on related topics as they pertain to the Australian context whose aged care system is, as the Royal Commission into Aged Care Quality and Safety (2021) concluded, underfunded, inadequate, and in great need of reform.

The training process provides students with the comprehensive technical and communication skills needed to successfully undertake the biography process, and includes learning to record, transcribe, and edit the stories shared by residents during their weekly visits with them. It also involves learning to take on a role that many students find counterintuitive. As future medical experts, medical students, in particular, are trained for a position of authority, power, and control. For the purposes of the Biography Project, however, students simply need to conceive of themselves as another human being. As well, unlike traditional biographers who will guide a person's story to make it as interesting as possible, here, the role of the biographer is to facilitate the writing of the resident's story in the resident's own words as the resident chooses to tell it. In other words, whereas biographies usually bear the stamp of the biographer who chooses what to include, leave out, emphasise, or play down, in order to make sense of events and anecdotes, in the context of the Biography Project, it is the resident who is the author and in control of all such decisions.

During training, roleplays and simulations facilitated by a team of trained biography volunteers expose students to challenging situations they could encounter while visiting residents. Students are asked to respond and work through different scenarios, some of which have previously involved a resident's fear of dying, a resident whose life seemed meaningless to them and who felt they had failed in accomplishing anything, or a resident with prejudicial values or cultural views that students could find either confronting or offensive. Key skills that other roleplays develop involve Karuna's values of care. The first value consists of setting one's motivation and intention to facilitate an attitude of kindness and compassion. Other skills informed by these values include deep listening; being present; holding the space for the other; and being comfortable with, and allowing for, extensive bouts of silence.

The final significant component of training consists of a presentation by a Karuna Buddhist nun and social worker to reinforce the project's spiritual framework. By speaking to the students about her work in spiritual care for the past 20 years, and answering their questions, Tenzin Chodron helps them better grasp how to put Karuna's principles of care into practice, and the impact of adopting such values when caring for others. The session begins with Tenzin Chodron initiating a short group meditation to set the tone, intention, and motivation of the discussion. She then explores with the students ways in which to prepare for interactions with people who are facing the end of life, including the importance of contemplating one's own mortality and being present. As she explains, when the question of dying comes up during a client visit, if the carer, or in this case, the biographer, has already thought about their own death, they will be more open, and much less likely to shut down the discussion or let their personal baggage and fears interfere with the space needed for the resident to work through what they have to say. Following the discussion, Tenzin Chodron speaks about her work in more detail, recounting different examples of her interactions with people at the end of life, to give students a sense that there is no one right way to go about this, and to encourage them, if the situation arises, to be comfortable in finding their own approach. She and the teaching team also tell students to trust themselves and never to forget that they are face-to-face with another human being.

6. Biography Project Implementation

After their training, students are paired with an older person living in residential aged care to assist them with the writing of their life story. Their field work involves two to four hours of weekly visits with a resident, during which, students observe, first-hand, and gain a better understanding of the challenges and complex needs of aging. They also have a rare opportunity to put into practice the core spiritual values of care learned in their

training. Without exception, students who have participated in the project have forged meaningful relationships with residents through their one-on-one interactions over the six to eight weeks that preparing a biography can take. Such engagement has been shown to actively contribute to the resident's care and quality of life.

Within the Biography Project, the integration of Karuna's Buddhist principles and values, and their integration through practice and reflection, are important because of their rarity in the medical system in which aged care residents live. Because biographers are "sitting with" and "being present" with someone who is reflecting on and sharing their life experiences, the biographer is not controlling the exchange through a series of interview questions. There is no certainty about what might come up for the person or the biographer. Some life experiences will differ greatly from the biographer's, but others may be familiar. And so, to be able to remain present and not unnecessarily interrupt the story being shared, biographers allow it to be told in its fullness, without side-tracking from where the story might naturally flow, through a biographer's discomfort, preconceptions, or because of random thoughts that might arise. The uninterrupted time and space that the biography affords can, at times, allow the resident to go back into the time of the story they are sharing and fully relive it. One biographer described this situation in the following way: "It was like I wasn't even there, having the story told to me. They had reverted right back to when they were a child".

The biographer's practice of handing the flow of the story to the person telling it allows the resident to fully come to terms with specific situations or their life as a whole; an opportunity that is rarely offered to anyone by another. In doing this, the second principle of "affirming the preciousness of life" is used and reinforced, hopefully with the outcome that the person can rejoice in the life they have lived and feel more at peace about leaving this life and their loved ones. Putting into practice the principles of intention, the preciousness of life, and the contemplation of one's mortality benefits students and residents, but also allows students to carry the confidence they acquire and the ability to "be present" forward to the work and interactions they will have in the future with family, friends, colleagues, and the residents or clients with whom they will work after graduation.

7. Biography Project and COVID

Owing to the vagaries of COVID-19 lockdowns and limitations, beginning in early 2020, the Biography Project shifted from face-to-face to online delivery, which worked well, with the sole exception of having to replace live roleplays with filmed versions. As well, the sixteen students who participated in the project in 2019 and 2021 conducted biographies with residents in face-to-face settings, whereas the ten students who participated in 2020 used online platforms to meet the residents with whom they had been matched. As such, over several months of lockdowns, members of the Biography Project team collaborated with facility managers and care staff to trial a range of digital communication platforms, including mobile phones, tablets, and applications such as Zoom and FaceTime, to communicate one-on-one with residents who were particularly impacted by the COVID-19 situation. The trials proved successful in terms of the platforms' effectiveness in providing an alternative means of communication to connect with residents that could be facilitated without overburdening care staff, and the residents' capacity and eagerness to participate in the project. As a result of the trials' successes, the Biography Project can now be delivered fully online and will, as such, continue to accommodate residents during periods of facility lockdown. Shifting between live and digital student–resident relationships revealed no variation in quality of the overall experience; although, a shortage of in-house devices, namely iPads, limits, at present, the extent of the Biography Project's digital reach. To train and calm students during online sessions with them on the spiritual dimensions of care, the teaching team engaged students in mindful meditative practices that included setting one's intention, learning to be fully present, and reflecting on the mentality they bring to the biography relationship.

8. Biography Project Feedback

Though the sample size is small, student, resident, carer, and facility feedback has been uniformly positive. Though recognising a strong contrast with the efficient outcome-based approach for which they are trained in clinical practice, the medical students, in particular, reported that the biography process made them realise the importance of taking time to be fully present and engaged with residents. They also related how surprisingly comfortable they had felt when residents wanted to speak about mortality or their fears of dying, which occurred more often than anticipated with residents who felt they could not approach the topic with family because they were too close to them. Students found learning to sit in silence and to refrain from filling the voids in conversation to be difficult at first, but, in the end, to have perhaps been one of the most helpful skills learned throughout their degree programs, not only for the purposes of the project, but also as a way to allow future patients to feel comfortable, and to freely express what they need.

Many students spoke of their apprehension prior to meeting residents because they had never spent time with an older person other than their grandparents, with whom they had had only limited interactions. Through their visits, many students were surprised to discover that, despite the intergenerational gap in age, they had things in common with residents, and were able to share their own experiences and form mutually meaningful connections with them.

As well, when visiting residents in aged care facilities, students were often horrified by the conditions of care, the general neglect of residents, and the degree to which quality of care could vary between one carer and another. Students were, for instance, shocked to see residents left to sit alone in their rooms and placed in front of a blaring TV set that they were not even watching, or having to wait hours to be taken to the toilet. They could not understand how people with such rich stories, who had lived full lives and contributed their full share to society, could be treated with the little regard, concern, and care they witnessed. Such experiences and observations drove home the need for better carer and staff education, and for significant change within the current aged care system. It also made evident the importance of intergenerational engagement and social programming, the need for more one-on-one engagement by carers, and the rarity of whole-of-person-care. Students recognised the roles they could begin to play by getting and staying involved, and, in fact, many of the students opted to stay on as volunteers after their role in the project ended.

In terms of residents, carers, and facilities, residents all greatly appreciated the opportunity to tell and share their story, which, in many cases, brought them closer to family, friends, and carers who, by leafing through their biography, discovered the person within the patient. It also allowed some residents to speak about difficult issues with the students, who then learned from the experience. It enabled residents to reflect on and find meaning in past events and memories that had emerged through the biography process, and that they had not thought or talked about in decades. Moreover, all said that they loved spending quality time with the students.

9. Conclusions

Other aged care service providers and rural communities across Queensland have asked the Biography Project team to extend the project in partnership with them. Through its facilitation of different forms of life review based on Karuna's Buddhist values, the team's objective is to continue to develop the Biography Project to help older adults recognise what they have accomplished in their life, work through potential unresolved issues, and regain a positive sense of self as part of coming to terms with and arriving at a sense of peace and acceptance in relation to their current condition or situation. It is also to push for a more holistic approach to resident care by instilling in the students who participate in the project, particularly those pursuing a medical education, an appreciation for their capacity to implement Buddhist principles of kindness and compassion within their own future practice. The Royal Commission into Aged Care Quality and Safety

(2021) found that aged care is an industry whose focus on financing and staffing "bed and body" (Cook and Brown-Wilson 2010) routines has abetted residents' isolation and loneliness. The Biography Project's aim to connect with residents' minds and spirits offers one way to redress residential aged care's shortcomings while opening the cross-generational relationships and awareness that will be needed to underwrite further system-wide change.

Author Contributions: Conceptualization, C.D. and C.W.; methodology, C.D. and C.W.; writing—original draft preparation, C.D. and C.W.; writing—review and editing, C.D.; supervision, C.D.; project administration, C.D. All authors have read and agreed to the published version of the manuscript.

Funding: This research received no external funding.

Conflicts of Interest: The authors declare no conflict of interest.

References

Annear, Michael J., Ema Lea, Amanda Lo, Laura Tierney, and Andrew Robinson. 2016. Encountering Aged Care: A Mixed Methods Investigation of Medical Students' Clinical Placement Experiences. *BMC Geriatrics* 38: 16. [CrossRef] [PubMed]

Atchley, Robert C. 2018. Spiritual Journeys: Elders' Stories of Spiritual Development. In *New Dimensions in Spirituality, Religion, and Aging*. Edited by Vern L. Bengtson and Merril Silverstein. New York: Taylor & Francis Group, chp. 3.

Australian Medical Association. 2019. Available online: https://ama.com.au/submission/ama-submission-royal-commission-aged-care-quality-and-safety (accessed on 28 February 2020).

Balboni, Michael J., Christina M. Puchalski, and John R. Petect. 2014. The Relationship between Medicine, Spirituality and Religion: Three Models for Integration. *Journal of Religion and Health* 53: 1586–98. [CrossRef] [PubMed]

Bernard, Mathieu, Claudia Gamondi, André Berchtold, Florian Strasser, and Gian Domenico Borasio. 2020. Meaning of Life and Quality of Life: Palliative Care Patients versus the General Population. *BMJ Supportive and Palliative Care* 2020: 1–9. [CrossRef] [PubMed]

Chinnaiyan, Kavitha M., Rishab Revankar, Michael D. Shapiro, and Ankur Kalra. 2021. Heart, Mind, and Soul: Spirituality in Cardiovascular Medicine. *European Heart Journal* 42: 2965–68. [CrossRef] [PubMed]

Cook, Glenda, and Christine Brown-Wilson. 2010. Care Home Residents' Experiences of Social Relationships with Staff. *Nursing Older People* 22: 24–30. [CrossRef] [PubMed]

DeLeo, Kirsten. 2019. *Present Through the End—A Caring Companion's Guide for Accompanying the Dying*. Boulder: Shambhala.

Essary, Alison C., Mark Lussier, Noah Stone, Barbara Volk-Craft, and Gillian Hamilton. 2020. Reflections on the Integration of a Narrative Medicine and Mindfulness Program in Hospice and Palliative Care. *Progress in Palliative Care* 28: 260–66. [CrossRef]

Gawande, Atul. 2015. *Being Mortal: Illness, Medicine and What Matters in the End*. London: Profile Books.

Johnson, Malcolm. 2018. Spirituality and Life Review Life at the End of Life in Old Age. In *New Dimensions in Spirituality, Religion, and Aging*. Edited by Vern L. Bengtson and Merril Silverstein. New York: Taylor & Francis Group, chp. 11.

Kessler, Christian, Manfred Wischnewsky, Alexander Michaelsen, Clemens Eisenmann, and Jörg Melzer. 2013. Ayurveda: Between Religion, Spirituality, and Medicine. *Evidence-Based Complementary and Alternative Medicine* 2013: 952432. [CrossRef]

Kopel, Jonathan, and Gary R. Habermas. 2019. Neural Buddhism and Christian Mindfulness in Medicine. *Proceedings of the Baylor University Medical Center* 32: 308–10. [CrossRef] [PubMed]

Longaker, Christine. 2011. *Facing Death and Finding Hope—A Guide to the Emotional and Spiritual Care of the Dying*. New York: Random House.

Mangione, Salvatore, Chayan Chakraborti, Giuseppe Staltari, Rebecca Harrison, Allan R. Tunkel, Kevin T. Liou, Elizabeth Cerceo, Megan Voeller, Wendy L. Bedwell, Keaton Fletcher, and et al. 2018. Medical Students' Exposure to Humanities Correlates with Positive Personal Qualities and Reduced Burnout: A Multi-Institutional US Survey. *Journal of General Internal Medicine* 33: 628–34. [CrossRef] [PubMed]

Murata, Hisayuki. 2003. Spiritual Pain and Its Care in Patients with Terminal Cancer: Construction of a Conceptual Framework by Philosophical Approach. *Palliative and Supportive Care* 1: 15–21. [CrossRef] [PubMed]

Ozawa-De Silva, Chikako, and Brendan Richard Ozawa-De Silva. 2011. Mind/Body Theory and Practice in Tibetan Medicine and Buddhism. *Body and Society* 17: 95–119. [CrossRef]

Plante, Thomas G. 2016. Principle of Incorporating Spirituality into Professional Clinical Practice. *Practice Innovations* 1: 276–81. [CrossRef]

Puchalski, Christina. 2001. The Role of Spirituality in Health Care. *Proceedings of the Baylor University Medical Center* 14: 352–57. [CrossRef] [PubMed]

Puchalski, Christina M., Robert Vitillo, Sharon K. Hull, and Nancy Reller. 2014. Improving the Spiritual Dimension of Whole Person Care: Reading National and International Consensus. *Journal of Palliative Medicine* 17: 642–56. [CrossRef] [PubMed]

Royal Commission into Aged Care Quality and Safety. 2021. *Final Report: Care, Dignity and Respect*. Canberra: Commonwealth of Australia, vol. 1.

Sloan, Richard P., Emilia Bagiella, and Tia Powell. 1999. Religion, Spirituality, and Medicine. *Lancet* 353: 664–67. [CrossRef]
Steinhauser, Karen E., and Tracy A. Balboni. 2017. State of the Science of Spirituality and Palliative Care Research: Research Landscape and Future Directions. *Journal of Pain and Symptom Management* 54: 426–27. [CrossRef] [PubMed]
Vachon, Mélanie, Lise Fillion, and Marie Achille. 2009. A Conceptual Analysis of Spirituality at the End of Life. *Journal of Palliative Medicine* 12: 53–59. [CrossRef] [PubMed]
Ventres, William, and Shafik Dharamsi. 2013. Beyond Religion and Spirituality: Faith in the Study and Practice of Medicine. *Perspectives in Biology and Medicine* 56: 352–61. [CrossRef] [PubMed]
Wagner, Maria, Christine Longaker, Martin Fegg, and Gian Domenico Borasio. 2005. Effects of SC Training for Palliative Care Professionals. *Palliative Medicine* 19: 99–104.
Yeary, Karen HK., Kassandra I. Alcaraz, Kimlin Tam Ashing, Chungyi Chiu, Shannon M. Christy, Katarina Friberg Felsted, Qian Lu, Crystal Y. Lumpkins, Kevin S. Mastersand, Robert L. Newton, and et al. 2020. Considering Religion and Spirituality in Precision Medicine. *Translational Behavioral Medicine* 10: 195–203. [CrossRef] [PubMed]