

特別寄稿

Caritas Processes
&
Mindfulness Based Stress Reduction
in an RN to BSN Program

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Dearest colleagues,

I am firstly honored by your kind invitation to attend this 31st Japanese Society for the Study of Nursing and Social Work conference. I am doubly honored, and humbled, to be speaking about Mindfulness in Japan, where meditation has such a long and rich history.

The stories I will tell today are about a sense of something missing in nursing, and a long search to find it. Dr. Patricia Benner, my mentor and friend, taught nurses that our stories paint pictures of shared worlds, shared meanings, and shared concerns (Benner & Wrubel, 1989; Gallager & Payne, 2015). They help situate and provide context for our work. All cultures are rich with such stories—heroes' journeys, transformational quests that often end where they began, in the comfort and new found stillness of everyday life. This week, I hope to learn if you have any similar sense of something missing from nursing in Japan. Perhaps these stories are products of English-speaking cultures rather than universal experiences. Or perhaps we will learn where our stories converge and diverge, and that would be a tremendous blessing in this precious and precarious time.

What is this time, our time together right now? We are living in the interval after the north pole and south pole started to melt, and yet before the seas rise so high, and the fires and floods become so severe, that conferences like this one become rare. In this interval, before the forced mass migrations that climate change will inevitably bring, nationalism and hostility to immigrants—the 'other'—is growing. And yet, we have been blessed by seventy years of relative peace, stability and prosperity. As the beneficiaries of this peace, we have a duty to better the human condition.

Kaiser's Challenge

In this precious, precarious time, Kaiser Northern California decided to establish a Nurse Scholars Academy that would sponsor three degree programs and cover a substantial portion of the tuition. Together with the nurses' contractual educational benefits, tuition would be almost free. Kaiser aspired to support 500 working registered nurses to earn baccalaureate degrees in five years, and was willing to make a multi-million dollar investment in a new program to enact their transformative vision. After

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Kaiser accepted our proposal, I asked Dr. D'Alfonso, the Academy's Founding Executive Director, what outcome they hoped to achieve with their substantial investment. His answer was simple and direct: "Change our culture" (and by this he meant, organizational culture). My team was a bit stunned by the scope of Kaiser's charge, and also honored to be their partners to accomplish it. In this context we began our work, and I have been strengthened by a quote sometimes attributed to Martin Luther: "If I knew with certainty that the world would end tomorrow, today I would still plant my little apple tree."

We met with Kaiser leaders over the next six months on everything from curricular frameworks, program length, roll out options, and communication strategies. When we announced that our program would start with a two credit Mindfulness Based Stress Reduction Course, Kaiser leaders were pleased—and had a serious question. "How are you going to sustain the experience from the mindfulness course throughout the program?" After a short silence, they answered for me. "You should begin each class session with a meditation." Tears came to my eyes. I had to explain that I had been waiting a very long time for this day, and to hear this request from leaders of major health system, was more than I had ever hoped for. To help you understand why I was so moved, I will share a story.

Liminality and Communitas

More than forty years ago, I was an orderly at Santa Barbara Cottage Hospital and an RN student at Santa Barbara City College. One evening during report on a medical-surgical unit, I was struck by the intensity of pain and suffering of the 32 human beings in our care. It was not the amount or pace of the work ahead. We had faced tough shifts before. The difference in this report was the enormity of fear, grief, anxiety, and numbness in these 32 sentient human beings. Three had new terminal diagnoses, one a teenage girl with leukemia. A young grandmother, was admitted with metastatic ovarian cancer and facing a Whipple procedure. Her husband had been in an accident a week earlier, and died in our own ICU the night before.

Their daughter was near death half way across the nation. A businessman was highly agitated due to multiple painful procedures, and a number of others had unrelieved pain. Two patients were near death. Mr. Ryan was dying of metastatic prostate cancer and suffering with frightening religious delusions. We knew him well from several previous admissions. He had no family or friends who visited. Two married women with young children were in for breast biopsies. Both were frightened in opposite ways—one loud and angry, the other not talking at all. And we had more than the usual number surgical complications, IVs, blood transfusions, procedures.

After report was finished, I deeply wished we could all hold hands for a few seconds to acknowledge the sacred work we would be doing for the next eight hours. The charge nurse recognized the difference in this report and said, "don't forget to ask for help if you need it." That was it. We went off, alone, to do the best we could. We would all try not to ask for help, knowing that each one of us would be stretched to the maximum. I yearned for a shared ritual that would help us acknowledge what we had heard and to connect with each other before beginning the sacred work before us. But no such ritual or social practice was available to us. There would be help in the doing, if we needed it. For being, we were on our own.

Turner (1969) says rituals mark passages in our social life and also in healing. He posits three stages for passages: separation, liminality (from the Latin, meaning threshold) and aggregation. Watson (2005, 2008) suggests that modern nursing, long separated from our monastic history, is experiencing a heightened liminality. Liminality can be confusing and disorienting, the time after old roles and customs are gone, and before new ones are firmly established. Turner (1969) and Watson (2018) see liminality as containing the germ of future societal transformation. In this liminal space, nurses are creating Communitas. Turner uses the Latin word to distinguish it from community, where relationships are more secular, hierarchical, static as opposed to Communitas where they are more sacred, egalitarian, transitory. The Communitas of nursing shares

expectations for excellent assessment, skillful intervention, advocacy, punctuality, and caring enough to take risks. In the United States, our different religious and ethnic traditions mostly merge into the homogeneous quality of *Communitas*, where the noble expectation to care for the other is often met. Nurses are trusted in the US. A 2017 Gallup poll found nurses ranked as the most honest and ethical profession in the nation for the sixteenth consecutive year (Brenan, 2017). We connect with our patients, engage with them, provide professional, humanistic care. Most of us do not burn out. Yet something is missing.

I once asked Patricia Benner how she would describe the culture of nursing that we shared in our everyday work. Her answer? “Techno-managerial” (Benner, 2016). Techno-managerial cultures are consistent with nursing’s Era I meta-paradigm that splits mind and body and perceives the world through a Cartesian lens of determinism, mechanism, and reductionism (Newman, Smith, Pharris & Jones, 2008; Watson, 1999). Techno-managerial cultures cannot support a culture of care and belonging that consciously and intentionally supports the work of caregivers and patients. Yes, many Anthroposophic hospitals in Europe, and Planetree hospitals worldwide are re-integrating a humanistic element in cultures no longer bound together by traditional ethno-religious beliefs or practices. We have pockets of excellence within a normative techno-managerial culture.

Our faculty decided that strengthening *Communitas* in this liminal time was essential. We adopted a cohort model so scholars could form community, and promised to keep it for at least two to three years while we learned what worked and what did not. We developed a no-barriers philosophy to guide administrative decisions. We agreed on our program’s purpose: to help nurses discover a vision, find their voice, tell their stories, and own their practice—a purpose repeated frequently by faculty and scholars alike. To accomplish this purpose, faculty designing the program drew on our own key professional experiences.

Self-Efficacy and Professional Agency

About thirty years ago, I was working as a house supervisor in a local hospital. One evening I walked onto the medical-psychiatric unit and heard woman screaming in pain, and thought she might be the dying cancer patient I had heard about from the day supervisor. Three registered nurses were sitting at the nurses’ station. After asking about the patient, the nurses reported she had been screaming for the last two hours, but the resident would not increase her pain medication. I visited the patient briefly to assess her pain and mental status and returned to the nurses’ station, asking the three RNs to sit with me as I called the resident. He repeated his unwillingness to change the attending physician’s medication order. I explained that letting a dying patient suffer in pain was not consistent with the philosophy of the Catholic order that owned the hospital, and suggested that he give us an order that would expire in 24 hours, an order that the attending physician could review in the morning. When he refused, I explained that my only other option was to call the attending physician myself, and if that failed, the medical chief of staff. The resident increased the medications for 24 hours, and the patient’s pain was controlled. I reminded the RNs to call the nursing supervisor if they had difficulty getting a resident or attending physician to do what was needed.

What was lacking in these three RNs was a sense professional agency (Eteläpelto, Vähäsantanen, Hökkä, & Paloniemi, 2013). A lack of professional agency can reflect an attitude or belief that there is nothing I, or we, can do. The concepts of professional agency, self-efficacy, and caring efficacy are grounded in Bandura’s work (1990, 2006) and should normally develop with education, opportunity, and experience.

Our faculty knew that enhancing the professional agency, self-efficacy, and caring efficacy was essential to achieving the outcomes Kaiser was expecting from 500 more BSNs. Magnet® hospitals have achieved the most prestigious and coveted award conferred by the American Nurses Credentialing Center (ANCC) for excellent nursing practice and high quality patient care. Magnet hospitals require

higher percentages of baccalaureate prepared RNs and have the best patient outcomes in our nation (McHugh, Aiken, Eckenhoff, & Burns, 2016). Only 9.2% of hospitals in the United States have Magnet designation (ANCC, 2017). While Kaiser has no Magnet designated hospitals in Northern California, a recent study found patient outcomes at Kaiser hospitals throughout California and nationwide approach those of Magnet hospitals, and are significantly better than non-Magnet hospitals (McHugh, et al., 2016). Linda Aiken's work suggests that if hospitals increased their baccalaureate prepared registered nurses by ten percent, 30-day mortality rates would be reduced by five percent and the incidence of failure to rescue would be reduced by five percent (Aiken, Clarke, Cheung, Sloane, & Silber, 2003; Yakusheva, Lindrooth & Weiss, 2014).

Our RN to BSN team understood that Kaiser was investing in our program to stay excellent, and to keep patient outcomes ahead of their competition. We asked ourselves why 30-day mortality and failure to rescue rates were lower in hospitals with more baccalaureate prepared nurses, and agreed the difference was likely due to a combination of knowledge, skill and attitudes—the KSAs articulated by Quality and Safety Education for Nurses (QSEN, 2009). We also decided to prioritize teaching and learning in the affective domain, and one of our faculty, Dr. Mark Beck, suggested we turn “KSAs” into “ASKs” to reflect our decision.

In the area of skills, our program is focusing on formal and respectful communication. A Johns Hopkins study reports that medical errors are now the third leading cause of death in the United States—700 people per day (Makary & Daniel, 2016). The Joint Commission reported 2,378 sentinel events in the United States in 2014 and communication was the root cause for almost 21% of them. When human factors, leadership and communication are combined, they account for 65% of the root causes attributed to sentinel events (Joint CommissionOnline, 2015). Attitudes, the ability to work with others, and communication are clearly key.

Some hostility in labor-management environments is expected, and these attitudes occasionally surface in

communication between students and faculty. When a scholar emails or voices dissatisfaction with unclear directions or too much work, the delivery can lack heart-centeredness, professionalism, and respect. Faculty now require scholars to put complaints and requests into a situation-background-assessment-request (SBAR) format that nurses have used for decades to organize information for physicians, especially in the middle of the night. SBAR has been incorporated into TeamSTEPPS®, developed by the US Department of Defense in collaboration the Agency for Health Research and Quality (AHRQ) “to optimize team performance across the health care delivery system” (AHRQ, 2014, 2017). TeamSTEPPS is the standard for inter-professional education and the SBAR format and has been adapted for managerial teams by the Chief Nurse at the American Red Cross and the Dean of Nursing at Samuel Merritt University.

Often, communication from our scholars would not even include a recommendation or request. Venting feelings seemed sufficient, putting the onus on the faculty to figure out what might ameliorate the situation. Permitting these interactions supported an infantilizing dependency that interfered with a maturing professional agency. That has nearly stopped. Scholars complete simulation exercises with standardized patient actors before and after TeamSTEPPS training, and the vast majority demonstrate keen insight and focused plans to continue developing their teamwork and communication skills.

Mindfulness Based Stress Reduction (MBSR)

Our faculty agree that the best nursing care embodies loving kindness, and the healthiest work environments sustain a palpable sense of human inter-connectedness (Sitzman & Watson, 2014). Watson has challenged us to develop Caritas-Veritas literacy, a literacy of the heart and a literacy of truth that can potentiate maturing attitudes about ourselves and each other (2018). Many of us think that we are all interconnected in a holographic type universe. What if that cognitive knowledge got translated into heart-felt experiential knowledge? How might that change how we

care for ourselves and each other?

Jon Kabat-Zinn, a professor of medicine at the University of Massachusetts started teaching Mindfulness Based Stress Reduction (MBSR) classes for patients, health professionals, and medical students at Massachusetts General Hospital. Some people call MBSR Buddhism for Americans. We chose MBSR because it brought diverse groups of health professionals together—people from a variety of religious, secular, and cultural traditions—to practice mindful presence, loving kindness, and new ways of being. Kabat-Zinn defines mindfulness as “...paying attention in a particular way: on purpose, in the present moment, and non-judgmentally” (1994, p. 4).

The MBSR curriculum is wholly secular, yet grounded in the non-dual universal dharma. The primary point of teaching MBSR is non-attachment, and during the course scholars learn to appreciate silence, stillness, and spaciousness (McCown, Reibel, & Micozzi, 2011). After Jon Kabat-Zinn described MBSR to the Venerable Ben Huan, the 98-year old Chinese Chan master replied, “There are an infinite number of ways in which people suffer; therefore, there must be an infinite number of ways in which the Dharma is made available to them” (McCown, Reibel, & Micozzi, 2011, p. xix).

MBSR was developed and is taught in the tradition of the Buddha and Hui Neng, with some differences. The group experience is fundamental. Classes include standing, sitting, walking, and supine meditations, body scans, light yoga and a number of breathing practices. Traditionally, MBSR is a 28-hour course with weekly 2.5 hour classes for 8 weeks. A day-long silent retreat is held after the sixth or seventh week. We keep very close to the traditional format. Scholars complete the Perceived Stress Scale (PSS) and the Caring Efficacy Scale (CES) (Coates, 1998) at the beginning of the course. The PSS is taken again at the end of the MBSR course and the CES again at the end of the program. Outside of class, scholars practice meditations, complete reflective journals, and read Kabat-Zinn’s (2013) *Full Catastrophe Living*.

While we wrote learning objectives for our MBSR course,

MBSR is taught with an interrelated set of five “teaching intentions, held lightly by the teacher, rather than pressed upon the participants” (McCown, Reibel, & Micozzi, 2011, p. 142). This spectrum of teaching intentions includes experiencing new possibilities, discovering embodiment, cultivating observation, moving towards acceptance, and growing compassion. The first, second and fifth intentions are introduced in the first week. Cultivating observation is introduced in the second week. Moving towards acceptance is introduced in the third week.

Integration of MBSR and Unitary Caring Science

We may be the first nursing program to require a traditional Mindfulness Based Stress Reduction (MBSR) course, but the Caritas Processes and Unitary Caring Science are used widely in nursing curricula (Bevis & Watson, 2000; Hills & Watson, 2011). These serve as our framework for teaching-learning, communication, teamwork, and affective domain competencies (Sitzman & Watson, 2014). To ensure that the culture of self-care and equanimity developed in the MBSR course is sustained throughout the program, each two-hour class begins with a short centering exercise led by a student or faculty member—as requested by Kaiser in the beginning. To ensure that all of us embody the principles we are teaching with authenticity and integrity, each of our faculty meetings begins with a meditation or centering exercise. Five faculty have completed Watson’s six-month Caritas Coach Educational Program and our new director, Dr. Paulina Van, will begin the program next year. Dr. Mark Beck just completed a post-doctoral program in Unitary Caring Science.

Authentic Therapeutic Presence

MBSR provides our scholars with a foundation for authentic, therapeutic presence, but does not provide clear “how-to” instruction. We have not yet formally integrated authentic therapeutic presence into our RN to BSN program at Samuel Merritt University and will be working on curricular revisions over the next year. I hope the following story of how presence became real to me is illuminating for

you.

Twenty years ago I moved to New York City to lead a new Division of Health Professions at Mercy College—a challenging position where I was responsible for academic programs in acupuncture, nursing, occupational therapy, physical therapy, physician assistant, and speech pathology. One day the acupuncture faculty approached me, complaining that after three years of intense didactic work, the only students who seemed prepared for clinical were those with previous experience as massage therapists. Despite three point-location courses with labs, the vast majority did not know how to be with patients, how to approach them, or even how to touch them.

That evening I reflected on my own visits to massage therapists. Each and every one of them had a similar yet powerful therapeutic presence. Their hands almost never lost contact with my body, even when moving around the table. I wondered how so many different schools could produce such a similar grounded, therapeutic, professional presence in their graduates. Nurses do this too, when it is very important, but in my experience, nurses are not as consistently grounded or as present as massage therapists. I started ruminating on whether we could teach nurses what massage therapists seemed to have learned about presence and continuous connection through touch.

One of our acupuncture faculty had previous experience as a Shiatsu therapist and we asked her to teach the first points class. I attended the first several classes and was deeply moved. This was very different from my experience with introductory nursing skills labs. She taught them how to be grounded, literally to be conscious of the ways their feet felt the ground; to be aware of their compassion and intention to heal—or their lack of those qualities. She helped them reposition their bodies in ways that supported their work. Intention, connection, and self-awareness were fundamental and foremost. Students loved the new class that was previously directed at the left hemisphere of the brain—all cognition and memorization.

What would it take to teach nurses how to develop a therapeutic presence that was personal, authentic, fully

awake, and loving. Our faculty knows what it looks and feels like, and when it is absent. We do not all know how to teach this skill, but we have met others who do. Dr. JoEllen Koerner, a past-president of the American Organization of Nurse Executives, is one of them. She and I served on the advisory council for health professions at Western Governor's University (WGU) and were asked to develop a course that would cultivate an authentic healing presence for WGU's online RN to BSN students. To prepare, we took a summer course at the Rudolf Steiner College in Sacramento, California. Steiner's Anthroposophic movement developed new approaches to medicine, agriculture, architecture, and childhood education that were grounded in Goethe's philosophy and the central truths of all the world religions, as well as artistic and poetic vision (Edmunds, 2005). Waldorf schools are an outgrowth of this philosophy. Dr. Koerner and I were brought up in the Mennonite faith tradition and had read many of the same holistic thinkers and spiritual teachers, Fritjof Capra, Ram Dass, Barbara and Larry Dossey, Krishnamurti, Eckhart Tolle, Ken Wilber. These writers fed our souls and deepened our appreciation for holistic principles and mental health, yet we did not think they would be right for more than a small group of nurses interested in holism or mental health—graduate students perhaps. We needed a way to teach practicing nurses the basic therapeutic presence that she and I both experienced with our massage therapists. Anthroposophy provided a foundation for us to develop a new course in therapeutic presence for students at WGU and I hope we will be able to integrate this skill in our program.

Curriculum Structure and Next Steps

Our curricular threads include leadership (focus on quality and safety); community/ public health; nursing science/ research, and general education (MBSR, statistics, genetics, humanities, health policy). The program is delivered over five semesters with six semester credits in each term. This is a 40% student load and workable for a majority of scholars who work full time. Each term emphasizes two Caritas Processes (Watson, 2018, p. 54-55).

In December 2017 our first cohort of 37 scholars completed the program and we celebrated their achievement with SMU's president, Dr. Sharon Diaz, and leaders from Kaiser Northern California, our Academic-Practice Partner. By August 2018 we had over 150 graduates and nearly 200 enrolled scholars. Program leaders continue to meet regularly with Kaiser Northern California leaders to articulate expectations, solve problems, and plan for success.

In January 2018, our university Institutional Review Board (IRB) approved a pilot study for our first cohort to determine the number of graduates needed to detect a 10% mean decrease in the Perceived Stress Scale (PSS) and a 10% mean increase in the Caring Efficacy Scale (CES). At the end of the first semester, Perceived Stress Scale scores for our first cohort decreased, with a medium effect size of 0.42 (Cohen). At the end of the program, Caring Efficacy Scale Scores for this cohort increased, with a small to medium effect size of 0.38 (Cohen). Work on a formal program evaluation study begins mid-August and we hope to have a full study approved in Spring 2019. We will employ two-tailed tests with the critical alpha set at 0.5 for the PSS and CES. To achieve 95% power, we will combine three to five cohorts to detect group differences. Additional data sources will include scholar evaluations of teaching effectiveness, changes in how scholars communicate disappointment and suggestions, and a reflective Caritas essay in the final leadership course. Administrators at Kaiser provide us with additional ongoing feedback about our scholars from their nurse managers and chief nurse executives.

Discussion

When we started this program, we were not certain we could teach concepts of loving kindness, compassion, equanimity, and presence. Kaiser leaders, program faculty, and the RN to BSN scholars at Samuel Merritt University are now confident that the program is indeed transformational. Our scholars' essays are authentic reflections on heroic journeys where suffering is met with

compassion, doubt is met with mentorship, visions are nurtured, and growth is realized. In their practice settings, our scholars and graduates are leading meditations before staff meetings. Some have initiated conversations to change the 'us-them' paradigm that characterized some unit-based communication between represented nurse clinicians and nurse managers. Several have applied to graduate programs. At the core of our work are two questions that have been with us for many years. The first is, how do we understand the nature of our own species, of these human beings we care for? The second is, what constitutes physical, mental, emotional, and social-environmental health? Our response to the liminality of our time is to fully embrace our interconnectedness and build a culture that nurtures the maturation of love in our caring practices. We can respond to the political and environmental challenges of this time by waking up, becoming present, being responsive. We can meet the moral, ethical, spiritual, and mental health crises of our time by deepening our literacy and understanding of the language of the heart. Watson calls this Caritas literacy, and like all languages, it is learned and refined in community and through shared practices. Watson identifies four Caritas Tasks"—surrender, forgiveness, compassion, and gratitude—to open our hearts and re-connect us to Source (2005, 2008). I created this picture (Figure 1) in the Caritas Coach Education Program to help me envision these qualities and the 23rd Psalm within my body during meditation.

The great spiritual teacher, Jiddu Krishnamurti (1975, 1997) taught that my mind is no different from your mind. We share the fundamental pains of fear, anxiety, hate, desire, sorrow, as well as love, joy and compassion. This is the condition of my mind which is not much different from the condition of your mind. The condition we share is not my mind or your mind, but the human mind. What I do to change my mind, changes the mind of humanity. What you do to change your mind, changes the mind of humanity. So we meditate. We practice. In this spirit, my colleagues and I seek to awaken in our scholars an awareness of their mind—our mind—the human mind.

Allow me to repeat the old saying: “If I knew with certainty that the world would end tomorrow, I would still plant my little apple tree today.” And again in German, that sounds so much stronger to my ears. “Wenn ich wüsste, dass morgen die Welt unterginge, würde ich heute noch mein Apfelbäumchen pflanzen.”

Dearest ones, we are each other’s little apple trees.

Domo Arigato

Namaste

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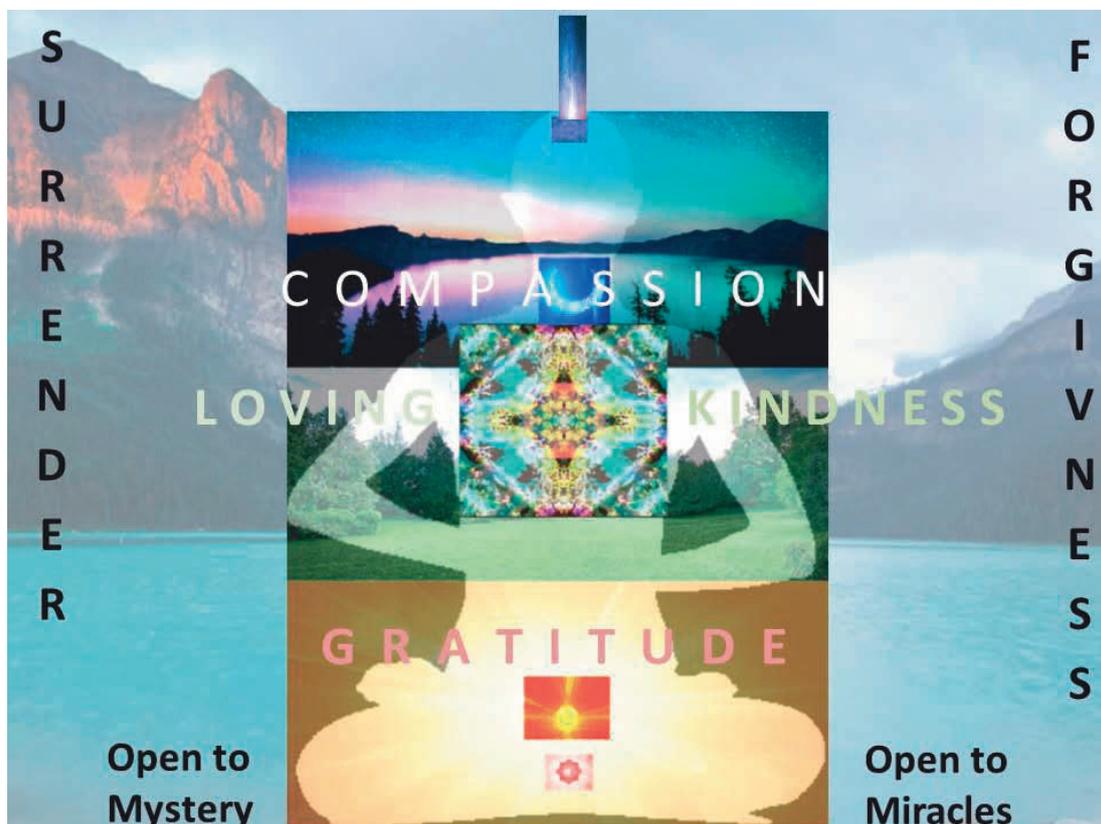


Figure1