HEALING ENCOUNTERS AT THE BUDDHIST CONTEMPLATIVE CARE SYMPOSIUM

The Garrison Institute and the New York Zen Center for Contemplative Care (NYZCCC) recently co-presented the Buddhist Contemplative Care (BCC) Symposium, the first-ever national, public symposium on “contemplative care,” which is the emerging field of contemplative-based approaches to end-of-life and palliative care. NYZCCC is the first and only organization to offer fully accredited Buddhist chaplaincy training, and delivers contemplative care through major providers. The Garrison Institute’s Transforming Trauma Initiative explores contemplative-based resilience trainings for various human service professionals and caregivers, and our retreat program frequently hosts NYZCCC, Rigpa Spiritual Care Program and Centering Prayer retreats focused on caregivers and patients. After two years of planning, and with support from the Shelley and Donald Rubin Foundation, the Frederick P. Lenz Foundation, Tricycle Magazine and Shambhala Sun, our two organizations held the symposium November 8-11, 2012 at the

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Craig Blinderman, MD, Diane Meier, MD, Robert Chodo Campbell and Koshin Paley Ellison at the BCC symposium

Institute. It attracted 160 leaders and practitioners from across the US – doctors, patients, nurses, chaplains, social workers and students. Here’s a synopsis of some of what they discussed there:

When Zen Buddhist priests and chaplains Robert Chodo Campbell and Koshin Paley Ellison founded the New York Zen Center for Contemplative Care in 2006, their goal was to build a Zen hospice in Manhattan with perhaps a dozen beds. As they met doctors, nurses, social workers, janitors, food service workers and others involved in caring for the dying, they realized

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their mission wasn’t just to patients, but to the whole spectrum of people involved in and integral to palliative and end-of-life care. They began focusing on broader ways to transform how we take care of our elders at the end of life, including Buddhist-based chaplaincy training, meditation programs for clinical staff as well as patients and families, and curriculum for students. “We see this care as a spiritual practice,” said Koshin, “and we held the symposium here at the Institute rather than in a hotel for that reason.”

Instead of a dozen patients and their families, today NYZCCC programs bring contemplative care to many thousands (53,000 in the last four years) and are growing fast, reflecting a widespread need and the accelerating evolution of hospice, end-of-life and palliative care.

REACHING PALLIATIVE CARE’S TIPPING POINT

Dr. Diane Meier, MD, Director of the Center to Advance Palliative Care (CAPC), MacArthur Fellow and professor at the Mt. Sinai School of Medicine, traced that evolution for the symposium audience, from 11th century church hospices caring for the sick and poor to the modern hospice movement. Until 1950, those who weren’t indigent died at home, including many children. “Around it was lots of ritual which I have never seen,” she said. “All that has been lost in the blink of an evolutionary eye.”

What has shifted is human life expectancy skyrocketing over the last century (though with some declines for less educated men in the past few years). Today more than half of those who live to 65 will make it to 85, and more than half of those will live to 92. But not everyone holds the greatest possible length of life to be a rational social goal or unalloyed social good. The first US hospices were pioneered in the 1960s and 1970s to promote quality of life for end-stage cancer patients. But they were not made available to those suffering from other things, despite the fact that only 22% of us die of cancer.

In 1982 a new federal Medicare hospice benefit gave impetus to the field, but it stipulated only those with six months or less to live could access it, excluding those with chronic illnesses, and required patients to give up their insurance and right to curative treatment. In 2007, The New York Times wrote, “Over the last eight years, the refusal of patients to die according to actuarial schedules has led the federal government to demand that hospices exceeding reimbursement limits repay hundreds of millions of dollars to Medicare.”

As Boomers age, the line between terminal and chronic illness continues to blur. Today, people can live 30 years with conditions that would have quickly killed them a generation ago. As a result, says Meier, “We have reached a tipping point for palliative care” which has expanded views about its role. It need no longer mean dying, or giving up treatment. People of any age with debilitating illness should receive palliative care and curative treatment as long as the treatment works, and when it no longer does, go into hospice referral.

Studies show palliative and end-of-life care can improve outcomes for patients and families, increase their quality of life and reduce suffering, and even prolong life. It’s also shown to reduce emergency room visits and help hold rising medical costs down as well as improve the quality of care. It is therefore a growth industry—a new nursing and medical subspecialty, with some 1700 palliative care teams in the US and counting, and a broad range of palliative care training programs.

LISTEN, LISTEN, LISTEN

Palliative care has a procedure, says Meier: “listen, listen, listen.” It deepens the traditional caregiver-patient relationship into one that values authentic witnessing and presence over the doctor’s charismatic mystique and omnipotent pose. “Sit with them,” wrote Elisabeth Kübler-Ross in her seminal 1969 book On Death and Dying. “You don’t even have to talk. You don’t have to do anything but really be there with them.”

But that takes training and practice, and often doesn’t come easily to caregivers. Oncologist Anthony Back, MD, Director of Palliative Care at the Seattle Cancer Care Alliance, learned it through contemplative practice. “Professionals acquire expertise and skills very deliberately,” says Back. “What an expert clinician does looks like magic to a first-year resident, but it’s really the result of laboriously acquiring a particular set of observational and strategic skills.” Similarly, contemplative...
practice, bedside communication skills and compassionate presence are a kind of expertise Back had to work hard to cultivate.

“The brain has a finite input capacity. If you’re worried about all your own ideas and anxieties, you are using up bandwidth you need for patients,” he said. “I wanted to build capacity, so I deepened meditation practice.”

He attended retreats, studied with meditation teachers and worked with colleagues to bring contemplative skills to the workplace – not seamlessly and not as a recipe or rigid protocol, but to create the inner space needed to make deeper connections with patients possible. “Joan Halifax would say compassion is an emerging process. You can’t train people to do it, to just be nice all the time. But you can train attention, self-regulation, empathy, and out of that, compassion will arise in a complex, unpredictable way.”

THE WOUNDED HEALER

Such skills are rarely taught in medical schools (though NYZCCC is currently developing a curriculum). Without them, trying to bridge what’s next for patients at the end of life isn’t just frustrating; it can affect patient care, threaten the well-being of clinicians and all those involved in care, and even put them at risk for trauma-related disorders. Research shows absenteeism and effectiveness of interpersonal communication and patient-centered care can track with clinicians’ sense of well-being or lack of it, leading to compassion fatigue and burnout. Attrition rates for end-of-life and palliative clinicians – both nurses and physicians – are surprisingly high: 30% for nurses and 30–50% overall for physicians, including 50% for oncologists. Dr. Michael Kearney, MD, an internist with over 30 years experience in palliative care, likens navigating these occupational hazards to “learning to breathe under water,” a metaphor for caregivers learning to maintain self-care and self-awareness at the bedside. “When we feel we are going under water, the normal response is to hold our breath until we come up for air,” says Kearney. Caregivers tend to endure deprivation as long as their shift lasts, deferring any self-care until they go home. What would it take to make working with patients itself a source of oxygen?

Clinicians’ risk of compassion fatigue would seem to point to empathy as a liability, but a 2009 study identified it as an asset, one of the qualities that allowed trauma therapists to thrive in their work. Those who had it were highly present, sensitively attuned, well-boundaried and yet heart felt towards patients who were suffering. They were invigorated rather than defeated by their work.

The key to unlocking qualities like empathy and attunement for clinicians is self-empathy and self-awareness, says physician, psychologist and Buddhist teacher Dr. Radhule Weininger, MD, PhD. Self-knowledge is basic to achieving contemplative awareness and applying it in the moment with patients. Clinicians have many modalities available for cultivating it, from mindfulness meditation to spiritual inquiry, prayer, mentoring, research and education, reflective writing and psychotherapy.

Dr. Michael Kearney, MD
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Our defects are the ways that glory gets manifested.
Whosoever sees clearly what’s diseased in himself begins to gallop on the way…
Don’t turn your head.
Keep looking at the bandaged place.
That’s where the light enters you.
And don’t believe for a moment that you’re healing yourself.

—Rumi, translated by Coleman Barks

Kearney cites the example of Jungian depth psychologist Adolf Guggenbühl-Craig, whose book Power and the Helping Professions describes the archetype of the wounded healer, which both clinician and patient carry in their unconscious. Like patients, clinicians are also

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“wounded;” their interventions in end-of-life situations will eventually fail, and suffering and dying is in their nature, too. Patients who suffer also carry an inner healer archetype. But in a typical doctor-patient power relationship, the clinician identifies uniquely with healer pole while the patient identifies solely with the wounded pole, and the other poles in each get repressed, staying beneath awareness. Cut off from their inner healer, patients often make impossible demands of the caregiver: “promise me I am not going to die.”

Clinicians who have achieved some self-awareness acknowledge the limits of their power to intervene, a manifestation of their own “woundedness” as healers. Stepping off the pedestal and out of the lonely fantasy of clinicians who can do anything, including defy death, is humanizing and grounding. As a result clinicians may recognize their own need to breathe or take a time out, and the truth of the fact that the experience of dying belongs not to them, but to the patient.

That can be of value to patients, encouraging them to stay with their own experience. “Then,” says Kearney, “something mysterious may happen. There may be a subtle internal shift. The patient may begin to experience a greater internal spaciousness, their own inner healer. Being in the presence of someone who is in touch with their inner healer can itself be a healing experience. What was a vertical relationship between clinician and patient becomes a horizontal, two-way relationship. We are entering here the mystery of compassion.”

THE HEALING ENCOUNTER
Recognizing appropriate limitations to what clinicians can do is not defeatism, says Judy Lief, a Buddhist and Shambhala teacher and author who is part of a Vermont initiative to improve end-of-life care. It’s the gateway to what she calls “the healing encounter.” She’s not referring to medical intervention, but to a healthy quality of presence and human interaction which benefits patients and caregivers alike. “I know people who are not cured who are healed, and vice versa,” she told the symposium. “We’ve discussed the role of caregivers, but really, there are no doctors, no patients, only humans with roles to play.”

The word “heal” is connected to “whole” and “holy,” connoting the sacredness of life as it is, no matter what the condition of mind, body or emotions. “There is no normal to go back to,” says Lief. “It’s not abnormal to be sick, not normal to be healthy. What is normal is what is happening. Accept another person as they are in the situation as is, without trying to fix it.” That includes the situation of dying. “Once you drop the desire to escape the problem, there is a chance for progress, connection. What I have noticed is that if there is a freshness and simplicity of encounter and you take an interest in the other person, if you pay attention to small gestures, how you speak, the space between you, that creates energy and a certain lightness of being that has more power than we think.”

Many symposium participants emphasized the importance of nonverbal communications with patients. Body language, how caregivers enter the room, where they stand or sit, speak volumes about their own fears, aversions, self-awareness and capacity for presence — “so much we’re not even intending to communicate,” says Lief. “How much more so if we’re aware and sophisticated and embodied, tuned in.”

The physical environment also matters. Lief’s teacher spoke of the hospital “as a place of broken glass and sharp edges.” “As the end of life approaches, just when life is most precious, in order to promote living, the healthcare system abuses the senses,” says Dr. Bruce (B. J.) Miller, MD, a hospice and palliative
Regarding illness and the end of life not as separable or exceptional, but as integral – intrinsically valuable and meaningful, worth our full attention and presence as opposed to denial, aversion or deprivation – isn’t a new idea. It cuts across Western philosophy, Buddhist ethics and other wisdom traditions.