NEW YORK ZEN CENTER FOR CONTEMPLATIVE CARE

SCOPE OF SPIRITUAL CARE PRACTICE

THE SCOPE OF PRACTICE OF NEW YORK ZEN CENTER FOR CONTEMPLATIVE CARE'S PROFESSIONAL CHAPLAINS INCLUDES:

- Enhancing the standard of care through the integration of spirituality into health care
- Providing expertise in evidence-based mindfulness, visualization and meditation practices
- Aligning chaplaincy performance with institutional goals and objectives in measurable ways
- Creating or enhancing current Spiritual Care Departments

COLLABORATING AS A MEMBER OF THE HEALTH CARE TEAM TO:

- Improve patient and family satisfaction
- Facilitate patient and family decision-making
- Lead meditation, stress reduction groups for family members, patients and staff
- Address issues of ethics, palliative care, and cultural competence
- Improve discharge planning to reduce readmissions
- Reduce high anxiety levels in emergency rooms, especially when there's long wait time
- Address patient and family concerns and complaints in conjunction with risk management and patient advocacy personnel
- Support bereaved families and staff
- Lead memorial services for patients, staff and familes
- Establish protocols for referrals to chaplaincy services
- Facilitate end of life discussions

COLLABORATING WITH HOSPITAL LEADERSHIP TEAMS TO:

- Address issues of ethics, palliative care, cultural competence
- Contribute to quality assurance and customer satisfaction goals
- Assist with community relations and building partnerships with community clergy
- Reduce staff burnout and compassion fatigue

NEW YORK ZEN CENTER FOR CONTEMPLATIVE CARE PROVIDES:

- Continuing professional education to our chaplains on topics of current concern and importance.
- Supervision by New York Zen Center for Contemplative Care's nationally-recognized senior chaplains.
- Consultation and support around questions of religious and cultural accommodation.
- Design and evaluation support for Quality Improvement projects customized for the institution.

The New York Times

EXPOSURES

A Good Death

Joshua Bright

SEPT. 16, 2011 John Hawkins, right, at his home in New York with Robert Chodo Campbell, a friend for decades and a Zen priest. More Photos »

April 13, 2013

A Good Death

By JOSHUA BRIGHT

FOR more than a year, I visited and photographed a dying man named John R. Hawkins. I had found him through the New York Zen Center for Contemplative Care when I went in search of both a photo project and a profound experience.

He was being ushered from this life by a good friend, Robert Chodo Campbell, whom he had known for 23 years and who is a Zen priest and co-founder of the Zen center.

Their exchanges, even in the face of death and the inevitable fear that precedes it, were honest and loving. John was a kind and intelligent man, although he was not particularly enthusiastic about talking directly about his impending death. But while he was lucid, we often laughed. Sometimes he cried, reflecting on the past. Despite his physical deterioration, the atmosphere around John's bedside seemed to grow warmer and more intimate with each visit.

I had never looked closely for a long period at a dying person. I had never listened to the strained breathing of a body barely functioning and had never put my head beside a man too weak to speak, smelled his pungent breath and silently shared his day in, day out view of the white popcorn ceiling. It was when I put the camera down and became present that I could feel my fears melting away.

With this deeper but calm proximity to death's physical attributes, I contemplated my parents' current and serious health concerns, as well as my own mortality. My consciousness became richer for it. As I would leave John's bedside to return to my wife and son, I was positively euphoric, as when walking away from a therapist's office or standing on a cliff. In the few hours after he died, on Jan. 9, 2013, before the people from the funeral home came, we stood around him and observed the changes to his body. We saw the sinking of cheeks and eyes and the revealing of the neck bones. We saw the way his forehead remained warm after his limbs had grown cold. We talked about death, and I took some photos and we teased the man who was now gone and we laughed, too. Gradually, his mouth was pulled into the cheeky smile that we knew so well.

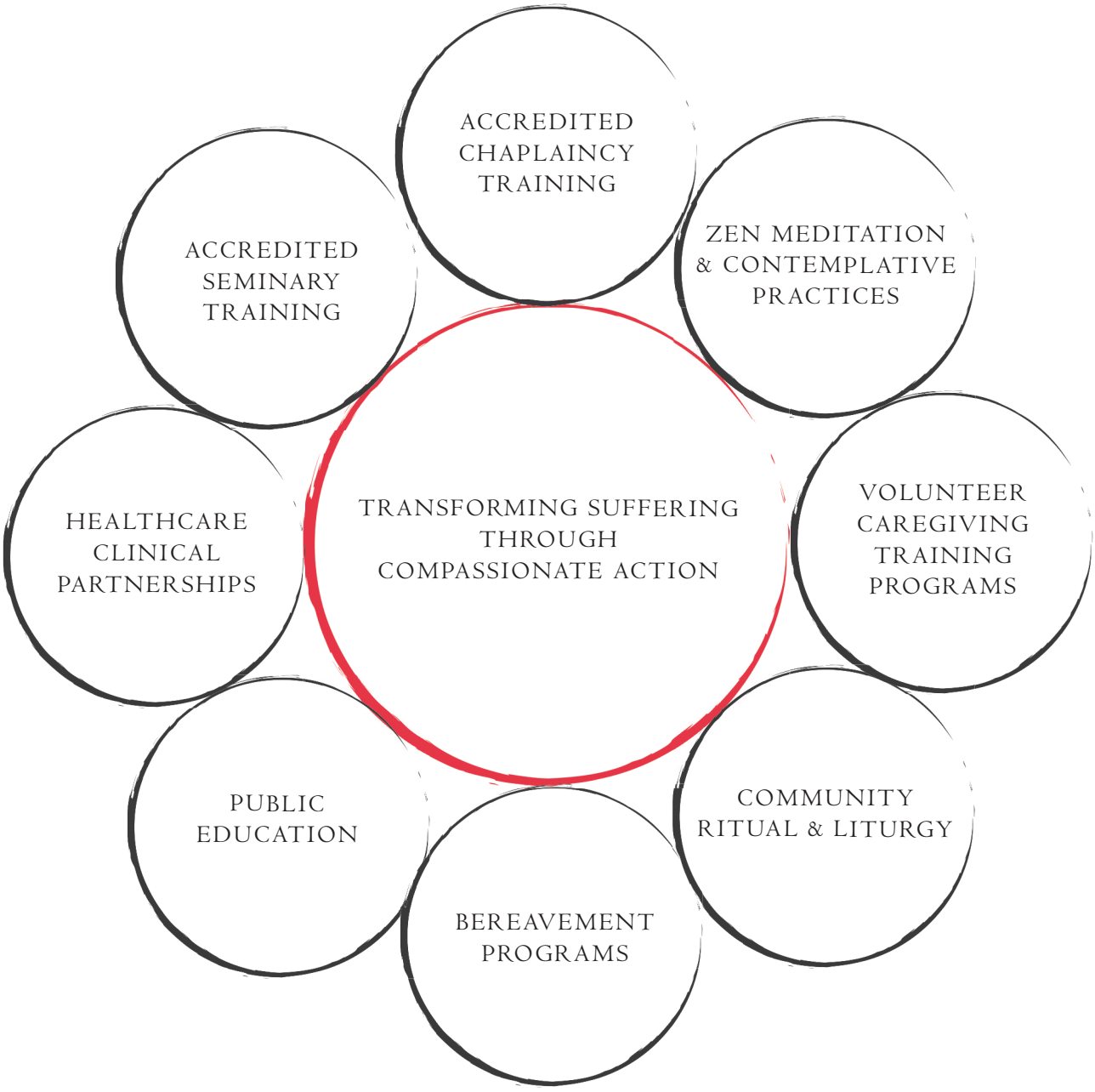
We could use news of a good death. Not a tragic death or a famous death, just a good one, the kind that might happen to any of us if we are lucky.

Joshua Bright is a photographer in New York and a regular contributor to The New York Times.

To view the Photographic Essay in a Slideshow, please go to the following URL:
http://www.nytimes.com/2013/04/14/opinion/sunday/a-good-death.html

NEW YORK ZEN CENTER FOR CONTEMPLATIVE CARE

OUR WORK



The New York Times

ZEN AND THE ART OF HOSPITAL CARE

BY KATHARINE Q. SEELYE

Anne Reigeluth, a chaplain-in-training at Beth Israel Medical Center in New York, was walking the oncology floor last week when a cancer patient began moaning in pain. Ms. Reigeluth stepped into her room, held her hand and tried to calm her.

She asked the woman if she had a favorite place. A lake, she answered. What time of year did she like to be there? Summer. Soon, the woman was quieter, imagining herself at the lake and recalling better times.

"I wanted to take her mind off her pain and agitation," Ms. Reigeluth said outside the room. "I said: 'I'll stay with you until the nurse comes. And I'll come back.' "

This is what hospital officials call Zen care, which is nondenominational and more about stress reduction, breathing exercises and "being present" with patients and their families than about quoting Scripture or administering last rites.

Ms. Reigeluth, 57 and a Buddhist, is in training under two Buddhist monks,

Chaplain Anne Reigeluth visits cancer patient Tony Siniscachi. Ms. Reigeluth, 57, a Buddhist is training under two Buddhist monks.

Robert Chodo Campbell and Koshin Paley Ellison, co-founders of the New York Zen Center for Contemplative Care. They also see patients at Beth Israel, one of the few hospitals where ordained Buddhist monks serve alongside priests and rabbis.

As Congress debates extensive changes to many facets of the health care system, it has pretty much ignored the institution of hospital chaplains. And yet, some hospitals are finding that chaplains of all faiths are playing an increasingly vital role, one made all the more important as workloads increase and budgets constrict.

A BLURRED ROLE

The chaplains' job has traditionally been to provide spiritual care. But the job description has blurred as the role of chaplains has expanded. These days, they join medical rounds and discuss crucial end-of-life issues with patients and families.

Barbara Ende, a Buddhist chaplain, visits Gerald Nitzberg, 83, in the cancer ward at Beth Israel.

"They are a critical part of the team," said Dr. Wayne Ury, an attending physician in the department of pain medicine and palliative care at Beth Israel. "They help the doctors and nurses see issues that we may not have been aware of, or minimized, or turned a blind eye to, or just been too rushed to hear."

Wendy Cadge, a sociologist at Brandeis University who is writing a book about hospital chaplaincy called "Paging God," said data on the value of chaplains was slim.

"But people think chaplains are really helpful around end-of-life issues and increasingly complex ethical decisions," she said, including organ donations, living wills and do-not-resuscitate orders.

"Chaplains do a lot to help reduce anxieties," she added. "One study says patients and families who see a chaplain are more satisfied with their care."

Nationally, the demand for chaplaincy services from hospitals and other providers is growing substantially, according to the Association of Professional Chaplains.

"Administrators, doctors and nurses are seeing the value that chaplains bring to the table," said the Rev. Sue Wintz, president of the association, whose membership has more than doubled, to 3,259, over the last 20 years.

Hospitals generally pay for chaplain services themselves, since taxpayer money cannot be used for religious activities, and insurance companies do not reimburse for them. But the costs are tiny in an overall hospital budget.

At Beth Israel, the hospital pays for a director of the pastoral care department, who is Catholic, and a full-time rabbi, and it shares costs with the Archdiocese of New York for two Catholic priests. The two Buddhist monks, who are not part of the department, are financed through a grant from the Nathan Cummings Foundation, a private philanthropic group rooted in Jewish tradition.

The hospital is also training 21 chaplain interns, 14 of whom, like Ms. Reigeluth, are practicing Buddhists; they are not paid.

While the priests tend primarily to Catholic patients and the rabbi to Jewish patients, hospital officials say the Buddhists and trainees care for patients of all faiths — and those with no religious affiliation. (Some patients decline such services.)

NO 'HARD SELL'

Gerald Nitzberg, 83, a patient at Beth Israel who has lymphoma and degenerative spinal arthritis, described himself the other day as nonreligious and said he appreciated visits from Barbara Ende, 50, one of the Buddhist chaplains-in-training.

"She is encouraging, without the hard sell," Mr. Nitzberg said as Ms. Ende sat by his bed and a puffy silver birthday balloon floated above his feet.

Ms. Ende and Ms. Reigeluth joined medical rounds last week with doctors, social workers and Mr. Campbell, 56, who goes by the name Chodo, given to him when he took his vows to become a Buddhist monk (he prefers the term "priest").

They discussed how to handle various cases: a woman who thinks she is getting better but is not; a man with multiple medical problems whose family does not want him to have a feeding tube, but who has not designated anyone to make decisions for him; a patient who says she is not in pain but whose family is demanding aggressive pain treatment.

The three did not fit the old stereotype

Zen monk Robert Chodo Campbell pays a visit to Sergio Simon, 49, at the Mapplethorpe House. Priest Chodo looks over some of Mr. Simon's family pictures in a small photo album.

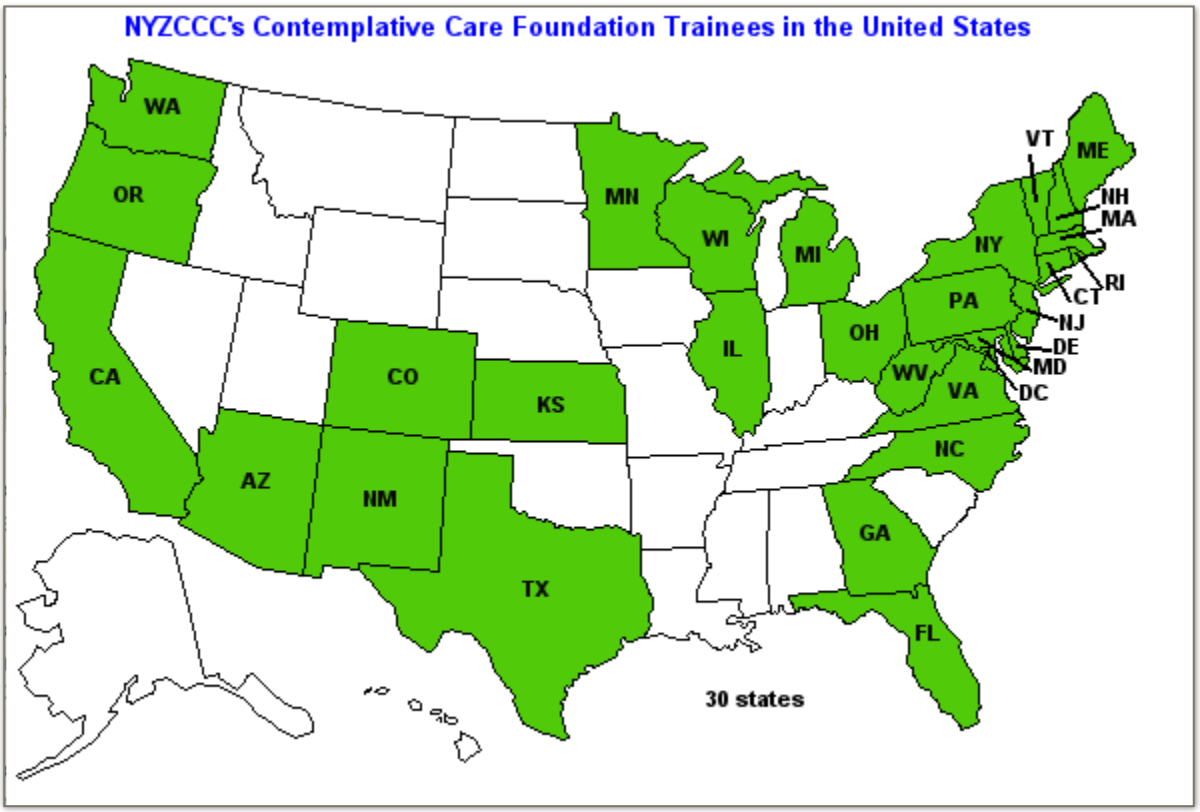
Chaplain Anne Reigeluth walks down the corridor at the hematology/oncology pavilion as she looks to visit another patient after a visit to patient Tony Siniscachi.

of Buddhist monks. There were no flowing robes. The women wore street clothes. Chodo wore a subdued dark top called a samue, which looked a little like a judo outfit. And after years of shaving his head, he is letting his hair grow.

But there were also signs that they were not traditional chaplains. At one point, Chodo described how he found a Bible by the bed of an elderly patient who could not speak, and he ended up reading the Book of Psalms to her for two hours. She became alert at Psalm 25, he said, and he read it to her three or four more times.

"What is Psalm 25?" Ms. Ende asked.

"You're asking me?" Chodo responded, prompting a rare laugh around the room.



Our students (including Integrative Medicine Fellows, doctors, nurses, social workers, and lay caregivers) provide direct care to the sick, dying and suffering. We care for patients, families and staff through our medical partners: Mount Sinai Medical Center, New York Presbyterian Medical Center's Cornell and Columbia Campuses, Beth Israel Medical Center, and the Visiting Nurse Service of New York's Hospice, as well as hospices, hospitals and Integrative Medicine practices across the country.

One patient at a time, NYZCCC manifests its mission of treating those who are suffering with the wisdom, compassion and equanimity of the Buddhist teachings.

Since August 2007:

- **67,332** individuals received contemplative care in the face of illnesses and death
- **28,273** family members, couples and friends received contemplative care as they dealt with grief, mourning, and loss
- **49,671** hours of compassionate care have been given by our volunteer chaplains
- **11,784** staff people in hospitals and hospice, received spiritual care, including doctors, nurses, and social workers
- **6,138** Contemplative care and meditation groups were run by our volunteer chaplains, with over 10,903 people attending
- **18,881** men and women from the general public have received education in topics such as death and dying, Buddhist approaches to, addictions, bereavement, care giving, spirituality, and contemplative practices.

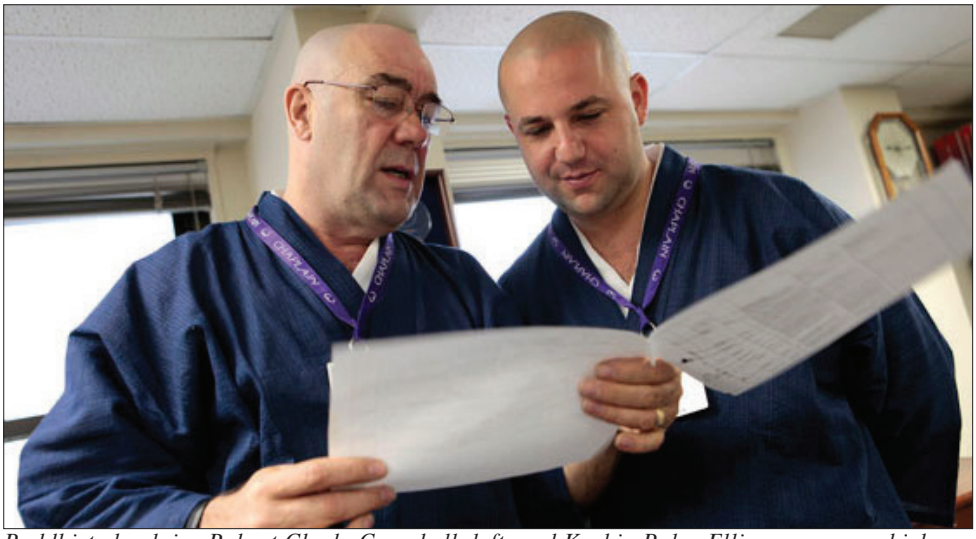
Los Angeles Times

COLUMN ONE

Zen in their bedside manner

By Tina Susman

At a New York hospital, Buddhist chaplains offer prayers, meditation and aid to the sick. 'We focus on listening,' one says.



Buddhist chaplains Robert Chodo Campbell, left, and Koshin Paley Ellison go over which patients to visit in Beth Israel's palliative-care unit. Like Chodo, Koshin goes by the name given him when he took the vows to become a Buddhist priest.

Nicholas Roberts / For The Times

Buddhist chaplain Koshin Paley Ellison, foreground, leads a meditation session at the Continuum Center for Health and Healing in New York. Clockwise from upper left are Bonnie Everhart, Hanniel Levenson, an unidentified man, Elizabeth Dowling, Dr. Martin Ehrlich and Koshin. Even members of the public can attend the session.

NEW YORK -- It was 8 a.m., and the subject was death.

A 55-year-old man was wasting away from lung cancer and cirrhosis. His weight was plummeting and his brain was swelling. But he was in denial, refusing to discuss hospice care or consider a "do not resuscitate" order.

A bright pink vase filled with yellow mums sat near the window, belying the grim task facing the healthcare workers at Beth Israel Medical Center who had clustered around a conference table.

"This has been really sad," said the Rev. Robert Chodo Campbell, a large man with thick brows who was wearing what appeared to be a cross between a judo outfit and hospital scrubs. He told the group that when faced with a similar case in the past, he had decided to disclose his personal battle with alcoholism to the patient -- also an alcoholic -- in hopes of spurring a conversation that might help ease the man's mental anguish and prepare him for whatever lay ahead.

"Is that a good technique?" asked a doctor, sounding slightly incredulous.

A psychologist interjected. "In this case, it could have been a gift," she said. "Psychologists don't disclose anything. Chaplains operate under a different set of rules."

And Chodo operates under a different set of rules than most chaplains as he spreads the spirit of Buddhism through the halls of Beth Israel, a 1,368-bed medical center in Manhattan. "If it seems appropriate in the moment and one is sure of one's motives -- the well-being of the patient -- then why not?" the Zen chaplain asked.

According to the American Hospital Assn., about 68% of public hospitals have a chaplaincy program. But few have Buddhist monks, and none compares with the program at Beth Israel -- where more than 20 Buddhist chaplains and chaplains-in-training offer bedside meditation, interdenominational prayers and other assistance to pregnant women, dying cancer patients and even stressed hospital workers.

"There is one rabbi and two Catholic priests. They're great people, but the rabbi sees Jewish patients. The Catholics anoint the sick. Then there's everybody else," said the Rev. Koshin Paley Ellison, co-founder with Chodo of the New York Zen Center for Contemplative Care.

Last year, Chodo and Koshin began bringing students into the hospital as part of the country's first Buddhist chaplaincy training program accredited by the ACPE.

"We're really trying to create a cultural shift," said Koshin, who like Chodo uses the name given him when he took his vows to become a Buddhist priest.

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Advocates say the availability of alternative treatments is crucial at a time when millions of Americans are struggling to pay for healthcare. Instead of relying on drugs and hospitalization, the Zen center encourages stress- and pain-relief through meditation, breathing exercises or simple conversation. Even if such methods cannot provide a cure, they can make patients more comfortable. And the Zen chaplains are able to spend more time with patients, time that busy doctors and nurses often cannot spare.

"We focus on listening," said Bob Allen, a chaplaincy student who has spent much of his training time on Beth Israel's oncology floor.

Not everyone, however, has welcomed him.

"I just started eating!" Allen recalled one patient yelling when he entered his room on a recent day. "I'm Jewish! Get out!"

In the tranquil manner that is pervasive among the Buddhist chaplains, Allen put a rosy spin on the patient's reaction. For someone facing death, throwing an unwanted visitor out of the room "can be empowering," Allen said. So if it made the sick man feel better about his situation, that's a good thing.

Some doctors too are skeptical about so-called integrative medicine, the melding of alternative care with traditional Western medicine.

Teaching relaxation and pain management is good, said Dr. Bruce Flamm, an obstetrician-gynecologist at Kaiser Permanente in Riverside, who has been an outspoken critic of studies suggesting prayer and spiritualism can heal the sick. But, he said, encouraging patients to pursue "kooky" approaches with no scientifically proven benefits would be a problem.

Flamm said integrative medicine programs reflected the competitive nature of the healthcare industry. Some mainstream medical centers, he said, have introduced alternative approaches in hopes of "trying to recapture some of those patients that are veering off."

"You can get your chemotherapy . . . and also get your acupuncture and therapeutic touch and reiki healing," Flamm said, drawing a picture of one-stop shopping for the ill. "The question is, is that really ethical?"

Beth Israel's Zen chaplains say they are careful in approaching patients and would never dream of countermanding a doctor's advice. But their differing approaches are clear.

During one meeting at Beth Israel, Koshin suggested that a severely diabetic 63-year-old woman who refused insulin might benefit from a visit to the alternative-care facility that is affiliated with the hospital and offers treatments such as herbal medicine and leeching.

A doctor disagreed. "She needs really good medical care to get her diabetes under control," the physician said.

So Koshin gently pushed his own theory that the woman might become "more compliant" if she received some sage advice from practitioners at the holistic center.

The discussion was left at that.

During a recent round of visits on the oncology floor, Allen, the chaplain-in-training, knocked lightly on patients' doors before entering. He moved silently into their rooms and sat beside them, ignoring TVs blaring pop music or squeals from "The Price is Right."

On this day, the patients included a Burmese man with nasal cancer who had requested time with a Buddhist chaplain. The patient appeared weighed down by the white sheets atop his slender frame. "You seem very tired. Do you feel bad today?" Allen asked the man, who requested that his name not be published. The patient nodded. He was too sick to eat, but he wanted to practice breathing exercises to relieve his pain.

He struggled to sit up in bed. Then he closed his eyes as Allen coached him in a soothing voice. "Take a nice, deep, cleansing breath," Allen said. "Blow out all that toxin from your face, your nose, your eyes, so you can bring peace and calm to yourself."

Next, Allen visited Victoria Exconde, who was facing breast cancer surgery. A Roman Catholic from the Philippines, Exconde broke down in tears as she discussed her condition and the difficulty of going through it without her late husband by her side.

The two then recited a Christian prayer together.

"Thank you, father," Exconde said.

"You don't have to call me father," Allen replied good-naturedly as he got up to leave.

Supporters of the Zen chaplains program say the monks' presence brings a calming influence to the often frenetic hospital floors, and that patients, for the most part, are open to them.

"I think a lot of it has to do with the fact that a lot of our patients don't really know what a Buddhist monk does," said Terry Altilio, a social worker in Beth Israel's palliative-care department, which focuses on relieving suffering of seriously ill patients. "For a lot of patients, there's a curiosity and an openness you don't necessarily see with rabbis, priests, etc."

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The Zen chaplains do not limit their services to patients.

Koshin recently accompanied a Catholic priest to tend to a couple whose infant had died at the hospital, explaining that "the priest didn't want to go alone because he'd never been with a dead child."

During morning rounds, when medical teams gather to discuss their cases, the chaplains sit in. In the case of one 30-year-old Chinese man with cancer, Chodo advised that they needed to be careful because in Chinese culture, "you don't normally discuss death in front of the patient."

Once a week, Chodo visits the Robert Mapplethorpe Residential Treatment Facility, part of Beth Israel's AIDS treatment program.

Most of the patients, whose harsh lives show in their tired eyes and bodies, have spent time in prison or on the streets.

But here they were, sitting in a dark room, chanting the lotus sutra while having their heads massaged. As Chodo's soothing voice filled the room, their chatter gave way to dreamy murmurs.

"When I meditate, it takes me to some beautiful places, even though I'm from Brooklyn," said Kevin, one of the center's residents, ticking off his visions of paradise: Paris, Rio, Jamaica.

George, another resident, asked everyone to remember the 228 souls lost when an Air France jet vanished over the Atlantic Ocean. The crash was a reminder of how life can be cut short without warning, Chodo said, urging those around the table to be kinder to themselves each day -- perhaps by having one less cigarette or doughnut, or making one less trip to Starbucks.

Then he cleared the room so he could meet privately with Rafael, an AIDS patient whose clothes hung from his once-buff frame. Rafael wept as he spoke of his fiancee in the Bronx, who no longer visited or returned his calls.

Chodo held his hand and simply listened, saying nothing.

After a few minutes, Rafael thanked Chodo and shuffled back to his room.

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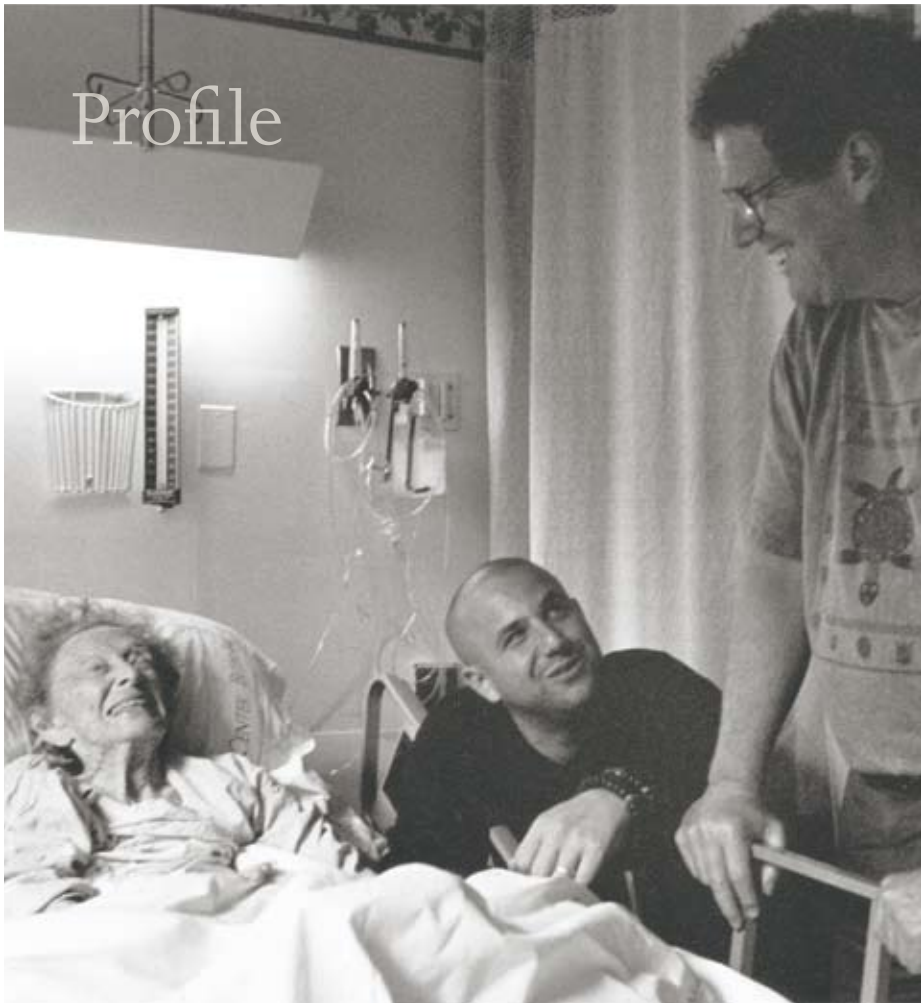


Koshin Paley Ellison (center) with his grandmother, Mimi, and his father, Richard.

TOBIAS KLUTKE

NEW YORK ZEN CENTER for CONTEMPLATIVE CARE

By Andrea Miller

When his grandmother Mimi got sick, Koshin Paley Ellison became her primary caregiver and moved into a hospice with her. "I found myself in the midst of this loving and intimate relationship with my grandmother," he says. "I went to the meetings with doctors and nurses and I felt really at home. But the weakest link in the care team was the chaplain. He'd come into the doorway and say, 'Mrs. Ellison, me and my wife pray for you.' And then he would leave. My grandmother turned to me and said, 'I think *he* needs a chaplain.'"

Ellison, who at that time had been practicing Zen for fourteen years, says his grandmother suggested that he look into doing chaplaincy work himself. That was eight years ago. Today, Ellison is the codirector of the New York Zen Center for Contemplative Care (NYZCCC). Established by him and Robert Chodo Campbell in 2006 in the heart of Manhattan, the center offers two principal programs. The first—Foundations in Buddhist Contemplative Care Training—is designed to teach caregivers and those interested in caregiving how to integrate contemplative practices into their work with patients. The second—Clinical Pastoral Education—is the only Buddhist program of its kind in the United States that is fully accredited by the Association for Clinical Pastoral Education. Trudi Jinpu Hirsch, who is on the core faculty of NYZCCC's chaplaincy training program, explains that the foundation program is a prerequisite for the clinical pastoral education training. She says it "is a way of seeing if people are actually—to use a Christian word—*called* to this ministry."

Hirsch began training people in contemplative care because she wanted to bring more Buddhists into chaplaincy, a field dominated by Christians. "The first noble truth is that there is suffering," she says. "Buddhists sit with that in meditation for long periods but we're not necessarily standing up and doing anything with it." Contemplative caregiving is a way to practice off the cushion. However, students of the New York center's program are not required to be Buddhist. They come from a number of religious traditions—Catholics, a rabbi, and an Episcopal priest have all trained there.

"We're not training people to serve Buddhists," Ellison says. "We're training people to be intimate with anybody." So if patients want to pray, Buddhist chaplains pray with them, and if patients want to talk, the chaplains talk with them.

How, then, does Zen center's approach differ from traditional care? Roshi Enkyo O'Hara, the NYZCCC's guiding spiritual teacher, explains: "We train people to really be present to what's arising in the room. What is the body language? What are all the things that are going on? And in that mindful way, which we learn after years of meditation, contemplative caregivers absorb the whole room in an instant and are able to find that little chink that allows a relationship to arise—just that one hair's breath that allows something to grow."

Providing contemplative care is largely about listening, Ellison says. "In the training, we say people are always telling their whole story." Hospital food is typically terrible, but why does one patient talk about it and another patient talks about

(Front row, beginning second from the left) Robert Chodo Campbell, Roshi Enkyo O'Hara, Koshin Paley Ellison, and Trudi Jinpu Hirsch with the 2009–2010 graduates of the Foundations in Buddhist Contemplative Care Training course.

something totally different? Ellison says the patient who's talking about food may be saying that he doesn't know how to nourish himself in hospital, whereas the patient who's talking about her favorite baseball player getting up to bat is perhaps talking about her spirituality and how she relates to events in her life. Really listening, says Ellison, makes everything come alive and makes you more fully yourself. "To me," he says, "that's the beauty of Buddhist practice as well." Through both listening and meditation, he notes, you realize that you're not separate from anyone else, and that the person in the sick bed will be you someday.

Another key is self-care for the caregiver, but that's not emphasized in traditional caregiving. Meditation practice helps people to slow down, and students in the program are encouraged to sit regularly. Ellison thinks back to his grandmother's chaplain. "That person had too many jobs," he says, "so he would come into the hospice and make his rounds as quickly as he could. That's a teaching in itself—if you find yourself racing, stop. This reminds me of the story of Angulimala and the Buddha. Angulimala is trying to chase the Buddha and says, 'Why won't you stop?' The Buddha says, 'I stopped a long time ago. How about you, Angulimala?' That stopped Angulimala in his tracks. It was the moment when he finally asked, 'Why *am* I racing around?'"

Students gain clinical experience through ten-month placements with the center's clinical partners in New York, including the Visiting Nurse Service of New York's Hospice and the Beth Israel Medical Center, one of the city's premier hospitals. "Not a week goes by that everyone, including the teachers, isn't actually in a hospital room or at a bedside," O'Hara says.

Ellison points out that each hospital unit is like a different world. "Patients on the cardiac floor are completely different from patients in surgical intensive care," he says. "The crisis is different. The family dynamics are different. The culture of the nurses and doctors is different." For that reason, each student's training includes work in three units. "In the hospital," he says, "that could be palliative care, neonatal intensive care, maternity, rehab, detox—it could be anywhere." Different units are assigned depending on the student's needs. "If we realize that the student may benefit from slowing down, they don't need to be in intensive care," Ellison says. "We talk with students about what would be helpful to them."

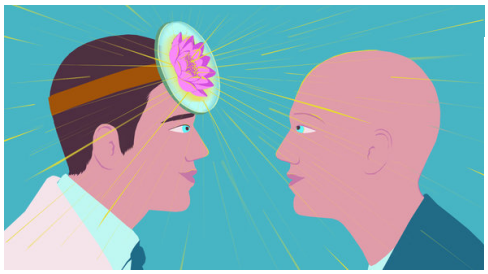
In chaplaincy training, the classes generally have six or seven students. The foundation program, on the other hand, has about thirty at a time, and Hirsch says every one of the participants is transformed. "They become a community of people who work together beautifully. They come in and they don't know each other at all, but by the end of the thirty-eight-week process, it's amazing the intimacies that develop and the heart opening that goes on." The students share with each other many aspects of their lives and losses.

"All of our students," Ellison adds, "have been touched by death intimately." Some have had cancer or another illness; others have experienced the death of a loved one. Sometimes the death was long ago, but through meditation practice the person realized how much the loss had affected their life and decided to investigate more through the center's training. Learning contemplative caregiving is a way of healing, Ellison says, helping people to channel their painful experiences into being of service to others.

To date, NYZCCC has trained 125 students, which has developed into a sangha that stays connected and practices together, holding weekly meetings and annual retreats. The center also leads retreats and workshops for doctors, nurses, and social workers. O'Hara says she hopes that someday the center will be able to bring the skills of contemplative caregiving into the mainstream so they can be used by people of any faith tradition.

"Contemplative caregiving is really about learning to trust that you are enough," Ellison says. "You're perfect and complete just as you are. You don't need to go into a patient's room and perform tricks, or juggle, or anything else. You just need to show up with your whole body and mind." BD

BUSARA NATHANSON



The New York Times

Aiding the Doctor Who Feels Cancer's Toll

PERSONAL HEALTH
Jane Brody on health and aging.

The woman was terminally ill with advanced cancer, and the oncologist who had been treating her for three years thought the next step might be to deliver chemotherapy directly to her brain. It was a risky treatment that he knew would not, could not, help her.

When Dr. Diane E. Meier asked what he thought the futile therapy would accomplish, the oncologist replied, "I don't want Judy to think I'm abandoning her."

In a recent interview, Dr. Meier said, "Most physicians have no other strategies, no other arrows in their quiver beyond administering tests and treatments."

"To avoid feeling that they've abandoned their patients, doctors throw procedures at them," she said.

Dr. Meier, a renowned expert on palliative care at Mount Sinai Medical Center in New York, was the keynote speaker this month at the Buddhist Contemplative Care Symposium, organized by the New York Zen Center for Contemplative Care and the Garrison Institute. She described contemplative care as "the discipline of being present, of listening before acting."

"Counter to how the American medical system is structured, which pays for what gets done," she said, "its approach is, 'Don't just do something, stand there.' "

But the idea is not to do just that. Rather, she said, the goal is to "restore the patient to the center of the enterprise."

Under the Affordable Care Act, she said, unnecessary procedures may decline as more doctors are reimbursed for doing what is best for their patients over time, not just for administering tests and treatments. But more could be done if physicians were able to step away from the misperception that everything that can be done should be done.

Dr. Meier's question prompted Judy's oncologist to realize that what his patient

needed most at the end of her life was not more chemotherapy, but for him to sit down with her, to promise to do his best to keep her comfortable and to be there for the rest of her days.

Occupational Distress

Patients and families may not realize it, but doctors who care for people with incurable illness, and especially the terminally ill, often suffer with their patients. Unable to cope with their own feelings of frustration, failure and helplessness, doctors may react with anger, abruptness and avoidance.

Visits may be reduced to a quick review of the medical chart, and phone calls may not be returned. Even though their doctors are still there, incurably ill patients may feel neglected and depressed, which can exacerbate illness and pain and even hasten death. Dr. Michael K. Kearney, a palliative care physician at Santa Barbara Cottage Hospital, told the Contemplative Care conference that doctors, especially those who care for terminally ill patients, are subject to two serious forms of occupational stress: burnout and compassion fatigue.

He described burnout as "the end stage of stresses between the individual and the work environment" that can result in emotional and physical exhaustion, a sense of detachment and a feeling of never being able to achieve one's professional goals.

He likened compassion fatigue to "secondary post-traumatic stress disorder, or vicarious traumatization — trauma suffered when someone close to you is suffering."

A doctor with compassion fatigue may avoid thoughts and feelings associated with a patient's misery, become irritable and easily angered, and face physical and emotional distress when reminded of work with the dying. Compassion fatigue can lead to burnout.

In one study of 18 oncologists, published in 2008 in The Journal of Palliative Medicine, those who saw their role as both biomedical and psychosocial found end-of-life care very satisfying. But those "who described a primarily biomedical role reported a more distant relationship with the patient, a sense of failure at not being able to alter the course of the disease and an absence of collegial support," the authors noted.

Healing the Healer

For doctors at risk of becoming overwhelmed by the stresses of their jobs, Dr. Kearney recommends adopting the time-honored Buddhist practice of "mindfulness meditation," which involves cultivating mental techniques for stress reduction that are native to all of us but practiced by too few. He likened meditation to "learning to breathe underwater, or finding sources of renewal

within work itself."

To achieve it, a person sits quietly, paying attention to one's breathing and whenever a distracting thought intrudes, turning one's attention back to the sensation of breathing. This can help calm the mind and prepare it for a clearer perspective.

Dr. Kearney said this practice could help doctors "really pay attention and be tuned into their patients and what the patients are experiencing."

"Patients, in turn," he said, "experience a doctor who's not just focused on a medical agenda but who really listens to them."

He said mindfulness meditation helps doctors become more self-aware, empathetic and patient-focused, and to make fewer medical errors. It enables doctors to notice what is going on within themselves and to consider rational options instead of just reacting.

"It's like pressing an internal pause button," Dr. Kearney said. "The doctor is able to recognize he's being stressed, and it prevents him from invoking the survival defense mechanisms of fight ('Let's do another course of chemotherapy'), flight ('There's nothing more I can do for you — I'll go get the chaplain') and freeze (the doctor goes blank and does nothing)." Such reactions can be highly distressing to a dying patient.

When a patient asks for the impossible, like "Promise me I'm not going to die," the mindful doctor is more likely to step back and say, "I can promise you I'll do everything I can to help you. I'm going to continue to care for you and support you as best as I can. I'll be back to see you later today and again tomorrow," Dr. Kearney said.

Although Dr. Kearney does mindfulness meditation for 30 minutes every morning, he said as little as 8 to 10 minutes a day has been shown helpful to practicing physicians.

In addition, doctors can factor moments of meditation into the course of the workday — say, while washing their hands, having a snack or coffee or pausing before entering the next patient room to focus on breathing.

To deal with the emotional flood that can come after a traumatic event, he suggested taking a brief timeout or calling on a friend or colleague to go for a walk.

This is the second of two columns about communication and cancer. Read the first: "When Treating Cancer Is Not an Option"

The Washington Post

Guest Voices
Other Views On Faith and Its Impact on the News.

Being the bridge

December, 6 2012

By Koshin Paley Ellison and Robert Chodo Campbell

Sarah is 60 years old and dying of cancer. Amid respirators and feeding tubes she refuses “all this noise and machines.” She says, “I am dying. My tears are not because I am sad I am dying. I am just so disheartened that no one wants to talk to me about this and just sit with me. I wish someone would sit with me, like you two, and just be with me at this crucial time.”

Like Sarah, we’re all going to die, and from her we can learn what’s most important in end-of-life (EOL) care: being human. Our advancing technology and aging demographics mean we’re living longer, but also that EOL care is now a growth industry, and often a hectic, stressful one. Hospice and palliative caregivers, volunteers and family members face the literally awesome task of guiding growing numbers of patients at the end of their lives through the most profound experience of all. Technology and bottom lines can distract caregivers from what we know: if we care and advocate for ourselves well, we can also take care of others with respect and dignity.

For end-of-life clinicians or caregivers, being the bridge to what’s next demands courageous presence in the face of death, the ability to listen without needing to fix the problem, maintaining compassion and avoiding empathy fatigue while caring for many suffering and dying patients.

Such skills aren’t taught consistently in medical or nursing schools, and working without them can be frustrating and draining for clinicians.

Hence the growing interest in bringing contemplation into caregiving settings, and the emergence of a new field that applies contemplative approaches to end-of-life (EOL) and palliative care. “Contemplative care” is what meditation practitioners bring to the bedside, integrating mindfulness practice, compassionate action, and moment-to-moment awareness into care, emphasizing well-being not only of patients but also of clinicians, family members and everyone involved in care.

Stress, empathy fatigue, secondary trauma and burnout are constant occupational hazards for EOL caregivers, which can also affect care. Prolonged imbalances lead to feelings of frustration, inadequacy, and guilt, as well as to higher rates of absenteeism, depression and even suicide. Attrition rates for EOL caregivers are shockingly high: 30 percent for nurses, 30 – 50 percent overall for physicians, including nearly 50 percent for oncologists.

Think about that. Why do so many leave the profession, and what could prevent it? Conventional self-care advice for clinicians usually focuses on keeping a professional boundary with patients and taking care of oneself after hours. A contemplative care approach trains EOL and palliative clinicians to be more present and intimate on the job — with themselves, patients, family members and staff. A mindfulness practice can improve communication skills, self-awareness, self-care, and the quality of EOL care, and help caregivers recognize when they need to seek help.

The New York Zen Center for Contemplative Care collaborates with major medical centers including Beth Israel and Columbia Presbyterian. We train chaplains and caregivers working in EOL settings, who deliver contemplative care to tens of thousands of patients and family members each year. Their work is rooted in Buddhist practice which has very specific teachings about being present with old age, sickness and death. But other contemplative traditions and approaches can and do apply. Our chaplains are grounded in mainstream theologies and accredited through the Association of Clinical Pastoral Education.

Earlier this year, we partnered with the Garrison Institute in New York to hold a first-ever national, public Buddhist Contemplative Care Symposium, through which we took stock of this new movement in caregiving, one that is committed to connection and compassion for everyone involved in EOL care: volunteers, hospital presidents, nurses, physicians, bed-bound patients. It was the first time doctors, nurses, chaplains and social workers and Buddhist teachers gathered and shared best practices and build community.

As we were leaving Sarah's room, she smiled and said, "Thank you both for pulling up a chair and sitting down. Thank you for looking at me. I felt you so engaged and that you were curious about me. When we sat in silence, which was kind of awkward at first, it turned out to be just wonderful because you didn't run out. Maybe this is what I missed my whole life—care, attention and curiosity and silence. Thank you for offering that."

She died quietly the next day, leaving us an invitation to imagine a health-care system that provides not only care and attention but also curiosity, presence and when there is nothing more to say, silence.

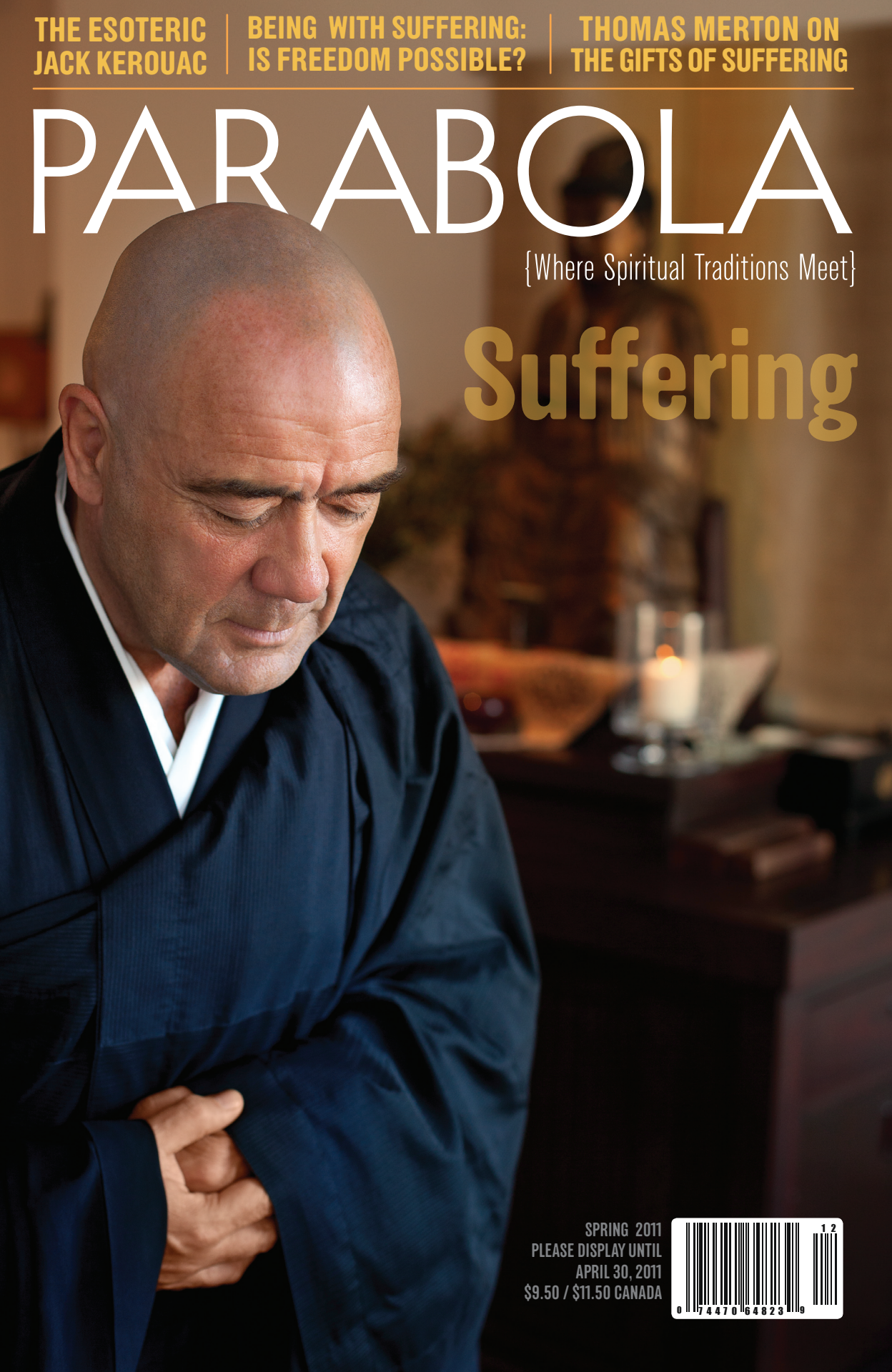
Koshin Paley Ellison and Robert Chodo Campbell are the co-founders of the New York Zen Center for Contemplative Care .

THE ESOTERIC JACK KEROUAC | BEING WITH SUFFERING: IS FREEDOM POSSIBLE? | THOMAS MERTON ON THE GIFTS OF SUFFERING

PARABOLA

{Where Spiritual Traditions Meet}

Suffering



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Waiting to see the nurse. Siza Suatter Camp South Africa

FIVE FULL MINUTES

Photos and Essay by

ROBERT CHODO CAMPBELL

Let me respectfully remind you
Life and death are of supreme importance
Time swiftly passes by and opportunity is lost
Each of us should strive to awaken
Awaken, take heed do not squander your life.

Zen Buddhist Chant

THE EVENING GATHA IS HEARD every night in Zen temples around the world. The words constantly guide me to the urgency of the moment. They helped guide me on my journey to becoming a Zen Buddhist Priest and chaplain. They encouraged me to co-found the New York Zen Center for Contemplative Care (www.zencare.org) and to find ways to teach students how to take their Buddhist practice off the cushion and out into the world to be of service to others. This chant enlivened me in new ways when I was invited to Island Hospice in Zimbabwe and South Africa to share our model of contemplative care. It is impossible for me to speak of the magnitude of personal and cultural hardships and desolation in a broad way. This encounter in Zimbabwe is just one of the experiences that remains with me as a reminder as to why I do this work.

Zimbabwe's population is about ten million, with an HIV infection rate in the double digits and widespread poverty and hunger. It

Chitungwiza Clinic Zimbabwe

is the home of Africa's first hospice program, Island Hospice. I spent a week at Island Hospice working with all the staff – administration nurses, social workers, volunteers, and visitors. The overall theme of the visit was to explore different models of spiritual care with them.

The nurses make their daily rounds driving out to visit with the sickest of patients. On my first morning, I accompanied Tando, a seasoned professional nurse with deeply held Christian values. I could sense that she was more than a little curious and, perhaps skeptical of my reasons for being in Zimbabwe. "I've never heard of Buddhism, there is only one God and he is my savior" were the first words she said as we set off on our rounds for the day.

The first patient we visited was a pastor in his sixties with end stage stomach cancer. From the outside the cement and wood single-story house looked small and gloomy, with a jumble of pots, pans, and household appliances in the yard, all in various

Freedom Park. Squatter Camp South Africa (2)

stages of repair, and of course the requisite chickens scurrying about. A woman I presumed to be his wife answered the door and showed us into a surprisingly spacious living room. The pastor was inside, slowly rising from his chair. He smiled at seeing Tando and was immediately courteous to me, offering me his chair. I was formally introduced as a pastor from America and he then sat on the couch with Tando. What followed was the most exquisite care giving I have seen from a nurse. We sat in silence while Tando gently held his hand and gaze for five full minutes. The room was bathed in beautiful quietude. And then she asked him, "How is your stomach today?" He replied, "Today I am blessed with some relief. The Lord has taken the pain away for an hour or two." His dark brown eyes, wide as saucers, filled with tears.

Tando, turning to me, explained to the patient, "Chodo would like to talk with you, as a fellow pastor. Would you like that?" The patient reached out to hold my hand and the three of

us sat together again in silence, and we began to talk.

At this point the pastor was scheduled for another round of chemo. He didn't want to continue treatment, which would put further financial burden on his congregation. He told us that most of the time he was in great pain. Tando explained calmly and quite simply, as if she were discussing the weather, that the pain would increase and he should take the limited supply of Tylenol only when it became unbearable. Tando made it clear that the pastor would quickly become bed-bound, and she inquired if his wife was going to be with him twenty-four hours a day from now on.

Our conversation revealed to me his resilience, his absolute faith in God, and his resignation about what

Freedom Park. Squatter Camp
South Africa

Chitungwiza Clinic Zimbabwe

lay ahead for him. With no money, no access to chemotherapy, and a brief window of time to enjoy his church and community, his plight made me almost ashamed to think how we complain here in the U.S. of how our healthcare system is so broken. He told me how much support his congregation had given him over the recent months, including a collection to send him to Johannesburg to see an oncologist, and his first round of chemotherapy. I asked him what gave him the strength to continue with his preaching. He began to cry. "Up until last month I was able to walk to the church and give the sermon, but now I don't have the strength to walk more than half way. Then I have to rest and just return home."

"Is there anyone who will come and fetch you in a car or taxi?"

"I don't want to be a burden. I will stay home now and pray for God's mercy."

"Perhaps God would want you to give your congregation the

Freedom Park. Squatter Camp
South Africa

opportunity to help you, by coming here and taking you to church," I suggested. Suddenly, a rush of tears as he looked directly into my eyes.

"Thank you, Thank you."

Tando squeezed his hand and mine, and with a nod she signaled it was time to leave. I asked him if he would like a prayer, and he said yes. I prayed for him, his wife, and his two sons, who are living with an aunt somewhere because he and his wife can no longer afford to send them to school or feed them. I prayed for him to continue to wonder what God's will is.

As we readied to leave he shook my hand. Both of us knew we wouldn't see each other again. He held my gaze and we both smiled. He thanked me for the visit and the prayer. Tando handed him Tylenol for the pain that was looming on his physical horizon. As we made our way back to the car she said, "We have run out of morphine and there's no funding for more." I asked, "How long before he will get some morphine?" She shook her head with a sigh. "He will die in great pain, but his suffering will be over in two weeks—three at the most."

Standing at the gate with a smile Tando said, " I think your Buddha must have been one of God's children." I took this as acceptance. I told her, "Perhaps Jesus was a Buddha." She nodded and laughed, and we got into the car under the watchful eyes of the curious kids playing with an old tire in the dirt street and drove to the next house on the list.

Robert Chodo Campbell (above left) is a Soto Zen Buddhist Priest He is a student of Roshi Enkyo O'Hara

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Zen Buddhist chaplains practice not knowing

One practice focuses on mindfulness meditation

In an unusual pairing, Beth Israel Medical Center in New York City has teamed with the New York Zen Center for Contemplative Care to apply the approaches of its Zen Buddhist chaplains to the anxieties and pains — spiritual or physical — of hospital patients.

The chaplains serve at the hospital by offering such care as bedside meditation, interdenominational prayer, and other spiritual support strategies not only to patients but also to the medical center's staff.

"One of the things I learned through my chaplaincy training was that many people who have a theology have an idea of how [spiritual guidance] is supposed to go," says the **Rev. Koshin Paley Ellison**, co-founder of the New York Zen Center for Contemplative Care. "And one of our basic tenets in Buddhism is to not know, to work with the awakened mind, which is not having ideas about things but directly experiencing someone."

Some U.S. chaplains steeped in more traditionally Western faiths have suggested that the role of chaplaincy is just that — to meet people where they are and not trying to move them into beliefs or directions where the chaplain would have that patient go, based on his or her own religious or spiritual beliefs

"Our basic practice is to really be intimate with what's happening right there," Ellison tells *MEA*. "I know from my fellow chaplains from other faiths [that they] have a bit of a struggle, because they kind of have an idea of how it should go."

The Zen Buddhist chaplains may stress such things as meditation, breathing exercises, or conversation to alleviate stress or pain in patients.

The Zen Center for Contemplative Care, which received a $30,000 grant for its work at Beth Israel, trains students in the chaplaincy from a Buddhist perspective, but as is the goal of many chaplains, their focus is on treating each patient as an individual with unique needs.

"Really, I think that our training is based on not having any ideas about how it's supposed to be for someone," Ellison says. "So, the Buddhology, as we call it, instead of theology — because we don't have a theology — is really based on not knowing and bearing witness to what's happening and trust that if we're really there, that a loving action, or the most appropriate action, will take place.

"So, I think in some ways, it's like our Buddhist training is to me, like chaplaincy training in itself," Ellison says.

As Ellison explains, "Buddhism was founded by the Buddha, wondering how we deal with old age, sickness, and death. So, it's very direct. As the Buddha says, as the story goes, the most important thing is to care for someone."

However, he says there are many ways to be an effective chaplain, and the Zen Buddhist perspective offers just one of those ways.

Appreciation comes from staff

While the Zen Buddhist chaplains have received a grant, as with many chaplains at hospitals across the United States that may be implementing or considering staff cuts due to current budget constraints, the Buddhists need more funding.

As an example, a friend and fellow chaplain at a hospital in Connecticut has seven staff members who serve as chaplains.

"I was like, 'How do you do that,' Ellison says. "And he said, 'Well, we fund-raise."

"In some ways it's great that they're doing that, and in some ways," he says it doesn't make sense.

Ellison doesn't doubt that the Buddhist chaplains' services are needed, based on feedback he receives.

"We met this morning with all the nurse managers, and there's this real hunger for our students and our presence in the hospital, because we're really, at this point, the only people in the hospital who . . . spend time with patients and staff," Ellison says.

"Basically, everybody else is really busy, so we have the privilege of our jobs as chaplains to just be with the staff, just be with the patients," he says.

Ellison recalls a nurse saying that so many of the medical center's patients come out of surgery, but nurses can only physically care for the patients and provide medication. The nurse told Ellison, "At least your group — your chaplains — can teach them about how to be with themselves, learn how to be with the pain in a different way."

"For me, that was the best compliment," Ellison says.

Evolution of the chaplaincy

One of the concerns expressed by chaplains is that they often have to justify their positions on hospital staff to administrators, who may see that position as a cost-center that does not generate revenue.

"We live in a culture where these things aren't valued by insurance companies, so it's not reimbursable — and the hospital doesn't make any money," Ellison explains. "So, because of their tight budgets, they can't afford to have a staff chaplain for oncology, a staff chaplain for staff — so it's a stretch."

Today, he says, there is also an emphasis — due in part to cost concerns — that requires research to prove that the benefits of chaplains are real.

"What I would like to see is a culture valuing [chaplains] more, because unfortunately, we live in a time where you have to have research in order to prove it actually is doing something about things that are kind of obvious — like, people who feel they are being heard tend to do better," Ellison says.

NATIONAL GEOGRAPHIC™

BUDDHA RISING

Holding on while letting go, a cancer patient receives comfort from her daughter and Robert Chodo Campbell, a Zen Buddhist Priest at a New York City Hospice.

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Newsletter Issue 12 - Spring 2013

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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 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:*

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

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.

Diane Meier, MD

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

Anthony Back, MD

Michael Kearney, MD

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 heartfelt 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.

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."

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Bruce (B. J.) Miller, MD presenting at the BCC symposium

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 non-verbal 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

Robert Chodo Campbell, Roshi Enkyo O'Hara and Koshin Paley Ellison at the BCC symposium

care specialist who directs the Zen Hospice Project. Drawing on the history of philosophy and art, Miller argues that beauty, sensual enjoyment and the innate human function of meaning-making are if anything more important at the end of life than at other times. Studies suggest they can also be therapeutic. Yet sterile clinical environments deprive us of them at life's end.

"Often people at the end of life are ready to go because life has become intolerable, but I wonder if there is another more inspired way," says Miller. "Do we have to choke the senses to prepare one for death? We could flip this – when we are so overwhelmed with love and beauty, that's when we let go." He takes inspiration from precedents like the UK's Maggie Centers where gorgeous architectural design is brought to bear on cancer management facilities (Frank Gehry designed one in Dundee, Scotland), and "Art for Recovery" which mounts patients' artwork in cancer treatment centers. The idea of an interdisciplinary team is central to hospice and palliative care; Miller believes that it might be broadened to include philosophy, humanities and the arts. Not incidentally, that evening New York State poet laureate Marie Howe gave a reading of her work in a plenary session of the symposium.

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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. In dharma talks at the symposium, Koshin Paley Ellison connected it to the ethical precepts written by the eighth century Indian Buddhist teacher Bodhidharma, and Roshi Enkyo O'Hara, Zen priest and abbot, expounded it in a Mahayana sutra written around 100 CE by Vimalakirti. Rich and well, Vimalakirti decided to become ill to teach people how to be present to illness "with compassion that is unerring… innocent of falsity and sham, free of sentimentality…full of peace and delight."

What is new, and palpably exciting for symposium participants, is the emergence of contemplative care as a professional field, and the opportunity to apply wisdom in modern clinical settings. As Roshi Enkyo said, "We are really at the beginning of something new, a new way of looking at distress, sickness, dying and death, and of working in that field."

You can access videos of complete presentations from the Buddhist Contemplative Care Symposium on our website at www.garrisoninstitute.org/contemplative-care-video