The Way of Contemplative Healing

Interview with James Duffy, M.D., Ch.B., F.A.N.P.A., F.A.A.H.P.M.

Russ Mason, M.S.

James Duffy, M.D., Ch.B., F.A.N.P.A., F.A.A.H.P.M., is president and chief executive officer of the Institute for Religion and Health in Houston, Texas.

He seeks to develop innovative interdisciplinary models for providing compassionate and effective care for patients and families coping with incurable medical conditions. Until recently, he was the director of the Division of Palliative Medicine at the Methodist Hospital System in Houston and a professor of psychiatry at Weill-Cornell Medical College in New York City and an adjunct professor of psychiatry at Baylor College of Medicine in Houston. He is now a professor of Psychiatry at M.D. Anderson Cancer Center at the University of Texas, in Houston.

Over the past 5 years Dr. Duffy has become increasingly active in the emerging specialty of palliative medicine, and was a founding member and chair of the Connecticut Coalition to Improve End-of-Life Care. He has received several grants to support his research in end-of-life care, including grants from the Robert Wood Johnson Foundation. In addition to his work with patients and families, Dr. Duffy has developed a professional renewal program for physicians and runs workshops for health care providers that are intended to help them recapture the meaning of their work. In 2001 he was awarded a Kornfield Foundation Fellowship to support his work in the area of physician wellness, and to support his study of the wisdom foundations of healing.

Dr. Duffy's spiritual practice is Tibetan Buddhism. He has received instruction from Tibetan teachers and has been inspired by the spirit of the Tibetan refugees he has met and worked with in the refugee camps of India. Much of his perspective on compassion, mindfulness, and contemplative practices in medicine draws on his understanding of Tibetan Buddhism and its powerful insights into health, healing, and the limitations of allopathic medicine.

Russ Mason: How do you define contemplative healing?

James Duffy: That's an interesting question because almost by definition, contemplation is beyond words. So there are conceptual limitations to contemplative healing. But I see it as any deliberate practice that examines one's relationship to reality. So it's

more than sitting on a cushion and doing meditative practices; it could be other things, such as dance or creative writing. Almost any activity can be transformed into a contemplative practice if one is consciously engaged in monitoring one's relationship to the activity and its outcome. A succinct definition might be "conscious entanglement."

RM: Is this vastly different from thinking?

JD: Yes, because the moment you bring thinking into it, you begin to move away from contemplation. Thinking creates conceptual categories that limit our experience. So, contemplation is a conscious engagement with experience rather than an attempt to contain or evaluate it.

RM: This touches on the Eastern traditions of mindful activity.

JD: Yes, absolutely. Our Eastern philosophers have spent thousands of years exploring the terrain of our subjective consciousness. They have provided us with remarkable roadmaps of consciousness. We should be taking their "subjective science" more seriously. Within the Eastern contemplative traditions there are very clear steps along the road of development. They are called *jhanas*, and there are eight of them. As one moves through those steps one moves out of linear thinking and into more relational thinking, and ultimately into a nondual experience.

RM: How do you see contemplative practice in relation to healing?

JD: I see them as being the same thing, and that is the interest I have in terms of health care. The more we can move toward understanding the nature of contemplation and reality, the closer we can get to understanding what healing really means. Then we can develop health care systems that are more effective. That is the answer to our current perceived health care crisis.

RM: How does one apply contemplative practices in a medical, or healing, environment?

JD: First let me go back a little, to explain the genesis of my current interests in contemplation and health care.

My interests really started when I became a palliative care physician. I had concerns about the inability, or unwillingness, of our

health care system to address the suffering of our patients. Like many people in palliative medicine, my first reaction was to find someone to blame. Typically, those were the physicians and nurses involved in health care. However, in my experience, those physicians and nurses were—and I don't want to use the word "victims" to describe them—immersed in the same culture as the patients they were attempting to treat. So both patients and healers were trapped in a consensus consciousness that led them to experience one another as separate and almost invisible to each other.

This was about 10 years ago. I began a journey to discover the dynamic within the culture that led to situations in which really nice people—and the data do show that people entering medical school tend to be more empathic and compassionately driven than their peers—were not behaving in a compassionate way when they became practicing physicians.

I began to examine what it was to be a healer in other cultures and traditions, and the nature of the "cultural container" that we could begin to develop that would support the emergence of more compassionate healers.

My 10-year journey has brought me back to the point where we are having this conversation about contemplation. It seems to me that healing has always, in a sense, been about a contemplative process, where the healer and the person being healed are engaged in a process that moves both of them toward a deeper connection with the universe of spirit.

My personal belief is that the only way one makes that movement toward healing, in the broadest context, is not by tinkering with the machinery of patients' bodies or brains, but by radically altering their experience of themselves in relation to everything else.

RM: Have you had the opportunity to practice this first-hand with your patients?

JD: I began my academic medical career as a neuropsychiatrist with a particular interest in the neural substrates of consciousness. That led me into some work with frontal lobes—and it was only in the early 1990s that we began to talk about the frontal lobes—in any meaningful way. It became clear to me that consciousness was not created in the frontal lobes or any other specific brain location. It is the so-called "hard problem" of consciousness: Where is the "I" experience located? In my humble opinion there is no "I spot" in the brain. Mind extends beyond brain—it is not contained by the brain. I am a strong advocate of autopoietic models of consciousness that describe consciousness as the experience created by the interaction of engaged sentient beings. Individual consciousness is always changing and reinventing itself according to its relationship with all other conscious beings. Many minds, one universe.

So to get back to your question, my interest in the experiential aspect of healing goes back to my moving into palliative medicine. As psychiatry involuted into a restrictive model of biology, the new field of palliative medicine arose.

RM: How, specifically, do you define palliative medicine?

JD: There are a lot of different definitions and some are more complicated than others. But I think most physicians would say simply that palliative medicine strives to relieve the suffering of others.

So with the rise of palliative care, particularly with the work of Dame Cicely Saunders'* work in nursing homes, palliative medicine supported a bio-psycho-social-spiritual approach to healing. Dame Cicely was a "velvet revolutionary" who radically challenged the involuting physical model of allopathic medicine. Dame Cicely broadened the conversation about what it meant to be a health care provider and a healer.

The only problem was that we are relegated to caring for people who are perceived by our allopathic model as having no available "cures." When I first entered the hospice world, I was blown away by the radical shift in the doctors' perspective of what healing is all about. The typical story that I would hear was something like, "I went to Mr. Jones's home. He has metastatic end-stage lung cancer. His pain is adequately controlled, and he was deeply sedated. I sat with the family and I was present to them." That would be the end of the case presentation and all would nod their heads in agreement and we would move on to the next case.

I listened to these stories, and at first I wasn't quite sure what they were talking about. What was this "presence" all the hospice workers referred to with such conviction? But over time I began to recognize that probably the most important gift, or insight, that palliative medicine brought to allopathic medicine was the idea that "presence" is, in itself, a healing experience. This means that health care providers can bring "presence" into the experience of patients and families.

I see "presence" as describing the contemplative experience.

So when I work with patients, many are at the end of their life journeys and are no longer verbal; some may not even be conscious. But by just pulling up a chair and being present to them, something profound happens. I can only describe that as the opening up of possibility and spaciousness.

RM: Please talk about presence and what characterizes it for you.

JD: I have formulated seven points that characterize presence and the contemplative experience of healing. The first is that it is wordless. Language often does little more than constrict, or restrict, possibilities in our capacities for becoming more whole. The perennial philosophies remind us that words inevitably obscure true wisdom. Unfortunately, in our world of modern health care, where everything is language-based, silence is often hard to sustain for more than a few moments. In fact, silence is often construed as an admission of ignorance!

The second characteristic of the contemplative experience, which involves presence, is authenticity. By that I mean for healing to happen, both parties have to show up as who they are, not who they pretend to be. I often tease medical students and physicians when I speak to them, telling them that we're "strait-jacketed" by our white coats. So the contemplative experience of healing is a radically authentic experience. When one is engaged in the contemplative experience of healing, one experiences it

*Dame Cicely Saunders (1918–2005) was a physician, a nurse, and a pioneer of the hospice movement. She founded St. Christopher's Hospice, London, the world's first dedicated hospice. (Visit www.stchristophers.org.uk/ and www.thenewatlantis.com/archive/10/soa/saunders.htm for more information.)

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as a fluid, dynamic, unpredictable process in which both participants are engaged in moving toward a place that provides more “spaciousness.”

RM: Please explain what you mean by spaciousness.

JD: It is the opening to possibilities that extend beyond our current horizon. Most of us spend our lives trapped by our fears and the assumptions we make about ourselves and the universe.

Radical authentic healing is a kind of dance of energy. If we go back to the definition of “conscious entanglement,” you as a healer are engaged in working in the patient’s energy field, with compassionate intention. That is radically authentic, and it can be somewhat unsettling, because one moves into areas where there are no answers—just possibilities. The shamans know this—they are [journeypeople] with their patients along the foreign terrain into healing.

I see this in my work with patients who are dying. The real healing happens at that moment of acceptance, which is the third characteristic of presence. When we are accepting that we can’t control what is going to happen next, we become open to the possibility of radical healing. The only thing we can control at those precious moments is our intention: the intention to be compassionate to ourselves and to others. The more we hold onto the illusion of ego control and the idea that the ego continues, the more threatening death becomes.

In terms of authenticity and wordlessness, the greatest gift we bring to our patients is modeling for them to simply sit and accept things for what they are, and not to have to “cognitively repack-age” uncomfortable, anxiety-provoking emotions.

A physician who walks into a room and changes the subject away from “am I going to die?” is essentially modeling for the patient that this is too overwhelming and, “if I can’t do it, you certainly can’t.”

Ken Wilbur[†] has created philosophical maps that have been very helpful. This information is not new, but according to him our explorations divide the world into four parts: the world of objective truth; the world of subjective truth; the world of interpersonal truths; and the world of systems relationships. I often like to ask, “whose enlightenment are you most interested in?”

James Duffy, M.D., Institute for Religion and Health. Image used for contemplation.

If one tries to apply objective evaluation to a subjective experience, one becomes stuck. I think the next great scientific revolution is going to be in “first person” science, or neurophenomenology. This is the study of the experience of the individual who is able to identify where he or she is in the journey of experience. Eastern adepts are able to induce specific states of consciousness and can then report when they are at those stages. We have also seen that real-time brain scan images confirm what patients describe as what they are experiencing. That is exciting.

When I talk with other doctors about the crisis in health care, I mention the four things that we need to do to educate healers. The first is to rediscover our mythological models of the healer and the healer’s journey. The second is to clarify the attributes of a healer and to provide transformative educational programs that support the development of these attributes. The third is to provide healers with contemplative clinical skills, such as ways of being present to patients and enhancing empathic accuracy. The fourth thing we need to do is to rediscover a lexicon of healing that has meaning.

[†]Ken Wilbur (b. 1949) is an American author, philosopher and proponent of Integral Thought, who founded the Integral Institute in Denver, Colorado, in 1998. (Visit www.integralinstitute.org/public/static/default.aspx for more information.)

RM: What is a lexicon of healing?

JD: I mean that we need to have some basic conversations about what is a healer, what it means to be healed, what is compassion? The biggest concepts in our culture have been squashed into the smallest boxes, words like “love,” for example. We have one word that might mean love for one’s dog, for one’s wife, for one’s country, or for one’s God.

In this context, does it have relevance when I, as a physician, have positive thoughts for my patients? I intuitively believe that the answer is absolutely yes. Can my “third person” objective scientific method ever prove that? I am not sure that it can.

To return to the list that we began earlier, the third aspect of contemplative healing is acceptance.

RM: What precisely does that mean?

JD: For me, as a person living in the Western Hemisphere, the first step in any disease process is the acceptance of oneself. For many, especially those living in the West, the hardest part of this is acceptance, because we often perceive ourselves as being “broken,” and this is a uniquely Western experience.

RM: So a Western individual may think, “I am broken because I have cancer?”

JD: It goes farther back than that. The model of original sin, and being separate from God, says that we are intrinsically flawed and imperfect. So a lot the work we do in psychotherapy is to create an experience for our patients of being all right just as they are. That is where acceptance starts. If you have a self-concept of being “stained” or inadequate, it is almost impossible for you to move into anything except resignation. Acceptance is far different from resignation; acceptance is about trusting the process.

RM: Is there also an “embracing” aspect to acceptance?

JD: Yes, absolutely. It’s about trusting that there is a process and an intention, in you and in the universe, or in others, that moves you to a healthier place.

RM: What also happens in the West is that the seed of original sin gets planted deep and early. So even if a person becomes highly developed and accomplished and goes on to achieve wonderful things, there is still this seed of being flawed.

JD: Right. That comes from the dualistic consciousness that the West has fostered. When we have dualism—good and bad, right and wrong, beautiful and ugly—we are set up for this torment. However, in the Eastern model, dualism is seen as the problem, not the solution. Even our sciences and healing traditions are all based on a fundamentally different perception of the universe.

In the West, there is “us” and there is “them.” When the comedienne Gilda Radner was dying of ovarian cancer, she only half-banteringly said, “I have to get this thing before it gets me.” We have the sense that the world is contaminated by infectious organisms and carcinogens and other adverse factors and that we need to “get” them before they “get” us. The Eastern traditions and also the Shamanic traditions maintain that we are all in relationship with each other, that disease is not the consequence of us being weaker than something else, but of us being out of harmony with some-

thing else. Therefore, Western culture is condemned to an eternal war between pathogens and physicians. The moment we “conquer” one disease, another manifests and the torment continues. Healing is found in right relationship, not in domination.

RM: How does this view manifest in your own practice?

JD: As a health care provider, what I hope to do when I work with people is to create a space where they become accepting of themselves. That is the first step toward accepting mortality. There is nothing quite as terrifying as going to one’s death believing that in your essence, you are not perfect. This does not leave you with too many reasons to be optimistic.

RM: Do you find, in your end-of-life care, that your patients are open to new points of view? And if not, how does one gently lead them into a new paradigm of perception?

JD: First of all, the practice of contemplative healing is extremely respectful, and takes into account that one is working in relationship with another person. We are not trying to push them anywhere, but to support them on their personal journey.

My agenda is never to impose my consciousness or philosophical worldview on somebody else. That would simply be manipulation, coercion.

Each of us comes into the journey with a different spectrum of consciousness, and I am often in awe of individuals who can have radical conversations at times in their lives when they are threatened by something as overwhelming as their own mortality. I am constantly amazed by the ability—the atavistic drive—of the human spirit to rise up to the challenge of mortality.

All people travel their respective journeys with their own particular conscious experience of themselves and the world. So if someone has a deeply felt connection to a particular faith tradition, it is my responsibility to allow that person to access that faith tradition in a way that is helpful to that person.

Therefore, I will use the term “God’s love” with a patient if that is the language the patient is using. I need to be mindful of myself as much as of what the patient is experiencing, because if I start to act in ways that put forward my own agenda and not my patient’s agenda, I am damaging the patient.

RM: So for the practitioner of contemplative healing, this involves constant monitoring of one’s position and viewpoint.

JD: Yes, and that means being consciously aware and engaging in the energetic experience of the patient. My job as a healer is not to challenge someone’s consciousness and not to describe things as being better or worse, but to be a kind of midwife through their emergence. The work of acceptance is probably the single most important thing that happens in psychotherapy or the healing relationship. When we experience ourselves as being less-than-whole, we experience pain.

The other thing that I find helpful in terms of acceptance is that life is suffering. In Buddhism, this is the first noble truth, and it is a truth that we in the West have never come to terms with. So for me, as a healer, it is important that my patients and I can understand that what is coming to them, through their diseases or illnesses or suffering, is as much about life as are all the good things about life.

RM: When you work with patients, what has been the process?

JD: The big shift that I see is when we move from fighting things as being unfair to accepting them as being part of the cycle of life. That is very liberating because it frees one up from finding causes or sources of blame or responsibility. Many patients are looking for mundane causes for their situations and not for the transcendent patterns in it.

RM: What do you say to your colleagues or medical students about all of this?

JD: I often refer to Ayurvedic physicians who teach that there are three foundations to being a healer. They are *seva* (which means being of service); *simran* (which means compassion); and *sadhana* (which means spiritual practice). I believe that the foundation of service and compassion is one's spiritual practice. By this I do not necessarily mean a religion-based practice, but one needs to have some kind of contemplative practice.

RM: But what if the physician does not have a contemplative practice, or doesn't know how to begin?

JD: The idea is to move to a place where all of one's work becomes a *sadhana*—a spiritual practice. Working with sick or suffering people is a powerful spiritual practice, but only if one is consciously aware of what one is engaged in. In contemplative healing we're blessed to be given an opportunity to do work in which meaning is so easily discoverable—imagine trying to create a *sadhana* out of working in a coal mine or a factory.

You engage in a spiritual practice every time you engage with someone who is suffering and you have the intention of compassion. We need to remember our heritage—that genuine healing has always been a spiritual practice, and our current emphasis on healing as a biomechanical process is an ignorant aberration of the healer's work.

RM: What are the other characteristics of contemplative healing?

JD: Thus far we have discussed “wordless,” “authentic,” and “accepting.” The fourth aspect is that contemplative healing is “abundant.” By abundant I mean the experience that the universe will always give you enough to meet your needs. One of the driving motivations of allopathic medicine is fear. We live in a consciousness of scarcity, the fear-based belief that there is not enough health or health care to go around. But from the viewpoint of abundance the universe will always provide for us if we simply trust the process. If we as healers do not experience the universe as having a compassionate intent, all is lost. This demands that we let go of our illusion of control. What the spiritual traditions tell us is that when you establish right intention, and you monitor that intention, you will perform the right action. By abundance I do not mean to suggest that the universe will deliver what the ego thinks it wants, but rather that it gives us what we need on our personal journey towards expanding consciousness. There is no guarantee that it will be a scenic route.

A fifth aspect to consider in contemplative healing is timelessness. When one engages in a contemplative entrainment, or synchrony, with another person, one moves into the space of timelessness. It is interesting to see that if you look at the data, pa-

tient satisfaction with a physician does not correlate with the amount of time the physician spends with the patient. Contemplative healing is marked by something that is transcendent; it cannot and should not be driven by CPT [Current Procedural Terminology] codes.

RM: Does this imply a need for more of the practitioner's time?

JD: That hasn't been my experience. Some practitioners are terrified of the idea and think, “oh my goodness, I'll have to sit there with patients for hours and I'll never be able to get my work done.” My experience is that when you enter into true and empathic communion with someone at a contemplative level, things happen almost instantaneously. Many of the people who read this are themselves likely to have had a similar kind of moment, when a patient experiences some kind of radical transformation.

RM: Can you go into that in a bit more detail?

JD: There is a moment when the patient and healer connect in a kind of synchrony, and something shifts. And shift is not driven by temporal constraints. It is possible to spend 6 hours with someone and nothing will shift, but the moment you connect with the person energetically, in an authentic and spontaneous way, something happens. And both patient and practitioner are changed by it.

RM: What are some of the other characteristics of contemplative healing?

JD: It is courageous—that is the sixth aspect. And that is because someone engaged in it must be authentically human—not as an expert with hierarchical authority over the patient. Very often, physicians in hospitals assume that they hold all the cards, and that is because the system is designed to create hierarchies. However, when I engage with someone at a contemplative level, I must have the courage to accept that ultimately I am just a participant with that person in the unfolding mystery that we call life. My technical knowledge is important, but it is simply a tool; I'm not playing the role of the medical craftsman. This perspective challenges us to let go of our need to be in control.

RM: That would create a challenge for many physicians.

JD: Yes, and part of that is relative to the “time” issue, in which many physicians are frightened that if they sit down and become present to their patients, they will lose control of the clock or the direction of their meeting. I think this is where the “compassion fatigue” takes root. Our modern day health care professionals are paying a high price for their illusion of control. My experience has been that as long as the practitioner establishes positive intent and sets boundaries, things will go where they need to go.

When you are present to your patients' suffering, you never come out of it untouched. Healers must be consciously aware of the energetic shifts that are occurring in the healing relationship—not only in their patients, but also in themselves. We need to create safe spaces for ourselves and support our own wellness. I think most healers will tell you that they never leave the healing relationship the same as they came into it.

RM: What is the final characteristic of contemplative healing?

JD: The last [seventh] attribute of the contemplative healer is humility. This essentially means that one is humble to the process of healing. Because at the moment when you believe you're directing the healing process, you have lost the point. Humility means trusting the process, and that the universe is always, essentially, evolving into something that is healthier.

RM: Are healing and compassion therefore manifestations of the same dynamic?

JD: I believe they are. But I would like to discuss that a bit further. In terms of healing and contemplation and compassion, I like the model that Jon Kabat-Zinn[‡] has put forward. He describes four levels of the emergence of disease, based on a model of contemplative experience.

The first level is one of inattention. In other words, if one is not paying "conscious" attention to one's physical, emotional, and spiritual experience, and is not mindful, and is not in a contemplative relationship with one's body, one's mind, and the universe, then one may become ill.

Prolonged disharmony will eventually lead to the third level of disorder (i.e., a dysregulation of the body's physiological systems). Finally, prolonged dysregulation (e.g., Syndrome X) will produce a defined observable pathophysiological manifestation that allopathy refers to a "disease." Allopathic medicine is preoccupied with disease; it has lost sight of the opportunities for healing that occur earlier in the process of disharmony, before disease sets in.

Suffering can occur at each of these four levels. You see it in young people not paying attention to themselves because they are

distracted by the various illusions that our culture creates. They become "attention-deficit-disordered"—eating harmful foods and polluting their minds with violent images. By the time an allopath gets to see a patient suffering from diabetes or heart disease, they're seeing someone who is at the fourth level, that of *dis*-ease. And that is so far downstream that the best we can do is a "patchwork" of measures to slow or arrest it, since we can't reverse the damage that has resulted from years of inattention.

Traditional Chinese Medicine [TCM] addresses an early level of bodily dysregulation and disharmony, and Shamanic healing traditions address even earlier stages of inattention by attempting to discover how a community is losing right relationship with the universe.

Each of these is a different way of approaching suffering than that of allopathic medicine, which is in fact an end game in health. What is so seductive about the scientific method is that it gives us the illusion that we are in control.

From my perspective, complementary and alternative medicine is about moving the correction of disorder to an earlier point than that addressed by allopathic medicine. And I see contemplative practice as being where the ultimate healing occurs—the space of radical transformation. The worst thing we can do is to see integrative medicine as an area for applying the scientific method to practices that are so far upstream that they can't be adequately measured by existing scientific technologies.

"Be the Change and the whole world will change," declared Gandhi. I believe that if our doctors and nurses became the change, and began to experience healing as a *sadhana*, a contemplative practice, our world would change: We would build a health care system that is motivated to support right relationships with ourselves, with one another, with our earth, and with the universe of spirit. □

[‡]Jon Kabat-Zinn, Ph.D. (b. 1944), is the founder of the Stress Reduction Clinic and the Center for Mindfulness in Medicine, Health Care, and Society at the University of Massachusetts Medical School (Worcester, MA). He teaches mindfulness meditation to help people cope with pain, illness, stress, and anxiety. (For more information, visit: www.umassmed.edu/cfm/index.aspx)

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