

Narrative Medicine and Contemplative Care at the End of Life

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Abstract Two important movements leading the way toward a new approach to healthcare are *narrative medicine* and *contemplative care*. Despite considerable common ground between these two movements, they have existed largely parallel to each other, with different literatures, different histories, different sub-communities, and different practitioners. This article works toward integration of narrative medicine and contemplative care through a philosophical exploration of key similarities and differences between them. I start with an overview of their similar diagnosis of healthcare's problems and then consider their related, but different, responses to these problems. Finally, I use the example of Margaret Edson's Pulitzer Prize winning drama *W;t* to highlight how these issues can play out at the end of life.

Keywords Narrative medicine · Contemplative care · Healthcare reform · Empathy · Phenomenology · Spirituality · End of life · Margaret Edson · *W;t*

Despite ongoing problems in healthcare financing and access, this is a time of growth and regeneration in healthcare. Practitioners and scholars are going beyond the obvious healthcare crisis problems to ask deeper questions: what kind of healthcare do we want, what kinds of clinicians do we most value, and what kinds of clinical encounters do we need in the face of suffering, disability, and death? These deeper questions take us to the heart of health and healing and to core issues of human empathy and wisdom in the face of morbidity and mortality. Healthcare reform devoted to these deeper questions aims at nothing less than combining the sophistication of scientific medicine with an equal sophistication in compassionate care.

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Two movements leading the way toward this new approach to healthcare are *narrative medicine* and *contemplative care*. Narrative medicine has emerged from decades of interdisciplinary work combining medicine with the arts, humanities, and cultural study. Contemplative care comes from the recent interdisciplinary combination of healthcare with contemplative practices from a variety of religious and spiritual traditions. Despite considerable common ground between these two movements, they have largely existed parallel to each other, with different literatures, different histories, different sub-communities, and different practitioners. But this separation is temporary, and they will soon integrate more and more—partly because they have a similar “diagnosis” of what ails medicine, but also because they bring complementary strengths toward the development of a more empathic and compassionate medicine. The future integration of these two approaches will bring us a long way toward improving our healthcare system.

This article brings narrative medicine and contemplative care together by working through key similarities and differences between them. I start with an overview of their similar diagnosis of healthcare’s problems and then consider their related, but different, responses to these ailments. Finally, I use the example of Margaret Edson’s Pulitzer Prize winning drama *W;t* to highlight how these issues can play out at the end of life.

Diagnosing Medicine’s Present Illness

To understand the similar diagnosis of healthcare from both narrative medicine and contemplative care, we have to start with a history. A history of medicine’s present illness, like all histories, could be told with many beginnings, middles, and ends. In the USA, a good place to start is with Abraham Flexner’s landmark report on Medical Education in 1910. Flexner began by setting as his benchmark for medical education the science and research emphasis he found in Germany and the few US schools that followed this model. Using this template, Flexner narrowly defined the proper goals of medicine as the “attempt to fight the battle against disease” (Flexner 1910, 23). He argued that the future of pathology, therapeutics, and medicine depends upon those trained in the methods of natural science. “The human body belongs to the animal world. It is put together of tissues and organs, in their structure, origin, and development not essentially unlike what the biologist is otherwise familiar” (1910, 23).

Flexner’s analogy between humans and animals meant to him that the biological sciences provided the core content for all medical education. Consequently, he argued for medical student admission requirements, what we now call “pre-med,” that concentrated on chemistry, biology, and physics. Once in medical school, Flexner’s first-year curriculum included anatomy, histology, embryology, physiology, and biochemistry, and the second year consisted of pharmacology, pathology, bacteriology, and physical diagnosis. Flexner’s third and fourth years took the student to the hospital setting for clinical experience in the use of the stethoscope, palpitation, and percussion along with laboratory and microscopic skills in the study of excretions, secretions, and tissues.

Flexner’s report was so successful that it transformed US medical schools and created the basic structure for most medical education today. Despite this institutional success, however, over the decades that followed, increasing numbers of clinicians and scholars gradually realized that Flexner’s radical approach to medicine—with its near exclusive interest in the body, biology, and natural science—had a fundamental flaw. Humans are not the same as animals. In addition to bodies, organs, and tissues, humans also live meaning-

centered lives, and they have complicated emotional, historical, cultural, political, religious, and spiritual relations with their bodies, their caretakers, and their social institutions like healthcare. Flexner's vision of medical education created physicians richly sophisticated in the animal part of medicine, biological variables, and biological interventions, but who all too often lost touch with the human aspects of healthcare and the clinical encounter.

By the 1970s and 1980s, meaningful resistance to Flexner's exclusive preoccupation with biology began to emerge from leading physicians. George Engel argued for an expanded "biopsychosocial" approach to medicine which included not only the patients' bodies but also their psychology and their social context (Engel 1977, 1980). Cassell (1982) chimed to redefine the proper goals of medicine not as the battle against disease, but as the tending to human suffering. And McWhinney (1986) joined the chorus of concerned clinicians and urged medicine to adopt a "person-centered" approach which "should aim to understand the meaning of illness for the patient as well as provide a clinical diagnosis."

In addition, many medical philosophers turned to a branch of philosophy known as phenomenology to better understand the limits of biomedicine and the meaning of illness. The founder of phenomenology, German philosopher Edmund Husserl (1859–1938), was a contemporary with Flexner, but he reached very different conclusions about European science. Flexner idealized European science, but Husserl worried about the tendency to idealize science. Writing on the eve of Nazi abuses, Husserl (1970, 299) argued that one-sided European objectivism had become so dominant that it had caused a crisis not only in science but a crisis in Western humanity: "The 'crisis of European existence,' talked about so much today and documented in innumerable symptoms of the breakdown of life, is not an obscure fate, an impenetrable destiny; rather it becomes understandable and transparent against the background of the teleology of European *history* that can be discovered philosophically."

Husserl offered not only a diagnosis of this European crisis but also a treatment. The solution for the crisis of objectivism was a return to the subjective phenomena of experience. Husserl's phenomenology begins by setting aside taken-for-granted presuppositions about the world to study lived experience: what is given in immediate awareness, the phenomena as encountered, precisely as they are encountered. Contemporary medical philosopher Kay Toombs explains that "the task" of phenomenology "is to elucidate and render explicit the taken-for-granted assumptions of everyday life and, particularly, to bring to the fore one's consciousness of the world. In rendering explicit the intentional structures of consciousness, phenomenological reflection discloses the meaning of experience" (Toombs 1998, 2).

This history highlights the key structural conflict within Flexnerian medicine, one could even call it "medicine's present illness." Not long after Flexner holds up German medical education as the supreme model for US medical training and research, Husserl, who many consider the most important German philosopher of the twentieth century, exposed a fundamental conflict at the core of this same European science. Medical science under Flexner so valorized "objective" medical facts that it lost sight of "subjective" and "human" dimensions of illness encounters. In the decades following the Flexner report, medicine drifted toward its own form of illness with the many well-known symptoms of the "healthcare crisis."

This healthcare crisis consists not only of unsustainable costs and gross inequalities of access, but also of "overspecialization; technicism; overprofessionalism; insensitivity to personal and sociocultural values; too narrow a construal of the doctor's role; too much "curing" rather than "caring"; not enough emphasis on prevention, patient participation,

and patient education; too much economic incentive; a “trade school” mentality; over-medicalization of everyday life; inhumane treatment of medical students; overwork by house staff; and deficiencies in verbal and nonverbal communication” (Pellegrino 1979, 9). This list of problems was first compiled by medical philosopher Edmund Pellegrino over 35 years ago, and they have not abated in that time despite many efforts to improve them. With the rise of biomedicalization and biomedical neoliberalism in the 1980s, they are in some ways worse than ever (Clarke et al. 2010). Most important, they all stem from the same fundamental flaw of an idealized objectivism which sits at the heart of Flexner’s approach to medicine—the loss of the human aspects of medical care.

Academic contributions from medical anthropology, medical sociology, psychology of illness, pastoral counseling, religion and health, disability studies, feminist studies, and literature and medicine all reached very similar insights. In addition, a range of playwrights, artists, and poets came to the same conclusions. They all argued for similar system-wide reforms to humanizing healthcare—not only in the clinical practice, but in education, research, and medical infrastructure (Lewis 2011a). There is not room to review this interdisciplinary work in detail, so I will end this section with a poem from physician-poet Rafael Campo—told from the point of view of a Flexner-trained physician—which can stand in for this additional scholarship and creative insights:

Technology and Medicine

The transformation is complete. My eyes
 Are microscopes and cathode X-ray tubes
 In one, so I can see bacteria,
 Your underwear, and even through to bones.
 My hands are hypodermic needles, touch
 Turned into blood: I need to know your salts
 And chemistries, a kind of intimacy
 That won’t bear pondering. It’s more than love,
 More weird than ESP—my mouth, for instance,
 So small and sharp, a dry computer chip
 That never gets to kiss or taste or tell
 A brief truth like “You’re beautiful,” or worse,
 “You’re crying just like me; you are alive.”
 (Campo 1994, 111)

This history of healthcare’s present illness and Campo’s lament brings us to the contemporary era. Medical scholarship has been able to diagnose, even if it has not been able to fully correct, the flaws of Flexner’s overly biocentric approach. These flaws leave hospital systems and even sensitive clinicians like the one in Campo’s poem largely unable to connect with patients at a human level, unable to “taste or tell a brief truth like ‘you’re beautiful,’ or worse, ‘you’re crying just like me; you are alive.’”

The Emergence of Narrative Medicine and Contemplative Care

Narrative medicine and contemplative care are two contemporary efforts to humanize medicine and to counterbalance many of the problems with Flexner’s model. The term “narrative medicine” comes from Rita Charon, an internist and literary scholar, who uses it to describe an approach to medicine that employs narrative skills to augment scientific

understandings of illness (Charon 2005). Narrative medicine brings together insights from more inclusive medical models, such as Engel and Cassel, along with research and insights from the arts, humanities, and interpretive social sciences. Narrative medicine practitioners use these resources to better understand human illness experience, “to recognize, absorb, interpret, and be moved by the stories of illness” (Charon 2006, vii).

As Charon argues, when clinician’s possess “narrative competency,” they can enter the clinical setting with a nuanced capacity for “attentive listening..., adopting alien perspectives, following the narrative thread of the story of another, being curious about other people’s motives and experiences, and tolerating the uncertainty of stories” (Charon 2005, 262). Doctors “*need* rigorous and disciplined training” in narrative reading and writing she argues not just for their own sake (helping deal with the strains and traumas of clinical work); but also “*for the sake of their practice*” (2005, 262). Without such narrative competency, clinicians lack the ability to fully understand their client’s experience of illness. For Charon (2004, 863) and others in narrative medicine, narrative study is not a mere adornment to a doctor’s medical training; it is a crucial and “basic science” that must be mastered for medical practice.

Narrative medicine helps students and clinicians gain this critical narrative competency through a variety of methods. Narrative medicine emphasizes that the process of healing begins with a story told by one person that another receives with the obligation to make sense of it. What the receiver does with the story will depend on the receiver’s “absorptive powers, interpretive accuracy, characterological tendencies, and the bank of stories in the receiver’s possession with which to compare or align this one” (Charon 2006, 108). For advocates of narrative medicine, “good readers make good doctors” because the fate of the received story depends on the preparation of the receiver (2006, 113). Narrative medicine prepares medical practitioners to receive these clinical stories through practice—by reading stories in clinical settings—and through theory—by using insights from humanities and interpretive social science to better understand how clinical stories work.

Using these and related tools, narrative medicine creates clinicians who can stay with the emotional and personal complexities of illness without retreating into silent detachment or worse simply avoiding the human aspects of healthcare all together. Since “sickness opens the door to knowledge of one’s self and one’s values,” Charon (2006, 182) explains, “then the person who cares for the sick has to be prepared to midwife the life scrutiny that inevitably accompanies illness. We have to learn how to listen to the multiple registers of the body, the self, and the storyline and how to respond ethically and dutifully to what we hear.” Physicians must tend to this human part of healthcare as much as they tend to the animal part, “for the body will not bend to ministrations from someone who cannot recognize the self within it, the self exposed to the new light of day by virtue of ruptures in its surface of health” (2006, 182).

The term “contemplative care” has emerged from a recent movement of Buddhist chaplains, care providers, and ministers to bring a rigorous training in meditation and contemplation to the bedside. Roshi O’Hara (2012, xi), a Soto Zen priest and spiritual teacher for the New York Center for Contemplative Care, explains that contemplative care enters healthcare with the core diagnosis that “something is missing in the secular, commercial approaches to caretaking.” But instead of drawing on arts and humanities as narrative medicine has done, contemplative care turns to “a wave of realization in Buddhists communities” that their very practices of contemplation, awareness, and presence render them “uniquely suited to fill this gap—to provide compassionate caretaking” (2012, xi).

This suitability arises because the Buddha, two millennia before Husserl, also advocated a turn back to the phenomenology of experience through the practices of mindfulness and meditation. These meditative practices can generate the skills of awareness and being with suffering that is at the heart of effective caretaking—“true presence, a grounding in the naturally arising reality of the moment” even in times of pain and distress (2012, xi). In the face of the anguish that patients and providers can feel at the bedside, and for which they aptly react with denial or worse, contemplative care practitioners sustain their presence and emotional availability with “a heart/mind that is clear and responsive... offering moment-to-moment opportunities to face the suffering in oneself as well as in others, and to hold in contemplative space” (2012, xii).

None of this means that contemplative care should be equated with “Buddhist care” because there are contemplative practices in other spiritual traditions and because most contemplative practitioners see themselves functioning in an interfaith capacity. However, to date, the bulk of the writing on contemplative care has come from Buddhist practitioners, and for that reason I will stay with contemplative care as understood by these practitioners. The Buddhist lineages contributing to contemplative care are many, ranging “from Japanese and Korean Zen to Tibetan Vajrayana and Shambhala, to Pure Land, to Theravada vipassna” to name a few (Simmer-Brown 2012, xiii). But, as interfaith minister and Buddhist Chaplain Jennifer Block explains, the seeds of contemplative care in all of these traditions goes back to the Buddha. “The three most common causes of people needing healthcare in our day—old age, sickness, and dying—were the very same that inspired the Buddha to reach beyond the familiar into greater truth and happiness. In doing so, he eventually found a path to peace in the mist of all that is difficult, uncomfortable, and confounding... For 2500 years, Buddhists have contemplated sickness, old age, and death to find an end to suffering” (Block 2012, 3).

To compare and contrast narrative medicine and contemplative care, we can use Block’s six dimensions to contemplative practice as an organizing frame. Block usefully articulates these as follows:

- (a) willingness to bear witness
- (b) willingness to help others discover their own truth
- (c) willingness to sit and listen to stories that have meaning and value
- (d) helping another face life [and death] directly
- (e) welcoming paradox and ambiguity into care—and trusting that these will emerge into some degree of awakening
- (f) creating opportunities for the people to awaken to their True Nature (2012, 7).

We can further sort this list by breaking it into two key aspects

1. empathic assistance
2. spiritual support.

The first three dimensions in Block’s list—bearing witness, discovering personal truths, and listening to stories—overlap with the empathic assistance fostered in narrative care. The last three—facing life and death directly, welcoming paradox, and awakening to True Nature—tend toward spiritual support of contemplative care that goes beyond the usual focus of narrative medicine. These two key aspects help us highlight a distinction between narrative care and contemplative care in their response to healthcare’s needs. Narrative medicine focuses on empathic assistance; contemplative care adds to empathic assistance a focus on spiritual support.

Another important distinction between narrative medicine and contemplative care is that contemplative care emphasizes not only the patient but also the *provider's ongoing practice*. In contemplative care, healthcare workers are more than providers, they are also “practitioners.” This practice runs deep in contemplative care, and it includes seeing healthcare service as an opportunity for contemplative and spiritual growth for the providers themselves. When providing healthcare becomes a contemplative practice, it insures that “the healing goes both ways... practicing contemplative care strengthens the care-takers’s own Buddhist practice” at the same time that it helps the practitioner provide the care needed (Simmer-Brown 2012, xii).

Narrative Medicine and Contemplative Care at the End of Life

Stepping back from this philosophic work, let us bring our study of narrative medicine and contemplative care to the bedside. For a “case example,” I use the dramatic portrayal of end of life in the Pulitzer Prize winning play *W;t* by Edson (1999). The use of literary narratives and characters as case examples has been well developed in narrative medicine (Lewis 2011b, 75–86). Often done in small groups and classes, this reading and reflecting on texts allows and encourages healthcare providers to stay present with issues and emotions, including those of suffering and grief, which can be otherwise lost in healthcare education, research, and practice. Accordingly, the goal in these readings is not to do a literary analysis, but to consider and contemplate the human needs and desires of selected characters as they work through the suffering portrayed in the artistic representation.¹

The story of *W;t* revolves around “the case” of Vivian Bearing, Ph.D., who is a renowned professor of English specializing in the sonnets of John Donne. Bearing has been diagnosed at age 50 with terminal ovarian cancer and is being treated throughout the play in a Flexnerian hospital. The key characters in addition to Bearing are her oncologist, Harvey Kelekian, M.D., his training fellow, Jason Posner, M.D., her primary nurse, Susie Monahan, RN, B.S.N, and Bearing’s academic mentor, professor emeriti of English Literature, E. M. Ashford, Ph.D. The plot provides a rich portrayal of Bearing’s narrative arch through her diagnosis, her experience of treatment, and her death. For teaching and discussion purposes, there is an excellent film adaptation directed by Mike Nichols with Emma Thompson playing Professor Bearing.

Edson begins the play with Bearing talking to the audience in a familiar tone about her experiences surrounding cancer, starting with a recollection of her diagnosis. In this scene (played as a flashback), Kelekian stands behind a large imposing desk and begins the clinical encounter with the blunt pronouncement “You have cancer.” Bearing sits, almost falls, down telling the audience she is in “shock” (1999, 7). Kelekian nonetheless continues relentlessly “Miss Bearing, you have advanced metastatic ovarian cancer... [it] went undetected in states one, two, and three. Now it is an insidious adenocarcinoma, which has spread from the primary adnexal mass...” (1999, 7). The dialogue between Kelekian and Bearing then splits in two—with Kelekian’s lines on one side of the page and Bearing’s lines on the other side. Kelekian goes on with a highly jargonized description of his treatment plan composed of an experimental combination of chemotherapies given in three-day hospital stays with intensive monitoring and testing that will be repeated through

¹ Interestingly, narrative medicine’s close reading of fictional texts combined with analysis and reflection concerning relevant issues for healthcare is perhaps the closest analogy within healthcare to a kind of spontaneous “contemplative practice.” One could see it as a kind of spontaneous *lectio divina*.

a series of eight cycles. While Kelekian is speaking, Bearing moves into a self-reverie about the emotional reality Kelekian's jargon and about what some of the words might mean, such as "insidious" and "antineoplastic" and "pernicious."

This scene opens up with surgical precision the core issues of healthcare's current illness as diagnosed by both narrative medicine and contemplative care. Kelekian, trained in the Flexner model to be preoccupied almost solely with biological variables and biological research, fails to connect with Bearing's phenomenological experience, much less her social context or her spiritual concerns. For Kelekian, Bearing has become a sack of body parts and organ functions, and she is no longer a human being with hopes, dreams, fears, and griefs. Indeed, Bearing has not only lost her subjectivity, she has lost her autonomy and her free will. Kelekian goes through the ritual of "informed consent" at the end of their parallel monologues, but there has been no meaningful communication or real consideration of options.

Kelekian, as a result, forces his will on Bearing at a time when she is in shock from the diagnosis. Kelekian signs her up for an experimental treatment for which he has much to gain, but which the benefits for her are minimal and the costs and risks are extreme. He provides some discussion of side effects which Bearing does not really hear or have time to process, but he provides no mention of the fact that this treatment has a very poor outcome or that the survival rate of stage IV ovarian cancer at the end of 5 years is 14 % and at the end of 10 years 0 %. There is no discussion that she might prefer to take a more palliative route rather than a curative route in this situation. Although it is possible, judging from Bearing's character style, that she would choose to go forward with Kelekian's plan even if she was more properly informed, that possibility remains only a possibility since Bearing was never meaningfully included in the initial treatment plan.

Kelekian's failure to connect with Bearing at the level of her phenomenological experience is passed down to his training fellow, Dr. Posner, and the two of them continue to treat her as biological material throughout the play. Edson portrays this in a series of embarrassing scenes, the most obvious being a medical history and pelvic exam where Posner is shown as wholly incapable of even rudimentary person-centered care. In another scene that Bearing labels "Grand Rounds," the medical staffs surround her bedside for teaching purposes and proceed to pull up her gown and discuss her as if she was a laboratory specimen. And the most horrendous scene is at the end of the play when Posner calls a code after Bearing's heart stops despite her specific request for him not to do so. Edson's choice to make these scenes so stark has led to some readers and viewers of the play, particularly in medical settings, to see *W;t* as a story of "bad apples." The problem from the "bad apples" perspective is not the Flexnerian medical system, the problem is that a few clinicians go to extremes.

But if we read the play at a more symbolic or structural level, Kelekian and Posner's preoccupation with biological variables and research above all else—with almost complete blindness to Bearing's lived experience—gives a fairly accurate portrayal of the amount of status and time given to person-centered variables in healthcare research, training, and infrastructure (particularly the limited time and reimbursement for humanistic care). In other words, Kelekian and Posner's relationship with Bearing is structured into their identity as Flexnerian physicians through their long training in the research, education, and infrastructural practices of biomedicine. It is true that some physicians rise above their training to develop an "art" of clinical care, and to be fair the Flexner system both encourages this and has made some strides to address it, but the relative amount of research, training, and infrastructural support for these aspects of healthcare remains minimal.

This problem is where medical humanities and contemplative care have sought to intervene. What is particularly interesting about *W;t* is that it not only portrays the key problems with Flexnerian healthcare, it also gives us windows into what more comprehensive and compassionate healthcare might look like. There are no specific portrayals of “medical humanities” or “contemplative care,” but the two other leading characters, Monahan (her primary nurse) and Ashford (Bearing’s mentor) can be seen, respectively, as embodying the skills and practices of narrative medicine and contemplative care. If we think of them from a structural or symbolic perspective, they both give us a good sense of what is missing from Flexner care—empathic assistance and spiritual support.

Monahan’s role in the play of providing empathic assistance is portrayed in a series of hospital scenes. Using Blocks’ outline from above, we can see Monahan’s “willingness to bear witness” from the way she responds when Bearing calls her for assistance in the middle of the night (even though Bearing has no specific biological problem at the time). This scene takes place fairly late in the play when Bearing has already gone through the tremendously arduous and repetitive treatment course with side effects of fatigue, malaise, nausea, vomiting, weight loss, hair loss, fever, chills, septicemia, intravenous antibiotics, and isolation with little or no impact on her cancer. To bring Monahan in the room, Bearing pretends like there is something wrong with her I.V., but the issue she is concerned about is not physical but emotional—she is scared. Monahan starts the conversation, “What is the trouble, sweetheart? (1999, 64).” Monahan’s use of “sweetheart” is an empathic move of considerable complexity as Bearing makes clear that no one ever calls her “sweetheart” in normal life. In this situation, however, not only is it appropriate, but Bearing seems to be able to make remarkable use out of the agape, or unconditional positive regard, “sweetheart” suggests.

Bearing goes on to tell Monahan about how frightened and unsure she has become about the treatment and what is happening to her. Monahan’s response is simply to bear witness:

Monahan: What you’re doing is very hard.
 Bearing: Hard things are what I like best.
 Monahan: It’s not the same. It’s like it’s out of control, isn’t it?
 Bearing: (Crying, in spite of herself) I’m scared.
 Monahan: (Stroking her) Oh, honey, of course you are.
 Bearing: I want...
 Monahan: I know. It’s hard.
 Bearing: I don’t feel sure of myself anymore.
 Monahan: And you used to feel sure.
 Bearing: (Crying) Oh, yes, I used to feel sure.
 Monahan: Vivian, It’s all right. I know. It hurts. I know. It’s all right. Do you want a tissue? It’s all right (silence). Vivian, would you like a Popsicle?
 Bearing: (Like a child). Yes, please.
 Monahan: I’ll get it for you. I’ll be right back.
 Bearing: Thank you. (1999, 65).

Monahan’s capacity to bear witness in this scene, to empathically connect and stay with Bearing in this time of personal need, contrasts sharply with what happened a little earlier in the play when Bearing tries to talk with Posner about similar concerns. In the scene with Posner, Bearing asks a similar question “What do you say when a patient is... apprehensive... frightened?” Posner responds completely out of context with the bizarre answer: “Of who?” (1999, 58). He then proceeds to give Bearing a mental state examination and

considers ordering another test. These responses leave Bearing alone with her fears and show that Posner has little understanding of the more humanistic side of healthcare.

Returning to the scene with Monahan, when Monahan comes back with the popsicle, Bearing invites her to sit down by the bedside and share it. Monahan agrees, and in this scene we see her empathic capacity to sit and listen to stories that have meaning and value and her willingness to help others discover their own truth. The “truth” at issue here is that the treatment is failing and Bearing’s death is imminent—a topic that has been avoided by Kelekian and Posner. Monahan begins by saying “Vivian, there’s something we need to talk about, you need to think about” (1999, 66). In the conversation, Bearing, seemingly for the first time, admits to herself the simple truth: “My cancer is not being cured, is it” (1999, 66). She realizes also that Kelekian and Posner knew this from beginning of the treatment: “They never expected it to be, did they” (1999, 67). Although these look like questions, there are no question marks. As a result, the statements that look like questions are, it seems, less questions and more acknowledgements of a truth Bearing has known but has not been able to face without Monahan’s assistance and empathic concern.

Bearing and Monahan sit with this truth, try to put it in some perspective regarding the value of research, and proceed to make plans about what to do when Bearing’s heart stops. Bearing is ambivalent, she has been pushing so hard for so long, but she decides in a kind of epiphany that she does not want to have a code. She would prefer to be “Do Not Resuscitate” (1999, 67). Monahan empathically recognizes the shift in Bearing attitude so she does not simply leave it at that—she double checks to see if this is what Bearing is really wants. Monahan starts by reassuring Bearing that if she wants a code when her heart stops “It’s okay. It’s up to you—.” But Bearing is clear and responds simply “Let it stop.” Monahan triple checks “Really?” Bearing responds again “Yes.” Monahan quadruple checks “So if your heart stops beating—” and again Bearing replies “Just let it stop.” Monahan checks one more time “Sure?” Bearing says “Yes.” Monahan agrees “Okay, I’ll get Kelekian to give the order” (1999, 69).

We have no evidence in the play that Monahan has been trained in narrative medicine, but throughout these scenes she gives a vivid portrayal of the empathic assistance that narrative medicine fosters. This is the very humanistic care that is so critical for healthcare and that can so easily be lost through the Flexnerian emphasis on biology as the primary variable and concern.²

But *W;t* does not stop with contrasting the biological care of Kelekian and Posner with the more narrative care of Monahan. Edson uses the play to also show another level of contrast, this time between the narrative care of Monahan and the more spiritual care of Bearing’s mentor, Professor Ashford. There is only one hospital scene between Ashford and Bearing, so it is something of an interpretive leap to call it “spiritual care.” But structurally the scene is important for understanding how—as important as humanistic care can be—there is still another register of care that Monahan would be unlikely to fulfill and

² In the case of *W;t*, humanistic care was not completely lost because of Monahan. But Monahan’s work is only a small part of Bearing’s overall care and there is no guarantee in today’s healthcare one will meet a nurse like Monahan. Certainly, the difference between nurses and doctors in terms of role and often gender means that there is a greater chance that a nurse will provide humanistic care. But this is just a chance because nursing has also largely embraced the primacy of biological science and gender and sex roles are fluid in today’s hospital system. Kelekian could have been played by a woman and Monahan by a man. It seems that regardless of the role or the sex of the healthcare worker, it is unlikely that the more feminine/maternal values of empathic, warm, and emotionally attuned care will be given priority in today’s medical system. And, even if these values are still around to some degree, it is unlikely they would flourish to the level Monahan exhibits without specific training and encouragement. It is this training and encouragement that narrative medicine provides.

that matters for many in the face of illness and death. If we use Block's outline again, we can see that Ashford's care in this scene includes the first three we have called "empathic assistance" but that it also brings in "spiritual supports" that provides an additional dimension to Bearing's care.

The hospital scene with Ashford takes place near the end of the play, when Bearing knows she is about to die and she is suffering from both physical agony and emotional despair. Bearing has not told Ashford of her illness, but Ashford finds out when she comes into town for a visit and is directed from the university to the hospital. As Ashford walks into the room, her remarkably high empathic attunement understands the situation almost immediately, and she quickly steps into the humanistic role of bearing witness, helping discover truth, and being with stories that have meaning and value. In addition, Ashford easily flows from humanistic care to a more spiritual care of the last three items on Block's outline: helping Bearing face life and death directly, welcoming and trusting paradox, and creating opportunities to awaken to True Nature.

These last three items are very far from hospital routine and Edson signifies this by having Ashford abandon all hospital protocol. Rather than stand at the bedside (as Kelekian and Posner do) or sit at the bedside (as Monahan does), Ashford takes off her shoes, lowers the bedrail, and gets into the bed with Bearing and puts her arm around her. By pointing this out, I'm not suggesting that spiritual care requires literally getting in the hospital bed, I'm only highlighting how Edson uses these stage directions to help us see that we have moved beyond the norm of even the most humanistic care.

Ashford, knowing that Bearing has made a career of John Donne's theologically inspired Holy sonnets, offers to recite some of Donne's poetry to help her face her imminent death to provide spiritual consolation. Bearing responds to this suggestion with an emphatic "Nooooooo" (1999, 80). It seems that the last thing spiritual care means for Bearing at this time is theological analysis and reflection. Ashford understands and even welcomes this reaction, abandons the suggestion, and paradoxically moves instead to a children's book *The Runaway Bunny* she has brought along for her grandson. Ashford trusts that being with the moment of Bearing's desires will bring fruits, even awakening, much more than trying to push an agenda for what Bearing may need. As Ashford begins to read, Bearing nestles in, drifting in and out of sleep:

Once there was a little bunny who wanted to run away.

So he said to his mother, "I'm running away."

"If you run away," said his mother, I will run after you. For you are my little bunny."

"If you run after me," said the little bunny, "I will become a fish in a trout stream and I will swim away from you."

"If you become a fish in a trout stream," said his mother, "I will become a fisherman and I will fish for you."

Ashford, on reading this line, thinks out loud:

"Look at that. A little allegory of the soul. No matter where it hides, God will find it. See Vivian?"

Bearing responds with a moan, "Uhhhhh," as Ashford continues:

"If you become a fisherman," said the little bunny, "I will be a bird and fly away from you."

"If you become a bird and fly away from me," said his mother, "I will be a tree that you come home to."

(Ashford to herself) Very clever.

“Shucks,” said the little bunny, “I might just as well stay where I am and be your little bunny.”

And so he did.

“Have a carrot,” said the mother bunny.

(Ashford to herself) Wonderful. (1999, 80)

In the process of Ashford’s reading, Bearing relaxes, her breathing calms, and she falls asleep. Ashford gathers her things to leave, leans over and kisses Bearing, and says in a whisper “It’s time to go. And flights of angels sing thee to thy sleep” (1999, 80). In the next scene, Posner walks into find that Bearing has died.

There could be many ways to interpret this scene, but, in the context of this chapter, it makes sense to see Ashford as providing spiritual care consistent with the last dimension of Block’s outline: “creating opportunities for people to awaken to their True Nature.” In the Buddhist tradition, Block explains spiritual care involves helping people realize that there is beauty and safety in change, including the change of dying. “We can learn to dwell peacefully in ‘things as they are’ and develop and unconditional openness to whatever arises, is born, and/or dies—within the self, others and all creation” (Block 2012, 5). It is the awakening of wisdom and compassion into this awareness of non-duality that Block calls “True Nature.” Citing Zen master Thich Nhat Hanh, wisdom here is the “awareness of the interbeing nature of all that one observes—seeing the one in the many, all manifestations of birth and death, coming and going, and so on—without being caught in the illusion of separateness” (2012, 6). With this understanding, “compassion can be defined as liberation of separateness. A heart can be broken open to compassion through suffering, as well as through love. One experiences compassion as a great affection for creation as manifest in the self, others, and the nonhuman world” (2012, 6).

Block’s choice to capitalize “True Nature” connects her particular Buddhist perspective to a long tradition of perennialist philosophy and theology. From a perennialist perspective not only Buddhism, but all the spiritual traditions open in their deepest wisdom to a common mystical core of unitary consciousness—an ineffable awareness that all things are One—combined with sense of clarity, sacredness, paradoxicality, and love (Stace 1960; Hood 2006). This means that Ashford’s reading of the Christian inflected story from *The Runaway Bunny* would be a finger pointing to the moon of a True Nature that can be found in many traditions, including Donne’s theological poems and the Buddhist idea of inter-being. Block sees spiritual care as helping people access this awareness, and she sees it as a possibility available anywhere and everywhere. “Spiritual care means helping people access the stillness, clarity, and love existing within our hearts.” Block finds that in hospital settings, sometimes her presence can be a catalyst that combines with the suffering and impermanence of illness for this kind of release to happen. As Block puts it, the awakening allows “room for grief, for relief, for mystery, for joy. Gone is the sense of separation, of internal nothingness, or of not being quite present. This is what I call the mystery of spirituality and healing” (Block 2012, 7).

It must be added that the perennial perspective of an underlying mystical truth, and a capital letter “True Nature,” is deeply controversial in religious studies and philosophy of religion. Strong anti-essentialist arguments have been marshaled against perennialism that makes the case for much more constructivist perspective (Katz 1978). But there are also “third way” approaches to mystical awareness that avoid setting up binaries between either “constructivism” or “essentialism” (Schmidt 2003; Kripal 2004; Ferrer and Sherman 2009; Tyler 2011). If we take these third way approaches seriously, we do not necessarily have to abandon Block’s capital letters. We can simply interpret them consistent with a

third way approach. The capital letters that signify coming home to our “True Nature” can refer less to an essential truth and more to a possibility of peace from spiritual wisdom that we can understand to be of capital importance (Lewis, forthcoming). Philosopher Cupitt (1998, 122) describes the spiritual peace that can arise from mystical traditions as “a happiness that so fills a person and her world that she can be confident that it will never entirely forsake her, however bad things get to be. It can and it does remain with one even during very severe suffering, which makes it the sort of happiness that delivers us from the fear of death; with it, as the saying goes, one can ‘die happy.’ Like a great love, this sort of happiness colors everything.”

As Bearing makes clear and as most contemplative care practitioners echo, these kinds of philosophical and theological arguments are rarely at issue in spiritual care at the bedside. What is being transmitted in spiritual care with regard to the possibility of peace in the face of bodily and ego dissolution is often beyond words or conscious recognition. When Roshi O’Hara (2012, xi) asked an oncology nurse to describe what contemplative care added to the hospital setting, the nurse simply smiled and said “there’s just something about the Buddhist chaplains—simply the way they walk down the hall seems to put people at ease.” This “just something” that is beyond words but can be felt by the very presence, the very walk down the hall, of a contemplative practitioner is critical to healthcare. But to achieve this “just something” goes beyond spiritual knowledge and philosophical arguments. As philosopher Michel (2005) put it in his later writings, to achieve this just something is the fruit of a spiritual practice—a way of life and a way of deep knowing—which arises experientially through a meditative emergence rather than through direct observation or rational arguments (Hadot 1995). One cannot for example see “heaven in a wildflower” directly or through arguments, but the insight can arise through a spiritual practice. This kind of practice is less about changing what a person knows, although that is part of it, and more about a very transformation of the person’s way of experiencing and being. It is about the cultivation of that “just something” that the oncology nurse is describing.

This aspect of meditative or spiritual practice brings us to our last comparison with narrative medicine. Giles and Miller (2012, xvii), in their groundbreaking collection *The arts of contemplative care: pioneering voices in Buddhist chaplaincy and pastoral work*, make it clear that contemplative care involves a rigorous training and regular practice in a meditative or contemplative tradition. Contemplative care, we must therefore understand, combines spiritual, emotional, and pastoral support with the provider’s personal practice through a consistent contemplative or meditation lineage and practice. Buddhist chaplaincy has worked this out in tremendous detail building on a range of Buddhist meditative practice traditions.

Practitioners from other spiritual traditions would also have to have a regular meditative or contemplative practice if they are to provide “contemplative care” as Giles and Miller define it. This is possible because contemplative practice rituals exist in most of the spiritual traditions. Psychologist, Oman (2010), in his review of these different contemplative practice traditions found four functions common to these practices—(1) a structured time for formal practice of meditation or contemplation, (2) the development of core character traits and virtues (such as compassion and forgiveness), (3) informal re-centering practices which bring back meditative strength and balance through the day, particularly in occasions of stress and anxiety, and (4) the use of revered spiritual role models and mentors to inspire, motivate, and encourage a sustained practice. It is the use of these practices within a practice community which provides the “just something” that is special to contemplative practitioners, and that is so missing in healthcare settings that it stands out even when a contemplative practitioner walks down the hall.

For the most part, this kind of contemplative practice is also missing in narrative medicine. And, yet, as we mentioned earlier, the narrative medicine practice of close reading does seem to be a move in a similar direction. It is instructive to consider Professor Ashford from *W;t* in this light. Although Ashford provides an excellent exemplar of contemplative care and although she clearly has that “just something” that the oncology nurse is talking about (at least in the film adaptation), she shows no evidence in the play of having a contemplative practice as that term is generally understood.

And yet, much of the play hinges on a scene of close reading similar to what happens in narrative medicine and could be developed into a kind of contemplative practice. The scene comes in a flashback to Bearing’s student days and involves a close reading between Ashford and Bearing of John Donne’s poem “Death be not Proud.”

Death, be not proud, though some have called thee
Mighty and dreadful, for thou art not so;
For those whom thou think’st thou dost overthrow
Die not, poor Death, nor yet canst thou kill me.
From rest and sleep, which but thy pictures be,
Much pleasure; then from thee much more must flow,
And soonest our best men with thee do go,
Rest of their bones, and soul’s delivery.
Thou art slave to fate, chance, kings, and desperate men,
And dost with poison, war, and sickness dwell,
And poppy or charms can make us sleep as well
And better than thy stroke; why swell’st thou then?
One short sleep past, we wake eternally
And death shall be no more; Death, thou shalt die.

In the scene, Ashford and Bearing are in Ashford’s office discussing a paper Bearing has written on the poem. Their discussion makes it clear that Bearing read and interpreted the poem with some comprehension, but her attention to detail does not reach the close reading standards Ashford practices—including the fact that she did not work from the edition of the poem Ashford recommends. Bearing gets the basic idea that the poem is about a “valiant struggle with death, calling on all the forces of intellect and drama to vanquish the enemy” (Edson 1999, 14). But as Ashford explains, on a more contemplative reading, the poem moves beyond the struggle with death and the attempt to conquer death through intellect or wit (which is where the title of the play comes from). The poem “is ultimately about overcoming the seemingly insuperable barriers separating life, death, and eternal life.” Without careful scholarship and a closer more meditative reading, one cannot experience this deeper interpretation. As Ashford puts it

In the edition you chose, this profoundly simple meaning is sacrificed to hysterical punctuation:

And Death—*capital D*—shall be no more—*semicolon!*
Death—*capital D*—*comma*—thou shalt die—*exclamation point!*

If you go in for this sort of thing, I suggest you take up Shakespeare.

Gardner’s edition of the Holy Sonnets returns to the Westmoreland manuscript source of 1610—not for sentimental reasons, I assure you, but because Helen Gardner is a *scholar*. It reads:

And death shall be no more, *comma*, Death though shalt die.

Nothing but a breath—a comma—separates life from life everlasting. It is very simple really. With the original punctuation restored, death is no longer something to act out on a stage, with exclamation points. It is a comma, a pause...

Life, death. Soul, God. Past, present. Not insuperable barriers, not semicolons, just a comma (1999, 14)

After this session of close reading, Bearing goes outside, “the sun was very bright... there were students on the lawn talking about nothing, laughing.” She reflects to herself: “The insuperable barrier between one thing and another is... just a comma? Simple human truth, uncompromising scholarly standards? They’re connected...” (1999, 15). Ashford and Bearing’s close reading in this scene, although taking place in a fully secular setting, has become something of a contemplative practice not unlike the practice of *Lectio Divina* in the Christian tradition (Matter 2012).

Conclusion

Putting this all back together, we can see a common ground between narrative medicine and contemplative care in their diagnosis of healthcare’s present illnesses. Healthcare at its heart is a human profession. A healthcare that disproportionally abstracts only biological variables will forever be inadequate to its mission and will remain in crisis. Narrative medicine and contemplative care understand this and have in common a goal to counterbalance healthcare toward these more human variables. They both value empathic connection with the experiential needs and desires of the clinical encounter. The difference between them is that narrative medicine has emphasized secular needs and contemplative care has emphasized spiritual needs. Since both of these are important, with more integration, they can both inform and augment each other.

Another difference between them is that contemplative care goes beyond narrative medicine to include a meditative and contemplative practice that aims toward a kind spiritual transformation of the practitioners. This transformation creates a way of being that can continue with practitioners in their interactions at the bedside and even when they walk down the hall. This is the “just something” of contemplative care that is largely absent in secular healthcare, including narrative medicine. But, if we use Ashford as an example of contemplative care, we can see that this kind of practice is not so far from secular settings as we might imagine. It is possible that the close reading practice fostered in narrative medicine could be developed more systematically into a kind of contemplative practice. This would involve taking the basic practice and developing it along the lines that Oman outlined in his study of contemplative practices from a variety of traditions. It is also possible to start bringing contemplative practices into healthcare training more directly. This is already starting to happen to some degree with the rise of mindful-based stress reduction for practitioners as well as for patients (Lewis, forthcoming).

How will these dynamics play out in the future? Obviously, no one can say, but the door is open for narrative and humanistic approaches to medicine to join with more spiritual and contemplative approaches. These two traditions have much in common, and they complement each other. They are both critical contributors to the deeper healthcare reform that is to come. This reform will go beyond administration and finance reform and will combine the sophistication of scientific medicine with an equal sophistication in compassionate care.

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