Cartesian Duality and Dissonance in the American Dying Experience

Thesis

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By

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ABSTRACT

The constructs of health and person-hood are created by a culture’s prevailing healing modality. This further defines how individuals experience dying. Through literature review and a personal narrative of American death, this thesis examines the unique situation of American medical authority as it is tied to the State through science-based validation and Cartesian duality.

It is concluded that dying is not a dualistic process and therefore creates a dissonance that must be addressed for individuals to meet death well. Modifications can be made without a loss of cultural identity and there is evidence to support a model of Western medicine that embraces the reductionism needed to advance scientific research while encouraging a return to relational modalities at a General Practitioner level. A medical system that provides for more holistic care approaches, including a return to the original intent of Hospice, will be necessary to provide a less dissonant dying experience.
Dedicated to memories of

Craig Combs and Janet Radakovich
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INTRODUCTION

*Life and Death in the Light of an Eternal Hope* includes a general discussion about the search for meaning in death. While focus is placed upon how death is affected by our religion, I resonated strongly with the statement that, “how death is met, understood and dealt with practically, arises from the social patterns and perceptions that inform that society” (Ballard, 7). While Ballard concludes that beliefs about the presence of a soul and where the soul goes after the body is dead shapes one’s experience of dying, there is more to consider. The compilation *Facing Death*, which Badham edits and includes his own work, attests that there are other considerations simply by the source’s organization of articles (Badham & Ballard, 1996). The book is an interdisciplinary work from lawyers, social workers, theologians, philosophers and medical providers, suggesting that there is a richness in the act of dying that is in need of being stitched into a whole. Ironically, in other work by Badham written from the standpoint of a Christian theologian, his belief in the immortality of the soul is predicated on an investment in duality. He argues in “A Christianity Modern Anglicans can Believe in,” that for the soul to be able to stand alone outside the body, we must accept that the soul and the body are independent structures (2013). This stance seems to suggest that if the soul and the body were to have interdependence during life that the soul could not step free into an afterlife after
death, a position with which those in a culture that allows for the body/mind/soul/social connection in their healing modality would disagree as evidenced by the rich afterlife of the dead in such societies as the Quechua of Ecuador.

Currently, in American hospice research, there is a great need to define how the medical professional should address each individual in their care based on their cultural background. This is an extension of a modern concept of patient-centered care that pervades clinical practice modalities. The very purpose of hospice is to provide a space where we understand that there is more than simply the physical to address during the act of dying. If some non-native Americans have blended into the larger American culture in life, they often return to their traditional cultural norms as a comfort in death, causing difficulties in communication between hospice/hospital staff and family.

The struggle to honor the process of dying is present not just in those that have a cultural background that constitutes the “other”. It seems nearly every day in mainstream media outlets such as newspapers and magazines writers are exploring a growing social angst and dissatisfaction associated with the process of dying in America. The majority of these writers are not lamenting a lack of individual cultural sensitivity; instead, their articles express a struggle with a notion that there is a lack of complexity and empowerment in the dying process. In Louis Profeta’s “I Know You Love Me, Now Let Me Die”, he expresses these missing components in the dying process from the perspective of an emergency
room doctor (2016). The body of Profeta’s patient is merely being kept alive while enduring the pain, indignity and a lack of empowerment for the person who inhabits the skin. The spirit that laughed with her brother as a small child, the young bride carried over the threshold by a new husband, these are forgotten amid the whir of medical technology in a sterile room (Profeta, 2016). The New York Times has also detailed the personal story of a mother’s death at the end of four months of hospital confinement and painful treatment aimed not at healing life but rather prolonging death (Moran, 2016). The American culture now struggles with issues of quality of life versus quantity of life in an age where medical technology can make many things possible demanding that we examine what is socially and/or spiritually acceptable as the definitions of life and death are both being transformed.

Recently, when presented with a personal experience with dying, I too felt a sense of angst and dissonance. There is a cultural undercurrent that I believe is propelling us toward examination of our underlying issues with the process of dying in America. It became clear to me after many conversations, analysis and reading that dying is intended to be complex. Unfortunately, as long as we focus merely on the moment of dying and our attempts to make it “good” we will continually overlook what I believe is at the root of the problem. For this answer, I had to go back to Badham’s assertion that how we meet death is rooted in our societal perceptions (Badham & Ballard, 1996).
The prevailing views of the body in American healthcare have strong roots in a collective acceptance of Cartesian duality, such as life/death, good/evil, natural/supernatural and real/unreal. Rene Descartes, who popularized this way of looking at how our bodies operated put forth the notion that the body and the mind are separate and further, that the body is merely a vehicle for a separately embodied spirit (Lock, 1987, 9). The body is healthy when physical symptoms are addressed and in terms of who is responsible for healing each aspect of the person, there are separate specialists if you are deemed to be ill in mind or spirit. A healthcare provider will generally address only physical symptoms and not treat the mind, spirit or social connections. This is in contrast to the understanding of a complex “person-hood” referring to the body/mind/spirit/social overlay of tangible and intangible bodies in which many other cultures and traditional medical systems base their view of health. In this view of person-hood, it is not just the physical that is addressed in an understanding of health. All parts of the person must be in balance; all must be treated at one and the same time in order for health to be achieved.

In America, the cultural understanding of the body in life exists within this duality as is defined by the dominant mode of healing, the Western medical system. The experience of death arises from social perceptions and an acceptance of this model, thus creating dissonance as the prevailing healing modality attempts to treat each of the layers of person-hood as a separate entity (rather than as an integrated whole). The original structure of hospice care was
created to reincorporate these bodies in the experience of death, but is currently being applied unequally with some Americans being offered alternative options aimed at integration and others dying in a dis-integrated manner. Hospital deaths are often entirely dis-integrated experiences unless someone who is present from the family assists in gathering all the layers into a whole with appropriate therapies. While a long-term solution to the problem would be to add more of the biopsychosocial-spirit model of care into medical practice in general, this is likely not practical in the short term. I believe this solution will involve a negotiation in the medical and scientific community that allows some practitioners to remain in a reductionist space, allowing for continued medical advancement, while the general practitioner model reincorporates the early 19th century model of integrating the idea of health more fully into the community and these layers of person-hood. In the short term, we may address the cultural angst and dissonance that is currently being expressed in mainstream media by investing more energy in reviving some of the original tenets of the hospice movement and ensuring that they are evenly applied to all who seek the service.
CARTESIAN DUALITY IN A PERSONAL DEATH EXPERIENCE

In the spring of 2014, I was present at the deathbed of my father-in-law as he chose to enact his final rite-of-passage at home. He had undergone chemotherapy treatment for liver/bile duct cancer for more than a year before it was evident that there wasn’t much time left. He was given the option of more chemotherapy to extend his life in increments of days or weeks or to enlist the aid of hospice. While he had lived far beyond the expectations of doctors, he considered his quality of life and chose to reach out to hospice.

Over the course of the week preceding his death, the family all gathered to be with him. My role was primarily as a support to my husband, but it was difficult to avoid my professional involvement. My perspective on the role and actions of hospice was different than the rest of the family. Everyone else present was at the time invested in a perspective governed by a dualistic view of his personhood. The doctors had had their say on his body, and the preacher had come to talk about his soul, but these were two very different entities treating separate aspects of the dying person independently. In contrast, my perspective of the situation was governed by a complex view of the need to address all aspects of his person at one and the same time.

While professionally an ethnobotanist and Certified Herbalist in the folkloric tradition, my concept of healing growing up was informed by the same
Western medicine tradition that held a dualistic perspective of the human body. By the time of my father-in-law’s death, however, my professional training had changed my viewpoint to a more holistic view. My training in Ayurveda, Traditional Chinese Medicine (TCM) and Energetic Western Herbalism, as well as personal experiences healing as, and being healed by, a shaman had led me to an understanding that the body/mind/spirit/social aspects of the person cannot be separated when addressing an individual. I had been a practicing herbalist for six years as a private health consultant.

Within the room, I was an outsider in my views and experiences. For that reason, I was very tentative about making suggestions. I did not disagree with the application of pain medicine or even the idea of using medical technology. I simply saw that hospice was not covering all aspects of the person. My first addition to his care was a massage oil I infused with CBD oil and several anti-anxiety and pain-relieving herbs. I taught my husband’s sister and mother how to massage this into the pelvic area to relieve pain, distention and constipation as his kidneys and liver failed. Had it been legal, I would most certainly have infused Cannabis sativa into the oil instead of just CBD oil. Even with this alteration, I was unsure of how the family would react to my suggestions of complementary therapies. Instead of resistance, though, I was met with open minds to whatever I might suggest that could help. My father-in-law had never had a massage before and it became a favorite therapy in his last days. Even when he found it difficult to speak, he would point to his feet, asking for someone to rub them. The family
reported that he slept more easily and needed less pain medication when they kept up the massage.

The night my father-in-law passed, I sat watch at his bedside and was the only person awake in the room. Around me were the sleeping forms of his wife, children and grandchildren. It was a precious gift to be there. The room was still and quiet with no buzzing or whirring from monitors, no announcements over an intercom and no interruptions from hospital staff. Coming from a white, middle-class background, it was a much different death than I had previously experienced. Most other encounters had entailed multiple trips to a medical facility to visit with a seriously ill family member. Inevitably, at some point while we were at home going about our daily lives there was a call informing us of the death during our absence. This is the reality for 80% of deaths in America, while most people polled say they would prefer to die at home (Stanford, n.d.).

This decision felt courageous and beautiful to me, but because of my draw to fill an indefinable gap, I knew that something was missing in the care he was receiving from this particular hospice. In many cases, hospice services include some of the options that I instinctively added to bring a sense of wholeness back to the dying process. In this case, either because of the beliefs of those in charge, or a hesitancy (perhaps similar to the one I had felt) to introduce alternative therapies into a community that is vested in a dualistic view of the body, these options were not offered. Throughout the hospice process I had felt a need to “do” something to fill in what was missing. In the last couple of hours, I
added flower essences to the massage oil that my husband’s mother and sister were working into each one of his hands as they stood comforting him across the veil. Still, in my limited awareness of how to help in this process I felt that I was ill-equipped to help him let go of his body. The energy in the room was “stuck” and oppressive and he repeatedly asked for help.

I will never shake the feeling that his passing could have been eased had there been a guide of some sort. It was as if there had been two teams playing side-by-side, but there was no hand-off. His medical consultants had been concerned with maintaining life, his hospice care was interested in minimizing physical pain, while the religious team was concerned with his soul and the assurance of its salvation and delivery to heaven after death. Because there was no cohesion in the way that his personhood was addressed in this moment of dying, the two teams left a gap with no one “minding the middle.”

It took me lengthy self-analysis to understand that I was the only person in the room who felt as I did. How I viewed the makeup of the person (body/mind/spirit/social) affected how I acted out my role as an observer. The discomfort I felt did not come from anyone else’s distress but my own. My father-in-law’s death had been one that our typical American culture would generally deem as “good.”

My father-in-law had time to prepare himself for dying. In the weeks following his decision to enter hospice at home, his children and grandchildren gathered around him and he held court. There were meetings with his minister to
arrange his service and with the funeral director to pick every detail of his burial. He had private conversations with each of his children and some late nights to reminiscence with his wife. He ensured that he was right socially with his friends and community, emotionally with his family and spiritually with his God and religion.

As I compared historical accounts (Aries, 1974; Fitzsimmons, 2015; Kawano, 2010; Kister, 1997; Lock & Schepers-Hughes, 1987) of how death should be accomplished against my father-in-law’s own death, it was clear that many would consider his to be a “good death”. One common theme emerged, the notion that the personhood of the dying individual should remain intact, that they be able to order their physical body, their mind, their soul and their social connections in order to leave the world in a satisfying way.
CONSIDERATIONS OF POWER IN DYING

My father-in-law was at the center of the performance of his dying. He was in power as much as is possible in the American culture. This was partly effected by his choice to use hospice in his home rather than waiting for a crisis that would take him into the hospital to die. Hospitals have been a source of confusion for the concept of “good death” for some time, instead attempting to provide “acceptable death” (Aries, 1974). Modern hospice research shows that “good death” is generally achieved when there is an awareness of the terminal nature of the situation by both the patient and their relatives and there is open discussion and closure. In Kearl’s model of good death, the individual’s social circle is included and considered (1996).

In the clinical setting, the medical professional is in power, and if the act of dying is painful or ugly there is the suggestion of failure. Thus, to avoid that failure, medication may be overused in some situations simply to avoid the performance of pain such as is described in the inpatient hospice story of Marnie who was sedated with “embarrassingly large doses of sedative drugs” to solve the problem the medical staff was having with her uncomfortable behavior (McNamara 101). Ironically, battles are currently raging around the country over the legal use of Cannabis sativa, which has the ability to provide powerful pain
relief while leaving a patient lucid enough to remain present to hold power over their situation.

I propose that an understanding of complex "person-hood" does not fit into a Cartesian dualistic model. It is rather a complex parallelism where the physical body is overlapped by the layers of intangible bodies (mind/spirit/social) that exist in parallel and are interdependent upon each other for health. The modern hospice movement was founded in 1967 at St. Christophers’ Hospice in London. Cicely Saunders had been caring for the terminally ill since 1948 as a physician and social worker. Her research on pain control in this environment led her to believe that holistic health care was needed for the terminally ill, care that provided for the physical, social, psychological and spiritual needs of each patient. She would eventually craft the idea of ‘total pain' (Saunders and Baines, 1983) that would encompass not just this complicated view of the patient’s personhood, but also the needs of the family, stating that this should be the true unit of care in hospices (Seale, 113-114).

At the time, in Europe, it was not uncommon for religious institutions to take in and care for the dying. The staff in such places were often nuns doing the work of the church, caring for the sick, feeding the hungry and supporting the community. One such place was St. Joseph’s in London where Cicely Saunders worked while gathering her research and which had begun operating as a hospice in 1905. When Saunders came to speak at Yale in 1963 it was to present the idea that there was a need for specialized medical care for dying
patients outside of these traditional establishments, but without the loss of an awareness of their complex needs of person-hood.

Unfortunately, some aspects of the hospice movement have gone down the same road as Western medicine, seeking legitimacy and approval (McNamara 68). In some cases, the practice is holding to its roots providing complementary therapies, a menu of sorts as is evidenced by a randomized trial written for the American Journal of Hospice and Palliative Care in 2009 (Downey et. al.). It has been established that when options are provided that bring a more holistic body experience to the ritual of dying, there are significant benefits for the patients and often for their social relations. Regulation may contribute to this uneven application, steering the movement away from its holistic roots and aligning it with a more palliative philosophy of medical care. One of the foundations of hospice care was its priority on medically managed pain control. This was undoubtedly an advancement over the suffering that Saunders must have witnessed at St. Josephs, but it ironically opened the door to more and more involvement by the medical establishment, eventually creating both the means for the validation of hospice as a scientifically based therapy and a way to carry the practice away from its original intent. The result is evident in what I saw with my father-in-law. In the last few hours of his death we were supplied with (1) a phone number to call when we wanted to increase his pain medication and (2) a pamphlet that detailed the physical steps that patients usually pass through before death (PCHH, 2015). The list was progressive and included changes in
coloring, respiration and even a description of the death rattle. I’m sure the list was intended to provide comfort in the absence of a physician’s real-time explanations about what was happening to a loved one at each stage. Markedly missing was any sort of ritual or ceremony honoring the passing of a soul or therapies aimed at maintaining a space where the patient could remain in charge of their own dying, keeping their personhood of body/mind/soul/social intact as they faced the transition from life to death.
HOW THE MEDICAL MODEL COMPlicates CARTESIAN DUALITY

Evolution of Power in the American Medical Model:

If it is true that the way in which we experience dying arises from our social perceptions, and that the chief perception in that social sphere is one of either duality or holism when it comes to our view of health and the concept of person-hood, then it is important to understand how the way we construct the body becomes entrenched in our social consciousness. We must comprehend how Western medicine in America gained authority over our individual bodies as well as influence in the way we view them. We must also establish how Western medicine in America gained authority over death.

The American medical model is unique because of Western medicine’s influence over regulatory power through the state. This situation does not allow for the legal practice of a healing modality with holistic views of person-hood and, operating in a monopoly, is only challenged at risk of the loss of personal liberty. This creates in the collective consciousness an idea not only of cultural solidarity, but also makes social deviants of those who wish to challenge the prevailing point of view.

In the early 1800’s medical practitioners were not given much credibility due to the oddity and/or severity of many medical practices such as bloodletting with leeches or the use of mercury. “Grannies” and herb doctors who were
practicing using traditional means were much more highly regarded when
treatment was needed. Even an 1837 cookbook suggested that a doctor should
only be called for "inflammation of the bowels, nosebleed or gravel" (Coffin 24).
All other ailments were generally handled by the local grannie, an herb doctor or
by the family matriarch herself.

In the post-Civil war era the medical practitioner began to gain esteem.
Until then, doctors were unregulated because they were seen as rather
ineffective. They might do some good, but doctors of the era certainly were not
going to prevent anyone from dying. Rosenberg (1979) tells us that by the early
19th century, the therapeutic model of medical practice was a holistic one that
viewed the organism and its environment to be in constant interaction (3-25).
Treatment consisted of maintaining balance within and without as evidenced by a
patient’s intake and output (food and waste respectively). This model aligns more
closely with traditional healing systems in other parts of the world that see an
interdependency between the body/mind/spirit/social aspects of personhood
such as is found in Ayurveda or Traditional Chinese Medicine.

As physicians became more successful with treatments, the focus slowly
switched away from this interconnectedness between the many facets of
personhood to a mechanistic and reductionist understanding of bodily functions
bringing practice much more in line with dualism. The popularization of laboratory
pathology gave many in the field a chance to “prove” effectiveness through
science. Advances in science did two things for the Western medical model.
First, it gave the state the ability to capitalize on a cultural acceptance of science-based medicine as being “best,” which allowed for the creation of laws to assure the medical establishment’s power structure. Professor Edward Richards (2003) of the LSU Law Center writes that “respect for individual physicians and respect for ‘proven’ medical knowledge prepared the state for later licensing efforts (8). This cleared the way for government to see that properly licensing medical professionals was in the best interest of public health, safety and welfare, so governments began to define these requirements on a state-by-state basis. These state licensing laws define who is legally allowed to claim the title given, defines the practice of medicine and makes provisions for the punishment of anyone caught practicing outside of those legal requirements.

Within the context of the dying process, this means in most states it is illegal for anyone to offer care to the dying unless they are working in conjunction with or are defined as a medical authority. By the power of the state, the practice of traditional medicine, where a holistic view of the person is usually found, is illegal. Since the creation of original licensing laws for physicians, states have gone on to define who can practice nursing, nutrition and midwifery as well as other medical-related fields.

Second, the “proof” of effectiveness, given through the bias of science, gave legitimacy to the practitioners of Western medicine that they hadn’t had before when they were regarded below the likes of the “grannie” or the herb doctor. Within this structure of scientific and medical authority, the state gained
control over birth and death through regulations on medical care at both the state and national level. These regulations made the medical practitioner the authority at any given scenario where life or death is at stake, relegating religion or traditional medicine practitioners to either secondary roles or outright illegal status. During this rise to power of the Western medical establishment, the practice gained confidence because it was able to forestall death in many areas where before it had been certain. The idea that the practice of medicine could prevent death and therefore, a medical practitioner should be sought in any case where death threatens, was the logical outgrowth.

Currently, there is a state by state call to establish protections on a legislative level for traditional and holistic health practitioners. Within the herbal community there is a split over whether such protections should be sought. Many clinical herbalists crave the legitimacy that has been gained by the medical professions through legislative actions. They long to be able to practice without fear of losing their livelihood or their liberty and wish to be taken seriously and respected by society at-large. Many herbalists, especially those with folkloric backgrounds fear that legislation will regulate the way traditional and holistic health is administered. With regulation comes potential standardization and a coinciding increase in legal requirements. Many herbalists fear a decrease in the ability to use intuition, personal relationship and a holistic view of the human body.
This split in today’s herbal community mirrors the one that occurred in the 19th century as a result of the attainment of legitimacy for rational medicine. A split was created between the scientific researcher and the practitioner who still wished to use personal relationship, intuition and holism in their medical art. This split continues today as we see more and more general or family practitioners being crowded out of practice in favor of corporate, reductionist Western medicine. The lack of ability to maintain relationships with patients and to practice in a manner that addresses the person as an individual is an important factor encouraging many practitioners to leave the medical field (Jauhar, 2014).

The aspiration for legitimacy and proof of effectiveness required a purposeful distance from magico-religious ritual and empirical remedy. Styers (2004) asserted that the “hallmark of modernity is the reflexive differentiation of the present from a “naive” past (4), and this has long been the case within the medical establishment as it works to define itself in opposition to anything not supported by laboratory work. Pellergino points out that as we modernized our medical system, any attempt to diagnose outside what could be tested against scientific evidence was no longer acceptable (245-266). Effectiveness eventually was defined as the capability of an agent to demonstrably and measurably alter the statistically predictable natural history of a disease. This is a marked difference from where the medical profession of the 20th century had begun just one short century prior.
Durkheim would have lauded this interconnected nature of the corporation, as represented by the American Medical Association and the state. He suggested in his work, *Division of Labor*, that in this type of association the state and the corporation naturally pull against one another, creating a system of checks and balances that keep society in order while also ensuring a greater degree of personal liberty (Giddens 16). Unfortunately, in reality this viewpoint is somewhat utopian. As this model played out in America, scientific validation quickly became a dogmatic authority that gave credence to the making of policies that are often in direct conflict with individual freedom. As an example, at the time of this writing the CDC (USHHS, 2016) is seeking public input into a proposal that would give them the right to detain and quarantine anyone that “looks sick” at airports and bus stations without due process in the name of public health and safety. The result of a consolidation of power between the state and an associated corporation can result in unchecked decision-making that perhaps unethically informs what the American society sees as either acceptable social norm or deviance. Through just this type of power consolidation, Pellergrino (1979) points out that the American medical model gained not just respect, but moral authority: “The unavoidable hubris which follows on the successes of scientific therapeutics leads subtly to the assumption that moral, as well as technical authority are vested in the physician” (257). It is this shift, as pathological anatomy and clinical experience combined to provide a new empirically-based clinical medicine and biomedical science, that allowed life and
death to become biologically defined processes and further lent credence to the authoritative stance given to medical practitioners and scientists described as the “medical gaze” (Kaufman & Morgan).

*The Dying Patient* examines the ways in which this new authority of the medical model within the dying experience is acted out. Brim et. al. suggest that expanded life expectancy is one of the most commonly used bits of evidence of Western medicine’s mastery over nature and is therefore its reason for being entrusted with the authority it is given over our bodies (Brim et. al, 1970). Advancements in medicine and medical skill have changed the meaning of the moment of dying, creating the need for new definitions. As a result of these changes, dying has become an unclear state allowing for medical interpretation. In many cases, the death state is determined by a consensus of the medical professionals in the room when no one can think of anything else to try (or as in the case of organ donation, when the body is no longer useful for other purposes) rather than much earlier when the patient ceased the biological functions that would clinically determine death (Volck, 2016; Lock, 2001). In the case of death within an institution, death requires both hospital equipment to assess brain death and medical authority to decide when they are done trying to save the patient. In hospice and institutional death, the determination of death must be made by a medical authority rather than a layperson.

Geertz’s (1988) concept of a “salvational belief in the powers of science fits well with America’s current belief system with regard to medical therapeutics.
People do not expect to die anymore from avoidable ailments, and those that do are relegated to a series of shaming and blaming for their social deviance. Death is the ultimate failure, an event that causes the curious to wonder what the dead did wrong. Health in America is “achieved” or earned. As a result, Scheper-Hughes and Lock (1987) tell us in their analysis of 20th century medical culture that illness is no longer perceived as accidental, but serves as a sign of individual failure to follow social mores, including the politically correct way to eat, exercise and partake of medical technologies (6-41).

It is perhaps most telling that the 20th century construction of dying, as proposed by both Glaser (1968) and Sudnow’s (1967) work, is understood best through the structural features of the hospital and the conversations that can and can’t be had in both the hospital and hospice. With so much research being conducted in the areas of hospital and hospice care, we now see a cultural dance that is impacted by belief of the melting pot concept. Social constraint dictates whether or not the patient should be told they are dying, who is allowed to make the decisions for care and how much is to be discussed regarding treatment. Further, this new construction of dying is now governed by a bureaucratic entity that is attempting to bridge the gap between the laser beam focus of the practitioner on the biology/physical status of the patient and the desire of that patient to integrate their culture, intellect, social status and spirituality (Glazer & Strauss, 1968; Sudnow, 1967).
The Problem of Cartesian Duality in the Medical Model:

Acknowledging Rene Descartes as the man responsible for popularizing substance dualism, we must also recognize that the mind-body problem (the question of how to reconcile that the mental state seems to have some impact on the physical state even though they are separate) he was attempting to solve still remains a problem to this day. Separating the body, mind, soul and social aspects are necessary in a dualistic worldview, but does that work in reality?

If we view the body solely as a physical space that is separate from its environment, we overlook the interdependence between the body and our social connections for health. Lock and Schep-er-Hughes (1987) point out that the body is more than its physical state in isolation by proposing that “the body in health offers a model of organic wholeness; the body in sickness offers a model of social disharmony, conflict and disintegration. Reciprocally, society in “sickness” and in “health” offers a model for understanding the body (7). Their work in critically examining the medical model in our collective consciousness underpins a parallelism between society and the body, or philosophically the awareness that even though the society in which one lives and the body one inhabits constitutes two separate realities, they are structurally alike and can assert causal control over one another.

If we truly believe that the body is separate from the mind, we then overlook the interconnectedness of both to create health. In fact, the Western medical model has grudgingly accepted that there is the potential for the mind to
create illness in the body. During the latter half of the 19th century, as the popularity of laboratory analysis had taken hold, medical therapy for “highly professionalized physicians” [a term used by Pellegrino (1979) to denote the new practitioner who accepted the model of scientific supremacy over relational practice] entailed only what they could tangibly reproduce. Yet Goodman (1988) asserts in her How About Demons that all of the behavioral sciences consider the human being to be a bio-psychological organism. Her work is an important one here in that it points out how the medical establishment continually attempts to explain spiritual experience with a mental disorder diagnosis rather than allowing that the spirit/body connection can elicit tangible physical symptoms.

Lock and Schepers-Hughes (1987) provide further support that the singular premise guiding Western science and clinical medicine is a commitment to dualisms, specifically between (1) spirit and matter, (2) mind and body and (3) real and unreal. They explain that there is a radical materialism that characterizes clinical biomedicine, creating a preference for chemical analysis and laboratory results over social or psychological reasons for illness. The ongoing tension between emerging science coming out of laboratories and health practitioners in private practice who wish to see beyond the numbers has given rise to the practice area of psychoanalytical psychology. Today you would be hard pressed to find a physician that was not aware of the fact that there is a connection between the mind and the body, and this link has been generally accepted within the medical community. Psychosomatic illness today serves as a
catch-all diagnoses for anything that medical science cannot physically define in the lab. In other words, if a condition cannot be physically and scientifically defined, it must be an illness that is “in the patient’s head.” Unfortunately, this awareness of mind/body connection only goes the way of pathogenesis. Western medicine still stops short of making claims that the mind can be involved in healing the body. If we truly believe that the body is separate from the spirit, experiences of spiritual healing that resolve symptoms of illness in the physical realm for those with holistic world-views as they relate to the concept of personhood must be explained away.

The emerging Biopsychosocial-Spiritual model of health seeks to integrate all layers of person-hood into the medical system. While this is not the description used for traditional healing modalities such as Traditional Chinese Medicine and Ayurveda, the concept of this emerging area of thought is similar. The model provides a way to incorporate the best aspects of Western medicine with the inherent structural wisdom of these other traditional systems.

Since 1999, research in the field has included the analysis of how to integrate a spiritual understanding into Western medical practice with representative works such as that done in the Medical Journal of Australia (D'Souza, S57-S59). He highlighted the need to incorporate the various aspects of the patient’s person-hood into clinical practice, believing that we can support the “core” of the patient, providing greater meaning and hope. This work directly applies to the current need in the American dying experience, the need to
reintroduce hope and meaning to the process. In contrast, the collective
consciousness created within American culture supports medical specialization in
the body and a dualism which necessarily requires that individuals must always
be under stress, gathering the specialist resources needed to attempt to piece
the parts of their personhood back together on their own if they want to heal
completely. When that gathering together of resources must be done at the
deathbed it creates an even greater stress. While Americans have now culturally
accepted as a collective that there is something to the mind/body connection, a
large portion of what it takes to treat a whole person in health and to
subsequently provide a satisfying experience of dying is still missing.
HEALING MODALITIES ARRANGED AROUND A HOLISTIC BODY VIEW

Concept of Body in Shamanism: Relation to Death among the Quechua

Shamanism is a system of healing that necessarily complicates the view of the Person, being aware of the physical and intangible layers of body/mind/spirit/social in the way it addresses both health and death. The shaman heals by way of assuring the interconnectedness of these layers and ensuring harmony between the body and nature by moving between the spiritual and earthly realms by way of an ecstatic state. The preservation of this awareness within the shaman’s community of the spirit world in connection with the day-to-day understanding of the body and health creates a more seamless transition between life and death in contrast to the stress of attempting to re-gather the disintegrated layers of self that must occur when dying in America under the Western notion of duality.

There is a strong shamanistic tradition in the Andean highlands among the Quechua who are descendants of the Incas. Shimada and Fitzsimmons tell us in *Living With the Dead In the Andes* that in the Quechua community, all matter is alive and there is no dualism of body and soul. In fact, there isn’t really a separation of life and death. Life merely goes from juicy to dry and brittle on a continuum (11).
In the time of the Incas, ancestor veneration began at death with songs, food, drink and ceremonial wrappings. It continued with offerings of libations in the form of chichi, or maize beer, intended to serve as revitalization and rehydration of the dry ancestor. Intoxication was part of the encounter between the living and the ancestors, and it is plain to see that it was the means by which the community could journey across the void, where the dead would give advice, provide healing or admonish by way of the shaman.

The idea of life moving from juicy to dry mimics the Incan understanding of the body as an interconnected part of nature, similar to a seed in fact. “Life and death have a circulating character; one dries into a seed-like being that gives rise to new life (104). The notion that life makes way, through death, for life mimics the way a plant grows, produces a seed and dies. The Quechua term maliqui (meaning the body bundle of the ancestor) translates to seed, sapling or young plant (Shimada & Fitzsimmons 220). The veneration that occurs then, is a continuation of the Incan practice of offering chicha (also called Agha) filled with aromatic spices to feed the dryness of the ancestors. The rejuvenating liquid nourishes the life that was buried in the dead body of the ancestors, bringing forth more life and engendering communication across the veil.

In the idolatry trials that followed the first wave of “civilization” of the Quechua by the Spanish, it was revealed that the afterlife, UmaPacha, was described as a farm where spirits, like seeds, could flourish back to life with the help of the living performing veneration (Shimada & Fitzsimmons 317). Dying
properly required help from the living as death involved rectification, addressing accounts and releasing tension. Eventually the soul was absorbed into ancestorhood.

In pre-modern societies such as the traditional Quechuas, not only does the dead body of the ancestor provide the resource of stored carbon and other minerals, but pre-modern people believed that the bodies of the dead were “partable”. These bodies housed material, physiological, social, economic and political forces that would become reallocated from dividing up the body. The historical and enthographic evidence of Ecuadorians suggests “pars pro toto”, or a part-whole relationship. In other words, parts of the body have the same life force as the whole body. This pervasive quality of life can be equated to the inseparability of life and death or the living and the dead (Shimada & Fitzsimmons, 86-88). Thus there is no duality.

Much of ceremony that is done today by shaman in Ecuador have to do with cleansing what would be best understood as the aura. The idea of an energy field is really the identification of another part of the person as it is not captured within the body/mind/spirit/social. Thus, the shamanism practice of Ecuador recognizes yet another layer of the person that must be harmonized with the whole to effect health.

As it was described to me, we accumulate energies from other people and experiences. This energy sticks to us like a magnet and must be cleansed in order for us to be free of disease. There are several plants that are capable of
producing an altered state in the rainforests of Ecuador. Both shaman and the practitioners of folk medicine (curanderas or curanderos) within the region will journey for the purpose of gaining wisdom from the ancestors. Both perform similar ceremonies involving limpia of various types. I have experienced both the egg and herbal limpia (bouquets of plants specific to the healing ritual for the individual), which are passed around your energy field to remove mal, or bad energy (Combs, 2014).

There are many ways for individuals to construct their belief sets. In the shamanic model, I believe one way in which people develop their notion of person-hood is by participatory consciousness as described by Sabina Magliocco in her work, Beyond Belief. As someone who has experienced shamanic journeying and healing, I was intrigued by Magliocco’s concept of participatory consciousness, defined as a state of mind that exists alongside rational thought that is intended to create emotional connections to the natural world, evoke ritual and animate the world with spiritual forces through the use of altered states of consciousness (5-24). In Ecuador, for example, the shaman journeys to the realm of spirits often for answers, cures and insight. The shaman goes on behalf of the client or the community. The average client may never journey themselves, but they gain access to participatory consciousness from the shaman’s treatment that allows them to see the complex nature of their person-hood in relation to the natural world. In both this example and with the kut (ritual shamanic performances acting out the presence of the divine among mortal gatherings) of
Korean shaman, the intention is to provide a context for the community’s connection with the spirit world, endowing their understanding of their body with spirit and keeping them whole (Shimada & Fitzsimmons, 2015; Kister, 1997).

Perhaps the clue to the tangible connection between body and spirit is in an ability that lies dormant within all of us, regardless of cultural conditioning. In 1963, Erika Bourguignon, a professor of anthropology at The Ohio State University began to look into altered states of consciousness that were used to communicate with a realm outside of everyday reality. She demonstrated that from a statistical standpoint, nearly all societies include some sort of religious trance that takes place as part of a ritual. Her theory was that there existed a psychobiological capacity for communication with the spirit realm that stood outside the notion of mental illness constructed by Western medicine to explain away any spiritual connection to health (Goodman, 1988).

Bourguignon contended that there is a “genetic endowment” or innate ability in the human body to slip into an altered state to communicate with spirit. Neurological tests show a fast heart rate and an increased rate of theta brain waves that match the rate during sleep. In this trance state, the nervous system appears to pulse or vibrate in a series of contraction and relaxation. Biologist Charles M. Fair believes that both the sympathetic and parasympathetic nervous systems may be involved (Goodman 9).

Trance states across all cultural examples are not typically accessed through accident, though there is a suggestion by some that they may be
“rediscovered” without access to cultural tradition. These states are a conscious shift that virtually all of the impacted cultures train in their young. Altered consciousness appears to occur as a result of the application of sensory cues that may include fasting, ritual bath, sweat lodge, music, drumming, singing, fragrance of incense or crushed aromatic herbs, flickering candles or bright lights (Goodman 11). Many who experience the trance state depict the transition between states as stepping across a physical barrier. I would agree with that assessment based on my initial personal experience with a shaman and subsequent experiences journeying on my own. A culture that discourages the development of this ability may be less able to fully heal and subsequently less able to satisfactorily die in the wholeness that would be available to someone holding a holistic view of person-hood.

In the shamanistic culture as exemplified by the Mudang in Korea, there is an awareness of a connection to nature, a wholeness that includes a connection to the spirit world in all healing experiences. The kut (performed by the Mudang (f.) or Musok (m.) shaman of Korea), for instance, are intended to promote harmony with nature and focus their work on making nature a place where contact with the divine is continually possible (Kister, 1997).

In suggesting that the shaman is capable of becoming a symbol of an inter-connectedness between the worlds I am reminded of Levy-Strauss (1963) in his work, *The Effectiveness of Symbols*. Levi-Strauss believed that shamanic cures were the result of a patient who both believes in the myth that the shaman
presents and is also part of a culture that believes in the myth. In *The Effectiveness of Symbols* he writes, “The tutelary spirits and malevolent spirits, the supernatural monsters and magical animals, are all part of a coherent system on which the native conception of the universe is founded (193-194). He goes on, explaining that those who are cured in the mythology of the shaman not only accept the mythical beings that are part of ritual, they have “never questioned their existence” (194).

At the time of Levi-Strauss’ analysis of the shamanic cure, he was examining a resolution of difficult births in the Cuna community. In the case that he used to support his theory, the shaman and the woman being treated were from the same cultural background and therefore had the potentiality of sharing a belief system. But what happens to Levi-Strauss’ theory when the “patient” and the shaman come from two very different societies? In a personal experience with my own shamanic healing, this was the case.

If we are to accept Levi-Strauss’ theory, my experience would need to fit the mold. First, the patient must believe in the abilities of the shaman. I had no basis for belief, having never met the shaman or studied her culture, at the time that I experienced a body/mind/soul healing. It is probably fair to say that I had enough open-mindedness to accept that there was something to the process, even without understanding it. The second condition according to Levi-Strauss is that the patient must be part of a social structure that believes in the shamanic
cure. Here is where my situation causes real problems for the Levi-Strauss theory.

In my experience, I was completely unaware of what was supposed to happen. There were no suggestions by the shaman who led the exercise. There were no practice forms or guides describing how to do it. My background included a strong Christian upbringing that prepared me for prayer, but set my tissue state at firm rebellion against the idea that I could wander into the spirit world. I had a preconceived notion that ecstatic states were deviant, that they lead to being ostracized. As a child I had seen a young woman kicked out of our church for speaking in tongues. Nonetheless, without any conditioning, cultural awareness or coaching, I found myself stimulated by the drumming and journeyed along with the shaman.

Critique of this positioning of the efficacy of shamanic practice is not unknown. Robert Deliege (2004) took issue with the theory when he suggested that not every mother that might be treated in this way is likely to be present or even conscious at the time that intervention by the shaman is needed. The notion that the cure is really just a precursor to modern psychoanalysis, harnessing a form of abreaction (the theory that repressed emotion can be released by reliving a representation of the situation that caused it) to affect a resolution in the in-between of the mind/body connection, becomes troubled when one half of the patient/shaman duo is not actively participating.
The true crux of my issue with Levi-Strauss is that he argues in *The Sorcerer and His Magic* that “the anthropologist cannot accept that there are supernatural forces capable of healing (164-182). In contrast to this desire to explain away any spiritual involvement in the healing process of the body is the theory of experience-centered spirit belief put forth by folklorist David Hufford. Hufford (1995) introduced the idea that the existence of the spirit world, as can be seen in a society that includes shamanic practice, can be based on real experience. He went on to suggest that this belief can be brought on by spiritual healing or contact with dead loved ones, experiences that would be typical in shamanic healing modality. Thus, Hufford’s theory suggests that experience can create belief rather than Levy-Strauss’ notion that belief must create experience. If we can follow this through to its logical conclusion, there exists the possibility that at least some of the healing that is predicated on a shamanic understanding of the person supports the notion that there is evidence of the interconnectedness of the body/mind/spirit/social and the natural world.
COMPARATIVE ANALYSIS

How a culture comes to view the body is necessarily tied up in how it chooses to organize its healing modality. In all cases, the practitioner must prove effectiveness and fit into the prevailing cultural narrative to gain authority. Both the traditional folk healer and the Western medical practitioner depends on three aspects of belief to prove that their view of the body is valid: they must believe in their own methods, the patient must be a part of a collective consciousness that provides legitimacy in the form of a larger belief set to the healer’s practice and the healer must demonstrate a success rate (proof for the belief).

With modern Western medicine in America, all three aspects of belief that form legitimacy of the practice can arise at a fixed point that does not necessarily need to be continually maintained. That is to say that all three aspects of how this healing modality is capable of informing the way in which a society views the body are entrenched within the collective consciousness and do not necessarily need to be renewed on a patient-by-patient basis. The medical practitioner must believe that their methods are sufficient to effect healing of the body and the patient that would seek help from this practitioner must believe that their personhood exists in either the physical plane or the mental plane, but not both, depending on the practitioner. The spiritual aspect of personhood is addressed by the religious practitioner who is outside the medical model and the social
aspect is always part of cultural discourse but often not well addressed by any specialist. This duality embedded in the collective consciousness and tied to the State through the “proof” of science allows the individual practitioner a greater leeway in the need to prove individual efficacy. Even if the patient doesn’t feel better after treatment, the reductionist state of this healing modality allows for the practitioner to produce statistics and facts that demonstrate efficacy where results are not apparent. Of course, any medical practitioner who is ineffectual with individuals will eventually lose patients, but again with the unique positioning of this model under state authority it is likely that they will be allowed to continue to practice so long as they follow the guidelines of their professional association.

In the case of the traditional healer, for the sake of this thesis we focus here on the shaman, while the first two beliefs can arise ambiguously in the past along a timeline and hold true for an undetermined amount of time, the “proof” of efficacy must be created each and every time a patient is treated. The shaman must believe that they are able to walk between the worlds of the living and the dead and bring about healing. In order to seek the help of the shaman, the community member must accept that there are other worlds that parallel our own and that their person is made up of both the seen and unseen. They must further accept that they can be made sick or well by forces in both the seen and unseen world. Thus, the seemingly fixed part of the belief set that provides legitimacy to the shaman is predicated on a holistic view of person-hood, leaving the individual shaman to prove whether or not they are effective with each case that they heal
or send away without help. The shaman that is not effective is not tied as an individual to any larger organization of power and as an individual will naturally need to find another line of work as patients will not return and new ones will not arrive.

As the basic body view and construction of person-hood is established in a culture it informs not just the way we live, but how we experience dying. The body that dies in the Western medical model in America is viewed as an entity that can be broken up and dealt with in pieces. Rather than a single practitioner that is capable of dealing with the complexity of the dying space, there is a medical doctor, a spiritual advisor, a psychologist and a nurse that often manages the social coordination of the members of an individual’s social sphere. There is no escaping this model because the social fabric is predicated on dualism, no matter whether you die at home, in hospice or the hospital. If the dying person comes from a culture that views the person as a holistic entity, or is part of the American culture but has had experience or education that created a holistic belief set, there will be dissonance at the time of dying due to the lack of seamless care for the whole person.

The evidence found within the example of the ancient Incan and current-day Quechua culture suggests that dying within a belief set that allows for a holistic view of the person is experienced as a continuum. In life, the body is viewed as containing interconnectedness with mind/spirit/social and nature. This
perhaps provides a path by which the mind/spirit/social and nature continues to be experienced even after the physical body has left the equation.

There is further evidence of a human awareness that the body is greater than its tangible manifestations within other cultural ways of healing. Healthcare models such as Ayurveda, Traditional Chinese Medicine and energetic Western herbalism are predicated on the knowledge that health is not achieved in the physical plane alone, that it is critical to balance the body/mind/spirit/social interactions if one is to do anything more than address symptoms.

Medicine, like the rest of culture, is believed to have developed “up”. Everything good was supposedly incorporated and improved while those things without value were discarded. Unfortunately, the evolution of clinical practice with its demand of professionalism has taken away the person-to-person contact. The doctor is no longer part of your community, knowing you personally. They are an authority figure that you often do not know and that you must put your faith in. This is in opposition to the shamanic model and even to earlier stages of Western Medicine where the healer was an integral part of your social group. We are invested in a culture based on duality rather than opening our eyes to the reality that healthy human life does not set itself against its surroundings but rather operates in a wholeness that many non-industrial societies still understand. As a result of this battle with nature, we live a divided life. We lack the understanding that our health is not divided. Health requires “wholeness” between us and the soil, the air, the water… just as individual health requires
“wholeness” between our minds, our bodies, our emotions, our spirit and our community. If we live a divided (unhealthy) life, this division is all we know in death. This is not the essence of the traditional belief of dying which was entirely a social and personal occasion.

Regardless of how modern academicians and physicians attempt to explain away the existence of the spiritual in the health of the individual, the awareness of a parallelism persists. Brady (2001) suggests in her Healing Logics that throughout the non-industrial cultures on the planet, the “most consistent of all, so deeply taken for granted that it escapes notice as a traditional health belief system is the profound almost universal assumption that soul and body are linked in some larger pattern of meaning that should be acknowledged and can even be altered, by prayer (3). This observation comes as part of her comparison of 20th century Western medicine and folk medicine, prying apart the foundation of the myth that we are advancing from one to the other and showing it to be false. Rather than classifying a world view that embraces an interconnected nature between the mind/body/spirit as irrational, she rightly states that these folk medicine systems merely encompass a different set of knowledge generation, incorporating intuition, introspection and experimentation much like the Western medicine model of the early 19th century.

This leaves us with a gap in belief systems that appears to trouble the dying process in America without a solution. Magliocco (2012) offers an option in her work Beyond Belief with her premise that participatory belief and causal
belief should not be seen as mutually exclusive (5-24). Participatory belief, involving all the senses and emotions as well as narrative and ritual and causal belief, involving detached observation of material things, would appear to be apt descriptions of the two very different views of person-hood this paper has presented. Instead of perpetuating the notion that there can be only one kind of information gathering for the foundation of belief, Magliocco instead suggests that the two can work in tandem within the same culture. Perhaps this is a good framework for us to begin to theorize how to put the death experience back together in America.
**CONCLUSION**

The American experience of dying will continue to be a cause for cultural agitation and personal angst while we persist in viewing it through the lens of a dualistic Western medical model. While there may be benefits from the dualism that has pervaded our predominant healthcare model, we have also lost much. The West moved away from the 19th century practitioner model involving intuition, integration of the body with its surroundings and personal touch, at roughly the same time. We have since attempted to force the necessarily holistic process of dying through the eye of a dualistic needle.

The concept of person-hood is not one of either/or, nor is our health or our dying. In the hospital, technicians providing care are trained to treat the body only. Our legal and cultural expectations allow them to do little else but to preserve life at all cost. Hospice was created as a response to this situation. At its inception hospice championed a view that the treatment of the terminally ill required a holistic approach to person-hood, involving the body/mind/spirit/community interconnection. Many communities are still experiencing a branch of this practice that is steeped in its original intention to return the holistic aspect of dying back to those who are leaving this plane while others are not offered the same options in care.
In the short term, if hospice is truly to be of use in our current environment, it needs to seek a revival of its founding principles while standardizing the offering of alternative therapies (massage, aromatherapy, religious counsel, talk therapy, herbal supplements, reiki, acupuncture, etc.) to its patients. It has to stick to its roots, regardless of the variation in the communities in which the practice is offered avoiding the uneven application of its principles from house to house and from house to hospital. I was surprised when my in-laws who were entrenched in Western medical authority were so open to my alternative suggestions. There is a lesson there in how we must provide these options to all families, regardless of what we think their cultural mindsets may be.

In the long term, we must examine whether it is appropriate for our collective consciousness in regards to healthcare to be exclusively dualistic. There is precedent within our own medical model, just a century ago, where our doctors practiced a more holistic form of medicine. Today we are losing General Practitioners and Family Practice M.D.’s at a startling rate, it simply doesn’t fit the model to know the patient instead of focusing on the disease.

To return to a different way of thinking does not necessarily have to mean a regression in our cultural development. I would agree with Durkheimian theory as laid out in his *Division of Labor* that the evolution and advancement of culture is inevitable (Giddens 16). Perhaps instead of seeing our culture as developing along a fixed timeline, which has repeatedly been debunked in cultural studies, we should see the incorporation of the best of the old and new as a next step in
our evolution. There is precedence within Western medical history of the willingness to respond to cultural cues as they relate to practice. In the early part of the 19th century, birth control methods were not mentioned to patients in the office because it was not culturally acceptable. When the American mind became more environmentally conscious and concerns about over-population began to surface, the medical practitioner responded by adding birth control counseling to office visits.

The dissonance surrounding the way we die is growing daily as evidenced in mainstream literature (Moran 2016; Mowe, 2016; Krelikamp, 2016; Lanaglois, 2016). There is a cultural movement to negotiate a way forward that does not take away autonomy in the face of death. There is every reason to hope that this cultural pressure on the medical community can cause another course correction. Magliocco gives us a theoretical framework, allowing the participatory belief we identify with the shaman and the causal belief we identify with the Western medical practitioner to exist within the same healing modality. If we could make room for both ways of defining the body, we might be able to follow Pellegrino’s suggestion in *The Therapeutic Revolution*. His analysis of the state we have come to in the era of “specific and radical therapeutics” (1979) supports my notion that perhaps we have gone a bit too far, giving authority of our bodies over to medicine because of a near religious view of the science which gives it its power. Pellergrino (1979) proposes that we might keep our reductionist research facilities and use them sparingly for well-defined disease states while re-investing
in a fuller understanding of the human body and the personal touch of private practice. Further, we can make more people aware of the biopsychosocial-spirit healthcare model and lend our energy to its legitimacy in general practice. This could go a long way toward redefining our concepts of the body and person-hood in our larger population.

The melting pot of America is continuing to simmer and immigration is changing the makeup of the soup continually. It is estimated that by 2040 the ethnic and cultural fabric will shift in such a way that whites will make up less than 50% of the Population (Frey, 2010). This suggests the possibility that the proportion of those immigrating with or being exposed to a holistic Body view will continue to disrupt the pervasiveness of the dualistic Body view on which America is currently founding its healthcare model. The dying experience is a cultural pressure point, whose dissonance is merely foretelling a coming shift. We could get ahead of the problem by assuring that as a short-term solution our hospice care allows for this more complicated view of person-hood. Until we address the collective consciousness of how we view our body though, allowing for the interaction inherent in such health models as that of biopsychosocial-spirit, we will spend our lives with a dis-integrated view of health and experience a dis-integrated and dissatisfying way of dying.
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