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Reading Medicine: Mind, Body, and Meditation in One Interpretive Community*

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In a series of fascinating lectures concerning the relationship between practices of reading and healing, Brian Stock investigates meditative reading as a mind-body practice that developed in Western societies prior to the scientific revolution. He argues that although we are at the beginnings of scientific investigation of the health benefits of mind-body medicine, such as meditation, there has been insufficient attention to how meditative practices developed not only within non-Western cultures, but within Western premodern societies as well.

Stock begins his historical review by noting that the West as well as the East has had significant traditions of mind-body meditative reading practices. And, like Eastern practices, these were once linked with healing. But unlike the East, the West does not have a continuous tradition of these. Why? Stock tells us that the discontinuity occurred especially during the scientific revolution, so one might suppose it was a result of the rise of modern medicine and science's rejection of religion. Yet this was not the case. The main battle in modern medicine was against the more philosophical treatments of Galenistic medicine. So, if this was not what broke the chain with premodern meditative therapies, what did? It was, he contends, largely due to a change in reading practices themselves—especially the reading of sacred texts. The premodern reading practice was meditative, tied to correction and change of the self. This was gradually replaced with a new humanism. A divide emerged between "the meditative world of the monastic past and the philologically oriented world of the early humanist present" (the 1300s).[1] The former "directed the reader's energies inwards toward the self: its goal was self-scrutiny and self-improvement." The latter, by contrast, "was channeled outwards to a wide range of literary expressions, including the writing of narrative autobiographies" (Stock I, 498).

This meant that we lost something important in our own tradition of reading itself. Stock asks, Is this loss permanent? If not, where might it be recovered? "Are we to assume that in the field of reading as in many others an unbridgeable gulf exists between the present and the premodern period, which cuts us off permanently from the spiritual resources of traditional Western society, as Max Weber long ago suggested, and can only be overcome through the literary and hermeneutic recreation of the past?" (Stock I, 499). He offers an intriguing answer. Such meditative practices and associated views of mind-body connections are being revived, but not within the old domains. Rather, and surprisingly, they have appeared within some new developments in biomedical research. "[Medical] researchers have not detached themselves from earlier attitudes toward mind-body concerns but are

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reexpressing those concerns in a different language. Many of the successful experiments in mind-body medicine are influenced by traditional presuppositions about what mind-body relations should be like: these in turn are rooted in approaches to mind and body that precede the emergence of the field of mind-body medicine by many centuries" (Stock I, 499–500).

In Stock's second lecture, he offers a more detailed explication of this shift in reading practices, one that gradually took hold in the late middle ages (twelfth to fourteenth centuries). Texts themselves, as well as reading practices, changed. They became material for correct understanding rather than material (and he includes visual imagery as well as actual written or oral texts) to be pondered (meditated upon), as an avenue for bringing about inner, and embodied, transformations of experience.

Stock's third lecture is most directly relevant to my paper, for in it he most clearly links narrative, spiritual beliefs and practices, and contemporary clinical work. His own historical analysis provides an invaluable backdrop to my own considerations of these connections in current clinical work. Based on my research, however, I would like to complicate one of his key arguments, namely, that "the period of decline in meditative reading corresponds more or less to the centuries in which there is a weakening of mind-body therapies which had long inhered in the reading process. When the value of meditation was rediscovered by contemporary mind-body medicine, it was done so largely outside the reading process" (Stock III, 516).

There are two ways I propose to amend Stock's very interesting proposal. First, I want to suggest that it is not only within alternative mind-body medicine that claims are being made about the need to develop clinical approaches that recognize the connection of mind to body. Within the "interpretive" or "narrative" traditions of medical scholarship (which include the social sciences, humanities, and activist clinical movements), this has also been a recent focus of attention. I will say a bit more about this presently. Second, a point I also develop subsequently, I will argue that while Stock's claim of a mind-body dualism holds within the framework of espoused biomedical beliefs, this becomes more complex if one expands the picture to include both the actual everyday practices of clinicians and the practices of consumers of medicine (that is, the patients and their families).

Medicine, Mind, Body, and Narrative: Views from Anthropology and Beyond

I enter Stock's argument from my home discipline of cultural (and more specifically medical) anthropology. Stock points out that Western biomedicine is not an obvious place to turn in considering meditative reading or mind-body practices of any kind. After all, he notes: "In Western medicine, disease and health are normally explained through chemical and biological processes" (Stock I, 489). He adds that despite recent experimental research on mind-body practices like meditation, there is still tremendous reluctance in the medical community to look to mind-body practices as legitimate approaches to healing.

Like Stock, anthropologists have described Western biomedicine as a practice that has eschewed a holistic mind-body approach to healing. Anthropologists have been quite critical of Western biomedicine in this regard. They have been especially attentive to a set of assumptions within the culture of medicine that portray biomedical practice and clinical reasoning as an applied natural science. It is not surprising that biomedicine has been reluctant to embrace mind-body practices imported from non-Western healing systems. For, as many have pointed out, biomedicine is based on a language, a mode of perception, and an organization of practice that disregards moral concerns. Those essential moral questions that plague the sufferer of disabling illness—"Why me? Why now? How can I go on with my life?" and even, "Who am I now?"—are precisely the ones biomedicine sidesteps. The history of Western biomedicine has been built upon a progressive distancing from the moral, the cosmological, and the emotional.[2]

This history has gone hand-in-hand with the development of a particular notion of reason itself and has offered a potent image of the doctor as working scientist. Medicine has drawn its prestige and claim to truth by its relation to science. As an applied science that deals with the body, it "is interposed between formal science—our special source of 'truth' about natural processes—and the everyday experiences of such processes."[3] The spiritual, which has been such an important component of healing in many cultural communities, has been firmly set to one side in modern medicine. The body becomes a thing apart from how it is given human (or cosmological) significance. In Western society generally, the rational and instrumental, in which medicine is squarely placed, are separated from the symbolic, the affective, the spiritual, and the social. As anthropologist Jean Comaroff succinctly puts it, biomedicine "asserts a cogent, if implicit world-view, centered upon man as a self-determining, biologically contrived individual, who exists in a context of palpable acts and material things."[4]

Although this dualism is powerful as an espoused picture, and also highly influential in shaping the beliefs of working clinicians, when one actually examines clinical practice, things get muddier. A number of scholars have contended that while medical professionals may have the self-conception that they are practical scientists trafficking in neutral facts and biological universals, their actions belie this. Clinical transactions are necessarily hermeneutic.[5] For one thing, clinicians are often aware that they cannot simply "treat the disease" apart from the person who has it. Such a commitment to a more holistic perspective is often propelled by a prudential concern. After all, patients (especially in the case of chronic or disabling conditions) do not merely *receive* care, they must participate in it. And participation is no minor element of efficacious treatment. They not only need to show up for appointments, or take their prescribed medications, they may also need to carry out arduous home programs of exercise, reform life-long dietary habits, or undertake other very basic and fundamental tasks. In other words, being a "good patient" can mean undergoing a profound project of life transformation that has to take place largely outside the clinical encounter. Clinicians are repeatedly confronted by unmotivated, fearful, or, as they often put it, "non-compliant" patients. For many clinicians (especially some, like rehabilitation therapists), this means that they are drawn, however reluctantly, into considering the patients' beliefs and values, just as a way of trying to figure out how to "motivate" their patients to make lifestyle changes. This difficult and subtle clinical work carries the health professional far from any espoused picture of scientist or technician treating a biological or mechanical problem. Instead, clinicians find themselves, for better or worse, in a much murkier domain where separating mind from body means that treatment is likely to fail.

Such practical, strategic concerns are not the only factors that challenge mind-body dualism in clinical work. There has also been, from many disciplines, an active call to reject a reductionist, biologically-based approach to biomechanical care in favor of a meaning-centered approach. From this latter perspective, a clinical encounter is an exchange between healers and patients who bring their own distinct ways of "making sense" of the disease, its causes, and its impact.

Such a conception of clinical care rejects the assumption that clinical work is confined to the treatment of disease. Rather, it is more appropriate to think of it as treatment of an "illness experience." Among other things, this shift in perspective brings mind and body (as well as culture) into the forefront as an inextricable unit of analysis. Quite obviously, patients' personal and cultural beliefs, values, and experiences influence how they experience the disease.

This alternative conception is grounded in a fundamentally social picture of illness, distinct from the individualism that characterizes biomedicine. For illness as *experienced* always occurs in a context of complex cultural and social worlds, including family and community worlds. An important context is also the interactional and institutional spaces in which health care occurs. This is part of the clinical encounter and the meaning an illness acquires for a patient or family caregiver, whether or not it is acknowledged by clinicians themselves. Narrative has played a significant role in this meaning-centered tradition. Often, though not always, there has been an interest in the dramas which surround illness, in the temporal contexts in which illness occurs, and in illness and healing as dynamic processes in which meaning is not a given but something actors struggle to discover.

Why has narrative become so attractive, especially in connection with chronic or disabling clinical conditions? When illness is protracted, when there is no chance of return to the person one once was, or when there is no hope of being “normal,” a person's very sense of self is lived in a special way through the body. Personal identity becomes intimately tied to the pain, uncertainty, and stigma that come with an afflicted body. What might it mean to be healed when a cure is only a distant possibility or no possibility at all? The inevitable poverty of biomedical responses to this question has a great deal to do with why narrative is so irresistible. Stories reveal a world. They can help transform identity, interpret the meaning of the past and even provide images of possible futures.

Stories can render experience meaningful by placing events into a culturally and personally understandable plot. It is often contended that narratives provide coherence to the chaos introduced by illness. This can be heard in anthropologist (and psychiatrist) Arthur Kleinman, in his influential discussion of illness narratives. “The illness narrative,” he writes, “is a story the patient tells, and significant others retell, to give coherence to the distinctive events and long-term course of suffering. The plot lines, core metaphors, and rhetorical devices that structure the illness narrative are drawn from cultural and personal models for arranging experiences in meaningful ways and for effectively communicating those meanings.”[6]

Telling stories can offer a way to make meaning of what is otherwise unthinkable, uninterpretable. It allows the sufferer to assimilate the illness experience into her life. Gay Becker, in her study of how people deal with disrupted lives created by illness and other unexpected tragedies, notes that creating a coherent plot out of these unexpected and disruptive events constitutes a “crucial imaginative task.”[7] The sociologist Arthur Frank argues along similar lines: “Serious illness is a loss of the ‘destination and map’ that had previously guided the ill person's life: ill people have to learn ‘to think differently.’”[8] He is speaking in general, but also autobiographically, mining his own personal narrative of illness. For him, this different thinking provoked by serious illness engenders a certain kind of storytelling. The ill “learn by hearing themselves tell their stories, absorbing others' reactions, and experiencing their stories being shared.”[9]

Medical and cognitively oriented anthropologists interested in the relation between culture and mind have examined stories in terms of socially shared “explanatory models” of illness and healing, which they explicate and draw upon. This work has resulted in studies of narratively structured explanatory models across a broad range of cultural communities.[10] Some have also turned to recent work in autobiographical memory, investigating culturally shared memories as resources for individual storytellers in constructing meaning out of illness experiences. Memories of the past shape future action, including actions individuals take in seeking to recover from illness.[11]

Narrative plays an increasingly significant role in contemporary critiques of traditional ethics and the rethinking of ethics generally. An interest in narrative within the clinical world has been linked to a concern with ethics—with how to provide a more humane, a more "human-centered" approach to health care. The "call of stories," to borrow an eloquent phrase from Robert Coles, has been a call for exploring life from the inside; a phenomenological concern to understand life (and disease) as lived by particular humans in their particular circumstances. Scholars of clinical practices (a number of them clinicians themselves) have examined narrative as one avenue for "reconcil[ing] the subjectivity and uniqueness of human experience with the physical reality of the body and a larger impersonal picture … "[12]

A number of scholars have proposed an ethical framework that pays special attention to the particularity and context-specific nature of practical action. Rita Charon, a preeminent spokesman for this tradition, puts it this way:

> Any number of alternative approaches to addressing the ethical problems in health care—feminist ethics, communitarian ethics, liberation ethics, phenomenological ethics, casuistry, and virtue ethics—have altered the conceptual geography of bioethics. With their foundations not in law and Anglo-continental moral philosophy but in the particularities of individuals, the singularity of beliefs, the perspectival nature of truth, and the duties of intersubjectivity, new alternative approaches to ethics share a realization that meaning in human life emerges not from rules given but from lived, thick experience and that determinations of right and good by necessity arise from context, plot, time, and character.[13]

All this may seem far afield of Stock's particular concern with meditative reading practices and their connection to healing. But I have made this excursion into interpretive and narrative-centered paradigms to point out the way actual practice can often involve clinicians not only in treating "the body" or "the pathology," but also in getting caught up in negotiations and interpretive struggles with their patients over the *meaning* of the illness as it pertains to a patient's life. Furthermore, as indicated by some reform-minded movements, such as the "narrative medicine" contingent, these forays into the world of meaning are not only occasional, unavoidable aspects of ordinary clinical care. Rather, such reformers argue, attention to meaning is something clinicians *ought* to cultivate in their practice.

Intriguingly, Stock's analysis puts this contemporary discourse in historical perspective. The perception that illness is connected to meaning is actually a revival of earlier traditions rooted in Christian and, prior to Christianity, Jewish and "pagan" beliefs. I will quote him on this point at some length:

> Christian thinkers believed that the essence of a person was nonmaterial. As a consequence, they championed the view that health and disease are best understood through the interaction of body, mind, and spirit. In the Gospels and patristic writings an alternative is proposed to the naturalistic interpretation of the disease; this consists in distinguishing between the *cause* of an illness and its *meaning*. The cause is considered to be natural, but the meaning is cultural (even religious, if one chooses to view the widespread prevalence of disease as the consequence of Adam's sin). The cause can be understood through the analysis of material conditions, but the meaning, however it is conceived, has to be understood through thought and language. (Stock III, 517)

But what of meditation and its role in healing in contemporary health care? Despite biomedicine's decided rejection of spiritual beliefs (which have been so responsible for the cultivation of meditative activities), I want to argue that there are spaces within Western clinical work where meditative practices thrive, though these are often unofficial or even “underground” moments of clinical care. To see where it flourishes, I turn my attention away from clinicians per se to explore the active role of family caregivers as purveyors, as well as recipients, of healing. In contemporary America, within certain highly religious communities, meditative practices, such as prayer, are a critical aspect of healing and are even intermingled with traditional biomedical care. To strengthen my claim that patients can be healers too—a position that is not, at first glance, obvious—I turn to quite another intellectual tradition: reception theory.

Consumers are Producers, Too

What are the implications of this portrayal of clinical care as an interpretive task, a hermeneutic, or, more specifically, narrative transaction? In other words, what is revealed by looking at clinical work as an encounter between clinicians, with their professionally influenced cultural beliefs about illness, the body, and patients, who bring their own beliefs and values to the table? For one, patients emerge not merely as the recipients of health care, but as active agents who help shape it. Modes of consumption are also modes of cultural production, reception theorists argue.[14] Arguments in this “reception theory” tradition have often been directed to looking at how mass media products are taken up and reinvented in local communities. However, this argument has particular relevance for the everyday consumption of biomedical texts as well. Patients and family caregivers are, as consumers, “readers” of the oral and written texts produced by biomedicine. In their reading, they are producers, for they “rewrite” or “reinterpret” the texts in particular ways. In consuming and receiving, they too “produce.” The line between patient (or family care-giver) and healer become blurred. Reception theory offers a compelling picture of just such blurring.

Reception theory's portrayal of consumption challenges any simple textual notion of meaning, that is, the idea that meaning is located in the commodity or media (text) itself. As Debra Spitulnik notes, reception theories presume that meaning is a complex and local practice of negotiation between the world of the text and the world of the audience.[15] Meaning is a historically particular invention shaped by local interpretive communities.

In a chapter entitled “Reading as Poaching,” social theorist Michel de Certeau points out that critiques of mass media generally presume that “the public is molded by the products imposed on it.”[16] This, he states, is based on a misunderstanding of the act of consumption. Such a misunderstanding rests on a notion that consumption is assimilation and that “‘assimilating’ necessarily means ‘becoming similar to’ what one absorbs” (*PE* 167). Against this passive picture, de Certeau offers a radically different view. Rather than *becoming similar* to, consuming can involve *making something similar to* what one is, making it one's own. Elites and the social sciences have, by and large, been inattentive to this aspect of consumption, presuming that “the efficiency of production implies the inertia of consumption,” producing its own ideology of “consumption-as-a-receptacle” (*PE* 167). Such inattention has the significant consequence of not recognizing everyday creativity. As de Certeau puts it, “by challenging ‘consumption’ as it is conceived … we may be able to discover creative activity where it has been denied that any exists” (*PE* 68).

Consuming Medicine and Meditative Healing: An Ethnographic Example

In the remainder of this paper, I will take up these claims about the active role of patients as interpreters and even producers of clinical work and look at how, through their participation, meditative healing practices are brought into clinical care. I draw upon ethnographic research my colleagues and I have been carrying out among one interpretive community. The primary research that informs this paper is a longitudinal ethnography that began in Los Angeles in January 1997 and has been conducted by an interdisciplinary team of anthropologists and occupational therapists. During this study, we have followed a cohort of

African-American families who have children with serious disabilities or chronic illnesses and the health professionals who serve them. We initially recruited thirty African-American families from the Los Angeles area whose children (aged birth to eight) were being treated in several clinical sites. Most families (though not all) were low-income. Eighteen of those initially recruited have continued to participate. Others joined subsequently as some families left the study for various reasons (for example, moving out of state). All families now participating have been part of the project for at least three years.

This continuity of families has allowed us to come to know the ebb and flow of chronic illness and to witness what that means in the never-ending process of negotiating health care with shifting casts of health professionals and changing bureaucratic processes. The research has involved accompanying families to clinical visits, observing and sometimes videotaping those encounters, and separately interviewing participants about what they perceived to have happened in the encounters. We have also observed and videotaped children and families at home and in the community, especially at key family events. This kind of longitudinal design has revealed a great deal about clinical encounters as events in family lives and about multiple perspectives between families and clinicians as these develop and change over time.[17]

As I will try to show, in this interpretive community, a great deal of work is done by families to redress what they see as a key neglect by the clinical community—the neglect of the spiritual. The consumption of biomedicine involves acts of imaginative appropriation in which families creatively remake or reinterpret the oral and written words of clinicians and incorporate them within their own narratives of miraculous recoveries, the power of faith, and the centrality of meditative prayer. Their narratives treat biomedicine as one, but only one, aspect of healing. These stories often underscore the comparative powerlessness and ignorance of biomedical professionals who mistakenly believe healing is only up to them.

Strong critiques of Western medicine are voiced in some of their stories. There is often a concern about its neglect of the spiritual. Without a spiritual perspective, families sometimes say, clinicians lose a broader perspective in which to understand illness and the nature and possibilities of healing. Christian beliefs and, specifically, beliefs in the power of God are called upon to contest the grim prognoses of clinicians. God, parents will often say, not the doctor, is ultimately in charge of life and death. For example, a father stated of his critically ill infant: “The good Lord always told me to wait for this child. She got [one] Christmas, she gonna see another Christmas, and another one after that, until He make up His mind and say her time is up. So I don't listen to the doctors for long.”

As evidence of the validity of such a stance, parents may cite past experiences where their own faith has proven them a better predictor of their children's fate than the “scientific” (and nonspiritual) knowledge that doctors called upon. For instance, one mother remembered a confrontation with a doctor when her daughter, who has had a life-threatening battle with asthma, as well as severe spina bifida, went into a medical crisis when she was an infant. She was rushed to an intensive care unit. Her mother recalls: “And then her doctor in ICU said, ‘She ain't gonna make it til the morning.’ I said, ‘I have faith. You watch and see.’ And she made it … I said, ‘If God wanted to take her, He would have taken her a long time ago.’” When she told this story to us, her daughter was eight-years-old.

Another mother spoke of her daughter who was diagnosed at age three with a cancerous brain tumor. Her little girl's prognosis was very poor and her mother was stunned and despairing at this terrible news. She felt she could not “give in” to this terrifying prognosis and the hopelessness it engendered. She turned to God, praying continually, not only for a miracle, but also as a way to strengthen herself so that she would not lose hope and would be able to fight hard enough to get good medical care for her child. As a poor African-American single mother, she realized she would need all her wits and strength to make sure her daughter received the best clinical care possible. She needed, as she put it, “focus.” She prayed for strength of character to take on this daunting job. She stated: “If I lose hope, then I lose focus. *If* I do. I just think positive every day. And pray that a miracle is coming. And that's it.”

A mother and father spoke of their refusal to give up on their dying child: “The doctors would say, ‘Bring the whole family up here. She's going to die. This is her last day.’ You know, we fed off of that … And [then] something told us … that baby ain't going nowhere. It's amazing, you know? You listen to them doctors, and then you get scared.”

This mother remembered a particular crisis with her critically ill little girl when she was three months old: “They [the doctors] gave my daughter four days. It was January first. It was on a Thursday. They told me before that Monday, my daughter would die. They called the funeral home. The funeral home called the hospital to make arrangements—everything. They told me to cut off my daughter's hair. And I kept telling them, ‘No, no. She's not going. I don't feel like she's going.’ I kept praying for the grace of God to help me, strengthen me because I wasn't ready. [And now,] … she's eighteen months old.”

Her husband recalled a later moment when their child was declared “gone” by the clinicians, but was later resuscitated. He told this story: “I told the doctor when the doctor told me that my child was gone, I said, ‘Doctor, who are you? Who are you? You aren't even nobody. God put you here to do your work, but once God say your time is up, your time is up.’ But me and myself, as being a dad—what I think all parents should do is get your kids christened. Take them to church. Give them back to God.”

As these quotations reveal, the response of many families we have followed is not only to criticize modern medicine for its spiritual oversight, but to undertake their own spiritual practices as part of their responsibility to their children. In the case that follows, it becomes even clearer how family caregivers may try to incorporate practices—including meditative ones like spiritual reading and prayer—within biomedical ones, and even attempt to “convert” their children's clinicians so that they, too, come to realize that healing is always spiritual as well as physical.

When Doctors Need to be Converted

Darrell and Anna had a critically ill baby, Darrelanna. She was born with severe spina bifida and had not been expected to live after birth. She spent most of the two years in which she lived in the neonatal intensive care unit. She was kept alive only with sophisticated medical technology that allowed her to continue to breathe. At the family's insistence, she underwent eighteen surgeries in her short life in order to keep her alive. She was never medically stable. There were a number of times when her heart stopped and clinicians had to revive her. These parents, who were deeply religious, found themselves in a difficult and ongoing confrontation with the clinicians caring for their child. The most basic conflict they faced was that the clinicians, who often told them that their very ill child was “brain dead,” were attempting to get them to agree to a “do not resuscitate” order the next time their child went into a medical crisis. They vehemently refused. Their position, like so many of the families in this study, was that it was not up to the doctors but up to God if or when their child would be taken from them. And because doctors did not incorporate a spiritual position into their practices, or consider it as part of their framework, Darrell and Anna had an added responsibility to bring this perspective into the clinic.

They firmly believed that naturalistic traditions (that is, biological medicine) were extremely important and should be combined with spiritual ones. Their perspective was that while doctors were skilled at some aspects of healing, they, as parents, could also cultivate practices that increased their daughter's chance for healing. Thus, they did not see their task as merely receiving the words of clinicians about the state of their child. Rather, through such meditative practices as lengthy prayer, they could help to bring God's power onto the scene. This might even result in miraculous curing. In this way, they too could actively assist in the production of healing, albeit through a very different avenue. For instance, at one point the doctors told them that their child was a “vegetable.” Darrell responded by intensifying his prayer practices, even bringing his children to church with him to help in praying. He told us, “I can see that we serve only one God, see, and He's a powerful God. And Sunday, me and the boys, we went to church, we sat in that church from eleven to seven, praying, you know.”

It is worth underscoring that Darrell and Anna did not view biomedicine as alternative to, or in contest with, spiritual practices. Both were essential for physical healing. Interestingly, this is a contemporary echo of a more ancient position. Stock notes that in ancient times, there were cultural traditions where spiritual healing and physical healing were united. This unity was not rooted within medical practices per se, which, since Hippocrates, were naturalistic ones. Rather, this complementarity was to be found in spiritually inspired meditative practices.

These parents were unceasing proponents of this perspective to the clinicians. What put this family at odds with their doctors was that this perspective was (unsurprisingly) not shared by clinicians. This was not merely a philosophical difference; it put family and clinical staff in direct and intense conflict. Darrell and Anna argued that their spiritual practices could bring God's power to bear on the fate of their child in a miraculous way. Thus, they were not willing to “pull the plug” on their child. They strongly believed that if the doctors would only come around to their perspective, then they would realize that they should do all within their “naturalistic” power to keep their daughter alive while all—doctors, parents, baby—awaited God's plan. God might either heal their child miraculously and allow her to get well physically, or “heal her in heaven” when he deemed that it was “her time.”

Their unrelenting efforts created great consternation in the clinical team. Since the clinicians could not dissuade the family, they had lengthy team meetings and many internal arguments about what their response should be. One of the most fascinating aspects of this case concerned instances, sometimes witnessed by us on the research team, sometimes told and retold by parents, when the clinicians themselves expressed astonishment that the baby, whom they thought had “died,” was alive after all. The parents saw this as agentive; their child was teaching the doctors about the wisdom and power of God through her own miraculous recoveries, even, apparently, rising from the dead. Such a recovery, of course, recalls the most astonishing healing stories of the Bible, such as the rising of Lazarus or of Christ himself.

The following story, narrated by both parents, recounts one vivid moment when their faith helped them to “convert” some of the doctors. In the passage below, I offer some key segments of their story. It begins with a call from the hospital, a call from a department (most likely social work) that helps families with funeral arrangements.

> Anna: [The hospital] had the lady that arranges for the burial and everything. She called us and told us we would only have to pay for the transportation and the headstone and all that. And I was like, “Well, she ain't dead.” She said, “Well most babies they send me, they be dead already.” And I was like, “Well no, my

> daughter's not dead.” But they still had her call us and stuff… . They had pronounced my baby dead to this lady.
>
> Darrell: Then that woman turned around and called us the same night. “Well where do you want to bury your daughter at?” I said, “My baby's not even dead. Why are you asking that?”

Anna, speaking angrily, relates the confrontation they had been having with the doctors at this time. She is especially incensed and injured that while she and her husband believe they are acting out of faith, out of an ethical position they have struggled to maintain through prayers and calling upon God, the clinicians accuse them of an ethical breach, of being selfish in trying to keep their daughter alive. Anna opens this part of their story in the voice of one of her daughter's doctors:

> That doctor told us, “You guys need to start accepting. Stop praying and start… .” And I said, “No, no, no.” I said, “You never stop praying.” “Huh?” he said. “You all need to start accepting.” No, what did he say? [She pauses, trying to remember his exact words.] “Stop hoping and start accepting, because she's dead… .” They told me that we were being selfish for not pulling the plug on my daughter. I said, “I'm not pulling nothing on my daughter. Nothing!” He said, “So what do you think about that baby just laying there being a vegetable. That's selfish. She's dead. Her brain is dead. You need to pull the plug and get it over with and start accepting it.” And I said, “I don't need to start accepting nothing! You better get away from me!” I was so mad. You know, he hurt my feelings. I was like, you know, how can you tell me something like that? That's my daughter. I want to hold on to her for as long as I can. If God ain't killing her, ain't no way I'm pulling the plug.

Anna and Darrell remember the clinical staff telling them that they could hold their daughter “while she goes” when they “pulled the plug.” To this, Anna narrates her retort: “I said, ‘I can hold her every day now, you know, and breathe with this plug for her.’ You know what I mean? ‘No, I don't want to pull the plug.’ [The doctor] said, ‘Well, it's up to you guys. It's you all's decision.’”

At this point, their story takes a dramatic turn. For, after this medical crisis in which all these confrontations occurred, their daughter revived. While for nearly all her young life she could not breathe without the aid of a ventilator, she improved sufficiently such that she was able to do so. Anna and Darrell recount how the doctors came back to them, apologizing and confessing that they had been wrong. They had presumed Darrelanna was dead (brain dead), but her ability to breathe on her own showed she was not—that she had more brain activity than they had anticipated.

Anna, recalling “the same doctor” who had told them they were being selfish and that they needed to let their child go, gave the following account. “And then the same doctor came and said, ‘This is a miracle. I don't understand why… . ’ He said, ‘But you guys were right. You guys knew your baby, and I am so sorry.’ He said, ‘This is a miracle.’ He said, ‘This is going to go down in history.’ He said he had to go to his higher people to tell them that what he told us, so that they can make it clear in the book that they did pronounce the baby dead. He said they were going to write that in the book, that she was dead, but he had to go back and tell them that she wasn't.”

What is particularly intriguing, from the point of view of Stock's articles, is that two books are juxtaposed here—a spiritual one and a clinical one. The clinical one is explicitly mentioned—it is a book that records clinical events, a clinical history. The revival of their baby constitutes a kind of medical miracle, an event that “is going to go down in history.” But this medical miracle recalls miracles of a spiritual sort, miracles in which God even raises the dead. Thus, “the clinical book” provides an echo of (“makes similar to” in de Certeau's language) the Great Book of God. This implicit reference to the Bible takes on material presence, because while their daughter was kept alive in the NICU through a network of complex machinery connected to many parts of her body, her parents left an open Bible next to her head. In the story Anna tells with her husband, it is the active presence of the two books together that keeps their daughter alive, against all medical odds.

In a later part of the interview, Anna returns to this moment and the doctor's response to the reawakening of their daughter: “The doctor says he's never seen a case like that in his life. But it's not for him to question. It came from Jesus. We prayed. Everybody prayed. I prayed to God that I was strong enough that He wouldn't take my daughter. ‘Please don't take my daughter yet.’ You know? And He didn't. He made her better.”

In subsequent interviews, this doctor conversion story is told and retold by the parents. Darrell tells us how he needs to keep educating the doctors, who are blinded by their own knowledge. “All of them went to college, and they was wrong this time.” He notes that this even shook their faith in their own wisdom. This experience with his daughter “had themselves doubting.” When one doctor expresses surprise at his daughter's continuing to live, Darrell explains to him that he sends God in as well as the doctor to help his daughter. Darrell tells him, “Because I sent her in there with Somebody. I don't just send her in there with you; I send her in there with Somebody else, too.”

In one of the most explicit renderings, Anna tells us: “That doctor said, ‘Well, she can't handle no more.’ I said, ‘What do you mean she can't handle no more? Our God is powerful.’ We had to go show them … All of them [the doctors] came back after she came back [was able to breathe on her own] and they apologized real nicely. They said, ‘You know, we thought that we knew our stuff. But we see now that it is Somebody higher than us. And your family showed us that.’”

This conversion narrative, so steeped in biblical images and plot structures, is naturally quite different from stories the clinicians told us. They spoke in much more ambiguous language to us in our separate interviews with them. But many expressed surprise at the baby's recoveries, and at the resilience of this little girl who, though she did finally die, lived much longer than anticipated and seemed to pull through crisis after crisis, surgery after surgery, despite their predictions.

Conclusion

I conclude by turning to one of the points Stock makes in the conclusion of his third lecture. He tells us, “In the past, as nowadays, mind-body healing can be divided into two parts. In the one, healing is concerned with specific illnesses; in the other, it has to do with a general philosophy of life” (Stock III, 522). Stock notes regretfully that while the new experiments being carried out to test the efficacy of alternative mind-body practices like meditation look at healing in the first sense, we have neither the means to test, nor the wisdom to remember, what the ancients knew, that healing must be linked to the second tradition as well. Or, as he eloquently puts it, “in the ancient view, whether among pagans, Jews, or Christians, the journey of life was conceived to be a preparation for the moment when such resources were needed: these were like a small capital sum that had been put aside for a period of economic turbulence, which, if unused, might continue to accrue interest. But if that capital is missing, mind-body medicine can only supply it in the short term. Our society has not yet relearned what the ancients knew, namely that the moment to prepare oneself for potential difficulties is not the moment when they take place” (Stock III, 523).

If we take the position that consumers of medicine can be producers as well, then matters are more complex. Our society is a heterogeneous place. Within the African-American communities where I have been doing my research (hence in that particular pocket of “our society”), the position about the importance of healing as a lifetime journey is repeatedly underscored. Such practices as meditative prayer are not only called upon in times of crisis when a miracle is hoped for. They are also part of the fabric of everyday life, part and parcel of a spiritual journey that is required in order to meet the hard times that come all too frequently. Meditative prayer is a key component of the work required to become the kind of person who can endure the special suffering brought on by bodily affliction—including the suffering of one's child. Prayer is needed to be “healed” from your own anger or fear, or from the need for control in the face of crisis.

The tragedy that comes with terrible physical suffering or the ominous presence of death also may require special spiritual work, the need to gain strength in order to face whatever will come. Prayer may be called upon in a particularly intense way in times of crisis, but healing is not simply a matter of asking God for a cure. It is always more intricate and subtle, a multifaceted term that treats the spiritual, the emotional, and the physical as interwoven threads of a single cloth. Families use the term “healing” when they refer to their own need to be “healed” from what suffering does to them; they need to get “strength” to face their lives, including the possibility of a loved child's death. I end by recalling the poignant words of two families in our study who have faced this possibility. One, the mother of a little girl dying of cancer, said, “I was praying so much and I was saying [hopeless things]. So I get to talking like this and thinking like this—and I'm believing my baby's not gonna make it, you know? Because I'm already planning to start what I'm gonna do. You know, so I said, ‘I can't take this.’ And then I started getting strength, you know. ’Cause I was praying and people was praying for me and praying for her. And I started getting strength and strength.”

When her child does indeed die a year later, this mother again affirms how God gave her strength and answered her prayers by allowing her to spend even one more year with her child before he “called her back home.” This mother then called upon the strength God had given her to help other families she had met in the hospital whose children were also critically ill. She saw her capacity to face death as a kind of spiritual gift she had cultivated, painfully, through her own prayerful practices she had relied upon so much during her daughter's illness.

The final quotation is from Darrell, the father in the case I gave earlier, who talked about his own struggle as he went to the hospital to see his critically ill child: “‘Lord, please help me. Help me Jesus, they need you.’ You know, but it's, you know, it's just so, it's just so much. [He sighs as he recalls how difficult it was to face his critically ill daughter day after day.] I'm glad the good Lord has strengthened us and made us able. You know, because He, the good Lord He, He ain't going to give us to ones that we can't help. He knows He can't give the ones He can't help. And that's the way He wrote it down for me, and for my wife to happen.”

Darrell remembers how far he and his wife have come on their own spiritual journey, a journey they needed to take to be able to care for such a critically ill child. Their passage has been made only through the help of Jesus. Darrell says, “We came from a long way.” Once he and his wife had been heavy drinkers and drug users, but they had “turned to Christ.” Instead of going to “AA” meetings, he tells us, they used spiritual practices to overcome their addictions. Darrell says Jesus “lightened me up.” Having been lightened up, he and his wife could take on the burden of a daughter who, for two years, hovered near death until she was finally “healed” in heaven.

NOTES

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2. See Comaroff, Jean. Medicine: Symbol and Ideology. In: Wright, Peter; Treacher, Andrew, editors. The Problem of Medical Knowledge: Examining the Social Construction of Medicine. Edinburgh: Edinburgh University Press; 1982. p. 49-68.Jensen, Uffe. Practice and Progress: A Theory for the Modern Health-Care System. London: Blackwell Scientific Publications; 1987. Kirmayer, Laurence. Mind and Body as Metaphors: Hidden Values in Biomedicine. In: Lock, Margaret; Gordon, Deborah, editors. Biomedicine Examined. Dordrecht, Neth.: Kluwer Academic Press; 1988. p. 58-93.
3. Comaroff. Medicine. Vol. 55.
4. Comaroff. Medicine. Vol. 57.
5. See Good, Byron; Good, Mary-Jo DelVecchio. The Meaning of Symptoms: A Cultural Hermeneutic Model for Clinical Practice. In: Eisenberg, Leon; Kleinman, Arthur, editors. The Relevance of Social Science for Medicine. Norwell, MA: D. Reidel; 1980. p. 165-96.Good; Good. The Semantics of Medical Discourse. In: Mendelsohn, Everett; Elkana, Yehuda, editors. Yearbook in the Sociology of the Sciences: Anthropological Perspectives in the Sciences. Dordrecht, Neth.: D. Reidel; 1981. p. 177-212.Hahn, Robert; Gaines, Atwood. Physicians of Western Medicine: Anthropological Approaches to Theory and Practice. Dordrecht, Neth.: Kluwer Academic; 1985. Kleinman; Eisenberg; Good, Byron. Culture, Illness, and Care: Clinical Lessons from Anthropologic and Cross-Cultural Research. Annals of Internal Medicine 1978;88:251–58. [PubMed: 626456] Charon, Rita. Doctor/Patient/Reader-Writer: Learning to Find the Text. Soundings 1989;72:137–52.Daniel, Steven. The Patient as Text: A Model of Clinical Hermeneutics. Theoretical Medicine 1986;7:195–210. [PubMed: 3738845] Hunter. The Physician as Textual Critic. The Connecticut Scholar: Humanities and Health Professions 1986;8:27–37.Hunter, Kathryn. Doctor's Stories: The Narrative Structure of Medical Knowledge. Princeton, NJ: Princeton University Press; 1991.
6. See Kleinman, Arthur. The Illness Narratives: Suffering, Healing, and the Human Condition. New York: Basic Books; 1988. p. 49
7. See Becker, Gay. Disrupted Lives: How People Create Meaning in a Chaotic World. Berkeley and Los Angeles: University of California Press; 1997. p. 27
8. See Frank, Arthur. The Wounded Storyteller: Body, Illness, and Ethics. Chicago: University of Chicago Press; 1995. p. 1
9. Frank. Wounded Storyteller. Vol. 1.
10. See Garro, Linda. Chronic Illness and the Construction of Narratives. In: Good, Mary-Jo DelVecchio; Brodwin, Paul E.; Good, Byron; Kleinman, editors. Pain as Human Experience. Berkeley and Los Angeles: University of California Press; 1992. p. 100-37.Garro. Narrative Representations of Chronic Illness Experience: Cultural Models of Illness, Mind, and Body in Stories Concerning the Temporomandibular Joint (TMJ). Social Science and Medicine 1994;38(6):775–88. [PubMed: 8184329] Garro. Cultural Knowledge as Resource in Illness Narratives: Remembering through Accounts of Illness. In: Mattingly, Cheryl; Garro, editors. Narrative and the Cultural Construction of Illness and Healing. Berkeley and Los Angeles: University of California Press; 2000. p. 70-87.Mathews, Holly; Lannin, Donald R.; Mitchell, James P. Coming to Terms with Advanced Breast Cancer: Black Women's Narratives from Eastern North Carolina. Social Science and Medicine 1994;38(6):789–800. [PubMed: 8184330] Price, Laurie. Ecuadorian Illness Stories: Cultural Knowledge in Natural Discourse. In: Holland, Dorothy; Quinn, Naomi, editors. Cultural Models in Language and Thought. Cambridge: Cambridge University Press; 1987. p. 313-342.Cain, Carole. Personal Stories: Identity Acquisition and Self-Understanding in Alcoholics Anonymous. Ethos 1991;19:210–253.Holland; Lachicotte, William; Skinner, Debra; Cain. Identity and Agency in Cultural Worlds. Cambridge, MA: Harvard University Press; 1998.
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12. Hurwitz, Brian; Greenhalgh, Trisha; Skultans, Vieda. introduction to Narrative Research in Health and Illness. Hurwitz; Greenhalgh; Skultans, editors. London: Blackwell; 2004. p. 3
13. Charon. The Ethicality of Narrative Medicine. Narrative Research in Health and Illness 27

14. Spitulnik, Debra. Anthropology and the Mass Media. Annual Review of Anthropology 1993;22:293–315.Caughie, John. Television Criticism: ‘A Discourse in Search of an Object,’. Screen 1984;25(4–5):109–20.de Certeau, Michel. The Practice of Everyday Life, trans Steven Rendall. Berkeley and Los Angeles: University of California Press; 1984. Hebdige, Dick. Hiding in the Light: On Images and Things. London: Comedia and Routledge; 1988. Lave, Jean; Duguid, Paul; Fernandez, Nadine; Axel, Erik. Coming of Age in Birmingham: Cultural Studies and Conceptions of Subjectivity. Annual Review of Anthropology 1992;21:257–82.
15. Spitulnik. Anthropology and the Mass Media.
16. De Certeau. Practice of Everyday Life. Vol. 167. hereafter cited in text as *PE*
17. Because of the informed consent process and my promise to ensure confidentiality, I do not include actual names of participants in the research study. Nor do I give any additional disclosing information that might identify them other than what is needed to make my argument.