Bertman, S. (2015). Using the arts and humanities with the dying, bereaved,. . . and ourselves. In Stillion J. Attig, T. (Eds.) *Death, dying, and bereavement: Contemporary perspectives, institutions, and practices.* NY:Springer. 245-259. Reprinted with permission.

Sandra Bertman

18

USING THE ARTS AND HUMANITIES WITH THE DYING, BEREAVED, . . . AND OURSELVES

Poets, artists, and writers have always illustrated and illuminated death, dying, and grief. This chapter documents how the arts and humanities have played a critical role in educating both medical personnel and budding thanatologists. The chapter also includes a brief discussion of art therapy and an introduction to specific techniques used with children and adults. Attempting to demonstrate the richness involved in this process to multiple audiences over a half century, I hope this chapter provides substance and inspiration for all who work in the field.

WHERE AND HOW IT ALL BEGAN

My 53-year-old mother was diagnosed with liver and pancreatic cancer in 1969, when I was 33. Immediately after the operation the doctors pronounced, "Nothing more can be done." After my father insisted, "She couldn't take it . . . she'll be destroyed," the physicians conspired with him not to tell her. Yet, on the eve of her operation, this serious, thoughtful woman who was terrified of hospitals, who was the caretaker of the entire family, three to four generations worth, and whose husband was in the midst of salvaging a business disaster, rose to her stature of barely 5 feet, looked me in the eye, and said in a soft voice, "Sandra, if it is cancer. . ." "Only hepatitis," she was reassured.

I felt impotent and angry. What sense did it make to tell her everything was fine? It just did not compute. Would this still be the refrain as her pain increased and she became sicker and more debilitated? Her body was and would continue to be telling her something. She knew something. (Years later, I discovered there was, in fact, a term: she had what Avery Weisman named "middle knowledge.") It seemed to me an act of deliberate cruelty to wait until she was weaker to face the reality of the diagnosis that she clearly suspected. A part of her was bracing herself for the truth in the very phrasing of those words to a daughter "If it is cancer. . ." My mother didn't need the physician's response to look beyond her dis-ease. Her head was already racing with the hypotheticals and with the real questions.

Kind physician friends gave me journal articles to read while my mother was dying. "Why are you giving me all this psychological stuff to read?" I asked in frustration. "You're acting like the only ones who know anything about suffering are the credentialed 'professionals,' the psychiatrists. Read Tolstoy's *The Death of Ivan Ilych*; read Tillie Olsen's *Tell Me a Riddle*; read John Gunther's autobiographical account of his son's brain tumor—or John Donne's poem—both titled *Death Be Not Proud*; read Simone de Beauvoir's chronicle of her mother's dying, anything but, as its title suggests, *A Very Easy Death*; read *The Notebooks of Rilke*, the poetry of Emily

Dickinson, Edna St. Vincent Millay, Donald Hall; see the plays or films *I Never Sang for My Father, Ikiru, Hamlet, Sunshine*." These books and others opened a door for me; a door to understanding the totality of death. And I walked through that door, armed with my background in teaching English, and began a 30-year career teaching prospective doctors how to begin to work with dying and bereaved people.

My mother's situation was reminiscent of the responses in Tolstoy's novel *The Death of Ivan Ilych* (1886/1960) to the physicians' assurances of hepatitis: "This deception tortured him—their not wishing to admit what they knew and what he knew, but wanting to lie to him concerning his terrible condition, and wishing and forcing him to participate in that lie." (p. 137). To Ivan Ilych (and to my mother) only one question was important: "Was my case serious or not? But the doctor ignored that inappropriate question" (p. 121; Figure 18.1).

In video clips—as in a physician's real experience—authenticity is immediately apparent. Humanities materials could be used to sharpen observational and critical-thinking skills. Stories, film, and cartoons vicariously present the encounters with illness, mortality, ethical challenges, and bereavement through shrewd eyes and, ideally, before one has to do so in actuality with patients and families. Things normally unseen are so small—might they not benefit from a close-up so big they must be taken in? The question Mr. Watanabe asks the physician in Akira Kurosawa's 1960 film *Ikiru* is almost the same one my mother asked (or rather, told) me: "Is it cancer?" What an opportunity for practice/rehearsal in viewing such a film clip: (1) Interactions can be witnessed firsthand as opposed to "reported" as was the custom in rounds and conferences. (2) Difficult moments can be honestly explored by freezing the frame, for example, and grappling with the situation before, during, and after viewing the actual sequence. (3) Scenarios can be instantly replayed for language cues (e.g., "All tumors aren't malignant, are they doctor?"), attention to nonverbal behaviors, complexities, ambiguities, and other discomforts.

FIGURE 18.1 Still from Akira Kurosawa's film *Ikiru* (1960).
Source: Bertman (1991). Used with permission.

What's to "update" about Ivan Ilych's experience? Were my mother's agonies any different from his, or from Mr. Watanabe's ("It's only an ulcer"). Isn't his facial expression proof of or an unmistakably excellent example of "inner knowledge"? Moreover, note the physicians' behaviors. How comfortable were they in their roles? How skilled were they in creating containers where healing might begin to take place?

About that time (the late sixties), forums to bring together those interested in the field of death, dying, and bereavement were being organized in Boston (The Equinox Institute) and Philadelphia (*Ars Moriendi*, which eventually became the International Work Group on Death, Dying, and Bereavement in 1974).

THE EQUINOX INSTITUTE (1969–1971)

By the time my mother died in February 1970, an oncologist, Melvin J. Krant, who cared as much about suffering as about tumors, had enlisted a group of three psychiatrists (Avery Weisman, Ned Cassim, and Jerry Adler), a rabbi (Earl Grollman), a nurse, and a social worker (Ruth Abrams) to meet evenings initially at his home to plan how to effect change in the care and treatment of the terminally ill and the bereaved. Because of my teaching experience, belief in ways of knowing other than the biomedical, and conviction that adult education and the public—not just health care professionals—have a stake in these issues, I was invited to participate in these colloquia and in the subsequent formation of Equinox Institute. Our mission then read not so differently from the one of the Open Society Institute's, particularly its Project on Death in America (2001–2003), which supported initiatives in research, scholarship, the humanities, and the arts "to transform the culture and experience of dying and to foster innovations in the provision of care, public education, professional education and public policy."

Offerings for teachers and counselors in the Newton, Brookline, and Belmont school systems ("Coping with Crisis and Loss") and periodic lectures ("On Ethics and Decision Making") at Tufts Medical School preceded the course offerings at University of Massachusetts, Boston campus ("Death, Dying, and Other Lethal Behaviors" created by Robert Kastenbaum and later my own field-study course for students who wished to work in nursing homes, on suicide hotlines, etc.) and the Medical Center in Worcester. The first course in the Boston–Cambridge area, "Perspectives on Death," offered at the Adult Education Center, Cambridge, had paved the way and set the syllabi content. The catalogue description read: "The American people have been characterized as death-denying when dealing with death and loss experiences. In an effort to become more comfortable with the subject of death, grief and bereavement, we shall explore attitudes and feelings expressed in the written, visual, and lyrical arts (especially story, film, music) as well as in documents such as Patients' Rights and Living Will. Materials ranging in tone from Tolstoy, Brel, and Beatles shall be viewed against the theories of professionals Kübler-Ross, Weisman, Farberow, and Feifel and shall provide the points of departure for reflecting on such topics as terminal illness, sudden death, isolation ('person' vs. 'patient'), a 'meaningful' death; repercussions (creative and non) that accompany loss, *carpe diem*, and talking about death with children." For the public, early media credits included the films *Death: The Great American Dream Machine* (Public Broadcast System [PBS], 1971) and *Dying* (WGBH-TV, 1976); and the United Press International award-winning radio show "Sing a Song of Dying" (WCAS, 1971).

FAILPROOF TECHNIQUES FOR ALL AGES

The ultimate goal of all art is relief from suffering and the rising above it.
—Gustav Mahler

One technique that is infallible for novice or experienced professional is expressive therapy. Expressive therapy is predicated on the assumption that people can heal through use of the imagination and various forms of creative expression in the arts—literary, musical, dramatic, and visual. Expressive therapy, also known as creative arts therapy, differs from traditional art expression in emphasizing the creative process rather than the final product or work (Figure 18.2).

Even the most insignificant sketch, a performance charade, four-line poem, aims boldly and blindly at the impossible, at striving for totality, an attempt to enclose chaos in a nutshell (adapted from Hesse, 1974). Why write? Why draw? More than catharsis, something as simple as taking pen or crayon to paper magically defuses stress, evokes curiosity, and inspires creativity. Research has shown the benefits of expressive writing. The very act of changing emotions and images into words affects the way a person organizes and thinks about an experience. "If it's mentionable, it's manageable," Mr. Rogers reassured the youngsters in the TV series, *Mr. Rogers' Neighborhood*. It would seem that only by making visible that which was invisible do we allow the healing process to begin. One might ask a group to add cartoon balloons to each of the figures in the drawing shown in Figure 18.2. For example, the youngster in front might ask, "Why did he die?" And the mother or person behind him might reply, "Because he was very *very* old and his body stopped working." Or "Sweetheart, everyone has to die" or "Why do you think he died?" or "__________________." Or one might ask about the nails in the coffin, or the antennae on the tombstone.

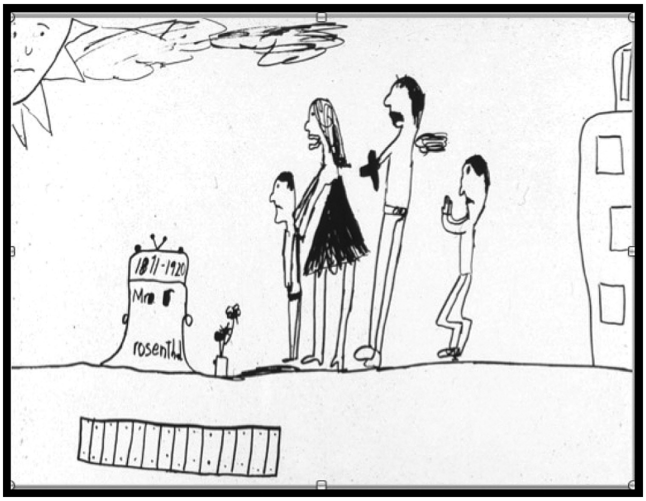

FIGURE 18.2 From *Death Education in the Face of a Taboo* (Grollman, 1974). Reprinted with permission.

For a quarter of a century, as professor of humanities in medicine at the University of Massachusetts Medical Center, I invited medical students, health care professionals, and therapy groups to reveal their worst-case scenarios or most stressful situations in coming to grips with dying, death, and grief. I might be accused of going for the jugular vein. My instructions were "Please devise an image of any sort relating to your thoughts and feelings as you anticipate the dissection experience, giving bad news, or supporting a terminal patient." For those who are more comfortable with writing, variations on the assignment include visual poetry (Bertman, 2011); 6- or 9-word stories; and haikus on hope, love, and grief or the current 55-word story exercise (Fogarty & Gross, 2011), which helps us to understand or to appreciate something about a patient or about a counseling incident. It's all about encouraging reflective practice, taking a conscious look at our emotions, experiences, actions, and responses, and using that to add to our existing knowledge base to draw out new knowledge, meaning, and to attain a higher level of understanding (Paterson & Chapman, 2013).

Another technique to use is the visual case study. The images offered in this chapter, for example, are nothing if not instantaneous visual case studies with an amazing capacity to ignite our therapeutic imaginations, creating a space where we can grapple with morality, mortality, and the relational aspects of our practices (Bertman, 2002, 2003, 2008). These images differ from the traditional medical case studies delivered in grand rounds in graciously/sensitively removing the practitioner's and patient's identities and potential for emotional vulnerability in disclosing thoughts and feelings about a particular experience (Figure 18.3).

A twist on the visual case study technique for using art is to provide the participants with masks. "Give a man a mask," the wry Irish writer Oscar Wilde (Ellman, 1968) tells us, "and he will tell the truth about himself." Poet Emily Dickinson (1830–1886) suggests addressing truth obliquely: "Tell all the Truth, but tell it slant" (Dickinson, 1890). Educator Parker Palmer calls this "the third thing." "Mediated by a third thing—a poem, a piece of music, a painting—truth can emerge from, and return to, our awareness at whatever pace and depth we are able to handle—sometimes

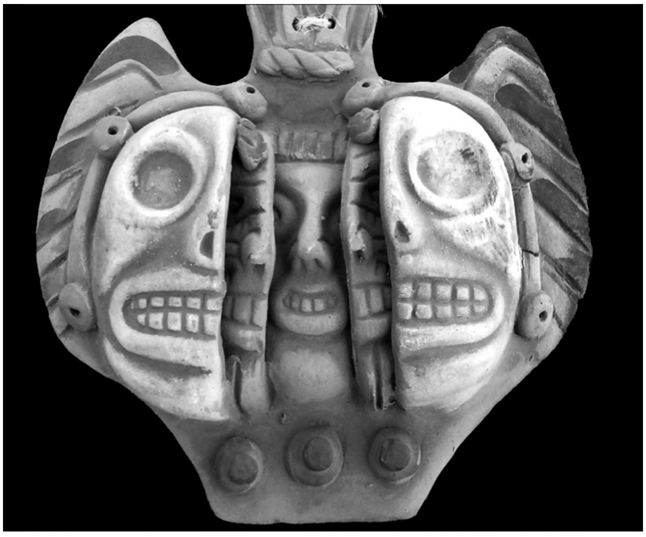

FIGURE 18.3 Clay-painted mass-produced .50″× 6″× 2″ artifact.
Source: Bertman, Multicultural and Visual Case Study Projects, Ward Street Studio Archives.

inwardly in silence, sometimes aloud in community—giving the shy soul the protective cover it needs" (Palmer, 2009).

For several decades before the computer came into being (or before I became aware of the digital age), I presented double-slide presentations to classes, conferences, and other gatherings. I invited audiences to select and comment on a Most Memorable Image (Bertman, 1991, pp. 101–163) from those that I projected. In them, I always tried to point out that choice is a critical variable. Several medical schools and residencies are now routinely using an adaptation of this technique in their training, accompanying their learners in visits to art museums. There, they are given instructions or tasks, such as: "Find an image that. . . . is difficult to look at. . . . says something about loss. . . . finds order in chaos. . . . and give reasons for your choice" (Gaufberg & Batalden, 2007, Miller, 2009, 2012; Brooks, 2013; Williams 2009, 2012). Art educator and curator Ray Williams explains how students benefit from being in a different learning environment than the classroom, citing David Carr's thinking (*The Promise of Cultural Institutions*, 2003) of the museum as a place that supports visitors in their "process of becoming." For most of us limited to a constrained lecture or workshop session, 5 to 10 minutes is usually ample time for participants to think of immediate responses or ideas, generate and write sketchy notes, and compose brief reflections—just a few pertinent phrases or sentences. I encourage the act of literally writing one's thoughts as a way of discovering what you think, what you see, what it means, and a way of stimulating—finding the words—for what you want to say. The excitement in sharing responses, particularly diverse responses to a single image, immediately builds community as it provides safety and tolerance for viewpoints other than one's own, all the while reminding us there is always more to see.

Thus, engaging in the arts, as participant or observer (in itself a creative act), is often catalyst enough not only to arouse our senses but also to stimulate our imaginations, causing us to wonder, to analyze, to feel connected (or disconnected), and to be inspired. The engagement with art, whether through reading or writing, viewing or drawing, listening or enacting, involves attention, analysis, identification, catharsis, and insight. The beauty of the process is its openness to interpretations, to the way any of us—therapist, nurse, patient, client, colleague—takes it in and uses it for oneself, in personal and professional contexts (adapted from Bertman, 1999).

Our role—the doctor, therapist, teacher, fellow human being—is less a question of treatment than of developing the creative potential within the client, patient, or person we are serving (adapted from Jung, 1954). Looking again at some of the images presented and to come (Figures 18.1, 18.4, 18.6), they seem to suggest we are moving from a paternalistic relationship to a patient-centered one, Martin Buber's "I and Thou." Are we ready—vulnerable enough to meet thou to thou? Soul to soul?" Remen (1996) challenges us as she puts this into perspective:

> There is a distance between ourselves and whatever or whomever we are fixing. Fixing is a form of judgment. All judgment creates distance, a disconnection, an experience of difference. In fixing there is an inequality of expertise that can easily become a moral distance. We can't serve at a distance. We can serve only that to which we are profoundly connected, that which we are willing to touch. (Remen, 1996, p. 24)

FIGURE 18.4 Copyright image from Bertman, *Exercising Our Therapeutic Imaginations* presentations, 1998.

FAST FORWARD: FROM DISSECTION TO PALLIATIVE CARE—SOUL PAIN, AESTHETIC DISTANCE, AND THE TRAINING OF PHYSICIANS

The Very First Patient

It is commonly known that medical students dissect the bodies of the dead; it is less commonly realized that these same dead do a great deal of cutting, probing, and pulling at the minds of their youthful dissectors.
—Alan Gregg, MD

Perhaps it is fortuitous that the first patient a medical student meets is a dead one. Absent in this inaugural encounter are the awkward introductions, the uncomfortable silences, and the embarrassments (for both parties) that always accompany the first laying on of hands. Although a measure of comfort can be derived from knowing that neither can pain be inflicted on nor can harm be done to this patient, there is no getting around the fact that he or she is dead. Yet, there is no escaping the gnawing thought that this could be my mother, my father, or me.

Medical students and practicing physicians alike make compelling arguments for early and ongoing "vaccinations" of education and training having to do with emotional armor. Physician writer Selzer (1996) reminds us that when the surgeon cuts into the patient, he himself must not bleed; he must find the appropriate, protective clinical distance. In *A Parting Gift*, pediatrician Sharkey (1982)

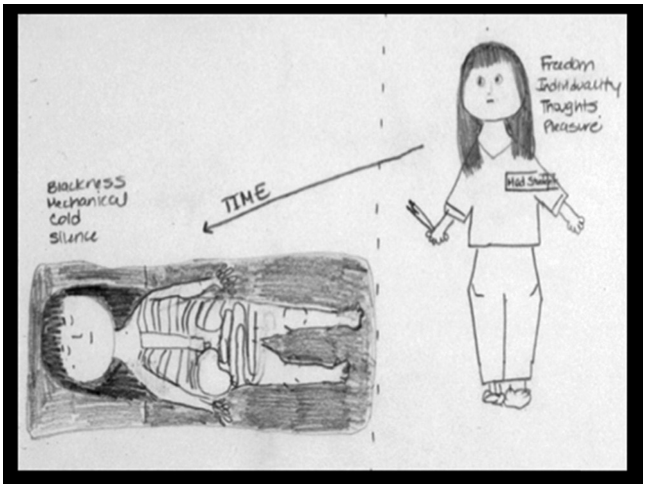

FIGURE 18.5 Medical student's identification with cadaver (1994) as intimated by Gregg quotation in *One Breath Apart: Facing Dissection* (Bertman, 2009), p. 50.
Source: Bertman (2009). Used with permission.

traces the development of her own "emotional detachment" as she makes her way through medical education, from her dissection experiences to the discomfort she has at deaths of patients she has attended. She vividly recounts how frequently she dreamed about her cadaver: "He was always very much alive in the dreams. I never told this to my fellow students. We didn't talk about the effects our cadavers had on us; nor did we talk about death" (Sharkey, 1982, p. 16).

Patients often find themselves looking to the physician for "metaphysical" expertise. "Just as he orders blood tests and bone scans of my body, I'd like my doctor to scan me, to grope for my spirit as well as my prostate" (Broyard, 1992, p. 46). So how do we train physicians to know when to treat aggressively, to be action oriented, and when (and how) to shift gears to grope for the soul instead of the prostate? How do we educate them to tolerate discomfort, ambiguity, and uncertainty when they are programmed to obtain answers? How do we teach them their job is not to provide ultimate answers but to manifest ultimate commitment? How do we teach them to feel comfortable sharing their own humanity with patients on the examining table who are grappling with the manifestations of soul pain—loneliness, hopelessness, valuelessness, meaninglessness?

Seeing Patients

In fact, what doctors do most of the time presupposes visual and auditory observation. A good diagnostician needs to be alert to body language, tone of voice, eye contact, blushes, and sudden flushes of embarrassment or shame. The white coat is no vaccination or immunization against irritation, antipathy, arousal, or discomfort. The good doctor needs to be aware of his or her own reactions so they do not interfere with this sacred relationship between two human beings, one who happens to be in this moment a doctor, the other, a patient. There is a shared self-consciousness in the doctor–patient relationship; the visible and invisible elephants (the uncomfortable silences and the embarrassments), is there not?

When I first began to work with medical students, I wanted an armamentarium of pictures, stories, photographs, poems, nonfiction accounts of sharply focused vicarious encounters for engagement, reflection, and discussion of the unmentionables and unmeasureables in health care. We meaning-making, meaning-seeking creatures cannot look at images or symbols or arrangements of letters or words or sounds without trying to make sense of them. What do I see? What do I think? Feel? Why do I think/feel that? What else do I see? How might I change that image? These “triggers” invite close inspection, while still taking responsibility for propriety and granting us permission to stare without having to avert our eyes or “modify” without feeling guilt or shame.

Medicine is and always has been a deeply spiritual profession. The earliest recorded images portray physicians as priests and priestesses. In an illumination from a 14th-century manuscript, “Treatise and Commentary of Medicine” in the Bibliotheque Municipale, Rheims, one could easily mistake the scene, which depicts a medical consultation, for a private confessional. So too in the contemporary painting *Mr. S. Is Told He Will Die.* Artist Robert Pope, a fellow cancer patient, portrays the moment during which two physicians present Mr. S. with his devastating prognosis. Pope says of his painting, “The cross symbolizes religion, and the doctors, in their white lab coats, symbolize science. The man is grasping onto both, and neither one can save his life and he knows this” (from Pope, *llness & healing: Images of cancer, p. 90, 1991,* Figure 18.6).

I see quite a different scene: compassion incarnate. The two physicians are seated with the patient on *his* bed, *his* turf. Whatever their personal beliefs—or those of Mr. S.— the physicians are sharing his suffering, deliberately touching yet allowing space for their patient to absorb the import of the moment. Seated beside the patient on his hospital bed, they are literally buttressing him with their bodies as they reveal their news. Comfortable with the silence, willing to suspend their busy schedules for as many moments as are necessary, they are fully present. The intimacy of the scene, the human relatedness, seems almost sacramental, the essence of soul, an earthly embodiment of love. At bottom, no equipment is necessary but the human heart. I see genuine connection. Sacredness has not so much to do with the content the physicians are imparting, but with the process they’re igniting. As

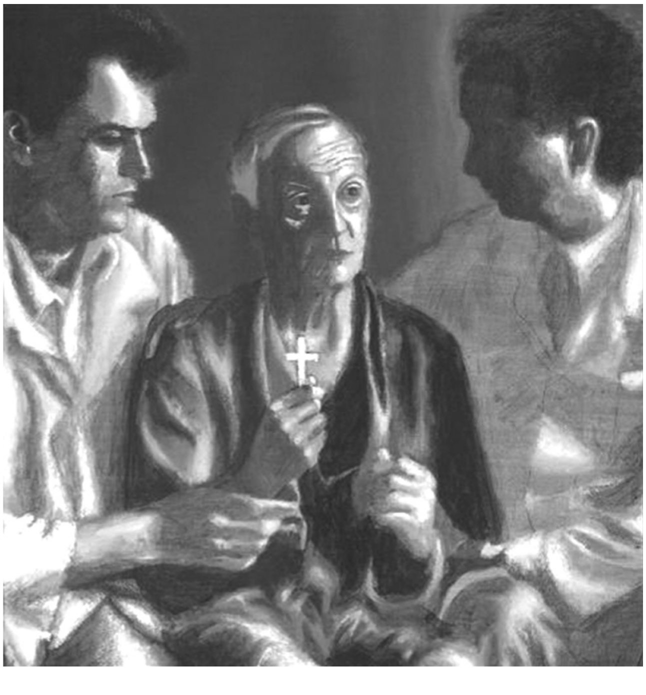

FIGURE 18.6 *Mr. S. is Told He Will Die,* acrylic on canvas (1989).
Source: Copyright 2005 by the Robert Pope Foundation. Used with permission.

Dr. Brad Stuart reminds us, "Despair can only be treated by meeting the pain that often aches deep and unnoticed inside the bone metastasis . . . the kind of pain that morphine cannot reach and that only can be treated by meeting soul to soul" (B. Stuart, personal communication, February 17, 2013).

Rx: An Image a Day

Art washes away from the soul the dust of everyday life.
—Pablo Picasso

Each of us needs periodic reinspiration to invigorate our imaginations and souls. An image a day—a painting, poem, lyric, cartoon—used as preamble or to pepper the most didactic medical conference may be just the prod to shake us out of the ruts of ordinary perception in medical practice and to approach what we cannot bear to look at—admit to—or interact with—in a fresh and strangely bracing way. In this light, it makes sense to change the basic motto for training physicians to "see one, do one, teach one, use one."

CHANGING IDEAS ABOUT HEALTH CARE

Art in health care is a diverse, multidisciplinary field that humanizes the health care experience for patients, families, and caregivers. Although each program and creative endeavor is unique to the community it serves, this rapidly growing field applies a multitude of art forms to a wide variety of health care settings for therapeutic, educational, or recreational purposes to enhance the well-being of patients and caregivers. Not only does creative self-expression provide solace, strength, and affirmation that alleviate personal stress, but it also contributes to self-awareness, understanding of patients and their families, and ultimately to forging stronger communities through support and empowerment. Our entire society is finding new ways to use the expressive arts in health care. The following section reviews but a few of these.

Holistic Care

Holistic care is predicated on the belief of the wholeness in one serving the wholeness in another. "The Arts and Humanities in Health Care and Education" (International Work Group on Death, Dying, and Bereavement [IWG], 2000) is a document of assumptions and principles ultimately adaptable to any culture, clinical practice, or educational setting. Created by the International Workgroup on Death, Dying, and Bereavement, this detailed statement of assumptions and principles underscores how the arts and humanities reflect the existential, inspirational, and transcendent realms of experience and can contribute to creating an aesthetic, nurturing, and healing environment.

Narrative Medicine

What's most thrilling now is the plethora of courses in narrative, visual, and spiritual studies in health professionals' clinical training. Charon (2006, p. 4) defines narrative medicine as "medicine practiced with these skills of recognizing, absorbing, interpreting, and being moved by the stories of illness." Caregivers who possess "narrative competence" are able to bridge the "divides" of their relation to mortality; the contexts of illness; beliefs about disease causality; and emotions of shame, blame, and fear. In her training and supervision, Dr. Charon has devised a "parallel chart" for interns and residents that allows them to record their own stories of their experiences in caregiving and to share and explore them with their colleagues for purposes of enhancing self-understanding and improving their effectiveness in responding to the whole persons in their care.

Bioethics and Humanities

With the growing interest in clinical ethics, the Society for Health and Human Values morphed into the American Society for Bioethics and Humanities (ASBH). The purpose of ASBH is to promote the exchange of ideas and foster multidisciplinary, interdisciplinary, and interprofessional scholarship, research, teaching, policy development, professional development, and collegiality among people engaged in all the endeavors related to clinical and academic bioethics and the health-related humanities. The founding documents maintain that these purposes shall be advanced by the following kinds of activities: (1) encouraging consideration of issues in human values as they relate to health services, the education of healthcare professionals, and research; (2) conducting educational meetings dealing with such issues; (3) stimulating research in areas of such concern; (4) contributing to the public discussion of these endeavors and interests, including how they relate to public policy (ASBH, n.d.).

ASBH members have created an amazing resource developed to be an accessible, comprehensive, dynamic online compendium for teaching and research in medical humanities. The Literature, Arts and Medicine Database is an annotated multimedia listings of prose, poetry, film, video, and art. It not only summarizes specific works (poems, novels, paintings, films, theatre) but also adds commentary and suggestions for their use in a number of settings (litmed.med.nyu.edu).

American Academy of Hospice and Palliative Medicine

Founded in 1988, the American Academy of Hospice and Palliative Medicine (AAHPM) is a professional organization primarily for physicians whose motto is to advance the science of comfort and affirm the art of caring (AAHPM, n.d.-a). The mission of the Humanities SIG (special interest group) is to infuse educational activities and publications with works from the humanities and arts. Visit (1) *End of Life: Visions and Voices* (AAHPM, n.d.-b), which showcases PDIA-funded humanities projects; (2) a *Staying Soulful* (AAHPM, n.d.-c) column; and (3) the *ArtSpace, Phoenix, 2004* (AAHPM, 2004) video of interacting with the creative process in the Healing Space (Figure 18.7).

FIGURE 18.7 (a): Dr. Florence Wald visiting the ArtSpace, AAHPM and APNA First Annual Conference, Phoenix (2004).

FIGURE 18.7 (b): *Art Space, Phoenix, 2004 video.*
Source: View Quicktime movie at http://www.sandrabertman.com/files/publications.html

The Global Alliance for Arts and Health

The Global Alliance for Arts and Health (formerly Society for the Arts in Healthcare founded in 1991) is dedicated to advancing arts as integral to health care by (1) demonstrating the valuable roles the arts can play in enhancing the healing process; (2) advocating for the integration of the arts into the environment and delivery of care within health care facilities; (3) assisting in the professional development and management of arts programming for health care populations; (4) providing resources and education to health care and arts professionals; and (5) encouraging and supporting research and investigation into the beneficial effects of the arts in health care.

Music Therapy

Using live harp music at the bedside of acutely dying patients in 1973, Therese Schroeder-Sheker pioneered the use of terms such as “music thanatology,” “music vigil,” and “prescriptive music” (The Chalice of Repose, n.d.). Music therapists have much to teach the world about the interrelationship of music and breath in their strategies to help patients, family, friends, and those of us who care for them lift the spirits and cope with the pain and distress that accompanies loss and that ends life. Musical memories (Berger, 2006) and the use of music to stimulate recall can be an enjoyable and emotionally engaging part of life review, at the same time providing a comforting background when words just aren’t needed. The clinical use of music-facilitated breathing techniques at the first and last breaths of life and with people who have cancer is explored (Hanser, 1996, 1999).

Thankfully there is new respect for and inclusion of these expressive therapies. There now is an enormous range and diversity of programs and settings. One doesn’t have to be a certified therapist. Volunteers, too, are trained to man music and art carts, which not only provide distraction and solace but often facilitate grief, healing, and moving on in life.

WHERE WE ARE GOING

T. S. Eliot's (1952) profound poetic insight in his poem "Little Gidding" comments on the circularity of life and death and the increase in our understanding of life as we move toward and think about death: "We shall not cease from exploration/And the end of all exploring/Will be to arrive where we started/ And know the place for the first time" (p. 145). In his novel *Siddhartha,* the German writer Hermann Hesse assures us that "we are not going in circles, we are going upwards and that the path is a spiral; we have already climbed many steps" (Hesse, 1992, p. 27).

The future is so promising. Thanks to technology (I hate to admit it), health services combat ageism and functional loss in ways that open us up to coping with all challenges. To cite just two examples: The Music Maker is an interactive human–computer interface that uses a set of cameras to convert body movements into real-time auditory feedback, providing patients with sensory feedback as a reward for correct actions. Playing the Music Maker does not require special musical talent and is possible for patients with very limited movement (Lahav, 2007). Even carmakers are using the new technology as some brands of cars are equipped with medical alert systems that keep seniors safe. And, I truly believe, though not in my lifetime, perhaps, it will be discovered that we are all born with two genes heretofore undiscovered: a creative gene and a spiritual gene.

Looking back, the joy for me is seeing the relevance and use of the arts and humanities materials. I'm still addicted to the multidisciplinary approach, and I'm noticing that the rest of the world is becoming more and more inclusive. It is no longer only the traditional silos (MD, nurse, social worker, chaplain) but also collaborations and inclusions (integrative therapist and practitioners, volunteers, artists, musicians, lay persons). Medical humanities, for example, is being broadened to health care humanities. As our field has changed from thinking of grief as pathologic or an illness, so too, there is a strong movement from the disease model to the wellness model, to one of well-being and healthy aging.

What is relevant to our world, besides an appreciation for the vast resources of literature and the humanities, is a deep respect for the intuitive, intelligent, creative potential within every human being—and, perhaps, a healthy skepticism for divisions by disciplines, experts, and curators of culture. I rest my case with this lovely quotation from Liz Lerman (2010), founding artistic director of Liz Lerman Dance Exchange, Takoma Park:

> Sometimes art achieves what therapy, medication or the best care cannot. These moments can feel like little miracles when they happen, but they are usually instances of art functioning as it normally does: inspiring motivation, engaging parts of people's bodies or brains that they haven't been using, or allowing them to transcend their environments for a little while.

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