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*The Spirit Ambulance:
Choreographing the End of Life in Thailand*

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A Review of *The Spirit Ambulance: Choreographing the End of Life in Thailand*

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The Spirit Ambulance: Choreographing the End of Life in Thailand. California Series in Public Anthropology 49. By Scott Stonington. Oakland, California: University of California Press, 2020, xvi + 187 pages, ISBN 978-0-520-34389-4 (hardback), \$85.00/978-0-520-34390-0 (paperback), \$29.95/ 978-0-520-97523-1 (e-book), \$29.95.

In this eminently readable and succinct ethnography, Dr. Scott Stonington has provided an exceptionally clear account of two major modalities in approaches to dying and care for the dying in contemporary northern Thailand. Stonington expertly weaves narrative and interviews with academic exposition and his experiences in the field, and at the opening immediately introduces the first of these modalities to the reader as we are swept into a relentlessly action-packed family drama. Frantically attempting to do right by their dying matriarch, a Thai family first seeks aggressive critical-care interventions. Upon reaching the limits of medicine, they then rush to get their dying loved one back home for her final breath. Transportation to and from the hospital is provided by a trusty pickup truck, a “spirit ambulance” of the sort that the book is named after, through various landscapes of rural Thailand. The author attends to the

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family throughout, in his unique position as medical trainee and ethnographer.

The story is representative of a more traditional way of caring for dying loved ones, occurring in two stages. Stage one is seeking all that medical technology has to offer as an attempt to pay back the “life-debt” (Thai: *nī chīwit*) owed to one’s parents for being the givers of our physical bodies. Stage two is an attempt to ensure the dying person breathes their last in their own home, considered to be the most auspicious place for their passing, both because the home is imbued with virtue through the meritorious activities in the Buddhist householder’s life and because the person is surrounded by loved ones and personal effects so there is no lingering longing that makes it harder to depart. The home as the ideal place to die is framed by Stonington as the *ethical location*, and both in hospital and on the way to the home from it, family members must navigate metaphysical landscapes to protect against potentially interfering ghosts and spirits.

Embedded in this particular way of dying and caring for the dying is a habit of families colluding to ensure that the person who is dying stays ignorant of their diagnosis and prognosis so they remain hopeful. Often the patients *themselves* ask to not have any grim details on their health status shared with them. Crucial to this intentional opacity is the concept of “heart-mind energy” (*kamlang čhai*), something that can be protected by blocking difficult information and enhanced through interaction with others, especially with those who have strong bonds with the person or those who are thought to have some spiritual power, such as physicians and clergy (Buddhist monastics).

The second modality of caring for the dying is introduced to the reader immediately after the first story through a second case study, this one very much in contrast to the earlier narrative and having more relaxed and reflective pacing. The person at the center of this second study is also in the last phase of her life, but rather than her family directing care activities, she is firmly in the driver’s seat. She knows everything

about her health status and chooses a more internalized approach to her disease, rather than relying on biomedicine. She treats her disease as an opportunity to transform and attempts to learn from her tumor and pain, introducing another concept to the researcher, “karma masters” (*čhao kam nāi wēn*), which is the topic of the final chapter. Karma, an Indic concept sometimes referred to as the law of cause and effect of actions and here appearing in a Thai Buddhist context, is considered by Stonington’s informants to ripen, for some, as a bodily manifestation of a past being in the body of the person who harmed them, and serves as an opportunity for the one who harmed to purify past negativities through experiencing the ripening effects and making amends. In the case study, the patient being in charge of her own care plan aligns with what is referred to as “the new end of life” in Thailand, a movement stemming from democratic waves among the Thai populace in the 1970s and 1990s and greatly influenced by Western-globalized, principle-based palliative care in which self-determination and patient rights are core concepts. The traditional and modern modalities in Thailand of caring for loved ones in the final phase of life come into tension with each other in various ways, such as within families which have outlier members vested in one or the other of these contrasting approaches.

These narratives, along with a third in chapter two concerning the complicated last phase of life of a revered monastic public figure,² are highly effective anchors for the key concepts explored in the study. Before diving more deeply into it, I will say without hyperbole that even before I had finished chapter one, this ethnography changed my practice of clinical ethics in a very deep way. In his conclusion, Stonington mentions that his fieldwork “provided action points for what to do at the deathbed in my own practice of medicine” (145) and was used by him, as a medical trainee and researcher, to “unsettle my own assumptions about how I (and

² Venerable Ajahn Buddhādāsa’s wishes for his own care were at odds with those of both the medical team and Thailand’s monarch, leading to much confusion among the monk’s close disciples.

possibly others) might practice medicine in the United States” (149). He then describes a family meeting in a Boston hospital after his return from the field, in which a family is grappling with the decision of whether to maintain life support for their loved one. Along with a particularly skillful intern, Stonington masterfully supports the substitute decision-makers by delivering sensitive information in a personalized manner and co-creating an ethical location for the withdrawal, both themes he had uncovered in the field.

For a bioethicist such as myself, working in a hospital system in my local jurisdiction of the Greater Toronto Area (in Ontario, Canada)—by many accounts the most multiculturally diverse region on the planet—daily intercultural engagement with patients, families, and healthcare teams is the norm. I find that end-of-life decision-making is the core of my life both professionally and academically, and, also being a medical anthropologist and ethnographer, I sometimes think that I have a pretty good handle on understanding and supporting families and substitute decision-makers who request aggressive medical management despite a grim prognosis, and that I can balance patient preferences and family views with consent and capacity standards in our provincial healthcare legislation. Despite my fieldwork in India with informants living in a context of historical tendencies towards joint families, collaborative decision-making, and non-disclosure of terminal diagnoses (which I refer to as attempts to block bad news), and my firm roots in symbolic interactionism and relational ethics (or the ethics of care), Stonington’s work has done me the favor of upending many of my ideas around family-based end-of-life decision-making. For example, one of my clinical recommendations for providers who are met with requests to not inform patients of a terminal diagnosis or poor prognosis is to ask the patient early on in their healthcare trajectory what information they may or may not want to receive (before there is any bad news to share, which could easily tip them off). Regardless of any ensuing family requests, we would then have guidance directly from the patient. Stonington shares a story of a physician who chose truth over the informational opacity preferred by a colluding

family when answering a direct question from a Thai patient about his diagnosis, only for it to end terribly for all players because of this well-intentioned breach of the traditional protection of the patient's (and family's) heart-mind energy. A principled approach utterly failed, and I too am left unsettled, in a helpful and transformative way, because my typical suggested approach (based on research, fieldwork, and years of clinical experience at the bedside) would have similarly failed and left the patient and all family members in distress.

This study caused me to reevaluate my own consulting habits on medical information-sharing, which seems mainly a function of Stonington's synthesizing and clear presentation of all that he gleaned from deep engagement with Thai respondents in clinical and community settings. In a recent family meeting with two adult children of a Vietnamese patient who were struggling with the decision whether to surgically insert a feeding tube or to palliate, with one of the siblings demanding the continuation of active interventions that had become non-beneficial, such as antibiotics, I hesitantly floated the idea that filial piety in their unique Southeast Asian culture might demand repayment of the life-debt, similar to Thais. The demanding son affirmed that this is indeed very influential for Vietnamese children, but that they "are not fanatics" and can reasonably recognize the limits of medical treatment. Such limit setting was in fact the case for the artificial feeding being deliberated, but not for other ancillary interventions. Although we remained at a respectful impasse, the sons were deeply appreciative of the encounter, and it seemed to me that my having the courage, thanks to this study, to peer backstage into such a cultural nuance at least left them feeling recognized.

After a quarter century in healthcare, I had never come across the fascinating elemental corollaries made here between what is received physically from one's parents, such as one's body, and medical interventions chosen in return for such parental gifts, such as somatic support in the form of lifesaving physical heroics. Parents gift us our physical body, with its breath and blood, and Thai children feel compelled to

correspondingly request ventilation³ and transfusion for their parents. This unique logical framework is one of many types of reasoning, such as the “sanctity of life” principle found in the monotheistic religions, used by families and other substitute decision-makers to justify ongoing aggressive medical management, and I intend to include this particular situated framework among my various efforts to improve cultural safety in healthcare delivery. I am unsure if other researchers have already uncovered this matrix but, regardless, it is a powerful finding.

Regarding Stonington’s methodology, I found details on the recruitment of informants, and background on consent for use of identifying details, quite lacking but was amazed at the tremendous access the researcher had to patients and families. This included access, as a practicum component of a “new end-of-life” workshop, to patients who were dying; the process of being granted such access was also left quite nebulous. After my experience of the almost impenetrable bureaucracy of hospitals in north India versus an almost complete absence of red tape at a hospice in south India, at which visits to the dying and their loved ones by strangers is not only permissible but encouraged, I would have liked to hear about the processes behind Stonington, as a medical trainee, being granted access as a researcher to patients and families in hospitals, and for staff to recruit on his behalf. (Multiple times, nurses suggested particular patients who they considered a good fit for the study; 11, 21, 46.) Sharing more about his techniques for recruitment among local community members outside the walls of hospitals, and a justification of his sample size, would both have been helpful for clarification as well.

I found the reasons Stonington shares for choosing to do his fieldwork in Thailand quite thin; he calls it “a place with several features that promised to highlight encounters between biomedicine and ‘other’ worldviews” (20). But why Thailand specifically? I am suspicious that

³ Stonington calls a ventilator a “respirator” which, by definition and according to some Canadian respiration technologists, is technically inaccurate because a ventilator provides mechanical support for breathing, while a respirator is a filtered mask.

there may be deeper reasons that are not shared with the reader, because, among other things, it is hard to imagine someone committing to years of language development for research purposes on a mere whim. Despite putting “other” in scare quotes, it reads as if Stonington was othering his research subjects even before he entered the field. In his reasoning for the field site, he also frames “biomedicine” as a monolith, which fails to capture the variety of cultures and ideologies under this umbrella category, as is sometimes done with religious traditions as well. Training under Thai clinicians who would be well familiar with their country’s approaches to dying and caring for the dying and who practice medicine in their own situated context, he could simply state that he is unfamiliar with Thai culture and religion and hoped to gain insight into how Thais interact with clinicians in their local context. The power dynamics between Stonington and his informants are also often palpably described, such as cases in which he intends to interview people as a researcher but then receives requests for medical support. Stonington is positioned on a razor’s edge.

Engaging in research while simultaneously completing medical training cannot be easy, and Stonington admits as much, saying that he had experiential “whiplash” from his travels between the USA and Thailand (19). His enhanced M.D. education in palliative care and training as an end-of-life doula seem to have served him well in the field as he was often both observer and participant, manually ventilating the person in the pickup truck in one case and participating in a forgiveness ritual in another. Stonington is impressively reflexive throughout, for example freely sharing his emotional reaction to extended approaches to autonomy, in contrast to its reification in the United States. He also shares some of his struggles with the fast-paced discussions in Thai he was privy to and the challenges he had with medicalized Thai language; as a researcher who was not able to perform interviews in my informants’ own languages (Hindi and Tibetan), I was often struck and slightly disoriented when reminded that this author was communicating almost entirely in Thai. Some more background on how he was technically able to accomplish this,

beyond the mere fact of spending many years in Thailand, would have added some depth to his positionality.

Also on language, one Thai term stood out as oddly translated by Stonington: *thēwadā* is rendered as “angels” (86). *Thēwa* bears a remarkable phonetic similarity to *deva*, the Sanskrit/Pāli term for “god,” and *thēwadā* is also very close to another Sanskrit/Pāli term, *devatā*, which usually means “deity.” I do not have any expertise with Thai, but I would hazard a guess that these terms were derived as the closest phonetic equivalent in Thai for the Indic terms. *Devatā* is sometimes treated as having the same meaning as *deva*, so without more context, it is hard to say if the monks who were “calling on angels to help” are petitioning celestial beings (shared in Hindu, Jain, and Buddhist cosmologies) or local deities, as both do take place in Buddhist traditions. Regardless, I question “angel” being used for either phenomenon, as it is lifted from Judeo-Christian terminology and simply confuses the issue for English speakers. I have the same criticism of Robert Thurman, who has also used the term “angel” in his translations, but in his case applied to a different Sanskrit term, *ḍākinī*, meaning “sky-goer,” another type of celestial being (xx, 245). These translations may be attempts to avoid the word “god” for fear that it will be conflated with the monotheistic “God,” but just as gods and God are conceptually distinct, so are gods and angels.

I admittedly struggle ethically with withdrawal of medical treatment being framed in the Thai Buddhist context as inherently unethical under all circumstances, an issue that appears at multiple points in the book (and in other studies on Thai end-of-life care, for example, Ratanakul’s “To Save or Let Go”⁴). This is no fault of Stonington, just a sticking point for me since I was exposed to the work of an academic trailblazer in Buddhist bioethics, Damien Keown. Keown also holds that withdrawal of life-sustaining treatment is impermissible by Buddhist ethics (174-177), relying on Pāli texts and applying their principles to the

⁴ This article concerns the same monk who is profiled in chapter two, Venerable Ajahn Buddhādāsa.

modern medical context despite his being entirely lacking in clinical expertise. Texts on Buddhist discipline elucidate five factors in a karmic act: intention, perception, object, effort, and result. The basis of this position on withdrawal being impermissible is that one's intention is *necessarily* negative when withdrawing care. This is quite presumptive and does not allow for the rule of double effect.⁵ Further, when withholding care (such as not starting ventilation, rather than stopping ongoing ventilation), the factor of effort is absent as the withholding is an omission; the logical extension is that an incomplete karmic act cannot be proscribed.

To be clear, I am critical of Keown's stance, not of commonly held Thai perspectives on the issue, because praxis and theory often do not align and are not required to. The limits of a purely text-based approach such as Keown's are demonstrated by Stonington from his time in the fray on a spirit ambulance with some of his informants. From that experience, he uncovers a flexibility based on a "logic of place" (4, 6, 146-147), in which the removal of life-sustaining ventilation is considered unethical *within* hospital but acceptable *outside* of the clinical environment. Lastly on this issue, I and many other bioethicists worry about the sustainability of health systems when critical-care patients are kept on life support indefinitely, despite the fact that talking about ethics and equity in resource distribution at family meetings is somewhat unseemly and typically avoided in our jurisdiction.⁶

Philosophically, I was surprised by some of the choices made by Stonington. Despite the (all too) brief identification of the historical influences of Indian pre-Vedic⁷ and Pāli Buddhist traditions on Thai religion

⁵ A theorem often used in medical decision-making in which, essentially, an action is permissible if a negative outcome is foreseen but unintended.

⁶ Canada, like Thailand, has universal healthcare, and many clinicians over the years have said to me that families would make very different proxy decisions if they had to pay for medical services.

⁷ Calling pre-Vedic religion "animisms" seems a broad miscategorization; it might be better represented by noting the meeting of the Indus Valley Civilization, with its emphasis

and culture, what seems to be resonance between the Thai concept of the “heart-mind energy” (*kamlang čhai*) and the Indic concept of *prāṇa*, often translated as “vital energy,”⁸ is not pointed to, which I think was a missed opportunity.

Another missed opportunity, in my view, was during the single, too-brief mention of Catholic technologies of confession as “techniques of the self,” as explicated by Foucault (123). Foucault names “avowal” as a specific “technology of the subject” (24) by framing it within a medical context in which a psychiatrist essentially bullies a patient to admit their diagnosis, thinking it essential to healing. Based on both Freud’s speech act theory and religious confession, avowal is seen as a therapeutic operation located “between the illness and the doctor” (14) through which the “individual is brought . . . to transform himself and to modify his relationship to himself” (24). Stonington does not name “avowal” in Foucault’s sense, but references it in relation to the cultural transformation needed in Thailand to accommodate the new end-of-life movement. However, it is unclear to me how confession fits here. Is the idea that admitting to the challenges of the traditional way of dying and caring for the dying, such as the collusive nature of families ensuring that vital diagnostic information is never shared with the patient, would help bring about this cultural shift? Although I appreciate the author’s well-executed brevity in his writing (done with quite beautiful prose), he fails to make the connection between Foucault’s concept and the Thai tendency towards non-disclosure, not uttering diseases by name for fear of it negatively impacting the patient. This non-disclosure is much discussed throughout the study, a phenomenon I have elsewhere called “avowal aversion,” as found among

on fertility goddesses, and the Indo-Aryans (or “Punjabi nomads,” as labelled by Doniger) with their elemental sacralization.

⁸ One key term in Tibetan, *thugs* (corresponding with *citta* in Sanskrit), similarly refers to both the heart and mind. Tibetans share the fascinating habit with Thais, described by Stonington, of pointing to their heart when talking about a mental event. Both cultural groups share strong Indic influences, with Thais following Pāli Buddhist traditions and Tibetans following the Sanskritic.

Tibetan refugees and Indian respondents in India. Perhaps this connection was simply not identified by the author, rather than being avoided.

Next is the issue of “self.” Unfortunately, Stonington treads somewhat lightly over the subject, one with a long philosophical history in Buddhist metaphysics. Stonington speaks in passing of “self” throughout but for some reason waits until literally the final pages to unearth some of the complications around the concept. Essentially, the predominant view on personhood in the Buddhist traditions is *anattā* (Pāli)/*anātman* (Sanskrit) or no-self (sometimes also referred to as no-soul theory).⁹ Stonington describes this as “the idea that the self assembles continuously out of conditions” (137). Allowing for the possibility that Stonington’s understanding of Buddhist no-self came about entirely from local lay understandings of the concept, and respecting these as valid positions, a more typical presentation is that there is *no self at all* because of the interdependent origination of a being’s five aggregates (form, feeling, discrimination, compositional factors, and consciousness), which are all based on causes, conditions, and mental labelling. Not an “assembled” self, but *no self*. An inherent “self” cannot be located among or apart from the aggregates, and because a person is contingent on the collected aggregates, it is also sometimes said that beings have no “own-being” (Sanskrit: *svabhāva*)—admittedly a challenging notion. While betraying at least a cursory knowledge of “no-self” late in the game, earlier in the book Stonington states without complication such things as “rebirth of the suffering self” (152), “[a]t the interface of body and spirit, the self arises” (29), and “the nugget of blood . . . became one’s body and thus one’s self” (40). He also states that “*winyān* is the part of the self that endures after death” (81) and variously defines *winyān* as spirit, soul, and consciousness. There are various views on consciousness among the Buddhist philosophical

⁹ Except for the *Pudgalavādins*, outliers among the Buddhist philosophical schools and relatively unknown in Western scholarship, who hold that there is an existent person (Sanskrit: *pudgala*). Some seminal translations of their texts were made by my first professor in Asian religious studies, Professor Emeritus Leonard Priestley of the University of Toronto (*Pudgalavāda Buddhism*).

schools,¹⁰ but, in general, it is the consciousness aggregate that is seen as having continuity between lives, not a self, soul, or spirit. I am conscious of being nitpicky on this technical point, but as it is a core concept in Buddhism, I think it would have been helpful for Stonington to explore the tensions between textual perspectives and those of adherents, rather than merely presenting what he learned about “self” directly from his informants and giving it as fact.

One last Buddhist philosophical issue to broach, and another technically challenging one at that, is karma. Stonington makes superhuman efforts to capture nuanced local understandings of karma, which at times seem slightly discordant with normative Pāli Buddhist doctrine (as religion on the ground often is). In the Indo-Tibetan traditions, karma is often said to be more difficult to understand than the nature of reality and that only an omniscient mind can perceive its subtle workings. So I will try to be gentle. I have always found some tension between the practice of transferring or dedicating merit to the deceased and scriptural statements that both ordinary and realized beings cannot change the karma of another being. If they could, logically, an enlightened being of infinite compassion and skill would dedicate their limitless merit to others, and their karma would be purified. But it is safe to say that almost every Buddhist tradition has some version of merit transfer, so I will not further problematize it here. A prime example of discordance, though, comes from some of Stonington’s informants, who shared that they were suffering from bodily and disease states that were caused by a being they had harmed in that very life somehow harming them in the present, such as a buffalo-keeper who developed bowleggedness. Putting aside for a moment that there are malevolent spirits in Buddhist cosmology, as a Buddhist logician it is difficult for me to see theoretically how the harmed being would technically accomplish direct reciprocation, and their ontological status would be unclear. Also setting aside local understandings of organs containing

¹⁰ The Mind-Only school (*Yogācāra*) holds that the karma for which we are accountable is held in a “storehouse” consciousness.

animating spirits (and the phenomenon of possession states), ideas of previously harmed beings cohabitating a person's body are fascinating but unique. With my bias as a philologist and anthropologist, I believe it could have been useful for Stonington to at least recognize the discordance between these situated understandings of karma and normative doctrine, perhaps by using more scriptural sources, as the few monastics in the study seemed to share some of the highly situated views of householders. Lastly, I will add Stonington's mention of an intermediary state between death and rebirth, which he merely describes as scriptural and then, oddly, compares to a similar phenomenon from a study on Borneo. It might have been better to share instead that the concept has a long history. Perhaps made most popular by the so-called *Tibetan Book of the Dead*,¹¹ a ritual manual for helping beings navigate this perilous transition, the concept of an intermediary period is found in the Indian Buddhisms (as *antarābhava* in Sanskrit), and by some accounts even predates Buddhism.

Overall, I commend Stonington on this powerful and practically useful study which will have a lasting impact on my practice of bioethics (and I imagine that of many others) in a culturally diverse context. I would highly recommend this book for scholars (such as those in anthropology and religious studies), for those with a general interest in various approaches to dying and caring for the dying, and especially for those who wish to improve cultural safety when planning and delivering healthcare with Thai patients and families in diaspora.

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¹¹ The popular title is bit of a misnomer as the author was in fact an Indian pandit, Padmasambhava, and the text is technically entitled "Hearing in the Between" (Tibetan: *bar do thos grol*).

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