

BIOMEDICINE EXAMINED

CULTURE, ILLNESS, AND HEALING

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utilized in any form or by any means, electronic or mechanical
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The human mind has at no period accepted a moral chaos.

George Eliot
Middlemarch, 1871

The conclusions that we seek to draw from the likeness of events are unreliable, because events are always unlike. There is no quality so universal in the appearance of things as their diversity and variety.

Michel De Montaigne
Essays: On Experience, 1580
(trans. Cohen, 1958)

If the cultural influences upon science can be detected in the humdrum minutiae of a supposedly objective, almost automatic quantification, then the status of biological determinism as a social prejudice reflected by scientists in their own particular medium seems secure.

Stephen Jay Gould
The Mismeasure of Man, 1981

Perfect health, like perfect beauty, is a rare thing;
and so it seems, is perfect disease.

Peter Mere Latham 1789-1875
Collected Works, Book I, ch. 443

A model is by definition that in which nothing has
to be changed, that which works perfectly whereas
reality, as we see clearly, does not work and
constantly falls to pieces; so we must force it, more or
less roughly, to assume the form of the model.

Italo Calvino
Mr. Palomar, 1983

. . . values and knowledge are always and necessarily
associated in action just as in discourse . . . *the
very definition of "true" knowledge reposes in the
final analysis upon an ethical postulate.*

Jacques Monod
Le Hazard et la Nécessité, 1970

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PART I

THE SOCIAL SCIENCES AND BIOMEDICINE

INTRODUCTION

The culture of contemporary medicine is the object of investigation in this book; the meanings and values implicit in biomedical knowledge and practice and the social processes through which they are produced are examined through the use of specific case studies. The essays provide examples of how various facets of 20th century medicine, including education, research, the creation of medical knowledge, the development and application of technology, and day to day medical practice, are pervaded by a value system characteristic of an industrial-capitalistic view of the world in which the idea that science represents an objective and value free body of knowledge is dominant.

The authors of the essays are sociologists and anthropologists (in almost equal numbers); also included are papers by a social historian and by three physicians all of whom have steeped themselves in the social sciences and humanities. This co-operative endeavor, which has necessitated the breaking down of disciplinary barriers to some extent, is perhaps indicative of a larger movement in the social sciences, one in which there is a searching for a middle ground between grand theory and attempts at universal explanations on the one hand, and the context-specific empiricism and relativistic accounts characteristic of many historical and anthropological analyses on the other.

For many years social scientists left unquestioned the dominant ideology of their time; scientific "facts" were reified, assumed to be pristine and beyond the realm of social analysis. Anthropologists were particularly blind in this respect, and while they blithely examined the exotic healing ceremonies and rituals of other cultures and situated them in local cosmologies, they stubbornly ignored modern medicine, assuming it to have evolved beyond the superstition, religion, and value laden beliefs so clear to them in traditional medicine. Anthropologists, of course, have been careful to show how local medical knowledge is not arbitrary, but grounded in the "seamless web" of local culture; scurrilous words such as "superstition" are studiously avoided and use is made of the more elegant term "belief", which has nevertheless, until recently, been assumed to be an explanatory system of an entirely different order than one grounded in science. Despite this major limitation, the heritage of ethnomedicine and the more encompassing comparative study of healing systems, is a rich one in which the methods of symbolic anthropology have been dominant.

Keesing states that symbolic anthropology is an "exploration, an excavation, of the cumulated, embodied symbols of other peoples, a search for meanings, for hidden connections, for deeper saliences than those presented by the surface evidence of ethnography" (1987:161). In medical anthropology, the task becomes one of describing local beliefs about the causes and prevention of distress, diagnosis, classification and labelling of illnesses, and the performance of healing rituals, and then attempting an interpretation of these beliefs usually by demonstrating the way in which they are related to and act upon other aspects of culture. This enterprise has been described as dependent upon a "virtuosity in seeing hidden meanings enciphered as tropes" (Keesing 1987:161), and in cases where it is well executed has provided us with stimulating accounts of the medical beliefs of other cultures (see for example, Good 1977; Ngubane 1977; Sindzingre and Zempléni 1981).

It is perhaps in connection with beliefs about causation that medical anthropology has made one of its most important contributions to the study of medical systems. A comparative analysis of causal explanations for distress is a constant and forceful reminder that by confining one's attention to the human body and to encounters between healers and patients, major distortions are introduced into the analytic procedure. In most cultures the social origins of illness and distress are of overriding concern (Lewis 1975; Manning and Fabrega 1973) and medically related activities are much more encompassing than a visit to a healer (Janzen 1978).

Worsley, in a review of the comparative study of medical systems, has argued that the "treating of bodily ills takes place in *any* culture within a "metamedical" framework of thought", an overarching philosophy which guides the basic features of medical knowledge, its organization and practice (1982:315, emphasis added). The characteristic settings of doctor's office, clinic, and hospital, and the battery of medical professionals and auxiliaries associated with the modern "health-care complex" are specific products of industrial society. Similarly, the very idea of a bounded medical system, reasonably autonomous and clearly distinct from other social institutions, is a cultural construct, as is the "belief" (superstition?) that diseases are "real" entities and that their elimination crystallizes the essence of what medicine is all about.

One strength of the interpretive approach in anthropology is that, although the researcher records an account of the medical beliefs of other peoples, the exercise is done with a sensitivity to the fact that the interpretation is itself a product of particular historical and cultural determinants. Ideally, no assumption is made of a privileged analytical viewpoint which is value free. This attitude, when combined with rich and detailed descriptive data, has furnished us with invaluable context-specific

accounts of medical beliefs, more of which would be a welcome addition to the storehouse of information on comparative medical systems. However, in portraying the complex and subtle shades of meanings which are thought to form the basis for everyday life in other cultures, two very important arenas have been almost totally neglected: firstly, the control, distribution, and dynamics of the actual application of medical knowledge, and secondly the relationship of knowledge and its application not only to social and symbolic healing, but also to the reduction of individual pain and suffering.

Cultures, including those of industrial-capitalistic societies, form systems of meanings which provide explanations of how the world works, of what is thought of as "real" and what is designated as "natural" and inevitable. These meanings link people to one another and form the basis for social action. There has been a tendency among symbolic anthropologists to emphasise the shared signification and meaning created by a culture in a positive light, to consider it only as a unifying whole, and as providing the *raison d'être* for human existence in social groups. On the other hand, the way in which culture constitutes not only meanings but also an ideology has been largely ignored. In all societies cultural ideologies serve to institute and legitimate certain political and economic realities. Inequalities in the distribution of knowledge, power, and privilege are accepted as cosmically ordained relationships: "Cultures are webs of mystification as well as signification" (Keesing 1987:161). A balanced description is needed in the case of medical beliefs, not only of ideas about causation and healing, but of who creates and defines these meanings and what significance this has for the allocation of responsibility for the occurrence of illness and for the restoration and maintenance of the social order. An account of the control of medical knowledge and the way in which it is selectively applied can demonstrate "the manner in which social interest becomes seamlessly incorporated in the set of tacit assumptions about reality" (Comaroff 1982:50).

Medical sociologists, unlike anthropologists, have traditionally paid attention to the unequal distribution of power and to the way in which medicine can act as an institution of social control (Zola 1972). They have also shown how medicine in capitalist societies reflects the values of society at large, including those of class, race, gender, and age (Ehrenreich 1978; Frankenberg 1980; Stark 1982). However, sociologists, in common with their anthropological colleagues, have until recently rarely made the content of modern medical knowledge itself a subject for analysis, and have tended to rest assured that, because it is supposedly grounded in science, it is not, therefore, a subject for sociological enquiry.

In the stimulating and important precursor to this present volume,

The Problem of Medical Knowledge (1982), Wright and Treacher discuss why some of the traditional assumptions about biomedicine have recently been called into question. They point out that the strategy of the modern medical profession has been to claim that it functions with knowledge which has a special technical status and hence is not contestible in the same way as are say, religion or ethics. Power and knowledge are clearly linked in this claim which has increasingly been criticized from a number of angles: that the self-interest of the medical profession influences at times the generation of medical knowledge and its practice (Jackson 1970; Lewin and Olesen 1985); a lack of autonomy of medicine in other cultural domains (Bastien 1985; Kleinman 1980; Lock 1980); and, most notably under the influence of Foucault, how the language of medicine does not merely describe a pre-existing biological reality, but instead creates its own objects of analysis (Foucault 1975, 1979; Armstrong 1983). Wright and Treacher are quick to point out that what is being demonstrated in research of this kind is not that medicine is "unscientific" because it is permeated by social forces: but, in contrast, that both medicine and science are essentially social enterprises (1982:7). This shift in thinking is not merely with respect to medicine, but is part of a larger reorientation in connection with science in general (Latour and Woolgar 1979; Mulkay 1979) and has entailed the incorporation of a perspective in which more attention is given to the interrelationships of "the researcher, the scientific community of which he is a member, the knowledge which the community shares, and the broader religious, social and political currents within which the community exists" (Wright and Treacher 1982:8). The way has gradually been paved for the examination of medicine as a social and cultural construction and for a simultaneous rapprochement and refinement of the methods used by sociologists, anthropologists and social historians in its analysis. The volume edited by Wright and Treacher was one of the first to make its focus an analysis of medical knowledge, and emphasis was placed in several essays on the way in which various topics related to medicine are perceived in different historical periods and how they change through time and space. A second book, *Physicians of Western Medicine* (1985), edited by Hahn and Gaines, focuses on modern medical settings and shows very clearly the way in which medical knowledge and practice is not the product of a monolithic autonomous institution but rather is made up of numerous sub-specialities, interest groups, and individuals who bring a variety of perspectives to their work. Use is made of the ethnographic approach, and the opinions and experiences of physicians are incorporated into the analysis. The present volume is heavily indebted to these and other earlier endeavors and has tried to develop more fully some of the arguments implicit in them. Most notably, an effort is made systematically to uncover some of

the cultural assumptions, the ideology, in which modern medicine is grounded, and to show how these assumptions are embedded in the creation and transmission of medical knowledge and practice. It is generally accepted by the authors that medical knowledge is not an isolatable autonomous body of information, but that it is rooted in and is sustained by practice. In the majority of the essays, rich ethnographic or textual accounts locate the data in specific contexts, which are also often analysed in terms of their implications for relationships of power and control.

Our purpose is to demonstrate the social and cultural character of *all* medical knowledge, but by so doing we are not denying the existence of real, painful stress and suffering. There is, of course, a biological reality, but the moment that efforts are made to explain, order, and manipulate that reality, then a process of contextualization takes place in which the dynamic relationship of biology with cultural values and the social order has to be considered.

The relationship of medical knowledge and practice to the sick human body is a topic which so far has not been taken up very seriously by researchers using either interpretive or political analyses. It has generally been accepted by anthropologists, for example, that a shared belief system can be mobilized in order to aid in the healing process, largely though its effect on the psyche (Levi Strauss 1963) or because it stimulates a restructuring of the social order (Turner 1968). The reader is rarely informed if and when biological healing occurs as the result of healing rituals; in common with the shamans who are so often featured in their analyses, anthropologists have tended to relegate the body physical to the background in their scramble to expose metaphorical and metonymical links between the various discourses on the cosmos, society, gender, and the body (*Culture and Depression* [1985] edited by Kleinman and Good is a notable exception to this tendency; see also Lock [1986]). Similarly, the biological status of the human body has not been made problematic in most sociological analyses, although the work of Bourdieu and Foucault has stimulated a move in this direction (see, for example, Turner 1984).

An examination of the social and cultural construction of biomedicine forces a questioning of a privileged status for its knowledge and at the same time reveals how the practice of medicine is laden with moral evaluation. In theory the biomedical model of disease causation, by focusing attention on the neutral terrain of the physical body, serves to "depoliticize" the medical encounter (Habermas 1971). In practice the question of ultimate causation, of why one particular person becomes sick at one particular time, is not readily cast aside, and patients, families, and healers generate and exchange explanations in which implications about responsibility are embedded. In their various ways, statements which

focus on social, familial, psychological, or biological explanations for disease causation all highlight contradictions and tensions between the postulated relationships of nature, the individual, and society. An analysis of these statements exposes the way in which beliefs in connection with health and ill-health are reinforced by the basic ideology of a culture, and also reveals how images of selfhood and the creation of social identities are intimately linked to ideas about a moral and healthy body generated both within medicine and society at large.

As the practice of modern medicine becomes increasingly a technical enterprise, it is more incumbent upon us than ever to recognize that the human body is not a machine, that health and illness are not merely biological states, but rather that they are conditions which are intimately related to and constituted by the social nature of human life. The study of health, illness, and medicine provides us with one of the most revealing mirrors for understanding the relationship between individuals, society, and culture; it is an exciting task which has only just begun.

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RELATIONSHIPS BETWEEN SOCIETY, CULTURE, AND BIOMEDICINE:
AN INTRODUCTION TO THE ESSAYS

The essays in this volume demonstrate the interdependence of biomedicine, society and culture. The authors, for the most part using an ethnographic approach, show how language, values, metaphor, ritual practices, institutions, and social organization, among other variables, contribute to the creation of ideas about contemporary medical theory and to clinical practice. In particular these essays demonstrate how cultural and social variables function to support certain assumptions about the natural order, the "reality" of disease, and their "rational" management, very frequently through the use of technological intervention. Although the argument in most of the articles is developed around specific issues or case studies, several common themes, which we will briefly consider, recur frequently throughout the essays.

The volume begins with Gordon's exploration of several ideas derived from the Western philosophical and cultural heritage which may account for the tenacity of certain medical assumptions and practices in biomedicine today. She highlights parallels between the assumed autonomy of nature in both the natural science and biomedical paradigms and the assumed autonomy of the individual in a Western understanding of personhood, society, morality and religion. As a corollary she emphasizes how in biomedical practice there is an assertion of the autonomy of the individual from a social and cultural context.

THE CONSTRUCTION OF "PSYCHE" AND "SOMA"

As numerous writers on Western medicine have noted, both in biomedical knowledge and practice, a separation is usually assumed between the working of mind and body. A number of articles in this volume illustrate the cultural construction of this separation, how it is created and perpetuated, and the kinds of discourse and practices which actually contribute to the credibility of this dichotomy.

"Mind" and "body" are metaphors, Kirmayer argues, polarizing two distinct constellations of feelings and values. Their dualist relationship and the meanings associated with them are reproduced through the specialty of "psychosomatics" which protects the biomedical model by siphoning off cases with which it is unsuccessful. Blame for intransigent

illness is placed on the patient's irrational emotions instead of inadequate medical theory, diagnosis, therapy, or difficult social relationships. Further, psychosomatic therapy itself reaffirms the triumph of reason over both the "irrational" and the body.

Similarly, Helman finds that physicians increasingly label patients' emotions or personality characteristics as "pathological" and cite them as causal in "non-organic" illnesses. In response, patients then "reify" these pathogenic emotions, traits, or body parts, separate them from their "ideal social self," and then blame these isolated factors for the occurrence of their illnesses. Psychological explanations such as these compensate for the limits of the biomedical model in diagnosis, treatment, and explanations of illness.

Several other papers provide insight into how the separation of mind and body, body and emotions, and medicine and emotions are brought about. Observing the rite of the anatomy lesson, Lella and Pawluch trace changing relationships among attitudes towards emotions, cadaver dissection, and historical periods. They argue that the matter-of-fact, non-emotional attitude toward the anatomy lesson that has characterized its teaching during this century is changing. Today, as was once the case in the past, the emotional and philosophical meanings of cadaver dissection for medical students are increasingly being given attention.

Another emotional situation many physicians must face is telling patients "bad news." As an example, Taylor observed surgeons while they were informing patients about a diagnosis of breast cancer. Although different physicians adopted different strategies, they all routinized the strategy they adopted, rather than adapting their behavior to each patient. The contrast between the patients' obvious emotionality and many physicians' discomfort with emotions probably accounts in part for these physicians' experiencing disclosure of diagnosis as a very stressful part of their work.

Two papers question the dominance of the natural science model of explanation in medicine, in which the observer (medical practitioner) is thought to sustain a detached attitude. Kirmayer suggests that it is important to arrive at an understanding of the metaphoric basis upon which explanations in modern medicine are built. Such an understanding will, he suggests, alert us to the involvement of both physician and patient emotions in medical practice. Similarly, Gordon discusses how knowledge becomes "embodied" through experience, such that "intuition" comes to supersede calculative reasoning. The common dichotomy of mind and body limits our understanding not only of illness, but also of what we accept as knowledge.

Kaufert highlights another dimension that contributes to the separation of body from emotions and experience in arguing that the medical construction of menopause is strongly influenced by the demands of the

scientific research paradigm. This paradigm favors the study of phenomena as discrete events rather than as a process. Kaufert notes the emphasis which is placed on the physical and biological changes associated with the mid-life transition to near exclusion of the actual experiences of women.

HOW MEDICINE PERPETUATES ITSELF

The transmission of medical knowledge and values is another theme which is taken up in several of the papers. Atkinson studied the teaching strategies used to reproduce clinical medicine. He shows how senior physicians teach physicians-in-training to construct normal or abnormal pictures of patient situations and to integrate and apply theory in practice. Indirectly, he also shows how physicians make use of patients while teaching students how to arrive at a diagnosis and that this is often accomplished by means of the Socratic method.

Sankar, in watching the reactions of senior medical students during and after visits to the homes of patients, discovered the power of the *context* of the clinic/hospital. This environment not only is the "turf" of the physicians, but also contributes to what information physicians will or will not have to confront. As one student put it:

In the hospital . . . you have social problems where you want them, you don't have to deal with them. There is no social . . . Whereas at home, there are all kinds of interactions that you really have no control over (Sankar, this volume).

MEDICINE ADAPTING

Medicine is continually undergoing change, adaptation, and expansion, another theme taken up in several of the essays. Armstrong traces changes in ideas about space and time in British medical practice. The location of practice in the health center made possible a new analysis of illness in terms of time (process) and "community." The rise of medical concern for chronic illness and the "biography" (the patient as a person) reflects these changes. A temporal model of illness is also revealed in the incorporation of "prevention" as the concern of general medical practitioners, a topic discussed by Williams and Boulton. How, in fact, this new domain is interpreted in theory and practice is left much to the discretion of individual physicians. Their interpretations reflect personal biography as well as age, subspecialty, or institutional affiliation. Wright also traces the incorporation of a new domain into the medical sphere – that of babyhood. He analyzes the complex culmination of interacting