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SICKNESS  
AND HEALING  
*An Anthropological  
Perspective*

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reincarnation of Hahn 1984; chapter 4 an expansion of Hahn 1985. Chapter 2 is revised from an article published in *Social Science and Medicine* (21 [1985]: 165–71); chapters 8 and 9 are revised from articles first published in *Medical Anthropology Quarterly* and its predecessor; and chapter 7 is a revision of a chapter in Hahn and Gaines 1985. I thank the publishers of these sources for permission to reuse previously published material. I also thank Appleton-Century-Crofts for permission to reproduce the frontispiece of early editions of *Williams Obstetrics* and the American College of Obstetricians and Gynecologists for the photograph and for access to its excellent library. Thanks are due also to many nimble librarians in Seattle and Atlanta for numerous searches into obscure places.

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## INTRODUCTION

At its best anthropology has always been subversive. By describing different social, cultural, and psychological arrangements, it challenges commonly accepted ways of perceiving, articulating, and understanding the world.

—Crapanzano 1990:145

In all epochs and everywhere, sickness and healing are primal human concerns. Yet the understanding of sickness and the response to sickness through healing vary greatly from time to time and place to place, fundamentally shaped by historical and cultural circumstance. Contemporary Westerners are accustomed to taking their own views of sickness and healing for granted—the way things are, reality. Such-and-such diseases exist, and there may be specific techniques for their treatment. Although Westerners recognize that their medicine, Biomedicine,\* is imperfect in detail, still, its underlying principles of pathology and therapeutics are presumed to be correct. Alternative, non-Western views are generally regarded as primitive, mystical, and essentially misguided and their occasional benefits—for example, medicinal plants—as empirical serendipity.

### THE ANTHROPOLOGICAL PERSPECTIVE

In this book, I attempt to step aside from the Western perspective. I examine the world of sickness and healing from an anthropological perspective.

\* I capitalize "Biomedicine" to indicate the name of the biologically oriented medicine that predominates in Western societies.

tive that differs from the prevailing Western view in regarding systems of sickness and healing everywhere as cultural systems—that is, organized patterns of thinking, judging, and behaving shared by the members of a society. In the first half of the book, I explore ways of conceiving sickness and healing in which the reality of Western medicine is not taken for granted. In the second half, having willfully suspended the perspective of Western medicine, I return to reflect upon it. I seek familiarity in the exotic, the exotic in the familiar.

The anthropological perspective has an egalitarian theme: although beliefs about sickness and practices of healing clearly differ from society to society, all are equally cultural systems. By translating across cultural boundaries, anthropologists seek a wider audience for the voices of others. They treat their "informants" in different cultural settings as teachers. They are particularly tolerant abroad and unusually skeptical at home—both sometimes to excess.

Anthropologists take as real the "new" forms of sickness discovered in foreign settings, sicknesses that may appear strange and implausible on first encounter. They also take seriously "new" ways of healing witnessed beyond their own cultural boundaries. What is "new" depends on where one has been and what one has seen. Anthropologists attempt to understand the concepts and theories and values that underlie forms of sickness and healing that are not part of their own tradition. By representing a broader range of human variation, they may expand Western ideas about humanity. The goal of this cross-cultural encounter is not to synthesize all variations into one gigantic, panhuman hodgepodge but to promote mutual respect, communication across boundaries, and exchange where it may be beneficial.

I deliberately say that I "attempt" to step aside from the Western perspective. I do not pretend to understand sickness and healing entirely from the perspective of another culture or all cultures, totally free of my own cultural assumptions. To do so would be to deny the fundamental anthropological tenet that the concepts and premises that guide the way people understand the world—their "worldview"—are profoundly shaped by the cultural setting they inhabit. Like patients, physicians, and other healers, anthropologists are creatures of their culture. I do not deny my cultural roots.

Nor do I deny the unprecedented knowledge of twentieth-century Biomedicine. I am astonished daily by its remarkable discoveries and inventions. When sick, I, too, resort to Biomedicine for medical care—not simply because it is relatively convenient but because I believe that for many conditions it offers the best treatment available anywhere. In my epidemiological research as well, I build on findings of Biomedicine. I am a Westerner and have grown up in a society where Biomedicine prevails.

Medical anthropologists commonly confront an essential dilemma and a

profound ambivalence toward Biomedicine, resulting in uncertainty about the validity of their own framework. Although they seek to compare medical systems across cultural boundaries without bias for or against any one perspective, they themselves are often rooted in the perspective of Biomedicine. Much of what they believe about sickness and healing has been learned from the teachings of Biomedicine and the broader culture.

The socialization of many anthropologists in societies where Biomedicine prevails has led to two visions within the field of medical anthropology as a whole, sometimes to double vision within single practitioners. One vision professes a fundamentally hierarchical view of the universe of sickness. At the superior level are the basic truths of Biomedicine; below are the distorted or simplified views of patients and the practitioners of non-Western medicines. Corresponding to the hierarchy of sickness is another hierarchy of participants—physicians as masters of Biomedical truths, nurses and other paramedical personnel, as well as patients and practitioners of other medicines, as adherents of simpler, less valid perspectives.

In the second vision, common in analyses of non-Western medical systems, researchers have professed to reveal the local medical "reality" in its own terms; in their concern not to impose their own vision on those they study, these researchers have assumed that the local, indigenous explanations of the world of sickness and healing are valid (Kenny 1983). In this relativism, researchers may minimize, ignore, or even explicitly deny universal biological and pathological realities (as formulated in their own culture).

The first vision, which assumes that the analyst's culture possesses exclusive truths, is "ethnocentric," and the second vision might be described as "xenocentric," now assuming that the cultures of *others* have exclusive access to the truth—at least in their home setting. I believe that both visions are false. That beliefs are part of a cultural system—our own or someone else's—argues neither for nor against their validity. There is no reason to assume that exclusive truth is to be found in any given system of beliefs before examining it. Moreover, the ability to understand foreign beliefs depends in the first place upon various assumptions on the part of the observer, assumptions that are most likely to come from his or her own culture (Quine 1960; Hahn 1973). Conclusions about another's logic and beliefs may be as much the product of one's own preconceptions or prejudices as of the processes of thought imputed to others. The xenocentric assumption that one can apprehend the cultural beliefs of others "as they are," independent of one's own beliefs, belies the basis of one's observations in just such cultural beliefs.

The observer needs a place to stand. Observation and understanding are built from categories, hypotheses, and principles of knowledge. Even among positivist philosophers in the early part of the twentieth century, it was recognized that one could not begin the reconstruction of knowledge without a conceptual platform and that the platform available was the builder's own

tradition. Otto Neurath wrote: "We are like sailors who must reconstruct our ship on the open sea, without ever dismantling at a dock and rebuilding with the best of parts" (quoted in Quine 1960:vii; my translation).

The challenge of anthropology—and of other disciplines that seek an understanding of human phenomena rather than of the phenomena found only in the observer's home setting—is to develop an observational framework that is as explicit, rational, and consistent as possible and that is at the same time receptive to the alternative truths of other cultural frameworks. If we begin from the culture in which Biomedicine prevails, we must first make our Biomedical framework as clear and systematic as possible. But, at the same time, we should not assume that the premises of this system are final or exclusive truths. Ours is not the only place to stand.

As they use the term *ethnobotany* (from the Greek *ethnos*, a "nation or people") to refer to a society's botanical thought and *ethnoichthyology* to its ideas about fish, so anthropologists have coined the awkward but useful term *ethnomedicine* to refer to the part of a society's cultural system concerned with sickness and healing. The total culture of a society consists of several *cultural systems*—for example, science, religion, economics, and medicine—each of which may be thought of as having three basic features: a distinctive *domain* of knowledge and practice; a means of *socialization*—the teaching of this domain to specialists and others; and an *arena* in which the activities of this domain are conducted.

The *domain* defines what a cultural system is about. The domain of medicine distinguishes things that are "medical" from those that are not. Included within the domain are the goals, values, knowledge, and techniques of both practitioners and laypersons. The domain also includes ideas about proper behavior (for both patients and healers) and about sanctions for misbehavior, such as the feigning of sickness by patients or the neglect of standards of practice by healers. In many "traditional," non-Western societies, the domain of medicine is not clearly differentiated from that of religion, politics, and the rest of social life; sickness may involve the world of ancestral spirits, and healing may require the resolution of social conflict.

*Socialization* is the way in which a cultural domain is inculcated in novices—for example, in the vision quests of shamanism and the premedical education, medical school, internship, and residency of Biomedicine. Through socialization, a society produces and maintains the personnel, such as its healers and specialists, who occupy its roles. In Biomedicine as well as in many traditional medical systems, the socialization of healers involves a prolonged and arduous apprenticeship in which expert practitioners play a leading role. Socialization is also the way in which a society educates its population about sickness and healing; it informs patients how to behave when sick, both in and outside of medical settings.

Finally, a cultural system has a defined *arena* in which its activities are carried out. The arena may include institutions and settings, such as hospi-

tals and doctors' offices, as well as designated roles—for example, "doctor," "pediatrician," "surgeon," "psychiatrist," "nurse," "lab technician," "patient." In traditional societies, healing activities may not have a fixed place but may be marked by time and ritual.

## SICKNESS

If the meaning of "sickness" varies widely from one cultural setting to another, what, then, do cultures have in common that might be called "sickness"? How can "sickness" be defined so that we know what to look for in a comparative study?

Broadly speaking, the essence of "sickness" is an unwanted condition in one's person or self—one's mind, body, soul, or connection to the world. What counts as "sickness" is thus determined by the perception and experience of its bearer, the patient (from the Latin *pati*-, as in "passion," to suffer, to bear affliction). Sicknesses represent and express the particularities of individual patients within a society. What counts as sickness and health may differ for a four-minute miler, a lower-limb amputee, an opera singer, and most of the rest of us. What *causes* the sickness may be environmental conditions or pathogens, the patient's physiology, or harmful behaviors. What *defines* the event for which we seek a cause, however, may be not the patient's body, behaviors, or potentially harmful environmental occurrences—its possible causes—but rather his or her subjective experience and values.

It is not commonly recognized in the West that ideas about what a "person" and a "self" are and should be differ greatly from one cultural setting to another. Indeed, the individuated person, separate from the rest of society and the universe, is a distinctly Western notion (Dumont 1965; Lutz 1985b); in many non-Western societies, persons are regarded as essentially and inextricably linked with other beings, human and nonhuman. Autonomy and independence are also largely Western values about desirable connections with others. Consequently, in other societies, ideas about "something wrong and undesirable in one's person or being" may differ greatly from Western ideas. For example, whereas disturbances in the capacity for *independence* may be thought of as pathological in the West, disturbances in the capacity for *interdependence* may be regarded as pathological elsewhere.

Sickness often obstructs or threatens to obstruct the everyday activities or life plans of persons. Often, though not always, sick persons themselves know best when they are sick. Often, but not always, afflicted persons suffer in their sicknesses either directly, from the pains of sickness itself, or indirectly, from actual or threatened impairment.

However much a society's worldview shapes its members' perceptions of their sicknesses, it is primarily how a person works well in the world according to his or her own vision that defines the person's sickness—as loss or as

threat to this desired capacity and function. The labeling of persons as "sick" who deviate from the standards of others, as has been reported, for example, in Soviet psychiatry in the mid- and later twentieth century, is a political abuse of diagnosis in which the purported well-being of society is imposed upon its members with a pretense of interest in the so-called patient. But, rather than label existing sickness, such societal acts are more likely to cause suffering, if not sickness. The societal labeling of conditions is akin to what has been called the "tertiary gain of illness" (Dansak 1973), in which a person's consociates support his or her pathological condition for some benefit of their own; in this case, the "illness" is a fiction.

Included as sicknesses are broken limbs, cancers, and "neurotic" habits that get in one's way. Where hunting is thought to indicate one's connection with the animal world (as in some Amazonian tribes) or with ancestral spirits (as in some traditional African societies), difficulties in hunting may be regarded as sicknesses and treated by healers. Also included are traumatic events such as automobile fatalities; although the victim may not have had time to experience these mortal events as wrong and undesirable, we expect that, unless suicidal, he or she would have made such judgments of the outcome. Childbirth is commonly a healthy event, which, however, produces levels of pain (and pleasure as well) exceeding most other events; it is not sickness unless taken to be an unwanted condition of the mother's self or body. Grief, too, may bring much suffering, yet may be a healthy reaction to loss; it may also be pathological when it plays into psychodynamic processes not directly related to the loss itself.

Unemployment and poverty are likely to be unwanted conditions, but they are not necessarily conditions *in* one's self or one's connection with the world. Yet they may become a part of the self, incorporated, and in this case would reasonably be regarded as sicknesses. What of personality characteristics such as greed or arrogance or shyness, and what of emotions such as rage—are these sicknesses? Again, I believe they are reasonably regarded as sicknesses when they are a part of the self and are unwanted. The same holds for bodily states—being fat, skinny, weak, clumsy, unable to carry a tune. Some of these states are *causes* of sickness. They may themselves *be* sicknesses when they play a conscious role in one's life and when they become subjects of regret.

On the other hand, we may exclude as "sickness" the result of immunization in which pathogenic matter is deliberately injected or ingested to enhance the body's defenses. We may also exclude otherwise "sick" conditions such as pneumonia, "the old man's friend," among the elderly or others who, following rational reflection, wish to die. Though with side effects, immunization and the old man's friend produce desired outcomes.

The conception of sickness outlined here differs substantially from the conception found widely in Biomedicine. The anthropological notion I formulate defines sickness essentially from the perspective of the patient, who

determines the work of the healer. In Biomedicine sickness is defined as disturbance in bodily or behavioral function in ways determined by the physician, who defines the problem of the patient, independent of and sometimes contrary to the patient's judgment.

## HEALING

Given this conceptualization of sickness, a definition of "healing" is relatively straightforward. Broadly speaking, healing is the redress of sickness. The words *heal* and *health* may derive from the Germanic terms for "whole, uninjured, of good omen." If one adopts this concept, ideas of healing will vary with notions of "whole," which, like notions of "self" and "person," vary greatly from setting to setting and epoch to epoch. I include as healing not only the remedy or cure of sickness—that is, the restoration of a prior healthy state—but also rehabilitation—the compensation for loss of health—and palliation—the mitigation of suffering in the sick.

Healing is a sequence of events, some of which may be deliberately caused, others unintended (Dunn 1976). Although we generally designate as healers persons who specialize in intentional healing, this designation can be misleading. Healers may facilitate healing, but they may also hinder it; and healing may occur without or in spite of their interventions. Patients themselves, their bodies and minds—often considered the passive recipients of healing—may and commonly do play a prominent role in their own healing. Other persons not regarded as healers may heal as well, intentionally or not. And nonpersonal forces, too—for example, the physical environment—may play a healing role.

## PLAN OF THE BOOK

In the first half of this book, I develop an anthropological framework for examining sickness and healing in all cultural settings, without assuming that the perspective of any one culture is true or better than others. Chapter 1, "The Universe of Sickness," explores issues in the classification of sickness and elaborates a definition of sickness in which the underlying reality is not, as assumed in Biomedicine, the patient's biology as assessed by a physician but rather the patient's perception of suffering and disturbance in him- or herself. Patients' anatomy and physiology may play a prominent role in the etiology and remedy of sicknesses. It is the patient, however, with his or her concepts, theories, and goals, who determines in the first place that he or she is sick.

Chapter 1 also proposes three basic kinds of accounts of sickness that may be held in different cultural settings: *disease accounts*, such as the theory of

Biomedicine, in which the patient's body is regarded as the seat of the causation and remedy of sickness; *illness accounts*, such as ideas about stress in recent popular thought in the West, in which the person, including his or her mind, body, and social environment, is seen as the focus of sickness causation and treatment; and *disorder accounts*, such as that of traditional Chinese medicine, in which imbalances in cosmic forces are seen as the source of sickness and the means of its redress.

Chapter 2, "Culture-bound Syndromes Unbound," argues that the notion of culture-bound syndromes, used by psychiatrists as well as by anthropologists, is itself also culturally biased. Supposedly, culture-bound syndromes are manifestations of sickness thought to be found only in delimited cultural settings. Running "amok," a behavior originally described in Malaysia, is the most infamous of culture-bound syndromes. Culture-bound syndromes are commonly described as congruent and largely explainable in terms of their settings. I claim that the idea of culture-bound syndromes assumes that some conditions are bound by their cultural settings and that others are not. I suggest, rather, that *all* conditions of sickness are affected by their cultural setting as well as by human biology, psychology, and the physical and social environment. I conclude that the category "culture-bound syndrome" is misleading and should be abandoned.

Chapter 3, "Three Theories of Sickness and Healing," reviews the wide range of theories that anthropologists have proposed to account for variations in the medical systems found in different settings. Some have argued that medical systems, and indeed cultures as wholes, are largely determined by adaptation to their physical environment. At the other extreme, some anthropologists appear to believe that medical systems, like the rest of human cultures, are arbitrary albeit systematic mental fabrications, minimally constrained, if at all, by the physical environment; the world becomes the way it is believed to be. I argue that both extremes are incorrect and propose a view between the two.

Chapter 4, "The Role of Society and Culture in Sickness and Healing," presents a wide range of evidence that the mind, social relationships, and societal organization profoundly affect processes of sickness and healing in a causal manner. The placebo effect is a good example of the role of beliefs—largely shaped by the patient's cultural setting—in events of healing (and of sickness as well). This view of sickness and healing as causally associated with the social and cultural environment in the same way that they are associated with pathogens and medicines runs counter to a fundamental premise of Biomedicine. The sociocultural model is proposed to complement rather than replace the Biomedical model.

Chapter 5, "Anthropology and Epidemiology: One Logic or Two?" reconsiders the relationships between two basic approaches to the understanding of sickness and healing. Some anthropologists and many epidemiologists believe that the basic methods of these disciplines are entirely distinct, if not

contradictory. I describe what practitioners of these disciplines believe themselves to do in their work. I then show how fundamental assumptions made by practitioners of each discipline are based on principles of the other discipline and how practitioners of each thus practice the other discipline without knowing it. I recommend exploration of basic commonalities to enhance the practice of both disciplines. I illustrate the potential of collaboration in plausible solutions to the problem of understanding the persistent gap between white and black infant mortality rates in the United States.

The second half of the book examines several facets of Biomedicine from an anthropological perspective. Chapter 6 portrays "Biomedicine as a Cultural System," concentrating on its preeminent practitioners, physicians. The chapter describes the way in which physicians define the domain of medicine—focusing on the body—and the way the body is divided by medical specialties. The chapter then describes the process of medical education, one of the most grueling rituals of socialization known. Finally, it describes the rules that guide relationships between physicians and their patients.

Chapter 7 illustrates the culture of Biomedicine in "A World of Internal Medicine: Portrait of an Internist." Internal medicine is the rational heart of Biomedicine. I observed an internist I call "Barry Siegler" for several months to understand how he thought of his work and how he treated colleagues and patients.

By reviewing the development of the principal textbook of obstetrics, *Williams Obstetrics*, from the first edition, published in 1903, to the eighteenth, published in 1985, chapter 8, "Divisions of Labor: Obstetrician, Woman, and Society in *Williams Obstetrics*," analyzes the twentieth-century evolution of Biomedical ideas about women patients and their suffering and about the distribution of authority in the medical setting. This text has likely guided the training of most obstetricians and the conduct of most deliveries in the United States since the turn of the century. Particularly in earlier editions, women are depicted as childbearing machines; they are treated mechanically, without attention to their experience. Editions of *Williams* in the 1950s introduced an effort to attend to the women themselves. Recent editions have given limited choice to women patients but have also given prominence and authority to a "new" obstetrical patient, the fetus.

Chapter 9, "Between Two Worlds: Physicians as Patients," explores the gulf between physicians and their patients by examining the experiences of approximately twenty physicians who became sick and wrote about their experience, thus revealing the encounter of two worlds—patient and healer—in one person. For the most part, there are commonalities among the experiences of these physician/patients—their initial clinical treatment of their own sickness, the subsequent recognition that they are suffering, their adoption of the patient role, their awareness of distance and coldness in their physicians and in the medical system, their acknowledgment of the need for external social support, and their ambivalent return from patienthood to

normal life. Many of these physicians are awakened by their journeys between two worlds; they alter their vision and their practice of medicine upon return.

Chapter 10, "From Medical Anthropology to Anthropological Medicine," suggests that an anthropological approach may address several dilemmas of contemporary Biomedicine. On the part of patients, there are often false expectations of what medicine can and should do, excessive optimism and excessive skepticism, dissatisfaction with a biological and fragmentary approach to their sickness, and resentment at not being listened to or heard. Physicians, too, are concerned with false expectations on the part of patients, with their difficulties in persuading patients to comply with what they, the physicians, think best, with the adversarial climate this promotes, with the excessive demands of medical work, and with the encroachment of corporations and government into medical decision making. An anthropological approach to medicine is proposed not as a panacea to these problems but as a critical element in their solution.

part  
one

AN ANTHROPOLOGICAL  
PERSPECTIVE

# 1

## THE UNIVERSE OF SICKNESS

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A good cook changes his knife once a year—because he cuts. A mediocre cook changes his knife once a month—because he hacks. I've had this knife of mine for nineteen years and I've cut up thousands of oxen with it, and yet the blade is as good as though it had just come from the grindstone. There are spaces between the joints, and the blade of the knife has really no thickness. If you insert what has no thickness into such spaces, then there's plenty of room—more than enough for the blade to play about in. That's why after nineteen years the blade of my knife is still as good as when it first came from the grindstone.

—*Ting, cook to Lord Wen-hui, in Chuang Tzu,*  
*translation by Watson 1964:47*

Although most of us are sick at least from time to time, none of us is ever sick in quite the same way twice. And each of us is sick in a way different from others. We are sick not only from different "things," or "causes," but we are sick in a manner corresponding to our singular bodies, our unfolding biographies, our cultural and historical positions, and our current circumstances. Each event of sickness is unique.

### THE NAMES OF SICKNESS

Given the vast universe of all sicknesses that have ever occurred, how can we classify the diversity into this, that, and the other kind of sickness? Are there such "things" as "depression," "cholera," or "broken legs"? Which ones are there, and how do we know? What makes all occurrences of "cholera" significantly alike—so that we can reasonably call all of them cholera—and each significantly different from occurrences of "rabies," "influenza," "heart attack," and "schizophrenia"? When and why do we then distinguish different forms of "one" sickness—for example, cholera of the el Tor and classic biotypes and the Inaba, Ogawa, and Hikojima serotypes, and more than one hundred recognized strains? Short of the listing of single

occurrences of sickness in individuals, what is the limit of such sub-sub- . . . specification?

And further, what about forms of sickness that have labels in other societies, but may not in our own? Are there sicknesses that are not captured in our thought or that are conceived of in very different ways? *Susto*, for example, is a condition referred to by many Indian and mestizo peoples in Latin America (Rubel, O'Neill, and Collado-Ardon 1984). Persons afflicted with *susto* are thought to suffer a loss of their soul because of fright; they commonly lose their appetite and strength; they are listless and restless, depressed, withdrawn, and lacking in motivation. They must be cured by restoration of their soul. Another example, *amok* is a syndrome diagnosed in Southeast Asia in which violent and homicidal outbursts follow a period of brooding (Carr 1978). A third example, *pora-keri dohari*, is a condition believed by the Desana of the Amazon Basin in Colombia to be caused by a malevolent shaman who puts a fence around the uterus of a pregnant woman and turns her fetus to the breech position, blocking its birth (Reichel-Dolmatoff 1971). *Pora-keri dohari* is relieved when a benevolent shaman ascertains the position of the fetus, turns it for proper birth, and gives it food for strength. Are conditions such as *susto*, *amok*, and *pora-keri dohari* any less a part of the reality of sickness than cholera, hypertension, and depression? Is *susto* another label for depression, *pora-keri dohari* simply the breech position misconceived? Is *amok* in Malay the same as *amok* borrowed in English? Is there one reality of sickness differently named or are there multiple realities?

In this chapter I explore the range and dimensions of the universe of human sickness and the classification of its forms. I consider whether the varieties of sickness found are so diverse that no commonality can be discerned or whether, in contrast, sickness has an essence. I formulate a definition of sickness as *a condition of the self unwanted by its bearer*. With certain caveats, the range of human sickness is all those conditions of selves that have been or might be unwanted by their bearers. I consider preconditions that must exist in order for persons to know their own sicknesses. I then describe four interrelated aspects of sickness found in all settings: (1) accounts of sickness, (2) sickness experiences, (3) sickness roles and institutions, and (4) causes of sickness. I consider how one compares sicknesses in different cultural traditions; and I examine the question of the relative truth of different medical systems. I conclude that the Biomedical conception of sickness as *physiological malfunction confuses conditions and their causes*. To comprehend human sickness in diverse settings, the Biomedical view must be revised and greatly expanded. The universe of sickness is refracted in multiple realities.

A classification of the forms of sickness is referred to as a *nosology* (from the ancient Greek, *-logy*, "discourse on," and *nos-*, "disease"). A nosology is to forms of sickness what the classificatory schemes of Linnaeus are to the

kingdoms of plants and animals, and what the nomenclature of contemporary nuclear physics is to the elementary particles of the universe—electrons, muons, quarks,  $Z^0$ s, and so on. Nosologies group events of sickness on the basis of criteria that are detectable and deemed significant. A nosology is useful if it helps us understand sicknesses, if it allows prediction of their course, if it facilitates communication of our experiences of sickness, if it enables a more effective response, preventing, curing, or palliating sickness.

Nosologies are critical in research on the causes, possible cures, or other measures against sickness. Before we demonstrate causes or cures, we must appropriately specify which particular conditions constitute the sickness of interest and which do not. If our definitions are too broad, we may not be able to evaluate hypotheses, since possible causal connections may be obscured by unrelated conditions. The generic category of cancer hinders etiological research because it includes heterogeneous phenomena. On the other hand, the specific diagnosis of adenocarcinoma of the vagina allowed determination that DES (diethylstilbesterol), a medicine taken by pregnant women in the 1940s and 1950s to prevent fetal loss, was a highly potent cause of this cancer in their daughters (Herbst, Ulfelder, and Poskanzer 1971). The category of squamous cell lung cancer allows investigation of cigarette smoke as a cause. On the other hand, if our definitions are too narrow, we may also be unable to find associations because a common cause may contribute to phenomena not included.

A nosology is an element of a broader medical system and a still broader total culture—a society's system of ideas, values, and ways of doing things. Anthropologists have referred to the systems of medicine found in different cultures as *folk* or *ethnomedicines*. Contemporary Biomedicine is an ethnomedicine as are the shamanistic medicine of the Amazonian Desana Indians and the traditional medicine of China. All ethnomedicines have their own nosologies and medical theories. Nosologies and the medical theories of which they are a part vary widely among societies.

## NOSOLOGIES IN THREE SOCIETIES

### *The Subanun*

The Subanun, described as a pagan population, inhabit a mountainous region on the Philippine island of Mindanao; they are slash-and-burn farmers (Frake 1961). Subanun have no designated diagnosticians or healers; patients call upon their own knowledge and that of kin and neighbors for diagnosis and for herbal and other treatment. Charles Frake, an anthropologist who studied Subanun life in the 1960s, reports that, after legal matters and the plant life of their environment, sickness is the third most common topic of conversation among the Subanun. All Subanun are active and informed participants in the classification of and response to sickness. They

most often agree in their theoretical discussions of sickness, even though they may differ in specific applications.

Frake systematically elicited Subanun diagnostic categories and found a total of 186 basic diagnoses. Categories were distinguished by four criteria: (1) Most conditions were distinguished on the basis of symptoms. (2) Other conditions were distinguished by their causal agents and mechanisms. Causal agents included not only the parts of particular plants and microscopic animals—for example, mites—but also stress, objects thought to enter the body, symbolic acts, and the loss of one's soul. (3) Some conditions were distinguished on the basis of "prodromes"—that is, the set of symptoms that preceded the sickness. (4) The remaining conditions were distinguished by their personal etiology—the circumstances that caused the particular occurrence of sickness. Etiologic determination required divination or seance with supernatural beings, costly procedures reserved for instances in which ordinary medicinal treatment had failed.

Early in the course of his field research, Frake had an infected swelling on his leg. He took the occasion to learn about Subanun diagnostics. He found 29 distinctive diagnoses for dermatologic conditions, collectively called *nuka*; diagnoses included *pugu*, rash, *nuka* (again), eruption, *beldut*, sore, and *buni*, ringworm. Subanun made various diagnoses of his infection, at least in part because his informants were responding to different levels of specificity—for example, skin diseases, or sore, or distal ulcer. (Frake does not say how or by what means his infection was resolved—presumably satisfactorily.) Subanun commonly use diagnoses to select among 724 botanical medicines for treatment and among 61 named offerings made to propitiate supernatural beings. It is the gods who effect cure.

### *The Ndembu*

Spirits also pervade the world of sickness of the Ndembu, a tribal people of Zambia. Victor Turner studied Ndembu social organization, ritual, and symbolism in the 1950s and early 1960s. Ndembu regard sickness as one of several kinds of misfortune, which also include "bad luck at hunting, reproductive disorders, physical accidents, and the loss of property." Turner claims that the Ndembu "are obsessively logical, though on the basis of mystical premises. . . . [They] consider that calamities and adversities of all kinds are caused by mystical forces generated or evoked and directed by conscious agents. These agents may be alive or dead, human or extrahuman" (1967:300). The Ndembu are said not to distinguish "natural" from "supernatural" conditions.

Turner describes twenty-two examples of Ndembu diagnostic categories and their therapies. The categories are distinguished on the basis of symptoms—for example, *mbumba yaluzong'a*, a disease that causes people to lose toes and fingers (most likely leprosy in the Biomedical classification), *kaseli*

*kamashi*, a disease with bloody urine (most likely schistosomiasis), and *mu-song'u wachingongu*, a disease that leaves pockmarks (most likely smallpox). Also included are conditions whose symptoms are paralysis, insanity, and fits.

Ndembu diagnosis makes visible the forces hidden behind particular conditions. Much of Ndembu therapy is thought to work by a form of sympathy: manipulation of a substance representing the disease produces a parallel effect on the disease itself. For example, *kaseli kamashi*, blood in the urine, is treated by consumption of a medicine made of the red gum of a certain tree. Turner suggests that the curative principle here is homeopathic. If this treatment fails, a white gum medicine is used. Sickness in general is associated with blackness, health with whiteness.

Treatment for insanity involves medicines concocted from the old bones of a mad dog, a fruit associated with revelation and clarity, parts of the leopard (which kills without reason), the wild pig (which moves at random), and the *mvundu* fish (which may swim upside down). The leaves of a plant from the top of termite hills are used because the insane seem to be above things. "He wanders about in the air . . . talks in the air. . . . This disease of insanity comes in the air" (Turner 1967:319). Its remedy works through mimicry.

### *Biomedicine in Western Society*

Western medicine is most often assumed (by Westerners) to be rational and systematic, based on empirical evidence and inductive and/or deductive logic. Its nosology is formally codified in the *International Classification of Diseases* (World Health Organization 1978), now in its ninth revision, known as ICD-9. Included in ICD-9 are places for 999 conditions, from "001, Cholera" to "999, Complications of Medical Care, Not Elsewhere Classified," and for more specific forms of many conditions—for example, along with "001, Cholera" is "001.1 Due to *Vibrio cholerae* el tor." Psychiatric conditions are included between ICD-9 codes 290 and 319, followed by "Diseases of the Nervous System and Sense Organs" (from which psychiatric conditions are thus, presumably, distinct); they are more fully defined in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders—III*, or "DSM-III" (American Psychiatric Association 1980). There is no apparent reason, other than coincidence or numerologic fancy, why the number of sicknesses allotted in the universe should accord so closely with the decimal system,  $10^3 - 1$ .

Diseases come and change and go in succeeding editions of the *International Classification of Diseases*. There are also vacant ICD-9 code numbers waiting for a disease—for example, ICD-9 codes 89 and 119. Conditions that are AIDS-related were assigned ICD-9 codes 42–44 in 1987. Smallpox, although eradicated in 1977, remains coded ICD-050; perhaps if and when known laboratory reservoirs of the infectious agent variola virus are de-

stroyed, this ICD code will be vacated. The DSM-III code 302.0, "homosexuality," was replaced in 1973 with "sexual orientation disturbance," and then in DSM-III with "ego dystonic homosexuality"; thus homosexuality came to be regarded as a disease only when unwanted and accompanied by heterosexual desires. (There are no parallel conditions specified for unwanted heterosexuality or bisexuality.) Definitional decisions are political and judgmental as well as scientific.

The overall rationale for the ICD-9 classification is not spelled out. I am not aware of principles by which certain human problems are included (and excluded) in ICD-9 in the first place and then, once included, distinguished from one another. A wide variety of criteria underlies the ICD-9 classification: diseases are classified by causal agent, vector of the agent (for example, the mosquito that carries the parasite that causes malaria), affected body part, organ or system, symptoms, pathologic process, stage of disease, and behavior of patient, and by various combinations of these factors. Variable principles of classification may correspond to differences in the conditions themselves, to what is known about them, and to the historical circumstances of their discovery.

The multinational authors of ICD-9 seek both to be exhaustive—to include all conditions—and to ensure that no particular event of sickness will be classified under more than one code number. The ICD-9 seeks coverage of all known conditions by use of categories such as "001.9, Cholera, *unspecified*," "727.3, *other* bursitis," or "——, not elsewhere classified"; this allows for comprehensive classification despite incomplete knowledge of the range or characteristics of each condition. The ICD-9 avoids overlapping classifications by a variety of explicit statements excluding categories defined by other codes—for example, "297.1, Paranoia, *Excludes*: paranoid personality disorder (301.0)." Thus, the ICD-9 is logical by fiat.

Fundamental questions underlie the elaboration of a nosologic system, though nosologic systems such as the ICD-9 are most often developed without providing clear or explicit answers. The comparison of nosologies across cultural boundaries raises fundamental questions:

- What kind of thing, force, event, or process is a sickness? What distinguishes sickness from health and from other kinds of problems? Does sickness have an essence?
- How do we measure sickness? What are its dimensions—location, shape, acuteness, pain, severity, duration, cause, cost? By what criteria do we say that a sickness has begun, is ongoing, or has ended?
- How is knowledge of sickness and healing distributed—for example, among healers and patients, between Western societies and others? Who knows best when someone is sick?
- How do we know whether two sicknesses labeled in two languages are similar or different? How do we know which terms are valid?

Answers to these questions are vital for the way sickness and healing are understood and confronted in societies. A society in which sickness is thought to be defined and caused by anatomical and physiological alterations will focus on these physical characteristics of persons in seeking prevention or cure; since afflicted persons may be unable to assess their own anatomy and physiology, such a system of medicine may not listen to their complaints or accounts. In contrast, a society in which sickness is thought to be defined by human experience and caused by human interactions—physiological as well as social—may attend more to its social organization and the understandings of its patients in addressing prevention and cure. How we think of sickness and the different kinds of sickness shapes our response, diagnosis, and treatment.

### THE UNITY OF SICKNESS

In the course of an analysis of the roles of storytelling in medical practice and in the process of healing itself, physician and philosopher Howard Brody argues that it is both futile and misleading to search for an essence of sickness (Brody 1987). What concept or principle could possibly unify such diverse conditions as warts, AIDS, schizophrenia, and paraplegia? Brody recommends that, beyond the abstract analysis of philosophy, we should study the range of stories (fictional and factual) of individual patients who have (or might have) suffered particular sicknesses. Brody quotes Oliver Sacks who equates persons with their biographies, their stories:

If we wish to know a man, we ask "what is his story, his real, inmost story?," for each of us *is* a biography, a story. Each of us *is* a singular narrative, which is constructed continually and unconsciously by, through, and in us—through our perceptions, our feelings, our thoughts, our actions; and, not least, through our discourse, our spoken narrations. Biologically, physiologically, we are not so different from each other; historically, as narratives, we are each of us unique. (Sacks 1985:12)

Brody claims that "suffering is produced, and alleviated, primarily by the meaning one attaches to one's experience" (1987:5); thus, healing requires listening and responding to the patient's story.

Brody notes that most if not all attempts to formulate a definition of sickness have been either too restrictive—excluding conditions that most of us would include—or too broad—including conditions that usually would not be counted. He proposes that, instead of seeking a single definition, we look for a loosely connected "family resemblance" among the variety of phenomena referred to as "sickness." He sketches five themes that might connect the members of this "family":

1. To be sick is to have something wrong with oneself in a way regarded as abnormal when compared to a suitably chosen reference class.
2. To be sick is to experience both an unpleasant sense of disruption of body and self and a threat to one's integrated personhood.
3. To be sick is to have the sort of thing that medicine, as an evolving craft, has customarily treated.
4. To be sick is to undergo an alteration of one's social roles and relationships in ways that will be influenced by cultural belief systems.
5. To be sick is to participate in a disruption of an integrated hierarchy of natural systems, including one's biological subsystems, oneself as a discrete psychological entity, and the social and cultural systems of which one is a member. (Brody 1987:22)

The third of these themes is peculiar. There may be sicknesses not treated by medicine (perhaps because medicine is currently incapable, perhaps because it is unaware) and other conditions treated that may not be sicknesses. The reverse definition seems more plausible—medicine as a craft intended to treat sicknesses.

Brody suggests that the last theme in his list—the systems view of humans and their internal and external environments—is the most comprehensive. But, more important, he is wary of all such generalizations; he warns that "each [generalization] should be seen as an approach to a further investigation of particular sickness episodes spanning the entire range of illness experiences, and not as a shortcut making such an investigation unnecessary" (1987:22). It is as if the term *sickness* were a homonym—as if, on hearing of *sickness*, we had to ask, "Are you speaking of sickness in the wart-sense, the schizophrenia-sense, or some other sense?"

Brody's argument against the search for a unifying notion follows the philosophical approach formulated by Wittgenstein (1958) and more recently advanced by Rorty (1979). This perspective transforms philosophy from an analytic discipline that criticizes the logic of other disciplines to reveal the true nature of concepts and the world into an observational discipline that, like anthropology and lexicography, more modestly describes how people use concepts and language. Wittgenstein professed, "Don't look for the meaning of a word, look for its use" (1958). The new philosophy would not attempt to discover by abstract reasoning what sickness "really is," but would examine the diverse ways in which the term *sickness* is used in different settings. Thus, individual stories of sickness become critical. (It should be noted, however, that traditional, non-Wittgensteinian philosophers also rely on stories—examples and counterexamples—to define the limits of their own or other analyses.)

I agree that the description of language usage has an important place in

understanding the meaning of concepts such as sickness. But I also believe that the critical analysis of concepts and ideas should play a fundamental role in the practice of disciplines. Moreover, resort to stories does not avoid the problem of definition. In response to the recommendation that the understanding of sickness requires listening to stories of sickness, we may ask what makes a given story a story of sickness rather than a story of another of life's problems? Particularly in a foreign setting, how do we know we are listening to a story of sickness? We are forced to return to the question said to be unanswerable and misleading—what is sickness? While philosophy could profitably employ the descriptive and comparative practices of anthropology, anthropology should also adopt the critical habits of analytic philosophy.

The discussion of whether or not sickness has an essence continues a debate about the fundamental relationship between words and things that has persisted at least since the days of Plato. Plato and his "realist" heirs argue that the phenomena labeled by words share essential properties—precisely those that allow us to properly call these things by the given word and to distinguish these things from others. In contrast, "nominalists," such as Brody and other followers of Wittgenstein, believe that words are arbitrary and conventional labels for collections of objects (or events or other sorts of things) that have no common essence. In an extreme form of nominalism, because concepts and words are defined by and are appropriate in the cultural context in which they are used, the use of concepts and words from one tradition to describe phenomena in another becomes logically impossible. Nominalists may be trapped and isolated in their own thought and language.

I take a position between realism and nominalism, perhaps closer to the realist stance. As a realist, I believe that the phenomena labeled by sickness terms, such as *schizophrenia*, *cholera*, *paraplegia*, or *warts*, share essential characteristics—namely, those that allow the determination of whether or not they fall into one of these categories. It is a group of signs and symptoms caused by cholera organisms (though not by these organisms alone) that leads us to refer to specific events of sickness as *cholera* and to exclude other events as *not cholera*. Assessment of the applicability of sickness terms to given conditions is the work of diagnosis. The diagnosis of other conditions—for example, schizophrenia—may not be as clear-cut as that of cholera, because the characteristics of the condition are not clearly defined and/or because defined characteristics may be difficult to assess. Nevertheless, the same semantic principle applies—phenomena are grouped under a common label because of shared characteristics.

As a nominalist, I believe that the characteristics chosen to distinguish among specific sicknesses (such as symptoms or causal agents) are somewhat arbitrary and vary among societies and historical periods. Choosing different characteristics might lead to different groupings of sickness events. And the labels used are conventional and also arbitrary—certainly they, too, vary

among societies and historical periods. But given the criteria chosen and the system of labels available, the conditions grouped under each label are no longer arbitrary but subject to rational determination.

### THE ESSENCE OF SICKNESS

I propose that *sicknesses are unwanted conditions of self, or substantial threats of unwanted conditions of self*. Unwanted conditions may include states of any part of a person—body, mind, experience, or relationships. Unwantedness comes in degrees, and individuals may have different thresholds regarding just how seriously unwanted a condition must be in order to qualify as sickness.

If sickness is a matter of unwanted conditions of self, then the patient's story retains a central defining role, because the story is an account of which conditions are wanted and unwanted. He or she may not be able to determine when a substantial threat of unwanted conditions exists; but it is his or her desires and conceptions of well-being that define in the first place what threats there are.

This formulation bears similarities to a proposal of Clouser, Culver, and Gert (1981). "We believe," they write, "that there are objective definitional criteria, and that they apply equally to mental and physical conditions" (1981:29). They examine the term *malady*, because it includes many other concepts—disease, illness, injury, and disability. They develop a compact definition as follows: "A person has a malady if and only if he or she has a condition, other than a rational belief or desire, such that he or she is suffering, or at increased risk of suffering, an evil (death, pain, disability, loss of freedom or opportunity, or loss of pleasure) in the absence of a distinct sustaining cause" (1981:36). In other words, a malady is a condition that produces or threatens to produce suffering. Rational beliefs or desires are exempted because such conditions—for example, rationally mournful thoughts about the death of a companion—though they may cause suffering, need not be pathological. "Absence of a distinct sustaining cause" indicates that whatever external force may have initiated the condition is no longer present; a malady is incorporated in the patient. Brody criticizes this definition because some of its criteria ("increased risk," for example) are themselves in need of definition and also because, by including "loss of freedom and opportunity," the proposed definition is too broad—it would include pregnancy, menstruation, and sleep.

Like Clouser, Culver, and Gert (1981), I also note that sickness conditions lie *within* the self—they are *of* the self, physically and/or mentally. Unemployment and poor television reception may be unwanted conditions, but unless one has absorbed them into one's person (being obsessed about the

television, say, or seriously lacking self-esteem because of unemployment), these conditions would not count as sicknesses.

A principal difference between the definition of *malady* proposed by Clouser, Culver, and Gert and what I have proposed for *sickness* is that, whereas maladies are the same for all persons in all cultures and at all times, sicknesses may vary by person, culture, and time. Sicknesses are unwanted by their *individual* bearers, but maladies are said to be diverse "evils" that have in common that "no one wants them" (Clouser, Culver, and Gert 1981:31; emphasis added). Malady restricts suffering to conditions unwanted by everyone; sickness allows suffering according to unique personal, cultural, and historical circumstances. Do not wanted and unwanted conditions depend on one's circumstances and individual character? Can sprinters, marathoners, scholars, surgeons, and pianists not suffer different conditions that are evil for one but not for all? What is a major sickness for one may be a minor irritation for another. Broken legs, rabies, and heart attacks may be universally unwanted, but there are other conditions that will be unwanted because of individual circumstances. Thus, it is more appropriate to define the universe of sicknesses by the biographical conditions of each patient rather than by the common denominator of all. Sicknesses are not only *of* the self; they are in essence determined *by* the self.

Although the matter has not been systematically studied, there is evidence that notions akin to sickness as I have described it exist in widely differing societies. The Subanun, for example, refer to *miglaru*, translated as "being sick"; they have numerous *njalan mesait en*, "disease names," each corresponding to a group of symptoms and treatments (Frake 1961).

Similarly, Turner reports of the Ndembu,

Ndembu conceive disease or illness (*musong'u*) as a species of misfortune (*malwa*, *kbualwa*, *kuyindama*, or *kubula kutooka*—this last term signifying "to lack whiteness or luck or purity"). . . . The Ndembu, like the Azande, consider that calamities and adversities of all kinds are caused by mystical forces generated or evoked and directed by conscious agents. . . . For Ndembu talk of different kinds of *nyisong'u*, "illnesses" or "diseases," and recognize that specific symptoms are connected with each of them. (1967:300–301)

Among the Desana of the Colombian rain forest, Reichel-Dolmatoff writes, "The concept of disease is called *dore*, a term that denotes a complex symbolism that, at first sight, obscures the sequence of interconnected ideas. The word *dore* is derived from *doreri*/to order, to send. Illness is thus commonly interpreted as a mandate, or the product of a mandate, sent by or through a supernatural agency" (1971:175).

Among Mayan Indians of the Chiapas highlands, Manning and Fabrega

report that despite "a lack of a conception of the *self* which is internally located, autonomous, and separate from that of other 'objects' (that is, persons, things, diets, animals)," there is a concept of sicknesslike phenomena. "The theory of disease that prevails . . . can best be described as a *sociological* theory, although illness is nonetheless an event of significance to the individual" (1973:263).

Anthropological observers in a variety of non-Western settings have noted that, in addition to roughly equivalent generic terms, sickness is connected to two broader phenomena: cosmological or religious forces, and social relationships and interpersonal conflict. Yet, though commonly embedded in distinctive worldviews, there is nevertheless a shared concept akin to unwanted states of self.

Since an essential feature of sickness is its recognition and unwantedness by the patient, a prerequisite to the existence of sickness is the effective functioning of the person's capacities of perception and desire. Potential patients must be able to perceive conditions and to evaluate them as desirable or not. Ordinarily this is not a problem—most of us are capable of recognizing conditions in ourselves, or of understanding what others report to us about ourselves (for example, about an asymptomatic condition). And we are then capable of judging what we recognize as desirable or not.

In some cases, however, we identify an unwanted condition, but incorrectly describe its characteristics or its causes. For example, we can often correctly and precisely locate a noxious stimulus, say, a pin prick or a burn, but our sensations can be misleading. One normal effect of neurological connections is "referred pain," in which physical damage in one part of the body is experienced as pain in another part. Appendicitis is commonly sensed in the upper middle of the abdomen instead of deep in the lower right where it actually occurs. Angina pectoris is experienced across the upper chest and down the left arm rather than near the heart. And inflammation of the diaphragm is commonly sensed as pain in the shoulder (Melzack and Wall 1982). Such conditions are symptomatic, but deceptively so. They are recognized by their patients, but they are misplaced.

Inability to assess conditions of self may also arise in persons whose perceptual or emotional capacities are abnormal or impaired. I refer to pathologies that obstruct the assessment of sickness as "metapathologies"; they are sicknesses that, in turn, constrain the capacity of patients to recognize their own sickness. A functioning self is a prerequisite for self-knowledge of sickness; as Sacks notes, "If a man has lost a leg or an eye, he knows he has lost a leg or an eye, but if he has lost a self—himself—he cannot know it, because he is no longer there to know it" (1985:36–37). In the extreme, we would not accept at face value the statements of an insane man about when or how he is sick.

In some instances, metapathology results from trauma and neurological damage. In the "phantom limb" phenomenon, for example, pain and other

sensations are experienced in limbs that have been (and that are known by the patient to be) amputated. Oliver Sacks (1985) has described other metapathologies in which neurological defects in patients have altered their experiential capacities—for example, a woman without proprioception (the ability to sense events in one's own body) and a man who incorrectly conceptualizes objects and literally "mistakes his wife for a hat." These disturbances impair the capacity of patients to know and judge their own conditions.

Another form of metapathology, similar to referred pain, might be called "altered reference." In somatization, for example, psychological conditions and stressful mental or interpersonal conditions are experienced as bodily conditions. The patient identifies an unwanted condition, but incorrectly identifies its source. Somatization is reported common in Taiwan and China, where the expression of mental conditions is stigmatized and physical symptoms are more readily acceptable (Kleinman 1980). Less well recognized is psychologization—conceptually the opposite of somatization—in which conditions judged by others to be physical are experienced by patients as states of mind. The doctrines of Christian Science explain all physical pathology as an illusion arising from the patient's lack of spiritual harmony; it is believed that only through proper religious faith can purportedly physical conditions be eliminated.

Personal knowledge of sickness may also be affected by "altered scaling" in which the patient's response appears either to exaggerate a condition (hyperaesthesia) or to minimize it (hypoesthesia), to the extreme of denial. Hypochondriasis may be regarded as a form of hyperaesthesia, in which ordinary sensations are interpreted as symptoms. In "medical student's disease," a common occurrence in the course of Biomedical education, students (erroneously) believe themselves to have the pathological conditions they are studying (Mechanic 1972). In the contrary event of denial, patients assert that a condition does not exist when it is apparent to others that it does exist. Denial is common in alcoholism and other addictions.

Most infamous among metapathologies is the Munchausen syndrome (named for the notorious German fabulist Baron Karl von Münchhausen) in which patients (often themselves medical personnel) feign or even fabricate sickness in themselves and then seek medical treatment for their "symptoms." They may claim pains or simulate scars or other physical damage; or they may cause physical harm to themselves—for example, by injecting feces or other pathogenic substances into their bloodstream. Whereas in denial patients deny the existence of pathologies observable to others, in the Munchausen syndrome, patients claim or create pathology not observable to others. Instances of "Munchausen syndrome by proxy" have been described in which one person (say, a parent) causes factitious disease in someone else (a child) and then seeks care in medical settings. One paradoxical case has been reported in which the patient sought treatment claiming, perhaps undeniably, to have Munchausen syndrome (Gurwith and Langston 1980). When

patients with Munchausen syndrome are recognized by hospital personnel for their dissemblance, they commonly move on to another hospital, beginning the cycle again. Though they have been described as false patients, persons afflicted with Munchausen syndrome are truly sick; but their sickness lies not in the sickness they present but in their experience and presentation of sickness.

More generally, acts in which people deliberately inflict harm on themselves or others should be regarded as sicknesses, even if the perpetrators derive pleasure from these acts and feel nothing wrong or undesirable in themselves. We would not want to count as healthy such forms of behavior as sadism, torture, homicide, genocide, and other forms of abuse. Reference to such conditions as "sickness" may violate the patient's sense of self—the condition may not be unwanted. It is likely, however, that metapathology could be demonstrated—that is, impairment of the patient's capacity to experience sickness.

There is one critical exception to the characterization of the deliberate harm of self as sickness. Suicide might be regarded as the ultimate act of self-destruction, and impulsive suicide or suicide in which there is little rational reflection may reasonably be considered a form of sickness. But rational suicide, in which the so-called victim has decided on self-destruction following a clear weighing of his or her life and its possibilities, should not be included as sickness. Under these circumstances, suicide may be the best means of fulfilling an integral life. Similarly, living wills define the physical limits beyond which a person no longer considers his or her life worthy of sustaining; violation of the living will might then be considered a form of battery. It is inappropriate to refer to acts that complete the self as self-harm.

Since sicknesses compromise desired capacities or states, they are most often disvalued and rejected, but patients may be ambivalent toward and attached to their sicknesses. Chapter 9 describes patients who, despite their rational wishes to return to healthy life, are fearful of the end of their sickness; they have become engaged in the society and the machinery of the hospital; they are uncertain if they can succeed without these supports.

Sicknesses are recognized to bring "gains" to patients and to others as well. A sickness may give its patient a "primary gain" by diverting the patient's attention from a more disturbing problem. Patients may also be exempt from difficult or tiresome duties, and they may receive the sympathy and care of others—benefits referred to as "secondary gain." Secondary gains are thought to be motivating factors in conditions such as Munchausen syndrome. When secondary gains play a role in the intentional initiation of a sickness, the sickness is referred to as malingering. Others, too, may benefit from a patient's sickness—for example, by being able to exercise a desired caring role. Such "tertiary gains" may impede recovery and contribute to the persistence of sickness (Dansak 1973).

## DIMENSIONS OF SICKNESS

I now propose a framework for thinking about sickness that allows for the validity of phenomena envisioned by Biomedicine without assuming these to be ultimate or exclusive truths. Elements in the framework are persons and their environments, including their society, culture, and physical environment. Each person has a body and a self that includes a mind, subjective experience, and relationships with the social and physical environment. Persons affect and are affected by their environments; and each part of a person (body, mind, experience, relationships) may affect other parts.

### *Accounts of Sickness*

Sicknesses may be thought of as self-inflicted or inflicted by another—perhaps a spirit, an ancestor, or some other force. They may be held to be lodged in the body, the mind, or the soul, or to be more widely dispersed in the web of relations among beings of the world. They may be accepted passively as natural or fated, or they may be actively resisted as obstacles to personal fulfillment or social duty. I refer to alternative conceptions and understandings of sickness as "accounts." Accounts of sickness explain the "who?" "what?" "where?" "when?" and "why?" of sickness.

Accounts are akin to what Nichter has referred to as "idioms of distress" (1982), to what I have previously called "ideologies of suffering" (Hahn 1984), to Brody's "stories of sickness" (1987), and to what Kleinman has called "explanatory models" (1980) and "illness narratives" (1988). For each event of sickness, the explanatory model is said to be specific and to address five issues: etiology, occurrence, pathophysiology, course, and treatment (Kleinman 1980).

Accounts of sickness and of the different forms of sickness are elements of larger cultural systems that assume that the world consists of certain kinds of "things" and "forces" of which events of sickness are instances. As elements in cultural systems, accounts of sickness also make assumptions about the sources and means of medical knowledge; these assumptions provide standards that allow the members of a society (for example, patients and healers) to assess conditions and remedies and to evaluate proposed accounts. Accounts of sickness also assume a system of values by which to judge states of sickness, their causes, and responses to them—as moral or immoral, worthy or unimportant, and so on.

Accounts may themselves play a role in the causation of events of sickness. The placebo phenomenon, described in greater detail in chapter 4, is a well-known form of causation in which beliefs affect the occurrence of the events believed in—persons are healed because they believe in the causal efficacy of certain things, even though these things are known not to have the independent effect credited them.

The diverse accounts of sickness may be usefully classified by expanding the terminology developed by Kleinman, Eisenberg, and Good (1978). The classification of disease, illness, and disorder accounts of sickness divides the conceptual space centered on and surrounding the patient as follows:

*Disease accounts* focus on the body of the patient as the source of sickness; disease is located within the body, at or beneath the skin, and most often "below" the mind. Diseases, write Kleinman, Eisenberg, and Good (1978), are "abnormalities in the structure and function of body organs and systems." Accordingly, bodily interventions are regarded as the principal means by which to relieve sickness. The Biomedical explanation of sickness is epitomized in Feinstein's notion of "paraclinical entity"—the physical reality of sickness that may or may not be manifested either in the symptoms experienced by patients or in the signs recognized by physicians (Feinstein 1967).

*Illness accounts* consider not only the body but also persons along with their bodies and their social environment as the source of sickness and the place of its occurrence. Illnesses are "experiences of devalued changes in status of being and in social function; the human experience of sickness" (Kleinman, Eisenberg, and Good 1978). Relief of illness is thus likely to require attention to persons and their environments as the target of interventions. In traditional African settings, explanations of sickness as caused by grudges and witchcraft are examples of illness accounts (Evans-Pritchard 1936; Turner 1967). In Western society, the popular belief in "stress"—the pressures of the social environment—as a cause of sickness is another example of an illness account (Young 1980). Psychological and sociological theories of the effects of the social environment on sickness and healing are also illness accounts.

*Disorder accounts* regard the source and locus of sickness as lying not only in the bodies of patients or in their persons but in the universe at large. When the universe is unbalanced, sickness may be manifested in particular locales and individual patients. Relief of sickness may focus on the redress of cosmic imbalances. Traditional Chinese medicine, in its theory if not its practice, is an example of a disorder-oriented account of sickness (Unschuld 1985; Porkert 1974). (In contrast, much of contemporary Chinese medicine and psychiatry, like Western Biomedicine, is strongly inclined to disease accounts.)

Disease, illness, and disorder accounts are proposed here as "ideal types," guiding themes that may orient an understanding of sickness. They may not be found in pure form in any particular setting; though one of these account forms may be thematic and dominant, different societies and social strata may combine elements of differing accounts. The classification of account forms thus serves to distinguish divergent emphases rather than to provide clear-cut, exclusive categories.

### *Sickness Experiences*

The sickness experience is the flow of sensations, beliefs, attitudes, and emotions that contribute to people's consciousness that something is wrong and undesirable in themselves. Symptoms are part of the experience of sickness; in Biomedicine, doctors often use them for medical diagnosis rather than to respond to the patient's experience itself.

Experiences of sickness may be more or less immediate. At a basic level are primary experiences—for example, "there is a sharp pain in my back." Primary experiences of sickness may be localized to parts of the body or they may be more general—for example, the patient may feel a vague uneasiness or anxiety. They may vary in modality—for example, discomfort, cold or heat, physical pressure or piercing; in intensity—sharp or dull; in severity—from minor and negligible, to moderate and debilitating, to excruciating and incapacitating; and in duration—brief, intermittent, or continuous. Such basic perceptions are not raw sense data, unaffected by the perceiver's expectations; but if they arise without reflection, they may be more direct than other perceptions.

Further removed from more immediate experiences are secondary reactions. Having a severe, sharp pain in one's back may evoke additional feelings, thoughts, associations, and interpretations—for example, memory of previous experiences, dread of immobility, or anticipation of care by someone else or of financial compensation. Sickness experiences may result from a dynamic interplay of unconscious as well as conscious memories and meanings—memories and forgotten events of sickness in oneself or others (Stein 1990).

Accounts of sickness and experiences of sickness may significantly affect one another. Accounts that become established in a society influence the experiences the members of society expect when they encounter sickness. Societal accounts give names and explanations to sensations. Patients who experience a particular symptom are likely to associate it with sicknesses recognized to manifest this symptom. They may then scrutinize themselves for other symptoms believed to be associated with the syndrome; and they may examine their past for recognized causes of this sickness. Experiences of sickness may affirm the accounts they are about, but they may lead to modification or rejection of accounts—for example, "my case of such and such was different."

### *Sickness-Related Roles, Actions, and Institutions*

Societies respond to the experience of sickness with social roles (that is, prescribed and patterned forms of action) and organized institutions. Sickness-related actions, roles, and institutions are commonly justified by ac-

counts of sickness; and the performance of these roles, in turn, may serve to affirm corresponding accounts. As I describe more fully in chapter 4, the social organization of roles, actions, and institutions powerfully shapes the way in which sickness is conceived of, distributed among individuals, and treated.

A "role" is a set of expectations of what incumbents of specific positions in society should do—how they should behave. Societies maintain rules about how roles come to be occupied, how they are maintained, and how vacated. Roles are deliberately designated positions and are thus named, for example, "patient," "healer," "physician," "shaman," "nurse," "therapist." Individuals who do not follow role expectations may be regarded as deviant; their deviance may be sanctioned. Patients may be expected to report their sickness experiences sincerely and then to try to find healing. When they fail to follow medical etiquette, patients are said to "abuse" the sick role; they may be described as "crocks." Healers are expected to pursue qualifying training and examinations and to follow community standards of practice. Persons who falsely assume the healing role are commonly described as "quacks"; those who fail to adhere to standards are said to be guilty of "malpractice."

An "institution" is a socially recognized and designated set of roles that is organized and conceptually, if not physically separate from the rest of society. In Western society, the most visible health-related institutions are medical settings, such as doctors' offices, clinics, and hospitals. But there are also organizations of professionals and of patients, insurance companies, drug and equipment manufacturers, medical schools, institutions of medical research, and governmental health agencies. In Western societies, institutions commonly occupy separate physical settings. In non-Western societies, healing institutions may be less readily distinguished from other social organizations—for example, religious or political institutions.

### *Causes of Sickness*

The causes of sickness are the circumstances that precede and lead to it. A *necessary cause* is one that must be present in order for the sickness to occur, or to put it the other way around, the sickness cannot occur in its absence (though the sickness needn't necessarily occur in its presence). A *sufficient cause* is one that makes the occurrence of sickness inevitable; the sickness can occur in the absence of a sufficient cause, but in its presence the sickness inevitably occurs. In Biomedical nosology, sicknesses are often defined in a way (by their causes) that makes specific causes necessary; the cholera organism is a necessary cause of cholera, motor vehicles a necessary cause of motor vehicle fatalities. Isolated sufficient causes are rare, because 100 percent causal efficacy—independent of other circumstances—is unusual. Untreated exposure to the bite of a rabid animal may be an exception; it is both a sufficient and a necessary cause of rabies (unless one is infected in a rabies laboratory) and of rabies death (unless one is immunized).

A complex array of causes precedes most events of sickness. In the chain of causation, there are relatively *immediate* causes of sickness (for example, promoters that accelerate the growth of malignant tumors that have already begun to grow); relatively *remote* causes (for example, smoking or cigarette smoke as an initiating cause of a cancerous tumor). There are causes *within* causes (for example, the compounds of tobacco that cause the cancerous process), and the causes *of* causes (for example, the circumstances that lead to the habit of smoking).

It is critical to distinguish the causes of sickness from the sicknesses themselves. Some inherited conditions, such as Huntington's chorea, may not manifest themselves until decades following birth. Were we to equate the sickness with its cause, persons who inherit Huntington's chorea would be sick at birth, if not before.

Similarly, chronically elevated blood pressure levels may be lethal, but are often "silent," causing no pain or other sensation. High blood pressure is an important cause of sicknesses such as stroke and heart disease; high blood pressure may be a sickness itself only when recognized and unwanted by its bearers. And a cancerous tumor may originate with a malignant division of a single cell many years before it can be detected by patient, clinician, or laboratory. We would not want to describe a person as "sick" from the instant of this cell division, since the disease might never follow or might follow only decades later. Such events may be common, though they are also commonly aborted by immunological processes. With a definition including all first events in causal processes as sicknesses themselves, we would all be sick from birth, for it is likely that causal processes of sickness and aging are present from the outset.

When in the causal chain does a sickness begin? Sickness begins when the condition becomes unwanted. It may begin when the person has unwanted symptoms, or it may begin when he or she has no symptoms but is aware of an impending condition. Asymptomatic conditions may thus be included as sicknesses, insofar as they are recognized and unwanted by their bearers. In the case of persons infected with the human immunodeficiency virus that causes AIDS, sickness may begin when manifested in symptoms. When recognized, however, the sickness AIDS may begin when a person is infected with the human immunodeficiency virus, because currently AIDS is unavoidable at the time of this event. Sickness is in the mind and heart of the beholder—the patient.

Causes of sickness are common foci of accounts of sickness. For example, the Azande of the Sudan look to witchcraft for the cause of sickness and to oracles for diagnostic knowledge of specific causes (Evans-Pritchard 1937). In traditional Chinese medicine, causality is sought in the imbalance of cosmic forces (Porkert 1974). And in Biomedicine, causality is most often examined as an alteration of human physiology, as in cells (see chapters 6–7).

## UNIVERSALITY, TRUTH, AND EFFICACY

The diversity of accounts, experiences, roles, institutions, and even of causal circumstances of sickness in different cultural settings raises serious doubt that a universal system for classifying sickness is possible. Can we define forms of sickness—for example, “diarrhea,” “depression,” “broken arm”—with criteria that can be assessed in any cultural setting? Or are nosological systems culture-bound, appropriate only to the setting in which they are formulated? In a more general form, this question arises throughout anthropological inquiry.

Biomedical physicians might respond that a universal nosology already exists, namely, the *International Classification of Diseases*. The ICD is a product of international collaboration, but collaborators have thus far all been trained in Biomedicine; traditional, non-Biomedical medicines have not been represented. Anthropologists are more likely to respond that a universal nosology, if at all possible, is highly problematic. Like all social phenomena, sickness is so affected by the social context in which it occurs that there will be no way to find commonalities across cultural boundaries.

Were a universal nosology *not* possible, then such labels as “diarrhea,” “depression,” and “broken arm” would be narrow in meaning and very different from current conceptions. They could not be appropriately used to refer to human sicknesses found anywhere, except, in this case, the societies where Biomedicine is the principal medical system. “Diarrhea” would more accurately be “diarrhea—implicitly Western,” “depression” would be “depression—implicitly Western,” and so on. The labels for sickness we commonly use and those in use within Biomedicine would no longer refer to generic human conditions. Moreover, there would be no language to talk about the sicknesses of one culture in the language of another. The practice of international health and of medical anthropology would be difficult, if possible.

I believe that a universal cross-cultural nosology is possible, but only if it takes cultural setting into account. By this standard, the ICD has thus far failed. If the object of a nosological system is ultimately to study, diagnose, and treat the diverse forms of human sickness; and if, to do so, the specific goal of a nosology is to group and distinguish conditions by basic features of etiology, diagnosis, manifestations, and treatment, then an effective nosological system must recognize the sociocultural environment in which sicknesses occur.

A universal nosology would have an appearance very different from those currently in use. Two alternative versions seem plausible. In one version, current entries in the ICD would be amended to describe the variability found in diverse cultural settings. However, since there is likely to be much commonality within each culture regarding multiple sickness categories, this version of a universal nosology would be repetitive and unnecessarily cumbersome.

In a more concise version, the standard ICD would be modified. It would be expanded to include conditions reported in other cultural settings, but apparently not included within current ICD categories. The so-called culture-bound syndromes (considered in chapter 2) would be added. The universal nosology would also have a companion volume reviewing the ethnomedical systems found in each culture around the world, cross-referenced to corresponding sickness categories.

Clearly, the preparation of such a universal nosology would be a major enterprise. It would, however, bring enormous benefits. By adding currently unrecognized sicknesses, it would make the ICD more comprehensive, exhaustive, and relevant in diverse settings; it would become the *Intercultural Classification of Diseases*. By describing the varying contexts of sickness conditions, the ethnomedical encyclopedia would allow users to understand how the range of conditions found in the ICD are modified and manifested in particular cultural settings. It would thus sharpen etiological analysis and diagnosis, enhance relations with patients, and improve treatments and outcomes.

In addition to the question of a universal nosology, a second question arises: how can we compare conditions described in one system with conditions described in another? When are two conditions found in different cultural settings equivalent—for example, *susto* and depression, *pora-keri dohari* and breech position birth? This question is closely related to the first question, since we must presumably know how to compare sicknesses across cultural boundaries in order to classify them as similar or not and to distinguish them from other conditions.

An extreme example of the difficulties of translation is illustrated in attempts to translate conditions described as psychiatric in Biomedicine. Problems in the comparison of depression across cultural boundaries have been pondered by anthropologists and colleagues (Kleinman and Good 1985). In Biomedical thinking, depression is an affective disorder, an emotional problem within the individual's psyche. To begin, many non-Western cultures do not attribute sickness to internal states of the mind. For example, on the half-square-mile island of Ifaluk in the South Pacific, people who mourn for extended periods are not thought to suffer an internal, emotional problem—such states are not even considered; rather, mourners are believed to have not yet found an appropriate replacement for the person they have lost (Lutz 1985a). The problem is not intrapersonal or psychiatric, but social, interpersonal.

Another issue in the cross-cultural comparison of depression is the value attached to perceived symptoms. Thus, for example, Sri Lankan anthropologist Gananath Obeyesekere finds strange the conclusion of an epidemiologic study that “*generalization* of hopelessness . . . forms the central core of depressive disorder” (Brown and Harris 1978:235). A Sri Lankan described in such terms should be thought of not as a depressive but as a good Buddhist

(Obeyesekere 1985). The Buddhist seeks the acceptance of the hopelessness of the world as a step in the path of salvation. Obeyesekere describes the Buddhist "meditation on revulsion" in which laymen deliberately contemplate death, decay, and filth in order to recognize the "transitoriness of the body and the world" and to develop a contempt for bodily pleasures. Given their willing participation in an accepted practice at the heart of Buddhist ways of thought, it would be perverse to describe successful practitioners as sick or, more particularly, depressed. (Perhaps the Buddhist feels depressed when failing to overcome a contentment in daily life.)

In seeking comparisons of sickness concepts across cultural boundaries, I recommend use of the four dimensions described earlier. Strict equivalence is improbable, even between two patients within a single cultural setting. Cross-cultural approximations may be found and differences noted, however. Regarding the translation of depression, for example, Lutz argues that we should examine "indigenous definitions of situations of loss and the blocking of goals, and the social organization of responses to them" (1985a:92). I suggest that such comparison on broad dimensions will improve our understanding of sickness and our ability to treat it.

We want not only to be able to classify and distinguish the diversity of human sicknesses and to find approximate equivalents (and differences) from one system to another but also to compare medical systems and ask whether one is closer to "the truth" than another and whether one "works" better than another. These questions are independent, since one medical system may be knowledgeable, but unable to put its knowledge into effect, whereas another's techniques work, despite relative ignorance. The questions may be asked of medical systems as wholes or of their parts.

Westerners may take it for granted that their system, Biomedicine, is both closer to the truth and more efficacious than other medical systems. But there are several difficulties with this assumption. First, cultures may share many goals of medical practice—healing a broken arm or stopping diarrhea—but other goals may differ. The good Buddhist pursues experiences of generalized hopelessness for which the Westerner seeks treatment. Second, standards of truth may differ from one system to another, so that comparison is difficult. Part of what makes a belief true is its accordance with other beliefs and basic premises; another part of truth is correspondence with observations, but observations, too, are shaped by the perspective of the observer. Third, as I describe more fully in chapter 4, the efficacy of an intervention may be powerfully affected by cultural setting; thus, efficacy is not a fixed characteristic independent of context.

Finally, all cultural systems of beliefs are at best *approximations* of the truth. The wide variety of accounts and their historical evolution suggest a persistent separation between accounts and their referents. Some may be closer than others—in whole or in part—but none are "there," or likely to get "there." As noted, single beliefs about the world, such as ethnomedical

beliefs, are elements in much larger systems of belief; the single belief makes sense only as part of the system. When a single belief improves, for example, by explaining more observations, it may drag the rest of the belief system along, forcing revision. Scientists are commonly impressed by what their predecessors, or they themselves, did not know or (erroneously) thought they knew even a decade before; they may also discover that new ideas have historical precedents. Ongoing revision may be an essential characteristic in the production of knowledge. Accounts are imperfect maps—perhaps inevitably so.

In recent decades, philosophers, historians, and social scientists, reacting to positivist and empiricist movements of earlier decades, have questioned the efficacy and superiority of scientific approaches to knowledge. They have challenged the notion of progress in scientific knowledge, arguing, like anthropologists, that what is known is relative to a given set of premises and that absolute criteria for the comparison of systems of belief have not been demonstrated and may not be possible (Richards 1987). This extreme relativism has been resisted by others (for example, Laudan 1977, 1990). But while objective reality is recognized to constrain the enterprise of human knowledge, the force of historical and cultural setting in the foundation and growth of knowledge is also widely accepted.

Even accepting the relative merits and progress of Western science, it is doubtful that Biomedicine, despite frequent professions of commitment of scientific foundations, is consistently scientific in practice. As described more fully in chapter 6, Biomedical practices are not always based on the best available scientific evidence. Practices may be adopted before evidence is available; they may be not adopted when evidence is available; and they may persist following evidence of inefficacy and even harm. We may believe in the relative merits of Biomedicine compared with most other systems for the understanding and treatment of many conditions, but scientific evaluation is not a consistent standard of practice.

For many, but not all conditions, Biomedicine appears closer to the truth and more efficacious than many non-Western ethnomedicines. Take the case of diarrheal diseases, estimated to cause between 5 and 7 million deaths per year around the world (Weiss 1988). In Western society, despite the demonstration a century earlier of the beneficial effect of intravenous rehydration, physicians continued their practices of bloodletting and fluid restriction; the use of purgatives and emetics continued as late as the mid-twentieth century (Weiss 1988). It is estimated that in the 1980s approximately five hundred U.S. infants died each year from diarrheal diseases, mostly preventable (Ho et al. 1988).

The Biomedical perspective currently claims that diarrheal deaths are most often the consequence of the severe dehydration associated with diarrhea. The principal Biomedical prescription is administration of oral rehydration therapy, commonly known as ORT, consisting of a solution of

glucose and salts in clean water. The World Health Organization (1985) estimates that 60 to 70 percent of deaths from diarrhea, more than 3 million per year, could be prevented by proper use of ORT.

But the medical traditions of many regions of the world differ from the current Biomedical perspective and approach. In some settings, traditional approaches to diarrhea are not contrary to Biomedical practice. In rural northern India, mothers continue to breast-feed infants with diarrhea, they do not reduce fluids, and they alter, rather than restrict, the foods they give (Bentley 1988).

In other settings, however, traditional beliefs and practices may exacerbate diarrheal sickness. In Swaziland, most contagious diseases are thought to be airborne; diseases are not associated with feces, and, except for schistosomiasis, few are associated with water (Green 1985). Several forms of diarrhea are distinguished by their symptoms; dehydration is not regarded as a symptom of diarrhea. Some forms of diarrhea are thought to be associated with improper food or drink. Older patients may be given purgatives, younger patients enemas, both of which exacerbate dehydration.

In rural Honduras, the more severe forms of diarrhea are thought to be caused by improper foods, by worms, or by the malicious, penetrating glances of others—"the evil eye" (Kendall, Foote, and Martorell 1984). Rural Hondurans believe that most severe diarrheal conditions are beyond the powers of Biomedical treatment. Fallen fontanelle, recognized by Biomedicine as a sign of dehydration, is regarded as a condition unrelated to diarrhea, requiring separate treatment. Purgatives are given to cleanse the digestive tract.

It is likely that in most or all settings, patients want to avoid diarrhea and to cure it when it occurs. Where traditional beliefs and practices hinder effective treatment of diarrhea, knowledge of ORT and its efficacy are not sufficient by themselves. There is a vital difference between having an effective technique and having it adopted in a given setting. As I argue more fully in chapter 10, international public health efforts have often failed because they assumed that they were introducing their lifesaving knowledge and techniques into an "empty vessel"—a setting without established beliefs or techniques—so that the new approach would be rationally adopted. Public health practitioners have failed to consider local knowledge, practice, and social environment; potential recipients thus have often rejected the new approach.

To make ORT acceptable and practical in those settings requires an understanding of local thought and practice. For example, Kendall has recommended that ORT be offered as a purgative in the Honduran setting where purgatives are thought efficacious. Honduran physicians have resisted this approach because it misrepresents ORT as a purgative and appears to recommend the use of purgatives. In rural northern India, ORT was used but subsequently rejected by mothers who were little concerned with dehydra-

tion and who claimed that ORT did not cure diarrhea. The translation of ideas about dehydration and its association with diarrhea is essential (Bentley 1988). We cannot dispense with knowledge of *non-Biomedical* theories and practices if Biomedical practices are to be introduced into settings where most needed.

There are other conditions in which traditional non-Western approaches may be more effective than Biomedical treatments. The World Health Organization's International Pilot Study of Schizophrenia (1973) compared the occurrence and course of schizophrenia in nine centers around the world. As in the case of depression, the comparison of schizophrenia across cultures is problematic because it is a condition that involves delusions, disturbances of affect, thought, volition, and sense of self; since what counts as normal varies from setting to setting, comparison of disturbance—that is, variations from normal—will also vary. In the diagnosis of individual patients, the study found substantially less agreement among diagnosticians in *different* settings than among diagnosticians in *the patient's own* setting. The study made extensive efforts to establish comparability and to recognize differences.

Assuming the comparability of diagnoses, several studies have reported similar rates of the occurrence of schizophrenia in different cultural settings. What was discovered in the International Pilot Study was that rates of relapse from schizophrenia varied substantially. Good outcomes (such as lack of relapse) were more common in the two developing country sites—Ibadan, Nigeria, and Agra, India—and least common in developed countries—Aarhus, Denmark, London, England, and Prague, Czechoslovakia (World Health Organization 1979). Persons initially diagnosed as schizophrenic in Ibadan had the lowest rates of social impairment when assessed in follow-up visits. It is hypothesized that differences in outcome were associated with differences in the social environments and expectations of patients in these settings—for example, the strong family bonds and supportive social environments of developing countries versus the urbanized stresses of life in industrialized countries. These hypotheses were not tested in the International Pilot Study.

Other examples of relatively efficacious approaches in non-Western settings can be found in the arena of obstetrics. Maternal and infant mortality in the Western world have declined dramatically since the beginning of the twentieth century to levels far below those of the developing world. Nevertheless, a number of common practices are followed in Biomedical obstetrics despite evidence that they are not beneficial and may be harmful (Chalmers, Enkin, and Keirse 1989; Davis-Floyd 1992; Jordan 1993). For example, a review of studies of electronic fetal monitoring concludes that routine monitoring is expensive and commonly does not produce useful information beyond that available by traditional auscultation; in addition, electronic monitoring leads to higher rates of cesarean section and may cause infection and other damage to the infant (Banta and Thacker 1979). Routine epis-

otomy—the cutting of the vaginal entry to prevent tears from birth—has also been found to have few benefits and many risks, including blood loss, pain, swelling, anatomical damage, and infection (Thacker and Banta 1983). Questions about the benefits and costs of cesarean sections, the use of the supine lithotomy position for delivery, and routine induced labor have also been raised (Marieskind 1980, Davis-Floyd 1992).

Abandonment of “external cephalic version,” used extensively until the late 1960s both in the United States and in non-Western settings to turn fetuses from the breech position to normal position, has also been questioned (Jordan 1993). Moreover, the supportive social environment common in many non-Western birth systems seems to be beneficial to mothers and has been recently readmitted into Western settings as part of the so-called natural childbirth movement (Leavitt 1987). (Since humans are creatures of cultures that profoundly shape the way they practice childbirth, there is no “natural childbirth” [Jordan 1993].)

### SICKNESS IN BIOMEDICINE

A recent Biomedical textbook of pathology begins, “Pathology is the study of disease by scientific methods. Disease may, in turn, be defined as an abnormal variation in the structure or function of any part of the body” (Anderson 1985:1). A similar perspective is reflected in the notion of disease proposed by Biomedical theorist Alvan Feinstein: “‘disease’ refers to a structural or chemical lesion (or derangement) in the human body” (1964:759). In Feinstein’s scheme, some events of sickness may be experienced by patients in the form of symptoms, regarded as subjective; other events of sickness can be detected at the bedside by physicians in the form of signs, regarded as objective. Objectivity and subjectivity are thus determined by the role of the observer rather than by what is observed. But sickness may not be detectable at the bedside by normal perception. The absence of clinical evidence of sickness implies the detectability of sickness in only its more fundamental form—“paraclinical abnormality” (Feinstein 1967). Paraclinical phenomena are the essence of sickness; evidence from paraclinical colleagues—radiologists, pathologists, laboratory workers—provides direct knowledge of sickness. Corresponding to this hierarchy of sickness phenomena, physicians have exclusive access to fundamental knowledge, and patients have at best occasional access to subjective experience of their own conditions.

In the framework I propose, the Biomedical hierarchy of patient and healer is turned upside down. I begin not with “underlying biological disturbance” but with the panhuman, though variable, biographical experience of sickness. While biological disease processes may play a role in the *causation* of sickness, it is the *unwantedness* of sickness *by its patients* that is primary and that dictates what is to be causally explained and therapeutically encoun-

tered. In contrast to the *paraclinical* entities posited by Feinstein as the atoms of disease, I have proposed as the essence of sickness the *preclinical* experience of an unwanted state in one’s person. The soul of sickness is closer to the self than to the cell.

The etymology of *pathology* suggests a view in which pathology is the science of “*pathos*,” or suffering. This vision is obscured in contemporary Biomedicine. I am recommending that we take this etymology seriously—not that we reject the vast discoveries and lifesaving tools of pathology as practiced in contemporary Biomedicine but that we regard this practice from a different, perhaps ancient, vantage point in which the medical enterprise is driven not by cellular abnormalities but by the experience of human suffering.

Contemporary Biomedical pathology marks its progress in terms of smaller and smaller units of observation, but I am recommending a complementary move in the opposite direction to include the mind, human relations and society, and the broader environment. Let us critically expand our theory of sickness and our practice of healing to allow the diversity of its forms, its contexts, its interpretations.

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