

Writing at the Margin

Discourse between
Anthropology and Medicine

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*For my colleagues in the field of medical anthropology,
so that conversations may continue.*

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What Is Specific to Biomedicine?

The Forms of Medicine

Medicine is nothing if not multitudinous. Defined in the broadest sense, as organized health practices and decisive therapeutic choices, medicine is so widespread around the globe that it is surely a universal in human organizations. In the same way that suffering can be said to be a defining quality of the experience of being human, happily not the only one but still one among a rather limited number, so too is medicine, as organized therapeutic practice (the process of care), fundamental to what is deeply human in experience amid the vast diversity of cultural worlds. At this high level of abstraction, it is even possible, if admittedly old-fashioned, by drawing on a large array of sources cross-culturally, to distinguish several general characteristics that would appear to be shared by nearly all social systems of healing, be they forms from small-scale nonliterate societies, low-income peasant societies, or even high-income industrialized states.

These shared characteristics have emerged in comparative studies of medical systems as distinctive as traditional Chinese medicine in Taiwan and China, Ayurvedic medicine in India and Sri Lanka, Bakongo medicine in Zaire, popular healing among laymen and laywomen in Brazil and North America, and professional biomedical practice in Japan, Russia, and Tanzania. They include:

Revised and expanded version of a chapter published in the *Encyclopedia of the History of Medicine*, ed. W. F. Bynum and Roy Porter (London: Routledge, 1993).

- categories by which health is normalized and illness diagnosed
- narrative structures that synthesize complaints into culturally meaningful syndromes
- master metaphors, idioms, and other core rhetorical devices that authorize practical therapeutic actions and the means by which their "efficacy" is evaluated
- healing roles and careers
- interpersonal engagements that constitute a vast variety of therapeutic relationships and modes of clinical interaction
- an immense panoply of therapies, seamlessly combining symbolic and practical operations (a distinction comparative research now shows is no longer tenable), whose intention is to control symptoms or their putative sources [see Kleinman 1980:207-208; 1988b:114-116, for earlier formulations of this list]

Of course, even more impressive is the multitudinousness, the polymorphous differences that distinguish the healing traditions of societies from each other; even the intrasocietal diversity must be for the comparatist disquietingly substantial. Different sociopolitical and cultural-moral contexts contain distinctive, sometimes astonishingly distinctive, forms of medicine. Thus, the gift exchange relationship central to the social structure of Hutu and Tutsi ethnicities in Rwanda shapes therapeutic interactions with native healers that are based upon ongoing, personalized transactions of intersubjective reciprocity (Taylor 1992). This generic mode of social transaction, to be sure, is modified, even nullified, by ethnic conflict and political rearrangements, as the horror of genocide and the forced uprooting of millions in that tragic nation demonstrates. The commodity-based exchanges and institutionalized professionalism in Taiwan constrain the Confucian pattern of paternalistic yet personalized patient-doctor interactions in traditional Chinese medicine, and even in urban shamanism, just as powerfully as they constrain that high-technology society's other bureaucratic practices and commercial activities. As a result, therapeutic relationships get transformed in the direction of an increasingly impersonal consumer archetype. Those relationships are responding as well to the pressure brought by a society-wide democratization movement and the advocacy of groups who support patient rights. That pressure for change marks surgical practice in Taiwan as distinctive from the work of surgeons in China. The movement from authoritarian toward more egalitarian relations in Taiwan, however, is not simply the result

of internal changes in its political and moral economy; a powerful global movement is remaking concepts of self and norms of interaction associated with the current stage of late industrial capitalism. The effects of that movement are also intensified by the international politics of democratic rights.

In contrast, the commune and work-unit forms of forced socialist communalism in China, prior to 1980, infected medical practice like all other professional activities with Maoist priorities—rural, anti-clite, low-technology, yet governed by centralized command and glorifying traditional Chinese medicine's integration with biomedicine while ruthlessly suppressing religious healing—that Taiwan has never experienced. Barefoot doctors, now called rural primary care physicians, and near universal health insurance—alas, now a thing of the past under the surging performance of China's new market economy, the fastest growing on earth—changed attitudes toward doctors and even the actual form of patient-practitioner communication as much as they altered access to biomedical knowledge and technology. Now, under the regime of economic reform, organized rural health care in China has broken down in some areas; it has become less salient in all but prospering rural areas; and the emphasis is all on high-technology practicing in urban centers and medicine as a business (World Bank 1992; Henderson 1990). In Taiwan and China at the moment both high-technology biomedicine and folk healing practices are flourishing for a variety of reasons, some shared but some different, owing to those societies' very different recent histories.

There is, then, no essential medicine. No medicine that is independent of historical context. No timeless and place-less quiddity called medicine. Practitioners of Chinese folk religion, *wu-s*, in mainland China and Taiwan may be classified as folk healers, but their attitudes and experiences and those of their patients are distinctive. Malay *bomohs*, Taiwanese *tang-kis*, and Temiar *halais*, in the same vein, all may be called shamans, yet the concrete ideas they enact and the rituals they conduct are as distinctive as the religious, kinship, and ethnomusical traditions of their very different societies (Laderman 1991; Kleinman 1980; Roseman 1991). It is simply misleading to relate these types of healers to some idealized notion of the essentials of shamanism. So much variety, indeed, is apparent even within the same society that to talk of "traditional healing," or for that matter "biomedicine," as if the term denotes a homogeneous social reality would be a serious misapprehension of ethnographic descriptions. Bonesetters, herbalists,

bonobos, practitioners of traditional Chinese medicine and of Ayurveda, and a wide variety of fortune-tellers and other healers make traditional healing in Malaysia a mélange of immense pluralism. Meredith McGuire (1988) has shown that almost as rich a diversity can be found among indigenous practitioners of "alternative medicine" in suburban America, where experts in various massage and dietary therapy, herbalists, acupuncturists, practitioners of many different Asian traditions of martial arts, Christian Science healers, pentecostal healing ministries, charismatic Catholic healing groups, rabbinical practitioners, astrologers, fortune-tellers, iridologists, chiropractors, homeopaths, naturopathic physicians, spirit mediums, self-styled shamans, hypnotists, together with a bewildering variety of lay psychotherapists compete among themselves and with biomedical practitioners for what must seem to them a dwindling supply of patients. Americans spend billions of dollars on these alternative practitioners (Eisenberg et al. 1993).

Among Bolivians living in the Andean highlands, medical pluralism matches the social pluralism of Catholic mestizos, rural Aymara Indians, and Methodist Aymara town-dwellers. Choice of a particular diagnosis and treatment becomes an idiom for negotiating ethnic and social class position and for claiming access to nonmedical resources, such as land, jobs, urban residence (Crandon-Malamud 1991). Medicine, then, like religion, ethnicity, and other key social institutions, is a medium through which the pluralities of social life are expressed and recreated.

Biomedicine is as plural as primary care practitioners in public clinics, rehabilitation experts in a veterans medical center, heart surgeons in a for-profit hospital chain, nurse practitioners in a rural hospital, psychoanalysts in office practice, social workers on the streets with the homeless mentally ill, and military health planners. The same therapeutic technologies—say, for example, particular pharmaceuticals or surgical equipment—are also perceived and employed in different ways in different worlds. Biomedical practitioners in Thailand and India have been shown to be strongly influenced by local norms (Weisberg and Long 1984). In technologically advanced Japan, the technology of transplantation in surgery is constrained by an unwillingness to accept brain death as the authorization to remove life supports and "harvest" organs for donation (Lock and Honda 1990; Ohnuki-Tierney 1994). Thus, in cross-cultural perspective it is as valid to talk about the cultural processes of *indigenization* of biomedicine as to implicate the *globalization* of local therapeutic traditions.

Nonetheless, for all the heterogeneity, there is something special about biomedicine and its Western roots, something that decisively distinguishes it from most other healing systems cross-culturally such as the great literate systems of traditional Chinese, Hindu, or Islamic medicine and, of course, the vast array of local healing activities described by ethnographers. So that it is appropriate to essay an answer to the question put to me by the editors of the *Encyclopaedia of the History of Medicine*: What is specific to Western medicine?

I shall employ the term *biomedicine* in place of "Western medicine," however, because it emphasizes the established institutional structure of the dominant profession of medicine in the West, and today worldwide, while also conjuring the primacy of its epistemological and ontological commitments. These are what is most radically different about this form of medicine (see Lock and Gordon 1988). "Western medicine" is an unsatisfactory appellation for other reasons as well. Biomedicine has long been a global institution. It is no longer only Western, either in its site of practice or even in its locus of knowledge production and technological innovation. "Cosmopolitan medicine," a term fairly widely displayed in anthropological publications (see Leslie 1976; Leslie and Young 1992), also seems less suitable than "biomedicine" because a surgical clinic can be in the distant, parochial periphery or in the cosmopolitan metropole. Moreover, this term doesn't carry the epistemological and ontological resonances that I seek to privilege. "Allopathic medicine," though perhaps widely understood in South Asia, seems to me an unaccustomed term, less well known to readers elsewhere. Intriguingly, if you ask biomedical professionals what word they would use to describe their field, most will say, in a powerfully succinct usage that does capture a sense of the hegemonic self-perception that has become almost a caricature worldwide, "Why not just call it medicine!"

For the purposes of this essay, I will not concern myself with Western religious healing, nor will I deal with other local folk and popular therapeutic practices that are indigenous to the West. The focus on biomedicine will also exclude alternative Western therapeutic professions or heterodox movements among biomedical professionals, such as osteopathy, homeopathy, chiropractic, naturopathy, or most recently "holistic medicine." Furthermore, I will primarily deal with the biomedicine of knowledge creators (researchers, textbook authors, teachers) and of the high-technology tertiary care institutions that dominate medical training and that represent high status in the profession.

I recognize that the working knowledge of the ordinary practitioner treating routine health problems in the community is more complex and open to a wider array of influences. I also know that nurses, technicians, and receptionists perform much of the work of biomedicine, especially through contact with patients and families.

What I seek to emphasize is the scientific paradigm that is at the core of the profession's knowledge-generating and training system (Fridson 1986; Good 1994). Charles Rosenberg, a distinguished historian of American medicine, rightly notes that biomedicine has long contained a holistic, humanly oriented stream that in the nineteenth century prior to the development of microbiology even had very substantial influence (personal communication, 1985). I concur, yet this is not what I take to be the dominant stream in biomedicine today, even though there are impressive examples of patient-centered care and psychosocially sensitive practices in many primary care settings.

Holistic medicine is another problematic term that challenges cultural interpretations of biomedicine that are too simplistically dichotomous. Several decades ago it was widely employed as a code word to juxtapose empathic, psychosocially valued care against medical practices that were viewed by biomedicine's critics (both outside and within the profession) as mechanistic, reductionistic, and inattentive to the human concerns of patients and families. In the 1980s, holistic medicine came to be appropriated by a commercial movement that brought together biomedical practitioners who advocated the use of various nonorthodox interventions (massage, dietary treatments, herbalism, acupuncture, and so forth) and mind-body techniques that had not been widely applied in primary care with a variety of alternative practitioners. Also included in this successfully marketed hotchpotch are New Age spiritual practices. Holistic healers today compete for patients with standard biomedical professionals in primary care practice who themselves have authorized greater use of interviewing and psychotherapeutic treatment skills—a clear example of the influence of a powerful American cultural shift on biomedicine. Anne Harrington (in press), a historian of German science, points to the deeply troubling appropriations by the Nazis in the 1930s of the metaphor of holism to stigmatize reductionistic medical science as “Jewish,” and therefore evil, and to tighten ideological connections with the romanticized yearning for organic healing associated with German folkloric traditions.¹ This disturbing irony can serve as a useful caution before I embark on my own cultural critique of “biomedicine.” Phenomenol-

ogist critics of technological society, such as Martin Heidegger, Arnold Gehlin, and Kitano Nishida, attacked the inhumanity of the instrumentality of technical rational procedures in the professions, yet they themselves were involved with the Nazis or other fascist movements. This is a sobering reminder of the substantial potential for abuse in the appropriation of criticisms of biomedicine. Holism in the 1930s started out as a movement to reform medicine, but ended up legitimizing political authority and disguising the real sources of oppression. Its salvational ideology came to serve truly dangerous political interests—a serious, destabilizing concern.

Monothism, Monotypic Order, and Medicine

The historian of Chinese medicine Paul Unschuld (1988) claims that the monothism of the Western tradition has had a determinative effect on biomedicine, even as it is practiced in non-Western societies, which distinguishes it in a fundamental way from Asian medical systems. The idea of a single god legitimates the idea of a single, underlying, universalizable truth, a unitary paradigm. Tolerance for alternative paradigms is weak or absent. The development of concepts is toward proof of the validity of a single version . . . of the body, of disease, and of treatment. Alternatives may persist in the popular culture or at the professional fringe, but they are excoriated as false beliefs by the profession as a whole, not unlike the accusation of heresy in the Western religious tradition. Conversion, ostracism, or sometimes more final solutions result from what William Connolly (1993) has called the Augustinian imperative for complete agreement on what constitutes a universal moral order.²

At least, this is the way biomedicine and the Western tradition look from the non-Western world, inasmuch as Chinese and Ayurvedic medical traditions tolerate alternative competing paradigms, seem less troubled by the uncertainty of human experience, and are more pluralistic in their theoretical orientations and therapeutic practices (see Zimmermann 1987; Leslic and Young 1992). Thus, *yin/yang* theory, the macrocosmic-microcosmic correspondence theory of the Five Elements Phases (*wu xing*), and differing operationalized, views of the body in acupuncture and practical herbology exist simultaneously: they are made compatible in the practitioner's practice. Even biomedical

concepts and practices are accorded a legitimate place in traditional Asian medical systems. Indeed, in India and Sri Lanka, traditional practitioners of Ayurveda often integrate biomedicine into their practice (Waxler 1984). No viewpoint ever dies out completely; alternatives are never totally discredited (Unschuld 1985).

Drawing from a deep Western cultural source, philosophy in ancient Greece developed a central distinction between reality and appearance. Behind the changing surface of events rests an immutable structure: an immortal soul, an imperishable form of beauty, a universal and objective justice. Rational principle and objective truth can be discovered within the uncertain particularities of changing phenomena. Truth, beauty, and the good are absolute and transcendent (Ames 1991).

"The signal and recurring feature of Western civilization which emerged to dominate the development of its philosophical and religious orthodoxy," according to R. T. Ames,

was the presumption that there is something permanent, perfect, objective and universal that disciplines the world of change and guarantees natural and moral order—some originative and determinative *arché*, an eternal realm of Platonic *eidé* or "idea," the One True God of the Judeo-Christian universe, a transcendental strongbox of invariable principles or laws, a geometric method for discerning clear and distinct ideas. The model of a single-ordered world, where the unchanging source of order stands independent of, sustains, and ultimately provides explanation for the sensible world is a dominant . . . assumption in this tradition. (1991:xv)

Similarly, William Connolly (1993a:176) sees the Augustinian imperative as "the demand that there must be an intrinsic moral order we can pursue and strive to embody in our conduct and politics." The imperative leads to the castigation of anyone who does not accept or fit within this monolithic moral order as an alien Other. The imperative's legacy is easily visible in the justification for stigmatizing and suppressing religious heresies, in the brutal oppression found in colonial movements of conquest, and more prosaically, but equally fraught with dangerous consequences, in the antagonistic absence of respect accorded theories that fall outside the Western canons of philosophy and science. Drawing upon Foucault's late turn to an ethic of "agonistic respect" among plural perspectives in increasingly plural societies, Connolly (1993b) argues for a postmodern moral code that engages with great seriousness alternative and even opposite formulations that

broaden the horizon of interpretation, which, in the absence of single truths and universal fundamentals, is all that we can expect. The presence of alternative medicines is yet another aspect of the pluralism of everyday life that is perceived as threatening by those unwilling to imagine health, illness experiences, and health care as having plural sources, forms, and outcomes.

The entailments of monotheism and monotypic order foster a single-minded approach to illness and care within biomedicine that has the decided advantages of pushing medical ideas to their logical conclusion, uncovering layers of reality to establish with precision what is certain and fundamental, and establishing criteria against which orthodoxy and orthopraxy can be certified. Indeed, from the point of view of Asian medical systems, the uniqueness of biomedicine lies in its method (of controlling existing data within its theory, and the resultant predictions and determinations based on past facts) (Nakayama 1984). While the more fluid complementary paradigms of Asian medical systems appear weak in methodological rigor and not conducive to empirical testing, their categories do represent the active ordering of relationships and have produced many positive practical results. The Chinese approach, for example, is grounded within the phenomenological constraints of time, place, and phase. Though excessive flexibility perhaps limits its function as a science, it presents a serious attempt to codify complex, subtle, interactive views of experience into therapeutic formulations that claim contextual rather than categorical application. Chinese medicine attempts to account for psychological and ecological and even moral as well as corporeal phenomena through the use of dynamic, dialectical, process-oriented methods of clinical appraisal (Nakayama 1984).

Biomedicine differs from these and most other forms of medicine by its extreme insistence on materialism as the grounds of knowledge, and by its discomfort with dialectical modes of thought. Biomedicine also is unique because of its corresponding requirement that single causal chains must be used to specify pathogenesis in a language of structural flaws and mechanisms as the rationale for therapeutic efficacy. And particularly because of its peculiarly powerful commitment to an idea of *nature* that excludes the teleological, biomedicine stands alone. This medical value orientation is, ironically, not nearly as open to competing paradigms or intellectual play of idea as is "hard" natural science, whose ways of approaching problems in cosmology and

theoretical physics seem more flexible and tolerant than the anxious strictness of the "youngest science," though ultimately natural science too discloses certain of the same consequences of monotheism.

The "hard" and the "soft," signifiers of a deep cultural logic in North America, figure importantly in biomedicine. Talk and cognitive activities more generally are "soft"; procedures that enter the body (various scopes, surgical operations) are "hard." Psychiatry and the primary care fields (pediatrics, general internal medicine, family medicine) are "soft"; the surgical subspecialties are "hard," as is pathology, which is responsible for autopsies and the interpretation of tissue specimens removed during surgery. The "soft" specialties are the ones that provide the lowest incomes and attract the most women practitioners, whereas the "hard" specialties attract more males and often make them rich. The "soft" specialties increasingly use procedures that make them "harder"; dermatology, which is a specialty of internal medicine, has added surgery to its practice; psychiatry in our time has tried to transform itself, with mixed effects, in a "biological," therefore "harder," direction.

What this cultural logic connotes is a set of deep dualisms between male and female, mind and body, strength and weakness, wealth and poverty, aggressive technological actions and what is popularly held to be more passive styles of intellectual behavior that are metaphors of social structural divisions. Perhaps because biomedicine's rise in status and power took place only since the Second World War, these symbolic markers can be read as residual signs on the road of professional success indicating what succeeds in North America.

In the biomedical definition, *nature* is physical. It is knowable independent of perspective or representation as an "entity" that can be "seen," a structure that can be laid bare in morbid pathology—as a pathognomonic "thing." Thus, special place is given to the role of seeing in biomedicine, which continues a powerful influence of ancient Greek culture. Biology is made visible as the ultimate basis of reality which can be viewed, under the microscope if need be, as a more basic *substance* than complaints or narratives of sickness with their psychological and social entailments (Good 1994; see also chapter 9). The psychological, social, and moral are only so many superficial layers of epiphenomenal cover that disguise the bedrock of truth, the ultimately natural substance in pathology and therapy, the real stuff: biology as an architectural structure and its chemical associates. The other orders of reality are by definition questionable (see Gordon 1988).

This radically reductionistic value orientation is ultimately dehumanizing. That which has been so successful a blueprint for a biochemically oriented technology in the treatment of acute pathology places biomedical practitioners in some extremely difficult situations when it comes to the care of patients with chronic illness; situations that, as I review below, offer obdurate resistance to affirmation of the patient's experience of the illness; to understanding the social, psychological, and moral aspects of physiology; and ultimately to the humane practice of medicine. These extreme situations are not created, at least with the same regularity and intensity, by other healing traditions described in the cross-cultural record.

This point is almost certain to be challenged. There is a feeling, not without justification, that anthropologists romanticize traditional healing systems, while at the same time we use that imagery to criticize biomedicine. I myself have raised this concern (Kleinman 1988a). S. X. Li and Michael Phillips (1990), among others, have reported serious abuses by indigenous healers in China. Others have been critical about how effective traditional forms of healing are for serious illnesses. Yet, after reviewing the most recent ethnographies of traditional healers, I am impressed that when these practitioners have been appropriately studied, they seem not to be constrained in the human quality of their care in the same way as are their biomedical colleagues. Rather, the structures of traditional healing—gift exchange relationships, local cosmologies, teleological narratives of suffering, aesthetic codes of performance—center on human experience and its modes of interaction. Less advantaged in technology, they are more advantaged, it seems, in humanity.

Disease sans Suffering/ Treatment sans Healing

Through its insistence on the primacy of definitive materialistic dichotomies—for example, body/mind (or spirit), functional/real diseases, and highly valued specific therapeutic effects/discredited nonspecific placebo effects—biomedicine presses the practitioner to construct *disease*, disordered biological processes, as the object of study and treatment. There is hardly any place in this narrowly focused therapeutic vision for the patient's experience of suffering. The patient's

and family's complaints are regarded as *subjective* self-reports, biased accounts of a too-personal somewhere. The physician's task, wherever possible, is to replace these biased observations with *objective* data: the only valid sign of pathological processes, because they are based on verified and verifiable measurements (see Murray and Chen). This is a view from a depersonalized nowhere. Thus, the doctor is expected to decode the untrustworthy story of *illness as experience* for the evidence of that which is considered authentic, *disease as biological pathology*. In the process, the doctor is taught to regard experience—at least the experience of the sick person—as fugitive, fungible, and therefore invalid. Yet by denying the patient's and family's experience, the practitioner of biomedicine is also led to discount the moral reality of suffering—the experience of bearing and enduring pain as a coming to terms with that which is most at stake, that which is of ultimate meaning, in living—while affirming objective bodily indices of morbidity. The result is a huge split between the constructed object of biomedical cure, which is the *dehumanized disease process*, and the constructed object of most other healing systems, which is the all-too-humanly narrated pathos and pain and meaning-directed perplexity of the experience of suffering (see Jackson 1989; Keyes 1985; Schieffelin 1985; Seremetakis 1991:115, 127, 201).

Thus, biomedicine constructs the object of therapeutic work without legitimating suffering. The physician correspondingly is hedged in in the role of healer. Providing a meaningful explanation for the illness experience is something physicians (and especially those in marginal subdisciplines such as psychiatry and family medicine, which are more oriented to experience) undertake, so to speak, with both hands tied behind the back. They may succeed in using their personality and communicative skills to assist patients; yet they do so, as it were, against the grain, against the consequences of the biomedical orientation for their training and the care they give. Meaning itself is not configured as a central focus or task of medicine. Because it *eschews* technology, the very idea of a moral purpose to the illness experience is a biomedical impossibility. That serious illness involves a quest for ultimate meaning is *disavowed*. Because of distrust of qualitative interpretations and concomitant emphasis on quantitative data, the biomedical framework accords no legitimacy to values. Hence, the practitioner of biomedicine must struggle to practice competent biomedicine, while at the same time searching for some extra-biomedical means to authorize the professional's empathic response to the patient's and family's

moral needs to have a witness to the story of suffering, to find support for the experience of illness, and to collaborate with others in the struggle to fashion a meaningful interpretation of what is at stake for them in their local world. It should not be at all surprising then that hospitals and clinics are frequently criticized in the current period of consumer interest in patient-centered care for their dehumanizing ethos. Indeed, it is a tribute to the stubborn humanity of practitioners and to the recalcitrant influence of extra-professional cultural traditions that these institutional settings are not *routinely* experienced as such.

That practitioners of biomedicine are trained in a radically skeptical method that ought to diminish the *placebo response* in their care is another curious corollary of this peculiar healing tradition, whose many positive aspects also must not go underemphasized. No other healing tradition possesses a significant fraction of the specific therapeutic interventions for serious disorders that biomedicine includes. Nor does any other tradition so distrust and choose not to elaborate nonspecific therapeutic sources of efficacy that are associated with the rhetorical mobilization of the charismatic powers of the healer-patient relationship that persuade patients and families to believe in successful outcomes and thereby enact scenarios of efficacy (Brody 1977; Davis 1992; Frank 1974; see also Lindholm 1990 for a review of the social basis of charismatic power).

And yet, the anti-placebo skepticism of the current phase of biomedicine must also be balanced by its associated antiauthoritarianism, which contrasts strikingly with the paternalism of most traditional forms of healing. Skepticism about charismatic healing power also has protected biomedical professionals from the charges and countercharges of charlatanism that abound in folk healing. Egalitarianism, demystification of medical terminology, informed consent, and concern for patient rights, in cross-cultural perspective, are also rather peculiar to the contemporary Western tradition of biomedicine. The virtues, such as they are, which Max Weber attributed to bureaucratic rationality—namely, generalizability, quantification, prediction, efficiency, quality control—are now ingrained in the professional structure of biomedicine; they have become a central part of industrialized society's processes of risk management (Freudenberg 1993), a protection against institutional recreancy, including *medical malpractice*. Their absence in folk healing systems makes those practices problematic. The rub, of course, is the iron cage of technical rationality which, as Weber also

saw, would come to replace sensibility and sensitivity (Wrong 1976: 247). Sadly, though tellingly, the professionalization of Asian medical systems has not infrequently led in the same direction (see Leslie 1976).

The Progressive Search for Powerful Operations

Biomedicine instantiates the Western tradition's idea of progress. The profession's self-portrait is of a scientific, technological program that is continuously progressing in acquisition of knowledge and especially in deployment of powerful therapeutic operations. Even in spite of limited progress over the past decade in the treatment of the chronic diseases that contribute most significantly to morbidity and mortality indices, biomedicine's self-image emphasizes awesome technological capacity to operate on the patient's organ systems. There is only a poorly articulated notion of an absolute limit to that progress. Organs can be transplanted; limbs can be reimplanted; life-support systems even "prevent" death. It is not surprising, then, that therapeutic hubris is commonplace. Physicians are not educated to feel humble in the face of sources of suffering that cannot be reversed or to place limits on the utilization of powerful technologies.

Indeed, suffering is converted into technical problems that transmute its existential roots. Thus, even the approach to ethical issues in the final period of terminal illness, the period when patients are near death on vital support systems, becomes a question not of constructing a good death but of the technical details of "advanced directives." What starts out as an effort to respect the patient's and family's perspectives on a moral crisis, ends up as yet another instance of medicalization—the application of the expert's rational technical rules to deeply human experience. Contrast this social dynamic with the way suffering is valued in rural Greece as moral experience and social commentary (Seremetakis 1991:231).

Whereas in traditional Chinese medicine, as in many other indigenous non-Western healing systems, and earlier within healing professions in the West, the idea of progress is balanced by the idea of regress, and suffering and death are viewed as expected and necessary, biomedicine again represents a radical therapeutic departure. Powerful

actions—from the earlier era of heroic medicine with its therapeutic purging and bleeding to our own epoch's stopping and starting the heart, delivering a short sharp shock to brain matter, changing the genes of cells to enhance anti-cancer drugs, or cloning a human embryo—not restraint (still less the appropriate use of inaction, John Keats's negative capability), iconically represent biomedicine's imagery of efficacy. Where Asian medical systems invoke weak treatments as virtuous because they are held to be "natural" and noniatrogenic, biomedicine's therapeutic mandate, for which all pathology is natural, emphasizes decidedly "unnatural" interventions. The historic Western interest in nature's healing powers has passed out of the mainstream of the profession and into homeopathy and the New Age fringe.

The burden on the practitioner of the idea of progress and the expectation of powerful operations is considerable, not least of all through the astonishing claim that ultimately death itself can be "treated," or at least "medically managed." Another aspect of this ideological influence is the euphemization of suffering, which becomes medicalized as a psychiatric condition, thereby transforming an inherently moral category into a technical one. An existential experience of tragedy and loss is reconstructed as a professionally managed experience of major depressive disorder. The consequence is a further transvaluation of therapeutic values (see Bottero n.d.). As a result, practitioners of biomedicine are in a situation unlike that of most other healers: they experience a therapeutic environment in which the traditional moral goals of healing have been replaced by narrow technical and bureaucratic objectives. Psychotherapy, in like fashion, whatever else it is, cannot be construed as a quest for the spirit, though that is what its felt experience is for many (see Shweder 1985; Csordas 1994). That physicians are depicted in the popular culture—for example, in TV soap operas—as inextricably engaged in the moral dilemmas of patients and communities does not disqualify these points. Rather it reflects the still considerable power of the social world to moralize experience, even that biotechnical version which claims independence from parochial passions.

The reader should not misunderstand this criticism. I do not indict the recognition and treatment of a depressive disorder when that psychiatric diagnosis and the antidepressant medications and the psychotherapy it entails can be clinically useful to someone who is in deep distress with a treatable psychiatric condition. But I do call into question the practice through which the suffering that is part of a serious