medical disorder is reinterpreted as a depressive disease so that an institutionally efficient technical fix (a drug) can be applied in place of a humanly significant relationship of witnessing, affirming, and engaging the patient's and family's existential experience. That the professional transmogrification of suffering is problematic is seen when virtually all seriously ill medical inpatients can be made to fit the American Psychiatric Association's official diagnostic criteria for major depressive disorder on account of the psychophysiological effects of their heart disease or cancer or their treatment. That is, the suffering of patients has been medicalized, inappropriately, into a psychiatric disease.

One other curious particularity of biomedicine, at least in its present-day form, is its anti-vitalism (see Canguilhem 1989). Traditional Chinese medicine, like many traditional systems of healing, centers on the idea of a vital power—in this instance, *qi* (energy that is associated with movement and breath)—at the core of health and disease. The source of disease is not traced to a particular organ, but to the disharmony of *qi* circulating in the body. Ayurvedic medicine shares a somewhat similar conception of vital breath. Other examples are the *semangat* (spirit of life) and the inner winds (*angin*) of indigenous Malay medicine; *isibo,* the flowing force in the health conceptions and practices of Rwandans; the unbounded souls of the Temiars; *hinona,* the vital force that makes the body breathe, among residents of Sabarl Island off of the coast of Papua New Guinea; and, of course, the *pneuma* of ancient Greek medicine (Trawick 1992; Laderman 1991; Taylor 1992; Roseman 1991; Battaglia 1990; Canguilhem 1989).

Vitality, efficacy, power—all capture the idea of a force of life that animates bodies/selves. Biomedical materialism decries a vital essentialism. Things are simply things: mechanisms that can be taken apart and put back together. It is a thoroughly disenchanted worldview. There is no mystery, no quiddity. Therapy does not, cannot work by revitalizing devitalized networks—neuronal or social. There is no magic at the core; no living principle that can be energized or creatively balanced. Thus, though depression feels like soul loss to many persons around the globe, there is no possibility of a lost soul in psychiatry. The devitalized imagery also negates the therapeutic powers within patients, denying efficacy to lay experiences of regaining force and overcoming fatigue. About power, an ordinary human experience, biomedicine is silent.

The attention of biomedicine is also focused on the solitary body of the individual sick person because of Western society's powerful orientation to *individual* experience. That illness infiltrates and deeply affects social relations is a difficult understanding to advance in biomedicine. Population- and community-based public health orientations run counter to the dominant biomedical orientation, which takes for its subject the isolated and isolatable organism. In contrast, African healing systems see illness as part of kinship networks and healing as a kinship or community effort (Janzen 1978; Taylor 1992). The foundation of biomedical psychiatry is also a single self in a single body. The presence of alternative selves or dissociated mental states, measured against this norm, is interpreted as pathology. Trance and possession, which are ubiquitous cross-cultural processes that serve social purposes and can be interpersonally useful, are invariably cast by biomedical nosologies as pathology. In contrast, the sociocentric orientation of various nonbiomedical forms of healing will strike many people as a more adequate appreciation of the experiential phenomenology of suffering cross-culturally.

Bureaucratization, Professionalization, and Medicalization

Because of its long development under the powerful regimen of industrial capitalism, biomedicine is the most institutionalized of the forms of medicine. When, early in this century, the doctor practiced his craft in the living room, kitchen, and bedroom of the patient, or in his own home, the intimate domesticity of suffering with its always concrete implications for treatment loomed much larger in the considerations of the practitioner. Now, at the close of the century, biomedicine is practiced in bureaucracies, whose effect is profound (see Rosenberg 1987; Rothman 1991; Starr 1983; Kleinman 1988b:77–107). The rule of efficiency governs the lived time of the patient-practitioner encounter. Regulations control practice, transforming the doctor into the "provider" of a "product" that is advertised, marketed, and sold. Care is commoditized. Even the lived space of practices is standardized to conform to the institution's blueprint for functionality. The technical rationality of the institution, its priorities and norms, shape biomedicine. The physician is a bureaucrat; the patient is a user, a consumer of the institution's services. The very imagery of care constructs an industrial logic to its delivery and evaluation,

reducing the moral space of the career of illness and of the work of doctoring to a minimum.

Equally momentous for biomedicine is its professionalization. Professional "autonomy" conflicts with bureaucratic hierarchy and control. Yet it, too, sets standards that normalize training and practice. If the former, bureaucratization, routinizes efficiency, the latter, professionalization, routinizes the "quality" of care. With these two powerful masters, which concentrate the influence of the state, no wonder the patient's and family's influence on the process of care is weakened. The degree and intensity of specialization is unprecedented. The object of diagnosis, treatment, and prognosis is fragmented into a single organ system. Expert judgment is further legitimated over and against that of the generalist and the layperson. And many other practical consequences make biomedicine different from other systems of healing, even where they are practiced in the same political economy.

Biomedicine is not just any bureaucracy and profession, it is a leading institution of industrialized society's management of social reality. Biomedical constructions of the various forms of human misery as health problems are reinforced by societal regulations that can influence all sectors of experience, from the courts to the workplace to the household. This process of ***medicalization*** is responsible for certain of biomedicine's most controversial attributes. Biomedicine's sector of influence continues to grow as more and more life problems are brought under its aegis. Alcoholism, other forms of drug abuse, obesity, aging, child abuse, violence—all are presently articulated as health (or mental health) conditions. Medicalization leads us to search for their genetic roots, to assess other individual risk factors, and of course to quest for treatments; yet, while giving the sufferer the sick role, medicalization can stigmatize as well as protect; it can institute a misguided search for magic bullets for complex social problems; and it can obfuscate the political and economic problems that influence these behaviors.

No other therapeutic system can exercise this degree of power, because no other has become so powerful a part of the state's mechanisms of social control. Indeed, in industrialized societies biomedicine along with the mental health, disability, and welfare systems that closely relate to it arguably have become the major form of social control. This may in part reflect the fact that in the current phase of global political economic transformations, so-called disorganized capitalism, the social and behavioral problems listed above seem to be a

direct effect of those societal changes that profoundly influence human conditions.

Thus, in the postmodern state, biomedicine has come to serve a major political mission. Its taxonomy holds legal and regulatory significance. Its definitions of what is a problem and how it should be treated carry greater public legitimation than that of most other professions. Its role in the political economy is at the center of the fastest growing sector, which threatens to surpass all other public expenditures. No other healing system is so central to social reality or so wrapped up in the leading political and economic issues of the time. Thereby has biomedicine, at least in the West, outstripped its own professional autonomy and become inseparable from the state.[3]

Another example is the passive acceptance by biomedical practitioners of a patient-doctor relationship that is just another instance of consumer-client interactions characteristic of a market economy. This economistic model represents the diffusion into biomedicine of the most powerful contemporary model of relationships throughout North American society. It runs counter not only to patient-doctor models in other societies' healing traditions but even to the earlier model of a fundamentally moral relationship in medical practice that characterized North American society until several decades ago. It is either another actual instance of the continuing conversion of gift relationships that are based in interpersonal moral meaning to commodity relationships that are based in impersonal market mechanics in the transnational political economy, or an example of the sentimental power of this image of change in social relations to conjure back a world that we are losing and feel the need to mourn.

As a result, the very purposes of biomedicine have been altered from an earlier emphasis on the deeply human grounds of illness and care, shared by other healing traditions, to economic and political priorities, which are the chief influences on research and teaching, organization and delivery of services, and the day-to-day work of the practitioner. Regulation via bureaucratic rationality, state control, and the "market" is remaking biomedicine in North America, for example, into an institution that has more in common with many of the other agencies of government and business bureaucracies than it does with healing systems in other societies or with the biomedicine that existed even a quarter of a century ago.

Much that we have associated with biomedicine at present can

also be found in other institutions in technologically advanced societies. To that extent, the sources of these qualities are societal rather than strictly medical. It could be argued, too, that in certain aboriginal Australian societies and other hunter-gatherer/hunter-horticulturalist groups the conceptions of illness and healing are so central to the core religious system that they play as predominant a role in the societal order. These points, however, do not lessen the special significance that biomedical institutions have come to hold in postmodern states.

In this sense, at least, biomedicine is, like other forms of medicine, both the social historical child of a particular world with its shape of experience and an institution that has developed its own unique form and trajectory.

3

Anthropology of Bioethics

The editors of the *Encyclopedia of Bioethics* invited me to write an entry on the anthropology of medicine. They asked that, in a short space, I show readers what the discipline is about and why it might be significant for ethical questions in medicine. I first sent them a contribution that centered on a cultural critique of bioethics. Clearly taken aback by the sharpness of the criticisms I leveled at mainline bioethics, they wrote me that my piece did not sufficiently describe the range of anthropological contributions, nor did they think I was up-to-date on new directions in medical ethics which already met the criticisms I had voiced. I returned to my study to read the more recent articles and books in bioethics that they recommended. That exercise did little to change my interpretation. However, I did take up their suggestion to expand the review of anthropological writings on ethical questions in health and medicine. The corpus is not huge, but it is larger than could be surveyed for a short article. Also, at the editors' request, I made the foolhardy effort to say something in a few paragraphs about medical anthropology more generally. Because it was so thin, that section is deleted from this chapter.

I also have added a response to several recent works by ethicists who have engaged multiculturalism. How could this not become a serious topic, if ethics is to have any pretense of being pertinent to North American as well as global realities. Indeed, I admire the effort

An earlier version of this essay appeared under the title "Anthropology of Medicine" in the *Encyclopedia of Bioethics,* revised edition, edited by Warren T. Reich (New York: Simon & Schuster Macmillan, 1995). It is reprinted here by permission of the Publisher.