

THE ANTHROPOLOGY OF MEDICINE

From Culture to Method



Lola Romanucci-Ross • Daniel E. Moerman
Laurence R. Tancredi, M.D. and Contributors

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***Preface.* The Cultural Context of Medicine and the Biohuman Paradigm**

Medical systems emerge from human attempts to survive disease and surmount death, and from social responses to illness and the sick role. Descriptions and analyses of this process within the variety of world cultures define a field known as medical anthropology. Although this process is itself an ancient one—perhaps sixty thousand years old—with roots in the middle Paleolithic, the field of study is a relatively new one that began with systematic inquiries by anthropologists into health practices and explanations of disease in primitive and peasant cultures.

This volume represents the state of the art of medical anthropology, emphasizing what we have called the anthropology of medicine: a study of medical thought and problem solving, the acculturation process of the healer and physician in diverse cultural settings, and the social and cultural context of medicine. Our approach is through the perspective of cultural and medical anthropologists who have taught and worked with Western-educated physicians immersed in clinical and research medicine, as well as those who have worked with other healers and patients outside the bounds of modern biomedicine and surgery.

Anthropological field research is an experience in abstraction; it is an exercise in putting “particulars” into brackets as we search for universals in elements and the relations among them. In this sense we have chosen to fuse the particulars of Western medicine with those from other cultures for conceptual analysis in what we have called the anthropology of medicine. Beyond the surface differences, we try to expose similarities of deep structure, to demonstrate that there is a path beyond culture and that one may focus on method.

We believe that medicine, in a very real sense, stands astride both the cultural and biological dimensions of humankind; we believe that medicine is a kind of applied anthropology in the broadest sense of the term: action for human beings. As anthropologists who have learned a great deal from physicians and surgeons, we

hope that the perspective we can bring to this complex cultural and biological exchange will be of value to those who, so much closer to the action, are in the very trenches we learn so much by observing.

This book, then, is designed for physicians and medical students, public health administrators and workers, and students in related health-science fields, as well as students and professionals in anthropology and social science who are interested in the practice or theory of health and healing. It is, in brief, a text for both the health sciences and anthropology.

For a century in the West, there have been two literatures regarding the health sciences. They have represented two different canons, or paradigms: the approaches of biomedical science and of behavioral science. To simplify somewhat, the biomedical paradigm tells us that, for example, tuberculosis is "caused" by *Mycobacterium tuberculosis*, whereas the behavioral-science paradigm tells us that tuberculosis is "caused" by poverty and malnutrition. It is our contention that these two approaches can be integrated into one biohuman paradigm; further, we contend that the unifying factor is the concept of culture. By culture we mean the system of meaning—belief, knowledge, and action—by which people organize their lives. Such organization structures the diseases to which people are subject: as a simple case, schistosomiasis is a disease of irrigation agriculture; as a less simple case, the *windigo* psychosis of Algonquian Indians is a disease (characterized by homicidal behavior and cannibalistic fears) of a hunting people subject to great environmental fluctuations.

Diseases, however, are never experienced directly; "illnesses," cultural constructs of "dis-ease," are what people experience; illnesses are constructed of belief and knowledge, which vary with both space and time. A contemporary example might be "hyperactivity," an "illness" with associated treatment(s), which did not exist twenty years ago. People debate whether or not it is a new "disease," a response perhaps to new environmental toxins (i.e., food additives), or whether it was "always there," but not recognized. *Either case* provides an example (slightly different ones, to be sure) of the role of the cultural process in sickness and health. If it was always there, but not recognized, then we have a case where an illness was invented. If it is a new disease, we have a case where cultural concerns (for foods with this color or that) have created a novel physiological disorder.

The theoretical value of such an approach seems evident. Human beings are simultaneously cultural and biological creatures, and these two dimensions necessarily interact. The historical concern of (at least North American) anthropologists with these two factors—differentiating anthropology from sociology or history on the one hand and from psychology or biology on the other—means that the study of human health and healing, where people *attempt to influence directly the relationship between biology and culture*, is one rich with potential for learning fundamental things about what it means to be a human being.

Perhaps the greatest difference between these two paradigms and the greatest obstacle to their resolution lies in the notion of efficacy. What on earth is there to learn, the biomedical scientist wants to know, from the bizarre medical practices of the past? Grounded in the history of Western medicine, such a scientist is aware of the awesome array of tortures perpetrated on sick people in the past thousand years: bleeding and purging, whipping devils out of the insane, the presumably medicinal use of bat's blood and bear feces, of frog sperm and earthworms, gruesome tales of septic surgery on nonanesthetized patients, and so on. Physicians seem, sometimes, almost gleeful when they reminisce about some sixteenth-century surgeon dying of infection from a nick of his own knife.

We do not deny the terrifying state of medicine in Europe between the twelfth and eighteenth centuries. The difference lies in the fact that the anthropologist takes a broader view of the world, and sees pre-modern Europe as a very unusual and special case—one of the least healthy societies in human history—subject to dozens of new and terrifying diseases as a consequence essentially of two things: the great growth then of the population of both humans and domesticated animals. This “one-two punch” of domestication and urbanization created conditions for the evolution and communication of infectious disease organisms on a scale unprecedented in human history, well beyond the abilities of the most well-intentioned physician.

Consider, as an ideal comparison, the health status of Europeans and native Americans in the year 1480. Paleopathological evidence indicates that the native Americans were extremely healthy: they had a life expectancy longer than that of Europeans of the time; life was difficult, and people suffered from accidents, fractures, rheumatic conditions, and, perhaps, from trichinosis contracted from animals that they hunted. Scholarly debate rages regarding the origins of syphilis; some argue that it was introduced into Europe from America by members of Columbus's crew, others, that it was an indigenous Old World disease. It is, however, the *only* ambiguous case; all the other diseases transmitted from one continent to the other went westward: smallpox, measles, typhoid, tuberculosis, cholera, diphtheria, plague—the list seems endless. These diseases, which had ravaged Europe for generations, were well beyond the abilities of European physicians. They were also the single most important cause of the cataclysmic drop in native American population. The most recent available estimates suggest that, between 1490 and 1890, the native population of the area of the 48 continental United States dropped 90 percent, from 1.9 million to 200,000 (Thornton and Marsh-Thornton 1981). Similarly, it is estimated that Australian population dropped by four-fifths between 1788 and 1933 (White 1977). The poor health status of native peoples in colonial times was a consequence of colonialism, and not a measure of indigenous health.

That native Americans or native Australians had little medical wherewithal when confronted with cancer or influenza seems a misplaced criticism. What is most

striking about non-Western medicine is how much people did with what they had. That many of the herbal remedies of the past have been supplanted by synthetic ones—many of which are, after all, modified natural products, such as, for example, aspirin—should hardly detract from the perspicacity of the original discoverers; and, as the chapters in this book, especially those by Etkin and by Elvin-Lewis, attest, there may be much more of value that we can learn from non-Western medicine to enhance the biochemical basis of modern medicine.

But, perhaps because of the relative lack of powerful specific drugs in the non-Western pharmacopoeia, it is clear that many of these peoples were far more sophisticated and far more inventive than we in manipulating the social and human dimensions of medicine. This aspect of non-Western medicine may ultimately have the most to teach us about healing. Once one recognizes that the *form* of medical treatment affects the *outcome* of treatment, one can hardly leave it to chance, any more than one can prescribe drugs (however effective) by chance. The chapters in this book demonstrate that this *is* the case, and they show some of the forms that medical treatment can take; they show as well how deeply medical systems are embedded in culture.

Human beings are simultaneously biological and cultural organisms. For physicians to achieve their goal—to optimize human health—they must be intently aware of this human duality. Our purpose is not to undercut the grounding of medicine in biology (tuberculosis *is* caused by a bacillus) but to assert that medicine has two feet, and that the other is grounded in culture (tuberculosis *is also* caused by poverty and malnutrition); moreover, and most important, these two dimensions are interconnected in many and complex ways.

As a very specific example, consider the character of medical diagnosis. Physicians, during the long years of training in which they gain their expertise, become increasingly members of the “medical subculture”—with a language, a system of values, and a conceptual framework for decision making—and, at least for a time, are separated from the arena in which they are later to be effective. Moreover, physicians must learn how to cope with the inevitable internal duality of medicine as both scientific and clinical. Whereas scientific medicine involves public research on aggregates, clinical medicine involves private treatment of individuals; the former is statistical, the latter idiosyncratic; the former is concerned with “the course of a disease,” the latter with “the history of an illness.” As clinicians confront patients, they have to mold them into categories, transforming unique constellations of experience, notions, beliefs, symptoms, and dis-ease into types, a “case of the measles,” the proverbial “liver in Room 446.” This is at best a disconcerting process. For patients, it is simultaneously clarifying and dehumanizing: whatever they “have” rules out another thousand possibilities, but the price they pay is that now they are no longer discrete sufferers, but members of a class. The loss of uniqueness is, at best, a double-edged sword.

And likewise for the physician: to diagnose is to classify and to predict a course and a treatment based on the vagaries of statistics and experience; it is to take what can always be a very serious risk. This risk has both structural and statistical dimensions. It is a structural risk in that validation is essentially derived from the response to treatment, which is temporally remote. It is a statistical risk in that "classic cases" are rare, in that medical theory must be manipulated to fit the unique characteristics of infinitely varying patients. To do this at all is to *ignore* much of what patients present and to select as *meaningful* a segment of their existence as being particularly diagnostic, that is, to ignore things that patients think are important, to dismiss some (perhaps much) of their lives as *unimportant*; this is by its nature a dehumanizing process. A mutual commitment of patient and physician to an intrinsically categorical process, an intrinsically dehumanizing process, is necessarily disconcerting; the process must inhibit people from acting in concert. And this must occur regardless of the cultural distance between physician and patient. Indeed, the experience of many physicians is that among the most difficult patients are other physicians; perhaps it is only that here the physician can more easily translate the patient's discontent—and, perhaps, less easily ignore it. This dehumanization can only be exacerbated by additional cultural differences in general education, class, ethnic origins, and so on.

Whatever else diagnosis may be, it is first a social process based on interpersonal communication between the scientifically knowledgeable physician and the concerned patient. The physician should understand why and when a person seeks medical attention, how he views his own sickness, how he reports his symptoms and interprets his feelings, and what changes in his life occur because of his illness or treatment. These factors are always influenced by the respective cultural backgrounds of patient and physician. Wide variation in patients' backgrounds and the cultural differences between doctor and patient may profoundly influence the diagnostic process and therapeutic course.

Yet if the patient cannot act in concert with the physician, how is the physician to control the course of the patient's disease? As the patient gives up his uniqueness for a diagnosis, he also gives up his independence. And his new dependence is on the physician. Dependence can take many forms. The skill with which the physician projects an appropriate, empathetic concern and strikes a responsive chord in the patient will affect the richness and utility of the interchange. If the process is to be dehumanizing, it may as well be as useful as possible. The therapeutic exchange can be so structured that the patient can develop a sense of trust and security while the physician can develop a sense of responsibility and confidence; this reciprocity can replace the prior independence and uniqueness of patient and physician. Trust and security in return for responsibility and confidence can only facilitate healing.

This relationship aside, the physician must remember that when a diagnosis is pronounced there should be no assumption that the patient understands it in the

same way as the physician does. The patient may never have heard the word before; or, if he has, it is inconceivable that he understands the term as the physician does. *And it is the patient's understanding that will influence his response to treatment*, to one degree or another.

Furthermore, there is increasing evidence that a significant group of patients, even those among the highly educated lay public, are unable to comprehend the nature of the medical information provided to give an informed consent (Tancredi, 1982). Many of these patients may simply be inattentive during the session with the physician. This attitude may reflect either that patients desire to place the responsibility for critical decisions about their care on the physician, thereby effectively waiving the requirements of informed consent, or, more likely, that, during a health crisis, patients are so distraught that they are incapable of making objective decisions concerning their medical care. The physician has to be sensitive to the many medical and emotional factors affecting the patient and make the necessary adjustments in the flow of communication to enhance the patient's understanding of the medical information that is being given.

The technique of patient interviewing can be a highly honed skill—focused, but not rigidly structured; flexible, to adjust to the patient's perhaps abnormal attitudes and behavior (he is, after all, at least by his own definition, sick), but organized to elicit sufficient pertinent information in the available time to allow the physician room to take the diagnostic risk; and so organized that the patient has an *appropriate understanding* of the diagnosis.

It is ultimately only the pathologist who can know for sure what the patient "had." By then, of course, it is too late. This is not to deny biological mortality: it is rather to assert the need for more than simply biological medicine.

This book is comprised of some twenty chapters on recent research in medical anthropology, which we believe will provide a foundation for a biohuman medical paradigm by demonstrating how culture—human belief, knowledge, and action—structures the human experience of disease, affects the ways in which *both physicians and patients* perceive and define illness, and influences the matrices of decision-making in the inevitable subcultures attempting to communicate about problems of health care.

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PART ONE

Interaction of Medical Systems

THE INTERACTIONS OF DIFFERENT MEDICAL SYSTEMS PROVIDE A FASCINATING CONTEXT for understanding the relationships between the biology and culture of medicine. In any particular case, the relative proportions of diseases, medicines, and ideas about each which are exchanged is an empirical question, but the fact of exchange is undeniable.

The exchange of ideas about medical phenomena is no simple matter. The common conceit of the West—that the benefits of scientific medicine are obvious, as are the truths on which those benefits are based—is a conceit held by all peoples regarding their own medical systems. It was as true for the bleeding and purging physicians of the last century as it is for the neurosurgeons and cardiologists of our own. These ideas, associated as they are with fundamental principles of belief about the major cosmological issues of life and death, are themselves generally very deeply held. In the United States in recent years, major political and social conflicts have raged over what can be narrowly conceived as “medical issues.” Abortion, the definition of death (or “medical death”), and the notion of “death with dignity” are all examples of such issues, where broad, deeply held beliefs influence medical matters.

A similar, and quite extraordinary, case involves the enormous social and ecological changes undergone by the Northeastern sub-Arctic Algonquian Indians in response to the introduction of European diseases (Martin 1978). Martin, in what is nominally a history of the fur trade, argues that the commercial involvement of Indians in the fur trade was more apparent than real. For a people whose essential notion of all illness was that it represented retaliation by the spirits of mistreated prey animals, the vast epidemics of European diseases (often occurring long before the Indians encountered actual Europeans) presented a serious enigma. They had not mistreated the animals; why, then, were the animals killing them? Martin’s argument is, in effect, that the Indians decided that, for unknown reasons, the animals had declared war on them. Adopting, when available, the providential armaments of the newly appearing Europeans (guns and steel traps), they fought back. The result was the Indian involvement in the fur trade, and, not incidentally, the extermination of much of the animal life of North America.

The most extraordinary aspect of this case appears in recent ethnographic accounts of the descendants of these fur traders (Tanner 1979). They are today returning to a pattern very similar to the one they pursued four centuries ago, carefully harvesting animals, with appropriate reverence and ceremony. The great epidemics of the past are, of course, gone, and (vaccinated) hunters may be as healthy as were their ancestors. The war, it seems, is over; and, after four centuries of incomprehensible social change, at least some essential notions of health for these people *are unchanged*.

The chapters in this section all focus on the ways in which the conceptual portions of medical systems change (or do not change) as a result of culture contact.

Romanucci-Ross’s discussion of medicine in Italy describes the contact of culture and subculture, and the “medicalization” of “folk” by “Western medicine”—the active attempt by official providers of health care to impose a standard structure on diagnostic and curing practices. Despite massive propaganda, and even apparent complicity—seen in repeated visits to state insurance doctors—traditional ideas of body image and dysfunction prevail. New factors embellish traditional folk notions, and metaphorical thinking yields “rational bases” for combining religious beliefs with the language and logic of science. A unified theory of health—based on an integration of a mind-body

unit linked with community and ideology—persists, absorbing on its own terms the language of the official medicine.

In Kidwell's account of the relationship between Aztec and Spanish medicine, we find that these systems exchanged a broad range of items that facilitated the identification and cure of a variety of diseases. Indigenous plants were used by the conquerors for the diseases they found in the New World; more problematical for the host populations were the diseases brought to them. Analysis of the Spanish and Aztec sources from the period can isolate features of the cross-cultural transactions in cognition. Upon what bases could the exchange of information occur? In this case, herbal medicine became a primary focus of exchange. Even though the Spanish had the Galenic binary structure of "hot" and "cold," whereas the Aztecs classified plants by their uses, both groups found plants useful as food, medicine, and ornament. Aztec epidemiology and pharmacology fused with Greek and Galenic views; in time, the Mexican folk-medicine system emerged, perhaps the most fully syncretic medical system known.

As the Spanish incorporated Aztec medicines into their conceptualization of medicine, the Ningerum of New Guinea are shown by Welsch to be incorporating Western medicine into their system. Western medicine plays a complementary rather than a competitive role, and Welsch sees the emergent system as integrative. Looking at the distribution of therapeutic knowledge and expertise in the Ningerum community and the locus of diagnostic and therapeutic decision making, this process is placed in Watson's (1980) broader social theory of "consensual complementarity." Welsch demonstrates that the *process* of syncretization, as well as the resultant system, can be documented, if one can talk with individuals to assess motivation and thereby specify the operation of belief in individual instances.

The Ostriak of Siberia have had a rather different response to the external alteration of their medical culture, under the pressure of Soviet antireligious and public-health programs. Here we find the original *shaman*, a prototype used by many anthropologists to describe curers in other cultures. The Ostriak differentiate three different kinds of practitioners: the family *shaman*, a sort of general practitioner; the trance *shaman*; and the "big man," whose spiritual travels take him far and wide. The *shaman's* patient is a colleague in the medical event and helps by confessing wrongdoing; cure comes through abreaction and transference. Since the entire community participates in the process, this is a sort of community-mental-health approach to individually focused group therapy. In this case, a deliberate attempt by the Soviet authorities to extinguish this indigenous system has succeeded to the degree that the systems have developed an antagonistic, rather than complementary or syncretic, relationship. During collectivization in the 1930s, *shamans* were characterized as "deceivers"; the campaign was successful enough that they are now characterized by many as "drunks," capable of doing evil. This example matches the traditional notion of "acculturation": Ostriak notions of health today generally mirror those of the larger Soviet public-health movement. Even such distinctive aspects of the traditional system as the manipulation of altered states of consciousness are now widely disparaged.

These cases, then, represent a wide range of medical interaction. If the Mexican case represents a fully syncretic system, the Siberian case represents a more nearly acculturated one. If the Ningerum case represents an emerging syncretism, the Italian case represents a stable, unshakable one. Exactly what determines the ultimate outcome

of the interaction of medical systems is not yet clear. However, it *is* clear that this interaction is a complex and difficult one, not susceptible to facile prediction.

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