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0521277868 - *Illness and Culture in Contemporary Japan: An Anthropological View*

Emiko Ohnuki-Tierney

Excerpt

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1 Introduction

This is a book on the contemporary health care system in urban Japan. It is not, however, the usual social science study containing only “facts” and statistics. Nor does it present cures for specific illnesses or descriptions of the effectiveness of certain herbs. Instead, it focuses on a culturally defined concept of hygiene, urban magic, deities and buddhas as medical doctors, and family involvement in the care of the sick, as well as clinics and hospitals. The book consists of descriptive data and my interpretations of the sociocultural patterns underlying the concepts of illness and health and the health-related activities of contemporary Japanese. The book illustrates that, despite industrialization and significant advances in modern science, including biomedicine, in contemporary Japan, Japanese concepts and behavior regarding health and illness are to a large extent culturally patterned, even when they are couched in biomedical idioms.

A latent but more ambitious aim of the book is to lay the groundwork for a future undertaking: the critical appraisal of some of the assumptions made in the social sciences about the effects of modernization on a culture and society. Data about the health-related behavior of contemporary urban Japanese, as presented in this book, challenge the view held by some social scientists that modernization produces a “rational” individual whose behavior loses symbolic dimensions. For this larger aim, then, the choice of the modern Japanese health care system as a subject for study is a strategic one. The contemporary Japanese are a non-Western population among whom both industrialization and the development of science have reached a high degree. Nevertheless, their thought patterns and behaviors are deeply symbolic; they are not simply “rational” or “utilitarian” in nature.

This book, then, attempts to make a contribution not only to the fields of anthropology called ethnomedicine and symbolic anthropology, respectively, but also to an understanding of Japanese culture. It provides an interpretation of Japanese culture and society based on examination of the health-related activities and beliefs of the Japanese.

The book consists of two parts. Part I describes daily hygiene practices and

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beliefs of ordinary people, as well as their concepts of health, illness, and related matters. Part II describes the various medical systems practiced today. The purpose of describing these systems is twofold: First, to illustrate how each system is embedded in Japanese culture and society; and second, to present a descriptive model of a pluralistic system of medicine, in which several systems of health care exist side by side within a single society – a pattern common to many societies of the world.

The primary emphasis in this book is on day-to-day health care, including daily hygiene and relatively minor illnesses. Except for a brief discussion in Chapter 3, serious illnesses do not receive an extensive treatment. This emphasis should be kept in mind in reading the book.

Throughout the book, I have labeled thought processes and behavioral patterns as “Japanese” or “urban Japanese,” but these labels are not intended to mean that the patterns, taken individually, are unique to Japanese. For example, cultural sanctioning of illness (Chapter 3) is found among other peoples, including American Jews and Italians (Zborowski 1952), and a Catholic priest praying for the recovery of the sick in the United States is not too dissimilar from a Buddhist priest reciting a sutra for the sick (Chapter 6). To give another example, the continued care by the family of hospitalized patients (Chapter 9) is a common practice among many peoples with strong emphasis on kinship or human relationships in general, including many African peoples, and among Westerners, Italians. Folk cultures in the United States are just as rich in symbolism as they are among the Japanese described in this book (see Summary).

Thus, the various “Japanese features” described in this book are not uniquely Japanese, when taken separately. The uniqueness that distinguishes Japanese culture from other cultures emerges with “a unique combination of factors which are not unique in themselves” (Vansina 1970:177). A systematic examination of “historical regularities” is often useful in demonstrating the uniqueness of a particular culture (Vansina 1970). I have therefore explored the historical background of certain aspects of contemporary Japanese health care. Without a more systematic examination of the history of Japanese culture and a broader coverage of Japanese culture, however, the book can only suggest how culture patterns the health-related behavior and concepts of contemporary Japanese.

Although the book is basically comparative in perspective, it by no means presents a systematic comparison. Only passing references are made to beliefs and practices in the United States in order to provide some basis for comparison for those familiar with health care systems in the United States. In addition, the book is not aimed at a highly specialized audience. More specific critiques of anthropological approaches to medicine (the field of so-called medical anthropology) and of theories of symbolic anthropology are presented in an earlier work, *Illness and Healing among the Sakhalin Ainu: A Symbolic Interpretation*

(Ohnuki-Tierney 1981a). Since this book is addressed to people interested in medical anthropology, as well as to those interested in symbolic anthropology and Japanese culture, there are sections that may be essential but not directly tied to health-related issues. For example, one section in Chapter 2 discusses early world view and the classification of people. It is included because it is vital to understand that categories of thought operative in the medical domain are related to thought governing other domains of Japanese culture, and that these categories show historical continuity. The details in these sections may be meaningful to the reader interested in Japanese culture; for others, only the main thrust of the argument may be significant.

The basic approach of the book

After professing not to address a specialized audience, I must briefly engage in a somewhat technical discussion here in order to explain my basically symbolic approach. I use the term *symbolic* broadly, and my approach is closest to that of Sahlins (1976:55) when he stated that “human action in the world is to be understood as mediated by cultural design, which gives order at once to practical experience, customary practices, and the relationship between the two.” This approach, which he calls the cultural paradigm, contrasts with the praxis or utilitarian paradigm, which sees cultural order “to be conceived as the codification of man’s actual purposeful and pragmatic action.” I use the term *symbolic* in order to emphasize the cultural paradigm, since “cultural” has been too commonly and broadly used in anthropological literature to carry any specific meaning.

The main focus of the book, then, is the conceptual structure or categories of contemporary Japanese thought, using some historical perspective. I examine health-related practices and concepts from the perspective of how they are organized according to the “logico-meaningful” structure of the culture. This approach contrasts with the approach that emphasizes the “technical” or “causal-functional” integration of acts and objects (Peacock 1975:4) – the approach that approximates the praxis paradigm of Sahlins and is frequently used by biomedically oriented medical anthropologists.

In a technical sense, “symbol” should be reserved for situations involving metaphors. Strictly speaking, an object, a phenomenon, and the like becomes a metaphor when it stands for another object, phenomenon, and so on through its connotative meaning, while the designative, or literal, meanings of the two belong to two separate semantic categories (Basso 1979). Using “symbol” more broadly, I follow Geertz (1973: 91), who explains: “It [symbol] is used for any object, act, event, quality, or relation which serves as a vehicle for conception – the conception is the symbol’s ‘meaning.’ . . .”

By choosing this definition of symbol, anthropologists do not confine themselves to an examination of formalized and/or religious rituals alone. In fact, the approach obliterates the distinction between secular and sacred ritual. Every behavior, object or phenomenon, be it in a temple or a factory, is subject to examination for its symbolic dimension (for an excellent theoretical explication of “ritual,” “symbol,” “meaning,” and “categories of cognition,” see De Craemer, Vansina, and Fox 1976; for a detailed discussion of “secular” versus “sacred” ritual, see Moore and Myerhoff in Moore and Myerhoff 1977).

Anthropological approaches to health care systems

Until fairly recently, anthropologists often failed seriously to consider such cultural institutions as witchcraft and sorcery and shamanistic healing practices as parts of the medical systems of their host societies. Instead, these were seen primarily as magicoreligious practices, or as methods of social control. This lack of recognition of the actual medical systems of host societies seems to reflect a not-so-surprising cultural bias among anthropologists, who are now increasingly aware of the fact that they cannot entirely escape their own cultural and personal biases in their attempts to record and understand other societies. As Carstairs (1977:1) points out, it might be true that even for anthropologists, the advancement of scientific medicine was “of such compelling importance that traditional concepts of illness seemed positively irrelevant.”

In recent years, biomedicine has clearly failed to live up to its almighty image, even in the Western societies where it originated. Public demand for alternative health care has placed considerable pressure on the medical profession. Medical anthropologists have been assigned the role of providing information on alternative medical systems elsewhere in the world, especially in the Third World. As a result, there is a growing body of anthropological literature on medical systems in other societies. The majority of anthropological writings, however, are about “folk medicine,” either in nonindustrialized sectors of the Third World or among “ethnic minorities” and rural populations in industrialized nation-states.

The work of medical anthropologists, then, follows an anthropological tradition – providing a sympathetic account of folkways, of which the medical system is a part. These folk systems are usually not institutionalized, and their practitioners, such as shamans, are not professionalized. There are as well a few studies of institutionalized nonbiomedical traditions, such as *kanpō* (Chinese-derived medicine) in Japan, Chinese traditional medicine in Taiwan and the People’s Republic of China, and Āyurvedic, Yunāni, and homeopathic medicines in India. Most of these studies deal with medical systems of societies that are not in the forefront of the industrial or postindustrial sectors of the world.

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In short, little exists in the way of a comprehensive overview of medical systems in a society comparable to some of the Western industrialized nation-states. This book, then, is intended to fill the gap in available publications by describing the medical systems of contemporary Japan, whose society is modernized in every sense of the word, and yet whose medical systems in many ways present striking contrasts to those of Western societies dominated by the biomedical tradition.

The book is not, however, intended to provide answers to the problems of medical systems in the United States or elsewhere. Since medical anthropology, at least in part, has grown out of dissatisfaction with biomedicine among the general public, many anthropologists feel, either implicitly or explicitly, that their task involves helping to solve the problem by presenting ideas for alternative health care. This trend has two unfortunate consequences for the rigorous theoretical development of medical anthropology as a field. First, the medical system under study often becomes idealized to suit the image that both anthropologists – who often are romantics – and lay people look for. Second, in order to legitimize their quest, anthropologists sometimes resort to simplistic medical positivism – proving “medical efficacy,” for example, by presenting the chemical constituents of a few herbs, and thereby elevating the medical system in toto to scientific legitimacy. Legitimacy may also be based on how their system, as opposed to ours, meets the needs of “individuals,” as defined and perceived in a Western society.

As Lewis (1981) chides, anthropologists become shamans who journey to distant realms “in search of enlightenment and knowledge” which, upon acquisition, they transmit to the people for their salvation. Unfortunately, this “what can we learn from them” approach often results in anthropological work that falls short of total understanding, since the utilitarian questions predispose the anthropologists to emphasize only those features of the culture that are directly relevant to the questions.

My goal in this book is to understand and describe the specific medical systems and general health care system of contemporary Japan, and to demonstrate how they are embedded in the Japanese sociocultural milieu – especially in their value systems and their patterns of interpersonal relationships. Indeed, if there is a message at all, it would be that the importation of any alien medical system is not a simple process; any imported medical system goes through a profound transformation in the recipient culture before it becomes a viable cultural institution.

Another goal of this book is to contribute to our understanding of medical pluralism. In recent years, a number of publications on medical pluralism in the Third World have appeared. Many of them focus on the problem of how people in a society with plural systems of medicine choose among the options available to them. Romanucci-Ross (1977) describes the strong competition between in-

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indigenous and biomedical systems among the Admiralty Islanders, and discusses how the people choose between them. In Lieban's work (1977) on sorcerer-healers among lowland Christians on the Philippine Island of Cebu, the decrease in the importance of sorcery is attributed to the modernization process. Press's (1978) work in Seville also points to the decline of folk medicine, as biomedicine, through its burgeoning bureaucracy, has expanded its roles to include a wide range of functions beyond the simple amelioration of symptoms. Janzen's work (1978), on the other hand, indicates that medical systems in Zaire fulfill not competitive, but complementary roles. Several other studies show that indigenous healers can remain viable or even successful, through skillful role adaptations, in a modern urban environment (see Landy, ed. 1977).

In some anthropological studies, indigenous medicine and biomedicine are often seen as distinct systems, or at least described as such, and the patient must choose between them in order to maximize his or her goal of obtaining the best health care available. Such studies often involve a situation in which Indian or black African medicine with "native healers" is juxtaposed against white people's biomedicine, administered by white doctors or native doctors trained by white doctors. Many such societies studied by anthropologists are former European colonies, adding the important negative factor of antagonism between the native medicine and biomedicine. Furthermore, except in a few cases, such as those of Lieban and Press, the studies often deal with remote rural areas of the Third World, where indigenous medicine is usually neither institutionalized nor professionalized. Thus, aside from the very brief overviews of Indian and other Asian medical pluralism by Leslie (1974, 1975, 1976), we have few ethnographies of medical pluralism that deal with urban medical systems that are institutionalized and professionalized.

Some of the inferences of these studies are misleading, since they depict a pluralistic system of medicine as consisting of several independent systems. This picture is inaccurate in most cases because within a given society, all the medical systems interact closely and are transformed through the interaction. Biomedicine, for example, which has been introduced to almost every society in the world, acquires a distinct form and color in each recipient society because it is transformed by the sociocultural milieu of that society, a milieu that includes other medical practices in the society. Part II of this book describes how the different medical systems in contemporary urban Japan complement and interact with one another. The more general aim is to provide a descriptive model of a pluralistic system of medicine in a modern society. The mechanism for successful coexistence is traced to a thorough patterning or embedding of each medical system in the Japanese sociocultural milieu.

As a work in ethnomedicine, this book presents a sociocultural analysis and interpretation of health, illness, and medical treatment among the Japanese.

Useful for an understanding of the ethnomedical approach taken in this book is the distinction between illness and disease made by Fabrega, who uses the term *illness* to refer to a socioculturally defined departure from health (see also *cultural disease* in Obeyesekere 1976), and *disease* as a category defined in biomedicine. Fabrega (1975:971) explains that “biomedical diseases are defined on the basis of deviations and malfunctions of the chemical and physiological systems of the body and any number of processes and structures can be implicated in disease.” He emphasizes that biomedically defined disease is “an abstract biological ‘thing,’ ” divorced both from the human individual who suffers from it and from the sociocultural milieu (Fabrega 1975:969). This distinction is useful in clarifying the basic difference between the ways disease is defined in biomedicine and illness is defined in other cultures. Nevertheless, I concur with Stein, who claims that the concept of disease in biomedicine in itself reflects cultural bias: “The mechanical-biological, pathogen-specific or organ-specific disease *is* the illness” (1977:15, italics in the original). My concern in this book is cultural germs and cultural illnesses, which never precisely correspond to microbes or diseases as defined in biomedicine.

In describing the way in which the Japanese manage health and illness, I prefer the phrase “health care system” to “medical system.” The former covers a broad range of practices, including management of the body, beliefs about health maintenance, and both formalized and nonformalized medical treatments. The phrase “medical system,” on the other hand, implies formalized medical treatments only, often excluding nonformalized systems such as healing at temples and shrines or healing by shamans.

Following Dunn (1976:135), many medical anthropologists prefer the term “cosmopolitan medicine” to “biomedicine,” which I chose for this book, as well as such other labels as “Western medicine,” “scientific medicine,” and “modern medicine.” Although I agree that biomedicine is cosmopolitan in distribution, I chose to use biomedicine in order to emphasize that the theories and practices of biomedicine undergo transformations in each recipient society; I avoided the possible inference from cosmopolitan medicine that this form of medicine, practiced in most societies of the world, is identical wherever it is practiced.

Scope of the book

Daily hygiene is basic to the understanding of any health care system, and yet it is rarely covered in anthropological literature. Chapter 2 provides a detailed description of Japanese daily practices and beliefs. This chapter, entitled “Japanese Germs,” best illustrates my own sociocultural or symbolic approach to the Japanese health care system. I argue that daily hygienic behavior and its

underlying concepts, which are perceived and expressed in terms of biomedical germ theory, in fact are directly tied to the basic Japanese symbolic structure. Contemporary concepts of dirt and cleanliness derive from symbolic notions of purity and pollution, which have been basic themes of Japanese symbolic structure throughout history. The same symbolic structure that generates the concepts of purity and pollution also governs the classification of space, time, and people.

Just as germs are culturally defined, so are illnesses, as described in Chapter 3, “My Very Own Illnesses.” In addition to describing Japanese illnesses, this chapter also examines Japanese attitudes toward the body and death. These descriptions reveal that the Japanese are “indulgent” in recognizing and caring for relatively minor illnesses. The cultural sanction of illness is explained within the dualistic world view of the Japanese, in which both good and evil, like health and illness, exist in complementary opposition.

Chapter 4 explains a prominent and important feature of the Japanese concept of illness; that is, the Japanese attribute causes of illnesses to objects and phenomena, such as nerves (in a physical sense), blood types, and aborted fetuses – a type of causal logic called *physiomorphism*, or *somatization*.

Part II, consisting of six chapters, describes the pluralistic system of medicine in urban Japan in the postindustrial era. It begins with a description in Chapter 5 of *kanpō* medicine, introduced from China by the sixth century. Basic theoretical premises of *kanpō* diagnosis and treatment are contrasted to those of biomedicine in order to demonstrate that the two systems, which the Japanese use simultaneously, are in fact diametrically opposed in their basic approaches. After an examination of the causes of its enormous popularity in recent years, *kanpō* is described in its various forms and at the several levels at which it is delivered: by biomedical doctors, by licensed paramedics, by priests and nuns at temples, by pharmacists and drugstore sales personnel, and by people in their own homes. *Kanpō* is indeed omnipresent in Japan, available not only as a highly professionalized medicine, but also as a part of daily health care, often in forms unrecognized by the people themselves.

The succeeding two chapters discuss the role of religions in health care. In Chapter 6, two case studies illustrating the use of shrines and temples are presented to demonstrate the importance of religions in contemporary Japanese health care. Chapter 7 examines the past and present “medical specializations” of Japanese deities and buddhas. A certain buddha or a deity, for example, may be known for healing children’s illnesses, while another is known for illnesses of the ear. In contemporary Japan, just as in the past, some of these supernaturals serve as pediatricians, gynecologists, or general practitioners. The difference between past and present practices is that the contemporary Japanese no longer formally acknowledge the medical role of religions, despite the fact that they still resort to them. An examination of the medical functions of these superna-

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naturals in a historical perspective is also meant as a contribution to the current controversy among scholars of Japanese culture over whether or not various religions (Buddhism, Shintoism, Taoism, and folk religions) constitute a multilayered structure or a single fused structure.

The next two chapters are devoted to a description of biomedical health care in Japan, with primary emphasis on its transformation within the Japanese sociocultural milieu, which renders it quite different from the way it is practiced in other countries. Chapter 8 starts with a brief history of the development of the medical profession in Japan to illustrate how the profession of biomedical doctor today is in large measure a product of history. After an overview of the current biomedical profession, the remainder of the chapter is devoted to descriptions of visits to doctors' offices and clinics. The absence of an appointment system at Japanese clinics and hospitals, the spatial arrangement of the examination room, the use of "surrogate patients" (someone representing a patient in the doctor's office), and various other aspects of visits to doctors' offices and clinics are interpreted against the background of Japanese culture and society. In the last section of the chapter, pregnancy and childbirth are described to illustrate how biomedicine is combined with traditional religious beliefs and practices.

The hospitalization process is evaluated in Chapter 9. The feeding of the patient by the family and visitors, despite the provision of three meals by the hospital, the extensive visitation allowed by most hospitals, and the gifts brought by visitors are all examined in relation to the values assigned to the state of illness and to the Japanese codification of the patient role. The chapter ends with a case study of the actors involved in the human "drama" of hospitalization, to complement earlier sections that emphasize hospitalization as a cultural system.

Chapter 10 concludes Part II by drawing together the information on pluralistic systems to seek the mechanisms that have sustained and promoted the successful coexistence of medical systems with quite distinct basic approaches. The success of the pluralistic system lies in the thorough embedding of each system in the Japanese sociocultural milieu. Further analysis of biomedicine, introduced only about a hundred years ago from the West, is undertaken to illustrate this point.

Although each of the medical systems, formalized and nonformalized, has always had its own place in the pluralistic system, there have been clear fluctuations in the popularity of each system. These shifts in popularity can be roughly charted through the developmental stages of Japanese society from the premodern to the modern postindustrial period. In order to avoid a simplistic explanation for the shifts in popularity, I seek factors responsible for the phenomena other than the narrowly defined medical efficacy of any given system. I attempt to link the phenomena to broader perspectives such as the Japanese world view and, in particular, the Japanese view of the collective self in relation

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to the outside world. The brief Summary discusses the effect of modernization on the symbolic dimension of human behavior. It presents a critical commentary on anthropological theories of modernization and the so-called primitive versus civilized mentality.

I omit traditional folk medicine (*minkanyaku*) and the medicine of contemporary popular culture, both of which are mentioned briefly in Part I. Also excluded from the present treatment are two types of massage (*anma* and *shiatsu*) and various other folk practices, some of which are popular versions of *kanpō*. A comprehensive treatment of nonformalized medical systems should also include dietary practices, as well as the use of baths and hot springs, and various other cultural practices. Indeed, hot springs are still used extensively for medical purposes, with each hot spring considered beneficial for the treatment of particular illnesses. Home manuals on medicine often have extensive lists of famous hot springs all over Japan and describe the medical efficacy of each (see Ariyoshi, ed. 1978). In fact, almost all cultural practices have some medical dimension, so that an exhaustive treatment of nonformalized medicine would have to examine all aspects of Japanese culture – an impossible task. Here I confine myself to a description of three medical systems: *kanpō*, religious systems, and biomedicine.

Fieldwork and methodology

When I initially conceived the plan for an ethnomedical study in Japan, I planned to conduct research on the health care system in a city rather than in a rural area. Japanese rural communities are rapidly being engulfed by urbanization, and they are also experiencing depopulation as younger people are drawn into cities. I envisioned my research as somewhat similar in methodology to a highly celebrated work by Dore (1973) based on the study of a ward in Tokyo. However, as several Ph.D. dissertations by young anthropologists on Japanese ethnomedicine started to appear, I realized there was no overall study of contemporary urban health care in Japan to provide a broader perspective for these microstudies.

When I began my fieldwork in 1979 in the city of Kobe in western Japan, it immediately became apparent that the artificial municipal boundary of the city was totally irrelevant in the health care of the people; the Keihanshin area thus became the unit for the study. Keihanshin is a term comprised of the initial characters of the three principal cities in the area – Kyoto, Osaka, and Kobe. In many ways, the three cities are very different from each other. Kobe, the smallest of the three, had a population of 1,366,397 in 1977 (Kōbe-shi Eiseikyoku, ed. 1978:2). Although its economic development since World War II has been slow due to a lack of industries, the city has been characterized by a unique international flavor since the opening of Kobe harbor in 1868, the first year of the Meiji Restoration. The harbor brought numerous foreign visitors to the city,