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# Medical anthropology and the problem of belief

Part of the special delight of being invited to give the Morgan Lectures was the opportunity it afforded me to read the work of Lewis Henry Morgan and be reacquainted with his life. Though largely remembered for his masterful ethnography of the Iroquois and his technical kinship writing, Morgan was no stranger to what we might now call applied anthropology. For Morgan, scholarship and activism were closely linked. During the 1840s, when the rapacious Ogden Land Company sought to deprive the Seneca of their land – as Morgan wrote, “[they] pursued and hunted . . . [the Seneca] with a degree of wickedness hardly to be paralleled in the history of human avarice . . .” (quoted in L. White 1959: 4) – Morgan rallied local citizens to the cause of the Indians, and carried the fight to the United States Congress. In recognition for his service, he was adopted by the Seneca, made a member of the Hawk clan, and given the name Tayadaowuhkuh, or “one Lying Across,” or “Bridging the Gap,” “referring to him as a bridge over the differences . . . between the Indian and the white man.”

Morgan’s commitment to utilize his knowledge of the Seneca in their behalf has special meaning for medical anthropology. But it is not simply his activism that lends relevance to his work. Morgan played a crucial role in carving out kinship as an analytic domain, and the conceptual problems he faced were similar in intriguing ways to those which face medical anthropologists. Robert Trautmann, in his fine book on Morgan’s “invention of kinship” (1987), notes that it may sound odd today to speak of the “discovery” of kinship, since aspects of family and kin relations are everywhere present and part of everyday experience. In reality, Trautmann argues, precisely this everyday quality of kin relations made them resistant to analysis.

. . . the provisions of the kinship system are everywhere attributed to some immanent order, whether of Nature or of God or some other, which gives it the transparency of that which constitutes “the way things are.” Like the air we breathe, it is all around us and we cannot see it. Kinship had to be discovered, and it was discovered through the discordant, noncommonsensical kinship of the cultural other. (Trautmann 1987: 3)

For Morgan, a practicing lawyer, it was his finding, to his great astonishment, that the Seneca attribute descent and prescribe the inheritance of property and office

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so differently than we do – that is through females only – that served to “denaturalize” kinship as a domain and “make it available to consciousness” (Trautmann 1987: 4). And it was based upon this recognition that Morgan designated kinship as a *cultural domain*, an aspect of human societies having coherence and structure and thus a domain for systematic research and analysis.

Those of us who would turn anthropological attention to disease and illness face an analogous problem. The elements of observation are readily at hand – in our own encounters with fevers and pains, chronic medical conditions, or life-threatening diseases, and in our experience of the suffering of others. And although we commonly recognize personal and cultural differences in beliefs about disease or in what medical sociologists have called “illness behavior,” the sense that disease itself is a cultural domain is strongly counter-intuitive. Disease is paradigmatically biological; it is what we mean by Nature and its impingement on our lives. Our anthropological research thus divides rather easily into two types, with medicine, public health, and human ecology providing models for the study of disease and its place in biological systems, and social and cultural studies investigating human adaptation and responses to disease. It takes a strong act of consciousness to denaturalize disease and contemplate it as a cultural domain.

From the perspective of the late twentieth century, it is difficult to appreciate fully the conceptual problem which Morgan faced in the study of kinship and the human family. It is easy today to be relativist when we consider aesthetics or philosophy or child-rearing in other societies, recognizing that others may have more profound or more interesting ways of understanding the world and organizing social life than we do. Kin systems are part of this social order, and with the important exception of our assumptions about the prohibition of incest, diversity of family relations seems only appropriate, given the distinctive forms of life in which they are embedded. For the Victorians, quite the opposite was true. The Victorians felt the family to be closely linked to the natural order, both biological and moral. Other forms of accounting kin and forming families were felt to be unnatural, abhorrently so.

If we contemplate for a moment our own views of medicine, we may recognize more easily what Morgan faced in his efforts to rethink the human family. We all know, of course, that medical knowledge has advanced rapidly over the past century, that it is progressing at a nearly unimaginable speed today. And we have little doubt that the medical sciences tell us with increasing accuracy about the human genome or the cellular contributions to disease – that is, about human biology, about Nature. This knowledge has yielded ever more powerful therapeutics and resulted in longer and healthier lives. As a consequence, we face a moral imperative to share that knowledge, to provide public health information to those whose beliefs serve them poorly as a basis for healthy behavior, in particular to provide broad public health education for societies with high rates of infant mortality, infectious diseases, and other scourges prominent in populations which have undergone neither the demographic nor educational revolution.

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Our views of medicine serve as an apt analogy to Morgan's understanding about the achievements of Victorian society and the family as a dimension of it. Societies are progressive. Change results from increasing knowledge of the order of Nature and increasing conformity of society to that knowledge. Progress occurs through accumulating practical and scientific knowledge, or as Morgan wrote, "man commenced at the bottom of the scale and worked his way up to civilization through the slow accumulations of experimental knowledge" (in Trautmann 1987: 173). For the Victorians, their system of family relations was felt to be such an achievement, a highly evolved realization of the natural order. We in the twentieth century conceive medicine to be a similar achievement.

Morgan was thus confronted with a difficult interpretive dilemma when he found that the Iroquois, whom he so admired, conceived family relations in a manner considered immoral and abhorrent by his contemporaries. His response, ultimately, was to reconceptualize kinship – not simply as a part of Nature, but as a social and cultural domain – and it is in this sense that he "invented" kinship. In developing his analysis, Morgan distinguished "descriptive" kin terms, cultural categories which correctly reflect natural blood relationships, from "classificatory" terms, which do not, thus shaping a debate which has been carried on in kinship studies since that time.

In the course of these pages it will become clear that similar issues are central to the comparative study of illness and medical knowledge. In particular, it is difficult to avoid a strong conviction that our own system of knowledge reflects the natural order, that it is a progressive system that has emerged through the cumulative results of experimental efforts, and that our own biological categories are natural and "descriptive" rather than essentially cultural and "classificatory." These deeply felt assumptions authorize our system of medical knowledge and, at the same time, produce profound difficulties for comparative societal analysis. Just such difficulties lie at the heart of the conceptual problems of medical anthropology. Although evolutionist thinking about kinship systems is hard for us to intuit, making Morgan seem very much a nineteenth-century figure, thinking of systems of medical knowledge as analogies to kin systems makes it clear that the issues raised by Morgan are alive today. Our convictions about the truth claims of medical science rest uneasily with our recognition of our own historicity and our desire to respect competing knowledge claims of members of other societies or status groups. Indeed, the confrontation between the natural sciences and historicism – the view that all knowledge is unavoidably relative to historical context – has been the central issue of philosophy, the sociology of knowledge, and historical studies of science for much of this century. Within anthropology today, I would argue that medical anthropology is the primary site in which these issues are being addressed and investigated.

While studies in medical anthropology share many philosophical issues with kinship studies, including such epistemological dilemmas, they also open onto quite distinctive domains. It was Morgan's great contribution to recognize the extent to which premodern societies are organized in terms of kinship rather than

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property relations, thus placing kinship studies at the heart of all studies of social organization. While this analysis is also relevant to social and cultural studies of medical systems, medical anthropology has unique concerns with issues of biology and culture, with human suffering and ritual efforts to manage disorder and personal threat, and thus with the investigation of human experience and the existential grounds of culture. These, as well as the philosophical issues at stake in cross-cultural studies of disease and health care, will be central to the discussion to follow.

In the 1960s, it was something of an embarrassment to be identified as a medical anthropologist. Medical anthropology was largely a practice discipline in those days, shaped by a group of pioneering anthropologists – Benjamin Paul, George Foster, Charles Erasmus, Hazel Weidman, and others – committed to putting anthropology at the service of improving the public health of societies in the Third World. Social theory was largely peripheral to this discipline, and given the splendid debates among structuralists, ethnoscientists, symbolic anthropologists, linguists, and ethnolinguists, all committed to rethinking cultural studies, medical anthropology seemed a kind of poor cousin. Since that time there has been an explosion of interest and activities in this field. In 1957, Ben Paul assembled the names of 49 American anthropologists with experience in public health; today there are more than 1,700 members of the Society for Medical Anthropology. More importantly for its place in the field, the diverse issues that concern medical and psychiatric anthropologists have moved ever closer to the center of the discipline, and have become ever more prominent in the social sciences and humanities at large. Discussions of culture and representation have increasingly turned to the analysis of illness representations, from popular medical knowledge to social representations of diseases such as AIDS (see Farmer and B. Good 1991 for a review). Medical institutions have become key sites for the analysis of power and domination, and feminist studies have drawn on medical phenomena to explore the gendered representation of women's bodies, birthing and reproduction, and the relation of these to changes in the division of labor.<sup>1</sup> Theoretical and applied work, though still in tension, increasingly nourish one another, and vigorous theoretical debates have developed, which have relevance throughout anthropology. Indeed, as I will argue, current concerns in medical anthropology today and the phenomena to which it attends have the potential to play a special role in revivifying aspects of our larger discipline.

Over the last decade, my own work – much of it carried out in collaboration with my wife, Mary-Jo DelVecchio Good – has addressed the theoretical and substantive issues in medical anthropology in ways which frame the questions addressed in the Morgan Lectures. First, I have attempted to situate medical anthropology in relation to a set of philosophical debates about the nature of language, subjectivity, and knowledge.<sup>2</sup> I have argued that our philosophical presuppositions, whether explicit or implicit, play an important role in formulating the research program in our field. And I have tried to demonstrate that

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medical anthropology provides an extremely interesting vantage from which to address these very debates.

More specifically, I have explored the idea that a view of scientific language as largely transparent to the natural world, a kind of “mirror of nature,” which has been an important line of argument in philosophy since the Enlightenment, has deep affinities with biomedicine’s “folk epistemology” and holds a special attraction for the medical behavioral sciences. I have argued, however, that this conception of language and knowledge, referred to in our writings as the “empiricist theory of medical language,”<sup>3</sup> serves poorly for either cross-cultural research or for our studies of American science and medicine. Those who employ it are led to formulate problems in terms of belief and behavior, and often reproduce our common-sense views of the individual and society. After years of teaching and carrying out research in medical settings, I am more convinced than ever that the language of medicine is hardly a simple mirror of the empirical world. It is a rich *cultural language*, linked to a highly specialized version of reality and system of social relations, and when employed in medical care, it joins deep moral concerns with its more obvious technical functions.

In place of a medical social science focused on belief and behavior, a number of medical anthropologists have pursued theoretical and analytic studies more in keeping with this view of medical language, giving special attention to illness meanings and experience. My own work has advanced a view of illness as a “syndrome of experience,” “a set of words, experiences, and feelings which typically ‘run together’ for members of a society” (B. Good 1977: 27). Drawing on research on popular illness categories in Iran and from American medical clinics, our work has explored the diverse interpretive practices through which illness realities are constructed, authorized, and contested in personal lives and social institutions. In this view, what philosopher Ernst Cassirer called “the formative principles” by which life worlds are constituted and organized become a predominant focus of attention.<sup>4</sup> Such a perspective requires an understanding of language and experience counter to that in much of the medical social sciences, and frames a quite different set of issues.

Medical anthropology has thus come to be a site for joining debate of critical social, political, existential, and epistemological issues. To use a metaphor suggested to me by Amélie Rorty, medical anthropology has become our discipline’s “London,” a metropole where diverse voices engage in substantial matters of the day. Many of the central concerns of anthropology are clearly present in the issues we face – the role of the biological sciences as both instrumental reason and soteriology in contemporary civilization; the efficacy of symbolic practices in the constitution of experience and the production and reproduction of social worlds; the human body as both the creative source of experience and the site of domination; and efforts to place renewed understanding of human experience at the heart of our discipline. The Morgan Lectures, and their elaboration in this text, were conceived as a contribution to this larger project.

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The view of medical anthropology I have briefly outlined here has been criticized from several perspectives in recent years. For example, in an essay published in *Current Anthropology* in 1988, Carole Browner, Bernard Ortiz de Montellano, and Arthur Rubel argue that the excitement generated by medical anthropology in the early 1970s and its hope for “uniting theory and practice in a new health science at once cumulative, comparative, integrative, and methodologically sound” has gone largely unfulfilled. Instead, they argue, medical anthropology has followed a “particularistic, fragmented, disjointed, and largely conventional source.” Citing specifically the work of Allan Young, Byron and Mary-Jo Good, and Arthur Kleinman, they go on: “This is because most medical anthropologists are mainly interested in issues of meaning and in the symbolic and epistemological dimensions of sickness, healing, and health . . . ” (p. 681). They conclude their indictment (p. 682) with a quote from Professor Joseph Loudon, a physician and anthropologist:

A supposedly empirical discipline which gets unduly concerned about epistemological worries is in danger of losing its way. . . . there are certainly some aspects of social anthropology [including at least some areas of ethnomedicine] where external categories of more or less universal reference are available which, if used with reasonable caution, make possible comparative analysis over time and space. . . .

Following this critique, Browner and her colleagues outline a research program for medical anthropology, counter to the “meaning-centered” approach, that focuses on “cross-cultural comparative studies of human physiological processes,” which are “essentially the same species-wide” and can serve as external referents necessary to prevent cross-cultural research from degenerating into pure relativism.

This essay represents a current debate within medical anthropology. It should be clear already, however, that it points toward much more fundamental issues. At stake is not only the question of the place of biology in the program of medical anthropology, a question I take very seriously, but a critique developed within medical anthropology over the past decade of biomedicine and the research paradigm of the behavioral sciences of medicine. At stake also are various debates in anthropology today about how we conduct cultural studies and ultimately about what kind of human science anthropology should be. And lying beneath these debates are opposing views of how historicism – the view that “human understanding is always a ‘captive’ of its historical situation” (D’Amico 1989: x) – can come to terms with the natural sciences, particularly in cross-cultural research. With all due respect to Professor Loudon, a medical anthropology that ignores epistemological worries is certain to reproduce important dimensions of conventional knowledge in an unexamined fashion.

The chapters of this book will explore several specific dimensions of the larger project I outlined above, all addressing the nature of language, subjectivity and social process in cross-cultural studies of illness and human suffering. I begin with an examination of the concept “belief” in anthropology. Specifically, I will argue



that “belief” is a key analytic term within the empiricist paradigm, and that this concept is linked to a set of philosophic assumptions in a way that is far from obvious. I hope to show that the emergence of “belief” as a central analytic category in anthropology was a fateful development, and that use of the term continues to both reflect and reproduce a set of conceptual difficulties within modernist anthropology. If by the end of this chapter, I can raise serious questions for my readers about that favorite collection of odd job words of Anglo-Americans – “believe,” “belief,” “beliefs,” “belief systems” – my first goal will have been achieved.

In the pages that follow, I explore several dimensions of an alternative theoretical framework for the comparative study of illness and medical practices. In particular, I discuss issues which have little prominence in an anthropology framed in terms of belief: the anthropology of experience and what we can learn from studies of human suffering; studies of interpretation and its constituting role in social process; and critical analyses of medical discourse and the institutional and societal relations in which they are embedded. The overall text of this book, as of the Morgan Lectures upon which it is based, is thus organized not around a particular piece of ethnographic work – although I will present data from research in Iran, Turkey, and American medicine – but is designed to explore a set of theoretical issues in the field.

### **Science, salvation, and belief: an anthropological response to fundamentalist epistemologies**

I begin with “an anthropological response to fundamentalist epistemologies” because of my intuition that there is – quite ironically – a close relationship between science, including medicine, and religious fundamentalism, a relationship that turns, in part, on our concept “belief.” For fundamentalist Christians, salvation is often seen to follow from belief, and mission work is conceived as an effort to convince the natives to give up false beliefs and take on a set of beliefs that will produce a new life and ultimate salvation. Ironically, quite a-religious scientists and policy makers see a similar benefit from correct belief.<sup>5</sup> Educate the public about the hazards of drug use, our current Enlightenment theory goes, heralded from the White House and the office of the drug czar, get them to believe the right thing and the problem will be licked. Educate the patient, medical journals advise clinicians, and solve the problems of noncompliance that plague the treatment of chronic disease. Investigate public beliefs about vaccinations or risky health behaviors using the Health Belief Model, a generation of health psychologists has told us, get people to believe the right thing and our public health problems will be solved. Salvation from drugs and from preventable illness will follow from correct belief.

Wilfred Cantwell Smith, a comparative historian of religion and theologian, argues that the fundamentalist conception of belief is a recent Christian heresy (Smith 1977, 1979). I want to explore the hypothesis that anthropology has shared

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this heresy with religious fundamentalists, that “belief” has a distinctive cultural history within anthropology and that the conceptualization of culture as “belief” is far from a trivial matter.

A quick review of the history of medical anthropology will convince the reader that “belief” has played a particularly important analytic role in this subdiscipline, as it has in the medical behavioral sciences and in public health (see chapter 2 for more details). Why is there this deep attachment to analyzing others’ understandings of illness and its treatment as medical “beliefs” and practices, and why is there such urgency expressed about correcting beliefs when mistaken? To begin to address this issue, I first describe in a bit more detail the general theoretical paradigm that frames what I have referred to as the “empiricist theory of medical knowledge.” I will indicate its relationship to the intellectualist tradition in anthropology and to debates about rationality and relativism, showing how the language of belief functions within the rationalist tradition. At the end of this chapter, I review recent criticisms that have shaken the foundations of this paradigm, criticisms that suggest the need for an alternative direction in the field. This discussion will serve to frame the constructive chapters that follow.

The language of clinical medicine is a highly technical language of the biosciences, grounded in a natural science view of the relation between language, biology, and experience (B. Good and M. Good 1981). As George Engel (1977) and a host of medical reformers have shown, the “medical model” typically employed in clinical practice and research assumes that diseases are universal biological or psychophysiological entities, resulting from somatic lesions or dysfunctions.<sup>6</sup> These produce “signs” or physiological abnormalities that can be measured by clinical and laboratory procedures, as well as “symptoms” or expressions of the experience of distress, communicated as an ordered set of complaints. The primary tasks of clinical medicine are thus diagnosis – that is, the interpretation of the patient’s symptoms by relating them to their functional and structural sources in the body and to underlying disease entities – and rational treatment aimed at intervention in the disease mechanisms. All subspecialties of clinical medicine thus share a distinctive medical “hermeneutic,” an implicit understanding of medical interpretation. While patients’ symptoms may be coded in cultural language, the primary interpretive task of the clinician is to decode patients’ symbolic expressions in terms of their underlying somatic referents. Disordered experience, communicated in the language of culture, is interpreted in light of disordered physiology and yields medical diagnoses.

Medical knowledge, in this paradigm, is constituted through its depiction of empirical biological reality. Disease entities are resident in the physical body; whether grossly apparent, as the wildly reproducing cells of a cancer, or subtly evident through their effects, as in the disordered thoughts and feelings of schizophrenia or major depression, diseases are biological, universal, and ultimately transcend social and cultural context. Their distribution varies by social and ecological context, all medical scientists agree, but medical knowledge does not. Medical theories reflect the facts of nature, and the validity and rationality of



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medical discourse is dependent upon the causal–functional integration of biological systems.

One central goal of the pages that follow is to develop an alternative way of thinking about medicine and medical knowledge, a theoretical frame that challenges this common-sense view while still accounting for our conviction that medical knowledge is progressing, and one that serves us better as a basis for cross-cultural comparisons. To do so, it is important to recognize the epistemological assumptions of this common-sense view, and to appreciate its power.

The empiricist theory of medical language is grounded in what philosopher Charles Taylor calls “the polemical, no-nonsense nominalism” of Enlightenment theories of language and meaning.<sup>7</sup> For seventeenth-century philosophers such as Hobbes and Locke, the development of a language for science required a demystification of language itself, showing it to be a pliant instrument of rationality and thought, as well as the emergence of a disenchanted view of the natural world. The development of such a natural philosophy and the attendant theory of language required the separation of “the order of words” from “the order of things,” in Foucault’s terms (1970), the freeing of the order of language and symbols from a world of hierarchical planes of being and correspondences present in Renaissance cosmology. What we must seek, Francis Bacon argued, is not to identify ideas or meanings in the universe, but “to build an adequate representation of things” (Taylor 1985a: 249). Thus, theories of language became the battle ground between the religious orthodoxy, who conceived “nature” as reflecting God’s creative presence and language as a source of divine revelation, and those who viewed the world as natural and language as conventional and instrumental.<sup>8</sup>

What emerged was a conception of language in which *representation* and *designation* are exceedingly important attributes. Such a position was bound to a view of knowledge as the holding of a correct representation of some aspect of the world, and an understanding of the knowing subject as an individual who holds an accurate representation of the natural world, derived from sense experience and represented in thought. Meaning, in this paradigm, is constituted through the referential linking of elements in language and those in the natural world, and the meaningfulness of a proposition – including, for example, a patient’s complaint or a doctor’s diagnosis – is almost solely dependent upon “how the world is, as a matter of empirical fact, constituted” (Harrison 1972: 33). Although this view has been widely criticized by now, it continues to have broad influence in philosophy, psychology (in particular cognitive psychology and artificial intelligence research), in the natural sciences, and in Western folk psychology. It is associated with an understanding of agency as instrumental action, and with utilitarian theories of society, social relations, and culture as precipitates of individual, goal-directed action (Sahlins 1976a).<sup>9</sup>

This broad perspective has the status of a kind of “folk epistemology” for medical practice in hospitals and clinics of contemporary biomedicine. A person’s complaint is meaningful if it reflects a physiological condition; if no such

empirical referent can be found, the very meaningfulness of the complaint is called into question. Such complaints (for example of chronic pain)<sup>10</sup> are often held to reflect patients' beliefs or psychological states, that is subjective opinions and experiences which may have no grounds in disordered physiology and thus in objective reality. "Real pathology," on the other hand, reflects disordered physiology. Contemporary technical medicine provides objective knowledge of such pathology, represented as a straight-forward and transparent reflection of the natural order revealed through the dense semiotic system of physical findings, laboratory results, and the visual products of contemporary imaging techniques. And "rational behavior" is that which is oriented in relation to such objective knowledge.

At this point in the argument, I sometimes feel I have painted myself into a corner. How can such a view be disputed? This is precisely what we mean by medical *knowledge*, and we should all be grateful that medicine has progressed as far as it has in identifying disease mechanisms and rational therapies. In later chapters, especially in chapter 3 where I examine how medical students come to inhabit this specialized world of medical knowledge, I argue that the empiricist theory hides as much as it reveals about the nature of everyday clinical practice and the forms of knowledge that guide it, and I develop an alternative approach to conceptualizing the nature of medical language. In the remainder of this chapter, however, I want to examine the extent to which the medical social sciences and some forms of anthropology share with medicine this empiricist theory of knowledge and outline some of the difficulties that arise for cross-cultural studies because of this.

### **Rationality and the empiricist paradigm in anthropology**

The empiricist paradigm is most clearly represented by the intellectualist tradition in anthropology, which was prominent in Britain at the turn of the century and reemerged under the banner of Neo-Tylorism in an important set of debates about the nature of rationality during the 1970s.<sup>11</sup> Although I can only briefly address some aspects of this debate, even a cursory examination will indicate how the rationalist position flows out of the "Enlightenment" tradition of anthropology, demonstrate the critical role of "belief" in this paradigm, and suggest why it has had such power within medical anthropology.

A central issue in the rationality debate has been discussion of the problem of "apparently irrational beliefs" (for example Sperber 1985: ch. 2). How do we make sense of cultural views of the world that are not in accord with contemporary natural sciences, it is often asked. Do we argue that members of traditional cultures live in wholly different worlds, and their statements are true in their worlds, not ours, or even that they cannot be translated intelligibly into our language? Advocates of a typical rationalist position hold that such relativism is essentially incoherent, and have often argued either that seemingly irrational statements must be understood symbolically rather than literally or that they represent