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Many Voices: Medical Anthropologists Explore the Meaning of Health, Illness, and Cure

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Lindenbaum, Shirley and Margaret Lock, eds. Knowledge, Power and Practice: The Anthropology of Medicine in Everyday Life. Berkeley: University of California Press, 1993. xvii + 242 pp. Including notes, references, and indices. \$50.00 cloth, \$15.00 paper.

Etkin, Nina L. And Michael L. Tan, eds. Medicines: Meanings and Contexts. Quezon city, Philippines and Amsterdam: Health Action Information Network and the University of Amsterdam, 1994. V +305 pp. \$15.00 paper.

Good, Byron J. Medicine, Rationality, and Experience: an Anthropological Perspective. Cambridge: Cambridge University Press, 1994. \$54.95 Cloth, \$17.95 paper.

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Introduction

From its roots in early ethnographic descriptions of illness, healing, and the influence of magical forces (e.g., Frazer 1932, Evans-Pritchard 1937), medical anthropology has grown to become an influential subdiscipline of anthropology. The work of medical anthropologists represents widely diverse research interests and methods (Johnson and Sargent 1990:1) and not only makes important contributions to the parent discipline of anthropology but speaks to the practical concerns of nursing, psychiatry and public health as well. The following three recently³ published books in medical anthropology represent the work of forty-two authors. Their research projects take place on five continents and focus on people living in rural, urban and suburban settings. Their methods range from a historical analysis of medicine and colonial imperialism in Africa (Comaroff, Pp. 305-29) to a quantitative analysis of the household storage of pharmaceuticals in Costa Rica (Ugalde and Homedes Pp. 65-83). They well represent the dynamic interdisciplinary nature of the field and the diversity of views currently enlivening the discourse among medical anthropologists.

Medicine, Rationality, and Experience is based on the Lewis Henry Morgan Lectures given by Byron Good at the University of Rochester in March of 1990. Good takes to task what he calls the "empiricist theory of medical language" and argues that illness is best understood as an aesthetic rather than an empirical object. For Good, the reality of illness is constructed by sufferers, healers, family members, and others in the community as stories or narratives. The stories persons tell of their suffering offer a broader means of understanding illness than the empiricism of biomedicine because, as Good puts it, "Disease occurs, of course, not in the body but in life." (Pp. 133).

Knowledge, Power and Practice has its origins in a conference sponsored by the Wenner-Gren Foundation in March of 1988. It contains fifteen articles grouped under five headings: (1) the cultural construction of childbirth; (2) production of medical knowledge; (3) contested knowledge and modes of understanding; (4) constructing the illness experience; and (5) body politics - past and present. The authors' task, as described in the editors' preface, was to critically question how the dominant version of medical reality comes to be accepted as truth and how this truth is put into practice by individuals.

Medicines, Meanings and Contexts also has its roots in a professional gathering, in this case an October 1991 international conference on the sociocultural aspects of the use of pharmaceuticals held in Zeist, The Netherlands. The participants in the Zeist conference sought to focus anthropological discussion on the pragmatic issues problems associated with the integration of western pharmaceuticals into the societies of Africa, Asia and Latin America. The resulting manuscript contains seventeen papers including two introductory articles, one by Etkin and Tan and another by Brudon-Jacobowicz, and a concluding overview by Nichter and Vuckovic. The remaining fourteen pieces are grouped under four headings: (1) perceptions and interpretations of pharmaceuticals; (2) injections, the "powerful" pharmaceutical; (3) availability, disposition and storage of pharmaceuticals; and (4) evaluating the training of health workers on "rational" use and formulating research strategies.

An Experience Near Approach to Illness and Healing

In the first two chapters of *Medicine, Rationality, and Experience* Good outlines the limitations of a positivist epistemology and provides an overview of medical anthropology in the twentieth century. As part of this review Good contrasts four approaches to understanding and investigating the illness experience. Each emphasizes different assumptions about how to depict and analyze the illness experience.

The first approach is a continuation of the empiricist tradition of medical social sciences and is marked by an analysis of culture as "belief," a view of medical systems as adaptive sociocultural strategies and a focus on the health seeking choices of individual actors. Good criticizes this approach for its positivist view of disease as an object separate from human consciousness and for being too focused on the utilitarian acts of individuals.

The second is rooted in the linguistic traditions of cognitive anthropology and is represented by the early work of Goodenough (1956) and Frake (1961) and the more current writings of such authors as Garro (1986a, 1988,1990). Work done in this tradition generally defines culture as shared knowledge and views illness representations as primarily mental and semantic phenomena. Like the empiricist approach, Good sees this perspective as being too narrowly focused on individuals. He also criticizes the cognitive approach for lacking an appreciation of how cultural knowledge is situated in a broader historical and social context.

Good highlights the late 1970's work of Arthur Kleinman (1977,1978,1980) as the beginning of the "meaning centered" approach to illness representations. Good and other proponents of a meaning centered approach understand disease to be constituted by the interpretive activities and social practices of culture. They take issue with the positivist view of

disease as an entity apart from culture. The meaning centered approach has been criticized for being overly relativistic and not attending enough to the universals of human biology (Browner et al. 1988).

The fourth perspective reviewed by Good, the "critical" approach to medical anthropology, views illness primarily through the lens of the political and economic forces that affect local health care systems and practices. The critical perspective has focused on such topics as the role of power in interactions between patients and health care providers (e.g., Waitzkin 1984, 1985, 1989), how political and economic conditions influence the distribution of sickness in a society (e.g., Waitzkin and Waterman 1974, Chavez et al. 1992) and how understandings of illness serve the interests of those in power (e.g., Lock and Scheper-Hughes 1990, Taussig 1980). Good points out that those working from a critical perspective are at risk of perceiving those they study as simply unknowing pawns caught up in an oppressive system. Good argues for the coming together of the phenomenological interests of meaning centered anthropologists and the political sensitivities of the critical perspective to develop an approach that examines lived experience in the light of the political realities of people's lives.

Next, Good advances his case for an phenomenological, yet critical, approach to medical anthropology by presenting ethnographic material taken from three diverse settings. In chapter three, he presents an ethnographic study of the education of medical students at Harvard Medical School. The thinking of Ernst Cassirer (1955a, 1955b) is introduced in support of Good's argument that culture organizes distinctive phenomenological "worlds" of knowledge and practice. Good argues that during medical training students do not simply acquire a new set of ideas or vocabulary but instead learn a different way of experiencing both themselves and others.

Specifically, medical students learn ways of seeing, speaking and writing that constitute a specialized world of bodies, cases and patients. Learning to see the body anatomically and present persons as cases are examples of what Good calls formative practices. Formative practices constitute and reproduce the distinctive phenomenological world of medicine, not simply in the mind, but in the arena of lived experience as well.

In prior work, Good has defined the term "semantic illness networks" as the linkages of "words, situations, symptoms and feelings which are associated with an illness and give it meaning to the sufferer" (1977:39). In chapter four he reintroduces the notion of a network of terms, categories, symptoms and practices to analyze two very different kinds of material. The first is a 22-year Boston woman's account of her difficulties with rectal bleeding and the second is the concept of "heat" in traditional Galenic-Islamic medicine. Good uses these diverse examples to draw attention to the difficulties of trying to translate the symbolic elements of one system to another. He argues that terms such as "bleeding" or "heat" do not gain significance from their correspondence to biological referents but, instead, draw meaning from their relationships to other symbols in a network of symbols linking cultural notions of self, social relationships and the nature of suffering.

In chapter three Good described the formative practices critical to the construction of the world of medicine. Chapter five uses the compelling account of a Boston man's struggle with chronic pain to depict the reverse of this formative process and to argue for the importance of phenomenological or "experience near" descriptions of illness. Drawing on the work of Shultz (1971), Merleau-Ponty (1962) and Scarry (1985), Good details how chronic pain undoes the taken-for-granted world of a man with a diagnosis of temporomandibular joint disorder (TMJ).

Borrowing from the writings of Shultz (1971), Good specifies three main features of this process: (1) transformation of the sense of self, (2) disruption of social relationships, and (3) alteration of the sense of time. Good also chronicles the man's efforts to reconstitute his world by searching for a name for his affliction. Good argues that naming symbolically moderates suffering, separating the sufferer from his or her suffering, thus, giving the sufferer a sense of power over it.

Chapter six makes use of a study of seizure disorders in Turkey to advance Good's argument that narratives provide the best means of accessing the phenomenological world of those suffering from illness. Good begins his argument with the proposition, widely accepted in cultural anthropology, that experience is intimately intertwined with culture. Narratives represent experiences worth telling a story about, thus, narratives provide a unique means of studying cultural phenomena. Crucial to this storying of experience is plot. Plot gives order and meaning to events and experience. The plot of a narrative is found both in its underlying structure and in the imaginative response or "emplotment" of the listener or reader.

Using three examples, Good presents five prototypical plots found in the stories told by his Turkish informants and their families. Features of these plots included emotional trauma or loss, childhood injury, chronic poverty and suffering and the malicious acts of supernatural beings. These prototypical plots were drawn from cultural forms that rendered the stories understandable to family members and others in the society. They are cultural resources drawn upon by those struggling to make sense of their experience with an illness.

These stories often contain what Good calls "subjunctivizing" elements, a phrase he borrows from Bunner (1986). In some narratives the story retains a provisional quality that

opens the possibility of multiple interpretations and multiple perspectives. No one plot has been settled upon, therefore, alternative explanations and possible outcomes are still in circulation. Other stories contain descriptions of extraordinary experiences such as encounters with the supernatural and the mysterious that also leave open possibility and hope. These two elements, the presence of multiple perspectives and encounters with the mysterious, lend illness narratives an inconclusive and future looking quality. They are signs that the story is unfinished, leaving open alternate possibilities and the hope for future healing.

In chapter seven Good concludes his argument that illness is best viewed as an aesthetic object. The meaning of an aesthetic object, such as the character in a novel, is not fixed by the structure of the story. It is instead created in the relationship between the text and the imaginative activities of the reader. In the same way, the experience of illness is not fixed by physiological states, but is given meaning through a synthetic combining of elements such as embodied experience, encounters with physicians, discussions with friends and family, things read, etc. Good places this imaginative process in stark contrast to the narrow instrumental rationality of modern biomedicine. For Good, the hopeful and open-ended stories of struggles with "fainting" portrayed by his Turkish informants position illness in the context of life and lived experience. This is both a more compelling and a more accurate way of describing the illness experience than the discreetness and finality of a biomedical diagnosis.

Although Good makes a compelling case for the importance of narratives as a way of organizing our understanding of the illness experience it is not clear if he succeeds in presenting an approach that is at once phenomenological and critical. Good argues for the importance of a critical phenomenology at the end of chapter three but, except for a short discussion of family

politics among his Turkish informants (Pp. 158-161), such issues as power, history, politics and economics receive relatively little attention.

Good also raises the question at the end of chapter three of how medical anthropologists should pursue comparative studies of illness. Good leaves the answer to this question incomplete. In the final chapter Good returns briefly to the question of comparative studies but his discussion of culture bound syndromes, possession and trance seems more afterthought than suggestions for a program of comparative research. His incompleteness here continues to leave the meaning centered approach open to some of the criticisms raised by Browner et al. (1988).

It is not necessarily a criticism that Good raises questions that he does not completely answer, rather it speaks to the largeness of the task he has undertaken in this book. *Medicine, Rationality and Experience* represents the cumulative thinking of one of medical anthropology's leading theorists, as such it represents one of the most comprehensive overviews of the meaning centered approach available to date. In distancing medical anthropology from the confines of a positivist view of disease Good carves out a distinct and important role for culture in understanding the experience of illness.

Knowledge, Power and Practice

Knowledge, Power and Practice begins by using the theme of childbirth to illustrate how categories of medical knowledge are culturally constructed. In the first of the three chapters in this section Jeffery and Jeffery seek to highlight the cultural variations that exist in the practice of midwifery and examine midwifery as a role embedded in a specific social and economic context.

Jeffery and Jeffery use data gathered from surveys, interviews of key informants and participant-observation to describe the work of traditional birth attendants in the north Indian state of Uttar Pradesh. The work of the *dai* or traditional birth attendant is regarded by both Hindu and Muslim villagers in the region as demeaning and undesirable. The work of the birth attendant has so little status that women often accept the role only under pressure of economic hardship or other duress. Unlike midwives in other parts of the world the north Indian *Dai* are not seen as possessing special skills or knowledge but simply provide a menial and perfunctory service other are not willing to do. Jeffery and Jeffery argue that the low status given birthing activities and traditional birth attendants mirrors the low status given to women as producers, bringers of wealth and reproducers in Uttar Pradesh.

The remaining two chapters in this section deal with the theme of how different perceptions of risk develop from disparate and sometimes competing versions of reality. Kaufert and O'Neil examine how different understandings of risk are interwoven into a dialogue between a Canadian physician and an Inuit woman on the relative merits of evacuation for childbirth. At a public discussion in the Keewatin region of northern Canada, health professionals defended the policy of transporting women for childbirth to facilities in larger cities south of the region and Inuits presented the problems associated with evacuation. Kaufert and O'Neil conclude that the exchange between the woman and the physician not only highlights the differences between risk as defined by community and personal experience, and risk as statistical artifact, but also expresses the larger conflict over whether local or state knowledge is dominant in policy setting.

Rapp also discusses diverse perceptions of risk. Following amniocentesis, prenatal patients in a New York medical clinic are asked to evaluate information provided by genetic

counselors and decide whether they wish to continue with their pregnancies. Rapp examines how these prenatal patients' decisions are informed by a multiplicity of influences including local perceptions of disability, religion, judgement of male partners and the place of the pregnancy in the woman's reproductive cycle.

These chapters highlight how pregnancy and childbirth are linked with many aspects of the broader culture including but not limited to medical knowledge. Cultural knowledge of human reproduction is presented here as the product of a multiplicity of voices. These voices reflect such diverse issues as the status of women in a society, the distribution of economic resources and the resistance of local communities to state control.

The next set of chapters in *Knowledge, Power and Practice* address the question of how medical knowledge is produced. In the first chapter, Good and Good examine the learning of medical knowledge by Harvard medical students during the early months of preclinical training. During this early period of medical education, training in the basic sciences is emphasized and medical students learn to "know" the body as a thing of tubes and compartments. The body, now perceived as a physical and biological object, becomes something to be acted upon or fixed.

Learning to know and respond to the body in this way is the beginning of a corresponding transformation of the self that takes place in medical students as they come to perceive themselves as "physicians." The boundaries between private-self and physician-self are actively contested as students struggle with how much to allow the world of medicine to intrude upon their personal lives. The boundaries between self and others defined as patients are also redefined to allow questions and procedures previously considered invasive and inappropriate to normal discourse. Good and Good conclude by questioning how distinctive "worlds" of

knowledge and practice such as the world of medicine come to appear so naturally convincing and "true." They argue that transitional periods or "critical moments" such as the early months of medical training offer the best entry point to examine this question.

The following two chapters, written by Allan Young and Lorna Amarasingham Rhodes respectively, focus on the production of medical knowledge in mental health settings. Young examines the role of institutional ideology in the production of medical knowledge at a specialized institute funded by the Veterans Administration and devoted to the treatment of posttraumatic stress disorder (PTSD). He deconstructs the production of knowledge at the institute into three stages: (1) elicitation and interpretation of patient narratives in individual and group psychotherapy; (2) presentation of the therapists perceptions, intentions and reactions in clinical supervision; and (3) production of theoretical propositions and policy recommendations by publication in memos, newsletters, journal articles and papers.

Young uses the terms ideology and discourse to describe two separate but interdependent systems of knowledge. Discourse shares the same language and assumptions as ideology but is not embedded in a particular institutional hierarchy. Professional discourse makes the existence of PTSD a natural and unquestioned assumption. Particular institutions then draw upon professional discourse to construct institutional ideologies. Simultaneously, ideology provides the organizational base needed to perpetuate the flow of professional discourse. Ideology assures that producers of knowledge, i.e., patients, therapists and administration, are integrated into the institutional division of labor and its associated knowledge producing process.

While the activities of the institute described in Young's chapter are focused on supporting a single ideology, the workers in Amarasingham Rhodes' inner-city Acute Psychiatry

Unit (APU) work in a world of multiple views and practices. Amarasingham Rhodes argues that current reforms in psychiatry do not supersede older approaches to human problems but continue to coexist with older views. Actions taken by practitioners at the APU spring from historically diverse and often contradictory approaches to psychiatry including confinement, traditional biomedicine and community psychiatry. These practices or what Amarasingham Rhodes call "gestures" do not fit neatly into a particular ideology but fit instead the exigencies of a specific context. Because these gestures correspond to situations found only in the daily events of the APU they can only be learned while "on the job," that is, in context.

These three chapters focus on the ways that sociopolitical, economic and cultural forces operate on the production of medical knowledge. Here, medical knowledge is not monolithic but varied and overlapping. The next series of chapters takes this theme further by examining examples of contested knowledge. Each author in this section present situations where medical knowledge is created from multiple, often competing, sources.

Drawing on ethnographic studies done among the Yoruba of southwest Nigeria, Tola Olu Pearce presents a framework for the understanding of the creation of lay medical knowledge. He argues that lay persons draw upon many sources to create their pool of medical knowledge. The framework within which they construct this knowledge has three layers: (1) a macro level of sociocultural factors such as the changing structure of the family and economic trends, (2) an intermediate level consisting of the various traditions of medical knowledge available to the Yoruba, and (3) facets of personal experience such as intuitions and dreams.

In their attempts to deal with health concerns, the Yoruba construct medical knowledge from the many sources available to them in their daily lives. Olu Pearce's description of lay

medical knowledge corresponds closely to Kleinman's view of lay explanatory models which Kleinman says " . . . do not represent single referents but represent semantic networks that loosely link a variety of concepts and experiences" (1980:106). These often link ideas and events excluded from the more formal models of medical knowledge used by medical practitioners.

Like Amarsingham Rhodes, Fabrega focuses on the tension in the practice of psychiatry created by contradictory roles and practices. Fabrega describes the conflict between the "clinical/individualistic" and "corporate/institutional" functions of psychiatrists in the role of expert witnesses. In two case studies Fabrega describes how psychiatrists are torn between the empathy and emotional connection developed in their clinical roles and the demands of the corporate and legal worlds to give so called "objective" legal opinion. Fabrega discussed the history of these contradictions in Anglo-American psychiatry and briefly touches upon the ways in which medical practitioners in other societies carry out legal and mediatory functions. He concludes that the tendency to medicalize deviant behavior and for medical practitioners to act as agents of social control is found in many societies and is not confined to modern Europe or the United States.

Gilbert Lewis raises provocative questions about standards of evidence in the judgement of medical efficacy. Medical anthropologists bring together the standards of scientific medicine and anthropology. The blending of biomedical standards ("our" cultural standards) with anthropological respect for the standards of other cultures is problematic. Using the example of leprosy treatment in the west Sepik region of Papua New Guinea, Lewis shows how difficult it is to make accurate judgements about the motivations and actions of others. He describes the

anthropologist's task as one of finding the difficult balance between credulity and faith. He suggests that anthropologists avoid the error of too much faith by not being too quick to offer an explanation for a medical treatment effectiveness, before knowing if it actually works.

Simultaneously, anthropologists must not be overly bound by credulity and be willing to ask and hear directly what benefits the recipients of medical treatment experience.

The shared ground between epidemiology and medical anthropology has been the subject of several recent works (Janes et al. 1986, Rubinstein 1984). Often the argument is that anthropologists would benefit from the methodological rigor found in epidemiological research designs and data gathering methods (True 1990:304). Frankenberg argues the other side of the issue by suggesting that epidemiologist view sickness as a "dramatic cultural narrative." This, he suggests, would move epidemiology beyond the view of sickness as timeless and episodic and allow for the inclusion of moral, social and political elements in epidemiological analyses.

Knowledge, multilayered and drawn from competing sources, is carried forward into lived experience. How the illness experience is constructed and lived is the topic of chapters by Estroff and Briceno-Leon. Estroff argues that the questions of who gets sick with what and why have been well investigated by medical anthropologists. Much less is understood about the impact of chronic illnesses on the lives of patients and the transformation of identity that accompanies a chronic illness. She further argues that the study of chronicity and variations in prognoses for persons with a similar diagnosis offers a prime opportunity for comparative research. Drawing on her longitudinal research with persons suffering from schizophrenia, Estroff proposes a multi-layered approach to the study of chronicity. This approach contains three components: (1) the symbolic and sociocultural processes by which chronic illness

transforms self and identity; (2) the political and economic context of disability; and (3) the biological and epidemiological dimensions of chronic illness.

Estroff describes the fusion of identity with diagnosis that takes place among persons with schizophrenia. This construction of self-as-illness comes about as a perceived sense of impairment persists over time, there is ongoing contact with professionals who diagnose and treat, and the person's access to non-illness related roles is restricted. This transformation in identity is reinforced and maintained by the political and economic system constructed in response to the medicalization of schizophrenia. The medicalization of schizophrenia is advocated for by both kin and professionals because it allows access to illness-tested resources and maintains employment of mental health professionals.

Using the examples of Bob and June, Estroff illustrates how there can be tremendous variation in outcome among persons with the same diagnosis. She challenges biomedical assumptions by pointing out how little of the variance in outcome can be accounted for by the biomedical elements of the illness such as psychotic symptoms.

In a very different kind of study, Briceno-Leon and his research team examined the socioeconomic and psychosocial factors related to the transmission of chagas disease in the municipality of Tinaquillo, Venezuela. Chagas disease presents a unique opportunity for the study of the illness experience because it is a biomedically defined disease whose symptoms take ten to twenty years to manifest. Because of the long time lapse between contagion and the first serious symptoms it is not a disease category in common circulation in the towns and villages of Venezuela. This renders the task of encouraging homeowners to make the changes in dwelling conditions necessary to prevent the spread of the disease more difficult. Using dwelling

conditions favorable to the transmission of the disease, such as palm roofs and unplastered mud walls as independent variables, Briceno-Leon analyzed the influence of three socioeconomic variables (ownership of land, status of the dwelling and occupation) and three psychosocial variables (locus of control, beliefs about the disease and rootedness). The results showed that dwelling conditions favorable to the spread of chagas disease varied together with occupation, locus of control, and rootedness.

These results were further tested by examining the efficacy of two related variables, income and self-confidence, in a government sponsored disease control program. This program involved small loans to householders to buy the materials necessary to make home improvements that would reduce the conditions favorable to the spread of chagas disease. Participation in the program was significantly related to increased self-confidence. Income was not significantly related to participation in the program. It was thought that those with better jobs and higher incomes often did not take part in the program because they had sufficient means to make improvements on their homes without the burden of government loans.

The last section in this volume examines the body as an intersection of biological and cultural processes. These three chapters, in different ways, present the body as an object laden with symbolic meaning and historical significance, rather than an object simply in and of the natural world. In the first chapter in this section, Comaroff examines the regulation, surveillance and social control of bodies by what Lock and Scheper-Hughes call the body politic (1990:50). Comaroff explores the historical links between British imperialism in southern Africa during the nineteenth and early twentieth centuries and the rational vision of nineteenth-century biomedicine. During the early nineteenth-century the language of medicine and the biological

sciences was used to codify life and determine man's relationship to the rest of the living world. Africans were assigned a place on the lower end of the human spectrum and thought to be the closest among humans to the apes and other beasts. This, of course, made natural and fitting the imperial ambitions of nineteenth-century Britain.

Next, Comaroff examines how nineteenth-century healing missions, unregulated by government or professional standards, served to introduce a European world view to Africans. Under the guise of controlling contagion and reducing disease, missionary healers established European forms of dress and personal habit. This introduced European definitions of person, health and economy that anticipated the social and economic roles native Africans were to have in the later colonial state.

With the discovery of diamonds in 1867 and the resulting influx of capital from Europe the influence of the healing missions faded to be replaced by government-sponsored health services. The colonial public health system played an important role in the control of the black population and in trying to create a stable and docile work force. Hygiene and the threat of disease provided the rationale for the separation of the blacks from whites that became an enduring feature of the South African social and political landscape.

In the next chapter Lock looks at differing perceptions of the body and menopause in North America and Japan. In North America, discourse about the end of menstruation is dominated by themes of loss, failure and decrepitude. To slow this slide toward a pathological and troublesome old age, hormone replacement therapy is often recommended, even though the medical evidence has shown it to be of dubious therapeutic value. The dominance of

replacement therapy as an appropriate medical response to ageing is maintained by the economic interests of physicians and pharmaceutical companies who profit immensely by its use.

In Japan, aging is much less pathologized and often women do not even associate menopause with the end of menstruation. Middle-aged Japanese women are perceived by society to play an important role in the care of elderly family members and the maintenance of the household. Physical symptoms suffered at mid-life are given little official attention and the qualities of self control and discipline are encouraged. Lock argues that in both societies women's subjective experience of ageing is ignored and social biases are expressed in the neutral language of medical science.

In the last chapter of this volume Haraway describes the multiplicity of voices within science used to ascribe significance to the body and self. Although often described in monolithic terms, Haraway views science as composed of many overlapping and contending views and systems of language. By examining the languages used to describe the immune system, a unique twentieth-century object of science study and practice, Haraway explores the fluid way that science constructs its subjects and the human self.

Knowledge, Power and Practice represents a surprising diversity of viewpoint and method. This diversity is at once a strength and weakness. The strength of this volume is that the work represents a wide sampling of questions, methods and ways of presenting data. In that sense this volume is an excellent overview of current activity in medical anthropology. However, at times the contrast between articles is so great it loses the connectedness of theme. It is not always clear how chapters as dissimilar as those of Haraway and Brieceno-Leon, for

example, speak to the common task of exploring how the dominant version of medical reality is accepted as truth and put into practice by individuals.

The Meanings of Medicines

The authors represented in *Knowledge, Power and Practice* generally take a critical stance toward the categories and practices of Western biomedicine. Diagnostic categories, therapeutic procedures, the social roles of patients and healers, and even the body itself are phenomena to be deconstructed, laden with economic, political and legal implications. The authors of *Medicines: Meanings and Contexts* are at times also critical but presume the usefulness or at least the considerable influence of modern biomedicines. Brudon-Jacobowicz expresses a starting assumption in his introductory chapter: "Drugs play an important, but limited, role in protecting, maintaining, and restoring health." (Pp. 9). This assumption leads to quite a different research agenda than expressed in *Knowledge, Power and Practice* and reveals a pragmatic side of medical anthropology more allied with the concerns of international public health.

The first six chapters in *Medicines: Meanings and Contexts* take up the theme of the meanings of medicines. The authors attempt to reveal the underlying reasoning used by peoples in Nigeria, Ghana, the Philippines, and Guatemala in their use of Western pharmaceuticals. In the first of two chapters presenting work done in the African nation of Nigeria, Etkin argues that distinctions between the "primary" and "side" effects of medicines are not valid in cultures that do not share the logic of Western biomedicine. The Hausa of northern Nigeria have easy access to pharmaceuticals and make frequent use of them to treat a wide range of sickness. Their use is guided by their own unique cultural understanding of sickness and its treatment. Some

medicines are used or not used because of "side "effects such as production of rashes and the coloring of urine or feces because these effects fit the logic of how the Hausa use medicines. Etkin concludes that a more relativistic view of the use of pharmaceuticals would move researchers and public health workers beyond viewing alternate uses of medicines as irrational or noncompliant.

B. Folassade Lyun examines mothers' perceptions of childhood diarrhea in Oyo State, Nigeria. Like Etkin, Lyun finds that the use of western pharmaceuticals is often guided by local understandings. Iyun describes how traditional understandings of illness, such as the classification of illnesses and medicines as hot or cold, influence the decision of mothers to treat or not to treat childhood diarrhea and the kind of treatment chosen. Some episodes of diarrhea are interpreted as reflecting normal neonatal and infant experiences such as teething or neonatal stools that clear the baby's throat and stomach after delivery and, thus, do not call for treatment. Specifically, Lyun discusses how the perception of diarrhea as a "hot" illness requiring a "cold "remedy hinders the acceptance of using boiled "hot" water in preparation of sugar-salt rehydration solution. This makes more difficult the task of convincing mothers to use rehydration solution when their babies are ill.

Hardon's chapter, based on research conducted in the Metro Manilla region of the Philippines, focuses on understandings of the efficacy of medicines used for respiratory infections. Like the Nigerian villagers described by Etkin and Iyun, these poor urban dwellers make use of their own cultural notions to understand and use pharmaceuticals. The concept of *hiyang* or suitability plays a key role in local understandings the efficacy of medicines and often guides decisions about choice and use of pharmaceuticals.

Tan analyzes the various terms used to refer to medicines in the Philippines to arrive at an understanding of perceptions of efficacy and safety. Tan discussed the distinction made between "medicines," which have the power to cure, and "drugs," which are dangerous. He also discusses how the Tagalog word *Gamot*, often used to translate the English term "medicine, connotes the ability to cure. This leaves ambiguous the status of medicines such as cold and flu remedies that relieve symptoms but do not actually cure.

Returning to Africa, Kodjo Senah questions why western pharmaceuticals are so popular among Ghanaians. Like the Philippines and Nigeria, western pharmaceuticals are available from a variety of both officially sanctioned and underground sources. Like the other peoples discussed in this section, the Ga-speaking villagers presented here use local understandings of disease, the efficacy of medicines and the anatomy of the body in deciding when and how to use western medicines.

Cosminsky moves the focus to the Pacific coast of Guatemala where she also examines the interplay between pharmaceuticals and local understandings of health, illness and cure. Pharmaceuticals are again widely available and play an increasingly important role in the popular, folk and professional health care sectors. Cosminsky discusses the medical, sociocultural and economic consequences of the pharmaceuticalization of the health care system. From a medical perspective, easy access to medicines can both make treatment easier or lead to harmful effects from improper use. Use of pharmaceuticals by traditional healers leads to their incorporation into the cultural realm of sacred objects and, thus, infuses them with power and meaning far beyond their prescribed use. Economically, consumers of pharmaceuticals become dependent on the money needed to obtain them and cost drives people to seek alternate resources

such as local lay suppliers of medicines or lay injectionists. Cosminsky argues that understanding these consequences makes more rational the health seeking actions of these Guatemalan villagers. For example, the decision to seek pharmaceuticals from a folk healer is more understandable when it is known that in this sacred context medicine takes on a very different significance than if the same medicine is obtained from a pharmacy.

Injection is a widespread and immensely popular means of administering medicine in the developing world. In one of two chapters dealing with the phenomena of injections in the developing world, Whyte and Van der Geest point out that injections are symbolically marked as potent by the complex steps involved in their use (insertion of the needle in the vial, pulling the medication up into the syringe, insertion into the skin, etc.). Such steps identify injection as the quintessential modern cure.

Whyte and van der Geest note that although injection is a unique cultural phenomenon it has been the object of little study. They propose a four-part research agenda that combines an examination of macro economic and political influences along with a "thick" description of local providers of injections, patterns of injection use and the meaning given to injections by both providers and consumers. For health care policy makers, concerned with reducing the number of unnecessary injections and improving the quality of needed injections, Whyte and Van der Geest recommend a series of five questions: (1) How frequently are injections given? , (2) For what complaints? , (3) How are they administered? , (4) Who gives injections? , and (5) How do providers and receivers of injections view them?

In the next chapter, Birungi examines the intersection of culture and injection use in Uganda. Survey and interview data are used to describe how the pattern of who gives injections

to whom (point four above) is structured by perceptions of risk and cultural norms governing intra-family contact. For example, needles are shared between spouses but not across generations and injections given in the home are judged safer than those given in hospitals or clinics.

The third section of this volume focuses on the accessibility and household management of pharmaceuticals. Streefland's chapter provides a theoretical framework for understanding the changing availability of pharmaceuticals. He describes integration of western medicines into the societies of developing countries as the fluid frontier of cosmopolitan medicine and discusses conditions under which this frontier expands, contracts and fragments. Streefland gives special attention to the influence on accessibility of the economic policies of the World Bank and International Monetary Fund, the AIDS epidemic and the Bamako Initiative.

Ulgalde and Homedes examined the accumulation and storage of drugs in households in Costa Rica. They found that many households have accumulated a large number of pharmaceuticals and that these medicines are often stored unsafely or without adequate labeling. Ulgalde and Homedes caution that this increases the risk of accidental poisoning and other misuses and advocates for a greater focus on the use of pharmaceuticals after they have been made available.

Tutor Silva, Amarasiri de Silva, and Wijekoon Banda make use of household surveys, health diaries and in-depth interviews of key informants to explore health seeking behavior in an urban community in central Sri Lanka. Although residents of the community made frequent use of western therapies, and had ready access to western medicines, they often bypassed a large local hospital and health center to seek care from the private sector. Even those with limited

financial resources often preferred to seek care from persons known in the community than from strangers at the hospital. The authors conclude that physical access to care is not sufficient to ensure improved health care for the urban poor.

The fourth section of this volume consists of four chapters focusing on the applied issues of patient compliance and the training of health care workers. Ofori-Adjei and Arhinful examine the training of medical assistants and other medical personnel who prescribe medication for malaria in the African nation of Ghana. They used surveys, structured interviews and focus group discussions to answer the question of whether in-service training results in conformity to standard treatment practice. Ofori-Adjei and Arhinful found that although training increased health care providers' knowledge about malaria it was not a strong predictor of clinical practice. Patient expectations and demand for particular forms of treatment, such as injections, proved to have a more important influence on the form of treatment chosen by health care providers.

In the next chapter Ngoh and Shepard describe a patient education program that uses visual aids and other educational materials to improve use of antibiotics in rural Cameroon. Their assumption was that increased patient knowledge would result in increased patient compliance. They found that using educational materials that are cultural appropriate and accessible to a nonliterate population significantly increased patient knowledge and, unlike Ofori-Adjei and Arhinful, also significantly increased correct use of prescribed medicines.

The final paper in this section takes to task the very notion of "rational" use of pharmaceuticals. Sachs and Tomson, a physician and anthropologist, offer a dual interpretation of patient-provider interactions in Sri Lanka and Sweden. They argue that our interpretations of the health seeking actions of others must be situated in the context of patient lives. Like other

authors in this volume, they also argue that it is short sighted to view alternate uses of drugs as simply the result of ignorance or illiteracy.

At its best, *Medicines: Meanings and Context* points to how the exigencies of public health can be informed by anthropological knowledge. Some chapters, the papers by Etkin and Cosminsky stand out as examples, show how anthropological sensibilities can make more understandable the health care decisions of those who might appear irrational, resistant or noncompliant. Other chapters do not seem to go much beyond statements of cultural relativism. As Brudon-Jacobowicz notes in his introductory chapter these descriptive studies add little to the development of policies or interventions (Pp.11). They also add little to the development of theory or practice in medical anthropology.

Many Voices

Medical anthropology is exciting because it grapples with complex real-life concerns in a multifaceted and interdisciplinary fashion. These three books present many of the approaches and methods used by medical anthropologists to understand the complex problems confronting them. It also shows that even decades after gaining legitimacy as an important subdiscipline of anthropology, medical anthropologists continue to struggle with such basic questions as what constitutes an appropriate object of study or valid data. Medical anthropologists have the immense task of describing how culture and society contribute to illness and cure. Such a large task calls for a multiplicity of voices and perspectives. These three volumes show how widely distributed these voices are. Some might decry the lack of a unifying perspective. Yet, perhaps the multiplicity of voices is needed precisely to convey this complexity and the object of our investigations is so fundamental to human life that it resists confinement.

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