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Healing Logics

Erika Brady

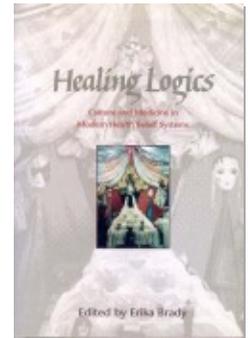
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INTRODUCTION

ERIKA BRADY

Sometimes the attraction of a field of study emerges naturally and predictably within the ivied structure of an academic setting; sometimes it ambushes you from an unanticipated stronghold. In the course of many years of academic training in folklore, I never regarded medical folklore as a specialty. Although my office as a graduate student at UCLA adjoined that of Wayland Hand, the distinguished American taxonomist of medical folklore, his room-length boxes of file cards and the boundless store of arcane tidbits painstakingly organized struck me at the time as more exotic than relevant to contemporary ethnography. It was not until the early 1980s, when I unexpectedly assumed the duties of a part-time chaplain associate at a midsize hospital in southeast Missouri that I began to see the implications of my training for work in a hospital setting, and grasped the emerging significance of efforts by folklorists and anthropologists in other medical institutions nationwide.

Cape Girardeau, Missouri, is located on the Mississippi River, at the intersection of several cultural regions marked by distinctive vernacular health systems: to the west, the richly diverse biome of the Ozark Plateau has produced a notable heritage of herbal treatment; to the south, the Missouri Bootheel is an economic and social extension of the Mississippi Delta, with flourishing practice of rootwork derived from West African patterns. Most consistent of all, so deeply taken for granted that it escapes notice as a traditional health belief system, is the profound, almost universal assumption that soul and body are linked in some larger pattern of meaning that should be acknowledged, and can even be altered, by prayer. As a chaplain specializing in oncology, I learned to recognize the verbal rhythms that preceded ecstatic trance in Pentecostal patients. I lit candles for Catholics, and obtained permission for holy medals to accompany them into surgery. From patients of all social backgrounds I heard the many

supernatural and natural, folk and “new age” remedies that had been tried and discarded before so-called “primary” care had been sought, and learned also of these nonconventional practices being surreptitiously or openly continued concurrent with official biomedical care—some of which knowledge posed delicate ethical issues for me as mediator between patient, family, and hospital. I came to realize the cures so aggressively and ingeniously sought, and the palliation of acute pain when a cure was past hope, were not necessarily goals most highly valued by patients and families. In corridors and waiting rooms following a death, many times the agonized question posed to me was not “Did he suffer?” but rather, “Was he saved?”

There was nothing out of the ordinary about these experiences in themselves—they could be replicated in various forms in any hospital at any time. Few people, medical professionals included, self-treat illness exclusively within strict biomedical protocols. Just as social practices deriving from folk custom rather than scientific method govern many aspects of hospital behavior (Hufford 1989; Stein 1980; George and Dundes 1978), nonconventional models for healing and wellness quietly and stubbornly coexist with the official allopathic approach, even in a hospital setting. What was unusual and new in my experience was the responsiveness of the staff to the possibilities of an ethnographic approach to patient and family issues my training offered, and their interest in learning more about making sense of the practices and beliefs they observed—not necessarily to suppress them, but, like folklorists and anthropologists, to understand them well enough from the patient’s standpoint to grasp their persuasive power. Their interest reflected a much larger trend in contemporary medicine: the incomplete but growing recognition that the four-hundred-year-old enterprise to institutionalize medicine and place health care on a fully secular, professional, and scientific footing can never—and perhaps should never—entirely succeed.

The dominant theme in the social history of U.S. medicine in the twentieth century has been the emergence of allopathic treatment—the lineal descendent of nineteenth-century “heroic” medicine—as preeminent, virtually excluding all competing modalities from participation in official status. Allopathic medicine enjoys all the privileges of what social scientists label “formal” or “elite” institutions. It is administered by a limited number of carefully credentialed specialists, change in practice is elaborately controlled, and the whole is supported by complex interrelationships with similarly “formal” institutions such as the legal, medical, and economic systems in this country. As is often the case with well-established formal institutions, the predominance of allopathic medicine has been so pronounced as to suggest an almost Olympian extracultural inevitability: it has achieved a superorganic mystique,

as though it exists outside the social, cultural, and historic contingencies that shape other aspects of custom and practice—a kind of secular religion. This process has been fueled by the dramatic advances of biomedicine, especially in treatment of physical trauma; bacterial, fungal, and parasitic infections; and hormonal deficiencies.

This privileged role, and the infallible status accorded formal medicine, can lead to a kind of biomedical absolutism which has been labeled “medico-centrism” (O’Connor 1995, 4), which finds expression in ways that overreach even the immense credibility accorded the practice. The official guide to alternative medical practices published by the American Medical Association defines “quackery” as the promotion of a scientifically unproven practice or remedy, regardless of intent (Zwicky 1993, 5). This definition would make a “quack” of a mother administering any nonscientific home remedy, no matter how amply supported by generations of informal empirical observation, not to mention any hospital chaplain who “promotes” the healing benefits of prayer.

Despite its aura of timeless mastery, the predominance of allopathic medicine in this country is relatively recent. The publication of Abraham Flexner’s famous report in 1910 on the state of medical education in the U.S. provides a convenient terminus a quo from which to date its ascendance. Using German universities and the European-influenced curriculum then current at Johns Hopkins as models, he outlined a system in which training of physicians would take place within relatively few research-centered institutions emphasizing scientific method first and foremost, with clinical skills developed later and somewhat secondarily. The consequence is now a comprehensive and lengthy process which in practice now involves nothing less than a full transformation of a would-be doctor’s way of knowing—as total an acculturative conversion experience as Roman Catholic seminary or military boot camp.

The Flexner report struck a responsive chord because his recommendations were both timely in terms of emergent economic and social forces of the period, and consistent with long-standing cultural values, practices, and preferences deriving historically from a much larger frame of reference than medicine alone. From the time of the ancient Greeks and the subsequent influence of Islamic thought, the Western European intellectual tradition has generally favored inductive, empirical processes of inquiry over deductive and metaphysical models. Regarding two essential methods of investigation and treatment in Western medicine, dissection and surgery, this attraction to inductive, empirical process was assisted (or at least relatively unimpeded) by the Christian theological division of soul from organism, permitting procedures which in other cultures would have violated a sacred unity of the being. In the application of these observations to therapeutic problem solving, the Western

fascination with cause and effect and its accompanying spirit of invention have driven investigators to devise ingenious pharmaceutical and mechanical innovations in treatment—techniques specific enough in intended action to be effectively tested in a controlled setting. Finally, these techniques of treatment have proven well suited for dissemination by means of yet another feature of Western culture shaping its formal medicine: the talent for constructing elaborate bureaucratic organizations, which now research, test, regulate, and administer the therapeutic product. The organizational commodification of healing in the West is one of its most striking characteristics: it is no linguistic accident that the term “medicine” describes both the broad field of endeavor, and its product.

These observations concerning Western official medicine as a social construct are by no means news to social scientists (Glaser 1968, 94–95). But their expression in recent *medical* literature is something new. The characterization of contemporary biomedicine as “a highly refined form of folk medicine . . . [which is] the traditional practice in industrialized Western nations” (Harrison 1992, 2594) would not be astonishing in a social sciences text, but it *is* striking to encounter it in the most recent edition of *The Merck Manual of Diagnosis and Therapy*, a standard desk reference published for physicians. This open recognition of formal medicine by its practitioners as a culturally contingent institution not only suggests a reevaluation of many of the assumptions underlying its teaching methods and practice, but also a reevaluation of attitudes toward nonconventional health belief systems with which it coexists and sometimes competes.

To some degree, pragmatic concerns motivate this self-critique on the part of the medical establishment. In 1993, the prestigious *New England Journal of Medicine* published an eye-opening article titled “Unconventional Medicine in the United States: Prevalence, Costs, and Patterns of Use,” in which the authors reported the results of a national survey conducted in 1990. One in three respondents had in the previous year made use of at least one of sixteen biomedically unproven modalities such as acupuncture, relaxation techniques, spiritual healing, et cetera. The estimated number of visits to providers of nonconventional therapy exceeded visits to primary care physicians by almost 10 percent, and the out-of-pocket expenditures for these visits was \$10.3 billion—an amount comparable to out-of-pocket expenditures for all hospitalizations in the United States during the same period. What is more, the individuals seeking nonconventional treatment during the period in question were generally those who were more affluent and better educated. This study represented a significant heads-up to anyone assuming that the institutional authority of biomedicine is currently unchallenged.

But perhaps more importantly, acknowledgment of the de facto interplay between diverse healing systems in the U.S. has been seen as a call for a more introspective self-critique, especially among practitioners of primary care. In a thoughtful essay now required reading in some family practice residencies, physician G. Gayle Stephens observes:

From where I sit, the philosophical beliefs and attitudes of medical educators, the problems of clinical practice, and the organization and structures of medical care have common root defects that were contained in Flexner's famous report. They are the preoccupation with the human body as the only proper object of medical knowledge and the faith in experimental biology as the solution to all problems of health and illness. Until we take the whole human person in his or her social and cultural dimensions as the proper object of knowledge, until we expand our notions of science to include forms of rationality other than the logical, we will continue to depersonalize and fragment medical care, increase its costs beyond all calculation, and fail to make its benefits equally available to the whole population. (1988, 187)

Clearly both medical consumers and medical providers are asking for a careful evaluation of the relational as well as institutional patterns of medicine and healing—an evaluation in which specialists in medical folklore are playing an increasing role.

Intrinsic to the practice of “Flexnerian” medicine is the importance of institutional authority: from a patient's standpoint, the credibility and accountability of a practitioner of official medicine depend to a significant degree on the validity of credentials that guarantee that he or she is a participant in good standing in the formal medical community. But there are other forms of authority to which a patient may turn when in need of medical assistance. Experiential authority—personal recall and application of what has worked in the past—is persuasive but limited. Far more extensive is the realm of relational authority: the credibility of those individuals and resources whose accountability lies not with a remote institutional affiliation, but exists within the community. The healing practices and customs supported by relational authority represent just a portion of the affective linkages that bind a community through many shared forms of expression, including linguistic patterns, foodways, music, and other cultural manifestations. These expressive forms derive strength not only from the ways in which they fulfill the immediate needs of community members, but also from the ways in which they embody larger patterns of shared beliefs and values. Relational authority may extend horizontally to influence health-related practices of a group at a given time—“everyone does it”—or it may extend vertically to invoke generations of past practice—“we have always done it.”

The concepts of institutional and relational authority are not absolute or mutually exclusive when applied to contemporary conventional and non-conventional medicine. No physician, however impressively credentialed, would care to suggest that his or her accountability lies only toward the state licensure bureau, and many nonconventional areas of practice such as chiropractic and acupuncture have official or quasi-official levels of institutional education and control. The very complexity of medicine and culture in this society invites analysis in relational and institutional terms. Observe, for example, how commercial medicine depends on one model or the other in its advertising to the general public, depending on the nature and effect of the product: television viewers are either lectured by actors in white coats gravely citing research results, or are entertained by commercial minidramas in which Dr. Mom is rewarded for her recommendation of an over-the-counter medication for yeast infection by her daughter's fervent "Gee, Mom, you're swell."

Riddling through the complex interplay of health belief systems in the U.S. is a task well suited to the skills of medical ethnography. Most of the contributors to this collection are medical folklorists, or medical anthropologists with close ties to the related field of medical folklore. For nonspecialist readers who are curious about the distinctions between the fields of medical folklore, anthropology, and sociology, it may be helpful to observe that folklore as an academic discipline has tended to address cultural aspects of behavior which, though informal and not protected from change, have nonetheless demonstrated a certain consistency of form over time and which are particular to a specific community or group within a larger society. Central is the concept of "traditional" forms of expressive behavior, both stable and dynamic, which satisfy basic human needs at the immediate levels of subsistence (food, shelter, healing), and which also reflect and maintain deeper beliefs and values within a social group. The method of inquiry into these patterns of behavior has always been qualitative, setting the discipline apart from sociology, and has tended to concentrate investigation in communities and cultures existing within the society of the investigator, rather than pursuing research in more exotic faraway locals, as has often been the practice historically in the field of anthropology.

The tendency of folklorists to examine discrete expressive forms—in the case of medical folklore, specific remedies—has been both a liability and an asset to the discipline. At its best, the study of folklore incorporates what is most valuable in both the social sciences and the humanities, interpreting traditional practices as texts as dense in meaning as poetry. Early folk-medical scholarship was decidedly "item-centered," resulting in ambitious cross-cultural comparative bibliographies such as the magisterial work produced from those long file

boxes by Wayland Hand, in which practices common to many different communities and cultures could be examined and commonalities adduced. But the item-centered approach—not unlike the extreme forms of allopathic practice—removes the object of their study from the rich matrix of social context, leaving behind much of what may be relevant to an understanding of the whole picture. In this volume, Bonnie B. O'Connor and David J. Hufford, both pioneers in the area of medical folklore, offer a comprehensive introduction to a contemporary approach to medical folklore centered on an understanding of folk belief systems, examining the ways in which these systems draw on bodies of knowledge and belief, support specific means of knowledge production, provide explanatory models for causation and treatment, and supply evaluative strategies to determine efficacy.

If effectively pursued, the methods necessary for the quantitative interviews customary among folklorists tend to undermine a purely item-centered approach. So-called “participant observation” has been at the methodological core of anthropology and folklore for decades, a process in which the investigator acquires an experiential understanding of social process by actually engaging in the activities of a community while simultaneously observing them with an eye to making sense of them in disciplinary terms. The consequences of this process of engagement have been pervasive. Readers whose background is medical may be surprised at the extent to which contributions to this collection are presented in the first person, unabashedly presenting “consciousness of self” as an integral part of the presentation of research. What may appear to be a radical (and unnerving) subjectivity reflects a current tendency in the ethnographic disciplines toward a radical empiricism—an experience-centered approach which not only attempts to take into account the full complexity of experience of individuals in the community being studied, but also the full complexity of the subjective and objective experience being reported by the investigator. Thus readers of the article concerning Los Angeles *botánicas* by Michael Owen Jones and his colleagues can expect not only an analysis of the meaning of these “invisible hospitals” in the communities they serve, but also an impressionistic evocation of their sights and smells.

When a field worker sets about studying a traditional healer, for example, he or she becomes a student, figuratively and sometimes literally an apprentice to that individual. The native preceptor may in fact become an active collaborator in the publication of the research, and, not surprisingly, an increasing number of researchers in the ethnographic disciplines are or become participants in the cultures which they study. A collaborative model for research is becoming increasingly common in folklore and anthropology. The articles “Invisible Hospitals: Spiritual Herbal Centers in Ethnic Communities” and

"The Poor Man's Medicine Bag: Empirical Folk Remedies of Tillman Waggoner of Knoxville, Tennessee" both represent such a cooperative model; in the latter the informality of the relationship between authors and practitioner is suggested by their references to the subject of the article by his first name, "Tim." Addressing the communicative conduits, both personal and commercial, in which folk medicine may be shared in a community, the authors raise old questions concerning the role of the practitioner as both healer and entrepreneur in impoverished, underserved, or "biomedically resistant" communities. These are issues which go back at least to the herbal publications of Nicholas Culpeper in the seventeenth century.

A common stereotype of folklore culture views it as existing in isolation from both academic, elite culture and from profit-driven and media-promulgated influences. "Folk" communities in which traditional ways predominate are scarce today, both in the U.S., and to an increasing extent, worldwide. A more useful model suggests that each individual within complex contemporary cultures appropriates systematic elements of health belief from a number of sources: communal and traditional, journalistic, commercial, and institutional. In "Competing Logics and the Construction of Risk," Diane Goldstein examines the subtle cultural contextualization of even "objective" information conduits concerning risk factors in AIDS, raising powerful questions concerning the consequences of policy based on such data. Shelley Adler examines the bases on which breast cancer patients evaluate conventional and nonconventional treatment choices, and the implied consequences for biomedical practitioners in addressing these patient choices. Both essays remind us that any approach to communication in health care is shaped at least in part by culture-based terms and parameters.

The so-called "new age" movement in health and spirituality has been something of a headache for folklorists and physicians alike. It is a loose term referring to a quickening of interest dating from the late 1960s in religious and health belief systems characterized by a perceived integration of body, mind, and spirit and attunement of cosmic or natural forces; an eclectic appropriation of American Indian, Eastern, and self-constructed systems of healing and spirituality; and an appreciation of the therapeutic spiritual effects of altered states of consciousness (Levin and Coreil 1986). Physicians are frustrated by the critique of institutional medicine both implied and directly expressed by many devotees of "new age" modalities. Accustomed to identifying and interpreting community-based traditional behavior, folklorists are annoyed by the cavalier popular appropriation of traditional practices in a manner that can be insensitive and even potentially exploitative, and are frustrated as well by the challenge to the traditional tools of investigation of cultural behavior, especially when the

“community” of practice is a virtual one often linked only by electronic means. William Clements and Frances Malpezzi discuss the dynamics supporting two areas of new age interest: the borrowing of practices relating to the American Indian sweat lodge rituals, and the attribution of authority to the medical recommendations of the German medieval mystic Hildegard of Bingen.

The final two articles in this collection raise powerful questions for both ethnographers and practitioners of formal medicine, both at the phenomenological and the epistemological levels. “Participant observation” as a methodological technique is relatively straightforward for the field worker when “participation” involves practices that do not challenge basic assumptions, values, and beliefs. Mastering the steps of a social dance or learning to pat a tortilla into shape may provide valuable experiential insights that have implications for much higher levels of meaning. But for investigators who accidentally or intentionally place themselves in the way of experiences that are uninterpretable within their native frameworks of understanding, the consequences of participant observation can demand not just an empathic grasp of the beliefs of others, but a radical transformation of one’s own beliefs and understandings and a concomitant distance placed between the researcher and his or her constituency of colleagues and students, not to mention friends and family. When it is the body as well as the mind that has undergone an experience uninterpretable save through “other” ways of knowing—when the investigator of healing practice is unexpectedly healed—the issues go to the core of what it means to know and to observe. Bonnie Glass-Coffin’s discussion of the questions crystallized by the challenge she faces in teaching ethnographic courses based both on the Western critical tools of inquiry and on her own experience of shamanistic practice and healing provocatively frames many of the tensions faced by medical ethnographers, whether or not they have the courage to address the tensions as directly and publicly as she does here. Pursuing related themes, Barre Toelken explores the meaning of a personal experience in which, in Navajo terms, his survival required of his adopted family a series of immediate personal sacrifices followed by tragic consequences extending to the present—a price with which he is only beginning to come to grips professionally and personally decades later.

Most of the contributors to this volume have worked directly with formal medical institutions, applying their ethnographic expertise to contemporary problems in medical education and practice—a relatively new area of “applied folklore” which has special relevance to those who look forward to an era in which a “post-Flexnerian” approach to primary care is an honorable and honored companion to purely scientific medicine. At the close of the above-quoted essay in *The Task of Medicine*, Gayle Stephens recalls Abraham

Flexner's likening of the role of the physician to that of an engineer who makes life and death decisions. Stephens suggests that "a physician also needs the creativity and intuitiveness of the novelist," the same qualities of observation that also make for good interpretive ethnography. The contributors to this volume look forward to updating colleagues on the status of research in this rapidly developing area of our discipline. We also hope that the results of our research will have a larger consequence, perhaps "ambushing" a few readers who as yet fail, as I too once failed, to see the dynamic, emergent nature of nonconventional health belief systems, and the importance of understanding, and when appropriate, honoring the diversity of healing logics.

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