MEDICAL ANTHROPOLOGY AND DEVELOPMENT: A THEORETICAL PERSPECTIVE

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Abstract—It is argued that social and cultural anthropologists concerned with health systems need to
insert their analyses into the wider perspective of three processes—development, the making social of
disease, and their view of anthropology itself. Development can usefully be seen as the complex, often
contradictory, process whereby capitalism as a mode of production comes to dominate over precapitalist
forms. At the same time these very forms remain an influence over health behavior even in the most
developed societies. Such an approach to development also involves attention to commoditisation and
the existence of not immediately apparent class interests in, for example, both Western and traditional
medical rhetoric, high technology medicine and pharmaceuticals. The making social of disease is facil-
tated by conceptually in three phases, crudely biological disease, psychological illness and
social sickness. The current disease/illness dichotomy is criticized as lending itself to a characteristically
ideological, individualist or at best dyadic approach to sources of ill health. The nature of ritualization
or ceremontalization in capitalist and precapitalist society is explored with the help of brief reference to
the author's own field work in Lusaka and to studies of Amhara in Ethiopia, a village in Tamil Nadu,
South India and of doctor-patient interaction in Swansea. Following and developing Young's ideas,
sickness episodes are characterized as dramatic "games" which create, recreate and confirm social
ideologies in all their contradtctormess. A critique of the Tamil Nadu study reveals the potential for
social change implicit in plural South India. Material from Swansea is used to suggest the differences
between the concentrated drama in space and time characteristic of precapitalist ritual and the diffuse
nature of both ceremonial and ideology in a developed capitalist society while once again pointing to the
potential for social change revealed within apparently conservative functionalist analysis.

Finally, social anthropological analysis is presented as the analysis of custom in local social process
and it is argued that this process in turn needs to be seen in a wider context which will help anthropolo-
gists to bring together the concerns of political economy, sociology and anthropology and to facilitate
social change rather than, or as well as, individual adaptation.

INTRODUCTION

It is sometimes argued that the post-colonial period offers special opportunity to anthropologists in the
field of health and medicine. They could contribute to the understanding specifically of the small scale social
process by which biological disease becomes an episode of social sickness perhaps by way of conscious-
ness of being ill. This view while in one sense ambitious now seems to me too limiting to the scope of anthropology [1]. In this paper, I argue that the medical anthropologist has to situate his/her work in the context of three processes—development, the making social of disease, and in the more general concepts of anthropological analysis.

DEVELOPMENT

An over-simple Marxist view, derived from the Communist Manifesto, suggested that the process of
development could be seen in the first place as a reliving of the stages passed through by European society
and the gradual total destruction of all social relations not determined by the cash nexus. Precapitalist forms of society are, in this view, inexorably smashed and destroyed by the greater economic efficiency of capitalist social formations, as indeed are egalitarian societies in the face of slavery or feudalism. In the last analysis this simple model may not be far from an accurate description of the product—but the process is more complex and more interesting and the number of pathways to the final goal manifold and various. A number of more or less Marxist writers on economic anthropology have tried to analyze the articulation and interpenetration, even interdevelopment, of more or less advanced modes of production. The economy of health care (traditional or Western), the ideology of beliefs and practices relating to disease and of the concept of disease itself, the politics of healer-patient and patient-patient relations, like other aspects of economy, ideology and politics, are all subject to and the subject of changes in the nature of production relations and the relationship between one set of production relations or mode of production and another. What we call pluralism in medical systems can be seen in these terms and as part of a continuum.

In Lusaka in the late sixties, it was no longer a surprise to anyone to see traditional medicines sold as commodities over the counter in the markets, isolated from both the rituals of the Nganga and the cosmology of their (very diverse) tribal origins. Wulf Sachs records the shock of his Black Hamlet "witch-doctor" observing the same process in 1936 Johannes-
burg [2]. In modern India the sale of Ayurvedic rem-
edies packaged with the paraphernalia of the modern pharmaceutical industry causes no pain to the pandit, although it may cause pique to the allopathic phys-
ician. The commoditisation of cures into a product, whether what is sold is a simple package of chemicals, or a complex social process is part of a number of
general choices and changes. In Lusaka at the extremes a potential patient chose between impersonal, universalistic ruling class backed Western Medicine at one end and personal, charismatic popular curing procedures at the other. These apparent extremes however not only overlap but share a secular trend towards the ideological values of dominant capitalist society. Ideally the personal relationships around which medical beliefs and practices are structured in traditional society or indeed initially in Swansea or New York [3, 4] are interpersonal. They are between the incumbents of domestic roles (spouses, parents and children), the known and named corner store pharmacists, the wise aunt or uncle, the specified and known Nganga who unlike the others is genuine, and whose genuineness [5, 6] arises and is perceived precisely in contrast to the fakeness of his/her competitors. This, in Lusaka, showed itself in the contradiction revealed in surveys between the universal theoretical content for Ngangas as a group and the equally universal practical resort to them as individuals.

Ideally, in contrast, and correctly in the eyes of at least some Western physicians and perhaps especially surgeons, biomedicine requires of its adherents a universalistic recognition of the abilities to control disease of all the members of specific categories who are labelled by name and symbol. Doctors, usually male and in white coats carrying stethoscopes exist at one level; nurses usually female and in uniform represent another. The task of the patient is to learn to read the signs, accept the symptoms and understand the symbols which, correctly read, reveal the limits not only of healing ability but of power and control derived by the individual from his/her category and its permitted level of information. Anthropologists can chart, and have charted, not only the invasion of the spheres of the particularistic first by the universalist second, but also the conversion of the first into the second as part of the process of capitalist domination. Studies in advanced industrial society, however, also reveal the resistance of domestic production systems to total submergence. The patient, outside the hospital, is only barely controlled by the physician. Simmons and Webb in their study of Going to See the Doctor in Swansea [4] show how the patient prepares her own ground with domestic and gender allies before entering the doctor's surgery; seeks against all odds to define the situation and control the action within the consulting room; and after leaving, again in a social context, relieves, redefines and re-evaluates the advice received, and takes her own decision what to do. Only when physicians transfer the patient's 24 hour life to the environment they control, the hospital, does the characteristic rational-bureaucratic organization of the capitalist mode of production totally dominate. An interesting account of a halfway stage in this process and the category struggles to which it gives rise is in David Boswell's account of Escorts of Hospital Patients (in Lusaka) [8].

As I shall argue (following and developing Young's seminal 1976 paper [9]) in the next section, part of the essential process of making social the disease, of transforming it to sickness, is what he calls the exculpation of the patient. I prefer to think of this in the more general terms of legitimation. This too can be presented as two poles of a continuum, stretching from particularistic to universalistic. The traditional healer points to socially determined if ultimately individualized external reasons for disease—an evilly disposed Mother's Brother or co-wife. The Western physician points to the ultimate in universality—biological causation affecting ego specifically and in a sense alone. In the last resort, he supplies in writing and in precise if sometimes spurious terms (e.g. Pyrexia of unknown origin) the specific cause of death or temporary absence from workaday roles. Traditional healers like all patients speak their minds with all the redundancy and lack of control that that implies. Weber's inclusion of written files as one of the characteristics of ideal type bureaucracy is important to remember here. Vieda Skultans notes a testing exception when she writes of spiritualists in Swansea: "In fact there is a stigma attached to knowing about spiritualism, especially mediumship and healing, from published material" [p. 196] [10].

Two further aspects of development penetrate from outside the subject matter of the medical anthropologist. First, the existence of actors outside the immediate social situation: like the steel axes which changed the culture of the Siane [11] before the representatives of the culture which made them followed them into highland New Guinea, so the products of the international pharmaceutical industry go ahead of the physicians who are their chief salesmen in the Western world; anthropologists need to be more alert to this than their sociological colleagues who neglected this aspect of the health industry for so long.

Second, the societies in which medical pluralism flourishes are invariably class divided. Evans-Pritchard [12] and others in their discussion of medical pluralism discuss the differential access and control of chiefs and commoners, but in countries like India and Zambia there have emerged at a national level classes with contradictory vested interests often saying one thing and doing another, presenting a familiar contradiction between ideology (as a set of overt and covert beliefs and practices) and rhetoric (an overt statement of beliefs). Thus, in both countries, part of the populist anti-imperialist rhetoric is, if not opposition to Western medicine, at least support for traditional healers and systems of medical thought, but as I have argued elsewhere, this support is literally skin deep [13]. Members of the ruling class whose ailments require deeper penetration look to injections, drugs or surgical intervention from the West. Facing the other way towards WHO and its conceptions of preventive medicine for rural masses, again the rhetoric conflicts with class needs either for personal curative medicine against the diseases of albeit relative, urban affluence, or for the symbols of power and status represented as much by the gleaming chrome of the recurrent finance-absorbing urban white elephant hospital, as by the airport and the processional way which customarily joins it to the capital.

Another aspect of class ideology is the over identification of an influential part of the petty bourgeois elite with the high status attributes of Western science and a characteristic overstatement of the merits of Western technology including medicine. In the metropolitan centers of the West, relatively unthreatened
physicians can claim less while they can usually achieve or appear to achieve more.

THE MAKING SOCIAL OF DISEASE

The second process which medical anthropologists are concerned with in the understanding of the relevance of medicine to development is the making social of disease. Here it is necessary if our analyses are to be adequate to suggest three phases which will not always all be present and which will not always manifest themselves as discrete stages—disease, illness and sickness. Disease by which I mean a biological or pathological state of the organism whether or not it is socially or culturally recognized, and whether or not the patient and his/her advisers, lay or professional, are aware of its existence. Many so called community surveys in industrial societies have revealed considerable pools of such disease, for example—uncontroversially diabetes and glaucoma: more doubtfully hypertension; most questionably depression. The effect of such surveys is, at one level, to bring such diseases into social consciousness as sickness, without the intervention of the personal consciousness of patients that they themselves are ill. They also raise (as Cochrane long ago pointed out) a particular variation of the ethical problem of should the doctor tell. Western curative medicine is predicated on the sequence—being diseased, feeling ill, involving healers in the legitimation and creation of sickness as a social state. Social epidemiology changes the order to sickness—disease, and if the doctor does tell, illness. It is this change of order which causes ethical discomfort to the physician to an even greater extent than the iatrogenic sequence—infection, sickness, disease.

The second category I wish to use is illness, by which I mean the patient’s consciousness that there is something wrong (about which in disease terms he/she may or may not be technically correct—alot here of course depends on who is to be the final judge). Brown and his associates in their recent studies of depression see themselves as concerned with the prevalence of a disease [14]. The expression they use is “psychiatrically ill”. Leeson and Gray [15] comment of their subjects, “we should prefer to say that they were severely distressed” (p. 164). Paradoxical, perhaps, if the usage proposed here is adopted, the contradiction between Brown and his commentators can be resolved. As Brown et al. themselves argue they transfer the problem to the consciousness of psychiatrists—the psychiatrically ill are those who would be accepted for treatment if they presented themselves at a psychiatrist’s clinic. More straightforward if more remote: were those “patients” in Lusaka who presented themselves at a healer’s because of a run of bad luck in love or litigation, or in preventive terms to avoid such an outcome.

The still more straightforward situation, the ideal type model is of the prepatient who notices a sore throat, a runny bowel, or an aching head, decides that he/she is ill and takes culturally and socially appropriate steps which result in the making social of his/her sickness.

Through the pioneering studies of Fabrega [16] and Kleinman, the distinction between disease and illness is becoming commonplace in American anthropology. The latter writes:

In the language of our model, disease denotes a malfunctioning in or maladaptation of biological and/or psychological processes. Illness on the other hand, signifies the experience of disease (or perceived disease) and the societal reaction to disease. Illness is the way the sick person, his family and his social network perceive, label, explain, evaluate and respond to disease [17, p 88].

Leeson and I [7] in our attempts to understand illness behavior in Lusaka followed earlier (equally American) sociologists in proposing the three phase model I am here reiterating. I think we were correct and that Kleinman’s model has highly characteristic inadequacies which mark its cultural and curative bias.

The individual patient and his/her family is seen as constructing a reality around the disease event out of the cultural material that comes to hand. The physician in contrast constructs his cultural reality which if there is “genuine” disease is likely to be correct. If he detects no “disease”, he collects a fee when appropriate and releases the patient to go elsewhere. The anthropologist imports his knowledge of the patient’s cultural construction to the physician whose ability to impose his own (correct) view of the situation is thereby enhanced. Social reality is easily reduced to dyadic transaction terms in this way. Thus Allan Young [9] imprisoned (if only temporarily) in this model is forced into an equally individualistic view and sees the process of making social as exculpating the individual by other individuals in a cultural context. This means that he has to append the genuinely social ontological aspects rather artificially to his argument (see however [34, p. 115]).

If, on the other hand, we restrict illness to the making individual of disease by bringing it into consciousness we can use sickness to apply to the total social process in which disease is inserted. This will force us to include in the same process of social interaction and historical development the totality of healers, lay and professional, and the totality of distressed.

By using the concept of illness, we enable the physician to see how his view differs from the patient—and how he can impose his cure. The concept of sickness enables us all including physicians to see more clearly the significance (in U.S. public medicine) of, for example, the maleness and the whiteness together with the class position of the physician and the maleness, blackness and subordination of the patient. Neither black woman nor white professional male steps outside society when they step into the consulting room. Indeed, as Young suggests, power relations within it are intensified because it represents the interface of life and death, culture and nature. Their differing perceptions of themselves and their respective situations come neither by chance (nor by science on the one hand and folklore on the other), but by their social experiences themselves, categorically limited if not determined. The experience of their interaction contributes in turn to the structure of society outside. Perhaps the most familiar example to us is the relationship Father/Mother/Child in the “traditional” elementary family and its parallel Doctor/Nurse/Patient in the “traditional” hospital [15,
Another example is provided by the neat stratification of Zambian urban society [21, 22] and its reflection and reinforcement in the hospital—a majority of Zambian black women patients and their children were treated by Black Zambian Medical Assistants and Enrolled Nurses, and Coloured (often South African) State Registered Nurses, controlled by White English Sisters and Matrons, Indian doctors, and white consultant physicians and surgeons. The only groups of equal ethnicity and status to the patients were the female relatives who fed them and the orderlies and messengers who, in this situation, provided the basic services in the institution. Leeson and Gray point out the way in which ritual practices reinforce and confirm the role/statuses of the British hospital—"the housekeeping of the ward sister and the consultant's ward round in which the patient is distanced both by the nature of the language used and not being addressed directly but only through the nurse. They remind us of the fantasy hospitals of literature in which patients (if they deserve to) nearly always get better and in which the (virtuous) nurses get their man, and thus transfer from a professional to an amateur mothering role.

This ritualization (or more strictly ceremonilization) is an essential part of the making social of sickness in most societies although the nature of ritual seems to me to vary only partially autonomously from the nature of production relations in general.

Social concern is expressed by public ceremonies in many pre-capitalist societies—"spirit dancing and cults of affliction as well as public divination [23–25]—and social distance is expressed by the positioning and differential participation of sufferers, healers and significant others. They are all, however, present at one time and in one place. In capitalist society one purchases the symbols of taking to one's bed and regular injections and measurements. Changes in status are marked by changes in transport (stretcher, wheelchair and walking stick), and ultimately by linguistic practices. Sickness through language, literature and "tale" precedes and survives individual disease, illness, personal consultation and legitimation.

In pre-capitalist societies, baths, washings and lustrations are seen as adding to the patient and perhaps his/her ailment; in capitalist society baths reduce. This is symbolic of a general difference—an episode of sickness is a disturbance of the relationship—biological-cultural-social. Treatment in pre-capitalist society is to contain by making social. The social mechanisms may emphasize interpersonal, and therefore in the last analysis, containable conflict. In all class divided society, but especially in advanced capitalist society, making conflicts social is too threatening. Sickness is therefore pushed back through psychological illness to biological disease. The social processes paradoxically operate in order to individualize. These points can be demonstrated and illustrated through work in Ethiopia [9], in Tamil Nadu [26, 27] and in Britain [4].

Young argues that among the Amhara, sickness episodes have what he calls ontological importance as dramaturgical contests which reaffirm and legitimate other aspects of the society's value system especially because, (a) sickness is always there and is relatively indiscriminate in the categories it attacks; (b) the onset of a sickness episode compels people to initiate or participate in it and in turn compels them to reflect on their social order; and finally (c) since etiologies are socially constructed but out of pre-given cultural elements it forces them to recreate and reinforce their culture. He notes the similarity with rituals in general. He might have continued explicitly to point out (following Caillois [28] and even Frankenberg [29, 30]) the similarity between such episodes and sports contests in other societies—a point his language makes implicitly. He writes:

Episodes of acute sickness have many of the characteristics of contests and so they are convenient mechanisms for making the kinds of decisions that I have discussed. They are episodic, their possible outcomes are clear cut, they are played according to highly conventionalized rules and generally their outcome cannot be predicted before the episode is played out.

One could add that they have other characteristics that Caillois attributes to some, if not all, games—there is characteristically an audience, and a sacred space: they involve both kinds of contest, between humans and against natural forces (including mystical ones); and they often involve mimetic, acting out, and vertiginous, trance-like activity (see below).

The process of making social sickness includes the converting of "signs" into symptoms which are "expressed, elicited and perceived in socially acquired ways". The symptoms in turn become polysemic expressive symbols which at once indicate the illness of the individual and the "extra-ordinariness" of the social situation, and the continuity of the culture (Frankenberg's esces). Societies other than Erewhon [31, 32] have special techniques which exculpate the sick person and transfer social accountability for their behavior to an agency outside the sick person's will [9, p. 16].

A sickness episode begins when the principal and/or his relatives decide the range of symptoms into which his signs could be translated. Next they must obtain the services of someone whose medical powers are appropriate to that range of symptoms. Under certain circumstances, they may have power enough themselves to translate the signs. Their choice of diagnose is a way of deciding what set of rules will be played, what individuals (including therapeauts and pathogenic agents) and audiences can be mobilized, and what sorts of social states will be involved. The therapist's task is to communicate and legitimate the episode's outcome, and this, too takes place according to rules shared by sick persons, healers, and audiences.

Here, notwithstanding his earlier emphasis on exculpation (for the individual) as the key organizing concept [9, p. 14–15], Young has correctly, in my view, shifted his emphasis to legitimation (for society at large). This enables him to conclude about the dramaturgical nature of serious/acute sickness episodes: the process of making social sickness includes the converting of "signs" into symptoms which are "expressed, elicited and perceived in socially acquired ways". The symptoms in turn become polysemic expressive symbols which at once indicate the illness of the individual and the "extra-ordinariness" of the social situation, and the continuity of the culture (Frankenberg's esces). Societies other than Erewhon [31, 32] have special techniques which exculpate the sick person and transfer social accountability for their behavior to an agency outside the sick person's will [9, p. 16].

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... on a field dense with expressive symbols; there is the expectation that events will move toward a climax; the episode is marked by a mood infused by extraordinary emotions rising out of man's profoundest fears; and it is sustained by a clearly articulated dialectic of persons and forces that lends a coherence to the world of events and experiences that is lacking or obscure in humdrum situations.

Young is, of course, right to continue to point out that in the West it is different because of the division of labor and the greater development of power stratification. What he there describes is consistent with the general lived ideology of developed capitalist industrialism.

The active and powerful healer and his passive and object-like client are symbolized in what seems to be a unique combination of ways the physician demands nakedness, recumbency, unresisting access to body regions that are called "privates" in everyday life and forbearance of the pain and discomfort which he causes— an assortment of forms that, in the West, is mainly limited to sickness episodes, the rearing of pre-adolescent children, the treatment of "unliberated" women during curtos and the management of the population of "total institutions."

Finally, he points out that the symbolization of sickness in the West also alienates the individual from the operations of his own body. The physician takes blood and looks at X-rays and seeks other signs independent of the patient's consciousness. He reserves the right to himself to decide whether or not to reveal what he thereby finds. One could go further than this, particularly for those physicians whose practice is informed either with one (by no means universal) approach to psychoanalysis or perhaps even by one kind of use of Kleinman's clinical anthropology and say that the Western physician seeks in his context with patients to alienate from them their very biography; their construction of the meaning of their own situational life project as well as the part of it which brings them to consultation.

The mechanism of this in one medical situation, the consultation with the general practitioner, and the symbolic opposition to it in the "story" is discussed below. Before turning to that however I want to discuss the intermediate situation of Tamil Nadu, described in two monographs by Djurfeldt and Lindberg [26, ?].

Although I share the general orientation of these authors I find their work difficult to use for, I think, three reasons. First, in a way that should make their work attractive to American sociologists if not anthropologists, they prefer counting attributes to analyzing cases. The reader is frustrated by the knowledge that they present in any detail only one case out of the one hundred and forty they confess to have collected. Second the classifications by which they proceed (and this may appeal too; see [33] passim, especially Kleinman and Fabrega) are not theoretical but typological. Thus healing is classified in terms of situations, and their construction of the meaning of their own situational life project as well as the part of it which brings them to consultation. The decision to grant one at all will be decided on the basis of caste; the amount and timing of repayment and interest is a matter of class [26, pp. 238–239]. The authors report a conversation with a chronic asthmatic:

If I take ill suddenly, I have to consult a private doctor in Kelambakkam. Then I need at least two rupees. Such expenses are usually covered by my cousin brother, Naguran. He gives me one or two rupees whenever I need. Is your cousin such a kind-hearted man?

Veerabadran laughed: It is no case of generosity. He is just paying for the services rendered by my eldest son who stays with him, grazing his cattle and doing other odd jobs. What do you think would happen if I called back my son and sent him to school instead? My so-called kind-hearted cousin would just turn his back upon me, even if I was suffocated to death by my breathing difficulties [26, p. 238].

Djurfeldt and Lindberg do not report any similar conversation with Naguran who perhaps might have said, "I can just manage to stay prosperous because my cousin allows his son to work for me." "He must be very generous!" "Oh no, I have to pay his medical expenses; if I stopped doing that he would soon take his son away and leave me to struggle as best I can."

Djurfeldt and Lindberg's main analysis of it comes in their description of the annual ceremony of the Mariyamma (Mother-Goddess) Cult, Adi-Kappu.
They argue that the social relations symbolized within it are now, like those described above, intra-caste rather than inter-caste (jajmani) and that this is an advance.

In the past [26, p. 250] the symbols of the ceremony and its organization stated the unity of society and all its castes, since all were present, and all contributed financially and by participating in the shared out sacrifice. But the complementary, hierarchical nature of relations of jati and jajmani was also reaffirmed (as well as the position of women and young family members. See discussion of kinship usage [26, p. 241]).

In the ceremony they witnessed and described, only one caste took part. It is a ceremony in one village, in one temple to one named goddess, Mariyamma. Other villages and temples celebrate other goddesses; villages are separate one from another. All the goddesses (they counted 25) are in a sense manifestations of the one goddess, Amman; villages are united one with another. The Goddess is seen (emically) as controlling relationships between society and nature.

“The aim of the Adi Kappu ceremony is to ensure the benevolence of Amman so that the crops may grow, the cows may calf (sic) and the women bear children, and so that no calamity may afflict the village.” “Only indirectly” is the ceremony concerned with social relations. The ceremony is in fact an exercise in preventive medicine and a symbolic statement about the most general social and natural significance of disease, illness and sickness.

The costs of the ceremony were met out of funds collected by the village caste council (jati panchayat). “Rich families gave generously to show off and gain in prestige, and the poor had contributed a rupee or so from their lean purses.” The ceremony [26, p. 245] consists of music, drumming and dancing until one man goes into a trance and is possessed by the Goddess who speaks through him. Questioned, the Goddess complained of the lack of a ceremony the year before, and a mere sacrificial hen the year before that. The ceremony is in fact an exercise in preventive medicine and a symbolic statement about the most general social and natural significance of disease, illness and sickness.

The authors argue that this ceremony reveals two elements of ideological significance—equality between equals and solidarity between non-equals.

Each member of the community should eat of the sacrificed food, as a manifestation of their equality before God (sic). Thus, the community approaches God as a collective, and communicates with Her through its representatives, the priest and the God-dancers. Afterwards the community shares the food sacrificed to God, as a manifestation of universal and equal membership of the collective body, which is the unit recognized by God. Solidarity, on the other hand, is stressed in the way of financing the ceremony, where the rich pay more than the poor; and in the food distribution, where all are entitled to a share, but where the poor have the right to receive more [26, p. 247].

They argue that the combined equality/solidarity of the ceremony is in sharp contrast to the “bitter reality” of everyday life—and the purification is a reconfirmation of the social order by asserting that unless man plays his role in the universe, by accepting his lot and his position, nature will cease to play her role too. This is the main annual ritual of the hamlet, but unless the goddess was mistaken or forgetful (the authors do not tell us) it does not appear to have taken place every year or when it did with equal expenditure. A more frequent renewal of social and natural order comes as Young has led us to suspect, with episodes of sickness.

Here, however, a multiple pluralism intervenes. Not only is there a choice between allopathic and “indigenous” pathways to healing, but each of these pathways branch in their turn. Those who follow allopathy can choose the Swedish Swallows Clinic in the village, private doctors in nearby towns, or government hospitals and clinics elsewhere. The authors number at least eight indigenous types of healers: Vaitiyen (doctors), specialists like snakebite curers, midwives, Manthiravathy (sorcerers), exorcists, God-dancers, priests, and astrologers. Nor is any one specific healer necessarily confined to one of these types.

The authors adopt, on the whole, a biomedical model of efficacy and show fairly convincingly that, from the point of view of patients, there appears to be little difference in the efficacy of the two pathways in general [27, Table 8.1, p.169]. They attribute this to the failure of the allopaths to live up to their own rationality in regard to use of resources, the imbalance between preventive and curative measures and the fact that the real “disease” is poverty which in rural India as in urban United States cannot be “cured” by medicine in either sense of the word. However their view that:

the persistence of the indigenous system (but of course not its genesis) and the reproduced cleavage of the medical system into two parts can be seen as a result of the inefficiency and irrationality of the allopathic one [27].

is surely simplistic in the light of their own analysis.

Perhaps part of the reason for this is their failure to distinguish between emic views (theories) of disease and illness and sickness behavior. Thus in rural South India, not only are there common sense explanations for disease in terms of poverty, water supply and the like, but there is a secular tradition of instrumental action. Since this is often outside or partially outside
religious activity they tend to ignore its ritual aspect.

The other difficulty in this part of the analysis is that following Levi-Strauss and Godelier (themselves perhaps limping behind Frazer and Tylor), they adopt an intellectualist view and analyze beliefs not in terms of the relationships of their production [34, 35] but in terms of supposedly universal patterns of human analogical thinking. For this reason, the only comparisons we are here able to make are the ritual and ideological nature of indigenous religious practice and that of allopathic medicine as represented in its local practitioners.

Recourse to the Swallows Clinic may on occasion be efficacious in biomedical terms, particularly for example against acute fevers. It does, however, involve submission to a Western system of values. For example, there are fixed days for different causes of consultation—a secular split between the disease and the patient which bafles the villagers who comment, “Maybe you can teach people to come on different days but you cannot teach fever to come on Mondays” [27, p. 109]. Again the clinic preaches in opposition to village ideology, complete egalitarianism between rich and poor, high caste and harijan. However within its own operation, nurses, doctors and ardes are hierarchically ordered with differential access to power, information and authority and all are seen as superior to patients. In addition, the clinic staff are seen as treating patients with equal lack of respect rather than with equal respect:

They do not step down from their position. They arrange the queues, and often which is natural in such a situation, they are overly strict and irritated. Many people are hurt by this lack of friendliness and consideration. As one patient said: “In Thayur clime they even ask the babies to keep quiet!” Or, as an experienced old woman said: “All the time they give you a red, a white and a yellow (vitamin) tablet, and then they just say, Nalla possidum Po’ (You will get cured Go!)”. The clinic personnel use the impolite and condescending po instead of poitive range which is the correct imperative to use between mutually respectful strangers [27, p. 111]

There is a drama hidden from the villagers but which they react to in allopathic behavior and which reaffirms European capitalist values. In Parsonian terms, it is concerned with system maintenance both at the clinical and the supraclinal level. Another example of it in the book under review, is the behavior of the allopathic physician who both conducted the nearest Government of India Clinic in the day time and his own private practice in the evening, and who “did not give any treatment to the child, probably because he thought it beyond recovery. His assumption was right, for the next day the child died in hospital.” He did, however, refer it to Madras Childrens Hospital. The author’s conclusion that the patient which baffles the villagers who comment, “Maybe you can teach people to come on different days but you cannot teach fever to come on Mondays” [27, p. 109]. Again the clinic preaches in opposition to village ideology, complete egalitarianism between rich and poor, high caste and harijan. However within its own operation, nurses, doctors and ardes are hierarchically ordered with differential access to power, information and authority and all are seen as superior to patients. In addition, the clinic staff are seen as treating patients with equal lack of respect rather than with equal respect:

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Naidu’s brother’s second wife had failed to conceive a child. His first wife gave birth to two sons when they were newly married. But both died, and then she did not conceive for 15 years. So they decided to send her back to her parents. Naidu’s brother married his present young girl-wife. But that did not solve his problems. It seems the young girl was put under heavy pressure in her husband’s family. Anybody would be unhappy being submitted to Naidu’s old mother’s regime. She is a miserly old tyrant; and she is the real head of the family. Besides being the youngest daughter-in-law, this girl failed to conceive. No wonder she was unhappy! Her anxiety was converted into a typical physical symptom: she developed spasms in her legs and chest pain. They took her to a muthirathu who gave her a talisman. That was two years ago. The talisman cured her from her spasms and the pains, but not from her childlessness. Recently she lost the talisman, and her symptoms returned.

When Adi Kappu was celebrated in 1972 the family tried to solve their problems using God as a therapist. During the Manyamma ceremony one brother-in-law first became possessed. He diagnosed the family troubles as due to evil eyes and spirits. He even drove one spirit out of the house. But this did not set the family at ease. The suspicion still remained that somebody in the family must also be possessed by an evil spirit. Then, later during the ceremony, Naidu’s old father became possessed. He pointed out the young girl and said, “You are the one who is possessed by
an evil spirit!" The priests, who led the ceremonies decided to try exorcism later in the evening. When they were preparing for the ritual, Nandu's brother-in-law became possessed again. He started to dance, swinging a bunch of neem leaves in the air. The girl was lying on the floor with an acute attack of spasms. The priests recited their manthiram. Suddenly one of them said, "It is very difficult to rid you of the spirit. If you cannot get rid of it, you'd better commit suicide." Apparently, the other pujaar felt he had gone too far, because they pushed him off saying, "This is not the right manthiram for this occasion. Let us stop here, and try some other manthiram, some other time." The ceremony was interrupted. All sat down and had their food.

Another case they briefly describe in terms of anxiety arousal can again be seen in terms of the mobilization of community concern for the recovery of sick (hysterical?) boy. It also illustrates the potential of Caillois categories already referred to as an extension of Young's approach.

The boy had been nearly run over by a jeep some weeks before, and since then he had frequently wept and could neither eat nor sleep. He was taken by his mother to a ceremony in the Madurai Veenam temple in Penapalli. There a man danced before the God and became possessed by Him. He was a frightening figure brandishing a sword and dancing in front of the boy who was standing alone in a big circle of devotees. The boy was pale and sweating, terror-struck by the God appearing before him. The dancer was going through a crescendo, dancing in a circle around the boy, coming closer and closer, brandishing the sword closer and closer to him. The climax came when he suddenly struck the boy fiercely with the sword. The boy broke down, deeply shocked, and had to be taken care of by his mother. We don't know the outcome of this case. We can imagine that the therapy was not very effective.

We can finally accept Djourfledt and Lindberg's conclusion that there is a pluralistic equilibrium in Thailur and by implication elsewhere in Tamil Nadu and South India but we have argued that the understanding of this equilibrium requires a more complex, because more sociological, model of the drama of sickness.

As a final example I turn briefly to a study of consultation in general practice in a British town although I do not have space to do justice to its fascinating ethnography. We have to see this against a background of medical culture which the authors do not specify. While the allopathic system is here the one dominant, and access to hospitals, consultants, etc. is by way of the general practitioners studied, clearly most ailments do not find their way into the hands of healers at all and some like those in Vieda Skul- lantas' study [11] in the same town seek, as well or instead, spiritual or other forms of healing seen as less orthodox. The patients discussed entered into consultation after lay discussion and, as we shall see, evaluate consultation in their own non-medical environment. This environment is colored by popular lore about health and disease and by ideologies of the medical system transmitted, reinforced and sometimes created by ever popular television series, romantic novels and newspaper anecdotes.

The key chapter for our purposes is the one in which the authors describe the "stories" told informally by patients about doctors and their encounters with them. As they correctly point out such stories are a form of communication (1) which highlight a process by which people make sense of past events, (2) in which certain standards of behavior of doctors and patients emerge, are sustained or are changed, and (3) in which some redress is made for the inequalities in the relations between the client and the professional. The story is thus a means of accounting for or explaining the social world of doctors and patients, is a means for the negotiation of norms and affirms the integrity of the patient [4, p. 90].

Let me give two brief examples of parts of such stories.

Now, I had, I've got a bunyon see, this was a scream. I was in agony with it, it turned septic. Well, I went down to the hospital now, and they laid me on a bed in a room, and well the doctors come in like that at Cranfield, in the doors. Well, I laid there for two hours with my shoe off, and Mr. Brondey came in and looked and said, "Do you want an operation?" "I don't know." I said. "Fair enough," he said, and that was that. I thought---well---I went over to my doctor raving, I said it was his place to tell me if I needed an operation. He didn't even touch me [4, p. 88].

(I think Cranfield is the site of a television series hospital—R.F.)

The other story I wish to quote illustrates iterarual the importance of labelling terms—lumbago and sciatica—and the rebellion against doctors which reinforces allopathic medicine.

Teller. Dr. Fletcher is marvellous. I've got complete faith in him, I trust him completely. Anything he says, that's right by me. Now Bailey, I don't like. There was this time when I had this terrible pain in my back. I was dragging myself around—I had to go on because of the baby, but it went on and on, it was driving me mad, I couldn't stand it any more. So my husband called for the doctor and Fletcher couldn't come, it was Bailey's day for home visits. And honestly, without a word of a lie, he was in the door, took one look at me, and said, "Lumbago, you'll have to take it easy." That's all he said and was gone. I didn't have a chance to ask anything, nor did my husband, he was out of the house too fast. We just looked at each other in amazement.

Interviewer. Didn't he do anything, didn't he give you anything for it?

Teller. No, he didn't give me anything for it—and I ask you how can you take it easy with a young baby? Well I wasn't satisfied, and Fletcher who came out to see me a few days later because it was no better said it was sciatica, which it was, and treated me for it. He appreciated I couldn't drop everything with a young baby to look after [4, pp. 104—105].

Unlike other conversations, even those about disease, death and doctors, stories have a dramatic ritual character. When the authors listened to their tapes, they found only one person spoke at a time in storytelling. Not only was there an audience but it was an audience which listened and empathized. It interrupted only to prompt and stimulate detail in the often familiar and often repeated tales. The stories had dramatic form and quality: a scene was set—hospital, home or consulting room—the characters were introduced—doctors, patients and supporters—a conflict of meaning and interpretation was presented and analyzed. Finally, the story has an exclamatory coda in which a moral is drawn. The stories were not
intended to be nor taken by their hearers to be apocryphal. They were essentially eye-witness tales—in which the actor/narrator was made to be (in retrospect) the active generator of events but nevertheless in the end, the victim also. In the rest of the study, we learn that the active role of patients in deciding when to consult and what to consult about which initiates patient/doctor interaction, is in the consultation interview itself, reduced to near passivity. The doctor invites the patient in, questions, examines, probes, comments, writes notes, prescribes and dismisses. He (almost invariably he) does all this in a firm, controlled, loudspoken, linguistically formal way. The patient listens, accepts and respects while she is in the consulting room. Action is determined outside at a different time, in a different interpersonal social context. The doctor's social context is bureaucratic, organized, rational—backed by a whole major industry and a clearly formulated ideology and culture. It is at its most essential concerned with pathological interruptions to biological processes. The patient's is personal, particularistic—and organized and rational in a different way. It is concerned with interruptions in a social process. The story reconciles the two and reverses the realities—passive/active, powerful/powerless, disease/illness. It is interesting that when the stories are challenged, their "reality" is defended by introducing new characters from the personal milieu—a husband or relative, or a personalized doctor rather than the incumbent of a doctor role. The authors did not collect or analyze doctor's stories but one knows from other contexts that these are not concerned with the same problems. They may be about patients unsuccessful attempts to sabotage the social order, or to refuse the medical definition of the situation. Or they may illustrate the hierarchical inequalities and attendant stupidities of physicians in other positions than the speaker—the social ignorance of the technically brilliant hospital consultant—or the similarity to the patient's ignorance of that of the general practitioner—in the eyes of the consultant so poorly trained, so long ago.

The authors conclude:

Storytelling is significant in terms of social control. It is both an appeal for action but at the same time an appeal to inaction. It is an appeal to action in that a latent function of the stories is in coaching people about how to behave in front of doctors, giving them recipes for action, warning them what to expect. But at the same time they appeal to inaction over those things that go wrong. Conflict is expressed not to the other actor in the situation, but to others who have no, limited, or very little power to do anything. A kind of fatalism is implicit. A picture comes across of the stoic, patient of the hardships (illness) and difficulties (doctors) of life [4, p 111]

From our point of view, it is the last sentence here that needs spelling out—in Swaziland, as in Ethiopia and India, disease provides an opportunity for the dramatic statement, reinforcement and restatement of ideological and social realities. But like the ideology itself, the statement is diffused over space and time. The experience of sickness—socialized disease—is not focussed for most people, most of the time, on a single dramatic incident or ritual. It is built up through specific cultural forms (TV, newspapers, novels), through isolated transactions of a quasicommercial exchange character, through isolated and isolating individual experience, through power-asymmetric dyadic relationships, and through a specific folk lore—which is situated in space and time, with an audience and in a social context. It involves not merely a cultural statement about what it means to be ill, but a social statement about sickness in process. This kind of mythic ideological representation can become destructive of the system but only if it is organized from outside and by a counter theory. The same stories repeated within a framework of gender consciousness raising, patients association rebellion, or overturning of status divisions in a Chinese village could (and at times have) become the tinder of revolution. The British National Health Service, of course, provides no such environment which could convert them to the material of radical social change.

**Processes of Anthropological Analysis**

There has been implied in what I have said up to this point, a particular view of anthropology and its methods which is not universally accepted or indeed acceptable and which must now be brought into the open. As I see it (following I think, Max Gluckman) the arm of the anthropologist is not merely to describe local custom, or even to show the manner in which diverse customs at a local level or in a particular society fit together in a more or less coherent cultural pattern. We have to go beyond this, at least to the extent of situating customs in the context of local social structural process (even if we thereby risk an accusation of structural-functionalism). It is because they do this I would suggest that classical writers as diverse as Evans-Pritchard on the Azande, Levi-Strauss on Myth, Radcliffe-Brown on Australian Marriage, and Herskovitz on East African Cattle are recognizably engaged in a similar exercise. This does not, of course, mean that we have to accept their analyses. These we judge further by their adequacy to the problems they set themselves, the importance of the problems, and the internal consistency of their arguments.

I am, however, here arguing that we have to go beyond this and to judge the analysis of custom and social process at local level by the degree to which it helps to explain the articulation of levels. If processes of social interaction are producing customs at the level of the village, how are these articulated with ideological, political and economic systems at national and even international levels. It is a criticism both of British sociology and anthropology as well as of ourselves that on return from Lusaka, Leeson and I were constrained to produce two papers—one, Intermediate Technology and Medical Care, was correctly foresen as interesting sociologists, hardly mentioned traditional medicine, and discussed the emergence of Western medicine in the context of Zambian class relations, and world politics. The other, although even then tangential to the exclusive interests of many British social anthropologists, ignored this general context and concentrated on the nature of the Nganga's activity—social aspects of choice of healer.

Social anthropology is unwise (as is sociology) to confine itself in this way for it seems to me that it can potentially reveal the "missing link" without which
the analysis of major social change founders (for lack of an anchor chain); what effects are produced at local level by national and international social processes; and what is coming from local level in return.

Read in the way suggested here, Djurfeldt and Lindberg and even Stimson and Webb can be seen as situating local promise and non-fulfillment first in the context of continuous and pressing problematic relationships between individuals and groups of differential power competing unequally for resources. Secondly, they enable analysis of the role of intermittent and continuous misfortune in providing a medium for the reiteration of ideology with all its internal contradictions. Moving from the local level we are able to see how the emergence of "elite" ruling classes in India and Africa, to be sure, but also in Britian and the U.S.A., feeds upon and reinforces practices and beliefs at that level. I have described the Rhetoric/Ideology division which is part of the Culture of Medicine as a whole, shared by patients and physicians—and which in terms of Western medicine emphasizes the literally concrete, the concretely literal, and the individual in dyadic relationship with his doctor, his gymnasium or his running clothes as responsible for his/her own health. Even preventive medicine is here reduced to a curative, individualistic model which reinforces general capitalist views on how social problems should be treated—the familiar paradox of personal social services. Finally at the broadest level the international political economy of medicine, dominated by great powers, themselves dominated by monopoly capitalist enterprise with an abiding interest in peddling pills and selling massive capital equipment, as well as changing the nutritional habits of the world's peoples in order to sell their products.

I would argue that a medical anthropology focussed on the making social of sickness can contribute to understanding at all three levels, it also enables us (as I suggest the mere disease/illness dichotomy does not) to go beyond merely helping physicians (whether allopathic or traditional) to confirm their occupationally and inevitably narrow view of the health process. Health institutions and folk society are not cultures in contact, as we can all now see. Malinowski wrongly categorized whites and blacks in Africa in the thirties [38]. They share their personnel, their social roles and their political economic context. Paradoxically but unsurprisingly Western social scientists have usually rejected the social process in favor of the individual attribute.

In medical anthropology, there is opportunity to turn over a new leaf.

REFERENCES
2 Sachs W. Black Humble. Little Brown, Boston, 1947
3 Freedson E. Profession of Medicine. Dodd Mead, New York, 1975
5 Turner V W. Muchona the Hornet, interpreter of religion. In In the Company of Man (Edited by Cun-grande J) Harper, New York, 1960
31. Butler S. *Erewhon.*


