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Although the anthropology of death and dying has a voluminous literature, including some excellent ethnographies, Sharon Kaufman’s richly detailed account of what the end of life is like in U.S. intensive care units is truly an important new contribution. This compelling and extremely well-written ethnography provides a multifaceted portrait of how deaths are culturally constructed in these highly technological care settings.

In 1994, Kaufman participated in a multidisciplinary workgroup on death in which her colleagues rightly suggested that an anthropologist could contribute much by studying how patients die in American (specifically, U.S.) hospitals. Fortunately, for us, these discussions led Kaufman to embark on several years of intensive fieldwork in three California community hospitals in which she followed the cases of “over a hundred critically ill patients who died (and many more who did not)” (p. 4). In addition, Kaufman frequently accompanied relatives and friends of the critically ill—who generally spend much time waiting around in these settings—to the various places where they passed the time in the hospital. During such interactions, Kaufman learned much about how these people felt and reacted when faced with wrenching choices about their critically ill loved ones. When possible, Kaufman had conversations with the critically ill themselves about their perceptions of what should be done; she was able to speak directly to approximately one-third of the critically ill people whose cases she followed. Both the conversations with the critically ill and the more frequent, lengthier ones that typically occurred with family members were often quite poignant. Kaufman also spoke with a wide range of health care staff about their opinions regarding what course of action should be taken in particular circumstances. Observations from staff meetings, family conferences, and patient chart review provided other kinds of data that enriched Kaufman’s analysis of how the “problem of death” was being handled in these settings. Twenty-seven detailed case studies are used to illustrate different dying trajectories, family situations, and how complex decision-making processes occur in these settings.

Two main theories orient Kaufman’s ethnographic analysis. She states, “the first of these suggests that medical practice and the varied responses to it are social enterprises, rooted in and influenced by cultural activities of all kinds. The second suggests that medicine—as art, science, and bureaucratic form—is, today, the most powerful framework for understanding the body, the person, dying, and most important, what to do” (p. 332). Although medical anthropologists can easily relate to this conceptual framework, Kaufman’s cogent writing also makes it easy for those without deep social science backgrounds to follow her theoretical framing of how these intensive care settings form a particular context for dying these days.

Part 1 traces the history of how death in the 20th-century United States moved from primarily being a home-based phenomenon to one that occurred in medical
institutions. Kaufman discusses a series of important technological, clinical, legal, ethical, and societal factors that shaped some newly emerging conceptions of patient personhood in the late 20th century. For example, Kaufman discusses the landmark 1970s, case of Karen Ann Quinlan, a young comatose woman whose family eventually won a major court battle to disconnect her ventilator. Although the Quinlan case has frequently been written about by end-of-life scholars from various disciplines, Kaufman skillfully links this famous case here to her line of argument that over time the recognition of new kinds of personhood resulted in new kinds of problems in managing end-of-life care. She concludes Part 1 by emphasizing that one cannot understand hospital death in these intensive care settings today without comprehending how “dying and personhood have become such entangled concepts in American society” (p. 84).

Part 2 exposes these links, further analyzing how hospital culture shapes various aspects of end-of-life experiences in these distinct settings. Kaufman appropriately devotes much space to discussing the concept of time and how the nature of waiting for death has significantly changed in U.S. hospitals, especially over the past half century. Kaufman outlines two major scenarios for how “things are moved along” that regularly occur in intensive care settings. By contrasting what she calls the “heroic intervention pathway” with the “revolving door pathway,” Kaufman is able to show how these multiple routes to dying have different associated characters and tempos. For each pathway, Kaufman presents a series of case studies that illustrate how various clinical, organizational, institutional, and linguistic practices impact dying in intensive care. Not surprisingly, many of the case studies involve older patients. As a specialist in the anthropology of aging, Kaufman adeptly summarizes ongoing debates about the relationship of “normal” aging, pathology, and dying and discusses related implications for contemporary end-of-life care.

Part 3 emphasizes even more how macrolevel political and social discourse about concepts such as quality of life and dignified death influence how critically ill individuals’ situations are perceived and treated. Again, Kaufman skillfully uses case studies to show how such broader rhetoric orients local care provision, even when those making decisions may not be fully aware of its influence. In carefully documenting the interactions between hospital staff, family members, patients, and others, she pays close attention to the ways in which particular kinds of language get used at certain times by those who are trying to “organize death” in these settings.

Part 3 also deals in depth with what can happen after the decision is made to employ certain forms of life support. One of the most fascinating chapters brings to light a healthcare realm that many are likely to be unfamiliar with: the emerging specialized care units housing those who can only survive with the use of life-sustaining technologies. In a society such as ours that highly prizes cognition, functional abilities, and independence, it is easy to see how the personhood of these most vulnerable patients with varying levels of consciousness becomes severely compromised. Interestingly, Kaufman documents how staff often go to great lengths to maintain and promote the personhood of those living in this “zone of indistinction.” It is likely that readers will not soon forget Kaufman’s rich descriptions of this new type of health care setting; her account should also stimulate much needed additional discussion about where to go from here in thinking about end-of-life care.

This book will be of interest to numerous audiences, including those who conduct research on death, aging, personhood, disability, bioethics, and science and society. It is likely to and should be widely read by clinicians and lay audiences as well. Kaufman’s writing style is eloquent but very accessible for her diverse readership. It is conceivable that some members of this diverse readership may wish the fascinating case studies began earlier in the book; some may balk at the overall length of this volume (400 pages when appendixes are counted). However, I would definitely encourage all
readers to read the whole book as there is much thought-provoking material all the way through. This book can be very effectively used for teaching anthropology students at the undergraduate and graduate level as well as a range of social science students, healthcare practitioners, and others.

Recently, this book was honored with the New Millennium Book Award from the Society for Medical Anthropology at the 2007 American Anthropological Meetings. On the SMA website, this prize is described as intended for an author “whose work is judged to the most significant and potentially influential contribution to medical anthropology. Books of exceptional courage and potential impact beyond the field will be given special consideration.” I can not think of a more fitting choice than this outstanding ethnography for the highest honor bestowed in our field.


Athena McLean
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In Culture against Man (New York: Vintage, 1963), anthropologist Jules Henry poignantly alerted us to the alarming conditions elders faced in nursing homes, where they were warehoused to die. Forty-five years later, despite continued concern, legislative efforts at reform, and genuine improvements in restraints use, U.S. nursing homes still fall short in providing person-sustaining residential care for its elders. Millions of older Americans have been forced to live out their final years without dignity in these medicalized institutions, which, fashioned after acute-care hospitals, were never intended to be permanent homes.

Some of the most highly regarded nursing homes are sterile and regimented; the worst are unsanitary, neglectful, abusive, and deadly. In all but the rarest, elders are dominated and managed by strangers: nursing assistants who wake them up to unfamiliar schedules; nurses who chastise nursing assistants for “wasting” time to talk to them; recreational specialists who rush them into activities that hold no interest; bathing assistants who line them up (men and women together) to complete their baths according to schedule, lest they lose their jobs. These endless tasks intend to satisfy nursing home regulators, rather than the needs and wants of elders. When dementia is involved, constraints are even more severe. The cost for this care is steep, upward of $6,000 monthly; elders qualify for a Medicaid grant only after they have spent down their life savings.

What is lost is the freedom to follow one’s internal clock and embodied routines, to rise and dine at will on foods of one’s choice, and to be free of the constant flow of instrumental pressures. What suffers is the human spirit. Residents experience a loss of control and self-esteem, and a profound sense of social isolation. These experiences are sadly visible in the pervasive postural “slump” and high levels of depression in nursing home residents.

Beth Baker, in Old Age in a New Age, admirably addresses these issues while focusing her attention on contemporary efforts to transform and humanize nursing home care. These are part of a “culture change” (CC) movement to improve life for both elders and their caregivers through environmental, structural, philosophical, and organizational means. CC proponents may choose to modify an existing facility to become more “homelike” or, following William Thomas (founder of the Eden Alternative and the Green House Project), they may work to abolish the current system and start from scratch. All question conventional practices.

Baker, an award-winning journalist and frequent contributor to the health section of the Washington Post and to the AARP Bulletin, spent four years working on her book in hopes of “improving the lives of elders” (p. 3). In the process, she visited more than two dozen nursing homes, a Quaker continuing care retirement community that
integrates residents who could live independently with those needing nursing home care (p. 131), and other facilities that she discovered on the way. Although she focused on nursing homes, she also included assisted living homes “to a lesser extent” (p. 2). She conducted extensive interviews with residents, caregiving and administrative staff, and families, spoke informally to countless others, and held phone interviews with administrators at many more homes. She also consulted with academics and policymakers and conducted an extensive literature review. Although embracing multiple voices, she pulls extensively from the wisdom and imagination of particular CC experts—for example, William Thomas, Steve Shields (of Meadowlark Hills), and Charlene Boyd (of Providence Mount St. Vincent [the “Mount”])—and the staff at their facilities. While enthusiastic about CC, she still tries to provide a balanced view by quoting elders who find even the finest facilities somewhat lacking (p. 145).

As a former dialysis technician, Baker experienced first hand the assembly line pressure to “process” patients and not take time out to talk with them (p. 66). Thus, she appreciates the conditions under which nursing assistants work in conventional settings and their related neglect of elder’s own needs, such as for a slower pace of caregiving (pp. 33, 45). She also celebrates the efforts of some homes to honor the requests of their elders, for instance to rent a limousine, go dancing, or take a Ferris wheel ride for the first time at the ripe age of 100 (pp. 124–125).

Baker does not pretend to be a social scientist, and her book is neither an academic text nor a nursing home manual. Rather, she intends to offer readers a “philosophy and approach” (p. 3) and to incite questions as they search for a nursing home or assisted living facility. Notwithstanding, Baker has the instincts of a social scientist, asking, “Is there no better way?”; listening attentively, “what we really need is someone to help us” (p. 72); and showing sensitivity to place, “I felt happy...there” (p. 3) versus “Everything about the place felt wrong” (p. 163). She also understands how constrained environments can lead elders to display undesirable “behaviors” (too often attributed erroneously but conveniently to medical conditions). Further, Baker appreciates how the “empowerment” promoted by CC facilities is a cultural construct that some workers might reject (p. 75). Importantly, she contrasts the social exclusion and rejection of cognitively impaired persons fostered by some continuing care retirement communities (p. 128) to Quaker or CC facilities that nurture social inclusion, caring, and security (pp. 171–172).

There are some minor errors. For example, Baker calls Lori Jervis a psychiatrist, when in fact she is an anthropologist (p. 64).

More importantly, there are places in the volume, though, where critique is lacking. For example, Baker rightly notes that Medicaid and Medicare were set up to pay for nursing home care only, not the preferred services that would allow people to stay in their homes. But she explains this as the result of Congress’s desire to keep costs in check (which might in fact have the opposite effect) or the result of well-meaning people who view hospitals as a site for healing (p. 13). In this, she ignores how Medicaid and Medicare were shaped by the lobbying activities of physicians wanting to retain control over the new source of funding being made available. Although Baker does show that more costly facilities are not necessarily more responsive to resident and family needs, it may be premature to accept the argument that CC will actually save money. Only with time and additional study will we be able to determine whether restructuring services according to CC principles will in fact be cheaper in the long run, especially in cases when one-on-one attention may be needed. Finally, although she is convinced of the need to articulate the moral imperative of CC as a call to action in humanizing elder care, she is somewhat defensive about doing so (p. 187).

Despite these minor flaws, this is a very welcome addition to the literature on long-term care. It would be useful in upper-level
undergraduate courses concerned with health or elder care services or in graduate courses for students in the helping professions. Research on CC is still limited, and I know of no published ethnographic research on this subject. Thus, Baker provides us with needed, if somewhat limited, access to the inside of facilities undergoing CC.

While writing on this subject recently, I found Baker’s work to be an invaluable resource. Yet if change is to endure, deeper study will be needed of the institutional transformations that are under way, the challenges they present, and their consequences for different residents and staff. Hopefully, medical anthropologists will build on this fine book through more extensive research in the future.


Brooke Grundfest Schoepf
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The cultural interpretation of chronic misfortune in terms of the action of living or deceased humans (“spirits”) is remarkably persistent among people with little formal education in Africa and elsewhere, as are assumptions regarding conspiracies attributed to outsiders. Take HIV/AIDS for example. Sexually transmitted it might be, but residents of Kinshasa (in the Democratic Republic of Congo, where I have worked since 1974) still ask why some notorious womanizers are not struck down whereas other (“innocent”) people waste away.

From the beginning in Kinshasa, HIV/AIDS deaths, rumored or confirmed, brought fear. Some desperately sick people and their relatives consulted indigenous practitioners in search of explanations, even as they tried to obtain care from various biomedical services. As with earlier afflictions believed to be sexually transmitted and “polluting,” HIV/AIDS became known as “a disease of women.” Other explanations focused on “illegitimate” accumulation and refusal to share wealth. Wealthy women traders, formerly believed to have sacrificed children to Mamy Wata to obtain wealth, were now said to afflict husbands with HIV/AIDS. One professional man was said to have been afflicted by his mother, who cursed him for lack of financial support. Some Christians invoked punishment of sinners by a vengeful God. Others accused the United States, considered a powerful supporter of racist and dictatorial regimes. Powerful men, believed by many to command occult forces and said to “eat” their opponents were reputed to do this by “sending” them HIV/AIDS.

None of the elaborate discourses, however, prevented those who had access to biomedical care from using it if they could afford it. But structural and cognitive barriers to health, including poverty, gender inequality, labor migration, dilapidated public health services, and schools, have grown stronger over the years that the pandemic has raged. School attendance declined, leaving fewer people with knowledge of biomedically based concepts of health and hygiene. Evangelical sects multiplied. In the 1990s, as deaths mounted and economic crisis deepened, families too poor to feed their immediate members used accusations of witchcraft to justify expulsion of pauperized survivors.

This brings me to Father Rodlach’s book on popular representations of HIV/AIDS in southern Zimbabwe. His work adds to the now-rich ethnographic collection of stories imagining the origins and etiology of HIV/AIDS. Father Rodlach speaks Sindebele, having spent eight years in Matabeleland as a parish priest before undertaking graduate studies in anthropology. Rodlach discovered widespread rejection of public health messages and pervasive discourses of blame and stigma in both a poor rural community and a periurban slum, presumably inhabited by people without secondary education. When he found the results of a questionnaire survey unproductive, he turned to interviews and focus groups conducted in Sindebele with research assistants. Verbatim notes of these discursive productions
provide valuable local data on beliefs. Those most likely to tell of witchcraft were sufferers’ families, who sought to avoid the stigma of HIV/AIDS associated with sexual “promiscuity.” Even skeptical informants evidently relished telling the tales of bewitchment and conspiracies. To some extent, one suspects that these constitute a collection of fireside tales told to épater le prêtre (from épater le bourgeois, thus “impress” or “shock the priest”).

How the elicited beliefs relate to practice, to ritual, or to other aspects of family and community life, however, remains unclear. We find little data on the complex dynamics of people’s pursuit of therapy. The consequences of discourses are not examined. Accusations, veiled though they may be in order not to run afoul of the misnamed “anti-witchcraft” law, may cause or exacerbate family and community conflicts. Rodlach also does not examine the bias that might have been introduced when he accompanied members of a faith-based organization who provided much-needed food, soap, analgesics, and prayerful solace. Elsewhere, much HIV/AIDS stigma has been fostered by Christian churches. Might Rodlach’s priestly presence actually have furthered efforts to alibi the “doubtful” moral status of relatives presumed to have contracted HIV through “sinful” sex? We miss a reflexive appreciation of respondent’s reactivity.

Informants’ discursive constructions testify to the persistence of structural, cognitive, and cosmological obstacles to HIV/AIDS prevention in southern Zimbabwe in the late 1990s. Many in the South are skeptical of public health advice associated with an international community, and especially the United States, which in the 1980s left the Ndebele and their freedom fighters to their fate from Mugabe’s army. From the 1990s, popular alienation from the State and its representatives has grown. Rodlach situates that mistrust in the context of dismally reduced public health budgets that in the 1990s, as scarcity and deteriorating quality of care destroyed the accomplishments of the early 1980s when the new Black majority government sought to provide broad access to biomedicine. The burden of HIV/AIDS patients in the 1990s further taxed the overstretched public health system. Even today, with free antiretroviral (ARV) treatment available to some, many rely by default on “traditional healers,” with their bricolages of interpersonal and supernatural explanations of affliction.

Given the circumstances, it makes sense that many people’s explanations of HIV/AIDS conform to the pattern of “sent sickness,” including accusations of witchcraft and sorcery. Rodlach’s informants also revealed the lasting effects of international and local mass media in fashioning disinformation or “conspiracy theories.” Informants elaborated these forms of externalized blame in light of their mistrust of international and governmental health authorities.

Rodlach might have provided more local information on such recent historical changes in the fieldwork communities, to provide insights on the interrelation of structural and ideological factors, and elaborate on the ways that loss of confidence in the biomedical health care system has influenced recourse to “traditional” healers. International conspiracy theories about the origins of HIV/AIDS rebound throughout southern Africa, helped along by misguided leaders who fail to address the issues. Many people continue to spin out tall tales. One is the old chestnut of “prostitutes paid by white men to have sex with dogs,” noted by others elsewhere, its racialized discourse richly analyzed by Rodlach. He documents the local effects of conspiracy theories crafted in the international mêlée as an obstacle to prevention, but his comparative treatment is mistaken due to the factual basis of some stories but not others. Take, for instance, the quite real horrors of South Africa’s medical apartheid, including Dr. Wouter Basson’s biological warfare scheme of the 1980s. Given South Africa’s close proximity to Zimbabwe, such explanations as Father Rodlach heard are to be expected. These are a legacy not of conspiracy theory, but of historical fact. The effects have been lasting.
Finally, to the mention of Westerners in the book’s title. Rodlach criticizes the failure of international HIV/AIDS prevention advisors to take cognitive obstacles to HIV prevention into account. He writes that he hopes to enlighten Western health care practitioners’ understanding of popular etiologies of HIV/AIDS so that they may improve health education and prevention efforts—but provides no concrete suggestions for change. Rodlach also fails to consider whether African health workers and scholars are aware of the cultural obstacles, and if so, why it should be left to a European researcher to enlighten Western planners?

Although still far from optimal, the situation of many HIV/AIDS sufferers, even in crisis-torn Zimbabwe, is now not quite as dire as it was in the years of Father Rodlach’s fieldwork. As more HIV/AIDS prevention programs register successes, and prevalence falls in some areas, including Zimbabwe, it is important to contrast the presumed effects of ideas on behavior. It is not clear whether ARV treatment will alter popular mistrust, for the limited availability of free treatment still leaves the majority of HIV/AIDS sufferers in Zimbabwe and elsewhere in Africa without access to life-saving biomedicine.

In sum, Rodlach’s book is rich and provocative. It would be quite useful in graduate courses that focus on HIV/AIDS or international health. There are many stimulating questions that a critical assessment can raise.


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Born in 1996 at the Roslin Institute, a center for research on animal genetics just outside Edinburgh, Dolly the Sheep captured the British imagination—or at any rate the imagination of the British media—as vividly as any royal girlfriend or flamboyant pop star. At a time when Monsanto was being reviled in Britain as a purveyor of Frankenfoods, people let their fantasies about this amiable woolly clone run amok. Was Dolly basically good or evil? Did Dolly’s complicated genesis portend a proliferation of grotesque human–animal hybrids? Or designer cloning of humans with all its attendant ethical risks? Or a powerful technical step toward new treatments for human disease? Or nothing particular given the present state of knowledge?

From the scientific perspective, Dolly was a significant first in several respects. The Roslin team was looking for precise techniques to develop industrial breeding of transgenic cattle or sheep that would produce human proteins in their milk for therapeutic purposes (in their terms, “pharming”). Although transgenic mice had previously been bred using embryonic stem cells, such cells had not yet been isolated from farm animals. In Dolly’s case, this challenge was successfully circumvented by inserting the nucleus of a mature cell taken from the teat of an adult ewe (Dolly was named after Dolly Parton) into the denucleated egg of another sheep. It had previously been thought that only embryonic stem cells had the capacity to develop into any of the specialized cells of a full living organism. Dolly demonstrated that the process of cell differentiation is reversible: the silent genes in a specialized cell can be reactivated so that it behaves like a newly fertilized egg.

The techniques developed to produce Dolly could thus, in principle, pave the way for stem cell research that did not involve embryos, and lead to new levels of precision and control in transgenics. Ian Wilmut, the former director of the Roslin team, has just received a knighthood, and Dolly (who had to be put down at the age of six because she had contracted lung disease) has been lovingly stuffed and placed on display in the National Museum of Scotland. These were public acknowledgments that each turned out well. Yet Dolly’s was not an easy birth: she was the single experimental success among 277 attempts. Today Wilmut and his colleagues remain guarded
about the practical applications of cloning through cell nuclear transfer.

Dolly mixture or mixtures, for the uninitiated, are an assortment of tiny striped cubes or tubes of candy in pastel colors, mixed in with little fruit jellies spangled with sugar. They are cheap and cheerful—ideal for sharing out or as pretend food for dollies—but bland and claggy: they stick to your teeth. They are one of those rather revolting foods that we British inexplicably enjoy, and so too it seems do Australians. Indeed, the sweetsies’ original name may have been “Empire mixture,” and like Marmite or spotted dick pudding, dolly mixture often seems to evoke rich Proustian veins of memory among former aficionadas. Sarah Franklin sees the distinctive blend as “a fitting point of departure to think about Dolly as a uniquely blended British breed” (p. 2).

Franklin is a distinguished contributor to anthropological readings of new reproductive technologies and the naturalization of new human lineages. In her stimulating quest to spin a “thickened” genealogy for Dolly the Sheep, a series of reflections on the meanings of Dolly’s birth, fertility, and mortality that might offer new ways to think about the significance of breeding present, past, and future, Franklin twists together ruminations on a spectrum of sheep-related topics far-flung in space and time: the Enclosures and “improved” livestock; Christian symbolism; different forms of cloning and their significance; a critique of Marx on reproduction; long-term patterns in the global wool trade; Australian colonialism and its expressions of racism; media representations of the 2001 foot-and-mouth epidemic in the United Kingdom; the etymology of terms like clone or genealogy; and, in the final section, a beguiling account of sheep’s highly developed social skills and their ability to remember (sheep) faces.

Franklin’s laudable goal in this work is to open a space for dialogue between specialist scientists and nonspecialist commentators, shifting her focus from the questions that science raises to the question “what is asked of science?” (p. 12). It is this shift that opens the way for Franklin’s thickened genealogies. Her fine-tuned presentation of a historical lineage of English sheep-centered colonial expansionism, inexorably extending first into Scotland, then into Australia, strikingly demonstrates the importance of sheep as political, economic, and cultural signifiers, revealingly linking terms such as breed and improvement; science and wealth; nation, empire, and race.

This thorough historical digging does indeed give us as medical anthropologists much to think about—and with—when we turn to the case of Dolly. As such, although it is rather too demanding for use in undergraduate classes, Dolly Mixtures will be an important resource for postgraduate courses in the new anthropology of global assemblages, as well as in the anthropology of science, kinship studies, and science studies.

One otherwise unexpected path that Franklin chooses to explore in detail is the much broader context of farm animals in the contemporary British sense of self, as revealed during the foot-and-mouth outbreak that devastated British farming in 2001. Choices for controlling the epidemic raised bitterly contending views of what farming should be about. Was the primary goal to earn money through efficient participation in international markets, or to preserve and enhance the traditional values of a uniquely British countryside?

I was much taken with Franklin’s arguments for our need to rethink history, economics, politics, and perhaps even science too, by acknowledging the importance of sheep in shaping the human condition. It certainly fits nicely for England, although I am sure equally good arguments could be made for horses or cattle. I would love to see an equivalently imaginative study of current biotechnology in China, where it might make more sense to focus on the redesigning not of animals but of plants—for instance the genetically modified rice that is currently generating hot debate.

I turn finally to the question of form and style. If I spoke earlier of Franklin’s ruminations, it is because Franklin herself unabashedly deploys innumerable sheep puns,
ranging from the unobtrusive to the truly painful. Often these puns serve to propel a section of argument, or to darn together sections within the somewhat woolly entity constituted by the book as a whole. Dividing the work into chapters entitled “Origins,” “Sex,” “Capital,” “Nation,” “Colony,” “Death,” and “Breeds” does help the reader sort out the threads of the arguments to some extent. But although complications and entanglements, the stuff of cultural critique, have natural affinities with sheepy scholarship, chewing and regurgitating the cud of one’s ideas is not necessarily the most attractive or accessible way to present them. In propounding her case for a sheep-centered view of human history and science, Franklin ambles from tussock to tussock, happily enacting her metaphors of matted tails or twisting sheep tracks, and—like those twisted sheep tracks—often backtracking in ways that make sense only to the sheep or the author. Without a detailed index, I found it very easy to get lost. It is truly a pity that Franklin’s important book, which offers so many things that are good to think with, is not written in a more accessible style. Like the sweeties of its title, it ultimately fails to melt in the mouth.


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I have long admired the writings of both Anne-Emmanuelle Birn and Marcos Cueto; however, because they may not be familiar to many in the MAQ readership, allow me to provide some background about them. They are both historians who specialize in medical history of Latin America. Anne-Emanuelle Birn is the Canada Research Chair in International Health at the University of Toronto. Trained under Elizabeth Fee at Johns Hopkins School of Hygiene and Public Health, her dissertation, “Local Health and Foreign Wealth: The Rockefeller Foundation’s Public Health Programs in Mexico, 1924–1951,” forms the basis for her book reviewed here. The second book included in this review was written by Marcos Cueto, a professor in the School of Public Health at the Universidad Peruana Cayetano Heredia in Lima, Perú. He is also the director of the Institute of Health and Development, the research center of the School of Public Health.

Whether previously aware of their work or not, MAQ readers interested in the history of international health, the relationship between U.S. medical philanthropy and Latin America, or the almost 100 years of choosing to ignore local needs in favor of donor-driven health campaigns should be familiar with the research of these authors. Both books are written in lucid and engaging styles, easily accessible to upper-level undergraduate or graduate students, and both would be appropriate for courses dealing with global health and medical anthropology.

Cueto’s book, The Value of Health, was written to tell the history of the Pan American Health Organization (PAHO). Cueto succeeds in bringing to life some of the great public health figures and campaigns from the early part of the last century in Latin America. Walter Wyman, Rupert Blue, Hugh Cumming, Fred Soper, and Abraham Horwitz and their roles in the development of PAHO from its original identity as a maritime quarantine and sanitary bureau to an international public health organization are detailed. He provides vivid descriptions of the early years, during which international health was conceived of as port protection, aiming to protect the business of transporting materials and to further economic development. Many MAQ readers will be familiar with the story of
sanitary bureaus, quarantines, and disease eradication programs like the paramilitary malaria control espoused by Fred Soper, but Cueto gives it new life in his description of the role that fear of the potential spread of cholera and the concern over the labor costs incurred by yellow fever played in the development of the premier international health organization. In addition to Cueto’s description of the cholera, dengue, and yellow fever campaigns that failed to eradicate those diseases, he also details the remarkably successful smallpox and polio eradication campaigns.

However, perhaps because the book was commissioned by PAHO to celebrate the 100 years since its founding, the analysis is relatively uncritical. Cueto had access to papers, documents, and interviews made available by PAHO that provide an insider’s view of the times, and Cueto does relate them to the world outside of PAHO, but not in a sufficient depth to be provocative. Most interesting is the tension that Cueto identifies both as a constant in the history of the organization, and as fluctuating as different directors imprint the organization with their own personalities and beliefs. The tension resides between two ideological positions: one that saw PAHO as a potential agent of change to improve underlying social conditions in member countries and thereby improve health outcomes of the populations and, on the other side, those directors’ perceptions that the organization’s role was to eradicate disease, and thus improve health outcomes, through vector control and not social conditions. It is a reflection of Cueto’s skill that these positions are treated fairly and provides the documentation to allow the readers to empathize with the two distinct points of view about the role of public health in society.

Notwithstanding the relatively uncritical gaze taken, there are two aspects of the book that elevate it from being simply an organizational history (other than being written by Cueto). They are: the final chapter (“Validity and Renewal”) in which Cueto brings readers into the current consequences for Latin American public health in the time of neoliberal reforms, and the detailed endnotes and bibliography Cueto includes. These are the scholar’s delight and they are all there waiting to be seen and analyzed again with a more critical eye.

Birn’s book, A Marriage of Convenience: Rockefeller International Health and Revolutionary Mexico, describes and analyzes the fascinating relationship between Mexico and a powerful and well-financed U.S. philanthropic organization in the years immediately following the Mexican Revolution. This was a period of self-conscious national self-creation for Mexicans. Birn covers the years between 1921 and 1951, but the story told sets the stage for global health in the 21st century. It is a long book, especially compared to Cueto’s, and that provides Birn the room to set the stage and then to critique the play afterward. Like Cueto, Birn provides a treasure trove of notes and references to tempt the scholar (fully one-quarter of the book are notes and references).

Birn’s book is not about U.S. exploitation of Mexico. Instead, it is a carefully crafted document, describing a dance between two argumentative partners, the dance at times enjoyed and at other times disdained, in which the partnership is almost always undertaken with some level of distrust, even in their common pursuit of science and trade. Whether the focus was on the control or (desired) eradication of yellow fever or hookworm, the partners’ eyes were always on their own separate and distinct needs. Birn’s research and writing allow the reader to understand the changing times and conflicting priorities, and to respect the duration of the most challenging set of relationships between the partners.

This is a richly textured book that adds to the store of information about classic cases of exerting top-down human control over the environment (e.g., draining swamps and destroying foliage with DDT to control the spread of aedes egypti, the vector for yellow fever). Such efforts evolved into the post-WWII reliance on the “silver bullets” of the technomedicine such as inoculations and, in the 1970 and 1980s, into vertical public
health programs like those for oral rehydration or family planning.

Birn’s description of the five principles that underlay the Rockefeller Foundation’s (RF) projects in the 1920s, 1930s, and 1940s are eerily prescient of those that determine current global health interventions today, and their concomitant failure to include local needs. The RF principles of international health cooperation were: primacy of donor needs, emphasis on budgetary incentives, reliance on the technobiological paradigm, attention to time and space delimitations, and a dependence on transnational professionals often trained in the donor country (2006:270). Very little, if any, concern with local needs or realities were acknowledged in these principles. Birn recounts how in 1947 one of the RF officers called for a social medicine approach that would take into account not only local needs, but also the living conditions in which people found themselves, such as lack of potable water or accessible health care. Two years later, an internal report from the RF included the following statement attesting to how the men who oversaw these projects saw themselves:

[We have a] maximum sense of our power, our own interest, our own goodness, and our own knowledge. We have very little knowledge of the parties of the second part—their social systems, their human relations situations, their resources in personnel, their philosophies and values in life. Our conceit and our desire for speed give us very little readiness to study these matters before acting. Yet, the delivery end is one of the crucial points of the whole problem. [2006:273]

Birn uses the RF–Mexico experience as a lens through which to view the power dynamics of international health and what Foucault and others refer to as biopower, the power of science and technology to commodify and minimalize individual lives. Lest we think that the global power of science and technology has diminished since then, Birn concludes her book by bringing today’s global health players into the discussion by noting the relationship between the WHO and the Gates Foundation and its focus on silver bullets and technology. She also provides a useful analysis of the increased power of the world banking system in determining which kinds of health initiatives are brought forward. As the world banking system has increased its role in global health, particularly since the 1993 World Bank’s report Investing in Health, the role of WHO has been diminished and the power of the international lenders and their interests have increased. Neoliberal global health policies, generated and supported by the global banking system, provide but one example of the increased domination of global health by financial concerns.

No one denies that global politics play an important role in global health policies, but the game has changed because RF and Mexico used each other. As Brin notes, Today the stakes have shifted, but the same motivations—now defined in terms of global security, human rights, and economic profitability—have persisted. For example, a 2001 Council on Foreign Relations document entitled Why Health is Important to U.S. Foreign Policy cites narrow self-interest, enlightened self-interest, and human rights leadership as the principal justifications for international health, harking back to concerns over the global spread of disease and the risks of economic, social and military disruption if health needs remain unmet. . . . Similarly, the imperative driving development along globalized market economic lines has brought international financial agencies—such as the World Bank—to the forefront of public health lending and investment “cooperation.” [2006:282]
I read both the Birn and Cueto books as I was preparing for a course I teach on global health. They would both be appropriate choices for such a course. The PAHO story would be a useful reference for students interested in the development of this significant global health organization. The analysis of the history of the RF public health relationship with Mexico, and of the five principles that evolved, in part, from that experience and how they play out in today’s global health arena would provide an outstanding background for the discussion of current global health plans and programs, as well as a discussion of policy and practice decisions. Birn’s ability to use her story to exemplify the continuing struggle between local and global needs, funder and community agendas, power relations and differing concepts of “public health,” what public health should mean and who should pay for it makes the text very relevant to today’s questions.

I will close this review as Birn closes her book, with a case from Cuba. Birn describes how today Venezuela is using Cuban doctors to staff a program called “Barrio Adentro” (Inside the Neighborhood). Birn uses the Barrio Adentro example to show how local health needs can be met without reliance on the world banking system or an international health organization. Barrio Adentro is, as Birn notes, a community-based system of primary health care where family practice doctors and nurses live in the neighborhoods and treat all the residents. Its development was the result of a foreign policy decision. Fidel Castro made an agreement with Hugo Chavez to exchange oil (which Venezuela has) for family practice doctors (which Cuba has). As a result, more than 13,000 Cuban doctors were sent to staff clinics in Caracas, Venezuela—in neighborhoods where Venezuelan doctors refused to serve. The Barrio Adentro case is based on the Cuban primary health care (PHC) program that has so successfully reduced infant mortality and infectious disease in Cuba since the Cuban Revolution (see Cuban Primary Health Care: The Other Revolution [Whiteford 2007]). I agree with Birn that the Venezuela case bears watching as the Cuban model is transported and modified to fit local needs without the intercession of either big money or big health care organizations. As she finds hope in this model, so I do also.


Brian McKenna
University of Michigan–Dearborn

In 1984, Cecil Helman wrote a compact red book whose primary purpose was to bring the insights of medical anthropology to biomedical professionals. The 242-page, nine-by-six-inch offering was called Culture, Health and Illness: An Introduction for Health Professionals. Over the past quarter century, as medical anthropology has grown, so has his text and its reach. The fifth edition, released in 2007, has expanded into 501 pages, and the subtitle is now gone, having been abandoned in the fourth edition (2000). The book is no longer aimed at just health professionals but a much wider audience. Significantly, it also promises to “cover all the main developments of recent years” in the field (p. vii).

This “fully revised” fifth edition is “the leading international textbook on the role of cultural and social factors in health, illness, and medical care” according to the book’s back cover. The text has been used “in over 40 countries in universities, medical schools and nursing colleges.” If true, then medical anthropologists had better pause and take notice, because Helman’s book is now the public face of medical anthropology at many powerful institutions. The Journal of the American Medical Association (JAMA) and Lancet are among its many salutories.

The dominance of Helman’s book is noteworthy considering that it competes in such a crowded field. Unlike 1984, there are a number of introductory textbooks to choose from in 2008. I’ve used four of them in my classes: The Anthropology of Medicine (3rd edition, Romanucci-Ross et al., Westport,
CT: Bergin and Garvey 1997), Medical Anthropology and the World System (2nd edition, Baer et al., Westport, CT: Praeger 2003), Medical Anthropology (Pool and Geissler, Berkshire, England: Open University Press 2006), and Exploring Medical Anthropology (2nd edition, Joralemon, Boston, MA: Pearson, Allyn and Bacon 2006). Abiding by the anthropological commitment to provide the social context of any inquiry, all four provide some level of critical discussion on competing theoretical schools and provide a brief history of medical anthropology. Curiously, and contrary to his plan to cover “all major developments in recent years,” Helman does not mention three of these four texts in his own book (he does cite World System but restricts himself to the older 1997 version), nor does he effectively theorize debates within the subdiscipline. For example, omitted is any mention of Bourdieu’s concept of habitus, Foucault’s theory of biopower, or the fundamental critique of neoliberal capitalism, which have all helped to advance medical anthropology in recent years. Medical anthropology luminaries such as Benjamin Paul, Jean Comaroff, and physician–anthropologist Rudolf Virchow are nowhere to be found.

These names are found, however, in another 2007 text that asks, “How has medical anthropology developed since the first manuals were published in the United States more than thirty years ago?” Like Helman’s Culture, Health and Illness (which it cites), Medical Anthropology: Regional Perspectives and Shared Concerns (Saillant and Genest, eds., Malden, MA: Blackwell 2007) attempts to cover the major developments of recent years, looking at the field in Canada, the Netherlands, Switzerland, the United States, the United Kingdom, Brazil, Mexico, France, Mexico, Spain, Italy, and Germany. Saillant and Genest trenchantly describe the recent movement to demedicalize medical anthropology and escape from “a question that has haunted medical anthropology since its beginnings . . . the question of its dangerous liaison with a profession that represents the establishment, biotechnological capitalism and a pernicious form of biopolitics, all too often to gain credibility, and sometimes accepting the role of a pale sociocultural variable in certain collaborations with medical professions” (p. xx). Sentences like that are missing from Helman’s book, which omits a sustained critical account of biomedicine as put forward by a host of medical anthropologists and other scholars.

Helman, being a member of both professions, serves as a cultural broker between the worlds of critical social science and biomedicine. But in so doing he mostly presents medical anthropology as a consensus enterprise: he smoothes over important intradisciplinary and other theoretical conflicts and focuses on how biomedical professionals might benefit from a mountain of cultural insights. This liaison is dangerous because, handled incorrectly, it can help reproduce the authority of biomedical practitioners.

Helman’s book has 19 chapters and more than 90 short case studies in boxes (each about 200–300 words). The original 11 chapters from the 1984 edition are all present. Some of these chapters have changed little over the years and often the references are quite old. For example, 50 of the 56 references in the 2007 “Doctor–Patient Interaction” chapter were also in the 1984 edition, in almost exactly the same order. A quick calculation uncovered that the average year for this chapter’s references in the 2007 edition was 1982, a quarter of a century ago. Also, most of the book’s references and footnotes are not actually included in the book. Instead there is a “key references” section at the end of each chapter directing the reader to the Culture, Health and Illness website “for the full list of references for this chapter.” To gain access to the references, one has to submit personal information and register for a password, delivered later by a marketing agent. I would have preferred ready access to footnotes to learn the quality and currency of the data.

The essential message of these familiar chapters is to respect the world’s wide-ranging cultural diversity in health and
medical practices. This remains an important message. Helman is a critic of “modern medicine,” especially its reductionist approach. Helman wants readers to recognize the vast amount of medical pluralism to improve medical care and treatment. By honoring rather than dismissing alternate worldviews, Helman believes that better clinical communication will take place, thus improving health outcomes. A central concern is to recognize “the meaning of the disease for the individual patient and those around him” (p. 123).

There are eight other chapters in the book, three of which also were available in the 2000 (4th) edition. New chapter topics now covered include migration and globalization, telemedicine and the Internet, the HIV/AIDS crisis, “new bodies, new selves,” genetics and biotechnology, and various pandemic diseases. These additional chapters signal an important recognition by Helman that the interpretive dimension of medical anthropology is insufficient in its ability to capture the plethora of research topics, methodological approaches, and global health problems that constitute the diverse field of medical anthropology today.

Despite these additions, the text is torn by a tension between an older medical anthropology of the 1970s and 1980s (that focused on validating alternate medical traditions) and the newer medical anthropology focusing on human rights, violence, social justice, and structural inequality. Helman struggles to overcome a radical discontinuity between his earlier vision, whose principle frame of reference was the biomedical clinic, and a more critical vision that recognizes how medical anthropology and environmental anthropology are inseparable as forces contesting the raw power of capitalist culture.

Helman is keenly aware that “modern medicine is often very reductionist in its approach . . . its focus is mainly on the individual patient, rather than on their families, communities or wider society” (p. 123). At the same time, he is critical of those who argue that what goes on outside the clinic is more important than what happens inside of it. In later chapters he discusses a wide-ranging number of problems and forms of social suffering associated with a migratory world drenched in poverty. However, many of these problems are presented in piecemeal fashion, fragmented throughout the text, or added on as later considerations. Generally speaking, Helman fails to show how to specifically confront these problems within the clinic (a terrain he privileges) or give precise models for how one can practice community-oriented primary care medicine (which is only introduced in the next-to-last chapter) in an oppressive political environment. Ironically, the often-segmentary manner in which ideas are presented can assist in reproducing biomedical hegemony. The “add on” nature of Helman’s social medicine segments parallels the sociology of knowledge in the specialized disciplinary worlds of biomedicine and health professions education, where critical (and unreimbursable) knowledge sits at the margins.

A good example is Helman’s discussion of cancer and environmental health. Remarkably, these two enormous subjects are not conjoined in any substantial discussion. Crucially, they are not integrated in Helman’s prescriptions for doctor–patient interaction. Helman talks instead about the impact of diet on cancer, recommending particular changes (such as to eat more fruit) rather than exploring cancer from a structural perspective. At one point, Helman discusses environmental pollution as being associated with “lay theories of illness causation.” He adds that, in France, these “modern notions of environmental pollution were, in many cases, a return to more traditional theories of miasmas, or ‘dirty air’ as cause of disease” (p. 137). That Helman does not bring air pollution diagnoses and the many studies clearly linking air pollution to poor health outcomes directly into the discussion is troubling.

In her landmark study, Cancer in the Community: Class and Medical Authority (Smithsonian Institute Press, 1993), Martha Balshem documents how a Philadelphia “lay community” rejected health educators’
advice to stop smoking, improve their diets, and schedule regular screening tests, instead blaming industrial pollution from nearby chemical plants and air pollution from traffic as the major causes of cancer in their community. Balshem juxtaposed the assumptions behind the two competing sets of illness etiology, the biomedical and the “lay community,” and determined that both had rational bases for being labeled legitimate knowledge. Balshem is unmentioned in Helman’s text. So too are more current references to the health and wealth epidemiological literature that links health problems to the unequal distribution of wealth in a social formation. Physicians who follow Helman are unlikely to diagnose cancer and other problems as the embodiment of capitalist social relations or the environment.

Helman’s book traverses much important ground in going beyond biomedicine and this makes it a significant work. Still, he marginalizes critical issues that would make his text more balanced. Take, as another example, his discussion of iatrogenesis. It is not until page 96 that Helman references Ivan Illich, and when he does so, the sentences are sparse. He dismisses Illich by referring to his ideas as “claims,” and devotes just a paragraph to “biomedicine’s iatrogenic effects,” which he asserts are “now widely known to the public” (p. 105). But with a few exceptions, this is not the case, as contemporary research on health care “clients” and “consumers” has shown. For example, few emergency physicians know that a typical CT scan of the chest is equivalent to 400 chest x-rays.

These shortcomings notwithstanding, when it comes to discussing the impact of meaning on individual health, Helman’s book shines. He provides an excellent discussion of the placebo effect and the nocebo effect. This section of the book is invaluable for health professionals’ education. This section is, however, like others, in want of updated references and information. For example Helman mentions Daniel Moerman’s 1979 work but makes no mention of Moerman’s spectacular 2002 book, Meaning, Medicine and the “Placebo Effect” (Cambridge: Cambridge University Press), which makes critical new points.

Helman cites community-oriented primary care (COPC) as a strategy but does not make reference to it until page 434, when the book is winding down. According to Helman, the role of COPC “is to assess the specific health needs and problems of a particular community, to raise awareness of the role of cultural beliefs and behaviors in their health (and health care), and to act as their advocates to the medical and other authorities where necessary” (p. 434). There is much activity in this area reported by the WHO and other groups that could have been (but were not) referenced to provide models for action. It is also surprising that Helman did not link this discussion with his otherwise useful section called “cultural factors in the epidemiology of disease” (pp. 377–382). There, he lists (exactly as he did in the 2000 edition) 94 bullet points that require epidemiological investigation, such as the relationship of occupations to disease, the modes of human waste dispersal, and whether personal hygiene is neglected or encouraged. Required is more than a laundry list.

Social theorist Zygmunt Bauman argues that culture is a knife pressed against the future (Kieth Tester, Conversations with Zygmunt Bauman, Polity Press, 2001). Culture, for Helman, is more akin to socially acquired guidelines that tell us how to view, experience, and behave in the world. Ideas of culture as struggle, resistance, and contestation over power are not part of Helman’s fundamental framework. But culture is not just a spoon making lucky dips into a diverse set of medical ice cream flavors. It is also a knife against the future, an armamentarium of cultural strategies—some of which are intended to defeat or at least subvert neoliberalism and authoritarianism in all guises.

Biomedicine’s scalpel is most often directed downward to the flesh of the victims, not upward to the powerful. Helman would no doubt agree. But there’s more to be said. Medical anthropology, in its best renditions, places its scalpels against
political-economic cultures that work to make millions of people disposable, turn nature into a tap and sink, impose social inequality, eliminate dissent, proletarianize health professionals, invade the clinical setting with insurance capital, speed up clinical work so that doctors do not have sufficient time to explore explanatory models, and deprive hundreds of millions of access to care. Questions about workplace democracy, the labor theory of value, the ongoing history of Western imperialism, the growing proto-fascism of our age, and revolutionary movements to contest domination are paramount concerns for many medical anthropologists. Helman’s book neither explicitly names nor rigorously details many of these central contradictions of our existence in a time when “culture, health and illness” are captive to deep-seated political and economic forces in increasingly authoritarian milieux.

In summary, Helman’s new edition of his now-classic text is powerful in its illustration of how medical pluralism matters. It is a vast improvement on earlier editions that sidestepped many issues in global health. Helman has assembled a great quantity of material that makes his ideas accessible to audiences completely new to the idea of medical anthropology. But the book also glosses over many important theoretical developments and many sections need to be bolstered with more current research. There is much to say positive about this book. However, in its continued attempt to appeal to biomedical health professionals, the full force of critical anthropological theory is not well represented.


Sarah J. Mahler
Florida International University

With this book, Parin Dossa intends to “bring to the fore a politically grounded understanding of social suffering as exemplified on the plan of displacement and societal issues” for Iranian women living in Canada (p. 4). She argues that immigrant women’s discourses about their mental health, their depression, and their struggles with adjusting to life in their new lands—including to the prejudice and the travails of dealing with service bureaucracy in particular—“have often been silenced” (p. 4). She endeavors to give them voice and she also identifies reasons for their silencing. Dossa links her efforts to give these women a voice to a generations-old tradition among Iranians of expressing experiences publicly through different forms of discourse—poetry, prose, and storytelling in particular—without breaking the rules that define propriety in their gender-segregated worlds (pp. 34–35).

To understand Iranian women’s plight in Canada, Dossa spends several years, presumably off and on, doing fieldwork in the North Shore section of Vancouver where many have settled. She does some participant-observation with them via a mall walking club, holds a “group session”—which appears to be a type of focus group—with six of them, and interviews 15 women individually. Four of these interviews are developed into the central four chapters, each of which is dedicated to one woman’s experience.

There are two interrelated theoretical contributions this book aims to make. One is to move our thinking about mental health and well-being away from the Western “objective” medical model toward a model that is culturally sensitive and appropriate. Dossa argues that “it has long been established that mental health is not confined to the medical realm but includes institutional practices and discourses as well as public spaces such as the workplace and everyday life. Yet, this established co-relation between mental health and social factors has not been put into practice; neither has it been theorized from the point of view of the sufferers” (p. 162).

This leads to Dossa’s second contribution, which is to push for a “more holistic and politically informed approach” that
implicates structural factors impinging on the women’s lives as much or more than individual and family factors. She characterizes the Iranian women “seizing” the interviews as an opportunity to have their stories told—stories wherein they made the “deliberate choice of not focusing on [their] mental health” but instead on the “connection between mental health and societal factors” (p. 169). In so doing, Dossa claims that her subjects shift the normative gaze of the Western medical model vis-à-vis “mental health” with its focus on clinical treatment of individuals, medication, and the “trauma of displacement” toward a “social language of suffering” (p. 169), identifying their problems as rooted in issues such as discrimination enacted toward them by non-Iranian Canadians and indifference from the health care bureaucracy.

Clearly, Politics and Poetics of Migration is a book the author has written to speak to a medical anthropology audience. Her own prose is continuously engaged in well-documented debates within anthropology overall, feminist ethnography and epistemology, as well as medical anthropology. She knows the literature and marshals it accordingly. As the book engages theory throughout, I would recommend it primarily to upper-division undergraduates and graduate students as well as professionals interested in the themes discussed.

The author’s constant reference to scholarly debates is both a strength and a weakness, however. The book’s subtitle, Narratives of Iranian Women from the Diaspora, enticed me to expect rich ethnography. Dossa even writes that her interviewees hoped she would provide their full narratives as if they had been “authored” by the women themselves (p. 7). Unfortunately the women’s voices are rarely heard. The book promises to make them central, but in reality the minimal direct quotes are overwhelmed by Dossa’s interpretations and the opportunity for the women to storytell their own experiences is truncated. As a reader, I found this highly confusing. The first two theoretical chapters I did not worry about, but when the four middle chapters featuring different women’s lives continued to emphasize scholarship over the women’s voices, I was disappointed. If Dossa’s interviewees read the book, I am afraid they will be too.


Stephanie C. Kane
Indiana University

Once set in motion, a myth mobilizes meaning and action. The more a myth excites the public imaginary, the more uncontrollable it will be. Emily K. Abel begins her historical account of tuberculosis (TB) in 19th-century Los Angeles (LA) with the city boosters’ attempt to refashion the mythic theme of its public relations (PR) campaign: away with Wild West adventure and in with a sunny-seaside-citrus-grove. LA was recast as an ideal place to recuperate from consumptive ills. Before long, however, the boosters felt overrun by tuberculosis cases.

In their imaginary, those who were meant to flow in and fill the spalike sanatoria were white men of means. Arriving with plenty of money and terribly ill after long rail journeys, they would spend a few months before nigh miraculous TB cures would allow them to return to the comfortable lives they had temporarily left, as if from long vacations. The boosters’ sense of the world was clearly skewed by optimistic greed; suffice it to say that those with employment issues or demonstrably insufficient funds were unwanted.

Alas, the boosters’ reality was rudely disappointing: too many poor orange pickers and not enough orange-grove admirers; too many immigrants and migrants, hungry refugees leaving who knows what behind, having crossed oceans and the wide U.S. landscape to reach this dream city, escaping foreign calamities or eastern seaboard tenements, midwestern dustbowls, or Spanish-speaking villages that California
colonizers ruled “across the border.” The tubercular came and composed a distinctive composite reality of race. In response, public health administrators, caregivers, and other officials—including journalists—perpetrated unjust and unwise policies that established (non)treatment regimes dedicated to practices of excluding the indigent sick.

In the process of precisely documenting and analyzing this discourse, Abel records the homologous shifts and sleights of hand repeatedly used to avoid responsibility for this unstable and insecure public. Readers will come to understand how Mexicans, Jews, Filipinos, blacks, and the destitute of any race, religion, or age, in good times and bad, were the first to be shut out of city and county health care institutions and given the least care when allowed to enter. Notwithstanding community needs, official discrimination was practiced on providers as well as patients. For example, women were allowed to become nurses but not doctors and black women had to overcome attempts by their white counterparts to exclude them even from that profession.

Charmed by its PR myth, people arrived in the golden city only to worsen in the rains, sometimes to sicken and die (some of the city’s boosters were themselves unable to overcome TB and spent their lives managing the stigma they helped to create). There was never enough money in city coffers, there were no pharmaceutical cures, and the epidemiological models underpinning policy focused on class and racial groups rather than risk behaviors and conditions (a theme resonant with the early decades of the HIV/AIDS epidemic).

Abel has deftly written a layered account, with chapters organized around axes of analysis that systematically reveal how the politics of exclusion is more likely to produce more illness, not more health. She approaches themes recursively by sifting through a comprehensive collection of texts including diaries and (auto)biographies; newspaper articles; official reports, notes, and announcements; institutional records (often quite scanty, she notes); oral histories; and scholarly writings in medicine and social history. She analyzes, too, what is absent from the textual data she discovers—what one might have expected would be under the purview of public health officials and health care providers: an ethics of service to human beings and a practical approach to reducing disease transmission. By relating medical policy discourse to dominant cultural tropes and political economic conditions through time and in contrasting situations, Abel guides us toward understanding the distinctive dynamics of prejudice that takes discursive form in the history of TB in LA.

Two themes emerge as unique strengths of the book. One is Abel’s attention to gender. Woven through this story, focused mostly on male TB sufferers who migrated to LA, often without family, are women’s and men’s personal self-portraits and those of caregivers and other support providers. These materials allow Abel to weave other clearly gendered voices with hers thereby providing perspectives in counterpoint to tactical maneuvers of institutional powers. Not that institutional powers were without diversity of viewpoint—the tensions among city boosters and health care providers and other officials are palpable in Abel’s rendering. Nor were these institutions without characters, some of whom come alive almost too much, like Edyth Tate-Thompson, director of the Bureau of Tuberculosis, a strong-minded woman who wielded racist epidemiological logic as an organizing tool.

The second embedded theme in Abel’s historical narrative is the use of the law. Disease control and border control can be fantasized as homologous enterprises, the spreader of disease accused of moving across forbidden territorial lines. Various legal processes were used to control the vulnerable sick, including property laws that took homes away from patients’ families to pay for government health care (p. 56); immigration restrictions, including passing medical exams as entry requirements (p. 66); residency requirements for receiving health care benefits, which were
lengthened during the Depression (p. 79); targeting Mexican patients for quarantine (p. 92); using legal language such as “public charge” to turn public attitude against patients (p. 97); exploiting the transition of the Philippines from territory to commonwealth as an opportunity to cut patient numbers (p. 102); using the police as a “Bum Brigade” together with other State Border Controllers to stop “transients” and “indigents” from entering the state—a patrol that was successfully challenged by the American Civil Liberties Union (p. 114).

In her epilogue Abel discusses the contemporary resurgence of TB and anti-immigrant rhetoric, although she does not address how late-20th-century legal advances such as antidiscrimination laws and human rights frameworks may have dramatically alleviated or curtailed some of the viciousness of which our bureaucracies are capable. Medical anthropologists and those interested in political and legal anthropology may be disappointed that Abel does not delve into the rich critical scholarship on cultural and epidemiological risk categories related to HIV/AIDS and STDs or on the structural violence associated with poverty and thus susceptibility to TB.

Nevertheless, Abel has written a fascinating account of TB in LA. The book will be useful to those interested in how inequality and discrimination can invade public trust and how hate and negligence can assume the guise of official responsibility. It is an important lesson for students to learn; for those of us who have learned it before by studying other places, or other diseases, Abel’s masterful work will be appreciated on its own terms. The book is written in a clear, informative style, and will provide a historically rich resource for seminars in medical anthropology. This book demonstrates how public health is managed at the city level and should be of particular interest to those who wish to focus on the ways that social actors in various positions define and apply organizing logics and material resources to extend or curtail comfort and cure.

**FILM REVIEW**


Catherine Wanner
Pennsylvania State University

The purpose of the film *Shapes in the Wax* is to illustrate the nature and practice of folk healing techniques that are currently enjoying a period of revival in Ukraine after the collapse of communism. The video’s author argues that this revival is not actually attributable to the breakdown of the Soviet health care system and new limits to medical treatment that the introduction of a fee-for-service system amidst an economic crisis has triggered. Rather, other dynamics play a more significant role in generating appeals to folk healers. With its religious idiom and integration of localized practices, folk healing has become an integral part of the national and religious resurgences that began when communism collapsed. At this critical juncture of national self-definition, folk healing is associated with an affirmation of what it means to be distinctly Ukrainian (as opposed to Soviet or Russian) and what it means to be a believer. The postcommunist self’s need of national restoration and bodily and spiritual healing, the film’s creator cogently argues, is the primary reason why folk healers have witnessed a renewed respect for their knowledge and new appeals for their assistance.

*Shapes in the Wax* focuses primarily on a single technique used by healers in rural western Ukraine to diagnose the source of maladies such as nervousness, depression, sleeplessness, and the like, which are often attributed to curses and the evil eye. Diverse narrative techniques are used to maintain the viewer’s interest. An overarching narrator provides background information on Ukrainian history, including the experience
During the Soviet period, such folk healing practices were outlawed and those healers who continued to practice did so quietly among family members and usually in rural areas, which in part explains the lack of scholarly attention to this subject to date. Given this history of suppression, passing down their knowledge to a member of the next generation turns out to be of acute concern for most of the healers. And yet, the film explores the reactions of several young people to their experiences and perceptions of folk healing in such a way that one understands that the techniques are unlikely to fade from memory as the healers feared during the communist era.

Such illnesses a laden with multiple layers of meaning. The healers are tending to the stresses individuals experience in harsh rural life every bit as much as they are to the social suffering brought on by the discrediting of the Soviet experiment and poverty triggered by the so-called transition to capitalism. The film, similarly layered, stands out as a unique contribution. Ethnographies of formerly socialist societies in any form—video or text—are in short supply. For this reason, the film is a welcome addition to a fascinating, yet understudied, area of the world. Although there is a rich tradition of studying Ukrainian folklore, this is the first ethnography that addresses informal techniques of healing from an anthropological perspective. The film’s use of vibrant images to contextualize the difficulties of rural life after Soviet socialism make it suitable for classroom use at all levels. This film will be relevant to anyone interested in informal, popular healing practices and how they are understood by individuals who use them.

Among the 11 healers interviewed, ten were elderly women and one was a man. They heal by blending elements of Orthodox ritual, such as prayers and devotional gestures, with the folk practice of melting blessed church candles, pouring the liquid wax into pure well water, and reading the “shapes” that the wax reveals as it congeals. The healers read the symbolic meanings of the shapes and relay them as the source of a patient’s distress. Using their “calling from God,” these healers are able to decode shapes in the wax as unresolved events in a person’s past that are causing illness today. This is followed by a cleansing ritual, which often yields a calming, hopeful effect, and a prognoses of a better future colored by the individual’s new status as a person cleansed and freed from the grip of the evil eye or some similar curse.

Of Soviet socialism as well as descriptions of daily rural life, and religious practice in Ukraine. As this narration unfolds, the viewer sees maps, still shots of rural life, and clips of healers at work. The essence of the film, however, is Phillips’s interviews with the healers, which are conducted as they perform their healing rituals. Speaking directly to the camera, the healers explain what they are doing and why it is they are doing it, which creates for viewers feelings of immediacy and engagement. These interviews, peppered with spontaneous comments from neighbors, are in Ukrainian, and subtitles are provided. The footage of healing rituals is interspersed with commentary and analysis provided by Phillips in a conversational style in a studio setting. These additional clips serve to deliver a fuller understanding of the meaning of these rituals for those who perform them and those who subject themselves to these types of cures.

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