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Cultural Constructivism:
Sickness Histories and the Understanding of Ethnomedicines beyond Critical Medical Anthropologies
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Introduction

The present paper has two goals. First it attempts to identify and outline some central assumptions of 'cultural constructivism' in order to unify and provide a common basis for a variety of interpretive approaches in medical anthropology. In line with this goal, an example of the cultural constructivist approach to sickness and biomedical knowledge is presented. This model of sickness, called a 'Sickness History', is offered to demonstrate the historical basis of the construction and meaning of contemporary sickness realities, realities found in both folk and professional Western medicines.

The second goal of this paper is to outline the views of a congeries of approaches in American medical anthropology currently vying for the label of 'critical medical anthropology'. Those appearing under this rubric claim a unique ability to truly explain and understand ethnomedical organizations and sickness realities, especially those of professional, Western ethnomedicines. A review assesses the validity and utility of the various critical medical anthropological approaches.

My reading of critical medical anthropological work is itself highly critical. However, the term 'critical' here refers to my use of interpretive anthropology to deconstruct forms of empiricist anthropology, i.e., the critical medical anthropologies, analogous to the "critique of culture" (Marcus and Fischer 1986), provided by anthropology with reference to our own culture. My notion of critique is not to be confused with cultural criticism, another version of so-called critical theory. The review develops a typology of critical medical anthropologies, highlighting the distinctive views and contributions of cultural constructivism and shows the numerous problems and limitations of the traditional, conservative ideology represented by critical medical anthropologies.

It is shown how the latter views are grounded in assumptions and ideology which are products of a particular European time and social space and social group, i.e., 'ideological group' (Geertz 1983: 148) which are no longer tenable in modern anthropology or social science. In this sense, the paper suggests, as earlier argued (Gaines and Hahn 1985), that interpretive or constructivist medical anthropology can provide a critique not only of medicine but of (medical) anthropology itself. This unravelling of the problematics of some forms of 'modern thought' being but an overture to an ethnography thereof, as Geertz has called for (1983).

The presentation is divided into two major sections. In the first section, the critique of critical medical anthropologies is advanced. After delineating the various positions self-labeled as critical medical anthropology, the critique focuses on the problems of Marxist and political economic critical medical anthropologies. Weaknesses in metatheoretical assumptions, theory and data are highlighted. Following this, I present cultural constructivism and outline its assumptions. Contrasts between cultural constructivism and social constructionism are presented. This is followed by the presentation of constructivist conception of sickness, the 'Sickness History', a notion of the cultural historical semantic origin and development of folk and professional nosological entities. It is advanced to demonstrate the highly complex cultural historical nature of sickness realities as a contrast to the functionalist empiricism of critical medical anthropologies.
L. Critical Medical Anthropologies

Preliminary considerations

At recent meetings of the American Anthropological Association (e.g., December 1986, November 1987), there has been some tumult and shouting, some sound and fury, apparently it seems, signifying perhaps less than meets the eye. The events relate to the development of a congress of approaches working under the label of critical medical anthropology. Morgan (1987), in a timely and important review from which I will draw here, indicates that most of what goes under the rubric of critical medical anthropology is one form or another of the political economy of health. As Farmer (1988) notes, members of this group are without a single agenda. And, as we shall see, the same authors float among the various perspectives without recognizing shifts and contradictions in their own views. For example Singer, Frankenberg, Navarro, Schepa-Hughes and Baur, among others have done work classifiable under several different rubrics.

Each of the several variations of critical medical anthropology has vied for the label and articulated its position(s) usually in direct opposition to "meanings and symbols" approaches here developed as "cultural constructivism". It is, incidentally, relevant in terms of an anthropology of science that such opposition has been marked largely by ad hominem attacks. Interestingly, we find this same response in biomedical sciences to disagreement (see Good, Good and Moradi 1985).

The problems of the term "critical"

It should be noted at the outset that advocates of the various critical medical anthropologies take this label toward some end. The term is clearly a pleonasm since the critical character of their perspectives is not in fact distinguishable from any good medical anthropological accounts, especially of a constructivist turn [1]. The use of the term strikes one, at least this one, as parallel of such terms as "The Moral Majorit"y/ in American religious politics. Both are terms which, simultaneously, seek to validate the in-group by wrapping it in a mantle of respectability and to denigrate the chosen out-groups, i.e., everyone else.

The term recalls the critical theory of European Marxist sociology, as Morgan (1987) notes, but seems to have forgotten that the Frankfurt school's intention was to be self critical (in terms of Marxist theories and constructs), to avoid dogma and to reestablish a neglected aspect of early Marx's writings; that is, an idealist concern for human consciousness as the agent of construction of the world (Jay 1973). Critical medical anthropologies, as we shall see, seem more in line with critical sociology whose name serves, according to one wag, to denigrate the West and other theorists through several forms of unctual Marxism.

Three general political economic views are outlined in Morgan's review, each of which is subsumed under the label of critical medical anthropology by its proponents. The first of these are said to be the more or less "orthodox" Marxist approaches. However, since followers may adhere to one or more of the various forms of Marx ("the young/early Marx", "the mature/mature Marx", etc.) or to any of a number of interpretations of one or more of those Marxes, the "orthodoxies" can be and are quite numerous (e.g., we note even an idealist version of an 'early' Marx above, from the Frankfurt School).

Cultural Constructivism

Marxist political economies in medical anthropology

Marxists insist that medicine be analyzed within the context of "capitalism", a putative entity which may or may not include "the modern world system" ("capitalist world system") from dependency theory, discussed below. "They (Marxists) draw attention to the interplay between social class formation and the power of the postindustrial nation-states" (Morgan 1987: 133). For these authors explanations are phrased in terms defined and set forth by Marx well over a hundred years ago (e.g., "commodities, class, class struggle, infrastructure, superstructure, ideology, exploitation, oppression, mystification, contradiction and revolution"). Notions of unilinear evolution also appear but well concealed. Medical knowledge is, expectedly, seen as "elite class ideology" (Navarro 1986, cited in Morgan 1987). Its function is to obscure the "real" cause of mortality and morbidity (capitalism) (Singh 1986, Taussig 1980, Waltzkin 1979, 1981b). Medical knowledge is here represented as ahistorical and as a conscious creation the functions of which are control and mystification.

For Taussig, disease signifies societal 'contradictions', said to exist in reality, not as constructs of the analyst's mind, which are expressed through the medium of the body. For Taussig and Schepa-Hughes, illness is potentially "revolutionary" (though Schepa-Hughes [1988] has argued that Biomedicine makes a folk illness of a 'biological' condition while others argue that, as an instrument of social control, medicine responds to illness by biologizing it. Biomedicine serves the "ideological needs of the social orders to the detriment of healing and our understanding of the social causes of misfortune" (Taussig 1980: 3).

All medical knowledge is mere ideology, and health status and the organization of health care are seen as direct results of "the capitalist socioeconomic formation" (Morgan 1987: 133). Since medicine is seen as an instrument of control and domination of the capitalist class, Singer suggests it should be labeled "capitalist" or "bourgeois medicine" (1986). The label Biomedicine, proposed by the early constructivist works and intended to designate a particular culturally constructed professional ethnomedicine (Gaines and Hahn 1982; Hahn and Gaines 1985), however, is the term now almost universally employed even by Marxists (Frankenberg 1988). Below, we consider a case study of a Marxist clinician and test the notion of an exclusively biomedical conspiracy to biologize sickness.

Medicine is also seen as a commodity which is poorly distributed to the detriment of most (Waltzkin 1981b, Navarro 1976). While the views expressed are clearly ahistorical, we also see a point of view uninformed by understandings of the social and 'natural' ecology of disease. Lacking is an understanding of the role of population density and sedentary settlement, patterns of social interaction, dwelling types, waste disposal, food and shelter supply problems, animal and human interactions and a host of other factors (e.g., Dunn 1977) which demonstrably vary with urban culture, not economy.

Another group uses some of the notions of this group but differs from it in significant ways.

Cultural criticism

The Ehrenreichs (1971) are most closely identified with the second group of political economic viewpoints, the "cultural critique of medicine". This group criticizes medical practices and organizations asiatrogenic and communalist but sees such practices as caused by group interests and a system geared for profit but which needs reforming (1971: 1-28). Illich's famous book Medical Nemesis (1976), as well as the work of anthropologists Stebbins (1986) on the maldistribution of Mexican medical services and Justice (1986) on health programs in Nepal are examples of this approach. Illich lays the blame for sickness on industrial society and medicine, not on capitalism per
so, we note.

However, this group appears misnamed. The researchers in this field actually have a poor or nonexistent grasp of a modern concept of culture, nor is there evidence of an understanding of Biomedicine as a "cultural system" (Gaines and Hahn 1985, Hahn and Kleinman 1983). As such, the group would be more appropriately referred to as the "group interest approach." The term cultural critique is best reserved for those recognizing cultural realities as cultural constructions (Marcus and Fischer 1986). It is also true that this group may be seen as utilizing some version of the archaic economic man theory found also in Marxism and elsewhere.

These writers direct their criticism toward reform and rationalization as unsatisfied consumers, and/or advocates thereof, within a society (also see Knowles 1977). Their criticisms are thus part of intercultural processes rather than the illumination of cultural processes, structures and forms. As such, I shall have little to say further about this group of writers beyond noting that their work can produce clues useful in constructivist investigations of medical knowledge, production and expression.

Dependency

The third form of political economy in medical anthropology is the group of explicit or implicit dependency theorists who see illness as caused by poverty, underdevelopment and misdistribution, themselves caused by the "penetration" of capitalism into the world's "peripheral" countries. This notion uses Wallerstein's model of the Modern World System, defined as a world economy in which ... a single political system does not exist over all, or virtually all, of the space" (1976: 230). A unified political entity would be a "world empire." "Capitalism as an economic mode is based on the fact that economic factors operate within an area larger than that which any political entity can totally control" giving capitalism a freedom to maneuver. Marxists may or may not adhere to this theory.

The ideas are renderings of Baran's earlier work (1957). The Political Economy of Growth. The central dynamic idea is that for one area to develop, another must be "dedeveloped" or "underdeveloped" (used as a verb). "Under such conditions, national and international social relations are determined by the expansion of capitalism and the intrusion of the (capitalist) world market into the periphery" (Morgan 1987: 136).

Further, the approach sees classes world-wide as things in themselves (as sich) (Wallerstein 1976: 233), and classifies "core areas" and states as opposed to and exploiting "peripheral" and "semiperipheral" areas. The latter two terms are applied according to a perceived relationship to what is perceived as a core area of production. Marxists, while at first taken with the world system idea, later felt it was not Marxist and so it was dropped, e.g. Navarro (1986) (Morgan 1987: 134). This group (Baer, Singer, Johnson 1986, Baer 1986, Singer 1986, Elling 1977, Maclean 1986) is also noteworthy for their avowed political stance and their calls for various reforms typical of Marxists. They seek, after Marx, to convince us that their mission is to both understand and to change the world in spite of their own assertions that all is determined from above.

Hegemony

Most recently a new development has been a concern for hegemony, the notion being taken from the Italian Marxist, Antonio Gramsci. Similar ideas had been expressed earlier (Frankenberg 1980) but recently these ideas have been grafted onto the work of Gramsci, a figure whose work was popular in the 1970's and 1980's in social science areas outside of medical anthropology but whose currency has declined there. Frankenberg's (1988) and Gramsci's notion of hegemony of Biomedicine ultimately rests on faith, for the formulation asserts that it is present and if one is not aware of it, its unremarkable character only demonstrates the efficacy of its domination.

Morsey (1988) also argues for a hegemonic view of Biomedicine. But her article argues contradictorily, that local level voluntarisms' development, of clinics and hospitals and which have succeeded in "power sharing" with the Egyptian state, is an example of biomedical hegemony because such facilities do not revile and install traditional Islamic medicine. Morsey has elsewhere argued for a form of postmodern political economy which while emphasizing Marxist interests also recognizes the existence and influence of culture (1990).

Critical theory

A final form of critical medical anthropology is defined by Lock. It is, "one which pays attention to macro-structural questions, the role of power in social life, and the way in which Biomedicine is culturally constructed, in addition to the more familiar and traditional ethnomedical approaches". She says that it, "is indeed a formidable task. It cannot be undertaken satisfactorily without recourse to theories and knowledge acquired within the disciplines of history, economics and political science, in addition to those of sociology and anthropology" (1986: 110). This view is not political economy and is articulated in opposition to it and is referred simply to as a "critical approach".

Morsey, in her review, incorrectly assigns Taussig (1980) to this group. He most decidedly belongs to the Marxist group, as Young (1982) notes. The critical group is clearly closest to those that I would term constructivist. However, this view mixes empiricist cause and effect with interpretive approaches without a synthesis. For example, considering "macro-structural" questions such as power is not different than considering how Biomedicine is culturally constructed, since power and medicine are both culturally constructed.

Power may be seen not as an empirical entity but as a dynamic cultural construct. After Weber, we recognize that power is the ability to realize one's will in an action in which others are participating. But the realization of one's will is made possible by cultural conventions. The conventional nature of power is apparent when one considers that those with power in one circumstance have none in another or that those in power one day may the next be 'out of power', whether through elections, coups, purges or 'retirement' and 'reassignment', or, as we have seen over the last year (1989) the collapse of dictatoral communist states and their ruling parties.

Likewise, contrary to Foucault's body of work, knowledge is not power unless it is culturally construed as such. In Foucault's French context, power is possessed and wielded by one group over others. However, research indicates that physicians are hardly all-powerful or autonomous or in league with the state (e.g., Rhodes, n.d.). What we see in Foucault's work may be more a reflection of power and authority in a particular place, France, not in Biomedicine in general or some generalized modern industrial society (Gaines 1989). As Goldstein's (1987) excellent historical study shows, French professional psychiatric medicine was a creature of French history and social organization, especially that of the French state. The notion of medical power and authority is thus shown to be culturally specific and grounded in culture history [2].

In the present critical perspective of Lock, the body is seen as the locus of sickness which reflects social and economic conflicts. Sickness is seen as a metaphor expressing the phenomenology of the 'indignities of postindustrial life', oppression and/or exploitation (Scheper-Hughes and Lock 1987).
Illness is seen not so much in terms of political economy as in terms of culturally constructed conflicts in social relations and roles (ethnic, gender).

A problem here is that the view of illness as metaphor for contemporary problems, or the "indignity" of work in modern industrial countries, while on the right interpretive track, produces synchronic, functionalist explanations and makes it difficult to localize, and thereby situate, explanations in real human contexts. Also, it is noteworthy that there are clearly more illnesses than there are problematic social statuses; and each status does not have a 'type' illness corresponding to it as this view would suggest.

The Critique of Political Economy, Dependency Theory, Hegemony and Marxism in Medical Anthropology

My principal criticisms, then, are directed toward dependency theorists, hegemonists and the Marxists who argue that they seek "to understand health issues in light of the larger political and economic forces that pattern human relationships, shape social behavior, and condition collective experience, including forces of institutional, national and global scale" (Singer 1986: 128).

Although this statement clearly shows the empiricist bias, the simple determinism, the materialism and the deductive nature of critical medical perspectives, writers outline their views in several different ways. Since I will focus my critique on them, I shall present their views largely in their own words.

Singer (1986) argues that world system and dependency theory paradigms have, "had a telling impact on the political economy of health literature. It is the starting point of both these theories that we cannot comprehend the contemporary world unless we understand global economic processes and class relationships brought into existence by the growth and spread of capitalism".

"Consequently, it has been the tendency of world system and dependency theorists to focus their attention on the macrolevel, analyzing how nations at the core of the capitalist system have methodically extracted wealth from, and thereby caused the underdevelopment of, peripheral areas" (1986: 128). As Baer puts it, critical medical anthropology seeks to "understand health related issues within the context of the class and imperialist relations inherent in the capitalist world-system" (Baer 1982: 1). Navarro (1976) also argues that Biomedicine is a creature of capitalism; an economic regime creates a medical system which in turn is an agent in its spread and the domination of others (Singer 1986) and which thereby creates the predisposition to mortality and morbidity (Waltzkin 1981a).

Waltzkin argues that medicine and health are so such creatures of capitalism that, "the Marxist viewpoint questions whether major improvements in the health system can occur without fundamental changes in the broad social order" (1981b: 333). Eiling (1977), for example sees diseases as generated within and by the "capitalist world system". This view, of course, remarkable only in its lack of accounting or recognizing such other influences such as ecological, genetic or those having to do with primate evolution and culture. As such, the perspective suggests that human diseases have appeared only recently in human experience, after the advent of capitalism. Also ignored are the rather obvious and dramatic improvements in health in capitalist countries over the last century (McKeown 1979).

The "microlevel" is distinguished and said to include, "the particular configuration of class, gender, and ethnic relationships, the availability of resources and technology, demographic and ecological factors, and the historic and cultural patterns (which) contribute to the short- and long-term effects of capitalist penetrations of health care, as well as to any micropopulation's ability to resist the agents, agencies, and agendas of biomedicine". "In short, critical anthropology struggles to synthesize the macrolevel understandings of the political economy of health with the microlevel sensitivity and awareness of conventional medical anthropology" (Singer 1986: 128, emphasis added).

Essentially, the task appears to be the humanization of Marxist thought through a symbiosis with the 'sensitivity and (human-centered) awareness' of what is misstated as "conventional" medical anthropology. An important point here is that proponents recognize the non-, even anti-humanist trend of Marxist thought, something that has been quite clear in China, Russia and Eastern Europe for some decades. However, the problem of mechanistic views remains despite Coote's (1982) suggestion that attempts to "mechanically and causally to relate medical ideas directly to social, political and economic circumstances" are (i.e., must be considered) moribund (p. 87). In the following, we consider the rhetoric, meta-theoretical problems, theories and ethnographic support and the stance vis-à-vis of change of the critical medical anthropologies.

A. Problems of rhetoric

As opposed to what is claimed as "conventional" medical anthropology, it is easily demonstrated that the theories of critical medical anthropologies are themselves conventional and traditional and, in fact were such even in the 19th century. However, their proponents obscure this by significant distortions in their representations of opposed viewpoints, especially those of constructivists. As an example, Singer (1986) refers to the sensitivity and understanding found in "conventional" medical anthropology. In point of fact, he refers to the rich (or "thick") descriptions and interpretations of things biomedical supplied by constructivist research (there called "interpretive" or "symbolic"). This research perspective represents the revolution in social science constituted by the turn toward an interpretive social science (Geertz 1973, 1983; Rabinow and Sullivan 1977, 1989). Clearly then, the interpretive work cannot be appropriately referred to as "traditional medical anthropology" nor traditional social science.

Constructivist approaches represent a genuine radical (instead of rhetorically radical) shift in the nature, form and goals of social science itself. The interpretive turn in social science rethinks the nature of the scientific enterprise and redirects us from things-in-themselves and cause-effect to meanings and understandings outside ourselves and which reflect back upon our own constructed realities and, in fact, demonstrate both their constructedness and their plurality.

Partly because of the traditional, 19th century scientific basis of the schools of thought under the label of critical medical anthropology, its members are led into making (false) rhetorical statements about regularities and patterns. A second reason is their tendency to convey a stance of certitude and great knowledge about their subject(s) (see Geertz 1988). That is, their terms have largely rhetorical functions. As examples, one can use the term "advanced capitalist societies" (Baer 1982, Singer 1986, Waltzkin 1981b), often used in conjunction with the phrase, "typical of". Since the nations of the United States or, for that matter, Germany or France, are unique, one cannot assert that particular features are "typical of" anything. As well, changes over time do not necessarily imply a direction or stage (e.g., "advanced") even in evolutionary biology. The implicit, and quite archaic, evolutionary view of Marx remains thus encoded in the views of critical medical anthropology.

The use of rhetorical methods is 'typically' employed by critical medical anthropologists. Other examples are noted elsewhere in this paper (e.g., Marxist social science referred to as a "struggle"). In my review I shall reverse things and appropriately employ terms (to critique critical medical anthropologies) which are often used by critical medical anthropologists, or Marxists before them, to criticize others.
B. Problems of metatheory

Utopianism

Under this heading can be considered assumptions that form the background of political economists and Marxist thought in medical anthropology. First, it needs to be emphasized that these political economic views of health appear guilty of naïve utopianism. Navarro, Waitzkin, Elling and others argue that capitalism is the sole cause of sickness in the world and that without it, human life would be sickness-free. Such an odd position denies, as Morgan notes, any role of biology or ecology in disease etiology. But also ignored are the health implications of other economic and technical regimes. That is, in order to argue that capitalism has dire health consequences, one must show the data on health consequences of other regimes, subtract these from figures for capitalist societies and have a positive difference. Such a process would yield the differences in health consequences. However, no writer has ever tried this. Rather, they use a form of the centuries old “argument from design” in a slightly different guise; i.e., if there is illness and capitalism at the same time, the illness must be caused by capitalism. Thus, the assertion that capitalism causes an increase in mortality and morbidity remains unproven and indeed, even from a common sense point of view, without merit.

Epistemology

The epistemology of this group is highly problematic. Like Hume and others, this group makes two epistemological assumptions which, in the light of modern cultural anthropology, are quite untenable. First, they persist in asserting a reality of ultimate truth and true knowledge. Second, they believe that true knowledge has but one source, science. Of course, with regard to the latter, Marxist critical medical anthropologists have a much narrower view of science than did philosophers or do contemporary scientists; they believe with other Marxists that only their truth and their knowledge real, all else false, “being mere ideology and expressions of “bourgeois class interests” (Hawthorne 1987: 1).

And, we note that while all others’ actions are “determined” by capitalism, the same appears not to be the case for critical medical anthropologists (or for Marxists in general). In fact, their views disprove their own assertions of economic determinism of local ideology.

Contradictions

Political economists, e.g., Navarro (1976), Waitzkin (1981b) often maintain a flatly contradictory position. On the one hand, they argue that medicine under capitalism is deleterious, even evil. On the other hand, they decry the commoditization, organization, ideology, etc., of medicine and the barriers to access encountered by “peripheral” groups to biomedical technology and services. If the initial characterization of medicine as fundamentally deleterious to health were correct, then marginal status and/or powerlessness would indeed be their own reward in capitalist society.

Obscurantism

Political economists typically argue that ideology, including disease theories, are designed to obscure and mystify class relations and obscure the means of oppression and, for cultural critics, for social control. However, it seems clear that political economic research is itself profoundly obscurantist. It conceals and/or avoids the very real thoughts, experience and actions of people at local levels. It conceals the cultural and social construction of reality, whether of illness or of social categories. Political economy accomplishes this by avoiding examinations of local level thought and action by remaining solely at an experience- and culturally-distant, putatively, “macro” level [3]. Thus, political economic studies, such as those cited here and in Morgan’s detailed review, tell us nothing about the actual thoughts and actions of healers, patients or their significant others. After asserting a problem is caused by capitalism or biomedical hegemony, sentiment is then imputed to others such that actors’ views are portrayed as justifying and corroborating the original analysis (e.g., Frankenberg 1988, Schepers-Hughes 1988) [4].

Political economic and Marxist perspectives take the traditional tacit view of viewing medicine and medical knowledge as distinct from other social knowledge (Wright and Trescher 1982a, b). Medicine is taken to be an independent, autonomous enterprise set apart and opposed to society and culture (Navarro 1976, Baer, Singer, Johnson 1986, Turner 1987). Since, political economists believe medicine is distinct from society, social forces in the form of recent or remote history and current events in society and culture can not be seen as playing significant parts in their analyses or their understandings. This leaves us with a view of professional ethnomedicines that is thin indeed.

As well, the distinction accorded Biomedicine actually support[s] the claims of the medical profession to a singular knowledge base and unique sociological and sociological status. This implicit advocacy of this view assists in obscuring and mystifying the cultural and social historical origins of professional ethnomedical knowledge and practice and the human agents (not impersonal system) responsible for them. The view of “system as cause” precludes meaningful discussion and development of research on ethics, a topic that should soon be enormous in the study of both professional ethnomedicine (Lieban 1990, Wez 1990) and ethnopsychiatry (Gaines n.d., Young 1990).

C. Problems of theory

Uncollected Theoretical Shift

Theorists (Baer, Singer, Navarro, Johnson, cited in Morgan, Waitzkin) have adopted and apply a market definition of capitalism rather than utilizing Marx’s notion of capitalism as a mode of production which creates relations of production. Thus, the nature of the central explanatory concept is dramatically changed without a working out of the vast number of consequences of such a change. For example, the notion of class derives from the mode of production definition, but is problematic in the market model, yet theorists use class as an explanatory concept despite dropping the theoretical basis for its use as such.

Ahistoricity and functionalism

Political economic theories are either ahistorical or have only a very shallow historical depth. While Morgan notes this great deficiency, she does not indicate an awareness that this omission derives from the functionalist nature of such theories. Additional criticism may be placed at the doorstep of the various political economic and Marxist perspectives in several domains. As Morgan puts it, a notion of “social dynamism is curiously absent from works of political economists of health” (1987: 131). Actually, given the inherently functionalist nature of such formulations, the absence is not curious, as
is noted elsewhere in the present paper.

Problems and archaic key theoretical conceptions

Several key formulations used by political economists are archaic. One central notion is that of class. The concept of class (and class relations) appears to be an expression of the same empiricism and ethnocentrism (or Eurocentrism as Dumont [1980] called it) which refines a world-wide prime mover, "capitalism." The notions of class and determinative class relations are artifacts of 19th century European, i.e., English social classification, not scientific truths [5]. Researchers, though they call themselves "critical," would do well to critically examine such seemingly unproblematical notions, taking note of their culture history, as is being done with other key realities of ethnomedicines, e.g., nature (Gordon 1988), "race" (Brandt 1978, 1985, Gaines 1985a, 1985b, 1987a), emotion (Lutz 1985, Obeyesekere 1985), mind (Gaines 1989, Kirmayer 1988), biology (Gaines 1986b, 1987a), medical competence (DelVecchio Good 1985), errors (Bork 1977, Paget 1988), and gender in medicine (Barrett and Roberts 1980, Marantz-Sanchez 1985).

Many of these conceptions, such as "race" and "class" and notions of gender, were clearly imported into medicine and social science from popular society. In using popular classifications, it may be argued that political economists support the continuation of culturally based invidious distinctions by reifying them and presenting them as natural elements and foci of "scientific" study.

It should also be noted that the notion of the state as a universal evolutionary development is also highly suspect. The state appears to be a cultural creation or an "invention" (Baddeley and Birnbaum 1984), not a result of any asserted social evolutionary process. This accounts for the fact that the French state is, in structure, organization and recruitment of personnel, radically different from that developed (and developing) in the United States (see Birnbaum 1981).

To Morgan's criticism, one can add that critical medical anthropology also renders Marx historically, failing to situate him, his ideas or his concepts in the context of European culture history. Related to this timeless view of Marx are the contemporary images of Marx or Marxism which are almost purely ahistorical, as Morgan notes, but also largely functionalist in nature. It might be useful to suggest a view of Marx as ethnographer, albeit not an extraordinary one, of 19th century English society. One then would regard his concepts as local cultural constructions and processes.

Another point may be added here. While critical theorists claim that their key insight is the social causation of illness, e.g., as mental illness, we find that this is precisely the official professional view of the etiology of mental illnesses held by American psychiatry in the 19th century (Grob 1987). Thus, what is heralded as a revolutionary insight today is the 'elite' (psychiatric) ideology of a century ago.

The problem of communist and socialist regimes

The final, and perhaps the most important point, is the fact that the key explanatory tool, the "modern world capitalist system" is most problematic if not entirely fictitious. The concept accepted and used willy nilly by political economists does not note, let alone explain, the central fact that most of the people in the world live under communist or socialist regimes. (This appears to be an area of change in the near future.) For some unexplained reason, political economic theory does not posit a "modern communist world system" or a "modern socialist world system" or a "communist-socialist world system".

The world's socialist and communist states appear, at least in Marxist-influenced political economic theory in medical anthropology, to have not the slightest power or influence in the world. The recognition that most of the world's people are not controlled by a capitalist system or systems starkly highlights the fact that "modern world capitalist system" is a construct of some social theorists, not a global socioeconomic reality. In fact, the very existence of non-capitalist states disproves the assertions of critical medical anthropologists that 1) all is determined by larger capitalist economic forces and 2) all contemporary human disease is caused by capitalism (though it is unlikely that any non-Marxist needed any proof of the latter).

D. Ethnography and the problems of evidence

To this point we have considered rhetoric, metatheoretical and theoretical problems with critical medical views. Below, we consider a number of challenges to critical medical anthropological views related to problems of ethnographic evidence. Morgan considers nine major deficits of political economic work in the domain of evidence. Political economic works may be shown to:

1. grossly simplify the complex nature of social interaction and social action.
2. fail to predict local level realities, i.e., hypotheses are not borne out by local level ethnographic research.
3. minimize the influence of local institutions and actions, including resistance, and local history, on developments and organizations in the local context.
4. overlook the central importance of local level social and class relations.
5. ignore extant and evident medical pluralism in favor of (inaccurate) characterizations of biomedical hegemony.
6. ignore abundant evidence demonstrating that economic formations do not correlate with specific forms of medicine or disease.
7. de-emphasize, if not totally deny, biology and ecology in disease etiology, stressing capitalism as the primary cause.
8. ignore improvements found in health status in locales where Biomedicine has been introduced.
9. ignore data which shows even the development of dependence is not infrequently beneficial to health status.

Criticism in this domain actually allow us to focus on a single fact: political economic theories are not in the least predictive and despite student claims, do not address anything approaching "determinants" of health and sickness. Ethnography does not demonstrate uniformly negative consequences of capitalism or Biomedicine nor does it show a unique etiological agency of capitalism. The notion of "rules" by which capitalism purportedly works espoused by critical theorists and which are said to give rise to mortality and morbidity appear unrelated to reality. The notion of "rules" itself seems little more than a holdover from early twentieth century logical positivism (Rabinow and Sullivan 1979). Thus we find the reason that critical theorists ignore ethnographic data or trivialize its meaning. Their theories find confirmation only in self reference, not in ethnography.

It is not difficult to see that for many political economists the real bête noire, is actually America (see also Geertz 1984) to which all manner of evil power and influence, past and present, is attributed, a conceptualization which, while more articulate in its presentation, is conceptually analogous to former President Reagan's simplistic cartoon quality notion of the USSR as an "evil empire". However, if this is the case, another major difficulty with the position arises and which is not confronted by theorists. That is, as Gilpin (1987) has recently detailed, America cannot be regarded as the hegemonic power in today's world because of decline at home and increases elsewhere in Japan and Europe, although Gilpin argues one such power will be needed to maintain the stability of a future
world economy that is highly interdependent. We may note also that America could not be considered the world power even as recently as 50 years ago, making the case for American dominance in world events and its role as cause of all human mortality and morbidity since industrialization extremely dubious.

In general, political economists, far from being critical, accept uncritically concepts from other times, other places and other disciplines ("class", "political economy", "world system", "capitalist world system") and convert them into immutable, timeless, universal realities and truths. In doing so they act as intellectual colonists imposing the "truth" of their Eurocentric views of the world on others.

E. Applicability, relevance and the status quo

Given that all is determined at the macro-level in the last instance, local initiatives can count for naught in the alleviation of human suffering. Thus, social science education, clinical anthropological work, patient advocacy, etc., of the constructivist bent should not have a salutary effect on patient care or health care delivery. Aside from the fact that a considerable amount of clinical and other medical anthropological work demonstrates the falsity of this prediction and assertion, the political economic viewpoints can offer no improvement at the local level and, indeed, thus argue implicitly for leaving things as they are.

The stance or pose of change agent asserted by advocates, then, is entirely illusory; the position in fact advocates inactivity unless or until "the revolution comes", since change short of that is irrelevant (for Marxists and political economists but not for cultural critics). In addition, the position makes it unlikely that change can or will be made at the local level for another reason; advocates cannot enlist the aid of the medical people concerned since they are predefined as "oppressors". But, since all is determined from above, there would be no reason to enlist the aid of locals to make changes since only "changes in the social order" are seen as significant and these must result from vast economic changes.

Political economists fail to note change instituted by constructivist approaches and which may be categorized as falling into two distinct types.

A. Direct Influence: research, and the various aspects of clinical work may directly alter the ideology and practice of Biomedicine.
B. Mirror for Physicians: Work that is not applied may be used in medical education of students or practicing professionals. As much, even purely theoretical, medical anthropological work can act as a "mirror for physicians" literature in a fashion analogous to the "mirror for magistrates" literature in Medieval Europe.

Both applied and theoretical medical anthropology can and does affect medical theory and practice at both local and national levels. In this regard, it is noteworthy that the influence of constructivist research and teaching (e.g., Kleinman and his mentors' (Eisenberg, Engel), associates' and followers' work) may be seen in the changes affecting American medical education. Consideration of psychosocial and cultural aspects of illness and treatment are being expanded at the expense of biological study. This is a major change which was initiated at local levels. Thus constructivists, accused of overlooking the "real" determinants of sickness, may claim some responsibility for minor and major changes in medical practice, education and even health status.

Since political economic theorists are materialists and empiricists, as are biomedical advocates, they indirectly support the ideology of science which both share. Political economy supports the status quo of medical and social scientific methods of discourse. One means of both is the eschewing of the interpretive turn in social science.

Since their conservative stances implicitly advocates maintenance in science and society, they are but rhetorical advocates of change and improvement in human affairs. As well, political economic theories conceive of others in different-and-therefore-unequal terms. Cultural differences are dismissed as reflections of economy and development/evolution. Differences in beliefs and behaviors are thus seen ultimately as illegitimate, as results of some form of deprivation, underdevelopment or development, not as distinct, valid forms of being in the world. Local cultural forms, unless they are rebellions, are thus seen ahistorically as ephemeral, inept and misguided actions (e.g., see Baer 1981 on enthusiastic Black religious experiences). This perspective does little but trivialize and render inconsequential the very essence of meaningful human action. The moral high ground claimed by critical medical anthropological advocates thus becomes awash.

The problems with political economic views as seen by this reviewer render it far beyond saving. Morgan states political economists "have much to learn from anthropology", especially cultural anthropology. However, this reviewer does not agree that such a learning process should or can lead to a "new" synthesis of anthropological and political economic approaches to health and illness (see also Lazarus 1988). Rather, given the very poor track record of the paradigm, its 19th century, Eurocentric, empiricist and anti-relativist characteristics (Geertz 1984), the perspective is evidently more ideology than old or new science. Thus, the salutary change would not be a synthesis, but a shift to interpretive paradigms.

F. The illogic of attribution in clinical Marxism

Typical of the work of those espousing putatively critical medical anthropological views is the assertion that capitalism (or "American capitalism" or "modern capitalism" or "the modern world capitalist system") is to blame for the incidence and prevalence of any form of morbidity and mortality, as if, depending on the writer, other modes of production produce no health consequences. Agriculture, or industrial work are seen as having negative consequences for health only in the context of capitalism (e.g., Susser 1988, Scheder 1988, Watzkin 1981, Navarro 1976). Related to this issue, Watzkin (1981b: 346) writes of maldistribution and says that "people in the U.S. do not have access to even the simplest forms of care. Because of maldistribution, there are still individuals who suffer death or permanent disability every year". Of course, Watzkin's utopian implications set one to wonder about a society where death and disability would be entirely absent. But, relevant here is the means he uses to prove his point. He considers three cases. They are short and can be presented here almost in their entirety and afford us a chance to see clearly the logic of attribution in Marxism. What we will see is purely impersonal, ahistorical, economic and biological reductionism in Marxist clinical practice.

The cases are of farm workers in the state of California. The first case is of an "11 year-old Chicana girl" (sic—gender indicated by final vowel) who cuts her feet on a rock in a fall. Though the wounds fester, the parents wait two days more after her feet become "painful, hot, red, and swollen (symptoms of inflammation with infection)" (1981b: 342-343). The final diagnosis showed acute glomerulonephritis that was a complication from a streptococcal skin infection. "The patient's wounds were cleaned and dressed with an antibiotic ointment. A course of penicillin, rest, and a nutritive diet were (sic) started" and follow-up showed recovery.

The second case is that of a boy with congenital heart disease. "B.C. is a 5 year-old Chicano boy (sic) whose grandmother brought him to the UFW (United Farm Workers in California) clinic because of poor appetite. The child had been delivered at home and had not been seen by a doctor previously.
No one in the family speaks English. Physical exam revealed a very small boy, with height and weight below the 3rd percentile. The child's fingernail beds and lips were slightly cyanotic; the fingernails showed clubbing. Examination of the heart showed a harsh grade V/VI systolic ejection murmur ... tentative diagnosis (later confirmed) was pulmonic stenosis with possible septal defect and possible pulmonary hypertension". Waltzkin concludes with this comment: "This child faced the probability of permanent functional deficit from heart and lung disease. If he had had access to a health worker by age 3, the defect probably could have been corrected without permanent serious deficit" (1981b: 347).

The final case is that of a 14 year-old boy, a member of another California migrant farm worker family. The boy had no immunizations or contact with health workers until age 9, when he developed a fever and subsequent nearly complete paralysis of both arms and the right leg. Details of contacts with other I11 individuals at the time are sketchy. He is followed at the clinic for vague abdominal symptoms that are thought to be psychosomatic, probably deriving from upset that he cannot follow his peers into farm labor. This is concluded with the statement, that the, "Incidence of polio has dropped markedly since the introduction of vaccines but has not yet been eradicated from the U.S. because of incomplete immunization" (1981b: 347).

As is apparent, the cases are presented in biophysiological terms only. Each is followed up with comments indicating that the case would not have occurred if it were not for "maldistribution" of resources which in turn is caused by capitalism. In point of fact, all cases show failed responsibility of families and that late intervention of the biomedical system, in the first two cases, actually saves the lives of the patients.

Waltzkin, in his failure to contextualize the cases, leaves unexplained and unexamined the conceptions, beliefs, logic, understanding or anything else, about the patient or his or her significant others. What were the perceptions of parents to a childless child of abnormal stature and clubbed fingers? What did they think was happening? Why was assistance not sought for these problems? We note the child was presented for treatment because of poor appetite, not because of the preexisting obvious physical problems. We have a clue that there may be a strong peer pressure to perform and hence there may be attempts to mask symptoms. Though this is noted, it remains unexplored.

We also see in his account an ahistorical view typical of biomedical sorts, as McKeown has noted ("an absence of any real interest among clinical teachers in the origin of disease, apart from its pathological and clinical manifestations" (1979: xi)). Waltzkin is so concerned to blame an external system that he completely ignores the one in front of him and in which people live and construct their world, including the reality or importance of physical symptoms. He does not mention, for example, the very well known fact that migrant workers are often illegal and or mistrustful of authorities. As a consequence, they purposely keep their children out of school and away from other institutional contexts in which their poor health otherwise would be noted.

Problems of seeking help late and do occur in cities near medical facilities and among the poor and the well-to-do as in cases of drinking, STDs, as well as when one overlooks potentially serious symptoms. These are dependent upon local definitions and local knowledge of the situations, not global forces. If the illnesses above were caused by capitalism, how did the clinical Marxist intervene and blunt these all-powerful forces? The presentations in these cases are in biomedical and biologically compatible voice only and are models of biomedical reductionism, consonant with the author's material/economic reductionism. There appears no place for a human story or human understanding as the scientific stance dehumanizes the account in two ways, through the biomedical and Marxist gaze.

Waltzkin's approach shows us several of the many central failures of Marxist medical anthropology. First, because something untoward occurs in America or some other society labeled "capitalist" does not mean the event is caused or even related to economic organization. Second, and most critical, putatively critical medical anthropologists fail to make valid comparisons if they make them at all. Generally, the comparisons are made with implicit utopian standards of perfection, not to any known human reality. And finally, we see how the human dimension, in phenomenal terms and in terms of agency, is effaced in a quest for empirical, extra-human causes.

_G. Problems of interpretation in critical medical anthropologies_

Singer, Baer, Navarro and others have noted, after McKeown (1979), that medicine cannot be credited with the great improvements in health over the last century or so. While they are correct, they fail to recognize that the decline in infectious diseases and the great increase in life expectancy and the decline of suffering from dental disease (McKeown 1979) must be attributed, according to their usual causal chain, to capitalism. It is in these countries so labeled by these writers where the greatest strides have been made. Instead, these authors point to capitalism as the cause of disease without taking into account the relative impact of different forms of disease in different social constellations. We may note here that ideas of the English hygienists and clean air groups of the 1800's were not based upon any notion of infection or contagion or bacteriologic theories, in fact many were anti-contagionists (see Cooter 1982) and so were outside of the medical establishment. However, they were yet most influential in the development of parks and sanitary conditions and alleviation of problems later recognized by Biomedicine as contributing to increased mortality and morbidity in urban populations.

Three points are important here. First, ideas such as these led to new social and political actions (i.e., local initiative, local changes). Second, these novel ideas, which improved urban living conditions, must be seen as creatures of capitalism. Third, the hygienists' ideas originated outside of medicine and later became a part of it. This suggests that a less than hegemonic reality of medicine, and a relationship of medicine to society (i.e., as part of it) not seen in Marxist works. Another example of this relationship appears in Johnson's work on physician impairment. He shows that this medical interest is a reflection of a society-wide interest originating in the human potential movement (1988).

In terms of the putative hegemony of Biomedicine in other contexts (Frankenberg 1980, 1988), it is clear that the "penetration of capitalism", does not eliminate other forms of medicine. It should also be stressed that the spread of aspects of the West's version of capitalism and medicine are often cases of borrowing rather than imposition, as accounts of Biomedicine in foreign cultural contexts demonstrates this (see 1978, Lock 1981, 1985, 1988, Ohrnuki-Tierney 1984, Weisberg and Long 1984), as Leslie had pointed out earlier (1980).

In such contexts, Biomedicine or capitalist medicine is in fact made into another option for health care, as in China (Kleinman 1980) and Africa (Jansen 1978) and or restructured according to local values of great historical depth, as in Japan (Ohrnuki-Tierney 1984, Lock 1981). As Lock (1986: 99) says, "Medical practice and health seeking behavior in Japan, while superficially very similar to corresponding activities in societies which embrace Western-style capitalism, are, on closer inspection, grounded in an unfamiliar ideology such that the paradoxes, ambiguities, and fears associated with illness are cast in a rather different light." And Ohrnuki-Tierney (1984) shows that while conceptions of health, illness, and cleanliness are couched in biomedical terms, they in fact refer to conceptions of purity and pollution that even predates the ancient established religions of Japan.

It can be argued that capitalism, like Biomedicine or Catholicism, is a set of historically generated cultural ideas which create social and economic forms. As it, or they, diffuse from one area to another,
changes necessarily occur in local contexts. I would suggest that capitalism is not just an idea of private enterprise, but has a myriad of related cultural notions including those of self, time, affiliation, world mutability, locus of and self control, perfectibility, truth, efficacy, novelty and more. Hence, only aspects of it translate to other cultures. For this reason, we find forms of capitalistic activity, e.g., Confucian (Lock 1986), Burmese (Spiro 1970) or Gallic (Gaines, n.d.c) capitalism, not a hegemonic "world capitalism".

We see in this the primacy of local knowledge over putative world forces in the shaping of local realities. Evidence of this with respect to local constructions of Biomedicine is likewise quite overwhelming (e.g., Brandt 1985, Gaines and Hahn 1985, Gaines and Farmer 1986, Gaines 1979, 1982a, 1985b, 1986b, 1989, Gilman 1988, Good and DelVecchio Good 1981, Goldstein 1987, Lock 1981, Marettaki and Seidler 1985, Norbeck and Lock 1988, Odnuki-Terney 1984, Pernick 1985, Welberg and Long 1984, Young 1988). Given the emerging recognition of quite distinctive features or ideology, practice and the social organization of medicine in modern countries such as Germany, Canada, America, Japan, Mexico and France, there is little evidence for authors' insistence on a unitary world hegemonic Biomedicine (Frankenberg 1988, Morsey 1988).

In the next section, I will present cultural constructivism. The constructivist perspective takes culture history, meaning, human agency, human experience and responsibility as focal, not ephemeral, concerns. It seeks to locate contemporary illness experience in continuous cultural historical processes which serve to frame, interpret and give meaning to experience.

II. Cultural Constructivism

On terminology

The term I employ here, "cultural constructivism", has an analogue in sociology, i.e., "social constructionism" (Wright and Treacher 1982a). I suggest the alternate term here for several reasons. First, I am concerned to distinguish an anthropological enterprise from a sociological one, and to stress the important differences in key concepts in each discipline. For sociology, the key concept is society, seen generally, synchronically, while for anthropology, it is culture, necessarily viewed, I would argue, diachronically. The implications of this difference are worth emphasizing and suggest the appropriateness of a distinct term. This anthropological enterprise takes as its task the 'deconstruction' of social and cultural realities.

In the last decades, anthropological research has developed in ways which strikingly distinguish it from its 19th century empiricism, and culturally untaught, ancestors (Elkana 1981, Geertz 1973, 1984, Marcus and Fischer 1986). The distinctiveness has been generated by a concern for indentity, "thick" descriptions, and attempts to approximate "the native's point of view" (Geertz 1983, after Malinowski) through the use of the ethnography of other people in other places. "... (I)f the locus of order and the source of modern anthropology's major intellectual contribution to scholarship were to be identified, it would be the ethnographic research process itself, bracketed by its two justifications. One is the capturing of cultural diversity and the other is a cultural critique of ourselves, often underplayed in the past, but having today a renewed potential for development" (Marcus and Fischer 1986: 20).

Such research replaced the grand, data- and "verstehen"-poor theorizing of 19th century anthropologists, sociologists and political economists of the chair, thus confronting us with the Other in detailed, rather than vague and confused, portraits. Implicit themes have also changed. Today, we are less enthralled with the idea of progress, "a synthesis of the past and a prophecy of the future" in J.M. Bury's apt phrase, than were our intellectual ancestors. Inseparable from a unilinear notion of time (Nisbet 1980: 5), the idea was confounded with that of evolution (an idea which, in its social form, is dubious at best). Authors looked into the future to see what great stage was to come, or was already here, each brought into existence by sweeping natural forces beyond the will of mankind.

Anthropological enlightenment has come in two forms. First, social cultural anthropology furnished detailed accounts of the culturally different. Second, such accounts allowed reflection on ourselves and our own world. "In using portraits of other cultural patterns to reflect self-critically on our own ways, anthropology disrupts common sense and makes us reexamine our taken-for-granted assumptions" (Marcus and Fischer 1986: vii).

In this way, cultural constructivism (and much social constructionism) provides the basis for important critiques of ourselves and our culture, including its ethnomedical beliefs and practices. However, as I argue below, cultural critiques from a cultural constructivist perspective are quite distinct from critical medical anthropologies which, alas, are still true to their 19th century intellectual ancestors (see Geertz 1973, 1983, 1984, Marcus and Fischer 1986, Mendelsohn and Elkana 1981, Rabinson and Sullivan 1979, Sahlin 1976, Wright and Treacher 1982a, b).

What is required is a perspective on ethnomedicines cognizant of their expressive, cultural nature, for such systems are not autonomous, isolable cultural units (Elkana 1981). Rather, they are phases or expressive moments of historically derived cultural systems. They are but aspects of their respective, larger cultures-in-the-making; one window among many we may use to gaze into the house of culture.

I use the variations of the root term constructive (e.g., constructivist, constructivism) in the stead of those of construction (e.g., constructionist, constructionism) used in sociology to distinguish the anthropological emphases in the study of medical cultures. Anthropological accounts should be seen as distinct from sociology's social histories of (professional) ethnomedicine (e.g., Starr 1982; Brown 1979) or of professional medical specialties (e.g., Baer 1987), for such histories are frequently quite acultural (e.g., Starr 1982, Brown 1979, Wright and Treacher 1982, but see Fox 1989).

In its initial dictionary meaning, the term constructivism conveys the notion that such an approach, "serves to advance a good purpose and is helpful". The good purpose for which the constructivist approach is helpful is the pursuit of cultural understanding of uniquely human beliefs, experiences and practices in their cultural context. However, the term constructionism in legal circles connotes an approach which is retrogressive and opposed to civil freedoms (in the guise of intellectual rigor). The legal constructivists ("strict constructionists") bring preconceived ideas and prejudices to a text and present these as "interpretations" said to be textually derived. Cultural constructivism, in contrast, takes a perspective which does not prejudge or assume an end result. Constructivists thus find only their preconceptions in new texts, a problem, that is found not only in the contemporary American jurisprudential circles.

Another resonance in my usage derives by analogy from contemporary art, where constructivism refers to a movement utilizing (industrial) elements (glass, metal, etc.) "to create nonrepresentational ... objects". Cultural constructivists would use animate (people) and inanimate (archives, film, plastic arts) cultural material to deconstruct and construct cultural meaning systems, replete with inconsistencies, multiple values, and beliefs and assumptions sometimes in conflict and sometimes in concert, but always cognizant that what they interpret (aspects of cultural systems) and what they produce (accounts, ethnographies) are not things in themselves.

Finally, I find the term cultural constructivism suitable because it conveys the notion that human conceptions, experiences, as well as endeavors, are constructed by and through cultures, seen as historical processes, including histories of contact with other cultures. They are constructed and
maintained in social processes and relations by means of negotiated definitions and redefinitions of life situations and events. Reality, the important, the good and the bad are those life aspects defined as such and maintained as such through human interactions wherein actors bring and exchange meanings and derive consensus, conflict or 'new' (variations of old) meanings.

The term constructivism allows the use of deconstruction as a definition of its enterprise which seeks to decode and reveal the underlying, fundamental constituent historical and semantic elements of cultural processes including medical systems. I do not see this in Derridian terms wherein anything can mean anything, but rather as suggesting a notion of cultural systems with finite underlying folk theories (see M. Turner 1987) and assumptions, including ethno-psychologies, which generate surface symbols of words (e.g., metaphors, metonymies), acts, gestures and or events as people try to make sense of experience and to construct it. Cultural meanings are thus seen as finite and constrained, not infinite and indeterminate.

Constructivism and the summation of existent perspectives

At the outset, it should be noted that my term "cultural constructivism" groups perspectives particularly relevant to medical anthropological research that are extant, but are now without a common designation. In this paper, I suggest a name and attempt to lay a coherent foundation for such research as well as to show some of its current limitations. I refer to work labeled "interpretive", "hermeneutic", "cultural/anthropological studies", "Kleinman's school", "the explanatory model (EM) approach", "meaning-centered", "semantic approach", "The Anthropology of Biomedicine".

Most recently, such perspectives have been referred to as "microlevel approaches" by some critical medical anthropologists (e.g., Singer 1986, Baer, Singer and Johnson 1986). These may all be subsumed under the cultural constructivist rubric, though some limitations are noted with respect to these approaches (or approaches called by these various terms) and we note that those who condemn so-called microlevel approaches sometimes engage in microlevel research (e.g., Waizkin 1984) calling such a focus "contextual". I employ the term cultural constructivism more as a summarizing rubric for I intend it to group all of the other of these terms except for the last ("microlevel").

My primary objection to the term "microlevel" is its inapplicability. Culture, history, social classificatory systems, status systems, systems of purity and pollution, conceptions of persons, theories of the body, of experience and suffering, ethnophysicsology and ethnoanatomy, local health care systems, and systems of power are all key conceptions and foci for understanding and interpreting medical experiences. Such foci simply cannot be appropriately characterized as "EM" or as "microlevel" approaches (Kleinman 1981, 1986).

While apprehended at the level of the clinic, the home, or other local area, which, one notes, are the only areas in which humans appear, individuals are always seen as representatives of extra-personal dimensions (e.g., culture, history and society). They are seen as isolates in the biomedical view and, apparently, the critical medical anthropological view. The outside is always and everywhere also inside. The distinction between the two amplified by critical medical anthropologists in fact suggests a particular, Western, view of self and a distinct, extra-human social order with its own 'laws'.

My second objection is, of course, the pejorative intent of the label. Critical medical anthropologists believe they are concerned with "broader", "larger" issues, for which read "more important". We note that they deal with them from local levels, usually precisely the same (the clinic, the library) as those they criticize. As Kleinman wrote some years ago, in what is still the most essential medical anthropological study, his model of health care systems emphasizes, "microscopic, internal clinical view, but the model I employ does not ignore the large-scale external factors that other models emphasize" (1980: 27). Since the intent is to provide a semiotic portrait of human sickness and healing, systems of meaning and knowledge are central, not ephemeral. The interpretive approach necessarily considers extracultural material as a matter of course.

In this vein, I note the use of the term EM (Explanatory Model) theorist is also incorrect (Baer, Singer and Johnson 1986, Young 1982, Lazarus 1987). And, Lazarus' view that the term (from Hahn and Gaines [1985], "The Anthropology of Biomedicine" is "another term for an Explanatory Model approach" is simply wrong.

The authors referred to by the "EM" label employ forms of interpretive anthropology (semantic, symbolic, hermeneutic, cultural) to medical issues. However, as is, or should be widely known, Kleinman's (1980) Explanatory Model is but one instance of the interpretive approach; there it is employed with respect to particular illness episodes of individuals in a cultural context. It highlights the nature of symbolic interaction (i.e., the meanings brought to and exchanged in social interactions as per Mead, Blumer and others) in clinical domains to understand participants' thoughts and actions. The related notion of Good's Semiotic Illness Network (Good 1977) specifies the meaning context of particular symptoms, the surrounding cultural ideology that is the source of the salience of sensations (which thereby become "symptoms") and their personal and group meanings.

The use of the appellation 'EM theorist' distorts the nature of the interpretive enterprise and makes its foci appear small and trivial and its concerns parochial. In fact the opposite is true. As interpretive social science, the approaches of constructivists call into question not only biomedical knowledge, practice and organization, but all the given including "laws" and seemingly irreducible realities such as "biology", "disease", capitalism, "class" or "domination", "power", "economy", and other conceptions and constructs of traditional, 19th century medical and social sciences.

Assumptions in Medicine and Medical Science

Assumptions of social sciences of medicine

The traditional approaches to Western professional medicine, Biomedicine, including various Marxist and other sociological forms of inquiry, all see medicine as autonomous, as an independent, sovereign institution set apart from and, especially for Marxists, opposed to society (e.g., Baer 1986; Baer, Singer and Johnson 1986, Navarro 1975a, b; 1976, Taussig 1980, Waizkin 1981a). Biomedicine in the view of many is seen as "having a unique scientific status which separates it from the influence of social forces" (Wright and Treadhe 1982b: 5). Wright and Treadhe enumerated four traditional perspectives or assumptions which they have identified in the sociology of Western professional medicine. These are:

1. Medical knowledge and or medicine is seen as unproblematic, as given in nature.
2. (Related to the first assumption) Medical knowledge is distinct from other social knowledge because it is built upon modern science and is, therefore, efficacious.
3. Diseases are naturally existing entities: they exist independent of their isolation and designation by medical science.
4. External social forces (since they are seen as distinct from medicine), may be ignored in the study of medicine or its development.
Assumptions of Biomedicine

Of primary interest to me is that Wright and Treacher are in fact indicating that sociological (and political economic) approaches employ some of the very same assumptions held by Biomedicine itself. A.Mishler, et al. (1981), Engel (1977) as well as others, have enumerated specific assumptions held by Biomedicine. These are:

1. Diseases are deviations from measurable biophysiological norms.
2. Diseases are universal.
3. Diseases are generic.
4. Medicine (practice and research) is an a-cultural, neutral scientific enterprise.

Although Mishler points to these as "silent assumptions" in Biomedicine, such a description is suitable for only three of the assumptions. The definition of disease (1) is actually explicit and articulated by members of Western medicine. The idea explicitly serves to organize their medical actions. At a deeper level, like that of purity and pollution in Japan, Gordon (1988) shows there is an uncultured philosophy of "Naturalism." This philosophy underlies and forms the "background" for medical thought. As a consequence, "biomedical practitioners approach sickness as a natural phenomenon, legitimize and develop their knowledge using a naturalist method (scientific rationality) and see themselves as practicing on nature's human representative - the human body" (Gordon 1988: 24).

Fundamental assumptions of constructivist approaches need to be explicated here. These key assumptions are my first attempt at outlining a common basis for the several constructivist approaches and present the list as somewhat preliminary. There are four key assumptions, as I see them, which researchers should keep in mind in the conduct of medical anthropological research in complex or simple societies.

Assumptions of Cultural Constructivism

1. Ethnomedical Knowledge is Problematic


Though axiomatic for interpretative sorts, it should be noted that many medical anthropologists, such as those working in ‘international health’, in the ecological and epidemiological fields and in physical medical anthropology, maintain views of biomedical knowledge as problematic (see Greenwood et al. 1988b). And, not all ethnomedical researchers see Biomedicine as a 'culturally constructed professional ethnomedicine' (Gaines 1982b, Hahn and Gaines 1985), for example, see Hughes (1968), and Foster and Anderson (1978).

However, cultural constructivism and social constructionism alike take as a central hypothesis that medical knowledge, including nosologies, theories, therapies, research practices, etc., is problematic and not given in nature, an entity which is itself a cultural construct (Sahlins 1976). No aspect of medical knowledge or practice should be seen as unproblematic or as a natural object existing independent of an ethnomedicine’s isolation, description and labeling.

Ethnomedicines are, to paraphrase Evans-Pritchard’s post-functionalist view of society, ‘moral’, not ‘natural systems’, and thus are human creations. Aspects of medical enterprises are to be seen as culturally constructed and not necessitated in form or function by biology, nature, society or economy.

In addition to the problematic of professional biomedical theory, the role of extra-medical cultural beliefs, such as various forms of communitarianism, for example, American forms of agism, sexism, racism, elitism, are to be expected within the theory and practice of ethnomedicine (see Barrett and Roberts 1980, Brandt 1978, 1985, DelVecchio Good 1985, Hahn and Gaines 1985, Harding and O’Barr 1987, Lock and Gordon 1988, Marantz-Sanchez 1985). Also central to understanding medical cultures are definitions of self and of medical practice (Cassedy 1984, Gaines 1979, 1985, Johnon 1985, Williams and Boulton 1988), pretraining assumptions (Gaines 1979, Lock 1985), distinct definitions of the situation occasioned by differences in cultural and or social affiliation (Gaines 1982a, 1985a, 1986b, Good et al. 1985; Gordon 1988), and the nature and character of disciplinary training (Gaines 1982b, 1985a, Kleinman and Good 1985).

Related to this notion of the problematic of medical knowledge, is the problematic of all knowledge including anthropological and other social scientific knowledge. As Young succinctly puts it, "an empiricist (empirical medical sociology) works in an epistemology-free social science. He supposes that his language and techniques, once they have been suitably refined, uncover facts about the world rather than produce them." "Social anthropology (and its application in medical studies) is a science in continuous pursuit of a satisfactory epistemology. What separates the anthropologist from the empiricist is that he regards his own concepts and ideas as simultaneously privileged and a part of a cultural system" (1982: 259-261).

With this in mind, medical anthropologists legitimately seek the forms and sources of knowledge in medical cultures as well as their historical roots and development, distribution, legitimation, validation and accountability. In short, constructivism is an anthropology of medical knowledge seen as a dimension and a moment of culture.

2. An ethnomedical system is an unfinished product of its culture’s history

A second central notion of the cultural constructivist approach holds that medicine, professional or lay, can neither be fully understood nor explained without reference to history. Specifically, medical systems are seen as the never-finished, historically derived products-under-construction. I suggest here a processual view of medical systems, including their roles, nosologies, therapies and the like, in the steady of synchronic, empiricist views.

The constructive process is to be found in the historically based interactions of members of a culture and of those who come into contact with them. Constructivism thus agrees with Evans-Pritchard in recognizing the kinship of anthropological and historical research. Most important here are historical studies of components of medical education, research and practice as well as the development of conceptions of particular diseases such as tuberculosis (Rittenbaugh 1982), depression (Jackson 1985), and of particular medical specialties (Hahn 1982, 1985, 1987), nosologies (Menninger et al. 1963) as well as categories of thought operative in medical domains, as studied by Foucault (also see B. Turner 1987).
Ethnomedicines and sickness experiences remain opaque and incomprehensible to synchronic, empiricist approaches, especially approaches which efface the human element in search of 'larger' systems. How apparent changes occur and how manifest local variations exist, as well as the historicity of medical realities, are problematic for macrolevel approaches.

3. Ethnomedical systems are cultural expressions

The cultural constructivist position views medicine, or any other identifiable human enterprise, as an expression of the culture wherein it is located. This is, of course, a view argued long ago by W.H.R. Rivers, though he was referring to isolated, autonomous, indigenous cultures. Today, one sees massive cultural contact making autonomous local groups a rarity. In the context of plural medical situations, one recognizes that imported elements do not obliterate local medical constructions. This would produce the improbable situation in which people thought and behaved in ways completely foreign and incomprehensible to themselves. As long ago as Spengler, researchers have noted that even imposed practices are transformed in their new locales. Such is clearly the case with the importation of ethnomedicines, including Biomedicines, with which one finds an integration with indigenous systems, some of which are themselves imports, such as in India (Leslie 1977a, b), China (Kleinman 1980, Leslie 1977b), Japan (Lock 1981, 1985, Ohnuki-Tierney 1984) and elsewhere.

Also noteworthy is the influence of European medicine on American medical organization and practice, for example, the influence of German Biomedicine on American Internal medicine (Hahn 1985) and American psychiatry (Gaines 1989, Gilman 1988, Young 1988). One needs to be cognizant also of the adoption of a range of foreign health beliefs and practices in America in both professional and lay sectors (e.g., acupuncture, aspects of Chinese and Japanese herbal medicine, forms of meditation and foreign health diets and heterodox medicines). The latter instances suggest that the modern world is witness to considerable borrowing, i.e., diffusion, of beliefs and practices rather than a one-way expansion of a single cultural European/American system, as some authors argue.

Although I do not see cultural constructivism as Kantian, it does recognize practical understanding in context and cannot be reduced to a closed system of categories such as "capitalist" or "bourgeois medicine", "ruling/oppressed classes", "modern capitalist world system", "core", "periphery" and "semi-periphery". These terms are used as empiricist explanatory realities especially in the works of Singer, Navarro, Waltzkin, Tausig and Baer (although the latter gives us a nice history of manipulative medicine in the US which pays attention to local cultures and actors' situational definitions (1986)). These terms, however, are defined only in terms of their asserted relationship(s) to one another and thus show the complete relativity of what is said to be real, objective differences. This problem is found with Marxian analyses outside of medical anthropology as well (see Rabinow and Sullivan 1979).

I might suggest also that the distinction between culture and society (Leslie 1977b) is problematic. Society (i.e., roles, social relationships, institutions) is but an expression of culture on the social plane. For this reason, different cultures, including "Western industrial capitalist" countries, in fact have very different social arrangements in their medical systems. For example, there are sharp differences in structure and organization of French Biomedicine as compared to Americans, including differing medical specialties (Letourmy 1985), and a different status system involving the hospital, which itself plays a distinctive role in French medicine (Pouvoirville and Renaud 1985). As noted here and elsewhere, there are also different sickness categories (Dodier 1985, Gaines and Farmer 1986, Gaines 1986b) and relations among physicians (Bassanger 1985, Gaines n.d., a). German medicine also shows distinctions (Maretzki and Seidler 1985, Maretzki n.d.). And, of course, these Biomedicines as well as all others in the West, except American, are socialized medical systems. Thus, the asserted key relationship seen by Marxists and political economists between capitalism and a particular form and organization of medicine has no cross-cultural reality.

As Ohnuki-Tierney pointed out, a discussion of early worldview and the system of social classification of people was important to include in her study of illness and professional medicine in Japan. "It is vital to understand that categories of thought operative in the medical domain are related to thought governing other domains of Japanese culture, and that these categories show historical continuity" (Ohnuki-Tierney 1984: 3). The import of local popular medical knowledge is clearly seen too in works focusing on Biomedicine in America (Hahn and Gaines 1985, Lock and Gordon 1988). And Worsey (1982) argues that medical conceptions are framed in and by metamedical, cultural concepts, a point made well by Gordon in her recent analysis of the philosophy of Naturalism in American biomedicine (1988) and noted in other early (Gaines 1979, 1982a, Hahn 1982) and recent interpretive work on Biomedicine (Gaines, n.d., d.e., Kirmayer 1988, Nuckolls, n.d.). The notion of the sickness history, presented below, builds upon this central insight.

4. Ethnomedicines concern human experience-near realities

Analyses of lay and professional ethnomedical systems should see them in human terms; in terms of real human experiences such as pain, relief, frustration, loss, joy, anger, fear and the like. Analyses which seek explanations in experience- and culture-distant terms omit the critical factors in health and illness, the phenomenal persons and groups wherein human experience and intersubjective (not subjective) realities are constructed. While medicine is thought to be objective and social sciences subjective, cultural constructivism seeks to find the intersubjective reality underlying both. Thus the perspective is not the antithesis of 'objective', empirical views; rather it takes them as its subjects of research as well. The constructivist approach does not lose sight of or efface the voices of patients, healers and sickness.

In light of this point it is appropriate to focus attention not only on patients, their experiences and understandings but those of healers. This focus does not preclude healers as instruments or agents of abstract systems whose views are mere ideology. Rather, a view of medicine must include human understanding and experience, and include "ethnographies of emotion" (Gaines 1987b) in professional, heterodox and folk medicine and of physicians, nurses and attendants alike (see Dwyer 1987, Paget 1988, Hahn and Gaines 1985, Lock and Gordon 1988).

Medical systems should be seen as novel recombinations of existing ideological and practical elements of the local culture and, in some cases reworked elements from other cultures. Folk or professional medicines are not bodies of instrumental, cultural scientific knowledge with praxis based upon such knowledge. Rather, medicines are systems of knowledge and understanding, criteria for interpreting and constructing culture members' sickness experiences (see also Wright and Treacher 1982b, Hahn and Gaines 1985, Kleinman 1980, Young 1977, 1982, 1988). The study of medical systems becomes a study of knowledge-in-formation and knowledge-in-use. Knowledge-in-formation refers to the processes whereby knowledge is created, historically altered, distributed and disseminated. Knowledge-in-use refers to knowledge as it is expressed in lay and professional ethnomedical ideology and praxis.

Having briefly outlined what I see are key assumptions in cultural constructivism, I now turn to a consideration the notion of Sickness History as an application of cultural constructivism. It shows that
sickness invokes issues, themes, cultural history and practices far beyond the micro-clinical context.

Sickness History

The notion of "Sickness History" might be applied profitably in medical anthropological research of the constructivist turn. As I see it, the construct is related to Kleinman’s EM (1980) and Good’s Semantic Illness Network (1977; Good and Good 1982) and Young’s (1982) notion of prototypes and chain complexes but is also distinct from all three. These formulations tend to place the definitional apparatus of illness episodes in the hands of an individual and within the temporal boundaries of a given illness episode or an individual’s illness experiences. I argue that illness is an expression of conceptual categories which are not individual products nor are they products of contemporary interactions. Rather, illness realities are historical products and historically meaningful categories and frames of and for experience. Thus, knowledge and thinking about illness may be seen largely as cultural historical productions rather than as individual, contemporary ones.

When presented with a sickness entity, whether from a professional or folk ethnomedicine, one might profitably assume that it is not a naturally occurring entity, but rather one which has been created, and is still in the process of creation and recreation. That is, the presence of a labeled, or even unlabeled, sickness gives one a glimpse at a moment in a cultural historical process. However, some writers explain the presence of illness in terms of putative world economics, or simply capitalism (Singer 1986; Navarro 1976; Taussig 1980; Waltzkin 1986). They thus avoid addressing the meaning of illness to human sufferers, as Schepers-Hughes and Lock note (1986).

However, their own approach suggests illnesses are forms of everyday rebellions against the "indulgencies of life and work under conditions of advanced industrial capitalism" (p. 139) which Marx and Parsons are supposed to have "understood well". (We will leave aside the vexing question of Marx’s knowledge of something called “advanced industrial capitalist life”). This approach, however, reduces the meaning of illness to complaints about current life situations, and views people as Durkheimian mirrors of social structure or structural conflicts. Though attention is directly paid to the meaning and experience of illness in this view, as in the case of Kleinman, Young and to a certain extent Good, the perspective is too synchronic and, hence, too ‘thin’.

A different approach might be suggested wherein sicknesses are viewed as historically created vessels of meaning. An understanding of a sickness designated in a culture, whether by folk or professional medicine, would need to attend to the cultural history of that sickness. Sicknesses should be seen as culturally constituted, historically derived modes of expression. Thus, while I agree that sickness episodes express something, I would argue that they symbolize important cultural historical meaning rather than a social structural or economic present.

Such a recognition allows us to understand the very different sickness episodes of people in different modern industrial societies, e.g., Japan, Taiwan, France, Germany, Canada and the like, for while they are all modern, capitalist, industrial, hierarchical, etc., they are also quite different from one another and exhibit distinct illness realities, beliefs, healing strategies and medical organizations. In what follows, I will look at just two forms of sickness known in the professional, popular and folk sectors of the French health care system.

Fatigüé

One disorder is labeled simply fatigüé, used as an adjective and expressed as, "je suis fatigüé" (“I am tired” or “fatigued”) or “je me sens fatigüé” (“I feel tired”). It is quite widespread in France. The expression refers to a state of being, an illness state, and may be contrasted with another experience of la fatigue, which expresses a sense of lassitude caused by work that is too difficult or too long (e.g., "Malgré la fatigue j’ écris” - I write despite fatigue).

In a recent article on sickness and its moral justification in the French workplace (Dodier 1985), ‘being tired/fatigued’ was shown to be a common sickness. In fact, it is one of the most common disorders experienced by both blue- and white-collar workers, a distribution contradicting the illness-equals-structural-position notion.

Diagnosis, treatment and management of this condition by physicians in France is usual, expected and appropriate. Leaves of absence for “rest” ranging from a matter of days to a month or more are prescribed by physicians. The etiology of the disorder is not overwork or lack of a few nights’ sleep, both causes of fatigue (noun). Rather, the etiology of fatigue (adjective) is a perceived burdensome life situation. This condition may appear at any time and does not necessarily derive from an unusually stressful of different period in one’s life.

The reason for this is that all aspects of phases of life are seen in France as difficult, burdensome and taxing. One’s day to day life, seen as a constant “struggle”, periodically simply “weighs one down”. In France, it is deemed appropriate to have a view of life as tragic or sad. To view life otherwise is an indication of shallowness and a lack of "seriousness", (a French notion approximating, but not the same as, that of ‘maturity’ in America) (Gaines 1982a, Gaines and Farmer 1986; Wylie 1957). The same notions of life as tragic and maturity are to be found in other cultural groups of the Mediterranean tradition (for those see Peristiany 1966; Gaines and Farmer 1986; Gilmore 1980). These include Iran (see Good 1977; Good, Good and Moradi 1985), Italy (Cornelsen 1971) and Greece (Campbell 1964; Lee 1959) and in the New World, Latin ethnic groups which are daughters of the Mediterranean tradition. All have named illnesses marked by sadness (e.g., susto, pena, saladera, tristitia).

Medical leaves for ‘being tired’ routinely are viewed by employers, colleagues and physicians as appropriate for this recognized, morally sanctioned sickness. Illness and disease thus coincide, though in my perspective, one is the other (also see Obeyesekere [1985] on this point). We note that the notion of tiredness as a common, morally justified, medically recognized and treated disease as well as a folk illness entity was entirely unproblematic to the French author (Dodier 1985), though such would clearly be problematic to both American clinicians, researchers and lay readers. For them, tiredness is a symptom of a number of disorders; it does not itself constitute a disorder.

The disorder appears in the form of a continuum. At one end is "fatigüé” (tired), "un peu fatigué” (a bit tired) or "bien fatigué” (very tired). The phrases, which indicate severity of problems on a physical plane also suggest a low emotional tide. It is important to note that the sickness presents with particular behavioral signs such as listlessness, incautiousness and some physical signs, a drawn look, even "pimples" (Dodier 1985: 123), recognized by others as indicative of "being tired”. Those who exhibit the signs are seen as a bit brave, even courageous, if they continue to work. Empathy and concern are voiced and, as Dodier also found, the recipients feel these are justified and appropriate. Our second sickness entity, presented below, is a bit more complicated.

Tristet/Fatigüé Tout le Temps

The second disorder I want to discuss is "triste (or fatigué) tout le temps” (sad (or tired) all the time) (see Gaines and Farmer (1986) and Gaines (1986a) for fuller descriptions and a case study). This
disorder is a chronic version of “being tired” but differs in that it generally appears to have a precipitating event. As well, the condition has two names which are used quite interchangeably. Informants queried in Paris and Strasbourg (1982, 1983) all knew of the disorder, could describe it and its various possible symptoms and could relate a tale of one or more people personally known to them who had been afflicted by the disease/illness.

Most interesting are the two faces of the sickness. On the one hand, one sees a physical problem, tiredness. On the other, one sees emotional difficulty, especially sadness. The symptoms of this French disorder are many and various and include chronic disturbances of vegetative signs, such as sleep and appetite, as well as problems of concentration and memory, sad affect, often psychomotor retardation, chronic tiredness and weakness, distractability, emotional lability, and other, but again nonspecific, multiple symptoms.

“Sad (or tired) all the time” is a syndrome with a widely varying symptom picture. Its origins are a reaction to some form of perceived traumatic event such as a miscarriage, a divorce, or loss due to the death of a child, spouse or close friend (Gaines 1986a, Gaines and Farmer 1986) or the termination of an important relationship. Informants in Paris and Strasbourg also suggested that the precipitating event may not be a loss but a failure to achieve some important personal goal, such as school entrance or a loss in a personally important sporting endeavor. The disorder is commonly depicted in films and novels and is seen as quite normal, i.e., not unusual or remarkable enough to explain or dwell upon.

An attempt to apply American psychiatric nomenclature to this condition would meet with failure, though it is in this domain of medicine that American diagnosticians would be led immediately by the presentation of the symptoms often associated with this disorder. Taking the descriptive approach championed by the 3rd Diagnostic and Statistical Manual of the American Psychiatric Association (1980), or its revision DSM III-R (1987), one could construct a label for the disorder, i.e., “chronic, reactive depression.”

However, in American psychiatric theory and practice such an entity is both unknown and nonsensical as psychiatric colleagues at Duke Medical Center in 1983 informed me, “assuming a normal premorbid personality”. As well, individuals afflicted by the illness were not able to care for self and others. Though psychodiagnostic instruments indicated that several persons, locally referred to as “saints”, with triste tout le temps suffered from severe clinical depression, ethnographic research and the saints’ activity levels rarely disconfirmed the diagnosis (see Gaines and Farmer 1986, for a detailed case history and psychodiagnostic test results). It is very important to note the clear relationship of suffering and a semi-sacred status in this disorder but it is also present in the case of fatigue.

Though this problem is recognized, active interventions to alleviate the condition appear to Informants as inappropriate. Informants see the condition as understandable and as a reasonable response to loss or misfortune. In this, the French show the cultural basis of the logic that sickness conditions necessitate actions to eliminate them (Parsons 1951). This sociological perspective misses the cultural validity and value of illness in some cultures, such as those of the Mediterranean and its daughter cultures in the New World.

The primary response to the condition, as Informants stated, is to allow rest and a reduction of expectations for the afflicted for months, years or even a lifetime. An attitudinal response of commiseration, support and indulgence from significant others is also appropriate. No cure is expected, just a modicum of relief from episodic exacerbations of the basic chronic picture. Thus, a reaction to a single loss or frustration perceived as traumatic produces a chronic sickness affecting mood, affect and cognition as well as behavior.

While manifested in the soma, these two disorders have neither a somatic seat nor etiology in American biomedical terms. Each sickness in its own way reflects culturally specific French views of the self (Gaines 1982a), the nature and the positive meaning of suffering in life (Cornelissen 1971, Gaines and Farmer 1986, Good, Good and Moradi 1985). The latter is commonly manifested as a culturally constituted “rhetoric of complaint”, an aspect of local discourse which communicates the suffering and misfortune and, therefore, the worthiness of the speaker (Gaines 1982a).

The illnesses also demonstrate the patterning of dysphoric affect in France and in the Mediterranean tradition more generally (see Gaines 1982a, Gaines and Farmer 1986, and Good, Good and Moradi 1985, for fuller accounts of the pattern of dysphoric affect in this tradition). But how did these two forms of sickness appear? Why are these forms used in France today? The sickness history helps explain these questions which are not well answered by other notions of sickness including EMIs and SINS, or by synchronic functionalist approaches.

The past in the present

Could the two disorders be related and share a common origin? A look at the history of the notions of “acedia”, “tristitia” and “melancholia”, forms of what Jackson (1985) calls “dejected states”, may allow an understanding of them. And, we note the other writers have begun to show the role of theology and philosophy in the shaping of the experience of dysphoric affect and depressive illness across cultures (Kleinman and Good 1985, especially see Lutz 1985, Obeyesekere 1985).

In Jackson’s work, he finds three forms of dejected states in the Latin tradition. These are “acedia”, “melancholia”, and “tristitia”, all of which “belong to the history of religion, in particular to the religious scheme of the cardinal sins in Christianity” (1985: 44). The condition of acedia, a sin, developed out of the examination of the particular experiences of members of the desert anchorite community near Alexandria in the fourth century A.D. The isolation and inactivity produced mental states which detracted from contemplation. The unusual mental states of acedia soon acquired behavioral referents. Shifts in emphasis from one pole (mental state) to the other (behavioral mode) have occurred throughout the centuries. On the one hand, acedia was described as “carelessness”, “weariness”, “exhaustion”, “negligence” (in contemplative duties), and on the other as “apathy”, “anguish”, “sadness” and “low spirits” (Jackson 1985: 45).

The concern for acedia, originally seen only negatively as a sin, changed and it acquired a positive meaning as well. This derived from the view that the condition of sadness and weariness were a result of one’s “penitence for sin” and or one’s “desire for perfection” (Jackson 1985: 48). These notions spread widely in Christendom beyond the clergy to the laity between 1200 and 1450, especially after the Lateran Council (1215-16) decided on the need to extensively disseminate penitential literature, clerical manuals (for the newly required sermonizing) and catechetical handbooks (Jackson 1985: 48, Wenzel 1960).

The penitential literature spread the benevolent view of acedia and “tristitia”, a term used interchangeably with acedia. In this view acedia, since it was a condition which afflicted only the devout penitent, seems to have become thought of as penance itself (Jackson 1985, Wenzel 1960) but also perhaps for itself; dejection as its own reward. Penance was seen “as medicine for the soul” (McNeill and Gamar 1938: 44). The most common governing medical principle of the time held that contraries cured contraries (Jackson 1985, McNeill and Gamar 1938) (one is reminded of Homeopathy’s dictum, “like cures like”).

Jackson points out how acedia and tristitia gradually lost their theological affinities and the positive
and negative connotations became part of the culture area's secular/philosophical theories of emotions. They later appeared in the context of medicine. The component of positive sorrow "became more identified with Christian tradition of the sufferer as an object for care, concern and cure" (Jackson 1985: 53-54). The conception developed further into "melancholia" as the Church lost its explanatory powers over human behavior and there developed a renewed interest in classical writers. This renaissance brought forth melancholia as both a medical term for an illness (Menninger 1963) and as a popular term referring to sadness (Jackson 1985). The popular term referring to sadness also developed an association (from Aristotle) of the later term "melancholia" with the very bright and the gifted; the two were seen as dispositional companions. It is impossible to see this association in the last century in France relative to the experience of tuberculosis and the romantic vision of the pale, wan tubercular intellectual (see Sontag 1977) (see Gaines and Farmer 1986, for the relevance of hagiography).

This history, brief as it is, provides us with some understanding of the meaning of dejected states and dysphoria in French culture and history. The meaning of such states, their positive value and their cultural significance make us understand better the existence and elaboration of related sickness conditions in French popular culture and in that culture's professional ethnomedicine which is its expression.

It seems evident that acedia and tristitia are the source of fatigued and triste/fatigued tout le temps and probably "spasmophillie", a disorder of concern in popular and professional sectors since the late 1970's. The two faces of acedia are well preserved; the mental face (triste) and the behavioral/physical face (fatigued) in the contemporary disorder. Spasmophillie and fatigued may also represent the Janus nature of the ancient sickness of acedia. And it is noteworthy that elsewhere in the Mediterranean and Latin traditions one finds tristitia as well as other disorders indicating inactivity and sadness, e.g., pena (Tousignant 1984) and susto (Rubel 1977) among others, as well as named modes of expression thereof (e.g., corrodes, ghinnda).

Here we see the historical development of folk theories which appear in a Biomedicine. Other, less historical works have also shown the presence of folk theories in professional ethnomedicine in America (e.g., Brandt 1978, 1983, Cassedy 1984, Gaines 1979, 1982a, 1985a, 1986b, 1987a; Gaines and Hahn 1982, Hahn and Gaines 1983), Germany (Mareztzi n.d., 1988; Townsend 1978), England (Elman 1983), Canada (Lock 1985, Katz 1985, n.d.) and Africa (Swartz n.d.).

As well, the impress of culture on Biomedicine has also been noted in Asia (Lock 1981, Reynolds 1979, Weisberg and Long 1984). It is suggested that such differences have to do with culture history in the form of sickness histories. As a culture maintains continuity with its past, it would "import", so to speak, its past into its present Biomedicine and thereby make it vary from another's (unless it was completely superimposed thereupon (see Kornfield 1986)). Diseases, as elements of medical knowledge, may be seen thus as products of sickness history, not as products of current hypotheses material forces.

Sickness as charter

A culture's history contains various sickness histories which serve as charters for subsequent personal and group interpretations of and responses to experience. Their historical meaning makes them uniquely realistic and significant. The Sickness History, then, is a culture's historical experience with a particular form of distress which frames both folk and lay understandings and responses to contemporary experiences and concerns. I intend the term to encompass sicknesses included in epidemiology as well, such as the plague in Europe. The experience of the plague still colors contemporary perceptions of epidemics. Likewise, the American response to AIDS is grounded in its cultural historical experience with Sexually Transmitted Diseases and how, then and now, STDs are interpreted in the context of peculiar American forms of communism (see Brandt 1978, 1985; Gaines 1986a). Thus contemporary sickness episodes may be seen to have deeper historical roots than synchronic approaches can appreciate and bear meanings and significance which critical medical approaches cannot approach.

Other sickness histories

In terms of other sickness histories, one might inquire into the meaning of "crise de foie" the most well-known of French disorders. And here I note that some 15% of all biomedical diagnoses made in France are not shared with other Western countries. Likewise, one might inquire into "dropped stomach" in Asian cultures which is diagnosed and treated in Asian Biomedicines as was the condition of "floating kidneys" in America until the late 1960's. Shinkeishitsu's history could also be unraveled although Reynolds (1976) has provided us with excellent contextual material. But one should not omit the history of seemingly unproblematic diseases, i.e., those said to be natural and universal, such as diabetes, asthma (Wright and Treacher 1982) and 'genetic' disorders which American medicine tries to construct as racial (e.g., sickle cell anemia, cystic fibrosis, Tay-Sachs, etc.). This is a part of an unconscious cultural (and racist) effort to (re)construct race as a biological reality instead of the nonbiological, cultural system of classification that it is (Brandt 1985; Gaines 1985a, 1986b, 1987a, n.d., b). This notion appears derived from German culture, medicine and science (Gaines n.d., c, 1989; Gilman 1988).

Another problem for researchers was hinted at above. That is, the conception of illness as negative. Sickness can be assertions of the positive. Seeing sickness as always the result of contemporary class relations may simply express Western views of normality and abnormality in implicit forms of deprivation theory (e.g., Navarro 1976; Waltzkin 1981, 1986). Current research indicates the positive nature and dimensions of sicknesses and dysphoric states in at least the Mediterranean tradition (see for example, Gaines and Farmer 1986; Gaines 1987a; Good, Good and Moradi 1983) and the Buddhist (Obeyesekere 1985).

Conclusions

Marxists and other political economists of health unwittingly seek to place the study of folk and professional ethnomedicines within a 19th century natural scientific paradigm, one which is a twin of that which so severely limits American professional Biomedicine itself. In their view, social action in historical and cultural contexts, is reduced to the operation of a purely epistemetic subject (Rabinow and Sullivan 1979: 4).

Critical medical anthropologies are, if I may adapt Navarro's own description (1975: 361) of Illich's Medical Nemesis, "radical only in style and rhetoric but intrinsically conservative" in meta-theoretical assumptions, theory, methodology and interpretation. Like the anti- or critical psychiatry of the 1960's and 70's, political economists give only the appearance of being voices from a change-oriented, humanitarian left.
Other Directions

A host of new avenues of research present themselves. Myriad others will doubtless occur to the reader. One such might be the cultural historical study of medical social sciences, such as the political economy of health. The self critical study of anthropology has been and is being done and is the cause for development of improved interpretive approaches in social cultural anthropology in general and constructivist approaches in medical anthropology in particular. Constructivist approaches have a singular ability to reveal to us things we do not know. Other theoretical traditions, it may be suggested, tend to tell us things we already know, believe we know or could have guessed without, because, often like medicine itself, they reproduce conventional lay wisdom.

Since even constructivists sometimes may be seen to rely on an external, implicit natural "biology" (e.g., Kleinman and Good 1985), it appears that work needs to be done to examine the cultural construction of biology in different Biomedicines, i.e. biology as a cultural construction. The meaning of biology is by no means everywhere constant across time or within or across cultures and appears a worthy topic for cultural constructivist deconstruction (Gaines 1986b, 1987a).

Another area of importance would seem to be the study of medical practice from a more experiential viewpoint, and "ethnography of emotion in medicine" (Gaines 1987b). This would seem especially timely given the care demand of the AIDS epidemic on health care professionals. I would like to see more on background philosophies in culture in general and in medicine in particular, such as provided by Gordon (1983) and Kirmayer (1988). The construction of the notion of scientificism, for example, and its association with numbers (statistics) in Western Biomedicine (see Cassedy 1984) seems a worthy topic of further study. Finally, the concept of Sickness History needs further development but may contribute to our understanding of the historical construction of illness realities; the distribution, the waxing and waning of same and of healing strategies and medical organization.

This paper has advocated the use of cultural constructivist perspectives in medical anthropology and beyond. Medical cultural constructivists see professional and lay ethnomedical realities as constructed through time in social interactions to which meanings are brought, exchanged and created and realities defined and actions charted. Medical knowledge and practice are held to be expressive moments of the cultures in which they are found and in the context of which they are and were created, recreated and transformed. Constructivist approaches allow for expanding our knowledge and understanding of this important domain of human experience, allowing its reconstruction and deconstruction and furthering our understanding of this vital domain and its webs of significance spun over and in time. These webs produce local versions of theories of coherence and give meaning to human health, life and suffering.

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Notes

[1] e.g., Marcus and Fischer (1986) who cite and refer to works by constructivists, examples of cultural critiques of our own society and medicine.

[2] As well, it may be argued that Foucault's concern with the medical gaze replicates the clinical emphasis of French medicine, an emphasis not shared by other Biomedicines, e.g., German and American which because of historical relationships, emphasize biological sciences and see clinical work as an applications thereof (Gaines 1985, Gilman 1988, Goldacrim 1987).

[3] See Smith (1984) who notes the same tactic is used by political economists in social anthropology more generally.

[4] We should also here note that these writers also regularly implicate motives, feelings and "needs" to their inanimate ideological constructs, e.g., to capitalism, production, industrialization, world system, etc.


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