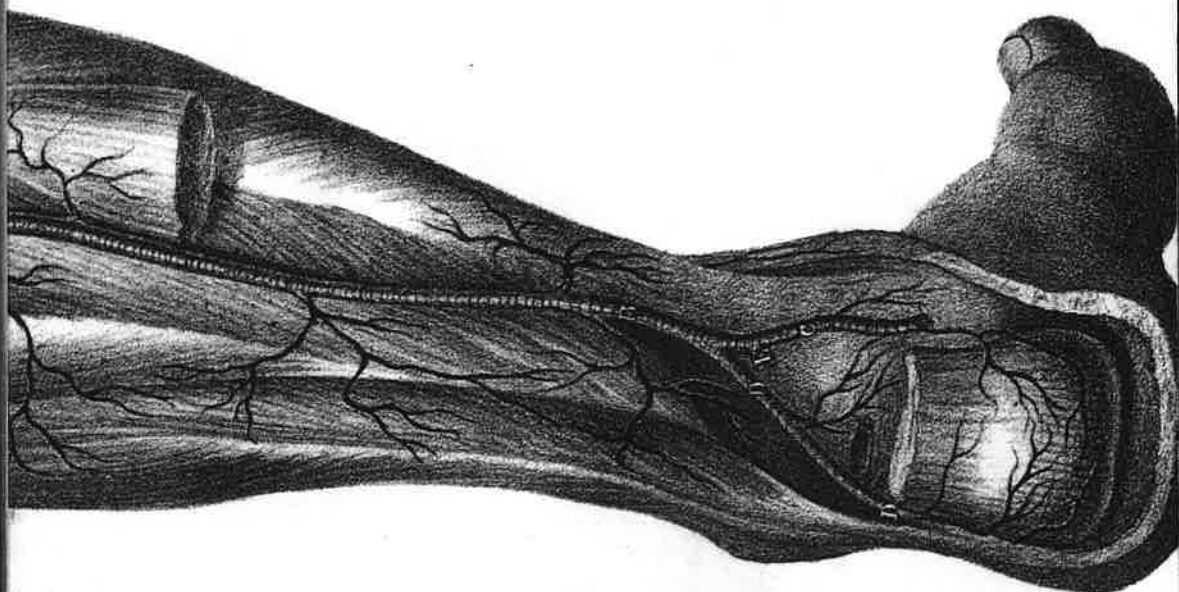
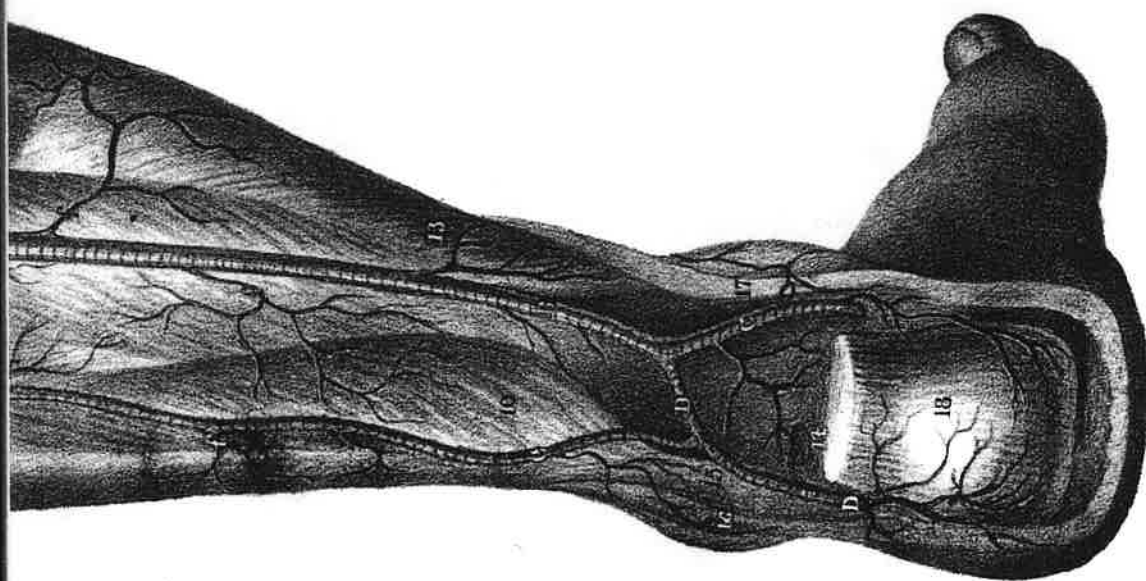




the body multiple: ontology in medical practice

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This is a book about the way in which (Western, cosmopolitan, allopathic) medicine deals with the body and its diseases. The questions it raises do not concern the ways in which medicine *knows* its objects. Instead, what the book explores is the ways in which medicine attunes to, interacts with, and shapes its objects in its various and varied practices. Or, to use the technical term: this is a book about the way medicine *enacts* the objects of its concern and treatment.

Thus, unlike many other books on medicine and its processes, this one does not speak of different perspectives on the body and its diseases. Instead it tells how they are done. This means that the book comes to talk about a series of different practices. These are practices in which some entity is being sliced, colored, probed, talked about, measured, counted, cut out, countered by walking, or prevented. Which entity? A slightly different one each time. Attending to enactment rather than knowledge has an important effect: what we think of as a single object may appear to be more than one. All the examples in this book concern atherosclerosis. But a plaque cut out of an atherosclerotic artery is not the same entity as the problem a patient with atherosclerosis talks about in the consulting room, even though they are both called by the same name. The loss of blood pressure over a stenosis is not the same thing as the loss of blood vessel lumen that radiologists make visible on their X-ray pictures.

The move, then, is away from epistemology. Epistemology is concerned with reference: it asks whether representations of reality are accurate. But what becomes important if we attend to the way objects are enacted in practices is quite different. Since enactments come in the plural the crucial question to ask about

there is how they are coordinated. In practice the body and its diseases are more than one, but this does not mean that they are fragmented into being many. This is difficult to think. But it is this complex state of affairs that this book explores. I have tried to capture it in the title, in which a singular noun comes with a pluralizing adjective. Thus, then, is a book about an intricately coordinated crowd: the body multiple.

The tone of the text is reflective rather than argumentative. I have no reason either to criticize or to defend medicine as a whole—as if it were a whole. Instead of creating a position outside medicine in order to judge it, I try to engage with a normality of a more intimate kind. I try to open up differences inside medicine and create better access to them. If the objects of medicine are enacted in a variety of ways, truthfulness is no longer good enough. Somehow, questions need to be asked about the appropriateness of various enactments of the body multiple and its diseases. I don't ask such questions here. I don't delve into the question of how the appropriateness of the various enactments presented are, or might be, judged. Instead I try to take part in creating a theoretical repertoire for thinking about this. I contribute to theorizing medicine's *ontological politics*: a politics that has to do with the way in which problems are framed, bodies are shaped, and lives are pushed and pulled into one shape or another.

Its concern with theorizing turns this into a philosophical book. But the philosophy I engage in here is of a quite specific kind. It is explicit about its local origins. Thus, throughout the book there are snapshot-stories about a single multiple disease and the way it is dealt with in a single hospital and some of its surroundings. The disease is atherosclerosis, and more particularly atherosclerosis of the leg arteries. The hospital is a large university hospital in a medium-sized Dutch town, anonymized into hospital Z. By starting out from such a well-circumscribed site, I try to move philosophy away from formats that carry universalistic pretensions, but that in fact hide the locality to which they pertain. However, the idea is not to celebrate localism instead of universalism. Instead, it is to keep track as persistently as possible of what it is that alters when matters, terms, and aims travel from one place to another.

Medical anthropology and medical sociology are rich disciplines. Thus, I had a lot to build on as I sought to incorporate an empirical investigation into my philosophical study. So much so that I have framed this book not only as a debate with the epistemological approach to knowledge, but also as a debate with the way in which the social sciences have studied the body and its diseases in the past. For a long time, social scientists have said that there is *more* than the physicalities treated by doctors. And then they used to study this "more": a social and an interpretative reality. They have differentiated between *disease* and

spective on disease has been included in the studies, too. This book is among those who try to take the next move. It says that a study of the enactment of reality in practice makes it possible to ethnographically explore the body multiple and its diseases in all their fleshiness. How? Outlining an answer to that question is precisely what all these pages are for.

The book draws on a variety of literatures: in philosophy, anthropology, science and technology studies, feminist theory, sociology, political theory. This is the present state of theoretical work: disciplinary boundaries get blurred. And yet I wanted to give you, the reader, a good sense of where this book is situated. I wanted to ground it not only in empirical "material," but also in the intellectual traditions of which it is a product. After hesitating for quite a while about how to do this, I have turned this question into a topic. Throughout this book you will find a subtext, in which I relate to the literature (or, more exactly, to exemplary books and articles) while self-reflexively wondering what it is to do so.

Readers who regularly surf between television channels will find this book easier to read than those who don't, since they are likely to find out how to shift between the upper text and the subtext more quickly. Others will have to invent a way of reading that works for them from scratch. It may help to know that the subtext is not glued to the pages where it happens to be printed—its location is even more contingent than that of footnotes tends to be. Depending on where and who and how you are, you may want to read the subtext before you read a chapter, or afterward, or maybe when the story line of the upper text starts to bore you and you are in the mood for something different. It is up to you.

The book is written in English. This hides the plurality of the languages that went into its production. In the literature I draw on a few texts in German and a very small number in Dutch (although I have learned a great deal from reading around in my mother tongue). A large part of the literature I relate to was written and read in French. A lot more was in English. As part of my fieldwork I attended some English-language medical conferences and read English-language medical textbooks and research articles (some of them written by my local Dutch informants). But during the day-to-day events in the hospital the language spoken was almost always Dutch. And I also made my field notes in this language. Discussions about the many earlier versions of (parts of) this text were conducted in English, French and again, mostly Dutch.

Thus, though Dutch was a relevant language in the production of this book, in its final version it has vanished. What to say about this? Dutch is understood by only some 25 million people in a few regions of the world (mainly in the Netherlands, Surinam, Belgium, and South Africa where some of those speak

ing Afrikaans manage to comprehend Dutch—in Indonesia people with a good command of the language of their former colonizer are getting more rare every day). The Dutch failed to combine economic and cultural imperialism, so these days Dutch doesn't travel far. This means that a Dutch language intellectual must make a choice between being *local* or *global*. This choice has little to do with seeking a *small* or a *large* audience. Even if there are far more than 25 million people able to read English, most scholarly texts printed in Dutch are printed in more or less the same numbers as similar books in English. The local is not contained in the global. It is somewhere else.

Its language, then, marks this book as an academic text, made to travel through universities, to be read by scholars and students. I regret it that an attempt to reach my "international" colleagues obliges me to write in a foreign tongue, for that not only brings a lot of extra hard work, but also helps to widen the gap between embodied and inscribed author. Although a book I would publish in Dutch would be read by academic colleagues in neighboring fields as well as by many a Dutch physician, most of these possible readers are far less likely to come across this one. But then again: I am also deeply pleased to not be stuck in Dutchness, but to have been given a chance to acquire access to a language that allows one to reach readers from Norway to India, from anthropology to philosophy, from Germany to Brazil, from medicine to sociology, from the United States to France, and from science and technology studies to feminist theory. Or sometimes texts do not travel at all. That, again, is up to you, reader.

And now for some private history, as introductions go.

The fieldwork for this text started in the early seventies, when, over dinner at the kitchen table, my father told me about his work on using Doppler measurements for the assessment of the carotid arteries. From long before I officially interviewed him, he has been a wonderful informant. My mother engaged with the second feminist wave in the late sixties, turning me into a feminist at age eleven. As a geographer she also made me attentive to the spatiality of landscapes, townscapes, and life in general, for which I thank her.

But this book only really got under way in the academic year 1977–78. I was in the second year of medical school by then and a first-year student of philosophy. Thursdays were the best. In the mornings I had a philosophy class about the body and in the afternoons an anatomy class where we dissected corpses. Barthes gave way to a large, white room that stank of formalin. Merleau-Ponty was followed by corpses wrapped in orange towels and green plastic. In the mornings I would learn to unravel Foucault's writings and in the afternoons I was supposed to explore the pelvic cavity of a female body without cutting through nerves and blood vessels. This is more than twenty years ago and yet

this book is to some extent a product of those long-gone Thursdays, not in the least the remarkable materiality of it all: sentences in difficult French, strange smells, my clumsiness in cutting.

For their help in the intermediate years I would like to thank various people. First of all Peter van Lieshout, with whom I wrote about the coexistence of "ontologies" in the early eighties and later about social theory and the delineation of the object of care in Dutch general practice and mental health care. All along he also helped me to tame the complexity of life—even if he increased it too, if only by fathering Elisabeth and Johannes, our children, whom I thank for being. Jan van Es made it possible for me to become a theorist of medicine in medical school. Lolle Nauta and Gerard de Vries tried to teach me how to argue. Dick Willems shared his energy and his investigations into medicine with me. Jeannette Pols worked on this project with remarkable zeal. Marc Berg and Ruud Hendriks did great work as well, in their shifting roles of research assistant, co-author, and coeditor. Agnes Vincenot, Pieter Pekelharing, Jan Willem Duyvendak, Sigrid Sijthoff, Tsjalling Swierstra, Bernike Pasveer, Hans Harbers, Marija Gastelaars, Sjaak Koenis, Rob Hagendijk, Rein de Wilde, Cor van der Weele, Eddy Houwaart, Baukje Prins, Paul Wouters, Evelien Tonkens, Marianne van den Boomen, Bertke Waaldijk, Mieke Aerts, Jens Lachmund, and Geertje Mak gave support both intellectually and otherwise. I have also learned a great deal from working with Bernard Elsmann, Ant Lettinga, Bart van Lange, Antoinette de Bont, Jessica Mesman, Ineke Klinge, Ariane de Ranitz, Brenda Diergaarde, Irma van der Ploeg, Amâde McCharek, Tiago Moreira, Benedicte Rousseau, Alice Stollmeijer, and Toine Pieters in various modes and modalities. I would like to thank Barbara Duden, Donna Haraway, and Marilyn Strathern for their challenge and the work they do and Bruno Latour and Michel Callon for their challenge and encouragement. It was good to sometimes come across Sarah Franklin, Isabelle Baszanger, Charis Thompson, Madeleine Akrich, Vololona Rabeharisoa, Ingunn Moser, Claudia Castañeda, and Vicky Singleton and so feel that I was part of an international *current*. Nicolas Dodier asked the right questions at the right time, and Stefan Hirschauer incited me to be ever more serious. Marianne de Laet listened to my stories and gave careful comments on a previous version. Three reviewers of Duke University Press, whose names I do not know, finally approved of this manuscript, but before that came up with a lot of valuable, constructive criticism. And so did Noortje Marres, who figured as a fresh reader for the penultimate version. John Law attended time and again to all the details of this book, improved on many of them, invented new rhizomes, coauthored and wrote about related topics, corrected the English of several consecutive versions, and pushed me to come to a conclusion. That is a lot. Thanks. To you all.

And finally I would like to thank my informants. Here I begin with Ab Struy-
enberg, who welcomed me into the hospital just before he retired and who kept
reading my drafts afterward. Of course I could not have done any fieldwork at
all without the collaboration of the many doctors, nurses, technicians, research-
ers, and patients of hospital Z who allowed me to observe and question them.
They not only gave me material to think about and to think with, but in some
cases also commented on my writings. Going along with the ethnographic habit
of protecting the identities of informants, I mention no names here. But I am
all the more grateful for their time and their trust.

For its generous financial support I thank the Netherlands Organization for
Scientific Research, which provided me with a Constantijn and Christiaan Huy-
gens grant that allowed me to do research and write about *Differences in Medicine*
for five years. Later grants, notably of the ethics and policy section of this same
organization, allowed me to continue to write on new topics and themes, mean-
while spending some of my time on revisions of and corrections to this book.

Even if in the end I wrote alone, I don't particularly want to be blamed for the
remaining errors. I would, instead, be very grateful to you, reader, if you were
to point them out and improve on them in your own writings.

chapter 1 doing diseases

A Movement between Fields

This is a study in empirical philosophy. Let's begin with the empirical. The
stories I will tell you in this book are mostly situated in a university hospital in a
medium-sized town in the center of the Netherlands, *Hospital Z*. For four years
I went there once or twice weekly. I had an identity card that allowed me to leave
my bicycle behind a fence and drink free coffee from the omnipresent vending
machines. I had a library card and the use of a desk in a succession of crowded
rooms. I had a white coat. And I observed.

I would go to the professor who headed a department and explain my pur-
pose: to investigate the way the tensions between sources of knowledge and
styles of knowing are handled inside present-day allopathic medicine—or at
least one of its exemplars. I would explain what made "atherosclerosis in the
lower limbs" a suitable case for my purpose and what I hoped to learn in their
department. I presented myself as both insider and outsider, having received
basic training in medical school as well as extensive training in philosophy. And
I gave the name of the professor of internal medicine supporting my study. Each
of the professors thus approached reacted in a friendly way. They all empha-
sized that academic hospitals must encourage research. My particular research
plans made some interested and some skeptical. Others simply were indiffer-
ent. But after some further questions I would invariably be sent to someone
one or more steps down the hierarchy to talk about and practically arrange my
observation.

So I sat for many mornings behind vascular surgeons and internists doing

their outpatient clinics, observing some three hundred consultations. (All surgeons and internists I observed for this study were men, and I will not hide that fact, so I use the generic "he" whenever I write about "the doctor," even though one of the pathologists whom I observed was a woman. Yes, this is a fading historical moment. The profession is undergoing a rapid gender change. But that is another story. One more complication left out here.) In university hospitals, both physicians and patients are used to observers: there are always students and junior doctors around who need to learn something. Yet I was surprised by the calm with which my presence was accepted—for I found these observations rather intimate. Patients tell about so much and undress so often. Although that is difficult for some and a relief to others, my presence behind the attending doctor hardly seemed to make a difference. When it risked to do so, I skipped a visit (once when a patient asked for it, several times when a doctor did, and once when I recognized someone I knew vaguely and left of my own initiative). The other transgression was into the privacy of the doctors. I was in a position to observe all kinds of details about the way they work. Some of them were visibly uneasy about the fact that I might judge the degree to which they were humane and kind in their interactions with patients. But (though that was sometimes difficult to resist) I wasn't out to make such judgments. Nor did I want to judge the so-called technicalities of their diagnosis and treatment. I wanted my obser-

How to Relate to the Literature?

In the ethnographic stories that I tell throughout this book, I do not try to sum things up. I do not describe Western medicine, but particular events in a single Dutch university hospital. And I assume that events in the next hospital, thirteen kilometers away, or over the border in Germany, or across the Atlantic have a complex relation with those that I have witnessed. A comparative analysis would show that there are similar patterns. Similar gestures. Similar machines. But also different self-evidences. Different needs and different norms. Different jokes. But which differences exactly? And what are their interferences and their diffractions? I haven't studied this. The relations of similarity and difference between one medical site and another are a topic in their own

right. By leaving that topic open I at least avoid the risk of answering it in the standard way. I avoid assuming that what happens in a single hospital forms part of a larger system of medicine: Western, cosmopolitan, modern, allopathic. If one assumes the existence of such a system, one can then be unpleasantly surprised by the amount of "medical practice variation."

But where is the standard way of understanding medicine as a system to be found? And where are the surprises that come with finding "variations"? Not exactly in the hospital I studied, where these things are hardly a matter for debate. No. They are to be found in the literature (see, e.g., Andersen and Mooney 1990). So what I have to tell in the present book does not just relate to the events that figure in my stories. It also relates to other texts. Lots

vations to be a means to get to know their standards, rather than an occasion to apply my own.

This made me shift sites and move around in the hospital. I observed technicians handling diagnostic tools in the vascular laboratory. I followed the tracks of radiologists and pathologists in their dealings with leg arteries. I went for months to the weekly meetings where the treatment options for patients with complicated cases of vascular disease were discussed. I witnessed several operations. Spent some days in the research laboratory of the hematologists. Held interviews or had conversations with epidemiologists, physiologists, internists, surgeons, and general practitioners. A couple of them read my articles and we talked about their reactions. I also went to the library and studied the textbooks and journal articles written, or mobilized as a resource, by "my doctors" and, when the references and my curiosity took me there, compared them with other publications. For two years I followed the monthly research colloquium on atherosclerosis. I coauthored with a junior doctor an article about the introduction of a diagnostic protocol. I supervised a medical student who interviewed vascular surgeons in several smaller hospitals and another one who analyzed discussions about the intake of cholesterol. And, finally, I had the temporary luxury of a research assistant—Jeannette Pols, a philosopher like myself, moreover trained as a psychologist—who held long patient interviews, transcribed them, talked them over with me, and coauthored publications about this material. She also was a good sparring partner with whom to discuss my work.

of them. Texts about other hospitals and other medical practices, texts about bodies and diseases, but also texts about entirely different topics. Systems and events, controversies, similarities and differences, co-existence, methods, politics. If I am to make explicit how this text departs from the others around it, if I want to show how it both differs from them and is made possible by them, I will have to relate to the literature. But how to do this? How to relate to the literature? That is a question that I take very seriously. So I have not hidden the answer between the lines. I do not follow one of the genres for using literatures without being explicit about it. Instead I have tried—will try—both to relate to the

literature and deal with the question as to how one might do so. To do this properly, I have separated out the question about relating to the literature from the core text of this book. I deal with the literature in a series of separate texts that resonate, run along, interfere with, alienate from, and give an extra dimension to the main text. In a subtext, so to speak.

Specificities

Relating to the literature, I might write: "In a variety of disciplines, the unity of Western medicine was a trope for decades. In medical sociology the unity of the medical profession explained this profession's social power. In medical anthropology the

Discussion was also what I sought in other worlds, outside the hospital. I could seldom go to those places by bicycle, for they were a lot farther away—and yet they were less alien to my writing and talking self. They were departments of philosophy, anthropology, sociology, or science and technology studies. I attended conferences and listened bored or fascinated to speakers presenting papers to five or fifty listeners. I read journal articles, wrote them, reviewed them. I went for talk-walks on lakesides or chatted over dinners. I was cross-examined about my field, my method, my purpose, my theoretical ancestors. Often such exchanges took place in an odd version of the English language, a transportation device that poses some difficulties to those who have not grown up with it, but reaches far. So though my stories come from the hospital in the town where I live, they went with me to many other places. To my intellectual friends and enemies in places like Maastricht, Bielefeld, Lancaster, Paris, Montreal, San Francisco. They managed to travel, my stories about leg vessels and pain. Immersed in theoretical arguments about the multiplication of reality.

For even if there are a lot of empirical materials in this book, this is not a field report: it is an exercise in *empirical philosophy*. Let's shift to the philosophy. The plot of my stories about vessels and fluids, pain and technicians, patients and doctors, techniques and technologies in hospital Z is part of a philosophical narrative. In conformity with the dominant habit of that genre, I'll give away the plot right here, at the beginning. It is this. It is possible to refrain from understanding objects as the central points of focus of different people's perspectives. It is possible to understand them instead as things manipulated in practices. If

divergence of medical traditions from all over the globe was specified by contrasting these traditions with a solid unity called Western medicine (either in order to show the superstitious character of the Others, or to highlight their ingenuity and greater sensitivity). In medical history the old eclecticism in which many schools and skills coexisted was turned into an intriguing counterpoint to the present homogeneity. And medical philosophy took a unity, the person-as-a-whole, as a norm: its wholeness deserved respect." Indeed, I have written (or rather coauthored) something like that. Elsewhere. (For a slightly

longer version of such an overview, see Mol and Berg 1998, 1–12.)

It is possible to relate to the literature in such a way: evoking four entire disciplines, in just a few lines. The level of generality is a bit overwhelming. So much so that it is hardly feasible to insert titles. Sure, this can be done. After each discipline a name and date may be put between brackets. In medical sociology in the seventies... (see, e.g., Freidson 1970). A gesture like that turns Freidson's *The Profession of Medicine* into a representative of the enormous pile of books and articles published in the 1970s under the heading "medical soci-

we do this—if instead of bracketing the practices in which objects are handled we foreground them—this has far-reaching effects. Reality multiplies.

If practices are foregrounded there is no longer a single passive object in the middle, waiting to be seen from the point of view of seemingly endless series of perspectives. Instead, objects come into being—and disappear—with the practices in which they are manipulated. And since the object of manipulation tends to differ from one practice to another, reality multiplies. The body, the patient, the disease, the doctor, the technician, the technology: all of these are more than one. More than singular. This begs the question of how they are related. For even if objects differ from one practice to another, there are relations between these practices. Thus, far from necessarily falling into fragments, multiple objects tend to hang together somehow. Attending to the multiplicity of reality opens up the possibility of studying this remarkable achievement.

Philosophy used to approach knowledge in an *epistemological* way. It was interested in the preconditions for acquiring true knowledge. However, in the philosophical mode I engage in here, knowledge is not understood as a matter of reference, but as one of manipulation. The driving question no longer is "how to find the truth?" but "how are objects handled in practice?" With this shift, the philosophy of knowledge acquires an *ethnographic* interest in knowledge practices. A new series of questions emerges. The objects handled in practice are not the same from one site to another: so how does the coordination between such

ology." But what about all the exceptions? What about Marxist sociologists who, in the same decade, claimed that there was a *class division* running right through medicine (see, e.g., Chauvenet 1978). Or, for that matter, feminists, who were active in drawing distinctions between those parts of medicine that they saw as good for women and others, against which they pressed charges (see, e.g., Dreifus 1978)? Not to forget the combinations between the two (e.g., Doyal and Pennell 1979).

It would be possible to shuffle them aside, claiming that those texts have been marginal. In general, I could say, a few exceptions aside, for quite a while medical sociology took the medical profession to be a unity. Or I could point to these exceptions as the initial steps at the beginning

of a new era. This would require me to say that up to the seventies medical sociology took the medical profession to be a unity, a position that slowly began to change. But this would still leave me with some problems. What if a more attentive reading of Freidson's book shows that its primary concern is not the profession's unity, but its *closed character*? When one reads him on his own terms, Freidson seems primarily worried about the lack of outside audit or control on medical mistakes and failures. If I still wanted to quote him as someone taking the medical profession to be a unity, I would then have to show that the profession's unity and its closure are closely linked, or indeed depend on one another. If that argument were hard to make, then I would have to find some other book

objects proceed? And how do different objects that go under a single name avoid clashes and explosive confrontations? And might it be that even if there are tensions between them, various versions of an object sometimes depend on one another? Such are the questions that will be addressed in this book. I cautiously try to sketch a way into the complex relations between objects that are *done*.

This book tells that no object, no body, no disease, is singular. If it is not removed from the practices that sustain it, reality is multiple. This may be read as a description that beautifully fits the facts. But attending to the multiplicity of reality is also an *act*. It is something that may be done—or left undone. It is an intervention. It intervenes in the various available styles for describing practices. Epistemological normativity is prescriptive: it tells how to know properly. The normativity of ethnographic descriptions is of a different kind. It suggests what must be taken into account when it comes to appreciating practices. If reality doesn't precede practices but is a part of them, it cannot itself be the standard by which practices are assessed. But "mere pragmatism" is no longer a good enough legitimization either, because each event, however pragmatically inspired, turns some "body" (some disease, some patient) into a lived reality—and thereby evacuates the reality of another.

This is the plot of my philosophical tale: that *ontology* is not given in the order of things, but that, instead, *ontologies* are brought into being, sustained, or allowed to wither away in common, day-to-day, sociomaterial practices. Medi-

to support my generalization. But which one? The problem is that many titles in medical sociology would do, in one way or another. There is a large corpus of texts in which the medical profession's unity is mentioned. But almost all of them, like Freidson's study, have other concerns at their core.

This is the point: generalizations about "the literature" always draw together disparate writings that have different souls, different concerns of their own. Stressing, in general, that the literature is attuned to medicine's unity may function to mark the originality of this study, a study that emphasizes disunity. But various dangers follow. One is that a false novelty is claimed: the ancestors are erased from memory instead of honored. A second is that, in the

case of this specific book, such generalities would create a tension between the ways in which "the field" and "the literature" are treated. If I take so much trouble to point out the multiplicity of medicine while I refer to sociology, anthropology, history, or philosophy in general terms, this might suggest that they possess the unity that medicine does not. But they don't. Just as it is possible to write about the multiplicity of the objects of medicine, this could be done about other disciplines. I won't attempt to do so here. But I will try to do justice to the variety of concerns, materialities, styles, and object framings in the various knowledges mobilized here by seeking not to suppress or hide these while relating to the literature.

cal practices among them. Investigating and questioning ontologies are therefore not old-fashioned philosophical pastimes, to be relegated to those who write nineteenth-century history. Ontologies are, instead, highly topical matters. They inform and are informed by our bodies, the organization of our health care systems, the rhythms and pains of our diseases, and the shape of our technologies. All of these, all at once, all intertwined, all in tension. If reality is multiple, it is also political. The question this study provokes is how the body multiple and its diseases might be done *well*. This question will not be answered here. Instead, I'll map out the space in which it may be posed.

The Perspectives of People

This is a philosophical book of a specific, that is, empirical, kind. It draws on social scientific and, more notably, ethnographic methods of investigation. But it does not just import these, it also mingles with them. For if I use ethnographic methods here, it is to study *disease*. That physicalities may be studied ethnographically is a quite recent invention. For a long time, "disease" was the unmarked category of anthropology and sociology of medicine. As the state of a physical body it was an object of biomedicine. Doctors told the truth about disease, or at least they were the only ones able to correct each other in so far as they didn't. Social scientists were careful not to get mixed up in this body-talk. Instead, they had something to tell in *addition* to existing medical knowledge. They pointed out that the reality of living with a disease isn't exhausted by listing physicalities. There is more to it. Apart from being a physical reality, having

Dates and Outdating

The work of Talcott Parsons is outdated. It is functionalist in character. *The Social System* is the title of his famous book of 1951 (Parsons 1951). It takes every social phenomenon to either be a threat to the system's stability or to have a stabilizing function. In chapter ten, "Social Structure and Dynamic Process: the Case of Modern Medical Practice," the social phenomenon analyzed in this way is *the sick role*. In modern society, Parsons argues, being sick is ritualized in a specific role. The sick don't need to work in the usual way but are, instead, taken care of. It is accepted that they are the victims of their sickness. This

is good for society because if people stop working and take rest when they are sick this lowers the risk that they will die prematurely. In this way the chance that society has invested in someone's upbringing and education with too little return is reduced. However, since escaping from the usual obligation to work means that "being sick" may also be attractive, there is a potential threat. If everybody were to stop working by calling themselves sick, the system would collapse. This is why, in addition to withdrawal from work and being excused for such passivity, "the sick role" has two more elements. The patient has to go to bed and generally do whatever needs to be

a disease has a meaning for the patient in question. A meaning that is open to investigation. Listen to the story about Mr. Trevers (an invented name; all names used in field stories are invented):

Mr. Trevers sits in a chair in the surgical ward. Sure, he's quite willing to answer a few questions. Jeanette, the interviewer, sits down next to him. She casually asks if putting on the tape recorder is a problem. No, it isn't. They talk about the wound on Mr. Trevers's foot. It was the reason for the operation on his leg arteries a few days before. "My problem was not that it hurt," Mr. Trevers says, "but that this wound didn't go away. It was quite frightening. This gaping hole. I didn't go to the doctor at first, when that beam fell on my foot. I didn't care about the pain. But when it never went away, my wound, but only became bigger, then I got scared. And I went to see my general practitioner. She sent me in to the hospital. And now I've got two diseases. I've got atherosclerosis, they tell me, and diabetes. I've also got diabetes."

Mr. Trevers became frightened when his wound didn't heal. To the vascular surgeon who has operated on him, this fear is hardly relevant. It is relevant that Mr. Trevers finally decided to go and see a doctor. But once he did, well, fear, this is "one of the things people feel," as is an aversion of wounds that stay "gaping holes." If there is time, Mr. Trevers may be allowed to talk about his feelings. But they need not be written down in his surgical files. As "a good doctor" the surgeon may explain some facts in an attempt to reassure his patient. But "fear" is not a part of Mr. Trevers's vascular disease, nor of his diabetes.

done in order to recover. And the patient has to call on and follow the orders of a doctor who must officially sanction his or her sick role with a diagnosis.

This is functionalism: the sick role is described as a role that consists of four elements, which are all explained in terms of the function they have for the social system. Two of the role elements have a good function but risk undermining the social system, a danger the other two must counter. Overall, there is a balance between undermining and protecting elements, and the system maintains itself: it remains stable. In the fifties functionalism was strong, but it has been thoroughly undermined

by later sociologists. By Marxists, who pointed out that functionalism forgets about antagonism, struggle, and change. By quantitative studies in which variables were isolated from each other and then correlated into causal chains, not functional schemes. By microsociologists, who pointed out that the many activities people engage in do not necessarily add up to form a stable whole, but point in various directions. And so on.

A lot more has changed in medical sociology since Parsons's time. Later medical sociologists still saw doctors as people who have the power to call a patient either "sick" or "healthy." Freidson, Zola, Szasz—they all insisted on this. But in their

As a complement to this, social scientists have made it their trade to listen for feelings when they interview patients. And they have persistently and severely criticized doctors for neglecting psychosocial matters, for being ever so concerned about keeping wounds clean while they hardly ever ask their patients what being wounded means to them. In addition to attending to blood sugar levels, bad arteries, wounds, and other physicalities, or so social scientists have been arguing in all kinds of ways, physicians should attend to what patients experience. This is how they have come to phrase it: in addition to *disease*, the object of biomedicine, something else is of importance too, a patient's *illness*. Illness here stands for a patient's interpretation of his or her disease, the feelings that accompany it, the life events it turns into.

In the social sciences, "disease" and "illness" were separated out as two interlinked but separate phenomena. Social scientists put "illness" on the research agenda. Shelves of books and volumes of journals were dedicated to it. InterViews were amassed, the attribution of meaning was analyzed, and ways of therapeutically attending to it were designed. All along social scientists left the study of disease "itself" to their colleagues, the physicians, until they started to worry about the power a strong alliance with physical reality grants to doctors. Then, social scientists gradually began to stress that reality isn't responsible all by itself for what doctors say about it. "Disease" may be inside the body, but what is said

work, the label "sick" was no longer presented as a potential favor a doctor may grant a patient, a good excuse to stop working temporarily. Instead, it was taken to be a negative judgment. A form of disapproval. In the 1960s the label "sick" came to be seen as a secularized form of the label "sinful." If doctors stick this onto people, they are being negatively labeled. So it wasn't only that functionalism became outdated. The label "sick" also changed from a kind of excuse or justification into a form of condemnation. And there is more. The kinds of examples used have also shifted. In Parsons's work, the implicit example is the infectious disease from which one either dies or fully recovers. The labeling theories that followed were concerned with forms of deviance like homosexuality and unmarried mother-

hood, which were called "sinful" in the forties and "sick" in the sixties. And after that came other examples: diseases caused by work or stress or social isolation. Chronic illnesses. AIDS. Reproductive technologies. So-called genetic diseases. One topic made way for another—though always only partially.

There are various layers of history to explore, and they all cover up Parsons and render him outdated. So why would one want to relate to his writings at all? The answer is that Parsons invented medical sociology. The crystallization of both of the objects of this discipline can be traced in his work. There they are: *illness* and *health care*. Let's look at chapter ten of *The Social System* again for their early articulation. Parsons links up with the broad definition of health that was popular in the

about it isn't. Bodies only speak if and when they are made heavy with meaning. In Mr. Trevers's case, a wound that doesn't heal is said to be a sign that points toward diabetes and atherosclerosis of the leg arteries. But this isn't necessarily so: this is a *meaning* that has been attributed. Such attributions have a history, and they are culturally specific. This opens them up for historical and social scientific investigations.

In this semantic approach, social scientists no longer primarily take doctors to be colleagues, colleagues who may be criticized for not listening to their patients carefully enough, but into whose object domain—physical reality—the social scientist wouldn't dare to venture. Instead of colleagues, doctors become the social scientists' objects. What doctors say when they talk about diseases is investigated with the theoretical tools that were crafted for studying the words of patients. Like patients, or so it is said, doctors have a *perspective*. They attribute meaning to what happens to bodies and lives. Even though doctors interpret the bodies and lives of others, whereas patients talk primarily about their own.

Perspectivalism turns doctors and patients into equals, for both interpret the world they live in. But to say this is also to reinforce their division, because the interpretations doctors and patients give must differ, linked as they are to the specific history, interests, roles, and horizons of each group. In perspectivalism, the words "disease" and "illness" are no longer used to contrast physical facts

medical world of his day. Health pertains to "a total physical, mental and social well being." (The definition was drafted at the first meeting of the World Health Organization in 1948 in a postwar atmosphere where hopes were high, but that's another story.) Illness, Parsons writes, "is a state of disturbance in the 'normal' functioning of the total human individual, including both the state of the organism as a biological system and of his personal and social adjustments. It is thus *partly biological and partly socially defined*" (431). A whole tradition of sociological thought can be traced back to this single sentence. Thus, Parsons's work is crucial. I must relate to it. Doing so may help me to escape from the coordinates in which it has been set.

How does Parsons frame these coordinates, how does he lay the grounds on

which subsequent medical sociology was to move? The part of illness that is defined biologically falls under the technical competence of physicians. "Caring for the sick is not an incidental activity of other roles—though for example mothers do a good deal of it—but has become functionally specialized as a full-time job" (434). Parsons is not going to quarrel with physicians over their "functionally specialized" job. Their *technical competence*, that is, their knowledge of diseases and their skills in dealing with them, is granted to them. That's their domain. The sociologist, however, takes it to be his *own* technical competence to talk about jobs, functions, and specialisms. Refraining from talk about the contents of the physicians' competence allows Parsons to analyze the *social role* of the physician.

with personal meaning. Instead, they differentiate between the perspectives of doctors on the one hand and those of patients on the other.

Social scientist commenting on a talk I gave: "So you are going to tell us about their different perspectives on atherosclerosis, are you? Who are you going to include: only surgeons and radiologists? Or also internists, cardiologists, and general practitioners? You should think about epidemiologists, too; they tend to have an entirely different perspective. And what about nurses, you seem to be skipping the nurses, aren't you? And if you ask me, I think you'd better attend a little more to the patient's perspective, for that, after all, always receives far too little attention. And patients are what medicine should be about."

Like patients, professionals may be supposed to have perspectives of their own. However, these are not what I'll be telling about. There are, or so I want to argue, some problems with this line of work. It may seem that studying "perspectives" is a way of finally attending to "disease itself"—but it isn't. For by entering the realm of meaning, the body's physical reality is still left out; it is yet again an unmarked category. But the problem has grown: this time the body isn't only unmarked in the social sciences, but in the entire world they evoke. The power to mark physical reality, after all, is no longer granted to medical doctors; it is granted to nobody. In a world of meaning, nobody is in touch with the reality of diseases, everybody "merely" interprets them. There are different interpretations around, and "the disease"—forever unknown—is nowhere to be

others engaged in health care practices). A space from which they could talk about the social specificities of health care—so long as they paid the price of refraining from talking about the technicalities of healing.

But then again. What is it to heal? Alongside the biomedical aspects that fall under the technical competence of the physician, there is the socially defined part of illness. Socially, being sick equals taking on the sick role. Parsons gives an analysis of this role that consists of four elements—but we've been there already. I've laid out the sick role for you while explaining Parsons's functionalism. There is, however, a good reason to come back to it. For if Parsons talks about "the sick role" as a sociologist, then sociologists apparently have the

round. *One disease recedes behind the interpretations, in a world of meaning alone, words are related to the places from where they are spoken. Whatever it is they are spoken about fades away.*

Or maybe not. And that is the second problem of perspectival tales. In talk about meaning and interpretation the physical body stays *untouched*. All interpretations, whatever their number, are interpretations *of*. Of what? Of some matter that is projected somewhere. Of some nature that allows culture to attribute all these shapes to it. This is built into the very metaphor of "perspectives" itself. This multiplies the observers — but leaves the object observed alone. All alone. Untouched. It is only looked at. As if it were in the middle of a circle. A crowd of silent faces assembles around it. They seem to get to know the object by their eyes only. Maybe they have ears that listen. But no one ever touches the object. In a strange way that doesn't make it recede and fade away, but makes it very solid. Intangibly strong.

Is it possible to tackle these problems? Here's the task I've set myself. That is why I will not tell about the perspectives of medical doctors, nurses, technicians, patients, or whoever else is concerned. Instead I'll try to find a way out of perspectivism and into disease "itself." How might this be done? By taking a third step. The first step of the social sciences in the field of medicine was to delineate *illness* as an important object to be added to a disease's physicalities. The second step was to stress that whatever doctors say about "disease" is talk; that it is part of a realm of meaning, something relative to the specific perspective of the person talking. And here is the third step. It consists of foregrounding

technical competence to talk about the socially defined part of illness. This means that sociology isn't simply outside health care, taking this as its object. Sociology also has the ability to acquire knowledge that may be useful to physicians. "If it ever becomes possible to remove the hyphen from the term 'psycho-somatic' and subsume all of 'medical science' under a single conceptual scheme, it can be regarded as certain that this will not be the conceptual scheme of the biological sciences of the late nineteenth and early twentieth centuries" (431). When "the hyphen" is removed, something will be added to biological science: sociologi-

cal and psychological insights. Parsons's sociological insights, for instance. They tell, after all, that there are attractive sides to the sick role, and thus that doctors have to be careful, since a *motivational component* may be involved in getting sick.

There are still introductions to medical sociology that do not present "the sick role" as an outdated theoretical concept, but as a part of social reality. They relate to Parsons's work as if it belonged to the present. In up-to-date books and articles, however, other words are used. We'll come across an array of them. What they have in common, however, is their starting point. The idea that there is *more* to say about

practicalities, materialities, events. If we take this step, "disease" becomes a part of what is done in practice.

Reality in Practice

Let's move to hospital Z in order to learn about practice. In the ward where vascular patients are nursed, Jeannette sits on a chair next to the table by the window. She talks with Mr. Gerritsen. They have a long conversation, for the interviewer doesn't stick to the topics scribbled down in her notebook, topics that are not to be forgotten. Instead, she allows the patients to talk about whatever they want — or almost. The conversation may go in many directions, indeed, to the point where some patients get confused about the role they're playing and the game they've entered, and say things like "but you don't want to know all this, do you?" or "now what did you say this interview was for?" Mr. Gerritsen, however, shows no such hesitation. He seems pleased to talk. He's got so much to tell.

Mr. Gerritsen is sixty-two. Now that he's got an early retirement from his job and his daughters live on their own, he expected to have a quiet time. He thought he deserved it. He has taken care of his wife all the time she was ill, more than seven years, from the onset of her cancer till the day she died. His girls were still young then; they were 13 and 11 when his wife died. He didn't remarry, but brought them up by himself. And then, a few years ago, his legs

sick people than is told in biomedicine. The idea that there is a domain of "personal and social adjustments" that does not derive from physical facts, but has a specificity of its own. In that sense, medical sociology still largely moves within the coordinates set out by Parsons.

My point in relating this is not to say that Parsons was there first. In medical and social science journals of his time there are many texts that articulate comparable propositions for attending to the *social* in addition to attending to the body. (Parsons himself footnotes a physician/physiologist: L. J. Henderson, "Physician and Patient as a Social System" [Henderson 1935].) Authorship and origin stories don't concern me here. But Parsons is clear, sharp, articulate. Relating to

his work allows someone fifty years later to discover how the social sciences established their rights to speak about health care and sickness in the 1950s — and at the same time how they set limits on this right. They turned the domain of the *social* into what they were competent to speak about. In this way the social sciences delineated an object of their own and granted biomedicine the exclusive right to talk about the body and its diseases. So if I relate to Parsons's outdated work here, it is because, at the very moment of medical sociology's invention, he articulated so clearly the outlines of the place subsequently occupied by medical sociology for a long time. The place from which this book (like various others that appear these days) tries to escape.

started to bother him. As they do now. And it isn't that he's frightened or depressed by that, at least that's not the story he tells us. What Mr. Gerritsen talks about is the practicalities of living with legs that refuse to carry him. That hurt. This raises all kinds of difficulties. With the housework. The shopping. Social life. He explains them in some detail. Here's one example out of a long list of difficulties.

"My daughter, my eldest, she moved to another place. She went to live somewhere up stairs. She's still a young woman, so she's not going to get a flat on the ground floor. I haven't visited her yet. I can't climb all those stairs. 'Dad, when are you coming?' she asks. The child understands. She's not going to put pressure on me or something. But you want yourself to go there, don't you? I do. The problem is: it's four flights of stairs. Four. Yet there must be a way to do it. So I said to them, I said, 'what about putting a rope around my neck and then, from up the stairs, from above, you pull and pull me . . . or . . . well, no' [laughs]."

This story reveals something about Mr. Gerritsen, all right. About his feelings, his sense making, and his self-irony. But in telling about the way he lives with his painful legs, Mr. Gerritsen also presents us with insights into the events that happen to someone with an impaired body. He tells about adapting his habits to his inability to walk without pain. And he tells about the limits of such adaptations. It may be possible to buy a small cart on wheels and so still be able

Aligning and Contrasting

In 1981, Allan Young published "When Rational Men Fall Sick: An Inquiry Into Some Assumptions Made By Medical Anthropologists." It is a critical article. Too many medical anthropologists, Young wrote at that time, listen to people talking about their sickness as if these people were "rational men." As if they presented theoretical knowledge and aimed to think along rational lines of argument. In contrast to these assumptions, Young argues that sick people's talk is usually of a different kind. When they talk, sick people do not necessarily refer to an internal state, but may instead attempt to reach some goal. They tend to not be in an operational mode, but in a preoperational one. This means that their own experiences are more important to them than any theory that might explain these experiences, that the words they use

may have an array of diverging meanings instead of a single one, and that their reasoning is not linear.

How to relate to this article? I might align with Young. He is right: anthropologists should not expect sick people to have "explanatory models." Patients should not be investigated as if they were the wild variety of the same species to which (domesticated) doctors also belong. The talk of sick people is a lot more complicated than the "rational man" scheme can hope to grasp. However, I could also be critical and distance myself from Young. Although he argues that sick people are not "rational men," he takes it for granted that doctors, by contrast, are. He takes them to be "operational" thinkers. However, it may well be that doctors are as nonlinear, complex, and self-contradictory as anyone else. (Here I might quote later studies

to do one's own shopping. But there are things, like visiting one's daughter, that become impossible, if she lives on the fourth floor, and one doesn't want to be hung on a rope.

Living with legs that hurt when walking does not only invite a person to make sense and give meaning to his or her new situation, but it is also a practical matter. A social scientist who wanted to know about the practicalities of living with bad leg arteries could follow Mr. Gerritsen while he does what he can and bumps up against what he cannot. Jeannette and I didn't undertake such an ethnography. But it is still possible for us to get to know some of the things we would have seen if we had followed him in his daily routine. We can listen to Mr. Gerritsen as if he were his own *ethnographer*. Not an ethnographer of feelings, meanings, or perspectives. But someone who tells how living with an impaired body is *done* in practice.

The stories people tell do not just present grids of meaning. They also convey a lot about legs, shopping trolleys, or staircases. What people say in an interview doesn't only reveal their perspective, but also tells about events they have lived through. If you agree to go along with this possibility for a while, and listen to patient interviews in a realist mode, the question becomes "what are the events people report on?" Here are three fragments, from three different patient interviews.

that investigate physicians' thinking and use these to support my argument; for example, Robert Hahn, "A World of Internal Medicine: Portrait of an Internist" [1985].

And then there is a third way of relating to Young's 1981 article. This is to take out a half hidden remark, inflate it, and run away with it. At one point Young mentions that while people's talk isn't only cognitive, neither is cognition confined to talk. There is such a thing as *embedded knowledge*. This knowledge cannot be deduced from people's talk. It is incorporated in nonverbal schemes, in clinical procedures, in apparatuses. The precise formulations suggest that Young takes the existence of *embedded knowledge* to indicate a lack: a lack in the ability or willingness of those involved to be more articulate. He says,

for instance, that clinicians have a "tendency to continue investing in this knowledge rather than to self-consciously examine it," because "from the clinician's point of view, embedded knowledge is a form of professional investment (absorbing money and professional time) and is integral to his reputation and capacity for continued work" (324). Doctors do not take the time and effort to make things explicit, especially when this might make them more vulnerable. Rather, they spend their time working along.

Perhaps this is right. But it may also be that doctors do not "prefer" to invest in work rather than being explicit. It may be that this is not a matter of discretion. That, in other words, working in, by, and through embedded knowledge is simply the way

"I've got this nice neighbor, she's a young woman. So she takes me along. And then we do the shopping together. On Saturdays. With her car."

"But the scaffolding, and stairs, if you had to go some ten or twelve meters up, I couldn't do it any more. And walking, I went by bicycle, but in the end that became too much as well, if there's wind and you have to put in some effort. So my boss, well, he said, let's do it the sensible way, and he gave me things to do in the office. Until I could get an early retirement. So now I'm on early retirement. [Sigh] Yes."

"Then you're there at home. Alone. The whole day. And then I shuffle over the floor. I get to the sink all right. I can do it."

In the interviews we held with them, patients gave us detailed descriptions of the way they reorganize their households, their work, their family life. They told about how to get into the car or when to take a taxi. About steps and stairs, bicycles, and dogs on a lead. About the trials and tribulations of dealing with an impaired body in daily life.

But daily life isn't just located in houses, on streets, and in shops. Most patients also have lots to say about what happens to them in the hospital. It begins with going there. Can your son, who's so busy, take a day off to drive you? Where to find this room Fo21 where you've got to go? And are you allowed to

things are usually done. Everywhere—or almost. This would imply that cognitive operations are not central to what happens in hospitals. And, thus, that unraveling medical knowledge requires an investigation into clinical procedures and apparatuses rather than into the minds and cognitive operations of physicians. And, if one follows the argument through, that it might be better when interviewing people (whether they be doctors or patients) to ask them about what they do and about the events that happen to them, rather than about their thinking.

To take up the theme of "embedded knowledge" and run away with it is a more subtle way of relating to the literature than either agreement or criticism. Instead it sets up a *partial connection* between Young's text and this one. The connec-

tion is formed by the notion "embedded knowledge" minus the negative connotations Young attributes to it. So here is a link between my work and this specimen of the anthropological tradition. I investigate what Young calls "embedded knowledge" even if I use a different terminology.

But should I relate to this one article at all? It is a fine article, but Young has written so much more that is equally good. And so have others. There is a problem in making relations to the literature explicit: it takes so much space to outline a single, simple link such as this. And there are so many of them, so many more. They are *embedded*, indeed, in the questions asked, the topics raised, the words used throughout this study. Is it possible to make all the partial connections between a text and its relevant others explicit? I don't think so. So many

have anything to drink at all on the day of that examination with the difficult name? It all matters. It may all be told—or skipped.

Mrs. Gomans had an operation four days ago. Her left leg was opened up. One of her leg arteries was stripped: the atherosclerotic plaque taken away. Jeannette asks her to say more about it. [Yawns.] Oh, well, the operation itself, you don't remember a lot about that. I had general anesthesia. So you come round again, and you have a suture, a scar in your leg, or two scars. And if it's all right your blood flow is good again. And then it's all done, and after ten days you can go home. And hop, you're a whole new person. That's the normal procedure."

The point is not that patients are necessarily the best possible ethnographers of the events that make up their own lives. They may be bad ethnographers. Mrs. Gomans, for instance, only tells about her scars when asked about her operation. She doesn't go into detail, but talks about a "normal procedure" in terms heavily colored by her hope of becoming a "new person." But then: Mrs. Gomans had general anesthesia. And general anesthesia is a pretty strong method of turning someone into a bad ethnographer.

Other patients have seen more. They've tried hard.

resonating terms, so many diffracting topics, so many shared words with slightly different meanings from one text to another. How much time and energy should we invest in articulating relations—might it not sometimes be simply better to get on with it, and show some "capacity for continued work"? The question may be asked. But then, if articulating embedded knowledge is hardly a matter of discretion for doctors, one may wonder to what extent it is for theorists.

But there are so many other fields,

places, literatures to relate to. Crucial among these are the dispersed studies

about the framing of boundaries between biology and the social sciences. After the Second World War it became important to draw these boundaries and to draw them sharply. Talk about biological differences between humans had become suspect. In an attempt to make a sharp contrast with the murderous eugenic practices of the

Disciplines

This book is about the multiplicity of the body and its diseases. Does that topic locate it within a specific *discipline*? Perhaps, but if so, then which: medical sociology? medical anthropology? or medical philosophy? I have a hard time thinking about where to locate myself, or better, where to locate this book. And the thinking

Mr. Jonas also had an operation a few days ago. He had a local anesthetic, so he was conscious. And he was fascinated. "I could see quite a bit of the last operation. I found it interesting. First they hang some cloth right in front of your face. I said [to the anesthesiologist]: man, take that thing away. I said: I can't see anything like that. He said, no, he said, I can't do that, most patients can't take it, they get sick, he said, and we can't have that, during an operation. So I said, well, if by accident I pull that cloth away then you shouldn't be angry at me, I said. For I do want to see it for myself. And then I was allowed to see it, I saw three-quarters of the operation. Yes, I thought it was quite interesting. After all, it's your own body [laughs]."

Mr. Jonas was eager to observe the interventions to which his body was subjected. When asked what he saw, he tells that there were lots of people around, all in green and with caps covering their mouths and noses. They were handling each other instruments. And at one point the surgeon said something about amputation. Mr. Jonas realized almost immediately, he says, that this was in order to teach the students present about the risks of people with bad arteries who are not treated. It was only a fraction of a second that he feared it was his own leg that would be amputated.

Nazis, the biological equality of humankind was stressed. Talking about differences between humans became a privilege of the social sciences, even if this privilege had to be reconquered over and over again (see, e.g., Rose 1982). In various forms and variants the social sciences delineated their own objects *alongside* those of biology. One of the arguments for doing so was that this helped to ward off racism.

In 1982, Martin Barker published *The New Racism*. It presented an analysis of the discourse of the British New Right of that time. It showed that in the discourse of this movement the dominant talk was no longer about the inferiority of so-called other races. Instead of biological inferiority, *cultural difference* was said to mark the contrast between "us" and "them." "Their" bodies don't stink, but "their" food does. And "they" do not need to be eliminated: all "they" need to do is go home—

wherever that is. Barker's book isn't in the field of medical anything. But even so it is a good text to relate to because Barker makes it very clear that a division between biology and sociology that was once helpful may lose its earlier power. In the case he analyzes, it no longer does the political work it was called in to do, which is to counter racism. Racism may be grounded in culture as well as in nature.

In *After Nature: English Kinship in the Late Twentieth Century*, Marilyn Strathern takes distance from the nature/culture division in another way (1992a). She shows that anthropology has undertaken studies of *kinship systems* all over the world, as if kinship systems were social constructions building on natural facts. Kinship studies departed from the alleged natural fact that children are the offspring of a father and a mother, inheriting equal amounts from either parent. Strathern, however, makes

So Mr. Jonas saw a lot. But when Jeannette asked him what happened to his legs, he only points to the places where his skin was cut. There's where it happened. He adds that he remembers images, and vividly too, but he can't tell anything much about them. How should he? The terms with which one might articulate the specificities of an operation do not belong to his vocabulary.

Mrs. Ramsey has had her first operation. Jeannette asks Mrs. Ramsey whether she thinks she might need another one in the future. There are, after all, many patients around who've already been here four, five times before. The question, however, provokes a frightened reaction. "Oh, please, not again. No, I hope not. I hope never to have another operation. For they laid me down on this sloping table. They had to work on the leg's side. The table was completely tilted, sloping. So the way you are hanging there, all the time, in that thing. You're stiff from that, too, of course, in the end. And your muscles ache when you wake up. They do."

Mrs. Ramsey doesn't yawn and she isn't optimistic, like Mrs. Goman. Nor does she express the remarkable curiosity of Mr. Jonas. Instead, her tone is anxious. She disliked undergoing an operation and the physical discomfort involved. But her aversion does not stop her from making several interesting observations. That the operation table was tilted. That this was related to the surgeons' task of reaching the side of her leg. That she was stiff afterward.

it plain that these "facts of life" were cultural all along. They were English, to be precise, expressions of the English kinship system of the twentieth century. The very terms in which the so-called natural facts of procreation were expressed already incorporated images of social relations, like the word "heritage," which was about inheriting wealth long before it was about inheriting genes. In order to take distance from her own Englishness, Strathern calls in the theoretical help of various Melanesian peoples, in whose conceptual schemes there are no nature and no culture. Instead, they know sons who give birth to their fathers. Women who are men in a female form and vice versa. Containers that are, in their turn, contained.

But it is not only Melanesian theories that help Strathern to escape from tradi-

tional English schemes. The current technical reshaping of human reproduction works in this way, too. Now that a newborn baby can be the genetic child of one mother and the anatomical child of another, the old schemes start to crumble. The opposition between a singular natural parenthood and a pluralist range of cultural constructions that shape it later on no longer holds. What will come next? Western/English culture is, in a material way, by changing nature, undermining the grounds of its own nature/culture divide.

And there is a third parallel move that I would like to relate to. It is not about race or kinship, but about sex. Sex and gender. Here's a quote from Donna Haraway's essay "Gender for a Marxist Dictionary: The Sexual Politics of a Word": "In 1958, the Gender Identity Research Project was

It is possible to listen to people's stories as if they tell about events. Through such listening an illness takes shape that is both material and active. It is an illness that consists of lying on a sloping table. Of arguing with your anesthesiologist about the cloth in front of your eyes. It is an illness made up of scars on your legs that do not stop you from becoming a new person. This illness is something being done to you, the patient. And something that, as a patient, you do.

Who Does the Doing?

The patient stories quoted above do not expel physical reality. Instead, they talk about it, for it is everywhere. The physicality of bodies, vessels, blood. That of shopping, trolleys, and staircases. And that of anesthetic drugs, green clothing, knives, and tables. What is important about this reality is that it hurts, makes noises, smells. That it bleeps or falls on the floor. That it is touched. Patients may interpret bodies, but they also live them. And so do doctors. Doctors figure prominently in the patient stories. They administer general anesthesia. They are dressed up in green, use instruments, cut open legs, and close them again with thread and needle. They teach, are taught. They tilt tables and work on the inner sides of legs. They do lots of things to the patient's body.

Perspectivalism puts doctors and patients on a par, with a great divide between them, because they cast their views from different angles. The traffic

established at the University of California at Los Angeles (UCLA) Medical Center for the study of intersexuals and transsexuals. The psychoanalyst Robert Stoller's work discussed and generalized the findings of the UCLA project. Stoller introduced the term 'gender identity' to the International Psychoanalytic Congress at Stockholm in 1963. He formulated the concept of gender identity within the framework of the biology/culture distinction, such that sex was related to biology (hormones, genes, nervous system, morphology) and gender was related to culture (psychology, sociology)" (Haraway 1991, 133).

Another division articulated in the fifties: one that made it possible to talk about a person's "gender" irrespective of

across the doctor-patient divide attracts much public attention. There are fascinating books written by doctors who describe the way their perspective changed when they fell ill and became a patient. Social scientists investigate whether and how patients incorporate medical schemes and terminology into their own thinking. Conversational analysis shows how the boundary is—or isn't—crossed when doctors and patients interact. And testimonies of patients who relate the inability of their doctors to understand them make for disheartening reading. But both the difficulties and the possibilities of crossing the gap point toward the existence of that gap. So there it is. A cleavage. A perspective from one point of view differs from that of the other.

In stories that tell about events-in-practice this is different. However shared or solitary perspectives may be, the practice of diagnosing and treating diseases inevitably requires cooperation.

The surgeon walks to the door and calls in the next patient. They shake hands. The doctor points at my presence and says that I'm there to learn something. He sits on a chair behind his desk. The patient, a woman in her eighties, takes a chair at the other side of the desk, clutching her handbag on her lap. The doctor looks in the file in front of him and takes a

analytically touch the way woman and man are framed in biology, we need to address the issue.

In the texts of Barker, Strathern, and Haraway I relate to here, the words "disease" or "illness" never appear. And yet these texts are worth relating to when I want to argue that we should no longer leave the study of "disease" to biomedicine. There are analogies. Differentiations between race and culture, biological parenthood and kinship systems, sex and gender, or disease and illness have a lot in common. Each of these distinctions was crafted in the 1950s in order to create a space for the social sciences alongside biology. Alongside: the metaphor may be taken seriously. The social domain was regionally separated from the biological domain. This both solved and created problems. Problems that were comparable.

Of what kind? Barker shows that making

space for "culture" next to "nature" is no longer a protection against racism. Racism can be framed in cultural as well as natural terms. Parallel to this, one might conjecture that it isn't only knowledge of "disease" that holds power over patients these days. Knowing "illness" also does; for example, the "quality of life" so important in framing present-day health care is defined in sociological terms. Strathern tells that the nature/culture divide is subordinate to its latter element: it is the invention of a quite specific culture. Where this very culture is changing its procreative possibilities, new schemes will (have to) emerge. Translating this analysis, it is possible to say that one of the dominant ways Western cultures live their "illnesses" is by taking them to be "diseases." Things doctors know about. But recent transformations in health care, like those that make patients into the guardians of their own

letter out. "So, Mrs. Tilstra, here your general practitioner writes you've got problems with your leg. Do you?" "Yes, yes, doctor. That's why I come here." "Tell me, then, what are those problems? When do you have them?" "Well, what can I say? It's when I try to do something doctor, move, walk, whatever. Like, I used to walk the dog for long stretches, but now I can't. I hardly can. It hurts too much." "Where does it hurt?" "Here, doctor, mostly down here, in my calf it does. In my left leg." "So it hurts in your left calf when you walk. Now how many meters, if you walk on flat ground, say, how many meters do you think you can walk before it starts hurting?" "What can I say? I think it must be, well, some, not a lot, some fifty meters I guess." "Good. Or not good. Well. And then, can you walk again, then, after some rest?" "Yeah, if I wait for a while, after that, yes. I can, yes."

In the consulting room something is done. It can be described as "pain in Mrs. Tilstra's left lower leg that begins on walking a short distance on flat ground and stops after rest." This phenomenon goes by the medical name *intermittent claudication*. Whatever the condition of her body before she entered the consulting room, in ethnographic terms Mrs. Tilstra did not yet have this disease before she visited a doctor. She didn't enact it. When all alone, Mrs. Tilstra felt pain when walking, but this pain was diffuse and not linked up to a specific walking

therapies, are in the process of undoing the former divisions.

Haraway, finally, warns that feminists who fight biological determinism in a dichotomizing way, one that puts the body's "sex" in a safe domain before starting to discuss a person's "gender," leave biology unanalyzed. "Biology" has tended to denote the body itself, rather than a social discourse open to intervention" (134). Thinking along with this, in an activist mode, one might say that leaving "disease" in the hands of physicians alone is a political weakness. For whatever one may say about the social shaping of the former sick role, whatever one may say about "illness," as long as "disease" is accepted as a natural category, and left unanalyzed, those who talk in its name will always have the last word. It would be better to mix with them, move among them, study them, engage with them in serious discussion.

By relating to it, I may try to import the work of Barker, Strathern, and Haraway into the fields of medical sociology, anthropology, or philosophy. Importing texts from other fields tends to be a good way to say "new" things. But where are these texts coming from? Not from a clear-cut discipline, but from an interdisciplinary, slightly undisciplined field. A flow of theory moving across boundaries. The boundaries of disciplines, of nature and culture, of theory and politics. Maybe relating to them is a good way to give this text a place in that nondisciplinary fluid space as well.

Visibility and Access

Relating to the literature may be a way of situating one's own text among others, which tends to be helpful to most readers. It may be a way to sketch the ancestry one is shaped by and the elders one seeks to depart from, and these may or may not

distance on flat ground. The trouble Mrs. Tilstra encountered when she tried to walk her dog did not yet have the shape that emerges when she answers her doctor's questions.

This does not imply that the doctor brings Mrs. Tilstra's disease into being. When a surgeon is all alone in his office he may explain to the visiting ethnographer what a clinical diagnosis entails, but without a patient he isn't able to make a diagnosis. In order for "intermittent claudication" to be practiced, two people are required. A doctor and a patient. The patient must worry or wonder about something and the doctor be willing and able to attend to it. The doctor must ask questions and the patient be willing and able to answer them. And in addition to these two people there are other elements that play a more or less important role. The desk, the chairs, the general practitioner, the letter: they all participate in the events that together "do" intermittent claudication. As does Mrs. Tilstra's dog, without whom she might not even have tried to walk more than the fifty meters after which her left leg starts to hurt.

Another scene.

Even if he has come all the way to the consulting room, Mr. Romer never gets to speak. His wife has come with him. She does the talking. "He's not doing well, doctor, he isn't. He

be the same. For all of these purposes it is best to relate to literature that has some authority. If I relate to Parsons, advanced readers are more likely to get at what I'm trying to do, for they know Parsons. And novice readers are well served as well, for they will have to get to know Parsons sooner or later if ever they want to be taken seriously. If I import Strathern my text becomes stronger, for whoever wants to argue against my playing around with the nature/culture divide now has to argue with her as well—and she's written a lot about it. But how do authors ever acquire authority? Answer: by being related to. It is a circle.

There is an interesting article by Robert Pool that I would like to relate to. Pool is a medical anthropologist who was sent out (and paid) to investigate why kwashi-

mon in the northwest region of Cameroon, even when there is enough food to go round. In order to start to answer this question, Pool tried to get insight into the way the people of the village where he lived talk about this disease. He wanted to explore their own perspective on it. Their interpretations, their illness story. But the stories that people in the village told Pool weren't about kwashiorkor. Or, if they were, they were also about a lot more. Talk shifted between *kwashiorkor*, *ngang*, and *bfaa*. There were no solid boundaries between these words. None of them was used in a way that stayed stable from one conversation to the next. And if it hadn't been for Pool asking questions, the stories wouldn't have been told (let alone in the way he recorded them) in the first place.

Pool makes it clear that if an anthropologist goes out to study "illness" as if it were

can't do a thing any more." "So, Mr. Romer," the surgeon says, trying to look the old man in the eye, "what's the problem? What do you come to see me for?" "It's his legs, doctor," Mr. Romer's wife answers. "He's had a heart attack, he's had two in fact. But now it's his legs. He can't get himself to walk any more. He has too much pain." Mr. Romer looks worn out. And despite the surgeon's stubborn attempt to address him, Mr. Romer doesn't speak. Maybe he can't. Maybe—the surgeon seems to reckon with that possibility—he has given up trying.

A doctor cannot diagnose intermittent claudication all alone. He needs others for it. But the scenario isn't rigid. Many of its elements are flexible. Instead of fifty meters, the walking distance may be a hundred meters. Instead of the calf, the thigh may hurt. And if the patient cannot speak, someone else may speak for him. But what is needed, indeed indispensable for clinical diagnosis, is that there be a patient-body. This must be present. And it must cooperate.

The surgeon looks from the file to the Romer couple and back down to the file, where he makes a few notes. His head up again, he says, "Now, if you please, Mr. Romer, I'd like to take a look. I want your legs, I want to see for myself what they look like. And feel your blood vessels. For you may have a problem with your blood vessels." After having said this in a loud voice, the surgeon turns his head to Mrs. Romer—thereby accepted as a spokesperson—and asks: "Do you think it's possible for him to take his trousers off and lie on the examination table?" It is possible but not for Mr. Romer all by himself. It isn't easy. The

the lay theory of a "disease" that doctors talk about in medical terms, he is trapped from the beginning. He is trapped in "disease" language. Why would laypeople, let alone in Cameroon, delineate entities in their own talk that nicely parallel the categories of Western medicine? To presume this is to presume that the disease categories of Western medicine are "natural." That they reflect a reality out there for everyone to stumble over before interpreting it in diverse ways. But people's categories, or so Pool argues, do not reflect a nature accessible, if in various ways, for all. Instead, they are part of a specific practice for dealing with life, suffering, and death. The article mentioned is entitled "Gesprekken over ziekte in een Kameroonees dorp: Een kritische reflectie op medisch-

antropologisch onderzoek" (Pool 1989). Do you recognize the language? It's Dutch. There must be lots of interesting articles I cannot relate to because they are in languages I do not understand. In Danish, Italian, Urdu, Kishwahili. And while I happen to read Dutch, I don't know when to relate to Dutch literature very well when I'm writing in English. If I do, the risk is that it does not increase the transportability of my endeavor. It does not help you to situate my texts but, worse, is likely to be frustrating for you. My reference might make you eager to read Pool. Well, in this instance you can. He's also published a book in English, in which he develops the same arguments (Pool 1994). But there you are lucky.

limbs are heavy. Shoes and socks can only be undone when the feet are lifted. The zip refuses, the trouser fabric is stiff. Then there's the height of the table. But after a while the vascular surgeon holds Mr. Romer's two feet in his full hands to estimate and compare their temperature. He observes the skin. And with two fingers he feels the pulsations of the arteries in the groin, knee, and foot. "Can you flex your leg a bit for me, please, yeah, yes, that's it, there you go. Very good."

In their consulting rooms, vascular surgeons add a physical examination to an interview. The patient's answers to the diagnostic questions may make a typical story or a vague one. They may be enough to talk of intermittent claudication straight away, or not quite so. In either case, the enactment of intermittent claudication is extended and strengthened by adding the elements a physical examination may yield. Cold feet, or one cold foot. Weak pulsations. A thin, poorly oxygenated skin. To add such elements, the patient's legs and the doctor's hands cooperate. As do the examination table and the person who helps a patient worn out with age to undo his shoes and take off his socks and trousers.

Who does the doing? Events are made to happen by several people and lots of things. Words participate, too. Paperwork. Rooms, buildings. The insurance sys-

No Space/Time Available!

What is important to note now is that this book does not go into history. Should it relate to historical literature even so? There are, after all, lots of intriguing and relevant studies to find there. One of them is Barbara Duden's *The Women Beneath the Skin* (Duden 1991). It does theoretical work. Duden's history delves under the skin of human bodies. That makes it of immediate relevance to the social sciences as well as the philosophy of medicine. Duden makes her readers *feel* that the experience of one's own physicality from the inside does not precede culture. Not that just about anything could be produced or constructed, precisely not that: the flesh is stubborn. It is stubborn as long as it is alive, but even so it is a historical phenomenon. And its historicity is not a mere matter of interpretations changing, but of the very fleshiness of being alive itself.

More about that later.

term. An endless list of heterogeneous elements that can either be highlighted or left in the background, depending on the character and purpose of the description. The descriptions given here are mine, not those of Mrs. Tilstra, Mr. Romer, or any other patient. And even if my descriptions are informed by what patients tell about events, I only rarely follow patients in this book. This ethnography (that is its force but also constitutes its limits) concentrates on medicine: it is made to unravel medical knowledge, medical technology, medical diagnosis, and medical interventions. It is informed by my own observations and by attending primarily to the words of another group of lay ethnographers: medical professionals.

The outpatient clinic. The patient who's next on the list never showed up. The one after that hasn't arrived yet. So we walk to the coffee machine and the vascular surgeon inserts his identity card and gets us two coffees. We stroll back to his office. Talk as if chatting. "You see, you've got to understand this," he says, wanting to be a good informant, "making a diagnosis is very different depending on whether or not they have a good general practitioner. Sometimes people come here and there's this letter and everything is in it: walking distance. Sometimes people come here and there's just some illegible sentence scribbled down like 'please see this patient for me.' So then your work is different. Often, in such cases, there isn't a vascular problem at all. It may be something neurological. Or whatever. Nothing."

Duden presents an analysis of detailed reports of the complaints and wishes of female patients that a doctor in a small German town published in 1730. There are a lot of intermediaries between these women's physical experiences and the readers of Duden's book. The situatedness of the medical practice of the author, the specificities of his medical vocabulary, the writing habits of his time, Duden's own selection as a historian: readers get to know a lot about these. And yet from what we read, it seems inescapable that the bodies of these women were different from those that we inhabit now—however large the differences between us. We simply couldn't do such a body any more, nor describe it from the inside.

I might never have noticed that the diagnostic work of a vascular surgeon differs considerably with the letters of general practitioners if it hadn't been for the conversation just quoted. Thus, in the ethnography engaged in here doctors become the social scientist's colleagues once again. They stop being "mere" objects of research whose interpretations may be listed and related to their historical and cultural context. But neither are they the colleagues they used to be, professionals who have knowledge of "disease," to which the social scientist may add knowledge about "illness." Instead, the territorial boundaries of professionalism are starting to leak. Doctors talking about their work may be listened to as if (like patients) they were their own ethnographers: ethnographers in their turn need not stop short as soon as they come across machines or blood, but can continue their observations. They may write about the body and its diseases.

In this unbounded territory, the disease/illness distinction is no longer helpful. When doctor and patient act together in the consultation room, they jointly give a shape to the reality of the patients' hurting legs. How to call what they thus shape? If I use the word *disease* here, this is not to locate my text on the disease side of the disease/illness distinction, but to breach it. To make it plain that I will attend to physicalities even if I am not a medical doctor. To underline that it can be done. That there are ways of ethnographically talking bodies. There are good reasons to try, if only this one: that the *humane* does not reside exclusively in psychosocial matters. However important feelings and interpretations may be, they are not alone in making up what life is all about. Day-to-day reality, the life we live, is also a fleshy affair. A matter of chairs and tables, food and air, machines and blood. Of bodies. That is a good reason not to leave these issues in the hands of medical professionals alone but to seek ways, *lay ways* so to speak, to freely talk about them.