Alienation Through Abnormality in (Bio)Medical Practice

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Abstract: In this paper I critically discuss the epistemological structure of medical anthropological inquiry. The patient has a central role in this analysis, as biomedical epistemology, which informs that of medical anthropology, serves to alienate the patient from society and one’s self. The link in epistemological structure therefore disadvantages the general intent of medical anthropology in the misinformation of how one understand one’s own affliction. I structure my argument by first laying out basic assumptions of medical anthropology, demonstrating the failure of medical anthropology in addressing the individual alienation of illness, and how the current epistemological framework perpetuates alienation of the individual through the emphasis on the physical body.

Criticism of the Western approach to medicine, or biomedicine, lacks an understanding of the effects that perceptions of illness have on the wellbeing of the patient. Given that medical practice operates much like any other business in the most basic sense—responding to a public demand by providing goods and/or services—I will base my claims on the common, ideological assumption that medical practitioners labor to produce healthier individuals. However, perception shapes the notion of what constitutes health. Across cultures it is defined by abnormal circumstance, ailment. It follows then that health industries produce by returning an individual to a more normative state. Yet, nothing has been said of wellbeing. While what is normative is not always
associated with wellbeing, the context of health provides sufficient grounds for such an association. With that said, the scope of this paper resides with the implications of a biomedical approach, but the basis in theory regarding perception is intended to leave discussion open for the sake of application to any form of human care.

Given that biomedicine is still too broad a field, I find it expedient to focus on the epistemological level of medical anthropological practice as it helps clarify some of the basic premises I have already established as significant factors in addressing ideological issues of medicine. Although the goal of the medical anthropologist is to communicate a better understanding of cultural perceptions of illness, the perceptions unique to the patient are often unacknowledged. Hence, the advice taken from medical anthropologists is too simplified to ever have any far reaching results. Part of the problem for this oversight is the shared theoretical assumptions between the biomedical field and that of medical anthropology. Because illness is defined culturally through the perception of normative characteristics—an assumption based on the occurrence of culture-bound syndromes—we as humans associate it with physical (perceptible) manifestations, hence the frequent emphasis on the body. As such, the physical body plays a central role in biomedical treatment in the effort to return the patient to his or her normative (healthy) state. This process becomes problematic if the person seeking treatment does not have the same perception of health as the practitioner. In this case, the medical anthropologist mediates. However, perception of health and illness on an individual level is more nuanced than the cultural understandings guiding mediation. This does not suggest that culture lacks complexity, but that in the case of illness, there is an extra pressure which can further complicate cultural perceptions of that illness, perceived in relation to the negative connotations of abnormality, thus alienating the patient from themselves and others. What have yet to be addressed in medical anthropological practices are the theoretical underpinnings of alienation of a patient experiencing illness. It is not only the effectiveness of the structure of the medical anthropologist’s epistemology that must be questioned in relation to the individual patient, but also that the emphasis on the body perpetuates the alienation of the patient in question by ignoring the totality of the self and treating the patient as defective in regards to the physical body.¹

To structure my argument, I will first lay out some of the basic theoretical assumptions of medical anthropology, as well as the intended results of medical anthropologists’ work. I will continue with a discussion of the individual alienation of illness and how the work of medical anthropologists has yet to address these issues. Additionally, I will point to the current epistemological failings, which perpetuate such alienation of the individual on the basis of emphasis on the physical body. I will conclude with a brief discussion of the importance of such proposed changes and the implications of some of the ideas that I will outline.

All general anthropology textbooks begin by defining anthropology itself. The definition always varies slightly depending on the author’s perspective regarding the goals of anthropology. Although the discipline is not very old, having its roots in the nineteenth century, these varying perspectives have fostered the development of anthropological study as a means to address issues within other fields as is beneficial based on the guidelines that the American Anthropological Association (AAA) lays out. Medical anthropology serves the purpose of addressing health issues as they arise in relation to culture. This calls for a definition of not only medical anthropology, but also health. Health, as it is framed in Medical Anthropology: A Biocultural Approach, is an idea founded on

¹ It should be noted here that the body does not preclude the mind. In fact mental health is an aspect of biomedicine. Hence, there is a distinction to be made between mental health and perception as the perception discussed plays into the current construction of health and is conflated with much larger ideological assumptions, thereby contributing to the structural norms which distinguish mental health within a given structure. Further explanation will be noted later on.
cultural notions of the body, thereby substantiating the value that the medical anthropologist’s perspective may provide new insight into the medical profession and its practices, while calling attention to their first parallel. The “locus of health” from the anthropological perspective of Andrea Wiley and John Allen is then the body and society (2013: 20).

Pulling from notable anthropologists, such as Nancy Scheper-Hughes and Margaret Lock, Wiley and Allen outline the three types of bodies relevant to the discussion of health from an anthropological perspective, the individual body, the social body, and the body politic. The individual body is the “self”, mind and body. Drawing from Marcel Mauss, the individual body is then the “embodied self” as it exists “apart from other individual bodies” (Scheper-Hughes and Lock 2009: 7). The social body is “the seam between the physical body and the social world of the individual” (Wiley and Allen 2013: 20). It is the interaction between the individual and the external world, which links the health of the individual body to social experience. The social body is the only perceptible form of the body in that it is perceived with the senses. Borrowing from Mary Douglass, it is the symbol of the individual, and on a cultural level, is the symbol of social ideals regarding the body (Scheper-Hughes and Lock 2009: 7). The third and final type is the body politic, which refers to the power of social and political forces in constraining the wellbeing of the individual body.

Following Foucauldian theory, the body politic may be constrained by ideological structures such as teachings pertaining to proper functioning of the body and how that reflects the character of an individual and what his or her role should be in society (Scheper-Hughes and Lock 2009: 8).

Nancy Scheper-Hughes and Margaret Lock take the route of defining these bodies as types of epistemological approaches in anthropology. This is a legitimate claim, but in recent years these overlapping principles have merged as medical anthropologists attempt to take a holistic approach. Given the influence that medical anthropologists can have on the practice of medicine, this holism is extremely beneficial. However, holism in its expansiveness is extremely difficult to execute. In the synthesis of differing approaches, some of what is important to each approach is lost. And so, my argument rests on how this synthesis of approaches has resulted in the simplification of each with a central emphasis placed on the physical body. This failing in itself complicates the matter of addressing the individual.

From a health perspective, all three conceptions of “body” are only significant in relation to the physical body. This could be because medical anthropologists attempt to understand the culture of the system within which they work. However, the primary motivation for medical anthropologists beyond pure research is the promotion of cross-cultural dialogues. If that is the case, the use of the term “body” as the central theme to each level of health contributors is alienating to cultures that do not maintain the same health understandings or values as those accustomed to Western medicine. Furthermore, each conception of the body, which is an attempt to define the human experience in relation to health, directly reflects biomedical ideologies, given the causal relation each has with physical wellbeing. I do not fault medical anthropologists for holding fast to their Westernized perspectives, likely derived from years of collegial study, because theories must be grounded in some sort of perception of the physical world, Western or otherwise, if intended to affect change of such a world. The fault I find is that having such theoretical underpinnings in these conceptions of the body highlights the abnormality of the afflicted individual in the cultural context, while the intention is to alleviate anxiety resulting from illness and treatments of such. This can only be understood provided that illness is first viewed from the perspective of the patient.

There are plenty of personal accounts of problematic medical experiences such as *The Spirit Catches You and You Fall Down* and *The Immortal Life of Henrietta Lacks*, which certainly call for questioning of the ethics of current medical practices. What these accounts do not explicitly draw attention to are the epistemological structures grounding such practices. Emphasis on the physical
body fundamentally ignores the alienation of the patient. That can be seen in the practice of medicine itself. The general biomedical process for identifying and treating illness involves a survey of the physical body whether it is through questioning about symptoms, physical inspection, biological sampling, or the use of machinery. All of these take the physical body into account while ignoring the patient as a human. This is not to say that medical practitioners have poor or no bedside manner, for that is a whole other sort of alienation. Rather, the patient is nothing more than a subject of study when it comes to diagnosing and treating an illness even though the individual’s interpretation of what is happening to them is as important. Perception of illness can have profound effects on individual health as is proven by the existence of culture-bound syndromes. Again, the resultant necessity is for medical anthropologists to bridge that gap. What medical anthropologists succeed in doing is translating biomedical practices into something the patient understands. This effectively dulls tensions between biomedical practitioners and patients, who struggle against treatment until they believe that they fully comprehend the intentions of the biomedical practitioners. In acting merely to mediate understandings, the medical anthropologist becomes a tool for the biomedical model, thus losing sight of the original goal, reducing the anxiety of the individual patient through enhanced understanding of all of the perceptions involved.

The patient has a unique relationship to illness as he or she experiences it as an affront to his or her self. However, this perception of illness is culturally bound in that the alienation one experiences in illness is derived from his or her cultural perceptions regarding the illness of others prior to falling ill. The Cartesian notion of a mind-body dualism is the initial source of this alienation as one recognizes one’s self through an awareness of thought, the mind, while understanding that same self as confined to a physical entity, the body. Andrew Warsop provides a view into the alienation of illness using this kind of thought by suggesting that the individual experiences his or her illness as a result of an invader (Warsop 2011: 485). This ‘invader’ reflects socially constructed experience in that ‘illness’ is perceived as an abnormality (Wiley and Allen 2013: 14). Drawing from S. Kay Toombs’ understanding, this abnormality manifests as a feeling of bodily otherness, and therefore alienation as it creates a conscious awareness of the body otherwise imperceivable in comparison to the “self” (Warsop 2011: 487 and Biro 2011: 41). This notion of bodily otherness applies even in cases where external forces are not the source of illness, but rather some sort of mutation within the patient, as in the case of cancer. Yet Scheper-Hughes and Lock suggest that this emphasis on the body creates a negative connotation of what the patient actually experiences by trivializing anything not directly related to the physical body itself or visible symptoms as insignificant, or even more pejoratively, unreal (Scheper-Hughes and Lock 2009: 8).

Fredrik Svenaeus further develops this idea in proposing that it is the “homeness” of the self that is disrupted (Svenaeus 2010: 336). This coincides with the notion that the “body in health offers a model of organic wholeness; the body in sickness offers a model of social disharmony, conflict, and disintegration” (Scheper-Hughes and Lock 2009: 7). Illness forces one to recognize one’s own body through its dysfunction while ordinarily the body works with one’s will without tension, making the seam between the body and consciousness indiscernible. Here the conflict is directly

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2 Guido Nocolosi and Guido Ruivenkamp posit that the epistemological framework of scientific studies has been rooted in a kind of Cartesian mind-body dualism, which depicts life as detached from its environment. Hence, studies look to the genetic code as “the informational representation of life as a code”, ignoring external factors. This is not so different from the way in which the biomedical system views health, as something to be studied and found within the physical body. The physical body is perceived as a machine and its mechanism as biology. As such, it is to be understood through formal scientific tools and reasoning, making health and the human body entirely inhuman. The result, they conclude, is the “fetishizing” of scientific truths, further conveying the alienation of the human subject (Nocolosi and Ruivenkamp 2011: 311, 312).
related to the aforementioned mind-body dualism, i.e. the individual body. The alienation arises out of the perceived separation of mind and body, problematizing any kind of understanding centered on the body.

Alienation extends further in dealing with the patient’s awareness that his or her body is the focus of biomedical study without any regard for one’s individual perceptions of illness (Biro 2011: 41). The social perception is that the goal of biomedical practitioners is to make the patient “better”, however this is in contrast with the defining of illness as abnormal, because the result of treatment then does not better the patient but returns them to “health”, that which is a symbol of normality. This conception of health and illness as a normal/abnormal binary also encourages the patient’s sense of alienation. In being treated as someone with an abnormality through the constant evaluation of physical symptoms, the patient is differentiated from ‘normal’ individuals suggesting that they are a deficient person. The result is alienation from other individuals encompassing both the notion of the social body and that of the body politic through the symbolic attribution of normality to health and the socially constraining ideals about universally human qualities.

The patient’s perception of his or her illness illustrates the same sorts of foundational understandings as the three types of body suggest exists, thus promoting the movement back to holism. All that is missing is thorough study into the influence of the core of each epistemological foundation, the body itself. As the source of all this trouble, one can see the common association among patients, practitioners, and medical anthropologists of illness to object, an object other than one’s self. This relates everything to the emphasis placed on the physical body, yet here the problem with doing so is clear. The creation of a mind-body dualism through alienation separates one’s mind from one’s experiential development, thereby dividing one’s individual body (Biro 2011: 44). In creating this divide one also retracts from the social body, through which one defines one’s self, further expanding the scope of alienation, whereas the body politic is reflective of biomedical practices on the individual. Hence a thorough understanding of the influence that perceptions of the physical body have on practice not only clarifies existing anthropological theory, but also engages the medical anthropologist in linking theory to practice, thus initiating a reevaluation of the way in which issues may most effectively be addressed and the seemingly disparate complications arising from both medical anthropological practice as well as the structure of the health system and its effects on practice at the social level. The emphasis on perspective then allows for new ways of addressing issues beyond the current point in time in that the initial point of social interaction can be traced back to the structures guiding such interactions by way of such a focused lens.

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