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Orientations 2: Culture, Health Care Systems, and Clinical Reality

HEALTH CARE SYSTEMS

The single most important concept for cross-cultural studies of medicine is a radical appreciation that in all societies health care activities are more or less interrelated. Therefore, they need to be studied in a holistic manner as socially organized responses to disease that constitute a special cultural system: the *health care system*.[1] In the same sense in which we speak of religion or language or kinship as cultural systems, we can view medicine as a cultural system, a system of symbolic meanings anchored in particular arrangements of social institutions and patterns of interpersonal interactions. In every culture, illness, the responses to it, individuals experiencing it and treating it, and the social institutions relating to it are all systematically interconnected. The totality of these interrelationships is the health care system. Put somewhat differently, the health care system, like other cultural systems, integrates the health-related components of society. These include patterns of belief about the causes of illness; norms governing choice and evaluation of treatment; socially-legitimated statuses, roles, power relationships, interaction settings, and institutions.

Patients and healers are basic components of such systems and thus are embedded in specific configurations of cultural meanings and social relationships. They cannot be understood apart from this context. Illness and healing also are part of the system of health care. Within that system, they are articulated as culturally constituted experiences and activities, respectively. In the context of culture, the study of patients and healers, and illness and healing, must, therefore, start with an analysis of health care systems.

The rest of this chapter elaborates this still not well-appreciated notion, and explores its implications for cross-cultural studies of health care as well as for a general anthropological understanding of patients and healers in society. This topic is indispensable for understanding the rest of our theoretical framework and our analysis of the empirical evidence, for the perspective it entails alters in a fundamental way our habitual orientation to patients, healers, illness, and healing. It dissolves old questions and creates new ones, introducing several analytic concepts for making comparisons across social, cultural, and historical boundaries. And it will bring our inquiry closer than hitherto possible to a phenomenological description of clinical processes in different settings and a hermeneutic interpretation of the beliefs and behaviors constituting and expressed in those processes.

Although this definition of health care systems is implicit in contemporary medical anthropological thinking, few formal models, such as the one I outline here, have been explicitly stated, and there has been no attempt to explore its clinical implications. For scholars from the health sciences, this is an "alien" concept that imposes a way of looking upon health-related phenomena that runs counter to the ethnocentric and reductionist view of the biomedical model, in which biological processes alone constitute the "real world" and are the central focus of research interpretation and therapeutic manipulation. Medical anthropologists have repeatedly criticized the biomedical model, but with a few exceptions (Fabrega 1974) they have refrained from openly challenging it by articulating the model of medicine as a cultural system as an alternative explanation of clinical phenomena. I see this as my task: to make this alternative theoretical framework transparent, directly relevant to clinical issues, and, I hope, compelling.

The health care system is a concept, not an entity; it is a conceptual model held by the researcher. The researcher derives

1. This subject is covered in Kleinman (1973a, 1974a, 1976). For other models of health care systems, see Alland (1970); Colson (1971); Dunn (1976); Fabrega (1976); Field (1976); Freidson (1970); Janzen (1977); Kunstadter (1976b); Leslie (1976a); Litman and Robins (1971); and Montgomery (1976).

this model in part by coming to understand how the actors in a particular social setting *think* about health care. Their beliefs about sickness, their decisions about how to respond to specific episodes of sickness, and their expectations and evaluations of particular kinds of care help the investigator put together a model of their system of health care. What I am describing is the process of medical ethnography through which local health care systems are reconstructed. In order to conduct such an ethnography, the investigator usually needs to step outside of the cultural rules governing his beliefs and behaviors, including his own health care involvements. Otherwise he risks contaminating his analytic model of the health care system with his largely tacit actor's model of his own health care system. Here is a reason for doing cross-cultural research or for studying a different sub-culture or social group within one's own society. If he chooses to study his own culture, however, the researcher must systematically alienate himself from his inner model of the system within which he is an actor, a most difficult task.

The model of the health care system also is derived from studying the way people *act* in it and *use* its components. It is both the result of and the condition for the way people react to sickness in local social and cultural settings, for how they perceive, label, explain, and treat sickness. The health care system, then, includes people's beliefs (largely tacit and unaware of the system as a whole) and patterns of behavior. Those beliefs and behaviors are governed by cultural rules. Hence, the health care system meets Geertz's (1973:3–30) definition of a cultural system: it is both a map "for" and "of" a special area of human behavior. Like other cultural systems, it needs to be understood in terms of its instrumental and symbolic activities. The beliefs and behaviors that constitute those activities are influenced by particular social institutions (e.g., clinics, hospitals, professional associations, health bureaucracies), social roles (e.g., sick role, healing role), interpersonal relationships (e.g., doctor-patient relationship, patient-family relationship, social network relationships), interaction settings (e.g., home, doctor's office), economic and political constraints, and many other factors, including, most notably, available treatment interventions and type of health problem. The health care system is organized as a special portion of the social world through the interaction of these variables. It is the nexus of adaptive

responses to the human problems created by sickness, and, as such, the issue of "efficacy" is central to it.

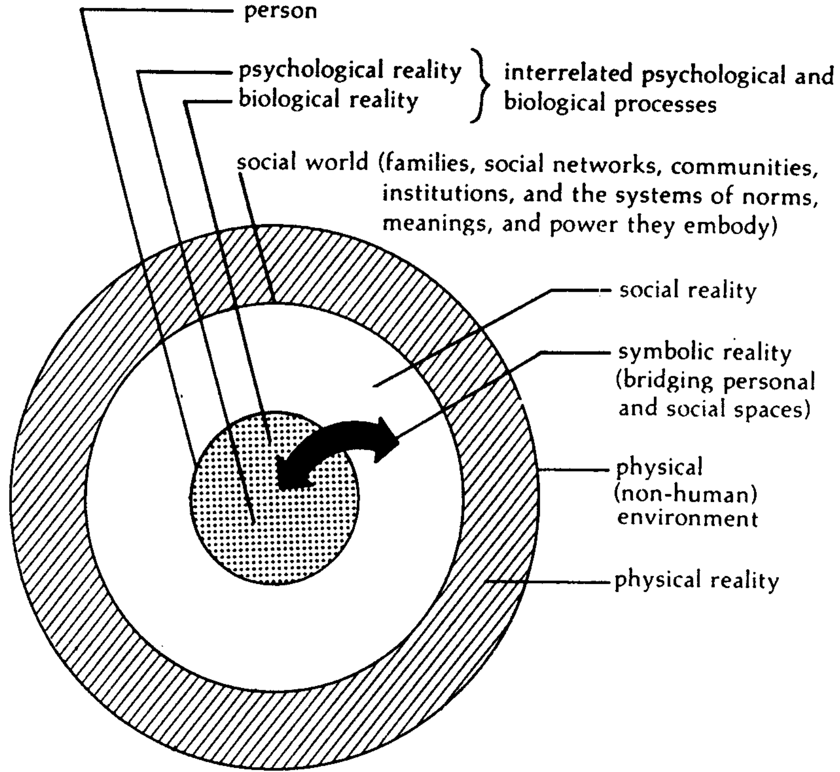
As we shall see, the model of the health care system developed in this book can be used across cultural, historical, and social boundaries to describe considerable variation in specific content along with recurrent structural and functional features. The model is not the only one that can make sense of the social and cultural context of health care. It is derived from my field research and clinical experiences. It is based upon the materials I have elicited and analyzed from informants, patients, families, and practitioners (Kleinman 1975a, b, c). But it is based as well on my reading of the cross-cultural literature (Kleinman 1973a, 1974a, 1976). Although I initially present this particular model at a high level of abstraction, it will be used to explain the inner workings of clinical care: illness behavior, practitioner-patient transactions, and healing mechanisms (see Figures 1, 2, and 3). Thus, it differs from models of health care systems that aim to explain the macro-social and bio-environmental aspects of health care in terms of large-scale social structural, economic, political, and epidemiological factors. I am primarily interested in a microscopic, internal, clinical view, but the model I employ does not ignore the large-scale external factors that other models emphasize.

The next sections of this chapter discuss the social construction of health care systems and examine their external determinants, their internal structure, and certain of their functions. They also discuss the development of this concept. These sections, together with a sketch of Chinese health care systems, define systems of health care and indicate what is to be gained from studying them.

ON THE ORIGIN AND DEVELOPMENT OF THE CONCEPT OF HEALTH CARE SYSTEMS

When cross-cultural studies focus on disease, patients, practitioners, or healing without locating them in particular health care systems, they seriously distort social reality. This flaw is found in many studies in cross-cultural medicine and psychiatry and in research in our own society. Studies of our own society, and comparative research, must start with an appreciation of health care as a *system* that is social and cultural in origin, structure, function, and significance.

Figure 1
Types of Reality



One might well ask why this concept is still not fully appreciated. Both Rivers (1924) and Sigerist (1951), two pioneers in the social scientific exploration of the relationship between culture and medicine, advocated holistic conceptions of that relationship and attempted to organize the findings available to them within unified theoretical frameworks. Neither one successfully unified the empirical evidence, much of which was either inadequate or inaccurate. But the idea of cultural systems of health care was held by these founders of cross-cultural medicine. After their efforts, the holistic approach to medicine in society fragmented into narrower views. Because much of the early interest in this subject grew out of the ethnographic study of religion in "primitive" societies, it is not surprising that anthropologists restricted their interest to the sacred forms of healing found in small-scale, preliterate societies and virtually disregarded the non-sacred aspects of healing and the overarching relationship of culture and medicine (see Seijas 1973).

Clements (1932) and Ackerknecht (see Walser and Koelbing 1971), for example, not only advanced a misleading dichotomy between "primitive" and "modern" medicine, but limited their comparative research to traditional forms of medicine and traditional societies. Ackerknecht, who has had an enormous impact on studies in this field, viewed non-Western cultures from an ethnocentric perspective based on the organizational structure professional medicine had evolved in the West. Thus, Ackerknecht wrote articles on "primitive surgery," "primitive psychotherapy," and "primitive prevention," in which he searched the ethnographic literature for cultural practices that he fit into these Procrustean categories. Clements worked in the same manner to compile a list of five fundamental beliefs about the cause of illness that he claimed exhausted the ideas about illness held by all traditional societies. The most far-fetched of these early cross-cultural medical studies was Benveniste's (1945) argument that all Indo-European societies have the same three basic illnesses, treatments, and types of healers. Most ethnographers, however, simply ignored medicine or studied exotic folk healers and healing rituals for their symbolic and religious, rather than their medical, interest. The legacy of this type of cross-cultural work frustrated the development of a holistic perspective on disease and health care in society. It had little or nothing to do with the basic issues of medical and psychiatric practice (indigenous or Western): the experience of illness on personal and social levels, health seeking behavior, patient-practitioner relationships, and the healing process. Such core issues only recently have received the systematic attention of investigators, after the "clinical" aspects of illness and health care were recognized as a key research focus by anthropologists and other cross-cultural researchers (cf. Adair and Deuschle 1970; Erasmus 1952; Gonzalez 1966; Gould 1965; Hallowell 1963; Harwood 1971; Hughes 1968; Janzen 1977; Kennedy 1973; Pouillon 1972; Press 1969; Rubel 1964; Saunders 1954; Snow 1974; Wallace 1959), and after cross-cultural research attracted the interest of medical and psychiatric investigators concerned with the social and cultural determinants of problems in clinical care (cf. Caudill and Lin 1969; Eisenberg

1976; Lambo 1969; Leighton et al. 1968; McDermott et al. 1972; Yap 1974).

The fact that some anthropologists are themselves clinicians and, as a result, have studied clinical questions in the field undoubtedly helped to advance the new perspective in cross-cultural research (see Fabrega 1974; Kleinman 1977d; Lewis 1975; Levy 1973; Loudon 1976). This clinical interest pushed researchers to formulate general principles to make sense of ethnographic variation and thereby contributed to the recognition that medicine is a cultural system (see references cited in Kleinman 1973a, 1977b). The contributing factors leading to the development of this concept included: the emergence of studies in the new field of medical anthropology concerned with health-seeking behavior and other clinically relevant issues (cf. Fabrega and Manning 1973; Good 1977; Harwood 1971, 1977; Schwartz 1969); sociological studies of patterns of utilization of health care facilities and particularly patterns of popular (lay) health behavior (cf. Chrisman 1977; Freidson 1961; McKinlay 1973; Zola 1972a); interest in the health care and public health aspects of modernization (cf. Leslie 1976a; Paul 1955; Polgar 1962); the tendency of ethnoscientific research to focus on medical taxonomies (cf. Berlin et al. 1973; Frake 1961; Fabrega and Silver 1973); the propagation of a new generation of transcultural psychiatric research, much of which concerned itself with comparisons of healing traditions (cf. Kiev 1964; Wittkower and Prince 1974; Kleinman 1977a, 1977e); the theoretical models constructed by anthropologists working on the health aspects of cultural ecology (cf. Alland 1971; Dunn 1976; Kunstadter 1976b); the influence of systems theory on the models developed in ethnomedicine (Fabrega 1972); and comparative studies of medicine in large-scale, non-Western societies (cf. Kleinman et al. 1976; Leslie 1976b). Certainly, the macrological approaches to medical care developed by political scientists, economists, and public health planners contributed as well (cf. Field 1973), although these were far removed from clinical issues.

One development played a crucial role in the recognition of the health care system: medicine, like religion, turned out to be an appropriate subject for linguistic and symbolic analyses. The work of Frake (1961), and especially of Victor Turner (1967), is famous for this kind of analysis. Both showed that medical

beliefs in small-scale, preliterate societies were part of well-developed cultural systems. Turner also demonstrated that Ndembu beliefs linked symbolic referents to diseases with psychophysiological reactions and culture-specific tensions in social relationships, on the one side, with treatment practices aimed at instrumental and symbolic efficacy, on the other (1967: 299–358). The result was a tightly integrated symbolic system.

This important research epitomizes a line of symbolic studies in which medicine is frequently the subject matter, though rarely the principle source of interest (cf. Beidelman 1966; Currier 1966; Glick 1967; Ingham 1970; Nash 1967; Rosaldo 1972; Tambiah 1968, 1975; Topley 1970; Yalman 1964). Nonetheless, these studies helped establish the concept of medicine as a cultural system. The fact that they were carried out by ethnographers who were not interested in health care itself, and who therefore did not write for an audience of medical and psychiatric researchers, may have contributed to the slowness with which this concept has been taken up in medicine, psychiatry, and public health. Such analyses have been recently carried out by medical ethnographers who are oriented to clinical issues. For example, Byron Good (1977), a student of Victor Turner, has made a semantic network analysis of illness terms in Iran in which he shows how popular illness categories make available particular health care options and set out criteria for evaluating the quality of patient-practitioner interactions and treatment outcomes—a line of analysis developed further in the chapters that follow. In works such as this, the relevance of the cultural analysis approach and the health care system model for health professionals has been unmistakable.[2]

Forces operating among professional specialists in the health

2. Certain medical sociology and social psychology studies also added to the health care system perspective. These studies, moreover, tended to widen that perspective to include family-based care, the modern medical profession, the United States, and other technologically advanced societies, as well as clinically relevant issues. Freidson (1970) developed perhaps the most inclusive theoretical framework for studying health care in society, one directed primarily at our own. The work of Suchman (1965) was an important early attempt to conceptualize health care systems and to provide a typology of the social organization of care. The ideas of Mechanic (1962), Zola (1966, 1972a), and especially Freidson figure importantly in the model of health care systems presented in this book.

sciences are responsible for their neglect of a holistic view of the health care system. Three of them are worth noting:

1. The ingrained ethnocentrism and scientism that dominates the modern medical and psychiatric professions (both in developed and in developing societies) follows the paradigm of biomedical science to emphasize in research only those variables compatible with biological reductionism and technological solutions, even if the problems are social ones. This disastrous bias has diminished the significance of all social science inputs into medicine and psychiatry, especially at the clinical level. It has strongly discouraged views of medicine in which health care is seen to include anything more than the modern medical profession and biomedical science or in which medicine is studied as a social institution from a "systems" perspective. Cultural and sociopolitical analyses of the determinants of health care delivery, for example, have not been considered appropriate venues for medical research, and the description and analysis of the total environmental context that ethnography provides has not yet been accepted as an appropriate scientific approach for medical research.

2. The bias of many health professionals in developing societies is to restructure health care delivery in their countries by copying an idealized model of *professional* care in technologically advanced societies. This fictive view of health care does not correspond to the actual situation in developed societies, where 70 to 90 percent of all illness episodes are treated solely in the family context (Hulka et al. 1972; White et al. 1961), and is even a greater distortion of the more desperate situation of health care in developing societies. This interest (frequently no more than professional self-interest) militates against using the health care system model, with its crucial sociopolitical, economic, and cultural concerns, to deal with health problems in developing societies. For example, it has delayed informed evaluations of self-care and treatment by indigenous practitioners, along with research on how these ubiquitous therapeutic approaches might be used in state planning for health care services.

3. The longstanding tendency of clinicians is to treat *healing*

as if it were a totally independent, timeless, culture-free process to be understood either as an isolated special case or by comparisons with clinical practices in psychoanalytic therapy, hypnosis, biofeedback, and the like. Medical researchers seem embarrassed by this archaic relic in their midst and have devoted little attention to healing, the most basic of all health care processes. They do not regard healing as a core function of health care systems to be studied in its own terms within specific social and cultural contexts. Instead, they make simplistic reductions or superficial comparisons to fads such as brain washing, occult forces, etc., which obscure more than they reveal. This bias can be found even in important works, such as Frank's otherwise excellent account of *Persuasion and Healing* (1974a). It is more commonly found in the misuse of cross-cultural comparisons, such as purposefully naive raids into ethnography to debunk psychiatrists by equating them with a vulgar, tendentious view of priests, shamans, and witch-doctors (e.g., Torrey 1972).

Contrary to these trends, the model that I advocate calls for the analysis of health care systems in the same way that political systems, religious systems, kinship systems, language, and other symbolic systems are analyzed. First, it is necessary to study the relationship of a health care system to its context. Cultural settings provide much of the specific content that characterize health care systems and, therefore, are major determinants of the peculiar profiles of given systems. For example, Chinese culture is the chief determinant, though certainly not the only one (local political, historical, and economic factors are others [cf. Unschuld 1976]), shaping the components of the local Taiwanese system limned at the beginning of the preceding chapter. In the past decade, anthropological studies have analyzed in detail how cultural rules and meanings shape health care systems, or at least certain of their key components.[3]

3. Among a substantial, though still growing body of such studies, those by Fabrega (1974), Fabrega and Silver (1973), Glick (1967), Hallowell (1963), Ingham (1970), Kunstadter (1976a), Leslie (1974), Lewis (1975), Messing (1968), Nash (1967), Obeyesekere (1976a, 1976b), Press (1969), Rosaldo (1972), Spiro (1967), and contributors to a recent volume edited by Lebra (1976) are notable. This approach has been carried over to the study of the health care systems of ethnic minority groups in the United States, for example, in re-

Although many ethnographies and comparative studies now begin with a holistic conception of medicine in society and examine the impact of culture on medicine, most anthropological, psychiatric, and public health researchers still isolate individual components of health care systems for study without exploring their linkages with the system as a whole or with its other components. Folk healers are the most popular subject for cross-cultural research, but studies of them fail to show: how they are related to other kinds of practitioners in the same system; how their relationships to patients and their style of practice compare with those of other practitioners in the same society; how their beliefs and "interests" contrast with those of patients and other healers; and how patients decide to consult them. Ethnoscientists who study ethnomedical systems elicit taxonomies of illness terms, but they do not demonstrate how these taxonomies are *used* in different clinical relationships and health care institutions to *treat* illnesses. Since beliefs about illness are always closely linked to specific therapeutic interventions and thus are systems of knowledge *and* action, they cannot be understood apart from their use. Freidson (1970) has argued that to understand any single component in health care, one must locate it structurally within its social context and show how it functions within that setting. The interrelationships between component parts form the *system* and guide the activities of its components.

Janzen (1977) has reviewed various models of "medical systems." He notes that some are too complex to use in field research or for cross-cultural comparisons, while others fail to confront the ways that systems respond to change. Janzen

search by Harwood (1971), Saunders (1954), and Snow (1974). It also has been used to study psychiatric disorders and psychiatric care (Kaplan and Johnson 1964; Reynolds 1976). There even have been efforts to write the history of medicine from the standpoint of the historical reconstruction of medicine and psychiatry as cultural systems, though the largely institutional quality of available evidence, plus the absence of evidence from the oral traditions of folk healing, make such efforts difficult (Foucault 1965; Lain-Entralgo 1970; Shryock 1969; Thomas 1971). Nor have studies in Chinese culture lagged behind. Ahern (1976), Gould-Martin (1976), and Kleinman (1977c) have performed similar studies in Taiwan, and the Andersons (1968), Potter (1970), and Topley (1970, 1976a, 1976b) have done much the same for Hong Kong. Recent volumes edited by Kleinman et al. (1976) and Leslie (1976b) analyze and compare various Asian medical systems as cultural systems.

maintains that comparative schemes for analyzing medical systems are vague and superficial when they stress universals rather than differences. He argues that models of medical systems must deal with *both* micro- and macro-analysis. Thus, they should examine specific episodes of sickness and treatment, showing how small-scale events within healing systems relate to large-scale social structures and processes of change.

Kunstadter (1976a, 1976b) sums up comparisons of medical systems in Asian societies with the view that perhaps all medical systems are pluralistic, that they contain multiple choice points for deciding among often quite different treatment options, and consequently that it is wrong to speak of *the medical system* of any society as if it were single and unchanging. Instead, Kunstadter, like Dunn (1976) and Leslie (1976a), reasons that medical systems are best examined as *local* social systems, which can be related to a potentially large number of variables impinging on a specific setting and which may differ from one locality to another.

We will return to this question about how medical systems are best conceptualized in later sections of this chapter. Now that I have sketched the background for the concept of medicine as a social and cultural system, I will focus on one particular conceptualization of the health care system. Before I specify the dimensions of this model, we need to examine the perspective on social reality within which it is embedded.

HEALTH CARE SYSTEMS AS FORMS OF SOCIAL AND SYMBOLIC REALITY: THE CULTURAL CONSTRUCTION OF CLINICAL REALITY

Health care systems are socially and culturally constructed. They are forms of social reality.[4] Social reality signifies the world of human interactions existing outside the individual and between individuals. It is the transactional world in which

4. This subject is treated slightly differently in several of the author's publications, see Kleinman (1973a, 1973b, 1976). My approach is based on the by now classical statement by Berger and Luckmann (1967), which itself is based on the seminal work of Alfred Schutz (1970). Another statement of this position is found in Burkart Holzner (1968). Translation of the concept of social reality to the medical field is principally the result of writings by Eliot Freidson (1970). A sociological cameo of the social reality forming the context of gynecological examinations is provided by Emerson (1970). Certain writings by Michel Foucault (1965, 1973) come close to being historical reconstructions of clinical reality.

everyday life is enacted, in which social roles are defined and performed, and in which people negotiate with each other in established status relationships under a system of cultural rules. Social reality is constituted from and in turn constitutes meanings, institutions, and relationships sanctioned by society. Social reality is constructed or created in the sense that certain meanings, social structural configurations, and behaviors are sanctioned (or legitimated) while others are not. The individual absorbs (internalizes) social reality—as a system of symbolic meanings and norms governing his behavior, his perception of the world, his communication with others, and his understanding of both the external, interpersonal environment he is situated in and his own internal, intrapsychic space—during the process of socialization (or enculturation). Socialization takes place in the family, but also in other social groupings via education, occupation, rituals, play, and the general process of internalizing norms from the world we live in. As Berger (1973) notes, the individual not only fashions his own sense of personal identity with the aid of this internalized view of the "real," but also externalizes (objectivizes) it and by so doing affirms or discovers this same social reality out there in the "real" world, like a self-fulfilling prophecy. The tremendous power of social reality is in large part due to this fit between inner (personal) and outer (social) beliefs, values, and interests. It fashions a world we accept as the only "real" one, commit ourselves to, often passionately, and react to so as to shape our own life-trajectories. In Chapter 4, I sketch some salient features of the social reality surrounding individuals in Chinese culture and suggest ways by which it influences the personal management of dysphoric affects and the presentation of symptoms of affective disorders in that culture. This brief outline of the concept of social reality is elaborated in the rest of this section for the special form of social reality that is established, learned, and expressed in clinical settings.

Quite obviously, social realities differ. They differ between different societies, different social groups, different professions, and even at times different families and individuals. Certain small-scale preliterate, traditional societies seem to some anthropologists to contain more or less homogeneous social realities shared by all individual members of those so-

cieties. On the other hand, sociologists describe the social reality of developed societies like the United States as fragmented into many distinct social worlds—the coexisting, small cognitive and behavioral fields that Schutz (1970) called plural lifeworlds. Developing societies are often viewed in an overly simplistic schema, as moving from the putative unified social realities (often called symbolic universes) of the traditional world to the plural life-worlds of modern states. Where such societies contain both indigenous literate and oral traditions, they are usually thought of as containing two quite distinct (classical, high-order/folk, low-order) kinds of social reality. Developing societies are said to be of special interest from this viewpoint since in them one can observe the change from old to new social forms, e.g., as expressed in their systems of beliefs, behavioral modes, and institutional structures.

The change from old to new social forms holds the same profound implications for health care systems as for other cultural systems. In such modernizing societies, one finds social realities that are a strange amalgam of modern and traditional beliefs, values, and institutions, held together in varying patterns of assimilation, complementarity, conflict, and contradiction. Since modern medical ideas and practices are often at the tip of the wedge of technology introduced during the modernization process, it is not surprising that health care systems provide some of the sharpest reflections of the tensions and problems of social development.

Social reality frequently varies as one moves from one locality to another. It may vary owing to family differences in past experience, differences in socioeconomic class, education, occupation, religious affiliation, ethnicity, and so on. These differences will be expressed by individuals who do not share the same perception of and response to their social environment, whose tacit knowledge and value-orientations may differ considerably. Furthermore, some may be incompletely or inadequately socialized or for other reasons may be deviant from the norms of their social world. Of course, for all individuals there is a distance between the ideal and the actual, between group beliefs and interests and individual ideas and motives. This gap represents an aspect of sociological and anthropolological theory that is still poorly formulated, but one

that holds considerable significance for our purposes, since it underscores the fact that individuals differ, often greatly, even in supposedly homogeneous social worlds. They differ in their conscious understanding and acceptance of social norms and in the degree to which they follow those norms in actual practice. All of this affects the way individuals think about and react to sickness and choose among and evaluate the effectiveness of the health care practices available to them.

With this theoretical orientation, I assert that clinical practice (traditional and modern) occurs in and creates particular social worlds. Beliefs about sickness, the behaviors exhibited by sick persons, including their treatment expectations, and the ways in which sick persons are responded to by family and practitioners are all aspects of social reality. They, like the health care system itself, are cultural constructions, shaped distinctly in different societies and in different social structural settings within those societies. These health-related aspects of social reality—especially attitudes and norms concerning sickness, clinical relationships, and healing activities—I shall call *clinical reality*. By this expression I mean to evoke a mixed image: namely, that clinical phenomena are socially constituted and that the social world can be clinically constructed.

Health care systems and the clinical reality such systems create and express can be studied at different levels. Most research takes a macro-social view aimed at whole societies or regions (Field 1976). In this book, health care systems are principally discussed in terms of a model based on localities: communities, neighborhoods, groups of families (cf. Kleinman 1977b; Dunn 1976). But occasionally our orientation will change when we consider particular social groups independent of locality. This model will allow us to narrow our focus progressively from the community to social institutions and roles and then on to families and individuals. Because health care systems exist and function by right of socially legitimated norms governing how the social group and the individual in the group react to sickness, as well as through social perception and use of available health care resources at the local level, views of health care systems may vary as much as views of social reality may vary from family to family and even from individual to individual.

Rather than refer to health care systems as they are differentially construed by individuals, however, I shall present a model of more or less integrated local systems composed of separate sectors, clinical relationships, and roles. According to this model "clinical reality" is differentially construed in these different sectors, roles, and relationships.

In other words, the health care system is created by a collective view and shared pattern of usage operating on a local level, but seen and used somewhat differently by different social groups, families, and individuals. Social factors such as class, education, religious affiliation, ethnicity, occupation, and social network all influence the perception and use of health resources in the same locality and thereby influence the construction of distinctive clinical realities within the same health care system.

Health care systems may be both socially and culturally unified on the local level (e.g., small village in preliterate society), heterogeneous but still integrated (e.g., the illustration from Taipei given at the beginning of this chapter), or multiple and unintegrated in the same locality (e.g., Hispanic-American and Hasidic Jewish groups living in the same urban neighborhood in New York City or middle-class Westerners and lower-class Chinese living in the same neighborhood in Taipei). In the last situation, separate groups may even attend some of the same health facilities. Yet, from the standpoint of how they view and use health care resources, their health care systems would appear to be almost entirely distinct. In developing societies, like Taiwan, rural/urban and social class differences may create multiple and divergent health care systems.

Greater variation tends to occur between localities than within the same locality, but a locality may contain diverse belief systems, clinical roles, and healing traditions. The analytic power of our model of health care systems comes from its association with local environments. It is preferable to think of one health care system in one locality, even when it contains considerably different configurations of social reality.

Systems of health care may differ with respect to many variables, including what falls within their boundaries. Co-existing systems within a society may illustrate the ways that cultural,

historical, socioeconomic, and political factors shape the *content* of health care systems. For example, in the United States, drug abuse and alcoholism only recently have become problems more appropriately managed within health care systems than within legal and ethical systems, where they previously were located. Foucault (1965) has shown how a similar redefinition happened to mental illness over a much longer historical period in the West.

Irving Zola (1972b), a medical sociologist, has argued that modernization carries with it a strong and potentially dangerous tendency to include within the health care system more and more problems traditionally located in other cultural systems. He has referred to this process of redefining social reality and enlarging the social space of health care systems as the progressive medicalization of modern society (see also Illich 1975). This process, he argues, also results in the increasing use of medicine and psychiatry for purposes of social control. This argument asserts that health care systems occupy a larger social space in modern societies than in traditional societies, and that they now perform functions formerly performed by other cultural systems. This hypothesis has not been systematically documented, but it could be validated or falsified by comparative social historical and cross-cultural empirical studies.

This is an instance of the value of the concept of the health care system for comparative research. The chief questions are: How do health care systems differ? How are they alike? Related questions concern: the factors determining those differences and similarities; the nature of the relationship within given systems of illness experiences, practitioner-patient transactions, and healing; and the reciprocal influence of health care systems on their particular social and cultural settings. One interesting question is whether the relative size and salience of health care systems is a function of culture alone. For example, it is my strong impression that health care systems in Chinese culture, independent of particular historical period or contemporary social setting, occupy a relatively much larger space and hold much great salience among their populations than do health care systems in the United States and other Western societies (see Kleinman 1976). Chinese people seem to be much more concerned about questions of health, illness, and health care

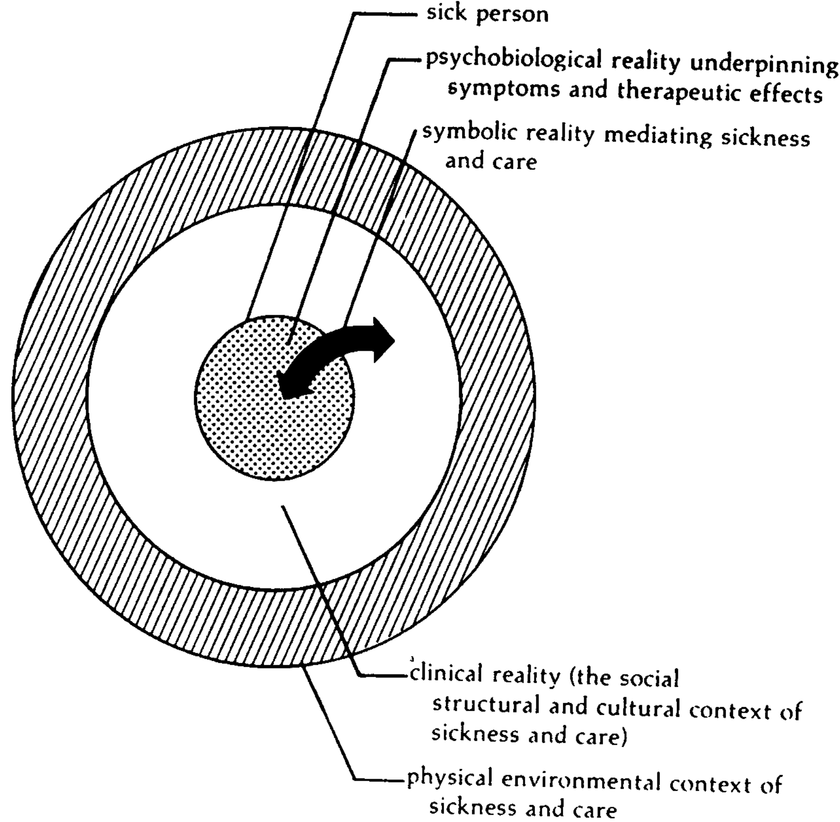
than Americans; and health care systems in Chinese societies seem to possess many more elements and take up more time in the lives of people than do those in our own society. This impression might be treated as a hypothesis to be tested by systematic cross-cultural comparisons. If it was confirmed, Zola's hypothesis would need to be recast in a more complex manner. While the territory under medical control may be increased in contemporary Western societies, that territory may have been reduced in a preceding period with respect to functions that health care systems frequently carry out in traditional societies. In traditional societies, for instance, health care systems may be *the major* mechanism for social control (Cawte 1974).

To return to the main argument, it is worthwhile for analytic purposes to distinguish social reality from: (1) *psychological reality*, the inner-world of the individual; (2) *biological reality*, the infra-structure of organisms, including man; and (3) *physical reality*, the material structures and spaces making up the nonhuman environment. For the purposes of our study, I also will distinguish between two aspects of social reality: (1) the social and cultural world that we have been describing and that I shall refer to as *social reality* per se; and (2) a bridging reality that links the social and cultural world with psychological and biological reality, to which I shall apply the term *symbolic reality*[5] (see Figure 1, p. 28). I have coined a new term, *clinical reality*, to designate the socially constituted contexts that influence illness and clinical care, which I shall describe as consisting principally of social and symbolic reality, but relating as well to psychobiological and physical realities (see Figure 2, p. 42).

Symbolic reality is formed by the individual's acquisition of language and systems of meaning. We know socialization, via the acquisition of language and other symbolic systems, plays a major role in the individual's response to his behavioral field of interpersonal relationships and social situations. But there is much evidence to support the additional thesis that the internalization of symbolic reality, as Mead (1934) long ago suggested, also plays an essential role in the individual's orientation to his own inner-world (Berger 1973; Church 1961;

5. See Kleinman 1973b for a formal philosophical presentation of the concept of symbolic reality in medicine and psychiatry.

Figure 2
Clinical Reality



"Clinical Reality" = The beliefs, expectations, norms, behaviors, and communicative transactions associated with sickness, health care seeking, practitioner-patient relationships, therapeutic activities, and evaluation of outcomes. The *social reality* that expresses and constitutes clinical phenomena and which itself is clinically constructed.

Cicourel 1973). That is, symbolic reality enables individuals to make sense out of their inner experience. It helps shape personal identity in accordance with social and cultural norms. In this view, symbolic meanings influence basic psychological processes, such as attention, state of consciousness, perception, cognition, affect, memory, and motivation. What is much less certain is by what mechanisms symbolic reality, either directly or via its effect on psychological reality, connects the social environment with physiological processes. Much evidence

is now available to suggest that this occurs, but how this happens remains unclear (cf. Kagan and Levi 1974; Mauss 1950; Kiritz and Moos 1974; Teichner 1968; Weiss 1972).[6] Recent evidence further suggests that symbolic reality may also link the physical environment to psychobiological processes (cf. Kiritz and Moos 1974).

In Chapters 4 and 8, I will use the concept of symbolic reality to analyze illness and healing. Here it is enough to underscore the fact that the clinical reality of health care systems is mediated by symbolic reality. Neither health care systems nor their clinical reality can be fully appreciated without examining how this biosocial bridge relates culture, as a system of symbolic meanings, norms, and power, to illness and treatment. An analogy may make this clearer: much as language can be thought of as a cultural system linking thought and action, health care systems can be considered cultural systems linking

6. Various models have been advanced to explain the symbolic connections between social environment and psychophysical processes, including operant conditioning, social learning, information theory, and others (Werner and Kaplan 1967; Platonov 1959; Schmale et al. 1970; Lipowski 1973). However this is accomplished, symbolic reality seems to be able to mediate changes in the social environment affecting the biological substratum of the individual (Kiritz and Moos 1974). Holmes and Rahe (1967) demonstrate this in the way stressful life-events lead to the onset of physical or psychological disorders. Lipowski (1973) indicates that the analysis of the mechanisms involved in the symbolic bridge between psychophysiological processes and environmental stimuli, which lead to psychosomatic and sociosomatic pathology, is one of the chief research quests in the new psychosomatic medicine. Mason's research (1976) already points to the critical involvement of neuroendocrine responses in psychophysiological disorders. Ader and Cohen (1975) have demonstrated that immunological reactions can be behaviorally conditioned. And Fabrega (1973, 1974) has suggested ways by which cultural beliefs may affect these mediating processes. Most recently, discovery of enkephalins and endorphins suggests that endogenous opiates in the brain may function as naturally occurring analgesics with a potentially important role in perception and reaction to pain and in placebo response. It is likely that these factors, triggered by the context of "meaning" established in therapeutic relationships and perhaps also by core symbols in healing rituals, mediate the effects of psychotherapy and other symbolic therapies on psychophysiological pathology (cf. Adler and Hammett 1973; Brody 1977; Frank 1975). Recent research on physiological correlates of biofeedback, meditation, hypnosis, and placebo effects is beginning to tell us more about the mechanisms by which symbolic reality acts as a biosocial bridge linking social and cultural contexts with the sick person and his treatment.

illness and treatment. Both of these cultural systems are forms of symbolic reality. Both are anchored in cultural beliefs and social roles and relationships, as well as in individual behavior and experience. Just as we divide language into distinct structural units—e.g., phonemes, morphemes—which convey meaning and create sanctioned behavioral options (Halliday 1976), so too, health care systems can be divided into interlaced structural components that establish a context of meaning and legitimation within which sickness is labeled and health care-seeking behavior is initiated. In the chapters that follow I will analyze Taiwanese health care systems precisely in these terms.

One aspect of social and symbolic reality requires further attention. Cultural systems are grounded in concepts and sources of legitimated power in society. Glick (1967) hypothesized that knowing a culture's chief sources of power (social, political, mythological, religious, technological, etc.) allows one to predict its beliefs about the causes of illness and how it treats illness. In a metaphorical sense, we can speak of socially legitimated power as the active principle fueling health care systems and of social reality determining what that power is (witchcraft, fortune-telling, science) and how it is to be applied (rituals, injections, psychotherapy), while symbolic reality lays down the pathways by which the application of that power may be effective. In turn, political, socioeconomic, and cultural power will determine which of a number of alternative perspectives on social reality (or alternative social realities) is legitimated (cf. Cohen 1976). For example, when differing views of clinical reality are in conflict, the sources of legitimation and power impinging on the health care system will eventually determine which view prevails, which clinical reality is sanctioned. Hence, such power is responsible for a certain clinical construction of reality. That type of clinical reality, which is culturally fashioned, in turn will have a major effect on the course of illness and treatment, as well as on the behavior of patients and health "professionals." The marginal status given to shamanistic healing in the People's Republic of China and the efforts there to integrate professional Chinese medical and Western medical therapies, the emergence of the peyote cult in Navaho healing as a new source of therapeutic efficacy related to changes in traditional Navaho values, the conflicting

public health approaches in many African societies vis-à-vis indigenous healing systems, the excessive application of hysterectomy and coronary artery bypass surgery in the United States, and the steep rise of consumer dissatisfaction with professional clinical practice in the West and concomitant increase in both demands for changes in the nature of that practice and use of alternative therapeutic systems all reflect the legitimation in those societies of quite different kinds of clinical reality established in quite different socio-political, economic, and cultural contexts. As Giddens (1976) demonstrates, a cultural analysis of any concrete aspect of the social world should attend to the effects produced by the interplay of three types of forces: systems of meaning, norms, *and* power. Surely this also holds for analyzing concrete episodes of sickness and therapy, in which, for example, power differentials in social status are built into the sick role and therapeutic relationships.

Describing the "powers" bearing on health care systems requires an analysis of a number of different *external* factors affecting those systems and the clinical realities they create. Therefore, before we relate social and symbolic reality to the internal structure and core clinical tasks of health care systems, it is necessary to review the external factors that function as important determinants of change. This review should provide a glimpse of the ecology of health care systems.

EXTERNAL INFLUENCES ACTING ON HEALTH CARE SYSTEMS: AN ECOLOGICAL MODEL

Besides culture, other factors shape the configuration of the health care system. These factors can be separated into those that are part of the internal structure of the system (to be discussed in the next section) and those external to it. The external factors include political, economic, social structural, historical, and environmental determinants. They act on or in the local setting of the health care system. Most research on health care has emphasized these factors, but since our orientation is principally concerned with the inner workings of health care systems, I shall only list them. Though they have received a great deal of attention, they are usually not studied in relation to health care as a cultural system or to the inner workings of clinical care.

The environmental determinants include: geography; climate; demography; environmental problems, such as famine, flood, population excess, pollution; agricultural and industrial development; and so forth. In addition, there are local epidemiological patterns of disease (prevalence, attack rates, and virulence of specific disorders) that combine with genetic endowment and susceptibility of the population and specific stressors to influence not only health, but also health beliefs and healing practices. Conversely, as Dunn (1976) argues, health care systems have an effect on these environmental factors. Historians and public health specialists claim that health care has a relatively small impact on populations when compared to major social, economic, nutritional, and other external changes (McKeown 1965). They are probably correct, but we know far too little about what health care systems (especially traditional ones) have accomplished with respect to specific disorders and health maintenance. We do not know whether traditional health practices have had positive effects on public health, since only their negative influences have been documented. For example, health care systems in China in the pre-1949 period were overwhelmed by epidemic diseases, but part of the problem was the general social dislocation of the period that promoted and spread these disorders and disrupted indigenous health care responses. In earlier periods these systems seemed to function more adaptively, though it is doubtful that they ever had much influence on epidemics (see Kleinman 1973c; Kleinman et al. 1976). The reciprocal effect of health care systems on external factors and vice versa is an important one, but it falls outside the scope of this book.

Dunn (1976), a physician-epidemiologist and anthropologist, and Alland (1970), an anthropologist who has written on medical anthropology from an evolutionary perspective, have suggested that medical systems should be evaluated and compared to each other with respect to their ecological success in coping with a variety of external stressors, such as epidemic and endemic diseases. They have argued that such comparisons of the "efficacy" of medical systems should lead to an appreciation of the evolutionary significance of these systems in biological and cultural adaptation. Adair and Deuschle (1970) and McDermott et al. (1972) have described health care systems

of American Indians in the Southwestern United States with respect to the major health problems they have had to respond to, the resources they have had access to, and their success in applying these resources to those problems. These studies also report experiments in changing local health care systems and evaluate the significance of those changes. Here, then, are exercises in the practical ecology of health care systems that differentiate between external and internal factors and demonstrate the differential effect of both on health care practices and outcomes. The complex and disappointing results, especially of McDermott's introduction of technologically advanced Western medical practices into an impoverished Amerindian society, indicate how extremely difficult it is to change these factors systematically and predict the result of those changes. One consequence of this research seems straightforward: just introducing biomedical technology without making needed social, economic, and cultural changes has little, if any, effect on most serious health problems. This highlights the crucial impact that external factors exert on the solution of health problems. Such studies suggest that technological changes alone can improve individual case management without having a major effect on the health of a population and also without improving (and possibly even worsening) the non-technological quality of clinical care. Although these lessons have been repeated throughout the world, they do not seem to have changed the habitual orientation of health planners.

The Chinese case offers numerous examples of the influence of historical (Croizier 1968), political (Oksenberg 1974), and socioeconomic (Wegman, Lin, Purcell 1973) factors, not only on health problems, but also on health care systems. That is, they have been demonstrated to contribute to the distribution of diseases in Chinese populations as well as to the particular beliefs, practices, and institutional arrangements that Chinese communities have elaborated to cope with disease. These influences extend right down to the level of primary care, as will be documented in the chapters that follow. I will attempt to show that the health care systems model enables us to determine how external factors bring about these effects (see also Kleinman 1974b, 1976).

Barefoot doctors; the use of acupuncture anesthesia on a

mass scale; the reported elimination of venereal disease, drug addiction, and starvation; the subordination of professional demands to political control and public interest; and the integration of traditional Chinese-style and modern Western-style doctors' services in local health facilities, which the public apparently can choose to use separately or together, are pertinent examples from the People's Republic of China. We have much to learn about health care systems in the People's Republic, especially what changes have taken place at the level of the inner workings of clinical care, about which we know virtually nothing at present. They may teach us about mechanisms through which small-scale changes in the structure and content of health care systems occur in response to major changes in external factors.

Obviously, external influences on health care systems can be demonstrated in all societies, albeit less dramatically than in the Chinese case or in the infamous instance of the use of psychiatry to control political dissidents in the Soviet Union. In the United States, for example, sociological essays in books edited by Dreitzel (1971), Freidson and Lorber (1972), and Kosa et al. (1969) summarize major social, economic, and historical-political influences on almost all aspects of health care, from professional practices and organizational structures to consumer interests and behaviors. For example, Brenner (1974) has demonstrated convincingly that mental illness is strongly influenced in our society by major socioeconomic changes, as evidenced by the fact that increases in admissions to mental hospitals in the United States have historically correlated most closely with periods of severe economic decline. Navarro (1975, 1976) shows that a Marxist analysis can be applied to medical systems because of the enormous impact these "external" factors exert so as to define better, for example, the way power relationships in capitalist societies simultaneously contribute to inequality in access to and allocation of limited health care resources and to grave socioeconomic and political constraints on the nature and growth of those resources. Whether or not one accepts this line of analysis, awareness of the enormous effect societal-wide forces exert on health care systems is essential if one is to avoid the mistake made by Illich (1975),

among others, in attributing the failures of health care systems solely to the machinations of the medical profession, as if it were able to operate entirely independent of its social and political context. While an ecological perspective on health care systems prevents this type of solecism, it does not resolve the question of how much of their efficacy or failure is constrained from "outside" and how much reflects the autonomy of the system and its components. That conundrum cannot be settled until we examine specific health care systems in concrete situations.

Health care systems are particularly affected by the level of technological and social development, including the status of therapeutic institutions, biomedical technologies, treatment interventions, and professional personnel. These aspects of the modernization of health care systems make them a locus of the tensions accompanying modernization (cf. relevant chapters in Leslie 1976b) and turn our attention from the outside of the system to its interior. Here we part company with most research on health care, since it has tended to stay outside the system itself and to disregard how external factors relate to the inner workings of clinical care, either to facilitate or impede clinical practice. In order to accomplish this shift in orientation, we first must examine the inner structure and core functions of health care systems: What are they? What do they do?

THE INNER STRUCTURE OF HEALTH CARE SYSTEMS

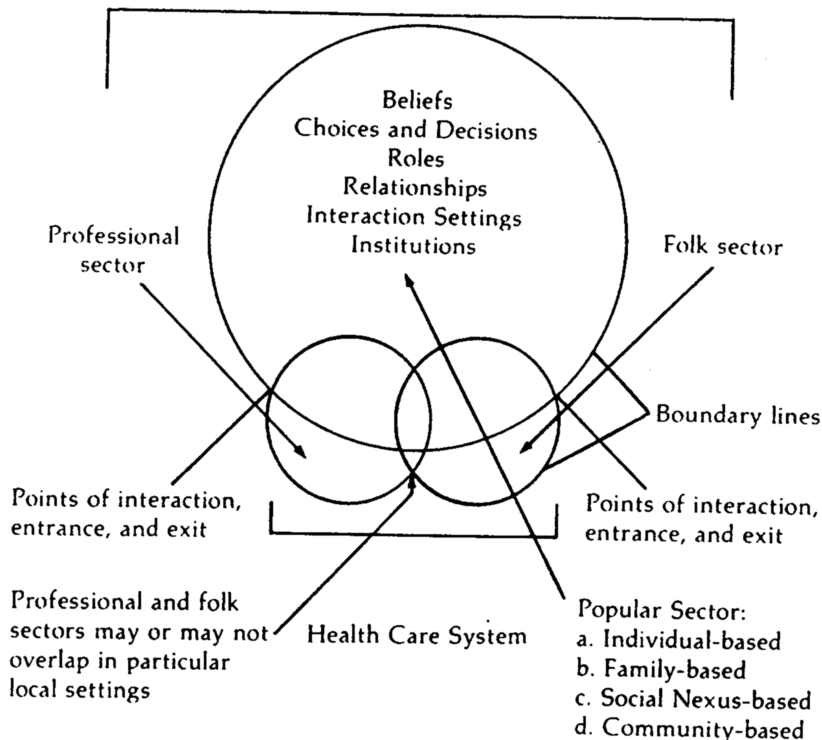
Health care systems are composed of generic as well as particular, "culture-laden" components. The internal structures are roughly the same across cultural boundaries, while the content varies with the social, cultural, and environmental circumstances of each system. The structural model I shall describe can be altered to analyze different cultural and other external conditions. Owing to these conditions, the structure may encompass and even generate distinctive content. The model can be applied to research in developed and developing societies and, especially, to study post-traditional societies that contain both high-order, literate (or classical) and low-order, oral (or folk) indigenous healing traditions. In our model, health care

is described as a *local cultural system composed of three overlapping parts: the popular, professional, and folk sectors* (see Figure 3).

1. *Popular Sector of Health Care*

Although the popular sphere of health care is the largest part of any system, it is the least studied and most poorly understood. It can be thought of as a matrix containing several levels: individual, family, social network, and community beliefs and activities. It is the lay, non-professional, non-specialist, popular culture arena in which illness is first defined and health care activities initiated. In the United States and Taiwan, roughly 70 to 90 percent of all illness episodes are managed within the popular sector (Hulka et al. 1972; Kleinman 1975a, 1975b; White et al. 1961; Zola 1972b, 1973). When people resort to folk or professional practitioners, their choices are anchored in the cognitive and value orientations of the popular culture.

Figure 3
Local Health Care System: Internal Structure



After patients receive treatment, they return to the popular sector to evaluate it and decide what to do next. The popular sector is the nexus of the boundaries between the different sectors; it contains the points of entrance into, exit from, and interaction between the different sectors. The popular sector interacts with each of the other sectors, whereas they frequently are isolated from each other. The customary view is that professionals organize health care for lay people. But typically lay people activate their health care by deciding when and whom to consult; whether or not to comply; when to switch between treatment alternatives, whether care is effective, and whether they are satisfied with its quality. In this sense, the popular sector functions as the chief source and most immediate determinant of care.

Anthropological and cross-cultural studies in medicine and psychiatry have been slow to examine this central part of the health care system (Chrisman 1977). Medical sociology has just begun to conduct sophisticated analyses of family-based health care, but these are limited largely to research on families in the United States and Western Europe (Litman 1974; Mauksch 1974). In cross-cultural studies, the popular sector has received far less attention than the usually more dramatic and exotic, but less important, folk healing traditions. The popular sector is excluded from most studies dealing with "indigenous" healing traditions, yet ironically it is for almost all societies *the* most active and widely used indigenous healing tradition. Self-treatment by the individual and family is the first therapeutic intervention resorted to by most people across a wide range of cultures. This is only one of the essential activities taking place in the popular sector (and especially within the family). The relative inattention given to this sector is responsible in part for the fact that so much past work in medical anthropology and cross-cultural medicine and psychiatry has been irrelevant to practical issues in health care.

In the popular sector, individuals first encounter disease in the family. We can think of the following steps occuring, at least initially: perceiving and experiencing symptoms; labeling and valuating the disease; sanctioning a particular kind of sick role (acute, chronic, impaired, medical, or psychiatric, etc.); deciding what to do and engaging in specific health care-

seeking behavior; applying treatment; and evaluating the effect of self-treatment and therapy obtained from other sectors of the health care system. The sick person and his family utilize beliefs and values about illness that are part of the cognitive structure of the popular culture. The decisions they make cover a range of possible alternatives. The family can disregard signs of illness by considering them to be ordinary or "natural," or they can validate the sick person's sick role. They can institute therapy with treatment modalities known to them, or they can consult with friends, neighbors, relatives, and lay experts about what to do. Should they decide to move outside the popular sector, which frequently means going beyond the physical as well as the health care boundaries of the family, other alternatives must be considered. They can enter professional or folk sectors and within each can choose among a range of treatment alternatives (cf. McKinlay 1973; Zola 1972a, 1972c, 1973).

Once people decide to enter either the professional or folk sector, they encounter different sets of beliefs and values in the cognitive structures of professional or folk practitioners. They make these encounters in the process of entering and exiting from healing agencies. The clinical realities of the different sectors and their components differ considerably. Popular, professional, and folk cultures and their subcultural components shape the illness and therapeutic experiences in distinct ways. But the power to create illness and treatment as social phenomena, to legitimate a certain construction of reality as the *only* clinical reality, is not equally distributed. The professional sector is paramount because social power is in large part a function of institutionalization, and the professional sector is heavily institutionalized (cf. Lee 1976) whereas the popular sector is diffused.

An individual is a "sick family member" in one setting, a "patient" in another, and a "client" in yet another context (cf. Fox 1968; Siegler and Osmond 1973; Twaddle 1972). In each setting, his illness is perceived, labeled, and interpreted, and a special form of care is applied. Each arena has entrance and exit roles and rules. For example, the sick person enters the modern professional medical sector by establishing his patienthood in a clinic or hospital. Similarly, in the family or folk arenas, he must receive sanction from others for a particular

type of sick role. He may claim and be given an acute, chronic, or impaired role, or he and those around him may disagree about the character of his sick role. He also will exit from the modern professional medical sector in a particular manner, as one who has been cured, remains ill, or is dying.

The sick person encounters different medical languages as he moves between the health care system's sectors (cf. Cassell 1976; Quesada 1976). He must translate from one language to another. Much of this book focuses on that process of translation, since it is crucial in the interaction between patients and practitioners, in the process of healing, and in the creation and resolution of communication problems that are "endemic" to clinical care. In the next chapter, I shall describe and illustrate a framework for conceptualizing the cognitive and communicative structures found in the symbolic space of patient-practitioner relationships, but already we see the outline of a central hermeneutic problem in clinical transactions: there are different interpretations of clinical reality reflecting different systems of meanings, norms, and power. In this sense, each of the health care system's sectors can be supposed a separate "culture."

Before turning from the popular sector, it is important to emphasize that most of it is not preoccupied with sickness and care but with "health" and "health maintenance." Just as the popular sector has not received its due from medical anthropologists, so too its preventive and health maintenance functions have been neglected. For instance, in Chinese culture we know much less about beliefs regarding health (*chien-k'ang*) and health maintenance (*wei-sheng*) practices than we know about sickness beliefs and treatment practices, yet most observers would concur the former take up more of the time and expenditure of families than do the latter. The increasing concern among social scientists and public health experts with self-care and the family context of prevention should remedy this oversight (cf. Dunn 1976; Zola 1972a).

2. *Professional Sector of Health Care*

A second sector of local health care systems is the professional sector, comprising the organized healing professions. In most societies, this is simply modern scientific medicine.

But in certain societies, e.g., Chinese and Indian societies, there are also professionalized indigenous medical systems: traditional Chinese medicine and Ayurvedic medicine, respectively (Croizier 1968; Leslie 1976a). In both of these societies, as well as in certain Muslim countries possessing Galenic-Arabic medicine (see Verma and Keswani 1975), the classical indigenous healing traditions have professionalized along lines similar to those of the modern medical profession.

In the United States, Freidson (1970) has succinctly described how the modern medical profession (allopathic medicine), using legal and political means, gained professional dominance in the health care field by forcing all other healing traditions to disband, submit to its professional control, or retreat into the quasi-legal folk fringe. Professional organization became a source of social power. For example, homeopathy and certain other non-professional healing traditions, which competed for patients with the modern medical profession well into the twentieth century, were eventually driven from the field, especially after the Flexner Report in 1910. Osteopathy at first was treated in this way but later gained a professional foothold, owing to its popular appeal in certain sections of the United States and its success in creating a professional organization. Recently, it has largely been absorbed into professional medicine. Chiropractic has remained a marginal practice but with too many adherents to be abolished. Naturopathy maintains an even more precarious existence. Pharmacy and nursing, severely restricted in practice, received professional status only by submitting to the authority of the medical profession. Indeed, Freidson claims they are virtually the only examples of professions that lack full autonomy.

In recent years technological advances and prolific medical subspecialization have combined to create many other health professions in the United States, all licensed as subsidiary, para-professional organizations functioning under medical hegemony and severely restricted in scope of practice. As recent studies show, however, the battle for professional independence is still going on: chiropractic (Kane et al. 1974) and certain of the non-medical ocular specialties (Shaver 1974) even seem to be making something of a comeback. In certain instances they have been shown to be as effective as and more

popular with health consumers than physicians treating the same problems. Increasing clinical responsibilities assumed by nursing practitioners and medical assistants give additional evidence of the changing character of the professional sector in the United States. Such changes are the result, not simply of pressures from within this particular sector itself, but also from the lay sector (health consumers) and from external political and economic forces in American society (White 1973).

Just as each sector of the health care system creates its own clinical reality, so too do the different healing professions (professional subsectors). These can vary greatly, as in the Chinese or Indian cases, or only minimally, as with certain paraprofessional and alternative professional medical organizations in technologically advanced societies. Within the professional sector, furthermore, institutional structure helps determine clinical reality. In America, chiropractic's clinical reality matched the beliefs, values, and life-style of mid-Western farm life and flourished in that particular environment (McCorkle 1961). Likewise, psychoanalysis flourished in the United States within a special social group attracted to the ideas and therapeutic approach of Freud and his followers: urban middle-class intellectuals (Roazen 1971).

Although studies comparing the modern medical profession in different societies are now common, one rarely sees studies that specifically look at differences in their clinical realities. This is equally true of research on the modern medical profession in our own society. Little attention has been devoted to differences in the cognitive and communicative processes, texture of relationships, and treatment styles of modern professional health services in urban or rural, inner city or suburban, public clinic or private office, fee-for-service or health-insurance medical settings. Yet these clinical aspects of social reality are significant criteria for judging differences that really matter in clinical care, differences that reflect social structural and economic contingencies of practice in home, market-place, and bureaucracy. I will have a good deal more to say on this question.

One of the more important insights into the professional sector of health care illuminated by cross-cultural research is the process of "indigenization." By this term is meant changes that modern professional medicine and psychiatry undergo after

they are introduced into non-Western societies. These changes involve the system of knowledge, health care institutions, and all the factors encompassed by the term "clinical reality." The result is the cultural re-patterning of professional clinical care to a greater or lesser degree. When I discuss Western-style medicine in Chinese culture in Chapter 8, I shall give examples of this process, which is a concomitant of modernization and Westernization. The health care systems developed over the past several decades in the People's Republic of China represent a unique form of medicine, which in part involves the indigenization of the professional sector. From the standpoint of clinical reality, indigenization transforms an essentially Western orientation into one more appropriate (even if frequently not appropriate enough) to the particular social conditions of non-Western cultures.[7] Many more problems for clinical care seem to result from insufficient indigenization than from too much of it. A related process is "popularization," by which certain aspects of professional care, such as scientific health concepts, are altered and diffused after they enter the popular health sector. This process will concern us later in this chapter and in the next.

So dominant has the modern medical profession become in the health care systems of most societies (developing and developed) that studies of health care often equate modern medicine with the entire system of health care; such studies become mere accounts of professional medical organizational structures and services, leaving out the rest of the health care system (Dreitzel 1971). Research by physicians and public health personnel, in most instances, is systematically limited to problem-frames defined by biomedicine; the solutions offered fit professionally sanctioned solution-frames and are evaluated only from that standpoint. Such researchers are unaware of their bias, since they are trained to see all of health care through the cognitive framework of their profession. Professional socialization of modern health professionals causes them

7. In a recent book, edited by Charles Leslie (1976b), containing essays on the varied experiences of Asian nations in the health field, examples of indigenization are frequent, sometimes amusing, but almost always important. Morita therapy represents indigenization of modern psychotherapy in Japan (see Reynolds 1976).

to regard their own notions as rational and to consider those of patients, the lay public, and other professional and folk practitioners as irrational and "unscientific." As Polanyi and Prosch (1975) argue, implicit concepts determine what will be considered "data," the analysis of which, not too surprisingly, supports the professional orientation like a self-fulfilling prophecy.

It is amazing to see how intensely this professional ideology is held by otherwise sensitive and responsible health professionals. It is maintained with blind conviction even in the face of evidence to the contrary. Other components of this professional ideology are such commonly encountered dogmas as: Any health-related activities undertaken by patients themselves or by members of the other sectors of the system are dangerous and should not be tolerated. The biological aspects of medical problems are the "real" ones, while the psychosocial and cultural aspects are second order phenomena and are thus less "real" and important. The encounter between doctors and patients (and families) is one between experts and those who are ignorant, so that the doctor's role is to "tell" or give orders to patients, and the patient's role is to listen passively and comply. Closely related is the professional bias that the doctor (or other health professional) is most responsible for the patient's care. Lack of compliance with the medical regimen is frequently regarded from the professionals' perspective as a moral offense (Stimson 1974). This view is not only found in those areas of the world where the medical profession does in fact control the health care system. It also is espoused by doctors in societies where most health care outside of the family in fact is in the hands of alternative professional and folk healers.

In the People's Republic of China, several decades of political indoctrination against the primacy of expert knowledge (and interests) over popular knowledge (and interests) apparently was insufficient to break the dominance of this professional ideology among health workers, since the public health establishment and the modern medical profession were criticized repeatedly for precisely this during the Cultural Revolution (Oksenberg 1974). Only very recently in the West have consumers spoken out against the loss of their autonomy in primary health care decisions to the modern professional medical leviathan. In technologically advanced societies especially, there

has been a general shrinking of popular autonomy, as more and more of its traditional functions have been usurped. Indeed, progressive medicalization has enlarged primarily the professional health sector of modern society.

One of the major contributions anthropologists and sociologists have made is to demonstrate repeatedly that the health care system is a great deal wider than the boundaries of the modern medical profession, even in technologically advanced societies. They also have shown how the locus of responsibility for health care decisions is beginning to shift from patients and families to health professionals (Zola 1972a, 1972b). These studies support the conclusion that the professional sector requires that its form of clinical reality be accepted as the only legitimate clinical reality. Health professionals usually are insensitive to the views of clinical reality held by other healers, and to the expectations and beliefs of their patients. This insensitivity is systematically fostered in both undergraduate and postgraduate medical education. The increasingly strident polemics of social scientists against the medical and psychiatric professions are one result of the conspicuous inattention of those professions to the lay public's viewpoint. When such arguments surface in the medical profession itself, they are met with considerable resistance. The most difficult aspect of clinical practice to teach to medical students, interns, and residents is how to elicit and evaluate objectively patient beliefs and values with respect to their illnesses and treatments and to negotiate with (or translate between) these differing perspectives in the same way an advisor gives expert advice to an advisee, who retains the right to accept, alter, or reject that advice. It is difficult to challenge the clinical reality imposed on patients by medical professionals or to get them to view it as not the "only" or "true" one, but as one among a range of clinical realities operating in the greater health care system. Especially difficult for medical and psychiatric professionals is juxtaposing their diagnostic and treatment formulations with those of their patients. Thus, one of the most significant contributions of the cross-cultural perspective is to foster a broadly based view of the entire health care system. It makes the researcher increasingly skeptical about the normative perspective on health care entailed by the socially constructed biomedical professional

ideology. It highlights terms like "compliance" and "denial" as value judgments dictated by the medical profession. Knowledge about the extent of self-treatment, the impact of the family on care, the role of the individual's values in determining satisfaction, and the activities of alternative professional and folk practitioners, taken together with knowledge of the impact of external factors on health care systems and their variation across societal boundaries, can be sobering. Cross-cultural studies can play an essential role in opening the eyes of health professionals and the public to these other sides of medicine.

3. *Folk Sector of Health Care*

The folk (non-professional, non-bureaucratic, specialist) sector shades into the other two sectors of the local health care system. Folk medicine is a mixture of many different components; some are closely related to the professional sector, but most are related to the popular sector. In those societies lacking professionalization, the folk sector and the popular sector constitute the entire health care system. Folk medicine is frequently classified into sacred and secular parts, but this division is often blurred in practice, and the two usually overlap. Early students of medicine in different cultures stressed sacred healing, since their interest emerged from studies of folk religion. Shamanism and ritual curing have continued to hold the attention of anthropologists up to the present. Far less attention has been given to the mundane secular forms of healing: herbalism, traditional surgical and manipulative treatments, special systems of exercise, and symbolic non-sacred healing. Recent ethnographies have begun to turn to these other traditions, but the ethnographic literature still remains heavily weighted toward sacred healing. Within medical anthropology more attention is being given to folk medicine as part of a broader health care system, but ethnographic descriptions based on this wider perspective are only now being written.

The efficacy of folk healing presents a serious question for cross-cultural clinical research. Virtually no systematic follow-up studies of patients treated by folk healers exist, with careful evaluation of their status before and after treatment. Similarly, almost no empirical work has been done on the mechanisms of folk healing although this subject has attracted considerable

speculation. In Chapter 9 I shall present field research findings that go beyond anecdote and speculation to throw new light on this problem. That data includes a prospective study with follow-up of patients treated by shamans in Taipei, as well as individual case studies and follow-up of patients treated by other folk healers in Taiwan. I will use this material to compare folk healing with other forms of healing and to discuss the healing process generally.

The many new forms of folk psychotherapies in the contemporary Western world, linked to the popular culture and to a recrudescence of traditional healing in these societies, and the persistence or even increase of folk healers in some developing societies indicate the significant function of folk medicine in many parts of the world. This phenomenon creates a difficult question for professionals and for society generally: what to do about folk practitioners in planning for health care. This question will be dealt with when we discuss the concrete situation of folk practitioners in contemporary Taiwan.

The structural components of health care systems—the three sectors introduced above—primarily interact because patients pass between them. The popular sector forms an undifferentiated matrix linking the more highly differentiated professional and folk sectors. The boundary lines between sectors function as points of entrance and exit for patients who follow the trajectories of their illnesses through the intricacies of the health care system. Before examining the distinct social worlds created by these differing sectors, I shall illustrate the model by analyzing the Taiwanese health care system described at the beginning of the first chapter.

HEALTH CARE SYSTEMS IN A CONTEMPORARY CHINESE SOCIETY: TAIWAN, AN OVERVIEW

The phenomenological fragment presented in the Prologue is part of a local system in urban Taiwan. But it is a quite special instance, for it records a tremendous concentration of health care components in a small geographical space. In other sections of Taipei and in other cities in Taiwan, the same components (and many others besides) are dispersed in a much larger area.

Instead of viewing the various health-related phenomena

described in the Prologue atomistically, our model helps us recognize an integral system.[8] It pictures elements of the professional, folk, and popular sectors. The professional sector is represented by the Chinese-style and Western-style practitioners, along with the Chinese and Western pharmacies. Here we have, side-by-side and intermingled, the elements of two completely different professional systems. Western-style and Chinese-style doctors have separate licensing procedures, practitioner associations, and bureaucratic organizational structures. They have their own clinics, hospitals, and pharmacies. These two professional subsectors maintain a competitive relationship, with little or no referral and other connections between them; in the People's Republic, they are said to be integrated by active referral, professional consultation, combined treatment, and even an attempt at sharing (to some degree) knowledge and skills.

The *Western medical profession* in Taiwan controls most of the power. It alone receives financial support from the state and is represented in the national and local government. The National Health Service, Provincial Department of Health, and municipal health departments are composed entirely of Western-style doctors (*hsi-i-sheng*) and other modern health professionals and have a structure indistinguishable from parallel organizations in the West. But there are distinct levels within the profession. At the top is the National Taiwan University School of Medicine and Hospital in Taipei. This institution is comparable to university medical centers in the United States. Although the clinical reality created there resembles that found in academic medical settings in the West, there are still some major differences: Families can and usually do stay with hospitalized patients in order to cook, nurse, and sleep near them at night. There are no appointment times in public or private clinics, including psychiatry clinics. Payment is made primarily for treatment received and hardly at all for the time the doctor spends taking a history or doing an examination.

8. A recent volume I edited (Kleinman et al. 1976) examines in detail the various aspects of health care systems in Taiwan and other contemporary Chinese societies. The interested reader is referred to the relevant chapters in that source for a fuller picture of health care systems in Chinese societies, since covering the same ground here is not feasible.

These and other practices make expectations and valuations of clinical care quite different from those in university hospitals in the United States.

The private practice of Western medicine in Taiwan varies enormously. Some practitioners function on the same level as the university hospital medical staff. Other physicians were inadequately trained in China prior to 1949 at third-rate (in some cases bogus) schools, or have received minimal training in the military or under the Japanese occupation. In addition to doctors, nurses and biomedical technicians have been trained as they are in the United States. Pharmacists form an especially important professional group, since they often provide primary care. Also, many unlicensed doctors practice illegally and, until quite recently, were tolerated by the authorities.

Chinese-style doctors (*chung-i-sheng*) vary even more in background and quality. Some have graduated from schools of Chinese medicine on the mainland before 1949 or from the China Medical College in Taichung, Taiwan. The latter is an unusual institution that teaches both Chinese and Western medicine; its graduates can be licensed in either one or both but usually practice only Western medicine. Most Chinese-style doctors study in a master-disciple relationship, which is the way Chinese medicine was taught over the centuries in China. They may, and often do, study very different books and are exposed to idiosyncratic teachings or different "schools" via the oral tradition. Their educational, social, and economic backgrounds are quite dissimilar. Some practice entirely along traditional lines, while others have self-consciously modernized their ideas and practices. Within this profession, acupuncture is frequently practiced as a separate specialty; its status is greatly enhanced by its new popularity in China and the West. There are also many part-time, unlicensed practitioners of Chinese medicine. Every educated Chinese in the past is said to have read some of the classical texts in order to treat certain illnesses for family members, neighbors, and friends. In present day Taiwan, education is in modern subjects rather than classical Chinese subjects, and educated people tend to know more about Western than Chinese medicine. But older people often possess some knowledge and skills to diagnose and to prescribe Chinese medicaments. Such knowledge, usu-

ally kept secret (i.e., not shared outside the family or social network), is considered to be an important family heritage. Skills of this sort are part of the family-based popular culture, separate from the practice of Chinese medicine as a profession.

The Chinese medical profession in Taiwan has benefited from unprecedented development in the past five years, owing to the worldwide interest in Chinese medicine. The number of candidates studying for and taking the licensing examinations in Chinese medicine is said to have increased considerably.[9] The fees for drugs and acupuncture have climbed steeply. Foreigners visit Taiwan to receive instruction or treatment in Chinese medicine, and well-known Chinese-style doctors have traveled to the United States and Europe to teach and practice. Chinese herbal medicines are now widely distributed throughout Asia and the West, though they still trail acupuncture in popularity. Chinese medicine, furthermore, is receiving much more attention in the mass media in response to public interest. Chinese-style doctors are pushing for government financial support, which they have never had in Taiwan, and, in general, have become much more active in asserting their professional status. As in the past (Croizier 1968), they claim a special cultural and national identity as the only indigenous medical profession in Chinese society.

Bone-setters (*chieh-ku shih-fu*) represent a case that illumines the boundaries of professional medicine and its relation to the other sectors of the health care system. They are not considered to be Chinese-style doctors by lay people or by Chinese-style practitioners. They are regulated by the government as if they were an entirely separate licensed profession, even though they maintain virtually no professional organizational structure. Except for a few who are also Chinese-style doctors, bone-setters do not enjoy the social standing of Chinese-style doctors. The situation is confused by the fact that some bone-setters practice folk healing, including fortune-telling and shamanism. This reflects the competitive, commercial nature of healing in Taiwan and the overlap between the sectors of the health care system. Bone-setters are so specialized and nu-

9. Personal communication from the President, Chinese Doctors' Association, Taipei, April, 1975.

merous that, while their skill is highly valued and the public makes routine use of it, each one tends to attract only limited numbers of patients. To increase their earnings, many do other things besides bone-setting. Some run businesses or function in other capacities that have nothing whatsoever to do with medicine; others practice other forms of healing to attract a larger clientele. Most bone-setters I interviewed regarded themselves as part of the professional health care sector, separate from and admittedly less prestigious than Chinese-style doctors. On the other hand, many Chinese-style doctors looked "down" upon this specialty as part of the folk system of care. Bone-setters need not take qualifying examinations and frequently have had limited training from books. Here is a peculiarity of health care in Taiwan, since bone-setting in traditional China was one of the techniques used by physicians, along with herbalism and acupuncture, within the same theoretical framework. Yet, even in traditional China, bone-setting seems to have been practiced occasionally as an independent specialty, along with other specialities in the unmarked borderland between folk and professional medicine.

In contrast to Taiwan, bone-setters in Hong Kong have a higher status than physicians who employ herbs or acupuncture (Lee 1976), and in the People's Republic of China the techniques for setting fractures are said to be a major contribution of traditional medicine to health care. In Taiwan, although bone-setters are not licensed to practice as physicians, many of them also treat arthritis, low back pain, and skin disorders. Thus, their practice overlaps that of physicians.

Bone-setting and the specialized treatment of hemorrhoids, other proctological problems, and skin disorders belong to the "external" branch of Chinese medicine (*wai-k'e*), which traditionally classified health problems and therapeutic practices into "external" and "internal" (*nei-k'e*) branches. The "external" specialities (whose name in Chinese is used to designate modern surgery) have a marginal professional status, though some Chinese-style doctors still practice them. In the poorer areas of Taipei bone-setters outnumber Chinese-style physicians, and in education, income, and life-style, they are more like their lower-class clients than the wealthier, better educated physicians.

Herbalists provide another borderline case between the professional and folk sectors of health care. Unlike bone-setters, they are not licensed and are, therefore, illegal practitioners. Until 1975 they were tolerated by the health officials, but since then the government has begun to arrest some unlicensed practitioners. Such actions have occurred before without affecting this category of practitioners, so that it is unclear what will result from the current policy. Government officials and modern medical professionals call all non-Western practitioners "herbalists," which they use pejoratively.

Herbalists diagnose and prescribe as well as sell herbs, unlike Chinese pharmacists who are licensed solely to prepare and dispense Chinese medicine, although they, too, often prescribe. Few herbalists have formally studied traditional Chinese medicine; many are illiterate or barely literate and unable to read the texts; almost all have learned their occupation as a family trade or as apprentices in the shops of other herbalists. In this last respect, they are not unlike Chinese-style doctors. Both possess "secret knowledge," reputed to be passed from generation to generation and jealously guarded from outsiders. Medicine was a hereditary profession in ancient China, and most traditional practitioners today claim family practitioners in at least three preceding generations. But lay people and health professionals frequently regard herbalists merely as proprietors of small shops rather than practitioners. They have no occupational associations and do not belong to the sacred tradition of folk medicine. They are part of the secular folk tradition but reject classification with other folk practitioners.

Both cases—herbalists and bone-setters—illustrate the importance of the boundary between professional and nonprofessional practice. On the professional side of the boundary, practitioners generally are of higher social status, earn higher incomes, have their interests represented by associations, and possess some kind of professional organization. They are licensed by the government and are concerned about controlling the entrance of practitioners into their sector. These two examples, however, demonstrate that the essential differences are government recognition of professional organization or the general social recognition of a kind of practice as "professional." This is further evidenced by the fact that unlicensed

Chinese-style and Western-style practitioners enjoy a "professional" image in the eyes of lay people and many fellow practitioners, even though their practice is illegal and they do not belong to professional associations.

The *folk* sector of medical practice is more heterogeneous than professional medicine. Herbalists belong to the secular tradition, while Taoist priests, shamans, ritual specialists in "calling back the soul," and temple-based interpreters of *ch'ien* belong to the sacred tradition. But the division is not clear-cut. For example, *tâng-kis* (shamans) while in a state of possession commonly prescribe Chinese medicine or local herbs. Fortune-tellers, astrologers, physiognomists, and geomancers are more difficult to characterize. They are non-professional specialists who participate in healing and whose systems of beliefs involve some of the oldest and most classical Chinese theories. Not uncommonly, they practice just outside the doors of temples. Although it is usual to classify them as secular healers, some make use of religious beliefs and paraphernalia. Those who divine by means of the eight characters (*pa tzu*) designating a person's time of birth and the related *pa kua* (Eight Diagrams or Trigrams from the *I Ching*) often work closely with nearby temples, telling clients which ceremonies they should have performed. The ideas they work with, while not usually including gods and ghosts, nonetheless belong to the Chinese religious tradition. But the popular culture differentiates between them and temple-based practitioners as if they were secular. Geomancers in fact are regarded as akin to "scientists," and geomancy is frequently referred to as "Chinese science." Since one of the key uses of divination is to help patients choose a particular treatment and practitioner, diviners play an important part in determining the hierarchy of resort in local health care systems.

The folk tradition also contains an assortment of other practitioners, many of whom are itinerant or part-time and some of whom are commonly found in market towns or traveling between festivals in rural areas. These include itinerant drug peddlers who also prescribe herbs and patent medicine, unlicensed specialists in particular diseases such as skin and eye disorders, teachers and practitioners of a variety of minor therapeutic techniques—massage, breathing exercises, systems of

calisthenics (e.g., *t'ai chi ch'uan*). These individuals sometimes combine healing functions with circus-like performances and with business practices. In some towns, one sees them lined up at night along market streets, healing, selling, and entertaining. Moreover, some folk practitioners, such as local or family experts, traditional midwives, and the like, function largely in the popular sector and shade into popular health care. Indeed, these examples illustrate that a too simple classificatory use of the distinction between folk and popular sectors is not useful.

In addition to these folk practitioners, a wide range of businesses also claim a therapeutic function. These include the tea shops and food and drink vendors pictured in the Prologue, as well as snake shops where live snakes (poisonous and non-poisonous) are kept and used to treat skin and eye disorders, sexual problems (especially impotence), and other sicknesses. In these shops, the healing function is only one of a number of money-making activities. For example, in snake shops wines containing pickled snakes are sold to treat illness or for their reputed cosmetic effects; purses and wallets made of snake skin are sold at another counter; snake food is sold as both a medicinal agent and a culinary delicacy. In tea stores, the healing power attributed to some teas accounts for a very small part of their business. This is not at all to say that the business activities of these stores distinguish them from the rest of the health care system. It is obvious that all components of the professional and folk sectors (including the religious sector) are competing in a special field of commercial life, and financial matters, as we shall see, also play an important role in the popular sector.

The unclear and overlapping relationships between various activities subsumed under the title "folk healing practice in Taiwan" are illustrated by a middle-aged owner of a small store in a traditional Taiwanese section of Taipei (Yen-Ping District). The store sells both Western and Chinese patent medicine along with local herbs, but it is not a Chinese or a Western pharmacy, nor is it an herbalist's shop. It is licensed as a drug store in which no prescription medicines can be sold. The owner is himself a Taoist priest and a shaman (*tâng-ki*). His shrine takes up more than half of his store. His calling card

states that he treats problems relating to bad fate and ghosts, geomantic questions, mental illness, and other illnesses that are "not cured by doctors." He also has a special office behind his shop and shrine where he and his wife practice bone-setting.

The *popular sector* of our Taipei health care system is represented by the people in the market street seeking to buy tonics, herbs, and foods believed to be symbolically "hot" or "cold." Self-treatment by individuals and families with foods and Western and Chinese medicines is by far the most common treatment in Taiwan. In a survey of illness episodes suffered during a one-month period by members of 115 Taiwanese families in Taipei, for example, 93 percent of these episodes were first treated at home, and 73 percent received their only treatment there (see Chapter 6 for a report of this survey). Lee (1976) similarly has found extensive resort to self-treatment in Hong Kong.

The sick individual or his family decide which type of practitioner to go to. Family, neighbors, or friends frequently accompany the sick person to consult a practitioner. Most families we interviewed saw themselves, rather than the government, the practitioners consulted, or the sick person himself, as most responsible for making decisions about health care and for assuring that the patient was adequately treated. This is a view supported by most indigenous practitioners I interviewed and even by many public health workers. Families develop criteria for when to use certain types of practitioners, and when to seek help from others. Since individuals can purchase from pharmacies virtually any Western or Chinese medicine they desire, they can prescribe and treat themselves with a wide variety of agents. This makes lay people considerably more autonomous in controlling their health care in Taiwan than in societies like the United States, Great Britain and the Soviet Union, where there is stricter enforcement of the laws that regulate medical practice and drug sales.

Many Chinese families claim to possess some "secret knowledge" or special herbs for treating particular illnesses. This knowledge frequently is quite different from that of the classical medical texts, although it is derived from that source. Nowadays, the health beliefs of families and communities in

Taiwan contain many notions from modern scientific medicine as well. What I am describing is a separate domain of medical knowledge belonging to the popular sector of health care systems and derived from the classical Chinese medical tradition, Chinese folk healing traditions, and more and more from Western medicine, psychiatry, and public health. This popular cognitive domain is the focus of discussion in the next chapter.

In studies conducted in fishing and rice-farming villages in Taiwan, I found that the popular sector frequently could be equated with the extended family, lineage, or even the entire village community. In urban areas, sick individuals, who often lived in nuclear families, turned to friends and co-workers much more often than to the extended family or community for advice and referral. Therefore, in talking about the popular sector it is essential to define the level: individual, family, social network, or community. Ethnicity, social class, and education also exert important influences on popular care.

Just as our structural model can be applied to the Chinese health care system, it also can be applied to studies of health care in other societies.[10] For example, Boston not only has easily identified institutions and practitioners of modern professional medicine, but also possesses chiropractors, podiatrists, and various licensed eye specialists who are not part of the medical profession but form alternative health professions. Christian Science healers, scientology practitioners, and a myriad of practitioners of popular forms of psychotherapy, so conspicuous in the area around Harvard Square in Cambridge, including non-licensed practitioners of various forms of meditation and occult religious practices, form a well-advertised folk healing sector. But this sector also includes people who specialize in healing herbs, massage, sexual therapies, and many other therapeutic practices. Indeed, folk healing in urban America is undergoing something of a renaissance. Furthermore, the popular sector of health care in Boston is still central

10. For example, the model of the health care system seems applicable to the following ethnographic reports of medical systems: Adair and Deuschle (1970), Fabrega and Manning (1973), Good (1976), Gould (1965), Ingham (1970), Kunstadter (1976), Leslie (1976), Obeyesekere (1976), Press (1969), Spiro (1967), and Wolf (1965). The model seems to hold for the United States as well (cf. Freidson 1970; Harwood 1971; Saunders 1954; Snow 1974).

in determining when and where a patient seeks care, and how he complies with and evaluates that care (Kleinman 1975a), despite the fact this is no more accorded "official" recognition by most medical professionals and public health planners in the United States than in Taiwan. The chief differences between this American example and the Chinese case are that the choices open to Americans have been greatly narrowed and the boundaries between the sectors of American health care systems are more sharply defined, largely owing to the laws regulating health care in the United States. Thus, Chinese residents of Boston's Chinatown, though they hold many traditional views about illness (Gaw 1976), do not have recourse to shamans or other sacred Chinese folk practitioners, who are not available in the United States, nor can they make as full use of drugs because of stricter laws covering prescription of medicinal agents. But their health care system can be readily described in terms of our model, where the popular cultural sector shows a fascinating mixture of both Chinese and American components.

Thus far I have described and drawn upon the Taiwanese example to illustrate the morphology of health care systems. Now I will turn to their clinical activities.

Bibliography

Aberle, D.F.
1966. Religio-magical phenomena and power, prediction, and control. *Southwestern Journal of Anthropology* 22:221–230.

Adair, J. and Deuschle, K.
1970. *The People's Health: Medicine and Anthropology in a Navaho Community*. New York: Appleton-Century-Crofts.

Ader, R., and Cohen, N.
1975. Behaviorally conditioned immunosuppression. *Psychosomatic Medicine* 37:333–340.

Adler, H.M. and Hammett, V.B.O.
1973. The doctor-patient relationship revisited: An analysis of the placebo effect. *Annals of Internal Medicine* 78:595–598.

Agren, H.
1976. Patterns of tradition and modernization in contemporary Chinese medicine. In A. Kleinman et al., eds., *Medicine in Chinese Cultures*, Washington, D.C.: U.S.G.P.O. for Fogarty International Center, N.I.H.; pp. 37–60.

Ahern, E.
1976. Sacred and secular medicine in a Taiwan village: A study of cosmological disorder. In *ibid.*; pp. 91–114.

Alland, A.
1970. *Adaptation in Cultural Evolution: An Approach to Medical Anthropology*. New York: Columbia University Press.

Anderson, E. and Anderson, M.
1968. Folk medicine in Hong Kong. *Etnoiatria* 2:22–35.

Apple, D.
1960. How laymen define illness. *Journal of Health and Human Behavior* 1:219–225.

Baker, T.D. and Perlman M.
1967. *Health Manpower in a Developing Economy: Taiwan, a Case Study in Planning*. Baltimore: The Johns Hopkins University Press.

Balint, Michael
1957. *The Doctor, His Patient, and the Illness*. New York: International Universities Press.

Barclay, T.
1923. *Supplement to Carstair Douglas's Dictionary of the Vernacular or Spoken Language of Amoy*. Shanghai: Commercial Press.

Beck, A.
1971. Cognition, affect and psychopathology. *Archives of General Psychiatry* 24:495–500.

Beidelman, T.
1966. Swazi royal ritual. *Africa* 36:373–405.

Benveniste, E.
1945. La doctrine medicale des Indo-Européens. *Revue de L'histoire des Religions* 130:5.

Berger, P.L.
1973. Identity as a problem in the sociology of knowledge. In G.W. Remmling, ed., *Towards the Sociology of Knowledge*. New York: Humanities Press, pp. 273–284.

Berger, P.L. and Luckmann, T.
1967. *The Social Construction of Reality*. Garden City, New York: Doubleday.

Berger, P. et al.
1973. *The Homeless Mind: Modernization and Consciousness*. New York: Random House.

Berlin, B. et al.
1973. General principles of classification and nomenclature in folk biology. *American Anthropologist* 75:214–242.

Bernstein, B.
1971. *Class, Codes and Control*. London: Routledge and Kegan Paul.

Blacking, John, ed.
1977. *The Anthropology of the Body*. New York: Academic Press.

Bowers, J., ed.
1974. *Medicine and Society in China*. New York: Josiah Macy, Jr. Foundation.

Brenner, M.H.
1974. *Mental Illness and the Economy*. Cambridge, Mass.: Harvard University Press.

Brody, H.
1977. "Persons and Placebos: Philosophical Implications of the Placebo Effect." Ph.D. dissertation, Department of Philosophy, Michigan State University.

Campbell, J.D.
1975. Attribution of illness: Another double standard. *Journal of Health and Social Behavior* 16:114–126.

Carr, J.
1978. Ethno-behaviorism and culture bound syndromes: The case of Amok. *Culture, Medicine and Psychiatry* 22:269–293.

Cartwright, A.
1964. *Human Relations and Hospital Care*. London: Routledge and Kegan Paul.

Cassell, E.J.
1976. Disease as an "it": Concepts of disease revealed by patients' presentation of symptoms. *Social Science and Medicine* 10:143–146.

Caudill, W. and Lin, T.Y., eds.
1969. *Mental Health Research in Asia and the Pacific*, Volume 1. Honolulu: East-West Center Press.

Cawte, J.E.
1974. *Medicine is the Law: Studies in Psychiatric Anthropology of Australian Tribal Societies*. Honolulu: University of Hawaii Press.

Cay, E.L. et al.
1975. Patient assessment of the result of surgery for peptic ulcer. *Lancet* 1:29–31.

Chang, Y.H., Rin, H., and Chen, C.C.
1975. Frigophobia: A report of five cases. *Bulletin of the Chinese Society of Neurology and Psychiatry* 1(2): 13.

Chessick, R.
1969. *How Psychotherapy Heals*. New York: Science House.

Chiang, Y.
1952. *A Chinese Childhood*. New York: Day.

Chin, R. and Chin, A.L.
1969. *Psychological Research in Communist China, 1949–1966*. Cambridge, Mass.: M.I.T. Press.

Chrisman, N.
1977. The health seeking process. *Culture, Medicine and Psychiatry* 1:351–378.

Church, J.
1961. *Language and the Discovery of Reality*. New York: Random House.

Cicourel, A.V.
1973. *Cognitive Sociology*. Baltimore: Penguin.

Clements, F.E.
1932. *Primitive concepts of disease*. University of California Publications in American Archaeology and Ethnology 32:185–252.

Cohen, A.
1976. *Two-Dimensional Man: An Essay on the Anthropology of Power and Symbolism in Complex Society*. Berkeley: University of California Press.

Colson, A.C.
1971. The differential use of medical resources in developing countries. *Journal of Health and Social Behavior* 12:226–237.

Crick, M.
1976. *Explorations in Language and Meaning: Towards a Semantic Anthropology*. New York: Halstead Press.

Croizier, R.
1968. *Traditional Medicine in Modern China*. Cambridge, Mass.: Harvard University Press.

Currier, R.L.
1966. The hot-cold syndrome and symbolic balance in Mexican and Spanish folk medicine. *Ethnology* 5:251–263.

D'Andrade, R.
1976. A propositional analysis of U.S. American beliefs about illness. In K. Basso and H. Selby, eds., *Meaning in Anthropology*. Albuquerque, New Mexico: University of New Mexico Press, pp. 155–180.

Davis, M.
1968. Variations in patients' compliance with doctors' advice. *American Journal of Public Health* 58:274–288.

DeGroot, J.J.M.
1972. (1890–1910) *The Religious System of China.* Volume VI, Book II, Part V: *The Priesthood of Animism.* Taipei: Ch'eng Wen Publishing Co., pp. 1187–1340.

Doi, L.T.
1962. *Amae*—a key concept for understanding Japanese personality structure. In R. J. Smith and R.K. Beardsley, eds., *Japanese Culture.* Chicago: Aldine.

Douglas, C.
1899. (1873) *Dictionary of the Vernacular or Spoken Language of Amoy* (new edition). London: Presbyterian Church of England.

Douglas, M.
1970. The healing rite. *Man* 5:302–308.

Dreitzel, H.P., ed.
1971. *The Social Organization of Health.* Recent Sociology No. 3. New York: Macmillan.

Dubos, R.
1952. *The White Plague: Tuberculosis, Man, and Society.* Boston: Little, Brown.

Dull, J.
1976. Implications of Chinese history for comparative studies of medicine in society. In Kleinman et al., eds., *Medicine in Chinese Cultures,* op.cit.; pp. 669–678.

Dunn, F.L.
1976. Traditional Asian medicine and cosmopolitan medicine as adaptive systems. In C. Leslie, ed., *Asian Medical Systems.* Berkeley: University of California Press, pp. 133–158.

Edgerton, R.B. and Karno, M.
1971. Mexican-American bilingualism and the perception of mental illness. *Archives of General Psychiatry* 24:286–290.

Eisenberg, L.
1976. Conceptual models of physical and mental disorders. In *Research and Medical Practice* (Ciba Foundation Symposium #44). Amsterdam: Associated Scientific Publishers, pp. 3–23.
1977. Psychiatry and society: A sociobiological synthesis. *New England Journal of Medicine* 296:903–910.

Elder, R.
1973. Social class and lay explanations of the etiology of arthritis. *Journal of Health and Social Behavior* 14:28–35.

Elliott, A.
1955. *Chinese Spirit-Mediums in Singapore.* London: London School of Economics Monographs.

Emerson, J.
1970. Behavior in private places: Sustaining definitions of reality in gynecological examinations. In H.P. Dreitzel, ed., *Patterns of

Communicative Behavior. Recent Sociology, No. 2. New York: Macmillan, pp. 73–100.

Engel, G.L.
1977. The need for a new medical model: A challenge for biomedicine. *Science* 196:129–136.

Engelhardt, H.T.
1974. Explanatory models in medicine. *Texas Reports in Biology and Medicine* 32:225–239.

Erasmus, C.J.
1952. Changing folk beliefs and the relativity of empirical knowledge. *Southwestern Journal of Anthropology* 8:411–428.

Evans-Pritchard, E.E.
1937. *Witchcraft, Oracles, and Magic Among the Azande.* London: Oxford University Press.

Fabrega, H.
1971. Some features of Zinacantecan medical knowledge. *Ethnology* 9:25–43.
1972. The study of disease in relation to culture. *Behavioral Science* 17:183–203.
1974. *Disease and Social Behavior: An Interdisciplinary Perspective.* Cambridge, Mass.: M.I.T. Press.
1976. The function of medical-care systems: A logical analysis. *Perspectives in Biology and Medicine* 20:108–119.

Fabrega, H. and Manning, P.K.
1973. An integrated theory of disease: Ladino-Mestizo views of disease in the Chiapas Highlands. *Psychosomatic Medicine* 35:223–239.

Fabrega, H. and Silver, D.
1973. *Illness and Shamanistic Curing in Zinacantan: An Ethnomedical Analysis.* Stanford: Stanford University Press.

Field, M.G.
1973. The concept of the "health system" at the macro-sociological level. *Social Science and Medicine* 7:763–785.
1976. Comparative sociological perspectives on health systems: Notes on a conceptual approach. In Kleinman et al., eds., *Medicine in Chinese Cultures, op.cit.,* pp. 567–587.

Foucault, M.
1965. *Madness and Civilization.* New York: Mentor.
1973. *The Birth of the Clinic: An Archaeology of Medical Perception.* New York: Random House.

Fox, R.
1968. Illness. In D. Sills, ed., *International Encyclopedia of the Social Sciences,* Volume 7. New York: Macmillan, pp. 90–96.

Frake, C.O.
1961. The diagnosis of disease among the Subanun of Mindanao. *American Anthropologist* 63:113–132.

Frank, J.
1974a. (1961) *Persuasion and Healing.* New York: Schocken.

1974b. Therapeutic components of psychotherapy. *Journal of Nervous and Mental Disease* 159:325–342.
1975. Psychotherapy of bodily disease. *Psychotherapy and Psychosomatics* 26:192–202.

Freidson, E.
1961. *Patients' Views of Medical Practice.* New York: Russell Sage Foundation.
1970. *Profession of Medicine: A Study of the Sociology of Applied Knowledge.* New York: Harper and Row.

Freidson, E. and Lorber, J., eds.
1972. *Medical Men and Their Work.* Chicago: Aldine.

Gale, J.L.
1976. Patient and practitioner attitudes toward traditional and Western medicine in a contemporary Chinese setting. In Kleinman et al., eds., *Medicine in Chinese Cultures, op.cit.*, pp. 195–208.

Gallin, B.
1966. *Hsin Hsing, Taiwan: A Chinese Village in Change.* Berkeley: University of California Press.

Gaw, A.C.
1976. An integrated approach in the delivery of health care to a Chinese community in America: The Boston experience. In A. Kleinman et al., eds., *Medicine in Chinese Cultures,* op.cit., pp. 327–350.

Geertz,H.
1968. *Latah* in Java: A theoretical paradox. *Indonesia* 5:93–104.

Geertz, C.
1973. Thick description: Toward an interpretive theory of culture. *The Interpretation of Cultures.* New York: Basic Books, pp. 3–32.

Giddens, A.
1976. *New Rules of Sociological Method: A Positive Critique of Interpretative Sociologies.* New York: Basic Books.

Glick, L.B.
1967. Medicine as an ethnographic category: The Gimi of the New Guinea highlands. *Ethnology* 6:31–56.

Gonzalez, N.
1966. Health behavior in cross-cultural perspective: A Guatemalan example. *Human Organization* 25:122–125.

Good, B.
1976. Medical change and the doctor-patient relationship in an Iranian provincial town. In K. Farmafarmaian, ed., *The Social Sciences and Problems of Development.* Princeton, New Jersey: Princeton University Press, pp. 244–260.
1977. The heart of what's the matter: The semantics of illness in Iran. *Culture, Medicine, and Psychiatry* 1:25–58.

Goody, J. and Watt, I.
1963. The consequences of literacy. *Comparative Studies in Society and History* 5:304–345.

Gould, H.A.
1965. Modern medicine and folk cognition in rural India. *Human Organization* 24:201–208.

Gould-Martin, K.
1976. Medical systems in a Taiwan village: *Ong-ia-kong,* the plague god as modern physician. In A. Kleinman et al, eds., *Medicine in Chinese Cultures, op.cit.*, pp. 115–142.

Gove, W., ed.
1975. *The Labelling of Deviance.* New York: Wiley.

Gunderson, J. and Singer, M.
1975. Defining borderline patients. *American Journal of Psychiatry* 132: 1–10.

Gussow, Z. and Tracy, G.S.
1970. Stigma and the leprosy phenomenon: The social history of a disease in the nineteenth and twentieth centuries. *Bulletin of the History of Medicine* 44:425–449.

Halliday, M.A.K.
1976. *Explorations in the Functions of Language.* London: Edward Arnold. (1973)

Hallowell, A.I.
1955. *Culture and Experience.* Philadelphia: University of Pennsylvania Press.
1963. Ojibwa world view and disease. In I. Galdston, ed., *Man's Image in Medicine and Anthropology.* New York: International Universities Press.

Harwood, A.
1971. The hot-cold theory of disease: Implications for treatment of Puerto Rican patients. *Journal of the American Medical Association* 216:1153–1158.
1977. Puerto Rican spiritism: Description and analysis of an alternative psychotherapeutic approach. *Culture, Medicine and Psychiatry* 1:22–48; 135–154.

Health Statistics
1974. *Republic of China, Vol. 1: General Health Statistics, 1974.* National Health Administration, Taiwan Provincial Health Department, and Taipei City Health Department.

Helman, C.G.
1978. "Feed a cold, starve a fever"—Folk models of infection in an English suburban community and their relation to medical treatment. *Culture, Medicine and Psychiatry* 2:107–138.

Holmes, T. and Rahe, R.
1967. The social readjustment rating scale. *Journal of Psychosomatic Research* 11:213–218.

Holzner, B.
1968. *Reality Construction in Society.* Cambridge, Mass.: Schenkman Publishing Co.

Horton, R.
1967. African traditional thought and Western science, 1. *Africa* 37:50–71.

Hsu, F.L.K.
1949. Suppression versus repression: A limited psychological interpretation of four cultures. *Psychiatry* 12:223–242.
1971a. Eros, affect and *pao.* In F.L.K. Hsu, ed., *Kinship and Culture.* Chicago: Aldine, pp. 439–475.
1971b. Psychosocial homeostasis and *Jen:* Conceptual tools for advancing psychological anthropology. *American Anthropologist* 73:23–44.

Hsu, J. and Tseng, H.S.
1972. Intercultural psychotherapy. *Archives of General Psychiatry* 27:700–705.

Hsu, J.
1976. Counseling in the Chinese temple: A psychological study of divination by *chien* drawing. In W. P. Lebra, ed., *Culture-Bound Syndromes, Ethnopsychiatry, and Alternate Therapies.* Honolulu: University Press of Hawaii, 1976, pp. 210–221.

Hu, H.C.
1944. The Chinese concept of face. *American Anthropologist* 46:45–64.

Hughes, C.
1968. Ethnomedicine. In D. Sills, ed., International Encyclopedia of the Social Sciences, Volume 10. New York: Macmillan, pp. 87–92.

Hulka, B.S., et al.
1972. Determinants of physician utilization. *Medical Care* 10:300–309.

Hwu, H.G.
1975. *Doctor and Patient.* Taipei: Hsing Wen Publishing Co. (In Chinese).

Illich, I.
1975. *Medical Nemesis: The Expropriation of Health.* London: Calder & Boyars.

Ingham, J.M.
1970. On Mexican folk medicine. *American Anthropologist* 72:76–87.

Inui, T. et al.
1976. Improved outcomes in hypertension after physician tutorials. *Annals of Internal Medicine* 84:646–651.

Jansen, G.
1973. *The Doctor-Patient Relationship in an African Tribal Society.* Assen, Holland: Van Gorcum.

Janzen, J.
1977. "The comparative study of medical systems as changing social systems." Paper presented at the Conference on Theoretical Foundations for the Comparative Study of Medical Systems, National Science Foundation, Washington, D.C., November 21–23, 1976. *Social Science and Medicine* 12(2B):121–130, 1978.

Jordan, D.
1972. *Gods, Ghosts and Ancestors: Folk Religion in a Taiwanese Village.* Berkeley: University of California Press.

Kagan, A. and Levi, L.
1974. Health and environment—psychosocial stimuli: A review. *Social Science and Medicine* 8:225–241.

Kane, R. et al.
1974. Manipulating the patient: A comparison of the effectiveness of physicians and chiropractic care. *Lancet* 1:1333–1336.

Kaplan, B. and Johnson, D.
1964. The social meaning of Navaho psychopathology and psychotherapy. In A. Kiev, ed., *Magic, Faith and Healing.* New York: Free Press, pp. 203–229.

Kennedy, D.
1973. Perceptions of illness and healing. *Social Science and Medicine* 7:787–806.

Kerr, G.
1965. *Taiwan Betrayed.* Boston: Houghton Mifflin.
1974. *Formosa: Licensed Revolution and the Home Rule Movement, 1895–1945.* Honolulu: The University Press of Hawaii.

Kiev, A., ed.
1964. *Magic, Faith and Healing.* New York: Free Press.

Kingston, M.H.
1977. *The Woman Warrior.* New York: Knopf.

Kiritz, S. and Moos, R.
1974. Physiological effects of social environments. *Psychosomatic Medicine* 36:96–114.

Kleinman, A.
1973a. Toward a comparative study of medical systems. *Science, Medicine and Man* 1:55–65.
1973b. Medicine's symbolic reality. *Inquiry* 16:206–213.
1973c. The background and development of public health in China: An exploratory essay. In M.E. Wegman et al., eds., *Public Health in the People's Republic of China.* New York: Josiah Macy, Jr. Foundation, pp. 5–25.
1973d. Some issues for a comparative study of medical healing. *International Journal of Social Psychiatry* 19:159–165.
1974a. Cognitive structures of traditional medical systems. *Ethnomedicine* 3:27–49.
1974b. A comparative cross-cultural model for studying health care in China. *Studies in Comparative Communism* 7:414–419.
1975a. Explanatory models in health care relationships. *National Council for International Health: Health of the Family.* Washington, D.C.: National Council for International Health, pp. 159–172.
1975b. Medical and psychiatric anthropology and the study of traditional medicine in modern Chinese culture. *Journal of the Institute of Ethnology, Academica Sinica* 39:107–123.
1975c. Cross-cultural studies of illness and health care: A preliminary report. *Bulletin of the Chinese Society of Neurology and Psychiatry* 1(2): 14–18.

1975d. The symbolic context of Chinese medicine. *American Journal of Chinese Medicine* 3:1–25, 1975.
1976. Social, cultural, and historical themes in the study of medicine and psychiatry in Chinese societies. In A. Kleinman et al., eds., *Medicine in Chinese Cultures, op.cit.*, pp. 589–658.
1977a. Depression, somatization and the new cross-cultural psychiatry. *Social Science and Medicine* 11:3–10.
1977b. "Concepts and a model for the comparison of medical systems as cultural systems." Paper presented to the Conference on Theoretical Foundations for the Comparative Study of Medical Systems, National Science Foundation, Washington, D.C., November 20–22, 1976. *Social Science and Medicine* 12(2B):85–94, 1978.
1977c. Comparisons of practitioner-patient interactions in Taiwan: The cultural construction of clinical reality. In A. Kleinman et al., eds., *Culture and Healing in Asian Societies: Anthropological, Psychiatric and Public Health Studies.* Cambridge, Mass.: Schenkman Publishing Co, pp. 329–374.
1977d. Lessons from a clinical approach to medical anthropology. *Medical Anthropology Newsletter* 8(4):11–15.
1977e. Rethinking the social and cultural context of psychopathology and psychiatric care. In T. Manschreck and A. Kleinman, eds., *Renewal in Psychiatry: A Critical Rational Perspective.* Washington, D.C.: Hemisphere Publishing Co., pp. 97–138.

Kleinman, A. et al., eds.
1976. *Medicine in Chinese Cultures: Comparative Studies of Health Care in Chinese and Other Societies.* Washington, D.C.: U.S. Government Printing Office for Fogarty International Center, N.I.H., DHEW Publication No. (N.I.H.) 75-653. Stock No. 017-053-00036. (Note: Although this book carries a 1975 publication date, it was not released until summer, 1976, and therefore the latter date is used throughout the present volume.)

Kleinman, A. and Sung, L.H.
1976. "Why do indigenous practitioners successfully heal? A follow-up study of indigenous practice in Taiwan." Paper presented at the workshop on the healing process, Michigan State University, April 8–10, 1976, to be published with the proceedings of the workshop in *Social Science and Medicine.*

Kleinman, A. and Mendelsohn, E.
In press. Systems of medical knowledge: A comparative approach. *Journal of Medicine and Philosophy.*

Kleinman, A., Eisenberg, L., and Good, B.
1978. Culture, illness and care: Clinical lessons from anthropological and cross-cultural research. *Annals of Internal Medicine* 88:251–258.

Ko, Y.H.
1973. Birth order and psychological needs. *Acta Psychologica Taiwanica* 15:68–80
1974. A study on the effects of psychotherapy. *ibid.* 16:141–154.

Koo, L.C.
1976. "Nourishment of Life: The Culture of Health in Traditional Chinese Society." Ph.D. dissertation, Department of Anthropology, University of California, Berkeley.

Kosa, J. et al., eds.
1969. *Poverty and Health: A Sociological Analysis.* Cambridge, Mass.: Harvard University Press.

Kuhn, T.S.
1970. (1962) *The Structure of Scientific Revolutions.* Chicago: University of Chicago Press.

Kunstadter, P.
1976a. Do cultural differences make any difference? Choice points in medical systems available in northwestern Thailand. In Kleinman et al., eds., *Medicine in Chinese Cultures, op.cit.*, pp. 351–384.
1976b. The comparative anthropological study of medical systems in society. In *ibid.*, pp. 683–696.

Lain-Entralgo, P.
1970. *The Therapy of the Word in Classical Antiquity.* New Haven: Yale University Press.

Lambo, T.A.
1969. Traditional African cultures and Western medicine. In F. Poynter, ed., *Medicine and Culture.* London: Wellcome Institute Publications.

Lamson, H.
1935. *Social Pathology in China.* Shanghai: Commercial Press.

Langness, L.L.
1967. Hysterical psychosis: The cross-cultural evidence. *American Journal of Psychiatry* 124:143–152.

Lazare, A.
1973. Hidden conceptual models in clinical psychiatry. *New England Journal of Medicine* 288:345–350.

Lazare, A. et al.
1975. The customer approach to patienthood. *Archives of General Psychiatry* 32:553–558.

Lebra, W.P., ed.
1976. Culture-Bound Syndromes, Ethnopsychiatry, and Alternate Therapies, Volume IV. *Mental Health Research in Asia and the Pacific.* Honolulu: University Press of Hawaii.

Lee, R.P.L.
1976. Interaction between Chinese and Western medicine in Hong Kong: Modernization and Professional Inequality. In Kleinman et al., eds., *Medicine in Chinese Cultures, op.cit.*, pp. 219–240.

Leff, J.
1977. Cross-cultural studies of emotions. *Culture, Medicine and Psychiatry* 1: 317–350.

Leighton, A. et al.
1968. The therapeutic process in cross-cultural perspective. *American Journal of Psychiatry* 124:1171–1183.

Leslie, C.
1974. The modernization of Asian medical systems. In J. Poggie and R. Lynch, eds., *Rethinking Modernization: Anthropological Perspectives.* Westport, Conn.: Greenwood Press.
1976a. The ambiguities of medical revivalism in modern India. In C. Leslie, ed., *Asian Medical Systems.* Berkeley: University of California Press, pp. 356–367.

Leslie, C., ed.
1976b. *Asian Medical Systems.* Berkeley: University of California Press.

Lewis, G.
1975. *Knowledge of Illness in a Sepik Society.* London: Athlone Press.

Lewis, I.M.
1971. *Ecstatic Religion: An Anthropological Study of Spirit Possession and Shamanism.* Harmondsworth, Middlesex, England: Penguin.

Levi, L., ed.
1971. *Society, Stress and Disease.* London: Oxford University Press.

Levy, R.
1973. *Tahitians: Mind and Experience in the Society Islands.* Chicago: University of Chicago Press.

Li, Y.Y.
1972. "Shamanism in Taiwan: An Anthropological Inquiry." Paper presented at the Fourth Conference on Culture and Mental Health in Asia and the Pacific, East-West Center. Reprinted in W.P. Lebra, ed., *Culture-Bound Syndromes, Ethnopsychiatry, and Alternative Therapies, op.cit.*, pp. 179–188.

Li, Y.Y. and Yang, K.S., eds.
1974. *The Character of the Chinese: An Interdisciplinary Study.* Nankang, Taipei: Institute of Ethnology, Academica Sinica. (In Chinese).

Lieban, R.W.
1977. The field of medical anthropology. In D. Landy, ed., *Culture Disease, and Healing: Studies in Medical Anthropology.* New York: Macmillan, pp. 13–30.

Lin, T.Y.
1953. Anthropological study of the incidence of mental disorder in Chinese and other cultures. *Psychiatry* 16:313–336.

Lin, T.Y. et al.
1969. Mental disorders in Taiwan, 15 years later. In W. Caudill and T.Y. Lin, eds., *Mental Health Research in Asia and the Pacific, op.cit.*, pp. 61–91.

Lin, T.Y. and Lin, M.C.
1977. "Ethnicity and pathways of patients seeking treatment." Unpublished manuscript.

Lin, T.Y. et al.
1978. Ethnicity and patterns of help-seeking. *Culture, Medicine and Psychiatry* 2:3–14.

Lipowski, Z.J.
1969. Psychosocial aspects of disease. *Annals of Internal Medicine* 71:1197–1206.

1973. Psychosomatic medicine in a changing society: Some current trends in theory and research. *Comprehensive Psychiatry* 14:203–215.
1977. Psychosomatic medicine in the seventies: An overview. *American Journal of Psychiatry* 134:233–244.

Litman, T.J.
1974. The family as a basic unit in health and medical care: A sociobehavioral overview. *Social Science and Medicine* 8:495–519.

Litman, T. and Robins, L.
1971. Comparative analyses of health care systems—a sociopolitical approach. *Social Science and Medicine* 5:573–581.

Liu, C.W.
1974. *Essays on Chinese Folk Beliefs and Folk Cults.* Monograph No. 22. Nankang, Taipei: Institute of Ethnology, Academica Sinica. (In Chinese.)
1975. The world of the divining youth. *Ethnos in Asia* 3:56–67. (In Japanese.)

Loudon, J.B.
1976. Introduction. In J.B. Loudon, ed., *Social Anthropology and Medicine.* New York: Academic Press, pp. 1–48.

Luborsky, L. et al.
1975. Comparative studies of psychotherapy: Is it true that "everyone has won and all must have prizes?" *Archives of General Psychiatry* 32:995–1008.

Mabry, J.
1964. Lay concepts of etiology. *Journal of Chronic Disease* 17:371–386.

Marsella, A.J.
1977. Depressive experience and disorder across cultures. In H. Triandis and J. Draguns, eds., *Handbook of Cross-Cultural Psychology, Volume 5: Culture and Psychopathology.* Boston: Allyn and Bacon, pp. 30–72.
In press. "Towards a conceptual framework for understanding cross-cultural variations in depressive affect and disorder." Paper delivered to the seminar on psychocultural aspects of ethnicity, School of International Studies, University of Washington, April 18, 1978. To be published in the seminar proceedings.

Mason, J.W.
1976. Emotion as reflected in patterns of endocrine integration. In L. Levi, ed., *Emotions: Their Parameters and Measurement.* New York: Raven Press, pp. 143–181.

Mathews, R.H.
1963. *Mathews' Chinese-English Dictionary.* Cambridge, Mass.: Harvard University Press.

Mauksch, H.O.
1974. A social science basis for conceptualizing family health. *Social Science and Medicine* 8:521–528.

Mauss, M.
1950. Les techniques du corps. In M. Mauss, *Sociologie et Anthropologie*. Paris: Presses Universitaires de France.

McCorkle, T.
1961. Chiropractic: A deviant theory of disease. *Human Organization* 20:20–22.

McCreery, J.L.
1978. Potential and effective meaning in therapeutic ritual. *Culture, Medicine and Psychiatry* 2(4), in press.

McDermott, W. et al.
1972. Health care experiment in Many Farms. *Science* 175:23–28.

McKeown, T.
1965. *Medicine in Modern Society*. London: George Allen and Unwin.

McKinlay, J.
1973. Social networks, lay consultation and help-seeking behavior. *Social Forces* 51:275–285.

Mead, G.H.
1934. *Mind, Self and Society*. Chicago: University of Chicago Press.

Mechanic, D.
1962. The concept of illness behavior. *Journal of Chronic Diseases* 15:189–194.
1972. Social psychological factors affecting the presentation of bodily complaints. *New England Journal of Medicine* 286:1132–1139.

Mendelsohn, E.
1976. Comparative studies in science and medicine. In Kleinman et al., eds., *Medicine in Chinese Cultures, op.cit.*, pp. 659–667.

Messing, S.
1968. Interdigitation of mystical and physical healing in Ethiopia: Toward a theory of medical anthropology. *Behavioral Science Notes* 3:87–104.

Metzger, D. and Williams, G.
1963. Tenejapa medicine 1: The curer. *Southwestern Journal of Anthropology* 19:216–234.

Metzger, T.A.
1977. *Escape From Predicament: Neo-Confucianism and China's Evolving Political Culture*. New York: Columbia University Press.

Meyer, B.F. and Wempe, T.F.
1947. *The Student's Cantonese-English Dictionary*. New York: Field Afar Press.

Mitchell, W.E.
1977. Changing others: The anthropological study of therapeutic systems. *Medical Anthroplogy Newsletter* 8(3):15–20.

Montgomery, E.
1976. Systems and the medical practitioners of a Tamil town. In C. Leslie, ed., *Asian Medical Systems, op.cit.*, pp. 272–284.

Meyers, J.T.
1974. *A Chinese Spirit-Medium Temple in Kwun Tong*. Hong Kong: Social Research Centre, Chinese University of Hong Kong.

Nakamura, H.
1960. *The Ways of Thinking of Eastern Peoples*. Tokyo: Printing Bureau, Ministry of Finance, pp. 167–226.

Nash, J.
1967. The logic of behavior: Curing in a Maya Indian town. *Human Organization* 26:132–140.

Navarro, V.
1975. The industrialization of fetishism or the fetishism of industrialization: A critique of Ivan Illich. *Social Science and Medicine* 9:351–363.
1976. Social class, political power and state, and their implications in medicine. *Social Science and Medicine* 10:437–458.

Neutra, R. et al.
1977. Cultural expectations versus reality in Navajo seizure patterns and sick roles. *Culture, Medicine and Psychiatry* 1:255–276.

Newman, P.
1964. "Wild man" behavior in a New Guinea Highlands community. *American Anthropologist* 66:1–19.

Nida, E.
1974. *Toward a Science of Translating*. Leiden: Brill.

Obeyesekere, G.
1976a. The impact of Ayurvedic ideas on the culture and the individual in Sri Lanka. In C. Leslie, ed., *Asian Medical Systems. op.cit.*, pp. 201–226.
1976b. Some comments on the nature of traditional medical systems. In A. Kleinman et al., eds., *Medicine in Chinese Cultures, op.cit.*, pp. 419–426.

Oksenberg, M.
1974. The Chinese policy process and the public health issue: An arena approach. *Studies in Comparative Communism* 7:375–408.

Park, G.
1974. *The Idea of Social Structure*. New York: Anchor Books.

Paul, B.D., ed.
1955. *Health, Culture, and Community*. New York: Russell Sage Foundation.

Pickering, G.
1974. *Creative Malady*. London: George Allen and Unwin.

Platonov, K.
1959. *The Word as a Physiological and Therapeutic Factor*. Moscow: Foreign Languages Publications House.

Polanyi, M. and Prosch, H.
1975. *Meaning*. Chicago: University of Chicago Press, pp. 22–45.

Polgar, S.
1962. Health and human behavior: Areas of interest common to the social and medical sciences. *Current Anthropology* 3:159–205.

Porkert, M.
1974. *The Theoretical Foundations of Chinese Medicine: Systems of Correspondances*. Cambridge, Mass.: M.I.T. Press.

1976. The dilemma of present-day interpretations of Chinese medicine. In A. Kleinman, ed., *Medicine in Chinese Cultures, op.cit,* pp.61–70.

Potter, J.
1970. Wind, water, bones and souls: The religious world of the Cantonese peasant. *Journal of Oriental Studies* (Hong Kong University) 8:139–153.

Pouillon, J.
1972 Doctor and patient: Same and/or other? In W. Munsterberger and A. Esman, eds., *The Psychoanalytic Study of Society,* Volume 5. New York: International Universities Press.

Press, I.
1969. Urban illness: Physicians, curers, and dual use in Bogota. *Journal of Health and Social Behavior* 10:209–218.

Public Health in Taipei
1973. Taipei: Taipei City Health Department.

Quesada, G.M.
1976. Language and communication barriers for health delivery to a minority group. *Social Science and Medicine* 10:323–327.

Reynolds, D.
1976. *Morita Psychotherapy.* Berkeley: University of California Press.

Rin, H.
1965. A study of the aetiology of koro in respect to the Chinese concept of illness. *International Journal of Social Psychiatry* 11:7–13.

Rin, H. et al.
1962. A study of the content of delusions and hallucinations manifested by the Chinese paranoid psychotics. *Journal of the Formosa Medical Association* 61:46–57.

Rin, H. et al.
1966. Psychophysiological reactions of rural and suburban populations in Taiwan. *Acta Psychiatrica Scandinavica* 42:410–473.

Rivers, W. H. R.
1924. *Medicine, Magic and Religion.* New York: Harcourt and Brace.

Roazen, P.
1971. *Freud and His Followers.* New York: Knopf.

Rogers, C.
1951. *Client-Centered Therapy.* Boston: Houghton Mifflin.

Rosaldo, M.
1972. Metaphors and folk classification. *Southwestern Journal of Anthropology* 28:83–99.

Rosen, G.
1975. Nostalgia: A "forgotten" psychological disorder. *Psychological Medicine* 5:340–354.

Rothman, D.J.
1971. *The Discovery of the Asylum: Social Order and Disorder in the New Republic.* Boston: Little, Brown.

Rubel, A.
1964. The epidemiology of a folk illness: Susto in Hispanic America. *Ethnology* 3:268–283.

Sartorius, N. and Jablensky, A.
1976. Transcultural studies of schizophrenia. *WHO Chronicle* 30:481–485.

Saunders, L.
1954. *Cultural Difference and Medical Care: The Case of Spanish-Speaking People of the Southwest.* New York: Russell Sage Foundation.

Schmale, A. et al.
1970. Current concepts of psychosomatic medicine. In O. Hill, ed., *Modern Trends in Psychosomatic Medicine II.* New York: Appleton-Century-Crofts.

Schutz, A.
1970. *On Phenomenology and Social Relations.* Chicago: University of Chicago Press.

Schwartz, L.R.
1969. The hierarchy of resort in curative practices: The Admiralty Islands, Melanesia. *Journal of Health and Social Behavior* 10:201–209.

Seijas, H.
1973. An approach to the study of medical aspects of culture. *Current Anthroplogy* 14:544–545.

Shapin, S.
1977. Scientific states of mind. *Times Literary Supplement* (London), May 20, 1977, p. 613.

Shaver, D.
1974. Opticiancy, optometry and ophthalmology. *Medical Care* 12:754–765.

Shryock, R.
1969. *The Development of Modern Medicine.* New York: Hafner.

Siegler, M. and Osmond, H.
1966. Models of madness. *British Journal of Psychiatry* 112:1193–1203.
1973. The "sick role" revisited. *Hastings Center Studies* 1(3):41–58.

Sigerist, H.
1951. *A History of Medicine, Volume 1: Primitive and Archaic Medicine.* London: Oxford University Press.

Sih, P.K., ed.
1973. *Taiwan in Modern Times.* New York: St. Johns University Press.

Singer, K.
1975. Depressive disorders from a transcultural perspective. *Social Science and Medicine* 9:289–301.

Sivin, N.
1972. "Folk medicine in traditional China." Mimeographed paper.
1975. "Classical medicine and popular medicine in traditional China." Mimeographed paper.

ıow, L.
1974. Folk medical beliefs and their implications for care of patients. *Annals of Internal Medicine* 81:82–96.

ılomon, R.
1971. *Mao's Revolution and the Chinese Political Culture*. Berkeley: University of California Press, pp. 1–133.

ıiro, M.E.
1967. *Burmese Super-naturalism: A Study in the Explanation and Reduction of Suffering*. Englewood Cliffs, New Jersey: Prentice-Hall.
1976. Supernaturally caused illness in traditional Burmese medicine. In A. Kleinman et al., eds., *Medicine in Chinese Cultures, op.cit.*, pp. 385–400.

radley, J.P. and Phillips, M.
1972. Culture and stress: A quantitative analysis. *American Anthropologist* 74:518–529.

nson, G.
1974. Obeying doctor's orders. *Social Science and Medicine* 8:97–104.

eckle, J. et al.
1964. The quantity and significance of psychological distress in medical patients. *Journal of Chronic Disease* 17:959–970.

hman, E.
1965. Social patterns of illness and medical care. *Journal of Health and Human Behavior* 6:2–16.

, S. and Wagner, N., eds.
1973. *Asian-Americans: Psychological Perspectives*. Palo Alto: Science and Behavior Books.

stad, B.
1976. Physician-patient communications and patient conformity with medical advice. In D. Mechanic, ed. *The Growth of Bureaucratic Medicine*. New York: Wiley Interscience Publication, pp. 220–238.

an's Health, 1972–1973.
1973. Department of Health, Taiwan Provincial Government, Republic of China.

biah, S.J.
1968. The magical power of words. *Man* 3 :175–208.
1973. Form and meaning of magical acts: A point of view. In R. Horton and R. Finnegan, eds., *Modes of Thought*. London: Faber, pp. 199–229.
1975. *Buddhism and the Spirit Cults in North-East Thailand*. Cam-
(1970) bridge, Engl.: Cambridge University Press.
977. The cosmological and performative significance of a Thai cult of healing through meditation. *Culture, Medicine and Psychiatry* 1:97–132.

r, C.E.
876. The place of indigenous medical practitioners in the modernization of health services. In C. Leslie, ed., *Asian Medical Systems*. Berkeley: University of California Press, pp. 285–299.

Teichner, W.
1968. Interaction of behavioral and physiological stress reactions. *Psychological Review* 75:271–291

Thomas, K.
1971. *Religion and the Decline of Magic*. London: Weidenfeld and Nicholson.

Topley, M.
1953. Paper charms and prayer sheets as adjuncts to Chinese worship. *Journal of the Malayan Branch of the Royal Asiatic Society* 26:63–80.
1970. Chinese traditional ideas and the treatment of disease. *Man* 5:421–437.
1976a. Chinese traditional etiology and methods of cure in Hong Kong. In C. Leslie, ed., *Asian Medical Systems, op.cit.*, pp. 243–271.
1976b. Chinese and Western medicine in Hong Kong: Some social and cultural determinants of variation, interaction and change. In A. Kleinman et al., eds., *Medicine in Chinese Cultures, op.cit.*, pp. 241–272.

Torrey, E.F.
1972. *The Mind Game*. New York: Emerson-Hall.

Truax, C. and Carkhuff, R.
1967. *Toward Effective Counseling and Psychotherapy*. Chicago: Aldine.

Tseng, W.S.
1972. Psychiatric study of shamanism in Taiwan. *Archives of General Psychiatry* 26:561–565.
1974. "Folk psychotherapy in Taiwan." Paper presented to the Fourth Conference on Mental Health Research in Asia and the Pacific. Honolulu, East-West Center, March 20–24, 1974. Reprinted in W.P. Lebra, ed., *Culture-Bound Syndromes, Ethnopsychiatry, and Alternate Therapies, op.cit.*, pp. 164–178.
1975. The nature of somatic complaints among psychiatric patients: The Chinese case. *Comprehensive Psychiatry* 16:237–245.
1976. Traditional and modern psychiatric care in Taiwan. In A. Kleinman et al., eds., *Medicine in Chinese Cultures, op.cit.*, pp. 177–194.

Tseng, W.S. and Hsu, J.
1969. Chinese culture, personality formation and mental illness. *International Journal of Social Psychiatry* 16:5–14.

Turner, V.
1967. *The Forest of Symbols*. Ithaca, New York: Cornell University Press.

Twaddle, A.C.
1972. The concepts of the sick role and illness behavior. *Advances in Psychosomatic Medicine* 8:162–179.
1974. The concept of health status. *Social Science and Medicine* 8:29–38.

Unschuld, P.U.
1976. The social organization and ecology of medical practice in Taiwan. In C. Leslie, ed., *Asian Medical Systems, op.cit.*, pp. 300–321.

Verma, R.L. and Keswani, N.H.
1975 The physiological concepts of Unani medicine. In Hakim Mohammed Said, *Hamdard: Voices of Eastern Medicine* 18:42–60.

Wallace, A.F.C.
1959. The institutionalization of cathartic and control strategies in Iroquois religious psychotherapy. In M. Opler, ed., *Culture and Mental Health*. New York: Macmillan.

Walser, H.H. and Koelbing, H.M.
1971. *Erwin Ackerknecht–Medicine and Ethnology*. Bern, Switzerland: Huber.

Wang, C.M.
1971. "A Folk Doctor and his Cult on Keelung Street in Taipei." B.A. thesis, Department of Anthropology, National Taiwan University. (In Chinese.)

Wartofsky, M.W.
1974. Organs, organisms and disease: Human ontology and medical practice. In H.T. Englehardt and S.F. Spicker, eds., *Evaluation and Explanation in the Biomedical Sciences*. Dordrecht, Holland: Reidel Publishing Co., 67–83.

Waxler, N.E.
1974. Culture and mental illness: A social labelling perspective. *Journal of Nervous and Mental Disease* 159:379–395.
1977. Is mental illness cured in traditional societies? *Culture, Medicine and Psychiatry* 1:233–254.

Wegmen, M.E., Lin, T.Y , and Purcell, E.F., eds.
1973. *Public Health in the People's Republic of China*. New York: Josiah Macy, Jr. Foundation.

Weiss, J.M.
1972. Psychological factors in stress and disease. *Scientific American* 226(6):104–113.

Wellin, E.
1977. Theoretical orientations in medical anthropology: Continuity and change over the past half-century. In D. Landy, ed., *Culture, Disease, and Healing: Studies in Medical Anthropology*. New York: Macmillan, pp. 47–57.

Werner, H. and Kaplan, B.
1967. *Symbol Formation*. New York: Wiley.

White, K.
1973. Life and Death and Medicine. *Scientific American* 229(3):23–33.

White, K. et al.
1961. The ecology of medical care. *New England Journal of Medicine* 265:885–892.

WHO International Pilot Study of Schizophrenia, Volume 1.
1973. Geneva: WHO.

Whybrow, P.C.
1972. The use and abuse of the "medical model" as a conceptual frame in psychiatry. *Psychiatry in Medicine* 3:333–342.

Wittkower, E.D. and Prince, R.
1974. A review of transcultural psychiatry. In G. Caplan, ed., *Child and Adolescent Psychiatry, Sociocultural and Community Psychiatry,*

American Handbook of Psychiatry. Volume 2, Second Edition. New York: Basic Books, pp. 535–550.

Wolf, A., ed.
1974. *Religion and Ritual in Chinese Society*. Stanford: Stanford University Press.

Wolf, M.
1970. Child training and the Chinese family. In M. Freedman, ed., *Family and Kinship in Chinese Society*. Stanford: Stanford University Press.
1972. *Women and the Family in Rural Taiwan*. Stanford: Stanford University Press.

Wolf, M. and Wittke, R., eds.
1975. *Women in Chinese Society*. Stanford: Stanford University Press.

Wolff, R.
1965. Modern medicine and traditional culture: Confrontation on the Malay peninsula. *Human Organization* 24:339–345.

Woodruff, R.A. et al.
1974. *Psychiatric Diagnosis*. New York: Oxford University Press.

Worth, R.
1963. Health in rural China: From village to commune. *American Journal of Hygiene* 77:228–239.

Yalman, N.
1964. The structure of Sinhalese healing rituals. *Journal of Asian Studies* 23:115–150.

Yang, L.S.
1957. The concept of *pao* as a basis for social relations in China. In J. Fairbanks, ed., *Chinese Thought and Institutions*. Chicago: University of Chicago Press, pp. 291–309.

Yap, P.M.
1965. Phenomenology of affective disorders in Chinese and other cultures. In A. De Reuck and R. Porter, eds., *Transcultural Psychiatry*. Boston: Little, Brown.
1967. Ideas of mental health and disorder in Hong Kong and their practical influence. In M. Topley, ed., *Some Traditional Chinese Ideas and Conceptions in Hong Kong Social Life Today*. Hong Kong: Hong Kong Branch of the Royal Asiatic Society.
1974. *Comparative Psychiatry*. Toronto: University of Toronto Press.

Young, A.
1977. Order, analogy, and efficacy in Ethiopian medical divination. *Culture, Medicine and Psychiatry* 1(2):183–200.
1978. "Mode of production of medical knowledge." Paper presented to the Conference on the Transition to Global Health: Rethinking the Western Health Enterprise, Case Western Reserve University, March, 1978, *Medical Anthropology* 2(2):97–121, 1978.

Zborowski, M.
1952. Cultural components in responses to pain. *Journal of Social Issues* 8:16–30.

1969. *People in Pain*. San Francisco: Jossey-Bass.

Zola, I. K.

1966. Culture and symptoms: An analysis of patients' presenting complaints. *American Sociological Review* 3:615–630.

1972a. The concept of trouble and sources of medical assistance. *Social Science and Medicine* 6:673–679.

1972b. Medicine as an institution of social control. *Sociological Review* 20:487–504.

1972c. Studying the decision to see a doctor. *Advances in Psychosomatic Medicine* 8:216–236.

1973. Pathways to the doctor—from person to patient. *Social Science and Medicine* 7:677–684.