Al-Hikmat
Volume 20 (2000), pp. 25-46

SOCIO-PHILOSOPHICAL CONCEPT OF HUMAN BODY AND ITS IMPLICATIONS ON HEALTH CARE SYSTEM

*MUHAMMAD ZAKRIA ZAKAR**

ABSTRACT

Spectacular achievements of Western medical science have created an impression that health and illness are 'concrete' and 'measurable' realities and could be studied with the help of laboratory-based 'positive' medical science. The basic premise is that human body is amenable to scientific and standardized analysis with the help of sophisticated diagnostic hardware. Therefore, philosophical and cultural studies of body have lost their significance.

This paper challenges this assertion and demonstrates that every culture has its own philosophical notions of human body. Consequently, all the actions/strategies to care and treat the body are grounded on these philosophical tenets. Hence there is no "scientific anatomy": every society has its own "cultural anatomy" – a reservoir of knowledge disseminated through cross-cultural interaction and understood within the ideological and philosophical 'world-view' of a particular civilization.

In order to concretize, this paper underlines certain situations where human body is treated by conflicting but competing professional (doctors versus healers) and putting the patient into great philosophical and existential paradox. Interpreting the same reality by applying different theoretical and philosophical perspectives have allowed various medical systems to operate in the same setup. It has far reaching

*Dr. Muhammad Zakria Zakar is Assistant Professor, Department of Sociology, University of the Punjab, Lahore (Pakistan).

repercussions on the health of the population and financial resources of the society. This paper also underlines some areas where health policy planners should be cautious and while planning the health care system, they ought to be sensitive to the phenomenological needs of the indigenous population.

INTRODUCTION

This paper has the following objectives:

1. To highlight how cultural and philosophical notions help people to understand the functioning/dysfunctioning of their bodies.
2. How these notions subsequently shape the behavior and decisions of the people when they seek health care from different professionals in the health care market.
3. How these conflicting views of reality (reality of body) are synthesized and simplified so that they could be acceptable to epistemological and phenomenological consciousness of 'lay people'.

In every society, the human body has a social as well as physical reality. Since the reality of body is "constructed" by the cultural knowledge, therefore, it varies from society to society and country to country. "The term 'body image' has been used to describe all the ways an individual conceptualizes, experiences, his or her body, whether consciously or unconsciously" (Helmann, 1996:12). Through a life long process of socialization, an individual develops his attitude, feelings and fanatics about his body as well as manner in which a person has learnt to organize and integrate his body experiences. Society tells us how to differentiate a sick body from a health one, a fit body from a disabled one and how to define a fever or a pain and how to perceive some parts of body as public and others as private, and how to view some bodily functions as socially acceptable and others as morally unclean. The body image, then, is something acquired by every individual as part of growing up in a particular family culture or society.

In general, concepts of body image can be divided into four main areas:

- Beliefs about the optimal shape and size of the body, including the clothing and decorating of its surface.
- Beliefs about the boundaries of the body.
- Beliefs about the body inner structure.
- Beliefs about how the body functions.

The above stated four factors could be the product of philosophical and ideological basis of a particular society. For example beliefs about the 'boundaries of body' is a philosophical question. Western positive philosophy views body in mechanistic and reductionist context. "When there is some fault in the body, it needs to be removed and the machine (body) would start its functioning again". But in most of the traditional societies, body is perceived to be interactive entity: and its functioning is influenced by the whole cosmos.

Based on these beliefs, medical system of a particular society develops. For instance, in the West, with the advent of secularism, the Judeo-Christian sacred body was undermined and mechanistic view of body was popularized. Accordingly all the views about the shape, size and function of the body were developed. Based on these beliefs, medicine started classification of bodies and its functioning.

> Medical bureaucrats sub-divide people into those who may drive a car, those who may stay away from work, those who must be locked up, those who may become soldiers, those who may cross borders, cook or practice prostitution, those who may not run for vice-presidency of the United States, those who are dead, those who are competent to commit a crime and those who are liable to commit one (Illich, 1976).

The role of medicine is no more restricted to 'cure'. It has expanded functions beyond the imagination. "Now medicine tries to engineer the dreams of reason. Oral contraceptives, for

instance, are prescribed 'to prevent' a normal occurrence in health person. And all the suffering are 'hospitalized' and homes become inhospitable to birth sickness and death. All these roles assigned to the medicine are legitimized on the basis of the very notion of the 'body' a particular culture up holds and adheres.

MODELS TO UNDERSTAND BODY

In the next few paragraphs, a brief overview of the different models explaining the nature and functioning of body is presented. Each model enables us to review body from a certain perspective. Some models are built more or less explicitly on a definite theory of knowledge while others are of more temporary nature.

1. The Religious Model

In religious model, body is perceived to function in harmony with nature. Disease is considered a imbalance in spiritual sphere which has disrupted the functioning of the body. According to this model, bodily dysfunction means a violation of the harmonious living. Hence the sick person looks for ultimate cause: this contrast with the Western biomedical model according to which the sick person contents himself/herself with the proximal cause – bacteria, virus, change in chromosome etc. As a rule, restoring the balance of body (healing), the treatment amounts to correct balance with nature. In this model, healer is the one, who diagnosis disease, communicate with spiritual world, carries out religious rites, administer medication and through all this restores the sick person to the correct level of harmony with his/her existence.

2. The Biomedical Model

The bio-medical model has its roots in traditional Greek medicine which is intimately associated with Greek philosophy. This is educationally oriented view of human body. Parts of human body and organs are seen as systems of molecules governed by chemical processes. For example in the field of brain research, the brain is considered to be a type of information

processing computers system which can learn remembers and take decisions. This model is reductionist in character. The model considers body in mechanical terms and diseases is reduced to being a sort of spanner in the works. Such a view is based on the assumption that disease is a pathological and mechanical dysfunction within the individual. The task of doctor is to control the pathology and repair the body.

3. The Psychosomatic Model

According to this model, "the very disease involves both the body and the mind, and those aspects are so interrelated that they cannot be separated one from the other" (Dubos, 1968:64). According to the approach of psychosomatic model, body functions through a continuous interplay between physical and mental factors which strengthen each other by means of complex net work of feed back loops. Recovery from disease is assumed to happen in similar fashion. Positive attitude in combination with stress-reducing techniques are considered to have a strong influence on the body mind system and help the individual regain the balance which is defined as health (Tamm, 1993:218).

4. The Humanistic Model

The humanistic model of body is holistic. Man is seen as a whole, *i.e.* as a psychological and biological organism in interaction with its social environment. In contrast to holistic religious model where the ultimate value and power are ascribed to God or the gods, man is seen in this model as the starting point of every thing. According to this model, 'normal human body' is not a condition but a process, which is ultimately synonymous with a wish, a desire or a force towards self-actualization. A healthy body is the one which could help the individual to actualize and live an authentic life. By analogy, sick body means that the internal relationships are disintegrated and inside is negative, twisted and sick. Further, according to the humanistic view, human being is intentional and has a choice, *i.e.* he or she has purpose, values and meaning, and creates his/her own experience of health and illness.

5. The Existential Model

According to this model, one seeks an understanding of his body in his concrete experience of reality, *i.e.* the basis of his own existence. The questions posed are question of existence: what does it employ for a person to exist? What should he do with his life? Is there a basic structure of existence that helps man to live a life free from false appraisals and from constraints of intrinsic conventions? Is there any meaning of life?

The above stated models show how the concepts of body vary from culture to culture. Behind these concepts "knowledge systems pervade our thinking, influence our conceptions of causality and guide our sensory perceptions. At all times we are immersed in knowledge system that organizes the way we conceptualizes the material world around us to fit this cognitive system" (Marcos, 1997:20). In the coming pages an effort has been made to elucidate as to how 'ideology of body' help the people to interpret and react to the realities of health and illness.

Towards Illness

People themselves make sense of the world when coping with their own health problems. More precisely, they select their explanations of health and illness from a number of existing contemporary explanations. These explanations could be based on both scientific knowledge or lay beliefs and have a value to the individual which cannot be judged from the point of view of rationality or scientific soundness. It is not authenticity which is being sought, but personal satisfaction and comprehension (Gillespie and Gerhardt, 1995).

It would, therefore, be instructive to examine how individual interprets and makes sense of disturbances in bodily functioning, and then makes decision to seek medical care being among a number of alternative courses of action.

At what stage a person thinks that he is ill, and, therefore, he should do something is a question of fundamental importance. This is the point which is sensitively linked with the whole social system there under an individual lives. He constantly monitors

the dynamics of his bodily functions and interprets each biological symptom in accordance with his health belief system.

Superficially, it may seem simple that when a person feels ill he/she goes to a care provider to get well. But, in reality, it entails a complex social and psychological process to 'define' oneself ill and thereby seek 'care'. Freidson (1961:9) remarked that "the basic conditions for medical practice are sociological in character". He enumerates 'six steps process' for a 'layman' to become a 'patient'. First, it is the patient who decides that he/she needs 'help'. Second, again, it is the patient who must decide that he/she needs help from a physician and not a lawyer, banker, priest. Third, he/she has to select a particular physician; of course, among many alternatives available. Fourth, he/she needs to cooperate in the process of examination and history taking. Fifth, his/her perceived problem must be properly diagnosed and treated or at least he/she may have realization that the diagnosis and treatment is proper. Sixth, he/she ought to cooperate in the process of treatment (Freidson, 1961:9).

It may be noted here that in the above stated six steps only the fifth one, *i.e.* 'proper diagnose and treatment' "is purely medical and technical capacity (of physician) is involved. That capacity cannot be exercised without fulfillment of prior steps which do not rest upon medical science at all" (Freidson, 1961:9). That is why it is persistently argued in the behavioral sciences that illness is largely treated at 'popular' or 'lay' sector and even when the individual depends on the 'professional care provider', this sector grossly influence in the treatment process.

For the proper understanding of the 'illness behavior' one needs to analyze the very 'state' of illness and the complex and subjective process whereby this state is evolved, evaluated, and crystallized. Each individual, irrespective of his 'cultural sophistication' constantly watches the 'developments' in his/her biological systems and actively makes preventive and curative measures to maintain a 'balance' at the same time. These measures are very much routinized, 'taken for granted' and culturally (and often not medically) driven. For instance, after drinking 'too much coffee' people prefer some 'fruit juices' to

maintain the 'balance'. Here it the 'culture' which defines as to what quantity of coffee constitutes 'too much' and how its 'negative' effect(s) be canceled out by 'fruit juices'.

Responses to Illness

Genetically, human beings all over world are the same; their bodies are subjected to same biological and natural laws. For this reason, at least at theoretical level, they share the same sensitivity if the functioning of their body is disrupted due to some outside or inside intervention(s). Whenever any human body organ gets functional impairment, the consequential biological symptoms should be the same. For instance, if one is suffering from liver hepatitis, the color of his skin and eyes would gradually turn pale in proportion to the seriousness of the malady. This is a uniform pathological behavior and, of course, does not vary from cultural or racial affiliations.

Nevertheless, what varies is the style of interpretation, mode of evaluation and subsequent actions relating to illness management. Such actions substantially vary from culture to culture. Pathological manifestations of the biological symptoms are the same but difference lies in application of cultural knowledge to draw conclusions from those symptoms.

What is the determining point when people seriously notice biological symptoms and make decisions to 'do something' to sustain the normalcy. Even in the normal state of affairs, one may notice various 'developments' and 'changes' constantly appearing in one's body. But these developments are generally ignored or taken for granted or even taken as a sign of good health. Nevertheless when some symptoms with particular properties appear, an individual takes notice of such symptoms and decides to go for intervention. It may be noted here that the interpretation is usually based on the popular 'health beliefs' which may not necessarily correspond to the 'scientific medical knowledge'.

However, this mechanistic view of human body make it possible in the Western societies to regulate the episode of

sickness in a formal structured way. For example, suppose, the bodily temperature of an individual is higher than normal one, he is declared sick and therefore qualifies to assume the sick role, of course, with the certification of a doctor. The temperature is empirically verifiable by an instrument (thermometer). As long as one's temperature is higher, one can assume the sick role. When one's temperature touches the normal point, one has to come out of the sick role.

In this way, one's sickness is 'sharply defined' in the Western system and to some degree 'empirically' verifiable in the 'pathological laboratory'. This standardization of pathological state greatly contributed to the 'bureaucratic and rational oriented' treatment of sickness as well as the sick people. One repercussion of this state is the 'mechanistic' behavior of the Western doctor who by virtue of his training, scientific 'ideology' and professional ethics is quite 'different' different from the 'sympathetic healer' in a traditional set up. The argument is that the doctor is more and more relying on the laboratory findings and consequently becoming more and more specific in his/her specialized area. The resultant factor is the more explicit demarcation of the 'state of sick role' and sickness itself especially in the industrialized Western countries.

Now come to the situation of the patient. In the Western industrialized countries, the assumption of sick role, sometimes, means more than just getting competent help. There may be some other 'gains' from being sick "whereby individual avoids responsibility for their sickness and is able to retreat from the demanding requirement of an industrial society based upon an activist culture and a norm of achievement" (Turner, 1995:40). In short, both doctor and patient, in the Western context, 'negotiate' on the 'sick role' for a variety of purposes not only limited to just treating the malady. The doctor's behavior is governed by his/her 'professional norms and ethics' while the patient proceeds according to his/her 'personal interests'

On the other hand, in the indigenous medical systems neither the illness nor the behavior of sick is so strictly structured. In the indigenous set up, the 'reality of health and illness'

is perceived and treated in an entirely different parameters. As such the role of the healer is neither so 'specific' nor laboratory confirmations are needed to diagnose the problem. So is the case with the assumption of sick role and the 'rights' and 'obligations' attached therewith.

It is a matter of common observation that in the indigenous set up the conceptions of health and illness are usually based on folk wisdom and religious precepts. Bodily symptoms are subjectively evaluated and interpreted. Health beliefs are vaguely defined and each individual makes his own classification of symptoms, draws conclusions and sets corresponding coping strategies.

Here healers are not as formally trained as is the case in Western system nor they do have explicit professional authority to give certification for the assumption of sick role. In the indigenous system the functions of medical care provision are shared by many individuals/institutions ranging from parents to religious scholars or 'wise men' of the community. Contrary to Western set up, where sick role entails certain 'rights' and 'duties', the indigenous medical systems usually deny such privileges for sickness as disease is perceived to be an out come of one's own 'misdeeds' for which he/she himself/herself is responsible. Here lies the crux of the problem. It can be assumed that societal response to illness is based on the societies view about the causation of disease. If society thinks that it is the individual who is responsible for illness, then, illness management would fundamentally be a responsibility of the individual. It is he who himself decides (or with the advice of lay peers) whether he is sick or not. And it is not necessary that he could avail the 'rights' associated with the sick role.

Society reacts to the ill person in accordance with the societal particular conceptions of health and illness. Every medical system imposes positive or negative sanctions to sick person in accordance with its basic philosophy of illness or the theories of disease causation propounded by the society. By the same token, individual also tailors his/her behavior in such a way that he/she minimizes the possible negative sanctions imposed by

the society and maximize the positive sanctions allowed therewith.

Right from the assumption of sick role, one may notice differences in the behavior pattern in illness management between biomedical system and traditional system. In the traditional set up, people are reluctant to assume the sick role. The underlying reason is that sick role may not entail the privileges which are given by the Western system. Additionally, the assumption of sick role is not an easy task: one has to demonstrate and convince the society that he is really ill and therefore unable to perform the social functions. There may not be a technically trained and professionally powerful doctor who can give illness certificate readily and mechanically which is the case in the compilation system. Since, in the traditional societies, evaluating and defining of symptoms and management illness is much more a social concern, so one has to get 'approval' of each step illness definition and management from the society. Otherwise society may not allocate the 'resources' for the illness management. It may not be an exclusive business of doctor and patient.

In this way, in the traditional settings, all the processes related to illness management, the individual plays a central role whereas the healer role is subsidiary. Individual himself interprets the symptoms and makes decision whether he should seek a competent advice or not; determines the time when such advice is to be sought so on. When all things depend on the individual, one consequence could be the excessive self-medication and dependency on the home remedies for an indefinite period of time.

Denial of patient's right to assume sick role at proper time and the absence of healers professional authority and functional specificity could have long term repercussion on the overall process of illness management in a society. When illness is treated by lay people and the sufferer is not given a formal status to be sick, the whole illness management substantially comes under the folk and indigenous beliefs and practices. Generalized and vaguely defined disease causation popular theories enable

every one around the patient to give his own 'expert opinion' regarding the cause and treatment. Furthermore, non-availability of clinical tests which could otherwise falsify the lay illness theories further give free hand to the people who manage illness by indigenous medical system. The symbolic and religious significance associated with treatment methods/substances further reduces the chances to have critical.

Concepts of health and illness are rooted in the culture. Medical system as a part of the cultural system not only defines and identifies the state of illness to the individuals but also provides a web of belief system whereby these 'cultural realities' are handled in a 'culturally approved way'

Interpretation of Body Symptoms

Care seeking behavior still need to be further investigated especially in relation to its social repercussions. It may be noted here that when a doctor interprets the symptoms of a patient and gives a 'name to those symptoms', he/she (doctor) gives meaning to the existing 'state of affairs' which could potentially change the whole life course of the patient either temporarily or permanently (Janzen, 1978; Mechanic, 1989; Lupton, 1994). More simply diagnosis means 'identification' of the problem. When a problem is identified the causes are also detected. And what caused the 'causes'? Responsibility is consequently 'fixed' on some social and environmental factors.

> .... interpretation is the core clinical reality requiring psychological, social and cultural analysis of both lay people and practitioner: and cultural processes are viewed as relating everyday reality with sickness through dominant idioms and metaphor concerning society, person, body, etiology, pathophysiology and therapy (ethnopsychology and ethnomedicine) (Chrisman and Kleinman, 1983:570).

For instance, a patient, in a developing set up, goes to a Western doctor for the treatment of 'fever'. The doctor 'diagnoses' that it is a 'typhoid'. Point may be noted here. After

this diagnosis, the fever is no more a matter of an elevated bodily temperature. Rather, it is a specific 'disease' with specific etiological causes and consequences. By giving this nomenclature to the elevated bodily temperature, the doctor has not only suggested a 'therapeutic package' of his own medical system but also automatically outlined the causes of the disease which laid deep in the whole social structure. Imagine, the doctor says that the water which patient drinks is 'contaminated' containing typhoid bacterium. (Whereas the indigenous culture and medical system see nothing wrong with that water which they are using for centuries.) This 'diagnosis' of the doctor further suggests that if the patient wishes to remain healthy, he/she must use 'clean water' ('clean' in Western standards). That means if the patient accepts the "diagnosis" he/she needs a different life-style – not only few Western drugs. In this way diagnosis not only identifies 'defects' in the human body but also points out 'faults' in the whole social structure. Obviously, a Western doctor, especially in a traditional set up, might not find enough power and legitimacy to "discredit" the whole system by applying his "science". One must remember that Western medical system too, is a product of 'specific cultural system' which grew mainly in the Western industrial societies in the late 19^{th} and 20^{th} century.

Now, what if the same patient goes to a healer. The healer might use the same or different set of drugs but would not brand the water as 'contaminated' nor would suggest culturally non feasible 'treatment package'. The patient might use some other name to classify the same symptoms which might not predict gloom as the disease "typhoid" does. The healer may explain this fever as a consequence of "excessive heat" in the body, which could also be 'empirically tested' by the patient himself. This type of explanation for the patient might be more plausible than 'germ theory' of a doctor. Additionally, non-clinical preventive and curative measures, which the indigenous healer usually suggests, are considered more convenient to arrange than the instructions of the doctor.

> Diagnosis is the focal point of thought in the treatment of a patient. From diagnosis, which gives a name to the patient's ailment, the thinking goes chronologically backward to decide about pathogenesis and etiology of the ailment. From diagnosis also, the thinking goes chronologically forward to predict prognosis and to choose therapy .... the taxonomy used for diagnosis will thus inevitably establish the pattern in which clinicians observe, think, remember and act (Feinstein, 1967:73).

That is why it is not necessary that a patient always agrees with the 'diagnosis' made by a care provider. Non-compliance of the advice of doctor is a universal phenomenon and reflects one dimension of the patients 'disagreement' with the care provider on diagnostic issues.

Given this context, one may assume that a patient might have his/her own "tentative diagnosis" which is usually based on his/her cultural health and illness beliefs system on the one hand and is feasible to manage within the available social resources on the other hand. Patient is usually prone to accept the "diagnosis" which is more or less near to his/her explanatory model of health and illness. If the diagnosis is altogether different and surprising, the patient may simply reject it and could go to another care provider. This is particularly relevant when the care provider takes an entirely different view of the problem. Take the example of the patient who is suffering from fever which was diagnosed as "typhoid" by the doctor.

Now, I want to discuss a different aspect of the same issue. For Western doctor fever is not a "disease" rather it is a symptom of a 'disease'. What a doctor "should" do is to ask for various clinical tests to detect the underlying 'disease'. Doctor needs laboratory based information to decide as to whether this elevated temperature is due to malarial parasites or the bacterium of the typhoid or some other infectious agent that could possibly raise the bodily temperature. Doctor has to follow his/her scientific procedures to "diagnose the disease". Additionally the focus of the doctor would be to treat the underlying disease and not the 'fever' itself, which is a 'symptom' and not a disease.

Similarly the possible diagnosis would not be the "fever"; but, most probably, some 'microscopic organism'. One can well imagine the reaction of the patient who considers the 'fever' a disease itself and is not interested in lengthy clinical procedures. Medical historian King (1982) comments on the subject

> Calling them disease or, conversely, refusing to call them disease, is a societal judgment. We cannot understand what we mean by disease unless we take into account changes in societal values and social pressers. The definitions of disease found in the 17th and 18th centuries are no longer fully satisfactory in the 20th century (King, 1982:139).

The basic problem is that there is fundamental difference of approach towards reality of health and illness between the indigenous medical system and the Western medical system. In case of fever, the indigenous medical system might consider it a disease itself and consequently normalization of temperature could mean health. But in the Western model, even if the temperature touches the normal point, the patient is not received unless the "typhoid" bacterium is active. The reason of difference of opinion is obvious: the indigenous medical system has not yet recognized "microscopic organism" as potential causative factor for creating health problem.

It is reported that patient usually differs with the doctor in terms of disease causation and diagnostic procedures and perceives the things according to his/her own perspectives But he/she is impressed with the "wonderful remedies" of Western system especially the quick effects of the colorful pills and heroic surgical skills often projected and demonstrated by the Western doctor for which the indigenous healer is lagging far behind. How to resolve this paradox? He/she needs both the systems to treat his/her illness as well as the diseases. The logical way out for a patient is to contact both and depend on both according to their ability to provide the services. Asuni (1979) pointedly reports the same situation in Nigeria.

> He (the patient) will use both facilities with or without the knowledge or approval of either. His concept of disease allows for this. While modern medicine can procure a cure, it does not deal what is regarded as the basic cause of his illness which may be a curse, the vengeance of a god, the evil machinations of an other person, etc. The objective of the traditional healing practice in this situation is to counteract the basic cause, thereby making the modern medicine effective and lasting in its cure. In other words, the traditional system complements the modern system (Asuni, 1979:37).

When a patient interacts with two fundamentally different medical systems to get his/her illness treated, the patient 'theorizes' according to his her own orientations and understanding regarding the suitability and efficacy of each system to treat his/her problem. The orientations of the patient largely rely on the folklore, media information and previous personal experiences. For a particular illness, patient has to make a decision: who should be selected for treatment, the doctor or the healer or both. Before making this decision, the patient first decides the nature of illness, its causes and consequences. He/she then evaluates the competency and suitability of the competing care providers in the health care market. There is, therefore, a possibility that the patient might utilize the services of a doctor to treat the certain aspect of illness, say symptomatic, and would go to the healers to treat the root cause of the trouble.

Paradox of Diagnose and Treatment

Scientific literature reports that the indigenous healers largely use culturally familiar concepts and terminology to define illness and its management. They may use popular Western nomenclature of diseases, but usually explain them in the local context, which is, understandable to the lay population. For instance, if an indigenous healer reports that he/she can treat "typhoid" but while telling its symptoms he/she narrates the symptoms of "malaria" (if it is judged in the Western model) and his suggested testament is some "herbs". Then it could be

concluded that though healer used popular Western diagnostic nomenclature but was not aware about the real Western model.

> .... health, illness, and medical care are social phenomena; that is, they are socially constructed categories that define and give meaning to certain classes of events. Whether or not a particular behavior or experience is viewed by members of a society as a sign or symptom of illness depends on cultural values, social norms, and culturally shared rules of interpretation. This approach is in contradistinction to the biomedical model of disease as defined by reference to universal, culture free criteria (Mishler, 1981:141).

The point here is that the patient wants explanations to his/her problem in the form of a diagnosis, so that he/she could estimate the causes and consequences of the problem. This diagnosis also plays very important role in the allocation of health resources and further decision making in care seeking. At this point the healers have edge over the doctors: they share and understand the 'need' of the patient – a need to have an 'appropriate' diagnosis. Patient presents various symptoms which could be seemingly random or unorganized; but in reality, the patient has 'something' in his/her mind which he/she wants to convey to the doctor/healer; and, through the specific presentation of the symptoms wants to put the doctor/healer on the 'right track': on the 'right diagnosis' – which he/she already has in his/her mind. It is argued that, in the clinical interaction, both care provider and patient try to find some 'common grounds' for perceiving and interpreting a particular set of symptoms. In this way, within a mutually shared explanatory framework, 'clinical interaction' makes a 'sense' and thereby they agree upon a specific 'diagnose'. Kleinman (1988) argues the point with more clarity.

> Thus, the patients order their experience of illness – what it means to them and to significant others – as personal narratives. The illness narrative is a story the patient tells, and significant others retell, to give coherence to the distinctive events and long term course

> of suffering. The plot lines, core metaphors, and rhetorical devices *that structure the illness narrative are drawn from cultural and personal models for arranging experiences in meaningful ways and for effectively communicating those meanings* (*italics added*) (Kleinman, 1988:49).

The fundamental difference between the doctor's and healer's diagnosis methodology is that healer traces the social causes of the illness which the patient and his/her family can also share and understand while the doctor concentrates on the laboratory based causes of the disease. Yoder (1982) reports similar situation in the rural Zaire where indigenous healers 'diagnose' the disease ".... in consultation with the local matrilineal kin group on the basis of the patient's behavior, verbal statements by the patient and observers and perceptible signs of dysfunctioning" (Yoder, 1982:1853). Consequently this society-based diagnosis is more affordable, understandable and less 'shocking' and unexpected. The society-oriented diagnosis also serves other purposes like an instrument of social control and suggests 'reintegration' of individual with the society. Additionally, the therapy suggested for such a diagnosis is usually feasible and within the reach of the patient and his family.

Interestingly, for every disease the cause is sought in the 'culturally deviant behavior' of the individual. Whenever one complains any bodily dysfunctioning, the family, the folk circle and the healer immediately traces the causes of that illness in the behavior of individual which is even slightly at variance with the prevailing cultural norms. For instance most of kidney and urinary track diseases are attributed to the violation of sexual mores of the society. Individual is strongly preached that if he wishes to stay health he/she must not commit any behavioral deviation. And if he/she has not committed any deviation then he/she should try to more strictly adhere the ideal behavior which is guarantee to remain healthy. Such a diagnosis serves three purposes: (*i*) responsibility of disease is fixed on the individual thereby excluding the chance to blame the inadequacies in the

food, life style etc., (*ii*) through the causation of illness and treatment more 'conformist' behavior is stressed; and (*iii*) treatment is usually within the range of the family resources principally in the modification of the behavior.

> Many practitioner of traditional medicine .... are deeply involved in the maintenance of social order and in preserving cultural institutions. They help the patient to live at peace with his or her family, clan, village, tribe and himself. Such healers have a broader social roles to play and more community oriented than the typical modern, Western style clinician (Meclean and Bannerman, 1982:1815).

In short, classification of symptoms, under some diagnostic nomenclature is the core issue of care seeking process. It is the diagnosis which tells what are the causes and consequences of the illness and what sort of remedies ought to be sought. It is also a matter of fixation of responsibility of the illness and in some cases determine the moral status of the individual. For instance in some societies leprosy is considered to be a wrath of God: a punishment for a heinous sin committed by the sufferer. In such societies patients hardly 'agree' with the diagnosis of the doctor. Even in developed countries, the diagnosis of terminal illnesses are frequently denied by the patients. As has been discussed above, patients are not usually 'neutral' or 'objective' while presenting their bodily symptoms. Rather they want to 'lead' the doctor/healer towards a particular diagnosis.

CONCLUSIONS

What is human body and how does it function? What are the causes (both ultimate and immediate) responsible for its occasional dysfunctioning? What is the proper way and who is competent to restore bodily functioning? All such questions need answers. To seek the answer of such questions, one relies on cultural knowledge (Remember, all medical systems, including Western medical system, are the product of culture) and hence culture specific. Understandably, every culture has its own ideological and philosophical basis, so the 'concepts of body', its

functioning, its care and treatment are rooted in the knowledge structures inherited by a particular society.

Given this context, this paper concludes that Western medical science has at its core a biologic theory: a mechanistic and secular model of the structure and functioning of human body. Whereas in the indigenous culture, body is perceived in more holistic and in supposed interact with the whole cosmos. The philosophical tents of both model are mutually exclusive rather contradictory. Here lies the crux of the issue. The incongruity between the Western and indigenous conception of body leads to conflict between the systems – having different configurations and worldview. For example an indigenous patient remains dissatisfied from the 'conduct and approach' of a Western doctor. Such a patient is more comfortable with a healer who may not be 'well qualified' but well understands the needs, aspirations and worldview of the patient. This article concludes that health care delivery system of each country should be tailored keeping in view the cultural and philosophical orientations of its population. This article underlines the fact that disease and illness are deeply rooted in the historical and cultural layers of the society. "The fact of health is cultural fact: it is bound up with the cultural concepts of good, bad, right, wrong, normal and abnormal. Each society has its own nation of normalcy" (Foucault 1973).

REFERENCES

Asuni, Tolani (1979). "The Dilemma of Traditional Healing with Special Reference to Nigeria". *Social Science and Medicine*, 13B: 33-39.

Chrisman, Noel J. and Arthur Kleinman (1983). "Popular Health Care, Social Networks and Cultural Meanings: The Orientation of Medical Anthropology". Pp. 569-590 in *Handbook of Health, Health Care, and the Health Professions* edited by David Mechanic. New York: The Free Press: A Division of Macmillan Publishing Co., Inc.

Dubos, Göran (1968). *Pills Against Poverty: A Study of the Introduction of Western Medicine in a Tamil Village.* London: Curzon Press Ltd.

Foucault, Michel (1973). *The Birth of the Clinic.* New York: Vintage Books.

Freidson, Eliot (1961). *Patients' Views of Medical Practice.* New York: Russell Sage Foundation.

Gillespie, Marre and Gerhardt (1995). *Medical Rationality and Experience: An Anthropological Perspective.* New York: Cambridge University Press.

Helmann, Cecil G. (1996). *Culture Health and Illness.* Oxford: Reed Educational and Professional Publishing Company.

Illich, Ivan (1976). *Limits to Medicine.* London: Marion Boyers.

Janzen, John M. (1978). *The Quest for Therapy: Medical Pluralism and Lower Zaire.* Berkeley: University of California Press.

King, Lester S. (1982). *Medical Thinking: A Historical Preface.* New Jersey: Princeton University Press.

Kleinman, Arthur (1988). *The Illness Narratives: Suffering, Healing and the Human Condition.* New York: Basic Books.

Lupton, Deborah.1994. *Medicine as Culture: Illness, Disease and the Body in Western Societies.* London: SAGE Publications Ltd.

Maclean, Una and Robert H. Bannerman (1982). "Utilization of Indigenous Healers in National Health Delivery Systems". *Social Science and Medicine*, 16:1815-16.

Marcos, Sylvia (1987). Curing and Cosmology: the Challenge of Popular Medicine. *Journal of Society of International Development*, 1:20-25.

Mechanic, David (1989). *Painful Choices Research and Essays on Health.* New Brunwick: Transaction Publisher.

Mishler, Elliot G., Lorna R. Amarasingham, Stuart T. Hauser, Ramsay Liem, Samuel D. Osherson and Nancy E. Waxler (1981). *Social Contexts of Health, Illness and Patient Care.* London: Cambridge University Press. (Please check this as it seems to be wrongly cited as a textbook instead of edited book).

Tamm, Maare E. (1993). "Models of Health and Disease". *British Journal of Medical Psychology*, 66:213-28.

Turner, Bryan S. (1995). *Medical Power and Social Knowledge*. London: SAGE Publications.

Yoder, P. Stanley (1982). "Biomedical and Ethnomedical Practice in Rural Zaire". *Social Science and Medicine*, 16:1851-82.