The Challenge of Chronic Illness

November 24, 2004

Read: Kleinman: 170-267

I. Discussion of anthropology and medicine

A. Review of Kleinman's final chapters

1. We have discussed some of his themes a bit already

a. For example, Kleinman's recommendations to write fuller medical records

2. I want to point out some potential problems with his formulation

B. He warns against a "hubris" (pride, arrogance) on the part of the physician that falsifies the patient's existential experience of illness

1. Clinicians shouldn't see patients as totally subjective

2. Nor see them as if they were overly rational mannequins

C. Are there risks involved in improving physician-patient interaction along the lines Kleinman suggests?

1. The physician (from now on a "he") is being asked to write down information that:

a. Might not be accurate

b. Might perpetrate stereotypes

1) Or might inappropriately involve the physician's unresolved psychiatric conflicts, etc.

2. His interventions might be experienced as way too intrusive

a. What makes us uncomfortable, worried, embarrassed about our psychiatric records

b. We might have similar apprehensions about what our physician records

3. Critiques of "behavioral medicine"

a. Critique of biopsychosocial models of treatment

1) Which emerged from critiques of medicine that did not take the larger social, cultural context into consideration

2) "The biopsychosocial model is a powerful, deceptive metaphor that converts non-scientific, non-technological treatments of disease into techniques that can be owned by modern professions"

b. If behavioral medicine's object is the patient as a "person"—the medical gaze can extend without limits to intervention into the patient's life

c. Then, according to these critics, all of a patient's existence is now "fair game" for professional management[1]

d. Much more responsibility is assigned the patient—must be open, cooperative, a co-manager of the problem

1) The physician then has significantly less responsibility—appealing in the case of chronic illnesses which cannot be cured[2]

4. Discuss: the Fadiman book's recommendations, and this critique

5. And where to end the medical record?

a. Discuss: what should the physician enter on the record of the obese woman with hypertension who lives in a ghetto and has had enormous crises due to poverty and violence (in Kleinman)?

6. Medical records are not only medical documents, they are legal and institutional documents as well

a. They are shared, and increasingly more available

b. Sometimes this availability is abused

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[1] Robert Kugelmann, 1997. The psychology and management of pain: Gate control as theory and symbol. *Theory & Psychology* 7(1): 43-65.

[2] See Irving Zola, 1978. Healthism and disabling medicalization. In I. Zola, *Disabling Professions*. Boston: Marion Boyars: 41-68.

c. Examples you have heard of?

7. Kleinman here adopts the perspective of a "good" physician practicing inside a "good" system

a. Neither physicians nor system are always good

D. Kleinman has very good criticisms and very good intentions

1. His criticisms remain valid

2. But there is a saying that the road to hell is paved with good intentions

a. Examples of unforeseen consequences and 20-20 hindsight that we have discussed already:

1) Deinstitutionalizing the mentally ill

a) What happened?

2) Development: construction of roads has been shown to facilitate the spread of AIDS, ebola virus and African River Blindness

3) The green revolution produced a disaster in Bali and many other places

4) The Tuskegee study

a) Syphilitic men left uninformed, untreated for decades

b) Discuss:

i) Good intentions?

ii) Or were they simply evil, racist individuals, utterly unlike ourselves?

5) Social psychologist Stanley Milgram's experiments on conformity

3. Other examples

a. A study that involved radiating retarded children in a school in Waltham

1) Often the institutionalized are the most vulnerable

2) Remember the convicts volunteering to be bitten by mosquitoes in the video about the Tuskegee study?

b. Israel: deliberate mass radiation of Sephardic youths

1) Film about it won "best documentary" at Haifa International film festival: title in Hebrew translates as "100,000 Rays"[3]

2) Every Sephardic child was to be given 35,000 times the maximum dose of X-rays through his head

3) Parents were told children were going on "school trips" and the X-rays were a treatment for ringworm

4) The film says 6,000 of the children died soon, many others developed cancers, those still living suffer from various disorders

5) The study was atomic medicine testing funded by the American government after US legislation ended human radiation experiments conducted on prisoners, the mentally feeble and the like (like the Waltham school)

6) The US government paid the Israeli government

4. Remoralizing the physician is a good idea; but how to do it this side of utopia is difficult

E. Take the example Kleinman gives of "a brief life history"

1. The physician must review "major continuities and changes in attitude, personality, major life goals and obstacles, and relevant earlier experiences of coping with illness and other serious conditions"

a. How to get at all this?

1) And then, how to verify it?

2) He himself points out that we often have mistaken memories, that our explanatory models fall short, that "relevant earlier

[3] "The Ringworm Children" directed by David Belhassen and Asher Hemias.

experiences" are found to be relevant only much later

2. Of course the physician should definitely guard against "dehumanizing" the patient; guard against stripping her or him of what is unique to the illness experience

    a. But Kleinman's model of interview is the psychiatric one

    b. Which may be fine for people with psychiatric illnesses, but perhaps not for every patient

3. Many physicians simply would not be very good at writing such records, even if they had the time and institutional encouragement to do so

4. Psychiatric interviews can produce social labeling and even secondary deviance (Monday's lecture)

    a. Again, the Rosenhan et al. study

II. Review of Kleinman's discussion of parallels in anthropology and clinical practice

A. Overall, he makes an interesting juxtaposition

1. Learn to observe

2. Learn to listen

3. Learn to interview

4. Acquire an ability to elicit and understand family dynamics, marital dynamics

5. These are all skills, and we often are terrible at all of them

B. Both clinician and anthropologist are interested in acquiring objective information—"data"

1. Both use the practitioner as part of the data-acquiring tool-kit

    a. A good idea, but also potentially risky

    b. Discuss

2. Both clinician and anthropologist have a problematic relationship with scientific method

a. Using one's subjectivity, intuition, and empathy as a way of acquiring information

b. Is not scientific

C. Both clinician and anthropologist stress the importance of looking at the context (one of Kleinman's and many others' complaints about physicians)

1. The psychosocial context

D. Both clinician and anthropologist stress the need to be sensitive to cultural variability

1. Medical school stresses this far less than graduate training in anthropology

E. Potentially problematic features of Kleinman's comparison?

1. Anthropology per se is not concerned with changing things—anthropology is scholarship, research, academic

a. Clinical medicine *is* concerned with changing things

b. By healing

c. By influencing policy (government, para-statals like WHO, non-governmental organizations (NGOs), etc)

2. Anthropology is not nearly as authoritative as medicine

a. Doesn't want to be, isn't allowed to be

b. Medicine is extremely authoritative; there are many vested interests, a crucial requirement that decision-makers have adequate authority

1) Discuss

3. Anthropology critiques more than medicine does

a. Only certain sectors of medicine mount critiques

b. For example, editorials in medical journals

c. Individual physicians griping about something doesn't count as critique

d. Medical science—research—does critique a lot—previous work, for example

4. A huge number of interest groups try to influence medicine

a. Self-help groups, lobbyists, pharmaceutical companies, etc.

1) For example, registrants at professional pain meetings have to sign a form about any potentially profitable equipment, etc., that might result from attending the meetings

b. There is nothing like this in anthropology—nobody tries to influence members, organizations in a parallel fashion

III. Finally, what do you think is "the art of medicine"?

A. How does a physician give her patients hope? Without distorting the picture in a harmful way?

1. How does she "empathically witness"?