Social Construction of Health and Illness: A Phenomenological Perspective[1]

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John Charles (Jack) Caldwell (b. Sydney, 8 December 1928 – d. Canberra 12 March 2016) was an eminent Australian demographer. A prolific researcher, Caldwell was the author or co-author of twenty-five books, 128 book chapters, and 139 journal articles. He is well known internationally for his extensive fieldwork in Africa and South and Southeast Asia and for his contributions to our understanding of demographic transition and health flows. In 1985, he received the Irene Taeuber Award for excellence in demographic research, the highest prize presented by the Population Association of America. During 1994–97, he was the President of the International Union for the Scientific Study of Population, the top-most international body for demography. And, in 2004, he was presented with the United Nations Population Award. 'These are the three highest international honours in the field of demography and no other person has won all three of these awards' (Douglas, Hull, and McDonald 2016). 'A 2009 survey of nearly 1,000 demographers worldwide, named him the most influential researcher of all time in the demographic field' (ibid.). To be invited to deliver a lecture in memory of such an illustrious scholar is a rare honour, indeed. I thank the Indian Association for Social Sciences and Health, and particularly its President, Professor T. V. Sekher for this honour.

On Selecting the Theme of the Lecture

Having accepted the invitation to deliver a lecture in memory of Professor Caldwell, I was in a dilemma about the theme of my lecture. I am neither a demographer nor a specialist in health studies – demographic transition and health flows being the areas in which Caldwell's work is cited almost invariably. But what is most striking about his fieldwork is the approach he pioneered, which is known as 'micro-demography, combining anthropological and survey research – initially in Ghana and Nigeria … and later in South Asia' (McNicoll 2016). Indeed, his was the leading voice in the call within demography for more anthropological methods. In their editorial introduction to *Anthropological Demography: Towards a New Synthesis*, David I. Kertzer and Tom Fricke write, 'Caldwell's own transformation from a traditional demographer to an internal critic grew out of his exposure to village studies and the reading of ethnographic literature, largely from the British tradition, in West Africa' (Kertzer and Fricke 1997: 12).

In his book *Theory of Fertility Decline*, Caldwell wrote,

> Most demographers work on large data sets, often with little contact with the people whom the statistics describe. Fortunately, in early 1962 it became clear that the 1960 Ghana Census was not going to yield material quickly enough to absorb my time. We [Caldwell and his anthropologist wife, Rosie 'Pat' Caldwell] thereupon used our limited funds for cheap and relatively small-scale investigations which meant borrowing methodology from the anthropologists (and reading them) and becoming intimately acquainted with each village and its families in turn. For a demographer with traditional training, the experience was illuminating – so illuminating that we have attempted to use similar methods ever since. (Caldwell 1982: 4, quoted in Kertzer and Fricke 1997: 12).

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[1] This forms the text of The Fourth Professor John Caldwell Memorial Lecture delivered under the auspices of the Indian Association for Social Sciences and Health at its seventeenth annual conference held at the Indian Institute of Technology – Mandi (Himachal Pradesh), on 8 December 2019.

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Writing with demographer Allan Hill, in 1988, Caldwell lamented the fact that demographic research was 'surprisingly deficient in theory', attributing this both to an (understandable) obsession with measurement issues and 'the reluctance of demographers to engage in research whose methods are unconventional and whose output cannot be measured in numerical terms' (Caldwell and Hill 1988: 1, quoted in Kertzer and Fricke 1997: 12). Surveys, they argued, are not only limited in the nature of the data they collect, but the data themselves are of questionable validity, for 'the tendency is to obtain normative responses or reflections of the rules, particularly on sensitive topics' (ibid.: 4, quoted in Kertzer and Fricke 1997: 12). To rectify the problem, they called for the adoption of a 'micro-level' or 'anthropological' approach, in order to 'encourage a more holistic view' (ibid.: 2, quoted in Kertzer and Fricke 1997: 12). Caldwell's work in South India (see Caldwell, Reddy, and Caldwell 1988) is but one illustration of the significance of this approach.

Caldwell's 'anthropological demography' was more than merely incorporating a fieldwork element in demographic research, adding a dose of qualitative data into what would otherwise be a predominantly quantitative study. To be sure, he recognised the objectivity and scientific importance of statistical data, as French sociologist Émile Durkheim (1858–1917) had shown in his classical study on suicide (see Durkheim 1952). But what Caldwell wanted to highlight was the need to move beyond the objectivist ontology and positivist epistemology underlying quantitative approach to studying social reality. To make numbers meaningful, he appreciated the significance of constructivist ontology and interpretivist epistemology underlying the qualitative approach.[3] The root assumption of constructivist ontology and interpretivist epistemology, as pithily stated by Peter L. Berger and Thomas Luckmann, is that 'reality is socially constructed' (Berger and Luckmann 1971: 13).

Taking the implicit cue from Caldwell's 'anthropological demography', I thought it would be apposite for me to dwell on the social construction of *health* and disruption or lack of it, that is, *illness*. After all, both health and illness are a reality in the sense that we recognise them 'as having a being independent of our own volition (we cannot 'wish them away') (ibid.). Although we generally take health for granted and appreciate it when our health is upset even slightly, the fact of illness is hardly ever taken for granted. The ideal of health, at the one end, and the reality of terminal illness, at the other, constitute a continuum. In our everyday life we encounter and experience this continuum in some way or the other, as concerning ourselves or our kith and kin. While the state of health as a value and the reality of illness is generally defined and measured in medical terms, our everyday engagement with health and illness goes beyond medical terms; it is articulated and transacted in socio-cultural terms. An understanding of the way health and illness is socially constructed is important to all those concerned with health and illness. This is the crux of the instant lecture.

Medicalisation of Health and Beyond

From time immemorial, human life on earth, from birth through growth to death, has been a matter of uncertainty and, as such, a cause of anxiety, too. In all historically known societies, the transitional periods in a person's life, such as birth, maturity/puberty (among girls), reproduction, and death are marked by ceremonies. The prevalence of such ceremonies worldwide was identified by the French anthropologist and folklorist Arnold van Gennep in 1909 as a class of phenomena, *rites of passage* – a phrase coined by him (Norbeck and Alexander nd). In many a society, the most commonly observed rites of passage relate to crises in the life cycle, and though these crises are primarily biological in nature, their relative

[3] On the contrasting ontological (objectivist and constructivist) and epistemological (positivist and interpretivist) positions, see Jayaram (2017).

rites articulate socio-cultural meaning, expressed in the form of beliefs and lore. As many as six of the *Shodasha Samskara*s (sixteen rites of passage) – *Garbadhana* (rite to mark conception), *Pumsavana* (rite to beget good progeny), *Seemantha* or *Seemanthonnayana* (rite for the protection of the expectant mother and womb), *Annaprashana* (rite for the first feeding of the solid food), *Ritushuddhi* (rite for attaining physical maturity by a girl), and *Antyeshti* (last rites or cremation) – in Hindu philosophy mark life crises (Vaidika Samhita 2017).

Given the anxiety surrounding health and illness, it is not surprising, that in all known societies, people have articulated ideas and beliefs about what it is to be healthy and what it is to be ill. Each society, in other words, has a set of assumptions about the basis of health and causes of illness (ontology of health and illness) and about the knowledge to validate the diagnosis of these states (epistemology of medical knowledge). As the Croatian-Austrian philosopher and Roman Catholic priest Ivan Illich (1926–2002) puts it,

> Each society has its characteristic 'nosology', or classification of diseases. Both the extent of conditions classified as disease and the number and kinds of diseases listed change with history. The official or medical nosology recognized in a society can be to a very high degree out of gear with the perception of the disease shared by one or several of the society's classes. (Illich 1977: 40, fn. 6; see also Foucault 1994)

Accordingly, each society's culture creates its own response to disease. That is, the course of treatment adopted to cure an individual of her/his ailment and help her/him to regain the state of health is also more or less unique. The course of treatment involves proscription of certain kinds of ordinary behaviour and prescription of certain kinds of extra-ordinary behaviour. Abstinence (stopping a person from having or doing something that he or she enjoys) and instructions (ordering a person to do or how to do something) are part of the treatment.

However, with the birth of modern medicine in western Europe in the closing years of the eighteenth century, and its spread – mainly as a part of European colonialism – the world over, nosology has come to be 'almost totally medicalized; ill-health that is not labelled by the [modern] physician is written off either as malingering or as illusion' (Illich 1977: 40, fn. 6). But, as Illich notes, 'to postulate for every society a specifically "sick" kind of deviance with even minimal common characteristics is a hazardous undertaking' (ibid.: 118).

Nevertheless, modern medicine embarked on a programme of standardisation of diseases,[4] their diagnosis, and their treatment using chemical substances as therapeutic agents and surgical procedures. The claim of modern medicine to the status of science rests on its positivist orientation rooted in Enlightenment and the principle of rationality. As the French philosopher and historian Michel Foucault (1926–1984) notes, the positive nature of the clinical medicine 'should be taken in the strong sense' of the term: 'Disease breaks away from the metaphysic of evil, to which it had been related for centuries; and it finds in the visibility of death the full form in which its content appears in positive terms' (Foucault 1994: 196).

Science insists on objective knowledge of reality and this knowledge is obtained through systematic observation, which is expressed through specific expressions (called objective expressions as contrasted with 'indexical expressions', to use a term from ethno-methodology[5]) and precise measurements. As Jean-Charles Sournia writes in his 1962 book *Logique et Morale du Diagnostic*,

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[4] On the standardisation of diseases in modern medicine for epidemiology, health management, and clinical purposes, see World Health Organization (2018).

[5] On the ethnomethodological distinction between 'indexical expressions' and 'objective expressions', see Garfinkel (1967: 4).

> In order to be able to offer each of our patients a course of treatment perfectly adapted to his illness and to himself, we try to obtain a complete, objective idea of his case, we gather together in a file of his own all the information we have about him. We 'observe' him in the same way that we observe the starts or a laboratory experiment. (Translated from the French and quoted in Foucault 1994: xv).

Thus, in modern medicine, the person suffering from an illness becomes *a case*, that is, an 'object of positive knowledge' (ibid.: 197). This is not just a methodological point, but an ontological and epistemological assertion, too. But 'medical certainty', points out Foucault, 'is based not on the *completely observed individuality* [as it would be in phenomenology] but on the *completely scanned multiplicity of individual facts*' (ibid.: 101; emphasis in original). In addition, modern medicine insists on precise measurement and, in some cases, even mapping the signs of the ailment. From the thermometer to measure variations in body temperature to very sophisticated instrumentation of medical diagnosis – including X-Rays, MRI (Magnetic Resonance Imaging), CT (Computed Tomography) scans, ultrasound, and a battery of various tests (glycosylated or glycated haemoglobin [HBA1C], estimated average glucose [eAG]; renal profile [blood urea, serum creatinine, sodium, potassium, chloride]; liver function test [Total bilirubin, direct, SGOT, SGPT, alkaline phosphatase, total protein, albumin, globulin, A:G ratio]; lipid profile [total cholesterol, triglyceride, HDL (high density lipoprotein) cholesterol, LDL (low density lipoprotein) cholesterol, VLDL (very low density lipoprotein) cholesterol, total cholesterol–HDL cholesterol ratio, LDL cholesterol–HDL cholesterol ratio]; thyroid stimulating hormone [TSH], and many more) – modern medical science has been inventing and refining its measuring and mapping instruments. Medical research (and some modern medical practitioners) use computer-aided analytical tools. The sophisticated application of bio-statistics has resulted in development of indices for the symptoms and signs of various ailments – diabetes, urinary tract infections, thyroid malfunction, cholesterol imbalances, etc. – and based on statistical averages mainly, it even fixes what is the *normal* (sometimes recommended as the ideal) body temperature, HBA1C, HDL, LDL, blood urea, serum creatinine, albumin–globulin ratio, liver function, TSH, etc., level or range.[6]

The traditions of medicine, however hoary a past they may have and which are still practised in societies in which they are rooted, are marginalised if they do not fit into this positivistic mode of diagnosis and treatment of illnesses. Ailments that cannot be subjected to the diagnostic protocols and treatment procedures of modern medicine are dismissed as malingering, hypochondria, or illusion. The efforts at curing these ailments by non-modern medical systems or indigenous practices, too, are dismissed as unscientific, and as being dangerous to the patient. It is not surprising, therefore, that to gain acceptability and respectability many an indigenous system of medicine imitates the protocols and procedures of modern medicine and of medical education and practice. The attempt at professionalisation of

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[6] Medical identification of normal (or ideal) level or range is a statistical average and such levels or ranges 'are changed *when sufficient new evidence suggests the old ones weren't accurate or relevant anymore*', as Dr Paul Conlin, an endocrinologist with Harvard-affiliated VA Boston Healthcare System and Brigham and Women's Hospital (Harvard Men's Health Watch 2018; emphasis added). For example, in 2017,

> … new guidelines from the American Heart Association, the American College of Cardiology, and nine other health organizations lowered the numbers for the diagnosis of hypertension (high blood pressure) to 130/80 millimeters of mercury (mm Hg) and higher for all adults. The previous guidelines set the threshold at 140/90 mm Hg for people younger than age 65 and 150/80 mm Hg for those ages 65 and older' (ibid.).

Persons who do not conform to the ideal level or range are not *necessarily* morbid; each body is different and will have its own 'normal' level or range, which is difficult to gauge. Sometimes, these averages seem to differ in terms of ethnicity and, in some countries, in addition to the normal level or range, the diagnostic laboratories also mention the expected level or range for the relative ethnic group.

Ayurveda as an Indian system of medicine – not as practised by the *nati vaidya*s (native 'physicians') – is a case in point (see Leslie 1968).

To be sure, the achievements of modern medicine in the last two centuries have been stupendous. The precision with which it has been able to assess the nature and extent of an ailment; the advancements it has made in medical mechanics through utilising bio-engineering and bio-technology, as witnessed in a variety of implantations, transplantations, and replacements; and the pharmacological innovations since the discovery of aspirin (acetyl salicylic acid) in the 1890s by chemist Felix Hoffman at Bayer in Germany are mind-boggling.

All this notwithstanding, modern medicine has come in for severe criticism. The earliest of such criticism came from the Irish physician V. M. Synge in 1925 (see Synge 1926) and there have been many critics of modern medicine in recent times, too (see Navarro 1977; Nandy and Visvanathan 1990; Doyal (with Pennell) 1994; Doyal 1995; Le Fanu 2002, 2011, 2018; O'Mohony 2019). The most systematic and comprehensive of such criticism of modern medicine is provided by Illich in his celebrated book, *Limits to Medicine: Medical Nemesis – The Expropriation of Health* (see Illich 1977).[7] While Illich and other critics, too, have concentrated on different aspects of the limits to modern medicine and its abuse and corruption by its practitioners, I will rest on the criticism of its ontology and epistemology, as that is the underlying thesis of this lecture.[8]

Illich argues, 'the fact that modern medicine has become very effective in the treatment of specific symptoms does not mean that it has become more beneficial for the health of the patient' (ibid.: 80–81). While 'the average life-span' has increased, 'the maximum life-span has not changed' (ibid.: 81). Modern medicine, to be sure, has been to a great extent successful in prolonging life; but, in many cases, this has also meant prolonging suffering for the patient as well as for her/his family. More importantly, 'health has ceased to be a native endowment each human being is presumed to possess until proven ill … Until proved healthy, [everybody] is now presumed to be sick' (ibid.: 122 and 121).

Modern medicine was introduced in India as part of European colonialism and its project of modernisation. As observed by Ashish Nandy and Shiv Visvanathan (1990), this has resulted in the marginalisation of traditional forms of medicine and effectively deprived Indians of the choices available within their pluralistic systems. They argue that 'though psychological and cognitive constraints on medical choice are different from political economic constraints, they are heavily influenced by politics and economics' (ibid.: Abstract[9]). They further contend that 'the refusal to acknowledge the cultural source of the bias in favour of modernization makes it even more difficult to defend tradition' (ibid.).

In India, modern medicine has developed and spread considerably, but the indigenous traditions, including *nati vaidya* and grandmother's home remedies, have not been eclipsed, though they are marginalised. Under these conditions, how do laypersons construct the reality of health and illness of their own as also that of their near and dear ones, and how do they negotiate modern medicine? An understanding of this necessitates the invocation of phenomenology of health and illness.

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[7] Illich's main thesis is that 'the [modern] medical establishment has become a major threat to health' (Illich 1977: 3). 'Iatrogenesis' (from *iatro* (Greek) = physician and *gennan* (Greek) = to produce), the axial concept around which this thesis revolves, refers to 'any adverse condition in a patient occurring as a result of treatment by a physician or surgeon' (*Dorland's Illustrated Medical Dictionary* [25th ed.], cited in ibid.: 14, fn. 5). He delineates three aspects of iatrogenesis: 'clinical iatrogenesis', 'social iatrogenesis', and 'cultural iatrogenesis'.

[8] In critiquing the ontology and epistemology of modern medicine, I draw heavily on Illich (1977).

[9] The abstract of Nandy and Visvanathan's chapter is available at https://www.oxfordscholarship.com (accessed on 29 November 2019).

Phenomenology of Health and Illness

Phenomenology postulates an intrinsic relationship between culture and health. As Illich puts it, 'Each culture gives shape to a unique *Gestalt* of health and to a unique conformation of attitudes towards pain, disease, impairment, and death, each of which designates a class of that human performance that has traditionally been called the art of suffering'[10] (Illich 1977: 128). Thus, 'each culture has its own characteristic perception [and definition] of disease' (ibid.: 44) and '… creates its response to disease' (ibid.: 118).

'Health' is an everyday word that is used to designate 'the intensity with which individuals cope with their internal states and their environmental conditions' (ibid.: 7). The Sanskrit words *Svasthya* (health) and *Svasth* (healthy) – from *Svasthi* [*su* (good) and *asti* (to live or exist) = coming to or realising one's own self] meaning wellbeing or welfare – capture the essence of this designation the best. Both '*Svasthya*' and '*Svasth*' are defined positively, and the lack of it, *Asvastha* designates not being well or being indisposed or sick. The other Sanskrit word for health, namely, *Arogya* or *Nirog*, is defined negatively to mean a state of being free of decease – *a* (non) and *rog* (disease).

In all cultures, Illich writes, each person's health is

> a responsible performance in a social script. How he relates to the sweetness and the bitterness of reality and how he acts towards others whom he perceives as suffering, as weakened, or as anguished determine each person's sense of his own body, and with it, his health. Body-sense is experienced as an ever-renewed gift of culture. (ibid.: 129)

'Cultured health', thus, 'is bound by each society's style in the art of living, feasting, suffering, and dying' (ibid.: 130).[11] And 'All traditional cultures derive their hygienic function from this ability to equip the individual with the means for making pain tolerable, sickness or impairment understandable, and the shadow of death meaningful' (ibid.).

Traditionally, most healing was a way of 'consoling, caring, and comforting people while they heal, and most sick-care a form of tolerance extended to the afflicted' (ibid.: 131). In fact, as Illich points out, most of human ailments 'consist of illness that are acute and benign – either self-limiting or subject to control through a few dozen routine interventions. For a wide range of conditions, those who are treated least probably make the best progress' (ibid. 79–80). He recalls Hippocrates' aphorism, 'For the sick, the least is best' (ibid.: 80).[12]

Interestingly, some of the traditional remedies, identified with *nati vaidya*s and grandmother's medicine chest, have been appropriated by modern medicine, without due credit being given them. The case of turmeric (*Curcuma longa*) – a standard ingredient of grandmother's remedies in India for centuries – is a case in point. Given its use in the treatment of many maladies, it was sought to be patented by the American pharmaceutical industry.[13] The role of massage, *jaṛī būṭī* (herbs), and special diet for treatment of some ailments in our

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[10] Regrettably, however, most of the anthropological and sociological literature on health-enhancing behaviour and on the beliefs underlying it deal with curing and not with the maintenance and expansion of health (Illich 1977: 128–9, fn. 6).

[11] In his article on 'primitive medicine', published way back in May 1946, Erwin H. Ackerknecht provides convergent evidence that medicine plays 'a social role and has a holistic and unitarian character in primitive cultures that modern medicine cannot provide' (cited in Illich 1977: 130, fn. 10).

[12] Elaborating on this, Illich writes,

> More often than not, the best a learned and conscientious physician can do is convince his patient that he can live with his impairment, reassure him of an eventual recovery or of the availability of morphine at the time when he will need it, do for him what grandmother could have done, and otherwise defer to nature. (Illich 1977: 80).

[13] The Government of India successfully challenged the US patenting of turmeric leading to cancellation of the patent (see Kumar 1997).

traditional medicinal repertoire may be noted in this context. Incidentally, the medicaments were sold in traditional shops known in Kannada-speaking areas as *gaṇḍige aṅgaḍi*. The practitioners of the so called 'alternative medicine', who also happen to be critics of modern medicine, have rediscovered and promote these traditional medicines.

A significant re-discovery by modern medicine is that of the singular significance of breastfeeding. Traditionally, babies were breastfed for at least a year, and for a longer period in some cases. If a mother could not produce enough breast milk by herself, other post-natal mothers (*bāṇanti* in Kannada) in the neighbourhood suckled the babies; the concept of 'wet nurse' encapsulates this practice. The first feeding of the solid food was marked by a rite, *Annaprashana*, which was one of the *Shodasha Samskara*s. Keeping in view the metabolism of the growing baby, it was given locally available nutrients as food. With modernisation there was a 'switch to the bottle' and the use of a variety of factory-produced 'baby food', and the feeding-bottle even became a status symbol. The damage that bottle-feeding did 'to natural immunity mechanisms fostered by human milk and the physical and emotional stress' and 'the menace of world-wide protein starvation' (ibid.: 87) forced modern medicine to give a call for 'back to breast-feeding'.[14]

'Old age' is designated by various vernaculars – *bārdhakya* in Bengali, *buḍhāpā* in Hindi, *muppu* in Kannada, *mutumai* in Tamil, etc. – to connote a culturally defined stage of life. Certain physical and mental conditions and behaviours were expected and tolerated in old people. In a monumental study of old age throughout history in the perspective of contemporary ageing, Simone de Beauvoir (1972, cited in Illich 1977: 81, fn. 142) observed that old age has been variously considered across societies – 'a doubtful privilege or a pitiful ending' (Illich 1977: 81) – but never a disease. Today, however, more so in western societies and even in urban areas in India, it has been medicalised. There is a special branch of medicine, called *geriatrics* (or geriatric medicine or medical gerontology), which aims to promote the health of the elderly by treating their diseases and disabilities. Under the influence of modern medical practitioners and medical media, more and more old people are made to internalise the idea that their old age is a medical condition that needs to be cured.

For the phenomenologist of health and illness, what Indian origin American surgeon Atul Gawande, the author of the famous book *Being Mortal* (2014), has to say about his grandfather who lived in his Indian village until the age of 110 surrounded by his extended family is important. In response to a question – 'Should we be nostalgic for that? – by Tim Adams of *The Guardian*, Gawande responds:

> My grandfather had an amazing life. He worked the farm right up to the end of his days, helped by his children and grandchildren. He was still the head of the dinner table, revered, people came to him for advice. He had some problems with his memory and his mobility of course, but no one ever thought that the answer might come from a nursing home. *In [the west] we tend to never ask people: 'What is a good day for you?' Instead we say: 'This is what the doctor says you have to do to stay healthy.'* (Gawande 2015; emphasis added)

Following old age, to talk about death is natural. Death, Gawande writes, 'is not a failure', it is 'the natural order of things', it is 'normal' (Gawande 2014: 8). He quotes the late surgeon Sherwin Nuland, who in his classic book *How We Die* (1993), lamented, 'The necessity of nature's final victory was expected and accepted in generations before our own. Doctors were far more willing to recognize the signs of defeat and far less arrogant about denying them'

[14] With bottle-feeding, 'new illnesses appeared among children who had been denied the breast, and since mothers lack traditional know-how to deal with babies who do not behave like sucklings, babies became new consumers of medical attention and of its risks' (Illich 1977: 87, see also fn. 158, 159 and 160 therein).

(quoted in ibid). Thus, every culture has its eschatology; every culture elucidates the meaning of death, both for the individual and those whom he/she leaves behind.

Among the Hindus, the *Antyeshti* (Sanskrit, *antya* = last and *isti* = sacrifice) or *Antima Samskara* (*antima* = last and *samskara* = rite), the rites which follow the death of an individual, embody the meaning of death and how, after a period of liminal mourning, those left behind would resume their quotidian routines. The *Garuda Purana*, one of the *ashtaadasha maha-purana*s – which is in the form of a dialogue between Lord Vishnu and his *vahana* Garuda – in Hinduism (especially Vaishnavism) deals with the meaning of human life and death and its aftermath. This epic, which is customarily recited whenever there is death in a Hindu family, describes the funeral rites, rituals, and ceremonies starting from death till the completion of one year (Thakur 2014).[15] To be sure, similar texts exist in other sects/denominations and religious communities which explain the meaning of death as a natural order.

With modern medicine death came to be medicalised. As Foucault puts it, 'death became the concrete a priori of medical experience' and with that death detached itself from 'counter-nature' and became '*embodied* in the *living bodies* of individuals' (1994: 196; emphasis in original). Foucault goes on to write,

> It will no doubt remain a decisive fact about our [modern] culture that its first scientific discourse concerning the individual had to pass through this stage of death. Western man could constitute himself in his own eyes as an object of science, he grasped himself within his language, and gave himself, in himself and by himself, a discursive existence only in the opening created by his own elimination … (ibid.: 197)

While this is the essential difference between the traditional folk-oriented and modern medicine-oriented views of death, mortality as a medical experience, which is now widespread in the western societies, is also gradually spreading in the traditional societies. In urban areas, at least, 'unmedicated death' is on the wane and 'hospital death' is gradually becoming common. As Illich comments, 'intensive care for the dying' has, in a way, become 'a funeral gift for the unburied' (Illich 1977: 106). Dying surrounded by people one knows is an entirely different experience from dying in isolation in an intensive care unit or surrounded by people one does not know (ibid.: 107). Gawande adduces evidence to show that the 'experiment of making mortality a medical experience … is failing' (Gawande 2004: 9). Hence, in his book *The Way We Die Now* the Irish gastroenterologist Seamus O'Mahony (2016) argues diligently that we should accept and embrace the inevitability of death (as people did in traditional societies), rather than deny and disguise it with endless overtreatment. Incidentally, modern medicine can hardly explain the meaning that human beings seek about death. We, therefore, finally turn to *Garuda Purana* or a similar eschatological text.

Patient–Doctor Interaction

The interaction between patient and doctor in modern medicine provides the context for the transaction between the subjective construction of her/his illness by the patient and its supposed objective diagnosis, prognosis, and therapeutics by the doctor. Mathew George argues that 'clinical interaction is not merely a two-way communication desired for exchange of information; rather, it is an outcome of doctors (thought styles) and patients (lifeworld) about an event (illness) within their respective contexts' (George 2010: 159). Consultation is the forum in which the 'voice of illness' (of the patient) meets the 'voice of medicine' (of the

[15] *Kathopanishad* is another Hindu text dealing with death. Rendered in verse form as 'The Secret of Death' by Edwin Arnold, it narrates the story of Nachiketä, son of sage Väjasravasa, and his encounter with Lord Yama, the Hindu God of Death and Righteousness (Yama Dharmaräja) (Saraswathi 2013).

doctor); the 'lay expressions of the experience of illness' by the patient encounter 'the biomedical and scientific assumptions of the doctor' (ibid.: 162); and the patient's category of *illness* is transformed into a medical category of *disease* (Old French, *desaise*, 'lack of ease' [from *des-* (expressing reversal) + *aise* (ease)]) (ibid.: 159).

In diagnosis, doctors interpret the symptoms reported by patients. Patients (or their caregivers) describe their illness and its symptoms using common-sense expressions or 'indexical expressions'. Doctors interpret these common-sense expressions in terms of the objective expressions of medical science. Of course, through a process of sedimentation, such objective interpretations by doctors of common-sense expressions by patients (or their caregivers) is standardised in doctor–patient interactions.[16] But the scope of subjective expressions being too vast, depending as they are on the socio-cultural location of the patients, the objective interpretation by the doctor need not necessarily be symmetrical; a shared world of meaning between the patient and the doctor largely does not exist. This asymmetry is a crucial issue in patient–doctor interaction and the appropriateness of the diagnosis, prognosis, and therapeutics of the illness by the doctor.

Since reporting of 'symptoms' by the patient is important for the doctor's 'diagnosis', some elaboration on the concepts of symptoms and signs is in order. Foucault writes,

> The symptom … is the form in which the disease is presented: of all the visible, it is closest to the essential; it is the first transcription of the inaccessible nature of the disease. Cough, fever, pain in the side, and difficulty in breathing are not pleurisy itself – the disease itself is never exposed to the senses, but 'reveals itself only to reasoning' – but they form its 'essential symptom', since they make it possible to designate a pathological state (in contradistinction to health) … The symptoms allow the invariable form of the disease … to *show through*'. (Foucault 1994: 90; emphasis in original; text within quotation marks are cited from G. Zimmermann).

The sign is semantically and morphologically different from symptom. According to Foucault, it

> … announces: the prognostic sign, what will happen; the anamnestic sign, what has happened; the diagnostic sign, what is now taking place. Between it and the disease is a distance that it cannot cross without accentuating it, for it often appears obliquely and unexpectedly. It does not offer anything to knowledge; at most it provides a basis for recognition – a recognition that gradually gropes its way into the dimensions of the hidden … (ibid.)

For example, 'the pulse betrays the invisible strength and rhythm of the circulation; or, again, the sign discloses time, just as the blueing of the nails is an unfailing announcement of death' (ibid.: 90–1), and so on.

Foucault clarifies, 'it is the sovereignty of consciousness that transforms the symptom into a sign' (ibid.: 93). He elaborates this cryptic observation thus:

> In its material reality, the sign is identified with the symptom itself; the symptom is the indispensable morphological support of the sign. Hence 'no sign without a symptom' [quoted from Augustin Jacob Landré-Beauvais]. But what makes the sign a sign belongs not the symptom, but to an activity that originates elsewhere. Thus 'every symptom is a sign' by right, 'but not every sign is a symptom'

[16] One consequence of this standardisation has been the trivialisation of the doctor's function in developing countries: the doctor has been turned into 'a routine prescription machine' (Illich 1977: 65). The patients or their caregivers incorporate the 'prescription' into their 'medical knowledge' and self-medicate subsequently whenever the symptoms of the illness recur. Not infrequently, the local pharmacist becomes the 'doctor' and peddles medicines, including the 'Schedule Drugs', which are to be sold in retail only on the prescription of a Registered Medical Practitioner. All this has an adverse consequence, as Illich points out: 'Powerful medical drugs easily destroy the historically rooted pattern that fits each culture to its poisons; they usually cause more damage than profit to health …' (ibid.: 63).

> [quoted from Augustin Jacob Landré-Beauvais] in the sense that the totality of symptoms will never be able to exhaust the reality of the sign. (ibid.: 93)

How do these conceptual categories vis-à-vis patient–doctor interaction relate to the phenomenological perspective on health and illness? I will answer this question by reference to an excellent ethnography of malaria in south Gujarat (see Lobo and Prasad 1998; Prasad 2005).

Ethnography of Malaria

During 1995–2000, the Centre for Social Studies (CSS), Surat conducted a multi-disciplinary research study (involving entomologists, epidemiologists, social scientists and health policy-makers) in Surat district in Gujarat with the objective to develop a strategy for malaria control and prevention. The study, sponsored by Government of India, mainly tested three interventions – Insecticide Treated Mosquito Nets, Indoor Residual Spray, and Early Detection and Prompt Treatment – in forty-two villages each in coastal, plains, and hilly zones of the district. As part of the study, ethnographies were conducted in these villages to largely elicit knowledge, attitudes, perceptions, and behaviour of people.

The asymmetry between the language of the patient and that of the doctor is confirmed by this malaria study. Sociologist Purendra Prasad, who was involved in this study, remarks,

> The terms used by laypersons to explain sickness often do not coincide with those used in the biomedical parlance…At times, both may be using the same term for indicating different things and, at others, both use different terms to mean the same thing. For instance, when people say they are affected with 'malaria',[17] they may not mean the same thing as medical professionals do, though both use the same word.[18] (Prasad 2005: 223).

The study found that, people in Surat district use two local terms, *bimari* and *mandgi*, for illness. *Bimari* is illness of short duration and includes cold, cough, fever, diarrhoea, etc.; *mandgi* is illness of a longer duration and includes jaundice, malaria, typhoid, etc. In addition, the term *rog* is used to refer to chronic illnesses like tuberculosis, cancer, asthma, paralysis, arthritis, skin diseases, etc., which require 'continuous attention' and cannot be easily cured. When the term 'Malaria'[19] is used by laypersons, it is *bimari* for some and *mandgi* for others, 'depending upon their perceived sickness, intensity of pain, frequency of sickness, etc. The reference group is always their own family members or kin group who were affected with intense sickness' (ibid.: 225).

The study identified 'fifty different local names for fever'[20] (ibid.: 234), terms which are meaningful in the local context. They differ in terms of the frequency of their occurrence, sites of fever/pain, causes, and season (ibid. 226). People recognised the fluidity of *tav* and distinguished between *zino tav* (simple fever) and *moto tav* (intense fever) (ibid.: 227). Similarly, pain and suffering were designated differently by different groups – for example, '*antario tav* was used in multi-caste villages in the coastal zone; *varino tav*, in the plains

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[17] 'Malaria is a parasitic disease spread by the bite of Anopheles mosquito which is active between dusk and dawn. Malarial symptoms can occur eight days after an infected bite. The principal symptoms are fever, malaise, headache, chills and sweats, but it can present itself as a respiratory or gastrointestinal illness, too' (Prasad 2005: 235, fn. 7).

[18] Prasad points out, 'the research projects and intervention programmes on malaria implemented by the government through different funding agencies also influenced people to largely adapt the biomedical or English terms whether they mean the same thing or not (Prasad 2005: 235, fn. 8).

[19] Incidentally, the laypersons use 'the biomedical term malaria … it also includes local fevers which may or may not correspond to malaria' (Prasad 2005: 235, fn. 11).

[20] *Tav* (in Gujarati) and *jora* (in tribal [Gamits] dialects) are the generic terms used to refer to fever in the district. These words derive from the Sanskrit *tapa* and *jwara*, respectively (Prasad 2005: 225).

(both tribe and caste villages); and *varkiliya jora*, in the tribal hilly zone' (ibid.: 226). Similarly, 'some fevers have different names even within the same village, like *antario tav*, which is same as *ekantario tav* (fever that comes on alternate days). Another example is *zeri tav* (poisonous fever) and *magazno tav* (cerebral fever) which are used synonymously' (ibid.: 226–7).

In the case of malaria, the symptoms of *tav* or *jora* are further elaborated: *kadtar tav*/*dukhavo* (internal heat/pain in the body), *sharir dhagu dhagu thaye* (steam comes out from the body), *jeev ukalat* (uneasiness), *hath pag fatva made* (acute 'tearing' pain in limbs), *sharir dhilu dhilu lage* (loosening of the body), *mathu fati jatu hoi tem bahuj dukhava lage* (severe headache), etc. *Ashakti* (general weakness) was another descriptor of illness, implying their condition of illness rather than a label for the illness. 'These terms or narratives not only indicated physical abnormalities, but also social problems or complications in day-to-day life' (ibid.: 225). Moreover, 'the biomedical term "malaria" is … understood in a varied sense in the study area' (ibid.). Prasad clarifies that

> These semantics, emanating from their bodily experiences, to describe their pain and sickness have no meaning in a different context. Moreover, these semantics, expressed to indicate their pain in terms of 'sickness in itself' and 'symptoms', do not get acceptance because the words used neither coincide with the bio medical term malaria nor the sequence of 'signs'. (ibid.: 227)

The study concludes that 'an analysis of disease/health that isolates the individual from her/his social environment not only fails to identify sickness [and] address contributing and causative factors, but [also] implicitly accedes to the continuation of power arrangements in social relations' (ibid. 233). Hence the importance of understanding health and illness from the sufferer's (and their caregivers') point of view, as suggested by the phenomenological perspective.

The malaria study conducted by CSS, Surat is but one example of understanding the social construction of health and illness. For want of space and time, I will not elaborate on similar studies focusing on other illnesses. Suffice is it here to mention the works of Aastha Kant (2019) on 'experiencing' pregnancy and childbirth in a resettlement colony in Delhi, Radhika Ramasubban and Bhanwar Rishyasringa (2001) on weakness (*ashaktapana*) and reproductive health among women in a slum population in Mumbai, V. Sujatha (1994, 2002) on medico-cultural compatibility in a Tamil Nadu village and on medical lore on food and health there, and Pooja Sharma (2017) on the ethnography of palliative care practices among cancer patients as some important examples of work on health and illness undertaken from the phenomenological perspective.[21] Invaluable insights on mental illness are revealed by the phenomenological works of George Morrison Carstairs and Ravi L. Kapur (1976) on stress, change, and mental disorder in a coastal village in Karnataka; of Renu Addlakha (2008) on an ethnography of psychiatry, women, and the family in Delhi; of Tina Chakravarty (2011, 2014) on medicalisation of mental disorder and on the interface in approaches (psychiatry, Ayurveda, and caregivers) to mental disorder in Mumbai, and of Divya Padmanabhan (2016) on possession and healing in Kerala.

[21] In a recent article in *Sociological Bulletin,* V. Sujatha has made a good case for the study of 'the social dynamics in the everyday life of people, the imperatives on their decisions under lived conditions and their cultural predispositions' for 'the understanding of their health status, whether or not they are statistically significant' (Sujatha 2017: 286). She rightly emphasises the need for 'qualitative and micro enquiries … to correct, complement and explain the issues raised by numerical data' (ibid.).

Conclusion

Western societies may have moved towards embracing an unitarian modern medical system, but societies with a rich cultural heritage of medical knowledge, pharmacopeia of herbs and roots, and a comprehensive philosophy of life and death, can ill-afford to do this. Of course, it would be foolish in going back on the advancements and achievements made by modern medicine. However, what is certainly required is to resist its claim to be the sole custodian of health and to recognise the value of what is called 'medical pluralism' (see Sujatha and Abraham 2012). Towards this, if I have conveyed the necessity and importance of understanding the social construction of health and illness, I deem the purpose of my lecture in memory of Professor John Charles (Jack) Caldwell to have been served.

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