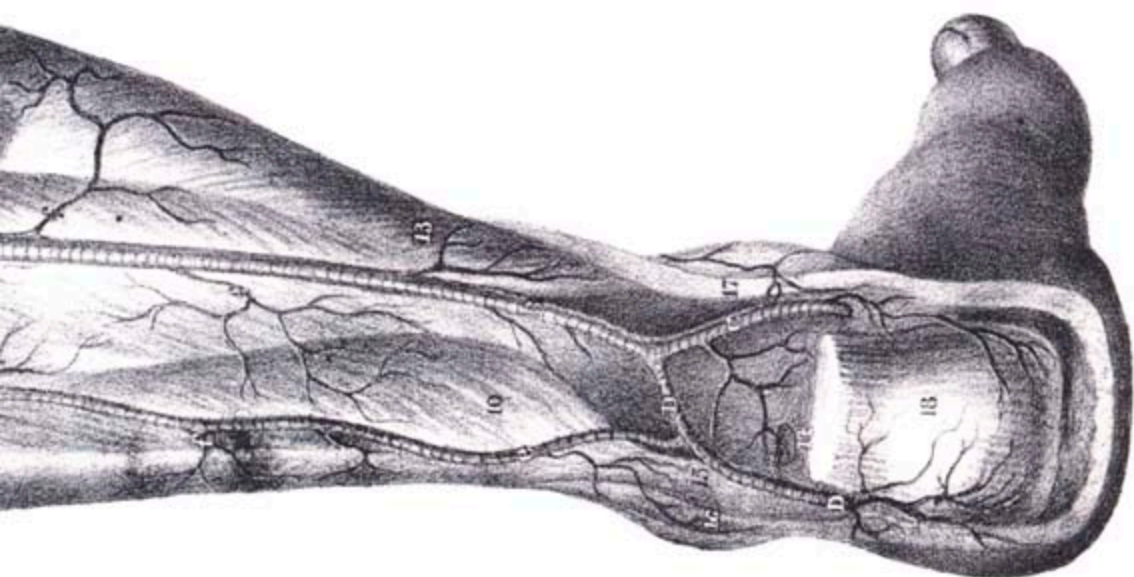


the body multiple: ontology in medical practice

annemarie mol



the body multiple

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preface

This is a book about the way in which (Western, cosmopolitan, allopathic) medicine deals with the body and its diseases. The questions it raises do not concern the ways in which medicine *knows* its objects. Instead, what the book explores is the ways in which medicine attunes to, interacts with, and shapes its objects in its various and varied practices. Or, to use the technical term: this is a book about the way medicine *enacts* the objects of its concern and treatment.

Thus, unlike many other books on medicine and its processes, this one does not speak of different perspectives on the body and its diseases. Instead it tells how they are done. This means that the book comes to talk about a series of different practices. These are practices in which some entity is being sliced, colored, probed, talked about, measured, counted, cut out, countered by walking, or prevented. Which entity? A slightly different one each time. Attending to enactment rather than knowledge has an important effect: what we think of as a single object may appear to be more than one. All the examples in this book concern atherosclerosis. But a plaque cut out of an atherosclerotic artery is not the same entity as the problem a patient with atherosclerosis talks about in the consulting room, even though they are both called by the same name. The loss of blood pressure over a stenosis is not the same thing as the loss of blood vessel lumen that radiologists make visible on their X-ray pictures.

The move, then, is away from epistemology. Epistemology is concerned with reference: it asks whether representations of reality are accurate. But what becomes important if we attend to the way objects are enacted in practices is quite different. Since enactments come in the plural the crucial question to ask about

them is how they are coordinated. In practice the body and its diseases are more than one, but this does not mean that they are fragmented into being many. This is difficult to think. But it is this complex state of affairs that this book explores. I have tried to capture it in the title, in which a singular noun comes with a pluralizing adjective. This, then, is a book about an intricately coordinated crowd: *the body multiple*.

The tone of the text is reflective rather than argumentative. I have no reason either to criticize or to defend medicine as a whole—as if it *were* a whole. Instead of creating a position outside medicine in order to judge it, I try to engage with a normativity of a more intimate kind. I try to open up differences inside medicine and create better access to them. If the objects of medicine are enacted in a variety of ways, truthfulness is no longer good enough. Somehow, questions need to be asked about the appropriateness of various enactments of the body multiple and its diseases. I don't ask such questions here. I don't delve into the question of how the appropriateness of the various enactments presented are, or might be, judged. Instead I try to take part in creating a theoretical repertoire for thinking about this. I contribute to theorizing medicine's *ontological politics*: a politics that has to do with the way in which problems are framed, bodies are shaped, and lives are pushed and pulled into one shape or another.

Its concern with theorizing turns this into a philosophical book. But the philosophy I engage in here is of a quite specific kind. It is explicit about its local origins. Thus, throughout the book there are snapshot-stories about a single multiple disease and the way it is dealt with in a single hospital and some of its surroundings. The disease is atherosclerosis, and more particularly atherosclerosis of the leg arteries. The hospital is a large university hospital in a medium-sized Dutch town, anonymized into hospital Z. By starting out from such a well-circumscribed site, I try to move philosophy away from formats that carry universalistic pretensions, but that in fact hide the locality to which they pertain. However, the idea is not to celebrate localism instead of universalism. Instead, it is to keep track as persistently as possible of what it is that alters when matters, terms, and aims travel from one place to another.

Medical anthropology and medical sociology are rich disciplines. Thus, I had a lot to build on as I sought to incorporate an empirical investigation into my philosophical study. So much so that I have framed this book not only as a debate with the epistemological approach to knowledge, but also as a debate with the way in which the social sciences have studied the body and its diseases in the past. For a long time, social scientists have said that there is *more* than the physicalities treated by doctors. And then they used to study this “more”: a social and an interpretative reality. They have differentiated between *disease* and

illness, taking the latter as their object of study. More recently, the medical perspective on disease has been included in the studies, too. This book is among those who try to take the next move. It says that a study of the enactment of reality in practice makes it possible to ethnographically explore the body multiple and its diseases in all their fleshiness. How? Outlining an answer to that question is precisely what all these pages are for.

The book draws on a variety of literatures: in philosophy, anthropology, science and technology studies, feminist theory, sociology, political theory. This is the present state of theoretical work: disciplinary boundaries get blurred. And yet I wanted to give you, the reader, a good sense of where this book is situated. I wanted to ground it not only in empirical “material,” but also in the intellectual traditions of which it is a product. After hesitating for quite a while about how to do this, I have turned this question into a topic. Throughout this book you will find a subtext, in which I relate to the literature (or, more exactly, to exemplary books and articles) while self-reflexively wondering what it is to do so.

Readers who regularly surf between television channels will find this book easier to read than those who don’t, since they are likely to find out how to shift between the upper text and the subtext more quickly. Others will have to invent a way of reading that works for them from scratch. It may help to know that the subtext is not glued to the pages where it happens to be printed—its location is even more contingent than that of footnotes tends to be. Depending on where and who and how you are, you may want to read the subtext before you read a chapter, or afterward, or maybe when the story line of the upper text starts to bore you and you are in the mood for something different. It is up to you.

The book is written in English. This hides the plurality of the languages that went into its production. In the literature I draw on a few texts in German and a very small number in Dutch (although I have learned a great deal from reading around in my mother tongue). A large part of the literature I relate to was written and read in French. A lot more was in English. As part of my fieldwork I attended some English-language medical conferences and read English-language medical textbooks and research articles (some of them written by my local Dutch informants). But during the day-to-day events in the hospital the language spoken was almost always Dutch. And I also made my field notes in this language. Discussions about the many earlier versions of (parts of) this text were conducted in English, French and again, mostly Dutch.

Thus, though Dutch was a relevant language in the production of this book, in its final version it has vanished. What to say about this? Dutch is understood by only some 25 million people in a few regions of the world (mainly in the Netherlands, Surinam, Belgium, and South Africa where some of those speak-

ing Afrikaans manage to comprehend Dutch—in Indonesia people with a good command of the language of their former colonizer are getting more rare every day). The Dutch failed to combine economic and cultural imperialism, so these days Dutch doesn't travel far. This means that a Dutch language intellectual must make a choice between being *local* or *global*. This choice has little to do with seeking a *small* or a *large* audience. Even if there are far more than 25 million people able to read English, most scholarly texts printed in Dutch are printed in more or less the same numbers as similar books in English. The local is not contained in the global. It is somewhere else.

Its language, then, marks this book as an academic text, made to travel through universities, to be read by scholars and students. I regret it that an attempt to reach my “international” colleagues obliges me to write in a foreign tongue, for that not only brings a lot of extra hard work, but also helps to widen the gap between embodied and inscribed author. Although a book I would publish in Dutch would be read by academic colleagues in neighboring fields as well as by many a Dutch physician, most of these possible readers are far less likely to come across this one. But then again: I am also deeply pleased to not be stuck in Dutchness, but to have been given a chance to acquire access to a language that allows one to reach readers from Norway to India, from anthropology to philosophy, from Germany to Brazil, from medicine to sociology, from the United States to France, and from science and technology studies to feminist theory. Or sometimes texts do not travel at all. That, again, is up to you, reader.

And now for some private history, as introductions go.

The fieldwork for this text started in the early seventies, when, over dinner at the kitchen table, my father told me about his work on using Doppler measurements for the assessment of the carotid arteries. From long before I officially interviewed him, he has been a wonderful informant. My mother engaged with the second feminist wave in the late sixties, turning me into a feminist at age eleven. As a geographer she also made me attentive to the spatiality of landscapes, townscapes, and life in general, for which I thank her.

But this book only really got under way in the academic year 1977–78. I was in the second year of medical school by then and a first-year student of philosophy. Thursdays were the best. In the mornings I had a philosophy class about the body and in the afternoons an anatomy class where we dissected corpses. Barthes gave way to a large, white room that stank of formalin. Merleau-Ponty was followed by corpses wrapped in orange towels and green plastic. In the mornings I would learn to unravel Foucault's writings and in the afternoons I was supposed to explore the pelvic cavity of a female body without cutting through nerves and blood vessels. This is more than twenty years ago and yet

this book is to some extent a product of those long-gone Thursdays, not in the least the remarkable materiality of it all: sentences in difficult French, strange smells, my clumsiness in cutting.

For their help in the intermediate years I would like to thank various people. First of all Peter van Lieshout, with whom I wrote about the coexistence of “ontologies” in the early eighties and later about social theory and the delineation of the object of care in Dutch general practice and mental health care. All along he also helped me to tame the complexity of life—even if he increased it too, if only by fathering Elisabeth and Johannes, our children, whom I thank for being. Jan van Es made it possible for me to become a theorist of medicine in medical school. Lolle Nauta and Gerard de Vries tried to teach me how to argue. Dick Willems shared his energy and his investigations into medicine with me. Jeannette Pols worked on this project with remarkable zeal. Marc Berg and Ruud Hendriks did great work as well, in their shifting roles of research assistant, co-author, and coeditor. Agnes Vincenot, Pieter Pekelharing, Jan Willem Duyvendak, Sigrid Sijthoff, Tsjalling Swierstra, Bernike Pasveer, Hans Harbers, Marja Gastelaars, Sjaak Koenis, Rob Hagendijk, Rein de Wilde, Cor van der Weele, Eddy Houwaart, Baukje Prins, Paul Wouters, Evelien Tonkens, Marianne van den Boomen, Berteke Waaldijk, Mieke Aerts, Jens Lachmund, and Geertje Mak gave support both intellectually and otherwise. I have also learned a great deal from working with Bernard Elsman, Ant Lettinga, Bart van Lange, Antoinette de Bont, Jessica Mesman, Ineke Klinge, Ariane de Ranitz, Brenda Diergaarde, Irma van der Ploeg, Amâde M’charek, Tiago Moreira, Benedicte Rousseau, Alice Stollmeijer, and Toine Pieters in various modes and modalities. I would like to thank Barbara Duden, Donna Haraway, and Marilyn Strathern for the example they set and the work they do and Bruno Latour and Michel Callon for their challenge and encouragement. It was good to sometimes come across Sarah Franklin, Isabelle Baszanger, Charis Thompson, Madeleine Akrich, Vololona Rabeharisoa, Ingunn Moser, Claudia Castañeda, and Vicky Singleton and so feel that I was part of an international *current*. Nicolas Dodier asked the right questions at the right time, and Stefan Hirschauer incited me to be ever more serious. Marianne de Laet listened to my stories and gave careful comments on a previous version. Three reviewers of Duke University Press, whose names I do not know, finally approved of this manuscript, but before that came up with a lot of valuable, constructive criticism. And so did Noortje Marres, who figured as a fresh reader for the penultimate version. John Law attended time and again to all the details of this book, improved on many of them, invented new rhizomes, coauthored and wrote about related topics, corrected the English of several consecutive versions, and pushed me to come to a conclusion. That is a lot. Thanks. To you all.

And finally I would like to thank my informants. Here I begin with Ab Struyvenberg, who welcomed me into the hospital just before he retired and who kept reading my drafts afterward. Of course I could not have done any fieldwork at all without the collaboration of the many doctors, nurses, technicians, researchers, and patients of hospital Z who allowed me to observe and question them. They not only gave me material to think about and to think with, but in some cases also commented on my writings. Going along with the ethnographic habit of protecting the identities of informants, I mention no names here. But I am all the more grateful for their time and their trust.

For its generous financial support I thank the Netherlands Organization for Scientific Research, which provided me with a Constantijn and Christiaan Huygens grant that allowed me to do research and write about *Differences in Medicine* for five years. Later grants, notably of the ethics and policy section of this same organization, allowed me to continue to write on new topics and themes, meanwhile spending some of my time on revisions of and corrections to this book.

Even if in the end I wrote alone, I don't particularly want to be blamed for the remaining errors. I would, instead, be very grateful to you, reader, if you were to point them out and improve on them in your own writings.

chapter 1 **doing disease**

A Movement between Fields

This is a study in empirical philosophy. Let's begin with the empirical. The stories I will tell you in this book are mostly situated in a university hospital in a medium-sized town in the center of the Netherlands, *Hospital Z*. For four years I went there once or twice weekly. I had an identity card that allowed me to leave my bicycle behind a fence and drink free coffee from the omnipresent vending machines. I had a library card and the use of a desk in a succession of crowded rooms. I had a white coat. And I observed.

I would go to the professor who headed a department and explain my purpose: to investigate the way the tensions between sources of knowledge and styles of knowing are handled inside present-day allopathic medicine—or at least one of its exemplars. I would explain what made “atherosclerosis in the lower limbs” a suitable case for my purpose and what I hoped to learn in their department. I presented myself as both insider and outsider, having received basic training in medical school as well as extensive training in philosophy. And I gave the name of the professor of internal medicine supporting my study. Each of the professors thus approached reacted in a friendly way. They all emphasized that academic hospitals must encourage research. My particular research plans made some interested and some skeptical. Others simply were indifferent. But after some further questions I would invariably be sent to someone one or more steps down the hierarchy to talk about and practically arrange my observation.

So I sat for many mornings behind vascular surgeons and internists doing

their outpatient clinics, observing some three hundred consultations. (All surgeons and internists I observed for this study were men, and I will not hide that fact, so I use the generic “he” whenever I write about “the doctor,” even though one of the pathologists whom I observed was a woman. Yes, this is a fading historical moment. The profession is undergoing a rapid gender change. But that is another story. One more complication left out here.) In university hospitals, both physicians and patients are used to observers: there are always students and junior doctors around who need to learn something. Yet I was surprised by the calm with which my presence was accepted—for I found these observations rather intimate. Patients tell about so much and undress so often. Although that is difficult for some and a relief to others, my presence behind the attending doctor hardly seemed to make a difference. When it risked to do so, I skipped a visit (once when a patient asked for it, several times when a doctor did, and once when I recognized someone I knew vaguely and left of my own initiative). The other transgression was into the privacy of the doctors. I was in a position to observe all kinds of details about the way they work. Some of them were visibly uneasy about the fact that I might judge the degree to which they were humane and kind in their interactions with patients. But (though that was sometimes difficult to resist) I wasn’t out to make such judgments. Nor did I want to judge the so-called technicalities of their diagnosis and treatment. I wanted my obser-

How to Relate to the Literature?

In the ethnographic stories that I tell throughout this book, I do not try to sum things up. I do not describe Western medicine, but particular events in a single Dutch university hospital. And I assume that events in the next hospital, thirteen kilometers away, or over the border in Germany, or across the Atlantic have a complex relation with those that I have witnessed. A comparative analysis would show that there are similar patterns. Similar gestures. Similar machines. But also different self-evidences. Different needles and different norms. Different jokes. But which differences exactly? And what are their interferences and their diffractions? I haven’t studied this. The relations of similarity and difference between one medical site and another are a topic in their own

right. By leaving that topic open I at least avoid the risk of answering it in the standard way. I avoid assuming that what happens in a single hospital forms part of a larger system of medicine: Western, cosmopolitan, modern, allopathic. If one assumes the existence of such a system, one can then be unpleasantly surprised by the amount of “medical practice variation.”

But where is the standard way of understanding medicine as a system to be found? And where are the surprises that come with finding “variations”? Not exactly in the hospital I studied, where these things are hardly a matter for debate. No. They are to be found in the literature (see, e.g., Andersen and Mooney 1990). So what I have to tell in the present book does not just relate to the events that figure in my stories. It also relates to other texts. Lots

vations to be a means to get to know their standards, rather than an occasion to apply my own.

This made me shift sites and move around in the hospital. I observed technicians handling diagnostic tools in the vascular laboratory. I followed the tracks of radiologists and pathologists in their dealings with leg arteries. I went for months to the weekly meetings where the treatment options for patients with complicated cases of vascular disease were discussed. I witnessed several operations. Spent some days in the research laboratory of the hematologists. Held interviews or had conversations with epidemiologists, physiologists, internists, surgeons, and general practitioners. A couple of them read my articles and we talked about their reactions. I also went to the library and studied the textbooks and journal articles written, or mobilized as a resource, by “my doctors” and, when the references and my curiosity took me there, compared them with other publications. For two years I followed the monthly research colloquium on atherosclerosis. I coauthored with a junior doctor an article about the introduction of a diagnostic protocol. I supervised a medical student who interviewed vascular surgeons in several smaller hospitals and another one who analyzed discussions about the intake of cholesterol. And, finally, I had the temporary luxury of a research assistant—Jeannette Pols, a philosopher like myself, moreover trained as a psychologist—who held long patient interviews, transcribed them, talked them over with me, and coauthored publications about this material. She also was a good sparring partner with whom to discuss my work.

of them. Texts about other hospitals and other medical practices, texts about bodies and diseases, but also texts about entirely different topics. Systems and events, controversies, similarities and differences, co-existence, methods, politics. If I am to make explicit how *this* text departs from the others around it, if I want to show how it both differs from them *and* is made possible by them, I will have to *relate to the literature*. But how to do this? How to relate to the literature? That is a question that I take very seriously. So I have not hidden the answer between the lines. I do not follow one of the genres for using literatures without being explicit about it. Instead I have tried—will try—both to relate to the

literature and deal with the question as to how one might do so. To do this properly, I have separated out the question about relating to the literature from the core text of this book. I deal with the literature in a series of separate texts that resonate, run along, interfere with, alienate from, and give an extra dimension to the main text. In a subtext, so to speak.

Specificities

Relating to the literature, I might write: “In a variety of disciplines, the unity of Western medicine was a trope for decades. In medical sociology the unity of the medical profession explained this profession’s social power. In medical anthropology the

Discussion was also what I sought in other worlds, outside the hospital. I could seldom go to those places by bicycle, for they were a lot farther away—and yet they were less alien to my writing and talking self. They were departments of philosophy, anthropology, sociology, or science and technology studies. I attended conferences and listened bored or fascinated to speakers presenting papers to five or fifty listeners. I read journal articles, wrote them, reviewed them. I went for talk-walks on lakesides or chatted over dinners. I was cross-examined about my field, my method, my purpose, my theoretical ancestors. Often such exchanges took place in an odd version of the English language, a transportation device that poses some difficulties to those who have not grown up with it, but reaches far. So though my stories come from the hospital in the town where I live, they went with me to many other places. To my intellectual friends and enemies in places like Maastricht, Bielefeld, Lancaster, Paris, Montreal, San Francisco. They managed to travel, my stories about leg vessels and pain. Immersed in theoretical arguments about the multiplication of reality.

For even if there are a lot of empirical materials in this book, this is not a field report: it is an exercise in *empirical philosophy*. Let's shift to the philosophy. The plot of my stories about vessels and fluids, pain and technicians, patients and doctors, techniques and technologies in hospital Z is part of a philosophical narrative. In conformity with the dominant habit of that genre, I'll give away the plot right here, at the beginning. It is this. It is possible to refrain from understanding objects as the central points of focus of different people's perspectives. It is possible to understand them instead as things manipulated in practices. If

divergence of medical traditions from all over the globe was specified by contrasting these traditions with a solid unity called Western medicine (either in order to show the superstitious character of the Others, or to highlight their ingenuity and greater sensitivity). In medical history the old eclecticism in which many schools and skills coexisted was turned into an intriguing counterpoint to the present homogeneity. And medical philosophy took a unity, the person-as-a-whole, as a norm: its wholeness deserved respect." Indeed, I have written (or rather coauthored) something like that. Elsewhere. (For a slightly

longer version of such an overview, see Mol and Berg 1998, 1–12.)

It is possible to relate to the literature in such a way: evoking four entire disciplines, in just a few lines. The level of generality is a bit overwhelming. So much so that it is hardly feasible to insert titles. Sure, this can be done. After each discipline a name and date may be put between brackets. In medical sociology in the seventies . . . (see, e.g., Freidson 1970). A gesture like that turns Freidson's *The Profession of Medicine* into a representative of the enormous pile of books and articles published in the 1970s under the heading "medical soci-

we do this—if instead of bracketing the practices in which objects are handled we foreground them—this has far-reaching effects. Reality multiplies.

If practices are foregrounded there is no longer a single passive object in the middle, waiting to be seen from the point of view of seemingly endless series of perspectives. Instead, objects come into being—and disappear—with the practices in which they are manipulated. And since the object of manipulation tends to differ from one practice to another, reality multiplies. The body, the patient, the disease, the doctor, the technician, the technology: all of these are more than one. More than singular. This begs the question of how they are related. For even if objects differ from one practice to another, there are relations between these practices. Thus, far from necessarily falling into fragments, multiple objects tend to hang together somehow. Attending to the multiplicity of reality opens up the possibility of studying this remarkable achievement.

Philosophy used to approach knowledge in an *epistemological* way. It was interested in the preconditions for acquiring true knowledge. However, in the philosophical mode I engage in here, knowledge is not understood as a matter of reference, but as one of manipulation. The driving question no longer is “how to find the truth?” but “how are objects handled in practice?” With this shift, the philosophy of knowledge acquires an *ethnographic* interest in knowledge practices. A new series of questions emerges. The objects handled in practice are not the same from one site to another: so how does the coordination between such

ology.” But what about all the exceptions? What about Marxist sociologists who, in the same decade, claimed that there was a *class division* running right through medicine (see, e.g., Chauvenet 1978). Or, for that matter, feminists, who were active in drawing distinctions between those parts of medicine that they saw as good for women and others, against which they pressed charges (see, e.g., Dreifus 1978)? Not to forget the combinations between the two (e.g., Doyal and Pennel 1979).

It would be possible to shuffle them aside, claiming that those texts have been marginal. In general, I could say, a few exceptions aside, for quite a while medical sociology took the medical profession to be a unity. Or I could point to these exceptions as the initial steps at the beginning

of a new era. This would require me to say that up to the seventies medical sociology took the medical profession to be a unity, a position that slowly began to change. But this would still leave me with some problems. What if a more attentive reading of Freidson's book shows that its primary concern is *not* the profession's unity, but its *closed character*? When one reads him on his own terms, Freidson seems primarily worried about the lack of outside audit or control on medical mistakes and failures. If I still wanted to quote him as someone taking the medical profession to be a unity, I would then have to show that the profession's unity and its closure are closely linked, or indeed depend on one another. If that argument were hard to make, then I would have to find some other book

objects proceed? And how do different objects that go under a single name avoid clashes and explosive confrontations? And might it be that even if there are tensions between them, various versions of an object sometimes depend on one another? Such are the questions that will be addressed in this book. I cautiously try to sketch a way into the complex relations between objects that are *done*.

This book tells that no object, no body, no disease, is singular. If it is not removed from the practices that sustain it, reality is multiple. This may be read as a description that beautifully fits the facts. But attending to the multiplicity of reality is also an *act*. It is something that may be done—or left undone. It is an intervention. It intervenes in the various available styles for describing practices. Epistemological normativity is prescriptive: it tells how to know properly. The normativity of ethnographic descriptions is of a different kind. It suggests what must be taken into account when it comes to appreciating practices. If reality doesn't precede practices but is a part of them, it cannot itself be the standard by which practices are assessed. But "mere pragmatism" is no longer a good enough legitimization either, because each event, however pragmatically inspired, turns some "body" (some disease, some patient) into a lived reality—and thereby evacuates the reality of another.

This is the plot of my philosophical tale: that *ontology* is not given in the order of things, but that, instead, *ontologies* are brought into being, sustained, or allowed to wither away in common, day-to-day, sociomaterial practices. Medi-

to support my generalization. But which one? The problem is that many titles in medical sociology would do, in one way or another. There is a large corpus of texts in which the medical profession's unity is mentioned. But almost all of them, like Freidson's study, have other concerns at their core.

This is the point: generalizations about "the literature" always draw together disparate writings that have different souls, different concerns of their own. Stressing, in general, that *the* literature is attuned to medicine's unity may function to mark the originality of *this* study, a study that emphasizes disunity. But various dangers follow. One is that a false novelty is claimed: the ancestors are erased from memory instead of honored. A second is that, in the

case of this specific book, such generalities would create a tension between the ways in which "the field" and "the literature" are treated. If I take so much trouble to point out the multiplicity of medicine while I refer to sociology, anthropology, history, or philosophy in general terms, this might suggest that *they* possess the unity that medicine does not. But they don't. Just as it is possible to write about the multiplicity of the objects of medicine, this could be done about other disciplines. I won't attempt to do so here. But I will try to do justice to the variety of concerns, materialities, styles, and object framings in the various knowledges mobilized here by seeking not to suppress or hide these while relating to the literature.

cal practices among them. Investigating and questioning ontologies are therefore not old-fashioned philosophical pastimes, to be relegated to those who write nineteenth-century history. Ontologies are, instead, highly topical matters. They inform and are informed by our bodies, the organization of our health care systems, the rhythms and pains of our diseases, and the shape of our technologies. All of these, all at once, all intertwined, all in tension. If reality is multiple, it is also political. The question this study provokes is how the body multiple and its diseases might be done *well*. This question will not be answered here. Instead, I'll map out the space in which it may be posed.

The Perspectives of People

This is a philosophical book of a specific, that is, empirical, kind. It draws on social scientific and, more notably, ethnographic methods of investigation. But it does not just import these, it also mingles with them. For if I use ethnographic methods here, it is to study *disease*. That physicalities may be studied ethnographically is a quite recent invention. For a long time, "disease" was the unmarked category of anthropology and sociology of medicine. As the state of a physical body it was an object of biomedicine. Doctors told the truth about disease, or at least they were the only ones able to correct each other in so far as they didn't. Social scientists were careful not to get mixed up in this body-talk. Instead, they had something to tell in *addition* to existing medical knowledge. They pointed out that the reality of living with a disease isn't exhausted by listing physicalities. There is more to it. Apart from being a physical reality, having

Dates and Outdating

The work of Talcott Parsons is outdated. It is functionalist in character. *The Social System* is the title of his famous book of 1951 (Parsons 1951). It takes every social phenomenon to either be a threat to the system's stability or to have a stabilizing function. In chapter ten, "Social Structure and Dynamic Process: the Case of Modern Medical Practice," the social phenomenon analyzed in this way is *the sick role*. In modern society, Parsons argues, being sick is ritualized in a specific role. The sick don't need to work in the usual way but are, instead, taken care of. It is accepted that they are the victims of their sickness. This

is good for society because if people stop working and take rest when they are sick this lowers the risk that they will die prematurely. In this way the chance that society has invested in someone's upbringing and education with too little return is reduced. However, since escaping from the usual obligation to work means that "being sick" may also be attractive, there is a potential threat. If everybody were to stop working by calling themselves sick, the system would collapse. This is why, in addition to withdrawal from work and being excused for such passivity, "the sick role" has two more elements. The patient has to go to bed and generally do whatever needs to be

a disease has a *meaning* for the patient in question. A meaning that is open to investigation. Listen to the story about Mr. Trevers (an invented name; all names used in field stories are invented):

Mr. Trevers sits in a chair in the surgical ward. Sure, he's quite willing to answer a few questions. Jeannette, the interviewer, sits down next to him. She casually asks if putting on the tape recorder is a problem. No, it isn't. They talk about the wound on Mr. Trevers's foot. It was the reason for the operation on his leg arteries a few days before. "My problem was not that it hurt," Mr. Trevers says, "but that this wound didn't go away. It was quite frightening. This gaping hole. I didn't go to the doctor at first, when that beam fell on my foot. I didn't care about the pain. But when it never went away, my wound, but only became bigger, then I got scared. And I went to see my general practitioner. She sent me in to the hospital. And now I've got two diseases. I've got atherosclerosis, they tell me, and diabetes. I've also got diabetes."

Mr. Trevers became frightened when his wound didn't heal. To the vascular surgeon who has operated on him, this fear is hardly relevant. It is relevant that Mr. Trevers finally decided to go and see a doctor. But once he did, well, fear, this is "one of the things people feel," as is an aversion of wounds that stay "gaping holes." If there is time, Mr. Trevers may be allowed to talk about his feelings. But they need not be written down in his surgical files. As "a good doctor" the surgeon may explain some facts in an attempt to reassure his patient. But "fear" is not a part of Mr. Trevers's vascular disease, nor of his diabetes.

done in order to recover. And the patient has to call on and follow the orders of a doctor who must officially sanction his or her sick role with a diagnosis.

This is functionalism: the sick role is described as a role that consists of four elements, which are all explained in terms of the function they have for the social system. Two of the role elements have a good function but risk undermining the social system, a danger the other two must counter. Overall, there is a balance between undermining and protecting elements, and the system maintains itself: it remains stable. In the fifties functionalism was strong, but it has been thoroughly undermined

by later sociologists. By Marxists, who pointed out that functionalism forgets about antagonism, struggle, and change. By quantitative studies in which variables were isolated from each other and then correlated into causal chains, not functional schemes. By microsociologists, who pointed out that the many activities people engage in do not necessarily add up to form a stable whole, but point in various directions. And so on.

A lot more has changed in medical sociology since Parsons's time. Later medical sociologists still saw doctors as people who have the power to call a patient either "sick" or "healthy." Freidson, Zola, Szasz—they all insisted on this. But in their

As a complement to this, social scientists have made it their trade to listen for feelings when they interview patients. And they have persistently and severely criticized doctors for neglecting psychosocial matters, for being ever so concerned about keeping wounds clean while they hardly ever ask their patients what being wounded means to them. In addition to attending to blood sugar levels, bad arteries, wounds, and other physicalities, or so social scientists have been arguing in all kinds of ways, physicians should attend to what patients experience. This is how they have come to phrase it: in addition to *disease*, the object of biomedicine, something else is of importance too, a patient's *illness*. Illness here stands for a patient's interpretation of his or her disease, the feelings that accompany it, the life events it turns into.

In the social sciences, "disease" and "illness" were separated out as two interlinked but separate phenomena. Social scientists put "illness" on the research agenda. Shelves of books and volumes of journals were dedicated to it. Interviews were amassed, the attribution of meaning was analyzed, and ways of therapeutically attending to it were designed. All along social scientists left the study of disease "itself" to their colleagues, the physicians, until they started to worry about the power a strong alliance with physical reality grants to doctors. Then, social scientists gradually began to stress that reality isn't responsible all by itself for what doctors say about it. "Disease" may be inside the body, but what is said

work, the label "sick" was no longer presented as a potential favor a doctor may grant a patient, a good excuse to stop working temporarily. Instead, it was taken to be a negative judgment. A form of disapproval. In the 1960s the label "sick" came to be seen as a secularized form of the label "sinful." If doctors stick this onto people, they are being negatively labeled. So it wasn't only that functionalism became outdated. The label "sick" also changed from a kind of excuse or justification into a form of condemnation. And there is more. The kinds of examples used have also shifted. In Parsons's work, the implicit example is the infectious disease from which one either dies or fully recovers. The labeling theories that followed were concerned with forms of deviance like homosexuality and unmarried mother-

hood, which were called "sinful" in the forties and "sick" in the sixties. And after that came other examples: diseases caused by work or stress or social isolation. Chronic illnesses. AIDS. Reproductive technologies. So-called genetic diseases. One topic made way for another—though always only partially.

There are various layers of history to explore, and they all cover up Parsons and render him outdated. So why would one want to relate to his writings at all? The answer is that Parsons invented medical sociology. The crystallization of both of the objects of this discipline can be traced in his work. There they are: *illness* and *health care*. Let's look at chapter ten of *The Social System* again for their early articulation. Parsons links up with the broad definition of health that was popular in the