

# MEDICAL RHETORIC IN THE US AND AFRICA: THE ONCOLOGIST AS CHARON<sup>1</sup>

*Prepared for Conference "Rhetorics of Healing," Section on "Literatures and Cultural Narratives,"  
Jan. 25, 2002, Centre for Rhetorics and Hermeneutics, University of Redlands, Redlands, California*

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*(N/um Tchai, by John Marshall,  
a 20-min. video on Ju/'hoan altered-state healing,  
is available for viewing at the conference.)*

## Abstract

A US oncologist's words, taped during a death in the last decade, dramatically ritualizes and reiterates pronouncements of his patient's terminal status, convincing her that death is imminent. She is encouraged to prepare herself rather than attempt healing. The oncologist termed the task of announcing terminal status a central responsibility, helping the patient to a "good death." He felt he was tasked with advising the patient to prepare spiritually and to make the best use of her remaining time. Simultaneously, he was reinforcing the claim of the medical establishment to ritual and symbolic hegemony over the bodily processes of life and death. This death is compared to rituals in Africa among the Ju/'hoan (!Kung) Bushmen (San). For them, healing and religion are inextricably linked in altered-state performance. Life and death are in the hands of God. Healers are not paid or set above others; healing energy only multiplies by being shared. Healers do not announce terminality; they affirm life and hope. The contrasting Ju/'hoan and US beliefs are both cultural constructs. Dying is a cultural performance of belief, one in which medical rhetoric can play a critical and determinative role.

## INTRODUCTION: JU/'HOAN MEDICAL RHETORIC

At first listen, it is hard to hear any obvious rhetorical back-and-forth between patients and healers in the medical practice of Ju/'hoan San ("Bushmen") hunter-gatherers of the Kalahari Desert of Southern Africa. In the small, face-to-face, extended-family communities in which the Ju/'hoan generally pass their whole lives, by the time the healer comes to the patient s(he), like others in the community, has heard the litany of the patient's aches and pains many times. Never does s(he) have to say anything like "Now, what seems to be the trouble?"

Instead, a healthy tradition of near-continuous "complaint discourse" (Rosenberg 1990) flourishes among the Ju/'hoansi. Thus the aural world is felt together on a daily basis, for healers as well as others, with up-to-date information on the state of health and happiness of each individual in the community. Rhetorical "exchange" between Ju/'hoan doctors and patients could thus be regarded sequentially, as discontinuous in time.

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<sup>1</sup> This paper owes a profound debt to my co-author, Dr. Robbie Davis-Floyd, on a related paper, "Dying as Medical Performance: The Oncologist as Charon" published in *THE PERFORMANCE OF HEALING*, Carol Laderman and Marina Roseman, eds., Routledge, 1994.

Important, more immediate exchanges do take place, however, between the healers and the spirits in the context of healing. These exchanges, occurring in “real time,” are heard by most onlookers, including the patient, as one-sided orations. The responses from the spirit world are audible only to those few others who are in a similar altered state.

These orations take place in a matrix of clear assumptions and practices regarding the gods and the spirits of the departed and their ongoing interactions with the living.

Ju/'hoan healing beliefs revolve around the concept of *n/om*, or healing energy, a supernatural potency residing in the bellies of human healers. This *n/om* is activated by strenuous all-night dancing until it boils up the spinal column to a spot at the top of the spine called the *n//ao* spot. From here it travels down the arms to the tips of the fingers, where it can be used for healing by laying on of hands. Both men and women, in fact large fractions of the population, at some time in their lives experience and cultivate the altered state, *!aia*, brought on by the boiling of the *n/om*.

When in the altered state, the healers are able to see and converse with the spirits, who have been attracted by the music and by the beauty of the firelit dancing. Most of their utterances are brief single lines directed outward towards these spirits. My teacher Lorna Marshall (1999: 87) recorded the kinds of things healers say, sometimes hurling burning sticks into the darkness to drive away the death-bringers:

“You are killing people.”  
 “Go away. You are bad.”  
 “You are a liar. This man will not die. I'll fight you.”  
 “Go away.”  
 “Take away the sickness you are bringing.”

They also shout insults at the spirits, like:

“Uncovered penis!”  
 “Hyena penis!”  
 “Lion penis!”  
 “Thrown-away penis!” or  
 “Filthy face!”

Members of the community thus have regular access to the power of altered states through their *n/om kxaosi*, or “owners of *n/om*,” who function somewhat as do shamans in Siberian societies. People celebrate the bravery of these healers, who they say have dared death itself to bring them healing power and knowledge from the other world. Associated with the ability to enter the altered state and to heal are other special powers like clairvoyance, out-of-body travel, x-ray vision, and prophecy, a list of second sight “gifts” not unlike that of the Bible.

The circular form of the dance, with men dancing behind a ring of seated women and the fire in the middle, unites the different Ju/'hoan players in this drama, causing them to participate in the making of a single, dynamic form. If there is bad feeling between two men, others will contrive to put them next to each other in the dance to promote interpersonal synchrony and thus reestablish harmony. Sometimes, an unspoken tension in the community is voiced by the trancers and in this way its threat to harmonious relations is dispelled. In these cases there is a one-way (unanswered) “dialogue” with those in the community, complete with meaningful rhetorical questions.

My colleague Richard Lee recorded and transcribed a long, intermittent dialogue-like chant sung by a Ju/'hoan curer, Haba-Utwe, while he was in trance. He has shared it with me through his fieldnotes. Some of the words of the chant—in some ways more like a rant-- have distinct reference to the specific social situation being aired and alleviated through the dance. The sick person is described to be sick as a result of tensions in the group:

...Are you looking at each other?

How is it that you are full adults yet you refuse to give each other an agreement? What makes you tremble at seeing each other? What do you see when you look at each other?

You people here who are arguing and glaring. You people who are arguing and glaring. You people who are arguing and glaring.

What makes you do that is your argument about your cattle. You are battling it out and you are killing each other.

His blanket, help him put it over his shoulders; can't you see, he is trembling? Help him cover himself.

He is exhausted; his arms are dry; his legs are dry. Help him take his blanket and cover him...

He lies there dying; while you sit above him wrangling and fighting, and arguing and glaring, arguing and glaring, arguing and glaring...

The Ju/'hoan people are former foragers who only recently acquired a few cattle. Ancient as the dance form is, it quickly embodies, through contemporary artistry, new realizations such as misunderstandings about recently introduced cattle. This open-endedness, this flexibility, is here as in the Ju/'hoan storytelling tradition, key to its effectiveness and the continuation of its ability to galvanize belief.

Another colleague, Polly Wiessner, recorded healing "dialogue" we came to see contained both stereotyped and new elements. In much of the dialogue there was specific address to both the healer's mother and his father (excerpts from Wiessner and Larsen 1979):

I am imitating //Gauwa (God).  
 I am imitating the medicine men.  
 I am imitating my father.  
 I am imitating those who teach medicine.  
 People here say that this will be a long night.  
 Mother, mother, my father!  
 When will I be able to trance?  
 Hey, hey, it's a long night.  
 I am trembling!  
 I am like a little child who is learning.  
 People must hate me, they don't sing up.  
 Mother, mother!  
 A child is teaching me.  
 I am like a falling star.  
 Sing for me,  
 Sing loudly for me, my mother!

Healing orations also take place in other musical contexts, such as in "self-delectative" playing of the thumb piano.

The following quotes are from "Song Texts from the Master of Tricks", which I published in 1975:

Terrible God deceives, torments.  
 God's arms descend into my fingers.  
 Yesterday God said 'Be my child and listen.  
 Take what I say to the people.  
 God's arms, God's arms.  
 A young soul lives in the western sky  
 And is still learning.  
 These are my tears:  
 I mourn at death, for years and years—this is what I have to tell.  
 God spoke, telling me to take up  
 These metal bits and this scrap of wood  
 And with them to sing.

Where will I hide from God's death?  
 The day when God speaks where will I be?  
 Where will I hide from terrible God who torments me?  
 The year of my death is known.  
 The day of my death is known.  
 Owner of tricks, yes, am I.  
 Master of lying, hoo!  
 One who can fool you, that's me.  
 Master of tricks, yes.  
 Owner of lies!

A young */ibi* bird am I,  
 A little bird living in its mother's house,  
 Still learning.  
 I am God's son,  
 I am like the lightning bird  
 Who just flies on,  
 Doesn't know where he's going,  
 Even goes to strangers' homes  
 And is not afraid.

## COMPARISON: US ONCOLOGICAL RHETORIC

In November 1990 a 70-year old woman, whom I will call Mrs. Margaret Bell, entered the hospital suffering from severe dehydration following chemotherapy. She had been diagnosed with colon cancer with metastases to the liver in July. Admitted, even in her weak state, she was convinced of her ability to recover. When she left the hospital, rehydrated and feeling better after a ten-day stay, she became determined to die. By her own report, the oncologist's words played a significant role in this transformation. As she explained her experience, his dramatically ritualized and repeated pronouncement of her terminal status, reinforced by other aspects of her hospital experience, eventually integrated itself in her mind as a primary "failure" that added heavy symbolic weight to other "system failures" she was experiencing. The terminal diagnosis quickly came to form one primary piece of a new reality matrix--a matrix that held her death to be imminent and her task not to attempt further healing but to prepare herself for death.

In a later interview, the oncologist shed light on this transformative moment: he called the task of announcing terminal status one of the central responsibilities of the cancer physician. In fact, he identified the doctor-patient interaction surrounding this announcement and its reception as a main determinant of "a good death." It was clear that the physician, "Dr. Henderson", had his most profound and anxiety-laden communication with the patient during the three days it took him to get her to accept the message that she was going to die. This freighted communication stood in marked contrast to the kind but brief and distant contacts the doctor had previously had with Mrs. Bell during her examination and chemotherapy sessions. The announcement of terminality seemed to be a key performative element in the oncologist's ritual role.

This inquiry into the performed roles of oncologists has an increasing number of parallel and complementary studies in the anthropology of biomedicine. These studies, both articles and books, deal centrally with issues of communication and empowerment in the relationships among patient, physician, and supporting others (Baer 1987; DiGiacomo 1987, 1992; Fisher and Todd 1983; Good et al. 1990; Good 1991, 1993; Kleinman 1988; Romanucci-Ross et al. 1983). This paper addresses both the humane purpose behind proper communication of the terminal diagnosis--helping the patient to prepare herself spiritually and to make the best use of remaining time--and the role this communication plays in reinforcing the claim laid by the medical establishment to ritual and symbolic hegemony over the bodily processes of life and death.

## **THE CANCER PHYSICIAN'S ROLE IN TECHNOCRATIC SOCIAL DRAMA**

The cancer physician plays a key role in the social drama scripted by the interplay between the medically defined disease he diagnoses, on the one hand, and the family affected by that diagnosis and its sequelae, on the other. In cases considered terminal, he is often called upon to perform not as healer but as conductor to the other world. In the popular view, oncologists as a class are alternately celebrated for their willingness to play the part of the necessary "bad guy," the bearer of the tidings of death, and condemned for their reputed unwillingness to include the patient as part of the healing team (Buckman 1986; Henriques et al. 1980; GIVIO 1986). Some are further characterized as heartless technical automatons unable to relate humanly to patients and families or as intent on speeding the patient to an early death through self-fulfilling prophecies. Still others, however, have come, in the course of helping dying patients, to seem like compassionate and competent conductors to the world of death, performing the important role of lessening pain and fear (Good et al. 1990). Because death is so often not only the literal but also the symbolic--i.e., expected--outcome of cancer, oncologists inevitably take on roles that carry ritual as well as medical freight. A perception that Dr. Henderson's performance encompassed aspects of the role of Charon, who ferried the souls of the dead across the River Styx, occurred ineluctably to me as a close observer.

This last comparison illustrates a critical point. Despite biomedicine's departure from shamanism, religious and medical practices align themselves again when an unknown such as cancer, and the fear of its outcome, is involved. Indeed, until AIDS came on the scene, cancer reigned as the most feared disease in America (Sontag 1990:16). I contend that this unity of medical and religious roles is operative for cancer doctors even where individual patients have histories of personal religious practice to help them through the period of dying. The symbolic and ritual dimensions of the cancer doctor's role thus are subjects appropriate for analysis by anthropologists. Mrs. Bell's experience illustrates the ways in which these symbolic and ritual dimensions of the physician's role can both enable the transformative process of dying and reinforce powerful tenets of the American technocratic model.

As medical anthropologist Robbie Davis-Floyd has written, the technocratic model of life processes is an important part of the American core value system which conceptualizes the human body as a machine, giving primary responsibility for its repair and maintenance to medical technicians (Davis-Floyd 1987, 1990, 1992). The technocratic model expresses two key dualistic organizing principles of American culture: the Cartesian separation of mind from body, and the belief (growing ever-stronger in the West from the Renaissance on) in the possibility and the benefits of human separation from and control over nature, including the body. The medical management of birth and death are key phases in the development and reinforcement of this model.

Likewise, a dramatic hospitalization experience focuses enormous socialization pressures on an ill, and thus liminally receptive, individual. It is instructive, then, to observe the elements of performance used by the hospital team, as led by the oncologist, in inculcating the patient with the core values of technocracy and in aligning her own perceptions and models of her illness and its meaning with those of the hospital staff. These performance elements include the "strange-making" (Abrahams 1973), time disruption (Zerubavel 1981), and symbolic distancing of practitioner from patient usual in hospital practice (Konner 1987; Stein 1990).

Melvin Konner (1987) has written eloquently of the pressures on hospital personnel that lead to such omissions and discomforts for patients. But he also identifies such care-less practices, which often are the rule rather than the exception in American hospitals, as part of an intentional pattern of socialization for medical students. He notes that during their journeys of initiation (residencies), students learn their roles as medical doctors from watching and imitating hospital practice--its manners perhaps as closely as its techniques. Both stem from the American core value principle of separation, as the separation of mind from body is mirrored on a larger scale by the separation of physician from patient. The messages of the relative powerlessness and dispensability of the patient are impossible to ignore.

## **STRUCTURAL CONTRADICTIONS AND PATIENT HELPLESSNESS**

As anthropologist Susan DiGiacomo, herself a cancer patient, has noted:

“Biomedicine as commonly practiced in the U.S. simultaneously individualizes its treatment of disease symptoms and routinizes dealings with the patient, so that the afflicted person is transformed from an integrated and fully functioning adult to a collection of diseased body parts. Further, biomedical opinion holds that sick people are less than fully competent adults simply by virtue of being physically unwell. The first difficulty of the patient, then, is not getting a fair hearing for his or her point of view concerning the illness and its treatment; it is getting the doctor to recognize that the patient, has, in fact, a point of view at all...Thus, from the outset, the afflicted person is required to accept a reduced and defective patient self constructed for him or her by the doctor” (1988:4).

Mrs. Bell had not been able to discuss with Dr. Henderson the holistic healing philosophy (Cousins 1979, 1989; Siegel 1986; Simonton et al 1980) that was animating one whole side of her self in her struggle against her disease. She and her family were shaken by the realization that in the entire oncology profession of their large city they had been able to discover only this single young doctor willing to administer an experimental treatment combination, but that even he stopped short of enthusiasm for "mind-made health." They were uneasy with the split between home, where one could take a hand in one's own healing, and clinic, where one could not. It wasn't that their holistic views were overtly denigrated in the clinic, but rather that the atmosphere at the clinic allowed them no conversational room to even bring up more holistic philosophies.

The fact that Mrs. Bell, like most female patients, was treated by a male physician also had symbolic repercussions. The relatively higher status of men in American society reinforces the drama of the doctor's role for a woman patient in ways that are further disempowering. However, as a result of years of working for a well-known holistically-oriented nutritionist, Mrs. Bell had also developed strong respect for self-care, patient responsibility, and the holistic approach to healing. Where the technocratic model is based on principles of separation and mechanicity, the holistic paradigm is based on principles of interconnectedness and organicity (Davis-Floyd 1992). This dichotomy set up a structural tension in Bell's own life--a tension that also structured the drama of her death. Yet in turn, this structural tension was ultimately resolved through the manner of her dying, for she partly chose, and was partly persuaded by her family, to live out her remaining weeks at home in ever-deepening connection with her family, and to die there. This resistance to the full application of the technocratic model to her illness and death (which might have resulted in the applying of "heroic measures" in the hospital, and a lingering death hooked up to machines) led the patient and her family to feel that she had died "a good death" in spite of the disappointments encountered in treatment--a judgment with which the physician too eventually concurred.

At many points, most of them rhetorical and performative, Dr. Henderson's role as Charon seemed on the point of actualization. Although did not see or interact with her in the last weeks of her life and did not symbolically or otherwise "ferry her across," his symbolic presence was with her and with the family until the end. It seemed clear that his perception of his role was informed by ancient models transmitted to him through centuries of Western literature and art and subtly codified in medical school pedagogy regarding the treatment of dying patients. There was an old, sure inevitability about the dramatic performance by this young doctor that went far beyond his physical treatment of the illness. It was fascinating to see how these ancient models were used in the service of modern American values.

### **TERMINALITY: A DRAMA IN THREE ACTS**

One day while Mrs. Bell was still in the hospital, Dr. Henderson informed her that there would be no more treatment. After examining her and reading her charts, he told Mrs. Bell without preamble that "resistance had developed," that she couldn't handle the treatment, and that there was nothing else known that could help her.

This was Act I in a dramatic three-day attempt to get Mrs. Bell to accept the "fact," as Dr. Henderson saw it, that she was going to die. On this first day, the stage was set as follows: the eldest daughter sat on the window ledge at her mother's bedside. The doctor sat slumped in a chair in the furthest corner of the room, his posture suggesting both earnestness and a lack of ease. Mrs. Bell and her daughter became suddenly anxious, both because they had waited six tension-filled days for this particular doctor to answer some questions about acute problems that had developed in the hospital, and because this was the first time in their three-month association with him that they could remember him actually sitting down with them. (His earlier talks had been careful and

calm, not lacking in communicative mutuality, but he had conducted them on his feet, while examining Mrs. Bell on a raised table, for instance, or passing by in the hall while his nurse administered chemotherapy.)

After briefly discussing her systemic problems, Dr. Henderson said that Margaret Bell was "in a terminal phase." He said that she would be getting no more chemotherapy because of the resistance, as seen in the elevated CEA level (a blood indicator of tumor activity) and on the CT scan, which revealed no appreciable shrinkage of tumors. Mrs. Bell drew herself up with what dignity she could muster, and said that she accepted the diagnosis but did not consider herself "terminal." She said that she was still fighting. The daughter by her own admission was "glaring" at the doctor and silently applauding her mother's spirited answer. Mrs. Bell then asked the doctor, with a sourness quite uncharacteristic of her, whether he thought nutrition could play a role in healing. The unwillingness of the medical profession to consider nutritional approaches had been a long-time sore topic with her both professionally and personally, so when Dr. Henderson answered with the single word "No," the atmosphere became very quiet--and very charged. Mrs. Bell said, "Then that's all I have to say to you for now," and Dr. Henderson stood and went out the door.

Early the following morning he returned for Act II. He seemed more rested than the previous day and quite energetic, like a person who knows he has a job to do and feels equal to the task. He said clearly that she was "terminal, and that isn't necessarily bad. One can prepare oneself for death." Mrs. Bell's response surprised even her daughter, who (though she had long ago thrown in her lot with the self-healing philosophies and had been listening to the personal empowerment tapes right along with her mother) thought that by now the diagnosis of terminality was quite clear. "What I want to know," said Mrs. Bell, "is how are you and "Dr. Abdul" going to build me up so I can continue chemotherapy?" Dr. Henderson appeared to realize at that point that Mrs. Bell and at least some of her family were still reacting with denial, and he just left it. Indeed, her daughter said that "It was as if she had not heard what he said." Before he left the room, Mrs. Bell requested a look at the CT scan taken a few days earlier and the addition of a vitamin C infusion to her IV bottle. Dr. Henderson quietly agreed to both requests and departed.

Later that day, when Dr. James Bell was sitting with his wife, Dr. Henderson returned with the CT scan of her abdomen. In technocratic diagnosis, the CT scan, as external, "objective" evidence obtained by tests and machines, constitutes a defining source of "authoritative knowledge" (Jordan and Irwin 1990), that is, knowledge that forms the basis for decisions made and actions taken. It was apparent that the liver was largely taken over by tumors. The nursing staff did add an ascorbic acid solution to the IV, though at a much lower percentage than that recommended by Mrs. Bell's nutritional therapy colleagues. Mrs. Bell spent a quiet afternoon listening to her husband read to her: her eyes were bothering her and reading was difficult, though it never had been before. She seemed untroubled by this annoyance.

Meanwhile, the family "cheering squad" (as they called themselves) went into action and rallied around the telephone checking out every possible lead. Much of the activity centered around the question of whether "Dr. Abdul" in the neighboring city concurred with Dr. Henderson's assessment of "resistance." When at last it was ascertained that he did, and had in fact already told Dr. Henderson that further treatment seemed counterindicated, Mrs. Bell's daughters began to confront for the first time the probable reality that their mother was going to die. This is how the stage was set as Dr. Henderson and Mrs. Bell went into the last act in their joint drama--acceptance of terminal status by the patient.

Early on Wednesday morning, when Mrs. Bell's middle daughter was with her, Dr. Henderson came back a third time. Mrs. Bell asked him what treatments she would be getting when she got out of the hospital. The question was in the context of possibly continuing Vitamin C infusions via a periodic IV drip. He said, "I'm not recommending any. It's important for you to not just keep trying quackery but to think about your death." Margaret then said, "Oh, so you're saying I'm really terminal?" Dr. Henderson replied, "You've been terminal since you got your diagnosis in July."

Later the middle daughter encountered Dr. Henderson in the hall, and said "She's finally accepted it." He said, "I was beginning to get worried." On the afternoon of the same day, when the eldest daughter was with her mother, Dr. Henderson again came in and repeated for a fourth time that she was terminal. It was as if he needed

to reassure himself that she had indeed accepted her status. And perhaps he also wanted to make sure that the eldest daughter, who had been the primary caregiver, had, like her sister, accepted it too. To this eldest daughter, it seemed as though her mother was behaving as if she were receiving the news for the first time. When the doctor left, Mrs. Bell said, "I wish he'd told me before, so I could have gotten my study in order."

In the weeks that followed back home, Mrs. Bell continued with the oral history her daughters had been recording for her for some months. During these weeks there suddenly appeared the motif of acceptance of death. Soon Margaret Bell had completed the process of cognitive restructuring that accompanies all lasting major perceptual shifts (d'Aquili et al. 1979; Laughlin et al. 1990); in other words, her cognitive system had reconstellated around the diagnosis of terminality. (When asked in an interview what were the deciding factors in this process, she answered that it was the combination of seeing the CT scan and the many repetitions by the doctor that she was terminal.) In the days following the interview, her behavior consistently expressed the thoroughness of this process of cognitive restructuring. Her clear-eyed acceptance of death's inevitability enabled her family too to relax into the next phase. Said one family member, "It was as if the whole house stopped fighting and gave a sigh of relief."

### **A CONTRAPUNTAL DIALECTIC BETWEEN PHILOSOPHY AND PERFORMANCE**

A chance discovery at that time that Dr. Henderson was working toward a doctorate in philosophy in order to pursue a strong academic interest in the ethics of euthanasia, led me to request a formal interview with him. The interview was conducted a week after Mrs. Bell's death. Early on, Dr. Henderson had remarked, "Dying is not something that happens to you. It is still something you can participate in." It quickly became clear that Dr. Henderson was committed to the social support of the dying in a profound way, and that he found his own niche as a cancer doctor to be just there, defining the limits of science clearly so that patients could prepare themselves for their deaths by completing their connections with life. What galvanized him was practicing "medicine," which for him included taking full responsibility for "taking care of them until they die" as opposed to surgery, which he said was "just slice-of-time oriented....where you do not have to take care of the whole patient, where you are either successful or not in that limited slice of time. It does not seem to be as rewarding."

He said that medicine, as opposed to surgery, "should be good at knowing when the battle is lost and you need to change directions and provide some comfort....It is trying to do everything you can and still be the court of last resort for a lot of people." A period of practice in a small Mennonite community had helped form his outlook in this regard: he characterized it as a community with "no loss of connection....The diagnosis of cancer was a signal that someone needed to be taken care of and hardly anyone went out of this little community to be taken care of." He went on to say that had he been in a big city he would have continued in academic medicine--doing hematologic cancer protocols, etc. "But I don't think I would have been as satisfied as I could be now because academic communities are so disjointed from the community of the patient that you can't provide total care. All you can do is provide heroic care."

He preferred, he said, that there be "some look over the long term even if it's only a couple of weeks. I'm not here to say, 'well, I have nothing to offer you and you need to go someplace else'." It was clear that the "long-term look" and "total care" meant for this doctor something different from what such terms might mean coming from, for example, a family pediatrician. They had a great deal to do with mediation of the dying process once curative medicine had reached acknowledged limits. In Mrs. Bell's case it was clear from the way Dr. Henderson went into action at the time of his announcement of the diagnosis of terminality that his sense of his role was centered just there--an observation confirmed by his own words in the later interview:

What the patient's whole life is has a lot to do with how they are going to live the rest of their life. Some will be satisfied with facing the end of treatment and some won't. They will want to do other things....The greater likelihood a patient has of being cured the more adamant I am about trying to get them to take chemotherapy. But if there is no cure rate we are really just talking about quality.

Dying is an event we all have to go through and it seems to me you are shortchanged if you don't [have the chance to] do the things you would regret not doing if you didn't know about it... You look at what you have to leave people. And that is all you can do. You leave something. You leave whatever you do through your connections....

So, I do believe a lot can be made of the death. It can be a good death. [But in our culture] it has been hidden. It has been suppressed by medicine. Medicine has held out a hope that has been unrealistic....People still die...too often in the hospital, too often not aware of what has happened to them. And they are older, and separated from their families. It's partly medicine and it's partly society.

Asked how he thought modern physicians--particularly oncologists--might help alleviate this problem in the social dimension of dying, Dr. Henderson said, "You have to develop some kind of philosophy that allows you to...get into somebody's life, to participate in someone's life...". But he went quickly into the difficulties this approach involves for physicians:

There are certain penalties you have to pay for being connected. One of them is that you will have feelings for a person, whatever happens to them. On balance that is okay...but it's just not easy sometimes. I can't see not doing this but I can see doing less of it. It is where I keep contact with what happens. I'm not sure it's a strength. It's just something I do....The greatest amount of suffering in someone's life may occur toward the end of that life so there is a need. And filling that need is what I feel fairly comfortable with. It's a good sense, you know. You get reinforced every now and then. We have had people who have had good deaths and we have participated in that to some degree. I think people's lives are better for that--it's just not as dramatic or visible as getting your appendix out. So there is reinforcement. There is a commitment to helping people at that time in their lives.

At almost every point in the interview, as here, the narrative arrows, returning, pointed toward death. As this was clearly a focal point in Dr. Henderson's perception of his role, I asked how his medical school training had prepared him to handle it. He answered that in medical school "it's not as intense since you are not the one who is primarily responsible....Now I find since I am primarily responsible for patients that it has become difficult, an emotional effort, to help people die"...

Characteristic features of biomedicine as described by a number of social scientists include a hierarchical physician-patient relationship in which the physician protectively contains his authoritative knowledge within the community of biomedical practitioners, doling out small pieces of information to the patient while maintaining a general unwillingness to share this knowledge and information (Fisher and Todd 1983; Jordan and Irwin 1990; Klein 1979; Lyng 1990). Susan DiGiacomo (1987) poignantly describes her five-year struggle not only with Hodgkins Disease but also with the resistance her physicians demonstrated toward keeping her fully informed. An anthropologist and Ph.D. candidate at the time of her initial diagnosis, she desired a collegial relationship with her physicians in which knowledge and information would be shared and treatment decisions mutually decided upon, while they sought to enforce a strict hierarchy in which she would follow the treatments they prescribed without asking too many questions. So pervasive is this approach in biomedicine that Stephen Lyng, in envisioning an ideal "countersystem," suggests that in such a system, "the practitioner's primary role would be educational, while the patient would assume primary responsibility for selecting a diagnosis and treatment regimen from among the various alternatives presented" (1990:61).

Like DiGiacomo, throughout the course of her illness Mrs. Bell keenly felt the disjuncture between the technocratic approach to healing and her own. This sense of disjuncture was intensified by her personal lifetime commitment to the idea of nutritional support for the immune system. She had doubts throughout the course of chemotherapy about whether she could fruitfully discuss nutrition with either her doctor or her nurse, doubts that were finally confirmed in the hospital during the dramatic announcement of terminality. The question she blurted out, "Do you believe that nutrition can play a role in healing?" was one she had been longing to ask for months, as the answer would precisely define the limits of their system of shared beliefs. Dr. Henderson's flat "No" cemented the disjuncture, making impossible any kind of conceptual reconciliation between Margaret Bell's own beliefs and those of the medical personnel treating her, ultimately augmenting her sense of hopelessness.

In other words, although Mrs. Bell and her family continued to pay every good attention to her diet, the sense of dissonance created by the total devaluation of this practice by the medical profession intensified her alienation from a part of herself. In Kleinman's (1988) terms, this situation constitutes a failure of conversation, a failure of the healer to empathetically enter into the patient's own discourse concerning her lived experience:

Of all the tradecraft of the physician, nothing more effectively empowers patients. The very act of negotiation, if it is genuine....necessitates that at the very least the physician show respect for the patient's point of view. The real challenge is for the physician to engage in negotiation with the patient as colleagues involved in care as collaboration. The practitioner begins this phase of care by elaborating an explicit comparison between the lay model and the professional biomedical model. The physician can determine points of disagreement....he must be prepared to hear out their criticisms....he must expose his uncertainty and the limits of his understanding, as well as his critical reaction to relevant popular and commercial images....The negotiation may end up in a compromise closer to the patient's position, a compromise closer to the doctor's position, or a joint lesson in demystifying professional and public discourse. (Kleinman 1988:243)

Such a joint lesson in demystification was precisely what Bell was longing for. The psychological trauma of her illness experience stemmed from the ultimate and total lack of this kind of mutual negotiation, which she experienced as an extreme philosophical tension and an ultimate putdown--a powerful argument in support of Kleinman's conversation-centered approach to healing.

### STRUCTURAL TENSIONS AND "BLAMING THE VICTIM"

Henderson: I think people do get the idea that what holistic doctors are saying is that if you can think about it you will get better, if you will it enough, when in fact this is not the case. In fact, that gives even the wrong meaning in that you end up with patients who blame themselves for their disease, which is just entirely wrong.

This notion that we can make ourselves both sick and well--the "New Age" concept of patient responsibility for illness (Ferguson 1980)--has been interpreted by social scientists as "blaming the victim" (DiGiacomo 1992). DiGiacomo (1992) also points out how neatly this concept articulates with the pre-existing tendency in biomedicine to "blame the victim" in a different way--"she failed her chemotherapy," "he ruptured his scar." Thus it can be easily coopted into the biomedical discourse, providing technocratic practitioners with yet another means of retaining control by separating themselves from the patient and then defining the patient's experience.

This acknowledgment points up the structural tension in Dr. Henderson's own working philosophy--fascinatingly, the same tension that structured Margaret Bell's experience of illness and death. In his own words, he values connectedness and seeks for patients to be connected with both their families and himself. Yet his orientation to diagnosis, treatment, and interaction with patients is highly technocratic; his words express, and his behavior enacts, a more-deeply held valuation of distance and separation. The pure science of complex tests is "fun," "a relief" from the strain of human commitment. ...he does not engage patients in two-way explorations of the experience or meanings of their illnesses.

In this, he is not alone. As Arthur Kleinman notes in *The Illness Narratives*, at the heart of healing lies the potential for a powerful dialectic that can draw the practitioner into the patient's experience and so can make of illness and treatment a rare opportunity for moral education. But instead, the modern medical care system

does just about everything to drive the practitioner's attention away from the experience of illness. The system thereby contributes importantly to the alienation of the chronically ill from their professional care givers and, paradoxically, to the relinquishment by the practitioner of that aspect of the healer's art that is most ancient, most powerful, and most existentially rewarding. (1986:xiv)

### THE ONCOLOGIST AS CHARON: ETHNOCONCEPTS AS CULTURAL CONTAINMENT

Anthropologists have identified the most destructive concomitant of illness as fear of the unknown. For example, drawing on the works of such earlier theorists as Levi-Strauss (1967) and Turner (1967), Edward Schieffelin (1985) describes Kaluli healing seances in Papua/New Guinea as emergent social constructions that draw upon and actualize group knowledge about the unknown. He emphasizes that removal of chaotic fear through such dramatic social ordering processes lies at the heart of shamanistic cures.

In official American ideology, religion and medicine, like religion and state, split off from each other long ago. However, in praxis the physician, laden as he is not only with responsibility for the body but also with heavy ritual and symbolic weight, has enormous influence over the psyche as well--a shamanistic function of which American doctors themselves are often aware, and whose potential they even consciously exploit (Spiro 1986).

Correspondingly, one of the main services American doctors, especially oncologists, provide is a cognitive system in diagnosis and treatment (or lack thereof) that organizes and alleviates the chaos of fear. Perhaps they do this partly by taking into themselves as ritual figures all those unknowns of mysterious disease processes and of death, thereby relieving patients of that wondering that is beyond their capabilities. As they are themselves untrained in shamanic myth and mystery, the full alleviation of such wondering is beyond the oncologists' skills, as well. Nevertheless, the ritual function of these doctors in Western society is consolidated by their exclusive control of authoritative knowledge--highly specialized scientific information--in spite of its conceptual emptiness/inability to explain. Yet the function itself is as simple and as old as the Christian idea of carrying another man's burdens for him, an idea shared by many ancient religions and healing traditions. It is as simple as piling symbolic unwanted baggage--disease, trouble, fear--on a symbolic camel and watching it walk off into the sunset.

"Man," wrote Suzanne Langer "can adapt himself somehow to anything his imagination can cope with, but he cannot deal with chaos" (1974:23). It was Malinowski (1925) who first made clear the roles of religion and magic in inducing socially-agreed-upon confidence in observances designed to keep chaos at bay. Expanding on Malinowski's insights, Turner (1967, 1974) and Geertz (1973) emphasized the processual nature of "reality," showing that ritual performances are not only models of what humans believe, but models for ensuring that they will believe it. "In these plastic models, men attain their faith as they portray it" (Geertz 1973:114). The metaphor of a camel loaded with symbolic baggage, for example, or any other metaphysical image used in a therapeutic context, can have the effect of lightening the load of mystery upon the ill person. The physician/healer whose ability to assume the load of chaos is consonant with general social belief in the effectiveness of such a maneuver will demonstrate a capacity to heal which may have little or nothing to do with specific knowledge of treatment or cures.

Seen this way, the oncologist's role must finally be understood as having profoundly mystical dimensions. This doctor is Charon in no mechanistic sense: even were euthanasia not legally problematic, morphine is ultimately no way out of the ethical dilemmas of his mandate. His task remains as hard as the task of the mythic thaumaturge has always been--harder, because he is also charged, today, with probing the furthest reaches of proliferating scientific fact to leave no healing possibility unexamined. Yet despite its medical connotations and emphases, the oncologist's role remains basically a social one. In effect, he does address the lived experience of illness as well as the mechanics of disease. As arbiter of both the potentials and the limitations of scientific medicine against a disease virtually synonymous with death, he holds the reins on what the unassisted patient and family both fear and dare to hope. The mystery they fear is clear; what they dare to hope for--new discoveries in the nick of time, the power of the mind to transcend statistics, the possibility that choosing the time and the manner of death may be an affirmation of life, the ultimate rightness of their hunch that death will be an opening-out rather than a closing-in--may be much more individual, a result of their histories as persons. But all individualism must be culturally contained, and this is where the cancer doctor's role has what is perhaps its central defining power.

The Greeks' model "of and for" dying was the Charon myth, the conceptual reality of which they expressed by burying their dead with *oboli* on each eyelid to pay the ferryman for passage to the Underworld. Just so does a modern cancer patient internalize her relationship to the cancer doctor's ritual power, once her own beliefs come into alignment with the technocratic model/myth. She gains, ultimately, the treasure of conceptual clarity, even if she must pay for it with the loss of individual hope.

I suggest that the power operating here is both social and religious. If a central act for many oncologists is the announcement of terminality and getting the patient to accept that diagnosis in the interests of "a good death," it is clear that defining "a good death"--known by anthropologists to be a social and religious preoccupation of

societies in general (Fox 1973; Needham 1973)--has become at least partly the province of these specialists. If one realizes further that under certain conditions medical euthanasia may be permitted by our society, that these conditions are most often met in cancer cases, and that providing the means for euthanasia under these conditions is defined by at least some oncologists as "bringing about a good death," the implications of a role far beyond the medical one as contemporarily conceived are inescapable.

In the end, in Mrs. Bell's case, the question of who does Charon's actual ferrying, and to where, was left open. But some boatman figure standing ready to meet the dying passenger and carry her across seems just as necessary in our age as in ancient times. If dying has become medicalized in America it has not done so without bringing elements of performance into the medical profession along with it. If the choice of euthanasia, which Dr. Henderson in an interview himself described as "exiting stage right" is not yet actually condoned medically in America as a good death, it is at least a ready metaphor for evoking the performative aspects of dying.

Ideas about illness and healing are as precisely idiosyncratic to specific cultures as is verbal language. Ethnoconcepts form part of the cultural signature: though there may be variation within traditions, part of what holds the members of a culture together is the containment provided by such ideas. This containment holds true for people whether they live in traditional or in highly industrialized societies.

The heritage of the Classical cultures of Greece and Rome held powerful sway in Euroamerican thinking for centuries. Economic fields such as medicine, politics, and law which have invested heavily in, and gained much from, this intellectual heritage, are slow to move toward "multicultural" (or even ethnohistorical within European traditions) awareness. They have the investor's unwillingness to learn of a possible threat to the return on their worldview. The science of anthropology goes largely unheeded by the science of medicine, for example, and a fortiori the ethnoscience of traditional peoples has little impact on medical practice, even as comparison or perspective.

But, as anthropologists often point out, a biomedicine that is trying to humanize itself could learn much from other conceptual systems and practices. The !Kung (Ju/'hoansi) of Botswana and Namibia, for example, have as we've said a long and trusted heritage of altered-state healing by laying on of hands. In this tradition, religion and healing are inextricably linked--by the practitioners, the n/omkxaosi or "owners of medicine," who are seen as both doctors and religious technicians, and by the expectations of all who participate. Such high value is placed on n/om (an intangible potency or energy which is activated both from within the healers' bodies and from within the highly social context in which they work) that herbal medicine, though known, is relatively little elaborated. Faith is put instead in the transformative experience shared by patient and healer.

#### **“SPEAKING THE SPEECH OF THE SPIRITS”**

In Ju/'hoan healers' ideas of death and fate lies an even more striking contrast to Western medicine. For them, the power to kill a person lies in the hands of !Xu or //Gauwa (God). A healer has no foreknowledge of what he can cure and what he cannot cure. He must just try to the limit of his strength and if he is defeated, the patient will die. No fault accrues to him if this happens: instead he is socially rewarded for having tried his best. For Ju/'hoansi or for Ju/'hoan healers, the strength of n/om is not a thing that one can augment by wishing or trying. It is a given. It is God-given. N/om is given to the healers through the whim of !Xu. It does not set its owners apart or above others in the society, and they do not receive material benefits for using it. They participate, as do all the people, in the dancing and singing which accompany healing, for the pleasure of participation in a beautiful social event.

Next, n/om is conceived as a thing only multiplied, never divided, by being shared. Thus Ju/'hoan healers are not concerned that when someone dies they have not tried hard enough (as a physician who has not kept up with the latest medical journals might feel) since a certain equable fatalism releases them from personal responsibility. These factors, it seems, have important correlates in the realm of individual psychology and social structure.

First, *n/om* is not jealously protected, because sharing it redounds to the good of all. Nor are there material rewards to be had for exclusive control of *n/om* or its secrets. So a priesthood doesn't form, and egotism in the defensive sense does not characterize the social interactions of the *n/omkxaosi* with the ill. Second, the ultimate responsibility for life and death is far removed from these practitioners. Unlike practitioners of biomedicine, with its stoutly defended turf (and concomitantly highly contested legal responsibility), Ju/'hoan healers are not assailed by accusations of ill-preparedness, coming either from others or from within themselves. They do not have to know everything. They can help ease the fear of sickness or of death, just as some biomedical doctors do, but they do not have to perform expert prognoses.

For these reasons, their role, even when dealing with grave illnesses like the recently introduced tuberculosis, does not define itself around an announcement of terminality or urgings to the patient to order her affairs. It is life- and hope-affirming throughout, holding to one source of hope--the patient's will to keep trying--as the indicator that effort should still be expended, that the patient should not be given up for lost.

It is here that Ju/'hoan traditional practices and newer holistic medical approaches in the U.S. most significantly converge. Neither treats the living patient as a "case." In both approaches the patient is an autonomous actor, her individuality valued, her inclusion on the healing team a given, her will and beliefs assumed to play strong roles in the healing process. But, contrary to the American holistic tradition's emphasis on acceptance as an important part of the dying process (Kubler-Ross 1975), in the Ju/'hoan tradition the sick are alive until proven dead, given the benefit of the doubt as long as they are still breathing (and sometimes even afterwards): they are culturally allowed the ability to make the miraculous recovery if it is in them--or if, as the Ju/'hoansi believe, it is in !Xu's (//Gauwa's) will.

Seeing the ease with which Ju/'hoan healers accepted that death was ultimately out of their hands, I was filled with compassion for doctors whose techno-scientific tradition forces them to incur so much personal responsibility. I remembered Dr. Henderson's words, "Since I have become primarily responsible for patients...it has become difficult, an emotional effort, to help people die."

Upon her return to the Kalahari, I told the story of Margaret Bell's death to the Ju/'hoan healer I had known and worked with the longest, a man in his fifties I'll call Komtsa Kxao. Komtsa listened gravely to the story of how the last afternoon of Mrs. Bell's life was spent quietly at home in a coma with her family present, and how she quietly slipped away in the evening. "Where was the doctor?" he wanted to know. "Well, they all knew she was dying so he wasn't there." Then Komtsa said, matter-of-factly and without a trace of criticism for the other medical tradition, "It's too bad she was so far away. If it had been me, I would have still been trying. If she could have been brought back, I could have done it."

Shortly after her mother's death, the eldest daughter had told us a strange story about hearing "garbled voices in the wall" above her mother as she lay dying, speaking incomprehensibly but so audibly that she actually went outside to see who was there, but found no one. It occurred to me to ask Komtsa Kxao if he had any idea what these voices might have been. He responded, "Of course I know. It was the spirits coming to take Mrs. Bell. If I had been there, because I'm a *n/omkxao* I would have been able to speak their speech and ask them to bring her back."

I believe that what we can learn from non-"experts" ministrations to the ill, through their spiritual or humane approaches to the whole person, is profound. Other cultures, other traditions, suggest more open paradigms of the healer than the technocratic biomedical model: in other models, it seems, the ferryboat to the other side can run both ways.

Perhaps the role of Charon for Western physicians much involved in terminal illness has a great deal to do with the privileged Classical heritage in which they have invested. It's not just the myth, though myths are powerful; it is the whole complex of ideas about Cartesian rationalism and the human potential for control of both nature and fate which come down to us with the strength of unassailable Truth. Yet these ideas, like any ideas, are cultural constructs, and the physician who enacts the matrix they form by diagnosing in its terms only is imposing a very narrow and culture-specific view of reality on the life/death of his patient. Fascinatingly, the attempt to

meaningfully move beyond this narrow matrix informs not only the philosophies of physicians and medical anthropologists who advocate conversation-centered approaches to healing (DiGiacomo 1987; Kleinman 1988), but also those of the popular advocates of holism so admired by Margaret Bell.

Dying is a physiological and often interactional event with profound religious, social, spiritual, and individual ramifications. Enactments of their cultural matrix by practitioners who wrestle with, talk to, or wait upon death, be they technocratic Western physicians, holistic Western practitioners, or traditional Ju/'hoan healers, work to ensure that, like giving birth, dying will also be a cultural performance. And whether the performance contain speaking or hearing the mysterious speech of the spirits or not, the rhetorical dialogue involving healer and patient can profoundly determine, if not the outcome of the illness process, every motion of their entwined minds as they step together towards the shore.

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