

MARKET RHETORIC AS AN OBSTACLE TO (TRADITIONAL) HEALING

M. NEIL BROWNE
ELIZABETH BARRE

INTRODUCTION

Despite bluster to the contrary, economics as a discipline does not have any special access to truth. (McCloskey, 1983: 482) The rhetoric of economics is highly perspectival, a collection of words and presumptions that privileges the market form of conflict resolution over alternative sources of social problem-solving. Hence, economists should be quite comfortable with our use of "market rhetoric" in this paper to designate their persuasive efforts.

Section one examines the significance of market rhetoric as a phenomenon of disciplinary practice, saving for later its specific effect on healing. But to anticipate a bit, healing requires purposive human interdependence guided by compassion. Apart from the rare applicability of the injunction to "heal thyself," healing makes sense only in a framework of human need and a subsequent social response. Hence, healing is a cooperative venture in which the parties identify success in terms of their joint accomplishment, the healing. Market rhetoric benefits healing to the extent that it encourages parties to see the distress of others as a proper focus for their energies.ⁱ

In this paper, we will argue that our concepts of health and healing, while not influenced by a religious narrative, have been influenced by the most powerful narrative within our culture—the narrative of the market. We will further argue that our concepts of health and healing have not only been influenced, but that they have been weakened by market rhetoric.

By surveying concepts of health and healing within religious systems and other cultures, we will show that our modern conceptions of health and healing are significantly different from the more traditional conceptions adopted by most cultures throughout history, conceptions that were they more widely appreciated would enable us to better appreciate that it not only takes a village to rear a child, but it takes the village to heal as well.

While the concepts of health within these non-dominant cultures certainly differ from one another in some respects, they have much in common--commonalities missing within the modern Western conception of health and healing. After surveying the other religions and cultures, we will then explore more fully the ways in which market rhetoric has infected our current conceptions of health and healing.

THE SIGNIFICANCE OF ECONOMIC RHETORIC

Truth as certainty excludes rhetoric from the domain of usefulness because rhetoric deals not with the certain but rather with the plausible or possible (Booth 1974, 59). As a "systematic search for ultimate truth," philosophy makes no room for rhetoric (McCloskey 1983, 483; Ijsseling 1976, 9). As their name would suggest, the social sciences have traditionally accepted the rhetoric/philosophy distinction and have identified themselves with the latter. Consistent with this allegiance to an ostensibly non-rhetorical quest for certainty, the social sciences have expressed a mistrust, even a fear, of words. As Hazelrigg (1985) points out, typical social science textbooks discount or omit the play and tactics of rhetoric.

Economics eagerly pledges fidelity to philosophy at the expense of rhetoric, as these terms have been defined in the ancient dichotomy. Illustrative of this assertion is the positive/normative distinction usually made in the first chapter of almost any principles textbook. Economists make it clear at the outset that they are in the business of saying "what is" not "what ought to be." That is, economists believe their work constitutes the conveyance of facts in a logical fashion, not the perspectival derivatives of particular value commitments. Persuasion, which is central to rhetoric, presumably has no place in such a project.

These claims to seeking truth, or "what is," to the exclusion of rhetoric have come under strong critique in the first half of the twentieth century. Common to all these critical viewpoints is the claim that there is no fundamental distinction between truth and rhetoric -- i.e. truth cannot be found outside of our rhetorical practices. Rorty (1979, 12) argues that it is pictures rather than propositions and metaphors rather than statements that determine most of our philosophical convictions. Similarly, Bell (1884) points out that facts do not speak for themselves, as many economists adhering to the fact/value dichotomy are wont to claim, but rather gain voice only through our articulation of them. And, following Kuhn (1962), Finocchiaro (1980, 5) argues that in the case of very fundamental scientific developments such as the transition from classical to modern physics, purely logical considerations rational argumentation, and appeals to the rules of scientific method are not sufficient to make a scientist change his or her mind. To put it another way, the new truths that emerge from these fundamental changes gain recognition only with the use of rhetoric.

While later parts of this paper will analyze the meaning of healing in some depth, it might be opportune here to note that the framing of "healing" itself is fundamentally a rhetorical practice. Indeed, one of the most vivid illustrations of rhetoric influencing our worldview can be found in our cultural understandings of

health and healing. While many cultures differ with respect to their conceptions of health and healing, all have constructed a narrative that attempts to explain the mysteries of suffering and death (Sullivan 1989).

The creation of this narrative requires the culture to create a vocabulary informed by and fitting within its current and broader cultural narrative (Frank 1979; Dow 1986). Thus, understanding the broad cultural narrative constructed by each society will give one a better clue as to the society's conceptions of health and healing. In fact, more precisely, some have argued that one should look to the dominant cultural centers of power to deduce concepts of health and healing because it is that cultural power that has most likely influenced the current broader narrative (Pilch 2000). In other words, if religion is the source of power within a society, the narrative associated with that particular religion would most likely influence the concepts of health and healing within that culture.

It is important to note that religion is hardly the only source of power from which concepts of health and healing can be constructed. All too often, many within our society mistakenly assume that our concepts of health and healing are free from any type of cultural influence—especially religious influence (Kinsley 1996). Such believe holds that our concepts of health and healing are completely objective and based upon nothing but that which science has revealed to us. This

perception, however, is largely the result of an inaccurate assumption that if our concepts are not influenced by religion they have not been "influenced" at all.

The point here is that the problem of healing and the approach to the healing are contestable. Various groups attempt to deploy tropes that advance their preferred version of these constructs. Even though the result may be seen as evolving, those who seek behavior and resources sustaining their preferred version of healing do celebrate or grouse depending on the effectiveness of their arguments. Hence, the "truth" about healing is a rhetorical outcome.

Attempts to divorce truth from rhetoric have occasionally been repudiated within the field of economics. McCloskey has led the charge in this endeavor offering several evocative arguments concerning the relation of rhetoric to economics. Perhaps the strongest of his statements asserting the rhetorical nature of economic practice can be found in his 1983 article that appeared in the *Journal of Economics Literature*:

They [i.e. economists] claim to be arguing on grounds of certain limited matters of statistical inference, on grounds of positive economics, operationalism, behaviorism, and other positivistic enthusiasms of the 1930s and 1940s. They believe that these are the only

grounds for science. But in their actual scientific work they argue about the aptness of economic metaphors, the relevance of historical precedents, the persuasiveness of introspections, the power of authority, the charm of symmetry, the claims of morality [482].

Elsewhere, McCloskey (1990) argues that economics makes use of the rhetorical tetrad of facts, logic, metaphor, and story [1]. It is the last two of this set that most economists would be surprised to find in their practice, and McCloskey makes a strong effort to facilitate this discovery. Among the many metaphors that he identifies in economics are models as reality, children as consumer durables (in the work of Gary Becker), and people as calculating machines [1994, 43-38].

And McCloskey has not been alone in debunking economists' claims to non-rhetorical practice. George (1990) argues that several metaphors are repeatedly implicit in economics texts, including "inflation is a destroyer of goods" [868-872]. Similarly, Browne (1987, 36) points out that economists often treat markets as auctions. More recently, Grappard (1995) makes a persuasive argument that the Robinson Crusoe metaphor as representative of the individual chooser pervades economic discourse.

The impact of this lack of rhetorical self-consciousness on the part of the propagators of market rhetoric may seem only distantly related to healing. However, the link is potent. Awareness of the nature of disciplinary rhetoric has social and political implications, no less virulent just because they are unintended. As Levine (1985) points out so well, the disposition to flee from ambiguities of human life and utterance has produced three characteristic failings in modern social science: (1) a trained incapacity to observe and represent ambiguity as an empirical phenomenon, (2) insufficient awareness of the multiple meanings of commonly used terms in the social sciences, and (3) where such awareness exists, an inability to realize the constructive possibilities of ambiguity in theory and analysis [8]. Insofar as economists become cognizant of their own rhetoric, they would probably realize the central importance of language in disciplinary discourse. As a consequence, as long as this realization results in more attention to language, economists may not be as reluctant to grapple with ambiguities, thereby possibly helping to solve those problems resulting from a neglect of these linguistic complexities.

To make this point more clear, consider the ambiguity associated with "progress." Economists with their focus on economic growth as social purpose do not grapple with the multiple forms of happiness that this understanding of

progress ignores. One struggles with problems about which one is aware. The polymorphism of language, *once it pervades a person's analysis*, opens our eyes to the need to consider the ramifications of alternative reifications of a particular construct.

But if one knows for sure, as economists seem to know, that THE ECONOMIC PROBLEM is resolved by GNP growth, then the only healing their substantial intellects will address is the injury and illness of material deprivation and waste of resources. Small wonder that a thorough search of the index of an economics textbook will not discover page references to "healing."

Instead those textbooks consist of thinly disguised persuasive briefs on behalf of market processes as instruments for human well-being. David George has argued convincingly that the use in these texts of specific metaphorical languageⁱⁱ permits economists to persuade their readers of several common assumptions: that government is an intrusive alien, that taxes are burdensome impositions, and that inflation is a destroyer of goods [1990]. For example, George notes that authors exalt the private sphere, and deride any governmental attempts to strengthen its role in the market's functioning. Taxes, though funding public goods and services (a fact that is systematically overlooked by text authors), are seen as being unjustly imposed upon the private sphere.

That these assumptions reflect and perpetuate staunch anti-government values is not *George's* main point. Most importantly, he asserts that texts are more a commodity produced for the market than a work of scholarship. As a market commodity, dependent for its success on the preferences of its buyers, texts "reinforce conventional interpretations that are favored by the business elite" (*George* 1990, 861). Textbooks that the market deems worthy are not those that challenge the folk wisdom of the reader, but instead those that share business's laissez-faire, libertarian leanings. The implications for any healing requiring social allocations of resources is obvious.

The reproductive process that produces these textbook writers is heightened in graduate school. *Klamer and Collander's* study of economists' graduate school training (1990) details the transmission process of the discipline's assumptions and methods of argumentation. *Klamer and Colander* note that graduate students do not come to the discipline proclaiming the dominant values of the profession -- that above all, graduate school training is, more or less successfully, a process of socialization. Graduate students' interests in economic policy, theory, and the application of economics to real-world problems coax them into the discipline.

For our purposes here, healing in all of its complexity may be highly pertinent to the prospective economist. However, the staunchly empirical methodology of economists make impermissible the application-oriented interests of students. Real-world, complex, and messy topics do not fit well into a precise, quantifiable, and exacting econometric framework. If they wish to be economists, they must first accept the empirical methodology of the discipline, and second, address only those questions that are appropriate to their methodology. The rhetoric of positivism admits into the mainstream economic discourse only those questions that are empirically grounded and testable.

The next section attempts to focus even greater attention on rhetorical practices by discussing the significance of rhetoric in constituting our understanding of healing.

THE RHETORIC OF HEALING IN WORLD RELIGIONS AND NON-DOMINANT CULTURES (We will call these sources "traditional.")

All cultures have created some type of narrative to understand the suffering associated with illness, disease, and death. As a means of understanding our own cultural narrative and its influence on our concepts of healing, it will be useful to survey multiple conceptions of healing constructed within non-dominant cultures. While most of us would define ourselves as

religious, yet we believe that no religion is dominant enough in American culture to influence our concepts of health and healing. Thus, in addition to surveying the narratives of eastern culture and religion, we will also look at the narratives of traditional Western religions—Judaism and Christianity.

It is important to note, however, the difficulty of completing such a task well in a brief survey. Many of the religions and worldviews that we will be surveying have been understood in multiple forms throughout their history, and it will thus be difficult to provide *the Jewish perspective* on healing.

We will do our best to capture this plurality of belief, but for purposes of this paper, it is not necessary to be exhaustive. What is important is that we display examples of unique and non-dominant cultures that have constructed unique narratives of health and healing. Thus, even if we have not captured *every* version of Christian perspectives on healing, we will at least know the extent to which those particular versions of Christianity have constructed cultural narratives about health and healing.

a. Rhetoric of Healing in Traditional/Tribal Religions and Cultures

While there are and have been numerous unique tribal religions throughout world history, there are enough similarities between the different cultures to lead many scholars to classify them as a group under the title of traditional

and/or tribal religions. One of the most distinctive features of tribal concepts of health and healing is that the understanding of health cannot be separated from the religious narrative of the particular culture (Pilch 2000). Tribal religions also understand health as having a fundamental moral nature in that illness is often considered to arise as a result of moral transgressions. There are generally 4 types of beings that can be held responsible for bringing about illnesses within tribal religions: Deities, ancestors, ghosts or other human beings (Kinsley 1996).

All of these beings can bring about an illness if they are angered by the behavior of the soon to be sick individual. In many cases, this anger is sparked when an individual violates some aspect of her relationship to God, her ancestors, or other human beings.

Illness is understood in terms of ruptured relationships (Dow 1986), because illness within these cultures involves the entire person and is not limited to the physical (Frank 1979). If illness within these cultures is primarily understood in terms of ruptured relationships, their healing practices are equally rooted within the group. Many of these cultures practice ritualistic healing ceremonies that require group participation in order to be successful (Frank 1979; Kinsley 1996).

Perhaps the most important figure within the healing process is the Shaman—a religious specialist believed to have special healing powers. The role of the Shaman fits within the religious-cultural narrative of the tribe, and his powers are never questioned. Fundamentally, however, the primary role of the shaman is to assign meaning to illness for the patient. In other words, the Shaman helps the sick individual understand the possible causes of his ailment within the assumptive framework of their society. Given the heavy connection between health and relationships within these cultures, the Shaman is most often attempting to help the sick individual understand which relationships he must mend (Frank 1979; Kinsley 1996).

b. Rhetoric of Healing in Abrahamic Religions (Judaism, Christianity and Islam)

The three dominant religious traditions that grew out of the teachings of Abraham have also constructed narratives about health and healing. While Judaism, Christianity and Islam are quite different, their common intellectual and spiritual root seems to have led them to construct similar conceptions of the nature of health and healing. All three traditions conceptualize health as something that involves multiple aspects of the human being—not just the physical.

For example, traditional Jewish sources recognize that ill health is often the result of multiple factors beyond the bio-medical. They understand ill health be the result of social, economic, and spiritual problems (Solomon 1999). Within the Islamic tradition, one of the two words used to speak about health can also be translated as "wholeness," "intactness," "peace," or "security" (Antes 1989), and both Christianity and Islam have understood illness as an unavoidable aspect of life that is a fundamental part of what it means to be human (Melling 1999; Sachedina 1999).

All three traditions have struggled to construct a coherent narrative that explains the causes of illness within their particular worldviews. Fundamentally, though, two streams of thought surface with respect to this issue in all three traditions. The first perspective holds that illness comes about as the result of human free will and sinfulness. In other words, because humans are free and sinful, they are free to make bad decisions that will lead to the inevitable consequence of illness.

This perspective can be seen most vividly within Judaism in the writings of the ancient Hebrew prophets who warn the Israelites that their evil deeds will eventually lead to their downfall. Christians often speak of illness as the result of "disordered living," and require confession of sinful behavior before one can

truly be healed (Frank 1979; Melling 1999). Additionally, many within the tradition of Islam speak of illness as the result of man's folly.

Those who propose a second narrative have trouble with the above narrative because the God within that narrative seems to lack authoritative power. Thus, within the second narrative, God is seen as all-powerful, and thus responsible in some way for the illness of human beings. While there are many within each tradition who believe that God is punishing individuals through sickness, most contemporary theologians in all three traditions hold that God may allow illness so that the individual may be purified in some way.

Within Judaism, one can find a debate about this issue in the classic Hebrew book of Job. Within this book, Job, a righteous man in every way, is afflicted with horrible diseases under God's watch. His friends claim that he must have done something wrong, but it seems that the author of this Book wanted the reader to recognize that righteous individuals can in fact acquire illnesses and that no one but God can understand why the individual had to suffer.

Christians often view suffering as a way of purging and individual of his sins and helping him to grow into a more spiritual individual. Without suffering in Christianity, one cannot be sanctified. While many laypersons understand suffering as directly inflicted by God (Hays 1998), most Christian theologians

have rejected such a philosophy (Melling 1999). Of all three traditions, it seems that Islam is most committed to this second position. Within the Islamic tradition, one of the fundamental tenets is that God is the cause of all things (Antes 1989). Consequently, most Muslims are more interested in the question of why God would will illness as opposed to whether He did.

Just as within traditional cultures, healing within the religious narratives of these traditions is understood within a social context. Within the Jewish tradition, the community is ethically obligated to visit the sick and intercessions for the sick are often made in public services (Solomon 1999). Christians also participate in this public praying for the sick, in addition to the practice of the laying on of hands (Melling 1999). This ceremony consists of individuals from within the community gathering around the sick individual, laying their hands upon the sick individual's body, and then praying collectively for the restored health of the sick individual. Within the Islamic tradition, healing is seen as communal, but perhaps more importantly, it is viewed as an act of worship. Thus, participating in the healing process is a way for individuals within the community to worship their God (Antes 1989).

c. Rhetoric of Healing in Eastern Religions (Hinduism and Buddhism)

In contrast to the Western religious traditions, Eastern religions such as Hinduism and Buddhism have constructed religious narratives that are in many senses based upon the alleviation of suffering. The Buddhist religious narrative, for example, speaks mostly about how an individual can achieve "enlightenment." Suffering is an inevitable aspect of the life one leads before enlightenment. Thus Buddhism teachings help one to alleviate their suffering on the route to enlightenment (Birnbaum 1989; Skorupski 1999). The suffering associated with illness often serves as a catalyst toward enlightenment in that it is a signal to the self to pay attention to his or her life and to improve (Fink 1979).

Because health is understood in relationship to enlightenment within both Hindu and Buddhist traditions, the concept of illness is broader than modern Western conceptions of bodily illness. Within the Hindu tradition, illness is understood as a disruption of either the soma, psyche, or polis—the three "orders of existence." In other words, illness is often the result of injury to the body, self, or social being (Kakar 1989). Similarly, Buddhism understands illness as a disruption of one of the four humors within the body—earth, wind, fire, and water. If these four aspects of being are out of balance in any way, illness comes (Birnbaum 1989).

Both Hinduism and Buddhism teach that the origin of illness is bad "karma" (Leslie 1999). In other words, illness is the result of sinful behavior in a past or current life that impinges upon the ability of the individual to achieve enlightenment. Within the Buddhist tradition, the socio-economic class in which one is born is believed to be the result of karma from past lives (Birnbaum 1989) and Hindus believe that physical deformity is also the result of bad karma (Leslie 1999). Thus, suffering continues throughout the multiple lives of individuals until they achieve enlightenment and rid themselves of their bad karma.

Because illness is understood to be the result of bad karma, "healing" within these traditions involves the improvement of one's karma—or the pursuit of enlightenment. Within the Buddhist tradition, this involves a great deal of meditation within which one becomes more aware of the self and his flaws and is thus able to improve his behavior in such a way that will lead to enlightenment. Part of this improvement process involves the recognition of one's responsibility to others. Within the sacred texts of the tradition, the Buddha instructed monks of the importance of caring for one another when in need (Skorupski 1999). Thus, without recognizing one's responsibility to others, one will never achieve enlightenment and will never relieve themselves of suffering and illness.

The Hindu tradition also places a huge value on the interconnectedness of the healing process. Illness is often understood in terms of the disturbance of an individual's bond with her polis thus the healing process often involves the restoration of relationships and incorporates the participation of many individuals from within the community. Because the Hindu tradition believes that a primary source of strength in life lies in the harmonious living with one's group, their conceptions of illness incorporates much more than the "bodily" order (Kakar 1989).

d. Rhetoric of Healing in Humanistic Thought

To this point we have surveyed the healing narratives of the major world religions. It may also be useful to survey the concepts of health and healing within a philosophical tradition that is and has been a powerful force throughout history: Humanism. A philosophy that dates back to *Ancient Greece*, Humanism is now in many ways a minority worldview in today's medical culture. The Humanist worldview privileges humanity by attempting to maximize human potential and by emphasizing the importance of those characteristics that separate human beings from the mere physical and natural. The intense respect for individual flourishing in Humanism implies that individuals are to be treated and recognized as autonomous human beings (Leininger 1979).

While Humanism is a minority position in America today, the healing narratives within the tradition are quite powerful and in many ways similar to the healing narratives of the major world religions surveyed in this paper. While the Humanist narrative speaks most often about the nature of illness and the way in which one should attempt healing such illness, there is also some talk about the causes of illness. Similar to the narratives of the surveyed world religions, Humanism conceptualizes illness as the result of multiple factors. For example, events at the level of the family, community or society as a whole could impact the health of the individual (Fink 1979). This understanding of the origin of illness is partially the result of the Humanist holistic conception of health. Humanism understands illness in terms of the entire complex of the body, the mind, and the group of which the individual is a part (Cassell 1991). Apart from the body, the mind, feelings, and spiritual needs of the individual are essential elements to a healthy individual and thus to the healing process (Fink 1979).

Within the Humanist model, the physician is the healer and she is to be sensitive, warm, understanding, and compassionate and her goal should be to build a personal bond with the patient while treating him (Leininger 1979; Trotter 1999). She must also recognize and restore all aspects of the human being beyond the body—especially the patient's relationships with others. It is

believed that disrupted relationships can serve to deepen the suffering associated with illness (Cassell 1991). Some have even claimed that to ignore "the patient's self and its many connections is to ignore the very nature of health and healing" (Hester 1999).

While Humanism holds that the physician should do whatever possible to respect the autonomous decisions of the patient, it also recognizes that one cannot fully understand the decisions of the patient without knowing the social background of which he was a part. The diversity of individuals arises within the context of a community (Hester 1999).

Because Humanism understands relationships to others to be an integral part of health, they also encourage the participation of others in the healing process. For example, Cassell believes that one of the crucial components of recovery is the borrowing of strength from others in a time of need. Either the physician or the group can lend their strength to the patient until the patient is able to use her own strength.

e. Common Themes

While the narratives of the above traditions are all unique in certain respects, there are important commonalities that should be noted before moving on to survey current modern concepts of health and healing. In terms of the origin of

illness, all traditions agreed that illness is not always the result of biological factors. In some traditions, illness was believed to originate in response to the immoral behavior while in others it was the result of disturbed or disrupted relationships.

This recognition that illness does not always have biological causation also leads all the traditions mentioned above to understand health holistically. Illness is seen as a disorder of the total person (Frank 1979). Human beings are more than just bodies, and, as such, illness affects all aspects of their lives. While the effect on the body is certainly recognized, all the above traditions also seem to recognize the effects of illness on emotional well-being and relationships with others.

Because the entire person is affected by illness, the conception of healing within these traditions is also much more holistic. Healers in these traditions are not primarily concerned with the mechanics of the body. While they certainly work with the body, they also work to mend the relationships of the patient and to provide patients with a way to make sense out of their illness in terms of their life meaning.

Almost all non-western conceptions of healing attempt to muster as much community support on behalf of the patient as possible (Kinsley 1996). It is clear

that one of the most important aspects of traditional conceptions of healing is the interconnectedness of the process. An individual cannot be healed within these traditions unless she is healed within the context of her community.

Modern Rhetoric of Healing and Market Rhetoric

a. Modern Concepts of Health and Healing

Little within modern conceptions of health that can be reconciled with more traditional conceptions of health. For example, while most traditional cultures recognize that illness can emanate from multiple facets of human life, modern conceptions of illness understand disease as the result of "germs" invading the body from the outside (Fink 1979). Illness in this sense is nothing more than the malfunction of the body as a computer might malfunction if infected with a virus.

This mechanistic model of the human being grew out of the 17th and 18th century empiricists and was most fully developed by the behaviorists of the 20th century (Wrubel 1989). The model allowed for the introduction of a new scientific age of medicine in which illness was understood only in terms of the "hard data" available to us through science. It was the bacteriological research of Koch and Pasteur that lead to the development of the germ theory of disease

(Schneider 1990). This new theory of disease led doctors to understand symptoms as signs of a deeper problem—not the problem itself. It was thus important that the physicians obtain an accurate understanding of the symptoms in order to deduce the disease that was invading the body of the patient. Within the scientific model, the best way to achieve hard data with respect to symptoms is to observe the physical symptoms first hand. The perspective of the patient is ignored as soft data because such a perspective is often clouded with feelings, values and beliefs that have nothing to do with the disease at hand (Cassell 1991; Self 1991).

In light of this understanding of the cause of disease and illness, the conception of the nature of illness is also quite different from the conception within traditional models of health and healing. Illness is no longer understood in terms of the whole person. Instead, illness is understood as the malfunctioning of certain components of the body that can be repaired once recognized (Frank 1979).

This bodily conception of illness also leads our culture to understand illness and disease in terms of the individual (Kinsley 1996). Disease is no longer the result of ruptured relationships, and it no longer affects ones relationships with

others. Illness arrives within the body of the individual, runs its course within the body of the individual, and is eradicated from the body of the individual.

Consequently, the individual needs to undertake choices that will preclude such infections in the future and address illnesses already diagnosed. The social context of illness no doubt is somewhat causal, but the onus of illness falls onto the already burdened shoulders of the ill themselves.

Peabody argues that once an individual enters a hospital today, she loses her social identity. She is no longer a person with relationships and feelings. Instead, she becomes an individual body with a disease (Peabody 1979).

The mechanistic model also has important implications for the modern conception of healing. Within this model, physicians are understood as skilled technicians (Frank 1979) fighting a "battle" against a disease that keeps the body from operating smoothly (Hays 1998; Pilch 2000). This technical conception of healing often leads to ritualistic behavior on the part of the physician (Hester 1999) and as more and more instruments are used to "fix" the machine of the body (Leininger 1979), the bond that traditionally exists between patient and doctor is beginning to disappear (Self 1991).

This technical conception of healing does not require the physician to know anything about the patient except his or her physical symptoms and physical

medical history. What need is there to know a patient beyond perceiving the illness and extracting it?

In addition to this mechanistic model of the human being, there is another crucial component of our modern culture that influences our conceptions of health and healing. The economic context in which healing is provided within our society plays a significant role in shaping our understanding of the healing process. Individual patients are not only viewed as machines, they are viewed as *customers* within a market for healing services (Trotter 1999). Understanding patients as customers within a market system of health care has important consequences for our conceptions of healing.

For example, if patients are viewed as consumers, there is likely to be less commitment to patient well being on the part of health care professionals. If health is to be distributed on the basis of the market, what is most important is that health is distributed most efficiently (Hester 1999). This formulation means that only those services that are most important will be offered to patients and those services that are most important have little to do with the emotions and feelings of the patient. Holistic healing cannot thrive within a market model of health care because it is inefficient (Trotter 1999).

b. Market Rhetoric as an Obstacle to Traditional Healing

Certainly the lack of awareness of their own reliance on rhetoric reduces any potential interest economists might have in the ambiguity of social problems. From their vantage point, illness and subsequent healing are but one more choice set that individuals should contemplate. While we would not want to overlook the benefits of human agency, our paper calls attention to the manner in which market rhetoric with its reverence for individual preferences and the efficacy of personal choice supplants the potential human connectedness implicit in traditional healing.

Market rhetoric is fundamentally individualistic. Therein resides its primary resistance to traditional healing. The individuals who truck and barter in markets interact with others instrumentally. The market urges people to produce, but it does not do so on the basis of moral argument or coercion. Instead, it urges people to produce through channels of self-interest (Hunt, 1995, 39) The market promises that those who work hard to produce that which is preferred by consumers will be rewarded accordingly.

According to Adam Smith, the surest way to advance the well being of the entire society is to permit each individual to pursue his or her own interestⁱⁱⁱ. The paradox of egoism's transformation into social benefit is a vivid component of the

market narrative (Heilbroner, 1953, 47) This view of self-interest was a radical departure from historical understandings of self-interest. More traditional cultures viewed acting upon self-interest as avaricious, and therefore sinful. The Church forcefully denounced greed and enacted laws prohibiting usury. Throughout the Middle Ages, the Church's grip on Europe thus undermined the widespread use of markets. According to Christian theology of the era, greed and avarice were vices that people must avoid. Furthermore, the Catholic Church, which dominated medieval society, taught that salvation was the result of good behavior and good works. Thus, deviation from the Church's teachings was thought to undermine an individual's opportunity for salvation.

But as surely as illness and healing have evolved in individualistic directions, so surely has greed been elevated to a position of respect as motivation for market achievement. That greed might result in a generalized lack of empathy for those unfortunate enough to possess a lavish share of societal resources is not a consideration in modern economics because such effects are external to the economic problem as it has been rhetorically established.

Our modern conceptions of health care have emerged from this dominant market rhetoric, and they are in many ways hostile to any and all traditional conceptions of healing in other cultures. The Mechanistic model of the human

being is inadequate for explaining the complexity of human activity and human illness (Wrubel 1989) because it fails to acknowledge the fact that our psychological and social well being can profoundly affect our physical well-being (Frank 1979). Cassell argues that the "anachronistic division of the human condition into what is medical and what is not medical has given medicine too narrow a notion of its calling" (Cassell 1991).

Equally problematic is our modern conception of healing as a market process. To understand health care as an industry and the sick individual as a consumer is problematic in that it ignores some fundamental differences between medicine and other goods and services. A patient does not "consume" medicine in the same way she consumes others goods and services because she often has less knowledge of what she is purchasing and is often emotionally unstable in terms of making a rational decision about which form of care would benefit her most (Trotter 1999). In addition, understanding the healing process as an "industry" seems cold and disconnected. The patient no longer visits the healer to receive comfort and restoration—instead she enters into an industry that seeks to fix her mechanical problem in the most efficient way possible without being sensitive to her feelings and personhood. Traditional conceptions of healing and health

care would not allow a patient's initial moments in a hospital to be consumed with the checking of her finances (Leininger 1979).

Frank argues that modern medicine's insensitivity to the effects of emotions on well-being has led to many medical failures that could have been avoided (1979). In addition, many have complained that the individualistic understanding of health has harmed the healing process of individuals. As traditional religions and cultures have instructed us, a sick individual cannot be extracted from his or her community and in fact *needs* this community in order to be healed properly. Thus it seems that one of the most fundamental problems of today's medical system is that it fails to recognize the interconnectedness of health healing.

SUMMARY

Economics, markets, illness, and healing each develop through the rough and tumble of discursive practice. They are fluid concepts to be shaped for human use. Economics and market logic have a well-deserved reputation for accomplishing certain tasks that we who want goods and services require. Healing in a crude, mechanistic sense is just another market service to be bought and sold as if it were a manicure or a paper clip.

But healing, if we will listen to traditional understandings of that need, is based on sentiment, commitment to one another, relational development, and friendship. Markets elevate the personal; they celebrate individual achievement and turn a cold shoulder to our vulnerability. Markets ennoble greed, but in so doing they ignore the danger of unleashing that greed and applying it in domains where it is deadly to the hard work of connectedness (Nelson, 2001). To the extent that illness is embedded in a web of social relationships, greed prevents our strengthening that web so that we can count on it when we need it. And need it we do!

REFERENCES

- Antes, P. (1989). *Medicine and the Living Tradition of Islam*. Healing and Restoring: Health and Medicine in the World's Religious Traditions. L. Sullivan. New York, Macmillan: 173-202.
- Birnbaum, R. (1989). *Chinese Buddhist Traditions of Healing and the Life Cycle*. Healing and Restoring: Health and Medicine in the World's Religious Traditions. L. Sullivan. New York, Macmillan Publishing Company: 33-58.
- Booth, Wayne C. *Modern Dogma and the Rhetoric of Assent*. Chicago: University of Chicago Press, 1974.
- Browne, M. Neil. "The Metaphorical Constraints to Pay Equity: Why So Many Economists Are Outraged by Comparable Worth." *Population Research and Policy Review* 6 (1987): 29-46.
- Cassell, E. J. (1991). The Nature of Suffering and the Goals of Medicine. New York, Oxford University Press.
- Dow, J. (1986). "Universal Aspects of Symbolic Healing: A Theoretical Synthesis." American Anthropologist 88: 56-69.
- Fink, D. (1979). *Holistic Health: The Evolution of Western Medicine*. The Healing Continuum: Journeys in the Philosophy of Holistic Health. P. A. R. Flynn. Bowie, Maryland, Robert J. Brady Company: 321-338.
- Finocchiaro, Maurice A. "Galileo and the Art of Reasoning: Rhetorical Foundations of Logic and Scientific Method." Dordrecht, Holland: D. Reidel Publishing Co., 1980.
- Frank, J. (1979). *Nonmedical Health: Religious and Secular*. The Healing Continuum: Journeys in the Philosophy of Holistic Health. P. A. R. Flynn. Bowie, Maryland, Robert J. Brady Company: 123-152.
- George, David. "The Rhetoric of Economic Texts." *Journal of Economic Issues* 24 (September 1990): 861-878.

- Hays, J. N. (1998). The Burdens of Disease: Epidemics and Human Response in Western History. New Brunswick, Rutgers University Press.
- Hazelrigg, Lawrence E. "Were It Not for Words." *Social Problems* 32 (February 1985): 234-237.
- Heilbroner, Robert L. (1953)The Worldly Philosophers. New York, McGraw Hill.
- Hester, D. M. (1999). Habits of Healing. Pragmatic Bioethics. G. McGee. Nashville, Vanderbilt University Press: 45-59.
- Hunt, E.K. (1995). Property and Prophets. New York, Harper Collins.
- Ijsseling, Samuel, *Rhetoric and Philosophy in Conflict*. The Hague: Martinus Nijhoff, 1976.
- Kakar, S. (1989). Health and Medicine in the Living Traditions of Hinduism. Healing and Restoring: Health and Medicine in the World's Religious Traditions. L. Sullivan. New York, Macmillan: 111-126.
- Kinsley, D. (1996). Health, Healing, and Religion: A Cross-Cultural Perspective. Upper Saddle River, Prentice Hall.
- Klamer, Arjo and David Colander. *The Making of an Economist*. Boulder, CO: Westview Press, 1990.
- Kuhn, Thomas S. *The Structure of Scientific Revolutions*. Chicago: University of Chicago Press, 1962.
- Leininger, M. (1979). Humanism, Health, and Cultural Values. The Healing Continuum: Journeys in the Philosophy of Holistic Health. P. A. R. Flynn. Bowie, Maryland, Robert J. Brady Company: 183-210.
- Leslie, J. (1999). The Implications of the Physical Body: Health, Suffering and Karma in Hindu Thought. Religion, Health and Suffering. J. R. H. a. R. Porter. London, Kegan Paul International: 23-45.

Levine, Donald N. The Flight from Ambiguity. Chicago: University of Chicago Press, 1985.

McCloskey, Donald N. The Rhetoric of Economics. @ *Journal of Economic Literature* 21 (June 1983): 481-517.

_____. *Knowledge and Persuasion in Economics*. Cambridge: Cambridge University Press, 1994.

Melling, D. J. (1999). Suffering and Sanctification in Christianity. Religion, Health and Suffering. J. R. H. a. R. Porter. London, Kegan Paul International: 46-64.

Nelson, Robert H. (2001). Economics as Religion. University Park, PA Penn State University Press.

Peabody, F. W. (1979). The Care of the Patient. The Healing Continuum: Journeys in the Philosophy of Holistic Health. P. A. R. Flynn. Bowie, Maryland, Robert J. Brady Company: 55-70.

Pilch, J. J. (2000). Healing in the New Testament: Insights from Medical Mediterranean Anthropology. Minneapolis, Fortress Press.

Rorty, Richard. *Philosophy and the Mirror of Nature*. Princeton: Princeton University Press, 1979.

Sachedina, A. (1999). Can God Inflict Unrequited Pain on His Creatures? Muslim Perspectives on Health and Suffering. Religion, Health and Suffering. J. r. H. a. R. Porter. London, Kegan Paul International: 65-84.

Schneider, P. C. a. J. W. (1990). Professionalization, Monopoly, and the Structure of Medical Practice. The Sociology of Health and Illness: Critical Perspectives. P. C. a. R. Kern. New York, St. Martin's Press: 141-147.

Self, N. S. J. a. D. J. (1991). "Separating Care and Cure: An Analysis of Historical and Contemporary Images of Nursing and Medicine." Journal of Medicine and Philosophy 16: 285-306.

- Skorupski, T. (1999). Health and Suffering in Buddhism: Doctrinal and Existential Considerations. Religion, Health and Suffering. J. R. H. a. R. Porter. London, Kegan Paul International: 139-165.
- Solomon, N. (1999). From Folk Medicine to Bioethics in Judaism. Religion, Health and Suffering. J. R. H. a. R. Porter. London, Kegan Paul International: 166-186.
- Sullivan, L. E. (1989). Introduction: The Quest for Well-Being and the Question of Medicine. Healing and Restoring: Health and Medicine in the World's Religious Traditions. L. E. Sullivan. New York, Macmillan Publishing company: 1-8.
- Trotter, C. G. (1999). The Medical Covenant: A Roycean Perspective. Pragmatic Bioethics. G. McGee. Nashville, Vanderbilt University Press: 84-96.
- Wrubel, P. B. a. J. (1989). The Primacy of Caring: Stress and Coping in Health and Illness. Menlo Park, California, Addison-Wesley Publishing Company.

ENDNOTES

ⁱ In a spirit of prolepsis, we must note that markets play a large, important role in creating the efficiency preconditions that enable social responses to individual need. Caring by itself takes us only so far by itself as a basis for healing. Self-conscious interdependency and concern for vulnerability are stimuli for healing endeavors, *but those intentions are effectuated by resource allocations*. Economic arrangements that are productive and prudent provide the material wherewithal to effectuate healing. However, as this paper will argue, those same arrangements work against the likelihood of those needed allocations when they encourage ways of thinking that highlight independence and the "redemptive" delights of personal consumption with its promise to take us far away from the dismal world of material deprivation.

ⁱⁱ George distinguishes between the discursive practices of the texts and the substance of the theory itself (1990, 861). The ways in which the theory is presented, or the discursive practices, rather than the theory itself is the focus of his article.

ⁱⁱⁱ In his 1987 ECONOMICS IN PERSPECTIVE: A CRITICAL HISTORY, J. Kenneth Galbraith notes that "Economic motivation for Smith centers on the role of self-interest. Its private and competitive pursuit is the source of the greatest public good. Galbraith points to a quote from Smith's The Wealth of Nations where he argued against the notion of people's being motivated by their desires to further the public good: "I have never known much good done by those who affected to trade for the public good. It is an affectation, indeed, not very common among merchants, and very few words need be employed in dissuading them from it."