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Under the Medical Gaze

Susan Greenhalgh

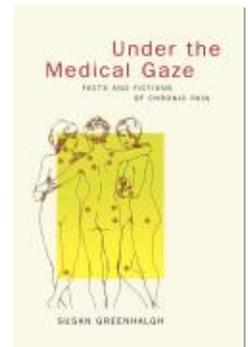
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Problematique

It was a slight slip, really—a misdiagnosis of an emergent chronic-pain syndrome. But when the misdiagnosis was followed by a raft of new symptoms, what started out as a little mistake grew bigger. The new symptoms were misinterpreted as part of the disease and then mistreated with a therapeutic plan that did not fit the problem. When the mistreatment failed to work and the debilitating new symptoms grew worse, threatening the patient's mind, dreams, and life, she went nearly mad. By the end of the eight-month ordeal, a small mistake by a doctor had undone the patient's life.

What went wrong? How could medicine, which is supposed to eliminate pain, end up creating it instead? Since the time of Descartes, the work of scientific medicine has been depicted by a metaphor of repair: the body is a machine, the physician a mechanic who fixes its broken parts.¹ Contemporary wags have likened the doctor's work to that of the automobile mechanic who fixes the carburetor and gets the vehicle back on the road. But this humble metaphor does not capture what transpires when the physician undertakes to treat a patient. The physician's work is not merely restorative, but also productive: he creates fears and hopes, images and identities, perhaps even side effects and symptoms that did not exist before. The repair analogy is also too optimistic, for although the doctor is supposed to fix body parts, he may inadvertently break them instead. The pill, given for the headache, produces stomach pain as well; the biopsy needle, aimed at the liver, punctures the bowel instead. Finally, the artisanal image is anachronistic, for the critical tools of the physician are no longer the physical implements of the mechanic; rather, they are the cognitive and linguistic tools of the scientific-professional expert. Today it is not the stethoscope or scalpel that does the fundamental work of medicine; it is the ideas, conveyed in words, that persuade us that what is done is right and good. Our repair metaphor is not just wrong; it is also dangerous because it is part of a powerful mythology that clouds our perception. It keeps us from seeing the real work of

medicine and its interventions in our identities, our emotions, and our lives. Metaphors matter more than we think.

Michel Foucault, the French philosopher and social critic, grasped these points well. In his 1963 study, *The Birth of the Clinic*, he described the penetrating “gaze” of scientific medicine and how it gradually gained sovereignty over the care of the ill.² Following new codes of scientific medicine in which the disease, not the patient, was the object of knowledge, the gaze of the physician gave him the power to know and name the patient’s disease and, on that basis, to organize massive interventions in his life.³ “The eye that knows and decides, [is] the eye that governs.”⁴ The patient comes to the doctor for help, but finds himself first transformed into an object of science and then reduced to a disease, an “endlessly reproducing pathological fact.”⁵ The process is jarring and violent, all the more so because the medical gaze denies its violence, claiming beneficence instead: “[T]o look in order to know . . . is not this a tacit form of violence, all the more abusive for its silence, upon a sick body that demands to be comforted, not displayed?”⁶ Although the patient remains a silent cipher in the *Clinic*, Foucault’s historical study remains one of the most incisive accounts of the conceptual nature of medicine’s power and the disruptive effects of scientific medicine on the patient’s inner world.

With the rise of social studies of medicine, much has been written about the disjunction between the physician’s narrow view of his task as finding and fixing disease, and the patient’s larger view of her illness as part of a life that needs to be put in order.⁷ But less has been written about what happens to the patient, not only physically, but also philosophically and psychologically, when her worldview is disturbed, her body and life rearranged according to the rules of an esoteric system she neither understands nor influences.⁸ The effects of this system on the inner world of the patient is a central focus of this book. To understand how a discipline of the body can deeply intervene in the mind and emotions, it is necessary to re-view the work of scientific medicine. Metaphors like that of the humble auto mechanic train us to *not see* the kinds of conceptual and linguistic tools that the physician uses all the time and the extra-bodily effects of these tools on the object of his attentions. A major task of this book will be to look beyond these commonsense metaphors to see how the creation of metaphors and stories is part of the work medicine does. The book’s central analytic task is to dismantle the pervasive myths surrounding medicine to discover how medicine works and with what effects on its objects. I maintain that the key to the workings of medicine is its “scienceness,” its character as the clinical branch of sci-

ence focused on the human body. Drawing on critical studies of science and medicine, I argue that scientific medicine is a powerful cognitive, linguistic, and material apparatus of social control whose power over us lies ultimately in a set of discourses, or understandings, about the suffering body and its healing. It is these discourses, which are enacted and concealed through rhetoric, that explain both the bodily effects, intended and unintended, and the “spillover effects” into the rest of our lives.

One of the ways scientific medicine keeps its myths mythic is by doing its daily work in private, behind the closed door of the examining room. It is in the private space of the doctor-patient relationship, out of earshot of professional peers and regulatory agencies, that the patient is turned into an object of medical scrutiny, his problems medicalized for his doctor to fix. This book provides an unusual opportunity to peer into an examining room and eavesdrop on what transpired during one long and lively doctor-patient interaction. Our access to this space is granted by the author, who was the patient in the medical encounter. Because she kept copious records of the experience, we have detailed information on much of what was said and done and with what consequences for the patient’s body, mind, and emotions over the full eight months of the interaction.

What gives this single case broader interest is that the illnesses in question were chronic. Medicine has made brilliant advances in the diagnosis and cure of acute illness. In the identification and treatment of chronic illness, however, it has made at most modest gains.⁹ Yet chronic illness is pervasive, diminishing the daily lives of huge numbers of Americans.¹⁰ In *The Illness Narratives*, a knowing book about chronic illness, the anthropologist and psychiatrist Arthur Kleinman warned sharply that: “[T]he medical profession is dangerous for such patients.”¹¹ I will have more to say about these dangers shortly. For now it is simply important to note that, in examining chronic illness, we will see medicine operating in the face of one of its greatest challenges. The study of chronic illness exposes both the weaknesses of scientific medicine and the dangers that medicine poses for patients.

Scientific medicine does not do its work in a social and cultural vacuum. Although science often claims to be uncontaminated by such forces, an impressive body of sociological and anthropological research has shown that every medical encounter is shaped by the social location and cultural beliefs of the particular patient and doctor involved. This case gives us an opportunity to investigate the shaping roles of two features of the social and cultural landscape that are generally salient in the medical en-

counter: gender relations and the cultures of illness. Gender dynamics influence who has voice and power in the medical encounter. From novels to personal narratives to social surveys, many sources suggest that when the doctor is male and the patient female, the patient experience can be trying. At its worst it can be hellish. This case will add layers of new meaning to the concept of a patient hell. Both cultural beliefs about illness and popular cultural alternatives to scientific medicine color the patient's views of the causes of illness and the therapeutic alternatives to conventional treatments. The case explored here will reveal how New Age and other alternative medicines that promise the sick person help and empowerment can end up hurting and disempowering her instead.

The particulars of this case make it especially suitable for studying the interrelations of science, gender, and popular cultures of illness. The doctor involved was ultrascientific, followed most of the rules of scientific medicine to the letter, and played his role as scientist of the body with utmost seriousness and sincerity. New models of physician empathy and egalitarian doctor-patient partnerships had not found their way into his practice. For her part, the patient was both an avid believer in scientific medicine and an eager consumer of the cultures of alternative medicine. Her gender identity was complex and contradictory, embodying the norms both of feminism and of white middle-class femininity (these latter, unconsciously). Although the consequences of the biomedical intervention were extraordinary, what took place during the eight-month encounter was but the ordinary workings of science, gender, and illness cultures. In this *problematique* I explain what I mean by the normal workings of medical science, gender relations, and illness cultures and introduce the constructs I use in the analysis that follows. In the final section I describe the book's genre, auto-ethnography, and its intellectual and political significance.

Science as Storytelling, Clinical Medicine as Science

Most of us, laypeople and scientists alike, think of science as representational—that is, as something that tells us the real truth about the natural world, without artfulness or expressivity. We also think of the truths of science as objective, disinterested, and value free. We think, that is, that the methods of science insulate it against the intrusion of the scientist's interests and values. It is on these bases that we have granted science its extraordinary cultural authority and social power over our lives.

The Stories That Science Tells

In his provocative study, *Science as Writing*, physicist-turned-literary-critic David Locke upends our comfortable assumptions.¹² He presents a compelling case that science is not representational, but expressive—artful, affective, and artificial. Our image of science as a conveyer of disinterested, value-free truths, he contends, is a product of an official rhetoric that draws attention away from the interests and values that inform the making of science and from the gaps and weaknesses that inhere in the methods by which scientific truths are obtained. Our supposedly artless science, he wants us to believe, is artfully constructed.

Why should science need to indulge in artifice? Because the natural world that scientists study is bafflingly complex and chaotic. Any number of interpretations might be right, depending on what part of the whole the scientist looks at, from what perspective, and for what purpose. Moreover, the methods of science, sophisticated though they are, have not been made error free. These methods are more like sieves, full of tiny holes through which human error can leak to infect the creation of scientific facts. “[I]n truth,” Locke writes, “about much of what they do, scientists are uncertain . . . Things *seem* to happen . . . but they cannot always be sure. Or they are sure, but mistaken.”¹³ Not only error but also the values and interests of the scientist can seep through the sieve’s holes to affect the making of scientific truth. But if we knew that science was error prone, it would not be Scientific Truth but merely scientific truth, one possible truth among others. If we knew that science was tainted by individual interests or values, it would no longer be a general Science, but merely a particularistic science, say, the science of physicist David Locke working in the Yale University Physics Lab in July 1985. If Science were shown to be only a collection of particular sciences, then the edifice of its power and authority would come tumbling down, the esteemed scientist reduced to the humble producer of partial and particularistic truths. For science to do its work, these aspects of the scientific project must be hidden—not only from the layperson but also, and more important, from the scientist himself.

Given the impossibility of eliminating human influence and technical error, Locke continues, the actual work of science is not so much to tell The Truth but to tell a truth and then to dress it up as The Truth. More specifically, the work of the scientist is to create a set of scientific facts and to compose these facts into a story about the natural world. The scientist must then persuade us, the public, that the story is good and true

and untarnished by his values and interests. Once we are persuaded that his story is correct, he or someone else (the engineer, the industrial scientist) can then apply his ideas to the world to achieve the ultimate end of science: to improve the working of nature itself.

The Science That Clinical Medicine Enacts

In this book I argue that this storytelling approach to science, which has been applied to a number of *research* sciences, can also illuminate the work of the *clinical* science of medicine.¹⁴ Calling the doctor's account of the patient's ills a story draws attention to the fuzziness of the boundaries between fact and fiction. Like fiction, medical facts are not discovered but humanly constructed. Stories are also compelling in ways that decontextualized facts are not. It is by weaving his handcrafted facts into a meaningful story that the physician tries to get the patient to accept those facts as true. In recent years some humanistic and social scientific students of medicine have begun to portray medical work as the telling of stories, or "clinical tales," in the felicitous phrase of Oliver Sacks.¹⁵ But the rhetorical aspect of narrativizing to which Locke calls attention—in the crass language of our consumerist culture, the selling of the stories—has received less notice in studies of medical storytelling.¹⁶ Moreover, existing work on medical narratives, which is scattered across a variety of disciplines, tends to portray storytelling as *the core task* of doctoring. This weight placed on narrative no doubt reflects the interest of the medical humanities and social sciences in language and communication. But there is much that goes on in clinical medicine that remains unspoken. If we view clinical medicine as a science, it becomes apparent that storytelling is only one of a larger set of scientific practices that the physician-scientist undertakes in his work on the patient-object.¹⁷ I argue that we need this larger view of medicine as science if we are to see the full impact of a medical encounter on the patient. We also need this enlarged view if we are to understand how medicine can inadvertently make mistakes and injure patients and then somehow make both the mistake and the injury disappear from view.

For insight into how clinical medicine operates as a science, I draw on two literatures that have developed in the borderlands between sociology and anthropology: constructivist perspectives on medicine and practice approaches to science. These two literatures are now coming together and revealing that the power of scientific medicine to alter our bodies, identities, and lives exists on a scale previously unimagined.¹⁸ Our

commonsense notion of illness is that it is a real, biological entity that medical science discovers, names, and treats. In the last two decades constructivist perspectives on illness have undermined these everyday beliefs by showing that illness is not so much a real phenomenon—although it has biological bases and produces genuine discomfort—as it is a phenomenon that is *made real* by the operations of medical science. It is “socially constructed,” or brought into being, by the specific practices, technologies, and styles of reasoning by which it is studied and represented by researchers and diagnosed and treated by clinicians.¹⁹ Although all diseases are socially constructed in this sense, the constructedness of illness is easiest to see in psychosomatic disease. One of the most arresting illustrations of this process is anthropologist Allan Young’s study of “post-traumatic stress disorder,” in which memories of trauma produce psychiatric symptoms.²⁰ Young’s historical study shows how PTSD was newly invented, slowly endowed with facticity, and eventually accepted as real not only by researchers and clinicians but also by patients and the public as well. Although I do not trace the process here, over the last two decades fibromyalgia was brought into being and “made real” in the same sorts of ways. (The preface highlighted some key dates and developments in the social construction of fibromyalgia.)

In this book I will show how a similar process of social invention of disease occurs in the microsetting of the doctor-patient encounter.²¹ In the typical case, a patient visits a doctor with a fairly clear-cut complaint, the doctor follows standard procedures to attach a disease label to it, they treat it according to established practice, and the symptom goes away. Here is medicine at its best. The case examined in this book is not typical, though such cases may be more numerous than is commonly thought. In this case, a patient came to her doctor with a clutch of enigmatic complaints, the doctor used scientifically prescribed techniques to affix a diagnosis to it, they treated the diagnosed condition according to standard protocol, and a bevy of new symptoms associated with that disease materialized in the patient’s body. In both cases, disease can be said to be socially or clinically constructed, that is, made an object of observation and intervention by the discourses, technologies, and practices of biomedicine. Yet in one case the symptoms disappear, in the other they appear *de novo*. In the latter case, in which the symptoms somehow emerge out of the clinical encounter, perverting the goals of medicine, we can say that the disease is clinically manufactured. Why did one doctor cure the disease while the other created it? The answer lies in the adequacy of the social construction, or the goodness of the clinical tale.²²

And the reasons one story was exemplary and the other deficient lie in differences in the tidiness of the patient body and differences in the susceptibility of the scientific procedures and thought processes to human error, interests, and values. I return to these points below.

To see how illness can be clinically manufactured, I view clinical work as a kind of laboratory science in which the physician-scientist uses the conceptual, linguistic, and material tools available in his examining room “laboratory” to do the basic-science work of deciphering which disease(s) the patient has and the applied-science work of treating them. In taking this approach I am following the lead of sociological and anthropological students of science, such as Bruno Latour, Karin D. Knorr-Cetina, Sharon Traweek, and Nelly Oudshoorn, who have viewed science as a practice and scientists as practical reasoners who create the facts in a highly prestructured setting.²³ The well-established discourses, rhetorics, and procedures of science shape and narrow the range of facts that can be created, and then shape and narrow the way the facts are represented to other scientists and the public at large. The doctor-as-lab-scientist approach dovetails with the “dense pragmatic perspective” of sociologists such as Isabelle Baszanger, who focus on the everyday routines by which clinicians operationalize theoretical knowledge and mobilize technical resources in organizing clinical courses of action.²⁴

Although Foucault’s influence on my thinking may not be perceptible to some readers, his penetrating vision of the nexus of language, knowledge, and power in modern life is deeply embedded in the intellectual infrastructure of this book. Key Foucauldian themes I advance include the discursive and productive nature of modern power, the centrality of scientific discourses and practices in constituting modern subjectivities, the social and historical constructedness of the body and illness, and the ubiquity of resistance to power.²⁵

How Biomedicine Works

I now step back from the literature to show how I weave together Locke’s ideas on stories, errors, and error-camouflaging rhetorics, medical constructivist notions of illness as a social construction, and science-as-practice images of the doctor as working scientist. The result is a wide-angled view of clinical medicine that takes us behind the myths to see how medicine routinely makes mistakes that have serious consequences for patients and then just as routinely makes us think that it has not.

Medical Myths and Medical Tasks

Medicine is a special branch of science because its objects are not lizards or quarks but human beings—you and me. When *we* are the objects of scientific scrutiny, which story science tells matters more to us, since the story can result in personal pain or pleasure. In addition to the mystiques of truth and objectivity that it shares with science generally, clinical medicine is haloed by another mystique: that it can do no harm, only good. This happy idea is reflected in the Hippocratic oath, which all physicians take and all patients know, if not by name, then at least in substance: Above all, do no harm. Based on these beliefs—truth, objectivity, and good—we as a society have given scientific medicine the exclusive legal right to name and treat illness.²⁶ On the basis of these beliefs, we as individuals allow doctors to define our problems and to alter our bodies with chemical and surgical interventions.

Does scientific medicine deserve the power and authority it now possesses? That is a big question that we cannot answer right away. Let us start with a smaller question: How does clinical medicine actually work? Most of us go to the doctor expecting him to help us fix our problems. But if we follow the logic outlined above, our doctor's project is more complicated than that. Thinking of medicine as a science and of science as storytelling, we might say that the project of clinical scientific medicine involves four tasks.

The clinician's first task is to turn the person who comes into his office into an object of medical scrutiny: a patient. This involves medicalizing her problems—defining them as bodily pathologies—because this is the type of problem the doctor is set up to treat. Of course, people who consult a medical specialist already see themselves as prospective patients whose problems are medical. Yet medicalization is not complete until the doctor turns the anticipatory patient into the type of patient he is prepared to treat. In turning the patient's problems into diseases, especially of the sort he is trained to manage, the doctor is simply constructing for himself a “do-able” problem, a task all scientists face in their work.²⁷

Second, the clinician must translate the disorganized details of the patient's suffering body into the “scientific facts” of the case—the diagnosis, prognosis, and treatment plan—and weave them together into a compelling story about what is wrong and what must be done to right it. Theoretically, the clinical story should also include the cause of the diagnosed disease.²⁸ Yet in chronic illness, our focus here, the cause is

often obscure, leading physicians to soft-pedal or even skirt the issue in their clinical tales.

Third, the doctor must convince the patient that the story is true, objective, and efficacious. That is, he must persuade the patient that the story is complete and error free, unaffected by his values and interests, and will work to ease her pain. Fourth and finally, he must put the prescribed treatment into effect to improve on the suffering body by alleviating the symptoms of the illness he has diagnosed (which may or may not be what ails the patient). These four phases might be called those of patient construction, storytelling, persuasion, and treatment.

Discourses and Practices

The tools the clinician brings to this four-part task are the discourses, practices, and rhetorics of biomedicine. Together they make up a powerful conceptual, linguistic, and material apparatus that shapes the story that is told, the treatment that is used, and, in turn, the bodily outcome of the medical encounter. The most straightforward of these tools are the material practices of biomedicine. These include clinical practices (the physical exam, diagnostic testing, and so forth), treatment practices (the administration of drugs, procedures such as injection and surgery), and many more. These bodily practices are most prominent in the patient construction and treatment phases.

These material practices are the most familiar of the clinician's techniques; they are what we normally think of when we think about how the physician does his work. But they are not the most important implements in the physician's tool kit. The most consequential tools are conceptual and linguistic. These are the instruments with which he creates his story and persuades the patient that it is true and good and viable. The most crucial of these tools are the discourses and rhetorics of biomedicine. Let us begin with the discourses.

The major item in the biomedical tool kit is a powerful set of discourses that together form the worldview of the biomedical practitioner. This worldview is sometimes referred to as "the biomedical model."²⁹ In the medical social sciences the term *discourse* is employed in two ways. Some scholars use it to mean serious talk between doctor and patient about illness and the body.³⁰ Others imbue it with a more Foucauldian meaning.³¹ In this book I use *discourse* in the Foucauldian sense to mean an historically specific body of knowledge (*the* discourse of biomedicine) that is made up of groups of statements (specific medical discourses) that

limit what can be said, written, and thought about illness and its treatment at a particular time. Although these statements are part of physician (and patient) talk in this ethnography, what makes them discourses is not their spoken character, but their role as key components of the larger body of biomedical knowledge.³² Each of these specific discourses embeds one or more underlying assumptions about how biomedicine works. These assumptions almost always go unstated, with the result that practitioners see their worldview not as one perspective among many but as the sole truth about the suffering body and its healing. In Foucauldian terms, for physicians the truth is a function of what can be said, what is discursively possible.

While each branch of medicine has its specialized discourses, all practitioners of scientific medicine share a general biomedical discourse. Common use of this discourse ensures that physicians work in a roughly similar fashion regardless of their specialty.³³ Over the last decade social scientific and humanistic students of biomedicine have carefully dissected the biomedical model and laid bare its fundamental tenets. As a result, we now have a clear picture of the mind-set of most working physicians.³⁴ For present purposes we can describe the specific discourses that physicians routinely use in terms of four sets of ideas, each of which performs a different conceptual function in the larger body of biomedical knowledge:

1. The discourse of *objectification* splits the patient into two parts, the “objective” body and the “subjective” mind and emotions, declaring the body the sole object of interest and the physician the expert on that body.
2. The discourse of *quantification* turns the patient’s bodily signs and symptoms into a set of numbers so that the only information that counts is that which can be quantified.³⁵
3. The discourse of *pathologization* makes disease, not health, the object of attention and affixes a set of disease labels to the patient’s ills.
4. The discourse of *amelioration* downplays the issue of cause, focusing instead on the urgency of treating the disease, thereby improving on nature itself.

These discourses inform all four phases of the biomedical endeavor, but they are particularly important in the patient construction and storytelling phases. For example, in turning the sick person who sits before

him into a patient he can treat, the physician confines his attention to the body (objectification), turns the symptoms and signs he notes into numerical measures (quantification), and attaches disease names to the ills he discovers (pathologization). In creating the facts of the case and assembling them into a larger story, he uses the numbers he has gathered to fashion a diagnosis and prognosis (quantification) and then outlines the treatment program that must be undertaken if the patient is to get better (amelioration).

Clearly, the discourse has a marked effect on the story that is told. A patient presenting a certain set of symptoms would have quite a different story told about her if she were consulting a practitioner of, say, Chinese or Ayurvedic medicine or any variety of more homegrown alternative medicines. It makes little sense, then, to talk about right and wrong stories, since a story that is wrong from the perspective of one discourse might be right from the vantage point of another. One can, however, talk about good and bad stories. Good stories are ones that fit the case: They describe the patient's signs and symptoms and specify a treatment that works. Bad stories are ones that do neither.

When a biomedical practitioner tells a good story, the strengths of conventional medicine's radically materialistic approach to illness become manifestly clear. By limiting their attention to the physical body and approaching its dysfunctions through systematic and scientific investigation, physicians can often isolate the physical causes of a bodily complaint and ease the symptoms through bodily intervention. Medicine at its best is a marvelously effective discipline.³⁶ But when the clinician tells a bad story, the limits of biomedicine's discourses stand out with equal clarity. Unfortunately, it is the bad stories and the limits of medicine that must preoccupy us here.

Prone to Error

The physician must convince the patient that his story is true and objective, but a second look at these discourses belies the idea that a biomedical story can be completely either. Perhaps most obviously, a biomedical story must be partial rather than complete, since the discourses of medicine by definition exclude affective and mental components of illness and signs or symptoms that cannot be quantified. A story created from these assumptions may be not only partial, but even poor. The story might be weak because the discourse of objectification makes the doctor the expert on the patient. Although the patient's knowledge might

contain crucial clues to what is wrong, the discourse has made that knowledge at best ancillary, at worst extraneous to the process of fact creation. Errors can also creep into the specification of the treatment, for the discourse of amelioration sidesteps the question of cause. When the cause is not identified, the treatment might address the wrong problem and fail to heal the patient's ills. This line of argument might strike the reader as silly or far-fetched, but I will show that these sorts of slips are part and parcel of normal medical practice.

The probability that a practitioner of biomedicine will tell a bad story is significantly heightened when the patient has a chronic illness. In chronic illness many of the symptoms are vague and nonspecific (aches and pains, fatigue and sleeplessness), increasing the likelihood of misdiagnosis.³⁷ Because the symptoms of chronic illness respond to stress and other social forces that wax and wane, the past pattern of disease may not foretell the future, raising the risk of a flawed prognosis.³⁸ In chronic illness the problems that exacerbate symptoms lie partly if not largely outside the body, in what students of social medicine call the patient's "lifeworld." When these causes are not addressed or are misunderstood, the likelihood that the treatment will be misguided and ineffective is enhanced. Although he did not use this language, the creation of bad stories is part of what Kleinman meant when he said that biomedicine is dangerous for the chronically ill.³⁹ What makes it hard to recognize this danger is that the physician has done his best to tell a good story according to the rules of biomedicine. The problem is not an incompetent or malevolent doctor, but a narrow and reductionist set of rules. Biomedical stories are very often bad stories for chronic patients.

It is not only the discourses of biomedicine that can result in ill-fitting stories. A large literature on medical mistakes shows how the messiness of the patient body and the still imperfect methods of scientific medicine can also weaken the stories medicine tells, especially about chronic illness.⁴⁰ This emphasis on mistakes may sound overly critical to the lay reader, but that is because the public has been kept uninformed about the true extent of error in medical work. Although few records of medical mistakes are kept, and those that are maintained focus on "serious harm," experts have long believed that iatrogenic, or doctor-induced, injury constitutes a "problem of enormous proportion."⁴¹ A late-1999 National Academy of Sciences report documenting the deaths of 44,000 to 98,000 people a year from mistakes made in hospitals alone both confirmed the experts' suspicions and suggested that such numbers, frightful though they are, represent only the tip of the iceberg.⁴²

In the cases of mistakes linked to bodily and methodological problems, it is less the truth than the objectivity of the story that is compromised. Let us consider the two types of problems separately. First, the patient body is inherently disorderly and chaotic. It comes to the clinician not as a neat collection of diseases, but as a tangle of aches and pains, complaints and cries, in which past and present are jumbled up together. When a number of different stories might fit the situation, the interests and values of the clinician can creep in to color his judgments about the best diagnosis and prognosis for the case.⁴³ These influences sneak in subtly, unconsciously. Consciously, the clinician's aim is only to do his level best to identify and treat the patient's diseases.

Objectivity is also compromised by the regrettable fact that the methods available to diagnose disease, forecast its future, and alleviate its symptoms remain inexact. In taking the patient's history, for example, the clinician might neglect to ask about something that would be crucial in detecting the patient's disease. In the physical examination of the patient's body, a slight slip of the fingers to the right or left of the diseased organ might result in an overlooked tumor. Similarly, minute changes in the degree of pressure exerted might affect which anomalies of the body are brought to light. Though useful protocols have been worked out, poking and prodding remains an art as much as a science. This treatment of methodological problems has been illustrative only. Yet this tiny handful of examples hints at the sorts of weaknesses in the science of clinical medicine that make the task of the physician difficult. Methodological gaps, combined with the messiness of the human body, act to compromise truth and objectivity, leaving room for human error or individual interests to creep in to shape the story that is told. When error and interest enter in, the result can be weak, even bad, stories that do not fit the case.

The Work of Rhetoric

I have argued that, given this room for slippage, making mistakes is as much a part of medicine as getting it right. Sociologist Marianne A. Paget puts it pointedly when she writes that medicine is an "error-ridden activity."⁴⁴ To do his job effectively, however, the physician must believe he has gotten it right, or at least as right as is humanly possible. Psychologically, it is difficult to admit error; it is harder still to see that one's stories have been subtly colored by one's values and interests.⁴⁵ In *The Healer's Art*, Eric J. Cassell, a physician himself, argues that the physician hides his doubts and fears behind a shield of invincibility and then

forgets that it is only a shield.⁴⁶ As important as convincing himself, the physician must convince his patient that his story about his body is right. He must persuade his patient that errors have not been made, that the clinical tale is true and objective, and that the treatment plan it includes will work to alleviate the patient's pain.

This work of persuasion is accomplished with the tools of rhetoric. The rhetorics of biomedicine perform heroic tasks, but they are the unsung heroes of medicine. Because the physician must believe in what he has done, he must use these slight turns of phrase, these subtle modulations of the truth, blindly, unconsciously, without seeing what they do. As a result, the everyday rhetorics of medicine tend to go unrecognized as professional tools.

Social scientists and humanists have shown that physician talk is full of colorful rhetoric, especially of a metaphorical sort.⁴⁷ Our interest here lies in how these linguistic devices work: how they fit into the physician's larger science project and with what effect on the object of scientific inquiry and intervention. It may well be that the more new, disputable, and/or error-prone the field of medical activity is, the more imperative is the use of a rhetoric of science to establish the field's credibility and legitimacy. If that is the case, we would expect the biomedicine of fibromyalgia to be especially replete with science rhetoric. Work on rhetoric in science at large suggests how this persuasional talk might be constructed. Evelyn Fox Keller, the biophysicist-turned-science-critic, has described the "rhetorics of domination, mastery, coercion" over nature that lie at the heart of the scientific project.⁴⁸ David Locke has teased out the rhetorics of reification by which scientists make things that are only probably true seem definitely true.⁴⁹ Both these linguistic devices were deployed by the scientist-physician examined in this book. Yet this was just the beginning. Because he was a skilled rhetorician, we can draw on his persuasive vocabulary to create a longer list of rhetorical devices that, following Locke, we can call the doctor's "personal rhetorics."⁵⁰ Some if not all of these devices also function as "official rhetorics" of biomedicine as a whole. Here, however, I am concerned with their use as the personal rhetorics of an individual physician. The list I have drawn up includes six persuasional devices frequently employed by the physician featured in this book. Some of these usages are common and probably form part of the personal rhetorical tool kits of the majority of clinicians. A few (especially numbers four and five) may strike readers as odd or extreme. Use of these verbal tactics is probably quite rare.

These six linguistic techniques can be divided into three classes ac-

ording to the primary uses to which they are put. (Most have more than one use; the discussion below focuses on the main one.) The first two rhetorical devices emphasize the objectivity of the clinical work, drawing attention away from any partialities, ambiguities, or holes in the procedures through which the interests or values of the clinician might enter:

1. *Scientism*: Everything that is said and done is rational, objective, logical—in a word, scientific.
2. *Reification*: Things that may seem uncertain or unknowable are real, knowable, and known.

The next two devices stress the truth value of the story and the efficacy and infallibility of the medical project. They divert attention away from the possibility that the disease might be unconquerable or that the doctor might make a mistake:

3. *Domination*: Medicine gains mastery over nature by discovering its secrets, determining its limitations, and intervening to fix them.
4. *Biomedical infallibility*: Medicine and its practitioners virtually never make mistakes; any problems that arise are the result of a bad body or bad attitude on the part of the patient.

The last two usages stress the beneficial nature of the treatment for the patient. These rhetorics deflect attention away from the possibility that the doctor might inadvertently do harm:

5. *Physician heroism*: The doctor is a medical miracle maker who conquers illness and improves on nature itself.
6. *Patient benefit*: Everything that is done is for the benefit of the patient; the physician derives no benefit other than personal satisfaction from anything he does.

Such rhetorics are usually harmless. Indeed, from the doctor's point of view, such exaggerated claims can prove helpful, even necessary, in getting a reluctant patient to comply with unpleasant treatments that the doctor knows—or thinks—will work. But use of this kind of rhetoric poses dangers for the chronic patient. Because of a history of ills that are never healed, many chronically ill people go through life with a deep yearning to find a doctor who can fix what is wrong. This longing for help, along with the sadness and inner turmoil that are always part of

chronic illness, leave the chronic patient emotionally vulnerable to the rhetorical appeals of a doctor who claims to be more scientific, more heroic, more infallible than his peers.⁵¹ The social isolation of the chronic patient, a result of needing more support than most friends and family members can bear to give, increases the susceptibility to the judgments of the doctor, who may be the only person in the patient's social world who can always be counted on to care about her problems.⁵² When the rhetoric turns out to be just that, and the ills remain unhealed, the patient ends up in deeper psychic pain and social isolation than ever.

Medicine often gets it right and heals the patient. When the illness is acute, this is probably the norm. However, when the illness is chronic, biomedicine often if not usually gets it wrong, and the patient does not get substantially better. To understand these cases, we need to grasp how the making and concealing of mistakes, small and large, is built into the workings of biomedicine. This little subplot within the larger drama of medicine is hard to see because the clinician himself does not see it. What I have depicted as rhetorics many physicians see as gospel truth: their work is scientific, they rearrange nature to the good, they make few mistakes, they are godlike healers, everything they do is in their patients' best interest. It is not surprising that they think these things, since these are the very attitudes that were inculcated in them in medical school.⁵³ But as observers rather than practitioners of medicine, we can and must step outside the biomedical discourse. We must get behind the rhetorics of physician infallibility and patient benefit, because unquestioned clinician belief in them is dangerous. Blind faith in these rhetorical exaggerations is perilous, because it can justify abuse and coercion in the name of patient benefit.⁵⁴ In addition, it fosters an unhealthy dose of hubris that makes it difficult for practitioners to acknowledge that they can make mistakes, let alone to take responsibility for their actions when things go wrong.⁵⁵ Although these problems can arise in any medical situation, they may be more probable, or at least more protracted, with chronic illness, which by definition is more stubborn and resistant to physician interventions. Finally, these rhetorics are harmful because they prevent us from seeing what actually happens to the chronic patient, especially inwardly, when she enters a long-term biomedical relationship.

Inner Disruptions

One of the most powerful myths of medicine is contained in the Hippocratic oath. Its no-harm ethic only makes sense if we accept the discourse

of objectification by which medicine treats the body alone. Once we step outside that discourse, we are forced to acknowledge that the body is ineluctably connected to the mind, the emotions, and the larger life of the person. Personal experience tells us that any intervention in the body inevitably affects these other domains of existence. Despite the seriousness of these consequences for the patient, few have ruminated on this set of problems. One who has is the physician Eric J. Cassell. In a penetrating essay on suffering, Cassell has described how medical care can actually *cause* suffering by treating only the body while ignoring that care's often destructive interventions in the patient's personhood, or sense of self.⁵⁶ Any aspect of the person—from social roles to relationships, emotions, and so on—can be disrupted by illness and by health care, leading to a kind of existential suffering that is different from, and more devastating than, bodily pain. This kind of damage is likely to be especially great in chronic patients, whose sense of self is fragile and constantly under assault from symptoms that come with no warning, disrupting life plans and creating pervasive uncertainty about the future.⁵⁷

For this sense of self that is vulnerable to biomedical disruption, we can coin the term *bodily identity* to distinguish it from the gender identity that will be discussed below. Because identities are multiple, these and still other identities coexist in the same person. At the most general level, bodily identities fall into two classes: "normal" and "stigmatized," or "ill." Erving Goffman's work on stigma suggests that most people probably struggle to retain a "normal" bodily identity.⁵⁸ A sense that one's body falls within the range of what is "normal" is worth fighting for, for once that identity is "spoiled" by a biomedical label, one is subject to all the problems of the stigmatized—from discrediting and discrimination by others to feelings of shame and inferiority that come from within.

From a broader perspective outside the worldview of biomedicine, what becomes clear is that the potential for disruption to the patient's inner world is built into the biomedical project. A closer look shows that it inheres in every phase of that project. Let me explain by example. In the patient-construction phase of the medical endeavor, the patient's mind and emotions are severed from the body, that body reduced to a disease that the physician alone can fathom. The physician claims to intervene only in the body, but in conceptually sawing off the body from the rest of the person and ripping the right to know that body out of the hands of the person inhabiting it, he intervenes in the mind and emotions just as surely as if he were an executioner of the self. This is strong language,

to be sure, but it is warranted if the speaker is a patient. The transformation from a person into a patient leaves the patient traumatized, yet with no guidance on how to recover. That trauma is philosophical, emotional, and even political—for ultimately this is about power.⁵⁹ The trauma deepens as the encounter proceeds. The diagnosis and prognosis conveyed in the storytelling phase are not mere labels for a disease and its future course; because they are weighted with personal and cultural meanings, they are interventions in the patient's self. As Kleinman has put it, "[M]eaning arrives with a vengeance together with the diagnosis . . . once applied to a person, [it] spoils radically that individual's identity and is not easily removed."⁶⁰ Depending on how dismal the diagnosis and prognosis are, they may be highly disruptive, forcing massive changes in the patient's sense of her self and her future. The persuasion and treatment phases have similarly disturbing effects that I invite readers to imagine for themselves.

When the story the doctor tells is a good story and the treatment works to alleviate the pain, these inner disruptions are temporary and readily forgotten in the joy of improved health. When medicine works this way, the patient's attention can stay focused on the benefits of medicine's reductionistic approach to disease. But when the story is bad and the symptoms persist or even worsen, the philosophical and emotional traumas become protracted, eating away at the patient's inner self. Unless the patient finds a way to cope with them—say, by giving up hope of getting better or by transcending them spiritually—over time these inner injuries can become as debilitating as the bodily injury caused by the disease. This, I believe, is the plight that many chronic patients find themselves in when they go to the doctor for help but get little. They suffer a double dose of pain, the first physical, the second psychic. This is precisely what happened in the case that we explore in depth below. Out of the discourses of biomedicine, the doctor fabricated a bad narrative that served his professional interests—although he remained unconscious of these interests to the end—but did not fit the patient's case. With the rhetorics of biomedicine, he persuaded the patient that the diagnosis was correct. From the material practices of biomedicine, he fashioned a treatment program that produced the symptoms to go with the diagnosis. The medical manufacture of illness not only worsened the patient's bodily conditions; it also undermined her bodily identity, her emotional equilibrium, and her life projects. Yet when she discovered the damage, there was no one to help her undo it. Biomedicine had washed its hands of responsibility for its mistakes, leaving it to the patient and to other social

institutions to fix what had been broken. I return to these issues of medical error, responsibility, and reform in the conclusion.

A Word on Managed Care

Although my central concern in this book is the scienceness of medicine, I cannot leave this discussion of established medicine without mentioning one aspect of the larger institutional context that profoundly affects the way in which it treats chronic illness (and, indeed, all illness): the recent spread of managed health care. Potentially risky for any patient, managed care poses particular dangers for the chronically ill, whose extensive needs simply cannot be met by an organization driven by an ethos of economy and efficiency. Although I will not analyze its role, managed care was a critical if silent actor in the drama that unfolds below, affecting doctor and patient alike. I return to the significance of managed health care in the conclusion.

Gender Troubles in the Doctor-Patient Relationship

Few of us think of ourselves as having “relationships” with our doctors. Yet we do, and they are complex, power-laden ones. When the doctor is male and the patient female, this is especially the case. In the medical setting gender often works to amplify the voice and power of the physician. The patient is doubly silenced and subordinated, first in the hierarchy of science and then again in the hierarchy of gender. Her life and happiness depend urgently on a successful treatment of her ills, but it is her doctor, not she, who controls the means to ensure one.

We owe our awareness of these gender troubles in the doctor’s office to the women’s health movement. In the late 1960s and early 1970s, groups of women across the country began to gather to compare notes about their experiences of medicine and many other matters. They discovered, in the words of the best-known group, a shared “frustration and anger toward specific doctors and the medical maze in general.”⁶¹ These sorts of frustrations gave birth to the women’s health movement which, in the ensuing decades, has been instrumental in raising women’s consciousness about the “condescending, paternalistic, judgmental and non-informative” manner in which doctors, in particular obstetrician-gynecologists, treat women patients and the consequent dangers attending women’s health.⁶² Among its accomplishments, the movement has stim-

ulated scholarly research on the political dynamics and bodily consequences of the interactions between male doctors and female patients. Despite the growing numbers of women in medicine, male physician and female patient remains the modal medical relationship.

Power and Sexism in the Examining Room

Medical sociology reveals how the hierarchies of science and gender overlap in the examining room, leaving women patients in positions of little power. This sociological work is important, because it is based on relatively large samples, giving us the big picture of what transpires in the modal medical relationship. This research suggests that male doctors tend to treat women differently and in a more dehumanizing fashion than they treat men.⁶³ While there are certainly many male physicians who treat female patients with respect, the sociological record suggests that women experience a remarkable degree of verbal abuse and personal degradation at the hands of male clinicians.⁶⁴ Yet for a number of complex reasons, women rarely talk back to their doctors. The studies of doctor-patient conversations conducted by Sue Fisher and Alexandra Dundas Todd, among the largest to date, contain virtually no cases of women openly challenging their doctors.⁶⁵ Today, as the larger social climate becomes more critical of institutionalized medicine, and medical information spreads on the Internet, more and more patients seem to be willing to confront their doctors. Yet the balance of power in the doctor-patient relationship remains highly asymmetrical.

This is not to suggest that women are simply passive victims of biomedical power. (It goes without saying that male doctors are not all active agents of biomedical domination either.) Women have their own needs and interests, which they actively promote in their medical encounters. Because these concerns and requirements vary with factors such as age, class, ethnicity, and illness, women's political responses to their physicians vary widely.⁶⁶ Some women feel comfortable and comforted allowing a male authority figure to take care of them. These accommodating patients do not regard their doctor's "Now, dear . . ." comments as demeaning and in general are happy to comply with doctor's orders. Others hear the same words as sexist or condescending and resist male medical authority in whatever ways they can. Perhaps the majority of these rebellious patients remain silent and compliant in the examining room, exercising their power at home by refusing to follow the doctor's directions or simply by not going back.⁶⁷ A small and probably growing

minority has the courage to challenge the doctor in the medical interview itself, but they rarely succeed in changing his mind. In one study, argumentative patients only ended up feeling powerless, producing long silences in the consultation that were “too often punctuated with barely restrained sobs.”⁶⁸ Unfortunately, when communication is so one-sided, the medical outcome often suffers.⁶⁹

The sociological research documents the power and sexism that pervade the medical encounter and the varied ways in which women patients respond. Although we know *how* women react in medical settings, we know less about *why* they usually comply with but sometimes resist biomedical power. To understand the dynamics of compliance and resistance, we need a more in-depth understanding of how the encounter with masculinist medicine looks from the perspective of the patient. Here the work of ethnography is helpful.

Medical anthropologists such as Emily Martin and Rayna Rapp have ethnographically opened up the world of the woman patient, documenting complex patterns of acceptance and, more rarely, rejection of the demeaning metaphors and seductive but disruptive technologies of biomedicine.⁷⁰ Anthropological work on women’s reactions to the medicalization of their problems more generally reveals mixed and unstable responses, ranging from selective compliance to selective resistance, with the dominant mode of response a kind of pragmatic ambivalence.⁷¹ Few anthropologists, however, have studied the workings of power in the doctor-patient relationship, an arena in which the power of biomedicine can be found in one of its most concentrated forms. To understand the gendered dynamics of compliance and resistance in this pairing of “intimate adversaries,” in Todd’s fitting phrase (just how fitting, we shall see shortly), we need to extend to this new domain the kinds of questions anthropologists have asked in other settings: How do women patients approach the problem of getting good medical care? Beyond passively resisting, what positive strategies do they adopt to get the help they need and to oppose unwanted intrusions into their lives?

The work of Martin, Rapp, and many others has underscored the importance of difference, in the sense of the *social difference* of race and class, in women’s proclivity to accept or reject medicine’s offerings. While emphasizing the instability and flux of patient politics, this body of research has shown that, in general, white middle-class women are relatively accepting of biomedicine, while women of color and less economic privilege adopt more oppositional stances.⁷² Social difference is indeed important, but there is another difference that may be equally significant.

This is the *inner difference* and inner instability that may lead a single patient to collude with biomedical power at one time and to challenge it at another. To understand this inner difference of multiple selves, we need to ask new questions about the patient's interior life. What is the psychological reasoning behind women's tactics of collusion and contention? What emotions impel their use? For answers to questions like these, we need to find a way into the innermost world of the patient. Yet what goes on in this domain is so private and so personal that it may be simply inaccessible to conventional anthropological and sociological research, reachable only through autobiographies or auto-ethnographies such as this one.

A Reflexive Look into the Patient's Inner World

Because so little is known about these inner landscapes of compliance and resistance, I began this part of my inquiry with some introspection. How, I asked myself, did an extended biomedical encounter look through the eyes of the patient? What was she trying to achieve in the interaction? How did she go about pursuing her ends? What was the emotional economy of the interaction with the doctor? Appropriate to a subject about which little is known, the exploration was unapologetically inductive. In looking reflexively at S.'s approach to the long adventure with Dr. D., I found, to my personal chagrin, that, to the patient, the doctor-patient relationship was first and foremost a *heterosexual relationship* in which the suffering body became a good excuse to see the doctor. This view of the doctor-patient interaction as a sociosexual relationship differs radically from the conventional biomedical picture of the doctor-patient relation as a technical, technology-mediated quest to repair a broken body.⁷³ It also departs from dominant sociological portraits of the encounter as a power struggle between competing interests (in the political economic view) or as a collusive negotiation of the disciplinary power of medicine (in the Foucauldian view).⁷⁴ But the differences do not end there. As a male-female relationship, in which the gender identities of the parties loomed large, the doctor-patient interaction studied here contained elements not only of the sexual politics brought out so well by the sociological research but also of veiled sexual desire. Far from being a peculiarity of this patient or this doctor, the element of desire, or personal feelings, is probably often present in cross-sex (or, for lesbians and gays, same-sex) medical encounters, especially long-term interactions in which chronic patients tend to be involved.⁷⁵ In this case,

the longing for a good relationship entwined itself with the longing for a well body, producing a degree of emotional investment in the relationship that was far greater than one would expect from existing work on the medical encounter.⁷⁶ And when things began to go wrong, the emotional aftershocks—from depression to betrayal to anger—were as intense as the longing and hope that had preceded them. These emotional oscillations were as much a defining feature of the medical encounter to the patient as were the vagaries of the body. To capture these dimensions of the medical experience, which were central to the production of rebellion, we need to enlarge our array of concepts to include self, relationship, and emotion. And to develop these constructs, we need to broaden our conceptual terrain to embrace the fields of women's psychology and feminist theory.

The centrality of identity, feelings, and connection to the patient's experience of the medical encounter led me back to the field of women's psychology, the long-abandoned focus of my study and research as an undergraduate. In their work on women's morality, socialization, and depression, described in detail below, Carol Gilligan and her colleagues Lyn Mikel Brown and Dana Jack have collectively sketched out important elements of the psychodynamics of women's self in relationships with others. Their picture of these dynamics provides a veritable road map to the psychosocial odyssey on which the patient studied here embarked and to the emotional peaks and valleys she traversed along the way. Although this body of work has been subject to extensive critique in the women's studies literature, it contains important insights and implications that have been overlooked by earlier readings of it as theoretically outdated and politically problematic.⁷⁷ New readings of the Gilliganian corpus, on which I draw below, stress its radical implications for theories of identity and morality.⁷⁸ In this book I highlight those insights that illuminate issues of gender identity. Gender identity is the core construct around which issues of emotion, relationship, and politics all cluster. Although Gilligan's principal concern was women's morality, not identity, here I appropriate her and her colleagues' work for my own purposes, placing it within a theoretical literature that provides ways to avoid the intellectual problems that their critics have worried about.

Gender Identities: The "Discursive Self" and Its Resistant Potential

Questions of identity, self, and subjectivity—all of which refer to our understanding of who we are and how we live our lives—have been cen-

tral concerns of feminist theory for the last two decades. Probably the dominant view today, and the one most useful for our purposes, follows Foucault and other poststructuralist thinkers in holding that there is no authentic, core, or essential self.⁷⁹ Rather, the self is a “discursive construction” that is actively constituted by individuals out of the discourses, or scripts, available in their environment. For this self, which she brings to theoretical life in her book *Moral Voices, Moral Selves*, feminist theorist Susan J. Hekman has coined the term *the discursive self*.⁸⁰ At any given time, Hekman explains, we are confronted with an array of discourses of selfhood, scripts we are expected to follow. We can either adopt the subjectivity that is offered to us or assemble a different identity from other discourses that are rooted in alternative social institutions and practices.⁸¹

For women living in a patriarchal world, the dominant discourses on subjectivity are those of femininity. These scripts on femininity are numerous and vary with social situations. Conveyed in the schools, the media, and many other social institutions and practices, the dominant discourses on femininity urge us to be motherly, wifely, and caring at home, professional but not bossy at work, and sexy but not aggressive in romantic encounters. The dominant script on the feminine self-in-relation is the pleasant, compliant self that is elaborated in the work of Gilligan and her colleagues. The predominance of this script in our culture undoubtedly explains why so many of Gilligan’s critics note that, despite their intellectual reservations, they find her model intuitively appealing because it “feels” right.⁸² In this book I want to honor that intuition and to suggest that the felt appeal of the model stems from its invisible presence in many domains of social life—including the medical encounter. Indeed, I will argue that this model of feminine identity delineates the self that many women patients unconsciously embrace in their relationships with their male physicians. What Gilligan and her colleagues tend to overlook, however, at least in their early, best-known work, is that scripts on femininity are written not for women as a generic category, but for women of particular races, classes, sexualities, and so forth. Thus, as the critics have noted, the “feminine” self in the world of Gilligan, Brown, and Jack is best described as the self of “mainstream” white, middle-class, heterosexual women.⁸³ Women of other races, classes, and sexualities are offered other scripts on femininity to follow. Later work by Brown, Gilligan, and their colleagues recognizes and explores these differences.⁸⁴

Although one identity tends to predominate at a given time, our gen-

der identities are not unitary, coherent, or fixed, as the earlier psychological work seems to imply.⁸⁵ To the contrary, they are usually multiple, often contradictory, and always in process, being constructed and reconstructed in ongoing power-laden social interactions in which the subjectivities of the parties are constantly open to contestation. Gender is not only something one *is*, then, but also something one *does* in interaction with others. It is, in the words of sociologists Sarah Fenstermaker, Candace West, and Don H. Zimmerman, a “situated accomplishment” produced in everyday interactions.⁸⁶ The central question here is which gender identity or identities emerge from the negotiated power dynamics of the medical encounter. We return to this issue shortly.

For both Foucault and feminist theorists of the self, identity is intimately tied to power. On the one hand, since our identities are fashioned out of extant discourses, in the mere act of creating our identities we subject ourselves to the power of those discourses. Thus, for example, when we unconsciously follow the good-girl routines set out for us in the dominant discourses on femininity, we become subject to the power of feminine ideals—which are rooted in the dominant institutions and practices of our society—to constitute our subjectivities and, in that way, define our lives. On the other hand, as Foucault famously wrote, power also produces resistance to domination. We are capable of resisting power because we are self-creating subjects who piece together elements of identity out of the discursive tools available. “The resistant subject,” Hekman explains, “is one that refuses to be scripted by the dominant discourse and turns instead to subjugated knowledges . . . [or marginalized subjectivities] . . . to fashion alternative discourses of subjectivity.”⁸⁷ Indeed, Hekman continues, the history of the women’s movement is precisely the history of women refusing to be scripted feminine and “claim[ing] the right to adopt subjectivities . . . that grant them equality, rights, and justice before the law.”⁸⁸ The discourses of feminism also provide individuals with discursive tools that enable them not only to claim new identities but also to critique the existing power structures and to take political action to change them. Simply by rejecting one identity and claiming another, women can resist domination. Such “discursive resistance” is real resistance, but when it is accompanied by political acts, it can also stimulate larger political change.

In their work on women’s self-in-representation, Gilligan and her colleagues have provided an elaborate psychological map of a dominant script on femininity written for mainstream women. In the following section I lay out the main elements of the dynamic and show how they pow-

erfully illuminate the psychodynamics of the “feminine” self that the patient studied here put forward in her relationship with her doctor. This work supports and deepens the sociological notion of limited resistance by showing how women collaborate in and contribute to their own oppression in the biomedical encounter. But there was another, “feminist,” self in this doctor-patient relationship whose psychodynamics are not captured in the work of the psychologists. It was this self, fabricated from the discourses of feminism, that broke through to anger and open revolt against biomedical power. A later section describes this more resistant “feminist” self and how it gave birth to political action.

*The “Feminine” Relational Self
and the Psychodynamics of Patient Compliance*

Research on women’s psychology has revealed the deep costs imposed on women’s inner selves by the still-sexist society in which they must live. Gilligan’s landmark study, *In a Different Voice*, began with the well-established notion that, in a society in which achievement in the public domain has historically been a male prerogative, women’s fundamental self is relational. That is, it is based on intimate relations with others, especially men.⁸⁹ Because that sense of self is threatened by separation and aggression, women try to avoid isolation and to prevent aggression through activities of care that make the social world safe. Out of this psychology of relationship is born an “ethic of care” in which the good or moral woman is one who cares for others, ensuring that no one is hurt. For this gift of care, she expects to be loved and cared for in return.

The developmental roots of this ethic are explored in Brown and Gilligan’s study of adolescent development, *Meeting at the Crossroads: Women’s Psychology and Girls’ Development*.⁹⁰ For girls, they show, early adolescence is a time of crisis. In a world that devalues them, girls learn to silence themselves. Rather than risk conflict that might sunder their relationships, leaving them alone and powerless, they split their selves into an “authentic” inner self that no longer speaks and a pleasing but “false” outer self that reflects what others want them to be: “good girls” on their way to becoming “perfect women.” In accordance with poststructuralist notions of identity, many readers have challenged the authors’ claim that girls have authentic and inauthentic selves.⁹¹ I understand Brown and Gilligan to mean true and false in an *experiential* rather than in an *essential* sense. To the girls they worked with, the voices that were silenced *felt* genuine, because they articulated the girls’ inner-

most sentiments. To say that a given self *feels* authentic is not the same thing as claiming that a given identity *is* authentic.⁹² Because it implies the existence of essentially true and false selves, however, in the ethnography below I avoid the terms *authentic* and *inauthentic*. I retain the phrases “silencing the angry self” and “creating a falsely pleasant outer self,” however, because they capture crucially important psychological dynamics.

The psychological costs of adopting that pleasant outer “feminine” self are steep indeed. In her study of women and depression, *Silencing the Self*, Dana Jack has shown how the ethic of care can hurt women by making them vulnerable to depression.⁹³ In muting their own needs and attending to others’, women become deeply confused about where their own self leaves off and the selves of others begin. The blurring of boundaries between self and other reduces their ability to recognize abuse and leaves them at risk of depression when they discover that they have lost their most fundamental possession: their sense of self.

In this book, I contend that many women (at least mainstream white, middle-class, heterosexual women) take this feminine identity and its relational reasoning into the biomedical encounter, where they put it to work in their quest to get the best medical care they can out of a system in which they are doubly silenced and disempowered. The strategies they use in their relationships with doctors are remarkably similar to those described by Gilligan, Brown, and Jack. Because the stakes are both emotional and physical, however, the consequences of caring too much are more devastating in the medical setting. This “psychomedical perspective” is useful because it provides a framework that makes psychological sense out of many of the findings of the medical sociologists. It is important because it suggests a new and disturbing set of consequences that flow from the potent mix of medicine and gender.

In generalized form, the psychomedical dynamic I postulate is as follows. When the medical stakes are high (as, for example, when the illness is serious or longstanding), many women can be expected to take a relationship-first approach to their health care. (Men may emphasize relationships with their doctors, too, but the psychodynamics of the process and the nature of the relationships they construct are likely to be different. This is a fascinating subject which, unfortunately, I cannot pursue here.⁹⁴) It is important to remember that this relationship-first approach is not followed by every woman patient in every doctor’s visit. When the health problem is relatively minor or temporary, the patient’s attention is likely to remain focused on fixing the problem, not on creat-

ing a relationship. But when the illness is serious or of long duration and/or involves major psychological problems, a different set of emotional—and thus also relational—dynamics comes into play.⁹⁵ It is in these circumstances that women “do gender” by enacting a feminine identity of the sort described above. Emotionally vulnerable and dependent, the seriously ill patient has little choice but to place her trust in her doctor. And, indeed, many very ill patients (and some not-so-ill ones as well) derive comfort and reassurance from allowing themselves to become completely trustful of and dependent on their physicians.⁹⁶ But how do they ensure that the doctor will not betray that trust? They do so, I contend, by investing heavily in the relationship with him. While women undoubtedly create special relationships with both male and female physicians, my concern here is with the connections they form with male health care providers. In these connections, the fundamental assumption is that if they form a warm, trusting relationship with their doctor, he will take care of their bodily needs. According to this relational logic, safety and health lie in a good relationship. Accordingly, women set about creating that good relationship, modeling it on the class of “intimate relations with men.” In this model, the woman must create an outside or public self that is compliant and pleasing to the doctor. This self is guided by an ethic of care in which making the doctor happy may become as important as, if not more important than, taking care of the self. Making him happy may mean silencing their critical concerns, suppressing their anger, and preserving the hierarchy of power in which the doctor makes all the decisions about their care. Though this strategy makes psychological sense given the social cards women have been dealt, it is patently risky. When carried to an extreme, it leaves women unable to communicate their worries, unprotected against their doctor’s mistakes, and at risk of a depression that can become more debilitating than the disease.

The “Feminist” Self and the Politics of Patient Resistance

The patient whose psychological makeup we will dissect below provides a textbook case of the compliant “feminine” self, its relational reasoning, and the heavy costs that reasoning imposes. But this case also contains elements of a different, contradictory gender identity—a different way of “doing gender”—that provided the emotional and intellectual wherewithal to talk back to and even openly to rebel against medical authority. This identity, which the patient saw as “feminist,” was scripted out of notions of equality and justice and critiques of patriarchy advanced

by feminist scholars and activists over the last three decades. Such understandings also served as political tools that in the end enabled the patient to challenge and dethrone her doctor. At any given time one gender identity tended to predominate and to shape the emotional, relational, and political dimensions of the self the patient presented to the doctor. While one identity dominated at a particular time, elements of both subjectivities were always present. Even when the “feminine” self held sway, the warring “feminist” self was actively struggling to gain expression.

By recognizing the existence of this other, partly submerged identity, we are able to see antagonistic emotions and forms of resistance to biomedical power that remain invisible in work on women’s subjugation in the medical encounter. In the case examined here, these political resources include a muted anger that the patient rehearsed in her mind but could not yet openly express and tactics of subversion that remained invisible to the doctor but over time empowered the patient.⁹⁷ What tied these tactics of resistance together was their silent character, their deployment in private writings and conversations that the doctor could not see or hear. Although the work of Gilligan and her colleagues tends to equate silence with powerlessness and psychological pathology, more recent thinking in feminist psychology recognizes that silence contains multiple meanings, which are anchored in different subject positions. Maureen A. Mahoney argues that silence can be a “psychological space of resistance and negotiation” in which “the capacity to speak out with confidence and authority” is nurtured.⁹⁸ Although these episodes of non-speaking are experienced as times of shame, confusion, and anxiety, Mahoney contends, far from being pathological, refusals to speak publicly can be healthy responses to being controlled as well as rich states of developmental growth.⁹⁹ In this ethnography, silent forms of resistance, rooted in the patient’s “feminist” identity, provided crucial emotional and intellectual resources that enabled her openly to challenge the doctor when the time was ripe. Although suffered in confusion and distress, the patient’s secret resistances became crucial pathways to public protest and personal power.

Recognizing the multiple, contradictory, and processual character of patients’ gender identities, and the relational, emotional, and political entailments these gender identities involve, suggests new ways of understanding power and resistance in the biomedical encounter. The focus on gender identity extends our grasp of power’s workings by showing that the politics of both compliance and resistance is rooted in an inner terrain—that of selfhood—that students of biomedical power have

scarcely begun to explore. These larger implications of the analysis of patient identity and politics are explored in the book's conclusion.

Cultures of Illness, Cultures of Blame

Biomedicine operates within a larger culture that today is obsessed with illness and the body. Spread by the media, books, and everyday conversations, popular beliefs about bodily suffering powerfully shape the sick person's understandings of why he is ill and what he should do to get better. The effects of these ideas are often more powerful than biomedicine recognizes and more insidious than alternative medicine, a major purveyor of these notions, intends.

In her influential essay, *Illness as Metaphor*, philosopher Susan Sontag drew attention to our culture's long-standing tendency to metaphorize illness.¹⁰⁰ Through metaphor, the culture has turned a bodily disorder into a moral matter in which outward signs of disease are seen as evidence of inner flaws. Psychological theories of illness, she argued, are punitive, for they blame the patient for being ill—"she deserves it," "she's one of life's losers"—and make her responsible for getting better. In the past few decades, not only illness but also health has become a moral matter. Whether promoting exercise, health foods, or other "wellness behaviors," health crusaders portray the pursuit of a healthy lifestyle as a moral duty, the achievement of good health an "affirmation of a life lived virtuously."¹⁰¹ Written twenty years ago, Sontag's critique of our moralization of illness has even more bite today, when the metaphorizing she described has become a veritable industry: Alternative Medicine, Inc.

In recent years the public has grown deeply dissatisfied with mainstream approaches to chronic illness. But it has not given up hope for a cure to chronic pain. Building on this wellspring of public interest, alternative approaches to healing have flourished, becoming some of the major articulators of our cultural discourses on illness. Although many widely divergent alternative approaches exist, the ones that have gotten the most attention are not the well-established therapies such as Chinese and Ayurvedic medicine but the less proven self-help and New Age approaches whose manifestos crowd the shelves of bookstores around the country. These approaches are the focus of attention in this book.

Virtually all holistic approaches hold that the mind and body are deeply interconnected and that our thoughts and emotions powerfully affect our physical selves. Although framed as a critique of, and alternative to, main-

stream medicine, holistic medicines are oddly similar to conventional medicine in important ways. Both neglect structural sources of pain—whether political, economic, environmental, or social—treating illness as an individual problem whose roots lie close at hand. Both overstate the extent of individual control, neglecting the powerful cultural and psychological forces that shape individual behavior and that place much of what we do beyond our immediate control. Both are therapeutic discourses that focus on treatment while slighting the question of cause. The self-help and New Age approaches share these features of alternative medicines generally, but they push the philosophy more toward the mind than the body in the mind-body duality. If scientific medicine promotes the body-cure, many of the self-help and New Age medicines advance the mind-cure, which holds that by changing our thoughts and attitudes we can change the state of our bodies. Like scientific medicine, these medicines are reductionistic, tracing illness to body *or* mind but neglecting the ways in which body and mind work together, in interaction with specific social and environmental contexts, to produce disease.

For the chronically ill, these self-help and New Age discourses are highly seductive, for they make sense of senseless pain and promise hope in a situation long bereft of it. But, as Sontag warned, the dangers of being seduced are great, for along with hope and empowerment comes a heavy dose of cultural blame. Today, when alternative therapies are available in every mall in the country, the ill person is blamed not only for getting ill, but if the therapies fail, he is also blamed for not getting better (“he gave up too soon,” “he didn’t want to get well”). Academic culture critics like Elaine Showalter inadvertently amplify the blame heaped on the sick by the popular discourses. In her much-touted book, *Hystories: Hysterical Epidemics and Modern Culture*, she attaches terms like *psychogenic* and *psychological plagues* to contemporary epidemics of chronic pain such as chronic fatigue syndrome and Gulf War syndrome.¹⁰² While the psychological dynamics she highlights undoubtedly contribute to these disorders, and the cultural dynamics she exposes turn them into virtual epidemics, Showalter neglects the ways in which biology interacts with psychology to place some bodies at risk, leaving other bodies with the same psychological makeup blissfully pain free.¹⁰³ “I don’t wish to offend these sufferers,” she writes, but then proceeds to do just that by implying that they possess a degree of control over their bodies that no one, sick or well, can achieve.¹⁰⁴ To break the cycle of “hysterical epidemics,” she urges, we must “claim . . . our full humanity as free and responsible [human] beings . . . ; we must look into our

own psyches . . . for the answers.”¹⁰⁵ Showalter’s study is part of a new wave of explanatory models of illness that blame the victim for his illness.¹⁰⁶ Many critics, especially in the social sciences, see these new models more as accusation than as explanation.¹⁰⁷ Though making others responsible for their own illnesses helps us deny our own vulnerability to disease and death, it adds to the burdens of the ill. By placing responsibility for illness on the afflicted, the culture compounds the problems of the chronically ill by adding to the misfortune of bodily pain, psychic distress, cultural censure, and social stigma.

The cultural discourses are intended to broaden the discourse on illness, but they may have the paradoxical effect of making the sick, or perhaps only the sickest of the sick, all the more dependent on scientific medicine. Feeling blamed, the ill person can react only with denial of the imputed connection between her mind and her body, her life and her disease. Hence the “longing for organicity,” the desperate craving for a biological disease label, that clinicians see in their chronic patients and that cry out from the pages of patient self-help newsletters.¹⁰⁸ These patients—too often labeled “malingerers” and “clinical headaches” by the biomedical community¹⁰⁹—are the wounded survivors of a culture that blames them for their illness.

Promising help, contemporary cultures of illness place the chronically sick in a trap: they cannot admit that psychosocial factors worsen their illness, because if they do they are blamed for causing their own problems. So they are forced back on biological labels and biomedical practitioners as their only source of solace and relief. By placing personal responsibility on the individual rather than looking at larger structural factors that may lie behind the individual’s personality or lifestyle, popular discourses prevent the chronically ill from addressing the problems in their lives that may contribute to their symptoms. The result is a kind of culturally induced paralysis that can discourage the use of helpful alternative therapies and can add psychological distress to the physical pain of being ill.

While much ink has been spilled over these issues by social commentators and medical experts, we know less about how alternative discourses and therapies play out in the lives of real patients. From illness narratives of the chronically ill, we know that struggles with mind-body issues are fundamental parts of the experience of chronic illness in our culture.¹¹⁰ But even when the use of alternative medicine is a major theme in illness autobiographies, the authors often write as converts to the cause and exude uncritical enthusiasm for the healing powers of mind

and emotion.¹¹¹ Self-reflective accounts of encounters with alternative medicine are rare. The case reported in this book provides an opportunity to witness critically the effects of some self-help and New Age therapies on the life of a chronic patient who turned to them in desperation when the therapies of biomedicine did not work. It shows how instead of “opening the blocks” to healing, some alternative medicines can block healing instead. But it also shows a way out of the trap, an escape route that avoids both the Scylla of biomedicine and the Charybdis of alternative medicines. The escape route the patient discovered was to locate the problem not in the individual body or personality but in the larger structures of inequality in society, in particular, in the structures of gender inequality. The idea that the production of “fibromyalgia” might be related to struggles over women’s place in society has led me, as author, to reflect on and worry about the larger historical implications of the invention of fibromyalgia for women. I share these worries in the book’s conclusion.

Auto-Ethnography as Cultural and Political Critique

In presenting my material I have chosen to write an ethnography, the classic genre of anthropology. Today many moving patient testimonials document personal struggles with serious illness.¹¹² Perhaps because medical anthropology has only recently turned its attention to Western medicine, however, we have few ethnographic accounts of what happens when patient meets doctor.¹¹³ But the ethnographic approach provides unique insights that other approaches—whether survey based, historical, or literary—cannot supply. Through close description and analysis of a small slice of social life, ethnography shows how the culture at large does its work. In this ethnography, I take medicine as a culture and use one intimately observed case to limn the workings of the system as a whole. Here ethnography takes the form of cultural critique.

This book presents not only an ethnography, but an auto-ethnography of a medical encounter.¹¹⁴ In auto-ethnography observer and observed are one and the same person. Auto-ethnography differs from autobiography in that the focus is not on the writer, but on certain experiences in the writer’s life that illuminate important or previously hidden aspects of the larger culture. The emphasis here, for example, is not on the patient herself, but on the patient’s protracted encounter with a doctor who fully embodied the scientific approach to medicine.

Avoiding Solipsism

In writing autobiographically one runs the risk of solipsism, or excessive preoccupation with the self. I have sought to avoid this problem through the use of three literary devices. First, as just noted, I have made the empirical focus of the study not the patient, but the doctor-patient relationship and its embeddedness in the larger cultures of medicine and gender. In this way, I have “written culture” while also “writing my (former) self.”¹¹⁵

Second, I have drawn a clear demarcation between the person observed, whose thoughts, feelings, and experiences are described, and the author-analyst, in whose voice the study is written. To enforce this distinction I have created a literary space between myself as author and S. as patient, using the first-person “I” for the author and the third-person “she” for S. This distance was easy to maintain, since a good part of S.—many of her hopes, dreams, and beliefs—died during the encounter described in this book. In addition to my desire to avoid overly focusing on myself, my creation of two literary figures was motivated by the social facts and some compelling analytic considerations.¹¹⁶ The social fact is that S. could not have written this book. She was in too much physical and psychic pain even to grasp what was happening to her, let alone to muster the energy necessary to write a book. Only the post-S. I, who was born at the end of the episode, was able to step back and make sense of that encounter and to undertake the long-term project of turning it into a book.

In separating “I” from “S.,” I also had two larger analytic objectives. First, a central argument of this book is that S., as a subject with a distinctive sense of her self and its place in the world, was extinguished during the encounter described below. The creation of another self, “I,” who succeeded S., underscores the point that biomedicine can profoundly damage, even destroy, the patient’s self. Writing about my former self in the third person also enabled me as analyst to adopt a variety of critical attitudes toward S. The ability to mock, scold, grieve for, and sometimes even praise the patient opened up a large volume of analytic space, allowing me to press critical points and to develop theoretical arguments that would have been difficult to advance had I written in the first person. Although these considerations may have led me to exaggerate the difference between the two social beings, the gap is nonetheless real. S. and the I who is writing this book have to some extent different understandings of life, emotional makeups, physical bodies, and even career

trajectories. In important ways, S. and I are two different people. Because S. is my former self, and because she lives on in my memory, I am able to use her testimonial as a positioned witness as the basis for this book. As many have suggested, the ability to give testimony to moving or traumatic events is part of what gives auto-ethnographic writing its power.¹¹⁷ But I as author am able to feature S.'s testimony only because she left diaries and charts documenting her experiences. S. as sentient subject no longer exists.

Third, I have presented the ethnographic materials within a larger structure that is analytical rather than historical or biographical. At the level of the chapter and of the group of chapters, or book part, the central narrative is not the unfolding of a life but the development of an argument.¹¹⁸ This theoretical framework deflects attention away from the individual life and toward the larger argument being advanced.

In addition to these literary means, I also develop a substantive argument that should help to put any worries about self-centeredness to rest. As elaborated above, I argue that the selves of individuals are not inherent or given, but actively created out of the discourses of the culture. The culture thus defines the possibilities of selfhood that are available to individuals at any given time. If this is so, then when we write about our selves in theoretically sensitive ways, we inevitably write about our culture. The boundary between self and society begins to break down, auto-ethnography blurs into ethnography, and concerns about solipsism should fade away.

Why Auto-Ethnography? Intellectual and Political Significances

Auto-ethnography is an especially productive vehicle for this project. First, because it can offer deep personal insight into the self and soul of the patient, it is uniquely suited to an exploration of the effects of medicine on the inner world of the patient, a central concern throughout this book. Second, because it allows me to use the patient's own contemporaneously penned words to describe her illness experience, the auto-ethnography enables an account of illness and its social origins that remains close to the patient's original experience. Such an account avoids the vexing problems of professional transformation of illness into social science jargon and the consequent dehumanization of suffering and silencing of the afflicted about which medical anthropologists such as Arthur Kleinman, Joan Kleinman, and Susan M. DiGiacomo have expressed concern.¹¹⁹

Use of the auto-ethnographic form also carries political significance in the discipline of anthropology of which the reader should be aware. In anthropology, interest in auto-ethnography arose out of a larger disciplinary critique of classic ethnography.¹²⁰ Like the science of medicine, the science of classic anthropology posited a distanced observer who, through close observation of a cultural Other, was able to produce the objective Truths of culture. Today many anthropologists see that earlier project as part of the deployment of Western power over other cultures. Moreover, though respecting science, they believe that its truths are always partial and interested, reflecting the social locations and cultural values of its makers. In an effort to reduce power hierarchies and to scale back claims to authoritative knowledge, a new generation of critical anthropologists has turned to alternative forms of ethnography in which to do their work. Although its use remains rare in anthropology at large, and rarer still in medical anthropology, the auto-ethnography is a promising means by which to pursue these political and intellectual ends.¹²¹ The auto-ethnography breaks down the barrier between observer and observed, scientist and object, cultural self and Other, by making them one and the same person (who, however, assumes two different roles). Moreover, the auto-ethnographer does not claim to produce objective truth. With science critics Sandra Harding and Donna Haraway, I fault claims to objectivity by knowledge producers who represent themselves as impersonal, impartial, and impassive—such knowledge makers remain unlocatable and thus not answerable to the consequences of their claims.¹²² The alternative to impersonal and irresponsible objectivity is the claim to produce *partial truths* that are rooted in identifiable social locations and that are thus responsible for their assertions. This auto-ethnography claims to tell such a partial truth. It is a “situated” or “positioned” truth reflecting the world as seen by a white, middle-class, forty-something academic woman with a particular history of bodily ills and care. This is very much that patient’s story; had the doctor written this book instead, it certainly would have been very different. In using this ethnographic genre, my aim is to furnish a political critique not only of the doctor’s brand of medicine but also of science’s larger claim to produce objective truth, including claims of this sort by anthropology itself.

Though I have highlighted some of the advantages of the auto-ethnographic genre, there are also drawbacks that need to be noted.¹²³ My particular positioning with regard to the illness described here has profoundly shaped the interpretations I offer of that experience. Although personal involvement has enabled me to see previously hidden aspects

of the illness experience, it may also have restricted my vision in ways I cannot perceive. My intense moral and emotional engagement with the medical encounter featured in these pages may also have tempted me to overgeneralize from my own experience. Although I have tried to minimize these problems by embedding my arguments in the scholarly literatures on chronic illness and biomedicine, such problems are to some extent unavoidable in auto-ethnographic writing.

The Rewards and Risks of Writing about Emotion

Autobiographical writing has also been favored by feminist anthropologists, in part because of its ability to acknowledge and to reveal the role of emotions in the production of anthropological knowledge.¹²⁴ In a series of introspective works published over the past decade, Ruth Behar has courageously pioneered this style of “vulnerable writing.”¹²⁵ In this study I push this process of exteriorizing the interior further by acknowledging the role not only of emotions but also of physical suffering and pain in shaping the creation of anthropological knowledge.

Writing of emotion and pain, however, is risky. In the Western philosophical tradition, emotions are regarded as suspect and their purported opposite, reason, is deemed the sole legitimate faculty with which knowledge may be acquired.¹²⁶ Writing emotionally thus leaves one vulnerable to charges of being irrational, particularistic, private, and subjective, rather than reasonable, universal, public, and objective. The risk is especially great for women, since they have long been associated with the emotional, irrational side of these binaries. Writing against the grain, the feminist theorist Alison M. Jaggar argues, persuasively I think, that feminists’ concerns about emotionality may be overdrawn. Far from threatening feminist scholarship, she suggests, certain kinds of emotions can play strategic roles in the development of critical social theory.¹²⁷ In a thoughtful essay on the role played by emotion in the creation of knowledge, Jaggar argues that the familiar dichotomies set out above are artificial.¹²⁸ Although feelings are experienced as private and particularistic, she demonstrates, emotions are actually social constructs taught to new members of society and shared by large categories of people. Moreover, far from being antithetical to knowledge, emotions are necessary features of all knowledge, influencing the values, observations, and thoughts that make up the process of intellectual inquiry. Most scholars, she believes, are unaware of the role of their emotions in their scholarship, because our culture encourages us to control or even suppress our

emotions. Jaggar suggests that emotional reactions that fall outside the bounds of convention—what she calls “outlaw emotions”—offer particular promise for feminist theory. Atypical emotional responses, which are usually appropriate to the person’s social situation of subordination, can facilitate the building of critical theory by motivating investigations into new issues and by enabling new versions of reality that challenge dominant views.

At the heart of this book lie a handful of emotions that most Americans would probably be happy to dub “outlaw”: deep depression about, rather than stoic acceptance of, chronic illness; personal fondness for, rather than cautious reserve toward, a physician; and, later, raging anger at, instead of quiet gratitude toward, the same practitioner. Because of their very unconventionality, these emotional reactions enabled—or rather forced—me to see the political and psychological dynamics of the medical encounter in new, nonconventional ways. These powerful yet perverse emotions not only motivated the writing of this book, they also shaped the theorizing that underlies its arguments. This book suggests that instead of fearing our emotions, we should attend more closely to them, for they have much to teach us about the workings of gender and power in the world in which we live. Having said that, I recognize that reading about these inner landscapes of pain may prove deeply discomfiting to some. This book will challenge readers accustomed to equating scholarship with cool objectivity to recognize that emotions can enrich our scholarly work in unexpected and productive ways.