

# Alexander Richman Commemorative Lecture

## Culture, Moral Experience and Medicine

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### Abstract

No one can doubt any longer that culture is crucial to medicine. The evidence for health disparities across ethnic and racial groups as well as for cultural influences on health care practices is too impressive to overlook. Yet the concept of culture and how it is employed in medicine today is quite different from the way culture is now regarded in anthropology, the discipline that originated and popularized the concept. Rather than understand culture as a “timeless” ethnic stereotype applied to patients—which is a common but dangerous practice—physicians need to understand how culture influences doctors as much as patients. And physicians need to understand that culture is not only about differences in dress, etiquette and diet, but also and most profoundly, about what really matters to people. That is, culture is about the changing moral experiences of patients, families, and practitioners, and how those moral experiences powerfully affect the doctor-patient relationship. This article suggests that there is a moral crisis in today’s medicine that reflects global cultural transitions. This crisis must be addressed if practitioners are to provide care at the highest moral and human level.

**Key Words:** Culture, moral experience, medicalization, anthropology, doctor-patient relationship.

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### Introduction

THE ISSUE OF CULTURE has become very important in health care and biomedical circles in the United States. This is not surprising. American society is one of great social, cultural, and ethnic diversity. And yet it also exhibits great health disparities across racial and ethnic groups (1). For all the medical advances of the past century, health disparities have not been eradicated. Rather, they seem to have widened. And the legacy of institutional racism is not absent from health care and biomedicine (2). It is for these reasons that culture matters in the clinic. And medicine exists in a cul-

ture. Cultural factors are crucial to diagnosis, treatment, and care. They shape health-related beliefs, behaviors, and values (3, 4). But medicine has not given culture the same degree of critical analytic attention it gives to biologically relevant issues. There is loose thinking about what this term means and how it ought to be used. Medicine has identified culture with the patient; hence, the “Latino patient” is assumed to have a core set of beliefs about illness owing to fixed ethnic traits. By contrast, it is assumed that the doctor has no culture.

We want to reconnect the concept of culture to how it is used in anthropology, the field that originated the culture concept (5–9), and to expand upon certain moral, social, and existential questions that make the concept especially relevant to our times. The publication of *The Illness Narratives* by one of us [AK] in 1988 helped to make culture a necessary part of best practices in biomedicine and clinical training (10). In particular, the “explanatory models” approach advanced in that book has been used routinely in the examination of internists and psychiatrists, in the training of nurses and social workers, and in the leading models of how to care for patients from different ethnic and cultural groups. The approach consists of a series of questions that doctors ask patients: What do you call this

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This work was adapted from an Alexander Richman Commemorative Lecture for Humanism and Ethics in Medicine at the Department of Medicine, Mount Sinai School of Medicine, New York, NY on September 28, 2004, and updated as of March 2006.

problem? What do you believe is its cause? What course do you expect it to take? How serious is it? What do you think this problem does inside your body? What do you most fear about this condition? What do you most fear about the treatment?

This approach was intended to reframe culture as “illness meaning.” The models provided a method for clinicians to more effectively communicate with patients and get at what an illness episode means for them. But what was originally intended to open up a conversation is often used as a conversation stopper. Explanatory models are materialized as a specific item (like X-rays or blood pressure). Patients’ answers are seen as mechanical responses ushering from a static set of cultural beliefs. It is of course highly appropriate and desirable for clinicians to be sensitive to cultural difference. But what culture means in medicine is out of step with what it means in anthropology.

Culture is not seen as homogenous or static by anthropologists, who emphasize that culture is a *process* through which ordinary activities and conditions take on emotional tone and moral meaning for participants. The development of interpersonal attachments, the serious performance of religious practices, the cultivation of an identity, and the embodiment of meaning in physiological reactions—these are all cultural processes. Something crucial is lost when explanatory models are used as a mere checklist. Illness is lived in a social world where sufferers have something at stake. Illness is everywhere a profoundly *moral* experience, since sufferers have things of great personal and collective value to gain or lose. Illness alters life plans and projects. And it provokes a response, however difficult and tenuous. Illness matters because real things are on the line: self-identity, physical and mental health, life chances, social status, employment, finances, religious aspirations, or personal relationships. Seen this way, illness and treatment are embedded in the local moral experience of a particular network, neighborhood, or community. Instead of a checklist, what clinicians want to get at in the explanatory models is what really matters for patients, their families, and for the clinician as well: a combination of cultural and personal meaning.

### Culture as Moral Experience

The phrase “moral experience” can be ambiguous, because the word “moral” has several meanings. In its broadest sense, “moral” refers to values. Experience is moral because something matters, is imbued with value. This does not mean that experience is “good” or “bad,” which it may be. We are not talking about ethics—what is right to

do—but rather about the moral core of experience, the fact that something is at stake for ordinary people, often deeply so. And what matters could be far from what is ethical. Hence, what matters is not universal, but differs across local worlds. Patients have different things at stake, even within ethnic, racial, or cultural sub-groups, because their worlds are distinctive and so are they as individuals. Serious attention to culture should prevent racial profiling or ethnic stereotyping.

The concept of moral experience also makes illness part of a broad category of personal and collective dangers and catastrophes. Life thrusts people into vexing circumstances and confounding conditions. Troubling realities riddle life: divorce, death of a loved one, injustice and discrimination, dead-end jobs, awful relations with supervisors, unemployment, bankruptcy, severe accidents, disability, political oppression, and alienation from one’s faith community. And there are large-scale social catastrophes. The Asian tsunami and Hurricane Katrina revealed the limits of prediction and prevention when it comes to natural disasters. They also revealed that government and humanitarian response could compound the problems. Public response was massive, but it was incomplete, confused and sometimes counterproductive. Failed and failing states in Africa, political crises in the Middle East, and countless economic and cultural changes have made people’s worlds seem fragile, as have September 11th, the war on terrorism, terrorist bombings in Madrid and London, and the forced evacuation of millions in the American Gulf region.

Illness is a catastrophe too, although a very intimate and bodily one. Illness is much more than a biological condition, then. Illness is principally something that happens *to someone* and *at a certain life juncture*. It singles a person out, and this is why support and recovery networks are so vital. Illness carries economic, familial, occupational, and personal peril. Most people will face the pain and constraint of a chronic condition. They will face diabetes, arthritis, ulcers, heart disease, one or more varieties of cancer, asthma, lupus, or Alzheimer’s.

Something crucial is lost when the lived experience of catastrophe is made into a medical pathology, when widely shared feelings of fear, anxiety, and peril are recast as individual abnormality. An epidemiological study conducted four months after September 11, found increased rates of cigarette use among adult smokers in New York City. Increased smoking was associated with probable post-traumatic stress disorder and depression (11). So, cigarette smoking was made into an abnormal response. It was not seen as an ordinary, normal response to the shared experience of dan-

ger and uncertainty. Not everyone took up smoking or started smoking more, but those who did probably did not do so on account of individual abnormalities. The feeling that life is changing and threatened—promoted and compounded by media images of September 11th—was a very normal response that gave rise, among other things, to increased smoking rates in New York City.

In response to real dangers and uncertainties, fear, dread, and anxiety are normative globally and therefore a normal part of living. Violence, political conflict, civil war, terrorism, street violence, and domestic violence—is the trauma from these situations a pathology? Or is it the normal physiological response of normal individuals to the physical, psychological, and moral threats of real danger? Stouffer's study of the American soldier in World War II found a dose-response curve between time in active combat and symptoms of what was then called war neurosis (now post-traumatic stress disorder [PTSD]) (12–14). Combat and killing—often associated with remorse and regret among soldiers—are moral problems that plague many for a lifetime because they are unaddressed by the military medical system.

Large-scale forces shape moral experience. They impinge upon and remake what matters most for ordinary people. How this happens involves the interaction of three very different phenomena: cultural meanings, social experience, and subjectivity (inner emotions and sense of self). As each one of these aspects changes, so too do the others. So when the reservoir of cultural images in our society changes, so too does the sense of who we are (Fig. 1).

### Cultural Transitions

Global changes (e.g., major changes in the economy, the rise and fall of governments and institutions,

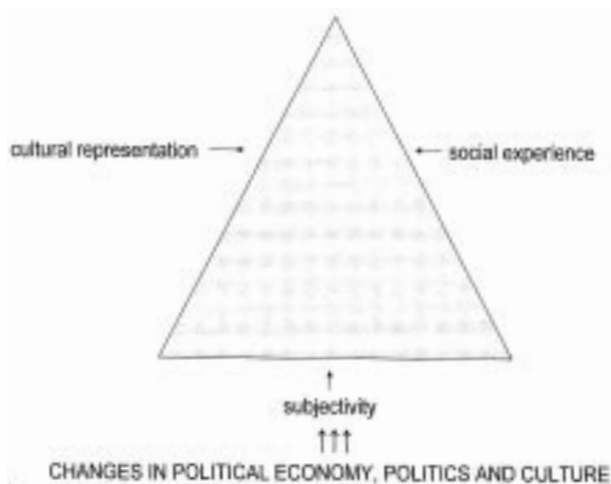


Fig. 1. The remaking of moral life.

natural and social disasters, and the reordering of life after a catastrophe) can dramatically alter the cultural meanings that people take for granted. They alter the way that people view the world, envision the future, and think about themselves. They help shape the stories people tell and the images they amass to represent their experience. One need only compare Marcovalado's renditions of the crucifixion in the thirteenth-century with Picasso's in the twentieth-century. There is the gradual abstraction of form and meaning in Picasso's pictorial rendition of dehumanization and the disoriented and disorienting force of large-scale changes. Picasso's is an ensemble of shapes and lines, yet with no sure semblance of a suffering body. It is as if the human itself—in the aftermath of the Great War and in the period of the threat of fascism—has been taken out of what suffering means.

These images tell us about major changes that are taking place right now. In our times, suffering, illness, and affliction are abstracted from experience. They are made into lines, shapes, and graphs. They become merely technical conditions (they can be charted, mapped, and coded). And as this shift in cultural representations occurs, the experience of suffering alters. Among the unintended consequences is that the experience of illness itself begins to "thin out," it loses its humanity. Anthropologists have revealed the great diversity and force of what suffering means across human societies. Affliction and suffering are endowed with enormous aesthetic, moral, and religious significance. Healing is a shared process of subjective, bodily, and worldly transformation. Ritual experience, transformations of the body and of the mind, religious transformations, and the somatic expression of pain, violence, and trauma—these universal phenomena make illness a foundational human experience, something that is shared as the existential core of what it means to be human.

This aesthetic, moral, and emotional meaning is purged when suffering and illness are recast solely in biomedical disease categories (15). Medicalization—the making of the social world into abnormality and foci for treatment—is among the most blatant examples of how the sense of human life is being fundamentally remade in medicine (16)<sup>1</sup>. Ordinary unhappiness and bereavement is remade into clinical depression, existential angst

<sup>1</sup>"Medicalization" refers to a few processes whereby the scope of biomedical expertise is expanded. There is an increase in the number and kinds of attitudes and behaviors that have come to be defined as illnesses. There is a shift from discourses of sin, crime, and deviance to illness and disease categories. Health, illness, and medicine are now major portions of gross national product.

into anxiety disorder, and the moral experience of violence, upheaval, and catastrophe into PTSD. Many American psychiatrists define normal bereavement as lasting for only several months, but the anthropological literature is filled with examples of normal bereavement regarded as lasting years, decades, lifelong (17–20). There is simply no scientific evidence to support the American Psychiatric Association's DSM criterion for normal bereavement as lasting two months. This remarkable example of cultural change is propelled as much by the political economy of the pharmaceutical and health insurance industries as by the unexpected consequences of technological innovation.

Quietly but ineluctably, beneath the surface of events large and small, the self itself is changing. We are not the same people as our parents or grandparents, and our children will not be the same people we are. The self is being thinned out. It is being emptied of the shared human core of life, a transition deftly captured in Picasso's abstraction. In its place there are now processes that lead us to a sense of who we are largely as consumers of things, including drugs, and with a thin, technological view of the world, ourselves, and others. The self is today "filled" via a prescription, and the ongoing, back and forth practice of prescribing and taking drugs makes sufferers into believers of disease as much as consumers of chemicals. Medicalization makes unhappiness, anxiety, and moral anguish things that should not happen, that are not normal, and pharmacology as an end in itself could end up undermining our human ability to cope with these very normal and serious conditions.

### Doctor-Patient Relationship as Culture in Transition

All of this adds up to a major change in the doctor-patient relationship. The crisis of the uninsured, commitments to efficiency versus quality, to markets versus moral concerns—this relationship is more and more becoming a bureaucratic imperative rather than a Hippocratic one. And for sufferers, this culture itself can seem dangerous. The experience of this 65-year-old man with worsening diabetes and associated kidney, visual, and metabolic problems is not uncommon:

They rush me in for a visit. There is hardly time to talk about what is happening. No one asks anymore how I am feeling. And then I am rushed out. I don't get a chance to tell all that has happened. Or even to ask about what is coming next. I am very angry and very disappointed. What good does it do?

For the French philosopher Emmanuel Levinas, suffering is primarily a moral issue. The first task of any caregiver is acknowledgement. One legitimates the reality and seriousness of what is going on for the sufferer (20). This involves a face-to-face encounter in which moral issues take precedence over scientific, cultural, or economic ones (21). This demands that the caregiver go beyond cultural stereotyping, for this would be an obstacle to engaging on a more existential level. On an existential level, doctors interact with patients as individuals who each have something at stake, not simply as technical experts standing over and above cultural stereotypes. The explanatory models do not ask, "What do Haitians call this problem?" They offer a direct appeal to an individual, asking the patient, "What do *you* call this problem?"

For Levinas, this direct appeal means that the moral burden of suffering lies not with the sufferer herself, but with the caregiver. In making a direct appeal, the caregiver is affected by the response given. The caregiver becomes a sufferer as well, who first acknowledges and then intimately experiences what is at stake for the other person. In this way, suffering is shared, if not as psychological or physical reality then as moral experience. It is validated as something that matters, for the sufferer and the caregiver alike. One of the great images of suffering is Michelangelo's *Pieta* (1500). It depicts the Virgin Mary holding Christ's body after his death. What shines forth in this image is not so much Christ's own suffering. It is the suffering of the Virgin. To say that we suffer on behalf of the other does not imply that the immediate physical experience of suffering is devoid of meaning. To the contrary, it affirms the seriousness, significance, and gravity of the situation *for the sufferer*.

The kind of empathy and mutuality of affliction that Levinas idealized is rare. And trends in global culture, the media, institutions, and even biomedicine are making it rarer. With large-scale changes, as we have noted, the self also changes, so that what we believe, how we act together, and who we are as individuals also becomes something new. And that change extends to how we regard ourselves and others. The affinity between people is changing. The relationship between doctors and patients turns on expertise, technical mastery over disease and distress, and the prescription of treatments. But patients and doctors perceive each other with ever-increasing wariness, distrust and ambivalence. The culture of our time becomes an obstacle: bureaucratizing, distancing, and auditing professional relationships.

Medicalization itself becomes an obstacle in human relationships. It makes neat groups of peo-

ple who either do or do not have certain disorders, rather than people who participate in common experiences, such as unhappiness, fear, distress, and social transformation. It is more difficult to understand how calamities large and small affect ordinary people when ordinary suffering is recast in terms of medical pathology. Three quarters of hospitalized terminally ill patients in the last weeks of life have most of the symptoms of DSM-IV depression based on inanition, symptoms of disease, effects of medication, and response to terminal care. In our view, they are not clinically depressed. They are experiencing serious suffering, a crucial moral condition: one that doctors of past generations recognized and dealt with as fundamental to living and dying with meaning. Calling them depressed is often a conversation stopper—time for antidepressant drugs. When what is often needed is a conversation opener so that people at the end of life can express and explore the most tellingly human of fears and concerns.

Picasso's painting, *Head of a Medical Student* (1907), speaks to the moral crisis in medicine today (Fig. 2). With one eye opened and one eye closed, the medical student is not really facing the world. And it is as if the expertise and technical skill that training cultivates depends precisely on this aspect of detachment. Hence, this is an image of cognition, mastery, and knowledge, all conveyed in the head. This representation is different from the *Pieta*, then, giving us an image of a *partial* or *half* witness. A lineage of artistic works in which doctors and patients are situated beside one another culminates, in the modern period, with this image of a medical student, without patient or context. The doctor becomes the isolated subject of medicine (and the subjectivity of suffering, its lived experience, is outside the frame). Consider the following words, given by a 39-year-old college teacher with a chronic intestinal condition.

You would think I was irrelevant to my disease from the way I get treated. Nobody asks me about my ideas. When I make a suggestion, it's taken as if it came from left field. It makes me angry, and it makes me want to do something, anything really to show them that I am part of this. Sometimes I purposefully miss an appointment or don't comply with the treatment, as silly and futile as that is. I'm sore because I want to have my opinion respected, taken into account.

Today, patients show resistance to doctors because of the bureaucratic indifference and cold treatment they experience at clinics. The rising

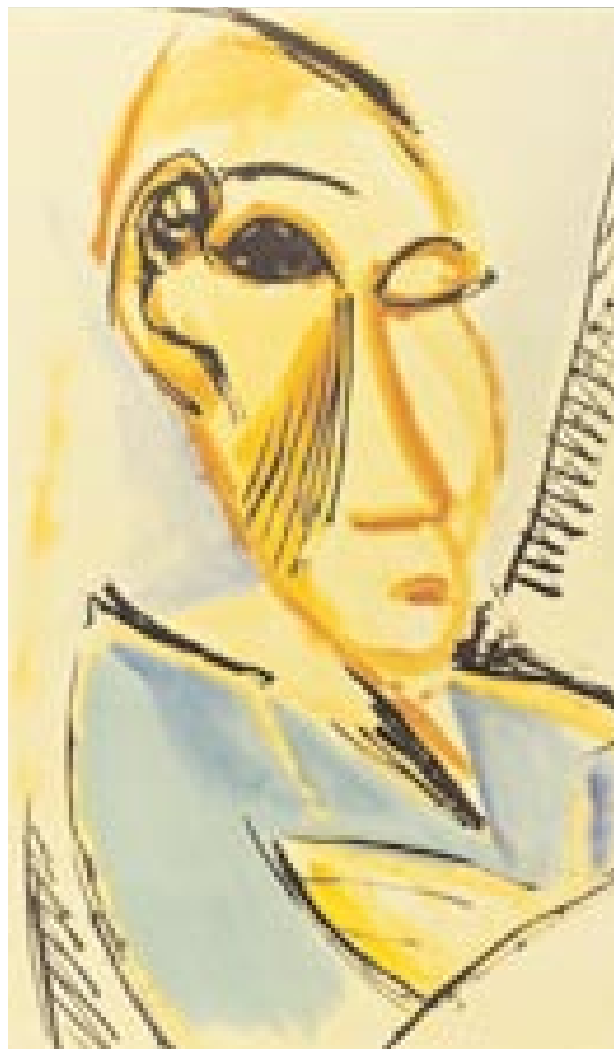


Fig. 2. Picasso's "Head of a medical student" (1907).

cost of health care makes one's own biology into a luxury and a lifestyle. And the deeper sense among sufferers that there is more to illness than a five-minute work-up brings into relief the economic, moral, and social shortcomings of biomedicine. The model of a caregiver who suffers on behalf of the sufferers, developed by Levinas, runs contrary to the culture of biomedicine and its institutions, a culture so deftly captured by Picasso. It recasts suffering as something that is shared between two people. And that way it should be more culturally appropriate to the worlds of care giving. But perhaps not any longer in America.

We are suggesting here that in addressing culture, biomedicine needs to come to terms with the moral conditions that culture signifies and also with the reality that the culture of patients and doctors is going through an epochal shift. Therefore culture cannot be dealt with via timeless stereotypes of members of racial, ethnic, and other social

groups. If culture is about what is at stake for patients, families, and doctors, then doctors need to be trained to inquire about what is at stake in illness and treatment, and to respond to what they learn about patients in their local worlds. Whether the patient is Russian, Haitian, or Dominican, or the practitioner is Arab, Chinese, or Indian, the focus needs to be on the vital cultural condition that connects their moral experiences, which in truth is our human condition, and therefore the basis for humane care.

This is what doctors need to cultivate side by side with technical competence. At present, one of the powerful consequences of global culture is the impediments it creates for cultivating the humanity of the patient *and* the doctor.

#### References

1. Deaton A, Lubotsky D. Morality, inequality, and race in American cities and state. *Soc Sci Med* 2003; 56(6):1139–1153.
2. Wailoo K. *Dying in the city of the blues: sickle cell anemia and the politics of race and health*. Chapel Hill: University of North Carolina Press. 2001.
3. Kleinman A. Culture and depression. *N Engl J Med* 2004; 351(10): 951–952.
4. Kleinman A. *Patients and healers in the context of culture*. Berkeley (CA): University of California Press; 1981.
5. Stocking GW, editor. *Volksgeist as method and ethic*. Madison (WI): University of Wisconsin Press; 1996.
6. Abu-Lughod L. Writing against culture. In: Fox RF, editor. *Recapturing anthropology*. Santa Fe (NM): School of American Research Press; 1991. pp. 137–162.
7. Clifford J, Marcus J, editors. *Writing culture*. Santa Fe (NM): School of American Research Press; 1986.
8. Gupta A, Ferguson J, editors. *Culture, power, place*. Durham (NC): Duke University Press; 1996.
9. Fischer MMJ. *Emergent forms of life and the anthropological voice*. Durham (NC): Duke University Press; 2003.
10. Kleinman A. *The illness narrative: suffering, healing and the human condition*. New York: Basic Books; 1988.
11. Nandi A, Galea S, Ahern J, Vlahov D. Probable cigarette dependence, PTSD, and depression after an urban disaster: results from a population survey of New York City residents 4 months after September 11, 2001. *Psychiatry* 2005; 68(4): 299–310.
12. Stouffer SA. *The American soldier: combat and its aftermath*. Vol. 2. Princeton (NJ): Princeton University Press; 1949.
13. Young A. *Harmony of illusions*. Princeton (NJ): Princeton University Press; 1997.
14. Shephard B. *A war of nerves: soldiers and psychiatrists in the twentieth century*. Cambridge (MA): Harvard University Press; 2001.
15. Christian W. *Visionaries: the Spanish Republic in the reign of Christ*. Berkeley (CA): University of California Press; 1999.
16. Fox RC. *Essays in medical sociology*. Piscataway (NJ): Transaction Publishers; 1988.
17. Bloch M, Parry J, editors. *Death and the regeneration of life*. Cambridge (UK): Cambridge University Press; 1982.
18. Kleinman A. The good death. *The Maine Scholar*, 1996; 9:1–8.
19. Aries E. *The hour of our death*. New York: Knopf; 1981.
20. Counts D, Ayers Counts D, editors. *Coping with the final tragedy: cultural variation in dying and grieving*. Amityville (NY): Baywood Publishing; 1991.
21. Levinas E. Useless suffering. In: *Entre nous: thinking-of-the-other*, 91–101. Smith MB, Harshav B, translators. New York: Columbia University Press; 2000.
22. Levinas E. *Otherwise than being or beyond essence*. Lingis A, translator. Pittsburgh (PA): Duquesne University Press; 1981.