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The Charm of Medicines: Metaphors and Metonyms

The ready availability and extreme popularity of Western pharmaceuticals in developing countries poses important general issues for medical anthropology. In attempting to explain why medicines are so attractive in so many different cultures, this article suggests that they facilitate particular social and symbolic processes. The key to their charm is their concreteness; in them healing is objectified. As things, they allow therapy to be disengaged from its social entanglements. Medicines are commodities which pass from one context of meaning to another. As substances, they are "good to think with" in both metaphoric and metonymic senses. They enhance the perception of illness as something tangible, and they facilitate communication about experiences that may be difficult to express. In the course of their transaction, they bear with them associations to authoritative professionals and the potency and potential of other cultural contexts of which they once were a part.

Medicines are absolutely central to health care in the views of both patients and practitioners. This fact, which has long been taken for granted in Western cultures, is being brought urgently to our attention as manufactured pharmaceuticals become widely available in developing countries. Reports on the intense interest in drugs have come in from all parts of the world. Anthropologists, who long neglected the study of medicines in favor of more "exotic" forms of treatment,¹ are now examining perceptions and uses of medicines in many local contexts. Yet there has been little discussion so far of more general issues. Why are medicines so attractive in so many different cultures? What social and symbolic processes do they facilitate?

"Medicines" are substances used in treating illness. In this article we want to suggest that the "charm" of medicines, both in the Western world and developing countries, arises from their concreteness as substances. Medicines are *things*. In making this our point of departure, we are able to understand why it is that medicines are the hard core of therapy and what it is that sets them apart from other forms of healing. In biomedicine, other kinds of treatment also have the quality of being tangible; surgery is a prime example. But surgery is not a thing

that can be separated from the surgeon. It is professional and esoteric, while the “thinginess” (cf. Ellen 1988) of medicines makes them “democratic” and exoteric. That “democratic” character has to do with the fact that medicines are widely believed to contain the power of healing in themselves. Anyone who gains access to them can apply their power.

After setting the stage for our argument, we examine the charms of medicines in four steps. First, we show that as things, medicines have *implications for social relations*. They permit therapy to be separated from the social relations in which it might otherwise be embedded. Second, we discuss medicines as *commodities*, the value of which is agreed upon and transactable, but the specific meaning of which is variable. As concrete substances, medicines are “good to think with”; in our third and fourth sections, we consider the ways they carry meaning in terms of *metaphoric and metonymic associations*. We argue that in both metaphoric and metonymic senses, medicines enhance the perception of illness as something tangible, which may be manipulated. In moving from one context to another, they carry metonymic associations with knowledgeable doctors and technologically sophisticated centers of production.

The Popularity of Medicines

Medicines are considered so essential to health care, that a health care program without them is almost an impossibility. In a review of essential drug programs in developing countries, Mamdani & Walker stress curative medication as the “carrot” that attracts people to primary health care (PHC):

The success of PHC workers in their promotive and preventive roles depends, to a large extent, on their ability to provide credible front-line curative services. This in turn necessitates a constant timely supply of appropriate drugs in adequate amounts. [1985:1]²

When medicines are lacking, people stop visiting health care services, for medicines are seen as the essence of health care. A clinic without medicines is, one could say, like a bar without beer. Melrose, reviewing the sorry state of public supplies of medicines in various countries, remarked,

The most obvious consequence of rural dispensaries running out of drugs is that people stop going to them. Meanwhile governments have to go on paying for health facilities that are under-used and paramedics find it double hard gaining acceptance as health educators when they cannot deliver basic drugs. [1982:183]

Similar observations were made by one of the authors (van der Geest 1982:2148), who did fieldwork in Cameroon. Drug shortages in public health institutions brought services to a virtual standstill and led people to look for other therapeutic solutions that did include medicines (for example, private clinics or medicine vendors in local markets). Some health centers had not received medicines for more than a year and had de facto ceased to exist. Hours (1985), who carried out research in another part of Cameroon, emphasized that not only patients but also health care personnel were frustrated by the absence of medicines. They, too, saw dispensing of medicines as the most essential part of their task. “Lavish” prescribing by health workers has been reported from almost everywhere (e.g., see Melrose 1982:86–89).

Even if a doctor does not see a need to prescribe medicines, he may nevertheless do so to comply with patients' demands. Ugalde and Homedes present the example of a doctor who:

preferred to satisfy the patients' demands for medicines, even if on many occasions they might not have been needed. He did not want to give the impression that he did not care for them; many had walked one hour or more and would get upset if they knew that medicines were available and not given to them. [1988:62]

A doctor's willingness to (over)prescribe may also be fed by personal interests: he may not want to lose clients by failing to give them what they want, or he may derive direct profit from dispensing medicines. Kleinman describes a situation in Taiwan where both considerations apply:

If a practitioner gives the patient a prescription to be filled elsewhere, he does not get paid; the pharmacy where it is filled does. If the practitioner gives the patient medicine to take orally, he gets paid, but less than if he gives the patient an injection. Furthermore, giving an injection is giving the patient the message that you are offering him the best treatment you possess. Consequently, almost all medicinal agents that can be given by injections are so administered. . . . Many Western-style doctors told me this was a dangerous, quite unnecessary practice, but one they could not relinquish given the "realities" of clinical care in Taiwan. They feared the loss of income and patients. Since referral by satisfied patients is how most patients in Taiwan get to doctors, it is not surprising that doctors fear going against such expectations. [1980:287]

For the same two reasons practitioners in other medical traditions adopt Western pharmaceuticals. Burghart (1988) worked with a practitioner in northern India who, bowing to patient demands for penicillin, incorporated it not only in his pharmacopeia, but in his world view, by declaring it an ancient Ayurvedic medicine. Wolffers (1988) found that in Sri Lanka Ayurvedic doctors dispensed analgesics, antibiotics, and corticosteroids to attract and keep their clients.

As these examples suggest, the "charms" of medicines are widely appreciated. What makes them so desirable? Of course, they are biologically efficacious. The impact of antibiotics on bacterial diseases has been spectacular, particularly in Third World countries. It is not unlikely that the efficacy of a few drugs has been overgeneralized so that even inefficacious and harmful products are in demand. Leslie (1988) reports that in Bangladesh about 75 million dollars were spent on allopathic drugs in 1981 (60% of the total health expenditure in the country). Yet an Expert Committee estimated that 70% of these drugs would be described as therapeutically useless by authorities in Great Britain or the United States. Not only are many medicines used in Bangladesh and other developing countries considered ineffective by Western medical authorities, many drugs are also thought to be dangerous. There is indeed abundant information that the dumping of pharmaceuticals in the Third World has caused considerable damage among their users (cf. Melrose 1982); yet this "evidence" does not convince people to reject these drugs.

Clearly the question as to what makes pharmaceuticals so desirable cannot simply be answered by saying that some are biochemically efficacious. The whole question of efficacy is now recognized as an extremely complex one. Awareness

of the “total” drug effect (Helman 1984:106) implies that several different aspects of drugs and drug-taking contribute to their impact. Discussions about the placebo effect suggest that *meaning* in some unspecified ways helps to heal (cf. Moerman 1983), and Etkin (1988) has argued that efficacy is culturally constructed.

Arguing that people want medicines only because medicines have a “natural” innate and obvious capacity to cure seems unsatisfactory. The motivation to obtain medicines is not simply that they *are* powerful, but that people *believe* them to be so. The question then returns in another form: why are people inclined to believe so strongly in the efficacy of drugs?

“Liberating” Substances

The nature of medicines as physical substances has important implications for social relations. In the first place, Western pharmaceuticals can be loosened from the professional territory of doctors and pharmacists. What writing and particularly printing have done to knowledge, pharmaceuticals have brought about in medicine. Writing removes the monopoly on knowledge of those who have produced it or “possess” it and makes it accessible to others. It objectifies knowledge—that is, makes it a *thing* which can stand on its own, be kept in a cupboard, locked behind doors, handed over to others across place and time. Writing thus makes it possible for knowledge developed as the exclusive property of an elite to become vulgarized. Ginzburg’s (1980) case study of a 15th-century north Italian miller, who expanded his religious and philosophical ideas by reading books, is a striking example.

In a similar way, pharmaceuticals objectify the healing art of physicians and make it into some-*thing* that can be used by anyone. Pharmaceuticals break the hegemony of professionals and enable people to help themselves. Medicines, therefore, have a “liberating” power, particularly in those societies where it is difficult to control their circulation and use.

Alland (1970), who did research among the Abron of the Ivory Coast, was one of the first to show how medicines as substances could be divorced from relationships to experts. He pointed out that Western medicines, including the most dangerous ones, were available in local markets and shops and could be purchased without a prescription. Penicillin tablets, for example, were available in every village. He noticed that people exchanged their views and experiences with drugs, building up a fairly wide popular knowledge of pharmaceuticals. They carefully kept empty boxes, tubes, and inserts that made them familiar with the names of many drugs (1970:171). Alland remarked that what people were really after was not so much the professional help of doctors or nurses but medicines. Hospitals were seen in the first place as sources of medication, places where you might be able to get better drugs than on the open market. Thus, in Alland’s words, “the doctor often appears to be an unnecessary adjunct to the distribution of medicine” (1970:170).

Since the publication of Alland’s book almost 20 years ago, his point about the disjunction between biomedicine and the distribution of pharmaceuticals has been documented from almost every country in the world, but especially from developing countries (cf. van der Geest and Whyte 1988). Self-treatment by med-

icines is made possible because drugs are for sale at the local market, often sold by the pill because people cannot afford larger quantities.³ As a technology of treatment, they are easily removed from the context of relationships to biomedical practitioners.

There is an even more embracing sense in which medicines may be "liberating," and this has to do with the relationship of the sick person to his or her community. Periods of illness are occasions of dependency and social control. They provide an opportunity to review social relationships and conceptions of the person in the world. In explaining and treating illness, ideas of obligation and morality are often mobilized, as countless ethnographers have shown. Family meetings, confessions, sacrifices, rituals of exorcism and collective prayer are examples of therapy embedded in kinship and community relationships (cf. Mullings 1984). To these kinds of therapy, medicines are an alternative, a treatment that can be carried out privately and that focuses on the individual body (cf. Whyte 1988).

Thus medicines can become vehicles of individualization, useful exactly at that point where more "relational" forms of therapy might have emphasized the person's involvement with other people and/or subjection to spiritual forces. In many Third World societies, this potential of medicines fits with a general process of individualization associated with changing economic structures, school education, and the creation of national popular cultures.

The fact that medicines are used individually and privately is particularly important when sickness might reflect poorly on the patient or family. The kinds of sickness which fall into that category may vary from one culture to another. However, it is very commonly the case that complaints of the genital organs require discretion. Illness symptoms of those parts of the body may be kept hidden for a considerable length of time, as the body parts themselves are likely to be hidden. Those suffering from venereal diseases are generally strongly motivated to cure themselves before others get to know their shameful condition. The great popularity of antibiotics, in particular Tetracycline, is probably explained by this concern.

The same applies, *grosso modo*, to medicines used to induce abortion. In many societies abortion is seen as a serious offense against one of the most cherished values, the production of offspring. Modern pharmaceuticals, as well as traditional herbs or other substances, are used privately and secretly by women to terminate their pregnancy (cf. Bleek and Asante-Darko 1986; Browner 1985; Sukkary-Stolba 1985). It should be noted that the desire to abort is itself a significant aspect of the individualization process taking place, particularly in peasant societies that were previously characterized by strong social approval of reproduction. Lack of social support, impoverishment, or the wish to complete an education may offset the prestige which used to accrue to having many children. When pregnancy does occur, abortion may seem the best rational alternative to the woman concerned. As we have seen, "medicines" may provide her with the means to solve that problem without the interference of others.

Thus, one of the "charms" of medicines is that they allow private individual treatment, diminishing dependence on biomedical practitioners, spiritual experts, and kin. The social control exercised by therapeutic specialists, from witchfinder to psychiatrist, from ancestor-priest to family doctor, can be evaded. Also the

influence of family elders, neighbors, religious leaders, and others can be greatly reduced, as the individual may be able to circumvent their interference by the private use of medicines. Divination, collective prayer, sacrifice, surgery, and counseling put the patient in other people's hands. Medicines enable him to take his condition into his own hands.

At a very practical level as well, Western pharmaceuticals are often seen as advantageous, if not exactly liberating. They are convenient and ready to use. Many indigenous herbs have the disadvantage that they have to be sought, usually outside the village, and prepared before they can be applied. That disadvantage is twofold. In the first place this process is time consuming; in the second, it diminishes the privacy of using medicines, for it may prove impossible to carry out the preparation of the herbs without others noticing it. Moreover, a person may have to depend on others to find and prepare a certain herb. That a medicine is ready for use assumes increasing importance, as time becomes more precious in the lives of individuals (cf. Sussman 1988:208–209).⁴

Medicines as Commodities

The concreteness of medicines makes them eminently transactable. They can be commoditized more easily and more thoroughly than other forms of treatment. What we have said about the private, the secret, the liberating, and the convenient characteristics of medicines presupposes their being commodities. They are items that can be exchanged, usually for money. Salability is the key indicator of commodity status (Kopytoff 1986:69).⁵ "Salable" implies that the item "survives" the change of ownership. This is not to deny that the passing from one owner to another may change the "life" of a commodity and may place it in a new context of meaning. But basically it retains its value, independently of who owns it. Otherwise people would neither sell nor buy it. An example of the opposite further clarifies our point. A personal souvenir, a trinket that is precious to one but practically worthless to another, will never be sold; it will not become a commodity. Its value is not resistant to change of ownership.

The value of medicines seems to be based on a perception of them as having an inherent power to heal. Manufacturers of pharmaceuticals, biomedical practitioners, and local consumers all agree on that. However, the specific meanings of a drug, the ideas about how it should be used and its specific capacities and effects, are highly variable. As *things*, medicines are transacted from one interpretive setting to another, retaining value but changing meaning.

Medicines have qualities that make them even more fit for commoditization than most other things being traded. The first quality is that medicines meet an urgent need in people. The demand for medicines is in principle unlimited, because health never seems to be ensured. People must always take steps to maintain or reestablish it.⁶ The fact that medicines are seen as a means to life and well-being means that they are attractive items to manufacture and to sell. Trading in medicines is indeed an exceptionally profitable business.⁷

A second quality that enhances the transactability and consequently the commoditization of medicines is their small size. Medicines are easy to transport. Especially in countries with a defective transport system this quality is important. The fact that one person on foot, or traveling by bicycle or motorcycle, can carry

an enormous value-amount of medicines greatly facilitates the distribution of drugs into the most remote communities. It also makes passage from the formal to the informal transaction circuit convenient and smooth. Poor medicine vendors can comfortably transport pharmaceutical products from the urban pharmacy to their village kiosk. Two types of informal distribution benefit particularly from the product's small size: smuggling and stealing. Traders who bring medicines from Nigeria into Cameroon, for instance, have a much easier job than their colleagues who smuggle cement. By the same token, the health care worker who takes medicine from the health center to his house can do so unseen by others.

The value of medicines is undeniable, and this is exactly the problem from the point of view of health professionals. For them, the power of most medicines must be controlled; they should not circulate as free commodities precisely because their power may be misused wastefully or harmfully. Their exchange should be limited; there is an effort to make them "enclaved commodities" to which access is restricted (see Appadurai 1986:24). This view is based on an understanding of pharmaceuticals and health care which is esoteric. It assumes that many medicines need a professional prescriber in order to be useful and safe. (In this view, even "over-the-counter" medicines should be used in accordance with established guidelines.) The meaning of each pharmaceutical has to do with its biochemical properties, and fits into a complex system of knowledge about disease and the biopsychological functioning of human beings. However, the meanings which lay people attribute to medicinal commodities may be very different. Efforts to limit access to certain pharmaceuticals may merely reinforce the view that they are valuable and powerful, without bringing potential consumers to share the meanings with which biomedical professionals imbue these commodities.

As Appadurai suggests, individual entrepreneurs often engage in strategies of diversion in response to the enclaving of commodities. They attempt to make restricted items available for general exchange (Appadurai 1986:25–26). Clearly diversion has triumphed over enclaving of medicines in many developing countries. As objects of exchange, medicines may be bought, stolen, smuggled, hoarded, forged, and used as gifts.⁸

While economists, planners, and health professionals may simply wish to determine the extent to which pharmaceuticals freely circulate as commodities, anthropologists must attempt to understand what particular meanings are attributed to these objects in particular contexts of transaction. A few vignettes will illustrate the particular "charms" medicines hold for specific consumers.

In Ashaiman, near Tema (Ghana), fathers often give medicines as a gift when a child is born. One favorite medicine used for that purpose is "Milk of Magnesia." Some people may think that it is some kind of milk. Others, who are aware of its laxative working, may want the child to defecate several times a day, as they believe this to enhance the child's health. Mothers in Ghana tend to believe that disease enters from outside the body and settles in the stomach and bowels. Frequent defecation is thus seen as an effective way to prevent sickness. Mothers often prepare enemas for their children and for themselves. The informant estimated that nearly all mothers in Ashaiman would give their children "Milk of Magnesia." [H. Kleinkowski, personal communication, 1980]

Many more examples have been reported of medicines being exchanged as precious gifts. Particularly in situations of scarcity or when medicines are expen-

sive, these gifts are highly appreciated. One of the authors noted that in Cameroon, physicians and other health workers fulfilled their family obligations by giving their relatives free medicines from their health center. Community elders and local notables were also presented with medicines to maintain good relationships with them (van der Geest 1982).

The very fact that a particular drug is limited to a specific type of patient may give it a special attraction in the minds of local people:

The head-nurse of a leprosarium in South Cameroon remarks that people from the surrounding villages are interested in the medicines that the lepers take, particularly in Disulone (Dapsone). They have asked him to sell the drug to them. They gave three reasons for their requests. Some of them believe that Disulone gives them energy to work hard. The nurse explains that the lepers are very effective in agriculture and handicrafts and that their neighbours attribute these achievements to the medicines they take daily. Some stress that the medicines will also increase sexual energy and a third opinion is that women should take Disulone if they want to become pregnant. Some of the lepers are believed to have sold their medicines to the people in the neighboring village. The nurse indicates that they now force all people in the leprosarium to take their medicines in front of them to prevent them from selling the drug. [van der Geest, fieldnotes]

The selling of antileprotic drugs to people not suffering from leprosy has also been reported from other parts in Africa, e.g. Kenya (Risseeuw 1978) and Nigeria (Alubo 1985). The reasons for these transactions seem similar: people attribute special powers to the medicines.

One drug which is believed to cure about anything in many African countries is Tetracycline. The following observation comes from Pradervand (1985:1).

Today, September 22, 1985, I purchased "tupaye" (pronounced two-pie) at the central market of Ouagadougou, Republic of Burkina Faso. "Tupaye" is the popular local name given to antibiotics, especially tetracycline. Of course I purchased it without a prescription, from a vendor who had no idea about side-effects, dosage and still less of an idea about its therapeutic use.

Over the following days I found out more about the availability of "tupaye." It seems there is not a single market in the country where it cannot be purchased. Even cigarette vendors and little girls sell it. . . . In fact, "tupaye" means "it heals everything" and the evidence I obtained in four towns of Burkina Faso and from numerous informers . . . indicates that it is used according to its name for *absolutely* everything: from stomach aches to backaches, from toothaches to open wounds, headaches to malaria, diarrhoea, and so on. Capsule contents are poured into open wounds, emptied into the cavities in the teeth, diluted in all sorts of liquids.

Ascribing fantastic effects to drugs is common. It may come up spontaneously, as appears to be the case in the previous vignette, but it may also be instigated by advertising. Kahane (1984) has described how TV commercials in Taiwan propagate images of potent drugs. *Nao shen ching shuai je* ("mind nerve weakness") is an illness that people in Taiwan attribute to accidents, "thinking too much," and other features of "modernization." Its symptoms include lack of energy, insomnia, headache, backache, and "nerves hurting." In the following quote from a TV commercial (Kahane 1984:165), a male announcer says, "You can't sleep. You have lots of dreams. You often have headaches. Your neck aches and has

pain. This medicine can help. If you use your head too much, you can't concentrate. Your memory is poor. You have *nao shen ching shuai je*. Protect the mind. This medicine works." Advertising will probably come to play an increasingly important role in the presentation of certain kinds of medicines in developing countries.⁹

Obviously, however, there are large segments of the population who are untouched by advertising. For them, the recommendation of a medicine vendor or personal acquaintance is far more influential in forming their views of the potential of various medicines. Alubo gives the following example of a pitch made by a vendor appealing to the passengers in a long distance bus in Nigeria.

My name is doctor-do-good, the world man. . . . I am the man doctors love to hate because I cure patients they have pronounced dead! And this is why I am with you this morning to introduce to you medicine which will cure those of you the doctors have pronounced dead, those of you the hospitals have rejected. [1985:97]

The same source quotes a medicine seller in a market claiming: 'Just take a small tumbler shot of this medicine early in the morning or in the night and I can assure you that no woman can give you gonorrhea ever in your life' (Alubo 1985:97).

Thus far we have discussed the concreteness of medicines in terms of their "liberating" potential in social relationships and their commodity status. We have emphasized that transactions of medicines as commodities involve a general agreement on their value and often diverging views of their particular characteristics and capacities. Now we must turn to a closer examination of this problem of meaning, holding still to the basic point that the concreteness of medicines is at the heart of their charm. When people acquire and use drugs, they do so against the background of their conceptualizations of illness and healing. Our question now is: how does the concreteness of medicines relate to people's attempts to understand and deal with illness? We answer it by examining processes of metaphoric and metonymic association.

Metaphoric Associations

Metaphors help us to grasp "reality" in an intellectual sense, to see the world in a certain way and, consequently, to communicate about that intellectual experience. Metaphors have a practical value; they help people organize their lives by providing "the semantic condition through which actors deal with" their reality (Crocker 1977:46). Fernandez (1986:8) applies Burke's definition of proverb to metaphor: a "strategy for dealing with a situation," but it is still not clear how metaphoric assistance works as a strategy. To explain this, Fernandez resorts to a spatial metaphor. Metaphors "take their subjects and move them" (1986:12), but where? One of the most popular "movements" accomplished by metaphors in everyday life is from inchoateness to concreteness. A metaphor, like a proverb, is "a predication upon an inchoate situation. It says that something much more concrete and graspable—a rolling stone, a bird in the hand—is equivalent to the essential elements in another situation we have difficulty in grasping" (Fernandez 1986:8).

Perceiving Illness

Let us apply this notion to the experience of not feeling well, a typical example of a situation that is difficult to grasp. Although bodily sensations seem very direct and concrete to the subject, they are elusive and obscure at the same time. Pain, for example, is an indefinite experience. The subject does not fully understand his own body and, worse, he finds it extremely difficult to communicate the pain sensation to others. Pain, by definition, is a lonely situation. What cannot be shared by others cannot be discussed and recognized by others and thus remains, in a sense, abstract, a non-experience. By likening the pain sensation to other experiences that are more tangible, we move, in Fernandez's terms, the inchoate to a domain where things are easier to grasp. The assistance of metaphor in dealing with not feeling well is that it makes the complaint specific, even palpable. Images from the tangible world of nature and physics are applied to the elusive experiences of nausea ("a wave") and pain ("a vise"). Illness assumes an appearance of concreteness which makes it accessible for communication and therapeutic action.

Which images are selected to describe and communicate illness varies, but it stands to reason that intensely experienced qualities of the physical world are useful in organizing the perception of illness. Metaphors to describe the experience may be derived from the world of animals and plants, from sensations of wet and dry, hot and cold, and, in our society, from the world of technology that has assumed natural proportions and has become a second nature. We could call this type of transformation "naturalization." As Lévi-Strauss (1966) explained some years ago, the "logic of the concrete" is not limited to "primitive" thought. Numerous examples of such concretization and naturalization of illness can be found in the medical anthropological literature.

Ohnuki-Tierney's (1981) study of the Sakhalin Ainu is a case in point. Dogs are of great importance to the Ainu. They pull sledges, and without them the Ainu could not survive through the severe winter. Dogs and some other animals have become "vehicles" of thought for the Ainu, for expressing feelings of happiness and misfortune. A certain kind of headache is called a "dog headache," and no less than 14 parts of a dog's body are used to treat it. Their thinking in natural and concrete terms thus "infects" their experience: metaphors not only express human experience, they turn around and *make* the experience as well.

A most impressive example of metaphoric concretization is found in biomedical thinking. Biomedicine is, as are all natural sciences, a systematized and exponential form of the cultural strategy of concretization and naturalization. Viewing biomedicine as a cultural strategy, however, has not always been a common practice. Cultural awareness arose as a result of historical and anthropological studies of "strange" medical ideas in other societies and periods. That confrontation subsequently raised questions about the cultural roots of biomedicine. Wright & Treacher (1982:6) believe that the work of Mary Douglas in particular has created that awareness.

Starting from tribal systems of belief, she has proceeded to demonstrate that modern science and medicine can themselves be understood as cosmologies: as systems of natural symbols which we today use to make sense of our existence

in the world. Modern medicine, it seems, . . . serves as a set of categories that we use both to filter and construct our experience.

The major technique of “filtering,” to which this quotation refers, is metaphorical: qualities of the natural and technical environment are applied to subjective feelings. These terms transform illness into empirically verifiable phenomena. In biomedicine both doctors and patients use physical and technical terms to describe the cause of the complaint: defect, tension, shock, rupture, stricture, pressure, perforation, stress, expulsion, and sedimentation. They speak of canals and vessels, flow and congestion, intestinal flora, growths, and invasions. The concretization of illness is pithily illustrated in the history of the term “disease.” The literal meaning expresses a subjective and personal experience of not feeling well, but the present meaning refers to a physical and measurable phenomenon (cf. Wright & Treacher 1982:4).

Cassel (1976) analyzed 2,000 tape-recorded doctor-patient conversations in New York City. He concludes that doctor and patient are inclined to refer to illness in terms that suggest a distance between the person and the illness. Illness becomes depersonalized, an “it.” This is also a way of objectifying and concretizing diffuse subjective experience.

Concretistic and mechanistic images of illness and health are familiar in popular speech. The body and the heart (“ticker”), in particular, are referred to as an engine that may break down, not run well, become worn out, and need to be checked. Terms like “fuel,” “battery,” and “spare part” are frequently used to describe health problems. The plumber’s model of the body, with its pipes, pressure, circulation, flushing, and draining, is apt for many of us (cf. Helman 1984:16).

The Metaphoric Movements of Medicines

Let us now return to the “charm” of medicines. It is not difficult to see that the concretization of illness brought about by metaphor prepares the ground for the use of medicines. If the problem is physical, then the remedy should be physical. Medicines appear the perfect answer to the problem.

Western pharmaceuticals, as substances, change the substance of the ailing body. Vitamins supplement deficiencies in the metabolic system of the body, thus restoring the normal physical condition. Diuretics promote the excretion of water and electrolytes by the kidneys. Insulin reduces the blood-sugar concentration in the body. Antibiotics and micro-organic substances destroy or inhibit the growth of other species of micro-organisms.¹⁰ In a medical system characterized by ideas of “hot” and “cold,” medicines are believed to influence the hot-cold balance. Among the Sakhalin Ainu (Ohnuki-Tierney 1981), as we have seen, medicines are selected on homeopathic principles: illness associated with a certain animal is treated with substances of that same animal. In Rwanda, medicines are applied to restore the regular flow of bodily liquids (Taylor 1988). Everywhere concreteness sets the tone.

So far we have argued that the metaphorization of illness, making illness a concrete and “natural” phenomenon, provides a favorable context for the use of medicines. But that paints too passive a picture of the role of medicines. Metaphors for illness assume a teleological character; they “know” where they are

going. Their direction is the taking of medicines. One could say that the existence of therapeutic substances invites the concretization of ill-being, or that the metaphoric objectifying of illness fulfills the expectations of medicines. Black (1962:37) writes that in some cases, "it would be more illuminating to say that the metaphor creates the similarity than to say that it formulates some similarity antecedently existing." Defining illness in a way that makes treatment possible (e.g., prescribing medicines, but also surgery, radiation, rest, etc.) is exactly what we have earlier called—in Burke's words—"a strategy for dealing with a situation." That is the "mission of metaphor" (Fernandez 1986:28–70).

The notion of illness as an entity within the body is widely found. The ethnographic literature suggests that people in many cultures live by this metaphor, using emetics, purgatives, sweat baths, and cupping horns to remove the sickness from the body. Our point is that the treatment calls for the conception as much as the conception calls for the treatment. Pellegrino, referring to Sigerist, points out the extremely common supposition that sickness arises from intrusion of "something" into the body or loss/damage of some vital substance. Both conceptions fit with medicines: "The act of prescribing satisfies a complex urge of ancient lineage which predisposes humans to combat disease by taking in a chemical agent, which either drives out the intruding cause or replaces the 'something' lost in illness" (Pellegrino 1976:625). But it also applies the other way round. Doctors use medicines to diagnose: "If Flagyl works, it must be amoeba!" Sickness and medicine, entity and counter-entity motivate one another.

The metaphoric movements of medicines in relation to psychiatric conditions are particularly revealing, because such conditions are especially difficult to communicate. Rhodes (1984) describes how psychotropic drugs are said to "clear the mind," "to straighten one's thoughts," or "to keep one's thoughts together." But for Rhodes, describing the metaphoric concreteness of the action of drugs is only a stepping stone to a more general conclusion: drugs are themselves strategies of concretization. They are "facilitators" for establishing meaning and for communication. What Lévi-Strauss (1963) said about animals and plants in his essay on totemism applies to drugs in a psychiatric setting: they are "easy to signify" (1963:60), "their perceptible reality permits the embodiment of ideas and relations conceived by speculative thought on the basis of empirical observations" (1963:89). Thus, communication about medication becomes communication about problematic and ambiguous experiences.

In an article about communication and medicines in a rural clinic in Sri Lanka, Sachs (1989) develops an interesting twist on this issue. She suggests that medicines bridge the gap in understanding that exists between doctor and patient. The concreteness of drugs provides a focus for each party in their conceptualization of the problem and at the same time overshadows the fact that they mean quite different things to each.

The anthropological interest in metaphor is rather different from the literary one. From a literary-aesthetic point of view it may make sense to distinguish between "dead" metaphors (clichés) and "live" ones (see Black 1979; Fraser 1979). The cliché in a literary text does not "touch" us, whereas a new metaphor catches our attention and moves us. In that sense it seems right to speak of dead and live metaphors. Black (1979:26) remarks that a dead metaphor may be merely a catachresis (i.e., an idiom that fills a gap in the lexicon). But we should take

into consideration that the aesthetic emotion is only a tiny part of the total gamut of human experiences. It is interesting to see what happens to a metaphor once it has lost its aesthetic brilliance and turned into a cliché.

Let us take an example from our own anthropological world. It is common among anthropologists to speak of “*data collection*.” At first sight, few may recognize this as a metaphor, but the implicit metaphoric movement from the inchoate to the concrete is clearly there. The metaphor is now dead; nobody is touched by the poetic originality of its presenting bits of conversation or observation as things that can be gathered together in the way one collects stamps. The term “*data collection*” may not even be regarded as a cliché; for many anthropologists it may have lost any figurative reminiscence—in other words, it is taken literally. Anthropologists may really think that data are things that can be found somewhere, brought together, counted, etc. From the artist’s point of view that metaphor may be dead; in the eyes of the anthropologist it has come to live. It has completed its journey from elusiveness to the world of substance and has settled there. It has become a “*native*” in that new world and no one remembers where it has come from, where it belongs. It has disguised its status as metaphor and passes for real, for literal truth.

Lakoff and Johnson (1980) provide various examples of metaphors that have become reality or nearly so. “*Time is money*” is one of them. Time has indeed become a valuable commodity, a limited resource. Our actions prove it. Expressions like “*spending time*,” “*it costs an hour*,” “*I have no time*,” “*I lost one hour*,” are no longer perceived as clichés, much less as metaphors; they have become reality.

Corresponding to the fact that we *act* as if time is a valuable commodity—a limited resource, even money—we *conceive of* time that way. Thus we understand and experience time as the kind of thing that can be spent wasted, budgeted, invested wisely or poorly, saved or squandered. [1980:8]

Such forgotten metaphors are the most effective ones. They have the greatest impact on how people organize their lives, create order, and distinguish between what is meaningful and meaningless, valuable and worthless, healthy and sick. By “*filling the gap in our lexicon*,” we have in fact added something to “*reality*.” We have tried to apply these insights to the field of medicine and medicines. The concretization that has taken place in our thinking about feeling ill can be seen as a metaphor in the process of losing its figurative character and becoming plain truth, even science.

Metonymic Associations

Since we have chosen to deal with metaphor and metonym separately we have systematically kept silent about the metonymic character of medical belief and use of medicines in the previous section. We have to admit, however, that such a separation was at times almost impossible and was certainly highly artificial. We turn now to the concept of metonym, and the ways in which metonym supplements metaphor in the processes of conceptualizing illness and attributing meaning to medicines.

In metonymic speaking, as in metaphoric, one entity is used to refer to another one; that reference is not based on similarity, however, but on some type of

connection. Lakoff and Johnson (1980:38–39) mention the following types: part-whole, producer-product, object-user, controller-controlled, institution-people in the institution, place-institution, place-event. Many more could be added to these. Metonymic references have an effect that is very similar to that of metaphors: concretization, either by putting a phenomenon more firmly in the natural or physical world (e.g. part for whole and place for event) or by linking it to a causal agent (e.g. producer for product). Lakoff and Johnson explain:

Metonymic concepts structure not just our language but our thoughts, attitudes and actions. And, like metaphoric concepts, metonymic concepts are grounded in our experience. In fact, the groundings of metonymic concepts is in general more obvious than is the case with metaphoric concepts, since it usually involves direct physical or causal associations. The *part for whole* metonymy, for example, emerges from our experiences with the way parts in general are related to wholes. *Producer for product* is based on the causal (and typically physical) relationship between a producer and his product. *The place for the event* is grounded in our experience with the physical location of events. And so on. [1980:39]

Locating Illness

There are two closely related metonymic processes that are of great significance for making illness concrete and facilitating the use of medicines. These are part for whole and localization. Locating a health problem in some part of the body has mainly two effects: it makes the complaint more specific and allows for directed action. Locating the complaint in a part does not deny the suffering of the whole body or the whole person. The implied causal ordering of the metonym is that the illness of the (whole) person is brought about by the dysfunctioning of one body-part, as is also suggested by the Biblical saying, “If one member suffers, all suffer together” (1 Corinthians 12:26). The opposite view, that a person’s suffering “settles down” in a particular part of the body, is less prominent in Western popular thinking.

Locating the complaint is, as it were, providing a geographical map for therapeutic intervention. Medicines, as we have seen, are believed to work in a very concrete manner. They change the physical composition or restore the mechanics of a body part. They can be applied locally or sent to the troubled area through the canals of the metabolic and arterial systems. The localizing metonym shows the way for medicines to be taken.

Producer and Product

In speaking about the metaphoric concretization of illness, we discussed only one style of concretization, likening illness to natural, physical phenomena. This type of metaphor dominates in the biomedical tradition and in many other medical cultures. Another common style of explaining and dealing with illness is, however, “personalization.” Negative experiences can be made concrete and tractable by seeing them as conditions that have been purposely brought about by the actions of willful agents, either human or non-human, person-like beings (Foster 1976). In this producer-for-product kind of connection the product, illness, is linked to a producer, the agent. Attributing illness to a certain person is trans-

porting the elusive experience to the concrete world of social relationships where power, knowledge, and specialized techniques of others can be marshaled to solve the problem. In this personalized world of illness explanation, the counter-agent, the healing expert, assumes a prominent place. Here we want to argue that medicines are metonyms in that they are treated as physical representations of a larger context of which they are part.

Personal relations can be crucial in that context. As we have seen, medicines “liberate” the patient from the hands of doctors and other therapeutic specialists. The doctor may control the situation in which the medicines are dispensed or prescribed. He may add certain words of reassurance and instruction. All this is part of the treatment. But the patient can take the medicine home, use it for awhile, keep it in her medicine cabinet for a year, and then give it to a neighbor who suffers from the same problem she used to have. This kind of separation of one concrete element from a total context of healing is not possible with other reifying forms of treatment administered by practitioners. One cannot separate surgery from the skill of the surgeon, nor acupuncture from the acupuncturist, nor massage from the masseur.

However, the attraction of this capacity for separation and conveyance from one therapeutic context to another is not simply that people can take medicines without consulting a doctor. One of the “charms” of medicines is that, even removed from their medical context, they retain a potential connection to it. The medicines have a metonymic association with medical doctors who prescribe them, with laboratories that produce them, with medical science that forms their ultimate ground. Through medicines people enjoy the fruits of medical expertise without the inconvenience of actually having to go to the doctor. Montagne (1988:421), quoting Pellegrino (1976), writes that medicine is “the visible sign of the physician’s power to heal, and in contemporary society, is a symbol of the power of modern technology.”

The reassuring effect of linking medicine with the doctor is also sought in drug advertisements. Tan (1988:126–127) cites the following examples from the Philippine radio.

“Take Tuseran capsule to be sure, for all kinds of cough.”

“For my cold too?”

“Yes, even for headache and fever. Doctors know that. Tuseran, when your doctor wants to be sure.”

“My doctor says Enervon is different. You get 24 hour energy and body resistance. It has the anti-stress formula not found in other brands.”

Balint’s (1964) adage that the doctor is a medicine is well known. “Medicine” is here used as a metaphor for the doctor. Cockx (1989) has turned this around and describes medicine as a doctor, not in a metaphoric but in a metonymic sense. The medicine is an extension of the doctor. There is, as it were, a dose of “doctor” in the medicine. Cockx views the placebo effect as the result of uniting patient and doctor through the intermediary role of medicines. The healing hand of the doctor reaches the patient through the medicines. By the same token, the doctor’s reassurance is presented to the patient in the form of a prescription. That piece of paper is the material proof that doctor and patient are still connected to one another. Both prescription and medicine bridge the gap between patient and

doctor. The confidence awakened in the patient by the doctor is recaptured in the concreteness of medicine or prescription, in the same way that a souvenir brings back feelings of the past. The medicine stands for a less tangible experience of which it was a part, as the seashell serves as a memento for the beach one has known as a child.

It is not only the case that medicines are associated with doctors, however. In many situations they also represent a whole cultural context. This metonymic connection probably explains the frequently cited popularity of medicines with a foreign origin (cf. Whyte 1988:225 ff.). Hand in hand with the near universality of ethnocentrism goes a widespread belief in cultures throughout the world that extraordinary knowledge can be found elsewhere, usually far away. Supernatural (or rather supercultural) capacities lie outside the domain of the familiar. An exotic provenance of medicines, therefore, is easily seen as a promise that these are indeed superior. Whyte (1988) has pointed out that this desire for foreign medicines is not limited to Western pharmaceuticals in Africa, for example. It seems to have been a feature of cultural interaction even in the precolonial period.

The allure of exotic contexts is exemplified time and again. A Danish chain of stores appeals to our images of the East in advertising "pure Siberian ginseng" and "genuine Korean ginseng" (the latter with a picture of a very Oriental-looking wise old man on the bottle). Tan (personal communication) assures us that the Chinese community in the Philippines considers ginseng from Wisconsin to be far superior to that from China.

The way in which a medicine's connection to another cultural context may be emphasized to enhance its charm is beautifully illustrated by a Philippine television ad for "Alvedon," a brand name for paracetamol, manufactured by Astra of Sweden. Pictures show a "Swedish doctor" taking the drug, while an announcer explains that Alvedon is the product of "the same Swedish technology" that produced the Volvo. This is followed by pictures of the tennis champion, Björn Borg, and the Nobel prize ceremony in Stockholm (Tan, personal communication).

It is against this background of the metonymic connections of medicines that we may understand the extreme importance of appearance and packaging. The immediately apparent form of a medicinal commodity has the potential for suggesting such connections. The particular appeal of "high tech" forms of Western medicine such as injections and capsules, is that they are so obviously products of advanced technology. Their metonymic associations are especially strong. To this must be added the power and prestige that accrue to political and economic dominance. A capsule is a bit of Western technology with all that implies of potency and possibility.

Conclusion

In our attempt to formulate some general issues in the cross-cultural study of medicines, we have emphasized their concreteness as substances. This approach fits with recent developments in anthropology emphasizing the culture of commodities (reviewed in Ferguson 1988). It is congruent with the wish, expressed by Ellen (1988:230), to draw attention to the "materiality of cultural phenomena . . . re-establishing 'things in themselves' as legitimate features of the cognitive

landscape.” In our view, the fact that medicines are concrete things is the central characteristic that sets them apart from other forms of therapy and that has implications which need to be explored.

We have chosen some tried and true analytical tools, the concepts of metaphor and metonym, in order to work with the problem of what and how medicines mean. These two concepts are particularly appropriate for dealing with the quality of concreteness, which is our point of departure. We argue that the meaning of medicines must be understood in terms of the experience and conception of illness. Metaphors and metonyms are often used to concretize illness, which opens the way for therapy by things. But the very existence of medicines as a form of treatment motivates the conception of illness in appropriately concrete (and therefore treatable) terms. In providing concrete models for feeling ill, medical science utilizes and vitalizes many of the metaphors we live by in Western culture.

The concept of metonym, in which one thing refers to something else by virtue of a connection, is useful in two ways. It, too, allows us to understand how the experience of illness is made more concrete by focusing upon one specific part of the whole in which suffering is localized. Metonymic aspects of medicines are also related to their “liberating” potential. While medicines and pharmaceuticals may be separated from social relations to healers, doctors, and health facilities and thus promote individualization, they still refer to that whole context of healing. Indeed, pharmaceuticals refer not only to doctors, but to the power and potential of advanced technology.

One question seems to us of central concern for further study: how does the use of Western pharmaceuticals fit with changes in the social relations of healing? We have mentioned the way in which medicines facilitate self-treatment and thus remove therapy from the social relations in which it would otherwise be embedded. In speaking of this as “liberation,” we have not meant to cast a value judgment on the process. In the back of our minds was the sense in which Marx spoke of peasants being “liberated” from feudal relations, so that their labor power might be available on the market. In the same way, people “liberated” from relations to doctors, senior relatives, or spirit exorcists, become dependent on less personal market relations in order to obtain medicines. In this process, new kinds of relations may be formed as well—to drug vendors, local injectionists, or shopkeepers who provide advice to the buyers of medicines.

A related aspect which we have not dealt with here is the possibility that it is the weakness of the social relations of healing which motivates the interest in medicines. Failures of health delivery systems and poverty which does not permit people to enter into relations with professionals may be factors that push people toward self-help.

Pharmaceuticals predicate a graspable world of healing for the sufferer, giving the imagined “itness” of the disease the countering “itness” of the medicine and vice versa. Though the sufferer is “liberated” from the social entanglement of sickness, it remains to be seen what the future consequences of this “liberation” will be for healing.

NOTES

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¹The use of Western pharmaceuticals by the people anthropologists study is no new phenomenon. In fact, most fieldworkers have themselves encouraged the use of such medicines by giving them as gifts to the people with whom they work. Yet reports of how pharmaceuticals fit into local systems of healing were few indeed until recently. Elsewhere (Whyte and van der Geest 1988), we have suggested that this is another example of the "exotic bias" of ethnographers, which tends to overlook the seemingly familiar in favor of what is strikingly different.

²In UNICEF's "Bamako Initiative," "One key factor in the increased use of health services is restoring the communities' confidence in the services by ensuring the availability of sets of basic essential drugs and supplies at the levels of the community health worker, the dispensary, the health centre and the district hospital" (UNICEF 1988:9). Paterson (1985:153) remarks: "It does not matter how well trained the health team might be, if drugs are not available at the point of delivering health care, clinical acumen becomes irrelevant." See also Vogel and Stephens (1989:479): "The availability of pharmaceuticals is the key to establishing credibility; there are many examples of dramatic upsurges in the demand for government health care when a new supply of pharmaceuticals arrives." That medicines are thought of as indispensable (or almost so) in the treatment of illness has been reported by many observers, e.g., Alland (1970:171), Haak (1989), Hours (1985), Kapil (1985:167), and Rosenfield (1981).

³Van der Geest (1989) shows how people adjust their medical ideas to their financial means. Customers at a market in Cameroon assume that one or two antibiotic capsules is a sufficient course of treatment when they do not have the money to buy more.

⁴Afdhal and Welsch (1988) describe the popularity of ready-to-use packets of "traditional" *jamu* medicine in Indonesia. *Jamu* is marketed as genuine indigenous medicine, but in a form just as convenient as Western-style pharmaceuticals.

⁵For Kopytoff, objects which are exchanged but not sold for money are also commodities, although salability is usually the defining characteristic in Western societies. We stick to salability here, because even though pharmaceuticals may be given as gifts, they always have a sale value at some time.

⁶As Montaigne said, "Health is a precious thing . . . without it our life becomes painful and offensive; pleasure, wisdom, science and virtue tarnish and fade away" (cited in Sandblom 1982:87).

⁷"Since the late 19th century the pharmaceutical industry has been the most profitable major manufacturing sector. Drug companies have also been among the leaders in capitalisation, product innovation, research sponsorship, multinationalisation, export earnings and numerous other areas" (Liebenau 1987:vii). See also Lall (1975:28, 1981:194); McCraine and Murray (1978:574).

⁸A good example of such diversion is given by Maina:

one of the reasons we have so many patients attending the clinics is the policy of the government of Kenya to provide free medication. The other observation is that there are certain unscrupulous people who, having obtained an antibiotic—say tetracycline—will then sell these drugs and the following day will attend a different clinic and obtain more. In this way an individual may make a living. [1974:485]

Van der Geest (1988:335–338) gives an overview of the many informal channels through which medicines find their way.

⁹More examples are provided by Tan (1988:111–154) in a chapter on drug advertisements in the Philippines.

¹⁰Several of these descriptions of how pharmaceuticals work have been taken from Martindale (1977).

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