A Movement between Fields

This is a study in empirical philosophy. Let's begin with the empirical. The stories I will tell you in this book are mostly situated in a university hospital in a medium-sized town in the center of the Netherlands, *Hospital Z*. For four years I went there once or twice weekly. I had an identity card that allowed me to leave my bicycle behind a fence and drink free coffee from the omnipresent vending machines. I had a library card and the use of a desk in a succession of crowded rooms. I had a white coat. And I observed.

I would go to the professor who headed a department and explain my purpose: to investigate the way the tensions between sources of knowledge and styles of knowing are handled inside present-day allopathic medicine—or at least one of its exemplars. I would explain what made "atherosclerosis in the lower limbs" a suitable case for my purpose and what I hoped to learn in their department. I presented myself as both insider and outsider, having received basic training in medical school as well as extensive training in philosophy. And I gave the name of the professor of internal medicine supporting my study. Each of the professors thus approached reacted in a friendly way. They all emphasized that academic hospitals must encourage research. My particular research plans made some interested and some skeptical. Others simply were indifferent. But after some further questions I would invariably be sent to someone one or more steps down the hierarchy to talk about and practically arrange my observation.

So I sat for many mornings behind vascular surgeons and internists doing

their outpatient clinics, observing some three hundred consultations. (All surgeons and internists I observed for this study were men, and I will not hide that fact, so I use the generic "he" whenever I write about "the doctor," even though one of the pathologists whom I observed was a woman. Yes, this is a fading historical moment. The profession is undergoing a rapid gender change. But that is another story. One more complication left out here.) In university hospitals, both physicians and patients are used to observers: there are always students and junior doctors around who need to learn something. Yet I was surprised by the calm with which my presence was accepted—for I found these observations rather intimate. Patients tell about so much and undress so often. Although that is difficult for some and a relief to others, my presence behind the attending doctor hardly seemed to make a difference. When it risked to do so, I skipped a visit (once when a patient asked for it, several times when a doctor did, and once when I recognized someone I knew vaguely and left of my own initiative). The other transgression was into the privacy of the doctors. I was in a position to observe all kinds of details about the way they work. Some of them were visibly uneasy about the fact that I might judge the degree to which they were humane and kind in their interactions with patients. But (though that was sometimes difficult to resist) I wasn't out to make such judgments. Nor did I want to judge the so-called technicalities of their diagnosis and treatment. I wanted my observations to be a

How to Relate to the Literature?

In the ethnographic stories that I tell throughout this book, I do not try to sum things up. I do not describe Western medicine, but particular events in a single Dutch university hospital. And I assume that events in the next hospital, thirteen kilometers away, or over the border in Germany, or across the Atlantic have a complex relation with those that I have witnessed. A comparative analysis would show that there are similar patterns. Similar gestures. Similar machines. But also different self-evidences. Different needles and different norms. Different jokes. But which differences exactly? And what are their interferences and their diffractions? I haven't studied this. The relations of similarity and difference between one medical site and another are a topic in their own right. By leaving that topic open I at least avoid the risk of answering it in the standard way. I avoid assuming that what happens in a single hospital forms part of a larger system of medicine: Western, cosmopolitan, modern, allopathic. If one assumes the existence of such a system, one can then be unpleasantly surprised by the amount of "medical practice variation."

But where is the standard way of understanding medicine as a system to be found? And where are the surprises that come with finding "variations"? Not exactly in the hospital I studied, where these things are hardly a matter for debate. No. They are to be found in the literature (see, e.g., Andersen and Mooney 1990). So what I have to tell in the present book does not just relate to the events that figure in my stories. It also relates to other texts. Lots

vations to be a means to get to know their standards, rather than an occasion to apply my own.

This made me shift sites and move around in the hospital. I observed technicians handling diagnostic tools in the vascular laboratory. I followed the tracks of radiologists and pathologists in their dealings with leg arteries. I went for months to the weekly meetings where the treatment options for patients with complicated cases of vascular disease were discussed. I witnessed several operations. Spent some days in the research laboratory of the hematologists. Held interviews or had conversations with epidemiologists, physiologists, internists, surgeons, and general practitioners. A couple of them read my articles and we talked about their reactions. I also went to the library and studied the textbooks and journal articles written, or mobilized as a resource, by "my doctors" and, when the references and my curiosity took me there, compared them with other publications. For two years I followed the monthly research colloquium on atherosclerosis. I coauthored with a junior doctor an article about the introduction of a diagnostic protocol. I supervised a medical student who interviewed vascular surgeons in several smaller hospitals and another one who analyzed discussions about the intake of cholesterol. And, finally, I had the temporary luxury of a research assistant—Jeannette Pols, a philosopher like myself, moreover trained as a psychologist—who held long patient interviews, transcribed them, talked them over with me, and coauthored publications about this material. She also was a good sparring partner with whom to discuss my work.

of them. Texts about other hospitals and other medical practices, texts about bodies and diseases, but also texts about entirely different topics. Systems and events, controversies, similarities and differences, coexistence, methods, politics. If I am to make explicit how *this* text departs from the others around it, if I want to show how it both differs from them *and* is made possible by them, I will have to *relate to the literature.* But how to do this? How to relate to the literature? That is a question that I take very seriously. So I have not hidden the answer between the lines. I do not follow one of the genres for using literatures without being explicit about it. Instead I have tried—will try—both to relate to the literature and deal with the question as to how one might do so. To do this properly, I have separated out the question about relating to the literature from the core text of this book. I deal with the literature in a series of separate texts that resonate, run along, interfere with, alienate from, and give an extra dimension to the main text. In a subtext, so to speak.

Specificities

Relating to the literature, I might write: "In a variety of disciplines, the unity of Western medicine was a trope for decades. In medical sociology the unity of the medical profession explained this profession's social power. In medical anthropology the

Discussion was also what I sought in other worlds, outside the hospital. I could seldom go to those places by bicycle, for they were a lot farther away—and yet they were less alien to my writing and talking self. They were departments of philosophy, anthropology, sociology, or science and technology studies. I attended conferences and listened bored or fascinated to speakers presenting papers to five or fifty listeners. I read journal articles, wrote them, reviewed them. I went for talk-walks on lakesides or chatted over dinners. I was cross-examined about my field, my method, my purpose, my theoretical ancestors. Often such exchanges took place in an odd version of the English language, a transportation device that poses some difficulties to those who have not grown up with it, but reaches far. So though my stories come from the hospital in the town where I live, they went with me to many other places. To my intellectual friends and enemies in places like Maastricht, Bielefeld, Lancaster, Paris, Montreal, San Francisco. They managed to travel, my stories about leg vessels and pain. Immersed in theoretical arguments about the multiplication of reality.

For even if there are a lot of empirical materials in this book, this is not a field report: it is an exercise in *empirical philosophy*. Let's shift to the philosophy. The plot of my stories about vessels and fluids, pain and technicians, patients and doctors, techniques and technologies in hospital Z is part of a philosophical narrative. In conformity with the dominant habit of that genre, I'll give away the plot right here, at the beginning. It is this. It is possible to refrain from understanding objects as the central points of focus of different people's perspectives. It is possible to understand them instead as things manipulated in practices. If

divergence of medical traditions from all over the globe was specified by contrasting these traditions with a solid unity called Western medicine (either in order to show the superstitious character of the Others, or to highlight their ingenuity and greater sensitivity). In medical history the old eclecticism in which many schools and skills coexisted was turned into an intriguing counterpoint to the present homogeneity. And medical philosophy took a unity, the person-as-a-whole, as a norm: its wholeness deserved respect." Indeed, I have written (or rather coauthored) something like that. Elsewhere. (For a slightly longer version of such an overview, see Mol and Berg 1998, 1–12.)

It is possible to relate to the literature in such a way: evoking four entire disciplines, in just a few lines. The level of generality is a bit overwhelming. So much so that it is hardly feasible to insert titles. Sure, this can be done. After each discipline a name and date may be put between brackets. In medical sociology in the seventies . . . (see, e.g., Freidson 1970). A gesture like that turns Freidson's *The Profession of Medicine* into a representative of the enormous pile of books and articles published in the 1970s under the heading "medical soci-

we do this—if instead of bracketing the practices in which objects are handled we foreground them—this has far-reaching effects. Reality multiplies.

If practices are foregrounded there is no longer a single passive object in the middle, waiting to be seen from the point of view of seemingly endless series of perspectives. Instead, objects come into being—and disappear—with the practices in which they are manipulated. And since the object of manipulation tends to differ from one practice to another, reality multiplies. The body, the patient, the disease, the doctor, the technician, the technology: all of these are more than one. More than singular. This begs the question of how they are related. For even if objects differ from one practice to another, there are relations between these practices. Thus, far from necessarily falling into fragments, multiple objects tend to hang together somehow. Attending to the multiplicity of reality opens up the possibility of studying this remarkable achievement.

Philosophy used to approach knowledge in an *epistemological* way. It was interested in the preconditions for acquiring true knowledge. However, in the philosophical mode I engage in here, knowledge is not understood as a matter of reference, but as one of manipulation. The driving question no longer is "how to find the truth?" but "how are objects handled in practice?" With this shift, the philosophy of knowledge acquires an *ethnographic* interest in knowledge practices. A new series of questions emerges. The objects handled in practice are not the same from one site to another: so how does the coordination between such

ology." But what about all the exceptions? What about Marxist sociologists who, in the same decade, claimed that there was a *class division* running right through medicine (see, e.g., Chauvenet 1978). Or, for that matter, feminists, who were active in drawing distinctions between those parts of medicine that they saw as good for women and others, against which they pressed charges (see, e.g., Dreifus 1978)? Not to forget the combinations between the two (e.g., Doyal and Pennel 1979).

It would be possible to shuffle them aside, claiming that those texts have been marginal. In general, I could say, a few exceptions aside, for quite a while medical sociology took the medical profession to be a unity. Or I could point to these exceptions as the initial steps at the beginning of a new era. This would require me to say that up to the seventies medical sociology took the medical profession to be a unity, a position that slowly began to change. But this would still leave me with some problems. What if a more attentive reading of Freidson's book shows that its primary concern is *not* the profession's unity, but its *closed character*? When one reads him on his own terms, Freidson seems primarily worried about the lack of outside audit or control on medical mistakes and failures. If I still wanted to quote him as someone taking the medical profession to be a unity, I would then have to show that the profession's unity and its closure are closely linked, or indeed depend on one another. If that argument were hard to make, then I would have to find some other book

objects proceed? And how do different objects that go under a single name avoid clashes and explosive confrontations? And might it be that even if there are tensions between them, various versions of an object sometimes depend on one another? Such are the questions that will be addressed in this book. I cautiously try to sketch a way into the complex relations between objects that are *done*.

This book tells that no object, no body, no disease, is singular. If it is not removed from the practices that sustain it, reality is multiple. This may be read as a description that beautifully fits the facts. But attending to the multiplicity of reality is also an *act*. It is something that may be done—or left undone. It is an intervention. It intervenes in the various available styles for describing practices. Epistemological normativity is prescriptive: it tells how to know properly. The normativity of ethnographic descriptions is of a different kind. It suggests what must be taken into account when it comes to appreciating practices. If reality doesn't precede practices but is a part of them, it cannot itself be the standard by which practices are assessed. But "mere pragmatism" is no longer a good enough legitimization either, because each event, however pragmatically inspired, turns some "body" (some disease, some patient) into a lived reality—and thereby evacuates the reality of another.

This is the plot of my philosophical tale: that *ontology* is not given in the order of things, but that, instead, *ontologies* are brought into being, sustained, or allowed to wither away in common, day-to-day, sociomaterial practices. Medi-

to support my generalization. But which one? The problem is that many titles in medical sociology would do, in one way or another. There is a large corpus of texts in which the medical profession's unity is mentioned. But almost all of them, like Freidson's study, have other concerns at their core.

This is the point: generalizations about "the literature" always draw together disparate writings that have different souls, different concerns of their own. Stressing, in general, that *the* literature is attuned to medicine's unity may function to mark the originality of *this* study, a study that emphasizes disunity. But various dangers follow. One is that a false novelty is claimed: the ancestors are erased from memory instead of honored. A second is that, in the case of this specific book, such generalities would create a tension between the ways in which "the field" and "the literature" are treated. If I take so much trouble to point out the multiplicity of medicine while I refer to sociology, anthropology, history, or philosophy in general terms, this might suggest that *they* possess the unity that medicine does not. But they don't. Just as it is possible to write about the multiplicity of the objects of medicine, this could be done about other disciplines. I won't attempt to do so here. But I will try to do justice to the variety of concerns, materialities, styles, and object framings in the various knowledges mobilized here by seeking not to suppress or hide these while relating to the literature.

cal practices among them. Investigating and questioning ontologies are therefore not old-fashioned philosophical pastimes, to be relegated to those who write nineteenth-century history. Ontologies are, instead, highly topical matters. They inform and are informed by our bodies, the organization of our health care systems, the rhythms and pains of our diseases, and the shape of our technologies. All of these, all at once, all intertwined, all in tension. If reality is multiple, it is also political. The question this study provokes is how the body multiple and its diseases might be done *well*. This question will not be answered here. Instead, I'll map out the space in which it may be posed.

The Perspectives of People

This is a philosophical book of a specific, that is, empirical, kind. It draws on social scientific and, more notably, ethnographic methods of investigation. But it does not just import these, it also mingles with them. For if I use ethnographic methods here, it is to study *disease*. That physicalities may be studied ethnographically is a quite recent invention. For a long time, "disease" was the unmarked category of anthropology and sociology of medicine. As the state of a physical body it was an object of biomedicine. Doctors told the truth about disease, or at least they were the only ones able to correct each other in so far as they didn't. Social scientists were careful not to get mixed up in this body-talk. Instead, they had something to tell in *addition* to existing medical knowledge. They pointed out that the reality of living with a disease isn't exhausted by listing physicalities. There is more to it. Apart from being a physical reality, having

Dates and Outdating

The work of Talcott Parsons is outdated. It is functionalist in character. *The Social System* is the title of his famous book of 1951 (Parsons 1951). It takes every social phenomenon to either be a threat to the system's stability or to have a stabilizing function. In chapter ten, "Social Structure and Dynamic Process: the Case of Modern Medical Practice," the social phenomenon analyzed in this way is *the sick role*. In modern society, Parsons argues, being sick is ritualized in a specific role. The sick don't need to work in the usual way but are, instead, taken care of. It is accepted that they are the victims of their sickness. This is good for society because if people stop working and take rest when they are sick this lowers the risk that they will die prematurely. In this way the chance that society has invested in someone's upbringing and education with too little return is reduced. However, since escaping from the usual obligation to work means that "being sick" may also be attractive, there is a potential threat. If everybody were to stop working by calling themselves sick, the system would collapse. This is why, in addition to withdrawal from work and being excused for such passivity, "the sick role" has two more elements. The patient has to go to bed and generally do whatever needs to be