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Chapter Sixteen

Fictive Kinship in American Biomedicine

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In the interview prior to one's acceptance into medical school, one is asked the obligatory question: Why do you want to become a doctor? I don't know what you said, but my answer had to do with Virgil. In the *Aeneid*, there is an old doctor who arrives at the siege of Troy to tend the wound of Aeneas, who has been struck by an arrow. The doctor's name is Iapyx. Now it happened that when Iapyx was a boy, Apollo fell in love with him, and offered him, as a gift, music, wisdom, prophecy or swift arrows. Iapyx chose none of these, and asked for Medicine instead. For he wished only to prolong the life of the father he loved. But as the battle of Troy raged all around him, Iapyx realized that he could not save Aeneas. All his skill was to no avail. He cried out to the gods to help him. Suddenly, the arrow, of its own accord, fell from the wound of Aeneas. Iapyx surmised that more than man had wrought this cure. Iapyx was right. Venus, the mother of Aeneas, had placed a healing herb in the water that Iapyx was using to bathe the wound of her son, and the arrow was miraculously extruded.

I became a doctor to prolong my father's life, and many times since, I have summoned the gods to my side for consultation.

—Richard Selzer, M.D., *Letters To A Young Doctor*

Systems of social organization characterize and, to an extent, define the group with which they are identified. Such systems may be referenced under a number of differing designations, all carrying with them the concept of relatedness, either through shared beliefs, ideologies, or blood. Blood relationships and those emanating from such consanguineal ties are referred to as systems of kinship. Consanguinity and affinity typify most classic systems of kinship. The orientation of kinship systems may vary widely with reference to focality, lineality, marriage patterns, incest taboos, and a host of other cultural measurements. Consanguinity and affinity are not, however, essential for the validity of

the term "kinship system" as a social descriptor. It is within the realm of non-consanguineal relationships that systems of "fictive" kinship are described.

Fictive kinship systems are those relationships that are not characterized by consanguinity. Among the most familiar of these relationships are the systems of ritual co-parenthood that are practiced among Hispanic cultural groups, known collectively as *compadrazgo*. The co-parents, known as the *padrino* (co-father) or *madrina* (co-mother) are individuals chosen by a parent or parents as a type of spiritual guardian, godfather, or godmother for their children. The responsibility assumed by the *padrino* or *madrina* within the scope of co-parenthood is one of social vigilance on behalf of the godchild by means of the extension of the dyadic *compadre/comadre* relationship beyond the family of the child into their own kin groups. This serves to increase the social network, thereby providing the participants freer access to systems of reciprocity, social and economic power, as well as the moral obligations inherent within the system. It is also, in many instances, the responsibility of the *padrino* or the *madrina* to ensure that the child is given the necessary resources in the event of the parents' deaths or inability to fulfill normal parental roles. The spiritual aspect of the relationship is oftentimes as important, if not more so, as the economic considerations of *compadrazgo* (Keesing 1975: 129, 130). Other, less formalized systems of fictive kinship exist within many cultures, whereby an individual assumes a role that would ordinarily be reserved for a blood relative. These relationships, while informal, can, nevertheless, exhibit characteristics as strong as consanguineal and affinal ties. This chapter examines a distinctive sector of American life—professional biomedicine—and analyzes relationships within the system itself in terms of fictive kinship. Taking narrative data gathered during interviews with biomedical practitioners, I present three cases of fictive kinship, demonstrating the value of this anthropological construct in the elucidation of these particular social relationships within the cultural system of biomedicine.

American Biomedicine as a Fictive Kinship System

Professions, while replete with shared values and objectives, have not routinely been identified with fictive kinship systems. Legal, medical, and various academic professionals tend not to be looked upon as having any unique relationship within their respective disciplines that would qualify as fictive systems of kinship. Within the field of medicine, however, a paradigm exists that has, for over two millennia, exerted an influence upon its members that warrants consideration as the catalyst for a type of fictive kinship. The paradigm lies partially hidden in the text of the Hippocratic Oath. The first portion of the oath, written in approximately 430 B.C., reads as follows:

I swear by Apollo the physician, by Aesculapius, Hygeia, and Panacea, and I take to witness all the gods, all the goddesses, to keep according to my ability and my judgment the following oath:

"To consider dear to me as my parents him who taught me this art; to live in common with him and if necessary to share my goods with him; to look upon his children as my own brothers, to teach them this art if they so desire without fee or written promise." (Hippocrates 1994)

The Hippocratic Oath represents the cognitive orientation of the practitioner of medicine as it has been transmitted from medicine's ancient forbears to the present. While, for the most part, the oath is viewed as a historical artifact that sets forth the moral ideal of the day in which it was written, it is, nevertheless, the document to which many medical practitioners look as their ideological touchstone. It could be argued that the Hippocratic admonition to "consider dear to me as my parents him who taught me this art" forms the basis for a system of fictive kinship that is demonstrable even in today's biomedical environment. Selzer, a physician and author of numerous medically-related literary works, described such relationships in his book *Letters To A Young Doctor*, in which he recorded the following discourse written to a young friend upon the young man's entry into a surgical residency program.

I send as your graduation present my father's old textbook of physical diagnosis. It was published in 1918. Lifted yesterday from a trunk in the attic it is still faintly redolent of formaldehyde, and stained with Heaven only knows what ancient liquid. I love my old books—Longfellow, Virgil, Romeo and Juliet and Moby Dick—but I love this Textbook of Physical Diagnosis more. I can think of no better thing to give you as a reminder that all of Medicine is a continuum of which you are now a part. Within you is the gesture of the prehistoric surgeon who trephined his neighbor's skull on the floor of a cave. Within you, the poultice of cool mud applied to a burn by an old African woman. The work of all doctors before you is in your blood. Yours will enter the veins of whosoever comes after you. (Selzer 1982: 13)

Selzer's letter to his young friend identifies a relationship that exceeds the bond of professional commonality and extends itself into a realm that resembles a familial tie. His metaphoric use of the term "blood" as a purveyor of the healing art further exemplifies the professional bonding that, as will be witnessed through subsequent interview data, serves to create relationships that correspond to consanguineal bonds. The image also engenders a sense of the spiritual or metaphysical aspect of healing; an almost sacred transmission of the ability and desire to restore the injured or the infirm. The fact that the author is passing on a book that belonged to *his* father, a physician, is suggestive of a relationship that carries a depth of emotion that would be atypical of a strictly professional relationship. Selzer appears, in effect, to be assuming the role of *fictive father*. Cassell, in her book *Expected Miracles: Surgeons at Work*, identified within the medical subspecialty of surgery an organizational complex that she refers to as a "fellowship of surgeons." She then proceeded to characterize the "fellowship" by a series of qualities that typify the relationships within the social organization that she observed. These characteristics closely resemble those typical of many kinship groups (Cassell 1991: 60–66). Cassell has also noted the power of influence that fictive kin relationships

might wield on the individual. In her research, she interviewed one surgeon who had given up smoking after having been asked to do so by his mentor when previous requests by his actual father had been ignored (Cassell 1996).

In his valedictory address entitled "Aequanimitas," delivered to the graduates of the medical school of the University of Pennsylvania in the spring of 1889, Sir William Osler, whose imprimatur on the form and structure of systematic medical education is evident to this day, wrote of a relationship that transcended the professional. In recalling his mentor, Osler wrote,

Personally I mourn the loss of a preceptor, dear to me as a father, the man from whom more than any other I received inspiration, and to whose example and precept I owe the position which enables me to address you to-day. There are those present who will feel it no exaggeration when I say that to have known Palmer Howard was, in the deepest and truest sense of the phrase, a liberal education.

"Whatever way my days decline,
I felt and feel, tho' left alone,
His being working in mine own,
The footsteps of his life in mine."
(Osler 1906: 10)

From an anthropological perspective, Osler is describing a relationship to his mentor that could quite accurately be characterized as a type of fictive kinship. His mentor, the late Robert Palmer Howard, was depicted by Osler as being "dear" to him "as a father," a description nearly identical to that employed by Hippocrates in the oath. Cushing, former chief of surgery at Harvard and student of Osler, in his two-volume work *The Life of Sir William Osler*, wrote of the relationship between Osler and his mentor as "truly filial." In depicting Howard's affection toward his famous student, Cushing noted, "Howard, in turn, had loved Osler as a son, and the three younger children (Howard's children), who from now on came to be regarded after a fashion as Osler's wards, had always looked upon him from their earliest years as a combination of elder brother, playmate and father confessor" (Cushing 1925, 1: 304-5).

Based upon the Hippocratic writings and the above observations from the record of medical history, it is clear that close professional and mentor-student relationships exist within the field of biomedicine that create a cultural solidarity within the discipline. When viewed in the context of fictive kinship, the nature and meaning of these bonds will be demonstrated.

Systems of kinship, apart from conferring identity both symbolically and literally, offer advantages to the individual through an extension of the familial or fictive bonds. In the example of *compadrazgo*, not the least among these advantages is the network that is established between the child and the *comadre* and/or *compadre*. These networks serve to provide economic, spiritual, emotional, and physical benefits to the individual in time of need. In like

manner, ties of fictive kinship within American biomedicine create networks that link individuals together through which benefits are bestowed, identity conferred, and social position established.

Thus, systems of fictive kinship within American biomedicine, serve at least a twofold purpose. In the initial sense, these systems identify their members as participants in a close-knit social organization with its own primary level culture (Hall 1983), thereby creating a sense of identity among members of the association. Second, such systems serve as networks through which members and initiates may communicate and interact with each other for the benefit of individuals within the group. These networks may form the bases for informal psychosocial support systems as well as vehicles through which members protect and perpetuate their economic viability.

This study of fictive kinship within the culture of American biomedicine was, of necessity, small, and confined to several biomedical fictive kinship clusters that I had previously identified as typifying a kinlike organization. I conducted a series of interviews with biomedical practitioners to elicit information from them that might be suggestive of fictive kinship systems within American biomedical culture.¹ While the exploration of the possibility of such systems remained the focus of the interviews, it was not my intention to invent systems of fictive kinship where they did not exist. It should be noted that physicians, for the most part, do not characterize their participation in these systems as a form of kinship nor do they describe such relationships with kinship terminology. Close relationships are acknowledged (as in the case of Osler) as being "as close" or "similar" to familial bonds, yet the anthropological construct of fictive kinship is a foreign concept to most biomedical practitioners. These relationships are typically referenced by their participants with nomenclature that is suggestive of a bond that is more meaningful than mere networking, yet, most practitioners do not use terms associated with kinship as descriptors.

Since the premise of fictive kinship in biomedicine was initially based upon the admonition in the Hippocratic Oath to the adherent to "consider dear to me as my parents him who taught me this art," it was necessary to operationalize this concept. I determined that the Oath itself would be employed in order to define the relationship Hippocrates spoke of as one of fictive kinship. I worded the questions (see appendix) to enable the informant to identify an initial fictive relationship. Thus, the informant was able to emically identify and define individuals within his social organization (Geertz 1983: 58). This format was employed for case one and for case three. Case two, a social discourse evaluation, represented an examination of group structure within an established medical practice. The purpose of this observation was to determine the nature and scope of relationships within the group itself, as well as the effects of the group dynamic on its individual members.

During the course of the research, it became apparent to me that fictive relationships did not exist or were not identified as frequently within the specialties of family medicine, general medicine, and internal medicine as they

appeared to occur within biomedical subspecialties such as cardiology, nephrology, gastroenterology, and so on. For this reason, the data that appear below reflect relationships within subspecialties of internal medicine (i.e., epidemiology, cardiology, and gastroenterology).²

Case One: The Making of a Medical Kin Group; Matters of the Heart

The formation of a kin group within the American model is, by many non-Western standards, relatively simplistic since kinship, within this model, is defined biogenetically (Schneider 1980: 23). Fictive relationships, on the other hand, are defined in a volitional manner; that is, they tend to trace their beginning to someone's choice. The choice may be made by the individual or, as in the instance of *compadrazgo*, on the individual's behalf. Nevertheless, such choices represent voluntary associations. Voluntary associations may be based upon varying degrees of commonality between members, ideological similarity, perceptual necessity (e.g., national defense, public safety), or in the instance of adoption, a desire on the part of individuals to create a kinship association in an environment in which direct biogenetic reproduction is either impractical or impossible.

Fictive relationships within biomedicine represent voluntary associations based upon common intellectual and ideological orientations that are shared by its members and initiates. The introductory phase of medical education is still Oslerian in outlook, owing its form and substance to the systematic theories of medical education set forth by Osler (Nuland 1988: 401; Cushing 1925, 1: 440). Osler's system of clinical clerkships, itself heavily influenced by the German educational model (Nuland 1988: 423-28) that has evolved into today's residency and fellowship programs, created a predisposition on the part of those who have been thus trained toward a hierarchical network through which scientific thought is disseminated. Such networks provide fertile ground for the formation of alliances among biomedical practitioners that assume characteristics of kin groups.

One such group came to my attention during a series of interactions with an individual who later became a principal informant. The individual noted that his relationship with medical school colleagues was similar to that of an "extended family" and that he maintained close personal ties to members of his "group" nearly thirty years later. During subsequent meetings and conversations, it became apparent that this "group" had definable form, structure, and organization, very similar to that of any traditional kin group.

The informant (hereafter referred to as M) is a board-certified cardiologist with a clinical cardiology and internal medicine practice in Texas. He has been in clinical practice since the early 1970s. He received his undergraduate degree from Harvard University (A.B.), proceeding from there to a well-known university school of medicine in the southeastern United States where he received his M.D. degree and completed a fellowship in cardiology.

I began the interview by asking M his motivation for pursuing a career in medicine. He indicated that a member of the faculty at Harvard Medical School, a Dr. T, had been extremely influential in directing him toward a medical career pathway. M had worked for T as a research assistant at Massachusetts General Hospital. Although the informant was attending Harvard on an academic scholarship, outside employment was necessary in order to supplement his income during his course of undergraduate study. M had originally intended to attend law school after receiving his degree from Harvard. During the course of his research assistantship, M participated in research projects that were subsequently published in scientific journals. The intellectual reward of having his name included among the investigators in the publication, coupled with the positive reinforcement from T, who encouraged him to attend medical school, provided the impetus necessary to convince M to consider applying to a leading medical institution. The medical school that M was to attend was chosen based upon T's recommendation, which itself was based upon T's personal friendship with several of the school's faculty members. M applied to the institution and was accepted. (It should be noted that although T played an important mentoring role in M's undergraduate development, the relationship was not characterized by the informant as one that would typify a fictive kinship relationship.)

The department of internal medicine at the institution and particularly the research efforts associated with that department were, at the time of M's attendance, under the direction of Dr. E, an epidemiologist who had come to the school from a prestigious medical center in the southern United States. E (while not considered by M to be a direct fictive kin relation) occupied a position similar to that of a spiritual patriarch. This relationship was reminiscent of Douglas's description of the Nuer's concept of the "founding ancestor" (Douglas 1986: 73). E represented an ideological leader to the members of the research group within the Department of Medicine. When M spoke of E, his references carried an almost reverential tone, denoting the great respect that he continues to hold for the individual.

During the beginning of M's medical training, he made the decision to pursue cardiology as a medical specialty. This decision was based upon his interest in preventive cardiology and the cardiovascular research that was being conducted at the institution. It was at this time that M was befriended by a faculty member in the cardiology department, Dr. D. It was D who, in M's own view, became his fictive father. This relationship was based upon D's personal interest in M's pursuit of a cardiology fellowship, a personal affinity based upon their congruent personalities, and their commonly held religious beliefs. Although M points to D as a type of fictive father figure, he was quick to point out that this relationship had greater social implications than it did professional ties. His relationship to D was characterized by social activities at D's home, interaction with D's family, and joint attendance of nonprofessionally related events or activities.³

M also acknowledged a relationship with his fictive "siblings," however, these connections were not the result of his relationship with D. The sibling relationships were formed within the department of medicine with individuals with whom M shared common interests. These interests were usually characterized as being partly professional and partly personal. A principal factor in the fictive siblings' relationship was their mutual participation in the developmental phase of an organization within the department of cardiology dedicated to cardiovascular research. This organization was developed primarily as an epidemiologic data center for cardiovascular disease. The aforementioned fictive founding ancestor was instrumental in the establishment of the research center. The sibling relationships that developed as a result of the common research interests within the research organization were between M himself; R, M's chief resident in medical school; F, a contemporary of M who now practices cardiology in the midwestern United States; G, currently a cardiologist on staff at the research facility; and C, a cardiologist also practicing in the midwestern sector of the United States. All five physicians continue to work with and contribute data to the cardiology research database. Another who was mentioned by M, a Dr. K, was a junior physician at the time of the informant's residency and fellowship. M was K's resident physician during K's early medical training. K now holds a position of prominence within a large medical institution and maintains a connection to the research center yet does not enjoy the fictive sibling relationship that is shared by the other five physicians. M attributed this to what he perceived as K's inability to view the research program in the same perspective as that of the five fictive siblings; an epidemiologic database, capable of providing insight into the etiology and potential treatment strategies for a host of cardiovascular diseases. K's interest in the research organization is, according to M, motivated by less altruistic concerns.

Thus, the fictive lineage that began with D the father, M the son, and M's siblings R, F, G, and C, and that remains nearly thirty years later is based, according to M, on a commonality of purpose within biomedicine. It is this intellectual/professional commonality that maintains these relationships over time and distance. It can be argued that M's "group," which I characterize as a "biomedical fictive kinship cluster," was, by the very nature of its members' proscribed training, culturally predisposed to a common connection with its foundations in interventional cardiology. This predisposition, coupled with common professional objectives and shared paradigms of the members of the group, is one explanation of the group's continuing connection.

Case Two: Rituals, Rites of Passage, and a Trip to New York City

Citing examples from the writings of Max Gluckman, Mary Douglas and Victor Turner, anthropologist Peacock notes that communities are "embodied in ritual." Peacock goes on to say that "ritual sustains belief, and belief is part of

culture" (1986: 40). The truth of this statement extends well beyond traditional concepts of culture into the "cultural system" (Rhodes 1996) of American biomedicine. The rituals of biomedicine serve several functions, among them being the psychological assurance the practitioner receives during difficult procedures (Koenig 1988: 465-96) as well as the creation of solidarity among members of a medical practice. From a psychological perspective, it is necessary that the biomedical practitioner view the practice of medicine as a set of constants with as few variations as possible. It is, after all, the *rules* and the *paradigms* of biomedicine that the practitioner must follow in order to alleviate suffering, heal the sick, and eradicate disease. When imprecision can be transformed into certainty, particularly when the outcome involves the prolongation of human life, the psychological comfort for the practitioner is immeasurable. Thus, the rituals of medicine, whether based on the results of hard scientific research or biomedical tradition, represent an important source of emotional, psychological, and professional power for biomedical practitioners. When the social aspect of ritual is invoked, as in the instance of rites of passage, its function becomes one of either committing the individual more intimately to the group or separating the individual from the group entirely.

The second case illustrates the traditions and rituals that are evident among many groups of physicians. It is based on interviews that I conducted with a group of physicians who are members of a specialty practice that is affiliated with a major medical teaching institution. The group is actively involved in patient care as well as in the training of physician fellows who have chosen the particular specialty as their area of professional concentration. For the purpose of the interview, members of the group were allowed to invite spouses or significant others.⁴ It was my intention to gain additional insight into the interactions and group dynamics of the physician group from spouses or others who have had the opportunity to observe these individuals over time. A second interview with two senior members of the practice was conducted at the academic institution in order to elucidate some comments made during the first session, elicit additional information, and verify my interpretation of the previous encounter.

My initial meeting with the director of the division, the two senior associates (hereafter referred to as Dr. Davis and Dr. Eggerton), and two junior members of the practice and their spouses took place at an arranged social event.⁵ The participants had been informed that they would be asked to participate in ethnographic research focusing on the group dynamics within their medical practice. All agreed to participate. They also understood that I was there to observe group interaction as well. Once introductions were made, I asked Dr. Davis, who had been acting as the group's spokesperson, to explain each individual physician's function and position within the practice. This enabled me to understand each individual from the group's perspective and to determine how each member of the practice was emically defined.

The spatial organization of the meeting place, while not seminal to the social evaluation of the group per se, was of interest as a cultural artifact. At the

center of the room was a large elliptical table where all members of the practice and their spouses would be seated. I was seated at one end of the table. I had assumed that the director of the practice would be seated at the opposite end. This did not occur. Dr. Davis systematically seated each member of the group. Spouses were not seated next to each other. The arrangement did not inhibit interaction but rather appeared to stimulate conversation among the members of the group. The interactions appeared, in fact, to be more suggestive of the interchange that one would expect from a consanguineal kinship group, with the preponderance of the conversations focusing on personal vis-à-vis professional issues. While the director of the practice did not assume the headship of the table, his positional station of leadership was clearly recognized from the deference shown him by the other members of the group. The majority of the evening's discourse consisted of narrative accounts of interactions with the director by each member of the practice, usually delivered in a humorous manner. These anecdotes are typified by the following narrative delivered by Dr. Eggerton regarding his brother, a former member of the practice, now practicing in a large metropolitan area in the eastern United States.

My brother was scheduled to come in to the hospital early one morning for patient rounds and he was late. He lived in the extreme northern section of the city and had to take the tollway in to the medical school. Since he was late, he was driving about eighty miles an hour down the tollway, hoping to get to the hospital quickly enough so that maybe he wouldn't be missed during rounds. Well, a cop was shooting radar and pulled him over when he was just about to get to his exit. The cop saw that he was in his hospital scrubs and asked him if he was on his way to a medical emergency. My brother said, "I can't lie to you. I'm late for work. But if you knew the guy that I worked for, you'd understand why I'm driving this fast." The cop asked him, "Who do you work for?" My brother said, "Doctor X." The cop said, "You can go ahead and go," and didn't even write him a warning ticket.

Upon the completion of the narrative, all of the individuals present were laughing while leveling mock criticism at the director for inciting such fear in his subordinates. The director, who was also laughing, was genuinely amazed that he had been viewed as such a source of intimidation by anyone in the group.

The conversation then turned to a recent trip that Dr. Davis and the director had just taken to New York City. Dr. Davis said that he and the director had gone to see a football game between the director's alma mater Columbia, and its rival, Princeton. During the recounting of the trip, Dr. Davis noted that they shopped for neckties, as they "always do," got haircuts at the "same place that [they] always do," ate at the same restaurant that they "always go to," and saw a Broadway production, just like they "always do." During the second interview, conducted with Dr. Davis and Dr. Eggerton, the trip to New York became the primary focus of discussion. The original trip, which had taken place a number of years ago, began as an excursion by the director and Dr. Davis

shortly after Dr. Davis completed his fellowship and joined the practice as a permanent member. The initial itinerary was to see the Columbia and Princeton game and to take a sightseeing tour of New York City. It was during this first trip that the traditions of the haircut, the purchase of neckties, the restaurant, and the Broadway production were established. The trip has been repeated every year since. Dr. Davis said that as the practice grows, thereby providing more coverage for members who are away or on vacation, it will be possible for more members of the group to participate in the trip. The trip, at this point, has taken on the characteristics of a social ritual.

The sense of community among the members of this particular medical practice has been fostered and perpetuated over the years by the director and by his senior members. This solidarity encompasses both professional and personal aspects of the members' lives, influencing their biomedical methodology, their scientific paradigms, their professional identity, and their commitment to the practice itself. The spouses' participation within the context of the interactions of the members of the practice indicated that they were very familiar with the day-to-day exchange that takes place between the members of the group. The sense of connection, therefore, extended well beyond the individual to include members of the individual's consanguineal/affinal family, expanding the scope and influence of the fictive kinship cluster.

Case Three: Paradigmatic Development: I Will Teach You How to Think

In his classic book *The Structure of Scientific Revolutions*, Kuhn detailed the essential nature of paradigms and paradigmatic development as a means of informing "normal" scientific thought (1996). So powerful is the paradigm, argued Kuhn, that scientists need no discoverable set of rules to legitimize the paradigm's validity. Kuhn noted, "Scientists work from models acquired through education and though subsequent exposure to the literature often without quite knowing or needing to know what characteristics have given these models the status of community paradigms. And because they do so, they need no full set of rules." He further stated that "Paradigms may be prior to, more binding, and more complete than any set of rules for research that could be unequivocally abstracted from them" (1996: 42). Paradigmatic development occurs during periods of discovery. While it may be argued that biomedicine has passed through delineable periods of discovery, it is equally valid to assert that scientific discovery, when applied to biomedicine, is best represented by a continuum of discovery that either builds upon or replaces previous theory. Such minor revolutions are attributable, according to Kuhn, to the applications of scientific theory or "law" in specific areas of research within the general scientific tradition. Paradigmatic development within particular subspecialties of science takes place, therefore, with little or no noticeable disruption to the accepted tenets of science. These *minor* revolutions of science have occurred and

continue to occur within biomedical thought with great regularity. The paradigmatic development that underlies these revolutions falls to those who have assumed the responsibility, either implicitly or explicitly, for the direction of scientific thought within a particular medical subspecialty. One need look no further than the accepted medical texts to determine who the so-called *experts* in any given field are. It is within the context of paradigmatic development that the third course of interviews took place.

I conducted a third series of interviews with two former members of a specialty fellowship program in a large academic medical institution. Several of the original members of the program are still affiliated with the department, although the founding physician of the group has since assumed a role in private medical practice. The principal informant, Dr. S, who trained under the founder more than twenty years ago, is the current chief of medicine of a major academic institution. A second informant, Dr. A, occupies a prominent position within the same institution. Both doctors trained under the founding physician, who became a mentor and type of fictive father to each.

During one interview, Dr. S was asked to recount his initial meeting with the individual who became his mentor/fictive father. In the course of the narrative, the informant revealed the basis for his decision to enter into an affiliation with his mentor. He noted, "I don't remember a lot about the interview other than a few things; one is he had his sleeves rolled up, he had no sport jacket on, he was very informal, he was very easy to talk to, he was very relaxed and . . . I think he had a can of Dr. Pepper in his hand, and he told me if I came here *he would teach me how to think*. And that intrigued me" (italics added).⁶

The defining moment of the interview was the mentor's statement, "I will teach you how to think." The statement harkens back to Kuhn's assertion regarding the priority of the paradigm to normal science (1996: 43–51). It is the paradigm that contextualizes scientific thought. It is the paradigm that gives meaning to research. It is the paradigm that constitutes the *lens* through which the scientist views the world in which he or she lives and works. The mentor was, in effect, saying, "I will enable you to see the world in the correct manner." This "intrigued" the informant to the degree that he chose to affiliate himself with the mentor and to enter into a relationship that would significantly influence his way of comprehending medicine. When asked if he considered the remark, "I will teach you how to think" to be a sort of challenge to his abilities, the informant replied, "I considered it, not so much a challenge in the sense that I would prove to him that I already knew how to think; I considered it more of a mystery; what exactly did he mean? I knew that . . . I had done some research, I had done very little; I knew that he had been very successful as a researcher and so I wasn't exactly sure what he meant, but I thought what he probably meant was that he would teach me how to think analytically and critically about research and that it would make me a better researcher. So I viewed it as he was going to open some magical door and expose me to a world that I had not been exposed to before, and I found it a little bit titillating."

When asked whether or not his mentor had influenced his mentoring of students, Dr. S responded affirmatively. He indicated that even the style in which he related to his students bore similarities to the mannerisms exhibited by his mentor more than twenty years previously.

Dr. A, a colleague and contemporary of Dr. S, is actively engaged in research as well as in the instruction and mentoring of residents and fellows within his subspecialty. His exposure to the mentor/fictive father bore similarities to that of Dr. S, yet his emphasis focused primarily on the deontological nature of the mentor's instruction. For Dr. A, the manner in which scientific inquiry *ought* to be conducted was unmistakable. The mentor provided a clear-cut, systematic methodology for the execution of the tasks that were assigned to those under his tutelage. These were set forth both tacitly and explicitly in a series of dictums that were issued with repetitive frequency, acquiring, at times, the air of ritual. Dr. A recalled several instances during which members of the program were called upon to present research data to the attendees of scientific symposia. The mentor would routinely call meetings of those who were responsible for the presentations that amounted to formal rehearsals, ensuring that the presentation would adequately reflect the proficiency of the program. These rehearsals themselves proved to be defining activities, serving to identify the individual with the standards set forth by the mentor.

Discussion

The fictive kin relationships that Dr. M in Case One described, based upon the reverence and fondness that were evident in his discourse, clearly went beyond a purely academic or professional identification. Each relationship remains active after more than twenty-five years. Although the members of this group do not meet or necessarily correspond on a routine basis, the relationships still exist and are maintained, irrespective of time or distance. The relationships described possess several key components that are extant in many consanguineal or affinal kinship systems. First, a commonality of professional and personal interests existed that were responsible for forming the initial relationship. In some instances, the academic interest took precedence (F and G), while in others, the relationship came into being via a social or personal interest (D and R). This could be looked upon conceptually as a form of *affiliation*, linking those of like interest through, in this instance, fictive kinship (see Fox 1967: 134). Second, all members exhibited a close identification with the social or public personae represented by the individuals in the group. This identification was implicit within the informant's references to his colleagues. Third, a dedication to a concept outside of themselves (in this case, the cardiovascular research organization) served as the "social mortar" that continues to hold the group together. The *institution* (i.e., the research center), in effect, conferred upon each member his identity (Douglas 1986: 55–67).

The relationships that emerge in Case One appear to align with aspects of kinship. This group is not a fictive kinship system within itself, but rather what I have designated as a fictive kinship "cluster," somewhat analogous to "agnatic clusters" as noted within tribal societies.⁷ Biomedical fictive clusters in many instances form ideological connections with other clusters in other institutions. For example, the ideological ties between the schools of medicine from which the fictive patriarchs, fathers and mentors, originated all represent institutions that are connected via fictive kin within each secondary or tertiary institution. Many members of the faculty at the institution in Case One received their training at the same institution in the eastern United States. E continued to maintain a strong affiliation with the southern medical school where he had previously served. Interviews that I have conducted in other institutions have uncovered similar connections.

Case Two, involving a group of medical professionals, revealed not only the relational aspect of the interactions between participants, but also the social dynamics that occur within the group. The concept of the "social father" (Keesing 1975: 13) accurately describes the role that the director of the medical practice assumed in the professional and, to a degree, the personal lives of his subordinates. Within the social milieu of the group dynamic, the positions of father, elder brother, and younger brother could clearly be identified. These positions carried with them both privileges and expectations implicit within the culture of the group.

Case Three represented an assessment of the extant relationships within a group that had been maintained over time, primarily by the psychodynamic authority of the primary mentor/fictive father. This authority, although tacit in nature, nonetheless represented the ideological basis upon which the relationships were founded and maintained. The authority further served to perpetuate a subsequent fictive generation, unrelated directly to the fictive father, yet dependent upon him for its existence. The foundation for this authority rests in the paradigm. The mentor's defining remark, "I will teach you how to think" speaks volumes. Ideological connection is strong. It requires a volitional surrender on the part of the individual to a particular way of thinking; a way of thinking with which she or he closely identifies. Ideology may change over time. The initial connection, however, appears to remain. It represents the intellectual touchstone to which the individual returns during times of uncertainty. Nuland, professor of surgery at Yale and author of *Doctors: The Biography of Medicine*, wrote of his own experience:

Even after almost thirty years of being a surgeon, my own occasional flutterings of self-doubt in the operating room can always be stilled by reminding myself that my professor was Gustav Lindskog, whose professor was Samuel Harvey, whose professor was Harvey Cushing, whose professor was William Halsted. The process of remembering is instantaneous, and the quiverings are gone in the wink of an eye. (1988: 406)

Bosk (1979) pointed out the protective nature in the resident/attending relationship. The relationship is a hybridization of peer-to-peer and subordinate-to-superordinate alliances, based primarily on their clinical association. To a certain extent, however, the attending (superordinate) is professionally defined by the proficiency of his resident (subordinate). This creates a functional bond that, in my view, tends to evolve into a fictive kinship relationship (1979: 134-35).

Mentoring relationships are often sought out by many physicians and medical students during the course of their training experiences. These relationships as well tend to evolve into relationships of fictive kinship (Kaufman 1993: 112-13; Cassell 1996).

The relationships and social organizations that exist within the biomedical community all contribute to the character and viability of the profession itself. Just as kinship systems tend to define certain cultural groups, so too, the fictive kinship of biomedicine characterizes the biomedical complex.

Although viewing biomedicine as a cultural system has given it some theoretical importance, few have sought to analyze the system itself. Much of what is written constitutes a cultural critique of how the system either acts, reacts, or fails to do either within the framework of other systems (Rhodes 1996: 165-80). A notable few have attempted to describe and define the system of biomedicine as it is (Cassell 1991; Bosk 1979; Starr 1982). When biomedicine is seen for what it is, a distinct cultural system, only then will it be properly contextualized within its appropriate setting. Seldom is biomedicine viewed in this light. Biomedical practitioners themselves rarely, if ever, characterize their organizational structure as a social system. As members of the system, they are seldom able to view the system itself with any degree of detachment that would lend itself to objective ethnographic analysis. I was made acutely aware of this fact when I presented much of the descriptive data that is discussed above to the faculty and staff of a medical department in a biomedical educational facility, located in the midwestern United States. During the question and answer session, which extended well beyond the allotted time for the discussion, numerous questions pertaining to the view of biomedicine as a cultural system were posed. The manner in which the questions were phrased and the types of questions that were presented indicated that the concept of viewing biomedicine as a cultural system was a foreign proposition, albeit one that evoked a great deal of positive inquiry. Possibly the most poignant question came from a cardiologist who had practiced medicine for more than thirty years and who had taught in various capacities over two decades. His question was extremely relevant for two reasons. First, it represented a legitimate inquiry into the utility of research directed at the culture of biomedicine. Second, and for me the more important reason, was that his query forced me, the researcher, to think more critically of the work that I had done with reference to its application. During the question and

answer session, this gentleman offered the following statement and question: "When I attend these lectures, I go through a process that I refer to as 'afterlearning,' during which I ruminate over the information that I've heard, and try to apply it practically. My question to you is, what can we as practitioners take back with us into our day-to-day activities and use?"

My answer, while spontaneous, was, I hope, adequate. My suggestion to the physician, based on the above research, was simple, yet, I believe, important to the application of such ethnographic work. Cultural systems are profoundly powerful in their ability to convey meaning and shape lives. Biomedicine as a cultural system is no different in this sense than any other clearly identifiable cultural group. The "afterlearning" that the physician sought can be stated very simply: As a biomedical practitioner who is engaged in the education of future practitioners, make certain that all that you convey, both explicitly and implicitly, is directed toward the benefit of the ultimate recipient of your teaching, the patient. Make certain that your instruction is founded upon that which has been adequately tested and found to be, inasmuch as is possible, consistently true. What you tell your students and those who look to you as a mentor, or, in the case of the above, a fictive parent, they believe you. They believe that everything that you tell them is unquestionably valid. Thus, they put into practice what you have told them, thereby affecting the lives of the patients who are placed in their care. The biomedical practitioner who is involved to any degree in teaching or mentoring should, therefore, approach his or her duties with no small sense of responsibility, both to the student and, ultimately, the patient.

The relationships that undergird biomedicine, when properly understood, enable the outsider to more accurately define the system. It is from such contextualization that the clinically applied medical anthropologist, in the role of cultural "broker," will be able to negotiate the differing cognitive orientations present in the practitioner/patient/institutional continuum. It is then incumbent upon the anthropologist to champion the interests of the patient (the ultimate beneficiary of medical care) as these differing orientations are evaluated, merged, modified, and adapted in pursuit of the ultimate goal, which is the healing of humankind.

Appendix

Please read the following excerpt from the Hippocratic Oath:

"I swear by Apollo the physician, by Aesculapius, Hygeia, and Panacea, and I take to witness all the gods, all the goddesses, to keep according to my ability and my judgment the following oath:

To consider dear to me as my parents him who taught me this art; to live in common with him and if necessary to share my goods with him; to look upon his children as my own brothers, to teach them this art if they so desire without fee or written promise. (Hippocrates 1994)

When you read the above quote, who, if anyone, comes to mind? Please write three or more sentences that would describe your current relationship with this individual.

Notes

1. The interviews took place during periods between the fall of 1995 and the spring of 1999. The settings for the interviews varied from locations away from the informants' offices and hospital practices, to on-site interviews in the office, hospital, or teaching situation. Informed consent was obtained from each of the informants and every effort has been taken in the course of this writing to protect the anonymity of the informants.
2. Initial contact with the informants was made by phone, during which time an explanation of the purpose and scope of the interview was discussed. The informants in cases one and three, as previously noted, agreed to a meeting at a time that was convenient to their academic and clinical commitments. A copy of the questionnaire (see Appendix) employed in the first and third series of interviews was made available to the informants prior to the time of the initial meeting and the interview. The informants were assured that the information gathered during the interview was for anthropological research only and that no names would be used in subsequent publications.
3. For a nonfictive explanation, see Keesing's (1975: 13) remarks on "social fathers."
4. The interview itself took place at a facility that was removed from the academic site of the practice.
5. The names Dr. Davis and Dr. Eggerton are pseudonyms.
6. It is of interest that the informant indicates that he did not remember a great deal about the interview, yet proceeds with a recounting of the interview in minute detail (e.g., "he had his sleeves rolled up, he had no sport jacket on, he was very informal").
7. Although structurally similar to an agnatic cluster (i.e., a group within a group), they are functionally unrelated. See Hammond-Tooke (1984).

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Chapter Seventeen

Going Nuclear: New Zealand Bureaucratic Fantasies of Samoan Extended Families

Ilana Gershon

Now that diversity is in vogue in multicultural nations, government welfare bureaucracies face a thorny dilemma. Their workers must encourage families in two tasks that are often contradictory. Government agencies expect families to raise productive citizens. At the same time, government workers try to support culturally different families in families' efforts to maintain their uniqueness. To what extent are these two tasks necessarily at odds? I heard one optimistic view while I was discussing a new government project, "Strengthening Families," with a New Zealand public relations officer at a regional social welfare office. When I asked her how her agency defined families, she explained that families, broadly defined, were similar to her family—a team, with every member contributing a fair share. She viewed all families as social mechanisms leading to good citizens. I had this interview toward the end of a sixteen-month period of fieldwork (August 1996 to December 1997) among Samoan migrants, New Zealand's largest Pacific island migrant group (approximately 90,000). Since I spent considerable time listening to Samoans' discomfort with the Eurocentric prejudices they found in government policy, my first reaction upon hearing the officer's assertions was to think "pure unadulterated ideology." Here, I want to take a step back, and take a serious look at both Samoan discomfort and government officials' optimism. I explore the question: "When and how does keeping families Samoan come into conflict with raising children to be productive New Zealanders?"

In *Democracy and Ethnography*, Greenhouse (1998: 1) suggested that this conflict arises because liberal democratic governments' conception of difference creates difficulties in accommodating cultural diversity. She argued that the conflicts are generated because governments protect collective identities using the same principles that promote individual welfare and