Sacred Healing and Biomedicine Compared

This analysis addresses the similarities and differences between sacred healing and biomedicine along several important dimensions that bear on the differential effects of patients' experiences of their treatment, including the physical setting, etiological beliefs, diagnoses, the practitioner-patient relationship, recruitment into the healing role, treatment repertoires, and perceptions of the body. The exploration of these differences illuminates the nature of medical regimes embedded in dissimilar systems of knowledge and reveals the strengths and weaknesses of each. The analysis demonstrates the dramaturgical nature of the biomedicine-patient encounter with its inherent underlying contradictions, in contrast to the sacred healer-patient interactions where the drama is lacking. The comparison reveals the importance of treatment techniques in sacred healing in contrast to the doctor's persona in biomedical treatment. The article concludes with a consideration of contemporary sociocultural forces that have led to the emphasis on the physicians' persona in biomedical practice. [sacred healing, biomedicine, doctor-patient relationship, healing process, Mexico]

Introduction

In this article, I compare two systems of healing—Spiritualist and biomedicine—as practiced in Mexico. The comparison addresses several dimensions, including the physical setting, etiological concepts, diagnoses, the practitioner-patient relationship, recruitment into the healing role, and treatment repertoires, as well as issues relevant to the patients' perceptions of their bodies and their existences. My extensive research on Spiritualist healing transformed my understanding of biomedical practice in Mexico and, in turn, my studies of biomedical practice in Mexico furnished me with fresh insights into Spiritualist healing in ways that I had not anticipated. While my specific focus is on Spiritualist healing in Mexico and biomedicine practiced there, the comparison illuminates broader issues relevant to sacred and biomedical treatment regimes cross-culturally.

As a participant and observer of both healing regimes and their patients, I noted similarities and dissimilarities between secular and sacred healing that broaden the grasp of the two medical systems and result in different impacts on patients. The comparison sheds light on the nature of medical regimes embedded in dissimilar systems of knowledge and divergent experiences. In practical terms, the comparison brings into relief the strengths and weaknesses of both.

With its origins in the 19th century, Spiritualism (Espiritualismo) in Mexico is both a dissident religious movement and a health care delivery system (Finkler 1981, 1983, 1985a, 1986a). Spiritualist temples, frequently headed by women, are widespread in Mexico and in the border states of the United States. Spiritualism provides followers with a clearly defined cosmology, ethics, and liturgical order, transmitted orally to its adherents through a medium in trance during weekly rituals consisting chiefly of sermons (Finkler 1983, 1985a). While Spiritualism incorporates an anti-Catholic stance (Finkler 1983), it is firmly rooted in Judeo-Christian teachings.

As a healing system, Spiritualism ministers to hundreds of patients. The majority of those coming to Spiritualist temples for the first time seek treatment from the healers for self-assessed, nongrave ailments. During the period of my study, about 10 percent of first-time patients became temple regulars and participants in the movement (Finkler 1985a).

The French model of scientific medicine was introduced into Mexico in the 19th century. At that time, French texts replaced the classical medieval ones upon which Spanish Colonial medicine was based, and Mexican physicians studied in France. Following World War II, the French influence waned, and the U.S. medical model came to dominate Mexican biomedical practice and continues to do so (Finkler 1991). However, while biomedicine has been transported from the United States to Mexico, it has also been culturally reshaped in its day-to-day practice.

Even a synoptic view of Spiritualist healing reveals that Spiritualism and biomedicine diverge along many dimensions. Spiritualism is embedded in a sacred world while biomedicine is sanctioned by secular science. Using Kleinman's typology (Kleinman 1978), biomedicine is a professional system staffed by professionals with many years of formal training and legitimated by the state. Spiritualist healers are folk practitioners, lacking formal academies, academic preparation, and state legitimation. And, although the two systems of healing may have developed in Mexico during the same historical period, they are rooted in disparate realities and distinct epistemologies. Nevertheless, they become unified in day-to-day life by the people who resort to them, a phenomenon that has been recognized cross-culturally. Unlike academicians, who regard the two healing regimes as diurnally opposed and in competition, the people who seek treatment do not distinguish the profound epistemological differences between sacred healing, such as Spiritualism, and biomedicine. In the search for the alleviation of pain, pragmatism prevails; people judge the treatments they are given by their effects. They look toward those who provide them with the best medicine for a given sickness episode.

By and large, people the world over, including those in the United States and Mexico, have assumed at least two distinctive postures regarding alternative healing, of which Spiritualist healing is one variant. On the one hand, folk healers are romanticized and idealized, especially when they are compared to physicians. In this camp, folk healers are usually regarded as enjoying an idyllic relationship with their patients. On the other hand, folk healers, including Spiritualists, are simply dismissed as quacks and charlatans, impeding the work of physicians. The argument is made, usually by local physicians, that patients stubbornly cling to
traditional healers and by the time they seek out physicians to treat them, they are too sick to benefit from medical care. Physicians, then, are constantly compared to folk healers, but such comparisons normally lack an empirical grounding in both systems of healing. The comparison presented in these pages emerges out of my research on Spiritualist and biomedical practice in Mexico (Finkler 1985a, 1991).

During my initial research on Spiritualist healing, I found that patients seeking treatment from Spiritualist healers usually did so after unsuccessful treatment by several physicians. Generally, people were referred to the healers by friends, neighbors, or acquaintances (Finkler 1985a), people whose pains had been alleviated by Spiritualist ministrations. This finding led me to carry out my study of biomedical practice in Mexico and to question what propelled people to seek alternative healing and why biomedical treatment failed to alleviate their non-life-threatening conditions.

Methods

During two separate research periods, I studied Spiritualist and biomedical healing and their respective patients. I spent two years in a Spiritualist temple in a rural region in Mexico where I investigated healers and patients and also trained as a Spiritualist healer (Finkler 1985a). Subsequently, I spent two years in a large urban hospital in Mexico City where I studied biomedical practice and patients’ responses (Finkler 1991).

In the Spiritualist temple, I observed 1,212 healer-patient interactions, and in the hospital, I sat in on 800 medical consultations. Subsequently, I followed up on the patients in both studies to assess their responses to treatment at each research site. I studied the healing practices of 10 healers and 17 physicians.

The patients at both research sites were from the lower echelons of Mexican society and had similar non-life-threatening complaints, including headaches, back pain, chest pain, abdominal pain, and general musculoskeletal discomfort.

Healers

Mexican Spiritualist healers are primarily women. They are usually recruited as a result of having themselves had an affliction unsuccessfully treated by physicians. Healers minister to the sick through spirit protectors who possess their bodies when they enter a trance. Mexican Spiritualists tame the spirits of the dead that roam the universe and harness them for the good of humankind, that is, for healing the sick. The spirits possess the bodies of the healers—individuals chosen to treat the afflicted. Spiritualist curers resort to a wide variety of healing techniques, including the use of an extensive pharmacopoeia, ritual cleansing, purgatives, massages, baths, spiritual surgeries, religious rituals, psychological anthologies, and, what I call “passive catharsis,” when a patient experiences a sense of release and relief without having said anything (Finkler 1985a).

In general, Spiritualist healers do not provide the patient with a definitive diagnosis, and when they do, it usually consists of informing the patient either that he or she possesses a gift (don) that requires cultivation or that the person is possessed by an obscure spirit that requires exorcitation. Normally, people whose illnesses were not readily alleviated by standard Spiritualist procedures were given these types of diagnoses. In either instance, the patient is required to enter training to develop the gift for healing or to expel the evil spirit. A person who does so becomes what I call a regular, an adherent of Spiritualism, and can become a healer or another type of temple functionary. When a healer declares that the patient is possessed of the gift of healing or by an evil spirit, it is a sure way of recruiting the patient into the ranks of Spiritualism. Spiritualist healers and those who become regulars are ordinary people whose lives become restructured by their participation in a community of persons immersed in weekly and monthly religious rituals and by new networks of associations.

While Spiritualist healing and its practices may be alien to many readers, Mexican biomedical practice, on first glance, will be familiar in its overall form. The 17 physicians I studied, two of whom were women, employed a similar technological accoutrements (for example, stethoscopes, sphygmomanometers, scales, X-ray machines) and the international vocabulary of disease entities familiar to physicians the world over. The government hospital in which I carried out the study was poorly funded, and its impoverished state was reflected in the conditions under which the physicians performed their medical activities. They received patients in small cubicles furnished only with a desk and a cot, and they shared stethoscopes, blood pressure monitors, and other basic medical tools. The majority of the diagnoses physicians gave to patients were related to nonspecific etiologies, followed by conditions associated with infections and parasites associated with digestive, genitourinary, and respiratory problems (Finkler 1991).

Before turning to the comparison between Spiritualist and biomedical practices, I must emphasize that my discussion attends to the general similarities and dissimilarities between the two regimes. It must be kept in mind that individual differences exist among Spiritualist healers and among physicians in the ways each type of practitioner exercises healing activities, including the advice a healer or a physician may give to patients concerning life’s problems.

Similarities between Spiritualism and Biomedicine

The disparities between Spiritualism and biomedical therapeutics and the ways in which patients perceive each of the two healing systems unquestionably outweigh the similarities, but the similarities between the two regimes are intriguing. For example, as E你好me focuses on the body (Pellegrino and Thomasma 1981), so too Spiritualist healers address their ministrations to bodily discomforts. It is important to stress that patients sought, and foremost, symptom alleviation from Spiritualist healers in much the same way as they did from physicians. In fact, as I noted earlier, the overwhelming majority of first-time patients in a Spiritualist temple arrive with bodily pains of some duration (Finkler 1985a) and after having been unsuccessfully treated by physicians.

Both physicians and Spiritualist healers adhere to a dualistic view of the body and its attendant disturbances. Biomedicine has been criticized for its mind-body dualism (Engel 1977), but it is frequently overlooked that a similar dualism prevails in sacred healing such as Spiritualism. Spiritualists clearly and forcefully distinguish between the corporeal, or in their terminology “material,” and “spiritual” disturbances in much the same way that physicians distinguish between organic and psychological sickness. This dualism is contrary to the more characteristic
Mexican holistic concepts of the body and sickness in which sickness is normally regarded by both sexes as an extension of day-to-day adverse experience or emotional discharges, especially anger. Thus, both Spiritualist healers and physicians impose a mind-body dualism on their patients.

There are structural, if not contextual, similarities between Spiritualist healers and physicians in their encounters with patients. In both regimes, the patient takes the role of a passive recipient of the practitioner's ministrations, and in both regimes, the practitioners require their patients' compliance. In both settings, I witnessed practitioners reprimanding patients for not having followed the prescribed treatments.

Both the Spiritualist healers and physicians I studied treated patients for "worms," although their underlying rationales for doing so differed. Spiritualist healers prescribe purgatives to remove the "filth" (mugre) from the stomach and cleanse the body of its impurities, whereas physicians prescribe antiparasitics for "deworming" the patient on the grounds that all poor people suffer from parasitic diseases.

As I noted previously, while academicians see profound epistemological differences between biomedical practitioners and alternative healers, such as Spiritualists, from the patient's perspective, biomedicine and Spiritualism accomplish similar ends. For example, in their desire to know what is wrong with them, patients expect to have their bodies examined and their "insides" seen. Both physicians and Spiritualist healers attempt to "see inside" the patient's body, the former with technological apparatus and the latter with the gaze of the spirits. According to Spiritualist healers, the body and its spirits penetrate the body of patients to ascertain their malady. The spiritual gaze exerted by the healer's spirit parallels patients' expectations for technological management that enables physicians, in the words of one patient, "to look inside my body" to make a correct diagnosis. Ironically, while physicians must juggle available resources and struggle with the decision whether to use contemporary technology (Finkler 1991) to make their diagnoses, the spirits' gaze is routine and intrinsic to Spiritualist healing. The spirits continuously proclaim their omniscience, and patients are not even required to say much, often to the patients' relief. In this way, patients undergo what I have called a "passive catharsis" (Finkler 1985a) when the healer tells the patient what the patient is experiencing, eliminating the need for patients active verbalization of their discomfort.

**Differences between Spiritualist and Biomedical Practice**

The dissimilarities between the two regimes exist along several dimensions of contrast, including the physical setting, etiological beliefs, diagnosis and treatment repertoire, reorientation of the patient's body, recruitment into practice, and most importantly the practitioner-patient relationship.

**The Physical Setting**

The physical setting of the healing encounter reflects broad prevailing themes in the respective societies in which each of the two healing regimes is embedded. Mexican Spiritualism evolved out of Mexican culture, and the spatial setting in which the healing takes place reflects Mexican cultural sensibilities. The physical context in which healers discharge their ministrations mirrors the Mexican culture's concern with family and community and its lack of concern with privacy. Not unsurprisingly, in Spiritualist temples, the healing experience is communal. Healers sit in one room, receiving patients separately. Consequently, there is a cacophony in Spiritualist healing rooms that imparts a sense of a collective experience, very unlike the physician-patient encounter that takes place in isolation in a cubicle, occasionally in the presence of onlookers such as students, nurses, and occasional visitors. The relatively private surroundings of biomedical consultations reflect the individualistic cast of biomedicine. As I noted earlier, biomedicine was transplanted into Mexico from Europe and the United States, and the spatial structure of the physician-patient encounter as we know it today and as it takes place in Mexico mimics Western industrialized society's emphasis on privacy and individualism. This model conceives of the person as an autonomous unit, independent of and isolated from other individuals and from social and cultural contexts, as the patient is when he or she enters the physician's cubicle for a consultation.

**Etiological Beliefs and Diagnoses**

The common pool of etiological beliefs in Mexico contains notions about environmental assaults such as climate (cold, wet), inappropriate diet and lack of vitamins, and hard work. Emotional, physical, and spiritual discharges, associated with adverse life events, and day-to-day experience are regarded as sickness producing. Most important, anger, usually associated with moral evaluations and conflicting social relations and frequently allied with nerves (nervios), is a singularly important etiological explanation of a sickness episode. Susto, or sudden fright, is considered to produce various maladies, but especially diabetes. Spiritualist healers subscribe to the ideas held by most Mexicans about sickness causality with one notable exception—belief in witchcraft.

If biomedical treatment fails, many people assume that the infirmity is produced by witchcraft. Patients seeking treatment from Spiritualist healers usually arrive at a Spiritualist temple believing that witchcraft has been worked on them. The Spiritualist healers I studied categorically deny this possibility. Spiritualists' denial of the existence of witchcraft removes the blame for the patient's disorder from a neighbor, relative, or other person with whom the patient interacts. Spiritualists fix culpability squarely on impersonal spirits for which neither the patient nor his or her social circle can be blamed. By doing so, they restore order in the person's disrupted social relations and thereby possibly avoid future anger resulting in illness.

In day-to-day practice, Spiritualist healers, unlike physicians, are not concerned with etiological explanations. Such etiologies as they do offer, however, are relatively limited and unchanging compared with those of biomedicine. Spiritualist healers confer a coherent system of explanation usually reduced to assaults by evil spirits. For example, Spiritualists believe that afflictions that stubbornly resist both biomedical and Spiritualist medical treatments must have been caused by the intrusion of a recalcitrant spirit that requires taming in the service of healing and removal from the body.
Mexican physicians combine biomedical and traditional folk understandings to explain sickness. In the majority of cases that I studied, the physicians’ causal explanations included biomedical understandings of the breaking down of the bodily machine, invasion by pathogens, stress, and obesity, coupled with folk understandings such as anger, nerves and fright and, to a lesser extent, environmental and social causes, or diet. The emphasis, however, is on the individual’s behavior and never on impersonal spirits or witchcraft. Most important, unlike the Spiritualist healer, the physician may provide more than one explanation, or may change explanations, especially if he changes the diagnosis.

Unlike physicians, Spiritualists draw on a limited diagnostic repertoire and eschew multiple diagnoses. There is usually consistency among different Spiritualist healers regarding etiology, as well as diagnosis and treatment. In fact, Spiritualists rarely furnish patients with a diagnosis, nor do patients expect to receive one, because they usually agree that the spirits are all knowing and know the patient’s affliction. On the other hand, patients do expect to be given a diagnosis by physicians. In my studies, whether or not a patient received a diagnosis was an important variable influencing the perceived successful outcome of a physician’s treatment (Finkler 1991). Theoretically, at least, physicians made their diagnosis on the basis of patients’ presenting symptoms, medical history, and a physical examination. In my study of physicians’ clinical judgments, I found that, in the last analysis, diagnoses were based on physicians’ stereotypic epidemiological understandings of the patient population, individual physicians’ training and experience, and moral values regarding, for example, sexual behavior. In other words, physicians often base diagnoses on understandings unrelated to patients’ symptomatic presentations and medical histories. For example, the majority of the physicians in the study diagnosed parasitosis in their poor patients regardless of the presenting symptoms (Finkler 1991). When the initial diagnosis failed, physicians established diagnostic validity on the basis of symptom alleviation. A patient’s report of feeling better as a result of the drug the physician had prescribed validated the diagnosis for the physician.

From the standpoint of good medical practice, a physician is required to test hypotheses and revise diagnoses according to empirical observations and the patient’s response to the prescribed treatment, but from the patient’s perspective, diagnostic revisions were distressing. For example, a physician would change the diagnosis if a patient’s complaints were not alleviated by the prescribed treatment. A modification of the diagnosis suggested to the patient that the doctor lacked the certainty and knowledge to cure the illness. Moreover, when patients sought quick relief from pain by consulting various doctors, they often ended up with several different diagnoses for the same symptoms. Patients who were given different diagnoses by the same physician or by several physicians (Finkler 1991; Helman 1985; Koran 1975) became confused and befuddled about the nature of their disturbances and wondered which physician’s diagnosis was correct. Interestingly, patients would occasionally ask Spiritualist healers to verify a physician’s diagnosis as a way of making sense out of the diverse diagnoses they had been given by other physicians.

Adding to this confusion, physicians reorient the patient’s view of his or her own body and the minutiae of its functioning when they explore with the patient the nature of his or her bowel movements and excreta, or when they dwell on issues relating to the patient’s sexuality. Biomedical consultations frequently focused on matters related to sexuality, a subject normally not broached by Spiritualist healers, except when women patients reported vaginal discharges or delayed menstruation. Whereas patients confronting Spiritualist healers discussed male-female relations in terms of rights and obligations, within the medical consultation physicians called attention to the individual’s sexuality in ways that Spiritualist healers never did. In the medical setting, marital relations became expressed in frequency of sexual intercourse or other issues concerning sexuality.

The focus on an individual’s sexuality was inherent to the medical consultation when physicians questioned women (Finkler 1994a) about the frequency of sexual intercourse, menstruation, contraceptive use, and number of births and abortions. Within the context of the diagnostic process, patients began to regard themselves in physical terms in ways that they may not have done before. Their social interaction with their mates, and all the powerful experiences that are associated with it, thus became translated into sexual intercourse in its elemental form. For Mexican women, perhaps more than for men, to make the leap from sociability to sexuality was often baffling and distressing. Physicians’ concern with a patient’s sexuality has become especially acute in the age of AIDS, and the physicians’ questioning of patients regarding the nature and number of sexual encounters was puzzling and troubling to both men and women. Whereas patients were concerned with anguish and pain often associated with culpability and unresolved contradictions, physicians focused on the nature of the patient’s excrement and frequency of sexual intercourse.

In addition, women were required to change their concept of the shape of their bodies when physicians diagnosed patients as obese and prescribed special diets. In the impoverished social classes, women are rarely concerned with their weight, and they adhere to a traditional Mexican diet of tortillas, salsa, and beans out of economic necessity and cultural commitment. Unlike Spiritualist healers, who never imposed an esthetic model of the body on their patients, physicians would frequently do so to the consternation of the patients.

The Practitioner-Patient Encounter

The doctor-patient encounter has become a central concern in the study of biomedical activities, given the widespread notion that the doctor-patient relationship provides the key to good medical practice. In this regard, alternative healers, including Spiritualists, are often held up as examples to show what the physician-patient relationship lacks. Numerous assertions have been made about folk healers’ personal ties to the patient. It is commonly held, for example, that the folk healer-patient relationship, in contrast to that of the doctor and patient, is based on shared etiological understandings and congruent explanatory models and that traditional healers care more about and are more attentive to patients. Such attentiveness is often measured in terms of healers’ having more eye contact with patients, more time with patients, and more empathy and compassion. It is also widely held that traditional healers, unlike physicians, have a holistic view of the patient.

My observations, however, are that Spiritualist healers, unlike physicians, lack eye contact with their patients and ostensibly fail to recognize the individual
standing before them. They sit in trance with expressionless faces, eyes closed, holding or stroking the patient, who briefly murmurs a description of the disorder. Being in the trance state precludes the healers’ displaying any kind of affect for their patients. By contrast, during the medical consultations in the present study, the physician and patient sit facing each other; their physical contact is limited to the physician’s physical explorations by palpation and auscultation. Physicians’ affective expressions vary, however. Some constantly smile at the patient, while others maintain a serious demeanor.

Furthermore, in the consultations, physicians spend about 21 minutes on average with a first-time patient (Finkler 1991), whereas the Spiritualist healer-patient interaction usually lasts less than half that time (Finkler 1985a). The affective content of the interaction varies among both physicians and Spiritualist healers. Some Spiritualist healers and physicians are relatively brusque and indifferent to a patient’s suffering, while some Spiritualist healers console their patients by reminding them that God and the spirits know their pain and some physicians demonstrate concern for a patient’s suffering.

The differing physical postures of the physicians and Spiritualist healers, the time they each spend with their patients, and the requirement that patients reorient their view of their own bodies highlight the dramaturgical nature of the physician-patient consultation in contrast to the Spiritualist healer-patient encounter.

In fact, in my fieldwork, I became aware that I was witnessing the unfolding of a drama in the medical consultation itself. I sensed a tension and a gradual denouement as patients presented their symptoms and revealed their lives to the physician, in ways that were absent in the Spiritualist healer-patient encounter. By regarding the medical consultation as a drama, we observe the inherent tensions and conflicts that are played out in the interaction, a drama that is lacking in Spiritualist consultations. In both Spiritualist healing and biomedical practice, a meeting between the health provider and patient is not an ordinary encounter between two strangers; the conditions that bring the protagonists together are extraordinary: one is in pain and under duress, and the other is expected to eliminate or transform the condition. In contrast to the Spiritualist healer-patient encounter, in the medical consultation the two actors stand in opposition to one another. Unlike Spiritualist healing, the encounter as scripted by the biomedical model brings the two players into conflict. Moved by a crisis, the patient arrives on the stage to seek advice from an expert who presumably knows more about how bodies work than the patient does. The physician claims to have a monopoly on the knowledge of disease. He is the authority on what went wrong. The patient comes laden with personal knowledge encoded by cultural understandings about the workings of his or her own body and the authority of experience with the specific condition. The patient is certain of his or her individualized experience of pain, whereas the physician is often uncertain of the diagnosis. In the words of one of the doctors, “I must sometimes invent a diagnosis.”

The drama that exists in the doctor-patient relationship is minimized in the Spiritualist healer-patient association. While a physician’s clinical judgment entails uncertainty and is grounded in a process of exclusion, the spirits treat patients with great certainty. Spiritualist healers are as sure of their diagnoses and course of cure as patients are certain of their pain. Spiritualist healers do not doubt that the spirits possessing their bodies in “the service of mankind” are omniscient, that the spirits know the person’s pain and also the required cure.

Significantly, too, while the physician must cast the patient’s sickness in a temporal frame and localize the pain in a specific part of the body, the omniscient omnipotent spirits transcend time and space in the same way that the patient’s sickness transcends temporal and spatial dimensions. The patient cannot confine the onset of the affliction to a specific time because the patient experiences the pain as timeless. The biomedical diagnostic process incorporates a temporal and topographical dimension, but for the patient the sickness transcends time and body topography. The physician is often frustrated by the patient’s inability to compartmentalize symptoms to a particular anatomical region to conform to the medical history format or to locate the symptoms within a time frame.

The patient’s major concern is that the healer or physician know his or her pain. When the patient confronts a Spiritualist healer, he or she need not tell the healer very much for the healer to know everything. In fact, the spirit constantly reminds the patient “I know everything.” In this way, the healer reassures the patient and also establishes legitimacy in the healing role. The physician, though, must question the patient and anchor the condition and locate it in chronological time and in a specific part of the body in order to make an accurate diagnosis.

While patients’ expectations of Spiritualist healers are that the spirits know everything, patients expect the physician to question them (Finkler 1991). In this way, they are assured that the physician will learn about their malady, a knowledge the spirit occupying the healer’s body already possesses. Most important, patients are also assured that the Spiritualist healer knows their pain because they know that Spiritualist healers too have suffered afflictions before becoming healers. This brings us to the important difference of recruitment of healers and physicians.

Recruitment into the Healing Role

The different ways in which Spiritualist healers and physicians are recruited into their respective roles have different effects on patients. Whereas those recruited into the medical profession are usually healthy individuals, as we saw earlier, those recruited into Spiritualist healing usually experienced an affliction themselves before becoming healers. As formerly sick people who have become health providers, Spiritualist healers are themselves examples of the potential for recovery through Spiritualist ministrations. Important, they convey to the patient that they have grasped the patient’s anguish through their personal experience. They experienced the pain in the past in the same way as the patient is experiencing it in the present. The doctor cannot provide the patient with experiential evidence, as Spiritualist healers proudly do, that his ministrations induce a transformation from having been sick to healing others. The potential conversion of a patient to a health practitioner, or other functionary serving God and the spirit world, forms part of the Spiritualist therapeutic repertoire, a technique that the biomedical therapeutic kit lacks.
Treatment Repertoires

As noted earlier, Spiritualist healers’ diagnoses are relatively simple, but their treatment repertoires are relatively complex. By contrast, the physicians’ diagnoses are complex, but the cure repertoire is limited. The physicians’ treatments are chiefly medication or, in extreme cases, surgery. On the other hand, the Spiritualist healers’ treatment kit contains a large array of treatment options, which also involve a patient’s participation in various treatment activities. These include the use of pharmaceuticals or herbs and other botanicals that rural patients are often required to collect in the open fields, getting massages, taking baths that require preparation by the patient, and other activities (for example, placing crosses under the bed), as well as participation in Spiritualist rituals. These activities, in effect, engage patients in their recovery. In keeping with this point, physicians take full responsibility for the patient’s successful cure, if not for their failure to heal, whereas Spiritualist healers assign responsibility to patients for their cure by constantly reminding them that they must have unrelenting faith in the Spiritualist God and His benevolence, further involving them in their own therapy.

Furthermore, while the biomedical technological management for which patients clamor carries a heavy symbolic load and no doubt aids in perceived recovery, the cleansing that Spiritualist healers supply embodies powerful symbols that address the profound contradictions in which the patient’s illness may be embedded. Not surprisingly, of those patients who perceived themselves as recovered through Spiritualist healing, most attributed the recovery to the cleansing they had received (Finkler 1985a). Whereas patients may have disagreed with the treatment course proposed by physicians, patients always agreed with the Spiritualist treatment, especially when it involved ritual cleansing, coupled with herbal remedies. With these cleanings, the healers symbolically removed evil that may have befallen the patient, and thereby resolved the disorder in the patient’s life, even if only temporarily.

Conclusion

To summarize the dissimilarities, perhaps the most crucial difference between biomedical and sacred healing of the Spiritualist variety is this: healers resolve contradictions for patients that physicians cannot because the biomedical script requires physicians to focus on discrete physical pains while the patient is experiencing a timeless and overbearing pain that is not necessarily localized in chronological time or confined to a specific part of the body.

Moreover, physicians do not address the contradictions in which patients are enmeshed. To explain sickness, the biomedical model may blame impersonal pathogens that attack the body, explaining the sickness in generalized terms rather than in terms of the patient’s personal suffering. Or, it blames the patient, especially his or her poor habits (McKeown 1979).

Biomedicine often requires patients to alter customary behavior such as diet, work, or drinking habits, as well as to alter profound notions of their bodies. It does not, however, attempt to transform the circumstances of a patient’s life in the way Spiritualists do for those who become regulars. Spiritualist healing can gradually transform the person’s existence by incorporating him or her, and sometimes the entire family, into a religious community. Over the long term, Spiritualist healing provides new interpersonal networks and also places the person in a new relationship with God. In the latter instance, relationships with other human beings become subsumed within the interaction with God. This process is further facilitated by Spiritualist insistence that witchcraft lacks any reality, that human beings cannot harm one another. By denying the existence of witchcraft and evil machinations by other humans, Spiritualists facilitate smoother social interactions, mitigating against anger and future illness episodes.

Spiritualist healing progressively reorders the existence of those patients who eventually become regulars by incorporating them into a community of sufferers who share a satisfying religious reality and symbolic meanings, by God appointing them to become functionaries in their movement, or by His having chosen them to become healers because they possess the gift. As I have emphasized elsewhere, Spiritualist healers do not produce miraculous cures. All transformations are achieved gradually, and some patients even experience great pain in the process (cf. Finkler 1985a).

It is noteworthy, however, that Spiritualist healing differentially reorders men’s and women’s lives; it reorders men’s lives to the ostensible advantage of women. Spiritualists teach against machismo in men, leading them to cease drinking heavily and womanizing. The men tend to spend their leisure time with their wives and families rather than with their former friends or other women. By restructuring men’s lives, Spiritualists promote smoother marital relationships (Finkler 1981), a change women recognize as salutary and healthful. As I explain elsewhere, adverse social relations, especially marital discord, can be as pathogenic as any virus, and women’s health in Mexico specifically is greatly influenced by their relations with their mates (Finkler 1994a). In the measure that Spiritualist healers succeed in easing the marital relationship, they are also promoting a woman’s health.

While biomedicine attempts to refashion the patient’s view of his or her body, Spiritualism alters the person’s experience of his or her body. On an existential level, healers embody a spirit through trance and, in so doing, experience their bodies in a new and sacred way. Uniformly, all healers and functionaries who entered trance to fulfill their healing roles reported that they experienced a tingling effect in their bodies, a heightening of the senses, and a vision of extraordinary colors. Additionally, trance may have physiological correlates that influence the healing process (Finkler 1985a). Clearly, biomedicine does not incorporate trance into its treatment repertoire, nor does it address the existential dilemmas, reinterprets them, give them new meanings, or change the social relationships in which the patient is embedded, including those between husband and wife (Finkler 1981).

Like the medical gaze that extends its power beyond the patient’s body to dominate the life of members of a society (Armstrong 1983; Foucault 1975; Turner 1984), Spiritualist healing encompasses the lives of those patients whom it succeeds in converting into participants and believers. For regulars, their bodies become extensions of the Spiritualist congregation upon which they become totally dependent (Finkler 1985a, 1986a), and this also forms part of their cure. Participation in the Spiritualist movement exerts power over the patient’s existence because, as many patients readily admit, if they failed to attend to the various rituals and to heal others, they would revert to their morbid states.
In the final analysis, Spiritualist healers, like physicians, fail to heal their patients when they fail to attend to the patient's world, with its attendant contradictions and requisite transformations (Finkler 1985a, 1991). To succeed in resolving non-life-threatening, subacute conditions, a healing system must address patients' bodily ills and concurrently transform their perceived existence (Finkler 1991, 1994a). Importantly, the process of transformation, in and of itself, alters the patients' lives, and, in the process, their state of health.12

One final point merits consideration. This comparison suggests that folk healers, such as Spiritualists, depend on their healing techniques rather than on their persona to effect a cure. Yet, as I noted at the outset of this discussion, great emphasis has been given to the relationship between the healer and patient in the same way as to the doctor-patient relationship in biomedical practice (see also West 1984). In fact, the doctor-patient interaction has formed a focal point of study, and it has become axiomatic that the doctor-patient relationship is a determining factor in successful primary health care delivery and by extension in the healing process (cf. Brody 1992). It has been asserted that a proper doctor-patient relationship, regarded as crucial in biomedicine, produces a placebo effect (Brody 1988), and that treatment outcomes depend on it. It is widely assumed that the relationship between patient and sacred healer has a similar effect.

My findings are (Finkler 1991) that only certain aspects of the doctor-patient relationship tend to influence the healing process in biomedicine for patients with self-limiting conditions, revolving around the physician's explanations of the patient's condition, the patient's agreement with the physician's diagnosis, and whether or not patients participated in the encounter,20 reemphasizing the role of patient participation in cures that, as I noted, are incorporated in Spiritualist treatment techniques.

This leads me to ask why so much emphasis has been placed on the doctor-patient relationship in the United States. To address this question is to gain insight into the contemporary U.S. experience. It is my assertion that the singular attention given to the doctor-patient encounter in biomedicine represents a contemporary bias for several reasons (Finkler 1986b, 1986c). Horton suggests that the scientific worldview gave rise to self-doubt in modern life and to the "essential loneliness of modern man" (1973:288), as well as to the conviction "that science and technology are destroying the fabric of society. With this have come various movements assuming an antagonism between reason and feeling, and vociferously exalting the latter at the expense of the former" (1973:289). Concomitantly, "the romantic search for a 'lost world' has given rise to an image of traditional culture which is understood entirely as a reaction to the stresses and strains of life in the modern West" (Horton 1973:293). Horton correctly argues that a yearning for the past promotes romanticism among anthropologists. Horton's argument needs, however, to be extended to incorporate the notion that we project our own cultural present onto other cultures. Against this background, we can identify several factors that are at play in explaining the reasons for so much emphasis on the doctor-patient relationship, including that modern Western society has given primacy to individual concerns and has placed the spotlight on egocentric interactions, as exemplified by the doctor-patient relationship and the emotional tones that the relationship may generate.

In addition, the emphasis we have placed on the role of the health practitioner, on his or her personality, and on his or her expression of concern for patients reflects the modern individual's yearning for personalistic affective ties (Berger et al. 1974) and for compassion that is regarded as absent in an impersonal, industrial, and postmodern world but as present in the past and as persisting in nonindustrial societies.21 Our contemporary emphasis on the doctor-patient relationship reflects contemporary people's longing for a compassion that they sense is missing in their lives in a Western industrialized society.

Furthermore, the psychotherapeutic tradition has focused on the individual (Orlinsky and Howard 1975), fostering the notion that the therapeutic process is rooted in the physician-patient relationship itself (Haley 1963). The psychoanalytic model of the therapeutic relationship has been extended to biomedicine. In fact, Wilson suggested that "although sensitive physicians have for centuries been alert to the importance of their interpersonal bond with the patient as an element in the course of illness and recovery, the self-conscious examination of the bond is a characteristically modern concern" (1963:285). According to Wilson, this view emerged out of Freudian therapeutics, especially out of the notion of transference (Wilson 1963).

My argument is that biomedical practice relies greatly on patient management during the therapeutic encounter because its healing techniques lack certainties; in Fox's words, "the development of scientific medicine, then, has both uncovered and created uncertainties and risk that were not previously known or experienced" (1980:19). As I observed earlier, the physician's therapeutic kit lacks certainty and means to resolve the contradictions by which the patient is encompassed, to deal with patients' subjective experiences and the certainties of pain, or to reorder their lives. For this reason, treatment hedges not only on healing techniques, as does sacred healing, but also on the encounter itself, including the time it lasts, and the physician's persona becomes part of the physician's tool kit. Significantly, Spiritualists insist that there are no differences among individual healers. I assert that this is because in Spiritualist healing, the healer-patient encounter is secondary to the healer's techniques, in which the person of the healer is submerged. The treatment techniques involve the patient in the cure rather than the healer's manner or personality itself and aid patients in restructuring the conflicts in which they may be entangled.

The emphasis on the role of the individual healer effecting the cure of the individual patient reflects Western industrialized society's bias, wherein the person has become an atomistic unit. The fostering of the drama in the consultation is based on the model of the doctor-patient relationship that mirrors the prevailing ethos of the abstract, independent individual confronting a self-interested, autonomous physician during the encounter. The individual in Mexico is not solitary, he or she is embedded in a family that encompasses his or her life, and each looks to the physician for alleviation of pain. Spiritualist healing addresses issues of culpability, evil, and witchcraft, and reorders social relationships, especially those with one's mate (Finkler 1981), which biomedicine fails to do.

Furthermore, the underlying contemporary, U.S. assumptions about "human nature" as being that of the self-interested individual heighten the drama in the medical consultation when the U.S. patient with his or her pain meets the self-interested physician. Facing the physician, the patient confronts a contradiction...
because the physician is presumably interested in the patient’s pain and charged to act in the interest of the patient, and yet the patient knows that the physician is also a human being acting in his own self-interest. I contend that the widespread notion of the uncaring physician may be rooted in the patient’s understanding of “human nature,” which, of course, must include the physician’s nature.24 The patient facing the Spiritualist healer confronts no such conflicts or contradictions, because patients know, and spirits constantly remind them, that the spirits work only in their interest and that the spirit and God are only concerned with the patient’s welfare because that is the “nature” and task of the spirit who possesses the healer’s body.

Paradoxically, as a folk healing movement, Spiritualist beliefs exert little hegemonic force in Mexico on a national scale, but by transforming patients’ existence through incorporation into a community of persons healed spiritually, they have created a religious movement comprising thousands of people. In so doing, Spiritualist ministrations have promoted, on an aggregate level, religious pluralism in Mexico. Spiritualism thereby contributes to advancing social change by mobilizing a sizable population and forming a growing movement that furnishes Mexicans with new options for religious participation. While Spiritualist healing may change a couple’s day-to-day interaction, on an aggregate level the movement fails to restructure Mexican society in ways that could benefit its participants economically or politically (Finkler 1986a). On the other hand, biomedicine, by treating individual bodies without transforming people’s lives, fails to contribute to new social forms for the collectivity. It succeeds only in maintaining its hegemony as the major authorized provider of health care legitimated by the state.

Notes

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1. There has been a surge of interest in alternative healing in the U.S. medical community, as evidenced by the fact that the National Institutes of Health have opened the Office of Alternative Medicine in 1993 to promote studies of alternative medical practices and their efficacy (see also Eisenberg et al. 1993).

2. The Spiritualist movement in Mexico was founded as a religious movement in 1861 by a recalcitrant priest named Roque Rojas, whose portrait hangs at the altar of every Spiritualist temple. (For a historical overview, see Finkler 1983, 1985a; also see Lagarriga 1991; Ortiz Echániz 1977, 1989.)

3. Sylvia Echániz Ortiz (personal communication) reported that in one Mexico City Spiritualist temple that she had studied for over 20 years, she counted as many as 5,000 patients in one day. In the rural area where I carried out my research on Mexican Spiritualist healing I counted as many as 125 patients in a day (Finkler 1985a). There are dozens of Spiritualist temples in Mexico, as well as in certain parts of the United States (Finkler 1983, 1985a).

4. In October 23, 1833, Valentín Gomez Farías instituted the Establecimiento de Ciencias Médicas and established French medicine in Mexico. (See Finkler 1991 for a discussion of the history of medicine in Mexico.)

5. See chapters 5 through 8 in Finkler 1991 for the specific cultural influences on Mexican biomedicine practice.

6. This has often been discussed under the rubric of medical pluralism (see, for example, Bastien 1992; Cosminsky 1983; Crandon-Malumud 1991; Janzen 1978).

7. For bibliographies in Finkler 1985a, 1986a, 1986b, see Finkler 1985b. Also, see a formal economic analysis done by Lehnin (1990). She compares the cost effectiveness of Spiritualist healers and physicians, using the data reported in Finkler 1985a and 1991.

8. I employed the same method in both studies. Because of space limitations, I refer the reader to Finkler 1985a and 1991 for a detailed description of the method. There I discuss with great specificity sampling techniques and selection, recruitment of patients into the study, instruments used in each study, and interviewing techniques at each research site. In both studies, patients were interviewed before they saw the healers and the physicians, and I observed the healer and physician consultations.

9. I followed up at their homes 125 patients in the rural region seeking treatment from the Spiritualist temple and 205 patients in Mexico City who were initially interviewed at the hospital (see Finkler 1985a, 1991).

10. The fact that the majority of the healers are recruited as a consequence of affiliation and that they are also women raises the important question of differential morality along gender lines. I initially addressed this issue in Finkler 1985b and more recently in Finkler 1994a where I explore in great detail and in new ways why more women experience sickness than men and offer a new theory to explain the phenomenon.

11. Many pharmaceuticals have now become part of folk medicine and have been incorporated into folk practitioners’ pharmacopeia, including Spiritualist healers. These may include terramycin, Enerofoforma, Dramamine, and others. Generally speaking, the pharmaceuticals prescribed by a spirit possessing the healer’s body reflect the healer’s experiences in a waking state. For example, the spirit of a woman healer who had worked as a nurse assistant tended to prescribe patent medicines, while others who lacked similar exposure prescribed only the standard medicines, baths, and teas that are regarded as the most pure form of Spiritualist healing (see Finkler 1985a).


13. See Finkler 1985a and 1991 for discussion of etiological beliefs in Mexico. It could, of course, be argued that Spiritualists concretize a holistic view of the body when they literally incorporate the spirits into their bodies during possession trance; nevertheless, they profess a dualistic perspective as do physicians.

14. It is possible that the Spiritualist healers’ encounters with their patients mimic in a religious idiom biomedicine’s secular practices, given their exposure as patients to biomedicine and its procedures. Spiritualist healers also wear white coats during healing sessions, as do physicians.

15. There is a serious dispute among researchers and physicians with regard to the physicians’ contentions that all patients in Mexico suffer from parasitosis (see note 20 below).

16. See Finkler 1991 where I introduce and discuss the notion of a cultural pool of etiological understandings, upon which men and women draw differentially when they are struck by a sickness (see Finkler 1994a).

17. The exact nature of Mexican physicians’ etiological explanations is highly complex. For a discussion of their beliefs and clinical judgment, see Finkler 1991 chapter 6.

18. For a detailed comparison of agreements among Spiritualist healers and among healers and patients regarding etiology and treatment, see Finkler 1984.
19. For a similar finding on psychiatric practice in the United States, see Gaines 1979.
20. It is common knowledge that parasitic infections are endemic across Mexico, although it is disputed to what degree people simply carry rather than experience parasitic disease, especially anemia (Gutierrez 1986). According to Gutierrez, “The fundamental problem consists of a tendency to erroneously diagnose anemia in cases of diarrhea and dysentery due to the difficulty in practicing laboratory examinations” (1986:375).
21. See, for example, the case of Rebecca in Finkler 1994a.
22. In fact, some physicians would claim that a patient was obese when they lacked a diagnosis for a woman’s condition. See Finkler 1994a, especially the case of Josefine who, like other women, was distressed by the physician’s suggestion that her body was abnormal. Also, see for example, the case of Nomii in Finkler 1991, where the physician prescribed a diet for the patient that was impossible for her to follow because of economic constraints and work routines.
24. In fact, when the head of the temple noticed that a healer spent a relatively long time with a patient, she would reprimand the spirit that it was spending too much time with one patient. This usually occurred when there were many people waiting for a consultation. During my initial study of Spiritualist healing, I counted as many as 125 patients seeking treatment from the healers in one day. On my subsequent visits, and as recently as the summer of 1993, I observed many more patients than the 125 I noted in my study in 1977–79, and the number of healers grew from 8 to 24, working two shifts, in this temple alone during a span of 14 years.
25. See Finkler 1994a for the case of Margarita. She provides an excellent example of how a woman changed from a sickly to a healthy individual in the process of becoming a Kariné champion. Her case emphasizes that it is the process of transformation itself that heals.
26. Other variables include: the physician’s giving the patient a diagnosis; whether or not physicians explained what the patients was wrong; whether or not patients agreed with the physician’s diagnosis; and whether or not patients posed questions to the physician, meaning they participated in the consultation (see Finkler 1991; for a multivariate analysis of these findings showing the types of patients most responsive to these aspects of the physician-patient encounter, see Finkler 1994b).
27. Torgovnick (1990), too, argues convincingly that Western peoples’ idealization of the primitive reflects a longing for the past.
28. Interestingly, Mexican patients have a dual conception of physicians in this regard. While they distrust private physicians “because all they are interested in is money,” they have great trust in physicians such as those in government hospitals “because they don’t charge any money.” However, patients also distinguish between physicians working in the Social Security Hospital and those in the hospital administered by the Ministry of Health where I carried out my study.

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