

# 'Sacraments' in the Hospital: Exploring the Magic and Religion of Recovery

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*This article proposes to look at the ritual dimension of hospital work, a chain of words and acts, which fill patients with hope for a 'future life'. Conventional boundaries between magic, science and religion are reconsidered. The author argues that biomedicine, far from being a cultural no-man's land, represents the basic values of culture. It provides a space where doctors, nurses and patients find their deepest convictions and values demonstrated and confirmed. Medical words and interventions express and re-create people's belief in the canons of science and biomedicine as ultimate truth. Pointing out the religious dimension of medicine in no way belittles medicine's role and therapeutic efficacy. Rather it provides us with a better understanding of the 'mechanics' of recovery.*

Hospitals in the 'Western world' have been characterised as places of secularisation at the fringes of life. While it has been commonly observed that religion becomes more prominent when life is in jeopardy, the opposite seems to happen in modern hospitals where religious agents have become nearly out of place, at least in my own society, The Netherlands. Medical scientists and technicians have taken over the role of priests and other religious specialists in times of crisis and in the face of death. Such, at least, is the popular view. Medicine has become thoroughly secularised.

The purpose of this article is to point out that this view of hospitals as unreligious places is based on a misunderstanding of what religion and science are. The conventional definition of religion as faith in supernatural beings typifies the naiveté of the—supposed—non-believer. My argument is that secularisation and medicalisation constitute processes of cultural change *within* religion, as hospital care addresses people's ultimate concerns regarding the purpose of life.

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ISSN 1364-8470 (print)/ISSN 1469-2910 (online) © 2005 Taylor & Francis Group Ltd  
DOI: 10.1080/13648470500139957

This paper is not based on systematic ethnographic fieldwork in a particular hospital, but derives its ideas from a variety of experiences in clinical settings, cursory conversations with doctors and nurses, and extensive reading. Most of all, it is the outcome of introspective reflection on the meanings of illness and recovery. As an exploratory exercise it is almost as akin to philosophy as to anthropology.

In his essay 'Magic, science and religion', Malinowski (1948 [1925]) discusses the resemblances and differences of these three concepts. He focuses most effort on the differences. Science, to Malinowski, is empirical knowledge based on people's acquaintance with the environment, allowing them to use the forces of nature. Religion is faith in the supernatural world, embodied and maintained by rituals. It establishes and expresses valuable mental attitudes such as reverence for tradition, harmony with the environment and the prospect of death. Magic is a practical art, a symbolic ritual technique to bring about what cannot be achieved by 'ordinary' technique. Science is rooted in logic and experience, religion in emotional stress and anxiety, magic in hope.

These distinctions between magic, science and religion confirmed most readers' self-perception at the time. Science has nothing to do with religion; science is verifiable knowledge, religion is faith. A scientist can have a religious faith, as, in his view, religion does not interfere with science. Magic is a primitive kind of science, not based on empirical knowledge but on the 'sublime folly of hope'. Traces of magical thinking may also be found in Western society, but strictly speaking, it was thought, they should not be there. A scientist may be religious, but he does not believe in magic.

The vicissitudes of anthropology over the years are vividly illustrated by its debates on magic, varying from extreme exotisation, defining magic as primitive thinking and erroneous acting (Tylor, 1871; Frazer 1960 [1922]), to social and moral understanding (Mauss 1972 [1902]), to psychological satisfaction (Malinowski 1948 [1925]; Douglas 1966), to rationality (Evans-Pritchard 1937), to efficacy of symbols (Lévi-Strauss 1968). Radcliffe-Brown (1952, p. 138) suggested the elimination of the concept as it had become the epitome of ethnocentric misrepresentation, a view repeated by Wax and Wax (1963). Others caused confusion by emphasising magic's exclusively instrumental character versus the symbolic and expressive nature of religion (Beattie 1964).

Tambiah (1990) in his Lewis Henry Morgan Lectures has attempted to make up the balance of what anthropologists, historians, philosophers and linguists had to say about magic in relation to religion, science and rationality. Tambiah feels attracted to Malinowski's presentation of magic, because unlike Tylor and Frazer, Malinowski viewed magic in close articulation with practical human behaviour:

... what makes him [Malinowski] unusually interesting is that he, more than any anthropologist up to that time, insisted that a primary issue to assess was how, within the confines of a single society or culture 'symbolic' activities like ritual and magic were linked to and interacted with activities of a practical or 'pragmatic' character. (Tambiah 1990, p. 68)

Tambiah further points out that Malinowski saw two functions for magic, one psychological, one social. Tambiah is sceptical about the psychological function (on wrong grounds, I believe<sup>1</sup>), but supports the social one. Magic creates and maintains relatedness. Magic, in other words, works upon human actors, not upon nature. We will see later on that the distinction between 'nature' and 'human actor' becomes blurred when we enter medical situations.

Recently 'magic' has fought its way back into anthropology whose post-modernistic flirtations welcomed antique and obscure concepts. An example is a collection of essays (Meyer & Pels 2003) that argue magic's firm position in modernity.

My own article is another example of magic's comeback. It has been written to 'relativise' the old demarcations between magic, science and religion. The concepts, I argue, have fallen victim to a dichotomist world view in which subject is posed against object, spirit against body, rational against emotional. In everyday experience, however, magic, science and religion are difficult to distinguish. That is particularly true in clinical settings, which are commonly believed to be the hard core of scientific acting. I invite the reader to look at clinical work with other eyes: as occasions for religious emotion and hopeful magic.

In his introduction to Malinowski's essay, Redfield (1948, p. 9) speaks of the 'warm reality of human living' and the 'cool abstractions of science'. My purpose is to argue that there is 'warmth' in the scientific achievements carried out in modern clinical settings and that the opposition of science versus faith and emotion, and of technical rationality versus ritual hinders the anthropological understanding of clinical efficacy.

## **Magic, Science and Religion**

### *Magic and Biomedicine*

'Magic' has long been considered a derogatory term. Tylor (1871, p. 116) called it superstition 'mistaking an ideal for a real connexion' Quoting the Latin statesman Pliny he emphasised the need to study it exactly because 'being the most fraudulent of arts, it had prevailed throughout the world and through so many ages' (Tylor 1871, p. 133). Frazer named magic 'bastard science' and 'pseudo-science'. In their views, magic shares with science the objective of controlling the forces of nature, but it is at the same time the opposite of science because it is based on wrong assumptions about the workings of nature. Early anthropological accounts of magic were primarily negative definitions of science. 'Magic' proved a useful concept to depict Western thought as superior to that of others. Wax and Wax (1963, p. 503) say the same thing when they note that '... *magic* derives its meaning from within a process of cross-cultural interaction'.

Malinowski (1948 [1925]) attempted to give magic more credit and turned away from Frazer's view of 'wrong science'. Magic is less irrational than we think, Malinowski argued. People are continuously confronted with the boundaries of their ability to bring about facts. In their uncertainty about the final result of their action

they add words, gestures, substances to increase the chance of success. People recognise that those words, gestures and other ingredients do not guarantee success—they do not even have a direct physical effect—but ‘one never knows’. To explain such magical behaviour we usually refer to psychological concepts and say that it gives us more self-confidence or that it brings relief. Malinowski (1948 [1925], p. 79) wrote:

Man, engaged in a series of practical activities, comes to a gap; the hunter is disappointed by his quarry, the sailor misses propitious winds, the canoe builder has to deal with some material of which he is never certain that it will stand the strain, or the healthy person suddenly feels his strength failing. What does man do naturally under such conditions, setting aside all magic, belief and ritual? Forsaken by his knowledge, baffled by his past experience and by his technical skill, he realises his impotence. Yet his desire grips him only the more strongly; his anxiety, his fears and hopes, induce a tension in his organism which drives him to some sort of activity.

Malinowski’s quotation is defensive. He attempts to convince the reader that not only ‘savage’ people practise magic but ‘civilised’ people do so as well. In that sense, magic is ‘normal’, though it remains a slightly irrational reaction, which accompanies scientifically rational behaviour. Malinowski’s contribution is that magic is no more something of ‘the other’. ‘We’ too, the educated, brought up with the blessings of science, practise magic. But magic remains a way of thinking which is radically different—even the opposite—of science. It is human to think and act magically, but, writes Malinowski, it does not work. Magic, therefore, should not have any place in biomedicine. It is incompatible with scientific reasoning. The history of biomedicine is one of casting out magic. Medical research, such as randomised controlled trials, are attempts to separate specific effects from placebo effects, to distinguish between science and magic.

In biomedical popular language, magic usually means ‘wrong’. Magic should therefore be eliminated from medicine. I want to reconsider this negative definition of magic. Magic as the use of symbols to control forces in nature is not out of place in biomedicine. It may seem in conflict with biomedical theory, but it is inherent to biomedical practice. Magic, in Malinowski’s (1948 [1925], p. 90) felicitous words, is the ritualisation of optimism, the enhancement of faith in the victory of hope over fear: ‘confidence over doubt, steadfastness over vacillation, optimism over pessimism’.<sup>2</sup> Biomedicine may continue to cast out magic, but it will always remain magical and derive part of its therapeutic success from its magic. Let us now turn to the other—related—dichotomy, between science and religion.

### *Science and Religion*

Geertz’s (1973) by now classic definition of religion (‘a system of symbols which acts to establish powerful, pervasive, and long-lasting moods and motivations in men by formulating conceptions of a general order of existence and clothing these conceptions with such an aura of factuality that the moods and motivations seem uniquely realistic’) has the advantage that God is not necessarily included in the definition. Religion is believing in ideas which are regarded as ultimately true.

Paul Tillich (1965) calls religion 'ultimate concern'. Religion provides believers with sense and security. Geertz's view of religion can be applied to supernatural beings and forces but also to ideas and explanations, which belong to 'science'. The etymology may be wrong, but 'religion' is often derived from the Latin verb *ligare* (to bind). *Re-ligare* could then be translated as to 'bind again', to bring together in second instance. In religion, one could say, a fragmented world is united to form one ordered whole. Things are brought into agreement with one another. The taming of diversity and contradiction into one cognitive system takes place in 'true' religions but also in scientific thinking, including biomedical science.

Without losing sight of a number of prominent differences between 'religion' and 'science' in the conventional meanings of the terms, it is helpful to stress here what they have in common: for those to whom science provides ultimate explanations, it is a (secular) religion. Critics may argue that science can never produce ultimate explanations and call this erroneous thinking ('scientism'), but in everyday experience, science does have this status of ultimate truth. To many, only what has been scientifically proven can be trusted as real, all the rest may well be an illusion, wishful thinking or fantasy. Science provides the type of knowledge from which they derive hope, comfort and security.

Calling doctors the new 'priests' is, therefore, more than a metaphor. Doctors have access to knowledge concerning the most relevant physical reality, the human body, and are able to formulate rules for correct and just living on the basis of knowledge. In The Netherlands, as in many other countries, good health is regarded as the highest value in life. Doctors are the most qualified mediums to point out the 'right way' for those who want to attain that ideal. Anthropologists and philosophers have done their best to delineate and distinguish science, magic and religion. This paper discusses their overlap.

### **Magic and Ritual in Medical Settings**

Magic has not been pushed back out of our world, as Thomas (1973) argues. Magic and ritual still occur within biomedicine. Parsons (1951, p. 468) remarked some decades ago: 'The health situation is a classic one of the combination of uncertainty and strong emotional interests, which produce a situation of strain, and is very frequently a prominent focus of magic'. But, he adds in the vein of Frazer and also Malinowski, '...the fact that the basic cultural tradition of modern medicine is science precludes outright magic, which is explicitly non-scientific' (quoted in Verrips 2003, p. 225). My view of magic and ritual in biomedicine is less derogatory, as we will see soon. It is an inherent part of medical practice, ranging from the simplest action by a nurse to the most advanced medical technique. Let me give a few examples.

The nurse who fluffs up a patient's pillow does more than make the physical condition of the pillow more comfortable for the patient. The effect of this technical act is multiplied thanks to the fact that it has a wider meaning than its technical one. There is a lot of 'psychology' in this simple action; it shows the nurse's concern

and fills the patient with good feelings which are likely to enhance the prospect of recovery.

A well-known example of magic in the hospital is described by Katz (1981) in her study of rituals in the operation theatre of a North American hospital. Taking clues from Firth (1972) and Moore and Myerhoff (1977) that secular events can be fruitfully examined as rituals, she observed communication and behaviour in an operation room, emphasising their ritual character. She focused on the functions and efficacy of sterility procedures in the context of isolation and hierarchy. Her observations are meticulous; she describes preoperative activities of scrubbing and dressing, explains the principles of sterility and contamination, and gives a detailed account of the operation. She demonstrates that the techno-medical acts are sustained by ritual rules and have ritual effects. They help to establish the operation room as a special (separate) place and define correct and inappropriate behaviour. 'Clean' and 'dirty', which are also dominant concepts in religious rituals, determine what is right and wrong in the theatre. The rituals also mark the different stages of the work and help the participants to get into the right mental state to carry out their task properly. The ritual's side-effect of the surgical procedures exaggerates the boundaries between categories of people and objects and between the stages of the work. That exaggeration has considerable medical value as any uncertainty during the operation could be fatal. Katz's analysis convincingly shows that medical acts have ritual effects and that these ritual effects again gave medical consequences.

In the same vein Felker (1983) and Moerman (1979) discuss ritual and magical aspects of surgical work. Moerman analyses the efficacy of symbols in the 'by-pass' operation. Felker describes the events taking place in an American operating room as a secular ritual in which not only the premises of biomedicine are confirmed, but also the norms and values of American society at large.

A further example of magic in medicine is the doctor's prescription at the end of a consultation. By taking his pad and starting to write a prescription, the doctor emits a tactful but definitive sign that the consultation is over. It forestalls further discussion and constitutes some kind of 'silent communication'. The positive appreciation of the prescription not only conceals the fact that hardly any communication may have taken place and that uncertainty still exists, it also removes the patient's disappointment about the shortness of the encounter. For the doctor, it is the most effective way to deal with the persistent problem of shortage of time and the 'overload' of patients. Writing a prescription can best be described as a closing ritual which is intended—and often succeeds—to send the patient away with hope and positive feelings towards his medical problem, himself and the doctor (Pellegrino 1976). Moreover, it provides the patient with an official legitimisation towards his environment that he is really sick.

All these examples show that 'forces of nature' are influenced by actions that do not make sense if we would strictly keep to the canons of medical science. The nurse's act is magical *in* its technical quality. The physician writing a prescription shows the patient a token of his concern (Pellegrino 1976), and the operation is at the same time an amalgam of ritual acts and messages that help the medical staff to perform well (Katz 1981). Biomedicine is rational and technical. It would, however,

be a mistake to conclude that it does not leave room for symbols and magic (with the accompanying emotions). As we have seen, symbols, magic and emotion are found *in* the rationalist-technical approach. Machines and advanced medical techniques conjure up faith, hope and trust, in patients *and* in physicians.

### Recovering

A common characterisation (and critique) of biomedicine is that it is atomistic, reductionist and neglects the whole person. We should, however, take into account that atomism and reductionism exist and work only by the grace of an underlying concept of wholeness and unity. The biomedical focus on specific details of the human body bears a striking resemblance to magic and fetishist practices which, following the metonymic principle of *pars pro toto*, affecting the whole person through the touch of a miniscule part of that person. Both are subject to what Frazer (1960 [1922]) has called the laws of 'contagious magic'. The concept refers to the belief that things which are in contact with one another, or have been in contact, influence one another (for a psychological interpretation, see Rozin & Nemeroff 1990). A lock of hair from a lover brings the lover closer. That view is also brought forward by Gordon (n.d., pp. 6–7):

[T]here is an identity between part and whole: the organ is the person. This brings to mind the abundant practices of sympathetic magic... which take a piece of the person—a lock of hair, a piece of clothing—for the total person himself, and work on this piece to affect the whole. Perhaps we are seeing some of the same processes here in medicine as organs or body parts symbolically stand for the whole person in the eyes and the experience of medical practitioners...

The term 'recovery' captures this movement from part to whole, from fragment to completeness. Getting better is the result of restoring the whole. Medical intervention, which may appear to be only concerned with one organ, one tiny part of the sick person, is in fact an act of restoring the entire system. Several authors have tried to 'demonstrate' that return to wholeness in medicine through ethnographic description or theoretical argument. Lévi-Strauss' (1968) analysis of a Cuna (Indian) incantation to facilitate difficult childbirth is a classic case in point. The shaman's song constitutes a psychological manipulation of the sick organ. The song, according to Lévi-Strauss, presents the woman in labour with a mythical world in which she believes and to which she belongs. The song is, as it were, an invitation to take again her place in that world where everything is meaningful to her. What happens during the healing session is that she reintegrates within a whole, which provides her with a sense of belonging. The context conjured up in the song 'infects' her body, she recaptures her ground and recovers. Interestingly, the ethnographic example of the Cuna shaman's incantation has been criticised for various reasons, but Lévi-Strauss' reasoning to explain the efficacy of symbols is still widely accepted.<sup>3</sup>

Another anthropologist who took an interest in symbolic healing and tried to explain it is Dow (1986). Dow describes sickness as a fragmentation of emotions and experiences. That fragmentation may take place at various levels of human existence;

in a person's natural or social environment, in his self-system, in his body, at a conscious level and finally in physiological processes which are not subject to individual consciousness.<sup>4</sup>

These various levels are linked to one another and are mutually 'contagious'. Their connection can best be regarded as a metonymic relationship. They border on each other. As a result, a disturbance at one level will spread to another. Thus a breakdown in someone's social life may lead to disruptions in that person's bodily functions, etc. The reverse may also happen. Restoration of order at one level can result in recovery at other levels. It suggests that a medical intervention may thus help to overcome a marital crisis and psychotherapy may contribute to the recovery of a somatic disease.

Symbolic healers make use of the connectedness of these different levels. As in the example of the Cuna shaman, they start from a mythic world, a system of ideas, which produce meaning and cohesiveness. Through language and ritual they manipulate the symbols in the mythic world to restore the patient's sense of order. Feelings of coherence must replace experiences of chaos and fragmentation. Powerful symbols, ritual emotion and the healer's charisma determine the outcome of the treatment. If the patient finds back his sense of coherence, this will be spread over other levels of human experience. Optimism and confidence return and take possession of the body. The patient recovers.

The prefix 're' proves indispensable in finding words and understanding for the process which takes place in and around healing: re-pairing, re-capturing, re-recovery, re-storing, re-cuperation, re-generation, re-formation and re-ligion (*re-ligare*). Rituals and sacraments have a re-petitive character. Repetition and remembering create recognition and make reintegration possible. They 'frame' experiences, put them in a certain place where they reconquer their meaning. Repetition of stories, prayers, song lines instil that idea upon the participants. Rituals often have a mnemonic effect, like tying a knot in a handkerchief. Rituals focus attention by framing and enlivening the relevant past (cf. Douglas 1966, p. 79).

### Sacraments

I am not using the term 'sacrament' simply as another word for 'ritual', just for a change. The term signals that I indeed describe a religious mood in the way medical services are offered and received.

'Sacrament' originated from the Latin *sacramentum*, which has three meanings: (1) deposit or bail, a sum of money which contestants in a court case deposited and which was given to the winner of the case; (2) oath taken by a Roman soldier that he would not abandon his General; (3) early Christians gave 'sacrament' its present meaning of a visible sign expressing some mystery of their faith. The Roman Catholic Church recognises seven sacraments, which are believed to have been instituted by Christ. Most Protestant Churches accept only two sacraments: baptism and the Eucharist.

In the Catholic view, a sacrament is, in Augustine's words, 'the visible form of invisible grace'. Through the sacraments God's grace is channelled to the recipient,

the believer who takes part in a sacrament. In anthropological terms, sacraments could be regarded as indexical signs of a reality, which cannot be observed and experienced directly. They are, in the terms of the Dutch anthropologist van Baal (1971), 'symbols for communication' and concretisations of an ungraspable world. For the faithful they make visible what they believe exists but cannot be seen in its real form. By participating in sacramental rites, people feel comforted and confirmed in their faith. They receive what Christians call 'grace' and Moslems '*baraka*': strength, blessing, spiritual power.

In order to clarify the meaning of 'grace', theologians sometimes use medical metaphors. What medicine is for the sick body, grace is for the soul. In popular German devotion, from the 16th century onwards, Christ has been portrayed as a pharmacist distributing medicines for the soul. Hein (1992) has identified 133 representations of Christ as a pharmacist.

Most portraits are elaborate allegories. The objects of the pharmacy take on a spiritual meaning. The medicines become Christian virtues, which are needed to achieve spiritual 'health'. One can obtain these 'medicines' from the pharmacist Christ. Books and sheets on the counter show us prescriptions, not for the body but for the soul (Kraft 2001). The scale, a conventional pharmacy instrument normally used to measure the correct dosage of medicine, is here a symbol referring to the Final Judgement where each individual will be weighed and judged. The outcome will be either salvation or eternal damnation.<sup>5</sup>

Metaphors work in two directions. If medical images help to grasp religious emotions, religious experiences may also clarify medical events. The medical techniques and interventions that I presented a little while ago could indeed be viewed as religious phenomena.

What religion and medicine have in common is their opposition to death. Malinowski regards death as the source of religion:

Man has to live his life in the shadow of death, and he who clings to life and enjoys its fullness must dread the menace of its end. And he who is faced by death turns to the promise of life. Death and its denial—Immortality—have always formed, as they form today, the most poignant theme of man's forebodings. (Malinowski 1948 [1925], p. 47)

Religion saves man from a surrender to death and destruction, and in doing this it merely makes use of the observations of dreams, shadows and visions. The real nucleus of animism lies in the deepest emotional fact of human nature, the desire for life. (Malinowski 1948 [1925], p. 51)

Religion is here presented as the ultimate expression of hope against the reality of death. In his monumental *Das Prinzip Hoffnung* [*The Principle of Hope*], the German philosopher Ernst Bloch designs a philosophy and anthropology in which hope, looking optimistically to the future, is the basic movement of human existence. Not only religion, but also fairy-tales, popular fiction, theatre, dance, film, travelling, medicine, technology, painting, poetry, opera, and above all music are presented as evidence of the human orientation towards a hopeful future, a better world. The human person is a Utopian being, a dreamer and believer in the possibility of a good life (but who will never be fully satisfied).

Bloch, who never quotes Malinowski, finds himself in the company of this anthropologist: ‘The jaws of death grind everything and the maw of corruption devours every teleology, . . . But all the more powerful is the necessity to set *wishful evidence* against this so little illuminating certainty, against a mere factual truth in the world unmediated with man’ (Bloch 1986 [1959], p. 1107).

Bloch elaborates his view by tracing the death-denying trends in several world religions. In the Bible we see how an initial acceptance of death is replaced by a belief in an eventual resurrection from death. According to Bloch that development cannot be merely explained as a desire for endless life but should be seen as the outcome of a ‘thirst for justice’ (p. 1126). ‘The world is full of slaughtered goodness and of successful criminals enjoying a long and peaceful old age’, Bloch noted a few pages earlier (p. 1106). Religion, thus, not only saves us from surrender to death, as Malinowski wrote, but it also prevents us from falling into chaos, as Geertz—and many others—remarked. Religion’s answer to the threat of metaphysical and ethical chaos (bafflement and suffering) is:

[T]he formulation, by means of symbols, of an image of such a genuine order of the world which will account for, and even celebrate, the perceived ambiguities, puzzles, and paradoxes in human experience. The effort is not to deny the undeniable—that there are unexplained events, that life hurts, or that rain falls upon the just—but to deny that there are inexplicable events, that life is unendurable, and that justice is a mirage. (Geertz 1973, p. 108)

Questions about metaphysical sense and moral justice, as we will see in a moment, also befall the seriously sick patient in hospital.

For Bloch, the principle of hope lives on in a world which has done away with the metaphysical beliefs of the conventional religions that deny the reality of death. His own Utopia is not situated in a life after death or a life in defiance of death, but in a socialist society (which to most of today’s readers—at least in my part of the world—is almost as difficult to believe in as in life after death).

Christian theologians have been deeply influenced by Bloch’s philosophy and have tried to develop a theology of hope which could be reconciled with Bloch’s radical desacralisation. Moltmann (1964), following Bloch’s concept of hope as the ground of human existence, sketches the Christian faith as rooted in and fed by hope. Simple promises of a deathless future are however hard to find in Moltmann’s complex theological treatise. Both Bloch and Moltmann argue that life is not worth living without the prospect of an alternative, without hope, whatever that alternative is.

For the patient who is critically ill, the alternative is clear and concrete, however. His hope is to get better, to recover his health, his life. In this case, hope for life after death becomes hope for life after the threat of death. It is also hope for justice as described by Geertz. To die before one’s time is a ‘bad death’ and raises doubts about the moral order and meaning of life. Being seriously sick and facing possible death is therefore a religious experience. The nurse and doctor fighting for the patient’s life become participants in a religious drama. Their actions, such as technical interventions, caring gestures, and medical substances, assume religious significance.

They feed the patient's hope for recovery, his/her desire for life. They could indeed be called 'sacraments', as I suggested earlier, not merely in a metaphoric sense. They *are* active ingredients fulfilling the patient's hope for a continuation of life. Biblical texts, which are quoted in Christian sacraments, strikingly suit the condition and wishful dreams of the patient: 'Rise, take up your bed and go home' (Luke 5: 24). Or: 'I am the resurrection and the life; he who believes in me, though he die, yet shall he live' (John 11: 25). People today, including patients in hospitals, may not believe the miracles reported in the biblical books, but they do believe in the 'miracles' of medicine (cf. Moerman 1979; Cassel 1991).

Hope for recovery, optimism against all unfavourable odds by critically ill patients takes a central place in research among cancer patients in a Dutch hospital (The 2002). In their desperate optimism patients even take 'bad news' for 'good news' and doctors contribute to that misunderstanding by their euphemistic and veiled way of speaking. Words, gestures, interventions, medicines and x-rays are taken as signs of a hopeful future. Doctors and nurses do not intend to perform religion. Their words and interventions are expressly secular, but they cannot prevent them from assuming religious proportions in the sense that they represent what is believed to be closest to ultimate truth.

### Concluding Remarks

It would be an overstatement to say that anthropologists have unanimously depicted biomedicine as a cultural no-man's land, an inhospitable place where patients are deprived of their most cherished values and subjected to a dehumanising regime of objectification, as Foucault (1975) once suggested. It is true that for a long time medical anthropologists were hardly interested in hospitals as places for fieldwork, as if there was no 'culture' to be found there. That negligence lasted until approximately the middle of the 1980s when Hahn and Gaines (1985) edited their *Physicians of Western Medicine* and Lock and Gordon (1986) their *Biomedicine Examined*. Long before them, Renée Fox (1959) had published her pioneering study based on participant observation in a hospital ward as a social system. Pioneering also was Bluebond-Langner's (1978) unusual account of terminally ill children in an American hospital, composed as a play with a dying child as the main character. These examples of hospital ethnography were followed by studies of Rhodes (1991), Nicolas Fox (1992), Anspach (1993), Pool (2000), Finkler (2001), Vermeulen (2001) and Zaman (2005) and by a special issue (van der Geest & Finkler 2004). All these authors describe hospital culture as closely linked to processes in society at large.

The aim of this paper has been to go one step further and argue that biomedicine represents *the basic values* of local cultures. It is a 'space' where doctors, nurses and patients find their deepest convictions and values demonstrated and confirmed. Hospitals and other medical institutions thus become secular churches where people perform acts and speak words, which express and recreate their belief in the canons of ultimate truth (i.e. science and biomedicine). 'Medicine, or faith in medicine, is a creed' (Lupton 1994, p. 1). That same view was expressed by Good (1994, p. 7)

when he wrote that there was a 'close relationship between science, including medicine, and religious fundamentalism' (see also Jones 2004).

Scientific, *casu quo* biomedical concepts and images fill our mind when we think about ourselves, our well-being, our past and future; they form the stuff of our dreams. Biomedicine is a science we believe in and which produces its own magic. This thorough embedment in culture provides a more satisfactory explanation for the efficacy of biomedical practice than a purely scientific one. Symbolic healing merges with biomedical treatment and reinforces its effect. As Katz and Kirkland (1988, p. 1180) wrote, 'Rituals can help prevent infection, allay anxieties, promote cohesion and liberate surgeons to respond adaptively and creatively while performing surgical routines . . .'

Divorced from its cultural-symbolic character, biomedical efficacy becomes unintelligible. As in symbolic healing (Dow 1986), medical intervention at one level spreads to other levels of a person's living system. Order restored in one place 'infects' other places, pessimism gives way to confidence and takes possession of all levels of being. The patient recovers. The moral, psychological and religious meaning of biomedicine must not be sought *next to* knowledge and technology, in the manner medical care is given to patients. They are *in* the medical activities and attributes themselves. Magic and religion flourish in the heart of biomedicine.

This observation should not be taken in a derogatory sense. It refers to the fact that medicine can only be thought and practised by meaning-producing beings. Doctors, nurses, patients and their relatives are hopeful and anxious, full of trust and full of doubt, pessimistic and optimistic. These emotions and expectations contribute to and are expressed in medical practices. Our visual imagination of emotion has conservatively stuck to conventional symbols such as sweet-scented flowers, cleft hearts, caring hands, colourful sunsets and smiling children. The cold and sterile machinery of intensive care units with their monitors, tubes and sensors and the forbidding appearance of the specialist with his gruff voice also conjure up emotions. They too have sacramental effects. Therapeutic efficacy is co-produced by ideas and emotions, words and gestures that may fall outside the scope of medical science and are interpreted in anthropology. The acknowledgement of this 'magic' opens up a rich potential for future medical and anthropological research.

In a collection of essays, Meyer and Pels (2003) discuss the continuation of magic in modern society and provide numerous colourful examples of magical practices that accompany processes of modernisation. Unfortunately, they focus on the exotic image that magic has acquired thanks to the work of anthropologists who claimed to de-exoticise it. The contributions to Meyer and Pels' book emphasise the anti-rational, obscure and 'wild' nature of ritual practices ('black magic') and ignore the rational and psychologically satisfying character of the more mundane phenomena that have been described in this article.

These final remarks lead us back to Tambiah's discussion of Malinowski's interpretation of magic. Tambiah was fascinated by the way Malinowski managed to bring together magical and clearly practical activities, which made him pose the question: 'How are we to describe and interpret the interlacing of magical and technical acts as to perform . . . a total activity?' (Tambiah 1990, p. 71). After

discussing the work of Lévy-Brühl, Evans-Pritchard and Edmund Burke, he concludes that the

... puzzling duality of magic will disappear only when we succeed in embedding magic in a more ample theory of human life in which the path of ritual action is seen as an indispensable mode for man anywhere and everywhere of relating to and participating in the life of the world. (Tambiah 1990, p. 83)

I have tried to show in this essay that clinical settings in particular provide that almost natural embedding of magic into people's general participation in life. The ritual character of medical treatment constitutes a substantial—but usually ignored, even rejected—part of its efficacy. I consider this good news, which, unfortunately, is often badly received. Medical professionals usually react with irritation at the idea that their therapeutic work has a symbolic effect, when it is called 'magic' or is compared with religious and ritual behaviour. They tend to take this as anthropological ridicule and belittling of their medical knowledge and practice. We must, on the contrary, recognise and take advantage of the added value which medical work, because of its symbolic significance, accrues in the bodies and minds of sick people and in the experience of those who take care of them.

Interestingly, double blind clinical trials in scientific research confirm the awareness of magic (placebo effect) in biomedicine, yet scientists fail to draw the logical conclusion from this awareness. Mank and Semin-Goossens (2003) suggest that effects of rituals should be examined from the point of view of evidence-based medicine. Re-examining the results of randomised clinical trials would provide us with useful indications of the efficacy of the symbolic 'ingredients' of medicine and nursing.

If sacraments are visualised concretisations of what people believe in, medical work and technology in hospitals have indeed sacramental value. Looking at clinical activities from this point of view, we gain a better understanding of the spectacular efficacy of medical treatment in hospitals.

### **Acknowledgements**

An earlier version of this text was presented as a paper at the Second International Conference 'Medical Anthropology at Home' in Tarragona, Spain, April 2001 (see proceedings: Comelles & van Dongen 2002). One of the themes of that conference was 'the liturgy of biomedicine'. I greatly benefited from the discussions and thank the participants for their useful comments. I am also grateful to the members of the Amsterdam Medical Anthropology PhD Club who commented on this text.

### **Notes**

- [1] Very briefly, Tambiah argues that Malinowski's own descriptions show that magic is not practised most where anxiety about the outcome is highest. Magic's psychological function should be taken in a less dramatic sense. People are almost never certain about the outcome of their action (especially when they concern other people). Therefore, some 'wishful thinking' and psychological support always accompany human activity. It would be too schematic

to say that 'magic begins where technology ends'; magic is the permanent companion of technology.

- [2] Malinowski's definition of magic is rejected by Thomas (1973, pp. 785–786) on the basis of historical evidence: magical practices in Europe were abolished long before technological innovations made them superfluous. Thomas' interpretation of the decline of magic has again been criticised by several anthropologists. Tambiah (1990), for example, points out that Thomas exaggerates the distinction religion/magic and uses a too narrow yardstick of rationality.
- [3] Laderman (1987) points out (as several others have done) that the chant of the Cuna shaman, which Lévi-Strauss used for his essay, had been several times transferred and translated and could impossibly serve as a reliable source of insight into its multi-layered meanings and metaphoric potency. Moreover, the words of the chant had probably been incomprehensible to the patient.
- [4] The anthropological literature on 'symbolic healing' within biomedicine is vaster than this essay may suggest (see, for example, Moerman 1979; Kleinman 1988; Kirmayer 1993, 2004).
- [5] For a more elaborate discussion of medical metaphors in (Christian) religious expression, see Pfeiffer (1992); van der Geest (1994); Kraft (2001). Similar metaphors occur in other religions.

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