# University of Exeter

## Modernism's Chronic Conditions
## Temporality, Medicine, and Disorders of the Self

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**Mind the Gap:**

**Traditional Indigenous Knowledge, Heterotopias, and Apocalyptic Desire**


**Abstract**

This paper considers the gap between the approaches of Evidence Based Medicine and that of ethnographically-based medicine, using the lenses of Traditional Ecological Knowledge and Foucault's idea of heterotopias. Identifying the gap as a 'chronic condition' for medicine, the author raises concerns about its description as 'crisis', the heroic model that brings forth, and the 'apocalyptic desire' that drives such a model. Turing to modernism, she suggests that it provides examples of suppleness and fluidity that create hybrid, 'third space' locations, and that it is suggestive, therefore, of approaches that could close the gap between EBM and ethnographic medicine, and cure healthcare's chronic condition.


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The category of Traditional Indigenous Knowledge, which may be thought of as local knowledge held by indigenous people, arose initially from the European colonial project, which created a violent, politicised binary between 'advanced' and 'primitive' peoples, the colonisers and the colonised. As indigenous critics point out, it is a term that asks 'What can savages know? and consequently is 'loaded with Eurocentric arrogance'.[1] As a category of knowledge, it lay at the heart of the colonial project, since 'the quest for precision and certainty is a typical Eurocentric strategy, so that 'it is a strategy explicit with the appropriating narcissism of Eurocentric thought', and 'the strategy of a language system that is not attached to an ecology or its intelligible essences'.[2]

At the same time, indigenous critics reflect that 'indigenous knowledge reflects the dynamic way in which the residents of an area have come to understand themselves in relationship to their natural environment'[3] as a practical part of living and enhancing their lives. From the need to decolonise knowledge and the need adequately to represent the lived experience of people inheriting and using that knowledge, the idea of 'Traditional Ecological Knowledge' has arisen, considered here as '*a cumulative body of knowledge, practice, and belief, evolving by adaptive processes and handed down through generations by cultural transmission, about the relationship of living beings (including humans) with one another and with their environment.*'[4] Thus, 'it is a way of knowing; it is dynamic, building on experience and adapting to changes. It is an attribute of societies with historical continuity in resource use on a particular land'.[5] Accordingly, non-indigenous groups may also hold traditional ecological knowledge, in the sense of multi-generational, culturally-transmitted knowledge and ways of doing things: Fikret Berkes gives the well-known examples of cod fishing in Newfoundland, ranching in Colorado, and users of Swiss Alpine commons, to which we might, today, add medicine and healthcare.

Before pursuing this thought, however, let us consider Foucault's heterotopias. Traditional ecological knowledge [TEK] is concerned with the everyday, messy, real-life experience of living with all the other inhabitants of an environment, and the evolving set of practices that accumulate over time to make that process more meaningful and more enjoyable. By contrast, heteroptopias mingle utopian desire with cultural ideation to create 'fundamentally unreal places' in which 'all the other real sites that can be found within the culture, are simultaneously represented, contested, and inverted'.[6] A heterotopia is 'a kind of effectively enacted utopia',[7] gathering together the people and concerns of the rest of a culture, with a symbolic situating that is additional to their physical location, operating, then, as a kind of cathexis of a culture's desire, providing a sort of Lacanian mirror, revealing identity and desire as idealised, illusory, and alien.

I suggest that if unrecognised and unaddressed, this gap between TEK and the Foucauldian heterotopia is in danger of becoming medicine's chronic condition. For while TEK is supple, flexible, resourceful, creative, and adaptive, because 'what is traditional about traditional ecological knowledge is not its antiquity but the way it is acquired and used',[8] heterotopias 'are most often linked to slices in time' which Foucault terms heterochronies, 'a sort of break with their traditional time',[9] frozen, and isolating. One way of thinking about the Mid-Staffs disaster is as a heterotopia, where all of the usual figures were present – patients, nurses, doctors, managers – but all occupying distorted roles, cut off from their traditions, values, roles, and expectations, trapped in repetitive, destructive cycles of behaviour.

To position myself, as regional head of education, at Kent, Surrey and Sussex postgraduate medical deanery, for 21 years my job was to manage slippages between government's heterotopic idea of the NHS and the TEK of hospital medicine. Minding this gap required creativity and innovation, using the educational processes that Vygotsky termed 'scaffolding', creating structures to bridge the 'zone of proximal development', the gap between the point the learner or organisation can reach unaided and their potential development when given appropriate support. Vygotsky's processes provided an early example of Homi K Bhabha's post-colonial 'third space' theory and its associated concept of 'hybridity' produced by the resolution of two binaries, which are important to my argument today.

Concurrently with this practical development work, it was clear that a new debate about the nature of knowledge was emerging in medicine. Evidence-based medicine announced itself just as I joined the Deanery, as 'a "new paradigm" for teaching and practising clinical medicine. Tradition, anecdote, and theoretical reasoning from basic sciences would be replaced by evidence from high quality randomised controlled trials and observational studies, in combination with clinical expertise and the needs and wishes of patients.'[10] The chilling term in this formulation is the word 'replaced', positioning all previous knowledge as unnecessary and disposable, while asserting a new orthodoxy. Given what we have already said, the refusal of 'tradition, anecdote, and theoretical reasoning' is eerily redolent of a colonial enterprise, the Eurocentric search for certainty being played out within its own body politic.

Unsurprisingly, a counter-current rapidly emerged: for example, Deborah Lupton's *Medicine as Culture* in 1994[11]; *Narrative Based Medicine*, edited by Greenhalgh and Hurwitz, in 1998[12]; *Medical Humanities,* edited by Evans and Finlay, in 2001[13]; David Greaves's *The Healing Tradition* in 2004[14]; Pool and Geissler's *Medical Anthropology*

in 2005[15]; *On Knowing and Not Knowing in the Anthropology of Medicine*, edited by Roland Littlewood, in 2007[16]; *Psychoanalysis and Narrative Medicine*, edited by Rudnytsky and Charon, in 2008[17]; and Gabbay and Le May's *Practice-Based Evidence for Healthcare*, in 2011.[18] These publications signalled the ethnographic turn in medicine, focussing on the real-life experience of the clinical encounter, valuing and critiquing the knowledge that arises from observation of the messy, problematic, everday world of working with patients, introducing qualitative methodologies and frameworks to an otherwise quantitative, technical-rational arena. In so doing, it produced a discourse that was at once counter and complementary to that of EBM, producing a dilemma recently described in the BMJ by Trisha Greenhalgh in as 'Evidence-based medicine: a movement in crisis?'[19]

Greenhalgh persuasively lists five major concerns about EBM, together with the key features of 'real evidence based medicine' and the series of actions required to avert the crisis. I am not concerned here with the detail of the concerns, or the legitimacy of the positions occupied, but with, first, the gap between them, and second, the presentation of it as 'crisis'. The counter-discourse positions EBM as a heterotopia, a fictionalised world of objectified laboratory trials and generalised scientific evidence, élite, pure, and certain, deliberately separating itself from the primitive world of tradition, anecdote, and theoretical reasoning, which it came to replace – to civilise, one might say, and thereby to solve a crisis in medicine's status as a positivist science. The ethnographic turn, by contrast, presents itself as closer to TEK, valuing the close observation of individuals, in a particular location, over time, through intersubjective interaction with them. Where EBM presents a highly defended narrative, refusing outside lenses that might disturb its picture-perfect image, ethnographic medicine is interested in both evidence and uncertainty, open to a range of conceptual and practical approaches, since its concern is how useful it is in helping patients to health.

EBM is increasingly reified as élite practice that will conquer uncertainty; ethnographic medicine is increasingly reified as a protesting subaltern. It is one of philosophy's oldest binaries, the gap between theory and practice, between the Academy and praxis, between what should work and what does work. This binarism is the gap that forms the first part of medicine's chronic condition.

The second part of that chronic condition is the idea of 'crisis'. Implicitly, EBM comes to solve a crisis of confidence in traditional medical practice; explicitly, ethnographic medicine points to the limitations of EBM and claims it, now, is in crisis. 'Crisis' is very clearly a feature of the present political discourse about the NHS, presented variously as an economic crisis, a crisis in professionalism, a crisis in resource, a crisis in staffing, and so on, which we must expect to hear much of during the electioneering of the next few weeks. Standing on the other side of 'crisis' is 'survival', a saviour, someone who will have the ability to end the crisis by applying stern or creative measures – usually both – and who will bring about safety and success. The discourse of 'crisis and survival' is a very particular one, a heterotopic fantasy that produces what Briohny Doyle calls 'apocalyptic nostalgia'.[20] The 'narrative of catastrophic challenge' she says, evokes 'an unproblematic, stable, universal masculinity' as part of an essential truth that it sets out to reveal. Doyle makes her argument with reference to films such as *Deliverance*, and *First Blood*, and what is known as Survival Television, a genre in which volunteers are located in natural environments, and placed under artificial stresses of time, travel, task, and resource, while an expert 'survivalist' helps them to complete their imposed trial or

observes and comments as they fail. At time of writing, in the UK, it is exemplified by ITV's *Mission – Survive*, an elimination game show in which eight minor celebrities are placed in the Costa Rican rainforest and are successively eliminated by the game show's host, Bear Grylls, based on his opinion of how well they would survive 'in real life'. 'Real life' is left behind immediately, however, for example, when contestants are required to drink their own urine 'to survive' even though they are in a rain forest where water is abundant. Through incidents such as this, the programme reveals itself as a heterotopia, a distorted image of real life, in which Grylls is positioned as playing out a neo-colonial fantasy of him as élite saviour and educator of his subaltern celebrities.

Turning back to medicine, then, this trope of crisis and survival, brought about by a heroic figure, is its commonest media presentation. From *Dr Kildare* to *House*, the figure of the doctor has remained unchangeably heroic: a romantic hero, a battling hero, a suffering hero, but always reified as heroic. What conquering heroes need is a space wherein they can be heroic: a location of crisis, where they can lead survival with the same panache and certainty as fictionalised, heterotopic figures, providing them with a kind of social 'capital' of 'experience stories', which may be confessional, or valedictory, or pedagogic, but which substantiate their heroic status. It is this need that I term 'apocalyptic desire', and which is, I suggest, the most dangerous aspect of the binary gap between EBM and ethnographic medicine. For the real danger is that medicine's chronic condition will be extended, not resolved, while both sides position each other as the cause of crisis and themselves as its heroic saviour, and thereby benefit from maintaining a binary, rather than seeking resolution through hybridity and thereby creating a new third space.

It is to Modernism that I should like to turn, to find ways of resolving that binary. Only in retrospect, perhaps, using the later lenses provided by post-colonialism, post-feminism, and post-modernism, can one see the flexibility and suppleness of modernist work, its ability to move from certainty to uncertainty, its fruitful transgressiveness, and its reworking of temporality, while nevertheless maintaining a stable, accessible discourse. This quality is important to medicine, whose surface discourse and everyday provision is presented as stable, while its research and practice acknowledges very high levels of uncertainty, provisionality, and contextuality. Let us see what might be learned from jazz.[21]

Colonialism was not limited to territorial expansion: it was and is an ideology and a discourse, strongly shaping cultures and we can see it at play in the rise of jazz in the 1920s. The élite Western Classical Music tradition prized opera, highly scripted, highly rehearsed, deliberately artificial, where women always die, either from vice or from an excess of virtue spontaneously bursting their overburdened bosoms, and the audience is tightly confined and stratified by conventions of clothing, seating, applause, intervals, and refreshments. Jazz prized improvisation, individuality, playing in dark cellars where casually dressed audiences might dance uninhibitedly and eat, drink, and move about the room at will, and where black women singers such as Bessie Smith and Billie Holliday were effectively positioned as band leaders, exerting the authority of their voice and desire over the performance of a usually male band, providing both a dissident and a vital, energising force. Crucially, where opera was highly scored and scripted, keeping carefully orchestrated and conducted time, jazz deliberately subverted temporality, focusing on an individual approach to rhythmic articulation, performing behind the beat in a way that defied notation, and

introducing a raw, immediate sensuality that was experienced on the body of the audience dancing to it.

Jazz itself, usually described as being formed by the Afro-American experience of entwining indigenous African music with European musical traditions and instruments, began as a third space, and a very particular example of hybridity was provided by Billie Holiday's performance of *Strange Fruit*, live at Café Society in Greenwich Village, in 1939. The song is an explicit description of lynching, of a 'Black body swinging in the Southern breeze/ Strange fruit hanging from the poplar trees'. Holiday performed this song under conditions that were more redolent of opera than of jazz. The house lights went down, leaving her face illuminated by a single spotlight; the waiters stopped serving drinks and retreated to the back of the room; her singing was 'profoundly lonely and inhospitable. The music, stealthy, half in shadow, incarnated the horror described in the lyric. And instead of resolving itself into a cathartic call for unity, it hung suspended from that final word. It did not stir the blood: it chilled it'.[22] After the last, abruptly severed word, the room went into darkness and when the lights came up again, Holiday had gone. Holiday's singing, which defied formal temporality, was hybridised with the precisely timed portrayal, positioning, and physical performance of the song: always her last song, always the attention of the audience directed and confined by the use of light and darkness, stillness and movement, sound and silence. And if the woman didn't die, Holiday was at least noticeable by her absence at the end of the song.

There is only space to suggest other examples of Modernism's deliberate, extended explorations of temporal hybridity: T S Eliot's profound meditation on time and eternity in *The Four Quartets*; Joyce's compression of an epic journey into one day in Dublin, in *Ulysses*; W. B. Yeats's complex explorations of identity and politics throughout all his poetry and prose; or Rilke's astonishing meditation on loss, in *The Duino Elegies*, and his remarkable assertion that 'beauty is nothing but the beginning of terror, which we still are just able to endure'. In the work of these writers – and one might add a long list of other modernists – 'mutual relationships exist among all forces and forms in the natural world: animals, plants, humans, celestial bodies, spirits, and natural forces . . . natural phenomena, forces, and other living beings can affect humans. Everything affects everything else'.[23] In other words, it has the holistic quality of TEK, and thereby reaches back to the Romantic tradition of Blake, Shelley, and Emily Brontë,[24] as well as forward to all the post-theorists.

This temporal hybridity, of course, is the experience of patients, whose condition is defined by time and pain. The first appeal of everyone who feels unwell is to their sensory relationship with the world, to adjust light and dark, heat and coolness, sound and silence. Their first reassurance is the familiar – the familiar touch of bed or chair, the familiar sight of familiar faces, the same cherished items in their same places, and the stability that represents. The first urge to wellness is the usual acts and rituals of everyday life: feeding the birds, watering the plants, making a cup of tea. For us ordinary, unheroic people, our everyday lives are holistic, defined by our relationships with all things in our worlds, which affect us deeply: we are sense and sensibility intertwined.

All of these affordances are lost when we enter hospital, and their loss initiates a process of depersonalisation and institutionalisation. Temporality becomes more acute: how long will I have to stay here? When will I see a doctor? When must I wake up, when eat, what are visiting hours? The first thing a patient learns is how to be a

patient, and these are lessons of waiting and endurance. In the heterotopias depicted by the media, and imagined by government, patients are comforted and cared for by staff who listen, spend time with them, and sometimes heroically go the extra mile to help them, even though it is against regulations. The heterotopia is a world of *Cherry Ames* and *Sue Barton*, filled with sympathetic smiles and dashing capes, whereas in the everyday world of clinical practice, nurses who spend time holding patients' hands and listening to them are more likely to be scoffed at for being 'huggy-wuggy' and 'doing all that soft stuff'. And now, for patients, their families and their carers, there is a new, additional undercurrent of fear, of the brutal inhumanity revealed in the Francis Report, of a world that is not just unknown but potentially terrifying, without compassion, without redress. This depersonalisation and fear is the gap between the narcissism of an idealised NHS and the ecological knowledge of patients and clinicians and managers who work in real-life practice.

What might a third space between heterotopia and TEK look like? My example is taken from north-west Canada, from colleagues who work at Whitehorse General Hospital, in the regional capital of the sub-arctic boreal Yukon Territory. The Yukon is three times the size of the UK, with a population of 30,000 people, about a third indigenous people and two thirds settlers. The main wave of colonisation took place when the Alaska Highway was driven through Canada in 1942, and so is in living memory. With the highway engineers came all the abuses of colonialism – appropriation of land, game, and water, residential schools, cultural loss, a degraded social status, exclusion and abjection for indigenous peoples, disease, sacrilege, and subjugation. Yukon First Nations are still working to recover from this violence.

However, Whitehorse General Hospital has a set of First Nations Health Programs built into it, not as 'bolt-on' additions but as a fundamental part of its organisation. There is a traditional healing room built as part of the structure, a traditional medicine co-ordinator, a traditional diet programme, a community liaison and discharge planner and, crucially, a group of health and social liaison workers. It is the role of the health and social liaison workers to 'visit each First Nations, Inuit, or Métis patient that is admitted to the hospital and, as needed, in the Emergency Department'.[25] I was privileged to observe some liaison workers carrying out their roles and was able to record some of its complexities. On the surface, they were simply checking on administrative tasks, such as whether a patient wanted traditional diet, or had family that needed notifying, or wished for traditional healing in addition to the Western biomedicine provided for all patients. Beneath the surface, however, it was clear that something more crucial was taking place. The conversation between the liaison worker and the patient might cover their mutual familiar histories, discovering relatives in common, or shared memories of people, places, and events. The patient might be an Elder in the First Nations community, but depersonalised as part of the homogenous category of 'elderly' by the Europeanised culture of the hospital, and the liaison worker might obliquely and gently help them to rediscover that sense of self, literally to re-member themselves as someone of authority and value to the community. Or the patient might have animals, land, or game, that needed attention while they were in hospital, and the conversation would cover the arrangements that they had made for that, and reassure them that the things that they held dear, that completed them, were cared for, as they themselves would be cared for.

This is Integrative Medicine at its best, an exemplar of good practice that has received a great deal of attention from other hospitals in Canada. It is important to recognise that this kind of hybridity can be achieved, because elsewhere, there is a

wide gap between Western biomedicine and traditional indigenous medicine, whether it is a tradition particular to a specific location and culture, or one that has been extrapolated as Complementary and Alternative Medicine [CAM]. Fundamentally, this is a philosophical gap, and one that other scientific disciplines have tackled and managed. What kind of scaffolding would support medicine in making such a change in its identity and practice?

'Whatever of philosophy has been made poetry is alone permanent',[26] W. B. Yeats says, and accordingly it is to the Medical Humanities that I turn to undertake this task. It is one that is intensely practical, and that at the same time requires an exercise of creative imagination. With my colleagues at Birkbeck, we discovered that practice-based medical humanities, beginning by examining SUIs and never-events through the lenses provided by a range of cultural, literary, and ethnographic approaches, could illuminate and change clinicians practice. Drawing on the AHRC project on *Beckett and Brain Science,* with colleagues at Warwick, we discovered that theatre workshop could inform the care and support of people with cognitive impairment. In particular, medicine's own discourse of certainties and provisionalities, of knowing and not knowing, is reflected and illuminated by the aspects of modernist literature that I have highlighted, making it a natural starting point for considering the complexities of creating a new vision and practice of integrated healthcare, and creating a plural medicine for a diverse society.

The quest is to find an intersubjective relationship between scientific medicine and humanistic medicine, that is at once personal and universal, that is, to find a professional creativity and authenticity that brings newness into the world, for the benefit of society as a whole. This is a real hero's journey, followed by those who hear the deep inner prompting of the imagination, who leave behind old forms, thereby providing space for new ones to develop, not for personal gain, and certainly not out of an overwhelming fear for survival, but because, simply, they make the care of their patient - of all patients - their first concern. Supporting practitioners who wish to develop in this way is, I suggest, the role of practice-based Medical Humanities, providing scaffoldings that enable clinicians to create third spaces, to bring newness to the world, and thereby to end medicine's chronic condition.

Zoë Playdon
Emeritus Professor of Medical Humanities
University of London

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[1] Marie Battiste & James (Sa'ke'j) Youngblood Henderson, *Protecting Indigenous Knowledge*
[2] Ibid., p. 36.
[3] Ladislaus M. Semali and Joe L. Kincheloe, *What is Indigenous Knowledge? Voices from the Academy* (London: Falmer Press,1999) p. 3.
[4] Fikret Berkes, *Sacred Ecology* (Abingdon: Routledge, 2012), p. 7.
[5] Op. cit.
[6] Michel Foucault, 'Of Other Spaces: Utopias and Heterotopias', ('Des Espace Autres') trans. Jay Miskowiec, *Architecture/ Mouvement/ Continuité,* October 1984 (March 1967), Online http://web.mit.edu/allanmc/www/foucault1.pdf [accessed 31 March 2015].
[7] Op. cit.
[8] Battiste and Henderson, p.46
[9] Foucault, p 6
[10] Trisha Greenhalgh, Jeremy Howick and Neal Maskrey 'Evidence based medicine: a movement in crisis?', *BMJ* 13 June 2014. Online http://www.bmj.com/content/bmj/348/bmj.g3725.full.pdf [accessed 31 March 2015].

[11] Deborah Lupton, *Medicine as Culture* (London: Sage, 1993).
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[17] Peter L. Rudnytsky and Rita Charon, eds. *Psychoanalysis and Narrative Medicine* (Albany: SUNY Press, 2008).
[18] John Gabbay and Andrée Le May, *Practice-Based Evidence for Healthcare* (Abingdon: Routledge, 2011).
[19] Trisha Greenhalgh, Jeremy Howick and Neal Maskrey
[20] I am indebted to Bushcraft expert and PhD student Lisa Fenton, from the Woodsmoke organisation, for drawing my attention to these ideas and this paper. See http://www.woodsmoke.uk.com/ for examples of her work.
[21] I am indebted to British-Iranian composer Soosan Lolavar for our discussion of these issues. See http://www.soosanlolavar.com for examples of her work.
[22] Dorian Lynskey, *33 Revolutions Per Minute* (London: Faber and Faber, 2010) p. 7.
[23] Battiste and Henderson, p.43
[24] See, for example, Alexandra Harris, *Romantic Moderns: English Writers, Artists and the Imagination, from Virginia Woolf to John Piper* (London: Thames and Hudson, 2010).
[25] Whitehorse General Hospital First Nations Programs, http://www.whitehorsehospital.ca/firstnationhealthprogram/healthsocialliaisonworkers/ [accessed 8 April 2015].
[26] W. B. Yeats, 'The Philosophy of Shelley's Poetry', in A. N. Jeffares (ed.), *Yeats: Selected Criticism and Prose* (London: Macmillan, 1980), p. 65.