**Fragmented bodies: the disciplined, the intractable, the beyond**

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**Abstract**

The map of faith healing in India is both huge and complex, even as the state continues unabated in its efforts to reorient the behaviour of subjects who access this space, in order to co-opt them within the ambits of biomedicine. Against this background, how could we analyse the behaviour of a subject who fragments her own body, and ‘allots’ a different part each for the respective interventions of these two counterpoised praxis? In this comment we sift through the normative ‘assumptions’ of the critique of modern biomedicine, engage with the scholarship on faith healing, and interrogate the healthcare-seeking behaviour of this ‘fragmented’ subject towards mapping the realities on the ground; we thereby argue that the need of the hour is to deliberate on other epistemological approaches to understand healthcare-seeking behaviours which subvert normative dyads, binaries and presumptions. This is an ethical imperative if we want to understand how subjects living at the cusp of different knowledge systems find a place – or fail to – in the larger healthcare map of India.

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***Meenu and her fragmented body***

In a village in Jabalpur one of us[[2]](#endnote-1) met Meenu, a middle-aged woman with a significantly swollen throat – a problem of goitre, as seemed obvious to an onlooker habituated to the diagnostic ways of modern medicine. When asked about it, Meenu explained that she had developed the swelling a year ago and had consequently visited the faith healer who had treated her with the fume of incense sticks. Her discomfort had dissipated over time, she said, but since the swelling was still there, she continued her visits to the healer, hoping to attain ‘total cure’. She never visited the government health centre for this problem though; we thought this was an intriguing behaviour on her part, especially because she was waiting at the government clinic OPD when we met her. Meenu explained she occasionally came to the clinic for the treatment of chronic knee pain.

Meenu did not perceive any contradiction in the way she fragmented her body; but to us, i.e., to researchers who had been trained in the social sciences, these two sites, viz. that of the medical clinic and of faith healing, represented two systems of knowledge, not only distinct and discrete, but mutually counterpoised as well. We are certainly not unacquainted with subjects choosing one system of healing over another, or even shifting their investment in one system to another, but Meenu was different: she accessed both systems at the *same time,* for the *same body*. What was her rationale for allocating as it were, her knee to the doctor and her throat to the faith healer? Meenu explained that she never perceived the ‘need’ to visit the doctor for her throat problem because it was caused by ‘abnormal forces’, something beyond the clinic doctor’s capacity to address; but her knee pain, she said, was a problem of ‘the leg’, a physiological aberration, something she knew was within the doctor’s domain of knowledge. These two cases – that of the throat and of the knee – were distinct for Meenu, even though part of the same anatomy: one was a ‘diseased’ knee and the other a neck which had ‘gone abnormal’. Needless to say, these initial ‘diagnoses’ were made by Meenu herself.

In this comment, we argue that by refusing to access any one healing system *in toto*, by fragmenting her body in order to delegate some parts to biomedicine and some others to non-modern healing systems but both at the same time, Meenu was scripting a text which subverts certain normative assumptions which, critiques of modern healthcare systems make about the healthcare-seeking behaviour of people who are not (yet) completely contained by biomedical mandates.

***The ‘assumptions’ and its ruptures***

Access to modern medical healthcare is a marker of development, and non-development is considered to be a three-pronged problematic: (i) the subject of development is unaware of the possibilities inherent in spaces and processes that embody ‘development’ viz. the medical clinic in this case, (ii) the subject is aware but lacks access (geographically and/or financially) to such spaces, and (iii) an inadequately resourced space fails to accommodate the (willing) subject.

Meenu however emerges as an anomaly: she fits into none of these three categories: Meenu does not lack awareness of the possibilities of biomedicine, in fact she regularly accesses a mainstream site of the medical clinic for her knee pain. Neither has the clinic refused to accommodate her. It is Meenu who decides *what* merits becoming her need when she comes to the clinic – the throat or the knee. To the archetypical query of modern medicine, “where does it hurt?” (1), she assumedly replies, “In my knee”. One could give the benefit of doubt to the clinic doctor who might have volunteered advice vis-à-vis the goitre staring back at him, but in all likelihood Meenu did not pay heed to it, for, in her own world of lived experiences and agentic decision-making, she reserved the throat and its unease for the intervention of the local healer; she is convinced that the doctor could not address the problem of the throat. The reverse was true as well: she did not take her knee pain to the healer. She decided the knee problem was beyond the capacity of the faith healer to treat.

When it comes to defining faith healing, most definitions point out its distinction from modern medical practice, implicitly making medical science the point of reference. While modern medical science is indeed hegemonic, anthropologists and cultural studies scholars have also stressed on the experiential world of faith healing especially through studying the significance of symbols, myths, beliefs and subjectivity (2). Siddiqui and colleagues point out that faith healing is neither institution-centric, nor clinical – “It opens up a mental health map hitherto marked by the dyad of either the institutional and the communal, or the psychiatric ward and the individual clinic” (3, p286), urging for a far more complex and nuanced description of faith healing especially because such sites “appear to be at the cusp of the institutional and the clinical […] neither wholly institutional nor clinical in the private sense”. In other words, the authors argue that “faith healing offers not just to mainstream psychology a form of gendered/subaltern criticality, a criticality bordering on a passive form of resistant differing, it also offers to the existing critical psychology tradition in India a new-fangled quandary” (3, p286). Engaging with Siddiqui and colleagues, we here extend the argument to say that to understand faith healing in itself is an ethical imperative, because if we try to understand faith healing only through the terms of reference made possible by biomedical science, we shall never be able to understand people like Meenu who do not espouse faith healing *over* medical science. She accesses what we identify as faith healing and yet exhibits faith in the possibilities of medical science. How do we conceptually navigate her healthcare-seeking behaviour? How do we understand the roles the healer and the doctor play in her life?

***Biomedicine and faith healing***

Biomedical science is only *a* system of knowledge which interprets illnesses and diseases of the human body in order to design treatment. It is *not the only system*: “there have been, and will be, other distributions of illness” (1, p1), and different distributions of illness will invoke corresponding configurations of healing. Modern medicine was born around the 15th-16th centuries, fundamentally inspired and influenced by the ‘germ theory’ of disease (1): needless to say, it was nowhere similar to how we experience it today. Mukherjee pithily and rightly posits, “Much of ‘modern medicine’ is, in fact, surprisingly modern”; before the 1930s, one would be “hard pressed to identify a single medical intervention that had any more than a negligible impact on the course of any illness” (4, p12). Medicine between the 15th and 19th centuries engaged in palliating pain and treating select ailments and morbidities, not attending to the specific illness afflicting the individual bodies (1).

The modern medical clinic heralded the idea of illness as individuated. The idea of the patient as a separate individual with a specific illness was born around the 16th century, and the doctor now had to tend to different illnesses afflicting *each* patient, not of the diseased population as a mass. This marked a paradigmatic shift not only in the doctor-patient relationship, but also in the way the doctor would relate to the *embodied illness* in front of him, viz. the patient. As one of the consequences of the way medical epistemology works, modern medicine has been critiqued for fragmenting the body, treating the constitutive parts as discrete (5): the super specialisations that we see around us, a defining feature of modern medicine, is symptomatic of the same. In seeking to treat illness, modern medical science focuses on the anatomical part that is affected by the said illness.

Gopichandran (6) points out that a crucial distinction between medicine and faith healing is symbolized by their respective objectives to treat and heal, i.e., medicine treats the illness while faith healing, as is evident in its name, seeks to heal. One could understand that while treatment implies eradication of the symptoms, a sort of exorcism, healing works more with helping the body learn to negotiate the problems, it lends the body a degree of power to cope with the source of the disturbances. In other words, a sort of empowerment of the sufferer is imaginable within the scope of faith healing. Davar and Lohokare also focus on the empowerment of the ‘sufferer’ (2, p268).

Another point is of language: medical science focuses on developing a *common* language, a language that would withstand change:

In its everyday practice, hospital experience resembles the form of a pedagogic system. […] It is a question […] of a domain in which truth teaches itself, and […] offers itself to the gaze of both the experienced observer and the naïve apprentice; for both *there is only one language*: the hospital, in which the series of patients examined is itself a school” (1, p78, emphasis added).

That is, the language of modern medical science seeks to unify the ailments, chart a common language of reference, a nosology of all diseases and symptoms and treatments for all accessing this epistemology whether they are providers or patients. Davar and Lohokare point out that different from the biomedical frame, language is ritualised in the space of faith healing, and “the rhetoric used in the sessions creates a predisposition in the person to be healed, akin to a placebo, a process central to mental healing” (2, p268). Understandably, the language changes and is customised to suit the mental-physical health requirements of each subject. The language of faith healing uses various dyadic categories such as light and darkness, purity and impurity, wellness and illness, to interpret, explain and address the ailments of the subject.

***Disciplined and intractable: both and neither***

The Indian state has been an unapologetic flagbearer of biomedical science; there are schemes and methods it has persistently deployed to get every subject within the ambit of biomedical science since, among other things, the biomedical paradigm symptomizes modernity and development. Kutty posits that “Patients who are not disciplined enough, and who are *therefore* intractable constantly frustrate the protocol of universal scientific medicine” (7, p237, emphasis added). According to Kutty there are two types of ‘patients’: those who are already-disciplined, and those who, because they are *not yet* disciplined, are ‘intractable’. But then, one would like to point out, this demarcation seemingly based on a subject’s behavioural attitude is not only too linear but ineffective in describing the real gamut of subject categories: there are also subjects who falter at the gates of ‘universal scientific medicine’, patients who *intend* to cross over to the institution but get caught in the slippage between the medical/scientific institution and its outside, those who do not frustrate ‘the protocol of universal scientific medicine’ but themselves are frustrated *by it*. Van Hollen talks of such slippages (8) while Ghoshal talks of a yet different form of fourth slippage (9).

The path *connecting* biomedical/scientific practice and its outside is also the one *separating* the two, this path is not just metaphorical but very real and material most of the times, and has to be traversed by the one who intends to move away from the space of the ‘non’ and move into the space of biomedicine. At the physical level, this path indicates the dusty tracts and winding kilometres that link the rural to the urban, which, those living in the rural areas need to traverse in order to reach the clinic/hospital. Perhaps also traversing variables of caste, class, gender in all its manifestations and divisions which more than often makes the marked faith healer more approachable than the unmarked ‘secular’ doctor in the clinic. Metaphorically speaking, this path implies ‘intention’: a patient *willingly* traversing this distance implies that s/he has now become an aware, conscientious subject, a disciplined, ‘tractable’ patient with legitimate healthcare-seeking behaviour. When such subjects get caught in the hidden quagmires this path entails, they are left in the real ‘outside’, for they are those who left the space of traditional healing behind them but are not yet-accommodated by biomedicine.[[3]](#endnote-2) This predicament also shows that patients are not necessarily categorizable as either disciplined or intractable beings – they at times blur the boundaries by being disciplined in intentions and efforts, yet ending up in intractable roles.

Meenu shows up a fifth possibility, as it were: she does not frustrate the medical mandate, she is herself not frustrated by it, she does not get caught in any slippage: she remains agentic. She arrives at the clinic occasionally, thus becoming the disciplined patient at those moments. She also continues to access the faith healer and in those moments actively resists/rejects biomedical care. We could well say that Meenu occupies a distinct ontology in this context, because when she enters the precincts of biomedicines she does not take her whole anatomy with her; she remains, in her intentions and subjectivity, disembodied, partial and fragmented. It is not medical science that fragments her; she does that to herself. She accesses plural nosologies at the same time, and subverts the aforementioned assumptions.

***Negotiating nosologies***

Nosology is the classification of diseases, a particular epistemological imperative born alongside the birth of the modern medical clinic (1). Naraindas argues that though “it is very difficult for most modern subjects to imagine multiple nosologies”, they are comfortable in imagining “*other* institutions, *other* professions and *other* disciplines, or systems” (10, p119, emphases added). The discursive value of these ‘other’ institutions, practices, systems, etc. remains encompassed within the hegemonic normative; i.e., even as biomedicine remains hegemonic both as epistemology and praxis, the symbols of the free-standing birth centres (as instances of ‘other’ institutions), of midwives (as instances of ‘other’ professions) and of homeopathy (as instances of ‘other’ systems)[[4]](#endnote-3) either shore up the relative better merits of the hegemonic, or complement the hegemonic by plugging the gaps that plague the disbursal of biomedical care (though more in terms of experience than epistemology). In other words, even for the liminalized, non-hegemonic and the alternative, we have a hierarchy: not all marginals are acknowledged by the hegemonic – there are marginals and marginals, we have non-legitimate marginals and more-legitimate marginals.

Naraindas hinges his chapter on the case of Sangita, an urban pregnant woman who simultaneously moves between the gynaecologist and the *vaidya* – the agent of biomedicine and of tradition respectively – during the tenure of her pregnancy. But as we see, Sangita ‘takes’ her state of being-pregnant *in toto* to the two different systems, alternatingly, on different days, not just temporally, but ontologically as well. Sangita does not fragment her body, the anatomy of her pregnancy. She moves between the two systems because she opts to appease her family’s wishes (that she be under the surveillance of modern medicine) and her own desires (to remain under the guidance and support of Teresa, a *vaidya*). One could argue that Sangita’s dualized access is a social compromise; given her own way, she would evidently have opted only for Teresa. To that extent, while she is the ‘intractable’ patient in her intentions, she ends up being not so in her actions.

Sangita’s compromise ultimately wins on the biomedical side as situations compel her to give birth in the hospital, under the supervision of the obstetrician. Looking back at the last few hours of the delivery, Sangita “explicitly compared her plight to that of a revolutionary about to be executed for a crime, which shows just how strongly she felt that she had been deprived of meaningful agency, of control over her own body” (10, p138).After successfully maintaining parallel agency by accessing both the *Vaidya* and the obstetrician throughout the pregnancy, she loses out in the last lap: anyway she would have had to make this choice at the last moment. But in apparent contrast, Meenu’s agency remains poised between the two opposed nosologies as she negotiates the nosologies at her disposal, never really having to make a crucial choice where, to the extent that we knew her, she needed to give up one for the other.

***A question of ethics***

The people in Meenu’s community were – as we gathered during the fieldwork – in a phase of developmental transition, making a gradual shift from traditional healing practices to a biomedical paradigm. This is not to suggest that faith healing is a repository of healing rituals that only the ‘less developed’ constituencies follow; faith healing in a variety of forms is active in urban spaces as well, spaces that well qualify as developed (11). Naraindas and colleagues mention how at times people tend to use “all available therapeutic options at once” (10, p7), but this is not true of people like Meenu, for, her actions do not imply that she is keen to use all available therapeutic options at once; her actions reflect clear, precise rationalisation done her own way. The problematic is that she allocates a part of her body to each system – she does not access everything available for her body as an integrated experience; she, as it were, *smudges* therapeutic boundaries, while not letting one system bleed one another, or blend with another. She does *not* wish to avail the best of both worlds as it were: Meenu shows that she has not taken any one world of practice and belief as the only possible paradigm that can accommodate her – her body, her being and her health far exceeds the scope contained and offered by any system of healing, whether the indigenous or biomedical. She lives and thrives at both the overlap of, and gap between knowledge systems, of different imaginations of praxis.

The epistemes are ruptured and subverted as Meenu refuses to either invest in any one, or herself be defined by the languages of any one of the paradigms. She moves in the manner of a möbius-strip, shifting between discipline and intractability, neither eager to grasp everything at hand, nor fearful of letting go. Somewhere, even in flickering moments of her healthcare seeking mechanisms, Meenu succeeds in exercising choice. She has faith not just in healing but in biomedical science as well, even as mainstream perceptions of development do not offset her choice. It thus becomes a difficult task to deliberate on what the possible contours of the register of ethics would be for subjects like Meenu. We need to critically reflect if the cardinal principles of biomedical ethics, viz., autonomy, beneficence, non-maleficence and justice would be able to circumscribe the ontology of Meenu and others like her. This is an ethical imperative if we want to understand how subjects living at the cusp of different knowledge systems find a place – or fail to – in the larger healthcare map of India.

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2. **NOTES**

   One of the authors (HB), while pursuing her MPhil course from the Centre for Development Practice, Ambedkar University, Delhi, was required to spend a year in a village as part of the Field Immersion Program. The other author (RG) joined her for the requirements of her own doctoral project in 2014. HB met Meenu at the local government clinic. [↑](#endnote-ref-1)
3. There could be a variety of reasons of why such slippage happens on this journey; for more reflections on this issue, see Ghoshal 2015 and Van Hollen 2003 (especially the Introduction). [↑](#endnote-ref-2)
4. These ‘examples’ are adapted from Naraindas 2014, p-119.

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