

the date of an important recurring festival called a Sigui. This controversy sparked efforts by other popular researchers such as Carl Sagan to assign the anomalous Dogon astronomical references to modern sources, along with rebuttals affirming the indigenous nature of the knowledge by Germaine Dieterlen.

Restudying the Dogon

During the 1980s, a second wave of anthropological studies were conducted among the Dogon by a number of researchers, including Belgian anthropologist Walter Van Beek. Notwithstanding Griaule's characterization of the now-controversial Dogon cosmology as a secret tradition, these researchers reported an inability to confirm Griaule's findings based on interviews conducted with the Dogon tribespeople.

FIELD NOTES

Initially, Van Beek suggested that the obliging Dogon priests had simply fabricated the cosmology as a way of satisfying Griaule's persistent questions. More recently, however, Van Beek's charges of fabrication have been directed against Griaule himself. More specifically, Van Beek referred to the classic plan of the Dogon granary as "a chimera known only to Griaule" in correspondence to me.

New Support for Griaule's Cosmology

My recent studies in comparative cosmology have turned up new support for the validity of Griaule's Dogon cosmology from an unexpected source. This new evidence derives from the architectural plan and symbolism of a traditional Buddhist shrine found across India and Asia called a *stupa*, and is reported by a leading authority on Buddhist architecture and symbolism named Adrian Snodgrass of the University of West Sydney, Australia.

Snodgrass describes a structure that is conceived of as a world-system, is founded on the same base plan as Griaule's Dogon granary, and which evokes cosmological and biological symbolism that is a close match for Griaule's Dogon symbolism, virtually theme for theme and symbol for symbol. Among its many points of commonality with Griaule's Dogon system, the *stupa* symbolism includes specific references to matter as a product woven by a spider, characterized as emerging like rays of a star, and conceptualized as a spiral.

The mere existence of Snodgrass's study—published nearly 20 years after Griaule's death in 1956—would seem to preclude the possibility of outright fabrication of Dogon cosmology by either Griaule or the Dogon priests. Likewise, the well-documented *stupa* tradition, known

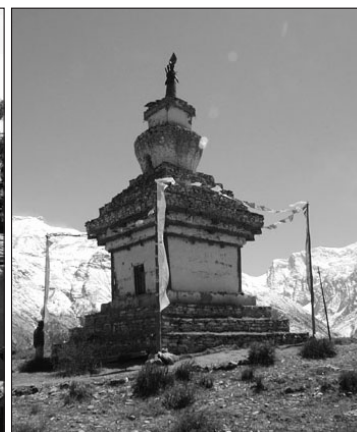
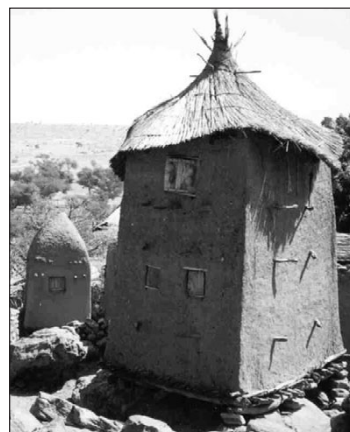
primarily to the most knowledgeable Buddhists, would seem to lend support to Griaule's claim of a similar esoteric tradition among the Dogon.

Fabrication or Protection of a Secret?

During the decade and a half of debate over the validity of Griaule's cosmology, it would appear that not

mologies before becoming aware of the match. Likewise, biographical sketches of Griaule report no extended period of Buddhist study.

This would seem to leave us with only two possibilities: that Griaule inexplicably chose to falsely report a Buddhist tradition as if it were Dogon



A Dogon granary in Mali and a stupa in Kathmandu. Scranton suggests that comparing these two architectures and their symbolic representations of world-systems offers new evidence to the scientific controversy about the Dogon cosmology as ethnographically described by Griaule.

a single anthropologist doing fieldwork in West Africa has attained an awareness of the esoteric Buddhist tradition sufficient to perceive the direct match to Griaule's Dogon cosmology. I, myself, required nearly 15 years study of comparative cos-

cosmology, or that the Dogon priests have simply lied to later researchers to guard an important tribal secret. ■

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How Doctors and Patients Talk Past One Another

The Clash of Scientific and Folk Worldviews

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Doctors and patients sometimes bring radically different perspectives to a consultation. These perspectives color the logic and language they use when talking to, or more accurately, past one another. While doctor's as professionals express a scientific worldview when discussing medicine and disease, patients of all social classes often operate from a folk worldview in making sense of their symptoms and their causes.

Entering the Consultation

I have observed hundreds of interactions between doctors and patients during consulting projects related to culturally understanding cholesterol, irritable bowel syndrome, arthritis, birth control, diabetes and hypertension.

In treatments for most of these conditions doctors often concentrate on drug prescription and the adjustment of drug classes and amounts. If they have the time and inclination they use the rhetoric of science to explain treatment options and goals to patients, offering explanations of drug types, functioning and effects. The doctor's primary objective in doing this is to convince the patient of the rationality of the prescription and treatment course and thus

to ensure compliance. Essentially doctors are interested in getting the patient to take medicine in the manner prescribed, and to accept that the the doctor's other recommendations are reasonable.

Doctors are generally exasperated by non-compliant patients, whom they see as unreasonable, irrational and stubborn, but most especially as resistant to their authority and expertise. One doctor I interviewed neatly summarized his view of patient intractability in managing hypertension:

How do patients trip themselves up? There isn't one way. They trip themselves up in every way. They stop [taking] their medication without telling me. Some say they "ran out" and couldn't find time to renew the

prescription. Or, the more honest ones say they don't like the way the medication makes them feel. Or, they take the medication at the wrong time and in the wrong way. A patient will come in once, and then for a follow up after he's been put on medication his blood pressure reading will go down. He assumes he's cured and never shows up again. You try to get them to make small reasonable changes in diet and exercise, but that's a really uphill battle. You try to explain to them how the drugs you prescribed for them work and why it's essential that they stay on them, and that they really have a life-long condition that they have to manage. But I don't know how much of that they really hear, based on what they do when they leave the office.

At times, doctor-patient interactions resembled conversations between a parent and a naughty child who cannot be trusted to be responsible:

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That's why every patient every time gets asked: what medicines did you take, when did you take them? For the ones that mess up over and over again, they get the written instruction sheet over and over again.

What doctors don't understand is that patients are not simply recalcitrant. Most patients wish to develop satisfying relationships with their doctors and to get as much as possible out of the consultation. But doctors do not couch their advice in ways the patient can hear and accept.

Patients' Folk Understandings

The anthropological literature on traditional, small-scale tribal societies is full of descriptions and analyses of folk theories of health, the body and procreation. But folk theories are just as much in play here in the US as they are in places such as Papua New Guinea. What anthropologists have found when looking at these folk systems is that they are a form of moral language.

Many folk medical systems place a high value on ideas of harmony and balance. Health is an outcome of balancing inner bodily and emotional forces—one immediately thinks of the four humors or of yin and yang in Chinese philosophy. At the same time, as Erica Brady noted in *Healing Logics*, health is also a function of "creating a balanced relationship between the person and his social community and physical environment." The moral element of these systems is often seen, Brady observes, "in the presumption of a sense of right behavior for health-protecting actions." Socially moral and physically disciplined action is correlated with health.

FIELD NOTES

The clash of scientific and folk worldviews was striking in a series of doctor-patient interactions I observed revolving around hypertensive management. In these interactions doctors focused on blood pressure numbers, on pharmaceutical intervention, and on explaining, sometimes in quite complicated fashion, drug chemistry and functioning.

In response, patients emphasized the emotional and psycho-social aspects of hypertension. Relying

on a folk model of hypertensive illness, patients viewed their high blood pressure numbers as an alarming barometer of a lack of balance in their emotional lives. In their view irregular lifestyles, stress, and emotional ups and downs resulted in illness:

There's nothing regular about my eating or sleeping. You know what I do for a living. I do a regular office job and then I go out and play in a band. There are times when my schedule is incredibly irregular.

Patients invariably credited the initial diagnosis of hypertension to a stressful life situation:

My father passed away and everything is just exploding in my life. That's what I attribute it to—a very stressful time in my life.

At the time I was first diagnosed it was a very emotional time—I was going through a divorce, and my husband was just torturing me. It was really just hell everyday.

The folk orientation is the patient's equivalent of the doctor's scientific account. It represents the patient's attempt to make sense of his condition. It is noteworthy the way patients accept a degree of responsibility for being ill. For example, these patients focus on personality factors as they relate to handling stress:

I probably have a control thing and that's part of it. I don't like getting behind and when I do and I think of all the things that I have to do I do put more stress on myself. I don't have any family history of high blood pressure so I really think it's what I'm putting on myself.

My sister says that I have a problem because I try to make everyone happy and that's where the stress comes in.

In these instances emotion was precisely what both patient and doctor were having difficulty coping with. Indeed the first discernable point of conflict between doctor and patient in this study revolved around the issue of emotion.

Difficulties With Emotion

Doctors ignored patients' emotionalist narratives, or talked past them, feeling most comfortable showing the "professional face" to patients and remaining firmly planted in the biomedical world view. They did not usually try to elicit patient narratives about the course of their hypertension as they

actually feared that patients would respond with stories of stressful situations and unbalanced lifestyles. Doctors perceived these narratives as a screen or evasion—an attempt by the patient to deny the reality of his medical situation:

Patients commonly, I mean that's the first thing out of their mouths—it's because they just drove down here in a car and the traffic was bad, or they had a blow-up with their husband or child. So, stress is one of the foremost things that people mention when they talk about their high blood pressure. To me that's one of the excuses they give about their pressure being high. To me that means they're in denial. They don't want to admit that they have hypertension.

Emotional aspects of the patient's experience of their conditions were considered to be peripheral to treatment, and in any case beyond the doctor's purview:

I don't have any influence on emotional factors, and it does not change what I'm able to do in the consultation.

This may explain the brevity of the doctor-patient interactions in this particular case study. The inter-

tors, but tended to be forgiving of doctors and often kept their own council:

To my mind it's stress. [The doctor] says yes to a degree, but really counters with other things—it's in the family, it's genetics—but there is no question in my mind that it's lifestyle and stress. He knows about my lifestyle and stress, but I don't think he gives it as much credence as I do. I do believe it's a much bigger percentage of the equation.

Wellness or Management?

As the project progressed I began to see that patients and doctors had different expectations of the treatment process and had differing therapeutic goals. To put things in stark contrast, patients seemed more interested in wellness, doctors in condition management.

Wellness involves emotional and social contentment, issues and concerns that are intricately woven into patients' understanding of disease states. This is why patients spoke about their conditions in informal, emotional terms. They discussed the effects that their condition had on their day-to-day lives, how it upset their

To put things in stark contrast, patients seemed more interested in wellness, doctors in condition management.

action usually involved the doctor asking a few questions during or after taking the blood pressure reading. Rarely did consultations last longer than five minutes.

Doctors were interested in symptoms and narrative descriptions only in so far as they indicated a developing emergency situation or that the prescribed medications were not being well tolerated. In established doctor-patient relationships conversation revolved around medication review and adjustment. In these cases patients typically came in with their own lists of medications, knew how long they had been taking them and in what dosage. The doctor would then consider the viability of the medication strategy, tweaking and adjusting this strategy as he or she saw fit.

Patients recognized that they were coming at matters from a different perspective than their doc-

emotional and physical balance, or how its origins were linked to perceived imbalances in their social and emotional lives.

Time and time again in my medical projects I find patients speaking the language of feeling and everyday events and occurrences. In effect, they speak a different language than do doctors during medical consultations. Patients bring with them folk understandings grounded in moral and ethical metaphors of balance and order. The medical or biological understanding of health and the body their doctors operate from as they try and manage the care of these patients often falls unheeded in the divide between worldviews. ■

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