

**RELIGIOUS-CULTURAL ATTITUDES TO PRESCRIPTIONS,
MEDICINES AND DOCTORS IN FRANCE**

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ABSTRACT

Although the social sciences have studied the influence of social environment on individual behaviours regarding medication, very little research has been done on the variations that exist between patients in equivalent social contexts but with diverse religious backgrounds. This article presents the results of research on the correlation between patients' religious-cultural background (Catholic, Protestant, Jewish or Muslim) and their behaviours regarding medication. It shows that the cultural origin as well as the collective history of the groups to which patients belong impact on their attitudes towards prescriptions, medicines, their own bodies, and doctors.

Key words: medicines – prescription – doctors - religion – culture.

INTRODUCTION

Most social science studies on medication have attempted to define types of consumption or degrees of observance by linking them to social or socio-professional determinations and to users' age and gender. Although this research has produced varied and sometimes even contradictory results¹, it has furthered our understanding of the use of medicines and especially of the impact of social, economic and demographic factors on that use. Yet there is a missing dimension: culture. From an anthropological point of view, and hence a comparative perspective so dear to this discipline which explores cultural invariants and differences, it seemed to me that the question of social use of medicines could be posed in new terms. These might allow us to explain why patients' attitudes vary within the same social category, and thus to complete the explanations provided by sociologists in terms of socio-professional category and class.

The idea here was not to break away from the explanatory models usually applied by the social sciences to explain health-related behaviours, but to define models that incorporate other dimensions into the cultural base. For example, medical sociology has shown that after consulting a doctor many patients do not stick to the prescription. In particular, it has revealed the fact that non-cooperation and a critical attitude have increased with time, for patients are generally better informed than in the past. To explain divergences that still exist between individuals in this respect, sociologists focus on the effect of class. Some even use the notion of "cultural differences" in relation to health care, to account for class habitus. But the very notion of culture is always related to that of class. Mormiche (1986), for example, notes that farming communities and the working classes are the furthest removed from the medical world, and talks of the "working-class culture" as opposed to the "white-collar culture". Although individuals in different social categories clearly have diverse behaviours regarding disease and medicines, due to the many disparities relative to socio-economic status or education, we know nothing about differences within a single social group and especially between individuals from different religious-cultural backgrounds, for example².

Moreover, most sociological, economic or epidemiological studies agree that the consumption of medicinal drugs is high "in France", and explain that phenomenon in terms of patients' particular relationship with medicines in France. But, apart from the reality of the social security system which is peculiar to this country, why would patients in France have a specific relationship with medicines? Is being "French" a cultural state, irreducible to other cultural affiliations, that suffices as an explanation?³

I therefore chose to study this question from the angle of patients' cultural and especially religious – an aspect of cultural – backgrounds. The issue of attitudes towards medicines was considered from

the point of view of its indissoluble relation to the use of medical prescriptions. This issue has a number of ramifications, for it raises questions that are coextensive to the first, among others: representations of the body, of efficacy, and of the relationship with writing, knowledge and medical authority. As a starting point for this research I chose to focus on two distinct cultural groups: Protestants and Catholics living in the south of France. My research then spread to other groups with a different cultural background: Jews and Muslims. Membership of these groups is not considered here as adhesion to a set of beliefs but, more broadly, as participation in a value system and culture, independently of beliefs and irrespective of how close to or removed from their religion the subjects are. This perspective renews the approach of studies on relations between health and religion.

Starting with the assumption that the cultural dimension implies the impact of values and representations conveyed by religious affiliation or background, and that this impact unconsciously impregnates behaviours, I posited that its imprint could be read at various levels, especially in the relationship to the body, to illness and to doctors, and in attitudes towards prescriptions and medicines. The idea was to identify the extent to which cultural-religious origin impacts on daily practices concerning medicines, prescriptions, the body, and medical authority. The approach of my object in terms of religious culture does not imply a concession to culturalism, but implies a will not to consider only strictly sociological aspects. This research thus does not aim at reifying a sterile culturalism, forgetful of social variables, but to highlight, among the multiple components of the individual, the mark of the religious origin. One could not indeed explain the differences in the behaviours observable inside a same social group only by psychological differences between the individuals; some of these differences may be put on the account of the cultural (religious) origin and, ultimately, of the history of the group to which people belong. The belonging to one or the other of these groups is not considered only as adhesion with a system of beliefs, but like participation to values and to a culture of which I try here to understand how it impregnates daily practices external to the field of religious practices. In other words, whether informants believe in God or not, and whether they have a religious practice doesn't make any difference here. All have a family religious cultural origin that has impregnated them⁴.

METHODOLOGY

The research took place over a five-year period and concerned patients, their families, doctors, nurses, pharmacists, and members of religious communities (bishop, priests, ministers, imams, rabbis, and hospital chaplains). Observations were conducted in various settings and situations. Some inquiries were carried out in hospitals during consultations both in specialized services – especially in a respiratory disease ward, a cardiology ward, and an internal medicine ward, with a view to comparing behaviours and representations of people with equivalent pathologies – and in the outpatients' ward, a context in which people are relatively available. Other inquiries were conducted at the homes of the people that I had either met in hospital or seen in other contexts, especially within associations (cultural, religious, of women, etc.). There I observed individual and family practices concerning prescriptions and medication (their use, conservation, storage, etc.). Such research obviously needs to consider more than individuals' statements. Precisely because the questions it raises cannot be answered by discourse alone, the conditions have to be created for collecting the data required to identify specific cultural influences. The researcher therefore has to visit the people concerned, in their homes, as an observer.

A total of 186 patients living in the south of France were questioned (74 were Catholic or from a Catholic background, 53 Protestant or from a Protestant background, 36 Muslim or from a Muslim background, and 18 Jewish or from a Jewish background). They belonged to diverse socio-professional categories. The research was undertaken in both rural and urban milieus, but also in varied social ones (offices workers, farmers, teachers nurses, executives, etc.). In order to neutralize the strictly sociological variable (the importance of which is well known as regards behaviours relating to the body, illness and medication) and to be able to examine the variety of behaviours within the same social category, I compared the persons studied on equivalent occupational categories. For example, inside the category of people living in a urban area, I compared charwomen

from these different cultural groups, that is catholic, protestant, muslim etc⁵. In the same way, my group of informants comprised high-educated persons belonging to these various cultural groups, such as protestant and muslim scientists.

THE FUTURE OF THE PRESCRIPTION

The symbolic value of the prescription is not new (cf. Dupuy and Karsenty, 1974). There is no certainty, however, that different individuals have the same relationship with prescriptions, nor that they grant them the same status. Claude Le Pen (1991) made a similar observation when he wrote that, especially in the case of tranquilizers, prescriptions are of a symbolic nature in so far as they attest to the reality of the pathological state. He furthermore pointed out the magical nature of the therapeutic value of a few scribbled lines. Yet, in my opinion there is good reason to wonder whether this relationship is identical for everyone, and hence to question the validity of this generalization in all cultural groups composing French society.

The question therefore turns around what patients do with a prescription once they have it. What value do they grant it? How do they deal with their prescription on a daily basis, from the point of view of its content (medicines prescribed) and its form (the piece of paper)? Do they keep it? Do they destroy it? Where do they put it? What place does it have in the more general framework of dealing with illness?

My preceding research enabled me to establish that once they have obtained a prescription, many patients do not purchase the prescribed medication. It is as if the prescription had the value of a therapeutic object per se, as if it were the vehicle of writing endowed with a certain power, something like the status of the "written thing" in Islamic societies (marabouts who give objects the value of a remedy by inscribing verses from the Koran on them). I then wished to establish whether the role of writing in the cultural backgrounds of patients in France determines a specific relationship with the written prescription. For instance, given the importance of the authority of writing and the Bible in the Protestant tradition, I initially considered the possible impact that this tradition might have on the relationship with the writing on prescriptions. I wanted to establish whether Protestants' relationship with writing is fundamentally different from that of other groups, and whether this relationship is objectified in different practices concerning medication in these groups. My main question was whether the written prescription is likely to be given far greater importance in one group than in the other.

In fact my research revealed that Protestants do not seem more inclined to stick to their prescriptions than members of other groups. It did appear, however, that they have different practices regarding this object. Prescriptions are more often kept by Catholics, while Protestants tend to throw them away after the treatment, although they often copy them down (in a note book, an exercise book or a diary). The significance granted to the fact of copying the prescription seems to be related not to the fact of over-valorizing the text written by the doctor (since, on the contrary, that text is not always adhered to) but to the need to be able to refer to it oneself, if necessary, at a later stage. The idea is thus to be able to consult the book in which the names of medicines are noted, possibly for future self-medication ("Like that, I will know what I must take if I have the same thing one day", a protestant farmer; "It enables me to remember what I took and to buy it again if I need it and if it is effective", a protestant secretary). When the prescription is kept in Catholic families, the aim is rather to be able to show it to other doctors if necessary, or to be able to answer a doctor's questions during future consultations ("It's better to keep them. If my doctor, or another, needs to know what I took!", a catholic secretary). Thus, whereas Catholics who keep their prescriptions do so in order for their doctor to be able to see what they have taken, Protestants keep them so that they can refer to them themselves.

The dominant tendency in Jewish families seems to be to keep prescriptions in order to be able to remember the treatment, without there being any clear concern as to whether this is for the doctor or the patient her/himself. Both are likely to refer to an old prescription, possibly together, when deciding on a new treatment. The patient reserves the possibility of being able to discuss its appropriateness, just as the prescription itself is discussed. Many doctors note that their Jewish

patients readily inquire about the medicines prescribed for them, discuss the treatment and frequently phone their doctor to ask questions. I shall revert to this point.

In Muslim communities prescriptions are almost never kept after the end of the treatment. There is no wish to keep them in order to show them to the doctor later or to refer to them themselves, first because self-medication is rare and second because the patient assumes that the doctor (always the same one) will know what she/he prescribed without being reminded. Not keeping a prescription for longer than the treatment does not mean that Muslims devalorize this object – far from it – but its value corresponds to its validity: "A prescription is like a bill", explained a Muslim mason, "it's a proof". "A paper is better, because there's the doctor's stamp" (the letterhead), "it's the proof that he prescribed, it's the proof that it was necessary to do that. The letterhead, the stamp and the signature, it's essential". It is the stamp of authority. On the rare occasions on which the prescription is kept, it is always out of a concern to be able to produce it in case it is requested by the social security services or by a new doctor – if the patient changed doctors in the meantime. Although the prescription is not sacred, in the sense of not normally referring to sacred texts, it is nonetheless considered as an official document, produced by an authority, and is consequently an object of great respect and valorization related to the person who wrote the text, the doctor, himself an object of veneration.

The question nevertheless arises as to why Protestants throw prescriptions away if they wish to remember the name of a medicine taken previously. Why do they not refer to the carbon copy of the prescription? Why do they recopy and then destroy it? In this respect it is interesting to note that when the prescription is destroyed in a Protestant home, it is frequently burned and not thrown away. Why burn it? We could settle for the explanation of keeping paper to light the fire, given by the individuals themselves to justify their practice, but this seems highly unlikely since symbolically destruction by fire can hardly be reconciled with an exclusively functional explanation. Moreover, observation revealed that other papers are thrown away and not burned – a sign that the prescription is indeed an object with an important symbolic load. We might suggest the purifying value associated with this destruction, but what is being destroyed? A trace of the illness? The mark of a disease? Or the trace of the person, of her/his body, attested by the refusal to leave papers lying around when they contain information on the person. The prescription is a secret domain, "confidential", that in all modesty one does not show. Or is it a trace of the prescribing doctor? This is probably the key, for by throwing away the prescription, patients have the impression that they are eliminating a trace of the doctor, obliterating her/his letterhead. By recopying the prescription they are able to refer directly to the information contained in it, in order to prescribe for themselves, in a sense, the medicine previously considered to be effective. This leads us to the heart of the relations that individuals maintain with their doctor, a point to which I shall revert.

USE AND CONSUMPTION OF MEDICATION

From the issue of use to that of compliance

In common sense discourse and in that of researchers, talking about the use of medication often involves looking into the question of compliance. But the issue of compliance poses problems for the ethnologist, in so far as it is defined as the degree to which the patient's behaviour (in terms of taking medicines, following diets or changing habits) *coincides* with medical advice (cf. Haynes & *al.*, 1979).

In this respect certain authors (Conrad, 1985; Trostle, 1988) have highlighted the epistemological difficulties likely to be encountered if we consider the phenomenon from the doctor's point of view. Trostle thus suggested considering the idea of compliance as an ideology that establishes and justifies the doctor's authority. He shows that the importance of debate on compliance stems from the fact that it relates to an ideology of the authority of doctors and professionals. According to him, although it claims to be concerned with improving health care, all literature on the subject is in fact a literature of power and control. He rightly denounces the fact that the social sciences that study this problem adopt the viewpoint of the health profession. The term "compliance" is thus frequently

challenged by anthropologists for reducing the issue of the use of medicines to one of adherence to the medical prescription (Dunbar & Stunkard, 1979). In this respect it is interesting to note that non-consumption of a treatment bought by a patient on her/his own initiative is not called non-observance, even though it expresses the fact of not having observed the prescription that the individual issued to her/himself, in a sense, and therefore of not having seen her/his choice through to the end. I shall take the liberty here of breaking away from the accepted use of the concept of compliance, normally reserved for the patient's management of the medical prescription, to talk rather of non-compliance in respect of medicines that I call self-prescribed⁶.

Not wanting to give in to the temptation of normalization in respect of compliance, or to subject this study to some kind of biomedical reductionism, my aim here is not to determine who good observers are nor why certain patients are not good observers (even if it is perfectly legitimate to analyse observance or compliance with its failures and conditions). The idea is rather to understand the different uses of the prescription, and to see under what social and cultural conditions these uses differ from those that the doctor prescribed, without determining the content of the notion of compliance in advance. What do we call compliance or non-compliance? For example, when a Muslim patient has just consulted a cardiologist and, instead of going to the pharmacy to buy the prescribed medicines, makes two holes on the side of the sheet, threads a piece of string through them, hangs the prescription around his neck and wears it against his heart, can we talk of bad compliance or even of non-compliance? As a matter of fact, such a behaviour is related to the muslim practice which consists in wearing a bit of paper on the body, generally around the neck, a paper on which a Koranic verse is written and which is supposed to have a protective value. So, in the patient's mind, it is a matter of a therapeutic act *in relation to the prescription*. It is therefore neither negligence nor a refusal to treat himself; it is a reinterpretation or a different understanding of the prescription.

Thus, reflection on uses of medicines is obviously vaster than reflection on the question of compliance. All uses have to be studied in terms of their own rationale, since misuse (from the medical point of view) can be a good use or a therapeutic act (from the subject's point of view).

Images and reality of the consumption of medicines

Many studies agree that there is a steady increase in the consumption of medicinal drugs whose use is becoming commonplace and sometimes irrational, and have tried to determine the reason for this supposed over-consumption. Unlike other tools in the medical field, medicines have the particular characteristic of being available, usable and used directly by patients. As Sjaak Van Der Geest and Suzan Whyte (1988) emphasized, biomedicine is put at people's disposal through medicines.

In practice, research on medical consumption is difficult to perform. It is likely that respondents will express their reluctance to take medicines and their refusal to take too many at a time when over-consumption is socially stigmatized. This increases the necessity, in this type of research, of relying not only on interviews and their content, and of observing individuals' actual behaviours.

Of those studies that report on the over-consumption of medicines, many fail to take sufficiently into account the gap between prescribed medication and medicines actually absorbed. Although Dupuy and Karsenty (1974) barely note this difference, they add that with very few exceptions concerning some rural cases, the prescribed medicines are bought (p. 109). In reality this says nothing of the fact that they may or may not be taken. Clearly, adherence to the prescription in terms of the *purchase* of prescribed medicines should not be confused with its observance in terms of *taking* the medication, as it is the case in numerous reports in France.

It appears that many medicines are bought and accumulated but not consumed. In this respect, rather than talking only of *over-consumption* of medicines, as is commonly the case, it would be also appropriate to recognize the existence of an *under-consumption* of medicines. Patients often do not consume (or only partially consume) the medicines either prescribed by the doctor or bought without a prescription for the purpose of self-medication, whether or not they are refunded by social security⁷. For patients the main concern is the presence of the medicines. Even when they are not absorbed by the body, it seems that for the patients their presence in the home has some efficacy. We

note here a symbolic fusion between body space and domestic space, so that if the medication penetrates one it is as if it also penetrated the other. This fusion is verified by the physical place occupied by medicines in the home. They are frequently put in an accessible place (most often in the kitchen, close to daily foods, e.g. in a bread basket, in a bowl on the sideboard) and then put away, without having been consumed, when the need is no longer felt and the illness has gone. This symbolic fusion between body space and domestic space seems to be quite unconscious, though it is also found in the storage of medicines in the domestic space (Fainzang, 2003, concerning the preferentially individual or collective use of medicines among Protestants and Catholics).

As mentioned above, it is difficult to judge the reality of consumption, due to the discrepancy between discourse and practice. This discrepancy is related to the social context of criticism of the over-consumption of medicines that produces a defensive attitude by patients who are torn between the wish to conform to the expectations of the medical profession and the desire to play the part of the good patient and simultaneously the good citizen. However, it is interesting to note that consumption is valued differently by different cultural groups. Many patients, mostly of Catholic origin, strongly deny taking a lot of medication, as if they knew that it were a socially reprobated behaviour and felt guilty, even when they prove to be heavy users. Muslims, on the other hand, claim to take *everything* prescribed, thus emphasizing the attitude of obedience vis-à-vis the doctor, even if they do not follow the treatment through to the end.

It is generally recognized that an individual's behaviour regarding the consumption of medicines can be related to her/his representations of illness. But here again, these representations are not only individual, they are also cultural. Some studies conclude for instance that the length of the treatment plays a part and that prescriptions are followed better at the beginning (Ankri & al., 1995; Dunbar & Stunkard, 1979). Yet, it is necessary to reach agreement on the idea of duration or, more exactly, of "a long time". The relationship to time and to "a long time" is not only an individual phenomenon; it is culturally constructed since it differs from one cultural group to the next. Moreover, saying that the patient stops her/his treatment because she/he considers it as useless and ineffective does not exhaust the question of the relationship between compliance and effectiveness, in so far as it fails to identify the criteria on which the patient judges that effectiveness. Effectiveness is not constructed or measured in the same way by everyone; it also has a social and cultural dimension. In a number of studies it seems that only a psychological explanation could fill the gap left by sociological studies such as statistical analyses. The question therefore remains as to whether cultural (religious) affiliation or background is likely to impact on individuals' behaviours.

This question of the relation to time clearly seems to be connected to the choice of following and continuing to follow a treatment in many other pathological cases. In some instances, irrespective of the illness for which it is prescribed, if the medicine does not heal swiftly (many patients give it only three or four days to have an effect) it is discontinued. In that case some patients do not return to see their doctor to ask for another treatment. They consider that all medicines are "much of a muchness" and simply stop the treatment. This is true mainly of Muslims. Stopping a treatment can result from the patient's conviction as to its ineffectiveness in the absence of immediate effects. Yet, for many Muslim patients, unpleasant or undesirable side-effects are proof of a medicine's effectiveness. They therefore believe that it is necessary to continue the treatment, even if the consequences may be regrettable. But they consider that there is no point in informing the doctor. The right medicine is "the one that does something". Moreover, many Muslim patients take a medicine only when they feel the need, despite the instruction to take it regularly, especially in cases of chronic diseases.

Adherence to the prescription, especially in the case of chronic illnesses, or, on the contrary, reluctance to observe it, or else changes made to the way in which prescribed medicines are taken, linked to the relationship with time, are not identical in all the groups studied. For instance, Catholics are not only more impatient to see the results of their treatment, and discontinue it sooner if they fail to observe immediate effects, especially in the case of respiratory diseases, they are also more inclined to stop a long-term treatment, even if they consider it effective. In this respect they differ from Muslims with whom it seems that the conviction of the treatment's ineffectiveness is the only obstacle to continuing it.

While many Catholics anxiously refer to the prospect of having to take a medicine for life, in the case of chronic diseases, most Protestants seem more willing to accept the idea of such long-term

treatments. It seems that this can be explained by Catholics' greater reluctance to force themselves to stick to a discipline for a long time. Perhaps this can be related to the difference between religious practices imposed by the respective religious doctrines, with Catholics having to watch their behaviour in the short term, marked by episodes of confession, while Protestants have to guarantee their salvation through life-long efforts. The fact of having to maintain the effort of following a long treatment, especially true in the case of chronic diseases, is thus tolerated better by Protestants who are more active and cooperative as regards medical institutions, and for whom it is a duty to take care of oneself.

Self-medication

The notion of self-medication needs to be considered in the broad sense, far broader than simply the use of non-prescribed medication even if its literal meaning is the use of medicines without a medical prescription, whether it concerns current medicines for colds, or more specific ones such as veinotonics, anti-inflammatories, anti-histaminics, intestinal antibacterians, antibiotics, anxiolitics, etc.. The choice of a medicine at a given point in time can be the result of an earlier prescription. A drug can be obtained on prescription but consumed in a different context from the one for which it was prescribed, either for a different illness or at a different time, or for another person. As Molina (1988) rightly points out, when a patient asks a doctor to prescribe a medicine that she/he considers effective, it is actually the patient who is prescribing the medicine for her/himself via the doctor and with the doctor's approval.

Self-medication is considered by Protestant patients, in particular, as a way of accepting more responsibility for their own health, and of taking care of themselves. From this point of view they practise it more readily than others, especially Catholics. Jews also sometimes practise self-medication, whereas for Muslims it is out of the question. In fact there is a fear among all groups of uncontrolled effects of medicines and the madness that could result from its indiscriminate consumption. It is interesting to note, however, that whereas Muslims and, to a lesser degree, Catholics refer to this fear to explain their refusal of self-medication, among Protestants it is used to justify the wish to limit the quantity of medicines consumed, without necessarily being a reason for avoiding self-medication. The fear of negative effects of self-medication causes Protestants to want to share this knowledge with their doctor, and some would like to see the creation of a computerized database that could be consulted to establish whether the medicines they wish to take are compatible. The important point here is that, independently of its actual practice, self-medication is perceived differently in each group. Whereas Protestants are fully in favour of it, Catholics often refuse it but sometimes practise it, and Muslims never practise it. Self-medication, condemned by the latter, is valorized by the former.

The image of psychotropic medicines

Representations of psychotropic medicines (neuroleptics, anti-depressants, tranquillizers, hypnotics) require specific analysis. Although these medicines are reputedly consumed extensively in France, there is a great deal of reluctance to take them, related to various types of fear (physiological or psychological dependence, alteration of cognitive faculties, personality change, feeling of discomfort, etc.) which differ according to the cultural group.

Catholics more willingly express their fears concerning the physical state induced by psychotropic drugs, especially the fact that they induce "sleepiness" and the impression of being "stunned" or "floppy" ("somnolent", "assommé", "ramolli" ou "ensuqué" in french). It is essentially the physical discomfort that is refused, the unpleasant feeling induced by sleepiness in the middle of the day. The same reasons are given by Muslims, especially women, who complain about sleepiness and other side-effects (effects that are dreaded because they clash with the social demands attached to women's status in Muslim homes, where they have to look after their families and not give in to a morbid or sleepy state). Muslim patients who express a reluctance to take psychotropic medicines also mention the negative effects of these substances on social behaviour, through harmful effects on the body and especially the heart. These medicines are believed to "act negatively on the heart and

mind" (we shall revert to Muslim's image of the heart).

Protestants criticize those who are unable to face their problems, condemn the use of a "crutch" and affirm their wish to deal with their problems directly (considering that they have no need for help or an intermediary). They are far more often reluctant to take psychotropic medicines due to a fear of becoming dependent on them. It is interesting to note that the refusal of dependence is a strong value among Protestants, also observed in the wish to deal with their illness, their prescription and their medicines independently.

Reluctance among Jews to take psychotropic medicines is related to the fear of memory-loss that prolonged use of this type of medication can cause. Whether they are believers or not, for Jews memory is an essential value that must not be undermined. On this point the order to remember, given to believers, shows how memory is celebrated through religious teaching. Yerushalmi (1991) notes that the verb "to remember" appears 169 times in the Bible. The necessity to remember has constantly resonated among Jews since biblical times. The fact that memory is also valorized among non-believers can be related to its historical ties: remembering means protecting oneself. The history of persecutions throughout the centuries and especially of Ashkenazi Jews in the 20th century has reinforced this injunction to remember and be wary. Reference to memory is a constantly recurring leitmotif in Jews' expression of fears relative to the consumption of psychotropic medicines.

THE BODY

The way in which patients treat their bodies, in relation to their doctor, varies from one group to the next. Catholics tend to dispossess themselves of their bodies more readily than do Protestants who manifest a marked desire to take charge of their illness and to choose an appropriate treatment. In general, dispossession of one's body or, on the contrary, taking care of it in the face of medical authority, corresponds to the attitude that members of these groups have towards religious authority.

Generally, individuals' attitudes to the prescription differ, depending on the area of the body concerned. Observation in specialized hospital wards has revealed that in the cardiology ward patients adhere scrupulously to their prescriptions, irrespective of their cultural background. This is clearly linked to the image of the heart as a vital organ, but also to its symbolic status, not as a central organ in the blood circulatory system but as a vehicle and form of expression of the person her/himself, representing – in all the cultures examined here – the seat of emotions, affects and character traits.

Yet, in Muslim families the heart has a privileged place, as individuals' most regular daily behaviours show. Even those Muslim patients who observe their prescriptions the least, adhere to them strictly when they concern the heart, irrespective of whether they feel symptoms. What does the heart represent for Muslim families? "A healthy person is someone with a healthy heart", "The right behaviour comes from the heart", "Bad thoughts should not affect our heart", "Good intentions come from the heart", "An intention straight from the heart", "A person's actions should engage them to the bottom of their heart" are all phrases that attest to the idea of the heart as the seat of spiritual and moral life. In fact the Koran reserves a prime place for the heart in so far as it is considered as the place from which a person's thinking rises up to God. It is thus a key element in religious faith. Religious therapeutic objects (generally verses from the Koran inscribed on a bit of paper and placed in a piece of cloth) are frequently worn around the neck, "on the heart". (It was not on the heart purely by chance that the Muslim patient mentioned above wore the cardiologist's prescription, like a charm, in a sort of rivalry, in terms of effectiveness, between medical writing and Koranic writing). The importance of these representations is found in their impact on the choice of a medicine or therapy. For example, a Muslim nurse chose to replace her child's paediatrician, recommended by a child-care centre, by a general practitioner whom she preferred because he always listened to the child's heart; a Muslim mason considered his doctor incompetent because he never listened to his heart, and decided to consult someone else; a Muslim shop-keeper complained that "some doctors are not thorough because they listen to your heart over your T-shirt". Finally, as noted above, it is precisely the heart that is seen to be most threatened by the consumption of psychotropic medicines.

Unlike some patients' focus on a particular organ, others see the body and mind as an indivisible whole. This is the case, in particular, of practising Jews who reaffirm the oneness of body and mind. The 613 commandments that, in Judaism, symbolically relate to the number of limbs and organs of the human body, attest to the importance of the body and its functioning, and to the articulation between body and mind formulated by the most religious Jews in terms of unity of body and soul. But what strikes us are other effects of this cultural tradition that conceives of the unity of body and mind – unlike the way in which Christian duality separates them –, especially the importance that Jewish patients, whether they are believers or not, grant to the *face*. Patients say they are highly sensitive to what the doctor transmits through her/his face, that is, to what that face reflects and expresses, and thus reveals of the person. For believers, the importance of the face is related to its significance in biblical writings, for the word "face" occurs very frequently, and the importance attached to the gaze is clearly equally meaningful. Yet reference to the face and gaze is also found among non-believers who argue that they are the expression of the entire person (Halpérin & Weill, 1994). This is another way of reaffirming the indivisibility of body and mind. Thus, the face is not conceived of independently of the being animating it, and of what it expresses. Note that in Hebrew the word "face" exists only in the plural ("*panim*" : faces); hence, it relates to the multiple expressions that an individual's face can have, all of which reveal the intrinsic plurality of the human being, of what a person can convey to others.

SUBMISSION, RESISTANCE AND NEGOTIATION

The relationship with prescriptions, medicines and the body, and especially the strong tendency among Catholics and Muslims to dispossess themselves of their own bodies, and among Jews and Protestants to take their bodies into their own hands, so to speak, can be matched to these cultural groups' different relations with medical authority.

The issues raised around adherence to the prescription relate partly to the question of submission to the orders it contains. As Dagonnet (1994) notes, the French word for "prescription", "*ordonnance*", relates to "order" and the verb "to order". But individuals' reactions vary, for order is something that can be circumvented, discussed or refused and because medicines may be the object of a reticence on the part of patients⁸. What are the dominant attitudes in this respect in the groups studied?

Irrespective of individuals' socio-cultural level, we note greater submission to the doctor's authority among patients from Catholic and Muslim backgrounds than among patients from Jewish or Protestant backgrounds. Submission to the doctor (explicitly based on recognition of her/his competencies in a field where the patient is ignorant) is linked to a more general relationship with order, as medical authority appears to be just one form of authority in general. Yet submission to the doctor is not equivalent to submission to her/his prescription; in other words, it does not necessarily mean that the patient observes the prescription better and passively accepts everything the doctor recommends. It attests to a different relationship with the authority embodied in the doctor, implying for example that the patient will not tell (and above all will not dare to tell) the doctor about his refusal to follow the prescription. Many patients from different social backgrounds, especially Catholics, say they do not want to "turn the doctor against" them, and therefore avoid the risk of displeasing her/him by openly refusing her/his prescription or saying that they use homeopathic medicines – which would make them guilty of transgression. Likewise, Muslims also have an attitude of submission to medical authority yet tend to be "bad observers" of prescriptions since they often discontinue their treatment as soon as the symptoms disappear – except with diseases where clinical signs are obvious, for instance when the patient feels out of breath, especially when she/he knows that the breathlessness is related to a heart disease. Yet they still tell the doctor that they took the prescribed treatment, even when they discontinued it⁹. It is as if it were forbidden to show one's refusal to follow orders from an authority. In fact, apart from the reality or fear of control experienced by Muslims in France, mostly of North-African origin, submission seems to be celebrated by Muslims whose very name (Muslim, *mousslim* in Arabic) means total "submission" to God. This attitude can be found among popular classes as well as among high-educated ones¹⁰. So,

what I refer to here as submission does not exclude all form of resistance, but that resistance is secret and hidden from doctors.

Submission to the doctor is not unrelated to Catholics' tendency to dispossess themselves of their bodies more readily than Protestants, and is attended by patients' greater passivity regarding their treatment. Some patients would like to hand themselves over entirely to the doctor's care, and seldom demand an active role in the treatment¹¹. It seems that objection is more direct and is withheld less among Protestant and Jewish patients than among Catholics and Muslims.

It is nevertheless interesting to note that the differences, compared to Catholics, observed among Protestants are more marked among the Reformists (Calvinists) than among the Lutherans and, within the group of Reformists, are more marked among the Cévenols (from the Cévennes region in the south of France) than among those from other regions. These differences stem partly from doctrinal differences between Lutherans and Reformists, in so far as the latter, in keeping with Calvinistic doctrine, are more likely to stigmatize the abuse of power and resist political authority. However, the differences stem above all from historical factors since the most critical patients, most concerned about asserting their autonomy, are those from the Cévennes region. It seems that the firm refusal of authority within this group is related to their past of persecution by those with political authority. Thus, within the Protestant population we can distinguish a threefold opposition: Lutherans / Reformists / Cévenol Reformists, in increasing order of attachment to freedom and less submission to doctors and clergymen alike. But although individuals' relationship with medical authority is not unrelated to their relationship with authority in general, it is perhaps in their history rather than in religious doctrine that the explanation lies.

In a sense, the analysis of individuals' relations with their doctor illuminates some of their attitudes regarding prescriptions. We now understand better why some Protestants prefer to get rid of the doctor's prescription but keep a record of its contents. For the patient this is a way of eliminating the trace of the prescribing doctor and thus of the medical authority to whom she/he referred. The patient then keeps only a trace of the remedy considered as adequate, that is, a trace of her/his own decision and judgement. She/he thus appropriates the very act of prescribing.

All in all, resistance to the doctor is more open and the attempt to negotiate more active among Protestants and Jews than among Catholics and Muslims whose submission to the doctor is greater and whose resistance is less explicit. We realize, when examining the relationship patients have with the medical authority, that the medical doctor is not far from playing, in the eyes of the patient, a role partly similar to that which the representative of the Church plays¹². Negotiation with the doctor seems to be related to the use of questions, which many doctors say is common practice among Jewish patients. They complain that these patients constantly phone them to ask questions. Questions put to doctors and negotiations concerning the treatment do seem to be far more commonplace among patients of Jewish origin than among the others, and observation of patient-doctor relations shows that Jews discuss a lot of their medicines with their doctors. They frequently question the doctor to know if there is not another more effective treatment or one that has fewer side-effects, and want to know about everything available, so that they can choose.

In fact the relationship with questioning is not foreign to Jewish traditions. One aspect of questioning, found throughout the Talmud, is controversy. Conflicts of opinion between various protagonists who use their elders' opinions or biblical verses to argue their point, are presented. The Talmud thus provides for and teaches contradiction (*pilpul* in Hebrew). In Talmudic schools there always has to be discussion on the texts. Jewish teaching is thus in the form of controversy. Discussion, even contradiction, is celebrated to such an extent that if all the members of a class agree, the teacher changes the composition of the class, considering it to be unproductive. To the requirement of interpretation, advocated by the Talmudic tradition, can be added the necessity for questioning. In this respect we refer to Derrida (1967) who, in connection with Edmond Jabès' *Livre des questions*, notes the importance in the Hebrew tradition of hermeneutics, and consequently of interpretation and commenting. He emphasizes the importance of the question, showing that the right to speech is part and parcel of the duty to question.

This material and its analysis suggests the relevance of re-evaluating the findings of studies of the doctor-patient relationship. The Interactionist school emphasized the conflict that sometimes exists between the two – a conflict that it has analysed as the result of diverging perspectives and interests,

highlighting the fact that the doctor-patient relationship tends to fit with the negotiation model (Strauss & *al.*, 1963). But this conflict is not always expressed in the same way, and patients' cultural characteristics are probably not unrelated to these different forms of expression. As we see here, not only is this undertaking of negotiation not identical in different socio-cultural groups, these attitudes are also partly attributable to a cultural tradition with religious roots.

CONCLUSION

Our research shows that the findings of some social science studies on the impact of socio-cultural, socio-economic, socio-professional or socio-demographic variables on individuals and their behaviours, though they are quite important, are not enough to explain certain differences within a single social category, since they don't account for certain recurrences within the same cultural group, between different social categories. This study did not aim to find other social determinants for behaviours. I simply wished to identify some tendencies that might explain certain differences, for individuals' behaviours regarding health and disease are not constructed exclusively on social group, age, gender or education. They bear the imprint of cultural-religious background, independently of the phenomenon of belief, that is, even when the individuals concerned have distanced themselves from the religion in question. This cultural impact originates not only in these groups' systems of thought or underlying doctrines, but also in their collective history.

The importance that Jews place on memory or the stronger will among Reformists from the Cévennes to assert their independence as regards medical authority, show that the values shared by a cultural group are expressed differently, depending on individuals' own history and that of their family, but also on their political context. It is therefore necessary to challenge the attempts to rehabilitate the concept of culture as it is currently used – so rightly criticized by various authors (especially Kleinman, 1995; Massé, 1998) for implying a set of values shared equally in a group or community. Of course, the erring ways to which culturalism drove anthropology should not prevent us from thinking in cultural terms. However, we need to re-examine the cultural by taking into account the social and the historical, precisely because cultural phenomena are influenced by social and historical dynamics. The reader is thus urged here to transcend culturalist analyses, and to acknowledge the sense and weight of history on the impact left by religious cultures. The idea is to identify the traces of history that religious culture has left on individuals and peoples – traces that attest above all to the way in which the individual situates her/himself in relations of power¹³.

This study calls in question stereotypes or generally accepted ideas such as for example the fact of considering that Catholics and Protestants would be, together (on the basis of their common membership to Christianity) very different from the others (Muslims or Jews). In this respect, this research poses also the question of the borders between these cultural groups: because if these cultures are, a priori, usually distinguished in the fact that they draw their origin from doctrines and systems of thought which are different between them, their borders can be redefined here according to new parameters, which are the modes of inscription in the world of the individuals who belong to them, but which are not necessarily identified with these systems of doctrines. We can thus make new bringings together, based not on the religious doctrines which generated them, but on the similarities or the oppositions which appear in the daily behaviours to which they give birth. The borders which apply to the membership of historically dated doctrines, are not necessarily worth for the values which they convey and behaviours that they involve. This redefinition even of the borders and new pairings which it authorizes testify to the role of the history. Therefore we can find, at the basis of these cultures, a combination of religious and historical elements.

Obviously, some of the diverse behaviours relative to the use of medicines are common to these different groups (Fainzang, 2001) – even if the purpose of this article was to highlight cultural diversity, one of the main interests of our discipline. Many invariants reveal that the patient is above all a human being, even if she/he is also a being of class, gender and culture. Exploration of cultural peculiarities does not exclude the anthropological aim of highlighting the universality of certain human behaviours.

Finally, as this article has shown, an anthropology of medication cannot be isolated from the

general anthropological project. It consists in knowing and understanding not only the use of medicines but also what that use reveals about individuals and society.

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1 After examining the literature on the subject, Ankri, Le Disert & Henrard (1995) note, for instance, that there are few convincing relations, or contradictory relations, between observance on the one hand and the age, gender or intellectual level of patients, on the other.

2 With the exception of the expression of pain (cf. Zola, 1966; Zborowski, 1952).

3 In this respect, the attempt to distinguish characteristics by country is, in my opinion, too simplified to be of heuristic value. Even if its validity can be shown for the analysis of health systems in different countries (cf. Payer, 1988), it cannot account for the complexity of the systems of thinking involved in individuals' representations and attitudes regarding disease.

4 As regards this issue of impact, for convenience we will use the terms "Catholics", "Protestants", "Jews" or "Muslims", to refer to people "of Catholic family background" or "Protestant background", etc. Reference sometimes made to religious belief or practice will be specified.

5 As regards the Muslim, the fact they were born in France or not, didn't appear to make a difference as far as the relation to their body and to their doctor is concerned, probably because most of them have been in France for a long time.

6 As we will see, apart from obvious reasons for not taking medicines he has been prescribed or he has bought on his own initiative, including disappearance of the symptoms, there are more complex mechanisms which account for the patient's non-compliance, such as the symbolic association between the body space and the domestic space (see below).

7 Use of the notion of "under-consumption" does not refer to a good norm in either therapeutic or economic terms. It is justified with regard to the choice that the actors themselves have made by buying the medicines (whether prescribed or not).

8 On the issue of the skepticism towards medicines and doctors prescribing them, see Whyte & *al.*, 2002.

9 Certain patients' lying to their doctor about taking medicines or not was studied with regard to the relationship of power that prevails in doctor/patient relations (cf. Fainzang, 2002).

10 "If a drug is not appropriate to me and that it has unpleasant effects, I stop taking it. But I do not say it to my doctor! I am afraid that he will say that I am making fun of him. It is true that if I consult him, it is not to tell him, afterwards, that I don't want what he prescribes me!" (a Muslim woman, having made high literary studies, daughter of a senior official of the French administration); "one cannot negotiate a treatment as one negotiates a cow! One cannot dispute the opinion of a doctor! if you go to his place, and that you ask him something because you feel sick, you cannot tell him that you don't want what he tells you to take" (a Muslim biologist); "all that my doctor tells me to do, I do it; in any cases, I will never say to him that I don't want to do it!" (a Muslim farm labourer).

11 Note that this tendency to put one's fate into the doctor's hands coincides with the wish of many doctors, generally of Catholic origin, to assume the right to knowledge on the patient's body and to refuse the patient choices concerning her/himself, related to the reality of her/his state. Deborah Gordon (1991) talks in this respect of the cultural base of the practice consisting of not telling and not knowing a cancer diagnosis. Unlike the situation in the US, she notes a cultural consensus in Italy around the fact of not saying and not knowing the truth on this subject. It is regular practice in Italy not to inform patients that they have cancer.

12 Patients thus maintain with the doctor a different relation according to the way in which the image of the one who embodies authority inside the various religious doctrines is built. The doctor is readily considered as the priest among Catholics, receiving confidences, managing treatments or ordering behaviors, his word being highly listened. On the other hand, among Protestants, he tends to be considered as the holder of some knowledge that one can possibly consult but to whom one does not alienate his choices. In the same manner, the attitude of the Jews with regard to the doctor is aligned on that which the practising ones have with the rabbi. If he is readily consulted, to resort to him does not necessarily imply to obey to him, and the consultant engages with him long discussions within which he can express his disagreement. While among Moslems, the word of the doctor is never contradicted, at least openly, no more besides than that of the imam or the mufti. The displayed respect is a moral and social requirement unceasingly reaffirmed, even if it is to circumvent, but secretly, the regulation delivered concerning the action to be taken.

13 And attested by the disagreement sometimes observed in mixed couples when they express a different understanding of these social relations.