INTRODUCTION
WORKING AT THERAPEUTIC PERSONHOOD

Kent Maynard

> As individuals express their life, so they are.
>
> Marx and Engels 1970: 42.

> [T]he cultural formative activity which is entailed in … work and identity unfolds in a social arena which positions [workers] … in fields of power and which should be seen as both historically and socially mediated.
>
> Ulin 2002: 694.

This is a book about 'medical identity'. Illness, and misfortune generally, are ubiquitous. It is no accident, then, that healing and other forms of giving or taking care are equally universal. Ironically, however, relatively little attention has been paid to the identity of those who heal or promote well-being. A significant, though partial, exception comes in regard to spirit possession, where there is a growing literature on mediums and personhood (and/or the body), at times in relation to wider issues of individual and social health or welfare. Much, though certainly not all, of the work on spirit possession and personhood, or larger issues of identity, comes from sub-Saharan Africa (e.g., Boddy 1989; Comaroff 1994: 306f.; Corin 1998; Lan 1985; Masquelier 2001; Rasmussen 1995). Yet, with the exception of these and other departures (e.g., Shaw 2002), a good deal of scholarship may either overlook 'medical identity' or implicitly assume that it is relatively unproblematic.

Of course, medical practice comes in many guises: healing may be highly professional and specialised, or far less formal; some societies are most concerned with prevention, while others focus on intervention. Based on rich and wide-ranging ethnographic data, the essays in this collection consider both the self-fashioning and collective work of identity formation involved in healing and the

pursuit of well-being. Whether as acupuncturists, physicians, diviners or midwives, among many others, care giving, in Ulin's terms (2002: 694), is socially mediated. All the authors ask, as well, about how lay people view medical identities, and how these identities are influenced by wider social and cultural factors. As the essays demonstrate, class, gender, sexuality, ethnicity, or state policy may all have a formative and/or formidable influence shaping cultural definitions of health and well-being, how they are delivered, and the character and prestige of those who contribute to our welfare in society.

Locating identity

In thinking about 'medical identity' let me begin with the noun, returning later to the adjective 'medical'. Identity is one of those concepts that simultaneously face in two directions – towards the individual and towards the group – at once opening on to an exterior world of sociality (and even the cosmos), yet equally personal. Even modified by the adjective 'social', the term 'social identity' implies both membership in a group and something about the individual as a self and as a person. It may be a truism to say that human beings are social; yet, understanding the myriad ways in which we 'embody' larger groups, while at the same time helping constitute them, remains deeply fascinating.

For Karl Marx and Fredrich Engels, that process is inextricably tied to work: not to oversimplify, we are what we do. Or, as they write in *The German Ideology*,

> As individuals express their life, so they are. What they are, therefore, coincides with their production, both with *what* they produce and with *how* they produce. The nature of individuals thus depends on the material conditions determining their production. (1970: 42; emphasis original)

Our very awareness that we need to associate with others – that we are members of a society – is utterly dependent on production, the satisfaction of material needs, and (historically) on the gradual increase in human population (Marx and Engels 1970: 51). Who we are, and those with whom we identify, presuppose how we make a living. Humans share a universal species being – or so Marx assumed, influenced by Enlightenment thought – but because what we do differs on a daily basis, we also fundamentally differ in how we think, feel and act.

Marx and Engels, prescient of so much anthropology to follow, did not expect the Inuit, for example, to resemble the Germans in their emotional, cognitive or social life. As Clifford Geertz (1973: 49) has famously said, 'there is no such thing as a human nature independent of culture. Men without culture … would be unworkable monstrosities with very few useful instincts, fewer recognizable sentiments, and no intellect: mental basket cases.' While this is an idealist harmonic on the Marxian theme, even Geertz recognises the import of what we do for who we are:

> To be human … is not to be Everyman; it is to be a particular kind of man, and of course men differ. … Within [Javanese]] society, differences are recognised, too – the way a rice peasant becomes human and Javanese differs from the way a civil servant does. (1973:53)

Although social identity – what it means to be a rice farmer – has received enormous attention over the years, the terms of the debate have shifted fundamentally during the last three decades. From an early Geertzian emphasis on the symbolic parameters of identity, the discussion moved first to the practices of identity and now to its bodily manifestations: that is, to how we act out our identities; indeed, how we bear them corporeally through sexuality, gender, comportment, the cultivation or modification of the body, clothing, and so on.

As Andrew Strathern and Michael Lambek (1998: 5) note with a certain humour, '[t]he body is suddenly omnipresent in academic texts'. In part, this is due to the 'increased visibility and objectification [of the body] within late capitalist consumer society'. Scholarly fascination with the body has been shaped as well by feminist critiques of essentialist views of sex and gender, and by 'the body's increased salience as primary signifier and locus of "home" for the uprooted, mobile, hybridized citizens of the transnational moment' (1998: 5). Concurrently, there is increased distrust of studying 'reified' cultural systems of identity, opting instead for the supposed certainties of practice, and the tangible evidence of embodiment. For a number of disciplines, imminence has become almost everything (Maynard 2002, 2003). Thus, the body, for Strathern and Lambek (1998: 5), is coming to replace the 'person' as a subject of inquiry, and I would add 'identity' as well.

For Strathern and Lambek, as well as Tamsin Wilton (1996), this signals a 'new materialism' in postmodernist thinking.[1]

> It is perhaps ironic that the anti-enlightenment tendency of postmodernism, with its suspicion of meta-narratives, its refusal to hierarchize truth-claims and its concomitant de-centring of science, has written the body back into theory. Ironic, because general opinion is that postmodernism is the ultimate in anti-materiality. … Yet others insist that it is precisely the theoretical iconoclasm of postmodernism, the casting down of the throne of scientific rationalism, that enables the return of the body. (Wilton 1996: 102)

Circuitously, and paradoxically, we can return here to the insights of Marx and Engels, that consciousness and identity are rooted in our bodies and our work. Or, can we? Robert Ulin (2002: 692–3) reminds us of the long history of critique concerning Marx' concept of work – by Jürgen Habermas, Hannah Arendt, and others – who show how he conflates work with meeting utilitarian needs, at the expense of the cultural work by which we give meaning to what we do, and who we are.[2] For Habermas, especially, Marx focuses only on instrumentality, overlooking both the critical and communicative rationality of human beings. 'In short, instrumental views of work, and more generally human action, tend to

eclipse, or at the very least to render derivative, social interaction as symbolic and the cultural construction of work and identity' (Ulin 2002: 693).

Taking French wine-growers as his example, Ulin examines how human agents construct their identity, but this work is not simply economic labour narrowly construed: it represents the full panoply of human activity. As such, it is grounded in interaction with others – with its implication of diverse cultural perspectives and unequal access to power – as well as the historical impedimenta and opportunities crucial to how we define both ourselves and our possibilities. As Ulin notes in the masthead above:

> [T]he culturally formative activity which is entailed in wine-growing work and identity unfolds in a social arena which positions wine-growers both literally and figuratively in fields of power and which should be seen as both historically and socially mediated. (2002: 694)

Put another way, work is inherently cultural. And, identity formation always implies – especially when it is part of larger culturalist movements – what Appadurai (1996: 15) calls 'the most general form of the work of the imagination'.

Working at medicine, imagining personhood

What does this mean for medical identity, and, more to the point, for the essays in this volume? If both our 'human nature' and our social identities are entwined with daily activities, then semi-specialities or occupations involved in medicine have a way of defining their practitioners. That is, if healers and other people engaged in medicine differ in what they do (and how they think of medicine, healing, and so on), then how they define themselves, and are defined by others, will likewise vary fundamentally. There may be, in fact, a world of difference between acupuncturists in China, diviners in South Africa, or care assistants in a British facility for the elderly. Even within the professional sector of biomedicine, medical identities may vary widely: consider here Jenny Littlewood's discussion of different interests and perspectives of midwives, nurses and obstetricians in a London hospital (p. 134). Finally, the same medical status may vary across time or in different social contexts. As Anne Digby demonstrates in her essay on physicians in Great Britain and South Africa (p. 14), the identities of general practitioners in rural Britain over the past century were often quite different from urban specialists, or their counterparts in the colonies.

Leslie Sharp (1993: 17) draws on Marcel Mauss (1987), along with Nancy Scheper-Hughes and Margaret Lock (1987), to set out the concept of 'the three bodies'; that is, we can distinguish three levels of identity: self, personhood and ethnic identity (or, in our case, medical identity). 'Selfhood', in this typology refers to the personal experience of identity, of who one is, though it is culturally

shaped; personhood also pertains to the individual, but defines her 'as a social being who experiences *structural* shifts in relation to her kin and friends, and these shifts affect her role and status in the community' (Sharp 1993: 17, emphasis original). Ethnic identity, by contrast, focuses on the relation of the person (and self) to the group (1993: 17).

Though we can separate these concepts analytically, Sharp (1993: 17) underscores their fluidity and dynamism. In her study of spirit possession in Madagascar, as a medium enters and exits trance she may move between all three forms of identity, 'shifts that may be temporary or permanent.' Self, personhood and ethnic or other social identities are cultural constructions, ineluctably tied to specific social circumstances. For example, we should be careful about associating the self too closely with either the individual or the body as presumably discrete 'things'. As Anne Becker (1995: 127) notes for the Fijians, 'Self-essence … transcends the body to affiliate with the collective. The two, body and self, do not share a mutually fixed or exclusive identity; their common substrate is the collective.'

From Richard Shweder and Edmund Bourne (1984: 193–4) we can conclude that the self and personhood – and certainly medical or other forms of social identity – vary cross-culturally, and are social constructs. Of course, the same is true in industrialised Western societies, so-called bastions of individualism. Here, too, the self is 'saturated' by, indeed relative to, social and cultural life (cf. Gergen 1991; Sennett 1998). Likewise, concepts of the self, person and identity vary over time; we certainly see that in Europe and North America (e.g., Sennett 1977; Taylor 1989; Reiss 2003), and we might expect to see it in non-Western nations and indigenous groups as well. In this light, we might consider the implications of cultural psychology, that the mind is culturally constituted (Cole 1996: 101f.).

The essays in this volume range across all three concepts – self, personhood, and social identity – to show their on-going dynamism and relation to practising medicine. All the authors underscore the keen observation of Maureen Schwarz (1997: 8), that 'over the last few decades, the classical anthropological opposition between the self – the awareness of oneself as a "perceptible object" (Hallowell 1955) – and the person as a social construct [and I would add social identity] has blurred'. Instead, these represent, in Gergen's deft phrase (1991: 156), 'relational realities.'

In this volume we see this fluidity most clearly in Gina Buijs' discussion of Zulu diviners (p. 84), especially men who receive female spirits and assume senses of self and personhood, bound up with transvestitism or homosexuality, that have profound implications for their social identities as diviners and healers. What does it mean for the individual 'male' *sangoma* to engage in such practices: how does it affect 'his' sense of self, 'his' prestige in the community, or even 'his' viability as a diviner?

We glimpse analogous questions in Elisabeth Hsu's distinction between 'participant observation' and 'participant experience' as she steered the latter course as an anthropologist, 'learning the skills and knowledge I intended to study to such a degree that I could perform these skills myself (p. 101)'. As her fascinating auto-

biographical account makes clear, there are profound implications for the self, personhood, and the larger social identity of the anthropologist in 'learning to be an acupuncturist, and not becoming one'.

The interweaving of self, personhood and social identity implies that who is recognised as having a medical identity, or who views themselves in this capacity, may vary over time. They may be thought of as quacks in one historical era, only to bear the imprimatur of authenticity in another. Or their legitimacy may never be in doubt, but their prestige may experience radical shifts in fortune. Such questions inform Anne Digby's discussion of rural British general practitioners. Her study likewise raises important methodological issues: rural GPs were often quite busy and not disposed culturally to record introspection about their medical identity. She poses the intriguing question: how does one study a group where self-effacement is part of their identity, where people assert that the 'private' self ought to be subsumed by 'public' experience?

We see a similar issue approached from a different vantage point by Jenny Littlewood in regard to midwife identity. When a birth goes wrong, or a baby is stillborn, what does it mean for the midwife's sense of self, as well as her personhood in relation to others, or her identity within the larger structures of the medical system and society? What are the implications for midwives of attempting to 're-naturalise' birth – to portray it as a highly personal, even intimate event between the mother, her partner and the baby – while also managing the birth technologically and bureaucratically?

Just as Littlewood situates the self and personhood of midwives in the context of their lower status and prestige relative to gynecologists, Janette Davies presents a similarly poignant structural dilemma for nursing-home care assistants: how do they conceive of themselves when they are essential to so much care-giving, yet are accorded such low social status and prestige (p. 117)? By 'conferring dignity' on patients, through the hard work of medical and personal care, auxiliary aides confer dignity on themselves. They see themselves as 'necessary go-betweens', with a profound sense of value that may outstrip the relatively menial sense of personhood accorded to them by nurses, administrators or, at times, the public.

If medical identity raises questions about society and the self, it also calls into question what we mean by 'medical'. That is, if the cultural work of identity points beyond mere utilitarian labour, as we have seen, then medicine, too, might imply a good deal more than biological or psychological health. Better said, medicine (again, as cultural work) has implications well beyond a narrow construal of healthcare as a material need for survival. Thus, I return to the adjective 'medical' in 'medical identity'. Medicine, as with most things, is defined in myriad ways cross-culturally. Indeed, in many indigenous societies medicine has far more to do with public welfare writ large than with solely interventive or preventive matters of illness (cf. Maynard 2004; Whyte 1997). As with the Kedjom of Cameroon in this volume (p. 61), health becomes only one diacritic amongst others denoting individual and social well-being; equally crucial may be economic prosperity, freedom from accidents, human fertility (as well as that of animals and plants),

and indeed political sovereignty of the society. Likewise, how a practitioner approaches medicine – for example, as a ritual versus commercial act – may say volumes about the perceived authenticity of his or her identity. 'Commercial medicine' in societies like the Kedjom may be oxymoronic; healers who ask for cash on the barrelhead may risk charges of charlatanism.

Finally, all the essays in this volume situate identity, personhood and the self within the wider structures of society. If identity is culturally constructed, it may be shaped as well by class, gender, ethnicity, racism, sexuality, colonialism, the state, and other exogenous factors. Again, Anne Digby compares British GPs with their middle-class counterparts who emigrated to South Africa, and the latter with black South African physicians who came to Britain for their medical education. Finally, she considers how the emergence of state control of health care, through nationalization of the British health service after the Second World War, meant profound shifts in medical personhood. As members of the National Health Service, physicians assumed a profoundly different identity than the old self-employed rural practitioner.

Similar shifts are found in Cambodia, again in response to the state: in this case, the massive social experimentation imposed under the Khmer Rouge, followed by the contemporary impact of the transnational pharmaceutical industry and the dominance of neoliberal economic policies. For Ing-Britt Trankell and Jan Ovesen (p. 36), matters of identity are played out against two backdrops: cultural conceptions of modernity in regard to the assessment of medicines and their providers, as well as how various drug-providers position themselves in respect to distributing medicinal substances.

Just as identity is a relational reality, so, too, for Trankell and Ovesen, we can speak of the 'social lives of medicines'. But both medicine and our own social lives are deeply etched by underlying structural or transnational processes. Whether larger economic forces in Cambodia or Cameroon, sexuality in Zululand, class in Great Britain, or ethnicity in China, external factors help sculpt medical identity, how we conceive ourselves, and how others assess our status.

Working at medical identity: an order to the argument

Based on rich and diverse ethnographic data, the essays in this book look at the medical identity of a wide array of healers and other promoters of well-being – whether acupuncturists or physicians, diviners or nursing home providers, medicine sellers or midwives. The authors ask multiple questions: about the self-fashioning of medical personhood, how other people in the society view care-givers, or the degree to which wider social and cultural factors shape their medical identities. As I have said, these essays demonstrate that class, gender, sexuality, ethnicity, or state policy may all play formative roles in constructing definitions of health and well-being, how they are delivered, and the character and prestige of those who provide for our health and welfare in society.

As authors, we explicitly set out to consider multiple medical identities, in multiple social and cultural contexts, across historical eras, and at several analytic levels. From the interpersonal to the institutional, from fine-grained ethnographies of local realities to structural analyses of identity in the context of transnational forces, these essays underscore the sheer diversity of medical identities and the external factors that impinge upon them.

We begin with the apparently unproblematic – what might seem virtually iconic of 'medical identity' – and immediately begin to complicate it, namely, the identity of the general practitioner (GP) in Western biomedicine. Anne Digby works on multiple fronts to remind us that there is nothing natural, nothing inevitable about how physicians think about themselves, or what we assume about them. The GP's identity is both an historical construction, and cross-culturally variable. Indeed, it may not be the same in rural or urban areas, or in other contexts in the same society. Digby contrasts the social identity and self-image of rural practitioners with that of their urban counterparts; likewise, she demonstrates how they may differ from specialists in their cultural construction of self. Historically, rural GPs in Great Britain constructed a profoundly 'local' identity, one wedded to their involvement in the community, both professionally and socially. Just as they were 'general' practitioners, so too their identities were general, multifaceted and intricately interwoven with the community, across the lifespan, across generations, across all the most intimate, and most public, events that mark a specific place.

Digby complicates the picture still further. She shows us how rural medical identity has changed over the last century, from the Victorian era to the post-Second World War world of the National Health Service. We see, in particular, how larger demographic, economic, and political forces have helped transform the medical identity of rural GPs from an heroic, self-sacrificing image – influenced by a Romantic celebration of rural life fated to disappear – to the more professional, bureaucratic identity of a 'panel physician' within the National Health Service.

Digby goes on to illustrate how the identity of the GP has also changed under the impact of emigration, as physicians have left the UK, often for economic reasons, to practice in colonial South Africa. As representatives of the colonial power, practising in a different society and culture, in a situation dominated by a racist view of indigenous people, British physicians in South Africa have assumed a very different conception of themselves and their relationships with African patients, from that which they might assert in the Scottish Borders. Finally, Digby garners evidence to show how this process works in reverse, the impact on black physicians of leaving the rigid racist dichotomies of South Africa to receive medical education in Great Britain.

With the second chapter, we continue the analysis of Western biomedical identities, focusing more directly on the impact of other societies and cultures. Ing-Britt Trankell and Jan Ovesen consider the 'social life of medicine' in Cambodia, but rather than focus on physicians, they remind us of a major medical

identity we may often forget: the pharmacist, chemist or local drug-providers. They consider two major macro-level external influences on such identities: the rise and aftermath of the Khmer Rouge regime and the advent of Western pharmaceutical transnational corporations in the Cambodian market. Drawing on a distinction by Vinh-Kim Nguyen and Karine Peschard (2003), Trankell and Ovesen argue that medical identity is shaped by three orientations in Cambodia: premodern, modern and a-modern (rather than 'postmodern') medical views. The premodern orientation of indigenous herbalists merges healing and curing, whereas the modernist view of the professional pharmacist focuses principally on curing biological pathologies through a capitalist exchange, the purchase of biomedicine. The vast majority of the population, however, and most of the commercial chemists, dwell more in an a-modern medical world, one that merges capitalist and indigenous assumptions in the same transaction.

In the third chapter on so-called 'traditional doctors', Kent Maynard charts similar terrain in Cameroon, though he focuses more intently on local forms of medicine. For the Kedjom people, we see a new tradition of healers, arising essentially since the Second World War, merging the iconography and etiology of the precolonial medicinal sphere with the principles of commercial exchange and Western institutional arrangements of hospital care. As with many medicine sellers in Cambodia, Kedjom 'traditional doctors' forge uneasy relationships between the precolonial and modernist principles of local and biomedicine. The question is: how do potential clients respond to their claims to a new medical identity? Maynard argues that patients are pragmatic yet cautious. They may go to such healers, and end up valorizing their assumptions about the practice of medicine for profit, if and only if healers are successful. Yet, if the therapeutic process fails they may become disenchanted, wondering if the healer has exaggerated his or her power for the sake of money. As a result, the trajectory of many healers can be meteoric; they may become immensely popular, but their success may be short-lived indeed.

Again for sub-Saharan Africa, but this time for diviners, Gina Buijs asks a question similar to Maynard's: how do potential clients respond to the identity claims of practitioners? In Buijs' case study, drawn from South Africa, this question is complicated less by what happens in Kedjom – turning medicine into a commercial transaction – than by the sexual orientation of the diviner. What do Zulu laypersons say about diviners, supposedly celibate, who may engage in homosexual practices? Interestingly enough, very few such diviners are denied legitimacy. In Buijs' account we see both how such diviners may construct their ambiguous sexual and gender identities, and the social and cultural context that allows them to continue practising as diviners.

Buijs is able to accomplish several matters in this chapter. On the one hand, she makes the important ethnographic point that homosexuality and transvestism are more institutionalised in sub-Saharan Africa than we might think. She makes an equally important point about why it may be condoned, if not accepted, that it does not de-legitimise the identity of the diviner. While transvestism is prac-

tised quite openly, homosexual relationships are not. They may be 'public secrets', that is, known at some level by everyone, yet never subjected so glaringly to scrutiny that such practices call into question the other identities of the person. This is due in part, Buijs observes, to the power of the diviner: they enjoy genuine cultural legitimacy in regard to their role as diviners, an authority that may override other aspects of their identity that might otherwise cause them to be stigmatised.

In Elisabeth Hsu's chapter, 'Learning to be an acupuncturist, and not becoming one', she considers a new region of the world and a new medical identity – acupuncturists in China – but also a somewhat different question that we have asked before. That is, she asks simultaneously about the identities of acupuncturists and her own as an anthropologist. Concurrently, she poses a methodological question that connects them: how can she best learn what it is like to be acupuncturist? For Hsu the answer lies in her distinction between 'participant observation' and 'participant experience'. She opts for the latter as both more humane and more methodologically sound: 'Engaging in participant experience meant to me that I should be involved learning the skills and knowledge I intended to study to such a degree that I could perform those skills myself'. Hsu's chapter, as a result, wends a distinctive path, a double journey as it turns out, exploring both what it means to be an acupuncturist and what it is like to become one as an anthropologist. Again, what we learn about the former (and the latter), as with all medical identities, is that they are shaped fundamentally by larger structural and institutional factors, both internal and external to medicine. For acupuncturists we see how they lack the prestige of doctors who practice Chinese classical medicine. But Hsu also shows us how their conceptions of the body, of *loci* and channels, bear the imprint of deep cultural roots, a set of widely shared cultural assumptions that may lend credence to the legitimacy of their identity.

In Janette Davies's chapter we return to the West, but to care assistants in a nursing home especially for those suffering various forms of dementia. Yet, as with acupuncturists in China, care givers in the UK must contend with a lower status in the medical hierarchy. Davies shows us tellingly the impact of a paradox on their identity: on the one hand they are considered virtually 'menial workers' in the wider reward system of biomedicine, yet on the other they are absolutely crucial to care within the residential home. Highly valuable yet undervalued; in such circumstances how do caregivers conceive their medical identity? Auxiliary workers, most of whom are women, draw on another of their identities – that of mother, wife or daughter – to give care where care is needed. By doing so, they affirm that what they do is essential, in spite of its low prestige and compensation. Although they occupy a world of commodified labour, they view what they do less as work than as care. Thus, by conceptually removing themselves from the commercial sphere and reconfiguring who they are more in the domestic arena, they attribute to themselves a value beyond price.

It is intriguing, and no accident, that similar themes emerge in Jenny Littlewood's final chapter, on midwives in a London hospital. She, too, demonstrates where midwives fit in the wider biomedical hierarchy, how their lower status and prestige contribute to their attempts to professionalise their identity as important to the birthing process. For Littlewood, this produces its own share of ironies: although midwives have gained prestige and status in professional medicine, they have done so at the expense of reducing their role in the community. As with Digby's discussion of rural physicians in Great Britain who joined the National Health Service (NHS); their identity has shifted from a local focus to a national one, their identification with the lay community has now shifted more to professional colleagues.

Yet, Littlewood equally shows us that the trauma of a less than 'perfect' birth may leave the midwife on her own, bereft of potential ties with either the community or her colleagues. We see here another irony: much of the midwife's sense of self and identity is premised on personal, hands-on involvement in facilitating a 'normal' birth. The midwife helps to construct this event as a natural, intimate event shared between her, the mother, her partner, and the newborn baby. Yet, this takes place within a highly bureaucratic, technological setting, one structured by the NHS to maximize statistics on 'successful' pregnancies. Midwives must, in effect, bridge contradictory cultural constructions: the personal and the bureaucratic, the natural and the technological, the intimate and the impersonal. This implies an inherently risky process of identification and selfhood, and Littlewood shows us clearly that there may be real 'costs' involved in the achievement of 'normal births.'

Conclusions

In the end, we are who we are through hard work. Work never done alone, but always with a profound sense of agency (the power to make a difference), is underscored by all the essays in this volume. Sometimes the work of medical identity is quite conscious – a matter of self-invention; more often, our identity emerges unbidden out of experience. What that experience is, the specific contours of the work, and how it bears the brunt of larger cultural and social matters, shape what we do and what we think about it. Working at or working in medicine is not unproblematic: the work itself, what we mean by medicine, and how it makes us (and others) feel about who we are, are all matters to be discovered. As these essays demonstrate, where the cultural work of medical identity ends up is equally something to be investigated, not assumed.

Notes

1. Terence Turner (1994: 30) introduces a perceptive note of caution about the tenuousness of this materialism, at least in post-structuralism:

   > The elevation of the body to the place occupied by subject, agent and social individual in older forms of Western social thought, notwithstanding its apparently 'materialist' character as a substitution of a concrete physical entity for an abstract metaphysical concept, has generally involved in practice a focus on conceptual or linguistic representations of the body and an indifference to the body as an objective physical reality.

   Thus, post-structuralists (and postmodernists) may hypothetically get us back to the body – as I imply in the next paragraph – but we need to complete important conceptual work to understand the body in all its senses, cognition and corporality, as an agent in the fullest sense, not simply as a semiotic text inscribed passively by culture (or Foucault's 'power/knowledge'), and read by someone else.

2. I am grateful to Jenny Littlewood in her chapter for this volume, reminding me of Ulin's (2002) trenchant essay on French wine-growers and their cultural work in constructing identity.

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