Bureaucratic rituals in health care delivery

Aaron V. Cicourel

Abstract

Following Roberts (1964), D'Andrade (1981; 1989; 1995), and Hutchins (1995), cultures and communities therein can be viewed as socially distributed cognition and socially organized knowledge systems (Schütz, 1962). The paper focuses on Western medical practices we will call bureaucratic ‘rituals’ that rely on folk knowledge and evolving, socially organized conceptual systems and technical activities we call ‘science’ and ‘technology’. All information processing involves expanding and compressing or limiting the processing capacity of individuals and collectivities. Cultural myths or beliefs about the origin of illness and possible cures persist despite what Max Weber (1968) called the rationalization of society. Bureaucratic rituals take on a life of their own and can create extensive technological domains of limited intelligibility for patients. It is, however, the patient, at least initially, who is the key source of information for triggering loosely coupled networks of oral and written or electronic communication and miscommunication. Patients’ ability to understand medical information can be hampered if they have anxiety-producing doubts about the care they receive, or fear that they may possess a serious or terminal illness (Crawford, 2005).

Keywords: distributed social cognition and knowledge; rituals; intelligibility and miscommunication

Affiliation

Aaron V. Cicourel, Department of Cognitive Science, 9500 Gilman Drive – Mail code: 0515, University of California, San Diego, La Jolla, CA 92093–0515, USA
email: cicourel@cogsci.ucsd.edu
Introduction

The term ‘ritual’ is often associated with ‘sacred’ objects and events that can be linked to healing practices embedded in religious beliefs and practices, magic or the supernatural. The term ‘ritual’ will be viewed as analogous to such secular Western medical practices as when the human body is covered during the application of invasive procedures (for example, surgery below the neck, a Paps Smear and dilation and curettage for women, and rectal and genital examinations). Perhaps less convincing examples of ‘rituals’ would include bureaucratic procedures for obtaining and using health care insurance, making appointments for health care services, and providing health care personnel with personal or biographical information.

Another way to describe the notion of ‘ritual’ is to follow Goffman’s (1955) reference to ‘face-work’ and the notion of a ‘sacred self’. My truncated interpretation of Goffman is that during situated social interaction, a person assumes he or she is expressing elements of a socially approved role or set of attributes or pattern of social action that may be subject to continual re-negotiation. The investment in maintaining one’s ‘face’ or self-image becomes ‘sacred’ in the sense of seeking to present a stable version of self that is not subject to disrespect or humiliation (loss of face). Thus ‘face-work’ is expected of others involved in the same situated social interaction. Continual effort is required to maintain one’s ritual, ‘sacred’ self-conception.

The general idea is that unless identifiable cultural ‘rituals’ are followed, ‘problems’ (including emotional reactions) are likely to ensue delay, or lead to the denial or refusal of health care. Within Western health care delivery, many analogous ‘rituals’ emerge in bureaucratically organized settings. Learning that one’s health is at risk and that one consequence may be an inability to maintain a previously perceived sense of a ‘normal’ self can be traumatic.

Healing practices within bureaucratically organized health care systems appear to typify what Max Weber (1968) called the ‘rationalization of society’; certain apparent conditions are routinized despite the existence of different kinds of rationality. For example, there exist ‘expert’ or primary care healers, apprentices, those in training, ancillary personnel, technicians, pharmacists, those who help with orthopedic prostheses, and a number of other services such as physical therapy and psychotherapy. There also exist ‘alternative’ forms of healing that can include herbal remedies and appeals to religious beliefs and divine beings.

The notion of bureaucratic ‘rituals’ implies closely followed administrative practices, including scheduling and canceling appointments, positioning and/or clothing for particular procedures, conducting a medical history and physical examination. Health care personnel orient patients to existing
services, including what they can expect during and after treatment. All of the aforementioned activities, and actual physician-patient interaction become sources of intelligibility and unintelligibility. For example, the patients’ ability to communicate their symptoms and follow the meaning of discourse during medical interviews, comprehending laboratory reports, prescriptions, and perhaps, later, more serious clinical activities such as surgery, heart transplants, angiograms, and colonoscopies.

Bureaucratic rituals and situated professional practices invariably are accompanied by different types of speech registers that are often domain-specific despite the ability of some physicians to move from a technical domain to one they believe the patient can understand.

The empirical issues in studies of all healing environments are: To what extent do patients understand and believe the remarks of health care practitioners and other personnel? To what extent are patients able or willing to specify their symptoms and beliefs to health care personnel?

Anticipating the case discussed below, a patient was initially told after a physical examination by a gynecological oncologist that everything appeared ‘normal’. A few days later she was told that she had uterine cancer. The patient’s subsequent discourse with the physician suggests she was attempting to deny the diagnosis while also suggesting how she might have ‘caught’ cancer from her husband who had died some months earlier of cancer. Perhaps we can say that her denial and unusual claim that she was affected by her husband’s illness was an attempt to protect or sustain a previously perceived ‘normal’ self-image. Or, that the patient’s ‘sacred’ self-image was being challenged by a powerful authority figure.

**Western bureaucratic medical rituals**

Western health care delivery largely consists of secular cultural ‘rituals’ (J. Comaroff, 1982) associated with a form of social organization known as a ‘bureaucracy’. The rituals are linked to formal and informal vertical and horizontal lines of authority (and inferred ‘power’), and patterns of interpersonal relations that can be called ‘strong’ and ‘weak’ social ties (Granovetter, 1973). Western bureaucracies are obsessed with the occupational, temporal, and economic aspects of rituals because time and cost are essential elements in the production of all Western economic commodities. The economic/temporal ‘rituals’ associated with the professional services of health care delivery are perceived as scarce resources. For example, sources of power can include scheduling appointments and procedures, the professional and technical costs associated with care, access to health insurance, and the enormous amount of electronic and paper documents that are processed. The routines or ‘rituals’
invariably compromise the limited time and attention available for the patient’s health problems and her or his working hours. An empirical challenge is identifying sources of intelligibility and unintelligibility during social interaction that can introduce misunderstanding in communication.

Scheduling appointments may be viewed as an initial source of elements of troubling ‘ritual’ behavior. Obtaining an appointment can be somewhat frustrating, especially if patients are experiencing symptoms they cannot understand. Equally frustrating is the cancellation of an appointment and an even longer delay before seeing a health care provider. In the USA, calling a medical facility (or any bureaucracy) often means being confronted with a menu of options that may not be self-evident. Large facilities can have several scheduling systems for appointments, and in some cases, physicians may insist they make their own appointments. Unintelligibility, therefore, can begin with a patient’s frustration with a system that presents the choice between an appointment after more than a few days despite uncomfortable symptoms or going immediately to a more expensive and time-consuming urgent care facility.

Specialty appointments can be especially challenging because physicians often work at more than one office and may only be at a particular clinic one day or morning or afternoon per week. Few patients understand the bureaucratic complexity of clinical appointments and patients are not likely to ever learn about the details of the way the system functions. For example, after a physician decides a patient should have a particular procedure requiring equipment such as MRI (Magnetic Resonance Imaging) or colonoscopy that someone must order requires paperwork or electronic communication by the physician and subsequent (often electronic) scheduling by other personnel.

Patients often are unable to understand how diagnoses and treatments are accomplished and such problems are often a source of unintelligibility. These activities can be viewed as mysterious or ‘magical’ and ‘God’ is sometimes invoked by patients to account for their condition (onset, worsening, or improvement). Patients rely heavily on folk theories, social networks, newspaper, radio and television advertisements or ‘health programs’ and related sources of news (Crawford, 2004).

Health care practitioners sometimes complain about the patient’s ability to be a ‘good historian’ or an inability to provide intelligible descriptions of their current and past symptoms and medication. Many physicians also worry that their patients are not following pharmaceutical instructions. Such instructions can be a source of confusion and hence misunderstanding, especially for older patients who can be taking as many as two to eight kinds of prescription drugs daily in addition to several vitamin supplements.

Medical procedures are often called ‘rational’, especially when they can invoke knowledge about technical information, and refer to the essential importance
of the physician's basic science training and clinical experiences. Yet medical practitioners may express doubts about the nature of laboratory findings if the latter do not appear to fit their clinical intuition about a problem.

The efficacy of 'rituals' invariably is contingent on the socially organized practices within a community or collectivity or bureaucracy. Empirically, this means going beyond the useful Bourdieu and Passaron (1977) metaphor of 'symbolic power' or the imposition of culturally arbitrary conditions by an arbitrary power under the guise of a legitimate order that is characteristic of all forms of religious and secular bureaucratic practices.

In all health care delivery, patients may also wonder about the healer's 'authenticity' and her or his knowledge about healing practices. 'Normal' diagnoses and many treatment practices are often carried out with only physician and patient present (though, depending on various circumstances, a nurse or technician may be involved). Hence, it is difficult to find settings equivalent to a non-Western 'séance'. There are, however, occasions in which a group of health care experts meet and discuss a patient's condition, including diagnosis and treatment plans, but often without the patient being present. In a teaching hospital, often a more formal meeting occurs weekly or monthly among practitioners to discuss special cases of clinical or basic medical science interest, and, in the case of 'Grand Rounds', includes a guest speaker who may give the professional audience a research lecture, be invited to make Ward Rounds and comment on 'unusual' cases.

Western physicians invariably practice their profession in a closed setting (often in one or more small rooms) within a private, group, or larger institutional complex in which nursing personnel greet the patient, direct them to the small examining room, engage in expected 'rituals' (e.g., taking their blood pressure and temperature), 'small talk' about their condition, and giving them a 'gown' while asking them to disrobe.

Administrative personnel at a health care facility in the USA must confirm that a patient has and/or can present evidence of health care insurance or identification that qualifies the person for health care services. In many countries, possessing a national identity card and other identifying information may also be necessary. All of the above descriptive material involves bureaucratic 'rituals' the patient is expected to 'know' and view as 'routine'.

The physician's actual performance may or may not be viewed with skepticism by the patient, but most (especially female) patients are likely to be sensitive to the practitioner or technician's engagement with their body. Hands-on activity is likely to be monitored carefully by female patients. My judgments are based on observing physician or nurse or technician-patient interaction in several Western countries. Some mixture of discourse, non-verbal, paralinguistic,
and physical contact always appears to be present, but I do not know of any systematic empirical, cross-cultural evidence to support my judgments.

**Bureaucratic rituals, intelligibility issues and patient anxiety**

Medical communication includes the routine use of terms not mutually intelligible among patients and physicians. There is often a discrepancy between the kinds of folk beliefs about illness held by patients and physicians. Patient anxieties are common and only add to the problem. Patients’ distress about their symptoms, therefore, is an obvious source of misunderstanding or unintelligible communication with health care providers.

A previously published paper (Cicourel, 1982) provided a somewhat dramatic (and probably not typical) example of how a patient’s folk theory could influence their thinking about illness. The patient was an educated woman married to a high-ranking Naval Officer who believed she had recently ‘caught’ cancer from her husband when they would visit him in the hospital and ate food she and her children had all touched. But there is more to the story.

For the patient, the way her own cancer was diagnosed involved a disturbing sequence of events. The patient had initially been seen by a surgical gynecological oncologist for what was thought to have been a routine gynecological procedure and judged as such by the physician after his initial examination. What was initially viewed as a ‘routine’ procedure turned out to be a case of endometrial cancer after the laboratory results arrived a few days later. The patient also linked her diagnosis to learning recently that the daughter had a benign tumor on her neck, and that the son was having prostate problems.

The physician’s ‘Progress Notes’ states the patient was ‘depressed’ but the term did not emerge during the three occasions I was able to record and observe the physician/patient exchanges. The patient seemed ‘upset’ because of the following:

1. After her first visit, she had been told by the physician that everything appeared to be ‘normal’. Two types of laboratory information were obtained; a routine Paps Smear and additional probes in the direction of the patient’s uterus.

2. She then received a telephone from the physician’s office asking her to return for a second visit because of laboratory results based on the material assumed to be from near her uterus.

3. She also received a letter addressed to her home with no name in the body of the letter stating that her Pap’s Smear result was ‘normal’.
The patient found it difficult to understand this form of letter which contrasted with the physician’s remarks during the second interview in which the laboratory results were discussed. He told the patient that an additional procedure he also performed during the first visit involved more than the Pap’s Smear and revealed cancer cells associated with endometriosis. The patient expressed doubts about the accuracy of the diagnosis, citing the physician’s initial remarks after the first physical examination and the subsequent letter.

An example of conceptual compression and miscommunication

During the initial interview, the physician tried to avoid technical terms by relying on the patient’s use of folk language to help him discover the kinds of medication and their dosage given to the patient during earlier visits to other physicians. She reported experiencing earlier prior swelling and soreness in her breasts after taking estrogen. The exchange between physician and patient presumes a world known in common and taken for granted, but where technical terms like ‘hormone’ and ‘dosage’ have overlapping meanings but different technical representations for the two parties.

The following exchange suggests that misunderstanding or unintelligibility emerged because of a gap between a patient’s folk understanding of the medication she had taken, and the physician’s professional experience in transforming the patient’s language into technical terms so that he could contextualize and formally summarize the patient’s medical condition.

Western medicine seeks to link the elicitation of information from patients to healing practices and the use of official bureaucratic reporting categories for which the healer is held accountable (for example, a diagnosis and subsequent recommendations for treatment). Observing such accountability, however, is difficult to document. Notice the way the physician and patient spoke to each other, in contrast to the healer’s formal re-descriptive account of the patient’s condition.

The gynecologist appears to be seeking a link between his assessment of the patient’s dosage of estrogen (‘hormone’) and the patient’s prior breast soreness and swelling. He relied on the patient’s use of color-coding to describe the medication (including the reference to a ‘different dose’). The gynecologist, however, presumes the patient understood the term ‘hormone.’ The physician does not make reference to the way he established a correspondence between the anaphoric folk color terms and the dosage of estrogen. It appears, however, that his understanding of the dosage was not problematic as he entered specific numbers into the patient’s medical record.

What is perhaps of equal interest was the fact that the patient did not consult a physician when she reported that (line 7, ‘I just stopped taking them...’),
nearly, the estrogen. The patient’s remarks again suggest misunderstanding by her folk reaction to the soreness in her breasts. For instead of thinking that consulting a physician was called for, she simply stopped the medication.

The physician’s cautious demeanor did not change despite the patient subsequently (not shown here) challenging the diagnosis. She agreed to the hysterectomy, but she also expressed concern as to whether this specialist (and not an assistant, resident or fellow) would perform all of the surgery. The patient had previously worked in a large hospital in Chicago and claimed she was aware of assistants being asked to perform many of the attending’s (specialist’s) tasks.

The reader should note that I have not explicitly made reference to systematic aspects of prosody in the discourse presented below and in a subsequent section. Also, my discourse materials lack systematic information on the relationship between language use and body movements, gestures or facial displays I selectively observed, yet these elements probably influenced my interpretation of the materials presented here.

Comparing doctor’s Progress Notes with the interview

Western medicine is saturated with bureaucratic requirements that include an official written accounting of the physician’s findings and treatment plan using handwritten notes and/or dictating a brief or long medical history (which today is subsequently transcribed and entered into a computer). The account serves both legal and medical contingencies; (1) legally because of possible charges of medical malpractice or excessive costs when assessing quality assurance, and (2) to provide a re-descriptive, compressed account to subsequent physicians about the patient’s re-description of prior conditions.

A. Wt: 146 B/P 112/64 Age 62
B. Widowed 9 mos. – Depressed. Saw Internist 4 mos. Ago
C. because of vulva irritation –
D. started 1.25 MG. Premarin -> breast soreness, so stopped EST.
E. On estrogen for 7–8 yrs. Up to 4 yrs. Ago, 1.25 MG. then 0.625 MG.
F. At Phipps’ Clinic – Mammogram – Fibrosis (1971) –
G. reduced dose of Premarin. (Progress Notes continue)

Interview material related to lines A-B of Progress Notes

1. Dr: What can I do for you?
2. P: Well, uh, I was concerned
3. about, uh...last summer I guess, I-I was having a problem in the uh...
   uh,
4. guess w-what you call the bulk of the outer uh part of the organ.
5. There’s like, paper thin uh cuts, just a little bleeding.
6. And finally when I went to have my checkup,
7. which was uh...about 3 months ago, my internist asked me if
8. I’d had a paps, test and I hadn’t so he took one and
9. he said uh my uterus was kind of spongy, and also I had uh, very low,
10. I was very low in hormones,
11. And he-uh-the estrogen
12. Dr: mh
13. P: the count was so low he said I didn’t get it so he put me on
14. uh...oh, on the estrogen pills.
15. Now about four years ago when I went through Phipps,
16. uh, they had cut me down to a half and I still was getting a lot of
17. swel-swelling and soreness in my breast
18. and they took a mamograph that time and
19. they told me to get one about every six months,
20. but, I sort of took myself off the estrogen and found that I didn’t
21. have any of that feeling,
22. so I’ve been off of it [...]
The physician's compressed Progress Notes ('started 1.25 MG. Premarin -> breast soreness, so stopped EST') combine the patient's apparent reference to having stopped taking estrogen because of swelling and soreness under both the full and half dosage of estrogen. The story becomes more complicated as the physician seems to seek more precise information.

Interview – continued

23: Dr: Now, 4 years ago when you were taking the 
24: hormones, uh...you were going to Phipps Clinic, 
25: how long did you take the hormones before- 
26: I mean, had you taken them for a number /of years? 
27: P: /I had been taking them. 
28: Yes, probably about...8, 7–8 years... 
29: Dr: And that was the purple one? 
30: P: That was the yellow one to start with, and then the purple one 
31: when they cut me down. 
32: Dr: Do you know /whi-which 
33: P: /So I (?) the 
34: Dr: /hormone you were taking? 
35: P: /yellow one, the orange, yellow one 
36: Dr: Have you ever taken a different dose from that? 
37: P: Well, uh, at Phipps they had uh, 
38: subscribed half that dose, the little brown one 
39: I believe...uh..but as I say, I, I don/'t... 
40: Dr: /But that still caused breast 
41: probl/ems, too, himm? 
42: P: /Hmm-hm. I mean, 
43: I just stopped taking them[...]

In lines 23–28, it appears the physician seeks to establish a timeline for when the patient had been taking estrogen and asks a difficult question about how many years the patient had been taking the hormone. Such questions can be difficult because our memory for such details, after so many years, is not very good. The memory problem is probably worse for (anxious? confused? elderly?) patients to answer. One strategy would be to rephrase the question by linking it to previous visits to a clinic and where the patient was living and working during the previous years. Such elicitation procedures can sometimes activate the patient's memory by some sort of contextualized, associative pathway. Asking (line 26) if the time has been '...for a number of years' is like seeking a guess and which the patient supplies in line 28.

The physician tries to locate the dosage within this unclear time frame by reference (line 29) to 'the purple one?'. Was the physician guessing about a dosage by citing the color of a pill for which he knew the dosage? The patient
(lines 30–31) responds by stating it was a ‘yellow one to start with, and then the purple one when they cut me down.’ Thus, in lines 30–31, the patient seems to link the color yellow with a full dose of estrogen and the color purple with one-half dosage. The physician’s suggestion in line 29 (‘And that was the purple one?’) remains unclear vis-à-vis the metric dosage he had intended. The exchange, therefore, points again to the kinds of misunderstanding or unintelligibility that can be associated with health care delivery when there is a taken for granted mixture of folk and medical terminology and the patient’s emotional status.

In lines 32–35, the physician appears to be uncertain about the dosage the patient had taken previously. Physicians often ask new patients to bring their current medications with them, but in the present case there were no current medications associated with the consultation and procedure. He asks the patient (line 36) about having ‘taken a different dose from that?’ The deictic term ‘that’ leaves the issue somewhat ambiguous but we can infer that the color of the pill was yellow/orange. In line 38, the patient refers to having been ‘subscribed half that dose, the little brown one.’ The reference to ‘the little brown one’ may have given the physician some sense of what the different dosages had been. Perhaps we can infer that the patient confused the ‘purple’ pill in line 30 with the ‘brown’ pill in line 38. Further, the reference to a dark color may have been unique for the drug premarin.

The intelligibility of the above exchange is far from clear. Neither the patient’s nor physician’s discourse exhibit self-evident intelligibility, but the physician’s Progress Notes suggest a medical and bureaucratically clear resolution despite the physician having elided the amount of unintelligibility or misunderstandings in the encounter.

Discrepancies often exist between the physician’s Progress Notes or medical history and what is discussed in the clinical interview (Cicourel, 1974). For example, a selective, conceptual compression of the official medical history vis-à-vis how the physician and patient conveyed their stories. The selective compression or blending can also truncate the chronology that becomes the official medical report, but the use of an official report is consistent with an expected cultural performance in Western health care delivery. We must, however, be quick to recognize that unless all medical histories were recorded, normal human information processing would make it impossible for any professional to reconstruct all of the presumably relevant details of the exchange. Even good recordings and careful transcriptions, however, require reconstructions and attributions to each participant that cannot be validated with respect to the presumed intentions and understandings and misunderstandings of the interlocutors.
We lack comparable data on healing practices in non-Western and Western settings that would permit us to document how the healer and patient's discourse and non-verbal, body movements, paralinguistic practices create traces of conceptual compression or blending as well as confusion and misunderstanding or unintelligibility. For example, although based on different stages of diagnostic processing discussed by Du Bois (1992), can we say that the distinctive Yoruba divinatory utterances derived from oracular signs are functionally similar to the Western physician's 'scientific' use of folk and technical utterances that are often derived from Greek and Latin terms?

We have limited data about the 'technical' and 'folk' nature of health care delivery exchanges in present Western settings, and are equally limited about the way patients collaboratively convey and comprehend each other's perspectives about illness and remedies.

The issue of unintelligibility is pervasive in Western health care delivery for several reasons.

1. Among professional health care providers, 'ritualized' interview discourse becomes a bureaucratically and medically expected technical register that is viewed as an efficient, succinct way to create and communicate standardized accounts perceived as 'intelligible'.

2. For the patient, however, the physician's use of folk and technical terms can introduce 'unintelligibility' and the likelihood of miscommunication. In the present case, this miscommunication is exacerbated by the emotional nature of the initial appearance of 'normality' with respect to the subsequent diagnosis of 'endometrial cancer'. What is routinized for the physician becomes an emotionally disturbing event for the patient (Ainsworth-Vaughn, 1998).

3. The conversion of patient talk into esoteric technical jargon, therefore, can lead to the creation of limited 'intelligibility' for non-medical persons but provides health care personnel with access to 'insider' information.

4. The interpretive discourse surrounding technical reports includes translating an esoteric register into everyday language, which rather than clarifying, can be a mystifying, confusing, and even frightening process for patients unfamiliar with the technical registers. For example, telling the patient she had 'endometrial cancer'.

Patient anxiety in all healing or health care practices, therefore, can lead to unintelligible or impaired processing of information provided by healers, especially when followed by serious surgery, medications, complex medical explanations and accompanying instructions.
Concluding remarks

Observer descriptions of social interaction requires empirically challenging ‘conceptual compression’ (Fauconnier & Turner, 2002). For example, linking a physician’s ‘Progress Notes’ to actual discourse.

For many patients, the onset of ‘illness’ and the consequences of medical treatment can be confusing; they can experience difficulty comprehending changing relationships between symptoms, ‘normal’ and ‘pathological’ bodily and mental functions, and remedies or treatment strategies.

Unintelligibility can also occur when patients are suspicious or doubtful of the efficacy of health care delivery. They may confuse the physician and themselves by their ‘historical accounts’ about past and present symptoms and medications. Such misunderstanding may also emerge by not adhering to a prescribed regimen of treatment.

In the above dramatic but atypical example of a diagnosis of ‘endometriosis’, the patient seemed to be somewhat ambivalent about accepting the physician’s reference to an ‘objective’ test result indicating a serious medical problem. She was more attentive to the clinical information from the physical examination suggesting no apparent problems, especially when the patient subsequently received a letter reporting a ‘normal’ Paps Smear test. Shortly after her initial encounters with the physician, I interviewed the patient at her home and found that she still appeared confused about the positive feedback she had received from the physician initially and the letter reporting the results of her Paps Smear test. She continued to suggest that she and her children’s health may have been compromised by her husband’s cancer.

A general problem faced by all social science research is that we must present our theories, conjectures, and findings in a narrative style that is both practical and perceived to be ‘objectively detached’. The goal is not to appear too ‘subjective’ to colleagues when describing the beliefs of non-Western and Western religious spirits, folktales and science. Our research, however, is never far from the taken for granted thinking and language of everyday life that pervades all science and mundane practices.

About the author

Aaron Cicourel is research professor in the Department of Cognitive Science at the University of California, San Diego. A general research interest is the role of tacit folk knowledge and implicit judgments during contextualized language use in local socially organized settings as speakers/listeners and observers process online discourse. His most recent book is Le raisonnement medical: Une approche socio-cognitive. Paris: Seuil, 2002.
Note

I am grateful to Mel Spiro for clarifying the fact that shamans, herbalists, and exorcists can be the same person performing different roles or different persons performing each role. See *Burmese Supernaturalism* (Spiro, 1996) for a useful discussion of actual cases of diagnosis and treatment.

References


