

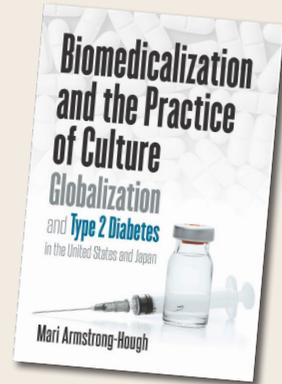
BOOK REVIEW

Biomedicalization and the Practice of Culture: Globalization and Type 2 Diabetes in the United States and Japan

By Mari Armstrong-Hough

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x + 171 pages.

Reviewed by Amy BOROVOY



Ichirō is a patient with type 2 diabetes at a Japanese hospital. His chronic condition of high blood sugar has, over time, impaired his kidney function to the extent that he must now undergo dialysis treatment in the hospital three times a week. Diabetic patients must carefully control their sugar intake, and dialysis patients have further restrictions. Yet doctors and nurses at the hospital note that Ichirō is not abiding by the prescribed regimen. In fact, in the hospital cafeteria he is observed filling his coffee with forbidden creamer and sugar. His physician, Dr. Saitō, recommends to Ichirō that he be admitted to the hospital for reeducation while Ichirō listens and laughs nervously.

Such a scenario would likely play out differently in an American health care environment. Dr. Saitō's approach might be seen as overbearing and invasive, even when handled politely and professionally. Furthermore, ordering the admission of a rational and non-acute patient would be outside the purview of basic medical care and possibly an infringement on patient rights—not to mention necessitating the cost of a two-week stay in an American hospital.

In *Biomedicalization and the Practice of Culture*, Mari Armstrong-Hough offers a discerning and revealing study of how biomedical care for type 2 diabetes is a “cultural practice,” not just a science-based medical intervention.

Biomedical interventions are often assumed to be universal in nature. Physicians participate in international knowledge exchange through conferences and fellowships. They share scientific data and medical approaches that are assumed to be “evidence-based.” Yet Armstrong-Hough's study makes clear that these approaches are also shaped by institutional practices, historically-rooted cultural beliefs, and what she calls doctors' “meaning-making tool kits” (p. 11).

Armstrong-Hough, whose study is based on 359 interviews with doctors, educators, nurses, and patients in Japan and the U.S., highlights the social context of biomedicine, particularly for an audience of American public health specialists, health care providers, and medical sociologists who are likely not acquainted with work by specialists on Japan. Importantly, she is careful not to reduce differences to stereotypes or broad generalizations.

Type 2 diabetes is caused in part by risk factors that are common to postindustrial societies, including increased consumption of starch and sugar due to the availability of

cheap processed foods, increasing portion sizes, sedentary lifestyle, excessive alcohol intake, and growing incidence of high blood pressure. These risk factors are common to affluent societies, but the causal narrative embraced by health care workers is not universal. U.S. physicians, nurses, and diabetes educators often blame the harms of modernity and the “unnatural” nature of our modern lifestyle, including TV channel surfing, driving, and snacking on starchy foods. This narrative advances a “global” model of risk which, while not entirely inaccurate, obscures both the effects of socioeconomic status on specific groups and the effects of genetic predisposition. It can also turn into a moral discourse which blames individuals for their lack of self-control.

In Japan a culturally-specific narrative has taken hold which emphasizes the unsuitability of Western foods to the Japanese body. While it is true that fatty, starchy, or salty foods contribute to the problem, Japanese doctors and educators often associate Western food with “junk food” while letting Japanese foods such as ramen, convenience store bentō boxes, or beef bowls, also salty and fatty, completely off the hook. It is fascinating that these culturally-shaped perceptions lead to markedly different treatment regimens. Limiting carbohydrates is central to American guidelines; in contrast Japanese guidelines tout the virtues of a Japanese diet, including white rice.

Japanese and American narratives of causality are both flawed and narrow. But the story gets more interesting when Armstrong-Hough considers the different ways in which medical interactions and treatment regimens are handled. Armstrong-Hough’s findings suggest that the Japanese case can inform broader public health debates in ways not usually appreciated.

Managing diabetes demands a great deal of self-discipline. A patient must measure and record his or her own blood sugar sometimes multiple times daily, administer shots of insulin, and rigidly control their diets, especially sugar intake. Interestingly, both Japanese and American health care providers eschew what they call medical “paternalism.” But they define that concept differently. American nurses and physicians associate paternalism with hierarchy and one-way communication. They claim to take a “patient-centered approach” (p. 79), attending to the patient’s specific needs and goals and supporting the patient to make good choices. Key words here are empowerment, personal responsibility, self-discipline (p. 83). When a patient fails to embrace the prescribed regimen, physicians may have to fall back on scare tactics.

Japanese physicians also eschew “paternalism,” at least in principle. But for them paternalism is associated with arrogance or lack of respect on the part of the physician. If a physician shows proper respect (using respectful verb forms and gaining the patient’s trust), then it is not inappropriate to tell the patient what to do (as we saw in the case of Ichirō, the dialysis patient). In fact, most physicians see the patient’s health as ultimately *their own* responsibility—not only the patient’s. Armstrong-Hough captures this difference evocatively: American health care providers imagine a patient’s diabetes as “your diabetes”; Japanese providers see it as “our diabetes.”

Here is where the Japanese approach offers potential food for thought. Mainstream care for type 2 diabetes in Japanese clinics and hospitals means comprehensive health education, communication, and the recommendation of concrete, quantified, and “immediate” lifestyle modifications. It is hands-on and intimate. The minimum frequency of Japanese patients’

visits to doctors—once every two weeks—is higher than the average number of visits by Americans. And visits in Japan are typically handled by physicians themselves. Armstrong-Hough’s findings made me reflect on how the notion of “paternalism” inadequately captures the nature of public health interventions in Japan, which rely not only on top-down orders but also on intensive forms of education and socialization, patient involvement through record-keeping and self-monitoring, and the cultivation of trust—practices which seem useful, but ones which medical anthropologists may lack a positive language for.

There is considerable critique of “biomedicalization” in social studies of medicine, referring to how medicine has come to intervene in a widening sphere of human experience, including childbirth, sadness, senility, and other natural effects of aging. Medicalization of chronic illness can result in an impossibly heightened sense of individual risk, in unnecessary surveillance, and in preventative care with pharmaceutical and other remedies directed not only at “illness” but also at “pre-illness.”¹

The term biomedicalization carries a negative gloss, perhaps influenced by the Foucauldian framework of “biopolitics.” In the public health context, it can also refer to deflecting responsibility onto the individual rather than society or harm-producing industries.² But Armstrong-Hough’s observations about Japan press us to consider how medical intervention through instruction and socialization may be necessary for growing caseloads of chronic illness in aging societies.

In fact, a salient feature of Japanese society beyond the clinic is the way in which education about health and the body is present in many social spheres—from elementary school training about regular bowel movements to the school lunch program, which educates children about hygiene, etiquette, and nutrition.³ Community health care centers (*bokenjo*), now on the frontlines of COVID education, educate the public about chronic illness prevention. Hospital admission for the sake of education, called *kyōiku nyūin*, is common. Mainstream practices of record-keeping including home budget-keeping (*kakeibo*) and the pregnancy log (*boshi techō*) required of obstetrical patients, inform the self-monitoring required of many patients. In 2008, the Japanese Ministry of Health, Labor, and Welfare implemented a screening program for metabolic syndrome (a group of symptoms linked to heightened risk of diabetes, cardiovascular disease, and stroke) that promotes not only health care but consciousness-raising and “lifestyle improvement” (*seikatsu shūkan kaizen*).

Socialization around health occurs in many spheres in social life in Japan.⁴ Perhaps we should more appropriately call this “bio-sociality” rather than “biomedicalization”? Certainly, there are spheres in which biomedicine has overreached, but this study also highlights the limits of the American pattern of deflecting the responsibility for health and wellness onto the individual. The book offers a window into Japan’s health care, a system the world knows little about, but is increasingly relevant to global health.

1 Whitmarsh 2013.

2 Benson and Kirsch 2010.

3 Borovoy and Roberto 2015.

4 Borovoy 2017.

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