Biomedicine, Religion, and Ethnicity: Healing in a Hasidic Jewish Community

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Abstract:

This article examines the utilization of the biomedical health-care system by Hasidic Jews. The history of the Jewish little community, the development of Hasidism, and migration to the U.S. are briefly reviewed. A Hasidic Jewish community is described in ethnographic terms with an emphasis on religious ritual and ethnomedical beliefs and practices. Finally, the clinical experiences of medical doctors and nurses who care for sick Hasidic persons are analyzed from a medical anthropological perspective which focuses on the autonomy of the profession of medicine and the phenomenon of ethnicity in the biomedical workplace.

Introduction

This paper addresses a universal problem: what do people do when they become ill? Although culturally unique, Hasidic Jews are motivated to seek biomedical technology from the health-care system because biomedicine is effective. However, biomedicine does not go unchallenged. Hasidic Jews use biomedicine on their own terms and, in doing so, illustrate core constructs in postmodernist social science: the relativity of knowledge and the salience of power in social relations.

History of the Jewish Little Community

In the pre-modern period most European Jews lived in villages, towns, or small cities within a Jewish section or ghetto (Goldscheider and Zuckerman 1984). These *shtetls*,[2] "little Jewish communities," were sometimes as small as 10 families. Most pre-modern European states harassed Jews with the imposition of social disabilities; e.g., restrictions on residency, travel, occupations, and intermarriage with Christians. Jewish communities were internal colonies ruled indirectly by European states through community councils called *kehillot* (singular, *kehilla*) (Goldscheider and Zuckerman 1984, 18-19). State laws were enforced by the *kehilla*. The *kehilla* also administered the Jewish Code of Laws, the *Shulhan Arukh*, "A Set Table," the fundamental religio-normative structure of Judaism.

Conceived of as divinely inspired from the Torah, the Jewish Code of Laws codified the sacred commandments and served as a manual regulating personal behavior. Rules for diet, clothing, travel, sexual relations, and religious rituals are within its domain. At the apex of the social control of a *kehilla* was the *rabbi*, "man ordained to judge matters of the law" (Mintz 1968, 448). Jewish communities shared the common European culture yet were culturally distinct: Jews spoke Yiddish (a language blend of Hebrew and German), symbolized ethnic identity with distinctive clothing and, of course, used a symbolic-normative system founded in Judaism.

The emancipation of Jews in Europe and the colonization of the Western Hemisphere enabled Jews to escape the ghettos and small town *shtetls* and move into urban cities, becoming integrated as Jews, not converts, into Christian society (Goldscheider and Zuckerman 1984, 32-62). The power of the *kehillot* and rabbis diminished as Jews left the small communities. However, the emancipation of Jews was essentially a phenomenon of Western Europe and North America. Millions of Jews remained in the "Pale" of Eastern Europe (northeastern Poland and the western border area of Russia) and continued to live in traditional communities well into the first half of the 20th century.

Hasidism is a Jewish social movement begun in Poland in the late 18th century (Mintz 1968). It has characteristics typical of revitalization movements and cargo cults: e.g., a belief that harsh treatment of an oppressed people is supernatural punishment for a failure to follow ancient traditions, and that a return to authentic culture will deliver a people from oppression (Wallace 1966; Cohen 1985). *Hasid* is Hebrew for "a pious person" (Roth 1973, 74). Hasidism seized upon a core symbolic form in traditional Judaism: messianic mythology. Hasidic Jews believed that the messiah's arrival was imminent, whereupon their harsh life of oppression and periodic massacres would end. Hasidism caused a fracture in Jewish society; Jews who followed Hasidism set up new communities. Traditional Jews who were not *Hasidim* were called *Misnagdim*, "Opponents of the *Hasidim*" (Mintz 1968, 448).

The founder of Hasidism was Rabbi Israel ben Eliezer (1700-1760) who became known as the *Baal Shem Tov*, "Master of the Good Name." He was

considered to be a rabbi with supernatural powers. At some point in the history of Hasidism, the *Baal Shev Tov* and rabbis who became his disciples came to be called *rebbeh*s (singular, *rebbeh*), "my teacher, my master" (Mintz 1995). Hasidic Jews believed *rebbeh*s were rabbis with special souls which allowed *rebbeh*s unique access to God and the capacity to divine supernatural secrets hidden in Jewish sacred texts. A *rebbeh* could work miracles, not the least of which was healing the sick, and some were known for what can only be termed (for lack of a better concept) shaministic healing power (Klein et al. 2002). Hasidic communities modeled themselves after European kingdoms, with the followers of a given *rebbeh* being known as his "court." *Rebbehs* and their families were treated as nobility, and the mantle of *rebbeh* was passed from father to son in dynastic fashion.

As modernization and assimilation spread through Western Europe and the United States, Eastern European rabbis and *rebbehs* closed ranks. Whereas Hasidic Jews and *Misnagdic* Jews of the 18th century had seemingly irreconcilable differences as to who had the proper way of following the Jewish Code of Laws, by the 20th century most traditional Jews were threatened by modernity (Heillman 1992). The majority of assimilated Jews had ceased observing even the most basic of the Jewish Code of Laws, e.g., observance of the *Shabbos*, "The Sabbath," and kosher dietary rules. A clear line divided modern Jews into two groups: religious and irreligious. Most religious rabbis and *rebbehs* advised their followers to remain in the *shtetls* and ghettos. They preached that immigration to America where "the streets were paved with gold" would cause Jewish children to abandon the Jewish religion.

After the German genocide only a small number of religious Jew were alive. Perhaps as few as 100,000 religious Jews and less than a dozen or so Hasidic *rebbehs* survived the Holocaust. Following WWII, as religious Jews and their *rebbehs* were discharged from displaced persons camps, the refugees took a second look at America and most immigrated to the religious Jewish neighborhoods of New York City. While the majority of American Jews were committed to ethnic identity, the immense wave of immigrant Jews that arrived America between 1880 and 1920 (almost two million persons) was almost completely assimilated into American culture (Heilman 1995). A few New York neighborhoods had created replicas of European small Jewish communities. Several of the surviving Hasidic courts found fertile soil in these neighborhoods and have thrived and rebuilt their courts with thousands of followers (Heilman 1992; Mintz 1968, 1992).

Shtetlville[3]

Shtetlville is a geographically localized Hasidic community located in the New York City metropolitan area. Its current population of approximately 5,000[4] is a large increase from the small group of several hundred Jewish refugees who settled in the community in the early 1950s. All are pious Jews committed to the Jewish Code of Laws. The economic and demographic characteristics of Shtetlville are more characteristic of a community in an underdeveloped country than a community in the world's wealthiest nation (Table 1).

	Shtetlville	**New York**
Per Capita Income	$5,237	$23,389
% of Families Living Below the Poverty Level	67	11
% under the age of 19	52	27.4
Average Family Size	5.8	3.2

Table 1. Comparison of Economic and Demographic Statistics Between Shtetlville and New York.

The low income and poverty of the community is related to the strategy Hasidic Jews have developed to resist assimilation. Hasidic Jews do not attend colleges or universities because schools of higher learning are perceived as conducive to cultural and social change. Higher education will expose the children of Hasidic Jews to ideological challenges to traditional Judaism and provide opportunities for intermarriage. Although this strategy works, it has the unintended effect of blocking entry into the professional-managerial class.

Most persons in Shtetlville work as plumbers, electricians, carpenters, or diamond cutters: skilled or semi-skilled occupations. A large proportion are either

owner-operators of small "mom and pop" businesses (grocery stores or small-scale manufacturers, usually clothing or food), or poorly paid religious teachers and administrators. There are a handful of exceptional men who have acquired wealth through private enterprise, but the majority of men and women work long hours for low wages and/or small profits at small, home-based businesses.

The large number of children is explained by a high birth rate resulting from religious rules that prohibit birth control except under life-endangering conditions. Moreover, Hasidic Jews are ideologically committed to having large numbers of children. It is not unusual to encounter women not yet 30 with four or five children, and families with more than 10 children are not considered exceptional.

With an impoverished, rapidly growing population (a three-fold increase from 1970 to 2000), Shtetville is experiencing difficulty meeting the basic necessities of life. Housing is expensive and crowding common. Although adequate nutrition is maintained and health-care services are available through the utilization of government entitlement programs such as Food Stamps and Medicaid, few families can achieve a lifestyle considered normal in middle-class America. Private automobiles and home ownership are rare; most people depend upon public transportation and live in crowded rental apartments. Assistance from extended-family contributions and philanthropic sources eases the economic burdens somewhat, but meeting the economic needs of large numbers of dependent children is a constant struggle for Shtetville families.

Religious Rituals

Shtetlville is a religious community in which several types of ritual behavior are reoccurring phenomena. Since it is a truism in contemporary social science that symbols and their meanings are imbedded in all social action, a minimal exegesis of Hasidic Jewish religious beliefs and rituals is essential to understanding the Shtetlville socio-cultural system.

A point of departure for an analysis of religious phenomena is the concept of the ritual:

> "the primary phenomenon of religion . . . ritual is religion in action, it is the cutting edge of the tool . . . belief, although its recitation may be a part of the ritual, or a ritual in it own right, serves to explain, to rationalize, to interpret and direct the energy of the ritual performance . . . just as the blade of the knife has instrumental priority over the handle . . . so does ritual have instrumental priority over myth. It is ritual which accomplishes what religion sets out to do" (Wallace 1966, 102).

The paradigmatic ritual in Judaism is fulfillment of the *mitzvot* (singular, *mitzvah*), "commandments" of God. Religious Jews believe the Torah, considered to be Divinely created sacred text, contains 613 *mitzvot*. Although impossible to fulfill all 613 commandments, the religious Jew must complete as many as he or she can and explain away the ones he or she cannot. A *mitzvah* can be as common as daily prayer or as unique and personally important as marriage. What all *mitzvot* have in common is that they are behaviors commanded by God. For a religious Jew to not obey the *mitzvot* is to imperil a fundamental sense of self.

Mitzvot are categorized into two types: 1) those which are transactions between humans and God; and 2) *mitzvot* regulating social behavior. The Jewish Code of Laws is rather like a manual providing instructions by which rules of ritual behavior are actualized. For example, there are *mitzvot* ordering a Jew to pray three times daily and observe the *Shabbos* and holy days. However, these commandments have been interpreted and elaborated by the Jewish Code of Law as to the content of the prayers, prayer schedules, and specific behaviors which are prescribed and proscribed in the conduct of prayer. There are *mitzvot* regulating diet (including food preparation), clothing, travel on sacred days, and numerous other rituals that involve humans carrying out the commands of God. These God/human *mitzvot* do not involve moral and political conduct.

The second group of *mitzvot* involve human relationships and are normative and political in nature. A good example of these are the extensive civil and criminal laws that serve as textual sources for normative guidelines; e.g., there are *mitzvot* regulating marriage and divorce.

In daily life, most rituals involve the first group of *mitzvot*. Normative, reflexive social interaction is not within the scope of ordinary religious ritual. However, value orientations can be rationalized through the *mitzvah*. A common metaphor for the *mitzvah* is a "good deed," or civil and/or proper behavior. A child helping an older person across the street would be said by his elders to be doing a "*mitzvah*." The concept of *mitzvah* has become a metaphor for the Jewish way of life, the ethos of the culture. A good Jew is one who upholds the very concept of the *mitzvah*.

Daily Prayer

The most reoccurring ritual for religious Jews is daily prayer. Jewish men and women recite precise sets of prayers three times a day, every day. Children begin the schedule almost as soon they are literate, at the age of four or five. Men and young boys pray in groups. Women can join the communal prayer, but the Jewish Code of Laws does not require their participation. In almost all aspects of social life (except within nuclear and extended families) men and women are kept within separate spheres of interaction. Group prayer in quorums called *minyans* (a minimum of 10) is essentially a male rite. The first prayer service (*Shakris*) is in the morning. The second and third services are in the afternoon (*Minhah*) and evening (*Ma-ariv*). Women usually pray privately, at home, but at some prayer services a few girls and women can be found in the balcony section of the synagogue.

Although prayer takes place as a group, prayer is not recited as a mass but individually, within a group choreographed sequence; i.e., the rite has sections of prayers and each individual must stay within the current section. The prayers are from a standard Jewish prayer book used by all religious Jews and are in Hebrew. Shtetlville residents speak and are literate in at least three languages: Yiddish (the primary language of the community), Hebrew, and English. English is difficult for many, in particular boys and men who have not yet terminated their formal religious studies and have not had much contact with the outside world. The prayers, composed by rabbis, are highly repetitious and seem to center on a few themes, including the creation of the world, Jewish history, the devotion of the Jewish people to God, messianic hope, the sovereignty of God, praises to God, and supplications to God for personal salvation and forgiveness of sins.

Anthropologists have interpreted rituals as communication systems which store information vital to the survival of a culture. The basic unit of ritual behavior is the symbol, a representation of "any object, act, event, quality or relation that serves as a vehicle for conception – the conception is the symbol's meaning. Rituals are a means of storing symbols" (Vogt 1992, 7). Such communication systems can either be verbal rituals (myths or oral narratives), or nonverbal rituals (sequences of behavior [e.g., prayer]) that fit together into ceremonial dramas. The performance of either type of ritual or, more typically, both, in conjunction constitutes the "communicative behavior" that serves to perpetuate knowledge essential to the survival of the culture" (Vogt 1992, 8).

Daily prayer at Shtetlville can be conceptualized as a non-verbal ritual. Every day the Shtetlville Jew repeats the same set of prayers three times. In each repetition the basic history, beliefs, and core values of the Jewish culture are precisely reviewed. In this sense prayer, as symbolic communication, is a "storehouse of traditional knowledge . . . messages about some sector of social or natural life" which religious Jews consider "worth transmitting down the generations" (Turner 1968, 2, in Vogt).

Shabbos

The symbolic nature of rituals contains more than information about society. Rituals are also "blueprints" of society; i.e., "models of patterned processes of believing, feeling, and behaving" (Vogt 1968, 10). That is, rituals are systems of meaning and can be multivocal, carrying a variety of meanings. *Shabbos*, "The Sabbath," is such a multi-vocal ritual. As a critical *mitzvah*, on *Shabbos* religious Jews are enjoined to obey a set of rules which, to the outside observer, are mostly negative in nature; e.g., working is forbidden, travel is not permitted, no lighting of fires, etc. However, observance of *Shabbos* in Shtetlville is a symbolic form containing a range of emotive experiences that go beyond the legalistic fulfillment of the *mitzvah*. Each Friday, beginning at sundown and continuing until after sunset the next day, the community of Shtetlville enters into a 24 hour communal sensory experience, a "communitas . . . a relationship between concrete, historical, idiosyncratic individuals … these individuals are not segmented into roles and statuses but confront one another rather in the manner of Martin Buber's 'I and Thou' . . . a direct, immediate and total confrontation of human identities" (Turner 1995, 133).

Community prayer service is not the primary social framework for Shtetlville residents "confronting one another"; another social encounter is a far more effective social drama: the *Shabbos* communal meal. Communal prayer, as noted in the sections on *mitzvot* and daily prayer, is an individual transaction between God and the person, rather than a communal presentation. The Shabbos communal meal is a ritual wherein men, women, and children interact in a ritual drama of food, blessings, and prayer. Each family conducts three ceremonial meals during *Shabbos*.

The family communal meal is followed by a community communal meal at the synagogue: the *Tish*, or "table." The *Tish* is a ceremonial male event attended by almost the entire male population of

Shtetlville. It is a meal at which only the *rebbeh* dines: a one person meal. The *rebbeh* is served the traditional *Shabbos* meal, and the men and boys watch him eat. As a man endowed with supernatural power, i.e., a *tzadik*, "holy person," his every physical action is believed to have mystical significance. To watch the *rebbeh* eat, according to Shtetlville *Hasidim*, is the equivalent of prayer.

The *Tish* is an intense rite that can last for hours. The physical movements of the *rebbeh* are observed intensely by the group, e.g., the number of slices he makes on the fish or the bread. The courses served are very large. The *rebbeh* eats what he needs from each course, and his *gabbai*, "personal secretary," distributes the remaining food to the men and boys (pieces of food are passed by hand from person to person). These *shirum*, "remains," are charged with spiritual power that can pass to anyone who eats the food.

Unlike the casual atmosphere of the family meal, the community *Tish* is saturated with intense emotion and spirituality. As many as 1,000 men and boys surround the *rebbeh*'s table (they stand on a set of portable bleachers). Sometimes in stunning silence, at other times in thunderous prayer and song, the young men and boys move to and fro, praying as they watch the *rebbeh*. Some have their eyes closed and appear lost in trance. After the meal is completed the *rebbeh* gives a *shir*, "lecture," a discourse on the weekly portion of the Torah read at *Shabbos* morning prayer service. The *shir*, in ritual terminology, would be a verbal ritual, or the telling of the myths of Judaism. The *shir* is an effective mode for socializing young males into the doctrine of Hasidism, a tutorial about the meaning of important symbols, and the history contained in Jewish mythology. The *Tish* is *Shabbos commitas* at its most intense moment.

The *Tish* is also a political event, a rally. *Hasidim* express loyalty, almost fealty, to the *rebbeh* and his dynasty by being at the *Tish*. A man who does not attend the *Tish* on a regular basis is sending a message to the community that he is not a *Hasid* and is just an ordinary religious Jew who chose Shtetlville as a convenient place to live because the ultraorthodox milieu meets his religious needs.

The culminating act of the *Tish* is a procession of all the assembled men and boys past the *rebbeh*. As they walk the *rebbeh* and each person exchange small nods or bows and the words *Gut Shabbos*, "Good Sabbath," the customary greeting all religious Jews say to one another on the *Shabbos*. Etiquette befitting a monarch is expected, i.e., no handshaking unless he offers, stand when he rises, do not turn your back, etc.

The *Shabbos* can be conceptualized as a "frame" (Douglas 1966, 63-64, in Vogt) or slice of time, in essence a weekly state of transition or "liminality" (Turner 1995). Ordinary experiences are elevated to holy status, e.g., food (the Jew needs to eat for two souls) or sexual relations (sex is mandated on the *Shabbos* night) are surrounded with mystical intentions. In terms of muti-vocality of symbolic meaning, the *Shabbos* conveys "emotional meanings that are frankly, even flagrantly physiological" (Vogt 1992, 10). The motivation to follow the *Shabbos* commandment is one the highest of the Hasidic Jewish psyche.

Hasidic Illness Beliefs

I would like now to discuss components of Hasidic cosmology: concepts of reality that serve to define illness and modalities of curing. Hasidic Jews live in a dual-plane "Cartesian" (Rhodes 1996, 167) universe: the natural world, visible and available to all humans, and the supernatural world, accessible only by holy persons or *tzaddiks* such as the Shtetlville *rebbeh*. The supernatural world is inhabited by God and the souls of all humans who have ever lived in the natural world. God controls both worlds. However, the natural world is ordered by natural principles, and biomedical scientists have achieved an effective understanding of these natural principles. As God created the natural principles that can be used to cure, the medical doctor is no more than a *schleach*, a "messenger" who uses science to cure illness. However, science and all its knowledge are Divine creations. A religious Jew sees no inconsistency between Divine causality and the "aura of factuality" (Rhodes 1996, 171) of science and is not ambivalent about using biomedicine to cure illness. It is important to note that the religious or moral character of the biomedical doctor is not a consideration in selecting him or her. As *Hasidim* are fond of saying, "even the best doctors go to hell." The doctor is just the messenger; he brings God's cure.

There is a "homologous" (Csordas and Kleinman 1996, 12) relationship between the supernatural world and the natural world. The two worlds are connected by the Torah, God's gift to the Jews. Ultimately, disease is caused by a failure to follow the mitzvot; i.e., God punishes people who transgress His laws with disease. Religious Jews are fascinated with numerology and believe that the 613 *mitzvot* correspond to 613 parts of the body. Violation of a *mitzvah* can cause its homologous body part to become diseased.

Ordinary humans do not have access to these homologous relationships. They are hidden in the text. The *rebbeh*, with his *tzaddik* soul, piety, and general wisdom, has the ability to study the Torah in such a way as to access these relationships. The *rebbeh* plays an important religious role in the curing of a serious illness. A person who has become ill "goes in to the rebbeh" A child or incapacitated person will have a parent, relative, or friend go in to the *rebbeh*. The *rebbeh*, utilizing his supernatural power for healing, will attempt to divine the religious causes of the illness. An example (Littlewood and Dein 1995) is illness caused by a *mezuzah* incorrectly written (A *mezuzah* is small metal case containing a portion of sacred text which is affixed to every doorway in a building owned by a religious person). The person goes to a *rebbeh* complaining of an illness that biomedical doctors cannot cure. The *rebbeh* divines that the *mezuzah* is defective, not written correctly, and recommends its replacement. The person follows the *rebbeh*'s instructions and is cured. Nonetheless, the sick person goes to the *rebbeh* in conjunction with consulting the biomedical doctor.

The *rebbeh* of Shtetlville uses his "holiness power" to divine which *mitzvah* is not being followed or has been violated. The Shtetlville *rebbeh* practices a kind of divination called "reading *kvitl*." A *kvitl* is a piece of paper upon which the *rebbeh*'s *gabbai* writes the following: the person's name, the name of his mother, and the request (in Yiddish). The *gabbai* gives the paper to the *rebbeh*, and he examines it. The *kvitl* helps the *rebbeh* use his supernatural powers to divine the cause of the illness and to give advice to the visitor.

The sick also pray directly to God to cure illness; however, the prayers of a *rebbeh* are believed to have greater influence with God. Going to the Shtetlville *rebbeh* also has the purpose of asking the *rebbeh* to intercede with God on behalf of the ill person. The supernatural access to God and knowledge of Divine intentions are important patron-client services that the *rebbeh* performs for his followers.

The Illness Experience

Two samples of illness events or experiences that anthropologists use in describing health-care behavior are clinical samples and community samples (Pelto and Pelto 1996). I refer not to differences between the knowledge validity of methods of statistic samples versus the knowledge validity of participant-observation and key informant interviews. Rather, the choice is between observing disease and illness from the context of the medical provider – the doctor's office, clinic, or hospital – or from the community context – the historical, contextual observation of illness as the events unfold.

My fieldwork recorded both types of data. However, this paper will use only data from the clinical context because interviews with more than a dozen doctors and nurses provided sufficient data regarding the interaction of the health-care system and the Hasidic symbolic systems and social networks to make a limited social analysis possible. Doctors and nurses consistently reported: 1) Hasidic Jews are concerned with results and use the biomedical system because it is effective at curing illness, but that; 2) Hasidic social networks and Jewish rituals mediate the use of the biomedical system. Sometimes the providers report that the involvement is positive for the patient, sometimes negative, and there are issues of social conflict. I will reserve for another paper the report of illness accounts as they occur contextually in the community.

The involvement of Hasidic Jewish religio-normative symbolic systems and social networks was consistently reported by biomedical professionals serving Hasidic Jewish patients. *Mitvzvot* were interjected into the process of biomedical diagnosis and treatment. Social networks were involved both in the relationship between the patient and the medical doctor and within the social organization of the hospital ward. I will try to illustrate both phenomena with three narrative interviews: 1) a family practice doctor with a large Hasidic practice; 2) a pediatric specialist doctor to whom primary doctors referred Hasidic patients; and 3) a nurse who worked at a hospital serving large numbers of Hasidic Jewish patients.

The Hasidic Lay Referral Network

As noted, sick Shtetlville residents visit the *rebbeh* for his supernatural intervention. They want the *rebbeh* to use his powers to cure an illness. However, this is not the sole reason for "going into the *rebbeh*"; it is not even the prime reason for conferring with the *rebbeh*. The dual epistemology of Hasidic Jews causes them to have a pragmatic orientation toward healing: sick people want their illness cured. While the *rebbeh's* supernatural powers may work, biomedical curing is acknowledged to be more effective. The problem is accessing the best possible biomedical technology. The *rebbeh's* judgment is considered to have a practical side; he has knowledge of the biomedical health-care delivery system. Sick people seek out the *rebbeh's* assistance in finding a biomedical doctor; the *rebbeh* is

a referral agent for doctors and manages a "lay referral network" (Friedson 1988, 306).

During illness crises the *rebbeh* enters into the relationship between doctor and patient. Depending on the illness, the *rebbeh* may serve as referral agent (an intermediary), patient advocate (helping the patient cope with the doctor), or patron (accessing an expensive or prestigious doctor). Shtetlville residents view the biomedical health-care system with a well-deserved skepticism: they know it can cause harm. They believe that the *rebbeh* has good practical judgment when it comes to choosing doctors and following a physician's recommendations. *Hasidim* sometimes find themselves intimidated by the doctor and use the *rebbeh* to help them communicate with him or her. Finally, the *rebbeh* can serve as patron and help a sick Shtetlville resident get access to prestigious academically based specialists. They report to the *rebbeh* the doctor's diagnosis and the *rebbeh* helps the sick person and his or her family come to a decision regarding the doctor's recommendations for treatment.

The Family Doctor

Bill[5] is a family medicine doctor. A slight, middle-aged man with a mild manner, he has practiced medicine in the area for more than 25 years. Many of his patients come from Shtetlville. He estimated that he had 10 to 12 families, about 200 patients. An assimilated Jew, Bill rarely commented on his ethnicity or religiosity. He is close to the families of his patients and concerned with their welfare; some of his child patients are third generation. "Shtetlville is my little village . . . my rewards lie there. There are warm, two-way relations. My families look to me and vice-versa. I can yell at them and they can yell at me."

Even though the parents of his child patients are close to him, Bill reported a pattern of parents wanting second opinions. They want to go to a doctor recommended by the *rebbeh*. However, they are sensitive to Bill's feelings. The parents ask Bill, "What would the doctor think if I went to Dr. X?" or, "The Rabbi thinks I should seek a second opinion." Bill does not mind having the *rebbeh* involved in the doctor-patient relationship. He sees the role as positive. It is Bill's opinion that the *rebbeh* must be knowledgeable in biomedicine since he usually recommends specialists that Bill knows and would have used anyway.

Bill provided a case illustrating the involvement of the *rebbeh* with patient care. He is currently watching a child for possible rheumatic fever. Dr. Y is a pediatric cardiologist at an academically based hospital in New York City. He has asked the parents of the patient about the possibility of calling in a specialist and has suggested checking it out with the *rebbeh* to see what he recommends. Bill knows the odds are high that the *rebbeh* will recommend Dr. Y because that is who the *rebbeh* has recommended in the past. Then he will get a call from Dr. Y, "I see you have sent me another of your flock." Sometimes Bill feels that the parents are testing him to see if knows what he is doing.

While Bill is tolerant of the *rebbeh* as a physician broker, he has a different attitude when Hasidic rituals interfere with biomedical care. He has had experiences with Hasidic parents waiting until after *Shabbos* to bring in children for emergency care. Religious Jews will not use vehicles on *Shabbos* unless an emergency is declared; on *Shabbos* they will also not carry objects, even a child, unless the area traveled is enclosed by an *eruv*, a light rope or wire encompassing the community, a symbolic fence.

Bill provided the following discourse:

> There is room in religious teaching as to where the line is to be drawn. Problems arise over the interpretation of religious dictum. A person may be seriously ill, and it is difficult to state outright that a medical emergency exists or if it could wait. What do you do? They stay within the range of their beliefs by walking the sick man into the hospital rather than driving. Let me give you an example. There was a religious man with a child with a vicious cut on his finger. The child had uncontrollable bleeding. Only after I declared an emergency did he get a taxi and take the child to the hospital. After the emergency was over the father walked three miles home. Other men might not ride in the first place or a non-religious man might drive the child both ways. A person in Shtetlville might walk to a nearby emergency room. However, if there was a child with convulsions . . . they have heard of meningitis and sudden vascular accidents . . . that child would be driven directly to his office. It's a two-way street. We learn to circumvent their rules and they learn to judge a real emergency.

The Medical Specialist

Bob is a pediatric specialist who teaches and practices medicine at an academically based hospital in New York City. Bob describes himself as the "hospital Jew"; he serves on all committees involving Jewish affairs and considers himself religiously orthodox.

However, he is native-born and college-educated; his first language is English; he dresses in American style and is not a member of an ultraorthdox community. In his 60s, with a direct, gruff demeanor, Bob is a man who takes his work seriously. Bob receives a lot of referrals from Shtetlville. He jokingly comments, "I deal with all the guys (doctors) in the Shtetlville area. Some of them are my former students. I hope you haven't heard I have been stealing their patients!"

According to Bob, *rebbehs* and *rebbetzens* (wives of *rebbehs*) began sending patients because "somehow word got around that I was sympathetic to *Hasidim* . . . I was called in as a consultant for people coming in to emergency rooms . . . these people are known to go to big medical centers with reputations." Most patients come to him for a consultation. He sees about 6 to 8 couples of parents a day.

Whereas Bill's patients use Medicaid to pay him, Bob does not take Medicaid because the payments are too low, and he doesn't like the paperwork. Instead, he takes a reduced private payment. Very few of his patients come in for primary care. He comments on a typical consultation: "A child had a fever for 6 days and had been seen by a primary care doctor three times. I looked at the history and determined that he was doing right. They came to me, the big professor, because the *rebbetzen* told them to go to me to be reassured." Bob follows up this case with another example to illustrate that sometimes he becomes irritated with this role. "A parent calls me: 'I have just left the doctor and he gave me medicine. Is it OK?' This happens twice a day."

Nonetheless, Bob does not feel that his consultations are completely gratuitous. He sees "legitimately sick" children. These children are under the care of competent physicians, but the parents do not want to make a decision without a consultation. He cites a case of a child who had been vomiting for four days. The doctor wanted to x-ray, but the parents were not going to go through with the procedure until Bob had examined the child. Bob has two or three Hasidic children in the hospital at all times and consults with several Hasidic *rebbehs*.

Consultation involves respect for professional autonomy. Bob is careful not to interject himself into a child's care without the permission of the primary physician. It is common for a *rebbeh* to call Bob because the *rebbeh* is dissatisfied with a doctor and wants Bob to take over. If the parents come in on an appointment, and only then does Bob discover that the child has been seen for a number of weeks by another doctor, he refuses to take the case until he contacts the doctor. He knows that the doctor will be annoyed with him and with the parents of the patient.

Bob does not have a personal relationship with any of the *rebbehs*. He likes to think that they send patients to him because "they have gotten a certain sense of confidence in figuring out the tough ones and because I am accommodating both to the *rebbehs* and the parents." However, he does not doubt that some of the *rebbehs* are more astute than others and actually check his professional credentials. Bob approves of the relationship *rebbehs* have with doctors. He uses the example of a child coming into the emergency room with a high fever. Bob knows a "red flag" for the parents will be when Bob suggest a spinal tap to check for meningitis. He tells them to go ahead and call the *rebbeh* because Bob knows when he tells the *rebbeh* that the spinal tap is necessary the *rebbeh* will never object. His point is that the *rebbeh* increases the power of the medical doctor to get patients to follow his diagnosis and treatment recommendations.

The Hospital Nurse

Sue is the head nurse of an intensive care unit in a large hospital situated in a polyethnic section of the metropolitan area. The hospital serves a relatively large number of Hasidic Jews. Sue is a woman in her late 40s who has worked at the hospital for 10 years. A passionate medical services professional, Sue has experienced problems in her work as a nurse stemming from the phenomenon of ethnicity, the social process characterized by people interacting across group boundaries who, by doing so, maintain those boundaries. In the following narrative Sue, who is not a Jew, comments on instances of providing health-care services in a social context where people are dichotomized into "us" (the nurses) and "them" (Hasidic patients, family, community), a behavior which is the hallmark of ethnicity (Erikson 1993, 18-35). Numerous problems range from minor issues over Hasidic norms, such as women nurses not being allowed to have physical contact with male patients, to life-threatening crises caused by medical care being delayed by the *Shabbos*. A core issue for Sue is the feeling of powerlessness and resentment experienced by nurses when they attempt to implement bureaucratic rules of the hospital, e.g., visitation policies.

Whereas Bill and Bob found the Hasidic lay referral network and Hasidic symbolic systems compatible (or at least manageable obstacles) to their medical work, the Hasidic social networks are a source of conflict for

Sue and her nursing staff. It is routine for Hasidic patients to have numerous family and community visitors who challenge her authority as a nurse. They come in large groups outside of normal visiting hours and will not leave when asked. "When you see a Hasidic patient come in the door you think, 'where is the parade!'" Sue is referring to crowds of extended family and community who insiston visiting the patient with as many as 10 to 20 persons at a time. Large contingents of visitors are against visiting privilege rules, yet the *Hasidim* flaunt the hospital's rules and often refuse to leave when asked by the staff. The problem is not *pro forma* enforcement of bureaucratic rules; the visitors interfere with patient care. Sue comments, "you know if the guy goes bad there is going to be a bunch of hysterical people running around the ward upsetting the other patients."

Sue's narrative of a nurse/visitor encounter demonstrates the tension between Sue's professional identity and her reactions to social interaction with relatives and friends of Hasidic patients:

> Visiting privileges are limited to the family, yet people try to sneak in. We try to discuss it with the family. We let them know we are doing the best we can and try to reassure them. Yet, in general, we are treated with discourtesy. I become the bad guy because the other nurses try to ask them leave and they won't. I come to people and ask them to leave. I tell them that they have been discourteous and that we have rules and they must leave. Then I will turn around and they look at you like you are stupid. You get to know all the games they play. I have been in this for 10 years, but they act like they can fool you, that they can sneak up the back way. Then you finally you go up to them say, "You just blew it . . . if you come up here one more time there is not going to be any visiting." They act scared and go away, yet three hours later they are up to it again. This is the biggest problem we have because it causes friction. You can be courteous and try to explain things but they really do not communicate easily. On the other hand, when they try something, it is guaranteed that they will be waiting at your door the next morning with a present. She will insist that I take it and won't take "no" for an answer. The majority of the staff feels a constant put-down.

Interpretation and Analysis

I now turn to interpretation and analysis of the interaction of the Shtetville religio-normative system and social networks with biomedicine. Two theoretical models appear to fit well with the ethnographic data: the Friedson[6] social constructionist model of the profession of medicine, and the Barthian theory of ethnicity (Friedson 1988; Barth 1969). These conceptual models of social organization complement each other. The former is concerned with dominance and power, the latter with the process of social action. Both share a postmodernisitic epistemology of the relativity of symbols and knowledge and the salience of agency[7] in social interaction.

Biomedicine is the dominant ethnomedicine in American society. Its "aura of factuality" is uncontested in ordinary life experience. People routinely consult biomedical doctors for diagnosis and treatment of illnesses that incapacitate and cause death. While other ethnomedicines may compete with biomedicine, none has established the equivalent of a profession of medicine, "an officially approved monopoly of the right to define health and illness and to treat illness" (Friedson 1988, 5). Autonomy is basic to the status of medicine as a profession. Its autonomy (its freedom from control by outsiders) is based upon three clams of the profession: 1) unusual skill and knowledge: 2) professional responsibility (they can be trusted to work conscientiously without supervision); and 3) the profession can be trusted to self-regulate and discipline doctors who are not competent (Friedson 1988, 143).

A central proposition of the Friedson model is that illness is a form of deviance and the agent of social control is the biomedical doctor. A corollary of this proposition is that "illness is a social creation and the values and the organized limits on the experience of its professional creators influence how and when it will be created as well as its content" (Friedson 1988, 143). The social construction of illness has become a well-developed concept in medical anthropology, and power is a central concept in the ethnography of health and sickness (Lindebaum et al. 1993; Sargent et al. 1996).

This "social contract" between society and the profession is problematic. Clinical practice is not identical to the use of application of universal scientific knowledge; i.e., medical doctors treat ill people on the basis of clinical experience as opposed to objective standards – the art of medicine versus the science of medicine. No two doctors have the same clinical experiences, and a person with the same set of symptoms and complaints may be treated differently by two different doctors. There is a problem with self-regulation because medical doctors are loathe to criticize the work of other medical doctors; "self-criticism is acceptable; criticism by others is not

(Friedson 1988, 178-179). Incompetent doctors who become known as such by their peers are not disciplined by the profession unless the malpractice becomes public. Instead, a dangerous doctor is "boycotted;" i.e., patient referrals are not made to him or her. Doctors become sorted into networks "of "consultation and cooperation." Finally, there is a bias in the profession toward illness known as the "medical decision rule" (Friedson 1988, 255). Doctors typically assume it is better to impugn disease rather than to deny it and risk overlooking a disease; the net effecting is that doctors overdiagnose for diseases that do not exist.

People of Shtetlville have a common-sense understanding of the above problems with the medical profession. The *rebbeh* lay referral network is a social adaptation to the medical profession's inability to flawlessly implement the best medical technology. It is adaptive; the *rebbeh* helps his followers locate doctors who are not only competent, but whose clinical experience is in accord with the best scientific standards; i.e., academically based specialists. As noted in the narratives of the medical doctors Bill (the family practice doctor) and Bob (the pediatric specialist), a common reason for patients' conferring with the *rebbeh* is concern with the doctor's use of the "medical decision rule," e.g., a spinal tap for a child with a high fever to rule out meningitis.

The Hasidic lay referral network allows lay people to exercise some control over an imperfect profession. Modern therapies don't always cure illness, and many are dangerous. Given the limitations of the current system it is understandable that ritual healing and lay referral networks continue to thrive at Shtetville.

Ethnicity

How is the lay referral network created and maintained? Lay referral networks are found throughout society and usually reflect "the particular culture of knowledge people have about health and health agents . . . and has implicit the idea of organized societal reaction to illness" (Friedson 1988, 306). Once it is recognized that these networks are "organized societal reactions" it logically follows that social organizations, such as ethnic groups, can contain within them lay referral networks:

> The strongest theory in ethnic studies is the Barthian model. He begins with what actors believe and think: ascriptions and self-ascriptions. The focus is not on cultural characteristic of ethnic groups but upon relationship of cultural differentiation: between us and them. The emphasis is not on the substance or content of ethnicity as upon the social processes which produce and reproduce organized boundaries of identification and differentiation between ethnic collectivities"(Jenkins 1997, 12).

Bob and Bill are doctors who are Jews. Bob is an assimilated Jew, Bill a religious Jew (but not ultraorthdox). As Jews they share a common membership in the same ethnic group as *Hasidim*. The New York City metropolitan area has the world's largest concentration of Jews (a minimum of two million people) outside of Israel. The city has huge possibilities for ethnicity both among Jews and between Jews and other ethnic groups (Glazer and Moynihan 1963). Notwithstanding differences due to American assimilation, Jewish doctors and *Hasidim* draw upon a common set of nationalistic symbolic forms; e.g., the Torah, the Holocaust, and Israel.

In short, Jewish doctors belong to the same "us" as Hasidic Jews and, just as importantly, non-Jews externally define Jewish doctors and *Hasidim* as the same "them." The networks appear to be created without personal contact. In Bob's narrative he noted that a Hasidic patient was referred to him by a *rebbeh*, "a fine man I know by reputation," and thereby indicated shared values but not shared community. Most of the physicians I interviewed had admiration for the religious community of Shtetville. As one doctor told me, "Man does not live by bread alone."

There is an attitude of common fate or destiny with *Hasidim* to be found among Jewish doctors. One doctor commented, "the *Hasidim* may be the first in the ovens, but I will be next." His point is that the external definitions of ethnicity do not distinguish social and cultural characteristics of people in the same ethnic group. One comes to the conclusion that Jewish doctors actively participate in *rebbeh*-centered lay referral networks because of Jewish ethnic identity. Ethnicity, by interjecting symbolic forms into the doctor-patient relationship, has the effect of moderating the imperial autonomy of the medical professional.

However, ethnicity is a double-edged sword. While it serves to minimize conflict between Hasidic patients and Jewish doctors, it has the opposite effect with Hasidic patients and non-Jewish nurses, as illustrated in Sue's narrative. Ethnicity also affects the relationship between nurses and doctors. Estimates are that at least half of all medical doctors in the New York metropolitan area are Jewish (Glaser and Moynihan 1963). My field work experiences provide anecdotal

evidence that the obverse is true for nurses: very few nurses in metropolitan New York City are Jews. Since ethnic boundaries and professional/occupation boundaries coincide in the biomedical workplace, the struggle for power and resources in the polyethnic New York social framework merges with power issues in the hospital. The nurses possess a relatively weak kind of power: enforcing hospital bureaucratic rules that can be easily disobeyed.[8] The doctor, on the other hand, has professional autonomy, a strong kind power. He or she has true agency in the biomedical hierarchy and can create orders that others must implement and/or follow. It is not surprising, then, that nurses feel resentment when what little power they have is challenged by members of the same ethnic group as the profession which has a monopoly in the biomedical workplace One must also consider the effects on ethnic boundary maintenance of the socioeconomic differentiation between nurse and doctor. Nursing's economic rewards and social status are dwarfed by the medical profession's prestige and relative wealth.

This particular New York metropolitan hospital, a biomedical workplace, has become a social arena in which members of multiple ethnic groups are engaged in various power struggles across ethnic boundaries defined by symbolic forms and social networks. Yet a second phenomenon is imposed on ethnicity: the dominance of the medical profession over the biomedical workplace. What appears to transcend the conflict and power struggle is the personal integrity of the doctor and the nurse and the motivation of the Hasidic community to receive the best possible biomedical technology.

Conclusion

This paper has examined the various contexts of sickness and healing that a Hasidic Jew traverses: the religio-normative system of Hasidic culture and community institutions, the *rebbeh* lay referral network, the family doctor, the referral to the medical specialist and, finally, the polyethnic, bureaucratic, and hierarchically structured biomedical workplace: the hospital. At each point along the path symbolic forms, social networks, and economic and political resources have the potential to serve as symbolic boundaries of ethnic groups and corresponding consequences for social action. Hasidic Jewish illness experiences illustrate the linked propositions that sickness is socially constructed and healing should not be interpreted outside the context of symbolic systems and social institutions.

Notes

1. David J. Rozen holds a B.A. and an M.A. in Anthropology from the University of Oklahoma, 1971 and 1973, and a Ph.D. in Social Sciences and Health Behavior from the School of Public Health, University of Oklahoma, 1980. This paper was written in his private capacity and reflects only his views.

2. Unless otherwise indicated all words in italic are Yiddish and are followed by commonly accepted translations in quotation marks. Yiddish words not in italics are believed to be understood in the common usage.

3. A pseudonym for a community in which I conducted particpant-observation and interviews for my doctoral research project. All ethnographic observations and interviews were conducted while I was a resident in Shtetlville off and on between 1975-1978. I have visited Shtetlville at least once or twice every year since then, have followed changes in the community, and have many good friends there.

4. All economic and demographic data are from the most recent U.S. Census (2000). Shtetlville is coterminous with a census unit.

5. Bill, Bob, and Sue are pseudonyms for actual persons interviewed between 1975 and 1978.

6. There are other similar models of the medical profession, e.g., Hahn 1995 or Mechanic 1978. However, as Friedson stresses the salience of power more than the others, I prefer his analysis.

7. Agency refers here to the acting subject, "the notion of human action logically implies that of power, understood as transformative capacity: 'action only exists when an agent has the capability of intervening, or refraining from intervening, in a series of events so as to be able to influence their course" (Giddens 1979, 256).

8. Nursing is not a true profession. It is an occupation that has not achieved autonomy. (Friedson 1988, 57-69). Its work occurs within the hospital where nurses are under the control of doctors in the same hierarchy as other paraprofessional occupations, e,g., medical technologists, respiratory therapists, phlebotomists, etc.

References Cited

Barth, Frederick
1969 *Ethnic Groups and Boundaries: The Social Organization of Difference.* Prospect Heights, IL: Waveland Press.

Cohen, Anthony P.
1985 *The Symbolic Construction of Community*. New York: Routledge.

Csordas, Thomas J., and Arthur Kleinman
1996 The Therapeutic Process. In *Medical Anthropology: Contemporary Theory and Method*. Edited by Carolyn F. Sargent and Thomas M. Johnson. Westport, CT: Praeger.

Douglas, Mary
1966 *Purity and Danger*. New York: Routledge.

Eriksen, Thomas Hylland
1993 *Ethnicity and Nationalism: Anthropological Perspectives*. London: Pluto Press.

Friedson, Elliot
1988 *Profession of Medicine: A Study of the Sociology of Applied Knowledge*. Chicago: University of Chicago Press.

Giddens, Anthony
1979 *Central Problems in Social Theory: Action, Structure and Contradiction in Social Analysis.* Berkeley: University of California Press.

Glazer, Nathan, and Daniel A. Moynihan
1963 *Beyond The Melting Pot*. Cambridge: Harvard University Press.

Goldscheider, Calvin, and Alan S. Zuckerman
1984 *The Transformation of the Jews*. Chicago: University of Chicago Press.

Hahn, Robert A.
1995 *Sickness and Healing: An Anthropological Perspective.* New Haven and London: Yale University Press.

Heilman, Samuel C.
1992 *Defenders of the Faith: Inside Ultra-Orthodox Jewry*. Berkeley: University of California Press.

1995 *Portrait of American Jews: The Last Half of the 20th Century*. Seattle: University of Washington Press.

Klein, Cecilia F. et al.
2002 The Role of Shamanism in Mesoamerican Art: Reassessment. *Current Anthropology* 43:(3)383-419.

Lindebaum, Shirley, and Margaret Lock, editors
1993 *Knowledge, Power, and Practice: The Anthropology of Medicine and Everyday Life.* Chicago: University of Chicago Press.

Littlewood, Roland, and Simon Dein
1995 The Effectiveness of Words: Religion and Healing Among the Lubavitch of Stamford Hill. *Culture, Medicine, and Psychiatry* 19: 339-383.

Mechanic, David
1978 *Medical Sociology*. New York: The Free Press.

Mintz, Jerome
1968 *Legends of the Hasidim.* Chicago: University of Chicago Press.

1992 *Hasidic People: A Place in the New World.* Cambridge: Harvard University Press.

Pelto, Pertti J., and Gretel H. Pelto
1996 Research Designs in Medical Anthropology. In *Medical Anthropology: Contemporary Theory and Method*. Edited by Carolyn F. Sargent and Thomas M. Johnson. Westport, CT: Praeger.

Rhodes, Lorna A.
1996 Studying Biomedicine as a Cultural System. In *Medical Anthropology: Contemporary Theory and Method*. Edited by Carolyn F. Sargent and Thomas M. Johnson. Westport, CT: Praeger.

Roth, Cecil
1973 *A History of the Jews*. New York: Schocken.

Sargent, Carolyn F., and Thomas M. Johnson, editors
1996 *Medical Anthropology: Contemporary Theory and Method*. Westport, CT: Praeger.

Turner, Victor
1968 *The Drums of Affliction: A Study of Religious Processes Among the Ndembu*. New York and London: Oxford University Press.

1995 *The Ritual Process: Structure and Anti-Structure*. Berlin and New York: Aldine De Gruyter.

Vogt, Evon Z.
1992 *Tortillas for the Gods: A Symbolic Analysis of Zinacanteco Rituals*. Norman: University of Oklahoma Press.

Wallace, Anthony F.C.
1966 *Religion: An Anthropological View*. New York: Random House.