

# An Ethnographic History of an Illness in a Hasidic Jewish Community

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## Abstract:

*This paper narrates the history of an illness in a Hasidic Jewish community within the conceptual framework of postmodernistic, critical medical anthropology. Hasidic Jewish illness beliefs and the socio-cultural context of Hasidic Jewish society are outlined. The author, as a resident in the Hasidic community of Shtetlville (a pseudonym) documents, sometimes on a daily basis, the historical process mediating symbolic and non-symbolic aspects of medical procedures and outcomes during an illness crisis (a pregnancy that becomes an illness). Multiple discourses and forms of social control are encountered by a woman and her "therapy management group" as they struggle to cope with a problematic health-care delivery system. Finally, the paper revisits the anthropological concept of patronage as a model of human relations in systems of resource inequality.*

## Introduction

This paper addresses the history of an illness in a Hasidic Jewish community. My previous paper (Rozen 2003) published in this journal described the utilization of biomedical technology by Hasidic Jews from the perspective of doctors and nurses in clinics and hospitals. I now turn to health-care behavior within the community: "the historical, contextual observation of illness as the events unfold" (Rozen 2003: 117).

## The Socio-cultural Context

Within the New York City metropolitan area are dozens of Hasidic Jewish communities that are social replicas of European Jewish *shtetls*,<sup>2</sup> "little communities" (Mintz 1968, 1992). Jews within these communities follow a schedule of rituals and rules of personal behavior listed in the Jewish Code of Laws, or *Shulhan Aruk*, "A Set Table." In addition to rules for properly conducting religious rituals, the *Shulhan Aruk* is a manual on diet, clothing, travel, sexual relations, and numerous other forms of personal behavior. Jews whose daily conduct is structured by the Jewish Code of Laws are a small minority in the American Jewish population, and Hasidic Jews are a group within this minority (Heilman 1995). Daily prayer, observance of the weekly Sabbath, and an annual cycle of holy days are basic rituals of all Orthodox Jews. Hasidic Jews are distinguished from other religious Jews by their commitment to a *rebbe*, a rabbi believed to have supernatural powers. A *rebbe* is a shamanistic-like individual considered by his followers to have unique access to God and the capacity to intervene in natural processes, i.e., a worker of miracles.

In terms of socio-political control, a Hasidic community is ruled by a miniature theocracy composed

of a *rebbe* and a ranked order of ordinary rabbis. This social elite interprets not only the *Shulhan Aruk*, but the core sacred texts of the Torah and the Talmud. The theocracy bans common venues of mass communication and entertainment such as television, movies, theater, and sporting events. Radio, newspapers, books, and magazines are under a form of censorship; i.e., only approved sources are permitted. Compliance with the edicts of the theocracy is mostly voluntary; however, there are institutions of power; e.g., children of a malefactor would not be allowed to enroll in the community parochial schools, people would not trade at his or her business, or they might find it difficult to marry their children within the community. Even without censorship, English-based mass media is simply devoid of content for a people whose ordinary discourse is in Yiddish and who lack an interest in thematic contents focused on sexuality or violence. Finally, as Hasidic schools are private, parochial institutions and few *Hasidim* (plural) work in businesses that are not overwhelming Hasidic, religious Jews do not have regular face-to-face contact with persons from different cultural backgrounds. Therefore, self-reflection, a commitment to Orthodox Jewish values, theocratic social control, language differences, and closed educational and economic institutions are socio-cultural factors that serve to isolate Hasidic communities and limit the sharing of American popular culture.

## Hasidic Jewish Illness Beliefs and Practices<sup>3</sup>

From a cosmological perspective, Hasidic Jews believe in the existence of a dual plane universe: the natural world, observable and ontologically transparent to all humans; and the supernatural world, mysterious, hidden, and accessible only by holy persons such as a *rebbe*. The existence of the supernatural world is real

to the Hasidic Jew through his or her faith in the testimonies of holy persons (living and in the past). The natural world is ordered by natural principles and can be described and explained by the epistemological framework created by scientists; however, the hidden, supernatural world can only be observed by a *rebbeh*. During illness crises, Hasidic Jews consider it appropriate to seek out both supernatural and biomedical forms of curing. While unseen supernatural causality is presumed, “the belief in the power of technology to preserve life” (Kaufer and O’Neill 1996: 40) is strongly held by Hasidic Jews.

Hasidic Jews have a social relationship with the community *rebbeh* that is analogous to patron-client relationships described in peasant societies (Foster 1963; Galt 1973; Redfield 1973; Wolf 1966). In exchange for the services of a *rebbeh*, a Hasidic Jew promises his or her loyalty to the *rebbeh* and his court.<sup>4</sup> This relationship provides two kinds of services utilized by the Hasidic Jew during illness crises. One category of service is, for lack of a better concept, shamanistic (Hughes 1996; Klein et al. 2002): the *rebbeh* uses his supernatural power to intervene in the illness process. A second kind of service is political in character: the *rebbeh* provides brokering/patronage services with medical professionals enabling the ill individual to access the best possible biomedical technology. Simultaneously, on behalf of the ill person, the *rebbeh* intervenes with God and serves as a broker and patron with the medical profession.

Nonetheless, the *rebbeh* is only one member of a “therapy management group” (Csordas and Kleinman 1996: 10) of family, friends, and community who aid the ill person during illness crises and help him or her cope with a problematic health-care delivery system. The health-care delivery system is problematic in that biomedical technology is controlled by medical professionals who vary in skill and competence (Friedson 1988). A successful outcome, i.e., avoidance of death or disability, often depends upon the selection of a doctor of above-average competence who can provide biomedical services grounded upon the best available medical science. Having found a competent physician, the patient has an additional problem: the selection of alternative treatment options offered by the doctor. The *rebbeh*, as the following history attempts to illustrate, is a resource in solving both problems.

### Shtetlville<sup>5</sup>

Shtetlville is one of the Hasidic Jewish communities located in the New York City metropolitan area. At the

time of my ethnographic field work (1975 to 1978), the population was about 2,000 persons. Then, as now, per capita income is low and most persons earn their living as skilled workers or proprietors of small owner-operated businesses. Few residents, with or without college educations, are members of the socioeconomic middle-class. The current population of about 5,000 persons, a more than two-fold increase, is the result both of people moving into the community and natural growth. Family size is high due to a religious ideology which encourages married couples to have as many children as possible.

My involvement with Shtetlville began during the early 1970s when I visited the community on summer vacations as an undergraduate anthropology student. Later, as a graduate student in anthropology/public health, a Shtetlville family allowed me to move into a back room of their family business for the purpose of conducting a community study. I became an *ersatz* resident of the community and the equivalent of an extended member of the family. My position in the community made it possible to practice participant observation and conduct key informant interviews.

As a member of a household, I was able to observe behavior within a kin-based group. Although they looked askance at the notion of serving as subjects for an anthropological study, the consensus of the extended family was that they felt an obligation to help a non-religious Jew such as myself become a religious person. They believed that by living in a religious community, notwithstanding that professional goals had brought me to it, I would eventually assimilate to the religious culture. In order to live in the community it was mandatory that I practiced daily prayer, followed a kosher diet, observed the Sabbath, and was in compliance with the Jewish Code of Laws. Therefore, it seemed logical to the family that I would eventually assimilate to the Orthodox Jewish culture. To my friends’ dismay, I never became a *bal te shuvah*, “a person who returns to the faith.” Yet, as Hasidic Jews are largely a tolerant people for whom ideology can accommodate friendship, I continue to have warm relations with the family and community documented in this paper. The following is the history of a childbearing experience which became an illness that I observed and recorded in 1976.

### May 1976

Abraham and Miriam<sup>6</sup> were a young married Shtetlville couple with three children in May 1976. Miriam was three months pregnant and was

apprehensive about having a miscarriage because she had previously experienced two miscarriages and an infant death. Childbearing is arguably the most important role of a Hasidic Jewish woman. Miriam, like most Hasidic women, was motivated to have as many children as possible and was determined to have another child. She had consulted the Shtetlville *Rebbeh* for medical counseling, and he had referred her to a university-based obstetrical specialist for prenatal care.

In the latter part of May, Miriam began to experience blood spotting. Miriam consulted an obstetrical specialist but the doctor was not unduly concerned by the small amount of bleeding. According to Abraham, the doctor told Miriam, "If you lose it, there is always another time." The doctor did not recommend any therapy or treatment that would reduce the risk of a miscarriage. Frustrated by the physician's inability to recommend treatment, Miriam and Abraham "went in to the *Rebbeh*."<sup>7</sup> He told her that doctors "do not know everything" and recommended bed rest as a prophylactic treatment to prevent a miscarriage. Miriam was aware that alternative medical therapies competed with biomedicine and believed that these non-traditional medicine practices had therapeutic value. She was an avid consumer of mega-vitamins and herbal supplements that she purchased at a local health food store and occasionally saw a chiropractor.

However, it was the Shtetlville *Rebbeh's* recommendation, not her own independent judgment, that caused Miriam to use bed confinement as a treatment to prevent a miscarriage. This treatment was a considerable hardship to her and the family. An active woman, used to work and socialization, she found it difficult to be confined. Moreover, Miriam was unable to perform normal household tasks and take care of her three children. She received assistance from several of her extended family members (Abraham's sisters and brothers and her own siblings) and *Bikur Holim* "sick visitation society" sent a volunteer to clean the house twice a week. Abraham and her children had their meals at Abraham's mother's (Sarah) home and Sarah prepared food to be brought over to Miriam's bed.

Neither Miriam nor Abraham confided to me the *Rebbeh's* recommendations regarding the religious-symbolic role of fulfilling the *mitzvot* on her pregnancy. However, it is common knowledge in Shtetlville that the *Rebbeh* encourages visitors to observe the Jewish Code of Laws with as much diligence and emotion as possible, and that the *Rebbeh* tells them that if they behave accordingly, "God will help." We must assume that the couple received such counsel from the *Rebbeh*.

During one night in May a miscarriage in process caused Miriam to hemorrhage massively. Abraham called the police who summoned an ambulance. As Miriam was in mortal danger, the ambulance crew declined Abraham's request to take her to University Medical Center<sup>8</sup> and instead transported her to the closest hospital with an open emergency room. The doctors at the emergency room were able to stop the bleeding, but the medical staff was unable to save the pregnancy. Even though Miriam was fortunate just to have survived the trauma, Abraham believed that, had the ambulance crew taken her to University Medical Center, the miscarriage could have been prevented.

Abraham stayed with his wife off and on during the entire hospitalization of several days. His mother and father, both elderly and suffering from arthritis and hypertension, assisted in running the family business. The business required heavy labor and constant attention to demanding customers. Abraham and Miriam's adult siblings and community friends provided child care assistance, but the burden of taking care of the three children fell to Abraham. He was exhausted and had difficulty staying awake to work and even conduct his normal routine of daily prayers. Although Miriam's hospitalization was brief, the human resources of the extended family were stretched and the small family business lost revenue because of the hospitalization.

A day or two after the miscarriage but before Miriam was discharged from the hospital, Sarah (Abraham's mother) talked with me about the miscarriage. She was concerned about the welfare of Miriam and her family:

Miriam has had two other miscarriages and a baby that died within 24 hours. Religious laws allow her to keep from becoming pregnant if a pregnancy would endanger her life. She has her children and husband to think about. During her last pregnancy she was in bed for 6 months. Miriam and Abraham suffer through each pregnancy.

*October 1976*

Miriam has become pregnant again, less than three months after the miscarriage. Sarah is upset that Miriam became pregnant again so soon after the miscarriage. She knows that Miriam is using an expensive specialist referred by the *Rebbeh*, but was unsure if the doctor advised Miriam to become pregnant. Sarah says that she knows Jewish laws would allow Miriam to practice birth control if a pregnancy would endanger her health, "The biggest rabbi would have told her to wait . . . her

insides are all falling down.” Sarah feels that the three children Miriam already has are “miracles,” and Miriam should not attempt to have more children. For each birth, Abraham’s father gave a contribution to the synagogue in gratitude for what he believed was the *Rebbeh*’s intercession with God.

As during the previous pregnancy, Miriam again has minor bleeding and is practicing bed confinement to prevent a miscarriage. The extended family, friends, and volunteers from *Bikur Holim* are providing assistance with food preparation and child care. However, the family has hired a home-care worker to come in once a week to clean the house. Miriam stays in bed almost constantly and stays busy by knitting and visiting with friends and relatives on the phone. Frequently she has female visitors. Abraham will often cook food and serve meals to her in bed.

In addition to frequent visits with the *Rebbeh* at his office, Abraham has started a practice of praying at the morning *minyan*<sup>9</sup> which is attended by the *Rebbeh*. As the men proceed past the *Rebbeh* to exchange greetings, Abraham will stop and have a brief conversation with the *Rebbeh*. I assume that these visits and exchanges are to brief the *Rebbeh* on Miriam’s pregnancy and her medical treatment. Abraham has made a point of not discussing Miriam’s pregnancy nor the details of his conversations with the *Rebbeh* with me. While Miriam and other extend family members have been tolerant of my role as anthropologist in the household, Abraham is less than enthusiastic about my research. Some members of the family do talk to me about Miriam’s pregnancy and her medical treatment. My best source is Abraham’s mother, Sarah.

*October 18, 1976*

Miriam is losing small amounts of blood continuously. Today Abraham drove Miriam to University Medical Center, and she was admitted for observation. While Abraham was gone, Sarah and I discussed the pregnancy. Sarah says, “The baby is made from blood . . . how long can she bleed and not lose the baby?” Miriam is using a very expensive doctor referred to the couple by the *Rebbeh*. Sarah still does not know if the doctor advised Miriam to become pregnant after only three months since the miscarriage. While Sarah is comfortable advising Miriam on health and how to take care of herself, she finds it awkward to approach Miriam about conception and sexual issues. Moreover, Sarah feels that since under Jewish law only the woman can engage in contraceptive methods, it would do little good to talk to Abraham.

Sarah knows that Miriam would have followed the *Rebbeh*’s counsel if he had told her to wait longer before becoming pregnant again. However, the *Rebbeh* will not discuss birth control. His mother, the elder *Rebbetzen*,<sup>10</sup> “wife of a rebbeh,” however, does talk to women about birth control. She says to wait two years after a miscarriage. Sarah treats the current *Rebbetzen* and the elder *Rebbetzen* with the same respect due the *Rebbeh*. She says that the women in the community agree in principle with birth control but the men, acting through the *Rebbeh* and the *Rov* (Head of the *Yeshiva*, “school for boys,” and ranking rabbi after the *Rebbeh*) are against it. The *Rov* has issued a ruling that allows a 6 month interval after a miscarriage. Yet Miriam did not even wait 6 weeks. Miriam desperately wants to have more children, and Sarah feels that Miriam, in light of the health risks, has been very self-indulgent.

*October 19, 1976*

Miriam is still in the hospital. Sarah tells me that Abraham went to the hospital today and has parked his truck loaded with merchandise needed at the family business at the hospital. Miriam wants him to stay at the hospital because she does not want to be alone. While we are talking there is a call from Abraham and he reports that Miriam is still bleeding. Sarah says that much of her information is second hand from Miriam’s friends. “The doctor told Miriam to stay in bed. . . . Maybe she needs blood, but only a doctor can tell.” Sarah asks me to call the hospital and speak to Miriam. I speak with Miriam, but she is reluctant to talk to Sarah. Sarah says, “We are all crazy.” It is obvious that Sarah is very nervous and on the verge of tears . . . “I am so scared for Miriam.”

Jacob (Abraham’s father) is running the family business and the children are with relatives. At a morning prayer *minyan* at the synagogue I encounter Max, a friend. He knows about Miriam’s hospitalization and inquires about her condition. “She has had so much trouble with miscarriages . . . she has been through a lot.” A woman across the street stops me on the way back to the family’s home and asks me if Miriam is coming home today.

*October 20, 1976*

Abraham rebuffs my inquires about Miriam. He has barely acknowledged her hospitalization. When he does discuss the crisis, he relates medical signs (e.g., blood pressure readings) that are unrelated to the real reason for hospitalization, i.e., a possible miscarriage. Since I am at the house a lot and answer the phone, I ask him

what to say when people call and inquire about Miriam. His response is to tell callers nothing and have them call back. He does not talk to the non-Jewish employees of the family business about Miriam. However, when the *Rov's* wife called he provided detailed information about Miriam's medical condition. Several women and children stop me on the street and ask about Miriam.

*October 26, 1976*

I am driving back to Shtetlville after an errand for the family and I notice Sarah waiting at a bus stop.<sup>11</sup> She has been to the dentist and had a tooth extracted. I offer her a ride home and we talk about Miriam. "Miriam called Abraham today . . . he said the doctor told her the baby is not growing. Miriam is very scared and Abraham went to the hospital." Sarah is clearly upset and asks me if Abraham has told me anything about Miriam. She wants to go to the hospital but does not want to go alone.

*October 27, 1976*

Sarah informs me that Miriam has become distraught. The doctor has told her that the baby was still not growing and he could not hear a heartbeat. Abraham has visited the *Rebbeh* numerous times during the past week. Abraham and I attend a 9:30 a.m. *minyan* today, and as we are approaching the synagogue Abraham sees the *Rebbeh* walking toward the synagogue. The *Rebbeh* is accompanied by his usual court retinue of *gabbai*, "secretary," brother-in-law, and sons. Abraham rushes toward the *Rebbeh* and intercepts him before he can enter the synagogue. They talk briefly. Abraham has become a little more informative, and although not talking about Miriam's medical problems, he has been willing to talk about health-care services in general. He wants to know if I know about a new hernia operation. He knows of a doctor who came to New York City from Toronto to perform an operation on a *rebbeh*. He likes the procedure because it is minor surgery and the patient is able to work in two days. He contrasts University Medical Center with a private hospital in another city. "There they do anything for you . . . here, you ring for nurse and wait . . . they take their time."

Sarah tells me that the *Rebbeh* has told Abraham that "doctors are not gods" and "maybe the doctor just wanted to make her eat more food." Sarah feels that the *Rebbeh* is a calming influence on everyone in the family. She is upset that Miriam is taking prescription drugs to calm her nervousness. "Everything she takes, the baby gets . . . it makes the baby sleep." She feels its

all right for Miriam to take vitamins and herbal foods; however, she is suspicious of doctor-prescribed medications. "Doctors will give you anything." Rachel, one of her other daughters-in-law, had suffered colds, the flu, and allergies while pregnant and refused all medications. She knows of women who have stayed in bed their entire pregnancy. She thinks that a difficult pregnancy is not something that Miriam or Abraham can prevent. "We all suffer when Miriam is pregnant. Everything is peaceful when she is not pregnant." Sarah makes a point to always be in the home when the children return from school. She buys them toys and tries to make them happy. Miriam's daughter is sleeping at home; however, her two young sons spend their nights across the street with a neighbor's family.

That afternoon I drive Sarah to University Medical Center to visit Miriam. We find Miriam in a four-patient room in the obstetrical ward. She is in a upbeat mood. She introduces Sarah to her fellow patients with a small joke, "Oh, look, my mother-in-law has come to see me!" Although she is a patient in a hospital bed, she wears her *shetitel*, "a wig."<sup>12</sup> Sarah has brought her some food: apple cider and a few rolls. Miriam engages in polite talk, but does not discuss her illness or medical treatment.

*October 28, 1976*

At about noon, Sarah informs me that Miriam has called Abraham. "He turned white . . . they want to take everything out" (therapeutic dilation and curettage procedure). Abraham immediately went to see the *Rebbeh*. Even though the current doctor is an expensive, prestigious physician and is probably providing the best possible medical treatment, Sarah thinks the *Rebbeh* may send Miriam to another doctor. Abraham went straight from the *Rebbeh* to the hospital. There is no one to run the family business except Sarah and Jacob. Abraham had already worked 8 hours (he has to go to wholesale markets that open at 4 a.m.) that day. Other family members have tried to help out, but they have their own jobs and family responsibilities. The customers are very demanding. Even though they probably know there is an illness in the family, they still want the usual custom service which has been the hallmark of the business.

Abraham calls the family at 8 p.m. Sarah says, "they did the operation and there was nothing . . . everything had gone out with the bleeding." Abraham will bring Miriam home tomorrow; tonight he will stay with her parents, who live closer to the hospital. Her youngest child is with her parents. Abraham plans to take Miriam

directly from the hospital to the child . . . “the baby will make her strong.” Miriam returns home the following day, the Friday before *Shabos*. Miriam, Abraham, and the three children observe an ordinary *Shabos*.

### A Medical Anthropological Analysis

The interpretation and analysis used in this paper is an explanatory model of illness, “sets of beliefs of understanding that specify for an illness episode its cause, time, and mode of onset of symptoms, pathophysiology, course of sickness, and treatment” (Rubel and Hass 1996:12). The theoretical model stresses both symbolic and non-symbolic aspects of illness and examines procedures of medical treatment, outcomes expected by patients, and the historical process that mediates procedures and outcomes. As an explanatory model it is an attribute of the individual; it has an inherent idiosyncratic bias. To correct this limitation I have described the symbolic and socio-political contexts of both the local community and the larger social system.

#### *Procedures, Outcomes, and Process*

Procedures (actions taken) . . . can be defined in terms of who does what to whom with respect to medicines administered, physical techniques or operations carried out, physical techniques or operations carried out, prayers recited, symbolic objects manipulated, or altered states of consciousness induced or invoked . . . it is the organized application of techniques with some goal in mind (Csordas and Kleinman 1996:8).

“Therapeutic outcome” is relatively transparent and easy to define, but much more difficult to verify due to the effects of confounding variables.

[Outcome] refers to the disposition of participants at a designated end point of the therapeutic process, with respect to both their expectations (high or low) and to change (positive or negative) in symptoms, pathology, or functioning. In biomedical terms, a successful outcome is the elimination of a disease or disorder; in sociological terms it is termination of what Talcot Parsons called the ‘sick role’ (Csordas and Kleinman 1996: 9).

Process is the historical phenomenon mediating procedure and outcome. “Process is understood as the sequence of actions, phases, or stages undergone by the participants.” This may be “the unfolding of a specific treatment event . . . a sequence of mental states . . . or

. . . the progression or course of a illness episode” (Csordas and Kleinman 1996: 9-11). Another notion of process is political and is one of the most salient concerns in contemporary medical anthropology and medical sociology. This is process in the sense in which therapy and healing articulate with broader social issues and concerns, and is concerned with “social control of the patient and ideological control of the values implicit in therapy and illness behavior. This is worked out in the process of deciding which treatments to use and in which order, as well as which are inappropriate and to be ruled out” (Csordas and Kleinman 1996:9-11).

In terms of the explanatory model, Miriam, the *Rebbeh*, and the set of kinspeople and friends who provided aid and assistance during the illness crisis correspond to a “therapy management group.” Miriam’s therapy management group (Csordas and Kleinman 1996: 8) negotiated the “sea of therapeutic choices” of the pluralistic American medical system and provided physical and emotional assistance during the illness episode. The outcome, two terminated pregnancies, was negative in the sense that she did not have a baby, but was positive in that the biomedical system prevented her from dying from blood loss in the first pregnancy, and in the second pregnancy terminated the pregnancy before a second hemorrhage occurred. The end of the illness process was when Miriam returned to her home and resumed her normal activities.

Throughout the process of the illness we see procedures presented in two languages, or sets, of “concepts, values, and symbols” (Kaufert and O’Neill 1996: 33). The first language is the epistemological framework of biomedicine. The second language is the supernatural religio-normative system of Orthodox Judaism and the shamanistic procedures practiced by the *Rebbeh*. The therapeutic management group engaged in a discourse, a “conversation” in which the two languages were contrasted and negotiated. Miriam and her family did not attempt to “bracket local systems of knowledge” (Rhodes 1996: 171): biomedicine versus Orthodox Judaism. Instead, they sought power to control the doctor when they feared he was not practicing the best possible clinical biomedicine.

In addition, the family also contended with the power of the *Rebbeh* and the rabbinical theocracy of Shtetlville to determine the behavior (prohibition of contraception) which placed Miriam at risk. The dominant interpretation of the Jewish Code of Laws, constructed by the *Rebbeh* and his theocracy, allowed less than 6 months between a terminated and a new pregnancy. An alternative interpretation, one without

power, of the elder *Rebbetzen* and many of the women of the community, allowed two years. In the end, Miriam's decision to become pregnant less than three months after a miscarriage was in no small part due to the dominant ideology that encouraged risk-taking to have children.

It is noteworthy that none of the persons in this historical narrative openly discussed the homologous relations between the natural and supernatural worlds. As other persons living in Shtetlville, all of the family members were meticulous followers of the Jewish Code of Laws. The *Rebbeh* was continuously consulted throughout the illness crises. We must assume the *Rebbeh* was confident that all relevant *mitzvot* were being followed or, if he sensed some were not, he advised on the necessary corrective behavior. My interpretation of the narrative silence is that this was one area of their religio-symbolic life that the family wanted to keep away from the anthropological gaze.

Another discourse is significant due to its absence in the illness history. This is the tension between two competing themes in the education of medical doctors: caring and competence (Good and Good 1993). Caring can be translated, in common-sense terms, to what most people define as bedside manner; i.e., does the doctor communicate to the patient that he cares about him or her as a person, as opposed to only a 'case.' The other theme is competence, i.e., skillful implementation of biomedical technology. Seldom did any of the persons in the family comment upon the caring qualities of the doctor. The primary concern was with competence. The closest that we come to a concern about the theme of caring was Abraham's contrast of hospitals in New York and another city, yet his concern was with the services of the nursing staff, not the doctors.

The caring role of the doctor was assumed by the *Rebbeh*. I asked Miriam what her experience was like when she "went in to the *Rebbeh*." She responded, "He is someone I can talk to. He listens to me." Hasidic Jews do not expect the doctor to necessarily be a kind or sensitive individual; rather, their expectations are for a skilled technician. As one Shtetlville resident commented, "the doctor is like a mechanic for the body; you want the best." Moreover, the professional autonomy of the doctor, i.e., control of biotechnical procedures, is not threatened by the *Rebbeh's* replacing of the doctor in the caring role. The physician appears to acquiesce to the *Rebbeh* in the function of managing psychodynamic factors in healing. As noted in the history, the *Rebbeh* will tell his patients that "God will help," or in crisis situations when the doctor is

pessimistic about outcome, that "doctors do not know everything." Such comments calm an anxious patient or the parent of a sick child. The strong, suggestive tone clearly shows that the *Rebbeh* is an astute practitioner who understands the power of suggestion. When Miriam was ill, Abraham conferred with the *Rebbeh* on a daily basis. These encounters had a calming effect not only on Abraham and Miriam, but on other members of the family as well, and thereby enabled a more effective use not only of the health-care system but in coping with the ongoing demands of childcare and work that continued while Miriam was ill.

Another phenomenon that is striking by its absence in the illness history is that of ethnicity. Seldom, if at all, did Miriam or members of her family describe their relationship with health-care providers in terms that would indicate a concern over ethnic boundaries. My informants did not comment upon the ethnic identity of Miriam's doctor, nor did they reflect upon possible conflicts between Hasidic religio-normative symbolic forms and structures and the health-care delivery system. The lack of ethnicity is remarkable, given that interviews with doctors and nurses provided numerous instances where ethnic similarities and differences demarcated a social boundary that impacted patient care. Therefore, one is led to the conclusion, at least on the basis of this illness history, that Hasidic Jews and health-care providers experience the crossing of social boundaries quite differently, with health-care providers being far more sensitive to boundaries in the biomedical workplace than are Hasidic Jews.<sup>13</sup>

Finally, I would like to return to the patron-client analogue as a model of the *Rebbeh*-Hasidic Jew relationship. In classic functionalist terminology, Howard Stein summarizes the literature on patron-client relationships and says:

One point of consensus is the functional or beneficial character of the relationship to the client. That is, in hierarchical systems, the mediating system of patronage is seen as an adaptive response to hostility and inequality . . . mediating the social universe in behalf of his clients, the patron offers protection in the face of danger, greater security in an insecure world, greater predictability for the powerless, more resources for the resource-starved or deprived, stability in fate faced of uncertainty, and reliability in an untrustworthy world" (Stein 1984: 30-31).

But, as Stein points out, the patron needs the client more than the client needs the patron. It is essential for

the patron, if he wishes to continue to enjoy the benefits of the “superordinate/subordinate dyadic relationship,” that the client not discover that the patron has been instrumental in creating the conditions that cause the client to feel he needs a patron. In the history of Miriam’s illness we find Abraham repetitiously, sometimes several times a day, seeking an audience with the *Rebbeh*. Abraham’s behavior is not unusual among Hasidic Jews coping with illness crises (Rozen 2003). A common belief among Hasidic Jews is that God has sent the *rebbeh* (plural form) to care for the Jewish people. One might speculate that the *rebbeh* lay referral system is a social institution created to enhance the prestige and social status of the *rebbeh*. The medical profession, given its institutional power to impugn illness, enhances the social status of the *rebbeh* by allowing the *rebbeh* to have a role in sanctioning biomedical treatments. Illness is a frightening experience that threatens the very existence of the self. What better crisis could the *rebbeh* select to demonstrate their unusual powers? Therefore, an important function or effect of Shtetlville Hasidic Jews utilizing the services of the *Rebbeh* during illness crises is to buttress the power of the Shtetlville theocracy.

## Conclusion

I have attempted to place the ethnographic history of an illness within the theoretical framework of medical anthropology. Hasidic Jews, like most persons in Western society, accept the “aura of factuality” (Rhodes 1996: 167) of biomedicine. Nonetheless, like any consumer of clinical medicine, Miriam faced a problematic health-care delivery system. Her experience was not as an isolate, but as a member of a socio-culturally distinct community. Our observation of Miriam found her engaged in discourses with multiple ideologies and forms of social control. Her path through the system was not unique; rather, it was probably typical of most persons with limited resources (economic, informational, political) when coping with a complex, intimidating system. I hope that this paper has contributed to our understanding of a core concern of postmodernist, critical medical anthropology: power in social life.

## Notes

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

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

3. Please see my previous paper (Rozen 2003) for a comprehensive discussion of Hasidic Jewish health beliefs, in particular the belief in a homologous relationship between the *mitzvah*, “divine commandment,” and disease. The essence of this belief is that if a Jew violates a divinely ordained commandment, he or she will be punished with a disease.

4. Shtetlville is a pseudonym for an actual community.

5. Hasidic communities are modeled after European monarchies. The *rebbeh* is analogous to a king and the community is his court.

6. All names of persons in this paper are pseudonyms for actual persons.

7. A capital letter is used when referring to an actual *rebbeh*. Lower case is used when referring to the generic status category of *rebbeh*. A *rebbeh* is never addressed by his name, but in the third person.

8. Pseudonym for actual hospital.

9. A *minyans* is a group of males assembled for daily prayer. A minimum of 10 persons is needed to establish a quorum. Jews are obligated to pray three times a day. As Shtetlville has more than 1,000 males who must pray daily, *minyans* are continuously forming in the morning and late afternoon at the community synagogue.

10. The elder *Rebbetzen* is the mother of the current *Rebbeh* and the widow of his deceased father. Her position in the community is similar to a European queen mother.

11. Automobiles are a luxury for the people of Shtetlville. The only vehicle in the family was a delivery truck. Moreover, the theocracy frowns on women drivers except under extraordinary circumstances (usually health related, e.g., a disabled child who must be taken to a special education school on weekdays).

12. The *Shulhan Arukh* has detailed rules on female modesty. A woman’s hair is considered sexually attractive, and a married woman is not allowed to



expose her hair in public. When in public a Hasidic woman usually wears a wig, although a kerchief is sufficient head covering. Ironically, the wigs are quite stylish and reflect the most current hair fashion. Similarly, the kerchiefs are never dull or drab cloth. Only an astute observer can distinguish a Hasidic woman among non-Hasidic women. On the other hand, Hasidic men are quite recognizable: full beard, long *payas* (hair about the temple that cannot be cut), black waistcoats, external *talait* (four cornered garment with fringes at each corner) and *yarmulke* (skull cap) that must be worn at all times, not to mention hats unique to each court.

13. However, ethnicity is a phenomenon of almost all social transactions between Shtetlville residents and non-Hasidic Jewish persons. All persons who are not Jews are categorized as *goyum* (singular, *goy*), “persons of another nation.” The term *goy* is laden with emotive meaning and a set of negative stereotypes. Ethnicity explains why Abraham was reluctant to discuss Miriam’s illness with his non-Jewish employees. Irreligious Jews are the equivalent of *goyum* except in circumstances where the boundary has been discussed, i.e., the irreligious Jew is able to identify himself as a Jew. Since in all probability Miriam’s doctor was an irreligious Jew (half of all doctors in the New York area are Jewish) and the hospital staff was non-Jewish, we must assume that the ethnic boundary was encountered and deemed to be a non-issue to the therapy management group.

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