

Multicultural Medicine and the Politics of Recognition

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Health care services increasingly face patient populations with high levels of ethnic and cultural diversity. Cultures are associated with distinctive ways of life; concepts of personhood; value systems; and visions of the good that affect illness experience, help seeking, and clinical decision-making. Cultural differences may impede access to health care, accurate diagnosis, and effective treatment. The clinical encounter, therefore, must recognize relevant cultural differences, negotiate common ground in terms of problem definition and potential solutions, accommodate differences that are associated with good clinical outcomes, and manage irresolvable differences. Clinical attention to and respect for cultural difference (a) can provide experiences of recognition that increase trust in and commitment to the institutions of the larger society, (b) can help sustain a cultural community through recognition of its distinct language, knowledge, values, and healing practices, and (c) to the extent that it is institutionalized, can contribute to building a pluralistic civil society.

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I. INTRODUCTION

Cultural diversity is ubiquitous, but only some forms of difference demand explicit recognition in health care and in the larger arenas of social and political life. There are at least three broad reasons for recognizing individuals' cultural background and identity in health care. First, the practical need to recognize individual differences follows from demonstrations that biological,

social, and cultural variations influence the causes, course, and cure of health problems. Recognition here serves the basic technical tasks of medicine. Second, some forms of cultural difference demand recognition for more overtly political reasons because they are associated with health disparities that affect whole groups of people defined by culture, race or ethnicity. These disparities reflect histories of racism, discrimination, violence, and exclusion that continue to maintain structures of inequality that are major social determinants of health and illness. Finally, some forms of radical difference or alterity demand attention because they identify individuals or groups as profoundly and disturbingly “Other”—threatening to derail our routine practices by our emotional reaction to the unfamiliar, strange, or “uncanny.” This response to strangeness can become an impediment to clinical empathy and service delivery and must be worked through to develop and maintain an effective clinical alliance (Kirmayer, 2007a, 2008). Viewing the cultural other as radically different or strange may also contribute to political processes that set limits on the recognition of others deemed “too different” to accommodate within a society. The politics of recognition inheres in who is considered different; who wields the power to name, categorize, or exclude the other; and how these differences in power and responsibility are created, negotiated, and resolved.

In this paper, I consider the politics of recognition in health care. My reflections emerge from the experience of developing a cultural consultation service in Montreal that aims to help clinicians better understand the mental health problems of immigrants, refugees, and members of ethno-cultural minority groups (Kirmayer et al., 2003). My discussion draws from Taylor’s cogent considerations of the politics of recognition in multicultural societies. My aim is to show some ways in which the microcosm of the intercultural clinical encounter offers a space for exploring ways of living with and working with cultural difference and a form of interaction that, when institutionalized in models of health care services, can contribute to the larger project of building a pluralistic society that allows the coexistence and coevolution of diverse traditions.

I will sketch two broad arguments: First, that insuring the quality of health care (in the sense of its clinical effectiveness and its equitable distribution) requires attention to culture. I use the term *culture* here to stand for the diverse ethnic, religious, and linguistic identities, developmental experiences, and current lifeworlds of individuals, their families, and communities. Second, that attention to culture, both in the clinical encounter and in the structure of health care institutions, can contribute to building a pluralistic civil society. In fact, these two arguments are related. Clinical attention to and respect for cultural difference: (a) can provide experiences of recognition that increase trust in and commitment to the dominant society; (b) can help to sustain a cultural community through recognition of its distinct language, knowledge, values, and healing practices; and (c) to the extent that it is institutionalized, constitutes an instance of pluralism in itself.

II. THE MORAL MICROCOSM OF THE CLINICAL ENCOUNTER

Every domain of social life—government, commerce, law, family, and community—constitutes an arena for building civil society. Civil society, in this context, is the aggregate of institutions, practices, and social spaces that enable uncoerced collective action around shared purposes, interests, and values; this freedom of choice extends to the adoption of different ways of life (Walzer, 2002). The diversity of contemporary societies constitutes a potential challenge to the unity, integrity, or coherence of civil society. For most immigrant societies, like Australia, Canada, and the United States, the demographic facts of cultural diversity make issues of pluralism and multiculturalism especially salient, but even countries that have maintained a fiction of cultural homogeneity are now engaged in intensive debate about the place of diversity in their collective identity and citizenship (Kymlicka, 2007). A pluralistic civil society allows multiple value systems and ways of life to coexist, with regions of overlap and of separateness or distinction. A multicultural society explicitly valorizes cultural difference and diversity and supports groups' expression of their culture in shared or public social spaces (see Kymlicka, 1995; Modood, 2007).

Medicine is an important context in which to consider the issues of pluralism and diversity in civil society for several reasons. Like other domains of practical knowledge, medicine focuses on specific cases that demand we translate abstract or general principles, procedures, values, and intuitions into explicit choices and actions. In so doing, we are forced to address basic areas of difference or disagreement between value systems and negotiate some common understanding and course of action. Through the expression of attentiveness, concern and commitment to appropriate and effective helpful action, the clinical encounter provides a site of recognition of the other (Tauber, 1999; Clifton-Soderstrom, 2003). This recognition can promote experiences of trust and learning that transform the participants' perspectives on the world. This transformative possibility works on both patient and clinician, as well as on the larger communities to which they belong.

Health care involves a hierarchy of levels of interaction ranging from the bodily physiology of illness and treatment, through the interpersonal dynamics of the clinical encounter, to the social, institutional, and governmental policies and practices that define and regulate the health care system. At the centre of health care is the clinical encounter, which has its own unique exigencies that include: the dynamics of the relationship between healer and sufferer; the heightened vulnerability of the suffering individual; the necessity for clinical responsibility; the need to translate general or generic knowledge into individualized or personalized intervention; and the ways in which patient and clinician are connected to larger social and cultural domains of family, community, institutional, and national or transnational networks.

Although the health care system is focused on diagnosing, treating, and ideally preventing disease, the clinical encounter has other functions as well. Among these other functions is the creation of a special type of relationship between patient and clinician. With that relationship come certain forms of relatedness to self and other—that is, to the body and to the “Other” of disease, but also to the clinician as an Other who bears witness to the suffering and confusion of affliction. The most basic elements of this clinical relationship center on the connection between two individuals when one is suffering and afflicted and one is in a position to help, through the profoundly human and humanizing response of listening, empathizing, and taking some form of compassionate technical action.¹ Through this expression of concern and commitment to being of help in some effective and appropriate way, the clinical encounter can promote experiences of trust like those of friendship that encourage the other to consider a new point of view.

People come to the doctor because of fundamental human needs for making sense of affliction and relieving pain and suffering (Kleinman, 1988; Tauber, 1999). They thus face the clinician with a heightened vulnerability in a situation of asymmetrical power that calls for empathic responsiveness and responsibility on the part of the healer or helper. The clinical encounter allows the possibility for recognition of the other not only in his or her essential humanity, but also with a specificity that reflects each individual’s unique experience and predicament. This response requires that clinicians go beyond the generic prototypes of diseases and disorders described in medical textbooks to understand the embodied and socially embedded particularity of an individual’s suffering in context (Kleinman, 1988, 1999, 2006). Patients’ illness experience is distinct from the diseases and disorders identified by biomedicine (Eisenberg, 1977). Furthermore, understanding another person’s illness experience requires knowledge of the social and cultural contexts in which their illness unfolds (Kirmayer, 2008). Empathy must be tutored by culture.

Beyond this encounter between individuals, there are larger social contexts of meaning that shape the clinical encounter: for physicians these social contexts include the technical system of medicine with its knowledge, ideologies, institutions, and practices, as well as also their own personal ethnocultural background and communities of identification and participation.

The scientific and technical basis of contemporary medicine creates a cultural divide between clinician and patient in that, while many patients respect the authority of scientific medicine, most lack detailed familiarity with its theory, making it difficult to follow medical explanations couched in technical language. In a sense, medicine constitutes a subculture with its own taken-for-granted background knowledge and, therefore, every clinical encounter is intercultural. Clinicians who strive to engage patients as active agents in their own care must work to communicate their medical knowledge in ways that enable patients to think through the consequences of

different choices of action. To be effective, this communication requires awareness of patients' background knowledge in order to present ideas in ways that are intelligible and accurately understood.

In situations where ethno-cultural difference compounds the distance between the perspectives of patient and clinician, effective communication demands attention to broader aspects of the personal history and social world of the patient (Kirmayer, 2008). To the extent that there are important differences in the perspectives of patient and clinician, the negotiation of a mutually intelligible and acceptable course of action can create a shared purpose and mutual understanding that mitigates other areas of conflict and divergence. A better understanding of the pragmatics, limits, and implications of this temporary "fusion of horizons" is a central issue for elaborating an ethics of intercultural care (Taylor, 2002).

In addition to these dynamics of the clinical encounter present in every area of medicine, mental health care is notable in several ways. Compared to more technological aspects of medical care, psychiatric practice is still highly dependent on the quality of the clinical relationship. Despite the ongoing "biologization" of psychiatry, mental health practitioners cannot function ethically or effectively without engaging essential aspects of the patient's personhood, which can be achieved only through a dialogical encounter that explores and acknowledges each patient's lived experience. Mental illness raises basic questions of the meaning of human vulnerability suffering, loss, and limitations. In most societies, these crises are addressed through fundamental cultural systems of meaning, including those of morality, religion, and spirituality.

Psychiatric disorders are associated with high degrees of stigma in most societies, perhaps because they affect the behaviors and experiences most central to our personhood, interpersonal bonds, and social integration. At the same time, given their complex links to individual choice or agency, psychiatric disorders raise moral questions about responsibility and blame, reflecting a tension between problems viewed as accidental misfortune (illness) and those we bring on ourselves by our own choices and actions, which fall under the domain of moral reasoning (Miresco and Kirmayer, 2006). These ways of partitioning human problems are deeply connected to cultural values, ontologies, and notions of personhood, and hence, the ways that we interpret and manage mental health problems inevitably have broader moral consequences.

III. MORAL REASONING, MEDICAL DECISION-MAKING, AND CULTURAL CONCEPTS OF PERSONHOOD

Health is a core value in most ethical systems, and health care is a good in liberal theories of rights. Hence, health services should be equitably available

and distributed to individuals within a society. However, it is abundantly clear that mere geographic or economic accessibility is not sufficient to insure that health care is equitably distributed. In addition to structural inequalities that persist because of the history of injustices within a society, cultural difference itself can lead to profound health disparities in a system that claims to be “blind” to such differences (Smedley et al., 2003). Inequality and even direct harm can be caused by the ways that cultural differences are dealt with in the health care system. This can occur in several ways, including: (a) failure to match the distribution of specific services to the needs of specific populations; (b) failure to recognize and respond to aspects of individual identity (which is rooted, in part, in cultural tradition) relevant to health care needs; (c) negative attention to cultural difference, as in racism, stereotyping or other forms of prejudice and discrimination; and (d) misrecognition or misunderstanding of cultural difference leading to misdiagnosis and inappropriate treatment.

The issues of culture go beyond the ethnic identity of individuals to include the values that underlie medical institutions, knowledge, and practice. Medical ethics itself is built on cultural assumptions (Turner, 2003). Much debate in medical ethics and moral philosophy proceeds without explicit attention to its own cultural frame, with a tacit assumption of the universality of the human condition. But the claim that we can resolve value conflicts by appeal to our common experience of the human condition begs the question of how we understand the human condition and, indeed, how we recognize who is, in fact, human (Levy, 2000). Cultures differ on what constitutes personhood and others’ concepts may be over- or under-inclusive from our own point of view. Differing notions of personhood can create ethical conflicts over who gets left out (as not a full person) and who or what is included (e.g., fetuses, animals, spirits, and ancestors). Intercultural clinical encounters must therefore work across substantial differences in ontology and corresponding value systems.

Ethnographic studies and cultural critiques of medical and psychiatric theory and practice have shown how notions of health and illness (and corresponding technologies of diagnostic assessment and intervention) are deeply rooted in specific cultural concepts of the person characteristic of Western individualism (Taylor, 1989; Gaines, 1992; Kirmayer, 2007b). These characteristics of individualism include an emphasis on the autonomy of the individual as an independent moral agent, the primacy of self-direction, free choice, and freedom of expression, and the notion that the central values in life have to do with individual self-realization. The sometimes one-sided emphasis on autonomy in liberal political theory, moral discourse, and medical ethics reflects this individualistic ethos (Tauber, 2001).² In the literature of cross-cultural psychology, this individualistic orientation has been contrasted with Asian, African, and other cultures where values of connectedness, family, and community predominate. In these *sociocentric* or collectivist cultures, the person is thought of more often in terms of their lineage and

location in a web of relatedness to others. Deference to authority, respect for social hierarchy, maintenance of harmony, and consensus in decision-making are valued over individual autonomy.

The dichotomous view of variations in personhood in terms of individualistic versus collectivistic cultures is something of a caricature drawn from the perspective of Western psychologists concerned to diagnose our contemporary malaise. Arguably, many in the West suffer from feelings of disconnection, isolation, and loss of community; the sort of malaise that de Tocqueville predicted as a likely consequence of the long-term expansion of American individualism (Bellah, 1985). As such, the critique of individualism emphasizes the positive value of community and connectedness, which sometimes seem strained to the breaking point in our frenetically mobile and atomized society (Taylor, 1991). Looking widely, we can recognize other kinds of personhood present in different societies including: various forms of *enssembled individualism* that valorize the individual but privilege intimate relations of family, clan or community; *ecocentric* selves (common among many indigenous peoples) that reference the environment and the natural world in constructing identity; and *cosmocentric* selves that understand the person in relation to ancestors or other spirits present in everyday life or accessible through ritual practices of divination, prayer, or possession trance (Kirmayer, 2007b). Cultural concepts of the person shape the experience of autonomy and the appropriate domains for the expression of individual choice and will. These cultural concepts are not only ways of construing the self but are actually constitutive of the self as a moral agent.

Each of these versions of personhood is associated with specific ways of narrating the self—explicating one's identity and biography according to culturally prescribed templates. Such autobiographical narratives encode cultural values, influence memory, and structure thinking about oneself. In addition to providing ways of understanding the self and its vicissitudes, cultural concepts of personhood undergird cultural idioms of distress, the meanings of illness and adversity, strategies of coping and healing, and the values given to various possible health outcomes (Kirmayer, 2004, 2007b; Groleau and Kirmayer, 2004).

It is important to emphasize that these differing forms of personhood never exist in pure form. Each individual in every cultural group has some mix of these ideal types or modes of construing and experiencing the self. This is more evident than ever in our current era of multiple and hybrid identities. However, it remains that individuals may differ in the amount of time they spend reflecting on the self in terms of one mode or another and the extent to which they use a particular mode of construing the self to guide their actions and decisions. For that reason, it is meaningful to distinguish different cultural concepts of the person and corresponding modes of self-construal and to recognize the specific conflicts and concerns they engender.

Intercultural mental health care must consider the impact of these differences in notions of personhood because they shape ideas about the self and the response to illness. Psychological models built on the individualistic concept of the person must be modified or supplemented by other models that recognize the dynamics of selves that emerge from these alternative forms of personhood. This requires a sort of pluralism of theory, person, and practice in the clinical encounter.

IV. FROM CLINIC TO COMMUNITY: THE POLITICS OF PLURALISM

A variety of models have been developed to address diversity in health services (Bhui et al., 2007). These vary with local ideologies of citizenship and ways of framing the cultural "Other" (Kirmayer and Minas, 2000). These models use a variety of strategies, including: ensuring representation of the cultural diversity of the population in the health workforce and the governance of health institutions; development of specialized clinics or programs; matching individual patients and clinicians in terms of language and ethnicity; and the cultural adaptation of interventions. What all these strategies have in common is an effort to recognize the cultural background and context of the individual as salient dimensions of their identity. In this way, the organization and delivery of health services support the political process of cultural recognition.

Critics of the politics of recognition have voiced the concern that recognition of culture and other aspects of identity will displace more fundamental problems of inequality that reflect economic and social structural problems (Fraser and Honneth, 2003). Added to this is the concern that attention to cultural difference serves to reify, essentialize, and reduce identity to cultural stereotypes and that this, in turn, will only increase intolerance, divide communities, and undermine collective solidarity and an inclusive society (Modood, 2007; Phillips, 2007). These political critiques of recognition have parallels in the medical domain. Thus, asked about their strategies for working with cultural difference, family physicians with much experience working in a highly diverse community in Montreal reported that they pay little attention to culture and ethnicity because what really matters is social class and poverty (Rosenberg et al., 2007). When asked for examples of cases where culture did make a difference, however, they reproduced common cultural stereotypes.

The dilemma is that disparities cannot be addressed directly without recognizing differences. Nor can a "one-size-fits-all" approach to medical care achieve equity, both because the distribution of problems is uneven and because the symptoms, illnesses, and interventions do not have the same meaning or impact for people from different cultural backgrounds. This is true not only at the level of illness behavior and help seeking but also even at the level of physiological responses to medical interventions (Kirmayer, 2004).

"Culture, moreover, is a legitimate, even necessary, terrain of struggle, a site of injustice in its own right and deeply imbricated with economic inequality"

(Fraser, 2000, 109). Clearly, this is so in terms of the historical origins and legacy of intercultural encounters, such as those of colonization. Colonialism constructed particular cultural identities that involved stripping away, suppressing, displacing, and devaluing preexisting identities. Assimilation itself represents a failure to respect difference and a substitution of self for other.

As Taylor (1992) has argued, ethno-cultural identity is important for social personhood and psychological wellbeing (see also Honneth, 2001; Kent and Bhui, 2003; Modood, 2007; Phillips, 2007). Recognition by others nurtures cultural identity and well-being. Misrecognition or negative recognition, in contrast, can injure people in several ways: they may be directly wounded by other's negative regard; they may internalize this negative view as part of their own self-image; and, more systemically, they may suffer from the negative or limiting social position assigned to them as part of this misrecognition.

The redress of misrecognition requires different strategies depending on how it is institutionalized (Fraser, 2000, 115). In medicine, misrecognition is institutionalized through unequal distribution of care and bias in medical decision-making but also through practices that employ diagnostic categories, procedures, and interventions developed and defined in terms of the cultural norms, values, and assumptions of dominant groups (Smedley et al., 2003). A crude form of misrecognition occurs routinely in medicine when the person is mistaken for their disease. This is compounded in intercultural settings when the patient's cultural background is either ignored (i.e., assumed to be like that of everyone else) or simply stereotyped. Recognition of the person involves recognition of their illness experience (rather than their generic disease, abstracted out of social context), which can only be understood in social and cultural context and which, necessarily, involves many aspects of their personal and cultural identity (Kirmayer, 2007a).

Recognition in itself can help redress problems of maldistribution (Fraser, 2000, Fraser and Honneth, 2003). Cultural identity is closely related to issues of maldistribution and inequality as manifested in health disparities (Smedley et al., 2003). Identity has larger social and cultural roots in histories of colonization, exploitation, oppression, and marginalization. So recognition of identity necessarily involves recognition of some of this history and can motivate actions to redress historical wrongs or injustices. Beyond this, recognition of culture in health care requires structural changes in the health care system (e.g., allowing adequate time and resources for intercultural communication using interpreters and culture brokers, attention to diversity in the workforce, education of practitioners to increase their social and historical background knowledge, moves toward patient empowerment, giving voice to ethno-cultural communities in the governance, and administration of health care institutions as well as policy and planning). Recognition of culture, therefore, can lead to structural and systemic changes that speak directly to maldistribution of health care resources.

Recognition of culture involves recognition of the collective identity of groups but also, always, recognition of individuals within such groups, who may have identities or aspirations that are at odds with those of the groups or communities to which they belong. To the extent that a group sees itself as vulnerable, it may resist internal critique and suppress individual voices that challenge its norms or values. The clinical encounter can work against this silencing of individuals—when it recognizes the suffering of some individuals arises from contradictions or injustices inherent in a particular cultural arrangement, which disadvantages some categories of person or creates intolerable predicaments. More generally, the encounter with other cultures in pluralistic societies provides an opportunity for members of a community to become aware of and challenge inequities that might otherwise be invisible, taken-for-granted, or viewed as inevitable (Phillips, 2007).

Pluralism requires social space for alternatives and this extends to the health care system. Of course, each clinician or institution need not embody or present all available alternatives. There are limits to what any given practitioner can sanction or accept. Clinicians usually cannot (and should not) deliver treatments that they do not believe are effective or endorse cultural practices for which the evidence of harm is unequivocal and unbalanced by any comparable benefit (Shweder, 2002). Indeed, health professionals are expected to contest or oppose patient choices they believe are harmful, but to be effective, they must do this in ways that respect the autonomy and perspective of the patient and not foreclose the possibility of continued dialogue. Even in situations where the dominant value system must be upheld or enforced, the way that difference is negotiated can contribute to an experience of recognition and respect that can build confidence in health care institutions and the wider civil society.

The need to recognize culture in the clinical encounter follows from the diversity of ethno-cultural communities in a multicultural society, as well as the diverse ways of constructing and construing the self, both within and among individuals. Because cultural systems provide alternative definitions of health and pathways to healing, this recognition supports a broader pluralism. Pluralism, in turn, requires an over-arching political structure that prevents one group from suppressing another (Walzer, 1997). Ultimately, pluralism is a liberal value that cannot tolerate fundamentalisms or other traditions that are resolutely anti-pluralist (Connolly, 2005). Pluralism can only accommodate traditions that allow free exit to their members and that do not aggressively proselytize, being content to live and let live outside the boundaries of their own ambit (Phillips, 2007). Participation in a pluralistic society requires a moral and political education that is itself transformative of cultures (Curtis, 2007). Pluralism will be corrosive to some traditions and compatible with others. The response to cultural diversity thus provides an acid test of the extent to which immigrant groups, minorities, or even majorities can sustain a pluralistic society. But even where the dominant society is hostile to

pluralism, the clinical encounter, with its commitment to respond to individuals in their distinct identities (which reflect their cultural background and which require a cultural community for their continued realization), can provide a site of resistance and a place from which a more pluralistic civil society can grow.

V. CONCLUSIONS

Health care in culturally diverse societies poses complex pragmatic, political, ethical, and epistemological problems. In this essay, I have focused on the political dimensions to argue that (a) attention to the cultures of clinician and patient is necessary to provide equitable and effective health care and (b) recognition of cultural diversity in health care can contribute to building a pluralistic civil society.

The first argument rests on evidence of inequalities in health status, access to health care, and treatment outcomes for many ethno-cultural minority groups. These health disparities follow from histories of colonization, selective migration, discrimination, slavery and exploitation, social stratification, and exclusion that have left enduring economic and structural inequalities in most societies. Cultural difference itself emerges from this same history and can be a major social determinant of health. Recognizing culture therefore is part of accurately identifying the origins and location of health disparities. Moreover, there is evidence that health disparities are not just due to economic or educational differences; some inequalities are directly related to failures to recognize cultural difference in the delivery of clinical services because this leads to poor communication, misdiagnosis, and inadequate or inappropriate treatment. Recognizing and responding to culture can improve these clinical outcomes directly.

The second argument rests on several observations. Medicine in a pluralistic society involves negotiating different illness meanings, treatment systems, roles of the family or community in decision-making, and hierarchies of values related to interventions and outcomes. Of course, health care is only one domain of the social and cultural systems that articulate values, but it provides a base of shared concerns or “fused horizons” from which to reflect on more divisive issues. The health care system provides intermediate structures between the individual and the community, where diversity can be recognized and the tensions between cultural systems can be examined and negotiated.

These two arguments are related. Generally, any institution that recognizes individual cultural identity serves to support collective identity and sense of belonging; health care here is simply one such institution. However, because health care is a vitally important service that people resort to for serious problems and in times of crisis, recognition in this domain may have great weight and lasting impact, working to restore fundamental trust, self-respect, and self-esteem and so strengthening both individual mental health

and collective identity (Honneth, 2001). A pluralistic society that recognizes cultural diversity, in turn, affords individuals the opportunity to construct robust identities that are socially valued.

If “[p]olitics is an ethical practice that arises in a situation of injustice which exerts a demand for responsibility” (Critchley, 2007, 92), then medicine is inevitably political since physicians are constantly uncovering new expressions of the structural violence of inequalities and injustices in society which demand a response (Wilkinson, 2005; Marmot, 2007). The response to cultural, racial or ethnic inequities in health status and access to care must begin with the recognition of difference as a legitimate political concern. Redress must go beyond the politics of recognition to understanding the specificity of the design of health care systems, policies, and practices that are truly inclusive because they actively seek to understand and respond to the cultural particularities of each individual’s experience in suffering and healing.

NOTES

1. It will be clear throughout that I am addressing a form of medical practice that involves authentic engagement with the experience of the patient. In this, it differs from the increasingly common mode of practice that ignores the personhood of the patient to treat the body like a machine. This de-humanization of medicine is an unfortunate consequence of an exclusive or excessive emphasis on the technical aspects of diagnosis and treatment, the bureaucratic rationalization of medical institutions, and the hurried time-pressured regime of contemporary life. As Taylor argued, this may be part of a larger social investment in instrumental reason at the expense of other forms of embodied relatedness:

“if we are to properly treat a human being, we have to respect this embodied, dialogical temporal nature. Runaway extensions of instrumental reason, such as the medical practice that forgets the patient as a person, that takes no account of how the treatment relates to his or her story, and thus of the determinants of hope and despair, that neglects the essential rapport between cure-giver and patient—all these have to be resisted in the name of the moral background in benevolence that justifies these applications of instrumental reasons themselves. If we come to understand why technology is important here in the first place, then it will of itself be limited and enframed by an ethic of caring” (Taylor, 1991, 106).

As I will argue, to move beyond this reductive instrumentality (or even to be instrumentally effective) caring itself must be framed in ways that are culturally meaningful to the other.

2. Critchley (2007) argues that “post-Kantian philosophy . . . is dominated by the weight of what we might call the autonomy orthodoxy” (p. 36). From Kant onward, it is reason, as an individual human faculty, that makes a universalizable morality possible in the first instance. And this reason depends on individual autonomy to think clearly and independently, free of the biases, demands, and coercion of others. But what if reason itself is, in truth, not autonomous but a collective achievement and hence, ineluctably social? Reason then depends on social and political processes that make possible certain forms of dialogue, debate, critique, and error correction within a community. This would certainly seem to be the case for the highly successful forms of reasoning that underlie science.

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