THE WHOLE PERSON AND ITS ARTIFACTS

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Abstract The joint themes of this volume of the Annual Review of Anthropology, the body as a public surface and new technologies of communication, are also woven into the design of the new Wellcome Trust Gallery at the British Museum, inspiring the reflections of this chapter. In the museum setting, moreover, an interesting question of scale arises: how particular objects can point sometimes to very particular values and sometimes to very general ones. This museological paradox is explored here. Taking a cue from the Gallery’s focus on well-being, we find a parallel in the contrast between particular medicines used for specific complaints and a more general demand made on medicine as a set of organized practices for promoting health. We also find ideas about the whole person. Attending to the whole person requires its own technology, its own artifacts. And looking at artifacts from different times and places compels us to ask, What kind of “whole” is being imagined? The question is posed with materials from early twentieth-century London, mid-century Papua, and turn-of-the-century biomedicine.

Scale plays all kinds of tricks. What, for example, constitutes sufficient information? This question is answerable on its own: One needs as much information as is relevant for the purpose in hand—whether to prove a point, get out of an impasse, or explore a concept. Information is the substance of that proof, solution, or reflection. But when one writes about the process, offers an exposition, the issue becomes what else does the reader need to know. Context cannot be taken for granted: What was implicit as the reason for taking a particular route in the first place must now be made explicit. So information must be added to information, a position that pushes into the foreground the choice of expository mode.

I take advantage of the two themes of this volume, the body as a public surface and new technologies of communication, to dwell on certain enduring moments in social anthropology over the past century. I also exemplify some of the tricks of the trade for handling information in the service of exposition. The materials depicting these particular moments (they come from early twentieth-century London, mid-century Papua, and turn-of-the-century transnational biomedicine) were inspired by a new permanent display at the the Wellcome Trust Gallery in the British
The exhibit employs the Museum’s extensive ethnographic materials to focus on how people respond to the challenges of life and how they sustain health and well-being. The theme of well-being is not something I would normally address. But one trick of the anthropological trade, being open to the unpredictable, is that one is ever assembling “more” information than one thinks one wants. There ought to be enough in the backpack to make a contribution.

I am not saying that anthropologists can write about anything, but rather that disciplines offer resources that can be put to use in unexpected situations. There is a difference between using one’s discipline and being an expert, a role that in these interdisciplinary days I find quite troubling.

One effect of the self-avowed knowledge economy has been to turn information into currency. Use value appears to depend on exchange value. Many certainly hold this view of scholarly knowledge. People openly state that there is no point in having such knowledge if one cannot communicate it, and they mean communicate it in the same form, that is, as knowledge. (Arguably, “knowledge” is communicated as “information,” but insofar as it is meant to be adding to someone else’s knowledge, the terms can be hyphenated.) The fact that knowledge may have contributed to a solution or reflection is beside the point: It is invisible, even useless, unless it can circulate as knowledge-information. The social source of (circulateable, consumable) knowledge-information becomes the expert. Of course there is a huge history behind the formation of the expert in modern times, and again behind the professional; I offer a tiny ethnographic glimpse in the first section. The same person may be both, but the roles are increasingly detached, as (at least in the United Kingdom) professions lose status and knowledge-information experts feed an appetite in public policy for evidence.

Here we have different answers to the question about sufficient information. The expert is like the industrial designer: Everything involved in a situation, any kind of material, must be calibrated for its contribution as evidence. If one provides information on internal migration in order to understand population movement, its sufficiency will be a function of the precision with which the origin of the migrant, economic standing, aspirations, and all other variables can be specified. The values must be unequivocal. Again, apropos marriage arrangements in the absence of registration procedures, deciding on a specific model for calculating a divorce rate, containing a nest of prior decisions such as what constitutes marriage in the first place, means that there is really only one route to collecting data. Development anthropology has long been an arena in which the anthropologist is fashioned as an expert, and a difficult role it is too. I chose London residents (Early Twentieth-Century London, below) to evoke the subjects of much third world development without type-casting such persons as dwellers in the tropics or

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1An earlier version of this text, called “Medicines and Medicines: the Whole Person and its Artefacts,” was delivered as the 2003 William Fagg Memorial Lecture, at the opening of the Wellcome Trust Gallery at the British Museum. The Wellcome Trust is a major funder of medical research in the United Kingdom.
the bush or countryside. (The reader also may find an echo with the emergence of “system” as a theoretical object of structural-functionalism.)

The professional, by contrast, closer to practitioners of academic disciplines, is expected to draw on evolving training and experience. A discipline provides ways of thinking to justify taking particular routes. Materials consist of models and theories, and sufficiency pertains to the degree of fit between problem and analytical procedure. Take the comparative method in social anthropology, a paradigmatic trick of the trade. Comparison entails thinking across contexts, juxtaposing values. Knowing what happens elsewhere, one might ask what kind of view of the migrant is preempted by focusing on economic aspirations, or query the relevance of a divorce rate to men’s or women’s preoccupations. Models for, say, thinking about economics or kinship also follow trajectories of their own. Sufficiency lies in how much one needs to know to satisfy the criteria that make data recognizable, and there may be more than one route to explore. Definitions condense whole debates: “We can refer to a judicial system then,” “don’t talk of buying women, talk of transferring rights over them,” and (a bowdlerized version of David Schneider to Meyer Fortes), “Ah, I get it! You mean that conjugal union is for real!” Perhaps such condensing of opposing stances is why symbolic anthropology, and its ambivalent relationship to structuralism, remains so influential. The second section, which includes selections from already highly analyzed material from Papua, depends on certain disciplinary traditions of interpretation.

Anthropology is blessed by the rich materials so many people have put at its elbow. I am not an expert on well-being, yet the discipline allows me to tackle issues surrounding it. Cues from the museum display, and familiarity with jumping context, suggest a comparative exercise. Comparison materially enlarges the possibilities of exposition itself, through analogies spoken and unspoken (it does not always matter if communication is uneven). At any rate, and inadvertently, the topic of well-being drew me into the themes of this volume. The first two sections touch on what can be read from bodies, and from body surfaces, strongly so in the Papuan case, in so far as the body regimens described here comprise a technology of communication. The final section is deliberately de-localized. It addresses one of the problems of genetic information, where ethical concerns focus on what should be known and what can be communicated about the body.

EARLY TWENTIETH-CENTURY LONDON

It is coincidence that the year 1914, which witnessed the last major expansion of the British Museum before the present decade, saw another enterprise move premises. There is no comparison with the small Nursery School and Baby Camp that opened in Deptford (South London), unless perhaps in the perception that only changes in scale could meet contemporary needs.
The teachers stand a little aghast. This nurture is all very well, but it is not their business. Not their business! Then nothing of the greatest things, the removal of disease and vice and dullness is their business! They are not going on to lead us, but only to find a simplified way of spelling?. . . . The teacher of little children is not merely giving them lessons. She is helping to make a brain and nervous system, and this work. . . . is going to determine all that comes after. . . . Others are going to teach a big girl history, or a big boy Latin. She is going to modify or determine the structure of brain centres. (McMillan 1919, p. 175, quoted by Bradburn 1976, p. 111)

Margaret McMillan had been campaigning since 1897 for reform in the training of elementary and nursery school teachers. At Deptford she experimented with an open-air school for nursery-age children. Need was obvious. Of the first 87 children who entered the camp, all purportedly fit, only nine were found to have no health problems (Stevinson 1927, p. 55). Some of the reasons were clear. Here is a snatch of reported dialogue followed by the author’s general comment (Stevinson 1927, p. 12):

“You wouldn’t go for to bath them, Miss, now would yer? It wouldn’t be right.”

“Oh, but, Mrs. Ruffle. . . . we always bathe our babies. They love it. Look at them!”

“Ah, Miss,” was grandmother’s sage reply. “We often like what’s bad for us and does us ‘arm.”

“Many of our mothers put too many clothes on their children. It is hard to make them realize how unhealthy it is. . . . One little boy came to us who suffered from a weak chest. We found he was wrapped round and round in layers of newspaper soaked in camphorated oil. How long this padding had enveloped his poor little body I should not like to say.”

McMillan’s vision went beyond immediate remedy. “The creation of a nobler human race in a nobler social order” was her ultimate goal but, as her biographer says (Bradburn 1976, p. 50), she realized the children could hardly wait for the new world order. Something needed to be done at once. Poor, in ill health, starved of education, many privations went together. Her ex postulation to teachers came from the conviction that children needed nurture in schools.³ She introduced infants to the rhythm of a well-ordered day, allowed for quiet times, and provided space, fresh air (all year round), wholesome food, and shelters in class-sized units that made up a village of family groups. And why was she concerned to instill professionalism in the teachers? A nursery school teacher needed to be of a higher class than

²“Margaret envisaged her nursery as providing an environment in which talent would be salvaged and children encouraged to develop the full range of their abilities. Thus the Deptford nursery could be described as an experiment in the manipulation of the environment” (Bradburn 1976, p. 55).
³“The real object of our work is ‘NURTURE,’” she said, “the organic and natural education which should precede all primary teaching and without which the work of the schools is largely lost” (Bradburn 1976, p. 55).
other teachers so that young children could be “surrounded by young women with cultivated tastes and minds” (Bradburn 1976, p. 113). A nursery school teacher was always dealing “with a brain and soul” even when she seemed to be caring for parts of the outer body such as “a nose and a lip.” At any rate, whereas 80% of the new pupils had rickets, none had it a year later; in the influenza epidemic of 1921, many children and adults died in the area but none in the nursery.

A vision of privation and a vision of well-being go together. McMillan put together her school system only by seeing various problems as linked. Deptford was a part of London where the combination of poverty, dirt, and ignorance made good health almost impossible, and without health, the children—some of whom came into the school barely able to articulate words⁴—could not learn. The school was to be a social, as well as educational, establishment. By seven, the upper age limit of the school, children were being introduced to A Midsummer Night’s Dream and the possibility of play writing.

London a century ago was another time, another culture. But it is as good an example as any of a concern with well-being that bifurcates into two parts. McMillan’s analysis has several distinct components. Deficiencies demanded specialist attention: If the school had to provide education, health, and nutrition, then each required a specific technology, specific artifacts. To get the children to rest one needed mats and beds; to get them to work outside in winter one needed coats and hot meals. In contrast, these different remedies all converged in the child: For the three- or four-year-old the diverse experiences will have run together, and that was the idea. One could not do things piecemeal. In the idiom of the time, nurturing the child meant caring for its every aspect. It was being treated, we might say, as a whole person.

If the first approach analyzes, the second synthesizes: The school experiment imagines that it must take a whole regime (of remedy, reform) to bring the whole person into focus. Regime for the system is, of course, regimen for the individual. It should be added that most of the children who were brought to the nursery already were being looked after in their own way. Parents applied both specific remedies (the chest wrapped in newspaper) and general regimens (the care to avoid contact between body surface and water).

The numerous philosophizings of the time on holistic approaches to health or education, with the driving idea that the whole is more than the sum of its parts, had obvious resonance in social science. Holism also has its own history in anthropology and continues to be summoned in appeals to social context. The display in the Wellcome Gallery invites one to consider how the whole is made

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⁴This was not only because of slovenly ways of upbringing, but from over-respectability, too. Melia and Bella were brought to school beautifully dressed, with silky well-brushed hair, practically mute, totally passive: “Of a morning, after I’ve washed ‘em, I set Melia in one chair and Bella in another, and I’ve learnt ‘em to sit quite still and not get theirselves messed up. They are good children...Never say a word, and where you put ‘em, there they’ll set” (Stevinson 1927, p. 18).
apparent. That it is a display of medical artifacts and issues is highly pertinent. We see both a collection of very specific items and the values or powers to which they point, items simultaneously significant as specifics and keying into wider understandings. This bifurcation is similar to the way persons perceive themselves both as one and as many simultaneously. And this duality in turn has an important bearing on how the efficacy of medicine is communicated.

Medicine, like technology, is only recognized in being efficacious (failed medicine is no such thing, i.e., is not medicine). It works if it achieves results. And those results will of course vary as widely as the subject of treatment. The subject of treatment could be a broken nose, crying at night, or being part of a population with insufficient vitamin D or part of a society in which a child will take home half its bread ration for its family. Treatments must focus on specifics. They entail all kinds of apparatus, artifacts, and specialized technologies, as might be collected in a museum. Medicines—pills, amulets—are such artifacts, particular measures to ward off particular ailments. Often visible and tangible as objects, there are of course other items not so displayable, such as prayers or spells, though these too take a specific form. Various aspects of affliction are identified by the singular treatment they summon. Indeed “specific” was, for long, a colloquialism for a dedicated remedy.

Now ethnographic museums are highly conscious of the nature of specifics, that is, of the tangible qualities of objects that give them singular form. Yet in many cases the curator or ethnographer knows so much more about them than can ever be displayed. Ethnographers are conscious of how interconnected things are. Show a stone axe and most people have some idea of how it will have been used, but show a shaman’s drum or a clay figurine and the visitor might not immediately connect these artifacts to a use. What is the museum ethnographer to do? One way is to show how the specific item is part of a larger whole.

Investigators have made several notable attempts in recent years to communicate the whole regime, to convey something of the whole context—the society, the culture—in which artifacts belong. These attempts bear comparison with Miss McMillan’s holistic school program. Insofar as there is an educative purpose in a museum display, it is argued, people should be exposed to some sense of the entire combination of circumstances in which an object is produced and used. The displayed object becomes a part of a whole society. Yet it can only be made into a part (that is, part of a whole) if everything known about its circumstances is made explicit—an impossible task. That exegesis has to be in media other than the object itself—wordy explanations, video clips—and there is no limit to the information that can be added. This has been a source of much debate in ethnographic museums and has required ingenious solutions. The new Wellcome Gallery suggests another way of doing things. It offers an alternative approach to the open-ended, never-really-to-be-completed goal of “putting things into context” (Hirsch & Schlecker 2001).

I also think of the work of Kuechler, Miller, and Pinney (University College London), O’Hanlon (Oxford), and Henare and Herle (Cambridge).
Because the gallery is dealing with people’s perceptions of a world that nourishes and afflicts them, the effects that events and ailments have on their lives, how bodies live and die, it can, museologically speaking, mobilize one highly significant resource; that is, people’s own ideas about what a “complete” remedy would be. These ideas may draw on a concept of the whole person, though in many societies that would be a poor translation for the completing or totalizing effects for which people strive. What we do find very often is something similar to the bifurcation encountered earlier in the discussion. Specific treatment for specific conditions accompany occasions on which people enlarge their sense of themselves and attend to well-being through techniques they perceive as encompassing or embracing. Though I use as a short-hand the term holism, recognizing that holism itself has no scale, and that it hardly captures the character of different totalizing practices, modes of holism can bifurcate, too.

On the one hand, all over the world we find systems that echo the kind of programmatic scheme that McMillan promoted, in which numerous distinct and specific items are drawn together, with the sense that nothing less than total enumeration will do. On the other hand, people can use the specifics as such to summon a larger vision of themselves. This idea is a different kind of access to totality: One artifact could be enough to point to the whole.

There is more to such a summoning than metonymy, the convention of parts standing for wholes. An item can remain particular and be animated as a whole entity larger than it appears. There is nothing mysterious about this idea. (An old exercise book may simultaneously recall attempts to write a novel and an entire epoch of aspirations and hopes.) It is a figure seen twice (Riles 2000, pp. 166–70). People understand that an object can both be a specific item and contain the world within itself; it condenses or miniaturizes a wider context. Thus an object may make present powers or forces that affect a person’s life, whether imagined as the environment, the cosmos, or the community. Paraphernalia used in seances or ritual performances are an obvious example. The museological outcome is that specific items on display do not have to be crowded around with other objects or other media to make the point about context. The skill is for themselves to point to the concept of wholeness. Not all subjects or themes would be amenable to this approach; well-being happens to be one that does.

In sum, if the relationship between the individual item and the whole world it points to is general in museum displays, the theme of the Wellcome Gallery brings it home by virtue of its focus on well-being and thus on people’s own sense of a wider context for their health. I suggested that remedial treatment may bifurcate. Whereas some treatments only seem to minister to body parts or specific afflictions, other treatments will summon a totalizing appreciation of what needs remedy. Here one found another bifurcation, between wholeness imagined as the sum of parts and wholeness summoned in an individual item. But what is part and

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6As in many of these instances, “part” and “whole” are relative, situated conceptions. Thus the specific “whole” identity being claimed may also be construed, merographically, as a “part” of a wider set of identities.
what is whole will depend on where the actor is, the culture he/she belongs to, and the period in history it is! Remedies for human affliction also will depend on what concept of the person is being summoned.

MID-CENTURY PAPUA

If ideas about health and well-being point to ways in which persons can be imagined in a totalizing sense, how is this made known? A few generations and too many wars since 1914, a good example is offered by current debate over the U.K. National Health Service.

Deptford, as was, is gone; the desirability of all-around health care has apparently won. Yet from all sides come accusations of fragmentation affecting health care delivery. We can never keep up with demands to offer a complete service. What is being fragmented now? The same thing—the complaint concerns the failure to treat the patient as a whole person. This is not because the person thinks every aspect of his or her well-being ought to be medicalized; rather the issue is that in addition to the ailment or affliction, the person him- or herself remains. One artifact has become a symbol for the very idea of attending to the whole person; it consists of a specific device—communication with the expert. The momentary conversation between doctor and patient required for passing on information may be sufficient for the patient to feel attended to as some kind of integrated being.

There is a haunting story from old Deptford of a little girl taken by a neighbor to the hospital after a fall to have her face stitched; as soon as the mother saw her, she responded to the girl’s hollering and took out the stitches (Stevinson 1927, p. 4). What then was attributed to the patient’s ignorance these days would be seen as a failure of communication by the hospital. But there is more than practical medicine here. In present times communication is valued for its own sake because it acknowledges the patient apart from the ailments. Patients may regard themselves as a repository of knowledge (they tell the doctor things) and one who gives knowledge also should receive it, treated not just humanely but also intelligently. Here the whole person makes its appearance as an agent. In short, a rather specific act, sharing information, summons something much more comprehensive—respect for the person as a subject rather than as an object—and that respect in turn (as far as Euro-Americans are concerned) activates the whole person.

If “medicines” depends on the analysis of specific conditions, I wonder if we might use the singular term “medicine” to refer to the synthesis, to the idea that treatment will only be successful in the long run if it also mobilizes procedures dealing with the health of the whole person. The power of medicine is different from the power of medicines. By and large we are happy if people can move between the two, as when the doctor moves from prescription to bedside manner. A small technique itself, that manner acknowledges the person in the patient.
As to information conveyed, the patient adds it to preexisting knowledge. Adding knowledge is what the museum does when it tells you what an artifact is. In the same way as items can become cultural objects or social signifiers through the information attached to them, medicines can become medicine when a little piece of knowledge is shared. Indeed, more generally, many procedures require that you add knowledge, however condensed, to make them effective on a grand scale. But addition may take many forms. Rehearse a spell, demonstrate a connection with someone, show you are the rightful possessor, and the person emerges in full social acknowledgment. Thus knowledge may be evinced in the information that passes between people, or in its retention by the holder who guards his or her rights of use or bestowal. To succeed aesthetically, Australian Aboriginal art requires the authority of ownership; conversely, those with intellectual and spiritual claims are those who enjoy and profit from the efficacy of the art form (Barron 1998). Such connections can be externalized in narrative or song, but that specific possession of knowledge will be enough to signal identity. Embedded knowledge may be added, then, in an artifact. Examples abound; indeed a previous British Museum exhibit on art and memory in world cultures (Mack 2003) showed how objects condense, code, and conserve knowledge of all kinds. Knowledge also may be embodied in small procedures, such as rules and protocols. McMillan’s charges did not need to know why they should wash their hands or were being encouraged at water play. All they needed to know was that in addition to their activities there were rules about them. A regime is transformed into a regimen.

If we adopt the term medicine (as opposed to medicines) to connote that well-being demands a totalizing approach (without specifying what that totality could be), I would want it to embrace the two techniques of holism: creating a wider context out of many things, and having one thing summon a wider context. We can think of the two techniques as the difference between a regime to be enacted through numerous rules all of which have to be observed, and a rule that in being observed activates the compulsion of the whole regime.

To make the point I introduce the Papuan North Mekeo studied by Mosko (especially 1985) over the past 30 years; the Mekeo see well-being as a direct outcome of correct bodily management. They take this idea somewhat to extremes and extend it to all manner of activities. A systematic cosmology, and something analogous to the whole person (with important caveats), is summoned by a whole regimen of behaviors, whereas knowledge in the form of rules and protocols means that any one specific rule can enact the power of the regime as a whole.

The North Mekeo have very clear ideas about the difference between well-being and its antithesis. Indeed they ascribe active and passive qualities to the two states: Being “hot” or being able to handle “hot” things means being in the advantageous position of affecting the states of others, productively or malevolently, whereas...
being “cold” exposes one to the machinations of others. They divide the world into entities that carry hot influences and those which render the person cold. The schema involves other oppositions as well, between what is sweet and unsweet, dirty and clean, inside and outside; they are not simple. Where to locate the body surface is a case in point. The inside of a Mekeo person’s body includes or encompasses an outside. The digestive tract and abdomen is not regarded as the innermost part of a person but, to the contrary, as a passage connected to the outside world, which makes it an appropriate repository of food: The tract is part of the outside that is inside the body. Conversely, wastes from the inside body accumulate in the abdomen and are regarded as the body’s interior extruded so its appears on the outside. If this is the Mekeo body, what are the signs of health and illness, and what does it take to attend to the whole person? Here, regimen becomes important.

The body is constantly susceptible to the outside world that flows through it. In a hot, healthy state the interior body (blood and flesh) processes sweet, cooked food, eliminating what remains cold and dirty from the abdomen. But an ill person excretes hot wastes (which may contaminate others; hot dirt is poison), and food remains cold and dirty inside (Mosko 1985, pp. 54–55). Concoctions made from plants such as ginger and chili are normally cold, but when given as medicines to someone who is ill they become sweet and hot and restore the normal functioning of the body. Food is not hot or sweet by itself. What gives ordinary food these qualities is the hot work that goes into its cultivation and preparation. It is not just that food takes work; it requires work (1985, pp. 48, 356), as a hot, bodily activity that renders inedible plants edible. Moreover what is true for food is true for other resources as well: Artifacts such as weapons, charms, pottery, dwellings, canoes are all rendered hot, and available for use, by labor, by the body’s heat. Men’s work is particularly important here.

Mosko (1985, p. 46) describes what happens when a house begins to get dilapidated and cold, unsweet, to the owner.

The idea of a fine new house becomes correspondingly sweet. . . . [People] gather building materials from the bush: timber for pilings and frame, palm or bamboo for flooring, split sago branches for walls. . . . These bush things are initially unsweet. Gathering, transporting, trimming, fitting, and binding them are separate skills. By virtue of their planned combination, hot bodily exertions transform the unsweet bush materials into a sweet village resource: the complete dwelling. The tools and other implements the house builders employ in their work are also sweet village resources that have been transformed by the bodily work skills in their manufacture.8

We see both analysis and synthesis here. The specific skills are like medicines, each suited to its task. Thus a stone axe is hot for cutting down a tree (and cold

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8As a final comment on how one ensures this state of well-being, he adds, “Thus, the sweet products of work conserve the hot of the active body and are themselves hot for transforming other unsweet bush resources to sweet village ones” (1985, p. 46).
for cooking food), even as fire is hot for cooking food (and cold for cutting down trees) (Mosko 2002, p. 98). Every artifact effects its own type of transformation and thus has its own agency. At the same time, medicine is mobilized in the combination of effort, the knowledge embodied in the coordination of activities, that produces the house as a totalizing object. And the medicine still works after the house is built. This is the twin to the perspective on the whole as a compilation of parts. People’s houses remain as singular monuments to their now invisible efforts and indeed are “regarded as extensions of their bodies and persons” (Mosko 2002, p. 100). House building, a specific process, enacts the wider capacity of persons to extend themselves. The specific artifact, the building, recalls that.

Human exertion has cosmological effect, and just as work renders food edible, tools must be rendered usable. Perhaps, after all, the museum visitor referred to earlier could not have immediately deduced what the stone axe was for: If one looks at an axe from Mekeo now, with this added knowledge, one knows it is part of a cycle that sustains human well-being. The axe can be used only at certain times by people in certain states; its efficacy is evidence of the exertion of effort and of the observance of rules. One element of this regime will be sufficient to summon the concept in the future. Indeed wherever the Mekeo look, they see things, occasions, activities that give tangible evidence of their wider aspirations to well-being. A rule about one of these says it about all.

If one rule says it all, no single rule appears in isolation. The same is true of persons. Persons can appear only as part of a nexus of relationships. Note that coordination of the house building involves several people so that a combination of skills is also a combination of persons. But it is not a miscellany. Mekeo have precise notions about the way persons affect one another; one might look here for whole person. As in many Papua New Guinean societies, health depends not just on what the subject does with his or her body but also on protocols that determine what kind of object he or she is to others. People can affect one another by the way they care for their own bodies, widely true in Melanesia through observing rules to mitigate (or enhance) states of pollution or danger. Conversely, well-being entails appropriate beneficial interactions between persons. The analogue to the Euro-American whole person, one could say, is being completed by relationships with others. Though there are as many kinds of completion as there are relationships, this is canonically manifest in interactions between spouses.

So what is medicine? For the Mekeo it lies in managing a body both constitutionally open and closed to others, depending on the phase it is in. In the right situation, and in the right gender, either openness or closure may be healthy or life-threatening. Men put themselves through the most severe regimes of semistarvation in order to render their bodies impervious to the attacks of others. It is virtual attack they fear, sorcery. Whereas an open hot body has the power to

9Mekeo is not the only area in Papua New Guinea where, in the days of stone axes, tools lost their edge and would not cut properly if used by the wrong people.
enter and receive the bodies of others, a light, dry, closed body renders the sorcery of one’s enemies cold. When men are in this second state, ordinary food becomes unsweet, and they avoid their families in order to protect them, purge themselves with medicines, and take pride in a tiny waist, tightening their bodies with belts, in a supermasculine state (Mosko 1985, pp. 86, 91). Rules for behavior and the aesthetics of self-presentation go together. However, men must alternate these states of being because fertility, as well as capacity for work, depends on their bodies being open. Women put themselves through an equally uncomfortable regimen, the proportions reversed. Leading up to and beyond conception, and for the sake of their child’s health, they must engorge themselves and, for far longer than men, keep their bodies open and grow the child through the transmission of substance. It is only when her child is weaned that a mother becomes relatively abstemious and closed. Body process is divided into distinct phases; the mutual calibration of husband’s and wife’s body form communicates their current well-being.

Mekeo people make themselves productive or dangerous to one another, and to themselves, and in corresponding degree seek out fruitful interactions and put remedies in place to overcome the dangers. The idea that harm and adversity can come as much from other people as from anywhere lies behind their remedial strategies. Knowledge is never sufficient: One must keep constant track of the consequences of one’s actions, and of the actions of others.

Where people locate their sense of well-being, then, is profoundly relevant for the efficacy they accord to treatment. We encounter several kinds of persons in these few examples. (They are exemplary and not exhaustive.) And the nature of the person indicates what it takes to sustain well-being and remedy affliction in any totalizing way. Following (a) McMillan’s children who can be molded by their social and economic environment, I glanced at the whole person revealed through (b) recognition of knowledge-ownership that gives the Australian artist rightful access to intellectual and spiritual creativity and through (c) acknowledgment of agency in the practices of clinical communication. Finally (d) the Mekeo show us

The converse of open fertility is exposure to all kinds of other persons, from a man’s point of view, including enemies. By closing his body a man hopes to make the sorcery of others cold and ineffective, while his own sorcery is potentially hot to those whose bodies are open and vulnerable. But when they resume sexual relations, they hope to make their wives pregnant as soon as possible (1985, pp. 86–88). Once his wife has conceived and sexual relations are abandoned, it takes a man some six months to “tighten” his body, during which he does as much agricultural work as possible, leaving his wife to continue when he becomes too “cold” for work. The ethnographic present here is the 1970s and before, and much has changed since. In recent publications, Mosko (e.g., 2001) shows how the power of this thinking nowadays works through money and charismatic Christianity.

11The open is also the “partible” body (cf. Mosko 2001, 2002); persons grow, have influence, and maintain their own well-being through detaching and attaching parts of themselves from and to others.
instances of persons taking alternate bodily forms that carry them through a life cycle of interaction with others.

Now, what is distributed through these examples may be found by some measure in all of them. I conclude with a single field of practices that yields several different delineations of the person.

TURN-OF-THE-CENTURY BIOMEDICINE

I have created a context of sorts for turning now to a present-day procedure that belonged first to the world of medicine and then more generally to science and technology that is now ubiquitous and has burgeoned over the past generation. In place of rules this procedure offers its own specifics: principles. Any specific principle can summon the whole regime, and the nature of the regime is such that if one observes any of its principles, then one is considering the whole situation. More than that, the field itself acts as a kind of specific in relation to what amounts to a vast area of medical and technological activity. I refer to bioethics.

Bioethics has come to occupy a special place in twenty-first century (Euro-American) governance. Here people talk readily about the whole person. One of the powers of bioethics is the way it can simultaneously stand for the whole person and the whole society. Two sets of materials from research, funded as it happens by the Wellcome Trust, belong to prevalent debates about well-being. One comes from a study of approaches to biomedicine in Sri Lanka (Simpson 2003), and the other is an investigation into pharmacogenetics (Corrigan 2004; O. Corrigan, personal communication).

Given a shift over the past 30 years toward deregulation, an open market economy, and the development of private practice, not to mention acceleration in the scope and diversity of medical treatments, the Sri Lankan medical profession now looks in two directions. On one hand are those who wish to sustain the Western-based medical tradition in which they were trained; on the other are those who think that more account should be taken of indigenous medical practices. Medical ethics dramatizes the split: the Hippocratic tradition and its translation via neoliberal cultural tenets about what constitutes well-being against attempts to introduce Asian religious and philosophical practices. As Simpson depicts this changing and contentious situation, the issue is about how society can be taken into account. People may regard the very action of raising bioethical questions as an index to broaden the context in which to scrutinize particular practices. Thus the Nuffield Report (by the UK-based Nuffield Council on Bioethics) on externally sponsored research in developing countries puts the practice of medical research into the context of economics, politics, and the conditions of primary care that pertain in the developing world. One of the four ethical principles that provides the framework for the Report is “the duty to be sensitive to cultural differences” (Nuffield Counc. 2002, p. xv). The report cannot consider every aspect of these societies, but raising
social and cultural questions at all makes society present as a significant reference point.\textsuperscript{12} This is one way in which bioethics works as a specific in relation to the whole society.

Sri Lanka is not, of course, the only place where social pluralism raises the obvious question of whose society it is.\textsuperscript{13} But the debates there do emphasize the point that worth and well-being are susceptible to local definition, and in any one place there may be several locales (Clark 2002, 2003). First, then, one kind of person who is the subject of bioethical considerations is known by his or her socioeconomic environment and by the cultural inclinations and the values significant to that person’s own dignity and self-respect. The specifics are the details of these values, and the whole person is recognized precisely to the extent that the values they hold dear are valued by others in turn.

In another arena all together, it is anticipated that one will be able to take advantage of the specifics of conditions and treatments precisely by considering the whole person. The focus is on diversity between individuals, and from this, on their uniqueness as well. Science offers a particularly powerful way of imagining uniqueness: the person as defined by the genetic body. The genetic body belongs to the person as an individual (give or take a few relatives), and here Western ethics is on its home ground, determining principles for personal good conduct and good conduct toward other individuals. Responsibility for one’s own well-being comes into view.

The advantage conferred by specificity belongs, above all, to pharmacogenetics. Pharmacogenetics is a potential solution to the capacity of specifics to proliferate. As far as medicines are concerned, particular ailments, again, call for particular remedies and the more specific the remedy, the more effective the treatment. Yet as our capacity to manufacture medicines increases, the specifics proliferate but never seem specific enough. Too many pills exist for too many diverse conditions and yet are never sufficient because there is no end to the permutations of affliction. Genetically tailored medicine enters with the promise of control that

\textsuperscript{12}“Individuals live within particular societies, the cultural assumptions and practices of which shape their understanding of themselves and others . . . . Even when they are in revolt against their cultural upbringing, individuals often tend to think of themselves in the light of the concepts and understandings they have acquired in their society, including their understanding of sickness and health . . . . As a result, the general duty of respect implies a duty to be sensitive to other cultures” (Nuffield Council 2002, sections 4.14 and 4.25, p. 51).

\textsuperscript{13}Simpson writes (2003, p. 15), “At a time when biomedical ethics appears to have begun to take on board the significance of inter-cultural differences, it is therefore appropriate to draw attention to the importance of intra-cultural differences. For the majority of Sri Lankans . . . the logical place to build a locally informed response to western biomedical ethics is out of Buddhism’s own tradition of a virtue-based, consequentialist ethical analysis. However, there are other traditions—Hindu, Christian and Moslem—and other positions—secular, humanist and rationalist—which render ‘culture’ [ditto, society] far from homogeneous . . . .”
works at an ultraspecific level. It addresses the diversity of individual responses to medication by focusing on them. In brief, pharmacogenetics is the application of knowledge about individual genetic variation to the production and administration of medicines. Control comes from being able to specify the needs of the individual patient as known through their genetic make-up. This is a second way of thinking about the person. Insofar as attention is paid to the individual’s genome, it summons a whole person of sorts because the genome is imagined as a totalizing or holistic description of the person as a subject of heredity, and persons are held to own these descriptions of themselves.\footnote{The person here is rendered unique by his or her genetically specifiable body. What is totalizable is the person’s entire genetic repertoire (this is not the same as saying that genetics provides a complete description of the person in other dimensions).}

The promise of pharmacogenetics is to eliminate the hazards of prescribing medicines. In lieu of knowledge gleaned from sampling populations, “a simple and decisive gene test would indicate to the doctor which drug would be optimal for the specific patient sitting in front of her” (Melzer et al. 2003, emphasis added). But, Melzer continues, the high levels of precision that people assume would follow genetic information can be seriously questioned. Having access to the whole genome is not in itself informative about the whole patient, given all the external factors (environment) that influence responses to drugs.

When environment is imagined not just as physical but also as social (B. Williams-Jones and O. Corrigan, personal communication), one encounters a third kind of whole person envisioned by bioethics, recalling the National Health Service patient who complains of fragmented treatment. In that case the significant complaint is that the person is not being informed of what is going on. In pharmacogenetics, a crucial issue over conveying information occurs long before the possibility of treatment. Treatment for the person may not even be a long-term prospect. This is the point when trials must be undertaken to establish a match between pharmaceutical remedy and genetic endowment. With the notion of people undergoing genetic testing to assist study of genetic endowment, questions may be asked on behalf of the subject. That is, the person is preconstructed as needing protection from intrusion. General ethical questions arise over the management of genetic information that belongs to the individual and the ownership of knowledge in terms of privacy and disclosure. But pharmacogenetics brings specific questions about consent to medical research, the kind of counseling individuals undergoing testing need, and the relay of information back to the research subject who may also be a patient (Nuffield Council 2003, p. 5, Ch. 3, 5).

Corrigan (2004) shows just what a comprehensive construction of the person is at issue. It is epitomized in the principle of informed consent, the hallmark of the contemporary ethical approach, the one principle that stands for many. Informed consent activates the whole person as a subject or agent. Corrigan’s context is the origins of bioethics stimulated by the postwar Nuremberg Code. It is a noble vision:

\begin{quote}
\textbf{THE WHOLE PERSON} 15
\end{quote}
[T]he voluntary consent of the human subject is absolutely essential. ... The requirement of informed consent [has been] declared a universal human right, grounded in the fundamental dignity and worth of every individual and supported by respect for the liberty and security of the person. (2004)

Liberty in turn includes free will, a force of cosmological proportions in Western thought. More mundanely, rights and obligations are bound up with one another:

[T]he right to autonomy comes with a concomitant obligation to make a rational choice about whether to consent. ... And there is a parallel obligation on the part of researchers to provide sufficient information for subjects to make an informed decision. (2004)

As in the case of being attentive to cultural sensibilities, one could not have a greater whole than human dignity compelling ethical action. But the way trials create research subjects draws us back to significant omissions. Corrigan also shows us the outlines of a fourth kind of whole person, the citizen who aspires to self-actualization, and who, in the case of the research subject, knowingly contributes to public welfare for the general good. For all this, she argues, in the field of pharmacogenetics constructing subjects as biological citizens is too narrow a definition of persons and their social environment. One could say, it is not holistic enough. In providing labor and bodily material, for instance, participants in research are coproducers of a particular kind: "representing consenting patients as 'active participants' fails to acknowledge the extent to which they remain objects in the research process" (2004). One might almost say they are divided between being, or occupy the alternating states of, subjects and objects.

Ideas about the person become embedded in these bioethical considerations in diverse modes, of which I have sketched four. The practice of bioethics is the artifact here. As a field of reflection and questioning, bioethics is the tool of a larger quest that seeks medicine beyond the demonstrable effects of medicines.

A PERSONAL NOTE

I conclude with an explicit comment on scale. In her study of the Trobriands, Weiner (1976) struck on a brilliant device for at once including and disposing of Malinowski's cumbersome works. (She had apt quotations from the texts running in parallel to her own and boxed off from it: Malinowski was there but not, so to speak, in her text.) Without suggesting a larger parallel, I borrow from that device and avoid direct reference to my own work. Instead, I draw examples from elsewhere, in a manner some Melanesians would recognize as creating a composite body. Thus the substance comes from other studies; at the same time, the form is necessarily molded by my own disciplinary preoccupations. These preoccupations are, on the surface, a matter of communication (I hope) with those
who share them. But perhaps this figure also amounts to what a former student (Crook 2004, Epilogue) would call a “textual person.” If so, it is a wholeness with all the limits of the expository mode I have chosen.

At the end of this chapter, the question is what kind of evidence would be sufficient to answer the Annual Review’s generous invitation to present “personal reflections on the discipline” and thus something of myself. My solution has been to deploy an artifact; this text (apart from the opening and this conclusion) is based on something I had already written for a specific audience and written without the present task in mind. Moreover, it is an artifact that deploys a certain amount of information-knowledge without bringing it in as information-knowledge. To add that information now, to make evident the chapter’s basis in past work, and thus the text that is me, one could delineate the person as follows.

Briefly, the opening of the chapter addresses some abiding concerns voiced in Partial Connections (Strathern 1991, scale) and the edited Audit Cultures (2000, expertise). There also is an allusion to earlier field research in Hagen, Papua New Guinea, apropos divorce in Women in Between (1972), and to a study of Hagen migrants in Port Moresby (1975). The Deptford example recalls the class analysis of Kinship at the Core (1981) and for me contains the kind of personal associations that inform After Nature (1992a) (my mother’s sister, Greta Martin, was one of Miss McMillan’s teachers). Feminist issues are largely unmarked in this piece, but this example does put a woman in the role of expert. Melanesia has been a constant source of intellectual inspiration. The several contributions to The Gender of the Gift (1988) are marked by one, a penetrating work on Mekeo that I did not overtly draw on at the time, though it would have saved me a lot of trouble; others will recognize running through the chapter the figurative/literal construction on which Gender of the Gift was partly built. Even more so has inspiration come from many Papua New Guinean acquaintances, among others, and in the final section the Sri Lankan case stands for everything that intellectual interchanges provide [sketched recently in Property, Substance and Effect (Strathern 1999) and the joint volume (Hirsch & Strathern 2004). Including the Nuffield Council on Bioethics is a gesture toward other kinds of public arenas (I am a Council member); interests here stem from Reproducing the Future (Strathern 1992b) and the joint Technologies of Procreation (Edwards et al. 1993). As to artifacts, the also joint Self-Decoration in Mt Hagen (Strathern and Strathern 1971) was an early foray. As to museums, I started out as an assistant curator in the Cambridge University Museum of Archaeology and Anthropology.

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