

Cultural Anatomy of a Cold: A Medical Anthropological Perspective on a Routine U.S. Illness  
Experience

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**Introduction:**

Anthropologists studying the practices of groups of people, especially those from their own culture, frequently analyze aspects of daily life that seem almost too quotidian to warrant scientific attention in an effort to understand the hidden meanings of a social group. Such an ordinary occurrence, and one I examine in this essay, is the medical phenomenon often given the folk designation the “common cold.” The experience of this disease of one U.S. university student, Amber,<sup>1</sup> illuminates how one individual, who relies on a larger cultural framework for interpretive guidance, confronts this phenomenon. Despite their seeming triviality, colds reveals a wealth of information about how individuals, embedded within a particular sociocultural environment, form explanatory models of human illness and go about promoting wellbeing, both of which are defined in terms of specific, albeit subjective, physical symptoms.

**Methods:**

The present case study draws on one ethnographic interview conducted on the campus of the University of Maryland, Baltimore County (UMBC). In the fall of 2011, I randomly selected a student to participate in the research project one evening at the university’s dining hall.<sup>2</sup> I

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<sup>1</sup> To protect the participant’s identity, and per anthropological convention, “Amber” is a pseudonym.

<sup>2</sup> By “randomly selected,” I do not suggest that any sampling frames or statistical means were used to ensure representativeness; rather, I simply took a convenience sample while trying to avoid any overt biases in my selection. My criterion of selecting a student sitting alone whom I could approach and interview with ease (again, for the sake of convenience) may have negatively influenced how well my selection mirrored the larger UMBC population. Regardless, since this

approached Amber, introduced the project, and took her through the process of informed consent (see Appendix B for a copy of the oral script used to ensure consent). Once she agreed to participate, I conducted an interview, following the guidelines presented in Appendix A and asking additional follow-up questions based on her answers. None of her contact information was obtained, and I assured her confidentiality. Following the interview, I analyzed her responses and synthesized what she said with a review of existing anthropological and medical research on the common cold. I present the results of this analysis here as a case study of one U.S. university student's culturally mediated experience of the cold.

### **Results and Discussion:**

The synthesis of this material is organized as follows. First, I present a short narrative of the cold experience as described by Amber. Second, I provide a background on Western biomedical understandings of the cold and routine responses to it (as well as the relevance of this biomedical worldview for Amber's story). Next, I expand on Amber's explanations of the causes, symptoms, and treatments for her cold and include my interpretations of these explanations. Lastly, I consider how medical anthropologists following different theoretical paradigms would approach her illness experience; ultimately, I suggest that interpretivist medical anthropology offers the most relevant insight into the social dimension of her cold, yet with additional information, critical medical anthropology could potentially offer equally valuable insights.

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case study is not meant to be interpreted as mirroring any specific population in a statistical way, the issue of the sample's representativeness is moot.

*Amber's Cold: A Narrative of the Mundane*

When I asked her to describe the last time she was struck with a minor illness, Amber replied that she was sick with what she described as simply a “cold” a few days before the interview. She described the sensation of this disease as generalized malaise: She used descriptors like being “sluggish” and just feeling “bad” to convey the concept of overall, corporal discomfort she experienced after the onset of the cold. More specifically, she noted that specific parts of her body were affected in more easily describable ways. She reported that her throat hurt (so that it was uncomfortable for her to swallow), her muscles were sore (despite the fact that she could not recall having done anything strenuous to cause such discomfort), and her head ached. She told me that this condition lasted a couple of days (she could not remember the specific time period, although she guessed that it was between two and three days). During this time, she was able to attend her university classes as normal, but her activities outside of formal class meetings was altered as a direct result of her illness. She temporarily put off completing her homework and instead remained in bed as much as she could. Gradually, in a relatively short period of convalescence, she found her physical condition improving; she regained her normal level of energy (as opposed to the “sluggishness” she experienced during the illness period) and she eventually found that her throat no longer hurt, at which point she considered herself cured of the disease. Even though she presented this cold as mundane,<sup>3</sup> her description of it, on closer inspection, reveals much about her construction of disease, which is conditioned in complex ways by her sociocultural setting. To explore this social construction, each element of her account must be examined in more detail.

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<sup>3</sup> No doubt due in large part to the fact that I stressed to her the need to discuss a *minor* illness, which by its very definition is, for most people, not an extra-ordinary event.

*The Biomedical Context: Dominant Western Models of the Cold*

Before considering Amber's story in more depth, however, it is necessary to sketch the dominant biomedical context in which her personal illness explanations take place and which has had a notable influence on them. The justification for this interlude is twofold. One point is that an elucidation of the Western scientific understanding of the cold will lend more scientific clarity to the descriptions and folk treatments she describes. However, more important is the fact that the dominant biomedical interpretation of human ailment has an enormous effect on how individuals perceive sickness. As critical medical anthropologists Hans Baer et al. write, even if multiple explanatory systems exist in a given society (as, they report, occurs in the United States), one may often be labeled "dominant" over the others in that it is afforded a greater degree of popular prestige and widespread acknowledgment (that is, people readily accept its knowledge claims and look to its treatment practices before resorting to other medical systems) (1997:10-11). Since the dominant medical model is so culturally intertwined with how people approach their health, regardless of other medical systems to which they subscribe, it is crucial to understand how this model approaches the cold in order to draw out possible influences on Amber's idiosyncratic interpretations.

In the case of the Western world, Baer et al. label the dominant medical system *biomedicine*, a term I adopt here. This model is characterized by an overriding emphasis on the physical, empirically measurable (in other words, corporeal) effects of illness as a basis for describing diseases, which are afforded an ontologically real status all their own. Notions of holistic wellbeing or even treatment of *people* are typically overlooked in favor of a preoccupation with "diseased bodies" (Baer et al. 1997:11). The authors point out that biomedicine ought not to be approached as a homogeneous ideology but rather as set of beliefs

modified by particular national settings. In the United States, for example, biomedicine is afforded a fuller realization of its powers of medicalization than in other Western countries in that so many dimensions of life—such as childbirth or mental illness—are drawn into the medical system and frequently treated with “invasive forms of therapy”<sup>4</sup> (Baer et al. 1997:12-13). Based on this broad overview, the dominant medical system in the United States would be expected to interpret the illness experience of the common cold as an overwhelmingly physical problem (thus, for example, ignoring possible social or environmental conditions that led to the prevalence of colds [Baer et al. 1997:13]). It would also be reasonable to suggest that biomedicine would encourage wholly physio-medical interventions for the treatment of colds; these interventions would likely come from the institutionalized medical system as a result of its tendency “on the part of physicians and health institutions” to control all aspects of the disease process (Baer et al. 1997:13-14).

What is actually found in terms of biomedicine’s approach to the cold largely confirms these expectations. In a diagnosis manual sponsored by the biomedical giant Merck & Co., Inc. and recently revised, Dr. Ronald Turner (2009) offers guidance for physicians in their approach to the common cold. This diagnostic guide defines the common cold as “an acute, usually afebrile [without fever], self-limited viral infection causing upper respiratory symptoms, such as rhinorrhea [commonly referred to as “running of the nose”], cough, and sore throat.” The cause of these colds is, in most cases, linked to one of over one hundred strains of rhinovirus, which is transferred from person to person via physical contact or, less commonly, through self-contained micelles released into the air from body secretions (such as nasopharyngeal discharge via

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<sup>4</sup> That is, medical interventions that are highly *physically* invasive and, consequently, reflect biomedicine’s penchant for treating the diseased body.

sternutation). In addition to the defining symptoms of rhinorrhea, cough, and sore throat, other symptoms mentioned are nasal congestion and malaise. In accordance with the biomedical model, this physician's resource offers exclusively physical definitions of and explanations for the common cold.

The most relevant data for the purposes of the present study, however, are the Merck guide's advice on diagnosis and medical interventions for the cold. Turner reports that "Diagnosis is generally made clinically." This observation is especially significant when viewed in the context that, according to the guide itself, there are usually no available diagnostic tests for this disease. The fact that the cold has been routinely integrated into the (biomedicalized) clinical setting, even when no explicitly "scientific" methods are available to diagnose it, indicates the degree to which physicians have authority in matters of identifying and treating the cold. Furthermore, although the manual reports that "No specific treatment exists," Turner goes on to enumerate five possible interventions (such as analgesics or intranasal bromide) that physicians may consider using when confronted with patients who are symptomatic. Most of these treatments are intended to mitigate the physical symptoms associated with the cold, rather than combating the virus that causes it.<sup>5</sup> It is important to note that even though this doctor begins by indicating that no biomedical treatment has been found to be curative or even especially effective, he offers half a dozen physical, pharmacological interventions to ease the throat pain,

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<sup>5</sup> In terms of recommended use of pharmaceuticals, it should be noted that Turner does suggest caution in the use of powerful drugs to combat the cold: "Antibiotics should not be given unless there is clear evidence of secondary bacterial infection." In other words, while physical interventions are encouraged to alleviate symptoms, they are not likewise recommended to kill the virus itself.



nasal congestion, and malaise of a cold while downplaying the effectiveness of what he calls “folk remedies” popular among many patients, such as the use of “citrus fruits [and] vitamins” to prevent colds. There is a tendency to automatically adopt what is labeled the “common cold” into the purview of the medical establishment (as opposed to being dealt with elsewhere), with the result being an emphasis on corporeality so central to biomedicine.

While it may be easy to jump to conclusions about how this biomedical model relates to individuals’ cold experiences (like Amber’s), the connection between the two can be problematized. Some anthropologists have urged that biomedicine not be conflated with the cultural interpretations of lay populations, essentially arguing that “biomedicine may have a distinct culture” apart from popular conceptions (Baer et al. 2008:151-2). Nevertheless, as I suggest above, despite the geocultural heterogeneity of “biomedicine,” its beliefs about the common cold are on the whole conversant with popular models. Baer et al. find that physicians trained in the culture of biomedicine agree with non-physicians in their respective communities on their core explanations of the causes of colds (2008:156-7). Some specifics of treatment models differ between these groups (2008:160), but on the whole they are much more similar than they are different (2008:161). Even though Baer et al. insist on the tentativeness and particularity of their findings (their study was conducted in the delimited sociocultural setting of Guadalajara, México and the U.S. state of Texas) (Baer et al. 2008:153-4), they indicate that their quantitative report may reveal trends reflective of widespread agreements in physician and lay explanations of the common cold (2008:163-4). Thus, while the overlap between biomedical perspectives and the worldviews of ordinary people is likely not perfect, there is evidence to suggest that they are related in an intimate way.

### *Etiology and Symptoms*

I now return to Amber's story to analyze it in light of this ubiquitous biomedical context. To begin, she explicated to me a unique underlying etiology of her cold that significantly mirrors that of the biomedical model. When asked what caused her to get sick, she responded that a few days before she started exhibiting symptoms, she was playing with her cousins who had colds at the time. She explained that she touched the same toys they did and that this physical contact transferred something to her. While she was unsure whether this medium of conveying the cause of the disease was bacterial or viral, she identified the root cause as microbial, just as Turner (2009) does. Furthermore, she provided a possible secondary cause for her contraction of her cousins' cold: They sneezed on her, and she overtly identified *saliva* as a likely medium through which she caught the virus/bacterium. Tellingly, these two causal factors (in the same order, no less) are the exact ones provided in the Merck guide for physicians described above. Consequently, as Baer et al. (2008) predicted, a lay person<sup>6</sup> had a very similar etiological concept of the common cold to that which the biomedical model presents.

Amber's symptoms also correlate closely with those suggested by the biomedical model. Following standards in medical terminology, I use *signs* to refer to objectively measurable changes in the physical body, while *symptoms* indicate subjective conditions as reported by the patient (Tortora & Derrickson 2009:11). Amber's primary symptoms—that is, the subjective conditions that indicated to her that she was sick—were that her throat hurt (so that it was difficult for her to swallow), her muscles were sore, she felt an imprecise sensation of feeling bad

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<sup>6</sup> Amber's view of the cold is, indeed, "lay" and not one of a medical professional or pre-professional, as reflected in her statement that she did not know much of the "physiological" workings of her cold.

(i.e., malaise), she started to have headaches, and her movements were “sluggish.” Most of these correspond well to the symptoms that Turner (2009) lists for the cold and that Baer et al. found physicians agreed were the principal symptoms of the common cold (2008:159). She experienced a cold much as medical doctors expect patients to experience it.

On closer examination, it is moreover significant that both the biomedical model and Amber’s model of the cold rely almost exclusively on symptoms as opposed to signs. Turner (2009), as seen earlier, admits that no quantifiable tests are routinely offered to diagnose the cold; instead, he encourages reliance on patients’ subjective experiences (sore throat, headache, and malaise) to determine whether a cold is present. Likewise, Amber reported the same symptoms that indicated to her that she had a cold; no quantitative measures (like body temperature) were used in her considerations. Thus, while both models purport to describe an entirely objective disease state, they ironically rely almost exclusively on subjective, personal measures to gauge the onset and progression of the common cold.

### *Treatments*

Likewise, what Amber did to get better mirrors the standard medical advice given to patients with a form of the common cold. She took DayQuil®, a popular brand of cold medicine that acts as a combined analgesic, nasal decongestant, and cough suppressant (Procter & Gamble 2011), a few times to alleviate her symptoms. Much like the model proposed by Turner (2009), her view is that she normally does not like taking a lot of medicine, out of fear of her immune system developing a dependency on it. Nevertheless, she is willing to partake in pharmaceutical interventions not to rid her body of the virus causing her cold, but rather to ease her symptoms.

When asked what ultimately caused her to get better, her primary response (in addition to the medicine described previously) was that the extra rest she got helped her recuperate.

Although she expressed a lack of understanding of the specific process, she indicated that a combination of these two factors “stopped [the] growth of the virus” and led to her wellbeing. The medical community, moreover, has also adopted the belief that rest is one of the primary ways to get over a cold (Braun et al. 2000).<sup>7</sup> Thus, her perspective is again strikingly in line with dominant medical standards of how one should go about responding to a cold.

*Perspectives from Interpretivist and Critical Medical Anthropology*

Finally, Amber’s illness experience, largely conversant with the perspectives of biomedicine, can be discussed in different ways depending on the theoretical approach taken. One paradigm for making sense of her account—and one that is particularly suited to the information she provided—is interpretivist medical anthropology. This theoretical perspective emphasizes the fact that what people commonly take for granted as natural phenomena—specific “diseases,” like the common cold—are actually cultural constructions (that is, “explanatory model[s]”) that help people make sense of their world (Good 1994:53). Consequently, an interpretivist anthropologist would approach Amber’s story from the perspective that the “truthfulness” of her given etiology and the “effectiveness” of her self-treatments are irrelevant; for this analysis, the only thing that matters is that *she* accepts the notion that microscopic biological entities, transferred in a certain way from her sick cousins, are causing her bodily discomfort and that she can mitigate the effects of these agents through rest and limited use of pharmaceuticals. How she and others like her make cultural meaning out of an inherently meaningless biological substrate is what the interpretivist tradition seeks to uncover.

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<sup>7</sup> In this same study, Braun et al. (2000) present the results of a survey that shows a huge majority (97%) of adults interviewed believe that rest is important for recovering from the common cold.

In contrast to this perspective, critical medical anthropologists would analyze Amber's experience in terms of power differentials and domination. These researchers focus on the ways that medicine, far from being a Platonic ideal, instead reflects the biases of power extant in a society (and helps to reproduce those power structures) (Good 1994:56-8). Crucial to this theory is that, in the words of the critical anthropologist Roger Keesing, "[C]ultures do not simply constitute webs of significance, system of meaning that orient humans to one another and their world. They constitute ideologies, disguising human political and economic realities.... Cultures are webs of mystification as well as significance" (qtd. in Good 1994:57). In other words, medical systems (particularly biomedicine) serve to hide from people the class structures that keep them oppressed. It would be entirely possible to interpret Amber's story in terms of critical medical anthropology by positing that the undue influence of biomedicine (controlled by the capitalist class) on her personal interpretation of her cold led her to overlook the structural problems (such as greater work and education stress, or more limited access to health resources) that ostensibly are the *real* causes of her illness. Indeed, the discussion above on the dominance of biomedicine relied largely on the interpretations of critical medical anthropologists (as cited in Baer et al. 1997). However, this critical line of questioning was not pursued during the interview, and consequently I have little knowledge of how Amber is situated in a system of domination. Therefore, any sweeping conclusions along the lines of critical medical anthropology would be unsubstantiated.

**Conclusion:**

Amber's account of her most recent cold may appear routine, but it forces social scientists to ask a plethora of questions about her interpretation of a personal biological event. Through the work of other anthropologists, such ethnographic accounts can be interpreted on a

broader scale, and it becomes clear that her mindset is inextricably intertwined with the worldwide ideology of biomedicine. Although in this paper I present merely a case study of one individual and her relation to the larger sociomedical environment in which she lives, Amber's ideas about what it means to get sick likely parallel the experiences of countless individuals who live in a biomedicalized world. Further research may reveal insights into how explanations of the common cold—influenced by biomedicine in divergent ways—are negotiated in other cultural contexts.

References Cited

Baer, Hans A., Merrill Singer, and Ida Susser

1997 *Medical Anthropology and the World System: A Critical Perspective*. Westport, CT: Bergin & Garvey.

Baer, Roberta D., Susan C. Weller, Javier García de Alba García, and Ana L. Salcedo Rocha

2008 Cross-Cultural Perspectives on Physician and Lay Models of the Common Cold. *Medical Anthropology Quarterly* 22(2):148-166.

Braun, Barbara L., Jinnat B. Fowles, Leif Solberg, Elizabeth Kind, Margaret Healey, and Renner Anderson

2000 Patient Beliefs about the Characteristics, Causes, and Care of the Common Cold. *The Journal of Family Practice* 49(2):153-156.

Good, Byron J.

1994 *Medicine, Rationality, and Experience: An Anthropological Perspective*. Cambridge: Cambridge University Press.

Proctor & Gamble

2011 *DayQuil Cold & Flu Relief Liquid Medicine*.

<http://www.vicks.com/products/dayquil/cold-flu-liquid-medicine>, accessed December 8,

2011.

Tortora, Gerard T., and Bryan Derrickson

2009 *Principles of Anatomy and Physiology*. 12<sup>th</sup> edition. Hoboken: John Wiley & Sons, Inc.

Turner, Ronald B.

2009 Common Cold (Upper Respiratory Infection; Coryza).

[http://www.merckmanuals.com/professional/infectious\\_diseases/respiratory\\_viruses/common\\_cold.html](http://www.merckmanuals.com/professional/infectious_diseases/respiratory_viruses/common_cold.html), accessed December 8, 2011.



**Appendix A: Interview Guide**

- When was the last time you got sick with a *minor* illness?
- How did you know you were sick?
- What caused you to get sick? How did it work?
- How long did it last?
- How did your behavior/daily activities change, if at all?
- What did you do (if anything) to get better?
- What do you think of popular remedies for the illness?
- Was anything preventing you from getting better?
- What ultimately caused you to get better?
- How did you know you were better?
- Is there anything else you want to say about the illness or your illness experience?

**Appendix B: Oral Consent Script**

I am a student in anthropology 312 / Medical Anthropology at the University of Maryland, Baltimore County. I am conducting research using personal interviewing to learn about how people experience minor health issues. You are being invited because I would like to hear a personal account of how someone experiences a minor health issue. If you agree, I would like to ask you some questions about how you knew were having a health issue, what you did about it, and how you knew it was resolved. The interview should take from about twenty minutes to a half hour. Your responses are confidential and I will use a different name to refer to you in the report to assure that there are no characteristics in my research paper that can identify you. Do you have any questions about the research project? May I proceed with the first question?