

Patients, Pharmaceuticals, and Time: Reclaiming the Temporal Ambiguities of Illness and Healing through an Ethnographic Analysis of Asthma

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Abstract: Across many advanced liberal societies, there has been an ostensible reduction in the variability of temporal perspectives, affecting a wide range of facets of contemporary life. With respect to chronic illness, illness and health trajectories are increasingly articulated through the imperatives of self-management programs and evidence-based medicine, both of which link the temporality of coping with illness to the profit-generating ventures of multi-national pharmaceutical companies. The discipline of anthropology has, however, long demonstrated the co-existence of multiple temporalities, highlighting the variability and malleability of understandings and lived experiences of time, as well as modes of temporal reckoning. This paper focuses on asthma treatment in New Zealand and the Czech Republic, examining variable experiences of the self and the symptom-within-time, as well as the ambiguous pleasures of stepping outside of everyday social rhythms. I argue that ethnographically examining the fluid and sometimes ambiguous nature of the temporalities of illness and healing trajectories can act as a counterpoint to advanced liberalism's promotion of subjective forms which are predicated on an increasingly constricted range of temporal visions.

Keywords: ambiguity, temporality, pharmaceuticals, asthma, pleasure, Czech Republic, New Zealand

Across advanced liberal societies a specific mode of reckoning and controlling time has become a key strategy for maximizing productivity, self-knowledge, and well-being.¹ One of the consequences is a reduction in the variability of temporal perceptions of many facets of contemporary life. With respect to chronic illness, for

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example, illness and health trajectories are increasingly articulated through the imperatives of self-management programs and evidence-based medicine (EBM), both of which link the temporality of coping with illness with the profit-generating ventures of multinational pharmaceutical companies.

The discipline of anthropology has, however, long demonstrated the co-existence of multiple temporalities, highlighting the variability of understandings and experiences of time and modes of temporal reckoning. This article focuses on how ethnographic attention to the ambiguous temporalities of illness and healing trajectories can stand as a counterpoint to advanced liberalism's promotion of subjective forms predicated on an increasingly constricted range of temporal visions.

My analysis is grounded in comparative fieldwork on childhood asthma treatments in New Zealand and the Czech Republic. From 2010 to 2016, I spent a few months each year conducting fieldwork among families of children with asthma, respiratory scientists, physicians, and environmental activists in the Czech Republic. Over the same period, I led a team of five graduate students in conducting interviews with families, physicians, alternative health providers, and health policy experts across New Zealand. Here I consider just two phenomena that emerged from this research: variable experiences of the self and the symptom-in-time among New Zealand asthma sufferers, and the pleasures of stepping outside of everyday social rhythms among Czech spa visitors.²

Like many Western, neo-liberalizing nations, New Zealand has transformed its healthcare services, streamlining professional care and increasing patients' involvement in self-care, often through the promotion of "self-management" programs. While physicians, nurses, and other medical professionals stress the importance of patients taking responsibility for their own care, they also decry low levels of patient "compliance" with the medical instructions they receive, particularly when it comes to the use of long-term, preventative medication for chronic conditions. My interest here is the role that differing temporalities play in constituting this conundrum.

In contrast to the streamlining of care in Western nations, asthma care in the Czech Republic takes many different forms. One of these, drawing from centuries' old understandings of the curative powers of water and, more broadly, exposure to the natural elements, is the spa sojourn. Contemporary spa care, I argue, raises another set of questions with respect to the temporalities of medicine, this time focused on the often hidden temporal trajectories of care. Aspects of healing that tend to fall far outside the scope of EBM – such as the imposition of radically dif-

² The case studies first appeared in a comparative analysis of asthma care in New Zealand and the Czech Republic (Trnka 2017a). A more thorough analysis of Czech spas also appears in Trnka (2017b), which I draw from here.

ferent temporal rhythms to patients' lives during their 6 week spa stay – become of key concern here.

Taken together, these two examples, I suggest, make a case for why we should pay greater attention to time's ambiguities, in both senses of the word.

Conceptualizing Ambiguity

Ambiguity, according to the *Stanford Encyclopaedia of Philosophy* is “a word or phrase that enjoys multiple meanings” (Sennet 2016: 1). Significantly, linguistics and psychology offer a second possible definition of ambiguity, as something “unclear as to meaning” (Ainsworth-Vaughn 1994). I draw on both definitions here.

In anthropology, the concept of ambiguity has arguably received the most explicit attention in studies of speech and communication. Michael Jackson (1982) and Charles Piot (1993), for example, examine how the ambiguity of indirect speech allows individuals to strategically exploit the possibility of disclosing something without actually articulating it. Similarly, Nancy Ainsworth-Vaughn (1994) describes the power of rhetorical questions in patient-doctor encounters in the US, suggesting how patients undermine medical authority by posing ambiguous comments about medical professionals' competence.

This is not to suggest that ambiguity does not feature in other anthropological studies. It does, including in works whose theoretical leanings might suggest they would be the *least* open to embracing ambiguity. Structural functionalism, for example, is well known for envisioning society as characterized by set social roles. Nonetheless, some structural functionalists, such as Irwin Press (1968), highlighted the importance of “role ambiguity” as a means of understanding social change. For instance, in his examination of Yucatan peasant communities, Press described the ambiguous role of the “culture broker” as enabling “a wider latitude of sanction-free behaviour than would be possible to incumbents of clear and/or traditional roles” (ibid.: 208).

More notably, despite the concept being left largely undefined in postmodern discourse, postmodern critics went out of their way to highlight ambiguity and uncertainty as inherent facets of both society and knowledge-making (e.g. Rosaldo 1993). Although postmodernism's heyday is long past, these insights spurred on work that continues to demonstrate ambiguity's central role in a range of otherwise seemingly impermeable cultural edifices, from law to science. In medical anthropology, for example, Ian Whitmarsh (2008) reflects on scientific research's employment of ambiguous illness categories to stabilize perceptions of race and genomics. In legal anthropology, Olivia Harris (1996) suggests that law must be understood as a continuous attempt at fixity and closure that translates ambiguous disputes into legal certainty. Both authors underscore the politically-charged nature of transforming the inherently ambiguous into “the certain”, as well

as how much can be gained by unearthing the uncertainties that such reifications conceal.

Another potentially fertile domain for similar analysis is temporal ambiguity. This is particularly so today, as many contemporary societies are currently experiencing quite *unambiguous* attempts to recalibrate understandings of time to a singular, dominant framing. Controlling time as part of political domination is hardly new. It is a well-documented feature of both capitalism (Thompson 1967) and Christianity (Robbins 2007). Advanced liberalism nonetheless promotes a specific valence of it. And one of the areas where such hijacking of time is most clearly articulated is in health and medicine, through the rise of the anticipatory or responsabilized subject, constantly on the look-out to maintain and improve their health.

What Happens when Anticipatory Subjects Refuse to Anticipate?

A broad array of neoliberal reforms has promoted a new form of subjectivity, epitomized by the forward-looking individual, focused on maximizing benefit and mitigating risk. Often referred to as *responsibilization* (Rose 2006), the phenomenon of individuals responsible for their own care is increasingly inculcated via the internalization and performance of specific forms of self-monitoring. Engaging in these new “regimes of anticipation” is both morally loaded and emotionally-laden, inculcating a particular kind of affective disposition that results in a subject who thinks and feels as if the site of life is just around the corner, rather than in the present (Adams, Murphy and Clarke 2009: 247).

Health inherently has a forward-looking dimension, be it physicians’ prognoses or patients’ hopes for a cure. The difference today is one of degree: of how much of the present is lived pre-empting the future. As Joseph Dumit (2012) argues, health is no longer defined by the ability to stay well or cope with present ailments. Rather, over the past two or three decades, we have entered a future-facing regime of health in which consumers respond to ever-shifting risk thresholds through the intake of increasing amounts of preventative medication or other anticipatory measures.

While there are different means of inculcating such forms of subjectivity, some of the most overt encouragements come from self-management programs. In the late 1980s and early 1990s, as Western liberal democracies migrated a range of lower-level healthcare activities out of institutions and into private homes, self-management programs were devised as a way of concentrating responsibility onto a single actor (i. e. the patient). Today there are standardized self-management programs for conditions ranging from diabetes to bipolar disease.

Some of the earliest self-management approaches were focused on asthma, instructing patients how and when to raise their medication doses if their breathing became compromised. The underlying premise of asthma self-management is

that sufferers should take regular, preventative medication, usually in the form of a steroid-based preventative inhaler, once or twice a day. Sufferers should also monitor their present condition to lower the likelihood of future respiratory problems. The logic is simple: asthma can be extremely debilitating, even deadly. But if sufferers can pre-empt asthma attacks by monitoring their health, they can raise their preventative medication at the first signs of unease and save themselves the distress of an asthma attack.

Indeed, many New Zealand physicians, respiratory nurses, and asthma educators consider that in the majority of cases, asthma has a “simple solution”. If patients adopt the principles of self-management, “asthma can be so well managed”, one nurse explained, “that it doesn’t interfere with your life *at all*”. According to the same professionals, patients’ “non-compliance” with medication, rates of which are thought to be as high as 80 % in New Zealand (Charles et al. 2007), are the primary reason why asthma treatments *fail*.

Why *do* so many asthma sufferers refuse to take such seemingly easy steps to ensure good health? Medical professionals usually identify non-compliance as caused by patients having highly inflated fears of steroid medication or lacking the discipline to regularly use an inhaler (or both). Similar depictions of patient-doctor struggles over non-compliance are noted across Western nations and for a range of medical conditions. The most common responses are health education campaigns coupled with programs designed to instill greater personal responsibility in patients, of which self-management is an exemplar.

Almost, however, since the concept of *compliance* was popularized in medical discourse in the 1970s, social scientists have submitted it to critical examination. Decades of analyses reveal the ideologies inherent in discourses of compliance, noting the underlying assumption that the only appropriate patient behavior is to follow doctors’ demands, labelling those who do otherwise as “deviant” or “ignorant”, and thus eliding patients’ capacities to make reasoned, and reasonable, decisions about their care. As, however, Peter Conrad (1985) asserts, rather than being “non-compliant”, patients may simply be reacting to social factors other than doctors’ directives. “Noncompliance” may also mask patient agency, as patients might be actively engaged in *other* means of self-care (ibid.).

But there is another aspect of non-compliance worth examining, namely the ambiguous – or multiple – ways that patients locate their symptoms and themselves in time. This facet of patient experience can, I suggest, be key to understanding the uptake (or not) of preventative routines.

The co-existence of multiple modes of reckoning time, often within a single society or a single individual, is well documented (Bergson 1889; Gell 1992). Scholarship has highlighted the intersections between temporality and power, analyzing temporal representations of the cultural “other” (Fabian 1983), the privileging of

specific temporal frames (Guyer 2007), and the politics underlying the temporal organization of daily life (Verdery 1996). Such works suggest more attention needs to be paid to the enfolding of the self, the body, and health within diverse temporal modes in order to improve understandings of how responsabilization regimes can segue with other ways of constituting time.

Simultaneously, there is a growing literature on the temporalities of health and medicine, examining, for example, the impact of diagnoses of chronicity on self-understanding (Smith-Morris 2010); bureaucratic temporalities' influence on therapeutics (Whyte 2014); and the "time work" required by self-curative measures (Vukovic 1999). While pivotal works emphasize the therapeutic importance of patients and medical practitioners collaboratively constructing healing trajectories (e. g. Mattingly 1998), a recent strand of this literature highlights how the *unpredictability* of illness can lead to discrepancies between medical practitioners' and patients' temporal framings (Shubin, Rapport and Seagrove 2015; Messinger 2010), resulting in various forms of "non-compliance". For example, in explaining why veterans learning to use prosthetic limbs disengage from physiotherapy, Seth Messinger (2010: 167) suggests that "patients experience a topological time where their past and their future are experientially closer to their identity than they are to their present conditions [leading to a] conflicting quality of the time orientations by therapists and patients", ultimately resulting in therapeutic breakdown.

I wish to expand on these insights by considering not only patient-doctor dynamics but also patients' perspectives of pharmaceuticals. Looking at how people live through and with symptoms in relation to their sense of being-in-time, I suggest that we view compliance as not (just) a question of discipline or knowledge, but as predicated on the implicit ways that patients view themselves and their (illness) experiences in time. Rather than a singular model of the anticipatory self, the future can often be seen as more ambiguously related to the present.

Phenomenologically, many people's experiences of asthma are refracted through the kinds of self-monitoring practices that self-management intends to instill. This is not surprising given the widespread uptake of self-surveillance practices in healthcare (Dumit 2012). Simply put, a great number of people in New Zealand (and elsewhere) happily take their medication.

Regularly using medication does not, however, necessarily denote compliance; many who use medication ignore medical instructions and use trial and error to determine their own combinations, dosages, and timings of drugs. Often sufferers refuse daily steroid preventative inhalers. Instead some use emergency reliever medications, such as Ventolin, on an as-needed basis. Others mix and match, using a daily preventer for a few weeks, circumventing their doctors and ordering antibiotics off the internet, or doubling drug dosages when they feel they are not getting enough. But rather than viewing their actions as driven by forgetfulness or

lack of care as doctors suggest, these patients often described feeling like they are the only person caring for their (or their child's) treatment.

Take Sally,³ a parent whom physicians are likely to deem non-compliant. When asked if her nine year old son Adam, who was repeatedly hospitalized with severe asthma a few years ago, takes daily medication, she replied, "Yeah, he does have to – well, he *sort* of does it every day, *if* I have noticed he's been coughing. Then I put him on Ventolin and Flixotide [a preventative medication] straight away. I suppose I would tend to keep him on the Flixotide for a week or two. Then if he seems completely better, I drop the Flixotide again, because sometimes he can go six months without needing it!" While most medical professionals would question why a preventer prescribed for daily, long-term use is being employed for only a week or two, Sally is thrilled that Adam can go for long periods relying on frequent doses of Ventolin, a drug largely intended for emergency use.

As with many other New Zealand sufferers and parents of asthmatic children, Sally has cobbled together combinations and timing of drugs based on her family's experiences of symptoms and medication-relief. Their refusals of daily preventative medication cannot, moreover, be explained as carelessness or miscommunication, but hinge on how they view not only pharmaceuticals but the companies that make and sell them. In this, the temporalities of both pharmaceuticals and pharmaceutical profits are crucial.

Pharmaceuticals require their own multiple ways of reckoning time. There is the timing of paying attention to symptoms and recalibrating one's drug intake accordingly. There is the temporality of pharmaceutical-driven experiences – the timing of how pharmaceuticals effect our bodies and minds. But there is also the issue of how pharmaceuticals *locate* sufferers in time. Like sufferers of other "chronic ailments", many asthma sufferers fear who they might *become* if they regularly ingest medication and, moreover, *for whose benefit* this transformation would be.

The rise of "drugs for life" and associated re-signification of time within the body of the consumer are clearly tied to the market and pharmaceutical companies' profit-making. Profitability is partially based on pharmaceutical sales, but also occurs, as Kaushik Sunder Rajan (2012: 326) explicates, through market speculation and perceptions of "how much *potential* there is for earning over and above the present rate of earning, which can be translated into shareholder value" – another way of assigning value to the future. The results can be dire. As Sunder Rajan (*ibid.*) describes, "Pharmaceutical industries [...] function less and less as discoverers of new therapy and more like investment banks, controlling, regulating, and betting on the flow of capital [...] result[ing] in the complete separation of value from considerations of patient needs of good health."

³ The names of all of patients, parents, and physicians in this article are pseudonyms.

The relationship with the market is intensified as self-care practices employed to ameliorate illness invoke the same ideals of disciplined self-surveillance that are broadly valued by advanced liberal economies (Ferzacca 2000). Most sufferers' critiques do not, however, focus on neoliberalism writ large. Rather sufferers focus on the more immediate entity of pharmaceutical companies and question physicians' quick and easy dispensation of pharmaceuticals. Sufferers' concerns are not only over *what* preventative corticosteroids might do to the body, but *how* they signify the creation of permanent patienthood.

Many sufferers are acutely aware of how pharmaceutical companies shifted the temporality of healthcare so as to turn the body into the *ongoing* site of the production of illness and preventative and curative regimes. In refusing to become a person with asthma and (re)categorize themselves as a patient with a chronic condition, they actively critique the pharmaceutical industry for desiring to profit from their respiratory troubles. In many cases, "non-compliance" thus constitutes a political act of re-negotiating the symptom and the self in time, re-opening the ambiguity of illness trajectories.

New Zealanders likely to be labelled "non-compliant" often have a strikingly different way of temporalizing asthma from that of received medical wisdom. Instead of describing themselves as "*people-*", much less "*patients-with-asthma*", they talk about the days they "have asthma" and the days they don't. They describe moving in and out of asthma, at times feeling happily symptom-free, and at others surprised that their asthma is lasting so long. Crucially, as both medical professionals and sufferers point out, on the days that they are well, they do not see the need for medication. Questioning whether and when one *really* has asthma or not is largely motivated by many sufferers' concerns that asthma diagnoses have grown too broad. Part of the problem, many patients recount, is the speed of diagnoses, relating how in a single doctor's visit, what they assumed was a bad cold or cough was declared to be a chronic case of asthma.

In most cases, physicians envision a particular kind of timeline for asthma with the aim of *stabilizing* the condition into perpetuity. Pharmaceutical companies promote a similar logic, focusing on stability and minimizing exacerbations, albeit premised predominantly on profitability rather than patient wellbeing. A significant number of sufferers, however, engage in a different line of reasoning, resisting the suggestion that they are ill when they do not feel their lives being compromised. Rather, the experiential temporality of symptoms suggests to them that asthma is a state that comes and goes and that therefore may not always require pharmaceutical amelioration, especially as pharmaceuticals involve their own potential dangers.

Asthma can be terrifying. Sufferers speak of feeling their breathing tubes constrict, struggling for breath, and feeling afraid that they are going to die. Through preventative regimes, self-management enables transforming that fear into antici-

pation. The desire for a seamless experiential narrative drives some sufferers to recast themselves as “a person with asthma”, a person who anticipates and pre-empts, rather than one who sometimes has near-death experiences. Others, however, resolutely refuse such categories and locate asthma attacks as discrete moments in time, choosing to maintain a self fragmented, a self constituted differently through time. Reclaiming the ambiguity of time, and of how symptoms and selves are temporally located, thus enables us to grasp the dynamics that lead some sufferers to resist both asthma and their medication.

Time, Pleasure and Efficacy

A second facet of contemporary medicine is the privileging of EBM in terms of not only streamlining procedures of assessment, but radically changing the categories of value that are used in determining efficacy. Since the 1980s medical care has increasingly been standardized according to the results of large-scale Randomized Clinical Trials (RCT). Indeed, any therapies that cannot be assessed using RCT have come to be seen as poor quality, regardless of their actual efficacy (Adams 2013). As Stefan Ecks (2008) has recently noted, the result is that there are “fundamental blindspots” inherent in EBM assessments of value. Not surprisingly, EBM tends to privilege pharmaceuticals, which are relatively easy to subject to testing, albeit using methods open to bias (Petryna 2009). This leaves medical practices that *don't* easily fit the rubric of EBM standards of “evidence” in a conundrum. Emblematic of such practices is the multi-faceted care provided by Czech *lázně* or health spas.

Known for their curative waters, healthy climates, and an array of intensive therapeutic “procedures”, ranging from massage to electrotherapy, spas have provided Czechs and visitors with a unique mode of therapeutics for centuries. At their height in the 19th century, spas were international hubs of culture. Today, some critics contend that spa visits amount to little more than state-funded “holidays” that are a waste of time and money, as compared, for example, to pharmaceutical-based care. Proponents, however, counter that spa stays are emphatically “not holidays” as they constitute scientifically-sound treatments, but often struggle to come up with credible evidence.

One fact not in dispute is that government funding for spas is precarious. Several years ago, strict reductions in government subsidies led to lower numbers of patient referrals, so that a number of spas let go of staff or even shut down facilities. In 2014 and 2015, some spas experienced a turnaround, with increased patients and reopening of services. Part of this was due to the privatization of facilities and currently controversies abound over how such privatization may impinge the average Czech's chances of accessing spa services. However, many medical professionals I have spoken to outside of Europe appear surprised that such institutions still *exist*.

Inevitably they raise the difficult questions of, do they work? And if so, *how*? This is where the concept of *ambiguity*, particularly its second definition emphasizing *lack of clarity*, is central.

Ask just about any patient and they will explain that the primary reason to stay in a spa is to have time to recuperate and strengthen the body under the care of medical professionals. But what exactly such care should include is a live question, as most spas employ a baffling array of treatments. In two children's respiratory spas I visited, Cvikov and Kynžvart, during their 6 week stay, patients were expected to breathe in healthy air, engage in a range of *balneotherapy* (water-based therapy) such as hot and cold immersion, Scottish sprays, and swimming, and take part in activities such as physiotherapy and saunas. Some of these activities were mandatory for all patients, but others were individually-tailored by physicians. But the most lauded therapy was the simplest one: going outside. Often referred to as climate therapy or toughening (*otužování*), the underlying principle is that the body will be strengthened by being active in the outdoor environment on a daily basis.

Efficacy is an issue on which many parents and doctors have strong opinions. Most parents have a sense of spa treatments' effects based on their direct experiences of their children's health. One parent after another related to me the spa's positive impacts on their child. Their accounts were *not*, however, cast in terms of diminished asthma symptoms or a decreased use of asthma medication but with respect to boosting their child's abilities to fight off illness.

Strikingly, even parents whose children remain unwell make such claims. Lenka sends her son Pepík to Cvikov every year. This year his stay there wasn't as effective as she'd hoped, as he was sick for three weeks of his six-week visit. But in terms of his treatment's *efficacy*, this is not a problem. The staff at Cvikov explained to her that sometimes children are sick for the duration of their spa cure, but the rest of the year, their immunity is bolstered and they are very healthy. If Pepík had not recently come down with another case of strep throat, she concludes that indeed, "he would be very healthy right now". Lenka's reasoning suggests her faith in a therapeutic practice into which she has invested a lot of time. It also, however, denotes the widely-held view that the curative effects of spa treatments are not necessarily immediately tangible, but act in more subtle and long-term ways to realign the body and increase health and wellbeing. Doctors similarly hail the outdoor environment as pivotal to spas' efficacy, but are unwilling to compartmentalize the effects of the various treatments on offer, suggesting they are best viewed as part of a package deal: from music therapy and massage to better inhaler techniques, patients must undergo the full treatment array. It is not only the individual therapies, but the unique *experience* of them provided in a health spa that is key. Importantly it takes time – *personal* and *social* temporal investment – for such an experience to take effect.

As a “total institution” in Erving Goffman’s terms (1957), health spas immerse children and their accompanying parents into new and rigorous self-care routines. Like most total institutions, spas create a unique and isolated environment – a space outside of the usual demands of sociality and time – in which new institutional regimes re-craft people’s routines, behaviors, and perspectives. Some aspects of these new ways of being are, moreover, intended to be brought back home. Part of the purpose of spa cures is thus the very time it takes to undergo the cure – “the time out of time” that spa sojourns create. Introducing not only different activities but establishing a different tempo of the day, a different way of being in the body is created, one that rests upon isolation, experiential difference, pleasure and discipline – a time out of time through which the body in time can be recalibrated.

When they happen, such changes are, moreover, accomplished not only through discipline and routine, but – contrary to critics’ contentions that spas are pointless holidays – through the potentially transformative effects of pleasure. The association of spas with holiday leisure has deep historical roots (Benedict 1995; Mackaman 1998). In the 18th and 19th centuries, for example, socializing and familial entertainment were serious aspects of a European spa visit (Benedict 1995; Herbert 2009). But little attention has gone towards what the pleasurable aspects of spa visits may have meant – or in terms of contemporary spas, may still mean – in terms of their therapeutic import. Indeed, in contrast to the range of studies documenting how the effects of pain and fear can profoundly alter behavior and subjectivity (e. g. Daniel 1984; Foucault 1995 [1975]; Scarry 1985), the role that pleasure may play in motivating behavior has received much less attention within the social sciences.⁴ With some notable exceptions – such as Foucault’s work (1978 [1976]; 1985 [1984]; 1986 [1984]) on sexuality – pleasure arguably remains under-theorized and largely implicit in analyses of embodied practices ranging from dance to sport or military training. Analysis of pleasure as part of therapeutics, in particular, is especially scant, with the exception of Annemarie Mol’s (2011) recent insights into the organization of pleasurable tastes as a motivational tactic in rehabilitative clinics.

But pleasure is indeed an important component of the spa experience. Today’s spas are particularly noted for the pleasures afforded by their beautiful, natural surroundings. Repeatedly, families who have been to spas together described to me the natural surroundings in glowing terms and spoke passionately about their new understandings of how to enjoy the outdoors (see also Speier 2011). A deep appreciation of the healthy aspects of nature (Trnka 2015; 2017a), as well as

⁴ This is not, however, the case in the natural sciences, where pleasure has received comparatively more attention. See, for example, Cabanac (1979); Kringsbach and Berridge (2009); Schooler and Mauss (2009).

frequent exposure to the outdoors through activities such as daily outdoor walks or the airing of interior spaces in order to ensure health and wellbeing, are widely encountered across Czech society. Nonetheless, spa sojourns were described as particularly valuable because they create a space within which such activities are a *central* facet of daily experience. Nor is it incidental that such elements of pleasure and escape occur within, and not outside of, a highly regimented therapeutic space. When it works, the total institution of the spa produces a sense of pleasure and bodily mastery not only through its leisure activities but also through bodily discipline (Mackaman 1998). Indeed, the twinning of discipline and rigor along with relaxation and leisure is not hard to understand if we think of spas as a training ground for the body and mind whose challenges ideally lead to a sense of recuperation and success.

The intensive therapeutics in spas are coordinated through a rigorous daily regime that can leave parents and children feeling a bit overwhelmed. Almost every hour of the day is allocated an activity, such as teaching patients and their accompanying parents breathing exercises, massage, water treatments, etc. It takes time to learn these skills properly and this is one reason why spa stays are so long. As Dr. Pejchal, a respiratory physician, explained to me, “Six weeks is the minimum as it takes this long to train mothers to know how to take care of their children.” But there is more than specific bodily techniques being taught here.

When Dr. Pejchal gave me a tour of Cvikov, he was keen that I see not only children learning better inhaler techniques, but also taking part in music therapy. Since there wasn't a music therapy class that day, we viewed one of his homemade videos. “Look at the drumming we have them do,” he said, pointing to a group of children sitting cross-legged in a circle on the floor, tapping on hand drums. “It teaches them two things. The children learn to relax to the rhythm of the music and we also teach them a different pattern of breathing, timing their inhalations and exhalations to the rhythm of the drumming.” As we watched further one, he pointed and cried out, “And now, look how the children are beating two sticks together, making another rhythm and breathing along with it!” The music therapy session comes to an end with the medical staff softly playing chimes while the children lay in a circle with their eyes closed. “Look how relaxed they are,” Dr. Pejchal sighed. Then he concluded: “You know, some kids do music therapy with their mothers in the room, but it is not as good. They are not as spontaneous because they just do what they think their mothers expect from them. And sometimes their mothers actively hold them back, saying things like ‘that’s enough now’ if they get too loud.” I was struck by this comment as the same man had earlier told me that one of the great benefits of spas is providing mothers with weeks of stress-free time with their children. He also explained one of the merits of daily massage therapy as ensuring “mothers touch their children. Not only is massage useful for

stimulating pressure points, but the very fact that the child is being touched and stroked by someone can be a very enjoyable and positive experience. We shouldn't forget how important it is to be touched".

Dr. Pejchal was not alone in his views. Another spa physician similarly related that just as elemental as the various respiratory therapies she oversees is the fact that for six weeks mothers do not need to cook or organize their daily routines, but can devote themselves to their children. "The children love the attention," she explained, "And the mothers love not having the stress." Many mothers I spoke with concurred. Radka who initially hesitated to visit Kynžvart, ended up having an excellent time, describing it as "super" because "there was no stress, I could have a real break".

Crucial here is that for Dr. Pejchal and others, helping children cope with the chronic condition of asthma is a larger project than conducting spirometry readings or teaching better inhaler techniques. In addition to addressing the body of the child, there is a psychological facet to this care, focused on alleviating children's and mothers' stress, re-enforcing the mother-child relationship, and giving children more space to express themselves. There are moments when these different objectives require a bit of juggling, as exemplified by the preference for keeping mothers out of music therapy sessions, but throughout their stay, mothers and children together are taught not only new ways of organizing their daily routines, but of thinking about and experiencing their bodies. Some of this instruction is explicitly conveyed through the spa's weekly health lessons or by the rigorous enforcement of daily schedules across patients' six-week stays. Other recalibrations are carried out more subtly through inhalations and exhalations timed with drumming or with eyes closed while lying on the floor, listening to chimes.

Those who are not only inclined to submit to the disciplined rigors of spa routines but to derive pleasure from the opportunity to take part in structured routines and enjoy the beautiful surroundings appear to get the most out of their spa visits. One mother encapsulated this when she described her family's spa experience as "fantastic. The nature was really great, and you had to go for walks all the time". When I ask her what she meant by "*having* to go for walks", she explained that there is no option to do otherwise. "It is a required part of the program and the spa staff walk up and down the dormitories at a certain hour of the morning, ensuring that everyone is out of their rooms and outside," she explained. Then, without any irony, she added that the health spa was "the best holiday I ever had". But with the state budget under increasing scrutiny, such praise is not necessarily helping spas retain their position as vital healthcare providers. Indeed, some critics question not only how cost-effective these institutions are, but whether or not they are effective at all. Spa directors responded by holding "Open Days" for visiting medical pro-

professionals to demonstrate how beneficial their services are. But as yet, there is very little rigorous scientific evidence at their disposal.

EBM studies of balneotherapy are just starting to be published. Most current research has been largely carried out by the spas' own staff, does not employ rigorous methods (for example, purportedly documenting efficacy of patients' treatments while lacking a comparison or a control group) and is often not taken as credible for anything beyond generating publicity. In response to such concerns, insurance companies try to ensure their clients do not use spa sojourns as "insurance-funded holidays" by mandating certain levels of therapeutics. As of 2012, for example, one leading insurance company requires that spa patients receive at least three procedures a day, six days a week. In 2014, another company told me that they would only support patients' repeat visits to health spas if they saw some visible, measurable change in their health status, such as a reduction in the amount of daily medication they take for chronic conditions.

Things such as pleasure, discipline, and changes in both the tempo and content of daily activities cannot be easily measured through RCT. If they were noted in RCTs at all, they would either be considered irrelevant "side-effects" or else actively removed from the study, as RCTs are designed to test "standardize[d]" comparisons, "by removing the background noise that makes regions and datasets incomparable" (Brives, Le Marcis and Sanabria 2016: 370). There is little space within EBM's system of values (Adams 2013; Brives, Le Marcis and Sanabria 2016; Ecks 2008), for such aspects of care to be recognized as part of the experiential realities that may in fact be integral to spas' therapeutic effects. Moreover, attempts to measure and ensure the efficacy of each individual element of a spa cure would run counter to both how spa treatments are frequently individually-tailored and the idea that the therapeutics on offer act as package deal (so that climate therapy works alongside massage, pharmaceutical oversight, music therapy and swimming lessons). What is significant is that the spa system has not yet given way to the imperatives of EBM and that pharmaceuticals have not diverted funding entirely away from other modes of care.

Today's spas should be considered, *inter alia*, for their experiential dimensions, as sites in which discipline and pleasure, challenge and mastery, and the dramatic recasting of daily responsibilities play a pivotal role in how children and their families come to cope with chronic conditions. To do so would, however, mean accepting that we cannot isolate one facet, such as exposure to clean air, as the key element of spa cures, bottle it, and sell it around the world as a curative measure – though some may like to do so. In New Zealand, for example, in 2016 a company called Pure Kiwi Air came up with the marketing strategy that the country's unpolluted air can be captured in a bottle and sold overseas, so that you can purchase up to 180 bottled inhalations of "medical grade pristine air" for

about 20 USD. And this is by far neither the first company, nor the first country, to do so.

If we wish to follow EBM standards of value, we are left with many problematic questions, such as:

- How *exactly* does time work within spa therapeutics?
- How much time is *enough* time?
- Can we measure the proportion of time necessary, or even the proportion of efficacy that each segment of time contributes?
- Similarly, if pleasure is an important facet of spa care, how much pleasure is *enough* pleasure to have an impact?

But I don't think following up on such questions is the direction we should go. Instead, I suggest we need to respect the wide range of factors that may be at play in therapies such as spa care. I am aware that my analysis of this case study is far messier than my first: it simply doesn't wrap up into a tidy, uni-factoral explanation. But then, not all evidence comes neatly packed like air in a bottle. Rather, this example speaks to how time needs to be reclaimed and recognized as *part* of healing trajectories as well as the need to consider therapeutic facets that are antithetical to the quantification and casual trajectories demanded by EBM, instead suggesting how (some) modes of healing can have *immeasurable* therapeutic effects.

Conclusion

Be it the symptom in time, or the rigorously constructed pleasures and pains of the "time out of time" of the health spa, these examples suggest how temporal ambiguity intersects with healing and illness. Reclaiming temporal ambiguity as an analytic concept is vital in the time of neoliberal audits, standardization, benchmarks and responsabilization processes such as self-management, as well as in the very constricted ways that "evidence" is being constructed through EBM.

To say this, is, however, *not* to embrace an "anything goes" attitude to uncertainty. It is, however, to embrace ambiguity as *sometimes* a possible answer – as a signpost for what we cannot, and perhaps should not, disarticulate but must look at from a different scale or level of analysis, resisting the demands for a singular, objectively measurable factor underpinning healing trajectories, or the assumption that we share a singular, shared vision of ourselves in time. It is to insist that at some points such forms of categorization and standardization are inappropriate and cannot capture the complexity of social phenomena such as illness and healing.

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