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32

Attuning to Food: Tensions and Relations in Diabetes Care

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Through an ethnographic engagement with the technosocial situations of diabetes care in Japan, this paper explores two ways in which the metabolism is acted upon: learning and patient advocacy.¹ The first section introduces a diabetes clinic where patients are treated for the prevention of diabetic complications. Metabolism, here, comes in an organizational form, as a diet regimen (*shokuji ryōhō*) that has to be mastered during the two weeks of hospitalization. The second section, by contrast, follows food as it is mediated through the collective activities of a patient group in a Tokyo neighborhood.

In the daily acts of coming to terms with diabetes, several seemingly disparate factors—from legal categories of disability to worrying wives to red blood cells—are linked together. Those who try to avoid long-term complications of elevated sugar levels in the blood must therefore learn to be affected by the internal secretions in their bodies in entirely novel ways. The search for complications in a series of diagnostic tests performs the metabolic disorder of enduring sugar excess in the body and its dreadful consequences over the years (Mohácsi 2004). Appreciating food, on the other

¹ The name of the hospital and the patient group, as well as all personal names appearing in the article, have been changed to protect the privacy of the people who were willing to tell me their stories. Japanese personal names are given in the customary Japanese order, putting the family name first, then the given name.

hand, reveals the routine calculations of carbohydrates and a concern for daily glucose fluctuations. With eating and diagnosing, the implicit principles of the metabolism are thus introduced into the body.

Exploring the interdependence of practices and ideas has been a common theoretical concern of anthropology sharing a deep sense of interest with more recent studies of science and technology (Evans-Pritchard 1937; Malinowski 1948). If one is to follow this tradition, it will become necessary to put aside the prevalent supposition that the relation between the medical knowledge of food and its individual experience are, in one way or the other, hierarchical. As I will briefly argue in what follows, such knowledges and experiences *become plural and differentiated in the acts of relatedness*. In other words, they are co-produced.

1. Food Talks: The Diabetes Clinic

Most patients at Suzuran Hospital—a private institution in a city in northern Japan—suffer from diabetes or one of its complications. As happens to be the case, this sometimes requires hospitalization so patients can better manage fluctuating glucose levels or come to terms with its consequences. Most of the time these two objectives involve each other. Doctors and nurses at Suzuran Hospital do not promise to unbundle them, but they offer a specialized treatment and follow-up of diabetes and its associated conditions by providing everything from diagnosing elevated glucose levels to complete dialysis care in a medical complex of seven floors and four wings.²

One, if not the most, important of the ideas surrounding diabetes in the clinic was nutrition.³ The implication seemed to be as simple as that: nutrients and chemicals necessary for maintaining life functions are derived from food, so consuming food is strongly related to states of health and disease.

² The complex consisted of three main units at the time of my fieldwork: an outpatient clinic (with more than 2000 registered patients), a 100 bed diabetes ward, and a 40 bed dialysis center making it a medium-size elite institution in the middle of the city.

³ The centrality of nutrition therapy is discussed exhaustively by anthropologists in the U.S. and the U.K. (Cohn 1997; Ferzacca 2004). For a Japanese case study see Chapter 6 in Ukigaya 2004.

Eating and the attention to what and how one ate were of the greatest importance in the treatment of diabetes. In popular books, academic conferences and at the clinic, diabetes care revolved around food: diet histories, food circles⁴, calorie calculators, glycemic indexes, dietitians, nutritionists, and long lists of food prescriptions (but, contrary to the common belief, very rarely prohibitions!).

From the very first event of hospitalization – the blood sugar monitoring tests on the first day – food was situated at the intersection of knowing disease and the conditions of doing it. Furthermore, since many patients arrived at the clinic with a medical history of obesity and an expressed concern about their weight, the talk about food, underpinned by the scientific language of nutrition, was an entrance into the medical practices in which diabetes was gradually unfolding.

I came across such “food talks” in the canteen during meal times, while having my lunch, which was not too restricted but slightly adjusted to the patients’ strict diet. During the two weeks of hospitalization, patients were expected to eat their meals together in the communal canteen, to calculate the calories taken in as food and burnt during the rest of the day, to learn to associate the main categories of nutrients with certain foodstuffs, and to see the various links between all this and their everyday lives. Nurses and dietitians (and less regularly doctors) visited the dining hall once or twice a week to sit down among participants of the program for some talk over lunch. In these conversations, patients contrasted the flavorless salad to the pickles (*tsukemono*) they were eating back home, or the small size of the fish on their plates to the variety of sushi at the family dinner table. A nurse would explain how food portions were calculated according to each patient’s normal calorie intake which was said to be different from person to person.

By far the most recurrent concern among these complaints was the blandness of the *miso* soup, a part of almost any Japanese-style meal. The medical staff, in return, tried to encourage people to make a virtue out of necessity by forming a habit of drinking thin *miso* soup (*usuaji no kuse wo tsukete*

⁴ In contrast to the U.S. and Europe, where food pyramids are used for modeling the hierarchy of nutrients, at the time of my research in Japan, food circles were much more prevalent in the popular literature of diet therapy giving the impression of a balanced whole rather than one of hierarchical clusters.

kudasai). There were at least two normalities in conflict here: one regarding caloric intake, and one regarding patients' eating habits. Although such norms did not necessarily fit nicely together, they were interdependent and overlapping; or it might be better to say that they *became* interdependent through the clinical encounters with diabetes.

It was there in the canteen where I met Satō-san, surrounded by nurses as he slurped his noodles. He was recovering from a serious operation, which had been undertaken in a different hospital, to remove a part of his pancreas due to cancer. His gaze, which alternated between me and the ceiling, struck me first as somehow disturbed by straying thoughts. But later I witnessed him injecting insulin, in which he was more prompt and competent than most of the doctors at the clinic. Besides such an expertise, he was also famous for being the fastest to finish his meal. The dietitian at his table cautioned him day after day that eating fast made it harder for the insulin in his body to react and contributed to his high blood sugar levels. He was listening, but in the end, he had to admit that it was the only way he could eat. He had been a *sarariman* for all his life, he explained, which meant he hardly ever had more than 15 minutes for a lunch. The rest of the lunch break, if there had been any, was saved for a short nap. "This is how I eat," he added. It seemed to cause little problem for Satō-san though, for he was able to regulate his blood sugar with insulin with a proficiency that allowed him to eat as he liked.

Normal calorie intake was thus not simply a matter of volume. It was also a matter of *how* one ate, *how many times* and of *how much* of the calories one burned in daily activities. It was a matter of what medications a person was taking, and what kinds of foods she liked. Above all, it was a matter of taste. Food, and consequently blood sugar, had to be monitored mostly and increasingly by the patient who supposedly knew the most about what he was eating. In other words, normal calories had to be related to one's own normality by knowing, mastering and feeling what health care professionals would call, for the sake of simplicity, "nutrition." *The way from the scientific to the social (at times) leads through the individual.* The diabetes management manual patients received at the admission to the program and carried with them everywhere was quite explicit about this:

"Nutrition therapy is the cornerstone of the treatment of diabetes. No

matter how competently drugs are applied, if they are not supported by adequate food, diabetes cannot be cured. However, current diabetic diet corresponds to the well-balanced daily caloric intake recommended for healthy people who want to lead a normal life. So, try to make it your own!” (educational material for the diabetes treatment program at Suzuran Center, p. 21.).

This is exactly what the burgeoning advocacy movement around diabetes in Japan is trying to achieve. Food, again, is central to this process.

2. Eating Together: The Self-Help Group

Kuromatsu-no-kai is a self-help group that brings together people with diabetes and their families in the Sunamachi area of Kōtō-ward. It is a blue-collar neighborhood in Eastern Tokyo, a fifteen-minute train ride from the center of the city, sitting on land that was reclaimed from the sea during the Edo period. The group has grown out from a small training workshop at the local health center that began in 1997 and benefited a great deal from the support of health authorities who helped them to gain an official status by the approval of the local medical association (*ishikai*). From then on, the maintenance of its activities, the infrastructural background and the planning of individual projects and annual schedules have been closely tied to the center – a fact that was a cause for concern for some members.

Murata-san, one of the founders, expressed his doubts about such a collaboration and put the emphasis on the separation between governance and advocacy:

“I was always nervous in front of the doctor and the five minute-examination at the clinic didn’t help much to get rid of that tension. I felt paralyzed ... And then I first attended this training program at the *hoken-jo* and it just gave me a different sense of the disease in me. We cooked together and enjoyed the meal that we prepared together. We shared our food at the table and our stories of struggling with diet restrictions. I kind of forgot that we were there for the disease. And then we decided to gather again and again to learn about diabetes. We formed this little learn-

ing group (*benkyōkai*). Well, I say ‘learning,’ (*benkyō*) but, you see, there are no doctors here, we don’t need them; we are all patients, we eat together, and we learn (*manabu*) about diabetes in our own way.”

Eating became a way of learning diabetes, an event of appreciating disease. Food, drink, and the acts of preparing and consuming them extended to the core of each patient’s being, providing a way to express suffering and distress in situations of knowing about the disease inside their bodies. The self-help group entered into this space of disease by crafting new configurations of engagement with food from organizing cooking days around particular themes (like ‘*bento*’, ‘Chinese’, ‘soup’, etc.) to inviting cooks from a hotel or sales representatives of catering services specializing in diabetic food delivery. These events connected them to things (food and more) they had never seen or done before by prompting them to take the painful aspects of living with diabetes as an access to knowledge.

Eating out in a restaurant once a year was one such event. At the meeting which preceded the annual restaurant gathering each member prepared a small memo with simple entries on it, like “salt, oily food, dietary fiber, balance”, etc. At last, they wrote the following sentence at the top right corner of the paper: “Let’s enjoy food!” (*Ryōri wo tanoshimimashō!*). No question, it was at this point where food became a commonsense of the anxious metabolism. Food prepared by someone else created the predicament of diabetes simply because its energy intake was hard to estimate. According to Takamura-san, a retired taxi driver, such a dilemma was only partly due to the administrative failure of enforcing the display of calorie count labels in public eating places in Japan; it was also, and probably more importantly, a practical consequence of having people eating together, which made them eat more, especially when they shared a whole table of food in a Japanese-style dinner. As Takamura-san put it very aptly, he cared less about calories and more about people, which made every single eating-out occasion a traumatic event for him, to say the least.

However, for many diabetes patients and their families “sociability is not simply a way of encouraging eating: it is also an end in itself for which eating and drinking provide the means” (Harbers, et al. 2002:216). This collective experience of disease was important for women like Takagi-san, who performed their public role as caregivers through preparing and measuring

food. Takagi-san wasn't sick herself, but attended the meetings on behalf of her husband who couldn't actively participate in weekday activities because of his work. As she put it: "I do the cooking anyway! He could learn nothing here even if he had the time to come."⁵

The point, however, is not that eating and cooking together has necessarily improved the understanding of nutritional values, nor that such activities had a profound effect on the daily management of diabetes (although it might have for some). What I rather suggest is that in this technosocial commensuration of numbers, types of nutrients and the daily pleasures or anxieties of eating, personal and social distress surrounding diabetes fuse into each other in a new—metabolic—collective. *Here, it is the scientific that incorporates the collective into the personal experience of disease.* As Bruno Latour put it in another context:

"...we don't assemble because we agree, look alike, feel good, are socially compatible, wish to fuse together, but because we are brought by divisive matters of concern into some neutral, isolated place in order to come to some sort of provisional makeshift (dis)agreement" (Latour 2005:21).

That is to say, food provoked intense concern and worry when it became nutrition because, and so far as, stress and diabetes extended each other in their effects of collectively calculating caloric intake. Indeed, the way metabolism, a model *of* the transformations of food inside one's body, turned into a model *for* patient advocacy suggests a novel articulation of what it is to have a (metabolic) body in contemporary Japan. Let me briefly summarize this in the context of philosophical and anthropological notions of embodiment.

⁵. Such a view of food may seem akin to what anthropologist Anne Allison has observed as the effect of 'education motherhood.' In her study of mothers who prepare lunch-boxes for their children at Japanese daycare centers Allison found that food practices embedded family bonds in a web of power relations from the collectivity of pupils to institutions of the state by blending personal discipline and collective life (*shūdan seikatsu*) so that everyone was expected not only to eat correctly but also to eat correctly as a member of the group (Allison 1991).

3. Internal Secretion

In the introduction to his “The Body as Spirit” (*Seishin Toshite no Shintai*), Japanese philosopher Ichikawa Hiroshi illustrates his phenomenological critique with the medical concept of the ‘metabolism.’ Most conceptions of the body, he writes, regard it

“as a material something with various physiological functions, such as metabolism, that becomes a tool for the spirit in acting upon a real world, sometimes resisting, and at other times troubling, the spirit, or being dominated by it”. [However, from a phenomenological perspective] “our concrete life in its great part is spent within the structure which cannot be reduced either to the spirit or to the body” (Ichikawa 1975:3–4).

A sensing body is certainly indispensable to experience diabetes. But it is not enough. You need more things and also more people: medical records, nurses, other patients, calorie exchange lists, scientific articles, and scales that measure food. Not at last, you need hospital canteens and self-help groups where the metabolizing body merges with the arrangements of its understanding and knowing becomes a way of relating to it. “In seeking... to join stomach to mind,” anthropologist Sidney Mintz notes, “I do not mean to violate a natural separation; I claim it is the separation which is unnatural” (Mintz 1996:35).

It is this unnaturalness (or “unculturalness,” for that matter) that I attempted to trace in this paper. Although at certain points I have referred to embodiment, the reader should be aware by now that this is done not in a strict phenomenological or symbolic sense. The focus is rather on disease as practice, and by that I mean the ways of knowing how different parts of the body are being related and how, along the way, such differences physically stimulate one to know more about oneself and others. Eating plays a crucial role in such relations.

Patients, doctors, bodies and technologies accomplish in practice what philosophers take for granted. While nurses and doctors were seeking in the metabolism a primal model for establishing and treating disease, patients and their families were hoping to act upon it in a way that reduced their suffering

and the risk of further ailments. So, the metabolism was intrinsically useful not only as a scientific paradigm⁶, but also by the virtue of the effect it had on human lives: it was an implicit principle of imitating the daily routines of diabetes patients. It imposed regular order while it was inscribed with irregular activities.

The idea that I have begun to develop is that the object of food depends on the practices of differentiation in the institution of the clinic and the patient group. The differences between modes of measuring glucose levels, between nutrition and food, or between disability and health were simultaneously individual and collective. Looking at the local sites of diabetes care, then, is not only a way of illustrating the emergence of mindful metabolic bodies in contemporary Japan, but also an argument about how such bodies “take form at the most personal juncture between the subject, her biology, and the interpersonal and technological recoding of ‘normal’ ways of being in local worlds” (Biehl and Moran-Thomas 2009:72).

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⁶ Christiane Sinding, for example, offers a Fleckian reading of the formation of what she calls ‘metabolic thought style’ among endocrinologists after the discovery of insulin during the late 1920s (Sinding 2004).

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