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Critical Medical Anthropology – a voice for just and equitable healthcare

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Abstract

The article presents a paradigm current in contemporary medical anthropology – Critical Medical Anthropology (CMA), which merges political-economic approaches with a culturally sensitive analysis of human behaviour grounded in anthropological methods. It is characterized by a strongly applied orientation and a devotion to improving population health and promoting health equity. The beginning of CMA dates back to the 1970s when the interdisciplinary movement called *the political economy of health* was developed. Today, CMA has grown into one of three major perspectives used in anthropological research devoted to health, illness and wellbeing. The author discusses the origins, key concepts and CMA's usefulness for social research, and its significance for the design of effective policies in the realm of public health. Examplary interventions and ethnographic researches are introduced and wider usage is advocated of such works and methods by bureaucrats and medical staff for understanding the patients' behavior, and the influence of social, economic and political factors on the workings of particular health systems.

Key words

medical anthropology, evidence-based medicine, social justice, cultural diversity

INTRODUCTION

Medical anthropology advances an interdisciplinary research agenda on contemporary practices related to health, sickness and healing, based on ethnographic fieldwork, bringing into focus the social roots of disease and wellbeing. Medical anthropologists derive inspiration from general social theory, as well as, they use inisghts from other sciences such as medicine, psychology, epidemiology or demography. Called a 'sister discipline' of sociology, with which it shares major theoretical premises, medical anthropology remains consistent and distinct in its usage of qualitative methodology with a preference given to long-term participant observation [1]. However, it is difficult to draw exact disciplinary borderlines in current anthropological research focused on health, sickeness and healing.

The field of medical anthropology has been developing since the 1970s. From its inception, it had an applied orientation i.e. anthropologists were strongly engaged in projects aimed at improving population health and promoting health equity [2]. Moreover, the emergent approach was characterized by a critical take on biomedical knowledge and practice. By biomedicine – also known as scientific medicine or evidence-based medicine – anthropologists understand a historically developed system of knowledge and social practice focused on scientific way of identifying disease and its etiology, as well as being devoted to the development of a universal system of diagnosing and healing. Medical anthropologists work within a few theoretical orientations. As classified by Ann McElroy and Patricia Townsend [3], these include: ecological theories, interpretive theories, political economy or critical theories (i.e. CMA), and political ecological theories. One of the most potent perspectives today is Critical Medical Anthropology (CMA) – the paradigm which merges political-economic approaches with culturally sensitive analysis of human behavior grounded in anthropological methods [2].

This article presents in a very concise manner the origins of CMA, the theoretical and conceptual framework and some of the examples of the ethnographic work conducted within this paradigm. It can be read as an anthropological appendix to the text by Włodzimierz Piątkowski and Michał Skrzypek which appeared in an earlier issue of the AAEM, titled *To tell the truth. A critical trend in medical sociology – an introduction to the problems* [4].

Works rooted in the CMA perspective constitute a strong and valuable voice for the humanization of contemporary practices related to health, sickness and the body, which the mentioned authors seem to advocate. The critical anthropologists allow real people to speak extensively about the politicalized medical realities of their everyday lives. These experiences and narratives often remain hidden, as in the case of the Polish women who use Assisted Reproductive Technology (ART) to become mothers [5]. Critical ethnographic insights bring people's stories to light, in particular the stories of those living at the social marigins, and return to them their proper worth. With this, article in turn, I wish to advocate CMA, which is known only by narrow circles of professionals. I believe the critical medical anthropologists can provide unique insights into the discussion concerned with making medicine more humane.

Critical Medical Anthropology – origins and influences. The critical perspective fostered by medical anthropologists shall be considered a part of a larger interdisciplinary movement known as *the political economy of health*. It has been diluted within such disciplines as: sociology, geography, public health, epidemiology, economics or environmental studies. Sal Restivo states that *the political economy of health*

is a theoretical framework used to study health inequalities. It proposes that health disparities are determined by

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> social structure and institutions that create, enforce, and perpetuate poverty and privilege. […] [Political economists of health – *AWM*] analyze the relationships between health status and political-economic institutions throughout the world, with particular emphasis on the detrimental health effects created by capitalist relations of production and sustained by specific political-economic arrangements [6].

The critical approach to health and illness is rooted in the Marxist tradition. Friedrich Engels' book *The Condition of the Working Class in England* [7] constitutes the classic of critical analysis of disease understood as socially conditioned and dependent on power and class relations. Another early intellectual influence was the German pathologist-anthropologist Rudolf Virchow (1821–1902), who gained fame with his socially-sensitive study of a typhus epidemic that broke out in Upper Silesia in 1848.

The beginning of critical perspective in medical anthropology dates back to 1973 and the symposium *Topias and Utopias in Health* organized for the Ninth International Congress for Anthropological and Ethnological Sciences. Important later developments were: Soheir Morsy's 'The Missing Link in Medical Anthropology: the Political Economy of Health' [8], published in *Reviews in Anthropology,* and Hans Baer's essay 'On the Political Economy of Health' published in the *Medical Anthropology Newsletter* [9]. These essays constituted an overview of the field of *the political economy of health* and aimed for the inclusion of its program into the anthropological agenda [10]. Anthropologists' warming up with *the political economy of health* shall be understood as a part of a larger process. The 1970s in the United States were marked by a general growth of interest in *the political economy of health* caused by revitalization of Marxist scholarship and the world system theory, as well as the voicing of such social movements as feminism, civil rights and the anti-war movement [6]. Nowadays, critical medical anthropologists enter into their studies beyond class and look into stratification due to race, gender, ethnicity, religion or sexual orientation as determinants of ill health.

Deriving from Immanuel Wallerstein's *World System Theory* [11] developed in the 1970s, critical medical anthropologists look at their subject from a larger perspective and recognize that 'disease and its treatment occur within the context of the capitalist world system' [10] which has produced new global and local configurations of class relations and structural inequalities. *The World System Theory* developed by I. Wallerstein is a socio-historical kind of analysis explaining the modernization process from a global perspective, with emphasis being placed on the changing nature of capitalism and related to it the supremacy of the Western world. Wallerstein developed a 'core-periphery' model arguing that the development of world capitalism produces the wealthy metropolitan core which extracts goods and services from the poor peripheries [11]. From this point of view, underdevelopment of the Third World is understood as a consequence of the expansion of world capitalism, as opposed to late modernization or backwardness [6]. Critical medical anthropologists are particularly interested in such issues as the advancements of biomedicine into this unprivileged area of the world, and the consequences of these processes on the wellbeing of the local populations, or exploitation of indigenous knowledge and practices by the pharmaceutical industry. Poverty and inequalities in access to health and wellbeing are recognized by engaged anthropologists as the most serious contemporary global challenge.

In the 1980s, with the advancements in poststructuralist thought, the concept of *biopower* authored by Michel Foucault [12] became popular among social scientists. *Biopower* refers to a new form of social control which emerged within the context of a modern nation-state. This kind of control based on specific modern regimes of knowledge and practice – e.g. hospital, public health or population measurement techniques – is not achieved through coercion but through dissemination of knowledge in an institutionalized form, for example, in schools. Such knowledge appears natural and normal to people and becomes the basis for their behaviours, choice-making and self-perceptions. With reference to the human body and health, it implies internalizing various body techniques (such as diet, sexual behaviour or drug intake) and cognitive schemata (such as the tendency to make oneself responsible for ill health as opposed to, for example, recognizing the social determinants of illness).

More recently, CMA has also been increasingly sensitive to phenomenological thought moving away from the pure Foucauldian mode of presenting patients as *docile bodies*, and penetrating the subjective dimension of health and sickness, treating patients as furnished with agency [13]. These developments coincide with the growing interest of the social sciences in the body as a significant component of the contemporary culture and mode of self-construction [14].

Eventually, contemporary critical thought tries to merge both structural and individual levels of analysis. It focuses on the interaction between individual agency and social processes of which institutional and discursive power is a part [15]. It uses the critical theoretical framework to unmask hidden sources of social inequality and ill health, both in the global and local dimensions.

Critical Medical Anthropology – classical key concepts. Merrill Singer, a critical medical anthropologist, distinguishes seven key concepts in CMA: health, disease, syndemics, sufferer experience, medicalization, medical hegemony and medical pluralism [2]. Health in CMA is defined as: 'access to and control over basic material and non-material resources that sustain and promote life at a high level of satisfaction' [2]. Disease in this approach is seen as both biological and social, and the critical analysis is meant to discover the relationship between the biological and social roots of the disease. Social epidemiology linked to CMA preoccupies itself with identifying social determinants of population distribution of health and disease asking: 'Who and what is responsible for population patterns of health, disease, and wellbeing, as manifested in present, past, and changing social inequalities of health?' [16]. CMA studies, very much aware of social inequalities, look at 'biological expressions of social inequalities', i.e. ways in which people biologically live through economic and social inequalities, and how such inequalities are being transcribed into the body – a phenomenon called by Margaret Lock and Vinh-Kim Nguyen *local biologies* [17]. One example of a recent work on *local biologies* is Clara Han's *Life in Debt*, which describes the reality of poor people living in the neighborhood of Santiago in Chile. She studied an impoverished group of people once marked by political violence and interpreted the mental health disorders present in their lives in relation to neo-liberal Chilean policies and rhetoric of reconciliation of the 1990s

[18]. Paul Farmer's body of work on AIDS is an important example of engaged critical work which reveals that poverty plays a key role in the contemporary spread of pandemics in various localities such as Haiti, USA or India [19].

Another key concept – *syndemics*, was introduced by CMA in the mid-1990s [20]. It can be read as a critique of the practice of treating disease as isolated and distinct entities, independent of social contexts. It refers to two or more epidemics and how they interact synergistically inside human bodies, contributing to an excessive burden of disease in a given group of people [2]. For example, the non-governmental organization *Partners in Health* (PIH) argues that most of the global vertical health programmes aiming at combating HIV/AIDS in rural areas of Africa or in Haiti were ineffective because they did not recognize that most of the patients came to see a doctor because of other ailments (most notably, people diagnosed with HIV/AIDS suffered from tuberculosis). PIH therefore suggested linking programmes combating HIV/AIDS with those addressing tuberculosis. These suggestions were based on well-grounded research conducted, among others, by critical medical anthropologists (see: http://www.partnersinhealth.com).

When CMA focuses on the individual sufferer's experience it never looses sight of macrosocial processes. The assumption is that the way people live through sickness depends on socially constructed meanings and the political and economic forces that shape daily life. Research programmes conducted in the CMA paradigm are meant to help improve people's health and wellbeing, hence its interest in poverty, deprivation, social exclusion, and inequalities. Recent theoretical focus on the human body observable in anthropology has influenced the way CMA approaches the individual experience of wellbeing and illness. In CMA, the body is analyzed not only as embodying social and economic inequalities, but also in the context of contemporary commodity culture. Today, people express and define themselves through commodities and appearance which reflect their concepts of self and the world. Attention to body maintenance implies interest in good health, sexual attractiveness, and a desirable external look. An immense demand on industry devoted to bodily maintenance means further expansion of biomedicine into new fields – for example, that of the human appearance [21]. In this way pharmaceuticals have become central for the contemporary sense of self and the way people represent themselves *vis-à-vis* others and relate to their social environment. Emily Martin called this phenomenon the 'pharmaceutical self'. In her public lecture at the British Museum she described, for example, how psychotropic drugs are imagined by Americans as means for improving oneself [22]. João Biehl develops this argument in his discussion of the complexity of becoming a 'pharmaceutical self' by presenting the ethnographic case of a Brazilian woman diagnosed with mental disorders who was deprived of social networks support, and for whom pharmaceuticalization meant development of dependency on medical and social institutions which led to further social alienation [23].

One of the most important terms in medical anthropology is that of *medicalization*. The notion was popularized by the sociologists Ivan Illich [24] and Irving Zola [25] in the 1970s, and describes the process of rapid expansion of scientific medicine into various walks of human life (e.g. medicalization of old age). It is important to note that recently, sociologists and anthropologists have observed that the phenomenon of medicalization is coupled with the processes of demedicalization, i.e. social behaviours set in opposition to medicalization. CMA built upon the concept of medicalization by relating it to the global capitalist economy and added a new phrase to the socio-medical dictionary i.e. *medical hegemony*. By *medical hegemony* CMA understands the global expansion of biomedicine as knowledge and practice along with 'the process by which capitalist assumptions, concepts, and values come to permeate medical diagnosis and treatment' [2]. The *hegemony of biomedicine*, according to CMA, should not be understood as a consequence of its curative efficacy but as a result of expansion of global market economy [10]:

> Hegemony refers to the process by which one class exerts control of the cognitive and intellectual life of society by structural means as opposed to coercive ones. Hegemony is achieved through the diffusion and constant reinforcement through the key institutions of society of certain values, attitudes, beliefs, social norms, and legal percepts [2].

Research based on CMA may, for example, look into programmes promoting health as a form of pedagogy which legitimizes ideologies and practices shaping individual daily lives in terms of food intake, physical activities, sexual behaviour, reaction to distress and suchlike [21].

CMA's interests in biomedicine can be expressed in the question of who controls it and what are the implications of such control. More specifically: Who has power over the agencies of biomedicine? How and in what form is this power delegated? How is this power expressed in the social relations of various groups and actors that comprise the health care system? [10].

In the CMA approach, studying health practices around the contemporary world entails a critical reflection on the Western domination in the field of health maintenance and healing. For example, medical anthropologists preoccupied with the concept of Global Mental Health (GMH, i.e. an emerging form of knowledge and practice focused on global dimension of mental health exercised, among others, by World Health Organization (WHO) through the Mental Health Gap Action Programme (MHGAP), which is meant to fight inequalities in access to mental health care in poor countries, point out that GMH programmes are dominated by western modes of diagnosis and treatment of mental illness, among others, according to the interests of pharmaceutical companies and the establishment of standard northwestern psychiatry. They argue that, *inter alia,* due to cultural differences, western diagnostic manuals for mental illness should not be treated as universally applicable [26]. An aggressive process of introducing mental health care in the Third World modeled after Western medical systems is driven by specific economic interests and proves that various medical traditions are differently valued by international agencies. This process, in turn, reveals asymmetries in power relations between the South and the West. In fact, anthropologists observe some resistance to biomedical hegemony which is often understood by local populations as a form of colonization. Such resistance may be expressed through support given either by the State administration or by lay people to local medical traditions, as opposed to biomedical practice, as it is in Indonesia, for example [27]. Yet, as illustrated by Guillaume Lachenal for the Democratic Republic of Congo, *biopolitics* in a form of bureaucratic

reinforcement of modernizing health reforms based on the western model may be also thought of by people with nostalgia and desire, as opposed to threat or repugnance [28]. Anthropologists are well-trained to show such culturally-conditioned differences, also those differences which surface among Western societies.

CMA is critical because it preoccupies itself with unmasking the profit-making orientation of biomedicine heavily reliant on high technology, massive use of drugs, and concentration of medical services in medical complexes [10]. National bureaucracies are seen as entities which give legitimacy and help maintain the corporate dominance in health arena, among others, through the shaping of medical training or national health programmes. The same applies to international actors like the World Bank or IMF which influence the health policies of the countries receiving financial assistance, demanding health care reforms developed in accordance with the rules of market-driven economies [10].

The critical character of CMA can be traced in its preoccupation with the functioning of the pharmaceutical companies [29], which, today, – as pointed out by Kalman Applbaum – increasingly resemble fast-moving consumer goods companies selling detergents, beverages or hair sprays. This author argues that marketing became the driving force in the drug industry leading to such developments as:

1) seeking to lower costs through foreign sourcing of raw materials – in this case clinical trial subjects;
2) seeking to expand the market for one's products by exporting to new markets and by deepening consumption in existing ones;
3) muscling into local healthcare policy and administration to guarantee country environments healthy for phrama growth.

Applbaum argues that citizens in western countries have become over-medicated and, as such, are less useful for medical trials; the search now is for 'naïve' populations, i.e. those living in poor countries. This tendency is problematic, both ethically (new drugs are unaffordable for the tested populations) and from the medical point of view (drug efficacy may vary cross-culturally) [29,30]. An approach tracing the social life of pharmaceuticals constitutes a crucial field for contemporary critical research [31]. It deepens knowledge concerning the local conditions of production and consumption and the functioning of the pharmaceutical industry. Using a 'biography' metaphor, anthropologists deconstruct various stages of pharmaceutics' life, such as the production, introduction to the market, distribution, prescription, sales and usage [32].

On a mezzo-level of analysis, doctor-patient interactions are approached in CMA as an example of hegemonic practice reinforcing the non-egalitarian structures of society. On the one hand, it is about placing the patient in a position of subordination to a medical expert, on the other, about directing the patient's 'attention to the immediate causes of illness, such as pathogens or bad habits, and away from structural factors of which doctors feel they have little control', e.g. working conditions or material deprivation. The doctor in the patient/doctor relationship plays a two-fold social role: he/she controls access to the sick role and he/she medicalizes social distress [10]. Another problem posed by critical thinkers on the intermediate level of analysis is the process of deprofessionalization or proletarianization of physicians [10, 33], which is linked with the fact that western health care institutions start to operate on such market-driven assumptions as profit-making entities under the guise of 'managed care', which is increasingly bureaucratized and where the physician looses much of his/her autonomy.

Eventually, the key concept in medical anthropology, as such, is that of medical pluralism. The term implies that in contemporary societies a number of healing traditions are present. Singer suggests that in most cases national medical systems are 'dominative', i.e. one medical system (most often biomedicine) enjoys dominant status over other practices (e.g. ethnomedical practices) [34]. It may work towards subordinating other medical traditions operating within a given society. Such a status is possible thanks to the support of the elites of society and legal solutions giving biomedicine monopoly over certain medical practices. Anthropologists mention also examples of heterodox medical systems (also known as *medical hybridization*), like Ayurveda and Unani in India, natural medicine in Germany, or two medicines in China [27]. Danuta Penkala-Gawęcka distinguishes also microsocial perspective on medical pluralism, i.e. individual patients' decisions to use services stemming from different traditions concurrently or interchangeably, as well as a reliance on various health ideologies when living through one's illness [35]. Many social scientists notice that the western biomedical model undergoes a crisis and that there is a move towards demedicalization [36, 37, 38, 39]. Critical medical anthropologists see in this a proof of agency and a potential of individual choice-making for bringing in a social change. The term *medical pluralism* has undergone some criticism. More recently, terms like *multiple medical realities* [40] or *medicoscapes* [41] have become more popular. They help grasp the transnational aspects of medicalized social life and research the heterogeneity of the actors involved in the production of the individual sense of health and illness.

A vision of social justice and political economy of health. The CMA approach to health and illness seems particularly potent for analyzing national contexts of countries undergoing political and social transition, for example, Poland. Recent reforms of health care meant transformation from the socialist model based on the assumption of equity, yet, lacking in resources, to the commercialization of health care, which implies differentiation in access to health care, a growing gap between rich and poor in the quality of received care, and an expansion of medical technology. Anthropological cross-cultural studies may help contextualize and compare the Polish medical system and the relationship between the historically changing political regime and provision of health to that of other countries. Restivo warns that 'Health is increasingly constructed as a pathway to economic growth and development, as well as an untapped source of revenue for the private sector' [6]. Addressing inequalities in global health and recognizing its local consequences requires decisive steps taken by the governments to protect their citizens and physical environments. The vision of social justice implies that the interests of corporate agencies and capitalist logic are set aside and a priority is given to a joint action of building a just and equitable health care which works towards combating human poverty [42]. As Nancy Krieger put it: 'If you have a social justice perspective on public health, it means that you have to seriously engage with the political economy of health' [43].

The article has presented one vibrant perspective on the current research conducted by medical anthropologists, called by Nancy Scheper-Hughes, a leading critical anthropologist, a *militant anthropology,* i.e. the kind of grounded research which helps eliminate poverty and create programmes combating social inequalities [44]. The critical perspective in medical anthropology guarantees that the social research has an applied character and is conducted with care for human well-being, and with an aim of reducing social suffering [32]. In the light of the crisis of the biomedical model, and the growing complexity of the global flow, this kind of work may provide a necessary guide and useful insights for all the subjects involved in the contemporary medical reality and, in particular, for those willing to improve it.

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