Why medical anthropology matters

Guest editorial by Cecil Helman

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Medical anthropology as a separate field of study is only about 30 years old. Yet it is today one of the most vibrant and successful of all the branches of anthropology, attracting large numbers of students, grants and the interest of other professions. The integration of medical anthropology into mainstream North American anthropology was comparatively rapid, and today it is one of the most popular choices among graduate students in anthropology. However, in the United Kingdom it has taken many years for it to become part of the anthropological mainstream. Here, many anthropology departments have regarded ‘applied anthropology’ as a contradiction in terms, putting the emphasis more on observing than on participating. Applied anthropology was seen as not ‘pure’ scholarship, but rather as contaminated by its close engagement with practical and policy issues.

As an increasingly confident sub-discipline medical anthropology has a lot to offer – not only because of its applied approach, but also because it has already contributed an enormous amount to the theoretical basis of anthropology. It is an eclectic discipline, drawing its ideas and research methodologies not only from anthropology itself, but also from epidemiology, genetics, medical history, literary criticism and semiotics, as well as from clinical medicine and psychiatry (see Helman 2001).

In recent years applied anthropology has been moving steadily towards centre stage in anthropology for a variety of reasons, among them the disappearance of the discipline’s traditional field bases: small-scale, bounded societies are no longer small-scale, nor are they quite as bounded as before. As anthropology’s core field of study diminishes, and new social issues emerge much closer to home, there has been a growing need to embrace the various forms of applied anthropology (Mars 2004). Population movements worldwide have generated many millions of migrants and refugees, resulting in an increasing mix of cultures and social groups. Populations (as well as languages and ideas) that were once ‘over there’ are now over here. For example, a survey in 2000 found that only two-thirds of London schoolchildren had English as a home language, and they now speak a total of 307 different languages (Baker, Eversley and Lam 2000). The situation is similar to that found in many other cities in Western Europe and North America.

This diversity in mother tongues spoken in any one place is paralleled by a diversity of views held about health and illness, and by a proliferation of ‘alternative’ healing sub-cultures, each with its own particular view of how illness (and other forms of suffering) should be explained, and then dealt with. Many of these therapeutic approaches, like acupuncture, shiatsu and ayurveda, are based on traditional healing systems borrowed from other countries, though often practised here in a syncretic form. At the same time, hundreds of traditional healers have been imported into Britain from abroad to serve different ethnic communities: vaidos and hakims from south Asia, marabouts and obeah men from parts of Africa, spiritual advisers from the Caribbean, practitioners of Traditional Chinese Medicine from Hong Kong and elsewhere, not to mention the many West African churches that practise religious healing.

All of this means a growing number of interfaces, and potential conflicts, between different therapeutic systems, but it also opens up a new set of opportunities for anthropologists: to act as brokers or cultural interpreters between health professionals and their clients, and between national health systems and local communities. In medical and nursing education anthropologists could help to promote ‘cultural competence’, but could also counteract some of the simplistic doctrines of the new ‘ethnic minority medicine’, with its stereotypes, static view of identity, and neglect of the social and economic contexts of health and illness. These are exemplified by the growing number of cultural ‘recipe’ books directed at health professionals, which include long lists of supposedly fixed ‘cultural attributes’ (‘Muslims always believe X’, ‘Hindus always do Y’), but take no account of personal, regional, class or generational variations within a community.

Understanding this increasingly complex medical pluralism requires a rather different, less traditional, way of carrying out research, especially in urban environments (cf. Mars 2004). We need this research, though, not only to understand the variety of syncretic healing forms now
available, but also for the light that they shed on Western medicine itself, and on its strengths and limitations. From a policy point of view, there is also a need to understand why some communities in Britain make use of the National Health Service while others are reluctant to do so.

**Medical advances also make possible the production of new types of liminal beings:** what Kaufman and Morgan (2005) term ‘new forms at the margins of life’, ‘not-dead-but-not-fully-alive’. These include stem cells, DNA samples, samples of blood and bodily organs, and frozen embryos, ova and sperm – as well as people who are severely demented or in an irreversible coma. They also produce increasing numbers of new types of human body, from ‘cyborgs’ or ‘bionic bodies’ (Nowak 2004) – fusions of humans and machines, ranging from simple pacemakers to artificial organs or complex life-support systems – to the ‘collage bodies’ resulting from organ transplantation (Helman 1988).

New reproductive technologies such as surrogacy and IVF are now having a major impact on notions of identity, kinship and parenthood. At the other end of life, developing fields such as biogerontology have begun to explore various forms of ‘life extension’ through the use of stem cells and nanotechnology, while others are focusing more on ‘life enhancement’, such as the growing number of surgical and medical interventions (including organ transplants and dialysis) now being carried out on very elderly people, especially in the USA (cf. Kaufman and Morgan 2004). Both approaches raise the possibility that physical aging itself can somehow be ‘cured’, or at least postponed almost indefinitely.

All the technological optimism of this medical ‘culture of life’, with its scientific millenarianism and its view of the body as being endlessly malleable by science, needs to be closely examined and critiqued. What are the ethical and other implications of these rapidly changing notions of ‘body’ and ‘self’, and of the beginnings and ends of life? What will be the overall social effect of these technologies? Will their benefits be available only to the few who can afford them (the ‘time-rich’, compared to the ‘time-poor’) or will everyone eventually become ‘time-rich’ (the ‘time-poor’)? Of course, for much of the world’s population these developments are largely irrelevant; for them, ‘life extension’ means surviving to the age of 50, while ‘life enhancement’ means available health care, clean water and proper sanitation.

Because of the multi-disciplinary nature of medical anthropology, the discipline must take other forms of academic background, experience and data collection more seriously. This benefits both anthropology and its sub-disciplines – and those with backgrounds in medicine and other health sciences should especially be welcomed into the anthropological community. Their particular experience is a contribution to anthropology rather than a dilution of its approach. For example, I calculated recently that in my own medical career I have carried out at least 200,000 consultations with patients, and have also made many thousands of house visits to patients at every level of British society, from titled aristocracy to squatters, from affluent leafy suburbs to shabby council estates crowded with immigrants or recent refugees. This has taught me more about the nature and context of human suffering than any academic seminar on the semiotics of bodily dysfunction ever could.

This type of experience provides another kind of ethnographic depth – different perhaps from more traditional forms of data collection in anthropology, but nevertheless one which can provide it with new insights and new theoretical models. My hope is that in the future different types of professional experience, even if they originate beyond the borders of anthropology, will be increasingly welcomed into the discipline, and encouraged to contribute even further to its development. Such an eclectic approach can only benefit, and enrich, anthropology.