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.

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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 parallelled 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: *vaid*s and *hakim*s from south Asia, *marabout*s 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.

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Medical anthropology is increasingly relevant for another reason – the daunting health problems now facing the global community. These include the estimated 40 million people with the HIV virus, the 350-500 million people who suffer from malaria each year, and the 2 million children under five who die each year in developing countries from infectious diseases, many of them preventable. Added to these are the looming problems of overpopulation, urbanization and, particularly in developing countries, the growth of the urban poor – a population who often suffer from new types of health problems, a lethal combination of First and Third World disease patterns (such as malnutrition and infectious diseases combined with the effects of air pollution, traffic accidents and housing sited near hazardous industries).

These global health crises cannot be ignored. In the years to come it will no longer be enough for most anthropologists to be merely academic voyeurs, analysing the situation from the sidelines. For those who profess a humanistic basis to their work, there will be a pressing need to actually do something to alleviate the situation. This means confronting a major shift in paradigm: from professional observer to active participant. It means becoming an informed contributor to health policy and practice, as well as to medical education.

One way of doing this is to help overcome the basic paradox at the heart of international health policy: namely, that global health problems require global health solutions, but no global health strategy can be universally applicable to all parts of the world, given the wide diversity of human populations, especially at the local level. Any 'one size fits all' health policy formulated in Geneva, London or Washington is unlikely to be applicable to all communities, in every part of the world – or even within the same country or city. The failure of many well-intentioned health policies is evidence of this, and of the need to take local realities – including poverty, religion, and local power or gender relations – into account.

A key role of the medical anthropologist here would be to mediate between health planners and bureaucracies on one side, and local communities on the other; to act as advocate for those communities, but also as a feedback loop, ensuring that health programmes make sense to the community in terms of their local social and economic realities, and are also acceptable to them. Where necessary anthropologists will also have to 'study up', to examine critically the ideology and internal organization of the international aid agencies themselves, and to point out how these factors may either hinder or help the work that they do. This type of mediation opens up a crucial role for medical anthropology, and many of my colleagues are already involved in it.

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Another reason why medical anthropology will be increasingly necessary in the future relates to the issues thrown up by new areas of medical research such as the human genome project, embryonic stem cell research and developments in biotechnology and transplantation, all of which represent major revolutions within medicine. Among other issues, these developments raise the possibility of the gradual 'geneticization' of both medicine and psychiatry, and perhaps of the social and behavioural sciences as well – a shift away from socially determined criteria towards more biologically determined definitions of behaviour and identity.

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 most people whose lifespan will remain short (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.

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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. ●

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