Cult Med Psychiatry
DOI 10.1007/s11013-010-9203-x

CIRCUMSTANTIAL DELIVERY

Millennial Medical Anthropology: From There to Here and Beyond, or the Problem of Global Health

Atwood D. Gaines

© Springer Science+Business Media, LLC 2010

Abstract While much of Medical Anthropology was and is what we can call "Normal" (following Kuhn) Medical Anthropology, I coined the term Millennial Medical Anthropology for that branch of the discipline that, in the 1990s, was departing from the Normal research paradigms and was deserving of a distinct sobriquet. This paper considers the Strong Program in Medical Anthropology's Millennial Medical Anthropology and its key subdivisions, the Cultural Studies of Science and Cultural Bioethics. Specifically it considers Medical Anthropology's movement from the past into an ethical future wherein Normal Biomedicine, Bioethics and Global Health are problematized. This provides the basis for the construction of a truly anthropological global health (i.e., Global, Global Health or Global Health 2.0).

Keywords Millennial Medical Anthropology · Biomedical entourage · Bioethics · Global Health · Global Health 2.0

Past, (the) Introduction

In the 1990s, one trend of knowledge dissemination in Medical Anthropology (MA) embraced the informal biomedical discursive practices encouraging the portability of decontexted knowledge. "Take-away messages" or "quick reads" began to appear for the benefit of medical colleagues, but they provided little food for thought. In a comment on such work, Kleinman (1995) explicitly noted the "thinning-out" of scholarship found in MA journals such that veritable sound bits were fast becoming the mainstay of publications. In a discussion of this "dumbing-down" of MA literature, a psychiatrist colleague asked of this author, "What are

A. D. Gaines (✉)
Case Western Reserve University, Cleveland, OH 44106, USA
e-mail: atwood.gaines@case.edu

Published online: 29 December 2010

they doing now: writing for doctors?" These comments were part of a larger concern in MA wherein many considered their job, essentially, to be one of handmaiden to Biomedicine in international contexts. Thus, much of what was being written had come to be rather thin handmaidens' tales ("more of this" or "less of that") rather than social science research that deepened or advanced the discipline.

I coined the terms Millennial Medical Anthropology and the Cultural Studies of Science and Local Biology (Gaines 1987, 1992) within it and saw these as branches of what I called the "Strong Program in Medical Anthropology" (Gaines 1998a). Early in the new millennium I added Cultural Bioethics to the mix (Gaines 1998b, 2005). The Strong Program was a branch of MA that I saw as departing from the Normal research topics and methods of the discipline and deserving of a distinct sobriquet. Work of this stripe began appearing in the 1990s as an outgrowth of the Anthropology of Biomedicine (Gaines 1979; Gaines and Hahn 1982; Hahn and Gaines 1985) and was quite distinct from the increasingly large service orientation of much of MA. In addition, the works were highly theoretical and not only looked at health but at medical theory and the sciences that medicine applied in their cultural contexts (Gaines 1987, 1992, 1998b; Kleinman 1995, Lock 1993; Young 1995).

These developments within MA were complimented by work in Anthropology outside of yet in Anthropology, in the Social Studies of Science (a.k.a. Science and Technology Studies, etc.) (e.g., Fujimura 1996; Haraway 1991; Latour 1988; Traweek 1988). There developed, then, a veritable Anthropology of Science. But much of the field outside of Anthropology, in its sociological dimensions, did not employ a sense of culture, of patterned beliefs shared within and without the scientific domains and of unique patterning within it. While traditional science studies focused on portrayals of rationality and logic, culturally studies could show cultural patterns and beliefs rather than an imputed rationality of the standard view (Hacking 1983). Such cultural beliefs were and are also clearly discernible in culturally informed historical analyses, as are personal beliefs and morality (e.g., Keller 1992; Latour 1988; Schiebinger 1993; Shapin 2008).

I employed the term The Strong Program for several reasons. First, the term suggests a "thicker" praxis than mainstream MA with its service dimension. Such work also engaged medical sciences beyond medical theory and clinical practice. Such work also stressed the construction of realities personal, medical and scientific, through historical processes. In addition, this sort of research engages theory in a meaningful way and, as such, is a "Strong Program" in MA.

To be sure, the elements of the Strong Program are not the traditional functionalist, causal realist, materialist theories of Biomedicine or its sciences or of MA's own Critical Medical Anthropolog(ies) (Gaines 1991). Rather, under this rubric we find interpretive, interdisciplinary social science with an historical cast. Increasingly, Millennial MA has implications for medical practice and scientific research, as it brings once silenced voices into dialogue and asserts and contests Biomedicine's discursive formations. Work now engages and interrogates the logic of biological sciences, that is, the sciences that Biomedicine applies. This research brings Millennial MA into dialogue with the histories and philosophies of science

and medicine that may put it at odds with advocates of a global application of biomedical ideology and practice. In my article in *American Anthropologist* (Gaines 1998a), I noted a number of trends that I envisioned would grow out of the MA of the late 1990s, but here I concern myself, for brevity's sake, to a mention of Local Biology, the Anthropology of Biomedicine and Cultural Bioethics. I conclude with a critique of Global Health as presently conceived in MA and a call for a different kind of global health enterprise.

Biomedicine, Local Biology, Bioethics and Global Health

From the perspective of Millennial MA, a serious divide exists in MA that is noteworthy and has implications for future work in the discipline as well as for many laypersons around the world. The development of the Anthropology of Biomedicine has led many to study the theory and practice of Biomedicine and to move on to the Cultural Studies of Science (done from a MA perspective) and/or to Bioethics, as already noted. Many others in MA have simply applied (and continue to apply) biomedical knowledge and practice to problems defined in biomedical terms here and abroad. Therein lays the problem—and a divide. Here I point out the myriad of problems with Biomedicine, all to suggest why it should not be the basis of an anthropological Global Health enterprise.

First, Biomedicine is a biological medicine, hence the name bestowed upon it (Gaines and Hahn 1992). However, its biology is only asserted to be a universal human biology. Students of Biomedicine and biology in the Cultural Studies of Science have clearly demonstrated that Biomedicine's biology is what I have called a Local Biology (Gaines 1987, 1992; Lock 1993), which has embedded within its theory and practice local biologized notions of gender and "race" (Benjamin 1991; Fausto-Sterling 1992, 2000; Gaines 1995, 2005a, b; Harding 1993; Martin 1987; Morris and Nott 2002; Scully1980) as well as many other problematic formulations. They include a variety of other forms of hierarchy and communalism in biomedical theory, practice and education (ageism, classism, heteronormativity) (Hahn and Gaines 1985; Lindenbaum and Lock 1993). Those who sparked the development of the Anthropology of Biomedicine, such as Kleinman, Engle and Eisenberg, noted its limitations in terms of its focus on cure, rather than healing, its overly biological notion of illness, its individual focus, and so on.

We may add to this long list of problems the fact that Biomedicine's biological focus engenders increasing use of pharmaceuticals and biotechnological fixes for everything defined as "abnormal," that is, that which is at variance with "nature" (a cultural construction) or simply unwanted (e.g., plastic surgery [see Haikan 1997]), all in terms of specific cultural notions of and for mind and body (as well as that very split in being) (e.g., Davis-Floyd and Dumit 1998; Hahn and Gaines 1985; Kleinman 1995; Lock and Gordon 1988; Weisz 1990; Young 1995). As one might expect, Biomedicine's response to the rising concern for minorities and women, which widely misses the point, is to create "racial medicine" and "gender medicine" as "more personalized" forms of medical theorizing and therapy. Biomedicine assumes that biology, and not behavior, is responsible for differences in mortality

and morbidity found among various "groups," the delineations of which are themselves cultural. Biomedicine's goal seems to be, "Find social difference and biologize it."

In addition to these monumental problems of Biomedicine, there are also the problems with what I call the *biomedical entourage*. I refer here to the fact that Biomedicine is a biological medicine that (over)emphasizes drugs and technology and has its own ethics. The first component, Big Pharma, as the major pharmaceutical companies are called, is known to exert enormous influence on medical research, theory and practice for its own benefit, as many, many authors have begun to enumerate (e.g., Graham 2000; Healy 2002; Whitehouse 2008). One of Big Pharma's interests is the abnormalization of typical aspects of the human condition (e.g., shyness, episodic irritability or sleeplessness).

The problem of medical technology is the second component of the biomedical entourage. Biomedicine is now a medicine of the machine, not the person or the physician's gaze, and its technological extensions revise, (re)create different bodies and abnormalities and define "disease" (Brodwin 2000; Davis-Floyd and Dumit 1998). Both the pharmaceutical and the technological components of the biomedical entourage are very costly, usually out of the reach of underresourced countries, often posing putative "ethical problems" over levels or standards of care in areas where there is little care of any sort (Farmer and Saussy 2010).

Another problematic element of Biomedicine is its Bioethics. Generally perceived as universal and rational, it has been shown to be quite gender biased (e.g., Sherwin 1992; Tong 1997). In addition, there is concern that bioethical issues are often articulated in line with Biomedicine's activities. Bioethics, for example, does not critique the very realities with which Biomedicine is concerned (for examples of which, see Gaines 1995, 1998b), but seeks out how to make medical practices "ethical." That is to say, it is an uncritical biomedical ethics.

Several authors have argued for a different kind of Bioethics, one that pays close attention to local context and circumstances, as Paul Farmer has argued (*viz.*, the "best" medicine is not always available—but it is not unethical to do what one can with what one has) (Farmer and Saussy 2010). And I have formulated Cultural Bioethics. On the one hand, it is a social science analysis of the clinical encounter (it asks, "Why is this person a patient with this condition in this setting and at this time?"), and on the other, it is the study of Biomedical realities in play in practice and of Bioethics itself (e.g., Gaines 1995, 1998a, b; Gaines and Juengst 2008). Both are in the stead of traditional Bioethics that is part of Biomedicine. Typically, MA has sought roles to play in the service of Bioethics and, hence, of Biomedicine.

The Problem with Global Health

The issues raised with Biomedicine here are well known, and have been for some time (to make this point, I have tended to use older citations, lest some think these are new revelations). My concluding point here is quite simple; there are, given the above, very serious problems with the use of biomedical theory and therapies

worldwide. This use is, of course, the thrust of Global Health: that "new" MA emphasis now all the rage. Global Health "problems" are those that Biomedicine designates as such. These designations or identifications are not without cultural baggage and preconceptions; in fact they are usually freighted with them (Farmer and Saussy 2010). And the means of measurement of the extent of given problems—again, those designated as such by Biomedicine or its programmatic arms (WHO, PAHO, etc.)—is epidemiology. But epidemiology is itself burdened with cultural presumptions and cultural logic (Farmer and Saussy 2010; Kleinman 1995; Kleinman and Good 1985). The problem is multiplex: the application of Biomedicine to problems worldwide brings with it the insertion of a Local Biology, biomedical communalism, invidious distinctions and the costs of Big Pharma and biotechnology, as well as a bioethics, that is, the *biomedical entourage*.

Global, Global Health or Global Health 2.0: A New Global Health

Briefly I suggest here that we rethink Global Health and come up with another way to function that does not have the culture and trappings of Biomedicine riding in on a white horse to aid the world, a happenstance that can in fact make matters worse for laypeople in many contexts. Perhaps a more salutary approach would be to formulate interventions that draw from and utilize the MA knowledge of healing (as opposed to curing) methods from a variety of health systems. Surely elements of other traditions could be brought to bear to alleviate problems as *locally defined*. I think here of traditional Chinese, Kanpo, Unani and Ayurvedic medicines as well as some of the traditions in the United States that were eclipsed or destroyed by the American Medical Association, such as Naturopathy, Homeopathy, Botanics and Hydropathy. Formulating an appropriate mix of therapies for a local area would then be a largely anthropological enterprise, rather than one in which anthropologists serve merely as cogs in a larger International or Global Health machine.

I think of such an enterprise as Global, Global Health or Global Health 2.0, as it entails drawing down global health resources including medications for the alleviation of locally defined problems (which may incorporate outside ideas), and doing so on a global scale. Such a strategy could save the lay populations of the world from the imposition of costly and impersonal curative medical actions and ethos that may become a form of (bio)cultural colonialism. While we can fashion a new Bioethics (Gaines 2006), we cannot fashion a new Biomedicine. And while Biomedicine has its uses, so too do other professional and popular medicines. In this light, we may be able to prevent Biomedicine from becoming a sovereign, foreign cultural global overlay. Creating a Global Health 2.0, with a new form of Bioethics and sharpened with a MA form of Cultural Studies of Science, truly would be worthy of a Millennial MA.

Acknowledgments This paper was presented at the Society for Medical Anthropology Meeting, Yale University, New Haven, Connecticut, September 2009. I thank Nicole Ueda for the label Global Health 2.0.

References

Benjamin, Marina, ed.
1991 Science and Sensibility: Gender and Scientific Enquiry 1780–1945. Oxford, UK: Basil Blackwell.
Brodwin, Paul
2000 Biotechnology and Culture: Bodies, Anxieties, Ethics. Indianapolis: University of Indiana Press.
Davis-Floyd, Robbie, and Joseph Dumit, eds.
1998 Cyborg Babies: From Techno-Sex to Techno-Tots. New York: Routledge.
Farmer, Paul, and Haun Saussy, eds.
2010 Partner to the Poor: A Paul Farmer Reader. Berkeley: University of California Press.
Fausto-Sterling, Ann
1992 Myths of Gender: Biological Theories About Women and Men. 2nd Edition. New York: Basic Books.
2000 Sexing the Body: Gender Politics and the Construction of Sexuality. New York: Basic Books.
Fujimura, Joan
1996 Crafting Science: A Socio-History of the Quest for the Genetics of Cancer. Cambridge: Cambridge University Press.
Gaines, Atwood D.
1979 Definitions and Diagnoses: Cultural Implications of Psychiatric Help-Seeking and Psychiatrists' Definitions of the Situation in Psychiatric Emergencies. Culture. Medicine and Psychiatry 3(4): 381–418.
1987 Cultures, Biologies and Dysphorias. Transcultural Psychiatric Research Review 24(1): 31–57.
1991 Cultural Constructivism: Sickness Histories and the Understanding of Ethnomedicines Beyond Critical Medical Anthropologies. *In* Anthropologies of Medicine. Beatrix Pfleiderer and Gilles Bibeau, eds. Wiesbaden, Germany: Vieweg und Sohn Verlag.
1992 Medical/Psychiatric Knowledge in France and the United States: Culture and Sickness in History and Biology. *In* Ethnopsychiatry: The Cultural Construction of Professional and Folk Psychiatries. Atwood D. Gaines, ed. Albany: State University of New York Press.
1995 Race and Racism. *In* Encyclopedia of Bioethics2nd Edition. , Vol. 4. Warren T. Reich, ed. New York: Macmillan.
1998a From Margin to Center: From Medical Anthropology to the Cultural Studies of Science. American Anthropologist 100(1):191–194.
1998b Culture and Values at the Intersection of Science and Suffering: Encountering Ethics, Genetics and Alzheimer Disease. *In* Genetic Testing for Alzheimer Disease: Clinical and Ethical issues. S.G. Post and P.J. Whitehouse, eds. Baltimore, MD: Johns Hopkins University Press.
2005a Race: Local Biology and Culture in Mind. *In* Companion to Psychological Anthropology. Robert Edgerton and Connerly Casey, eds. Oxford: Blackwell.
2005b From the Ethnographic Past to the Bioethical Present. Paper presented at the Health Care Ethics Symposium. American Anthropological Association Meeting, December 3, Washington, DC.
2006 From Margin to Leading Edge: A Cultural Bioethics for the New Millennium. Paper presented at the Society for Medical Anthropology Meeting, April 30, Vancouver, BC, Canada.
Gaines, Atwood D., and Robert A. Hahn, eds.
1982 Physicians of Western Medicine: Five Cultural Studies. Culture, Medicine and Psychiatry Special Issue 6(3).
Gaines, Atwood D., and Eric T. Juengst
2008 Origin Myths in Bioethics: Constructing Sources, Motives and Reason in Bioethic(s). Culture, Medicine and Psychiatry 32: 303–327.
Graham, Janice
2000 Harbinger of Hope or Commodity Fetishism: Re-cognizing Dementia in an Age of Therapeutic Agents. International Psychogeriatrics 13(2): 131–134.
Hacking, Ian
1983 Representing and Intervening: Introductory Topics in the Philosophy of Natural Science. Cambridge: Cambridge University Press.

Hahn, Robert A., and Atwood D. Gaines, eds.
1985 Physicians of Western Medicine: Anthropological Approaches to Theory and Practice. Dordrecht, The Netherlands: D. Reidel.
Haikan, Elizabeth
1997 Venus Envy: History of Cosmetic Surgery. Baltimore, MD: Johns Hopkins University Press.
Haraway, Donna
1991 Simians, Cyborgs and Women: The Reinvention of Nature. New York: Routledge.
Harding, Sandra, ed.
1993 The "Racial" Economy of Science: Toward a Democratic Future (Vol. 1). Bloomington: University of Indiana Press.
Healy, David
2002 The Creation of Psychopharmacology. Cambridge, MA: Harvard University Press.
Keller, Evelyn Fox
1992 Secrets of Life Secrets of Death Essays on Language, Gender and Science. New York: Routledge.
Kleinman, Arthur
1995 Writing at the Margins. Berkeley: University of California Press.
Kleinman, Arthur, and Byron Good
1985 Culture and Depression. Berkeley: University of California Press.
Latour, Bruno
1988 The Pasteurization of France: Cambridge. Cambridge, MA: Harvard University Press.
Lindenbaum, Shirley, and Margaret Lock, eds.
1993 Knowledge Power and Practice. Berkeley: University of California Press.
Lock, Margaret
1993 Encounters with Aging. Berkeley: University of California Press.
Lock, Margaret, and Deborah Gordon, eds.
1988 Biomedicine Examined: Dordrecht. The Netherlands: Kluwer Academic.
Martin, Emily
1987 The Woman in the Body. Boston: Beacon Press.
Morris, Anne, and Susan Nott
2002 Well Women: The Gendered Nature of Health Care Provision. Surrey, UK: Ashgate.
Schiebinger, Londa
1993 Nature's Body. Boston: Beacon Press.
Scully, Diana
1980 Men Who Control Women's Health: The Miseducation of Obstetrician-Gynecologists. Boston: Houghton Mifflin.
Shapin, Steven
2008 The Scientific Life. Chicago: University of Chicago Press.
Sherwin, Susan
1992 No Longer Patient: Feminist Ethics and Health Care. Philadelphia, PA: Temple University Press.
Tong, Rosemarie
1997 Feminist Approaches to Bioethics. Boulder, CO: Westview Press.
Traweek, Sharon
1988 Beamtimes and Lifetimes: High Energy Physics: Cambridge. Cambridge, MA: Harvard University Press.
Weisz, George, ed.
1990 Social Science Perspectives on Medical Ethics. Dordrecht, The Netherlands: Kluwer Academic.
Whitehouse, Peter J.
2008 Why I No Longer Consult for Drug Companies. Culture, Medicine and Psychiatry 32: 4–10.
Young, Allan
1995 The Harmony of Illusions. Princeton, NJ: Princeton University Press.