Key Theories from Critical Medical Anthropology for Public Health Research. Part II: Medicine in the social system, Medicine as a social system

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This article summarizes four significant theoretical concepts from the field of Critical Medical Anthropology in two parts: in the first part, biopower/discipline and explanatory models; in the second, structural violence, and identity politics and biological citizenship. The four subjects reviewed here have been chosen for their importance to our understanding of human behaviors related to health and illness, as well as for the impact that they can have on theory, research, and practice in the field of public health. These critical theories can provide new ways of thinking about professional roles, medical decisions, disease diagnosis and etiology, treatment adherence, prevention messaging, and all sorts of health-related behaviors and systems of understanding. They can also help public health researchers shed light on the human beliefs and activities that shape patterns of disease within and across populations. Whether a research question is being formulated or research findings are being analyzed, the critical social theories outlined here can foster a more holistic understanding of the human element in any public health project.

KEYWORDS: social anthropology; medical anthropology; social theory; qualitative research; public health; illness; explanatory models; structural violence; identity; biopower; Foucault.

Ключевые теории критической медицинской антропологии, которые могут быть применены в исследованиях общественного здоровья. Часть 2: Медицина в социальной системе; Медицина как социальная система

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Данная работа резюмирует четыре важные теоретические концепции, существующие в области критической медицинской антропологии, и состоит из двух частей: в первой части обсуждаются биологическая сила/дисциплина (biopower/discipline) и объясняющие модели (explanatory models), во второй части – структурное насилие (structural violence), а также политика идентичности и биологическое гражданство (identity politics and biological citizenship). Выбор этих четырех тем был продиктован их важностью для понимания поведения людей в связи со здоровьем или болезнью, а также их влиянием на теорию, исследования и практику общественного здоровья. Эти критические теории могут предоставить новые подходы для рассмотрения профессиональных ролей, медицинских решений, диагностики и этиологии заболеваний, выполнения лечебных предписаний, формулирования профилактических посланий, а также всех прочих видов связанного со здоровьем поведения и систем его понимания. Они также могут помочь исследователям в области общественного здоровья пролить свет на представления и действия людей, которые могут формировать особенности заболеваний при их сравнении внутри и между популяциями. Как при формулировании исследовательского вопроса, так и при анализе результатов исследования, перечисленные здесь критические соци-

альные теории могут послужить более целостному пониманию человеческого элемента в любом проекте, касающемся общественного здоровья.

КЛЮЧЕВЫЕ СЛОВА: социальная антропология; медицинская антропология; социальная теория; качественные исследования; общественное здоровье; болезнь; объясняющие модели; структурное насилие; идентичность; биологическая сила; Фуко.

Ключові теорії критичної медичної антропології, які можуть бути застосовані в дослідженнях громадського здоров'я. Частина 2: Медицина у соціальній системі; Медицина як соціальна система

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Ця робота резюмує чотири важливі теоретичні концепти, що існують у галузі критичної медичної антропології, у двох частинах: у першій – біологічна сила/дисципліна (biopower/discipline) та пояснювальні моделі (explanatory models); у другій – структурне насильство (structural violence), а також політика ідентичності та біологічне громадянство (identity politics and biological citizenship). Вибір цих чотирьох тем був продиктований їхньою важливістю для розуміння поведінки людей у зв'язку зі здоров'ям або хворобою, а також їхнім впливом на теорію, дослідження та практику охорони громадського здоров'я. Ці критичні теорії можуть надавати нові шляхи розгляду професійних ролей, медичних рішень, діагностики та етіології захворювань, дотримання лікувального режиму, формулювання профілактичних повідомлень, а також інших видів пов'язаної зі здоров'ям поведінки та систем її розуміння. Вони також можуть допомогти дослідникам в галузі охорони громадського здоров'я пролити світло на уявлення та дії людей, що можуть формувати відмінності захворювань усередині популяцій та між ними. І під час формування дослідницького питання, і під час аналізу результатів дослідження перераховані тут критичні соціальні теорії можуть слугувати більш цілісному розумінню чоловічого елементу у будь-якому проекті, пов'язаному з громадським здоров'ям.

КЛЮЧОВІ СЛОВА: соціальна антропологія; медична антропологія; соціальна теорія; якісні дослідження; громадське здоров'я; хвороба; пояснювальні моделі; структурне насильство; ідентичність; біологічна сила; Фуко.

INTRODUCTION

Critical medical anthropology (CMA) is a branch of cultural anthropology that explores the nature of health, illness, and medicine. CMA is, in large part, defined by the equal attention it gives to the social and to the biological when investigating matters of health and medicine. In other words, CMA takes the position that epidemics, while biological in form, "are fundamentally social processes" (Maher, 2002, p. 312).

In the first part of this review (Carroll, 2013), the theoretical foundations of CMA as well as the theories of *discipline/biopower* and *explanatory models* were discussed. In this second part, the concepts of *structural violence* and *identity politics and biological citizenship* are discussed. Both are useful for exploring how persons interact with each other and with larger social structures vis-à-vis health, illness, and medicine. Structural violence illuminates the way in which larger social systems become apparent in public health problems. Identity politics and biological citizenship emphasize different ways in which people can use their health status to navigate larger social systems and secure much needed cultural or material resources.

All of the theories presented in this review, which are central to CMA, are useful in that they encourage the *reconceptualization* of the social forces and human behaviors that drive public health problems. They cannot be directly applied to public health problems like other methodological or analytical tools. By thinking about public health problems in new ways, we risk complicating our approach to issues that are already very complex; however, it also creates the opportunity to develop a deeper understanding of public health problems—an understanding equally grounded in the biological and social forces at work in patterns of human health and illness.

STRUCTURAL VIOLENCE

The term 'structural violence' has its origins in an article written by a peace researcher John Galtung

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(1969). Galtung draws a distinction between violence where there *is* and where there *is not* a specific actor who inflicts that violence upon its victims. He chose to call violence that comes about with no single, identifiable actor *indirect* or *structural violence* (Galtung, 1969, p. 170).

> In both cases, individuals may be killed or mutilated, hit or hurt in both senses of the word, and manipulated by means of stick or carrot strategies. But whereas in the first case [*direct or personal violence*] these consequences can be traced back to concrete persons as actors, in the second case this is no longer meaningful… The violence is built into the structure and shows up as unequal power and consequently as unequal life chances. (Galtung, 1969, pp. 170–171)

This concept has proven deeply influential in the field of CMA. It helps to illuminate a number of social, political, and behavioral factors that cause or shape health inequalities and is a key concept for understanding trends in population health.

Medical anthropologists' use of the term 'structural violence' has been strongly influenced by classical Marxist ideas about the social origins of disease. The writing of Rudolph Virchow is exemplary in this regard. Virchow was a medical doctor living in the Kingdom of Prussia in the 19th century. In 1848, he was dispatched by the Prussian Minister of Education to report on the situation of ethnic Poles living in the territory of Upper Silesia and offer his assessment and recommendations as a medical professional on an outbreak of typhus in that region. In the conclusion of his report, entitled "Report on the Typhus Epidemic in Upper Silesia" (Taylor & Rieger, 1984), Virchow argued that the epidemic was caused by social and economic oppression:

> There cannot be any doubt that such a typhoid epidemic was only possible under these conditions and that ultimately they were the result of the poverty and underdevelopment of Upper Silesia. I am convinced that if you changed these conditions, the epidemic would not recur. In theory, the answer to the question as to how to prevent future outbreaks in Upper Silesia is quite simple: education, together with its daughters, freedom and welfare. (Taylor & Rieger, 1984, p. 206).

Virchow argued that social and political changes were necessary in order to end the typhus epidemic and prevent it from recurring: "mass education through primary, commercial and agricultural schools, cheap books and mass newspapers, combined with complete freedom of community life," "the absolute separation of church and school" (Taylor and Rieger, 1984, p. 207), "free and unlimited democracy," "a just and direct system of taxation and the abolition of all privileges and feudal duties" (p. 208).

Even though the concept of structural violence, as it is used today, was not yet developed when Virchow wrote his report, he was certainly assigning blame for the typhus epidemic in Silesia on structural violence maintained by harmful government policies. In other words, Virchow believed that the epidemic was *social* in nature. He believed that the residents of Silesia were living in conditions so poor that they didn't possess the means to prevent this illness, and he argued that those living conditions, the social structures that created them and the political isolation that perpetuated them, was created not by a single actor or group of actors, but by the organizational principles of Prussian society at that time.

The concept of structural violence has been popularized more recently by medical anthropologists who, through their research, have become advocates for oppressed groups. Paul Farmer and Nancy Scheper-Hughes have received the most credit for bringing this concept into the literature of CMA. Farmer has defined structural violence as:

> one way of describing social arrangements that put individuals and populations in harm's way. The arrangements are *structural* because they are embedded in the political and economic organization of our social world; they are *violent* because they cause injury to people (typically, not those responsible for perpetuating such inequalities) (Farmer et al., 2006).

In Farmer's view, the simplicity of this concept is an asset. With it, he hopes to "inform the study of the social machinery of oppression" (Farmer, 2004, p. 307). Farmer also highlights the fluidity of structural violence; it may take many different forms and enact many different forces. He continues:

> Structural violence is structured and *structuring*. It constructs the agency of its victims. It tightens a physical noose around their necks, and this garroting determines the way in which resources—food, medicine, even affection—are allocated and experienced (Farmer, 2004, p. 315).

The key insight here is that structural violence is dynamic. It changes with society and causes secondary and tertiary changes in

return, thus shaping and ultimately constraining the lives of individuals.

The concept of structural violence is useful in public health research, because it helps trace the social causes of disease. This fact can be seen in the work of social epidemiologist Nancy Krieger, whose work has forcefully demonstrated that "[social] discrimination harms health" (Krieger, 2005, p. 101). She describes this causal mechanism as follows:

> Critical causal components conjointly include (a) societal arrangements of power and property and contingent patterns of production and consumption, and (b) constraints and possibilities of our biology, as shaped by our evolutionary history, our ecologic context, and individual trajectories of biological and social development. These factors together structure inequalities in exposure and susceptibility to—and also options for resisting—pathogenic insults and processes across the life course. (Krieger, 2005, p. 104)

Krieger supports these conclusions with a review of more than twenty independent studies linking poorer health outcomes to minority status in the United States (Krieger, 2005, pp. 118-127). Examples of the relationships demonstrated by these studies include: higher blood pressure among African-American men than white men (James et al., 1984; Krieger, 1990), increased psychological distress (Amaro et al., 1987) and depression (Salgado de Snyder, 1987) among Hispanic women than among white women, higher levels of stress and psychological distress among African Americans than among whites (Murrell, 1996; Mays & Cochran, 1997; Williams & Chung, 1999), and higher levels of psychological

distress among queer and lesbian (homosexual) individuals than among heterosexual individuals (Bradford et al., 1994; Meyer, 1995).

The work of medical anthropologists involved in the UFO[1] Project in San Francisco, California, is a good example of the direct application of this theory on a local scale (Bourgois, Prince, & Moss 2004). One of the goals of this project, a comprehensive study lasting from 1994 to 2003 on health and wellness among homeless youth in San Francisco's Haight-Ashbury neighborhood, was to gain an understanding of why the incidence rate of Hepatitis C among homeless women was so much higher than among homeless men. These researchers found that young women who had recently come to live on the street were at higher risk for Hepatitis C because they surrendered control over their drug injection to their male romantic partners. The researchers observed, "it is difficult and dangerous for young women to remain independent and autonomous on the street" (Bourgois, Prince, & Moss, 2004, p. 256). Women enter into predatory relationships with older men to ensure their safety on the street. In return, "[the] men often attempt to increase their control over resources generated by their female partner by refusing to allow her to inject for anyone else…[and] these forms of jealous male control result in women being forced to engage in riskier injection practices" (2004, p. 258).

The discovery that Hepatitis C infection in homeless women was directly fueled by structural violence against women on the street allowed the UFO researchers to make new and appropriate recom-

mendations for slowing the spread of Hepatitis C. They suggested that a public health intervention would "be more effective if it [began] by focusing its messages and programs on the social dynamics of gendered violence before attempting to address the micro-level practices of injection that physically transmit molecules" (Bourgois, Prince, & Moss, 2004, p. 260), such as the typical syringe cleaning or exchanging, which are usually promoted by harm reduction efforts. In other words, they offer the conclusion that variable incidence rates of Hepatitis C among homeless men and women can neither be understood nor effectively controlled without a clear understanding of the structural violence at play within this community.

IDENTITY POLITICS AND BIOLOGICAL CITIZENSHIP

Closely related to Foucault's notions of discipline and the morality of individual actors are the concepts of *identity politics* and *biological citizenship*. Medical anthropologist Susan Whyte defines 'identity politics,' as "the revaluation of difference: the assertion of a difference that has been disvalued, the witnessing of discrimination, and the struggle for rights and social justice" (Whyte, 2009, p. 7). She also describes biological citizens as "'made up' from above (by medical and legal authorities, insurance companies). And they also make themselves. The active biological citizen informs herself and lives responsibly, adjusting diet and lifestyle so as to maximize health." (Whyte, 2009, p. 9). These concepts are, in a number of ways, an elaboration of Foucault's theories of subjectivity; they focus, specifi-

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cally, on the political and moral conflicts that surround the creation of social subjects.

While similar to Foucauldian theories, the concepts of biological citizenship and identity politics also have roots in theories of 'labeling'. Labeling is not the same thing as identity politics; it is, instead, a foundational theory that helps explain what identity is and how it works. Erving Goffman and Howard Becker are two 'classical' sociologists who helped to articulate 'labeling' theory in the mid-twentieth century. Goffman's work focused on stigma. He emphasized that the acceptance of a negative social label is key to one's stigmatization (Goffman, 1990 [1963], p. 19). Becker explored social deviance in his research, noting that a 'deviant' act is not defined as such simply because it violates rules or norms. Rather, it is how others respond to certain behaviors that determines whether they are classed as deviant or not (Becker, 1973 [1963], p. 11). According to these theories, social labels can either be accepted or resisted by the social actors to whom they are applied, and this resistance, when it occurs, may or may not be successful. As Becker noted, "[these] differences in the ability to make rules and apply them to other people are essentially power differentials," (Becker, 1973 [1963], p. 17). In other words, labels are, more often than not, ascribed onto people by other, more powerful actors who have the ability to do so.

Whyte argues, "identity politics fit well with current paradigms for health and development that emphasize the 'rights-based' approach" (Whyte, 2009, p. 9); however, identity politics is not simply a deliberate effort to identify one-self with a particular group or label. Rather, it is an attempt to render oneself as a particular kind of subject with a specific moral profile, located in a specific position within larger power structures. This is accomplished not only by asserting identity and difference, but also by controlling and shaping socially produced knowledge about different social roles. For example, anthropologist Sarah Phillips observes that wheel-chair bound individuals living in Ukraine often employ a "strategic intersectionalty" (Phillips, 2011, p. 7), which downplays certain biomedical characteristics about themselves, with the intention of changing or avoiding the formal label of *invalidnist*' (disability)—an individual who qualifies for social welfare according to specific medical and biological criteria. In other words, they resist the social role assigned to them by their disability status, and attempt, with mixed success, to forge new social identities that are distinct from their biological or biomedical characteristics.

In another, less traditional example, a recent study among patients undergoing genetic screening for cancer risk found that patients determined to be at low-to-moderate risk for cancer were less satisfied with the outcome of their screening than those patients determined to be at high risk for cancer (Scott, Prior, Wood, & Grey, 2005). The higher the determined risk for cancer, the happier the patients. The authors suggest that this strange reaction was caused by patients' discomfort with occupying an ambiguous role within the medical system. This discomfort lead them to negotiate a worse prognosis (i.e. a 'high risk' status) simply because having a worse prognosis feels more certain. They are not 'maybe' at risk; they are '*definitely*' at risk, thus assuring that they are placed fully under the surveillance of a trustworthy biomedical system that will 'keep an eye on them' (Scott, Prior, Wood, & Grey, 2005).

Also exemplary in the area of identity politics is the work of medical anthropologist Adriana Petryna (2002), whose ethnography among victims of the Chernobyl disaster introduced the term '*biological citizenship.*' Petryna defines biological citizenship a bit differently than Whyte (2009). Petryna uses the term to describe "a massive demand for but selective access to a form of social welfare based on medical, scientific, and legal criteria that both acknowledge biological injury and compensate for it" (Petryna, 2002, p. 6). Petryna illustrates this definition by discussing the ways in which some individuals chose to expose themselves to radiation following the Chernobyl disaster. Their purpose for exposing themselves was to improve the likelihood that the effects of radiation would be visible. Most of these individuals were already sick and suffering the consequences of the Chernobyl disaster, but not badly enough for the state to acknowledge them as injured and provide them with compensation. Further exposure would help them become diagnosed as victims of the disaster, and, in turn, receive the assistance and compensation that followed this diagnosis.

Petryna notes that "the linking of biology with identity is not new. What is new is how connections between biology and identity are being made" (Petryna, 2002, p. 14). Here, Petryna is reversing Talcott Parson's famous concept of *the sick role*. The sick role is a fundamental concept in CMA that views illness

as a social role, which, when attained, excuses individuals from traditional social and labor obligations (Parsons, 1991 [1951], p. 436). Citizens living in the Soviet Union had the right to work, but they did not necessarily have the right to *not* work. Therefore, one's status as ill or injured (and therefore excused from work) took a significant amount of work to attain. "To be sick," Petryna remarks, "meant that one *had to be equally motivated* to work to obtain permission to be sick" (Petryna, 2002, p. 90).

The notion of biological citizenship has been adopted by a number of other researchers as they have looked at major disease categories such as HIV/AIDS (Biehl & Eskerod, 2007; Nguyen, 2010), and disability (Phillips, 2011), but it has also been met with some criticism. Medical anthropologist Jonathan Stillo, whose research has focused on the lives of TB patients living in state-run sanatoria in rural Romania, has argued that "though [these authors] invoke 'citizenship,' what they are more accurately referring to is rights and entitlements, that is, social rather than political citizenship" (Stillo, 2012). He continues:

> While it is true that for globe-trotting, transnational citizens, the world is a dramatically different place, people who are making claims to health related citizenship are in desperate circumstances. Especially for the most vulnerable, claims of patient citizenship emerge out of desperation, not liberation. Some patients are lucky enough to differentiate themselves from the masses, but the more common outcome, whether one is a homeless AIDS patient in Brazil, or a poor Ro-

manian TB patient is death, not citizenship-related redemption (Stillo, 2012).

In short, citizenship has been, and still may be, a useful concept for characterizing how some actors, like some Chernobyl sufferers in the early 1990s, have negotiated health, medicine, and political authority, but it is equally important to note that such theoretically elegant claims to biological citizenship are not universally available because they are not universally successful. Rather, they are the tools of a privileged few whose social networks, health status, political context, etc., intersect in a way that makes citizenship claims both reasonable and achievable.

In the above examples, we can see identity politics in action, individuals laying claim to social recognition as a group or as a member of a group as well as to the legal, social, and political rights and privileges of that group. As such, it is equally appropriate to describe these as moments of self-labeling or, in Foucault's words, as human beings "turn[ing themselves] into subjects" (Foucault, 1982, p. 208). In practice, these attempts to achieve and promote particular identities in public health or health care settings can create significant ethical dilemmas. In some situations, the chance to obtain much needed material or political resources may indirectly coerce certain individuals to seek a particular illness or disability status, as Petryna observed among some Chernobyl victims. On the other hand, the desire to preserve one's identity as a good citizen may also deter at-risk individuals from seeking necessary medical assistance.

For example, recent legislation in Ukraine regarding methadone ther-

apy as a treatment for addiction presents one such situation. In 2012, the Ministry of Health's enacted Order No. 200, which dictates that all patients in methadone programs must be formally diagnosed with opioid addiction before becoming eligible for this treatment and that diagnosis must be placed in a national registry of opioid addicts (Ministry of Health of Ukraine, 2012). Entry into this registry can have far-reaching effects on one's public identity, thus the desire to keep that identity unpolluted and unspoiled may deter high-risk individuals from seeking assistance that could reduce their risk for disease and other forms of physical harm.

CONCLUSION

This article has outlined significant theoretical contributions from Critical Medical Anthropology and the connections that those theories have to public health research. This review, like all reviews, is subject to certain limitations that are important to keep in mind. These theories reflect, in large part, the trends of the American anthropological community and are limited to academic work that is available in the English language. To that end, these theories, while arguably of great utility to anyone working in social or medical research, have developed within a particular context and are certainly reflective of the social structures and values of that research community. This summary should not be considered a representative list of the different contributions that thinkers, researchers, and writers have made to human health and social understanding throughout the world.

Regardless, it is very important to consider the ways in which the so-

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cial world and the medical world intersect. Indeed, our medical systems and public health interventions exist within the messy realm of human relations, interactions, and politics. It is necessary to consider, for example, the ways in which the work of major international donors (The Global Fund, USAID, UNAIDS, the World Bank, etc.) may be shaped by unexamined social values and cultural assumptions. Are there ways in which these projects are complicit in the perpetuation of the very health inequalities that they seek to alleviate? This sort of thing can (and does) happen! Human systems produce human consequences, and the creation of new forms of inequality is one of those consequences.

By considering public health practices from a critical medical anthropological perspective, we improve our ability to understand these systems in action and the consequences, both good and bad, both intended and unplanned, that they produce. We also gain the ability to think about our research differently, understand slippery elements of human behavior, and contribute to more holistic understanding of human health and wellness that better serves us all.

FOOTNOTE

1.The term "UFO" is not an acronym. The name of the project was simply "The UFO Project."

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