Preface

Critical medical anthropology in Latin America: Trends, contributions, possibilities

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In Mexico the trend for writing critical medical anthropology (CMA) emerged in the 1970s from a questioning of integrationist perspectives that had been dominant from 1940 to 1960 (notwithstanding the contributions of authors such as Gonzalo Aguirre Beltrán or Julio de la Fuente). Beyond their – sometimes radical – differences, these CMA works merge with contemporary critique and find common cause in seeking a solution to the exclusion, marginalisation and poverty of indigenous peoples, building on the contributions of Latin and Afro-American intellectuals including Guillermo Bonfil Batalla, Orlando Fals Borda and Frantz Fanon. Both in theoretical and ideological terms, this perspective is a critical continuation of proposals by authors such as Darcy Ribeiro and Pablo González Casanova in relation to US and European perspectives. This continuity persists, largely, through a focus on colonial/neocolonial situations and relationships, often framed by class structure, even when these studies are classified under other conceptual denominations (Menéndez 2002).

Regional Latin American CMA emerged through a shared concern for the high rates of avoidable deaths among indigenous people, and the accompanying dearth of solutions – either biomedical or material. While by no means excluding sociocultural factors, CMA locates political economy intrinsically within the process of health, disease, treatment and prevention (h/d/t-p). It is also an anthropology that draws on and utilises epidemiological data, while merging and interacting with trends in Latin American social medicine, particularly in the case of Brazilian anthropology.
Critiques, proposals and (whenever possible) intervention are an integral part of CMA. In a region like ours, characterised by poverty, stark socio-economic inequality and cultural and ethnic diversity, both ‘hard’ and soft scientists should not only try to create new low-cost drugs or prosthetics and incorporate traditional medicine but also offer descriptions, analysis, explications and proposals. This may involve improving healthcare services on all three levels of care, both in general and in relation to specific ethnic groups. Moreover, I think that CMA should not only be directed towards biomedically generated policies and activities in order to reduce maternal mortality, to take one example; it should also describe and analyse the role played by practising midwives, and traditional medicine in general, in the high rates of maternal and neonatal mortality that occur when midwives attend the majority of deliveries. This is necessary in order to capture both the positive and negative aspects of all healing/healthcare that occurs in any real context. All forms and systems of healthcare need to be described and analysed in order to observe their structure, operation and degree of efficacy for addressing, preventing and resolving the healthcare issues of an ethnic community or nation. Similarly, we must identify the social meaning that these forms have for the population, which almost always go beyond the actual h/d/t-p processes themselves. This must be undertaken as part of an effort to contain, if not eliminate, our ideological preconceptions, which can end up distorting the very reality that we are studying. This is also the case when we study native communities’ healthcare systems. We must observe the make-up of these systems and their efficacy in reducing mortality, and try to identify what sociocultural and ideological functions these systems serve for communities and for subjects. However, I stress that we must do so while trying to determine the efficacy that such systems have in actually reducing healthcare problems.

Currently, different Latin American trends of medical anthropology (including CMA) study almost every process among very different social actors and sectors, with the goal of describing and understanding these processes and, to a lesser extent, influencing their outcomes. However, although the social actors examined here are not exclusively indigenous peoples, they continue to be central to Latin American studies. Latin American CMA has made significant contributions in very different fields and issues. It has propelled the use of qualitative methods and technologies in the study of h/d/t-p processes, gathering strategic information and explanations not otherwise obtained by statistical methods and approaches. Recognition of the benefits of qualitative techniques has led to their extensive use by biomedical researchers, a use that has frequently
been questioned by anthropologists, mostly in terms of the need to apply these techniques to the medium- and long-term fieldwork being done by these researchers: we must assume that, in every sense, anthropological work is personalised work at every stage of a research project.

Medical anthropology evidences the connections that subjects and groups make between different forms of care that occur in specific contexts, and the processes of appropriation that all social sectors have of biomedical knowledge. Specifically, medical anthropology in Latin America has shown that traditional and alternative medicines are normalised aspects of treatment, and that all forms of care, not just biomedical care, are constantly changing. It has also demonstrated that society and culture, along with biomedical and traditional healers, can create the ailments that they subsequently treat and can sometimes cure or heal.

Medical anthropology increasingly studies the power dynamics of healers and patients and within other relationships when these revolve around inequalities such as gender. It has permanently underscored the importance of fieldwork, although theory-driven proposals are constantly and intermittently generated. It has continued, where possible, to put forward a holistic view of h/d/t-p processes that question the unilateral and exclusionary perspective of the biomedical model. In summary, it has tried to consider h/d/t-p processes in a way that is not only different from but also in opposition to biomedical forms of thinking, generating new types of explanations and interpretations, and potential modes for action.

One of CMA’s most consistent contributions is that of documenting and attempting to understand popular knowledge of h/d/t-p processes through the study of subaltern social actors. All areas of medical anthropology have tried to describe the rationality that different social and ethnic groups use to explain and counteract the ailments that affect them, and to understand their supposed or real rejection of biomedicine. Medical anthropology has also attempted to evidence the cultural and technical rationality of so-called traditional medicines in order to underscore their explanatory and applicative abilities while seeking to rehabilitate not only traditional ‘medical’ knowledge, but also the culture of indigenous peoples themselves.

Anthropological studies have demonstrated that every social group, regardless of its level of formal education, creates and uses preventative criteria regarding some of the illnesses – both real and imagined – that subjects and groups believe to impact their health and wellbeing. The majority of preventative criteria that social groups use are sociocultural; but for anthropologists, the crux lies not in considering these correct or
incorrect, but rather in considering how social groups necessarily create and replicate preventative social practices and ideas within their group, questioning the medical gaze that treats populations and subjects, particularly the ‘uneducated’, as though they reject preventative care. The development of preventative measures for real or imaginary threats therefore becomes a structural process in the life of social groups.

For medical questions such as ‘Why do patients with high blood pressure, diabetes or HIV/AIDS not comply with their prescribed “treatment” and/or change their “habits” or lifestyles?’ – or, ‘Why are different vaccines increasingly rejected?’ – anthropologists try to understand the cultural, economic, political and ideological rationales behind practices and behaviour. They make reference to the larger context in which these behaviours occur and they seek a rationale, based at least in part on the premise that scientific evidence does not immediately change the behaviour of some social sectors. Furthermore, CMA has documented that some actors – including healthcare professionals – use scientific arguments and new medical technology in order to justify, for example, the social and professional rejection of vaccination.

Hence, I reiterate, sociocultural, economic and technical rationales should not be sought only in the habits or lifestyles of the population, but also in those of medical staff and within the healthcare/disease industries. Often anthropologists appear only interested in describing and understanding the sociocultural rationality of traditional healers, but not of doctors – as if we only think of sociocultural rationality as it pertains to the first group – a fact that has negative consequences for understanding how to deal with communication difficulties that may exist between a doctor and an indigenous patient; or in promoting changes in communities in order to foster self-detection of diseases such as Chagas, or to reduce the consumption of sugary beverages to prevent chronic and degenerative diseases.

Some specific changes have been difficult to achieve, while others have happened more quickly than expected. To understand why this happens we must analyse the often contradictory messages and practices with which we live (Bateson 1985; Ruesch and Bateson 1965) and understand both traditional knowledge and the latest digital practices on h/d/t-p processes, so that the actions of subjects and micro-groups can be guided accordingly (Menéndez 1998).

Intentionally or not, by analysing h/d/t-p processes, CMA describes the contexts of exclusion, degradation, racism and aggression, to which secondary social sectors in general, and some ethnic groups in particular, have been subjected. Medical anthropology has sought to expose
these processes, identify possibilities for their reduction or elimination
and boost mechanisms for empowerment through h/d/t-p processes.
Indigenous peoples, and in recent years indigenous women in particular,
have been the subjects of much of this research.

Latin American anthropologists have mostly tried to describe and
understand alternative knowledge without considering it false or erro-
neous, independent of the efficacy that this knowledge may have and in
stark contrast to biomedical knowledge and institutions. We have stud-
ied the knowledge that groups and communities have formed about their
own ailments; nevertheless, these studies have, at least until the 1990s,
dismissed the question of subjectivity. Under neoliberalism and together
with cultural difference and ethnicity, paradoxically we also recover a
focus on subjectivity. Thanks largely to theoretical tendencies emerging
in the USA, the region began to develop an anthropology that consid-
ered questions such as addiction, suffering, experience and emotions.
These analyses were essential in order to more fully explore subjectivity,
to build on previous work and perspectives and so that we could take our
understanding of cultural rationalities more deeply to the level of subject
and group.3

One of CMA’s principal contributions has been demonstrating that
the majority of traditional illnesses are generated by social relationships,
such that, for subjects, micro-groups and communities, the causes of
physical, mental or psychosomatic illness may be the result of conflicts
that occur within the family or among neighbours. We should be stud-
ying this issue in terms not only of traditional illnesses but also non-
traditional ones, given that their causes and solutions can be mediated
by the action of subjects and groups.

A review of the ethnographic bibliography on h/d/t-p processes
shows that in the context of incidences of illness, the majority of inter-
viewees made reference to conflictive relationships among subjects
and micro-groups, transgressions of community norms, the role played
by witchcraft and divine or magical schemes. Most of the people inter-
viewed attributed their illnesses to daily hot or cold temperatures, to
what happened with a neighbour, to not satisfying a craving, to not hav-
ing money or milk to feed a newborn baby, to witnessing a sexual act
at an inappropriate age, or to divine intervention or will. Ethnographic
descriptions show not only that many of these illnesses generated by
conflict or commonplace social problems (related to land-ownership,
maintenance agreements between families or other violence) but also that
in the majority of these relationships a large role is played by envy in the
context of poverty – a situation that cultural, functional, structural
and Marxist anthropologists have been describing and explaining since the 1940s. I consider that the relational aspect of these illnesses requires wider investigation, so that we might better explain economic-political issues and processes at both family and community levels and understand why some social rituals and murderous violence persist.

Some specific problems of CMA

As I have already noted, some principal anthropological contributions have been critiques of biomedicine and proposals for changing some of its elements. These critiques have been directed towards the theoretical, methodological, educational and interventionist aspects of the field, and especially biomedicine’s negative treatment of indigenous peoples and, more recently, women of every social sector, including but not exclusively from these communities. Both directly and indirectly, the structure and function of biomedical institutions and knowledge have been described and analysed, weakly noting its positive aspects whilst homing in on its negative ones. Because biomedicine appears uninterested in obtaining information for understanding the rationality of subjects and groups undergoing care or in preventative procedures, the biomedical focus is often imposed through physical or symbolic violence.

Such critiques have generated different possibilities about the relationship between anthropology and biomedicine. One end of the spectrum argues that it is structurally impossible for biomedicine and the healthcare sector to take into account and apply specific cultural, political and subjective issues affecting the comprehension and solution of illness and ailments; the other end of the spectrum, although questioning certain aspects of medical knowledge and institutions, posits that there remains confidence in the possibility of change within biomedicine, and the potential for it to complement socio-anthropological proposals. The first position suggests that a radical incompatibility exists between anthropological and biomedical perspectives, asserting that all professionals working within biomedical institutions – including anthropologists – will end up medicalising both their interventions and modes of thinking (Sarti 2010). Others hope that independent anthropological ways of thinking and acting can be maintained, even when working within biomedical institutions. Some authors even go further to propose a form of division of labour, by which the main focus of CMA is using its own perspectives to complement and fill in gaps in education, research or even interventions, overlooked by biomedicine.
Nevertheless, medicalisation remains among the most reported dangers by CMA. At least since the 1970s, US and European anthropologists and sociologists (Conrad and Schneider 1980; Conrad 1992) have been concerned about not only the medicalisation of behaviours, but also the increasing medicalisation of medical anthropology itself (Baer 1990; Morgan 1990; Singer 1989), as is also occurring in Latin America (Menéndez 2013). This is an extremely disquieting issue for Latin America, not only because it seems to be on the rise, but also because medicalisation reduces the potential for contributions from socio-anthropological perspectives, since the results generated through medicalisation are almost identical to those of biomedicine.

Even the most divergent among anthropological trends agree that biomedical perspectives tend to impose their ways of thinking and implementation. This becomes evident through, for example, how the healthcare sector manages family planning programmes, its negative (pre)conceptions about preventative care in certain groups, its simplistic notions about influencing the lifestyles of subjects and social groups, the way it tends to use qualitative techniques as fast-track research, and how it stigmatises self-medication – despite recognising the role played by ‘self-care’.

For Latin American anthropologists, there is no doubt that h/d/t-p processes are an intrinsic part of the culture inhabited by different social groups, subjects and particularly, ethnic groups. These processes are part of the cultural identities of subjects and groups. It is possible that the majority of CMA specialists perceive the expansion of biomedicine, including its use by traditional healers, as a threat to the survival of traditional medicine itself, and to the cultural identity of the ethnic groups to whom it belongs. This growth is usually analysed through either of two basic positions. One focuses on the expansive character of biomedicine – and the social forces supporting it – invoking the increasing dominance of instrumental rationality or all-encompassing medical biopower that excludes the role of groups and subjects. The other, while recognising biomedical expansion, focuses its analysis on the persistence of traditional healing and its ability to remain relevant, relegating biomedical expansion and penetration to a secondary concern.

Rather than concentrating on the relationships of hegemony and subordination, power and resistance, each of these trends focuses on only one of these interrelated social forces or groups. Such power dynamics are created through different kinds of social transactions, which, although they reveal the expansion of biomedicine, include not only the persistence and redefinition of traditional medicines, but also
the role that they play in questioning important aspects of biomedicine (Menéndez 2018). Hence, with exceptions, what we see in Latin America is the constant expansion of biomedicine in general, and as related to ethnic groups in particular. This demands an understanding of why biomedicine is produced and expands, but the analysis must not be Manichaean, referring exclusively, for example, to responses to interests of the chemical and pharmaceutical industry. Rather, an analysis must attempt to examine the roles of every important social actor related to biomedical expansion, including both the pharmaceutical industry and secondary social actors – not only ethnic groups, but also indigenous healers. We must explain why the ethnic groups that have most strongly propelled indigenous empowerment in political terms are those that least resist biomedical expansion. We must explain why pro-indigenous governments (like that of Evo Morales in Bolivia, which engages in indigenous identitarian discourse leading to the creation of an Intercultural Health sub-ministry within the Bolivian healthcare system) nevertheless devote resources almost entirely directed to promoting biomedicine, especially biomedical treatment, rather than traditional medicine. One explanation lies in the efficacy of conventional medicine compared with traditional medicine, for treating and reducing the illnesses that have been historically responsible for the highest mortality rates. I also attribute it to the mandate that governments receive from their citizens, including ethnic groups, for promoting the biomedical services sought by the population. But additionally, NGOs, and religious institutions from Catholic, Protestant and other denominations, have also played an influential role in criticising traditional medicine and promoting biomedical treatment.

Recognising biomedical expansion does not undermine the many critiques that can be made about biomedicine and the healthcare sector. But it must be emphatically noted that if we do not identify and analyse the positive functions that biomedicine fulfils for some social groups, the results of these studies will scarcely be relevant to the common, dominant processes and tendencies emerging in the coming years. Notwithstanding the existence of Latin American ethnic groups that have experienced low biomedical penetration, we need to assume that the majority will eventually experience this process, even so-called ‘forest peoples’ (Hill and Oliver 2011; Kelly 2011; Kroeger et al. 1991; Zent and Freire 2011). Additionally, in various regional contexts, subjects and ethnic groups not only prefer biomedicine for certain ailments, but also prefer private medicine to official public medicine.

Not only does CMA question biomedicine, but doubts also emerge about some of its objectives and results, in which medical anthropologists...
have played a (sometimes leading) role. In several countries in the region, special healthcare services for ethnic groups were created and intercultural healthcare policies formulated by regional governments, and supported by the Pan-American Health Organization. Although most of these healthcare services have been questioned on several grounds, intercultural healthcare policies have had little impact and, with the exception of a few cases, are considered failures and have been discontinued, as is the case of mixed (intercultural or multicultural) hospitals (see Menéndez 2016).

A set of critiques have been made regarding the healthcare subsystems for indigenous peoples that were created under neoliberalism, of which the most common and important are: insufficient financing and/or poor financial administration; bureaucratic and corrupt administration of services; bad patient care; a lack of coordination between biomedicine and indigenous medicine; a strong tendency to impose a biomedical model and exclude indigenous medicine; subordination, asymmetry and verticality between healthcare staff and the indigenous population (including its healers) and the homogenisation of inherently distinct ethnic groups (Cardoso 2015; Freire 2015; Kelly 2011; Langdon and Garnelo 2017; Puerta Silva 2004). Several of the intercultural tendencies that have developed since the 1980s proposed and anticipated a level of coordination between biomedicine and traditional medicine that has never played out, proving, for many anthropologists, the incompatibility of anthropology and biomedicine. Despite biomedicine’s apathy towards, and even rejection of, the intercultural healthcare programmes promoted during the 1980s and 1990s, we must critically analyse them, since most were destined to failure. The influence of biomedical dominance (in opposing or ignoring these types of programmes) was not taken into account, nor were these ethnic groups’ conditions (in economic, influence, and cultural terms) or urgent needs considered, a fact that also led to apathy towards these programmes, insofar as they lacked both resources and institutional management.

A second issue meriting reflection, and a cause of ongoing concern, is related to the capacity and quality of the agency that secondary social sectors have over h/d/t-p processes. Here I am not questioning the agency and capacity of ‘managers’ at the micro-group (such as family) level in addressing the illnesses suffered by the members of their group. My doubts relate to civil society’s capacity for creating autonomous alternative organisations, such that they will not be co-opted or redirected by dominant social forces. I am also concerned as to whether civil society can foment resistance, empowerment or concrete action on h/d/t-p
processes so that it can achieve (or at least ‘impose’ or generate consensus on) some of its ideas, requests and proposals. Thus, without denying the existence of resistance organisations and efforts (Berrio 2017; De Melo e Silva 2017), the things I see, particularly in Mexico, are troubling. H/d/t-p processes do not often appear to be central to ethnic movements, their leaders or scholars, beyond their rhetorical value. With few exceptions ethnic leaders or movements do not seem to really promote their own forms of healing as potential alternatives to biomedicine, nor do they consistently demand improved biomedical healthcare services. We do find that the population itself requests services such as healthcare centres, permanent physicians or even hospitals. Similar self-propelled efforts are also manifested in the work of small groups of activists on HIV/AIDS, and for women in particular the efforts focus almost exclusively on procedures and violence related to reproductive health. It is worth noting that these groups are composed of many kinds of professionals, including anthropologists.

On a related note, we must refine some issues. What constitutes resistance, not only in terms of social movements, but also for individuals, micro-groups and communities? Such a determination implies making interpretative decisions that can be difficult to establish, such as, for example: when is not going to the doctor the consequence of a lack of doctors or economic resources? And when is it actually the result of a negative attitude towards biomedicine? When does self-medication constitute a form of empowerment with regard to biomedicine? And when is it a social process of rational time management or economic saving for a subject or micro-group? (Dias-Scopel 2015; Ortega and Palma 2017).

Central to these and other questions is the power of establishing the capacity for agency in subjects and subordinate groups, so they can not only practise self-care or resistance but also negotiate and, especially, advance their own proposals for the improvement or modification of healthcare activities and policies operating within their territories. This should include real recognition at the governmental and healthcare-sector levels of their particular forms of care (Cardoso 2015). Fostering agency in terms of h/d/t-p processes is an issue that requires urgent analysis in every Latin American country, given that it is the capacity for collective agency that can – at least temporarily – maintain traditional forms of care that are effective in addressing illness, while continuing to serve as a principal means of asserting identity through curative ritual. Collective agency can also be a mechanism for the social control of biomedical policies, activities and directions, especially through different alternatives for self-care.
Notes

1. I consider that the denomination ‘medical anthropology’ is not the most appropriate; nevertheless, anthropology of healthcare, anthropology of medicine or ethnomedicine are even less appropriate because of their ideological connotations, incongruence or specificity. Hence we retain the name, despite criticism, for the simple reason that we most commonly use it.

2. Subjects and ethnic groups increasingly use preventative biomedical criteria, whether or not these have been culturally redefined.

3. While, between the 1930s and 1950s, a set of anthropological currents developed in the United States recovering the subject, or at least the person, in Latin America these tendencies were frequently questioned as psychologising, especially by authors who adhered not only to functionalism or structuralism but also to anti-colonialist and/or anti-classicist theories. It is interesting that the tendencies that in fact recovered the subject in this region did not usually make reference to, for example, a large number of biographies, autobiographies or life-stories that North American anthropologists and sociologists developed during this period. This is even the case when we leave aside, in the case of Mexico, the biography of Juan Chamula developed by Ricardo Pozas, and practically the entire oeuvre of Oscar Lewis about Mexico City.

4. A large part of the criticisms of biomedicine and the healthcare sector by CMA is not only correct, but also necessary; nevertheless, others are characterised by a unilateral perspective, such that they only acknowledge negative biomedical perspectives and actions and omit many of the contributions related to its efficacy. Even anthropologists denounce some medical deficiencies, including, for example, failing to recognise the symbolic efficacy of these professionals, when at least some of them know that both doctors and medications can have a placebo effect.

References


