Medical Anthropology, a tool for Social Anthropology

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The specialisation and the division of Anthropology in sub-fields or sub-disciplines, which led among other things to the constitution of medical anthropology, implies a focus on a particular object related to illness and medicine and supposes the elaboration of specific problems induced by the object itself. However, any reflection on what medical anthropology contributes to general social and cultural anthropology, includes a reflection on what makes such a contribution possible. I propose to examine here the conditions under which the type of research we do in medical anthropology can contribute to general anthropology, and to show that these conditions are the result of the alchemy between the problematisation and the construction of the object.

The aims of the research

Medical anthropology is characterised by two main research orientations that have different purposes and are based on two distinct postulates:

1) The first postulates that examining the problems connected with health and illness from an anthropological perspective can contribute to enrich medical research.

2) The second postulates that the problems raised in the fields of social and cultural anthropology find a privileged field of reflection in medical anthropology.

Despite the apparent similarity of these two postulates, we can see, on close examination, that they cover two completely different positions. In the first case, anthropology is applied to the medical field. In other words, the point is to use anthropology to enlighten medical practice, through

knowledge of the cultural facts. A great number of contemporaneous works, mainly American, testify to this perspective, the aim of which is to improve knowledge of the cultural factors that determine the behaviours of sick people, and thus increase the usefulness of medical programs. In this perspective, the anthropologist must work in conjunction with medical doctors, contributing method and data, in so far as cultural or ethnical factors can help to understand the causes, characteristics and consequences of an illness, as well as the behaviours of patients.

This perspective has probably been at the origin of a certain misunderstanding about the nature of this new knowledge constituted by medical anthropology. The misunderstanding is that this discipline as a branch of the medical sciences, which focuses on the cultural conceptions of illness in order to help health professionals in their task. Such a misunderstanding leads to medical anthropology being situated on the fringe of social and cultural anthropology.

In the second case, illness is considered as a domain of social anthropology. This tendency has asserted itself in France with Marc Augé (1986) who postulated that the practices relating to illness are indissociable from an articulate symbolic system. He also questioned the very existence of a constituted field of medical anthropology with definite frontiers. The idea is that social anthropology is a unified whole; that is to say, that there is only one anthropology, which focuses on distinct empirical objects, and that these constitute *one* object of analysis which must not be fragmented. Illness as an object is, in this perspective, an opportunity for enriching anthropological problems. The detour through representations of illness becomes an advisable itinerary (or even a necessary one) for the anthropologist who wishes to analyse the systems of thought and behaviours in such and such society. In these conditions, the study of the phenomena related to illness becomes a necessity if social life is to be understood. The first aim of medical anthropology is, therefore, not to conceive finalised research on a biomedical target, but to access the knowledge of society through one specific gate. In this perspective, medical anthropology is a privileged path towards this knowledge.

Therefore, the French school has developed a perspective that focuses on the medical field but which insists that medical anthropology should not be separate from the other fields of anthropology. It is, then, necessary to connect the data collected in the medical sphere to the other spheres: politics, religion, genders, kinship, etc.

In keeping with this last perspective, one of the conditions that enables medical anthropology to make a useful contribution to general anthropol-

ogy is that the object is constructed with a centrifugal perspective. In other words, if we are inspired by the globalizing approach that social anthropology has taught us to have, we must connect the object we choose to study to the other spheres of social life, by identifying the systems of meanings between different registers. This means that we must attempt to link elements that belong to different areas and which the cutting up into various fields has sometimes artificially disjointed. In short, we must not "cut out" the object but, on the contrary, "re-stick" it.

To give an example, the symbolic numeric system which prevails in some African societies and that organises care (according to which a treatment is codified along the line which attributes number 3 to men and number 4 to women) has to be analysed in the light of the place these numbers occupy in other spheres (namely the rules of residence and the rules of transmission). Indeed, among the Bisa of Burkina, for instance, the number 3 refers to the three parts which constitute the *nyi* (the main component of the person) in a man, and the number 4 refers to the four parts constituting the *nyi* in a woman. The three parts of the male *nyi* are: one part of his father's *nyi*, one part of his mother's *nyi* and one part is his own individual *nyi*. The *nyi* of a woman is made of these three parts, to which must be added one part of her husband's *nyi*, meaning that she acquires the complete status of a person only once she gets married. The centrifugal approach shows that this technique of care giving and treatment is connected to the relationships between men and women, and to the inscription of the person in the social space (Fainzang, 1985). In the present case, not only does it allows the basis on which the perception of the efficacy of a treatment is built to be understood, but also the way human societies naturalise and thus legitimise social relations by founding them on the definition of the person.

Thus, to contribute to social and cultural anthropology, medical anthropology must, as general anthropology, take part in this work of weaving the various social levels. Now, this weaving has to do with the content we assign to the notions we use and with the way we construct our object, that is to say, with the tools we handle.

The tools of Medical Anthropology

I have already stressed the importance of dissociating medical anthropology from medicine (Fainzang 2000 [1989]). In this respect, I have underlined the need for medical anthropologists to maintain their identity as anthropologists and not medical doctors (cf. Fainzang 1998). It seems to

me that medical anthropology can make a useful contribution to general anthropology only if it keeps its identity as a discipline of social science. That is to say, medical anthropologists must construct themselves through their difference with medical doctors. The proximity between medical anthropology and medicine is widely discussed today (see Browner, 1999, who speaks of the "medicalisation" of medical anthropology). However, there are many anthropologists who, while they defend the idea of a necessary "demedicalisation" of the discipline, tend to construct their researches with the tools borrowed from medicine and with medical problems. This medicalisation of medical anthropology tends to leave it on the fringe of social anthropology only because medical anthropology is excessively inclined to building its objects within the lines of medical problems.

The first difficulty arises from the use that many anthropologists make of the notion of illness itself, within what is intended to be a clarification of concepts. The problem with the term « illness » is that it claims to have a large consensus among medical anthropologists but it is far from being commonly used and from having similar epistemological implications. All medical anthropologists have found cases which do not correspond to the medical definition of disease but which are nevertheless regarded as illness by the subjects. Yet many anthropologists, while rightly distinguishing the concepts of disease, understood as a bio-medical reality, and of illness, as a personal experience, still tend to regard illness as a *response* to disease and, therefore, never conceive of it as a separate and independent phenomenon. They still follow the point Kleinman made long ago that "illness includes secondary personal and social responses to a primary malfunctioning (disease) in the individual's physiological or psychological status (or both). Illness is the shaping of disease into behaviour and experience. It is created by personal, social and cultural reactions to disease" (1980:72). If Kleinman succeeded in transcending some of the notions he used at first and in particular the notion of medical systems which he enlarged to the political and the moral dimensions of the systems of health (1995), many anthropologists still give a reductionist content to the notions and concepts used.

Yet what anthropologists should be interested in, and what should govern their theoretical construction of the object "illness", is not only the feelings which the subjects have about the reality of a disease and the analyses which they make of it, but also everything they consider as illness. This means that illness should not necessarily be dependent on its phenomenological reality or, at least, on the way biomedicine defines this reality. There can be representations and even identifications of illness without

there being any diseases in the bio-medical sense, and without any implications of psychic disorder. They are anthropologically important, for it is the way in which people perceive and interpret their condition as illness that determines their recourse to therapy and many other kinds of social practices. That's why I suggested that the category of illness should be taken as an "empty" category, to be filled by people in the light of their own social position, history and culture.

What is striking here is that a concept, which aimed to create some distance from the medical perspective has paradoxically reinforced this perspective!

In the same vein, anthropology must consider the ethnographic materials and the notions that are related to them without depending on the bio-medical perspective. I showed that people have certain notions of prevention, contagion and efficacy and the content of our group study is often quite different from that which health professionals give them. They have, therefore, an anthropological content, which may be different from their medical content. That's why I argued that medical anthropology should question the content of all the notions used in the domain of health and illness (Fainzang 1998).

In an attempt to bring fruitful elements of reflection to social anthropology, medical anthropology must renew the approach to these notions by relativising, shifting or enlarging the bearing and the meaning of its objects. For example, the complex and stormy debates that health professionals have about the issue of knowing whether Aids is a «contagious» or a « transmissible » disease is not only a purely technical question. The use of these notions of contagion and transmission is in itself an object for anthropology since they have social reasons and social implications.

Even a term such as «risk» must be questioned and rebuilt by medical anthropologists. By analysing the perception of risk, medical anthropology must admit that people's dealings with risk involve many social processes and dimensions (economic, symbolic, relational, etc.) other than the purely medical way of considering risk in its sanitary dimension. Indeed, anthropologists cannot content themselves with noting that there is an important gap between scientific knowledge and lay perceptions of medical risks, and with accrediting the opposition which actors of Public Health and epidemiologists make between "real risk" and "perceived risk". Admittedly, anthropologists have a role to play in understanding the way in which these risks are perceived and managed by the population. Their role is

also important in the apprehension of the whole context in which they fit, in order to connect the perception of risk with this context. However, they also have a particular role to play in the deconstruction that must be carried out if risk, and how it is built, is to be understood. Although it is clear that risk belongs to a given social context, and that the way this risk is dealt with is in keeping with this context, anthropology has underlined the social constructions of risk which hide behind the apparent objectivity of its medical or epidemiological definition. The construction of risk depends partly on social institutions, as Douglas showed (1992). In her approach, the reality of the dangers does not determine the perception of risks: what prevails is the way in which risks are considered as serious and are judged acceptable or not, in relation to a given context. According to Douglas, the concept of risk is a way of satisfying a goal: that of moralising and politicising the dangers within an industrial society. The hierarchy of the risks formulated by the medical institutions or the media is thus related to an arbitrary culture, which makes it possible to speak about the "social uses" of the epidemiological concept of risk.

The field of AIDS research has prompted greater reflection on the issue of risk. Many studies have aimed to highlight the social factors that explain or determine why people adopt behaviours with risk. Several authors have shown that behaviour with regard to the condom can represent, according to the partners, a usable resource for constituting the relation. To refuse explicitly to use it may be a way of expressing confidence and attachment to the other person. On the other hand, attempting to impose it, may be a way of marking a certain distance and a desire not to commit too much to the relationship. Research in Africa came to the same conclusions: accepting the condom may mean that the relation is weak; refusing it may mean that the relation is strong. The logic of protection is the logic of positioning vis-à-vis the partner in a relation. On the whole, the stakes of health are integrated like resources for the benefit of relational stakes. In addition, the risk of contamination coexists (or competes) with other risks. These are biological and social risks [1]. Under these conditions, the risks of transmission are often regarded as lower than the family or social risks of rejection.

As we can see, risk-taking has nothing to do with unconsciousness or ignorance: it is, in a way, rational, since it is a means to an end in the relational field. Risk-taking can bring important relational benefits compared with which the concerns for health can appear derisory. Therefore, it seems clear that if some individuals adopt risky behaviours, it is not because they ignore these risks, but because they respond to a second stake that com-

petes with the first. The risk, then, is clearly not only sanitary and taking a risk is a response to stakes that are not necessarily those of prevention. Besides, when the risks of transmission are regarded as less important than the risk of exclusion and when dealing with risks leads the individual to choose in favour of the least important, this dealing is made according to the personal (and collective) appreciation of a risk vis-à-vis other risks. In this respect, rather than speak of dealing with risk, we could speak of calculating risks. For example, a woman who does not procreate considers that the risk of endangering her social recognition is less important than the risk of losing her health.

If it can be agreed that there is a bond between risk evaluation and the choice of taking a risk, it must be admitted that the question is not so much one of taking a particular risk as of refusing to take another. Therefore, anthropology's contribution is that it can focus on the social context in which this "calculation" of risks takes place, and on the very deconstruction of the medical concept of risk. From this point of view, the opposition between "real risk" and "perceived risk" does not hold because the perceived risk of being socially excluded is just as real as the "real" risk of being contaminated by AIDS. One can have a judgement, as a doctor, an epidemiologist, or an actor of public health, on the gravity of one risk compared to another (if one starts from the criterion of health), but this must not be the approach of the anthropologist. If for the actors in public health it is perfectly reasonable to make a choice, for anthropologists it is not. Anthropologists must not decide the primacy of one risk over another. That is why anthropologists must reappropriate the notion of risk which has been, in a way, confiscated by the medical perspective, in order to understand the various dimensions which compete with the sanitary one and which are the ground for people's behaviours.

Yet admitting to the relativity of such concepts and categories as the normal and the pathological must not lead us to cultural relativism. These notions must not be seen as fixed, as categories that are given forever, but as social constructions, within a society, subject to the variations of the social contexts in which they have been elaborated. If their social and historical bearing are to be discovered, it is indispensable to think about the notions generally used in public health in a new way, and to free them from the content that medical sciences assign to them. This epistemological course is a prerequisite to the contribution of medical anthropology to anthropology.

Now the notions and concepts themselves are part of the way of constructing the object, and the latter is connected with the way of problematising the research.

From the problem to the problematisation

Strictly on the level of the problems it raises, medical anthropology makes a decisive contribution to social anthropology by the exemplary character of illness. For instance, illness, as a paradigmatic example of misfortune, reveals the nature of social relationships. In this respect, many questions can be asked by the field of medical anthropology which directly interest social anthropology (namely: what do perceptions of illness and therapeutic recourses reveal about the relationships between individuals and between groups? How are these practices and representations articulated with the cultural specificity of the various groups? Do representations of illness produce specific social practices? What social logic do they refer to?). Medical anthropology may be useful for social and cultural anthropology in so far as the way people think and deal with illness teaches us a lot about the relationships of people to society. For example, the kind of interpretation they have for explaining the occurrence of their sickness, and the possible modes of blaming someone else for being responsible for their condition, implies a certain way of thinking about one's inscription in the world and in the social network. The relationship to illness reveals the social relations and the symbolic systems that prevail in a society, and it functions as a grid for understanding these relations and systems. (Fainzang, 2000 [1989])

But the particularity of this domain is that it is the specific place of the body and suffering. Illness activates representations of the organs, the substances and fluids, the person, the sexes, etc., the deciphering of which is a privileged way of studying symbolic logic's governing life in society, one of the main purposes of anthropology (cf. Sahlins, 1976). Besides, the very discourse about the body is a kind of lexicon of social relationships. For instance, the study of the representations and practices associated to the issue of nerves and nervous illnesses has shown that they largely refer to the construction of the relationships between genres (Cayleff, 1988). The study of the causes of alcoholism and of the consequences of over-consumption of alcohol on the body, as perceived by alcoholics, shows how far the symbolic connections they make and their motivations to consult a medical doctor are related to their adherence to the schemes resulting from the social construction of genres (Fainzang 1996). The medical field is but one social field among others even if the questions it raises are exacerbated by the radicality of what is at stake, such as life, death, and sexuality.

There are of course many ramifications of the questions raised by suffering (see for instance Kleinman's new perspectives on the political dimensions

of suffering in Lock & Das 1997). In this regard, medical anthropology has made an important contribution to the development of critical anthropology and its political implications in the fight against injustice and social sufferings, and has also allowed us to sharpen our look, even in a less militant vein, on social realities (inequalities, conflicts, etc.).

In any case, medical anthropology may enlarge our understanding of social life, thanks to a remodelling of the problems. This remodelling assumes that the problems themselves must be studied from a perspective other than the medical one and in the light of other spheres of social life, and of other social and cultural settings.

For instance, there is much to be gained by examining the issue of anonymity, which divides some associations of ex-alcoholics, in the light of the spheres of ritual and political life in various cultural settings. Not only will such an examination allow us to understand the deep significance that anonymity has in the frame of the theories of illness and recovery of these associations, but it will also allow us to enrich our understanding, in general anthropology, of the issue of the person and identity. Of course, one could be satisfied by studying the meaning of anonymity within the frame of associations for ex-drinkers, by saying, as many social scientists do, that it is limited to the case of Alcoholics Anonymous, and that anonymity is either a means of attracting members who feel too guilty or who fear the social consequences of recognised alcoholism, or a means of lessening the individual differences among the members of the group, by promoting mono-morphous histories, fighting attempts at self-promotion and encouraging self-sacrifice, or even as the condition of the constitution of an alcoholic identity, itself a condition of the efficacy of this type of group. However, a group of former drinkers like *Vie libre* rejects anonymity: here, the individual is asserted, patronymics are known, and the ex-drinkers' stories are not monomorphs. The unity of the group is not achieved at the price of silence over personalities or individual stories. Everyone knows quite a bit about the others: their names, their addresses, their professions, their life histories, their families, and their work places (Fainzang 1996). Therefore, we must go beyond the single explicit discourses of these associations on anonymity to understand what is really at stake. We must also try to push the analysis usually made by social scientists and psychiatrists further if we want to explain the therapeutic role of anonymity. Anonymity refers to something other than a technique that allows people to come and remain in these types of groups.

To this end, we can fruitfully compare our materials to data collected in quite different cultural and social settings, namely to data drawn from two examples of African societies.

1) Describing a nomination ritual for a sovereign chief amongst the Ndembu in Zambia, Victor Tumer (1990 [1967]) mentions that the chief, during the period of liminality, shares the name of *mwadyi* with his wife. This name is equally given to boys going through initiation. It is a sign of the anonymous condition of the candidate, explains Turner. Here, although the context is not that of sickness, anonymity is what marks the state before a passage.

2) Among the Bisa of Burkina-Faso, a sick man is not spoken of by his name. He is spoken of as "the sick man". The sick man's anonymity can be explained because he becomes excluded from all forms of transaction, from all alliances, from all collective rituals (other than therapeutic ones), and because he does not exist socially as an individual integrated in a network (of kinship and production, for example). Being sick means being excluded from social relationships; recovering means being able to enter exchanges and relationships.

The wider significance of anonymity in both these situations allows the issue of anonymity in ex-alcoholics' associations to be reconsidered. If we compare them with what happens in *Vie libre*, we find that there are common points with the way that this movement deals with the issue of identity. These points appear when we study a particular ceremony (the presentation of the pink card). This ritual is held at the end of a period of six months of abstinence from the time the member joined. It is the moment when the ex-drinker is integrated into the group of pink cards and into the large *Vie Libre* family. From this moment on, the term «pink card» or «cured drinker» designates him, after his own name. During the ceremony, which refers to the belief in the alcoholic's cure, a paragraph is read from the Association's charter that stipulates the rights and duties of pink cardholders. The designation ("pink card" or "cured drinker") is not an individual identifier; it does not single out the individual: it integrates the person into a family-like structure. The individual's new identity is, therefore, like a second patronymic or like a lineage name that bestows specific rights and duties. We notice that *Vie Libre* does not fully include alcoholics into social life until they are "cured drinkers," in other words while they are still sick; they cannot take part in elections; they cannot carry out militant action. The state of sickness renders the subject sociologically anonymous. In *Vie Libre*, the passage to the state of "cured drinker" is equivalent to regaining an identity that grants the right to act within the group. The cured drinker becomes active; the member of a network, a militant, and a person qualified to take responsibilities and to have say.

The light that these African examples shed on the problem gives us a different understanding of what anonymity means and implies in the ex-drinkers' association. The fact that the members of AA remain anonymous and grant the subject the sole identity of "alcoholic" means that

the individual remains at the stage of a sick person and that there is no passage. Indeed, AA assumes that the individual remains an alcoholic forever. On the contrary, the *Vie Libre* movement allows the individual it considers cured to acquire a new identity. By bestowing the identity of cured drinker on a specific individual, *Vie Libre* demonstrates that it refuses to leave the sick person in that state. Furthermore, this cross-cultural approach to the problem allows us to see how far dealing with anonymity plays a part in the constitution of the person. A joint reflection on the place that anonymity has in self-aid groups and in quite different cultural and social groups or settings helps us to understand the deep significance anonymity has in the construction of the link between the person and his/her inscription in the world. If such an approach clarifies the motivation behind *Vie Libre's* rejection of anonymity and leads to the proposal of a new interpretation of anonymity in Alcoholics Anonymous [2], it also provides new insight into the general issue of anonymity versus identity in social anthropology.

Therefore, another condition for the contribution of medical anthropology to general anthropology is to model the problem set by the research in medical anthropology so as to give it a shape other than that given by medical doctors. I shall illustrate this point with another example: the issue of the use of medicines.

In a study about the social uses of medicines and prescriptions among patients, I was struck by the fact that doctors could not understand what I was attempting to study if it was not the issue of compliance. Yet it is obvious, from an anthropological point of view, that the question of knowing what the patients do with their prescriptions and their medicines is not the same as the question of knowing if they do what the doctor prescribes that they should do.

As some authors have shown, the issue of compliance creates difficulties for the social anthropologist because it implies studying the phenomenon from the perspective of medical doctors. In fact, compliance is defined as the measure in which the behaviour of the patient coincides with the medical advice (Haynes *et al*. 1979). In this respect, Trostle (1988) proposes that the idea of «compliance» should be considered as an ideology which settles and justifies the authority of medical doctors. Trostle also shows that the importance of the debate on compliance is linked to the fact that it refers to an ideology of the authority of doctors and health professionals. According to him, the whole literature devoted to this issue, though it pretends that it is concerned with the improvement of health, is in fact a literature on power and control. He denounces, with reason, the

fact that the social sciences that study this problem adopt the vision of the world of health professionals. The issue of compliance reduces the problem of the *use* of medicines to that of the *conformity* of the use of medicines to medical prescription. Conrad (1985) goes so far as to question the anthropological relevance of studying compliance, in that this issue creates the suspicion that the anthropologist is working *for* medical doctors.

The point, therefore, is the following; anthropologists should not give way to the normalising temptation of the problems defined by medicine, such as the problem of compliance, or submit our studies to some form of medical reductionism. In the use of medicines and prescriptions, this means that we must be cautious in our attempts to understand the representations and behaviours induced by prescriptions and all the social relationships built around medicines [3], and and we must not satisfy ourselves by studying who the good and the bad compliant patients are. When studying the social uses of medicines, the point is not only to find out how drugs are used but also, more importantly, to find out what drug use can reveal about individuals and society (Fainzang 2001).

This example illustrates the last point I wish to make here, which is to distinguish between the problem and the problematization. It seems necessary to transcend the formulation of a medical problem in order to set it in anthropological terms and with an anthropological purpose; that is to say, the problem set by medicine needs to be deconstructed and then reconstructed in accordance with anthropological questions. Demedicalisation, which is a prerequisite if medical anthropology is to make a contribution to social anthropology, passes along a new path of problematizing.

Finally, the work advocated here on concepts, the construction of the object and problematisation argues in favour of using medical anthropology, not as an aim in itself, but as a tool, in the service of social anthropology.

Notes

[1] Morbidity and mortality are linked to pregnancy and childbirth in many African countries. Women who fail to get pregnant or who refuse non-protected sexual relationships, which would be interpreted as sterility or a refusal to procreate, risk being socially excluded and withdrawn from the institution of the levirate.

[2] For a more detailed presentation of this issue, see Fainzang 1994.

(3) For example: the relation to writing expressed through the perception of the prescription as a material object, the relation to time expressed through the use of a medicine in the long or short term, or the relation to power, expressed through the way of behaving towards medical doctors, etc.).

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