AM
Rivista della Società italiana di antropologia medica / 11-12, ottobre 2001, pp. 381-393

Medicine and change: making agency count

Aivita Putnina

Ph.D., Department of Sociology, Faculty of Social Sciences, University of Latvia (Riga, Latvia)

The aim of this paper is twofold. First, I will reflect on the theoretical approach of agency. Second, I will problematise it from my field position. Medical anthropology has a well-developed tradition of using the agency approach in the field. In the 1980s, with the reflexive approach, social scientists themselves came into the text (1). Actually, anthropologists have always been in the text, even though they initially thought they were not. The fashions had changed and it had become unnecessary to try to blend into the wallpaper (2). 'It is an academic convention that authors are present to a greater or lesser extent in their texts. These 'conventions' caused me considerable pain when I was struggling to expose my agency in my texts. I gave up any hope of writing the right 'style' and made it part of my argument: it is an essentially Western tradition to see social reality in terms of agency. I stated in the foreword to my dissertation that the thoughts, which were not otherwise annotated in the text, belonged solely to me. That was my agency in me, which I was failing to show.

Turning now to the main theme of the conference, medical anthropology, depends heavily on the agency that we, medical anthropologists, have in academic, medical and political fields. I want to go further than Bourdieu (1990) by saying that anthropology should not only be a critical discipline, but also be responsible for the critique it produces.

What does 'agency' mean and how useful is it for interpretation? In a recent international meeting, which tried to establish an interdisciplinary micro-approach network of social scientists between Nordic, Baltic, and Russian scholars, a discussion of micro vs. macro approaches arose. Macro-sociologists appeared to have acquired a great deal of the power in the current everyday practice of their discipline, leaving too small a space for other perspectives. Anthropologists could proudly withdraw from the dis-

pute, claiming a complete absence of the problem from their discipline. Even more – we all used either discourse or agency (or networks as agents did) as tools to interpret our texts.

I will stress a few basic premises of the debate, which are central to my later argument. First, the agency vs. structure approach is one of the central questions and debates in social theory. However, relationships between agency and structure have always been more important than agency itself. Second, agency can be seen to be located either in structures or individuals. Regardless of the initial position of interpretation, actions can always be analytically traced back to agency [3]. Third, agency is a product of a particular historicity and space. It is at once a theoretical term that bridges the tension between the individual and structural perception of one's own person in the Western world [4]. Agency as such has been problematic, further questioning the centrality of human agency. This problem seemed to have been solved by actor-network theorists that allowed relationships, foetuses, scallops, machines and others to join the club without involving structures. Agency itself was still taken for granted.

I believe that by developing a theoretical perspective on agency anthropologists can contribute to solving many practical problems in the field. This would also mean that anthropologists move from a passive to an active research position. It would allow us to avoid the uncomfortable position of detached observers.

I started as a critical anthropologist, examining doctor-patient relationships and the medicalisation of human life, which I considered rather evil. I found that critical medical anthropology has been a driving force behind the change in doctor-patient relationships. Methodologically, I tried to blend in with the wallpaper during my fieldwork, knowing at the same time that it is impossible. In my dissertation, I described the ways in which doctors and patients communicate and how childbirth practices change over time. I criticised the field I studied and withdrew from it.

None of our works (even if made for the enjoyment of our own scientific community) is politically neutral. Wilfully or not, we become participants in the process. The divide between the 'academic' and 'politics' is curtailing our agency. Anthropologists had had implicit or explicit intentions to influence the policy process. I can mention Margaret Mead as an example of setting 'natural' childbirth movement in the USA and inspiring a theory of child development.

Traditionally anthropologists work as experts on behalf on academic or other funding institutions. In the 1990s the approach began to change.

Reacting to the failure of the health care reforms in the developing states, the World Bank began to advocate a bottom-up approach [5]. This approach is based on the belief of human agency. Democratisation of the developing countries became the issue for insuring the success of different policies, including health policy. Participatory democracy is also one of the key slogans of the European Union. Social scientists are taking part in this process, becoming moderators between the science, government and society.

I came back to the field I could traditionally call mine as an expert on behalf of the European Commission and the UN Development Programme. I noticed a dramatic change. The emerging Western type of agency I saw in the mid 1990s began to fail since 'agents' could not see a space to exercise it. It appeared that there could be no participatory democracy in the society, which basically believes that only structures can possess agency.

Working in a group of experts for the European Union I participated in the drawing up of the Latvian National Development plan. It was a plan for the state's future activities in definite areas, including health care. It was important to the medical field since the pre-structural funds of the EU would be distributed according to the priorities of the plan. At the same time the plan defines the broader relationship of the medical field to state politics. The previous version of the plan failed to obtain EC approval because it was designed as a shopping list for various ministries and lacked societal perspective. The mistake was corrected, putting societal interest as a strategic goal in the preamble of the plan. Backstage experts were encouraged to provide this 'societal imitation' throughout the body of the plan. In large, the effect was thought to be reached by two means. First putting something 'social' in the plan like health care and unemployment. Second, the plan had to imitate the participatory democracy and 'sound' social enough. Under these two covers there was still the same shopping list since the distribution of the means between the different fields depended on their political capability to negotiate. The non-governmental sector was not allowed in even though there is the practice of delegation of the state functions to NGOs.

The image of participatory democracy combined with the absence of corresponding agency resources pays back double. As is commonly known, Latvia is a democratic country moving towards the European Union. According to the principle of new democracy, agents should express their views in a forum. In the previous Soviet system of rigid structures the basic principle was 'you do not count as a person without a paper'. In the participatory democracy papers have become less important, the person became unimaginable without the voice.

The grassroots of agency I fixed in the mid-1990s had disappeared. Previously active participants 'fell' back into the system approach, merging with the structure and giving up the voice. It appeared too difficult to achieve goals partly because members of the medical staff were badly organised, partly because they came to distrust the state. Their skills were not sophisticated enough to count as agencies. This drawback allowed the state officials legitimacy to ignore their potential voice, making the situation more dramatic.

The first apparent example of losing voice occurred on a slightly different scale when I was still writing up my fieldwork data into my doctoral dissertation. A woman who had longed for home birth and conducted it at home despite the opinion of her midwife suddenly began to interpret the event as the irresponsibility of the midwife. In a year the birth event ceased to be a 'wonderful miracle truly born out activity of both – father and mother'. Now their midwife and health care in general were responsible for putting the life of the patient and the baby at risk.

Several similar transformations happened amongst the doctors. Previously active and reflexive agency seemed to implode. The new meanings and activity had collapsed within themselves. A depressive mood and helplessness dominated in interviews. In the mid-nineties these doctors were in the middle of events. They initiated and enacted the change in their wards and health care programmes. Wards became open and patient-oriented. The practice itself changed. Medical technology masked under 'human help' replaced wooden stethoscopes in obstetrics. A new knowledge became a requirement for practice.

Reasons for the imploding agency can be found in the status of the health care system within the broader political context. Firstly, the medical profession is one of the least valued, along with that of schoolteachers. Doctors' salaries are well below the average salary and nurses receive slightly more than the minimum wage of the country. The historical roots of this tradition can be found in the Soviet period. At that time the medical profession became female dominated and therefore lower paid. However, in comparison to the Soviet period, doctors' wages have fallen twofold.

Secondly, health care appeared to be a rather costly policy. Latvia underwent a rather complicated health care reform. The rationale of the reforms themselves is poorly understood not only by patients but also by medical staff. Channels of financing are tricky, combining the state budget, local government resources and obligatory and voluntary health insurance. Local governments are put in an especially difficult situation, being forced

to sell and buy their own health care products. Financing is always insufficient to implement the health-care programme. At the end of the budget year or even in the middle of it a sudden hole in the budget opens up. In 2000 it appeared that the budget did not have enough means to cover the medicine compensation programme. The first solution offered by the large service providers was to draw the sum from the doctors' salaries. In 2001, the largest maternity hospital announced that it had fallen into debt because more women are giving birth than expected. When the state insurance company refused to lift the quota, the hospital threatened to send the birth-giving women to the company's offices. Finally, the Ministry of Welfare reminded them that deliveries are the state's priority and should be covered by all means. No additional means from the budget were allocated to solve the problem given that the quotas for planned operations in several central hospitals were also exceeded 5-6 months earlier.

Additionally, the financing of the medical care changed from one principle to another. Currently a mixed system of points (given for certain operations) and capitation (a certain amount per registered patient) applies. Doctors have named the new principle 'decapitation (of doctors)'.

The femaleness of the profession is a poor explanation for the status of the profession. Another argument (which I will unfold later) is the absence of appropriate tools and skills to voice and advocate the professional interest. To explain the argument of implosion of agency, I will illustrate it with a real case.

A director of a hospital refused to accept any new patients on the grounds that the state evaluated quota (and financing) for the patients had already been reached. This problem arose in October 2000 in many hospitals when their quotas for the year were reached two or three months early.

Clearly, a refusal to accept patients at the hospitals' own risk could be called a political protest action aiming at influencing policymaking. This is what the director of the hospital *could* mean when one is looking with the eyes of a Westerner. What his colleagues in this action saw is the following:

> *«Look at A, he is a director in one hospital and holds a post of a state representative in another. He commands his hospital and tries to put that other hospital on its knees (to join the initiated protest action). Well, medicine really needs resources and I support this. But A is doing this to gain popularity before elections [A is on the candidate list for local government elections]. So it is done – the same people moving from one post to another, mixing between themselves like in a dark pocket. Others are not welcomed in. This is why one cannot understand the system of health care now. Why is the institution X established? B didn't have an important post, so others establish one for him to preserve the solidarity. All this system is made to ensure posts for its members but not for developing a coherent health care system.»* (Dr. B)

Dr. B was a previously politically active doctor. Some 10 years ago she pioneered the change in maternity services all over Latvia. She was proud that her opinion and experience were highly regarded in Moscow. She managed fund-rising abroad and ran programmes of developing maternity and neonatal services in Latvia in the first years of independence.

Moreover, she was not the only doctor ceasing to see her agency under new circumstances. 'The structures' became a serious obstacle to exercising one's agency. For example, Dr. C actively started a new private exemplary practice some six years ago. At that time his initiative was in line with health care reform. He had managed to use resources to establish his practice at the right time and place. Now the process was interpreted differently:

> *«That process of certification (post-diploma education) costs my month's salary. I would die from hunger if my wife did not support the family and me. Look, where does this money go? OK, lecturers should be paid, but they do not take that amount of money. The rest goes to private account of the president of our association D.»*

When I inquired why nobody objects, given that money for the certification is considerable amount for a doctor, C replied:

> *«I have not passed the certification yet. It is too risky to start the protest before I go through. Besides exclusively D does all this education. I think it must be taken by the university.»*

'Inaction' to a great extent is conditioned by the perception of the field. What helped in adopting this perspective? First, there is strong competition between the doctors in the field. Any collective action is still in doubt since hospitals and doctors are competing for scarce resources. Latvia still has a rather high number of specialised doctors and not so long patient queues for treatment. This model ensures more jobs for the medical staff. However this system is rather costly. The situation is especially difficult for specialised providers of maternity care. This sector mostly depends on the state budget since assistance at delivery is within the state granted health-service minimum. With the drop in birth-rate the competition between the hospitals and doctors became fiercer. Now a reverse effect can be observed. The birth rate rises slowly. However, hospitals do not receive more money that was planned in the budget. Hospitals and local government do participate in the planning process but nonetheless they see the whole planning process in a rather dim light.

The agency implosion is also due to the fact that the state policy is not explained to the doctors. I heard various beliefs about the way the health system works and I could not find any single person at the executive level of the hospital who would volunteer to be an expert in the current health

care system. The knowledge of practitioners helps in perceiving the events in the field without giving control of the process.

Another reason for passivity is the already mentioned financial shape of the medical staff. Most of them take extra-hours at work to survive. Female medical staff have their double burden at home – taking care of their parents, husbands and children. Some doctors and nurses are single heads of their families. Some of them work additionally. I met a gynaecologist who worked as a cleaner in the evenings. She was a single mother and had to take care of her ill mother. An extra job was an absolute must to feed the family. Comparing the input in the work, the second job was much more rewarding. The doctor herself felt shy telling me this; that was a low prestige job and incompatible with the doctor's position in society.

As a justification for one's passivity a strong and closed power hierarchy is mentioned. This power is attributed to the posts and structures, rather than to the participants themselves. This helps the agency to transcend. With agency transcending, the individual responsibility dissolves. One does not participate in the policy process because one does not count as a participant and one is not responsible for the process. The only strategy for reflecting on the situation is talking to friends and relatives. Being (or rather feeling) outside the process allows one to criticise it implicitly without being responsible neither for the critique nor the (in) action.

There are still doctors who carry a different interpretation of the field. These had chosen a different strategy already in the early 1990s, starting to work through an NGO structure. I must explain that professional associations, which include virtually all doctors and nurses also, are non-governmental organisations. However, these organisations deal with exclusively professional and regulatory matters. In fact associations are structures, not a collectivity of individual agents. For this reason, medical professional associations are not very suitable for dealing with advocacy matters. On the one hand, professional medical organisations work as the state partner regulating the discipline. On the other hand, they lack sufficient authority beyond professional competence.

There are examples of spontaneous protest actions in medicine. One of the most recent ones concerns so called middle-level medical staff – nurses and midwives. British and Norwegian governments have expressed a wish to contract Latvian nurses for work in their countries. The Norwegian government has even agreed to support nursing education in general and Norwegian language courses for the selected nurses in exchange for work contract of Latvian nurses in Norway. Latvian hospitals already lack nurses

since the salary is rather low. In this respect the situation is similar to that in Britain and Norway. Latvian clinics are expected to lose much of their qualified and experienced staff. The event was widely discussed in media and many nurses have already applied.

However, it did not turn out to put pressure on Latvian government concerning nurses' wages. Nurses organised a protest action at the Cabinet of Ministers asking for a rise in salary. Even though the protest meeting was well attended by nurses, and some doctors and patients joined them, the protest action did not achieve the expected result. Government officials explained that the budget structure should be changed to satisfy the demands of the nurses. This, of course, could not be done in a day. It is not done even in a month's time. As an answer, the Latvian Association of Nurses plan to strike.

When compared to other member benefit professional organisations, the scope for the action of medical associations is rather limited. For example, the Latvian Association of Fishermen and Fish industry works exclusively as a lobby for members' interests. Acknowledging that their interest would not be taken into account when they were absent from the policy process, the group had delegated a representative who actively searched for the right time and place to interfere in the decision-making process. The representative expressed the interest of his association, mentioning that this is the view of 80% of Latvian fishermen. He was proud to present the fact that the Ministry respect and fear their opinion to a great deal. At the same time the state officials rarely informed the representative about the course of events. It was solely his responsibility to present the opinion.

Protest actions like strikes, demonstrations and meetings are the most popular form of public involvement in politics in Latvia [(6)]. They are believed to be most influential ones after voting in elections. Even though protest actions take a significant place in the political landscape of Latvia, compared to France, Latvians use these means rarely. An average 13% of Latvian population had participated at least once in such an action.

Many more strategies are used by non-governmental organisations. Around 280 of them deal to some degree with the issues of reproductive health. Around 20 deal exclusively with the matters of reproductive health.

Non-governmental organisations in the medical field unite members of different professions. When I started my fieldwork in 1996, there was one major organisation for family planning and reproductive health "Papardes Zieds [(7)]" (PZ). Its major aim was education in reproductive health and contraception. By 2000 they had established their local network all over Latvia.

They prepared volunteers for lecturing at schools and organised interest education for youth. However, when the network was stabilised, another need occurred. The organisation managed to deal successfully with the lack of information by providing it itself. The failure was in not influencing education policy at large.

It did not succeed in establishing education as a part of school programmes. To affect the education in reproductive health, the subject syllabus was prepared and handed on to the Ministry of Education and Science. Teaching courses for teachers were initiated. The result was a small number of enthusiastic teachers actively working with children. Health lessons were not obligatory. The rest of the system remained intact. As a 16 year old girl recounted:

> *«Our teacher of biology took over the health classes. She is old. With all her views what is proper and what not. She lectured about hygiene in these classes. That was only one class when she shortly and generally told us about process of reproduction. I doubt she had ever heard of contraception and like. That was not what we expected to learn.»*

At the beginning of the education campaign PZ turned its main attention to youth. In fact the older generation felt repelled by their actions, considering talk about the intimate part of human life indecent.

Broadly speaking, the problem was not in the generating of new kinds of ideas. It was in their implementation. Looking back at the establishment of the health NGOs, it happened mostly due to the fact that those individual gynaecologists became aware of the abortion problem in Latvia already in the 1980s. Then, abortion procedures were seen as a personal pain when conducting an unacceptable operation and personal inability to prevent the high rate of abortions. Almost 9 % of women of reproductive age had undergone an abortion [(8)] in the 1980s. Abortions were a part of the state reproductive policy and certainly not a medical or ethical problem since the 1950s. These individual anxieties of doctors became collectivised by establishing a non-governmental organisation for family planning and reproductive health. The initiative came from a foreign Latvian. This is typical of Latvian NGOs in general. At that time not only new ideas but also skills and attitudes to affect these ideas were learnt. NGOs took a different path from that used in hospitals or professional associations.

> *«This started with the right attitude. We came together and realised that we think similarly, that real things can be done to cut down the abortion rate. I personally learnt the argumentation and presentation skills. How to present my ideas effectively. I work with a female collective. I know how difficult it is to make the Department meetings, how difficult it is to discuss matters here. People are not used to positive communication.»* (Dr. L, member of PZ)

The strategies selected by NGO members looked beyond the traditional medical field, choosing a flexible approach. They also opened a space for open discussion and collective action.

Firstly, PZ co-operated with its international counterparts in attracting the financing. Their first projects were financed by foreign aid organisations. The state ministries were not ready to participate in the international Cupertino projects and potential donors preferred to invest in NGOs. Secondly, a PZ member represented the whole Latvian State in the Cairo conference. Due to her professional and NGO experience, she simply appeared to be the most suitable candidate to address questions of population growth and reproductive health. The doctor L recounts on her experience:

> *«It was an incredible feeling. A doctor from Latvia raises the card with state name and says: In the name of Republic of Latvia. I learnt all that language and the way people talk and advocate their interest. Feeling that you can do the same. In the late conference I heard the representatives of the Holy See? speaking. I almost forgot for a moment what my own position concerning abortions was.»* (Dr. L)

Acknowledging the limits of their educational strategies, the attention of the PZ members was turned towards advocacy of their interest. It was done by all possible means, from educating politicians during ordinary trips to conferences and meetings to influencing them as patients. Besides, PZ participates as an official and unofficial partner in developing the state health policy. Although civil servants consult the NGOs in preparing projects of the normative acts, NGOs are not participating as partners. PZ also represents the NGO health sectors in all Summits, presenting an alternative report on developments. PZ co-operates with other health sectors NGOs influencing health-care legislation. Different means are used to gain influence. This year the Baltic Congress of Gynaecologists and Obstetricians has the Prime Minister as its Patron. At the time of the invitation he was the Mayor of the capital of Latvia – Riga. His political advancement helped to raise the prestige of the whole Congress.

In the long run, non-governmental organisations have appeared the most effective space for exercising one's agency. This appeared to be a suitable environment offering not only knowledge but also developing skills for exercising that knowledge. Speaking about change and improvement in the health sector, NGOs were the most suitable agents for it.

Medical anthropology has a strong agency approach. This is good base for further development of the theory of action, which could be utilised not only for the academic but also for empowering our informants. Of course, this need is born out of specific time and space. Where is the place for anthropologists in present-day Europe? Anthropological theory has been

in line with politics, going together with funding from the colonial to the post-colonial era. No opinion can be politically neutral, even that expressed according to academic standards. Science students are taking an open position of mediators between the society, science and the state.

With anthropologists becoming mediators and responsible participants of the social processes, medical anthropology as a discipline will be strengthened. Medical anthropology has always been a critical discipline in relation to biomedicine. Its critique has helped develop the medical field itself [9]. However, the critique should become constructive by providing ways to solve the problems diagnosed.

The proposal goes well beyond the scope of applied anthropology. I call for developing theoretical and methodological means for participatory research. It is certainly possible to continue the analysis, for example using Kleinman's model. One can improve the model and adopt it to specific cultural backgrounds. However, the core of the problem might not be in the models of transactions or education of doctors. It might be in the respective agencies of the participants. The same educational background due to agency skills may result in different modes of translation.

In a conversion with a polyclinic doctor I discovered that the polyclinics have gynaecologists for the 'rich' and the 'poor'. The doctors worked next door to each other and used the same equipment. Reflexivity and ability to use their reflexivity drew the borderline between the two kinds of doctors. The educational background of these doctors was similar. The difference in the doctor-patient relationship was enormous. The doctors of the 'rich' attracted the most affluent patients and received higher fees.

The solution of the poor doctor-patient relationship can be hardly found in the models of mutual understanding or education. Using the concept of agency allows us a broader approach, relating all factors curtailing or strengthening one or another expression of agency.

Looking at the events in the field of health care in Latvia, a critical approach will hardly provide solutions. It is not enough to conclude that the health care system is chaotic. Health politicians do not read academic reports in social sciences. Doing research simultaneously becomes the responsibility of an anthropologist to the field he or she criticises. Otherwise, an anthropologist becomes an echo, reproducing the same problems he or she brings out.

Pointing out the hegemonic nature of biomedicine and believing that the expression of the critique in academic texts is the limit of our activity, I rather propose going beyond the critical function of medical anthropol-

ogy towards designing the strategies to go beyond the critique – detecting potential agents for change and proposing strategies for solutions.

In my case it was evaluating the change in the field; reaching the conclusion that change was linked to the change in perception of agency and evaluating strategies to develop agency and skills for sustaining that agency. The doctor-patient relationship goes well beyond the medical field; it is as much about the welfare state and international politics.

Empowering the subjects of research, we, as developers of empowerment strategies, will gain a strong agency of our own. Therefore my suggestion is rather to develop a stronger agency for medical anthropology itself rather than trying to reach influence by contributing to the field of general anthropology. Developing strategies for exercising agency may become an important advantage especially doing anthropology at home where social scientists from different disciplines respond to the same problems. This allows for the growth of the discipline and the finding of common goals with anthropologists working in fields other than medicine.

Notes

(1) e.g., Woolgar, Ashmore, Krumeich.

(2) See Tonkin, E. (1984), p. 216-217.

(3) See Ashmore (1994), p. 734-735.

(4) Foucault (1972).

(5) See also Krumeich (1994), p. 5.

(6) Human Development Report 2000, UNDP, 2001.

(7) This is the name of a mythical flower which blossoms only on midsummer night in the forest. One can find happiness just by seeing the flower. However, both happiness and the searching process are strongly linked to sexuality.

(8) *Demographic Yearbook of Latvia* 1997, Riga, 1998: 82.

(9) See Putnina (1999).

References

Ashmore, M. [*et al.*] (1994) "Humans and Others, Agents and Things". *American Behavioral Scientist*, Vol. 37.

Bourdieu, P. (1990) *Reproduction in Education, Society, Culture*. London: Sage Publications.

Foucault, M. (1972) *Archaeology of Knowledge*. New York: Pantheon.

KRUMEICH, A. (1994) *The Blessings of Motherhood: Health, Pregnancy and Child Care in Dominica*. Amsterdam: Het Spinhuis.

PUTNINA, A. (1999) *Maternity Services and Agency*. Doctoral dissertation. Cambridge: University of Cambridge.

TONKIN, E. (1984) "Participant Observation". In ELLEN, R. F (ed.) *Ethnographic Research: A Guide To General Conduct*. London: Academic Press.

WOOLGAR, S. and M. ASHMORE (1988) "The Next Step: An Introduction to the Reflexive Project". In WOOLGAR, S. (ed.) *Knowledge and Reflexivity: New Frontiers in the Sociology of Knowledge*. London: Sage Publications.