Ethical issues in medical anthropology:  
Different knowledge, same bodies  
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Syracuse University  July 2003

This brief thematic essay has two sources of inspiration: one is a specific trigger event, and the other a cumulative set of experiences.

The immediate impetus was the last panel I attended at the 2003 conference on "Dialogues for Improving Research Ethics in Environmental and Public Health" -- a session on "Field Experiences with Gaining Community and Group Rights." Niem Nay-Kret, Executive Director of SABAI (Southeast Asian Bilingual Advocates Inc.) of Lowell, MA was this session's final speaker. She offered a nicely organized and illustrated description of misunderstandings that sometimes arise when recent Cambodian immigrants in Lowell turn to Euro-American doctors who lack linguistic and cultural knowledge to facilitate communication. The most dramatic potential for trouble involved some of the traditional healing methods Cambodians use, such as "cupping," that leave marks on the treated person's body. These marks have been misinterpreted as signs of abuse, leading to additional and unnecessary anguish for the sick person's family, especially when the marked patient is a child.

This material, revealing of medical pluralism in the Cambodian community, was fascinating in its own right. But what aroused my particular interest was the unexpected audience response -- an enthusiastic outburst of storytelling. Perhaps half-a-dozen persons in the room were moved to provide animated and gripping anecdotes from their own individual and cultural experiences with diverse, successful ethnic healing practices outside the biomedical domain. By and large these were personal, not professional accounts. There has been much media attention in recent years to Americans' increasing attraction to, involvement with, and expenditure on so-called "alternative medicines." What I heard at the panel was a kind of spontaneous testimony to this phenomenon -- a lively conversation raising many issues concerning the relative values of mainstream medical knowledge versus home remedies, as well as the interpretation and narration of healing.
Twenty-some years of intermittent fieldwork in rural India, including six weeks in the winter of 2003, provide the cumulative experience that propels and informs my current inquiry. My research interests in pilgrimage, ritual and ecology have intersected frequently with discourses and practices of health and healing (see for example Gold 1988: 136-186; Gold 2003). However, I have never made these my focus and never located my work within medical anthropology. As I scan the broader field of medical anthropology with a view to highlighting ethical issues peculiar to it, I find myself acknowledging some reasons for my own sense of distance from this disciplinary branch.

This winter I visited numerous goddess shrines with the aim of collecting origin myths and miracle tales. One place I went, Kuchalvara Mataji, is famous for healing "hopeless cases." Many pilgrims have been referred here by the hospital, I was repeatedly told, because their cures were beyond the skill of any doctor. The goddess called Kuchalvara Mataji specializes in afflictions such as epilepsy or other types of seizure and paralysis. According to several ritual experts and pilgrims interviewed on a single afternoon visit, as well as a few of my closest friends, most afflicted persons will gradually recover by the Goddess's grace. (Others, I presume, remain ill and eventually depart in search of other curative means.) I confess this place disturbed me, much as does a hospital visit in the USA. I found I had no desire to photograph or interview these terribly debilitated pilgrims and their worried caretakers, who were camped in small groups with minimal bedding and cooking utensils on an unsheltered stone terrace. Some of the sick were children; some were very aged; some were young women in disheveled dress; a few were bound with cloth or wearing awkward mittens to keep them from thrashing or scratching themselves; most appeared very weak.

Although the priest of Kuchalwara waxed eloquent about the shrine's beneficial effects on the seriously ill, I found it hard to believe in miracles in the presence of so many suffering bodies and anxious families. My purpose in visiting shrines this winter was to collect myths and legends – not to witness pain. I certainly wished to record tales of miraculous cures, but just as certainly did not wish to get too close to seekers after miracles whose stories had not yet attained a happy ending. No one was asking me for help; they were convinced that the mother goddess would succor them. Yet my self-protective preference was to gather healing tales at a remove in time and space from the afflicted; and to avoid meeting their eyes, whether empty or full of hope. Retrospectively I can analyze my desire to escape as precipitated by a discomforting sense of

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permeability pervaded by helplessness. Many who do social science of medicine write about the way that sick others remind us of our own fragility and inadequacy. But the emergent ethics is an impulse toward action not flight.

Taken together, the conference discussion and the lingering, vivid and ethically unhappy memory of Kuchalwara Mataji (along with many other recollections of physical distress I have observed in rural India) evoke two aspects of research ethics in medical anthropology I wish to highlight in this essay. These may be grouped as 1) multiple questions surrounding the relative efficacy or validity of different forms of knowledge and different practices of healing; and 2) impressions or moral imperatives arising from encounters with embodied suffering. I believe these have signal relevance for all health research.

A third important element to be noted in advance are encompassing conditions of differential power and resources. As Rhodes puts it "medicine cannot be described apart from the relations of power that constitute its social context" (1996: 173). Distinct but interrelated and pervasive inequalities inevitably separate doctors from patients; well educated from poorly educated; researchers from research subjects; the authority of "science" and biomedicine (in the singular) from traditional, folk, or ethno-medicines (in the plural). I will not examine these power differentials and the ethical quandaries they entail as a separate topic. They suffuse the entire field of medical anthropological research (and most social science research projects). In all that follows here I shall try to keep such factors in view, as do most of the authors I discuss. Participatory or community-based research methods have been hailed as offering at least a partial solution to this power divide, and have been successfully instituted in many public health research programs. However, these have not become dominant strategies in medical anthropology.

I begin with a brief and cursory introduction to the anthropological study of disease and healing. Part II deals with diverse concerns surrounding the validity and efficacy of various medical knowledges. A haunting and daunting query, recurrent in the literature, is do specific indigenous healing practices work, or not? Why is this so hard to answer? Related to issues of validity and efficacy are other knowledge issues. For example, when might an outsider's "superior" knowledge make intervention ethical? or, alternatively, when is non-intervention unethical? Suppose a culturally sensitive researcher becomes aware of a health problem that could be helped only by altering someone's world view?
The opposite situation also generates ambiguities. Is prospecting for useful and exportable cures ethical? Where indigenous remedies have the potential for wider healing uses, property rights and profits are at stake. How can researchers credit and compensate indigenous healers when their treatments are reproduced for sale on the global market? Knotty questions such as these are only sample a vast gray area. What if a well-meaning anthropologist who wants her shaman-informant to receive credit for expertise in wider domains ends up inadvertently exposing the person to public glare in a way that weakens her spiritual power or attracts dangerous enemies?

Finally, in a concluding segment I discuss how some medical anthropologists claim that research involving bodies and health is qualitatively different from other kinds of social science – because its ethical principles arise from a visceral human response. To confront suffering flesh and minds is to confront one's own embodiment.

I. Medical anthropology: research agendas and practices

Whyte and van der Geest note, "Just as anthropology itself grew out of the colonial encounter, so medical anthropology grew out of the spread of western biomedicine to other cultures" (1988: 10). Thus they highlight issues of hegemonic knowledge / power at the discipline's core. In a 2002 essay, Margaret Lock, an influential and accomplished medical anthropologist, describes the field she has helped to define in recent years. Lock depicts an historical progress toward increasing respect for indigenous medical knowledge. She writes:

As far as we can ascertain, peoples everywhere have amassed knowledge and practices designed to preserve health, account for the occurrence of illness, and provide therapeutic relief. Anthropologists started to record such knowledge during the latter part of the last century, but not until the 1920s did the physician/anthropologist W.H.R. Rivers argue that medicine in nonliterate societies is not simply a random assortment of practices based on custom and superstition (2002a: 190).

Rivers' argument helped to shape the field's future. Hence the widely used concept of "systems of healing" terminologically stresses the organized, explicitly non-random nature of indigenous knowledge.

Lock also reflects on and critiques a far slower acknowledgement of parity between ethnomedicine and biomedicine (Western medicine). Even when indigenous healing methods are treated respectfully, she finds that, "biomedicine is usually taken as the gold standard against
which other types of medical practice are measured" (2002a: 191). Only very recently have a few pioneers in medical anthropology -- including Lock (2002b), Mol (2002), Scheper-Hughes (2002) and others -- appreciated the need for a cultural approach to biomedicine. And only if medical anthropologists are willing to treat biomedicine as a system among systems, can they avoid assuming its "gold standard" supremacy.

One problem that immediately arises in any attempt at cross-cultural comparison of therapeutic methods has to do with each culture's differently constructed definitions of medicine, treatment, and health, as well as the boundaries that may or may not separate healing practices from religious, or familial, or political practices. Just as some religions are conventionally described as "ways of life" in opposition to religions that are more confined to particular spaces and times, so in many cultures healing merges with other aspects of life. This includes, of course, numerous Christian groups who may set themselves apart from the larger society by embracing spiritual healing practices (Csordas 2002).

Kleinman, an important, senior voice in medical anthropology, pointed out as early as 1980 that the study of "ethnomedicine" as opposed to biomedicine, "would take the context of meaning within which sickness is labeled and experienced as its central analytic and comparative problem" (1980: 380). On the one hand, by writing this Kleinman participates in the failure to treat biomedicine on a par with other systems (because surely it too has a penetrable context of meaning). But at the same time he highlights an important feature of many situated healing practices: their embeddedness in cosmological, societal and familial circumstances.

To take an example frequently cited, Native American concepts of balance or harmony hold relationships with other people and with spirits as crucial to bodily and psychological well being. Even a Tony Hillerman mystery novel will deliver a crude version of this vision of health as held by Navajo peoples.

A clear and concise Native American definition of health, using the medicine wheel image, appears on the web site of the Akwesasne Health Facility, called Kanonhkwa'tsherio or "a place of Good Medicine":

The mission statement of Kanonhkwa'tsherio is "Te ia khi ia te rien:tha re" (deya khey ya de leyen thale). This is a Mohawk word which means we take care of every aspect of a person as a whole. The person is very important to us and is on our minds. This represents the holistic approach we strive to achieve.
The logo of Kanonhkwa'tsherio was designed by Stephanie Thompson of the Kahwenoke District. The logo represents the medicine wheel respecting the cycle of life and the four directions, the partridge feathers represent Akwesasne, the family shows the strength of the family unit and illustrates the generations. The family stands upon the turtle representing mother earth, the nation flag and the tree of peace are illustrated on the turtle (Mohawk Council of Akwesasne).

In a South African cultural context, Katz describes healing for the Kalahari Kung as similarly multifaceted:

For the Kung, healing is more than curing, more than the application of medicine. Healing seeks to establish health and growth on physical, psychological, social, and spiritual levels; it involves work on the individual, the group, and the surrounding environment and cosmos. Healing pervades Kung culture, a fundamental integrating and enhancing force (1982: 34).

Nichter also elaborates on the ways that ethnomedicine overlaps other domains of meaning, identity, and morality:

Central to the study of ethnomedicine is a study of how "others" and "selves" are constructed in the contexts of affliction and social transition, the role illness constructs play in defining moral worlds, relations of power and perceptions of normality, and the process of provisional closure entailed in healing . . . (1992: xvi).

Thus, Kleinman, Nichter and many others point to a difference that might be glossed as the difference between treating fragments of the body and treating the whole self. Moreover, this self is not treated as an individual self, but as a self enmeshed in family and society, nature and cosmos. "Holistic health" is a category readily located in popular bookstores, but it is a phrase I have noticed to be markedly scarce in the medical anthropology literature. Doubtless "holistic" is eschewed for its un-rigorous "new age" tone; nonetheless, scholars repeatedly point to integrating processes in ethnomedicines that are apparently absent in biomedicine.

Recently, especially in works that connect healing with narrative, we find studies of biomedicine that attempt to consider registers inclusive of meanings residing in and beyond the biophysical (Frank 1995; Mattingly and Garro 2000, Mol 2002). Mol describes her approach to an ethnography of atherosclerosis in a Netherlands university hospital: "Thus, an
ethnographer/praxiographer out to investigate diseases never isolates these from the practices in which they are, what one may call, enacted. She stubbornly takes notice of the techniques that make things visible, audible, tangible, knowable. She may talk bodies—but she never forgets about microscopes (2002:33).

II. Other People's Knowledge:

Validity, efficacy and ethics in medical anthropological research

Issues surrounding validity of non-Western medical treatments are multiple, as are the ways of approaching these issues. I begin by juxtaposing two positions that exemplify how a seemingly straightforward question about efficacy resolves into complexities that may ultimately be more illuminating than any tidy black and white answer.

Robert Anderson's bluntly titled essay, "The Efficacy of Ethnomedicine: Research Methods in Trouble" (1992) takes an impatient stance: why after all these years are we still in the dark? He writes, "As we attempt to give an anthropological perspective to traditional healing, it makes a difference in our overall interpretation of cultural dynamics whether or not a given treatment exerts a beneficial effect upon the natural course of the disease" (Anderson 1992: 13). Moreover, Anderson points out, while evidence of the anecdotal type steadily accumulates, research that tests it has often remained inadequate, right up to the present. Anderson seems to suggest that if researchers really wanted to know the truth about any indigenous medicinal practice's healing efficacy, they could simply design a test, conduct it, and settle the matter once and for all. His insistence appears naïve when we enter more fully into the worlds of healing practices.

Devisch and a team of co-authors attempt to describe some of the genuine complexities involved in any appreciation or assessment of such practices in their essay, subtitled, "Mediating the Realms of Healers and Physicians." They argue that:

There can be no one-sided thrusting of scientific (medical) criteria (originating from a written culture with a visual logic) upon the cult/folk healers to evaluate their fundamentally oral and even gestural way of gaining and transmitting therapeutic knowledge in the healing cults and folk practices. Each cult plays on the emotions, and engages the totality of sensorial corporeality, cosmology or life world (that is, beliefs and
In other words, while controlled experiments as recommended by Anderson might work to test, for example, a particular herbal compound's claims to settle stomachs or heal infections, such methods could not ever test the totality of subtle processes evoked by Devisch and his collaborators. Moreover, in the process of attempting tests, the delicate system on which success might depend could be fatally disrupted. Devisch et al. do not aim to romanticize, exoticize or otherwise valorize and isolate realms of traditional medicine. Rather, they wish to negotiate a pragmatic rapprochement between healing systems, a healthy pluralism. They observe that a "dialogue between healers and researchers" only becomes possible "due to a "mutual respect of the other's vocation" (2001: 135).

One of the points of contrast often posed between "local knowledge" and "scientific knowledge" in the literature on environment is a contrast between knowledge that is highly contextualized or situationally appropriate and knowledge that must above all be measured by its "generalizeability." A similar contrast is particularly salient in looking at the efficacy of medical practices. Barre Toelkin describes the bafflement of doctors in the face of Navajo healers' abilities to help Navajo patients emerge from comas more often than statistical chances would predict. This is a case where the medical establishment tacitly acknowledges efficacy, but makes no move to test or to reproduce it.

Doctors at the Indian Health Service hospital in Tuba City, Arizona, told me that they had started "allowing" Navajo chanters to visit patients in the hospital, in the hopes that hearing a trusted and familiar voice would make them feel more at home and relaxed. Indeed it did, and the doctors had a sense that healing rate and successful treatments had gone up. They were not prepared to discover one day that the chanters were also able to bring Navajos out of comas almost every time . . . . (Toelken 2001: 204).

To the doctors, the very nature of Navajo chanters' efficacy is seemingly impenetrable and evidently non-exportable. These chanters would not be able to perform the same miracles for patients who were not Navajo. Here is perhaps an anecdotal moment, of the type Anderson deplores, but which many fieldworkers and laypersons alike tend to enjoy. We like to hear about a victory of local knowledge; we like to see doctors baffled.
Sometimes, healing practices do leap across cultural boundaries. Sometimes even ethnographers get healed, and this may lead to more severe cognitive dissonance and other professional problems, as Brady points out.

But for investigators who accidentally or intentionally place themselves in the way of experiences that are uninterpretable within their native frameworks of understanding, the consequences of participant observation can demand not just an empathic grasp of the beliefs of others, but a radical transformation of one's own beliefs and understandings and a concomitant distance placed between the researcher and his or her constituency of colleagues and students (2001:11).

A few medical anthropologists have described such experiences; some jeopardize their academic reputations if they go too far in appreciating other people's healing systems.

Richard Katz's first book *Boiling Energy* is a classic ethnography of healing in Africa published by Harvard University Press (1982). Katz, whose African experiences convinced him of the validity of the Kalahari people's integrated healing methods, has found an appreciative audience outside academia even as he strives to make his research methods increasingly rigorous. His most recent book, *Healing Makes our Hearts Happy* is published not by Harvard but by Inner Traditions. Unfortunately, this has resulted in its exclusion from at least some university library collections; it appears in the holdings of neither Cornell nor Syracuse.

Glass-Coffin has written extensively and with unusual candor of her experiences working with Peruvian healers, and one female shaman in particular. She grapples helpfully if not conclusively with complex issues of knowledge validity (2001), as well as with the ethics of her relationship with her informant-healer-teacher. In Glass-Coffin's account we see where the "do no harm" first principle of anthropological ethics may be violated quite inadvertently by a well-meaning, sincere ethnographer.

Glass-Coffin describes a moment in 1988 when, while she was photographing sacred objects, "an amber-colored bottle that occupied a central space on the healing altar of my primary informant broke." The shaman learns in a subsequent visionary experience that the breakage "would shorten her life span by one-third" and exhorts the anthropologist to "make something of your life, so that this event, which has shortened my life and for which you were responsible, will not have been for nothing: (2001:101).
Isabel diagnoses the anthropologist herself as a victim of sorcery; and Glass-Coffin finds this expedient: "She always retained the power and the position of the healer. This suited me fine because it helped resolve for me some of the ethical dilemmas with shamanic research" (2003: 237). However, this resolution is only temporary. Although a "long and fruitful association" evolves between the two, their relationship becomes strained in 1998 when Glass-Coffin brings Isabel to an "International Forum on Indigenous Spirituality." At first it seems that this was a wonderful, empowering experience for Isabel. However, Glass-Coffin learns later to her distress that Isabel has been hexed by a jealous rival who has employed a photograph taken at the conference and a magazine article authored by Glass-Coffin also featuring her picture. Medical problems, biomedical mis-diagnosis, and healing rituals follow. And although all seems to end relatively well, Glass-Coffin's rueful reflections offer poignant warnings for what can go wrong. In her experiences with Isabel, more than one thing did. She believed that, "it is our responsibility to give our research subjects their own voice by writing their stories, but even more than this, by empowering them to speak for themselves. This stance requires careful brokering, to be sure, but is more ethical than gate-keeping" (2003:244).

Yet in facilitating the shaman Isabel's exposure to a broader public, Glass-Coffin has inadvertently brought about a series of results that Isabel herself explicitly judges to have been damaging. Glass-Coffin concludes, "As was painfully obvious in retrospect, my naive wish to empower Isabel by allowing her to stand-out and to speak-out as an equal in my world was not ethical at all. Instead it was at least unconsciously grounded in my desire to cleanse myself of the consequences of my research rather than to protect her in her world" (2003: 246). These are sobering reflections. Glass-Coffin does not prescribe a return to gate-keeping. Rather, she offers a humbling lesson not only in the slippage between intention and result, but even more troublingly between the ethical stories we tell ourselves and what may transpire in more complicated real life events.

There exist examples of less what may appear to be less ambiguous situations where researchers have helped to transact knowledge deals that beneficently recognize intellectual property rights in indigenous communities, while enabling exports. For example, Lewis, a biologist interested in "ethnopharmacology" details a complex agreement negotiated between an American university, two Peruvian universities, "clan organizations of certain Aguaruna indigenous people in northern Peru" and the American corporation Monsanto/Searle and

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Company. As Lewis describes the agreement, it recognizes that Aguaruna knowledge "represents a cultural legacy that needs to be wisely and responsibly used for the benefit of their people now and in the future" (2000:81). This sounds almost too good to be true; it would be useful to have some ethnographic testimony to how such agreements operate on the ground.

Ethically queasy issues related to efficacy also converge around intervention, and when it may or may not be appropriate. Gilbert Lewis, writing a new book based on thirty-year old fieldwork, speaks of the conflict in anthropology's paradoxical "participant observation" methodology when illness is the object of study. He writes:

I went with the intention of studying responses to illness in the community. Although I was medically qualified, my aim was to make a social-anthropological study in which I would seek to learn about the community's understanding of illness and treatment. What should I do, then, about treating them or giving them advice? The question had obvious practical implications for my research, as well as an ethical side (2000:14).

The lines between participation and intrusion, intervention and interference, are not always clear. Mark and Mimi Nichter, excellent fieldworkers, have argued that even when research is in the service of intervention, intervention without cultural sensitivity is hopeless. But are there limits to sensitivity? Researching "cultural notions of fertility" in Sri Lanka in 1974, the Nichters encounter a childless, middle-aged couple who have visited traditional practitioners as well as temples and medical doctors in their, thus far, fruitless quest for fertility. The two anthropologists learn, in separate confidential conversations with the husband and wife respectively, that "for seven years the couple had been engaging in coitus only for the first three days following the menstruation purification bath." The pair, it emerges, were convinced that by refraining from intercourse during the rest of the month, the vital part of the husband's semen would be strengthened and the wife's overly hot body cooled. Thus she would have a better chance of conceiving during the days they considered to be most fertile (Nichter and Nichter 1989: 8).

The rest of the chapter takes off from this anecdote to expand on ideas in and beyond South Asia about women's fertile days. Using the technique of "metaphorical interviewing" the authors evoke beautiful images of the "womb as like a flower" most open to conception "during and following menstruation." This article is a pleasure to read. Moreover, it is intended to have "applied" consequences in terms of recommendations for family planning programs. But I kept
waiting for the writers to return to the unhappy childless couple, for a hint that one of them might have whispered to one of this pair that they ought to try having intercourse at a different time of the month! Unless I missed a footnote somewhere, this never transpired, at least not on the record. And in spite of my strong predisposition to sustain the adage of my graduate training that "the informant is always right," I felt an ethical let-down. Here we may see anthropology at work, revealing exquisite cultural poetics of a view of physiological processes that our high school biology books convince us is wrong. Yet what would happen to the poetics of wombs like open flowers if the researchers had intervened?

Frederique Marglin's critique of the campaign to eradicate smallpox in India stirs up related ethical quandaries – albeit after the fact -- in what would seem a most extreme case: the elimination of a horrible affliction. As we know, this campaign was successful, but Marglin nonetheless deplores the militaristic nature of its language and strategies: "The non-ecological, monocausal approach to disease leads to a policy of eradication" (1990: 122). She documents effectively the ways the campaign totally disregarded preexisting indigenous practices of inoculation (variolation) that were embedded in the worship of the goddess Sitala. Marglin certainly never takes a position against the eradication of smallpox, but nonetheless she is bold enough to criticize the ways this medical assault constituted a kind of preemptive symbolic violence. Marglin's position is strongly condemned by philosopher Martha Nussbaum as an "assault on universalism"; Nussbaum seems fairly appalled that anyone would ever even think about cultural sensitivity when universal health criteria were at stake (1995: 64-72). She cannot appreciate Marglin's nuanced ethnographic description of the indigenous knowledge and ritual practices over which the World Health Organization ran roughshod.

Issues of context-sensitive moralities versus universal ethics also emerge in the new literature on bioethics, a fertile field for anthropologists and one that is beyond my present scope. I would just point to a convergence of this field with broader research ethics issues. As Marshall and Koenig put it:

The bottom-up approach of cultural interpretation, situating the moral dimensions of care in local ethical practices, is antithetical to the universalizing discourses of both basic science—which assumes that scientific rules and principles can be applied successfully to human bodies in all times and places—and to the universalizing discourse of the most dominant traditions in philosophy . . . which define a good ethical theory as one that can
produce "objective" results, an "ideal observer" approach that yields rational standards by which to judge cultures, irrespective of their history or locality (1996:350). They report that "As medical anthropologists working in bioethics, we toil in environments where we are constantly uncomfortable" (1996: 350). Still, they and others also find these challenges and disciplinary stretches highly worthwhile (see also Kleinman 1995:41-67).

Whyte, van der Geest and Hardon contrast two common approaches to research and interpretation in medical anthropology. One favors an ethnography that richly describes "the situated concerns of particular people using specific medicines for the problems they think are pressing." The authors label this approach – where Marglin might fit -- "populist." They call the starkly contrasting stance "enlightened" and describe it as one which "reveals people's knowledge of medicines as inadequate; their medication practices as irrational . . . ." This is where Nussbaum would doubtless be willing to take her stand. Whyte and co-authors point out that much applied anthropology takes an "enlightened" position, almost of necessity, but they add that "a critical version of the 'enlightened' position problematizes the knowledge and practice of both specialists and lay people" (2002:167).

Finally, thankfully, Whyte, van der Geest and Hardon suggest a third mediating possibility. This third offers a working, ad hoc attitude toward efficacy and many other things. They label it, appropriately, "pragmatic."

It emphasizes the participation part of participant observation, and takes applied research as an opportunity both to work for limited change and to create knowledge through practical grappling with problems. The attraction of this position is that it is contingent and processual: it is oriented to the 'truths' of a given situation as they happen over time (2002: 169).

In concluding this section, I observe that issues of local knowledge and its validity evidently play extremely critical roles in environmental health research (Bradford and Gwynne 1995; Williams 1998; Minkler and Wallerstein 2003). Brown (2002), Wing (2002) and many other participants in the Research Ethics project have written powerfully about this. Schepers-Hughes (2002) points to the medical establishment's "denial of poor people's fears" in the particular context of organ transplants, but this denial has broad relevance in multiple health contexts. Moreover, in the case of environmental health issues, often involving legal judgments, corporate culpability and financial settlements, the stakes are much higher than those
anthropologists usually encounter in contemplating ethical dilemmas. Here the implications of local knowledge's validity may extend to social justice at national and international levels.

III. Suffering, embodiment, listening, and action

A number of scholars argue that medical anthropology is of a different order from other anthropologies for reasons that are not just ethical but visceral; or to put it another way, they claim research ethics in medical anthropology emerge from embodiment as a human universal. To observe fellow humans suffering cannot be from a detached position. Judith Farquhar portrays this as a recursive move, a return to the familiar via the strange: "What is it we ethnographers learn when we join others as participants and observers in everyday lives previously unfamiliar to us? Must we historians and anthropologists reconsider our own carnal existence" (2002: 289).

Rhodes makes a similar point:

. . . the vulnerability of self, body, and society to illness engages us, to a greater or lesser extent depending on context and inclination, in the same problem faced by clinicians: the need to act, to provide useful understanding or in some other way to contribute to the alleviation of suffering (1996:176-177).

Whyte, van der Geest and Hardon also stress that other people's systems of healing are "not simply data to be analyzed," but inevitably engender some kind of desire for engagement in the observer (2002: 166).

In her earlier ethnography, Whyte offered a biting critique of an anthropology capable of evading this kind of ethical imperative to pursue a detached symbolic analysis:

We skip quickly over morbidity and mortality figures, if we have them at all. We describe healing rituals, and the effectiveness of symbols, without going back three weeks later to learn how the patient is doing. We are entranced by the logic of ritual, the form, the assertions, but we tend to ignore the logic of affliction when it resists efforts to shape it (1997: 21).

She implies that this kind of detachment would be premised on a "hit and run" type of fieldwork (and I recollect my haste to depart from Kuchalwara Mataji). While Whyte does not take a superior, "enlightened" attitude, she does advocate moderate intervention as an ethical necessity.
In this she draws conceptually upon William James and John Dewey, proposing an approach grounded in "meliorism" -- or the possibility of improvement (1997:232).

One promising ethical prospect emerging in the context of witnessed suffering is what Frank calls an "ethics of listening." Frank is a sociologist whose own experience of critical illness informs his research on sickness and narrative. He writes of the need for storytelling by the sick, its importance and its ethical nature. Frank asserts:

One of our most difficult duties as human beings is to listen to the voices of those who suffer. The voices of the ill are easy to ignore, because these voices are often faltering in tone and mixed in message, particularly in their spoken form before some editor has rendered them fit for reading by the healthy. These voices bespeak conditions of embodiment that most of us would rather forget our own vulnerability to. Listening is hard, but it is also a fundamental moral act; to realize the best potential in postmodern times requires an ethics of listening (1995: 25).

The ethics of listening emerge from the vulnerability of embodiment – a shared human characteristic.

One of the most compelling, articulate and honest voices in medical anthropology is that of Paul Farmer who is himself a practicing physician and activist, and a gifted writer. As do Scheper-Hughes and others, Farmer speaks not just of empathy but of advocacy in the anthropology of suffering. In his 1992 book on AIDS Farmer writes of a "focus on experience and insights of those who are afflicted." He tells us that "Listening to these stories offers us privileged insight into what it means to be sick and poor and aware of the causes of their suffering" (1992: 262).

In his recent book Farmer states powerfully, "no matter how great the pain of bearing witness, it will never be as great as the pain of those who endure, whether in silence or with cries, the indignities described in these pages" (2003:28). Farmer finds witnessing and listening entail a moral obligation to work for public health and social justice. Farmer is a listener who has also become a storyteller – one whose eloquence reaches a readership beyond academia. Here again I see convergence with community health research, and the stress there on listening to local stories, and helping to make them more audible -- even when, or especially when, the powers that be deny their validity. Such an ethics of listening and retelling links directly with the earlier discussion of respect for knowledge that cannot necessarily be verified.
Lock and Scheper-Hughes effectively capture the measured but passionate move from observation and analysis to engagement and action that seems to lie at the heart of medical anthropology's ethical practices (and dilemmas). I therefore use their words to conclude this brief inquiry:

Metaphorically, flights of fancy come crashing down in the face of the anguish and pain that often surround birth, illness, and death. The relationship between theory and practice takes on special meaning in such a context. The medical anthropologist is repeatedly studying situations where drama is commonplace and action deemed imperative. Hence the work of the medical anthropologist rarely stops at an ethnographic description of medical theories and practice but extends willy-nilly into the world of decision making and action" (1996:44).
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