

# Examining biomedicine

## On distancing and visibility

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A major goal of *MAT* was to provide a forum for ongoing and emerging debates that mobilize the social sciences and humanities to address issues raised by the global expansion of biomedical ideas and technologies. As medical anthropologists outside of the United States, we were struck by both the dominance of US-based scholarship and its growing isolation from a larger pool of engaged thinking that it rarely acknowledged. The lack of engagement with scholarship from outside the United States was justified by the prevailing assumption that theoretical debate and innovation was unlikely to come from scholars whose work was more ‘applied’ and therefore beholden to a dominant biomedical epistemology.

We were acutely aware that most medical anthropology journals were rarely read or even known where we work in Africa, Asia, and the Middle East. Most practitioners and activists we worked with did not perceive academic medical anthropology to be relevant to their struggles. For instance, the paucity of medical anthropology scholarship on the massive humanitarian, political, and ecological catastrophe wrought by the ongoing conflict in the Middle East is perhaps the most striking – and perhaps not surprising – example, given the close relations between powerful US academic anthropologists and US foreign policy and international aid institutions. Relatively little attention to the urgent challenges of global health efforts, digital firewalls, and at times hermetic prose kept many readers and ‘organic intellectuals’ at bay. Producing an open-access, readable, and visually engaging journal, we hoped, would help to break down both material and academic walls and promote theorizing from outside the dominant Anglo-American academy.

With this, our seventh issue, it is clear that *MAT* has indeed become a venue for theoretically productive, empirical, and engaged scholarship in and of biomedicine around the globe. This issue continues ethnographic engagements with biomedicine and histories of biomedical technologies to bring forth strong thematic oppositions that can be glossed as visibility/invisibility and distance/intimacy. Perhaps the clearest statement of the stakes comes from Cinzia Greco's discussion of the ethical and epistemological contradictions that emerge when 'activism' is viewed as antithetical to science: as Greco points out, distancing is a way of making invisible. Before returning to these thematic oppositions, we propose to briefly frame how anthropologists have constituted biomedicine as an object for empirical scrutiny and theoretical production.

Conceptually, anthropological studies of biomedicine trace their genealogy to E. E. Evans-Pritchard's seminal study of witchcraft (1937), which demonstrated the rationality of witchcraft as a system for managing misfortune, and established a comparative framework for the anthropology of medical systems, including biomedicine: the 'modern' form of medicine that emerged with the rise of the modern state. Several articles in this issue complicate a simple narrative that links biomedicine and (European) state formation. A powerful alternative narrative emerges from Alexander Friedrich and Stefan Höhne's important theoretical article, translated from the German for this issue's 'Found in Translation' section, which argues that a key infrastructure of the biopolitical state is the ability to cool, and therefore slow, life itself – what the authors call the *Frischeregime*. The refrigeration of blood, tissues, cells, embryos, and so on equips the invisible, deep infrastructure of biomedicine as a regime for managing the very substance of vitality. The state–biomedicine nexus is also complicated by Gaurav Datta's essay, which uses audio recordings and photography to document a Catholic HIV clinic for terminally ill patients, a regime of pastoral power as yet unarticulated to that of the state. More generally, these photos evoke and thereby add to other ethnographic works that examine what happens when biomedicine and regimes of clinical care function untethered to a functioning state apparatus.

The theme of visibility is present not only in Datta's audiovisual essay, but also runs through the article by Sara Offersen and colleagues, the reviews of Salmaan Keshavjee's *Blind Spot*, Francesca Cancelliere's review of the translation of Hervé Guibert's important AIDS memoir *Cytomegalovirus*, and Gabriel Girard's exploration of the traces AIDS has left on Montreal's urban landscape. These concerns with visibility and biomedicine bring us back to Michel Foucault's argument in *The Birth of the Clinic*. The 'clinical gaze', he argued, was formed in the nineteenth century with the conjunction of hospital-based medicine, social welfare systems that concentrated (largely poor) patients in hospitals, structured observations of patients and the lessons discovered at autopsy, and laboratory-based investigations of disease states (Foucault [1963] 2003). Foucault's thesis pointed to the structures of

intelligibility – what he would later theorize as *episteme* – that emerge from the clinic and constitute it as a centre of authorization. By ‘authorization’ here we refer to practices that produce authoritative knowledge, that produce authors of narratives (the subjectivities of patients and physicians), and that allow transactions to occur through systems of commensurability, as in when blood is extracted and exchanged for knowledge in the form of blood tests or clinical trial data. The pieces in this issue point to the work of authorization that continues to spill forth from the clinic, embedding itself in subjectivities (Offersen et al.), economic regimes (Glabau, Keshavjee), built environments (Borgstrom, Datta, Girard), and memories (Cancelliere, Girard). These pieces also contribute to destabilizing the assumed continuum between ‘normal’ and ‘pathological’ (Canguilhem 1972) that informs biomedical thinking. Structured observations of populations through epidemiological research, the growth of a vast pharmaco-therapeutic industry, and biotechnologies were added onto the structure of biomedicine resulting in ‘biomedical platforms’ spanning laboratories, clinics, and populations. The paper by Offersen and colleagues on the potentiality of bodily symptoms shows how the clinical gaze is internalized and experienced by ‘ordinary’ Danes, as bodily changes evoke potential future pathologies.

‘Medicalisation’ refers to the reframing of social problems in medical terms, and the gradual processes of normalisation and social control that result (Conrad 1992). More recently, ‘biomedicalisation’ has been introduced to account for how advances in biomedical knowledge about molecular processes and epidemiological outcomes have introduced powerful linkages between genes, behaviour, and risk (Clarke et al., 2003). In this view, control and normalisation have been replaced by the ways in which individuals govern themselves in order to achieve health. Theoretically, these concepts mark a shift from Erving Goffman’s sociological theories to those of Foucault, notably his theory of biopower. Biopower spans two poles: that of techniques for disciplining the body and that of techniques disseminated more broadly through the modern state’s attempt to foster healthy populations through public policy and infrastructure. Biomedicine stitches these two poles together, most tightly in the arena of reproduction and sexuality, but more generally in the application of biomedical knowledge to prevention and care. Gaps remain between these sutures, as Kim Sue’s investigation into the diagnosis of ‘failure to thrive’ explores. What these gaps show, the author argues, is the powerful hold the state continues to have over life and death, and how it produces resistances captured and labelled as ‘FTT’. Erica Borgstrom’s photo essay on hospices and the ‘#notdingy’ campaign in the United Kingdom also captures a moment of resistance, in this case against the assumption that hospice care is equivalent to abandonment and decay.

While the ‘bio’ in ‘biomedicine’ refers to biology as the frame through which health is to be understood, in ‘biopower’ the ‘bio’ refers to the attempt to exercise power through the

government of bodies and populations. Paul Rabinow (1992) introduced the influential concept of ‘biosociality’, which initially referred to the emergence of social relations around biological self-understanding but has been applied more broadly to highlight biomedical forms of social relations. In this vein, notions of biological or biomedical citizenship have been used to examine how patient groups make claims on the state, NGOs, and the international community, while leaving unquestioned the ‘biological’ as an organizing concept (Fassin 2006). More recently, the concept of biocapital has provided an analytical framework to account for the growing role of biotechnologies in biomedicine (Rajan 2006). ‘Biocapital’ therefore refers to the political and economic arrangements that have made it possible to manipulate living substances such as cell lines, ova, and genes to produce value, notably through the exchange of commodities. The related concept of bioavailability points to how populations are made available for harvesting of living substances such as organs for transplant (Cohen 2005). Miriam Waltz and Fiona Ross’s examination of the nodes through which breast milk is channelled as therapeutic substance, commodity, and gift in a large public South African hospital highlights how the circulation of living substances challenges moral categories. Maternal milk is unlike cell lines or tissue cultures in that it embodies a profoundly intimate relationship, yet here it circulates impersonally, through tubes and machines. A similar conundrum exists in the tensions generated by the imperative to prevent serious allergic reactions by equipping those with food allergies with expensive devices (‘Epipens’) that inject adrenaline in the event of a reaction. This issue shows the power of biomedical technologies to confuse distance and intimacy, care and management.

We are grateful for the quality of the scholarship that continues to be submitted to *MAT* and for the thoughtful and extensive feedback provided by our external peer reviewers. A special thanks is reserved for Jenna Grant, who is stepping down as section editor of Book and Film Reviews, and we extend a warm welcome to Rita Isabel Henderson from the University of Calgary, who joins our team as incoming editor of that section. Finally, we would like to acknowledge once again the tremendous support we have received from our host institutions, the University of Amsterdam and the Graduate Institute in Geneva.

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