Abstracts zu Workshop 13

Appropriation of Medical Technologies: Local Moral Worlds and Socio-technical Change within Biomedicine

Organisation: Bernhard Hadolt, Viola Hörbst und Babette Müller-Rockstroh

Marcia C. Inhorn, Yale University, (keynote lecture)

Globalization and Gametes: Reproductive Tourism, Islamic Bioethics, and Middle Eastern Modernity

Since the beginning of the new millennium, media reports have highlighted the growing global phenomenon of "medical tourism," or the movement of individuals across national and international borders for the purposes of medical care. Within this realm, "reproductive tourism" has been defined as "the traveling by candidate service recipients from one institution, jurisdiction or country where treatment is not available to another institution, jurisdiction or country where they can obtain the kind of medically assisted reproduction they desire" (Pennings 2002, p. 337).

Scholars who are beginning to theorize the relationship between nation-states, reproductive tourism, and global reproductive rights suggest that the causes of such transnational tourism may be manifold. Seven discrete, but often interrelated, factors promoting reproductive tourism have been cited in the existing literature: 1) individual countries may prohibit a specific service for religious or ethical reasons; 2) a specific service may be unavailable because of lack of expertise or equipment; 3) a service may be unavailable because it is not considered sufficiently safe or its risks are unknown; 4) certain categories of individuals may not receive a service, especially at public expense, on the basis of age, marital status, or sexual orientation; 5) certain individuals may have personal wishes for privacy; 6) services may involve shortages and waiting lists; and 7) finally, services may simply be cheaper in other countries. This presentation highlights empirical research on reproductive tourism undertaken over the past 20 years—and especially since 2003—in a variety of Muslim-dominant Middle Eastern societies. A "high-modern" Middle Eastern assisted reproductive industry is flourishing, largely as a result of permissive Islamic *fatwa*s allowing in vitro fertilization to be performed in overcoming intractable infertility. However, reproductive tourism in the Middle East is deeply inflected by local moral attitudes toward science, technology, and medicine, particularly varying Sunni and Shia bioethical approaches to the donation of human gametes. Furthermore, these varying bioethical stances on gamete donation have tremendous implications for modern marriage, kinship, and gender relations, as will be shown in a series of case studies of infertile Muslim couples.

Josiane Carine Tantchou Yakam, Marc-Eric Gruénais, Observatoire Régional de la Santé (PACA), Marseille

Blurring boundaries: the appropriation of the operating theatre and surgical equipment in the context of a health system crisis

Ethnographic literature on operating theatres and surgical practice are rare. Cassel (1986; 1987) examined the personality traits and the standardized emotional stances which a surgeon's work requires. Pearl Katz (1981) analysed sterility procedures as rituals which contribute to the technical functioning and efficacy of surgical procedures by clarifying the categories "clean" and "dirty". Stephan Hirschauer (1991) presented surgical operations as encounters of two disciplined bodies and the process of anesthesia as procedure by which bodies are made operable. In this paper, we put Katz's and Hirschauer's analyses into perspective within the context of a health system crisis.

Data were collected as part of a research project to study health worker "burnout" and its impact on care for people living with HIV/AIDS. For five months, we conducted observations and interviews in a major public hospital of the North Province of Cameroon. With the hospital administration and chief surgeon's agreement, we followed the surgical team in daily hospital rounds, attended the chief surgeon's consultations and all the surgical operations performed. We produced a daily account of these observations in a "surgery service journal". These served as a basis for formal and informal interviews which were recorded and transcribed verbatim. The paper provides an analysis of the material.

We show that in the context of a health system crisis, the boundaries of "clean" and "dirty", "sterile" and "non sterile" blur; restrictions which make the operating theatre a space to be maintained sterile vanish, the operating theatre trivialised. We show that the production of bodies which takes place before surgical procedures begin, enables a new type of relationship between the bodies involved. We finally pointed out the importance of the team capacity to adapt to this context of crisis.

Hanna Kienzler, McGill University

War trauma and psychiatric intervention in the Kosovar context

The war in Kosovo brought, once more, international attention to the gendered aspects of war crimes and traumatic experiences. Serbian forces killed, tortured, and kidnapped a vast number of Kosovar Albanian men and used rape as a tool of political terror on women. According to several researchers, the prevalence of psychiatric symptoms and rates of Posttraumatic Stress Disorder (PTSD) among Kosovar Albanians are high and impair their current social functioning and wellbeing. Due to these findings, a variety of different Western psychiatric intervention strategies and programs were imported as well as developed on-site. The international trauma mental health movement arrived at the Balkans largely in form of "trauma training". Programs were set up to train local psychiatrists and general practitioners to lead support groups, to conduct psychological interviews, to systematically administer clinical evaluation tools such as diagnostic scales, checklists, and protocols to identify patients who

require further treatment, to provide adequate psychosocial- and pharmacotherapies, etc.

Retrospectively, however, critiques argue that although traumatic stress and mental health knowledge were applied widely and enthusiastically, the outcomes were not always beneficial, and that international psychosocial intervention programs have the tendency to construct war-affected populations as traumatized, psychologically scarred, emotionally damaged, hopeless, or brutalized, and, thus, vengeful enough to start a new cycle of violence. Furthermore, evaluations of psychological interventions for rape victims in Kosovo identify problems of insensitive and inappropriate trauma work and highlight the need to understand the 'multiple' traumas women suffer in war. It is, thus, argued that mainstream Western psychiatry is insufficient to explain and treat trauma cross-culturally. This paper is based on my ethnographic fieldwork in Kosovo and focuses on the question of how Kosovo Albanian general practitioners and psychiatrists employ, adapt and change the psychiatric tools and lessons learned during the trauma trainings in order to render them meaningful to their local cultural context to better understand biological processes; embodied experiences of injury, pain, and fear; and narratives of personal biography.

Claudia Lang, Eva Jansen, Institute of Social and Cultural Anthropology, LMU Munich

Glocalizing depression in an ayurvedic mental hospital in Kerala, India

In the past ten years or so, the idea of depression has gained enormously in importance both socially and in the field of health care politics. Yet the embodiment of what biomedicine calls "depression" differs enormously within different local contexts in terms of identifying and experiencing the symptoms, interpreting them and explaining possible causes, and also with regard to social consequences and treatment practices.

Using the case of depression we show how a biomedical concept and related technologies of diagnosis and treatment are appropriated and transformed in an ayurvedic mental hospital. In this paper we will address the following questions: How are diagnostic tools like DSM-IV or ICD-10 appropriated and hybridized with local diagnostic practices, nosologies and etiologies of depression or related categories? How are psychiatric concepts of mind and body as well as of illness/disease and health translated into ayurvedic ones? How are antidepressant pharmaceuticals and practices of psychotherapy integrated within ayurvedic treatment practices of mental problems that basically aim at purifying the body?

In this paper we will give a progress report based on the first period of our field research in an ayurvedic mental hospital in Kerala, India, from June to September 2009.

Stefan Ecks, Social Anthropology, University of Edinburgh:

Unseen dissemination: Antidepressants in India

What is "new" in "new medical technologies"? The newness of medical artefacts, diagnostic procedures, and treatment protocols has both temporal and spatial dimensions. For a technology to be "new," it has to be novel in relation to what technologies were *previously* available in a particular *location*. This spatial-temporal entanglement explains why anthropological studies of "new" medical technologies do not only look at the local introduction of innovative, fresh-from-the-lab artefacts, but also the transmission of older medical artefacts into contexts where they had not been used previously (for example, the transmission of Indian Ayurvedic drugs to pharmacies in Europe or North America). The story of "newness" that anthropologists encounter is nearly always one where a technology was unequivocally *not* available in a location before, and where the introduction of a technology can be dated with reasonable precision. This paper explores a different situation: what if a medical artefact that is supposedly "new" in a particular location had already been long in use there? The case described here is that of SSRI antidepressant drugs in India. Over the past few years, the World Health Organization, among other major authorities, has been propagating that there is a big "treatment gap" for depression between developed and developing countries. The WHO is urging that governments and donor organizations need to invest far more money to make psychopharmaceuticals available in low-income countries. The WHO campaign for closing the "treatment gap" is, basically, a campaign to transfer an existing medical artefact (SSRI antidepressants) to a different location (South Asia). The urgency of the campaign comes from the supposed "newness" of the drugs in South Asia. But this sits oddly with the fact that there are already hundreds of brands of SSRI antidepressants manufactured and sold in India. It sits oddly with findings that SSRIs are more easily available from even remote village shops than many antibiotics. And it sits oddly with ethnographic findings that Indian GPs and even untrained "quack" doctors are routinely prescribing antidepressants to their patients. Based on data from the collaborative research project "Tracing Pharmaceuticals in South Asia" (2006-2009), this paper ask how the creation of "newness" of medical artefacts must itself be investigated as a peculiar socio-economic process.

Payam Abrishami, Medical Anthropology Unit, Faculty of Social and Behavioral Sciences, University of Amsterdam:

Contribution, Challenge, or Threat? Dutch Psychiatrists' Attitudes towards Pharmaceutical Promotion

<u>Introduction:</u> This qualitative study seeks to contextualize the interaction between psychiatrists and pharmaceutical promotion and to describe how they perceive the influence of pharmaceutical promotion.

<u>Method:</u> 26 Dutch psychiatrists, residents included, were selected based on a purposive sampling method with an acceptable diversity in age, gender, setting of practice, and years of experience. They were interviewed using an in-depth semi-structured technique. The respondents' accounts were then analyzed in accordance with a critical theoretical perspective in medical anthropology.

Findings: Pharmaceutical promotion often appeals to the psychiatrists' unconscious selves, influencing their decisions and prioritizations in prescribing. Promotional strategies to differentiate a new product are reported to be extremely diverse, innovative, and often intense. Rational prescription is viewed as maintaining a proper combination of introspection, knowledge, and criticality towards the 'why−ness' of prescribing medicines. However, psychiatrists believe that uncritical colleagues are dominant.

Pharmaceutical promotion is seen ambiguous due to the unclear border between science and commerce in its very nature. A conflict of interest due to this ambiguity is perceived but conceptualized differently. Conservative psychiatrists view it as a threat to the code of professional conduct, thus hesitate to interact with the industry while those who call themselves 'liberal' emphasize the inevitability of being influenced, thus keep a cautious communication.

Psychopharmaceuticals are generally viewed as not clinically-effective enough. The contingent effectiveness of pills leads to an ongoing hope for more effective medicines to emerge rather than a skeptical though toward the existing ones. Simultaneously, the inherent "newer−is−better" mindset reinforces that perception. New medicines, whose effectiveness is still questionable, are believed to be promoted with claimed fewer side effects or with hyping the misery of side effects of the existing alternatives.

Conclusion: The extent of the influence of pharmaceutical promotion has been progressively moving beyond compelling advertisements. Whether this influence is conceptualized as a contribution, challenge, or threat to psychiatric practice, a "slight paranoia" derived from the critical scrutiny of the dynamics of promotion is seen reasonable to prevent inappropriate prescribing.