'Medicine in context'
An epistemological trajectory

Hansjörg Dilger and Bernhard Hadolt

What is the role of medical anthropology in a globalized world that is becoming increasingly complex and interconnected? Where does the defining domain of our subdiscipline begin and end with regard to our 'classical' objects of study such as 'medicine', 'health system(s)', and 'the body', and how is it possible to decide what constitutes the anthropologically relevant 'context' of these (empirically defined) research fields? How can we open the horizons of the subdisciplines of social and cultural anthropology to medical anthropology, and to what extent do the demarcations between medical anthropology and other areas of the discipline that deal with politics, economics, law, science, religion, and urban environments even make sense? Where do the inter- and transdisciplinary junctions emerge that can provide for general reflections about the themes, challenges, and positions of medical anthropology in an interconnected world?

These were the questions occupying our minds as we prepared for the conference 'Medicine in Context: Illness and Health in an Interconnected World', organized in 2007 by the Work Group Medical Anthropology within the German Anthropological Association on the occasion of its tenth anniversary. The following text forms the introduction to the anthology of the same name (Dilger and Hadolt 2010), which was published under our oversight as the

then chairs of the work group. It recapitulates some of the abovementioned questions based on the contributions to the conference and the ensuing discussions that took place.

The anthology is an important milestone in the establishment of the still-young subdiscipline in the (predominantly) German-speaking region,[1] which especially in Germany is closely interwoven with the history of the Work Group Medical Anthropology. After the group had published its first collections of medical anthropological research in the German-speaking countries in 2003 and 2004 (Wolf and Hörbst 2003; Wolf 2004), the conference 'Medicine in Context' identified central fields of the work group's members' research along five thematic clusters, namely: new technologies and medical practice, migration and medicine in transnational interrelationships, 'traditional medicine' as a strategic resource, social security and health financing, and urbanization – a threat to health? In considering the questions outlined above, the anthology and its introduction also served to articulate a programmatic outline regarding the 'whereto' of medical anthropology in the German-speaking domain.

The history of medical anthropology in Germany, Switzerland, and Austria is heterogeneous and not exclusively linked to the Work Group Medical Anthropology, but characterized by specific, and often more long-term, trajectories in each of the three countries. Medical anthropology has been firmly established in Switzerland since 1992, primarily through the activities of Medical Anthropology Switzerland, a subsection of the Swiss Ethnological Society, but also thanks to the extensive research carried out in the different (German-, French-, and Italian-speaking) universities independently (Van Eeuwijk 2012). In Austria, the subdiscipline has been formed by the efforts of individual scholars (Hadolt 2012) as well as the Österreichische Ethnomedizinische Gesellschaft (see Kutalek, Münzenmeier, and Prinz 2012), which was distinguished by its interdisciplinary orientation and furthermore had a close cooperation with the Arbeitsgemeinschaft Ethnomedizin (AGEM) in Germany. The AGEM was founded in 1970 and has been publishing the internationally renowned journal *Curare* since 1978.

The history of ethnomedicine eventually became a determining factor in the 1997 foundation of the Work Group Medical Anthropology as a part of the German

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1   It needs to be emphasized here that especially in Switzerland, there are also significant traditions of French- and Italian-speaking medical anthropology that are partly oriented towards the French- and the Romanic-speaking world. The highly diverse development of medical anthropology in Switzerland, Austria, and Germany – and the relations between different, partly linguistically shaped strands of research and thought in the field – cannot be covered in this introductory text. This history was also not the focus of the introduction to *Medicine in Context*, published here for the first time in English.

Anthropological Association. Since its formation, the group has included members from all three countries (Dilger 2012). From the beginning, this network of then young scholars mainly consisted of students, doctoral candidates, and postdoctoral researchers, though today it counts tenured professors and lecturers among its members as well. Its formation was primarily motivated by the wish to establish an explicit platform within the internationally oriented field of social and cultural anthropology. In opposition to ethnomedicine and its evidently personal, institutional, and content-related intersections with medicine, medical history, and psychiatry, the objective of the group was to create a firm base for the consideration of medicine- and health-related phenomena based on anthropological theories and methods. Another purpose of the work group was to promote the institutionalization of medical anthropology in universities and academic research institutions, and thus to achieve a solid embedding of the subdiscipline with regard to research and education within the field of social and cultural anthropology.

By setting these early agendas, a basis for the further development of medical anthropology in the German-speaking domain was instituted, and to this day the subdiscipline is chiefly characterized by its proximity to other subdivisions of social and cultural anthropology such as the anthropology of religion, kinship, politics, gender, migration, as well as science and technology. From the beginning, this position additionally caused medical anthropology in the German-speaking domain to be less clearly defined with regard to its object of study than, for instance, its counterpart in the English-speaking realm, which, especially in its formative years, focused on health behaviours, medical systems, and medical pluralism.

Over the last decades, medical anthropologists in Switzerland, Austria, and Germany have framed their work in dialogue with each other, as well as with a global network of scholars exchanging ideas and concepts from the larger field of medical anthropology. Young (and more senior) scholars today are participating in international workshops and conferences – in Europe and beyond – and also publish their research in international journals, edited volumes, and other publications, thus deliberately addressing a non-German-speaking readership. At the same time, however, regional networks continue to be important for scholars in all stages of their careers, as they provide an important opportunity to discuss 'locally' prevailing theoretical and methodological ideas (that are often framed beyond the field of medical anthropology), as well as institutional developments and professional opportunities in the region. With the aim of fostering such an exchange, representatives of the regional networks are currently preparing an international conference that is going to take place in 2017 and will discuss current and future research perspectives among medical anthropologists in Switzerland, Austria, and Germany.

How the field of medical anthropology in (mostly) German-speaking countries will continue to develop in the years ahead, and what the contribution of the volume *Medicine in Context*

will mean in this regard, is yet to be seen. For us as editors of the anthology, the publishing of its translated introduction in *Medicine Anthropology Theory* is a welcome opportunity to make the specific discussions of German-speaking medical anthropology more accessible to an international readership. Accordingly, it is our hope that it will have an influence on the international debates of the field, too.

A formal note to the translated text: references in the original German text that point to chapters published in the anthology *Medizin im Kontext* have been updated to the corresponding sources in the bibliography of the English translation. Likewise, texts referred to in the original that were unpublished in 2010 have been updated with their current bibliographical data.

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Medicine *in* context
Towards a social and cultural anthropology of medicine(s) in an interconnected world

Hansjörg Dilger and Berhard Hadolt

In the context of a transnational and globally connected world, medical knowledge and practices are subject to continuous changes. Transformations in collective and individual responses to illness and health, partly influenced by demographic and epidemiological shifts, are often negotiated across regional, cultural, and social boundaries, and political and

economic forces structure the transfer of medical concepts and technologies, as well as *materia medica*. Furthermore, the increased individual mobility of both patients and health care professionals within a context of migration and displacement is changing medical practices and knowledge. Medical tourism and mobile health care experts challenge the 'closed nature' of medical systems, and thus renegotiate the medical, religious, and ethical foundations of regionally developed treatments and cures. Finally, the gradual dismantling of public health care systems and the subsequent reallocation of global, national, and communal resources cause transformations in the field of medicine and health care. In many places these processes lead to a diversification and alteration of prioritization and implementation strategies in both governmental and nongovernmental politics of health and the body.

The present volume presents a number of different thematic fields, which each in their way demonstrate just how profound current shifts are in terms of how medical anthropologists deal with and think about health and illness in a globalizing world. The collected contributions not only cover the circulation and appropriation of medical technologies in the context of globalization or the question of health behaviour and medical practices in relation to migration. They also address the worldwide politicization of 'traditional' medicine and associated identity politics; local and transnational concepts and practices in the domain of social security, and, consequently, the financing and introduction of health care insurance systems; and, finally, how medical anthropologists conceptualize the social processes and configurations of rapid urbanization. Collectively, these contributions are intended to stimulate a discussion about the challenges that medical anthropology will face in the coming years against the backdrop of ever-expanding global and transnational networks, and in terms of the developments that these shifts will bring about for the theoretical, methodological, and ethical positions of the field (see Hörbst and Krause 2004; Wolf 2004; Wolf, Sommerfeld, and Ecks 2007).

On a different level, this book is intended as a contribution to the discussion of the concepts of 'medicine' and 'context'. Both play an essential role in the discipline of medical anthropology, and it is our firm belief that their specific and mutually constitutive interconnections have yet to be discussed exhaustively. Starting with a look at the recent influenza outbreaks in Asia (Kleinman et al. 2008), this introduction proceeds with a discussion of the terms 'medicine' and 'medical practices'. Our focus on these terms reflects

a shift in recent debates about 'medical anthropology',[2] while simultaneously calling for the comprehensive study of how problems associated with illness and health are related to social processes and their implicated power structures. We then continue with a comprehensive consideration of the concept of 'context' and its significance for medical anthropological research against the backdrop of globalization. We argue that in a globalized world, it is not only necessary to consider the emerging phenomena relating directly to medicine and social constellations (for example, technical innovations and new methods of distributing medical services, urban health, migration and health, and the introduction of health insurance plans), which are important for the analysis of illness and health in an interconnected world. There is also a need to establish a thorough understanding of the different social processes and configurations in which sociopolitical constellations and practices (such as health institutions, cities, family-based or religious forms of community and cure, and globalized forms of health policies) are constructed or differentiated with regard to the presence of medically defined risks and problems – as well as the different kinds of medicine used in preventing, treating, and curing them – in an interconnected world.

Why 'medicine in context'?

In a special issue of the journal *Anthropology and Medicine* about the 'Asian flus' (especially the H5N1 virus popularly known as 'avian flu'), Kleinman et al. (2008) write that the policy-oriented studies and factsheets from both national and international institutions and authorities generally draw a simplified picture of the local contexts and conditions in which both the (potential) spread and extermination of such kinds of epidemics take place. In this perspective, this policy-driven research fails not only to address the local lifestyles and social constellations that partly determine individual and collective ways of handling the (still largely abstract) risk of disease contraction, but also the complex experiences and motivations that relate to the relevant practices or 'behaviours' of families, communities, and individual agents (such as poultry farming). According to Kleinman and his co-authors, comprehensive knowledge of local contexts provides the necessary foundation for defining possibilities for efficient cooperation between people and public health initiatives. Furthermore, this knowledge would assist in identifying reasons for the often-documented unwillingness of people to respond to proposed public health measures, which in certain

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2   In German-speaking academia, different terms are used for the subdiscipline: *Medizinanthropologie*, *Medizinethnologie*, and *Ethnomedizin*. The exact meanings and histories of each of these traditions – and how they relate to each other in current intra-, inter-, and transdisciplinary debates on medical anthropology in Switzerland, Austria, and Germany – will not be addressed here. For further discussion of these various traditions and the corresponding terminologies, see Greifeld 1995; Lux 2003; Tiedje and Schröder 2007.

cases can also be a form of resistance (cf. Leach and Fairhead 2007; Vaughan 1991). Kleinman et al. present a comprehensive study of national, international, and social contexts that could be relevant to individual and collective perceptions of risk with respect to the (potential) containment of pandemics such as avian flu. Additionally, they advocate for following a biosocial approach, which is potentially able to comprehensively explain the complex interplay of biological and social factors in the spread of epidemic disease and the establishment of public health measures.

In the light of increasingly complex constellations of problems in a globalized world, the previously mentioned case of 'Asian flus' raises various issues relevant to contemporary medical anthropology.[3] Aside from the question of the applicability of research results and the challenge of exploring specific constellations of problems by utilizing inter- and transdisciplinary approaches, this especially concerns the often-presented postulate that medical anthropology is necessary in order to recognize and analyse the management of disease and the preservation of health in *significant contexts*. Only by situating a specific phenomenon within the context of relevant fields of meaning and practice can one develop a thorough understanding of the given problem constellation and, accordingly, face the problem by articulating adequate measures. Like numerous other contemporary studies in the discipline of medical anthropology, the special issue published by Kleinman et al. (2008) extensively considers the interconnectedness of global, national, and local constellations and practices that affect health-related phenomena in the context of globalization. However, as in other medical anthropological publications analysing health and disease 'in a cultural context' (Tiedje and Schröder 2007, 102) or 'in specific cultural and social realities' (Whyte and van der Geest 1988, 3),[4] the special issue remains unclear about how an understanding

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3 Parallel to the publication of the edited volume, and in the following years, transregional outbreaks of infectious diseases such as H1N1 ('swine flu'), EHEC (enterohaemorrhagic *Escherichia coli*), and Ebola have raised similar questions regarding the role of medical anthropology.

4 Tiedje and Schröder (2007, 103) adopt the term 'cultural context' to analytically explore the concept of the 'lifeworld' and address health and illness as social and cultural phenomena in relation to 'the immediate (subjective) experience of the world, of everyday life and the practical lifestyle of every human being' (our translation). Alternatively, in establishing an initial overview of anthropological studies of *materia medica* in so-called developing countries, Whyte and van der Geest (1988, 3) state in the introduction to their anthology *The Context of Medicines*: 'We wish to emphasize the "*context*" of medicines, by which we mean the constellations of cultural meanings and social relations within which medicines exist in a given time and place. While ethno-pharmacology concentrates on "indigenous medicines" of Third World people, pharmaceutical anthropology is concerned with the co-existence of Western and indigenous medicines and with the issue of how each affects the perception and use of the other' (emphasis in the original).

of health and disease management in the relevant constellations and contexts of a globalized world is to be ascertained, and by whom, as well as on which epistemological assumptions such determinations should ultimately be based. Who decides which contexts are relevant to a phenomenon, and how? Where does a context or its corresponding phenomenon begin, and where does it end? What constitutes the connection between a phenomenon and its context? What is our actual understanding of 'medicine' in a globally and transnationally connected world? Over the course of the next two sections, we address these questions, without necessarily being able to provide comprehensive answers to all of them. In the following section, we begin first with outlining the programmatic and epistemological shifts in the field of medical anthropology over the last decades, which will serve as a foundation for our application of the term 'medicine'. These shifts primarily relate to the development of an anthropology of medicine and the supplementation (or occasional replacement) of questions of representation with issues regarding practice and performance, and related to this, a new emphasis on material matter (mainly the body and technology).

From medical pluralism to a social and cultural anthropology of medicine(s)

Classical medical anthropological studies have primarily focused on patient behaviour or patient interpretation and the logics of medical systems, and in so doing, have examined the intercultural, and in some cases also the internal social variability, of medical concepts, actions, and institutions. What characterized these studies was that their objects of investigation were almost exclusively instituted within the medical domain and their inquiries addressed cultural representation. In other words, the studies chiefly focused their attention on the cultural mediation of phenomena such as illness and treatment, as conceptualized in the often-quoted terms 'explanatory model' from Arthur Kleinman (1980), 'therapy management group' from John Janzen (1987), and 'medical systems' from Charles Leslie (1976).

Critical medical anthropology has assumed a critical position towards the abovementioned research and its conceptual utilization of 'medical pluralism'. In contrast to the above-cited studies, critical medical anthropologists have first of all examined the connection between health-related behaviour and the surrounding macro-level context of society – predominantly its politics and economy (Young 1982). Secondly, they have brought biomedicine itself and the interconnections between medicine, power, and knowledge within broader societal dynamics (such as the proliferation of different forms of capitalism and their concomitant disciplinary consequences for the people involved, as well as the production of biomedical knowledge) to the centre of their interest (cf. Comaroff 1982; Lock and Gordon 1988; Morgan 1987; Pfleiderer 1995). In addition to the shift in the scale of examination

from the micro-level, such as research on interactions between doctors and patients, to the macro-level focusing on the social emergence of disease and the embeddedness of the medical domain within society, critical medical anthropology has thus supplemented the issue of cultural representation with questions about interest and power structures.[5]

In recent years, the complexity of social processes and configurations in correspondence with medically related issues has been examined more thoroughly. Medical anthropology is no longer considered merely a virtually autonomous subdiscipline of anthropology with its own methodology and theories (or even a branch of biomedicine as to some extent implied in the tradition of *Ethnomedizin*). Instead, it is considered an integral part of general social and cultural anthropology, which deals with its own specific thematic focus and exhibits certain distinctive features (such as its focus on the body and illness), while employing the same methodological and theoretical approaches as other branches of social and cultural anthropology (Hadolt 2004). In this sense, it is more accurate to speak of an 'anthropology of medicine' than 'medical anthropology', inasmuch as 'medicine' stands out more distinctly as a research field within social and cultural anthropology than in the case of an anthropology specified by the adjective 'medical' (cf. Cambrosio, Young, and Lock 2000, 4ff.; Fainzang 2001; Lindenbaum and Lock 1993). However, such a shifting perspective implies not only that medical anthropology is drawn closer to social and cultural anthropology epistemologically, but, deriving from a fundamental hybridity of social life, increasingly stronger socio-ontological positions are revealed as well (Latour 1993). This includes, moreover, a reconceptualization of the material dimensions of anthropological research on health and medicine, especially with regard to the human body, not unlike the concepts of the 'mindful body' (Scheper-Hughes and Lock 1987) or 'embodiment' (Csordas 1990), and additionally, to other material objects in the context of consumption (Whyte and van der Geest 1988) and (new bio)technologies (Lock 2002). The boundaries of what can be considered 'medical' are permeable and increasingly empirically defined. The attention to hybridity in relation to anthropological research objects makes the discreteness of medical anthropological studies and other (sub)disciplines ambiguous.

The emergence of concepts and approaches from other disciplines is a prime contributor to the shifts outlined here. This is most notable from feminist and science and technology studies, but also from (medical) anthropological confrontations with globalization processes

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5   The increasing commitment to social processes of 'salutogenesis' (those which generate health) in the field of medical anthropology is a major factor in the shift towards increased attention to biomedicine. To read more about the integration of health and social vulnerability in this context, see Obrist 2007.

and the reciprocal relations between 'local' and 'global', as well as studies dealing with medicine, development, and modernization. In accordance with Appadurai (1990) and within the overall framework of the concept of 'medicoscapes', Hörbst and Wolf (2003, 4) address the 'worldwide scattered landscapes of people and organizations in the field of medicine and healing, which as they converge locally may manifest themselves in a specific place, while also connecting distant places, persons, and institutions with each other' (our translation). The ideas of Collier and Ong (2005) also potentially refer to the global, but in a more diversified manner, as they introduce the manifold combinations of heterogeneous elements such as people, practices, objects, and ideas contributing to the *global assemblages* of interconnectivity and complexity in the world today. These global networks present formations of entities, ideas, and practices that cannot be reduced to a single logic (such as those originating from medicine, economy, or technology), but are often based on unstable relations and subject to contingent transformations.

A third example of the attempt to conceptualize the ever-growing complexity of the world is in this context the concept of 'intersection', as employed by Cambrosio, Young, and Lock (2000) in reference to new biotechnologies. By 'intersections' the authors denote 'temporary convergences that can lead to advances on some particular problem, with no pretence of providing a comprehensive world-view or a theoretical manifesto' (ibid., 1). These convergences are, according to the authors, observed between traditions and postmodernity, between different analytical approaches, and between a wide range of human actors, tools, entities, and bodies, which when combined constitute new biotechnologies. Additionally, this concept accentuates the provisional nature and processual quality of social phenomena, yet it is open to external input and emphasizes the question of practices developed within these convergences, and hence to the shift from the representational idiom of social and cultural anthropology towards practice and performance. The attention to power and its prefigurations, modes of operation, and consequences plays a central role in all three conceptualizations, however, more so within a Foucauldian perspective than in the understanding of power within earlier critical medical anthropology, which is founded on the intellectual tradition of Marx (Lupton 1997).

Whether referred to as 'scapes', 'assemblages', or 'intersections', these notions all demonstrate that, in view of the increasing complexity of the world, we need a multifaceted and wide-ranging concept of medicine. This becomes particularly evident in the anthology of Lock and Nichter (2002), which promotes a concept of medicine that espouses a variety of perspectives about the socially connected processes and phenomena of illness and health (such as the different identity politics involved in the revitalization of 'traditional medicine', the role of NGOs in the establishment and maintenance of moral orders in public health and international development, and 'risk talk' in the context of contraception). Furthermore, this concept of medicine opens up a view on power structures in the context of globalization,

while considering the complexity and contingency of social processes. In this perspective, power is not conceptualized unidirectionally, such as from global to local or from 'above' to 'below', as in critical medical anthropology à la Baer, Singer, and Susser (1997), but rather in the sense of a branching out and productive power *in actu*, similar to Foucault. For a concept of medicine this broad, heterogeneous, and politicized, it is necessary to apply a more differentiated look at the relationships between illness and health, as well as the social contexts in which they are situated and from which they originate.

'Medicine' in this volume

The authors of the present volume embrace medicine in its full diversity: as condition; substance or technology; meshwork of ideas; network of practices; symbolic order; object of social and religious relations; social domain; and part of ethnic, national and international politics – as well as, finally, the relations and overlaps between them, which are, to a certain degree, fraught with tension. What makes all these articulations of medicine interesting to medical anthropology and relevant to society and health politics is not only that they all, in some way or another, relate to individual or collective actions and ideas in the thematic field of illness, health, and healing. In a broader sense, they also relate to a wide range of different forms of human existence and well-being and reveal their complexity, contingency, and embeddedness within power structures, both analytically and politically.

However, the contributions contained in this volume reveal not only a diversification of the concept of medicine and a reconsideration of the power structures related to different kinds of healing. Hierarchies and power are also introduced on another level: while classical writings considered 'medical pluralism', today it is about the 'politics of medical pluralism'. We have (partly) ceased to describe the 'simple' interactions between healers and patients and their health-related and local worldly consequences, or the conditions for patients who decide to receive treatment by, or conduct themselves in accordance with, an independent field of 'biomedical', 'traditional', or 'religious' healing practices. While all these questions remain of particular relevance to medical anthropologists, we are no less interested in the wider political and historical circumstances that determine and encompass these interactions, and situate them in new contexts of meaning and power relations. This becomes evident in the contributions to the section '"Traditional Medicine" as Strategic Resource' with its different analyses of how certain practices are constituted under specific (health-related) political circumstances – colonialism, WHO politics, and indigenization politics – first as marginal and 'backward', but also as 'useful' medicine with transregional and 'transmedical' significance and objectives (Knipper and Wörrle 2010).

Secondly, this volume aims to show the extent to which specific medicines themselves are constituted as heterogeneous phenomena on their own terms, in the context of a pluralistic and diversified field. This will be addressed in the contributions found in the section 'New Technologies and Medical Practices', as they emphasize, among other things, how 'global' medical technologies are shaping and differentiating specific medical practices in the course of the appropriation process (Hörbst 2010). Additionally, Mol and Berg (1998, 3) make a strong case for applying this point to biomedicine in general by showing the various differences and multiplicities in the biomedical field:

> (M)edicine is not a coherent whole. It is not a unity. It is, rather, an amalgam of thoughts, a mixture of habits, an assemblage of techniques. Medicine is a heterogeneous coalition of ways of handling bodies, studying pictures, making numbers, conducting conversations. Wherever you look, in hospitals, in clinics, in laboratories, in general practitioners' offices – there is multiplicity.

In order to justify these *differences in medicine*, it is inadequate to search for an obscured unity in which these various differences collapse. And the aim is not to assess these differences as such – positively or negatively – but simply to let them stand. Moreover, Mol and Berg (1998, 7) advocate for an understanding of the diversity within biomedicine as both the cause and the effect of tensions, as 'between making the world run in this, rather than in some other way'. The medical configurations constituting the diversity of biomedicine, whether as forms of conflict or as coordination problems, do not only unfold in a fundamentally contingent manner, but also implicate the dimensions of reality surrounding the sphere of biomedicine, since the body and its illnesses are not exclusive elements of the medical domain. As a consequence, the boundaries between the inside (medical practices and forms of knowledge) and the outside (the context) of medicine are blurred. This entails that a tension-laden understanding of medicine always *contains* the political, and thus makes medical anthropological research about understanding the *politics inside medicine*. For our own purposes, we can accordingly conclude that 'context' is not just located outside of medicine, but also transpires inside its domain. This is not only valid for biomedicine, but for all forms of medicine.

From the context *of* medicine to medicine *in* context

In the previous subsection, we outlined how, in a social and cultural anthropology of medicine(s), 'medicine' – as institution, social domain, technology, and practice with regard to illness and health – becomes rather complex, undetermined, and charged with tension and power. Yet this diversity remains a central area of inquiry for medical anthropological research. The real-world specificity of medicine, and hence its relevance for anthropology

and society, does not emerge without considering the respective and actual contexts *in* which it is constituted, as well as the contexts partially generated on its behalf. 'Medicine' without an account of its (internal and external) contexts is an amorphous and detached term. It is bereft of any real-world substance until it becomes embedded in its respective interdependencies with the world. Merely considering the cultural contexts of discretely bounded phenomena will be grossly inadequate. In the following, to further clarify the relationship between medicine and context in a social and cultural anthropological perspective, we will return our anthropological gaze to past discussions on context and its place in anthropological research.

The idea of context in anthropology

According to Dilley (1999, 4), 'context'[6] refers to an act of interpretation or contextualization in which connections between the phenomenon of examination and other seemingly relevant phenomena and constellations are established (or *not* established). Based on this definition, the general epistemological challenge arises of how to decide on how much context is necessary in order to explain a particular phenomenon and to be able to distinguish its specificity from other similar phenomena (ibid., 6ff.). Secondly, at least since the critique of the hegemony of knowledge and knowledge production emerged during the course of postcolonial debates, researchers have had to raise the question of the circumstances in which – and more specifically, according to which forms of science practices or social interaction – contexts were constituted as such, since the definition of a context in the latter case is always a political act.

In anthropology, the description – along with the describability – of contexts was for a long time taken as largely unproblematic. Earlier anthropological studies addressed the functions of social phenomena within a community, which in terms of a synecdochical relationship between the part and the whole were equated to their 'culture'. Others examined the structural connections and oppositions between different phenomena situated inside a community's defined yet self-contained system of signs. Others again broached the diffusion of cultural phenomena across spatial boundaries and utilized their findings to postulate the similarity between widely distant cultures. However, the embeddedness of local communities within the wider world, and the further economic and political implications of this relationship, was not explicitly discussed until the emergence of world-systems theory in the 1970s. Wallerstein's definition of the world system entailed the formation of a hierarchically structured world community, mainly founded on trade and economic relations, which was

6   The term is derived from the Latin *contexere*: 'to weave together', 'to connect'.

then further divided into three mutually constituting spheres (centre, semiperiphery, and periphery). While world-systems theory had an evident impact on North American critical medical anthropology (Baer, Singer, and Susser 1997; see above) – and while it subsequently made way for the research of resistance against world systems, as in the context of peasant studies (cf. Probst and Spittler 2004) – the seclusion and inner consistency of contexts (predominantly situated within the boundaries of nation states), along with the unidirectional hierarchies extending from centre to periphery, were not fundamentally questioned within these theoretical frames.

Questions addressing the representation, and hence the production, of 'local' contexts were not raised in anthropology or other social sciences before the advent of postcolonial theories and resulting discussions of globalization, transnationality, and diaspora. As anthropology turned to focus on the global circulation and interweaving of locally manifested occurrences, ideas, and practices brought up by the discussion of globalization, as well as its call to dissolve the dichotomies of 'local' vs. 'global' and 'centre' vs. 'periphery', the discussion about transnationalism focused its interest on the effect of nation states. Although nation states (and by definition their diasporic communities), along with their related processes of developing community and identity, today (and historically) extend beyond politically and territorially defined borders, nations and their institutions continue to play an important role in the definition and formation of social and political configurations (such as in the context of immigration politics and policies of citizenship; cf. Glick-Schiller, Basch, and Blanc-Szanton 1992; Kearney 1995; Vertovec 1999; see also the sections about migration and medicine in this volume).

The fundamental methodological and conceptual criticism of the production of anthropological knowledge – and the epistemological assumptions supporting this knowledge – was exercised on an additional level in both the 'writing culture' debate and the discussions about space, site, and place,[7] which were addressed in conjunction with the 'anthropological crisis', the 'disappearance of spaces (Augé 1995), and the 'collapse of contexts' (Dilley 1999, 24). The growing criticism of a fixed concept of culture was also expressed in the fields of globalization and transnational studies, and it had to make way for the increasing focus on multiple identities, the negotiation of cultural meanings, and the potency of 'culturalisms', especially with regard to politically relevant debates (Abu-Lughod

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7   Within the framework of this introduction, we are only able to present a rough sketch of the debates
        about 'place', 'space', and 'site' in the context of globalization and their resulting implications for
        anthropological knowledge production. For more detailed discussions, refer to the quoted authors, as
        well as Appadurai (1996); Clifford (1997); Coleman and Collins (2006); Probst and Spittler (2004);
        Tsing (2000).

1991).[8] In addition, the assumed objectivity of anthropological researchers themselves, and of their researched 'fields' and 'places', fell under the gaze of critical dispute: anthropological knowledge became 'uncertain', 'incomplete', and 'perspectival'. The 'field' was no longer (necessarily) connected to a stable place or a stable community and examined phenomena themselves were often revealed as the result of ethnocentric categorizations (for medical anthropology, see for example Pool 1994). While some researchers have consequently wanted to amplify the different voices involved in knowledge production (Clifford and Marcus 1986), others have demanded an expansion of the research context into many different field sites, since an explanation of global ideas, phenomena, and actions can only be brought about by means of their integration (Marcus 1995). Furthermore, yet others have emphasized the epistemological, yet completely pragmatic, dilemma of, on the one hand, having to pay attention to increasingly complex contexts in order to understand the researched phenomenon adequately, while, on the other, never being able to consider *enough* contexts (cf. Schlecker and Hirsch 2001).

'Context' in this volume

While in recent years, differentiated reflections on the boundaries and problem constellations relating to essential anthropological concepts such as 'context', 'field', and 'place' have been presented, other publications have directed their attention to the possibilities and perspectives emerging as the result of anthropological knowledge production and theorization (cf. for example Coleman and Collins 2006). On the basis of the above-presented ideas and the general characteristics and motivations of the contributions, we aim to formulate several lines of orientation for future medical anthropological research.

In our opinion, there is, first and foremost, a need within medical anthropology for a profound discussion about how to determine the respective 'contexts' of a researched phenomenon in terms of relevance and level of detail, and how to meaningfully transfer the determination of such boundaries to pragmatic research and analytical perspectives. To use

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8   Also within the framework of medical anthropology, it has often been emphasized that 'culture' does not constitute an adequate explanatory background for health-related behaviour. A number of other social, economic, and political processes and powers have to be considered in order to explain the status of people in terms of health, and hence their health-related behaviour (cf. the literature about biomedicine cited above; for the context of migration, see Verwey 2003; for the international HIV/AIDS discussion, see Seidel and Vidal 1997; Farmer, Connors, and Simmons 1996). The meaning of structural violence has furthermore been addressed through the conception of 'social suffering' (Kleinman, Das, and Lock 1997; Das et al. 2000; Das et al. 2001).

an example from the present volume: when we examine the relationship between medicine and migration in the section 'Migration and Medicine in Transnational Interrelationships', how much are we (as *medical* anthropologists) supposed to know and present about the wider correlations of 'migration' and its historical background in order to adequately explain and categorize the health-related behaviour of migrants? How much knowledge can we include from primary and secondary sources, and how much empirical background knowledge do we need to acquire ourselves before being able to do our research (for example, by conducting fieldwork in the home country of the studied group)? To what extent does the conceptual context of 'migration' make sense when examining the health-related behaviour of academics in Germany originating from China (Kotte 2010) or the mobility of health care professionals from Ghana within a global labour market (Böhmig 2010)? And are we doing justice to the spiritual authority and charisma of Portuguese healers from Angola and Brazil (Saraiva 2010) when we classify them as 'migrants'? The necessity of raising these questions is not only based on the increase of so-called audit cultures (for example in the form of ethics committees, as well as institutions that fund and promote research) that determine the conditions of medical anthropological research in German-speaking countries (and beyond), and, in this regard, the development of specific hypotheses, research questions, and procedures in the research design, which then have to be applied exactly during fieldwork (cf. Coleman and Collins 2006, 10ff.; see also Strathern 2000). It is also in the interest of researchers themselves to consider these questions with regard to feasibility, criteria for termination of data collection, and the conceptual and sociopolitical implications as early as possible, in the interest of avoiding the outcome that the research schedule becomes incrementally overwhelmed by the boundlessness of contexts such as migration, urbanization, or 'simply' globalization.

Secondly, this first question raises the issue of the nature of the relationship between phenomenon and context, and how we are supposed to account for the often contingently extended reciprocity of this relationship: the co-production of the investigated phenomenon and context (cf. Dilley 1999, 18).[9] Medical anthropologists have in recent years not only demonstrated that macro-level social contexts such as migration, technology transfer,

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9   From the perspective of practice theory, Theodore Schatzki makes a promising attempt to grasp the relations of social practices through their sites. He introduces the concept of the site as a specific type of context that is characterized by the principle that at least a part of that for which the site is the context (in other words, for the social practice in question) is an inherent part of the site itself. Sites are 'contexts of which some of what exists or occurs within them are inherently parts' (Schatzki 2003, 176). A social practice and a certain context (a certain site) are thus interconnected in an immediate way (cf. Hadolt and Lengauer 2009).

urbanization, and globalization must be considered when accounting for 'local' health and health-related behaviour, since, for instance, structurally anchored political and economic power relations pose a risk to general health and welfare, all the while having reconfigured access to health-related resources in large parts of the world (often towards greater inequality). They have also shown that phenomena related to medicine are themselves constitutive of these contexts, and that the actions, ideas, and social fabric implicit in migration, globalization, or urbanity are often reshaped or caused by tension- and conflict-laden processes. The latter aspect was, among other things, illustrated by the understanding of citizenship that has emerged in relation to diseases such as HIV/AIDS – and the subsequent health-political configurations and forms of international development – which, along with the social relations and forms of community arising from the disease, could be regarded as both a consequence and an acceleration of globalization and modernization processes (cf. Dilger 2005, 2006, 116ff.; Nguyen 2005, 2009; for the concept of 'biological citizenship', see Rose and Novas 2005). In similar ways, the contributions in this book demonstrate that experiences and actions shaped by their connection to disease and health play a constitutive role for social relations and configurations in a globalized world, and that the current discussions about 'traditional medicine', urbanization, social security systems, migration, and new medical technologies worldwide should not only be regarded as *mirroring* social and political constellations, but as *mobilizing* and *shaping* specific forms of identity, politics, bureaucracy, community, trust, and mutual obligation.

Thirdly, we need an exact reconsideration of the theoretical, methodological, and ethical foundations that make it possible to research the object of examination and its context in a meaningful fashion, while integrating their mutually constitutive relationships. This requires first and foremost a thorough discussion of the specific research methods that characterize our investigations in the specific places where we engage our research partners and informants and are able to follow their social and work-related everyday lives in an unmediated fashion, though often in an increasingly fragmented way. According to Coleman and Collins (2006, 17), contexts and fields do not arise until the performative act of ethnographic research is carried out, and they assume their actual form by way of identifying boundaries and social phenomena during the research process, depending not least on the respective analytical and rhetorical preferences of the anthropologists. Additionally, we are in need of a differentiated discussion about research dealing with the transnational and virtually configured spaces relevant to the political and natural sciences, which constitute both the position and emergence of 'medicine'. This also goes for the encounter of challenges when researching phenomena such as 'social security' and 'medical technologies', as well as biodiversity and intellectual property rights, in the context of globalization. In particular,

discussions about technologies of assisted reproduction or health economics, and their arising development politics and 'biobureaucracies',[10] often require the incorporation of subject-specific terminologies, argumentation, and forms of documentation and presentation that reach far beyond the usual instruments of social and cultural anthropology. Nevertheless, their knowledge is a necessary prerequisite for understanding the basics of the data collected here, as well as its relevance to the phenomenon examined by us.

Finally, it is necessary to understand how an inter- and transdisciplinary approach can establish an understanding of the relationship between phenomena and contexts, while acknowledging different disciplinary and methodological approaches and making them benefit from one another. To clarify these challenges by an example: epidemiological studies must exhibit an awareness of the connection between pathogenic or health-promoting factors (context) and health-related outcomes (phenomena), not unlike the modus operandi of medical anthropological research. Utilizing a large number of samples, the epidemiological method aims to resolve these connections in terms of a cause-and-effect relationship, and thereby identify risk factors for public health. In contrast to this strategy, anthropology generally works associatively and accepts that its generated knowledge about a studied phenomenon, as well as the contextualization of the phenomenon conducted by the researchers, always remains incomplete and marked by the subjective position of the researcher. The definitive certainty that, for instance, a decision made in Washington, DC (or rather, the preceding US domestic economic crisis?) restricts access to public health care systems for a woman in rural Tanzania, while promoting the growth of charismatic communities in urban areas, is not and cannot be established (Dilger 2012). The same uncertainty probably applies to the factual effects that recent political, social, and economic transformations in Ecuador have had on user behaviour and the position of healers in the region with regard to global shifts in 'traditional medicine' (Knipper 2010), at least not with a methodological approach focusing on a low number of cases and the collection of 'thick' case studies with multiple perspectives.

An anthropological-associative approach nevertheless makes it possible to focus more precisely on the question of which constellations and connections are actually relevant for the consideration of a phenomenon, and how such hypothetical connections are experienced and negotiated by the researched actors themselves. Conclusively, the associative gaze is able

10   According to Wolf (2012), the term 'biobureaucracies' refers to the relationships between health-related bureaucracies and individual agents (in other words, the clients of health insurance companies and health institutions), which have emerged as a result of the global expansion of biomedicine.

to suggest how qualitatively raised contextualizations can be validated by applying other methods and approaches, and thus be made fruitful for health-political practices. What such trans- and interdisciplinary constellations might look like, and what specific contributions medical anthropology can provide within them, remain exciting questions for the future. Relevant results are to be expected from the research configurations of working with a biosocial approach, as described by Kleinman and his co-authors above, but this is also true for the trans- and interdisciplinary research team currently working on urbanization and vulnerability in selected locations in Africa, as presented by Brigit Obrist (2010) in the final contribution to this volume. In general, we see a need for medical anthropological research that focuses attention on the material and socio-ontological dimensions of the different articulations of medicine, while making the social and cultural anthropological perspectives of these articulations valuable to other interdisciplinary contexts.

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