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Why and how to include anthropological perspective into multidisciplinary research in the Polish health system

Anna Witeska-Młynarczyk

Institute of Ethnology and Cultural Anthropology, Adam Mickiewicz University, Poznań, Poland

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Abstract

The article focuses on ways in which anthropological knowledge, incorporated into multidisciplinary and multilevel research projects, can be applied for understanding health- and illness-related behaviours and functioning of the health system in Poland. It selectively presents potential theoretical and methodological contributions of the anthropological discipline to the field of applied health research, and briefly reviews selected ethnographic theories and methods for researching and interpreting socio-cultural conditioning of healing, health and illness related practices. The review focuses on the following approaches: Critical Medical Anthropology, Cultural Interpretive Theory, phenomenology, narrative analysis, and the biography of pharmaceuticals. The author highlights the need for team work and use of a holistic perspective while analyzing the health system in Poland, and underlines the need for serious attention and financial support to be given to multidisciplinary research projects of which anthropology is a part.

Key words

medical anthropology, methodology, research design, multidisciplinary communication, Poland

INTRODUCTION AND OBJECTIVE

The biomedical model of healthcare, famously criticized by Illich [1], is in a phase of crisis which manifests itself by a lack of trust on the side of patients towards biomedical practitioners and managed healthcare [2, 3, 4]. After a vigorous historical process of state-controlled *medicalization* and based on capitalist logic commodification of biomedical health services, people are now searching more intensively for non-biomedical methods of treatment, both when they face illness and as a way of maintaining good health. Patients' recourse to alternative therapies is often attributed to disenchantment with biomedicine, difficulty in accessing affordable biomedical services, patients' desire for empowerment in the face of illness and biomedical authority, and the need to make 'sense of their own illness and identity' [5, 6, 7]. Theoreticians claim that we encounter a new phenomenon – that of *de-medicalization*, i.e. we are dealing with a set of transcultural and locally specific ideas and practices which encourage people to be less dependent on the biomedical model of healthcare [8].

In a neoliberal model of economy, patients are imagined as knowledgeable consumers capable of taking responsible and conscious decisions in the realm of health and healthcare [9, 10], while the state is supposed to loosen control over the health system. These processes are strengthened by *healthism* – a widely-practiced belief in contemporary societies that health can be perfected and that it is up to the individual to stay in good shape. Since a significant number of people take decisions to use non-biomedical healing methods in everyday life, many governments feel compelled to respond to consumers' interests in non-biomedical healing methods [8]. Coincidently, non-biomedical practice appears less costly in comparison to highly technologized biomedicine, which does not remain without relevance for state bureaucracy in time of crisis [11, 12]. 'Fiscal crisis and escalating health costs prompted governments to re-evaluate their health spending' [8], and as Cant and Sharma notice 'many models of collaboration exist in spite of the continued antipathy expressed by many professional associations' [8]. These processes unavoidably raise questions of a moral and economic nature which should be addressed at both international and national levels. It is important to note that these processes have been unfolding unevenly and should be analyzed, taking into consideration the local and cultural specificity of each national context [8]. Multidisciplinary research undertaken in specific local contexts placed in transnational perspective should serve as basis for new policies.

Włodzimierz Piątkowski in his most recent publication 'Beyond Medicine: Non-Medical Methods of Treatment in Poland' explores one such national context. He describes Poland's *differentia specifica* as far as the increasing popularity of non-biomedical methods of treatment are concerned. The author describes dissolution of the 'old scheme' implemented by the socialist state – i.e. centralized, formalized, bureaucratic, inefficient system of national health care service and its loss of monopoly over treatment, accompanied by an emergence of new entities ruled by a free-market. Culturally-wise, the author argues, Poles, plugged into the globalized well-networked world, developed 'new awareness' characterized by: popularity of ecological movements, critical approach to techno-chemical medicine, and susceptibility to alternative approaches to health and illness. The growing interests of both rich and poor Poles in non-biomedical methods of treatment is not followed by development of a

Address for correspondence: Anna Witeska-Młynarczyk, Św. Marcin 78, 61-809 Poznań, Poland.
E-mail: anna.witeska@gmail.com

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stable collaboration model between biomedicine and non-biomedical practices [13]. In Poland, where the recent history of reform in the realm of health system remains complicated and still in the making, the aforementioned processes, their roots and social consequences are still to be explored.

Polish medical sociologists point out that the relationship between social structure and health is crucial for making the Polish health system work efficiently; they also urge reaction to existent inequalities in healthcare, particularly disturbing in the case of people who faced social exclusion as an outcome of political and economic transition [10, 12]. In 2009, 63% of Poles expressed dissatisfaction with the functioning of the national healthcare system [14]. In this particular context, vital research questions will tackle issues related to the malfunctioning of the healthcare system and people's dissatisfaction with it, the popularity of non-biomedical methods of treatment, their validity, as well as the possibility and consequences of their incorporation into main-stream healthcare, quality of patient-doctor communication and differences in their cultural competence, social life of pharmaceuticals, growing disparities on the line of rural-urban, rich and poor, as well as gender divides – to mention only a few. Professionals concerned with such indicators as adult health decline in Poland advocate work towards designing practical solutions in a form of strategic intervention programmes on a national level [15]. While designing health research projects, it therefore remains necessary to think of their applied aspects.

In a given situation it seems crucial to pose questions concerning ways in which to overcome the crisis, provide patients with a satisfying healthcare, and work towards closing the gap between rich and poor, be it on a national or on the EU level [15]. Policy designers in Poland should be more sensitive to socio-cultural and economic changes, as well as to transforming ideas and practices related to health. Importantly, research designers should seek to learn about beliefs and practices not only of 'ordinary people', but should equally thoroughly explore culturally specific ideas and practices characteristic for bureaucrats, doctors, or big pharmaceutical corporations. A thorough and holistic exploration of the Polish medical system would be of interest to all participants who co-create it i.e. biomedical and non-biomedical practitioners, patients, state bureaucrats, pharmacists and private medical and insurance companies alike. Reliance on multidisciplinary research programmes in which anthropology plays an important role is crucial for understanding the Polish health system, and to generate valid suggestions for reforms.

The presented article focuses on ways in which anthropological knowledge and its closer cooperation with other disciplines, such as history, human geography, medicine, sociology, pharmacology, psychology, and others, can be applied towards achievement of an effective and humane health system in Poland. The article argues that health research in Poland, which has traditionally relied heavily on quantitative data, would gain a unique depth if anthropological methods were to complement other more macro- and mezzo-structurally oriented approaches.

Examples of multidisciplinary and multilevel analysis. From among the Polish researchers who have devoted themselves to fostering interdisciplinary dialogue in the field of health and illness, the closest cooperation developed between Polish sociologists and anthropologists [16, 17]. Representatives of these disciplines remain open to possibility of a wider team research on health and illness[1]. Multidisciplinary projects are now gaining a momentum, in particular since they are supported by European Union funding policies. Two examples will be shown of theoretical and methodological reflections developed by sociologists and anthropologists which could be applied by Polish researches when designing health research projects on international or national levels.

Rubinstein et al. [18] underline the importance of a deeper integration of various disciplines at the theoretical and methodological levels while designing multidisciplinary research projects. They advocate a holistic approach to health and illness and prompt researchers to place analyzed phenomena in wider settings of space and time, and research it on a number of different levels at the same time (they mention after Laughlin and Brady – surface structure, societal infrastructure, cognitive infrastructure, and biological infrastructure). Such constructed projects need the close cooperation of diverse disciplinary partners. An exemplary project based on these principles is Scrimshaw's research on abortion in Ecuador [19]. Methodologically, it implied ethnographic work in a family context with women seeking abortion, community surveys on abortion, observation of family planning clinics, and interviews with national and local policy makers. Clearly, these levels of analysis follow the rule of minimal inclusion and are selectively tailored according to the research question and problem. However, the multilevel view of sociomedical methodology opens up the way for team work and allows the realization of different shares of a research project by various disciplinary experts, while remaining focused on a specific research problem. Such projects are further characterized by flexibility of scope and a number of disciplines that cooperate within its framework.

Differently, McElroy and Jezewski [20] categorize theoretical and methodological approaches in health research into three groups: macrocultural – referring to economy, ecology, social organization, politics, and health care systems researchable, using methods of political economy, political ecology, critical analysis and historical analysis; microcultural – where themes of ethnicity, class, household health management can be researched through rapid assessment, sick role, health belief model, focus groups and discourse analysis; and individual – with themes of age, gender, genetics, health history approachable through illness narratives, explanatory models, phenomenology and life histories. Such a methodological triangle used as a research model can reveal how differently positioned people, individually and collectively, respond to health problems through multiple systems which furnish them with different resources enabling and restraining health-related practices.

[1] A conference was organized recently by the Polish Academy of Science and the Institute of Ethnology and Cultural Anthropology of the Adam Mickiewicz University in Poznań, under the title 'Health, Illness and Healing: An Interdisciplinary Perspective', attended by anthropologists, sociologists, historians, philosophers, psychologists, botanists, pharmacologists and literary critics. As underlined by Professor D. Penkala-Gawęcka in her closing remarks, the meeting outlined the areas of possible cooperation pointing at the necessity to undertake transdisciplinary research programmes devoted to health, illness and healing. Similarly, W. Piątkowski in his latest publication emphasized that multidisciplinarity research should constitute an 'effective research guideline' for interpreting the phenomenon of non-biomedical healing [9].

The holistic model of research allows for engagement of representatives of various disciplines in a joint research project. It opens up the possibility of work towards contextualizing health problems as a part of global and regional systems, and to discover their local dimension which manifest itself in psychological and cultural aspects of social relationships as they are dynamically transformed by illness. It further allows for including into the analysis phenomenological aspects of health and illness experience idiosyncratic for each individual. In such projects, anthropology is best fitted to explore microcultural and individual levels using qualitative methods with a priority given to participant observation.

The following section focuses on selected theoretical and methodological themes present in medical anthropology literature pointing to their applied character and explanatory value for multilevel and multidisciplinary research in the field of health and illness.

Medical Anthropology. Anthropology has traditionally focused on tribal cultures, traditional healers and healing rituals set in a framework of cross-cultural comparison. It is only recently that anthropologists have turned their attention to the field well-known to sociology i.e. complex societies, biomedical institutions, and doctor-patient relations, penetrating it with its well-grounded research methods. Today, the scope of interest for medical anthropologists includes such themes as: culturally sensitive concepts of body and health, experience of illness, medical pluralism, biomedicine, complementary and alternative healing methods, economies of health, or cosmopolitan biomedical culture. From the outset, medical anthropology has been largely critical to biomedicine for its reductionist and non-human character. The discipline channeled its efforts to expose the significance of the social roots of a disease and the meaning that experience of illness has for its sufferers. In this paradigm, complex societies are imagined as functioning in a state of medical pluralism [6], which implies the 'existence of diverse standards of medical knowledge, functioning of different explanatory systems and healing traditions, where transactions between patients and healers are imagined as complex transactions among systems of meaning, technologies and power' [21].

For a long time, biomedical science and care in fully modern societies were excluded from cross-cultural comparisons. Medical anthropology placed biomedical health care in a comparative framework depicting it as one among many structures of knowledge and practice related to health and illness. Various methods of treatment imply different conceptions and bodily practices, as well as health and illness related behaviours. Identifying these patterns would allow the designing of better policies and effective transformation of health systems. Anthropology is well-equipped to trace and explain such behavioural, cognitive and phenomenological differences.

Below, selected key approaches in medical anthropology which enable ethnographers to shed light on these key aspects of health system are briefly reviewed.

Cultural interpretive theory. Meaning centered approach introduced by Arthur Kleinman highlights the socially constructed character of people's experience of health and illness. One of the main contributions of medical anthropology to health studies was the introduction of the analytic distinction between illness and disease [22]. 'Disease' is defined as 'the practitioner's construction of patient complaints in the technical terminology of a particular healing system' [23]; this means that in both biomedical and non-biomedical healing systems there emerge specific definitions of disease. Disease functions here as an explanatory model belonging to the specialized culture of medicine. Baer clarifies that disease is known both to the healer and sufferer through a set of interpretative activities, i.e. the interaction of biology, social practices, and culturally-constructed frames of meaning, which lead to the construction of clinical realities [24]. Patient-doctor communication therefore remains crucial for the way in which people live through illness and imagine health. This communication is dependent on many factors which are researchable, and is prone to changes, among others, through such techniques as designed educational projects for doctors. 'Illness', on the other hand, is defined as 'a person's perceptions and experiences of certain socially disvalued states, including, but not limited to 'disease' [25]. Here, we can trace a growing fascination with patients' worlds and ways in which they live through illness. As a consequence of this distinction, there followed an anthropological focus on in-depth exploration of personal narrative experience of illness [26, 27, 28].

Narrative linkage. Artur Kleinman and Don Seeman are among the anthropologists who speak for a morally engaged analysis of narratives produced by patients. These authors go against the mainstream of cultural anthropology by claiming that 'cultural knowledge alone will never allow us to predict, or even to describe, the outcomes of medical and policy interventions in the lives of real people and communities' [23]. Kleinman [27] argues that the stories patients tell do not simply reflect the experience of illness, but rather, these accounts exert a shaping influence over the way in which symptoms and suffering are endured and interpreted. It is thus crucial to understand ways in which people form their stories while living through illness in different social contexts. Also for these authors, experience is not individualistic, rather, their interest in personal experience allows them to look into a wider social dimension of illness understood as 'intersubjective' experience, i.e. 'the intersubjective, felt flow of events, bodily processes, and life trajectory which always takes place within a social setting' [23].

Kleinman and Seeman claim that ethnography relying on diverse methods, such as, participant observation, interviewing, focus groups, historical research, and other qualitative methods, is a key approach allowing for understanding the ways in which illness 'intersects with a particular life trajectory to produce a unique and irreducible constellation of experience' [23]. In this sense, anthropological work can open up a lot of venues for more macrosocially- and quantitatively- oriented research eagerly taken up by sociologists. It can also provide a multitude of in-depth case studies illustrative for macrosociological theories.

Phenomenology beyond the patient's world. While designing their research programmes, medical anthropologists often choose to rely on phenomenology. Johannessen warns against extensive reliance on a subjective dimension and phenomenology as having a potential to obscure the equally important structural level of analysis

[29]. Yet many analysts of intimate experiences of health and illness underline that, similarly to narrative analysis, this research philosophy allows the linking of individual and social dimensions of health and illness experience in one research programme. It seems that this form of multidisciplinary research project could work further towards assuring that the structural level is well-linked with the subjective level.

In the phenomenological approach, culture is seen as 'grounded in the human body' [30] which interacts with larger processes of objectification, such as medical knowledge. Lyon and Barablet, who worked on a model of body and emotion in society, argue that:

> if the body is to be fully understood as a social phenomenon, (…) it is necessary to avoid a conceptualization of it which draws exclusive attention to the subject individual. Rather, it is important to conceptualize the body in a manner which directly refers to the interactive, relational, and therefore social (as opposed to socialized) aspects of the body' [31].

In a similar fashion, Critical-Interpretative Medical Anthropologists Margaret Lock and Nancy Scheper-Hughes present analyses which take into account ways in which people's images of their bodies in state of health and illness are mediated by social meanings, and claim that from bodily actions an analyst can read about local and global power relations [32].

Lindsay French [33], who worked on the experience of damaged bodies among amputees living on the Thai-Cambodia border, argues that 'even the most apparently subjective and personal of experiences – the experience of one's own body – is shaped in important ways by the relations of power and domination in which the body is involved'. She sees such relationships as embedded in the social order of which everyone who participates in that order is a part.

Phenomenologically-orientated anthropologists do not loose a sight of larger structures ordering people's experience of health and illness. Yet, the questions of hegemony and power relations are most distinctively articulated by Critical Medical Anthropology.

Critical Medical Anthropology. The aim of this form of anthropological analysis is 'an examination of contending forces in and out of the health arena that impinge on health and healing' [24]. In this sense, the approach corresponds with Andrzej Wojtyła's remarks recognizing the significance of the political system as a factor shaping differences in health [34]. Analysis undertaken in this stream is tailored in particular for understanding the dynamics of the capitalist societies and post-colonial areas. The underpinning belief is that 'in capitalist societies, achieving health entails a struggle against class-dominated powers that do not exist in indigenous societies' [24]. Health care systems are defined outside the health sector by dominant social groups, including large corporations or insurance companies [24]. This approach allows for looking critically at the health related issues with a broader framework in mind, acknowledging such processes as globalization of biomedical cultures, as well as transcultural and local political economies of medicines.

Good and Good [21], for instance, successfully link critical approach with narrative analysis. They propose treating the analysis of clinical narratives as an entry point to larger processes. They argue that relationships between clinicians and their patients mediate larger relations of culture, knowledge, and power. Apart from seeing how the process of story-making under condition of changing course of illness furnishes the illness experience with meaning, they treat emerging communication between patient and doctor as a site that mediates transnational relations, biotechnologies, professional cultures and political economies of health care [21].

Murray Last argued that:

> there is usually an uneven distribution of knowledge in a society, and that frequently for anthropological observers it is <layered>, becoming ever less certain the deeper we get into it. But some alternatives are more central than others, more closely bound to the central ideology or central system of economic relations, leaving those practices at the bottom of the hierarchy much less systematized than those above, with their patients and practitioners having a less formal set of ethnomedical ideas [35].

In this sense, a truly anthropological endeavour would be to map such hierarchies as present in particular ethnographic context – be it a nation State or a specific clinic. Anthropologists will follow ways in which knowledge is distributed within society and how it structures group and individual behaviours.

The biography of pharmaceuticals. One of the innovative and very rich approaches advocated by medical anthropology is that stemming from material culture tradition and the idea that things can have a researchable social life [36]. The research based on this paradigm implies establishing a biography of pharmaceuticals, which are imagined both as products of human culture and its producers. In this approach, researchers look at various stages of a medicaments' life set in specific contexts, and involving such particular participants as the production side – including research and marketing, medical practitioners, pharmacists – whose interactions with the sick are structured by pharmaceuticals, and patients – whose expectations towards medicines shape their experience of illness [37]. Tracing the social life of pharmaceuticals can add another dimension to multidisciplinary research trying to link intimate patients' worlds with larger socio-economic process dynamically reshaping national and transnational realities.

Janelle S. Taylor shows how the social life of things approach can be applied in ethnographic research beyond the biography of pharmaceuticals. Her research, based in the USA, focuses on the technology of ultrasound and the social and cultural life of its imagery, arguing for monochromatic images to exert influence over women's attitudes to foetuses. The author shows the emergence of a new consumer market of a nondiagnostic ultrasound business and establishment of a new medical standard in prenatal care [38].

The attention paid to the material world enables researchers to see how things mediate cognition and action – both of vital interest to sociologists, psychologists and anthropologists. By analytically following objects into various contexts of their lives, the approach allows for the uncovering of numerous connections and diverse meanings and practices evolving around the materiality of medicine.

SUMMARY

The presented article selectively reviewed the potential, theoretical and methodological contributions of the anthropological discipline to the field of applied health research in Poland. It argued for anthropology to offer crucial methodology for researching and interpreting the health system and practices which evolve in relation to the body, illness and healing. It highlighted a need for a team approach and use of holistic perspective in tackling the issues related to illness and well-being. It agued for an effective health system in Poland to be a realistic project if the serious attention and financial support are given to multidisciplinary research projects of which anthropology is a part. Anthropologically informed research will surely allow for designing better international and national programmes in which patient's interest constitutes a starting point.

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