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Title: Afterword: ghostly ethics

Author: Alice Street

Affiliation: University of Edinburgh

Contact details:

School of Social and Political Science

University of Edinburgh

15a George Square

Edinburgh

EH8 9LD

+44 (0)131 6515573

Alice.Street@ed.ac.uk

Twitter handle: @DiaDev_Research

Website: www.diadev.eu

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Author biography: Alice Street is Senior Lecturer in Social Anthropology at the University of Edinburgh. Her research focuses on hospital ethnography, health systems research, global health interventions and medical innovation. She has carried out ethnographic research in Papua New Guinea and India and is the author of 'Biomedicine in an Unstable Place: Infrastructure and Personhood in a Papua New Guinean Hospital'. Her current research investigates the design and use of diagnostic devices in global health (www.diadev.eu)

Afterword: ghostly ethics

Alice Street, University of Edinburgh

Patients in Madang Hospital Papua New Guinea, where I carried out ethnographic fieldwork in the early 2000s, knew hospitals to be haunted by spirits for a simple reason: people die there. The proximity of death in the hospital - the cold concrete slabs of the morgue lay only a few metres away from the wards that housed patient beds – was not unnerving in itself. Instead, it was the unresolved nature of hospital deaths that raised the prospect of malevolent forces circulating. Patients and relatives often perceived hospital deaths as untimely, either brought about by murderous acts (including sorcery or poison) or hastened by the failure of the hospital staff to 'see' the patient's sickness and give it a 'name'. But all deaths in the hospital were also unresolved in that they occurred in the wrong place. Admission to the hospital, where a patient is separated from their kin and is unable to contribute to the relationships that sustain life in their home village causes intense '*wori'*, which prevents hospital medicine from working, depletes the body, and can ultimately bring about death.

Patients and relatives also lamented the fact that deaths in the hospital, by contrast with the village, could not be dealt with in the appropriate way. The closely governed institutional environment inhibited the outpourings of grief that would normally follow a death and, in any case, there were rarely enough relatives present to show the proper levels of reverence for the deceased. This overwhelming sense that deaths in the hospital are out of place was compounded by the difficulty and expense involved in transporting bodies to the village, and the spirits of the deceased who had been abandoned by kin in the hospital ward were said to wander the hospital grounds looking for a way home, confused, angry and

vengeful. Nurses used white bandages to tightly bind the body as soon as possible after the time of death, ostensibly to ensure that infectious fluids did not leak out of the cadaver, but also in a bid to contain the dead person's spirit until they could be repatriated to their home village.

The association between hauntings and unresolved deaths is not peculiar to Papua New Guinea. It also pervades Euro-American popular culture, with hauntings in novels and films often representing the resurfacing of unknown or unresolved crimes. But what is notable about Madang Hospital's ghosts is that hospital deaths are unresolved precisely because they occur in the hospital. Is there then something specific to the hospital as an institution and a site of biomedical care that is conducive to haunting? The contributions to this special issue would lead us to think so, and in this afterword I briefly explore two productive engagements with hospital hauntings that run through the papers, with wider implications for how anthropologists approach hospital ethnography more generally. First, and most prominent, are the authors' theoretical elaborations on the affective politics of hospital space. Actual or metaphoric hauntings interrupt rational, technocratic orderings of hospital space and reveal the awkward coexistence of the spiritual and ephemeral with the biomedical and political in hospital encounters. Second and less explicit, but I suggest potentially more significant, is the engagement with haunting as a form of ethical critique, and the initiation of a conversation about the alternative futures that anthropologists might imagine for hospital biomedicine in contexts of longstanding social and economic inequality.

Haunting and affective infrastructures

Euro-American scholarship on haunting, which is heavily influenced by psychoanalytic theory, often construes hauntings as repressed memories or events from the past that erupt into the present (see Derrida 2004; Frosh, 2012; Gordon, 1997). Ghosts transmit silenced

knowledge across time and between generations. They are remnants of events from another time that have been repressed but not wholly forgotten. Like psychoanalysis, which seeks to exorcise ghosts by drawing them to the surface, revealing them and giving them voice, many of the anthropological contributions to this collection actively 'conjure' (as Pinto puts it, following Derrida, in her introduction to this issue) the traces of past colonial and medical traumas as a means of understanding people's uncanny experiences of hospital space in the present. The focus by several authors on the haunting of hospital infrastructures by past unresolved inequalities, injustices and suffering conform to this genre of ghostly analysis. Thus, we learn that physician-patient interactions in a Parisian hospital are haunted by assumptions about race and immigration that were built into the hospital's original construction as a labour hospital for North African migrants and colonial subjects (Kehr, this issue). Stories about Jinns encountered in a hospital in the former princely state of Jammu and Kashmir and today, the militarized India-Pakistan border signal the surfacing of buried yet also continuously affective colonial histories, and 'suggest the complex imprinting of loss on physical geographies, and the rising up of trauma through soil, space, and infrastructure to unsettle the present' (Varley and Varma, this issue). The locally funded sections of a hospital in Cameroon, where the meagre infrastructure that is available contrasts starkly with that provided through externally funded disease control programmes, are haunted by 'traces of a repressed past, of the practices of colonial medicine, state violence, health inequalities, and global neglect' (Chabrol, this issue).

It is noteworthy that several articles attend to hospitals as 'ruined' spaces; zones which come across, as much for the anthropologist as their interlocutors, as being simultaneously appalling and riveting. The work of Ann Stoler, and her concept of 'ruination' – understood as the 'degraded environments and personhoods' that are produced by the longue duree of empire – is an influential presence (Stoler 2008:196). The concept of

ruination draws attention to the affective, emotional and political qualities of the material spaces they studied and experienced, enabling them to 'see hospitals beyond Weberian rational "ideal institutions"' (Varley and Varma, this issue). In some cases, ruins emanate the sense of loss that accompanies failed modernist aspirations; they are haunted by lost futures. In others, institutional decay carries long-term experiences of injustice and social exclusion into the present. Haunting thus summons the affective excesses and remainders of modern science and planning to the surface of ethnographic analysis.

As Pinto points out in her introduction, many of the articles in this special issue are not *about* ghosts as such, but about *ways of knowing* ghosts – in this case as reappearances of a repressed past – to explore the ways in which colonialism and past conflict shape biomedical space and relationships in the present and undergird hospitals' imagined futures. This interpretive move from conceptualising ghosts *in* infrastructure to conceptualising infrastructure *as* ghostly, as Pinto points out, might tell us as much about how we seek to know the world as the worlds we seek to know.

This collection engages with haunting as a mode of critique rather than nostalgia. When coupled with the concept of ruination, haunting, however, also continues to carry a lot of epistemic baggage. On the one hand, the danger of a ruination optic that demands long descriptions of broken equipment, rusted roofing, and peeling paint, is reminiscent of the orientalist gaze that obsessed over the fall of past civilisations. On the other hand, the civilisation that has fallen (or never had its ambitions fulfilled) risks being understood as our own: the unrealised ruins of modernist projects can captivate anthropologists, and those trained in a Euro-American tradition, for instance, precisely because of what they tell us about the hubris intrinsic to the desire for epistemic and territorial control.

This is why I find it fruitful to explore another dimension of haunting that runs through these papers, but which has perhaps been made less explicit in the framing analysis.

Temporal constructions of haunting as repressed histories and submerged traumas do not exhaust the concept and the contributions to this special issue; rather, they signal the beginnings of an enquiry into affective infrastructure that moves us beyond the provincializing optics of ruination to engage with haunting as a form of ethical critique.

Haunting as ethical critique

The hospital ghosts that feature in this special issue do not only make the past visible in the present. They also portend the affective and structural uncertainties inherent in how anthropology's interlocutors engage with hospital infrastructures, and make sense of medical outcomes, in the future. These ghosts disrupt the very notion of the hospital as a site of life-sustaining care. The ghosts we meet in these pages, then, are not external agents that force their way into the institution from outside; they are the progeny of hospital biomedicine. The hospital jinns described by Varley and Varma, for example, are 'neither alien to nor separable from medicine, but inextricably bound up with its local practice and outcomes.' What these ghosts make visible, then, are the excesses, harm, and suffering that are integral to hospital medicine, but are commonly excluded from formal accounts (and the accounts that medical practitioners tell themselves) of Hippocratic biomedical ethics.

It is apt that many of the articles explicitly attend to iatrogenic suffering. In the public hospital in Cameroon described by Chabrol, haunting takes a pathological form. Irresponsible and racist colonial medical campaigns resulted in widespread infection with viral hepatitis. The patients diagnosed in the hospital today often only find out they have the disease when they attend the blood bank to donate blood for relatives who have been admitted to the hospital with more acute conditions. Here , Viral Hepatitis appears as a 'ghost' from a violent colonial past. But, importantly, Chabrol also employs the concept of haunting to question the

ethics of diagnosing people with a disease in the present, for which there is little prospect of treatment, when knowledge of that diagnosis can itself disrupt kinship relationships and affect social and mental wellbeing in the future. In Gilgit Town in Pakistan-controlled Kashmir, sectarian violence frequently threatens to erupt inside the hospital and patients voice concerns that the exclusions generated by everyday triaging and staff neglect follow sectarian lines. Here stories about Jinn articulate the precariousness of hospital living in a setting where strangers cannot automatically be trusted to care. In both papers, Jinns or ghost-diseases draw attention to the disjuncture of dominant narratives about biomedical ethics, which emphasize the life-sustaining capacities of medicine, and actual practices of biomedical care, which can be disruptive and damaging to social and biological life, in many hospital settings.

The effect of bringing these different articles together under the figure of 'haunting' is that iatrogenic suffering does not figure as a rare exception to biomedical norms, but is a constant 'ghostly' presence that challenges the very notion of the hospital as a site of care. The Papua New Guinea example is a case in point. What, for example, would it mean to understand *wori* as an iatrogenic disease? In these tragic accounts of iatrogenic suffering, the trope of haunting – especially in fraught postcolonial settings or medical modes - serves as a means for anthropologists to introspectively engage with local understandings and criticisms of hospital medicine, and to scrutinise its intrinsic shortcomings and failures.

Even when ghosts themselves do not appear in the articles, haunting is employed as a form of ethical critique. Krauss interprets women's collective expressions of pain in Mexican abortion clinics as the forced embodiment of the moral paradoxes that lie at the heart of Mexican abortion law, which simultaneously criminalises all abortion and grants exceptions from prosecution for morally acceptable cases. Krauss conjures pain as a ghost that haunts the law (and anthropological preoccupations with the law) with fundamental ethical questions

about the ways in which the moral ambiguity of (Catholic) legal codes affect the wellbeing of women. Kehr employs the concept of 'haunting' to describe physicians' discomfort with the racialized medicine that they practice in the hospital and to capture their desire for a 'medicine otherwise', which might be understood as a desire to build a racially attuned hospital ethics. In Srinagar, the long-term mental health patients that are left behind in the hospital ward in the wake of a policy shift towards care in the community are described as Jinn-like, 'both their physical existence and the fact of their incarceration are disruptive to the social order, embodying the limited reach of current totalizing projects.'

In her recent article on the hauntings of shipyards on the Hoogly River, India, Laura Bear argues that the frequent appearances of ghosts – in the form of jinns – help workers to articulate the limitations and exclusions of a labour ethics premised on perpetual growth (Bear, 2018). Stories about jinns express an alternative ethics of labour, in which work leads to death and suffering as well as growth. In a workplace where horrific accidents and minor injuries alike are daily occurrences, ghosts 'draw attention to the excluded element' of a capitalist ethics premised on productivity, growth and vitality —'individual suffering, decay and death' (Ibid). The ghosts of popular working class Hinduism 'do not manifest a traumatic collective *memory*—an unacknowledged past does not emerge through their agency. Instead… they allow hidden individual suffering *in the present* to return as a collective tangible visceral experience' (Ibid: references omitted). I, too, suggest that ghosts fulfill a similar purpose in the hospital environment, giving voice to counter-narratives that challenge the medicine:disease oppositional dyad and making visible the ways in which hospital medicine, precisely because of its embeddedness in colonial institutional histories and social inequalities, may be generative of disease, death and suffering.

Hospital futures

Ghosts have fulfilled a dual analytic function in the articles that feature in this special issue. In one mode, often dubbed 'hauntology' (following Derrida (2004), and influenced by psychoanalytic and postcolonial theory, they make affectively present the un-extinguishable, deferred remnants of repressed violence and wrongdoing that took place in the past. The contributions to this special issue show hauntology to be a singularly productive means of drawing attention to the 'multidimensional and multiply temporal' nature of hospital space (Varley and Varma, this issue). In the second mode, which I term 'ghostly ethics', they reveal the excesses, limitations, and impossibilities of a biomedical ethics that is premised on care, trust, and medicine as a life-sustaining force, when it is embedded in hospital infrastructures. Ghostly ethics reveal the abusive relationships that shadow hospital care in places of sectarian conflict, the fruitless pursuit of diagnostic knowledge in places without therapeutic resources, the uncertainty and unpredictability that perpetually haunts medical claims to authority, and the moral ambiguities that saturate medical law. In all these instances, ghosts give voice to people's experience of hospital medicine as the cause of suffering, uncertainty and death, as well as their amelioration.

From the perspective of ghostly ethics, hospitals are haunted because hospital medicine is always shadowed by unresolved ethical questions about the good or harm that institutional care can do. In Papua New Guinea spirits frantically travel through hospital corridors because people die in the wrong place: institutional relationships between patients, doctors, nurses, and kin are experienced as prohibiting the production of healthy bodies. As ethical critique, haunting gives voice to concerns about the intrinsic failings of hospital medicine and generates conversation about what 'medicine otherwise' (As Kehr puts it, this issue) might look like for the future.

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