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Ontology as an analytical approach to concerns of medical anthropology

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By Tanja Ahlin

What might arise from an encounter between medical anthropology and science and technology studies (STS) as they investigate the common subject of health and (bio)medicine? One answer could be found at the panel [Repositioning health, illness and the body: the challenge of new theoretical approaches to medical anthropology](#), organized by [Simon Cohn](#) and [Rebecca Lynch](#) at [ASA^{\[1\]} decennial conference](#) in Edinburgh this past June. The panel presenters were tinkering with the application of “the ontological turn” as an analytical tool in medical anthropology, inspired by the STS notion of “ontology,” which posits the existence of multiple realities of the body (Mol 2002, Farquhar et al. 2014).

As Simon Cohn noted in his introduction, the analytic approach(es) offered by the ontological turn might inspire new insights into old distinctions – such as nature/culture and reality/representation – that persist in medical anthropology. According to Cohn, by emphasizing cultural variation, anthropology has perhaps “not only reproduced but also reinforced the position that reality is fixed and singular.” Since anthropology has historically focused strategically on representation it has “left it to other disciplines to make claims about reality itself,” Cohn suggested.^[2] In following the way in which STS has unpacked representation, medical anthropologists are reminded that realities, including those of the body, are constructed through practices.^[3] Along this line of thought lies a realization that not only culture, but nature too is plural: the scientific (biomedical) idea of the body as a universal standard becomes questionable, since the human body is not the same in societies around the world.

Rebecca Lynch and Simon Cohn illustrated this point through their ethnography of self-monitoring technologies in weight reduction. They proposed that the body is not culturally, but *literally* constructed by medical practices, scientific discoveries, and individual actions and experiences. In the trial that Lynch and Cohn analyzed, the medical body was “done” through measurements and monitoring of the participants’ bodies (i.e. their body mass index, height, weight, blood pressure and so on), as well as through participants’ own experiences of fitness. In the cases they unpacked, monitoring became “a further means to know how the body is

in the present, and to experience the body through new terms, new concepts and new forms of bodily knowledge.” Bodies, they found, were objects and subjects simultaneously.

[Maryon McDonald](#) also investigated how the body is “done” in the biomedical context, though in the case she presented this happened not through measurements of the body, but through its various representations. She explored the construction of biomedical realities of the body in anatomy classes. McDonald showed that medical education was not simply about learning to “see what is there,” but that becoming a biomedical practitioner involved acquiring “a particular kind of vision.” Such medical “eyes” were trained through a number of two- or three-dimensional representations of bodies, from photos to skeleton models to cadavers and live bodies. According to McDonald, these representations testify to the multiplicity of the body in anatomy with which students live all the time. In order for students to become (good) doctors, they must learn what McDonald referred to as “ontological choreography,” namely rapid switching between different representations, from bodies as x-ray images to bodies as live patients.

[Susie Kilshaw’s](#) study of miscarriage in Qatar illustrated that biomedical categories are far from fixed, as there is considerable movement and flexibility of definitions within the medical field. While miscarriage could be defined in terms of measurements such as “weeks of completed pregnancy” or “weight of the fetus at the time of miscarriage,” Kilshaw’s fieldwork showed that there is no definite answer to the question of *how many* weeks have passed or *how much* a fetus weighs. Further, both obstetricians and patients constantly shifted between various medical and religious (in this case Islamic) categories: there was much ambivalence about when an object was a fetus, a baby, an (imagined) child, or, in case of miscarriage, a “bird in heaven.” Kilshaw noted that each fetus may hold multiple realities for those that come into contact with it, such that the body of a miscarried fetus may be at the same time a piece of the mother’s body tissue, an embodiment of a lost potential, and a missed opportunity for a mother (and father) to secure social standing.

In a project examining interdisciplinary research on appetite and weight loss after obesity surgery in Denmark, [Bodil Just Christensen](#) found it crucial that medical scientists use their clinical knowledge much like the “lay ethnographers” described by Mol (2002). This enabled biomedical doctors and anthropologists to work *together*, rather than *alongside* each other. The joint exploration of the practices through which appetite was enacted led the researchers to a shared definition of appetite, which arose as a fractional “material-semiotic assemblage consisting of layered meanings of many ontological kinds.” This approach revealed how the taken-for-granted “nature” of appetite was constructed through the

scientific categories of the biological, the psychological, and the social. Biology and society were not ontologically given, but brought into reality in specific, situated ways.

A notable argument made in the panel was that the ontological turn should perhaps not focus on multiple realities of “the body” to the degree that it has. Based on her case study of weight reduction in Guatemala, [Emily Yates-Doerr](#) explained why she was wary of “the body” as a focus of medical anthropology. The field of medical anthropology has long divided “the body” into individual, social, and political forms (see Scheper-Hughes and Lock 1987). While this division may be an attempt to add complexity to the biomedical treatment of the body as a biological unit, it also risks inserting the analytic of “the body” into arenas where bodies are not (or ought not to be) a central matter of concern. In her research, a division between individual and political bodies “allowed practitioners to treat obesity as a problem of personalized medicine,” thereby ignoring the health concerns of those seeking obesity treatment, in which personal health was not separable from food and land sovereignty or the well being of spirits and networks of kin. Yates-Doerr suggested that the theoretical approach of the ontological turn was useful in its encouragement of “engagement with empirical specificity”; rather than aiming to establish the truth of the body and its health, it made space for “a possible truth that exists among others.” Her final appeal to the audience was to “consider what might emerge if we depart from a focus on ‘the body’ and its enumeration.”

[Else Vogel's](#) presentation turned away not only from the body, but also from biomedicine as the research context. In her study, participants of a “mindful weight loss” course in the Netherlands strove to see weight loss as one of the consequences of a renewed relationship with *eten*, which in Dutch refers to both food and eating. As course attendees explored eight different types of hunger (of eye, nose, ear, mouth, belly, body, mind, and heart), the body became much less important than it appears in the biomedical approach to obesity, which emphasizes the correction and normality of the body. In contrast, in the practice of mindful eating, obesity and weight loss were about relationships with one’s emotions, one’s self, and one’s body, which Vogel discussed in terms of hungers, desires, and needs respectively. In illustrating that the pressing issue for the people she worked with was not “what *is* the body?” but “what can the body *be made to be*?” Vogel reminded us that ontology may not be the most salient concern for the analysis of all bodily practices.

As Cohn noted in his introduction, “talking about ontologies is talking about power and politics ... in terms of close and proximal ways in which diverse ontologies sometimes contradict, sometimes cohere, and at times manifestly compete with each other.” But what are the risks of juxtaposing

ontologies that arise from different disciplines or social contexts? Stefan Reinsch, for example, discussed multiple realities in the case of early detection of schizophrenia in Germany through patients' self-reporting and specialists' diagnoses that were based largely on "gut feeling." This practice was directly related to early detection and prevention of psychosis, before the actual onset of the condition. The key was to discover who was at risk and, as Reinsch showed, this was done by means of comparison with representations of actual patients, specifically their eyes and particular utterances. The risk in this kind of practice is, of course, the possibility of false identifications that entail potentially unnecessary preventive measurements.

Similarly, [Sahra Gibbon's](#) work on cancer genetics in southern Brazil mentioned the danger of juxtaposing the ontology of molecular biology and the ontology of inheritance as explained by (potential) cancer patients. According to the latter, a person may inherit cancer not through genes, but through the conjoined effects of emotions, stress, problematic family relations, and traumatic events. As Gibbon explained, the notion that the body can be biologically altered by the impact of emotions across generations evokes a particular neo-Lamarckian conceptualization of inheritance and transforms the understanding of epigenetic mechanisms of disease. In the Brazilian context of expanding neoliberal ideas of the self, particular evangelical Christian beliefs and practices, and the rising media discourse on self-improvement, the emerging idea that cancer risk is embodied through intersubjective emotions could influence (perhaps in troublesome ways) how cancer is assessed and treated. Since such "local biologies" have real and far-reaching political consequences, Gibbon suggested that this was an important area for further anthropological analysis.

Some papers in the panel also evoked possible problematic aspects of applying the ontological approach too broadly. For example, Kilshaw suggested that in the contemporary social and political context in which the trope of Islamic terrorism thrives, the ontological turn could be misused against some groups of people. Following Vigh and Sausdal (2014), Kilshaw warned that advocating incommensurable difference as an analytical point of departure could lend itself quickly to (potentially dangerous) political constructions of Otherness. Ontology as a tool to investigate reality construction seems to be a useful approach for studying biomedical practices, but extending it to other contexts requires thoughtful caution.

In the panel conclusion, the discussant [Judith Farquhar](#) emphasized that the notion of multiple realities, which is central to the ontological turn, is not really news to medical anthropology. This point was also made by some of the presenters; among them, Kilshaw suggested that social

scientists should not completely neglect “a certain commonality (which is) a methodological precondition for our research.” Instead, she recommended that we try to engage with both the notion of alterity and commonality simultaneously, as they are both parts of reality. Additionally, despite some hints that this question has already been dealt with in some other time and place (though it is unclear, exactly, where), I would have found useful a more engaged discussion of how the term “ontology” differs from expressions such as “representation,” “perspectives,” “point of view,” and so on, and in what ways these words are more than synonyms.

Finally, Farquhar also stressed that there were concerns more pressing than that of overcoming Cartesian dichotomies. Instead of rendering everybody’s history equally as empiricists, she proposed that we bring the focus back to ethnography, not forgetting its main aim, which is, in Farquhar’s view, “an intervention from outside medicine.” The panelists had indeed offered some hints about the answer to this query in their presentations. Christensen, for instance, said that health interventions might improve because of the recognition of “ecological complexity” (Cohn et al. 2013), which could help to avoid simple reductionism, make way for alternative explorations of knowledge production, and make space for different and better intervention practices. Likewise, Yates-Doerr called for a “chang[e in] how we understand – and do – politics.” Instead of *prescriptive* politics, “made of stable, countable, knowable units to be added together and subtracted apart,” she advocated for a *descriptive* politics that “incorporates mess and contradiction” and “makes room for a health not located within a bounded body.”

But I wonder if it is perhaps time to make our interventions more explicit than that. One of the [post-ASA conference reports](#) pointed to the irony of social scientists having theoretical conversations about society (societies) among themselves while happily ignoring that very society. This concern is especially pertinent to medical anthropology, where our informants may have to tackle yet another distinction – that of life and death, however fluidly and complexly they might think of these terms. The question that remains is how to introduce and discuss these and other related important observations from the panel to the biomedical and patient societies that were talked about, but not with, in the event. What new universes would come into being if, for instance, this panel were presented at some other kind of conference, outside the realms of social sciences? What politics and futures would follow if we were to launch such discussions with the biomedical scientific community, health practitioners, and patients in the audience?

This may seem like an ambitious venture, but long journeys are always undertaken in small steps. For example, just before the ASA conference

took place, a workshop on narratives and dementia was organized at the [Amsterdam Institute of Social Science Research \(AISSR\)](#), which included anthropologists as well as practitioners working with people with dementia. Among other topics, the discussion considered how the two groups could enrich each other's work. Naturally, the workshop involved some tensions of approach and framework, but far beyond that, it shed light on the potential rewards of social scientists reaching beyond the ivory tower. It seems that these grounds could and, I suggest, should be more fruitfully explored in the future.

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[1] Association of Social Anthropologists of the UK and Commonwealth.

[2] This echoes Mol's (2002: 21ff) statement that by trying to add their specific knowledge about bodies (explained through meaning, experience and embodiment) to the medical conception of the body, anthropologists have both solved and created the problem of nature/culture distinction in medicine, which exemplified by the disease/illness dichotomy.

[3] Among others, Bruno Latour reiterated this point in his opening statement as a part of "The ontological turn in French philosophical anthropology," an executive session of the AAA Annual Meeting in 2013. A revised version of the speech has been published recently (Latour 2014).

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