

of cultivated detachment in professional formation by investigating practice in Malawi. There, where needs routinely outstrip resources, self-consciously peripheral professionals struggle with the burden of knowledge that extends beyond capacity. Overworked and often overwhelmed, they learn the art of “flexible resourcing” and search for ways to make sense of their predicament and the suffering around them, including increased political activity. One thing they emphatically do not do, however, is blame their patients. In this terrain illness appears far less a matter of personal responsibility.

I find little to object to and much to endorse in the author’s account. The scenes she describes will be familiar to anyone acquainted with what is politely glossed as a “resource-poor setting”—the stark prospect of hard mats, cinderblock walls, and fetid smells, the sheer surplus of suffering. Any one of the anecdotes she provides effectively dissolves the bureaucratic patina on the phrase “health care delivery.” Biomedicine here involves constant struggle, in terms that are as much ethical as technical. It is little surprise that the shift from theory to practice would thus prove particularly disruptive.

However, I would expand on the comparative reference Wendland makes near the end of her article. Throughout, I was struck by the similarities to humanitarian medicine, at least as practiced by organizations like Médecins sans Frontières (MSF). If generally better equipped, they face a similar excess of need. Moreover, they likewise prize passion as much as medical rationality and treat patients as categorically deserving. The mere fact that such humanitarian NGOs exist recalls the moral ambitions invested in health work by some practitioners and publics. So too does the striking popularity of medical aid projects and the continued proliferation of programs in “global health.” Thus, it seems clear that the technical reorientation of biomedical training and its emphasis on body over person does not invariably lead to emotional detachment, at least when projected onto a global frame. Rather, what is most distinctive in this setting is that the evident lack of means appears a *national* failure, a breakdown of the political promise of a modern nation state. As Wendland notes, Malawian doctors in training focus not on biological reductionism or the individual sufferer but rather on broader social and political frames.

Here too one can note parallels in the moral logic of humanitarian actors. The classic narratives of contemporary aid are ones of rupture (emergency relief) and progress (economic development). The real patient in metaphorical terms is the social and political order, embodied in state capacity for service delivery. Beyond this common diagnosis political prescriptions differ as to whether an increase of governmental structure or market activity would provide a surer remedy. A Christian NGO like World Vision and a secular European one like MSF (not to mention a Cuban international medical brigade) maintain distinct sensibilities about the state. But in the face of endemic poverty they do share a common respect for need, one that differs significantly from the emphasis on

individual responsibility usually ascribed to the neoliberal moment.

Rather than a global norm of medical work, adjusted to varying circumstances, Wendland suggests we think in terms of exchange. Her vision of moral economy involves a trade in explanations and moral ideologies, one that privileges those that “offer opportunities for meaningful action.” The practice of medicine, it seems, makes poverty newly visible, even to young Malawian doctors familiar with life beyond the clinic walls. It does something similar to those involved in international aid or exchange programs, including Wendland herself when she asks repeatedly, “What kind of hospital is this?” Poverty in this sense is not simply a preexisting condition but a direct confrontation with incapacity in the form of clinical failure that exceeds the patient. The question then becomes where one seeks meaningful action once beyond health education and the formation of hygienic subjects. If framed in political terms, what forms to advocate in response to gross inadequacy? Some of the Malawian student doctors Wendland encountered pursued classic forms of advocacy for particular causes, battling corruption and injustice. Aid organizations sometimes do the same in the name of either human rights or humanitarian needs and on occasion engage medical training (Minn 2011). But whereas Gramsci wrote with reference to revolutionary change, it remains less clear whether any of these actors imagine political orders beyond the postcolonial nation state.

One challenge for anthropology, then, is to better grasp the plural legacy of moral exchange around medicine, and its relation to contemporary concepts of practical action. In that endeavor this article is a most salutary start.

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This article is about the traumatic transition from classroom to bedside for Malawian doctors-in-training and the political awareness this engenders in them. Claire Wendland’s description leads her to a surprising against-the-current statement that Malawian medical professionals are not the frustrated, disinterested, authoritarian, and callous practitioners that are portrayed in public opinion and popular media as well as in serious publications about doctors and nurses in sub-Saharan Africa (e.g., Andersen 2004; Jewkes, Abrahams, and Mvo 1998; Senah 2002). The author positions her interpretation in the now widely accepted view that biomedicine is not a universally identical phenomenon but takes different forms in different cultural, political, and economic contexts, in spite of globally similar medical textbooks and theories (van der Geest and Finkler 2004; Zaman 2005). Almost provocatively she contrasts the politically conscious Malawian (future) doc-

tors with their American colleagues who—she says—turn apolitical, reductionist, and cynical when they start practicing their profession.

I admire her lucid exposé of an African biomedicine and welcome her respectful ethnography, yet I have some concerns about the outcome of her argument. My comments can be—extremely briefly—summarized as “too nice to be true,” although “nice” may not be the best qualification for the deplorable conditions in the hospital that provides the scene for her study.

I am afraid that the ethnographic evidence for her conclusions about the politicization and demedicalization of these doctors-in-training is not entirely convincing. The author must have a tremendous amount of observation at her disposal, having taught and worked for several years in the hospital and its medical college, but in this text she is mainly led by words that her students spoke (and words that they did *not* speak). I am inclined to take these words not as evidence of a different medical attitude but as a way of coping with the situation and rationalizing their impossible position. The words seem to me a performance of dignity, almost like Scott’s “weapons of the weak” (1985). There is no concrete evidence (in the text) that—apart from these words—the students practice what they preach. Of course, they hardly engage in medico-technical reductionism as their American counterparts are said to do, because there is little technological apparatus with which to carry out such reduction. But evidence of whether a demedicalized and politicized medicine takes its place is nowhere to be seen in this article. It seems more likely that they just try to manage with what they have (as the author also indicates a few times).

Zaman (2004, 2005), in his ethnography of an impoverished Bangladeshi state hospital (full of frustrated doctors), speaks of the “inventiveness” of doctors. Martin (2009), who studied the deep gap between school and clinical reality for nurses in an equally poorly equipped Ugandan hospital, remarks that nurses emphasized how they “improvised.” That term cleverly united the good intentions of the nurses with the severe handicaps they met in their work. They recognized the poor quality of their work but could blame it on others. The similarity between these two accounts and the Malawian situation is indeed striking. Criticizing the “failing state” (as Wendland calls it) is not only justified, it also helps the doctors and nurses to keep up their self-esteem. I suspect, therefore, that the main difference between biomedicine and, more specifically, hospital culture in Malawi and—let us say—the United States, is not so much the political-mindedness of the Malawian doctors versus the narrow clinical gaze of the Americans but the material conditions under which the two groups have to work.

Finally, although the brain drain of Malawian doctors is mentioned, its relevance for Wendland’s argument is not taken into account. I searched in vain the Internet for reliable statistics; what I found varied from 10% of doctors trained in Malawi working abroad to almost 60% (including those

who were trained abroad and chose to stay there). Apart from the brain drain overseas, most Malawian doctors who stay in the country try to find work in the private or semiprivate (church-related) sector where conditions are much better than in the public facilities. And finally, I suspect—based on my own research in Ghana and Cameroon and on publications about other African countries—that doctors in public hospitals often have their own private practice where they work part of the day to top up their meager income. All these maneuvers would indicate that they do try to make a living as medical doctors rather than entering the political arena to change the structural problems that obstruct humane health care.

Reply

It is a real pleasure to be engaged so thoroughly by 11 scholars whose work has enriched my own thinking over the years. Their comments give me much food for thought, now and as my research continues. I read the responses as falling roughly into three categories: ethnographic questions, concerns of scale, and theoretical directions.

Some of the commentators sought additional ethnographic information. Because the timeline for this article was unexpectedly prolonged, I am in the awkward but delightful position of being able to refer readers to a book-length exposition of this argument, submitted after but published before this paper. Many of the ethnographic questions raised here are discussed in detail in Wendland (2010). I will nonetheless address them briefly.

Kyaddondo wondered whether students’ personal experiences with Malawi’s medical system, either as patients or as the “guardians” who care for hospitalized family members, prompted them to become doctors. He correctly supposes that kinship obligations are important to students’ professional trajectories. Many students described encounters with illness or injury in the family as the initial impetus to a medical career. In some cases they were compelled by clinicians’ careful therapeutic work. In others, mistreatment at the hands of medical professionals pushed them to become doctors themselves. Several students noted that facilitating access to medical care for family members was an important (if burdensome) facet of becoming doctors. Kyaddondo’s other question is more challenging: why, given earlier exposures to Malawian hospitals, did students react so strongly to their clinical immersion? Most students were indeed already aware of the material realities they were to face. (A few were from wealthy families who consistently sought medical services outside the devastated public sector.) However, they had not yet faced these realities as people charged with healing, newly possessed of the medical knowledge necessary for treatment but dispossessed of many key technologies. Many but not all seemed