Social Science & Medicine 99 (2013) 176–186

Contents lists available at SciVerse ScienceDirect

Social Science & Medicine

journal homepage: www.elsevier.com/locate/socscimed

The good-enough science-and-politics of anthropological collaboration with evidence-based clinical research: Four ethnographic case studies

Luke Messac [a], Dan Ciccarone [b], Jeffrey Draine [c], Philippe Bourgois [d,*]

[a] University of Pennsylvania, Department of History and Sociology of Science and School of Medicine, USA
[b] University of California San Francisco, Department of Family & Community Medicine, USA
[c] Temple University, Department of Social Work, USA
[d] Department of Anthropology and Department of Family Medicine & Community Health, USA

ARTICLE INFO

Article history:
Available online 17 April 2013

Keywords:
San Francisco, Philadelphia, United States
Participant observation ethnography
Injection drug users
Incarceration
Structural vulnerability
Underserved populations
Homelessness
HIV prevention/treatment
Politics of science and health

ABSTRACT

The apolitical legitimacy of "evidence-based medicine" offers a practical means for ethnography and critical social-science-and-humanities-of-health theory to transfer survival resources to structurally vulnerable populations and to engage policy and services audiences with urgent political problems imposed on the urban poor in the United States that harm health: most notably, homelessness, hyper-incarceration, social service cut-backs and the War on Drugs. We present four examples of collaborations between ethnography and clinical research projects that demonstrate the potentials and limits of promoting institutional reform, political debate and action through distinct strategies of cross-methodological dialog with epidemiological and clinical services research. Ethnographic methods alone, however, are simply a technocratic add-on. They must be informed by critical theory to contribute effectively and transformatively to applied health initiatives. Ironically, technocratic, neoliberal logics of cost-effectiveness can sometimes render radical service and policy reform initiatives institutionally credible, fundable and capable of generating wider political support, even though the rhetoric of economic efficacy is a double-edged sword. To extend the impact of ethnography and interdisciplinary theories of political-economic, cultural and disciplinary power relations into applied clinical and public health research, anthropologists – and their fellow travelers – have to be able to strategically, but respectfully learn to see through the positivist logics of clinical services research as well as epidemiological epistemology in order to help clinicians achieve – and extend – their applied priorities. In retrospect, these four very differently-structured collaborations suggest the potential for "good-enough" humble scientific and political strategies to work for, and with, structurally vulnerable populations in a punitive neoliberal era of rising social inequality, cutbacks of survival services, and hyperincarceration of the poor.

Introduction

Anthropology's version of participant-observation ethnographic methods has carved out a productive space within the social sciences as a creative, but unruly, step-child. Anthropologists maintain their methodological feet very much on the ground but keep their theoretical head in the thin, provocative air that straddles the social sciences and the humanities. In the health sciences, however, participant-observation is not, for the most part, on the radar screen and qualitative methods remain underdeveloped and, for the most part, subordinated or openly distrusted. Quantitative experimental methods are the basis for clinical scientific credibility. To be considered valid, replicable and generalizable, research measures must be conceptually focused and unambiguously quantifiable – preferably based on biological endpoints: sero-markers rather than behavioral self-report. The gold-standard arbiter of modern evidence-based medicine is the double-blind randomized controlled trial (RCT) which stratifies research subjects to two or more treatment alternatives with a placebo arm in order to test the most basic questions of relative effectiveness of

* Corresponding author. 415 Anthropology Museum, 3260 South Street, Philadelphia, PA 19104-6398, USA. Tel.: +1 267 273 0051; fax: +1 215 898 7462.
E-mail addresses: lmessac@sas.upenn.edu (L. Messac), Ciccaron@fcm.ucsf.edu (D. Ciccarone), jeffdraine@temple.edu (J. Draine), pbourgois@gmail.com (P. Bourgois).

0277-9536/$ – see front matter © 2013 Elsevier Ltd. All rights reserved.
http://dx.doi.org/10.1016/j.socscimed.2013.04.009

specific behavioral, pharmacological, and or/technological therapies.

In public health and medicine, the methodological term "ethnography" when it is used at all, generally refers to a standardized research protocol that would not be recognized by most anthropologists as valid: One-shot, enumerated, formal interviews conducted in an unnatural office environment that is often hampered by the bizarre hoops of arcane regulatory protocols that limit access to "human subjects." Health researchers often use vague, somewhat oxymoronic or even Rorschach terms to describe their version of ethnographic interviews, including "semi-structured" and "guided by grounded theory." To an anthropologist this would raise concerns that the interviews might generate impressions management discourses.

In contrast, anthropology's version of ethnographic methods strives to document context, process and meaning. Methodologically, the goal of clinical research is to rule out alternative explanations, while ethnography is attuned to the contradictory nature of social life. In fact, during the 1980s/1990s with the rise of postmodern critiques of facticity, Euro-centric discourses of linear progress (Clifford & Marcus, 1986), and the brutal legacy of colonialism in North/South relations (Asad, 1973), anthropologists, if anything, over-developed their self-critical faculties teetering on practical, collaborative and political paralysis. They are skilled at documenting the contradictions of power constraints, exceptionalisms, complications, ambiguities and the positionalities of all research participants, including both the subjects and the practitioners. Some epidemiologists might interpret these valuable self-critical theoretical anthropological concerns over the social constructedness of truth as potentially useful for identifying systemic bias or confounding variables, but many quantitative researchers simply ignore ambiguity and inconsistency by dismissing it as statistical noise that can be "controlled for" with a large enough sample size determined through a statistical technique called "power analysis." In this techno-scientific epistemology, there is little room for thinking about "power" as an organizing force in social relations affecting health outcomes. Instead, the epidemiological term "power" is limited to a methodological concern with sample size and statistical calculation techniques.

Despite these deep epistemological differences, there exists the potential for productive scientific and political engagement in cross-methodological collaboration because of ethnography's ability to contribute to a more complexly robust "best practices research" alert to history, social structure and the unequal social power relations that damage health. The case studies that follow seek to highlight both the potential and limits of anthropological engagement with the positivist logics of quantitative epidemiology and even, at times, with cost–benefit analysis. For social scientists studying the roots of poverty in the long shadow of the punitive neoliberal turn since the 1980s, such collaboration can, in certain instances, allow for meaningful improvements in the lives of the poor and marginalized.

For the past two-and-a-half decades, the senior author, Philippe Bourgois (PB), an anthropologist located in medical schools, has been attempting to bring participant-observation anthropological methods and critical theory – at times openly but often by stealth – into direct, practical dialog with epidemiology and clinical research. Most challenging, but potentially most productive have been collaborations with random controlled public health trials and large exploratory prospective studies of medically underserved indigent populations. We present four case studies where distinct strategies of ethnographic engagement with different types of clinical, service, research and policy reform initiatives promoted institutional and political changes with varying success.

The first two ethnographic initiatives contributed to the initiation of quantitatively-organized clinical pilot-tests of new medical procedures and service deliveries for indigent patients in the San Francisco County Hospital. The third initiative is a still-ongoing randomized controlled HIV-prevention behavioral trial testing a Paulo Freire educational model of critical consciousness-raising among inmates cycling through Philadelphia's county jails system. The fourth initiative, in alliance with community-based AIDS activists, used a technical review by medical students of the "evidence-based scientific literature" on "best-medical-practices for the destitute sick," to pressure politicians to allocate funds for subsidized housing for the HIV-positive homeless.

Case 1: founding an outpatient abscess clinic at the San Francisco County Hospital

From 1994 through 2007 PB was conducting participant-observation ethnographic fieldwork in the homeless encampments of an extended social network of heroin injectors and crack smokers in San Francisco. Consistent with the HIV-prevention focus of his NIH mandate, he and his ethnographic team focused their observations on the micro-details of potentially risky injection practices. They added a photo-ethnographic component to document practices visually in real time in the natural environment (Bourgois & Schonberg, 2009). Their first medically-applied observation was that, in contrast to East Coast cities where white powder heroin prevailed, the heroin in San Francisco consisted exclusively of "Mexican black tar" and appeared to be generating severe soft-tissue infections among street-based injectors. They soon realized that "abscesses" were the health pathology of primary concern to local injectors, and were the main reason the homeless sought care in the County Hospital emergency department. Unfortunately, systematic hospital records of this major health problem were not being tabulated, and no national or international best-practices standard existed for the surgical care for soft-tissue infection caused by injection drug use. Virtually the entire San Francisco ethnographic cohort of homeless injectors complained that surgeons at the County Hospital had cut into them without anesthesia and refused to prescribe them painkillers for aftercare. They bore extensive bodily evidence of the post-operative consequences of clearly invasive procedures (scars and open wounds). Sympathetic nurses in the emergency department confirmed that occasionally clinicians refused to provide patients with analgesia and cut more widely and deeply than necessary. Usually this kind of purposefully punitive care was

Photograph 1. Sonny seeks help from Spider-Bite Lou for post-surgical pain and infection after his release from the County Hospital © Jeff Schonberg.