# Web Roundup: Dr. Jim Yong Kim at the World Bank, and, Dr. Robert Spitzer's revocation

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By

In the spirit of the web round-up series, this post gathers links to news stories and timely events of interest to the Somatosphere community that have appeared lately in the popular press and in medical anthropology circles. This month, the spotlight falls on two conversations, which will be treated separately: (1) the on-going conversation about ethics and humanitarianism, highlighted by Dr. Jim Yong Kim's nomination to the World Bank, and (2) prominent psychiatrist Dr. Robert Spitzer revocation of the conclusions of his 2003 study, which supported the possibility that adults may change their own sexual orientation through therapeutic intervention.

**(de)humanitarianism**

Paul Farmer has, over the past years, come to represent the beacon of a medical anthropology that blends the medical impulse of the Hippocratic oath with an ethical humanitarianism; Farmer's key contribution is that being poor – an expression of "structural inequality," rather than some personal moral failing – is no reason that one ought not to receive the best possible medical treatment. Arguing that, from the mountains of Haiti to the prisons of Russia, *health* is a *human right*, Farmer and his colleagues at Partners in Health (PIH) have become a ubiquitous presence in conversations about global health, international humanitarianism, and the public face of medical anthropology.

However, some medical anthropologists remain concerned that Farmer's convictions leave much unexamined. Is the PIH strategy really about combating structural inequality, or is it just a wolf in sheep's clothing, liberal individualist solutions masquerading as redemptive relief?

In a recent blog post, Sam Dubal, a former student of Farmer's at Harvard Medical School, and now a joint MD/PhD student in medical anthropology at UC-Berkeley, argues poignantly for a renewed attention to the socio-political roots of the poverty that produces poor health. Even as Paul Farmer highlights structural inequalities, Dubal points out, the PIH model treats individual bodies, not systemic problems. In fact, Dubal writes, Farmer and PIH cofounder Dr. Jim Yong Kim urge medical doctors

concerned with intervention to forge business partnerships with global players, which may reinforce the same systems of power that inscribed the health disparities in the first place. Citing several medical anthropologists (Fassin 2007; Redfield 2005), Dubal writes:

> Of course, there is no such thing as neutrality or impartiality in humanitarianism. Didier Fassin, a fellow physician-anthropologist and former vice president of Doctors without Borders (MSF), has repeatedly stressed how contemporary humanitarians shift attention from the causes of violence to its consequences in a way that replaces a politics of justice with a politics of compassion – in essence, refuses politics for ethics. Humanitarians, he argues, operate on an inequality of life and a hierarchy of humanity, aspiring to moral untouchability while avoiding a 'parrhesia' – a truth that, once told, can incur a high cost for the teller himself. For humanitarians, this truth is precisely that humanitarian interventions are always political. They are guided, as Peter Redfield points out, by a 'non-ideological ideology' – that is, an ideology that refuses to recognize itself as such. When PIH insists that all life, especially the poor's, is worth saving, it partakes in a negative form of politics that denies the selective reality of its political practices, including questions of sacrifice and triage. … by accepting funding from Bill Gates, it stands politically together with the notion that a ruthless pursuit of profit can be counteracted by charity.

Dubal's blog post was circulated via the H-medanthro listerv, as part of an ongoing, dispersed scholarly debate among medical anthropologists about just what the nature of a critique of humanitarianism ought to be. On the other hand, as one contributor pointed out, Farmer and Kim are themselves critical of "the anthropologist who does not act".

Meanwhile, Kim, who holds an MD and medical anthropology PhD from Harvard, among myriad distinctions, was appointed in March as the new head of the World Bank (WB), following his nomination by President Barack Obama. Some lauded this appointment as a "testament to the power of anthropology to contribute to development and well-being around the world," highlighting, in particular, the fact that Kim's background as a public health professional departs sharply from the general trend of past WB leaders with expertise in finance. At the same time, however, Dr. Kim's appointment reinforced the US monopoly of control of the WB, the Guardian reported. And, other medical anthropologists, critical of the economic platform of the WB, which some argue amounts to neoimperialism, and bearing in mind the ethical questions about humanitarian health interventions that Dubal voiced, perceived Kim's

appointment as merely a minor parallax shift.

Kim himself responded to some of the issues raised with his appointment in a New York Times blog interview. In particular, Kim addressed his own past criticism of the WB's policies and objectives; he asserted that many policies of the WB have changed, particularly regarding what he calls "pro-poor" policies, or institutional objectives that consider the interests of the very poor. Kim articulates a vision of a WB that works within the development economics framework, but does so with the local level in mind.

Kim's path forward is hybridized and optimistic. He situates himself as valuing his anthropological training. Yet, he continues to profess a model of intervention that is positivist, that holds that tested models may be applied again to achieve the same result; and, that subscribes to the logic of economic development as commensurable and even central to the betterment of the lives of the very poor. As Sam Dubal pointed out in an article for a Stanford newsletter, this logic relies on an essentializing logic of both what development is, and who the poor are, imagining either static entities, or entities that move along a singular path of progress. Or, in Dubal's words, central "to the relationship between the aid worker and aid recipient today is a mutual fetishization of each other." Dubal argues that aid intervention, changes both the intervening and the intervened upon in unpredictable ways; and, that the opportunity for mutual transformation goes far beyond health, altering in a profoundly cosmological (as well as political) way, the very consciousness of both aid workers and aid recipients. The same issue of consciousness – especially an ethical consciousness – pertains to altruistic and humanitarian health care initiatives within the United States, as, for instance, medical anthropologist Michele Rivkin-Fish has demonstrated regarding the complex ethical issues that arise when dental students provide care to low income populations (Rivkin-Fish 2011).

On a lighter note, this issue of ongoing mutual transformation (or lack thereof) between aid workers and those targeted by humanitarianism is unpacked, chewed over, and, well, spit back out in the serial blog-novel Disastrous Passions, a tongue-in-cheek bodice-ripper about what really matters to humanitarian workers. Or, for further efforts to consider the "diaspora" culture of expat aid workers, visit Stuff Expat Aid Workers Like, a blog for, by, and about the "SEAWs" highlighting everything from Pinterest boards to self-deprecating memes.

So, the medical anthropology community continues to wrestle with the ethics of intervention, and, indeed of postulating a unified humanity, let alone a universal humanitarian morality. At the same time that some scholars see the world of humanitarianism as effectively feeding a

dehumanizing industry, others continue to struggle to render humanitarianism more receptive to the insights of medical anthropology.

**changing minds: sexual behavior**

This May, prominent psychiatrist Dr. Robert Spitzer of Columbia University, announced publicly in a letter to the journal *Archives of Sexual Behavior*, and in several media outlets, that he now wishes to retract his earlier statements based on the results of a 2003 study, originally published to much controversy in the same journal, to the effect that gay adults who make a concerted effort to reverse their own "sexual orientation" were able to do so through the process of engaging in "conversion therapy" (Spitzer 2003 and 2007). Dr. Spitzer now states that in spite of his initial analysis of the study, he now realizes that it is impossible to verify the factuality of study participants' responses to the end that they had or had not actually changed their sexual orientation through therapeutic processes. Spitzer came forward to revoke his 2003 statements, because, he said, he feels that it is important that he apologize to those fellow psychiatrists, and to those gay adults, who may have "wasted their time" on conversion therapy, due to his perhaps unfounded interpretation of the research data.

As Slate author William Saletan summed up the revocation,

> "Given the fallibility of memory for past events," Spitzer wrote, "it is impossible to be sure how accurate individuals were in answering questions about how they felt during the year before starting the therapy, which on average was about 12 years before the interview." The nature of the therapy was never defined, and in half the cases it was administered by a pastoral counselor, support group, Bible study, or other religious practice. As for subjects' claims that they had stayed gay-free after therapy, Spitzer confessed that he "relied exclusively on self-report" and that this reliance "deserves careful examination in light of the participants' … high motivation to provide data supporting the value of efforts to change sexual orientation.

Spitzer, in a radio interview (listen here), attributed the fact that he was able to publish such a tenuous study to the fact of his standing in psychiatry, as one of the "architects" of the modern DSM (prior to his interventions in the 1970s and onward, the field of American psychiatry lacked the systematic manner of linking symptoms and diagnosis that the DSM has since provided). A popular audience description of Spitzer's

hand in recrafting the DSM appeared in The New Yorker magazine in 2005, and was discussed in an episode of This American Life in 2002. Notably, Spitzer is widely credited with the removal of homosexuality from the DSM during its initial restructuring (and Sptizer has in the past called for Christian organizations to stop citing his study as evidence that same sex attraction can be changed: watch these video appeals here and here).

Spitzer's announcement came on the heels of a North Carolina ballot vote, which passed an amendment to the state constitution, limiting "the only legally recognized union" to marriage between one man and one woman, and President Barack Obama's subsequent announcement that his perspectives on same sex marriage have "evolved" and now supports the legalization of same sex unions as a civil rights issue.

In such a political climate, Spitzer's public revocation made front page news in the New York Times, and fit neatly into what has become a very heated, partisan debate about the moral nature of same sex partnership, and the bio-social nature of same sex attraction.

The Pan American Health Organization, in partnership with the World Health Organization, issued a statement condemning conversion therapy as medically unfounded and damaging to health, seemingly unrelatedly and only a few days off of Spitzer's revocation. In an online press release regarding the statement, PAHO/WHO described the move as such:

> "Since homosexuality is not a disorder or a disease, it does not require a cure. There is no medical indication for changing sexual orientation," said PAHO Director Dr. Mirta Roses Periago. Practices known as "reparative therapy" or "conversion therapy" represent "a serious threat to the health and well-being—even the lives—of affected people."
>
> The PAHO statement notes that there is a professional consensus that homosexuality is a natural variation of human sexuality and cannot be regarded as a pathological condition.

At issue here seems to be the question of whether one particular human difference – same-sex attraction – ought to be considered a biological pathology, or an inoffensive human variation. The issue is complicated by the culturally contingent identity categories that are tied up in perception of same sex attraction. In similar territory, bioethics scholar Alice Dreger has argued that Gender Identity Disorder (GID) should be removed from the DSM for relatedly unnecessary stigmatization, here and here. Which raises the question, IS biology destiny? Should solutions to problems of identity be biological or cultural? And where therein does a workable

balance lie? Can looking to other cultures, with actually existing cultural solutions to what we have defined as biomedical problems help? Paul Vasey, Dreger points out, who researches biological men who live as social women in Samoa, thinks so, arguing that in the case of these Samoans (called *fa'afafine*), a sociocultural adjustment, rather than a bio-cognitive change in the individual, creates acceptance where Westerners might find medicalized pathology.

All of which is to say, over the course of recent decades, scientists keep changing their minds about same-sex attraction. Medical anthropologists have problematized the DSM, generally, for its failure to capture the cultural and historical contingency of what masquerade as cognitive-biological facts (e.g. Young 1995; Cohen 1995; Valentine 2007). And, we find that a similar critique is relevant to the ongoing changing of minds about whether or not science can change the minds (and bodies, and sex lives) of people who self-identify as having same-sex attraction. Cultural attitudes and norms delimit and shape scientific and medical interpretations.

As Josh Fischman wrote in the Chronicle of Higher Education, Spitzer's revocation highlights not only the ever-ongoing nature/culture debate, but also the question of what makes good science, and whether a scientist ought to be given the space to be wrong, and, having found himself wrong and said so publicly, to be forgiven. That is, Spitzer's letter gets to the heart of just what we think it means to "do good science" (in the parlance of the behaviorists and lab researchers). From the perspective of critical medical anthropology and science studies, the question of our cultural presumptions and valuations about "good science" have already been a subject for scrutiny. Science creates a unique climate of being "right," when each new hypothesis (or in this case, statement) in progression is allowed subsume all previous suspicions, hypotheses or statements (see: Chakrabarty 2000, Latour 1993). In this way, Spitzer's revocation does more than simply state that as of May 2012 he no longer agrees with his study; instead, it swallows up the nine years between 2003 and 2012, casting his own opinions and the citation of his work during that time into a kind of purgatory. Spitzer changed his mind, and changed, also, all future interpretations of those who accepted his hypothesis about same-sex attraction during that interim.

As Dr. Spitzer now points out, we will never know if the conversion therapy that took place managed to change any minds as, "there was no way to judge the credibility of subject reports of change in sexual orientation" (from his revocation letter). At least, not until another scientist designs a different study model to test this hypothesis.

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Read the original 2003 journal article and its responses, which has been opened for public viewing for June and July without the usual subscription firewall, here.

NB: Regarding the phrase “a non-ideological ideology,” in the above quotation from Sam Dubal, Peter Redfield (to whom Dubal credited the citation) writes, ”The phrase he quotes is actually Renée Fox’s.”

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***(de)humanitarianism***

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***changing minds***

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