Moral Maps and Medical Imaginaries: Clinical Tourism at Malawi’s College of Medicine

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ABSTRACT  At an understaffed and underresourced urban African training hospital, Malawian medical students learn to be doctors while foreign medical students, visiting Malawi as clinical tourists on short-term electives, learn about “global health.” Scientific ideas circulate fast there; clinical tourists circulate readily from outside to Malawi but not the reverse; medical technologies circulate slowly, erratically, and sometimes not at all. Medicine’s uneven globalization is on full display. I extend scholarship on moral imaginations and medical imaginaries to propose that students map these wards variously as places in which—or from which—they seek a better medicine. Clinical tourists, enacting their own moral maps, also become representatives of medicine “out there”: points on the maps of others. Ethnographic data show that for Malawians, clinical tourists are colleagues, foils against whom they construct ideas about a superior and distinctly Malawian medicine and visions of possible alternative futures for themselves. [biomedicine, tourism, Africa, imaginaries]


RÉSUMÉ  Dans un hôpital d’enseignement africain, en sous-effectif et manquant de ressources, les étudiants malawiens apprennent à être médecins alors que les étudiants étrangers, « touristes cliniques » en visite au Malawi, s’informent sur la « santé publique mondiale ». Les idées scientifiques circulent rapidement; les touristes circulent facilement de l’étranger au Malawi mais pas vice-versa; quand les technologies médicales circulent, c’est lentement. La mondialisation inégale de la médecine est exposée. J’accrois la recherche sur les imaginations morales et imaginaires médicaux, argumentant que les étudiants dépeignent cette expérience comme étant un lieu où, et par l’intermédiaire duquel, ils recherchent une médecine meilleure. Les touristes affichent leur schéme moral et représentent également la médecine de « là-bas »: des repères pour les autres. Les données ethnographiques démontrent que pour les Malawis, les touristes sont des collègues à travers qui ils construisent les concepts d’une médecine malawienne supérieure et d’un avenir différent.
Dr. Crispin Kamwendo arrived late. He had crossed the dirt courtyard directly from the minor surgical theater, where the morning’s list of abscesses to drain and wounds to clean had been long. Dr. Kamwendo was an intern on the surgical service at “Queens”—Queen Elizabeth Central Hospital, a large public hospital in Blantyre, Malawi—and these minor cases were the intern’s job. So he was late, and apologetic, but I was later and more apologetic. No other doctors had made it to antenatal clinic. I had been working since early morning through a queue of chitenje-wrapped women waiting on the wooden benches: diagnosing twins, making insulin adjustments for diabetic patients, doing the little evaluation possible for women referred with “bad obstetric history”—an umbrella diagnosis that covered everything from recurrent miscarriage to chronic syphilis to several children dead of malnutrition or malaria. The last woman finally left, headed for the Johns Hopkins research project to get an HIV test. At that time, in February of 2003, the hospital’s own laboratory had been out of the test reagents for months. I hung up my physician’s white coat, slipped my anthropologist’s notebook and tape recorder out of the coat pocket, and welcomed Dr. Kamwendo into the now-empty exam room.

We had already met on the wards. A thin man, neatly dressed, he carried in a stack of books: an ancient battered Guide to Patient Evaluation was on the bottom, a memoir by the U.S. Christian inspirational writer Catherine Marshall on top. As we talked, the open window allowed a fresh breeze to chase away the sweat and soap smells of clinic while admitting the occasional mosquito and the omnipresent kraaak of pied crows. Late in the interview, Dr. Kamwendo’s conversation turned to the European and U.S. students who circulated through Queens on short-term visits. “We look at them as very, very privileged people,” he said. He had read about magnetic resonance imaging (MRI) machines in textbooks, he noted; the visitors had used them. He had failed to arrange his internship pay—“a peanut salary,” he scoffed—to cover four siblings’ school fees. For Crispin Kamwendo, the visiting students were “our friends.” They were also measures against which his own access to technology, money, and opportunity appeared painfully limited.

They have so much advanced technology, and medicine is quite a—quite a field which requires quite a big advancement in technology. And we look at our friends as being so fortunate to have all those technological advances at their disposal. Again, the other thing, we see most of them coming here for electives. I don’t know how that is there, but when I was a student I actually wanted to do that elective, but I couldn’t do that because I couldn’t find the funds. So we look at our friends as being so much fortunate. [interview, February 11, 2003]

Dr. Kamwendo spoke from experience: although drawn to internal medicine, he intended to jump on chances for advanced training in any specialty. Specialty certification was an “open door to self-advancement,” he said, a gateway to better jobs and bigger salaries. There was some urgency to the task. Both of his parents were dead, and he was stretching his internship pay—“a peanut salary,” he scoffed—to cover four siblings’ school fees. For Crispin Kamwendo, the visiting students were “our friends.” They were also measures against which his own access to technology, money, and opportunity appeared painfully limited.

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Dr. Kamwendo looked ahead to years as a poorly paid general practitioner. The visiting students, he imagined, would have good salaries and abundant specialty-training prospects awaiting them.

In funds, they are far much better paid than here. And that is why many [Malawian] doctors want to work outside—yeah, but most of them tend to stay because of their extended families, because of lack of opportunities to go outside or what. And I guess the other thing is, the opportunities are so many. If you finish the medical school [elsewhere] and you want to specialize, you will eventually sort out what you want to do and you will find a way to do it. So you will specialize in something you really wanted to do. And like here, where scholarships are hard to find, hard to come by, some people take just only a specialty course because the opportunity was there. Not because the—not that the doctor really wanted to specialize in that. But he thought that if he doesn’t jump on that chance, then he might never find it again.

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### CLINICAL TOURISM

The foreign students that Dr. Kamwendo encountered at Queens represented a wider phenomenon, a demand for “global health experiences” growing so rapidly that medical schools have had difficulty keeping up. By 2000, over a third of graduating medical students in the United States and Canada reported such experiences (Thompson et al. 2003), a three-fold increase in 20 years. Proportions in the United Kingdom are higher. Some students travel to industrialized countries; most favor poorer nations. African hospitals are popular destinations. Returnees’ stories, recounted in conferences and classrooms, alumni magazines and blogs, contribute to popular understandings of global health. Their clinical journeys also have effects at destination sites, as Crispin Kamwendo’s wistful reflections suggest. In this article, I examine those effects at Queens, an urban African hospital that was both a popular site for expatriate medical students on educational electives and the major teaching hospital for medical students from the University of Malawi College of Medicine.

Transnational travels of many kinds characterize 21st-century biomedicine, and the burgeoning literature that documents such movements features a confusing and overlapping set of terms. A detailed taxonomy is beyond the scope of this article. One way to distinguish among these travels, however, is by length. The longest-term journeys are permanent migrations of nurses and doctors, overwhelmingly from poorer nations to wealthier ones: the medical brain drain. Medium-term travels include health professionals’ paid stints in humanitarian or mission organizations, both typically requiring require two- or three-year contracts, and the multi-year sojourns for specialty credentialing that graduates like Crispin Kamwendo seek when such training is not available domestically. Only the shortest-term transnational medical journeys, whether undertaken by those seeking medical care or those seeking to provide it, have
been labeled “tourism” (see, e.g., Bezruchka 2000; Turner 2007).

In this article, I use the term clinical tourism to indicate the activities of health-professions students and clinicians who learn or volunteer (a distinction that is often unclear) for periods of less than a year outside their home countries. Clinical tourism avoids the ambiguities attending medical tourism—a phrase that more commonly applies to patients than to doctors, referencing travels undertaken in pursuit of pharmaceutical, surgical, or experimental treatments unavailable or prohibitively expensive at home. More importantly, clinical tourism directs our attention to those places where the tourist gaze (Urry 2002) and the clinical gaze (Foucault 1975) come together. Thinking about those intersecting gazes, as I argue below, advances our theorizing of global biomedicine—and of the many other entanglements of expert knowledges and technologies with the movements of actual people.

Clinical tourism should also interest anthropologists for practical reasons. Future doctors, nurses, and others who aspire to be without borders all show up at our office hours looking for advice, in our classrooms preparing for their journeys, and at our workplaces and field sites mingling with other expatriate experts, tourists, trainees, researchers, and missionaries. Many of us are called on to administer prophylactic doses of cultural preparation to clinical and nonclinical students headed abroad—for clinical tourism is only one manifestation of a larger push for service-learning projects in poor places that blur easy distinctions between humanitarian action, educational experience, and adventure travel.

I first considered the effects of clinical tourism while conducting ethnographic research on medical training in Malawi over three fieldwork periods between 2001 and 2007. In the teaching hospital where I worked and studied, visiting medical students came and went in a stream that at some times threatened to become a flood and at others slowed to a trickle. I was at Queens not to study the visitors, however, but to understand the experiences of Malawian students. That project began with focus groups involving a total of 20 students at four different stages of their training. Sixty-one semistructured interviews followed, most with University of Malawi College of Medicine students and interns, some with faculty and graduates. Working in the hospital as an obstetrician over 15 months provided me ample opportunities for participant-observation and enabled hundreds of informal conversations and encounters with approximately 60 local and 20 visiting medical students. Although I never asked explicitly about clinical tourism in formal research settings, the issue arose spontaneously in half of the focus groups and over a third of the formal interviews. The analysis I present, then, is preliminary. In particular, because I collected no systematic data from the tourists themselves, I cannot generalize about their experiences.

Even this preliminary analysis reveals that the wards of Queens, where both clinical tourists and their Malawian counterparts learn, become sites of contestation over the meaning and location of good medical work. On these wards, medical students try to imagine meaningful professional futures. In the process, I argue, they plot imagined times past and times future, locations “outside” and “here,” on moral maps that chart their quests for good lives and good work.

The concept of “moral maps” draws from theories of value-laden imaginaries while attending explicitly to pathways across time and space in those imaginaries. Julie Livingston (2005), in examining Tswana concepts of “de-bility” from colonial to contemporary times, used the term moral imagination to describe how people conceived other possible social worlds, past or future. Moral simply meant imbued with value: judged as good or bad. Because Livingston’s informants often compared those imaginings with “the way things are now,” however, moral imaginations also produced temporal trajectories of improvement or decline. Other times were not just good or bad but, rather, better or worse.

Moral maps incorporate space as well as time, charting paths to better or worse among known locations and unknown destinations. Tim Ingold notes that “every somewhere must lie on one or several paths of movement to and from places elsewhere” (2007:2). Along those paths, people live their lives, learn to know their world, and compare that world to others. A person who moves physically along a path also moves through time and selects among alternatives; one can follow only a single path at a time. On a map, however, one may plot out several journeys and imagine several possible destinations at the same time. The ethnographic material I present shows students doing exactly that and mapping those destinations—and the clinically needy bodies to be found there—onto ideas of medical progress.

The metaphor of moral maps trains our attention on how actual travels of people, ideas, and things suture notions of poverty and privilege, suffering and good work, to places (specific or generic) and to times (past, present, or future). I hope that the concept will be useful not just to medical anthropologists but also to others working on development, tourism, humanitarian relief, technology transfer, and other forms of global exchange in which notions of place-based potential or pathology prevail.

Although their precise definitions are specific to this article, neither moral map nor clinical tourism is a new term: the theoretical contribution of this article does not entail addition of neologisms to the anthropological lexicon. In the medical literature, a few authors have used clinical tourism to refer to short-term travel by health professionals or students (see, e.g., Levi 2009). Richard Shweder (2000) has used moral maps to critique analyses that plot problematic ideas of socioeconomic progress or decline against problematic notions of national culture. I build here on that work and on scholarship from many others who have found topographic metaphors—scapes, paths, fields—useful in
considering the effects of global exchanges and excursions (see, e.g., Appadurai 1996; Sparke 2009; Whiteford and Manderson 2000). The contribution of this ethnographic case study is, first, to show how the uneven terrain of such exchanges shapes the moral imaginations of people caught in the middle: in this case Malawan medical students who are at once subjects training their clinical gazes on the bodies of their fellow citizens and, with those fellow citizens, objects of the tourist gaze. Second, it is to show how the imaginations trained by these two gazes layer together place, value, and time such that a good past can be found far away, or a better or worse present here, or a good future elsewhere—with implications both analytical and pragmatic.

MALAWI AS DESTINATION

Malawi is a particularly attractive destination for foreign medical students, who every year travel east from the United States and Canada, south from Western Europe, and northwest from Australia on the same global currents that carry tourists on safari, secondhand clothes, and donated medical equipment. The country is peaceful, friendly, small, and a relatively inexpensive place to travel. In this polyglot nation, once a British protectorate, all postprimary education is in English, so English-speaking travelers can get by without learning any local languages. The prevalence and severity of various “tropical” diseases has made the nation a favored site for international medical research ever since the London School of Tropical Medicine opened a malaria study ward in Blantyre in the 19th century (King and King 1992); long-term clinical research projects and Christian medical missions laid down institutional and social tracks that clinical tourists follow to Malawi.7

Biomedicine is no recent import here: transnational movements of researchers, clinicians, pharmaceuticals, and technologies date back well over a hundred years. Africans were learning microscopy, dispensing medicines, and dressing wounds by the late 19th century in the area now known as Malawi. Formal nursing training was available by the 1930s, but training for doctors took much longer. Although a very few students were sent abroad for medical education, Malawi’s own College of Medicine did not open until the 1990s (King and King 1992; Muula and Broadhead 2001). Its establishment was controversial: medical schools are expensive, and standard economic measures place Malawi among the world’s poorest nations.

Health indicators, like poverty statistics, tend to be most uncertain where life (and record keeping) is most precarious. Official estimates of disease in Malawi, however wide their uncertainty ranges, are typically worse than average even for the region. AIDS, respiratory illness, malaria, diarrheal diseases, and malnutrition all make the top-ten list of killers.8

Word on the street corroborates the overall picture, if not always the specific causes: people in and out of the hospitals often commented that life was shorter and more insecure nowadays, that many young adults were dying, and that poor health was more widespread.

These challenges overwhelm the threadbare government health sector that provides medical care for most citizens. Over the two decades since I first visited Malawi, public hospitals and clinics have visibly deteriorated under the triple pressures of budget austerity measures, increasing population, and a huge surge in HIV-related illnesses. Nearly every medication and supply—including such basics as sutures and iodine—ran out on a regular basis during the years of my fieldwork there. Staffing was so skeletal that one clinical officer might care for several hundred inpatients in a district hospital, and one nurse might be responsible for a ward of 60.9 Queen Elizabeth Central Hospital held 1,100 hospital beds and 1,600–2,000 patients—on, under, and between beds, in overcrowded wards sometimes staffed solely by trainees.10

Spread among those wards at any given time were 30 to 60 Malawian medical students, plus clinical officer students, nurse-midwifery students, and interns. In addition, one could find anywhere from 2 to 20 clinical tourists.11 Although most foreign students stayed for five to six weeks, their journeys could be as short as a week or as long as several months, Malawian medical students lived together in student hostels, paid tuition to the College of Medicine, attended classes and clinical trainings, and were accountable to strict attendance, exam, and clinical-work documentation that required long hours at work. Visiting students staying in “guest houses” or with faculty from their home institutions, paid a small (US$50) affiliation fee to the College of Medicine (their tuition went to their own universities), and were generally supervised quite informally. Their activities and hours at the hospital varied widely. Two Dutch students kept our obstetrical operating theater running for a week when three theater nurses were absent. A student from the United States assigned to the same theater turned up late on his first day, enthused about the “great cases” he had seen on surgery, and then never appeared again. Some clinical tourists cherry-picked procedures of interest, those they would never see—or be allowed to do—at home. Others excused themselves from any procedure involving blood, acting on their universities’ risk-reduction guidelines or their own fears of contracting HIV. Still others worked and learned for long hours, following a staff doctor or attaching themselves to a single ward, as did a U.S. student who worked in the pediatric nutritional rehabilitation unit daily for months.

Foreign and Malawan students occasionally drank together at the Cactus Bar or the more sedate Blue Elephant nightclub, but most Malawians were too busy and had too little money for clubbing. Their contacts within the hospital were frequent but usually superficial. Malawan trainees who talked about medical student visitors, even when they spoke of them warmly as “our friends” and “our brothers,” never referred to any by name. Encounters of clinical visitors and their Malawan counterparts seemed to produce a mutual recognition that was more generic—sometimes verging on caricature—than specific.
MEDICAL IMAGINARIES, CLINICAL REALITIES

Malawian medical students and the clinical tourists who joined them at Queens were all in the process of becoming doctors. Ethnographic studies of that process show it to be marked by uncertainty, frustration, fleeting triumphs, and devastating failures (see, e.g., Good 1994; Sinclair 1997). Medical students must manage incongruities between what they expect of medicine and what they experience in clinical practice. Mary-Jo Delvecchio Good’s concept of the “medical imaginary” (2007:362) can be helpful in understanding this disjunction. The phrase indicates an affect-laden vision of biomedical science in which limitless potential for high-technology cures lies just ahead. It is an imaginary that shapes professional subjectivities and popular expectations as it circulates globally in “a political economy of hope” (Good 2007:364). This future, a medical version of the moral imagination that Livingston described, is always both near and not yet; its promise alters clinicians’ perceptions of the present. In the United States, as Good shows, imagined technologies of hope obscure realities of toxicity, as when cancer patients and their doctors normalize experimental science as “therapy” and downplay both questions about its efficacy and painful experience of its dangers. In Malawi, imaginaries of medical abundance serve to highlight realities of scarcity.12

At the College of Medicine, the imaginary of high-technology biomedicine was richly available, but the diagnostic and therapeutic tools ubiquitous in virtual worlds were generally absent in fact. Nearly all available medical literature, like that Dr. Kamwendo carried, was English-language material from abroad. Technologies like fluoroscopy or gene assays cropped up in textbooks, in lectures from visiting faculty, and in diagnostic algorithms students memorized for exams but not in the laboratories where they did “practicals” or the wards where they saw patients. In the medical school’s small library, it took me over a month to track down a recent study of region-wide causes of maternal death in the Malawi Medical Journal but mere seconds to locate a review of advances in prenatal genetic diagnosis (unavailable in Malawi) in the British Journal of Obstetrics and Gynecology. A rich virtual medicine from “outside,” as students typically referred to wealthy places, pressed on their materially poor actual world.13

Further weighting the sense of the medical near and not yet, internationally sponsored research projects and foreign NGOs made enclaves for some technologies, pragmatically inaccessible to students and their patients even though tantalizingly close by.14 In 2003, viral loads and CD-4 counts could be measured in the Johns Hopkins research labs, antiretrovirals were available in projects run by Médicins sans Frontières (MSF) in Thyolo and Chiradzulu, and one kidney dialysis unit existed in Lilongwe for the use of one government official. None of these were available to patients outside the enclaves’ boundaries. The priorities of donors, transnational research projects, and politicians could produce a bizarre hodgepodge of resources. There were no pregnancy tests at Queens, for instance, but by 2008 the hospital had the MRI of which Dr. Kamwendo dreamed: a research consortium imported one at great expense and difficulty to aid in studies of cerebral malaria. Students were particularly conscious of the lack of day-to-day necessities: gloves, soap, resuscitation equipment, thermometers, blood pressure cuffs, catheters. As their discussions will show, they knew such supplies were well provided in the practice worlds from which the clinical tourists came.

International Doctors

Although a third of the comments students made about clinical tourism reflected Malawians’ desire to be tourists—medical spectators rather than medical spectacle—one of the medical students I interviewed had yet done any medical training in hospitals beyond Malawi’s borders. Dr. Ellen Mchenga, who had never managed an outside elective, thought such opportunities were critical: “Even if it might mean maybe just to go to Tanzania to see how the medical college is like there. Or to Zambia or Kenya. . . . It would be good, rather than just being trained in Malawi. We would be trained as international doctors, not just as national doctors” (interview, May 16, 2003).

Sponsorships for prolonged postgraduate studies, a vital means to train Malawian faculty in the college’s earliest years, were increasingly scarce after 2000: they opened doors to emigration, seen as a threat to the medical corps. Without certification beyond the general-practice license issued after internship, one was likely to be excluded from international networks of circulating experts and to remain in Malawi indefinitely—a “national doctor.”

Although well supplied with imaginaries of biomedicine, students had limited sources for understanding the clinical practice lives of doctors elsewhere. Some referred to the few physician biographies available locally: an inspirational account of missionary doctors who worked (and died) in Uganda; a locally produced history of the medical school featuring seven influential physicians, all of whom trained outside Malawi, and only one Malawian. No student cited fiction or images of television or film doctors.15 In a place with scant outside imagery, clinical tourists provided important glimpses of “international doctors.”

If their most frequent comments on the subject reported the wish to be tourists themselves, nearly as common were reflections on the riches available to the tourists. Some differences caught the eye. Clinical tourists’ white coats bulged with stethoscopes, penlights, pocket medical guides, and other accoutrements. One Malawian student initially claimed to be undaunted by working with scant materials, telling himself to “seek more knowledge, and in the very end you’ll be able to do something, however basic it might be” (interview, April 3, 2003). Later he worried about what knowledge alone could not do:

I had the chance of meeting some electives from Michigan. They had all the equipments! The only thing I had was a thermometer and my stethoscope. I didn’t have, I never had a BP machine [blood pressure cuff]. I didn’t have a [reflex] hammer or any of
that. Yeah, but then you are required to do everything on the patient! So if the limitation would be the equipment, I’m sure you will turn out to miss some things which would have given you clues. [Interview, April 3, 2003]

As Ellen Mchenga noted, “In Malawi it’s really hard, unlike some other countries, as we can see from you people” (Interview, May 16, 2003).

**Dirty Work**

A Malawian doctor’s working life, even as it appeared very high status to most ordinary Malawians, tended to look hard and dangerous when compared to the working lives of the visitors. The medical students I interviewed were well aware that they were among their nation’s elites. Their status was extraordinary, their education unmatched among their age-mates, and their income—by Malawian standards—would be high. But very few could buy a plane ticket and none had a car. Their visiting “brothers” could look forward to high salaries, abundant gloves, postexposure prophylaxis for HIV, and plenty of nurses to do the dirty work—not so for the Malawians. One Malawian intern’s nonmedical friends teased him about his work, which they imagined as difficult, poorly paid, and grubby. He could not disagree, he said, but “even though a job may be dirty, still it has to be done and it has to be done by somebody. So I think, well, it may be a difficult thing, but somebody has to do it. It may be a cross—but somebody has to carry the cross. Maybe that is me” (Interview, July 11, 2003).

Beyond the grubbiness, students noted danger: “We have a lot of HIV/AIDS and TB here. The chance of contracting disease is high. The working environment is nasty, unhygienic, not clean” (Personal communication, October 4, 2002). Some students contracted cholera on the pediatrics ward during the rainy season outbreak. One died of multidrug-resistant tuberculosis during the period of this fieldwork, and an unpublished student research project showed nursing trainees to have double the expected rate of TB. The greatest fear for most was HIV: students often suffered needle sticks and scalpel cuts, and the medications that reduce HIV risks in such circumstances were unavailable.

The gulf between medical imaginary and clinical reality could make work on Queens’ wards feel darkly surreal. One late afternoon I followed sounds of commotion to a bay in the labor ward where a pregnant woman lay convulsing in a prolonged seizure. It was hot, and the air felt thick with the smells of blood, bleach, and amniotic fluid. In the ward’s 14 open bays, women in active labor lay on steel tables. Handwritten notices taped to the walls reminded staff how to resuscitate newborns, clean equipment, and manage hemorrhages. On the hallway floor, cardboard boxes made makeshift containers for “sharps”—the blades and needles that pose particular dangers in southern African hospitals—and bright plastic buckets of antiseptic waited for the labor ward’s midwife to rinse her gloved hands between patients. In one of the labor bays, the midwife stood holding the seizing woman’s head to one side, ensuring that she could breathe.

Two sweating Dutch medical students flanked her, struggling to draw up medication to stop the seizure. The bay was littered with discarded syringes and medicine vials. When I examined them, I found the same donated medicine in three different strengths, labeled in three different languages. The syringes were donations, too; they featured special “safety” needles that retracted once used, making reinsertion into the patient all but impossible. Meanwhile laboring women in the other bays cried out: “Asista, adokotala, thandizani” [sister, doctor, help me]. One of the students looked up, met my eye, and said quietly, “Welcome to hell.”

Some Malawian students characterized medical work in similar terms. “Being a doctor in Malawi is hell,” a student about to graduate wrote me. “There are limited resources: manpower, equipment, and drugs. Another thing is poor salaries (packages). HIV/AIDS is very high, making life really difficult in patient care because the picture and severity of disease has changed for the worse” (Personal communication, June 2003). For tourists and Malawians, the wretchedness of clinical practice in Malawi depended on a contrast with medicine as practiced elsewhere, remembered or imagined.

This obvious gap between national realities and “international” possibilities could prompt doubts about medicine as a career. In one focus group, Bridget Nyasulu spoke angrily of foreign experts who had recommended training more Malawian doctors: Did they understand what they were asking?

> What they have, they are advanced. They have advanced medicines. All we have are basics. We don’t even have the basics sometimes! And maybe they should try to imagine if they were in this place, where they don’t have many opportunities, many medications—what would they do? Would they still follow the same path? . . . If they had to come here and they’d do this, would they go through with it? [Focus group, February 5, 2003]

A richer and more cosmopolitan world imagined as “out there” can serve as cruel reminder of one’s abjection—or forcible disconnection—from modernity’s promises, as James Ferguson (1999) showed among struggling Zambian mineworkers. Bridget Nyasulu’s bitter words suggest that a similar sense of abjection could arise where the (unmarked) global and (marked) local members of an imagined international community of doctors met. Abjection was not the only possible outcome, however.

**Better Doctors**

One effect of the tourist gaze, for both travelers and locals, is the opportunity it affords to see one’s own life through strange eyes: to reconfigure the self in relation to an image of the Other (Stronza 2001). If many Malawian medical students recognized in the tourist encounter a vision of Malawian medical practice as hellish, some also fashioned there an image of themselves as more flexible and creative, as more committed and empathetic, and sometimes as better able to see the big picture of health and disease: that is, as practitioners of a better medicine.
Malawians often compared their clinical skills favorably with those of visitors from “out there.” Some noticed that their foreign colleagues could seem helpless in the absence of high-tech imaging. “This person has a pain in the neck, I have to order a CT! I have to do this and that,” said intern Diana Kondowe, gently mocking the rigidity of outsiders. “But here—well, in our situation you can’t get a CT! . . . You see what you can do based on the physical exam, based on the history, maybe an X-ray. But some people just are not able to do this: they have one way that everything should be done, only one way” (personal communication, May 14, 2003).

Visiting students could rarely feel an enlarged spleen with their hands or confirm profound anemia without a hematocrit by examining a patient’s nail beds and mucous membranes. Accustomed to following protocols in which one diagnostic or therapeutic step led to the next, visitors had little capacity to improvise when the required materials were not available.

“They may take a lot of things for granted,” commented student Tuntufye Chihana. “There you have got so many resources and, you know, so it’s easy to do all these investigations or maybe even management interventions, treatment. Whereas here you really have to work with, make the most out of minimal resources. And people do improve! And you can help people, even with the minimal resources that we have” (interview, February 7, 2003). The dearth of equipment that turned a seizure on the labor ward into a clinical hell could also engender a capacity to “resource” and repurpose funds, ideas, social networks, and technologies—an essential and valued skill that I saw Tuntufye and others demonstrate.17 If sutures ran out, they might sterilize fishing line. They rewired autoclaves and soldered forceps, repurposed IV bags and tubing as urinary catheters, and used window latches as IV poles. A newly donated ultrasound from Utrecht was wonderful—but we had none of the gel that facilitates sound-wave conduction from the transducer to the patient’s skin. Bridget Nyasulu (who as a student questioned whether foreign doctors would “follow the same path” they asked of Malawians) was an intern in 2007, and she taught me to improvise. A chunk of cheap pink naphtha soap in a kidney basin half full of water dissolved into a slimy mush that made a reasonable substitute for gel. It wasn’t perfect, it was corrosive to the equipment, and the fumes were awful, but it worked: gray-scale ultrasound images appeared on the screen, allowing clinical diagnosis and intervention.

Sometimes even the prevalence of local pathology could be interpreted positively. Crispin Kamwendu found his textbooks’ emphasis on geriatrics unhelpful for a clinical milieu without many elderly people. His experience with infectious disease, on the other hand, outpaced his texts: “We have got many more conditions in this part of the country, especially in the village where we have got much infectious disease. I think we are so, so rich in that!” (interview, February 11, 2003). One student explained foreigners’ inferior anatomical knowledge: “I hear out there they have plastic cadavers or something, dolls or something to replace, since they can’t get [bodies]. . . . Maybe we’re more better off in that way” (personal communication, February 5, 2003). Another student was blunt: “This is the deep end in terms of student training. Becoming a medical doctor. Some of the things that you see around here you could not possibly get them or see them as a student anywhere else in the world” (interview, March 6, 2003).

Some Malawian trainees also contended that the difficulties they faced gave them both empathetic and intellectual insight into the larger context of illness—understanding that eluded outsiders. Empathy sprang in part from endangerment. “If you want to die quickly, you can do medicine,” one student’s secondary-school teachers had warned (interview, January 30, 2003). The constant reminders of death, an intern said, meant a Malawian doctor could not possibly forget that “you are still as human as everybody else” (personal communication, July 11, 2003). Another felt that his experience on the wards had changed his “whole picture of life.” “You have to face the realities of life, to say nobody is actually immortal, everybody is going to die one of these days. Death actually is the reality—I am going to die.” This awareness would help make him “somebody who feels the needs of the people,” a capacity he considered key to good doctoring (interview, January 24, 2003).

Trainees often reflected on the translation of severe poverty, inept or corrupt governance, and ill-founded public policy into disease: social pathology made corporeal. One student insisted that the key to improving the country’s health indicators was educating Malawians on human rights to health; he studied medical law at night and planned to become a policy maker. Another hoped to start a health-education radio show; he has since done so. Two interns independently attributed high rates of traumatic injury to poor transport regulation and infrastructure. Such etiologies, intern Zaithwa Mthindi argued, were invisible to foreign doctors who tended to think “that answers are only drugs. And maybe health education very specifically confined to medical issues—disease and pain and things like that” (personal communication, July 11, 2003). Malawian medicine required him to discern a bigger picture.

Real Medicine

Students, interns, and faculty gathered daily in the obstetrics and gynecology annex for rounds. One morning in 2007, Dr. Paul Mbanda led a discussion of recent cases. An antena-patient had improved on the antihypertensive nifedipine, but the nifedipine had run out and her blood pressure skyrocketed. Dr. Mbanda proposed two other medications: one was out of stock; the other had never been available at Queens. “I’m fed up with this!” he said. “Out of this, out of that, we’re not going to talk about this this morning” (field notes, February 26, 2007). An older physician suggested methyldopa, a once-common drug now supplanted by newer medications. Mbanda rejected it: “We are just giving things . . . I think we are doing this but I think if medicine
has gone to that level it’s not medicine at all.” Dr. Mbanda was among the earliest College of Medicine graduates, from a class pushed to get years of advanced training abroad, and in 2007 he and several colleagues were newly returned to Queens to teach. Some of them never spoke favorably about medicine in Malawi. Mbanda proposed more than once at rounds that Queens should be bulldozed and argued that “the best thing we can do is to see what they are doing out there and that is what we should do here” (field notes, February 8, 2007).

In the gap between the global medical imaginary and Malawi’s clinical reality, alternative imaginaries arose. Some questioned whether Malawian medicine was “medicine at all.” Others saw particular strengths. Malawian medicine was uniquely flexible and creative. It was second rate. Widespread pathology made medical training there superior, a deeper immersion. Pathology made it dirty and dangerous. Risks of infectious disease stirred empathy among medical students and stirred fears for their own lives. In these struggles, Malawians mapped their work and their progress—for better and for worse—against imaginaries of medical worlds “out there.” Clinical tourists helped to fill in those maps.

**CLINICAL TOURISM AND MORAL MAPS**

The clinical gaze reads truths from the body. The tourist gaze reads truths from Other spaces and the inhabitants of Other worlds. But bodies and spaces reveal different truths to differently positioned observers, and those truths mark out different paths to medical progress. The two Malawians who discussed high trauma rates saw transportation infrastructure and traffic-law problems requiring structural reforms. The U.S. student who spoke of “great cases” on the surgery ward read exotic cultural practices and ignorance in the pathogenesis of traumatic injury and culture change as the treatment: the three great cases he described were a psychotic villager whose hands were burned off in an attempted cure, a man whose eyes and testicles were “harvested” to be used in witchcraft, and a badly burnt epileptic whose relatives feared the burns were contagious.

Malawian doctors too could read bodies and spaces variably, as a discussion on the obstetrics unit shows, and could base differing prescriptions for progress on those readings. One night in 2007, a young woman who had been admitted with a threatened miscarriage in her first pregnancy bled to death on the ward. The sole nurse overseeing 60 patients did not notice the hemorrhage or call the intern promptly. The intern could not get the patient to surgery quickly enough because her faculty supervisor was in the operating theater—following routine practice—refused to provide any unless the patient’s family members came in to donate. The next day, three faculty members, all College of Medicine graduates who had spent years in specialty training abroad, interpreted the death.

Paul Mbanda: We have here abnormal situations and we make them normal. We see them as normal. The whole hospital cannot afford to have plaster [surgical tape, which had also run out overnight], and we are still operating? I am really waiting for the day Queens Hospital closes down.

Ian Jere: Of course this is far from ideal. It’s a learning process, and we will get there eventually.

Gray Bwanali: To my mind this is a useful reminder: women can die of miscarriage here. This woman came in, she was fine. Now she is dead. Yes, there is scarcity—but much can be done. When our system is not so strong in terms of supportive services, we must rely on our hands and our brains. [field notes, February 21, 2007]

In their postmortem diagnoses, these Malawian doctors drew various readings from this body, inflected by comparison of their own medical locations with elsewhere. Dr. Jere read the death as a moment on a path of gradual progress. Dr. Bwanali saw evidence that weak systems require doctors to have greater flexibility and ingenuity. To Dr. Mbanda, this body was symptomatic of a space so pathological that the only cure was obliteration.

The discussion above presents more than one affect-laden vision of the medical future at work in the wards of Queens. In the space that remains, I outline how the medical imaginaries of the Malawian trainees—and perhaps, as indirect evidence suggests, those of their expatriate visitors—layer together time and place to make moral maps that guide them to where (and when) they might find real medicine and where (and when) medicine is not what it should be.18

Spatial terms dotted Malawians’ talk about medicine. Foreign medicine was outside, out there, a place to which one might find a path or door. Local medicine was the deep end or, as Dr. Gray Bwanali once called the antenatal ward, “the forest”—a term invested in Malawi with notions of wildness, fecundity, and danger. Malawian clinicians, effectively collapsing spatial and temporal images of progress, often posed the rhetorical question: “How shall we know the way forward?” Their language plotted Malawi’s medicine on a developmental path on which the today of clinical tourists’ home countries was Malawi’s anticipated tomorrow. When Dr. Jere promised that “we will get there eventually,” he evoked a Malawian future in which women would not regularly die of miscarriage, a future already present “there”—elsewhere. Medical student Joe Phoya, who had previously worked as a clinical officer in a decrepit district hospital, spoke in similar terms: “The world out there should recognize us and give us help, you know? We are a developing country, especially in the medical field . . . If you guys out there cannot assist us, then progress cannot be ours. It may be there, but it will be so sluggish. We want things to move fast! We want at least to be closer to other places out there” (interview, March 3, 2003).

But the people to whom Joe appealed—“you guys out there”—may have been following other moral maps to a different kind of medical progress.
Pilgrimages to Far Away and Long Ago

Tourism is in some ways an imperfect rubric under which to consider the journeys of students who seek “global health experiences.” If tourism is conceptualized as leisure activity, much clinical tourism is a poor fit. Furthermore, tourist can be used pejoratively, and in the medical literature it usually is (Bezruchka 2000; Wall et al. 2006). Plenty of student travelers would indignantly reject a label that can suggest inauthenticity or exploitation of an exoticized Other, preferring to consider themselves medical humanitarians. Are some the “ego-tourists” or “middle-class leeches” against whom Ian Munt (1994:59) inveighs, their hospital stints little more than adventure travel “in its new wafer-thin disguise as a more ethical and moral pastime of the new bourgeoisie”? Perhaps. Perhaps clinical tourism is in part a fad, a strategy for students from wealthier countries to accrue cultural capital and academic credit alongside the thrill of the exotic—and of virtue. Some clinicians involved in global health suspect as much of themselves; one Canadian doctor confesses disarmingly that “my motivations for involvement with global health have surely been mixed with a desire for professional intrigue and escapades to punctuate what may be an otherwise dreary career” (Philpott 2010:281).

For me to denounce clinical tourists who go to Malawi to learn on the bodies of the poor—or, more generously, to volunteer their services to people in great need—would be both hypocritical and inadequately complex. Hypocritical, because I first went there myself in exactly that capacity in 1990 during my last year of medical school and because the line between their travels and the journeys of ethnographers is blurry. And inadequately complex because depicting clinical tourism as invariably extractive, neocolonial, or exploitative would disregard many cases in which students’ travels lead to long-lasting connections among Malawians and expatriates that appear to enrich all concerned.

Although the rubric of tourism is imperfect, it serves two useful purposes. First, it helps us to recognize similarities with other kinds of tourism on which a richer literature exists. The most obvious connections are with volunteer, educational, or science tourism (West 2008). When medical tourists seek out especially poor or HIV-affected areas, we may also note echoes of the “dark tourism” of travelers who chase dangerous thrills in war zones (Lisle 2000), safely view threatening others in prisons (Schrift 2004), or ponder mortality at sites of genocide (Stone and Sharpley 2008). Plenty of student travelers would indignantly reject a label that can suggest inauthenticity or exploitation of an exoticized Other, premised on regaining and reminding conjures a past in which medicine was more meaningful—and perhaps higher status, because physicians from wealthier parts who write about African medicine often characterize geographical journeys as temporal ones to a simultaneously primitive and romantic past. The Lancet editorial that characterizes electives in poor countries as transformative also promises students “19th-century” panoramas of disease. In the American Journal of Medicine, two educators claim that global health opportunities “provide Western physicians with the opportunity not only to work towards a critically important goal, but also to regain our center and our focus, and in the process remind ourselves of the fundamental values that define our profession” (Shaywitz and Ausiello 2002:355). This emphasis on regaining and reminding conjures a past in which medicine was more meaningful—and perhaps higher status, as the later promise of “renewing the dignity of our calling” (Shaywitz and Ausiello 2002:357) hints. Physicians and students who go to the world’s poorest nations become good doctors not just by providing good care, then, but by recapturing an imagined history in which doctors were humanitarian figures, not well-paid technocrats.

Two centuries ago, a U.S. medical education could best be capped by a stint in the hospitals of Paris. Returnees from “the Paris School,” as John Warner (1998) has shown, used the social capital accrued through their journeys to advocate for medical reforms that some characterized as returns to Hippocratic tradition: corrections to a wrong path taken by the U.S. medical profession. In the early-19th-century United States, reformers urged a return to empiricism and a move away from overly theoretical “systems” of medical thought. In the early-21st-century United States, the medical transformation also characterized as a Hippocratic return...
is a move toward idealism, not empiricism. Although both movements appear to draw moral maps in which a better medicine can be found elsewhere, the parallels should not be overdrawn. The simultaneous location of a better medicine in poor countries and relative inattention to domestic medical reform are distinctive to contemporary times. So is the scale of today’s global health phenomenon. True, earlier generations of medical students admired medical missionaries like Albert Schweitzer and Tom Dooley, but few actively followed in their footsteps. Current students are more likely to take secular missionaries like Paul Farmer as role models and to seek direct experience of what their forebears mostly imagined.19

The U.S. student who worked on the Queens pediatric nutritional rehabilitation ward described her work repeatedly, with self-conscious irony, as “feeding starving children,” simultaneously evoking a humanitarian imaginary (and the images of African desperation it often deploys) and an ethos of medicine as caretaking. Contemporary clinical tourism, however variable the underlying motivations, is surely also part of a wider struggle to convert knowledge into useful action, and even—for a generation of students bombarded since childhood with reminders of global suffering—to orient one’s professional self meaningfully to the world.

Suffering Strangers and Unintended Consequences
Margaret Lock and Vinh-Kim Nguyen remind us that “the promise of and the actual effects of biomedical technologies are embedded in the social relations and moral landscapes in which they are applied” and call for ethnography in which “the views of local actors provide insights into the ways in which the global dissemination of biomedicine and its specific local forms transform not only human bodies, but also people’s hopes and aspirations in ways that may well have broader repercussions for society at large” (Lock and Nguyen 2010:5–6). Both transformed aspirations and broader repercussions can be seen in the moral maps of Malawian students and the would-be humanitarians they meet.

Medical humanitarianism, like other forms of humanitarianism, “offers a seductive simplicity, suggests no grand commitment, allows a new generation to find solidarity not in ideas of progress but rather in projects of moral urgency and caretaking” (Barnett and Weiss 2008:6). Such projects entice many medics: MSF volunteers often hope initially for “the views of local actors provide insights into the ways in which the global dissemination of biomedicine and its specific local forms transform not only human bodies, but also people’s hopes and aspirations in ways that may well have broader repercussions for society at large” (Lock and Nguyen 2010:5–6). Both transformed aspirations and broader repercussions can be seen in the moral maps of Malawian students and the would-be humanitarians they meet.

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The dazzling light of moral clarity can blind clinical tourists to both complexity and complicity. The “suffering stranger” depicted in many humanitarian appeals and some anthropological work is “a discursive construction that reduces global entanglements, and potentially rich human stories, to a moral model that allows for a sustained dependency between one group of people (i.e., those coded as needy) and another group of people (i.e., those coded as expert),” as Leslie Butt (2002:17) cautions. It may be hard to argue with experts, or would-be experts, who envision the most “real” medicine as ministry to the most needy. But such visions risk reducing “global health” work to a technical gift from donor to recipient rather than seeing it as either the mutual struggle of equals that Malawians like Joe Phoya imagined or the ambiguous social process that anthropologists often see at work (Crane 2010).

WHERE PATHS CROSS: WHY MAPS MATTER FOR THOSE IN THE MIDDLE
Student doctors, both tourists and Malawians, are middle figures on the wards of Queens: not quite laypeople, not yet experts. Their paths cross at a liminal moment, when their medical imaginaries and professional identities are in flux. They also cross in a place where possible professional lives—like therapeutic options—are dictated by the unevenness of medical globalization. Technologies and pharmaceuticals flow fitfully across this difficult terrain, people a bit more freely, if for now mostly in one direction. Ideas travel fastest of all. These middle figures’ mapping of ideals, technologies, riches, and heartfelt work onto places—a specific here and a generic “out there”—illuminates their struggles over what it means to be real doctors.

If you want to be a doctor in Malawi, and you want to live the way real doctors live, then this is not the place! Because as a real doctor, you are supposed to be rich. But for sure, I might finish my school, and I might work two or three years without even a car. Your expectation is to say as a doctor you are supposed to have this. But here in Malawi, no. [interview, Arthur Kamkwamba, medical student, March 6, 2003]

One part of society [says] “this person has been to America, UK, western countries, and they are very good,” but you find that the true doctors—the real doctors—they’re out here. They are really doing their job. They’re putting their hearts out... If it was in that part of the world [points away], I think these people would be getting a Nobel prize every year. Every single year. [Interview, Gift Mkango, medical student, May 8, 2003]

As these brief interview excerpts show, students compare their own anticipated futures with their imaginations of the lives of doctors elsewhere, as they work out what, whom, and where “real doctors” should be. Is the real doctor the visitor, who travels from afar, owns a car, has wielded the technologies of the textbook, and represents a humanitarian international? Or is it the Malawian, who understands how to work in scarcity, speaks patients’ languages, and sees deeply the causes of illness? In these struggles, we can see that the Malawians are also middle figures in a second
sense, simultaneously representatives of medical modernity to their African patients and of Africa to the medical moderns who visit their wards.20 Like the Indonesian conservation biologists studied by Celia Lowe (2006) or the Nepalese community-development workers studied by Stacy Pigg (1997), they are transnational subalterns and aspiring national elites.

In this middle, tourist and clinical gazes both shape moral imaginations. Both gazes use the eye and the mind’s eye; both interpret the sensory through the imaginary. Medical students learn to look on the bodies of others using “a gaze equipped with a whole logical armature” of medical rationality (Foucault 1975:107). But the Malawians who learn to gaze on Other bodies simultaneously understand themselves as Others in others’ regards. Like the visiting students, they are subjects deploying the clinical gaze. Like their patients, they are objects of a tourist gaze. This dual position as subject and object is an unstable one that allows for shifting alliances and for different ways of understanding their work. Now they imagine themselves as tourists, learning to be “international doctors” in Zambia or Tanzania; now they recognize themselves as sacrificial objects of pity: “somebody has to carry the cross.” At times they ally themselves with their own patients: endangered, mortal, “as human as everybody else.” At other times they identify strongly with their clinical-tourist “brothers.”

In this vulnerable moment, where paths cross and gazes meet, students plot the same people and places onto very different maps of good (or bad) work. One medical student’s short-term humanitarian intervention site and space of “global” need is another medical student’s long-term home and national development project. One’s morally clear past beyond is another’s grubby, dangerous, and ill-paying workspace. One student’s starving Africans are another student’s fellow citizens. Textual evidence suggests that tourists whose trust in medical modernity has been shaken may seek in Africa a return to an imagined past in which medicine was an unambiguous good. Their geographical journey becomes a temporal and moral one: from present to past in search of a more authentic medicine and a better professional self. Ethnographic evidence shows some Malawians meanwhile seeking out that medical modernity; their moral maps chart courses from present to future in search of real medicine and a better professional self. On these maps, times have places and places times: for some clinical tourists the past is an elsewhere, and for some Malawian trainees the future is an elsewhere. That is not all that is happening, however. Some Malawian trainees are also rethinking their medical present, casting their own version of medicine as superior—not elsewhere or sometime, but here and now.

Their imagined moral maps matter, analytically and practically. Practically, moral maps chart for student doctors actual routes to coherent professional lives. Malawians were alert to the privileges of medicine “outside,” and to their exclusions from it, yet some mapped the best medicine at home. Others did not. Those who imagined real medicine to be “out there,” where doctors have specialty training opportunities and CD4 counts, will likely envision their own futures “out there” as well. Conversely, if real medicine requires starving children and suffering strangers, the moral clarity allowed by brief encounters across huge social and geographical distances, then clinical tourists risk disenchantment with the obese children of their domestic poor and the suffering of those all too familiar.

Analytically, mapping forces us to attend to place and direction and, therefore, to the actual processes of globalization when we consider medical imaginaries. The examples given here show how people (real doctors and witchcraft victims), things (reflex hammers, cars, cadavers, and ultrasound gel), diseases (parasitic infections and geriatric disorders), and medically relevant values (sellessness and technical adeptness) take positions on students’ moral maps.

Unequal processes of global exchange shape the actual distribution of these entities. The travels of clinical tourists, like those of other trainees and experts, are made possible or impossible by those same processes. To consider the specific effects of global exchanges on imaginaries is to move beyond assumptions that moral worlds are largely local (Kleinman and Kleinman 1991) and beyond analyses that seem to see globalization as transporting an essentially similar imaginary into vastly different places (Good 2007). Instead, we find that the specifics of one-way travels and unequal exchanges are consequential for people’s pictures of the world and of their own places in it—a longstanding anthropological concern.

In the course of our work, many anthropologists encounter humanitarians, migrants, tourists, trainees, and experts of various sorts following their own moral maps to better lives, worthwhile work, or places of “real need.” We create and follow such maps ourselves. Our discipline too has staked claims to discursive, scientific, and (sometimes) moral authority on experience in an “out there” conjured as different, sometimes in both time and space (Fabian 1983). As Redfield (2005:349) notes, we too can be included in “the greater industry of transnational virtue.” Moral maps layer pathologies onto places, and progress onto time and direction, in the imaginaries of the mobile experts and would-be experts (including clinical tourists and Malawian medical students) who people that transnational industry. Attending to those maps gives us the binocular vision we need to discern the complex motivations involved and the complex consequences of mapping virtuous work onto faraway places.

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NOTES

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1. All individuals’ names are pseudonyms, as is required by the University of Malawi College of Medicine Research Ethics Committee, which approved this study. Names are matched for gender but not for ethnicity. Neither Queens nor the College can be anonymized: at the time of this project Malawi had only one medical school.

2. In 2003, interns earned $2,148 yearly, including all allowances. Starting salary for a civil service doctor licensed postinternship as a general practitioner was $2,904.

3. After eight years as a general practitioner in Malawi, Dr. Kamwendo secured a position in a specialty program (not in internal medicine) elsewhere in Africa. When I last spoke with him, in January of 2011, he was to begin training there later that year.

4. The yearlong limit on “tourism” is arbitrary: most stints are much shorter, typically a week at the least and two or three months at the most. These brief clinical tourism experiences sometimes pave the way for later mid- or long-term journeys.

5. Readers can find the larger study, with details of research methods, in Wendland 2010. Students’ participation was voluntary and uncompensated. I obtained formal consent for interviews and focus groups. Before training in anthropology, I practiced for years as an obstetrician-gynecologist. Colleagues at the College of Medicine felt strongly that my active participation in the wards, clinics, and operating theaters at Queens would be important to this project. I am grateful for their insistence on this point.

6. Julie Livingston built on the concept of moral imagination proposed by T. O. Beidelman in 1980. Beidelman, in turn, drew from Clifford Geertz (1977). Because neither Beidelman nor Geertz provided a definition of the term, I have used Livingston’s. In addition to anthropologists, ethicists, epidemiologists, and others have also used the term, sometimes in relation to global health (see, e.g., Benatar 2005); in that literature, it often simply connotes empathy.

7. Such tracks vary among nations even within southern Africa. In Zambia, for instance, also once under British rule but eastward-leaning during the Cold War, many short-term expatriate doctors are Cuban, Russian, or Chinese. Tanzania’s long-term exchanges with China, as Stacey Langwick (2010) demonstrates, mean that biomedicine there differs from its Malawian equivalent in many respects (including practitioners’ greater openness to herbal medicines).

8. All data is from World Health Organization n.d.

9. Clinical officers are mid-level clinicians who remain crucial to Malawi’s medical system, performing most surgical operations and treating all but the most complex medical cases.

10. The College of Medicine also used a secondary teaching hospital in the nation’s capital, where conditions were even worse—famously so. An image of patients in Lilongwe Central Hospital dying three to a cot has circulated widely, showing up in talks by Bono, writings by Jeffrey Sachs, and other venues (Richey and Ponte 2008). Such images, accessible to white experts—including me—who show up on the wards at Malawi’s hospitals, contribute to the country’s status as what Lisa Bintrim [personal communication, January 2010] calls “the poster nation for poverty.”

11. Numbers peaked during malaria season, when a U.S. malaria research team provided housing for visiting students from its home institution. Queens keeps no central registry of visiting trainees; these totals are based on observation.

12. Medical technologies cause iatrogenic damage in Malawi too, but toxicity was less obvious against a background of high morbidity and mortality.

13. I owe the image of the virtual pressing on the actual to a comment from Adriana Petryna.

14. Research, mission, and humanitarian aid groups bring into Malawi much of what medical technology, pharmaceuticals, and specialist-level expertise exists there. With only rare exceptions, these groups are not involved in medical students’ training. James Ferguson (2005:380) notes that in Africa international capital and national governance work not on standardized national grids but “spread across a patchwork of transnationally networked bits” or enclaves, with the rest of an Africa deemed “unusable” left to its own devices. Ferguson did not discuss biomedical care or research, but the metaphor fits both well (see Sullivan 2011).

15. Television was unavailable in Malawi until 1995, and even afterward access remained limited. The medical television dramas watched by people in the United States and Europe (and Indonesia and China, as Good [2007:366] notes) were not in circulation.

16. Eclamptic seizures are complications of a pregnancy-related hypertensive disorder.

17. Elise Andaya (2009: cf. Brotherton 2008) finds a similar emphasis on abilities to resource (there the term is resolver or “resolve”) among Cuban physicians who use social networks to access what cannot be obtained through formal state mechanisms.

18. The term moral geographies, which might also be considered here, refers to ideas about who (and what) belongs where: which people, objects, or animals are in or out of place (Cresswell 1996). The moral maps of medical trainees seem to me to function less as atlases of belonging and exclusion than as route guides: where to go—and when—to find good or bad medicine.

19. Here I am concerned with Paul Farmer’s role as medical culture hero (Kidder 2003) rather than with his anthropological scholarship.

20. The term middle figure is Nancy Rose Hunt’s (1999). Her study of the introduction of colonial obstetrics to the Congo paid close attention to Congolese mediators (nurses, midwives, medical assistants) who reworked the missionaries’...
therapeutic practices as they learned and then practiced mission medicine.

REFERENCES CITED

Andaya, Elise

Appadurai, Arjun

Barnett, Michael, and Thomas G. Weiss

Beidelman, T. O.

Benatar, Solomon R.

Bezruchka, Stephen

Brotherton, P. Sean

Butt, Leslie

Crane, Johanna T.

Cresswell, Tim

Fabian, Johannes

Ferguson, James


Foucault, Michel


Good, Byron J.

Good, Mary-Jo Delvecchio

Graburn, Nelson

Hunt, Matthew R.

Hunt, Nancy Rose

Ingold, Tim

Kidder, Tracy

King, Michael, and Elspeth King

Kleinman, Arthur, and Joan Kleinman

Lancet

Langwick, Stacey

Levi, Amy

Lisle, Debbie

Livingston, Julie
Lock, Margaret, and Vinh-Kim Nguyen  

Lowe, Celia  

Munt, Ian  

Muula, Adamson S., and Robert L. Broadhead  

O’Neil, Edward, Jr.  

Philpott, Jane  

Pigg, Stacy Leigh  

Redfield, Peter  

Richey, Lisa Ann, and Stefano Ponte  

Schrift, Melissa  

Shaywitz, D. A., and D. A. Ausiello  

Shwedner, Richard A.  

Sinclair, Simon  

Smith, Janice K., and Donna B. Weaver  

Sparke, Matthew  

Stone, Philip, and Richard Sharpley  

Stronza, Amanda  

Sullivan, Noelle C.  

Thompson, Matthew J., Mark K. Huntington, Dan Hunt, Linda E. Pinsky, and Jonathon J. Brodie  

Turner, Leigh  

Urry, John  

Wall, L. Lewis, Steven D. Arrowsmith, Anyetei T. Lassey, and Kwabena Danso  

Warner, John  

Wendland, Claire  

West, Paige  


Whiteford, Linda M., and Lenore Manderson, eds.  

World Health Organization  

FOR FURTHER READING  
(These selections were made by the American Anthropologist editorial interns as examples of research related in some way to this article. They do not necessarily reflect the views of the author.)

Feldman, Ilana  

Mindry, Deborah  
Nguyen, Vinh-Kim and Karine Peschard

Redfield, Peter

Speier, Amy

Zhan, Mei