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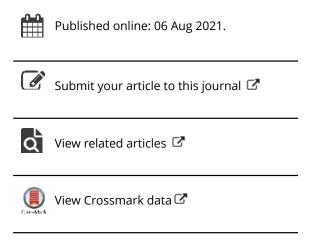
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Introduction: medicine's shadowside: revisiting clinical iatrogenesis

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ABSTRACT

Drawing on the work of Ivan Illich, our special issue reanimates iatrogenesis as a vital concept for the social sciences of medicine. It calls for medicine to expand its engagement of the injustices that unfold from clinical processes, practices, and protocols into patient lifeworlds and subjectivities beyond the clinic. The capacious view of iatrogenesis revealed by this special issue collection affords fuller and more heterogeneous insights on iatrogenesis that does not limit it to medical explanations alone, nor locate harm in singular points in time. These papers attend to iatrogenesis' immediate and lingering presences in socialities and structures within and beyond medicine, and the ways it reflects or reproduces the racism, sexism, and ableism built into medical logics.

I want my voice to be harsh, I don't want it to be beautiful, I don't want it to be pure, I don't want it to have all dimensions. I want it to be torn through and through, I don't want it to be enticing, for I am speaking of man and his refusal, of the day-to-day rottenness of man, of his dreadful failure.

I want you to tell.

–Frantz Fanon, Letter to a Frenchman, *Toward the African Revolution*

This special issue is dedicated to Leah M. Ashe (1980–2020).

Shadowside medicine

This special issue grew out of our experiences as ethnographers of the clinic who witnessed a number of uncomfortable and distressing situations, which starkly limited our agency and capacities to theorize. One of us watched patients receive electroconvulsive therapy in psychiatric settings without anesthesia or sedatives, in contravention to Indian law and UN human rights guidelines (UN Human Rights Council 2013). The short-circuiting of law was justified as necessary in a resource-poor setting; some care, psychiatrists argued, was better than no care. Another of us was a bedside witness to the cumulative impacts of

medical neglect and misadventure on childbirth outcomes in a government hospital in northern Pakistan. There, labouring women's iatrogenic injuries and losses were almost-always left out of medical records or dismissed as inconsequential by treating providers, catalogued in their fullness and frequency by the ethnographer only. The clinical harms we witnessed were catastrophic—and achingly ordinary. Their 'ordinary' extraordinariness included or occurred alongside other impactful forms of iatrogenesis: misdiagnosis, faulty procedures, unnecessary or delayed interventions, adverse pharmaceutical effects and interactions, surgical complications, blood-borne and nosocomial (hospital-acquired) infections, and many other potentially grave consequences. They also included the psychological aftermaths–what Fanon (1964) called 'pain without lesions'–of care encounters, that disproportionately sediment on minoritized, racialized and colonized bodies. Even if unaccounted by providers and systems, these harms were plainly evident to patients and their families.

Iatrogenesis, defined as 'any adverse condition resulting from treatment by a physician or allied health professional as well as the failure to provide adequate care when it is warranted' (Garner 1985, 701), is the fifth leading cause of death in the world (Peer and Shabir 2018). In the United States, where several papers in our special issue are ethnographically located, medical error alone is the third leading cause of death (Makary and Daniel 2016). Driven by crosscutting concerns for patient safety, quality improvement assessments, and reducing providers and systems' liabilities, across medicine and its sub-specializations, entire journals and everyday clinical practice are dedicated to elaborating the origins, kinds, and effects of iatrogenic illnesses and injuries.[1] Some forms of iatrogenesis are intrinsic to treatment; others follow from medical errors ('slips' and 'lapses' [Kohn, Corrigan, and Donaldson 2000, 54]), negligence ('acts' and 'omissions' that 'deviate from accepted norms of practice' [Bal 2009]), and malpractice. While negligence is framed as a mistake causing unintended harm, malpractice results when providers knowingly fail to adhere to standards of care. When determining iatrogenic cause and culpability, particularly in cases of patient death or severe disability, providers rely on a 'taxonomy of errors' (Makary and Daniel 2016), which includes errors of 'execution' and 'planning' and those that occur 'person' and 'system side', with the latter otherwise known as active (or, 'sharp') and latent (or, 'blunt') end errors. Where sharp end errors 'occur at the frontline operator', and have immediate effects, blunt end errors 'tend to be removed from the direct control of the operator and include structural or technical factors, such as poor design, incorrect installation, faulty maintenance, bad management decisions, and poorly structured organizations' (Kohn, Corrigan, and Donaldson 2000, 55). Medicine also recognizes how fault-based medical liability systems lead providers to practice 'defensive' medicine, where they pre-empt crises by checking and intervening at every opportunity (Garattini, Padula, and Mannucci 2020, 117) on the one hand, or 'refuse care to high-risk patients or avoid risky procedures' (Ibid) on the other. Ironically, both stances can yield the very iatrogenesis providers seek to avoid.

While conversations around medical injury in medicine and public health are elaborate and robust, they remain limited. Neoliberal medicine and the medical industrial complex's (MIC)[2] concerns with iatrogenic outcomes are shaped by statistically managing and minimizing injuries, illnesses, or deaths that can be counted and measured. Incidents that demand clinical attention are those that can lead to litigation, are potentially career-ending for providers, or reputation-harming for hospital systems, rankings, prestige, and funding, among other things (see Beard 2020; Buzzacchi, Scellato, and Ughetto 2016; Calikoglu and

Aras 2020). As a result, accounts of iatrogenesis from within medicine overwhelmingly prioritize provider- and system-side concerns over patient experiences. Despite its breadth, then, the medical literature foregrounds narrow, proximal clinical and institutional mechanics that generate risk and harm. Meanwhile, patients, particularly those who have historically been marginalized by medicine, may have entirely different understandings of the social, bureaucratic and legal norms to which they are subjected. When things go awry, providers may hold individual patients responsible, while patients, relatively powerless, may self-blame. These interlocking expectations and limits, both tacit and explicit, accumulate to invisibilize or delimit the full scope and contours of iatrogenesis.

Where medicine focuses on iatrogenesis' most immediate origins and outcomes, for decades, medical anthropologists have attended to a broad scope of medical violence–from diagnoses and the creation of new disease categories, to the deleterious effects of technological interventions for chronic or life-threatening diseases, to unequal obstetric outcomes, to the subjectivating possibilities of global health interventions, and more. Anthropologists have empirically investigated iatrogenic injuries and debilities without naming them as such, including iatrogenesis social, political, and structural antecedents, and its radiative and distal effects (Briggs and Mantini-Briggs 2004; Buchbinder 2015; Castro and Savage 2019; Dickson 2015; Jain 2013; Kaufman 2015; Livingston 2012; Greenhalgh 2001 especially). Consequently, while biomedicine's production of harm is a veritable truism in much medical anthropology, iatrogenesis as a standalone concern remains largely invisible[3] – appearing only rarely in our indexes, article keywords, and book and chapter titles.[4] Anthropologists have also generally not engaged with medicine's own elaborations of iatrogenic injury and illness, nor with questions of culpability, liability and accountability, even though these concerns preoccupy our hospital-based interlocutors. Thus, anthropological assessments of medicine's harms are socially rich, but not always clinically specific.

Drawing on the work of Ivan Illich (1975a),[5] our special issue reanimates iatrogenesis as a vital concept for the social sciences of medicine, while calling for medicine to expand its understanding of how the injustices that unfold from clinical processes, practices, and protocols that have far-reaching, reverberating effects into patient lifeworlds and subjectivities beyond the clinic. The capacious view of iatrogenesis revealed by this special issue collection affords fuller and more heterogeneous insights on iatrogenesis that are not limited to medical explanations alone, nor locate harm in singular points in time. These papers attend to iatrogenesis' immediate *and* lingering presences in socialities and structures within and beyond medicine, and the ways it reflects or reproduces the racism, sexism, and ableism built into medical logics. Our effort takes seriously the articulations and theorizations of iatrogenic injury offered by patients and others, especially those neglected or denied by the MIC and elided by institutional metrics. As a technical designate, 'iatrogenesis' conceptually adjoins significant moral and practical concerns in biomedicine and medical anthropology. By specifically invoking 'iatrogenesis', we ensure the link between medicine and harm is never lost, either to ethnographers, their audience, or our stakeholders beyond the academy.

Through ethnographies of medicine in the United States, Canada, England, and Brazil, our contributors follow two analytic threads: first, how racialized and racist medical knowledge and infrastructures produce particular forms of abuse and injury for marginalized communities. Second, how medical interventions produce disrespect, disadvantage, suffering and trauma, including when efforts to achieve resolution and cure constitute

dangerous overreach and even torture, paradoxically risking life itself. In tracing these effects and impacts of medical encounters, our contributors offer accounts of iatrogenesis that exceed its clinical presence, considering how its effects and aftershocks are often displaced onto intimate kin, social, and political worlds.

With iatrogenesis as our focus, shadowside ethnography describes our method, ethic, and analytic. In our collective formulation, a 'shadowside' approach challenges and confounds how medicine routinely rationalizes and absolves itself of its harms. Shadowside ethnography also exceeds neutral public health figurations of social determinants of health and social scientific conceptualizations of 'social suffering' or 'structural violence', which tend to be located alongside or outside medicine. Instead, a shadowside approach, which centers racial justice, confirms medicine as a structural determinant of health, as capable of producing as resolving disparities and inequities.[6] Shadowside ethnography requires medical anthropologists to confront the role played by providers' intentions, choices and actions in injurious care arrangements, such as those marked by accident and error, avarice and malintent, or sexism, racism, or transphobia, among many other possibilities (Bosk [1979] 2003; He 2014; Shapiro 2018; Varley Forthcoming). In centering patients and providers' accounts of the myriad forces behind clinical peril, shadowside ethnography contests biomedicine's role as a curative or palliative redressal for suffering. Rather, the overwhelming presence and (mal)distribution of iatrogenesis as an everyday reality is a symptom of how the medical industrial complex (MIC) has, is, and will be weaponized to further projects of exploitation, oppression and subjugation (Moniruzzaman 2012).

Racialized iatrogenesis

Scholarship on medical racism has shown how the MIC fails to address its imbrication in white supremacy,[7] and continues to perpetuate racialized oppression and terror (Gordon-Achebe et al. 2019; Lux 2016; Metzl and Hansen 2014; Nuriddin, Mooney, and White 2020; Roberts 2017; Stern 2005; among many others). Building on this work, this special issue shows how the largest share of suffering attributable to medicine in the Global North occurs on the bodies of BIPOC (Black, Indigenous, and People of Color), including poor, women, queer, and disabled folx.

The Black Lives Matters protests of 2020 coincided with the over-distribution of COVID illness and death among BIPOC across the globe (CDC 2021; Russo Lopes and Bastos Lima 2020; Garth 2021; Pirtle 2020; Razai et al. 2021; Yearby 2021). Both world-historical events have brought renewed attention to the clinical, social and structural factors that produce medical risk and harm. As preventable deaths collected in migrant detention centers, prisons (Frois 2020) and care institutions (Cohen 2020), connections between biomedical and carceral regimes became clearer (Chua 2016; Terry 2017; Varma 2020).[8] The pandemic has yielded treatment inequities and exclusions, forms of medical experimentation on formerly colonized populations in the Global South (Bajaj and Stanford 2021, 1; The Straits Times 2020), new techniques of racialized surveillance,[9] and potentially risky relaxations in ethical guidelines around clinical trials, therapeutics, patient triaging, and resource allocations (see Ezekiel 2020; Goold 2020; Maguire 2020; Varma, Vora, Fox, Berkhout and Benmarhnia, 2021; Warren et al. 2020; Weber and Bliton 2020). Covid-19 has also reignited fears about nosocomial–or hospital-borne–infections, as healthcare providers and patients alike worry about becoming vectors of community spread. Finally, the grotesque inequality of the global

distribution of Covid vaccines has produced a 'vaccine apartheid' (Yamey 2021), reinscribing racist hierarchies of value.

To these important conversations, we add the concept of *racialized iatrogenesis.* Racialized iatrogenesis refers to how racist medical mistreatments are not incidental or external, but internal and central to clinical processes, procedures, and to the history of biomedical 'progress'. Racialized iatrogenesis describes how BIPOC and QTPoC (queer and trans people of color), are most likely to be subjected to iatrogenic harm because of medicine's interlacing with forms of colonial, capitalist, and heteropatriarchal modernity (Khanmalek et al. 2020; Malatino 2020; Ureña 2019). Medicine remains integral to justifying, maintaining, and expanding empire. Deployed to promote superior health, hygiene and sanitation among colonial subjects, medicine helped disguise imperialism as progressive and humanitarian. However, as many scholars have shown, colonial subjects' encounters with medicine were, and remain, far from benevolent (see Chabrol 2018; Hoberman 2012; Owens 2017; Oyarzun 2020; Vora 2009; Washington 2006). Rather than care, the MIC 'enact[s] state-sanctioned and/or legal production and exploitation of group-differentiated vulnerabilities to premature death, in distinct yet densely interconnected political geographies' (Gilmore 2007, 28).

While most clinicians and medical students are now aware of the excesses of the Tuskegee experiments or the theft of Henrietta Lacks' cervical cells, racialized iatrogenesis reveals how these spectacular forms of iatrogenic harm coexist with more mundane, daily harms experienced by marginalized or BIPOC communities–from denying Black patients access to pain medications, to assumptions about certain bodies or places as 'disease ridden', to how algorithmic risk assessments of 'good' and 'responsible' patients are deeply gendered, classed and racialized. The list goes on. Racialized iatrogenesis insists that medical harms and vulnerabilities remain disproportionately distributed on marginalized bodies *despite* the well-meaning intentions of individual providers. It recognizes that, for people of color living in white settler settings, harm, not care, remains the default, expected outcome of encounters with the MIC.

Kara Granzow's powerful paper on hospitals for First Nations people in Canada (known as 'Indian Hospitals') reveals how settler colonial regimes of tuberculosis care exemplify racialized iatrogenesis for Inuit communities. In separating TB patients from their kin and communities–often by thousands of kilometers, and often without their knowledge or consent– treatment's harms were not incidental to, but built into the structure of colonial 'care'.[10] In evocative and emotionally charged letters written by patients and kin to Canadian state authorities, letter writers located iatrogenesis not only within individual bodies, but in broken lateral and intergenerational kin relationships whose impacts are still being felt today. Granzow's powerful analysis demands a recalibration of medicine's effects and harms beyond those clinically discernable. Meanwhile, this essay also focuses on how Inuit people countered the genocidal treatment to which they were subjected by maintaining other imaginaries of relational care and wellbeing.

In another account of racialized iatrogenesis, drawing on ethnography among Black women in Brazil, Eliza Williamson shows how a state health policy called Rede Cegonha, intended to reduce iatrogenic harm in childbirth, ends up perpetuating unequal health outcomes for Afro-Brazilian women and children. As Williamson poignantly argues, Black women are much more likely to suffer from a lack of timely intervention and quality care than from overmedicalization ('too much, too soon') that is often the focus of global health reforms around maternal health. Extending Davis' (2019) concept of obstetric racism,

Williamson's paper reveals the myriad ways anti-Black racism manifests and affects birth outcomes and women's subjectivities in Brazil's public hospitals. By centering Black women's experiences, Williamson joins ongoing social movement efforts by Afro-Brazilian feminists to center racial justice in health policies and help women renew and heal their bodies after racialized iatrogenesis.

Attending to processes of racialization in iatrogenesis reveals that it is not a time-bound, clinically specific or isolatable event, and to reduce it as such means enacting or reproducing deep histories of racism (anti-Blackness, anti-Indigenous and others), medical harm, and entanglements between medicine, social, and carceral control. While carefully accounting for these histories, the papers do not reduce those subjected to racialized iatrogenesis to helpless victims (Tuck 2009). Rather, they showcase how Black and Indigenous communities have exercised agency–from anger and frustration to reclaiming expertise—in response to detrimental encounters with medicine.

Medical excess and torture

Shadowside helps us articulate the harms that occur in overreaching, overly-technical, and capitalistic medical industrial complexes (Illich's primary concerns; see also Ecks 2020) to what occurs in low-resourced or 'unstable' health settings (Hamdy 2008; Jaffré 2012; Street 2014; Towghi 2018; Varley and Varma 2018, 2019; Varley 2019). The concept helps us find continuities between the wounding caused by the 'too much' medicine and 'too little' care that happens in neoliberal healthcare regimes. Reiterating Illich's critique, the following papers demonstrate how providers in litigious settings avoid medico-legal liabilities by over- and under-intervening, resulting in what Illich called 'counterproductive' medical practices.

Drawing on decades of experiences as frontline providers and ethnographer-witnesses in the United States, Liese, Davis-Floyd, Stewart and Cheyney describe how technocratic models of birth engender disrespect and danger for pregnant women, especially women of colour. Under the guise of reducing obstetric risks and ensuring 'good outcomes', biomedical providers surveil and act 'too much, too soon' (TMTS) on women's bodies, amplifying rather than decreasing childbearers' chances of injury and even death. In noting the processes that lead to iatrogenesis, they emphasize how medical education and training socializes providers into risky or abusive practices (see also Diaz-Tello 2016; Sadler et al. 2016). Both patients and providers learn not to see iatrogenic harm due to cultural beliefs about obstetric efficacy, the 'supervaluation of high technologies', and the social acceptability of over-intervention. The authors call for an 'epic paradigm shift' in obstetric medicine, including minimizing interventions, incorporating midwives and support persons capable of affirming women's total needs and prioritizing the normal physiology of birth. Together, these transformations demand a new care configuration, 'RARTRW care—the right amount at the right time and in the right way'.

In Sobo's ethnography of intractable pediatric epilepsy, iatrogenesis proliferates as unwanted, excessive, and debilitating effects from anti-seizure medications. Children's treating providers casted iatrogenesis as inevitable, and parents were encouraged to accept unwanted outcomes, even when safer and less injurious treatment alternatives were present. Fueled by frustration, anxiety and love, parents created online and ad hoc networks to access what were then-illegal cannabinoids, which they hoped would offer

reprieve from conventional therapies' most toxic and unwanted outcomes, permitting their children's 'true selves' to re-emerge as pharmaceuticals' character- and body-altering effects receded. Yet, as Sobo shows, even parents' resistance to iatrogenesis reified biomedical hegemony and uncannily reproduced biomedicine's idealized middle-class white norms. Parents' CBD dispensing efforts mimicked allopathic techniques, and they relayed their seizure-control successes in empirical terms. In so doing, parents (not all of whom were white) distanced themselves from 'illegal' and 'criminal' marijuana use associated with Black people and mass incarceration. Thus, while iatrogenesis transformed bodies and personhood, in many cases, responses to it shored up norms of ableism and whiteness.

In two powerful papers about the opioid epidemic in the United States, iatrogenic injury paradoxically emerges from medical intervention and protocols designed to *minimize* risk, injury and harm (Chary and Flood, Textor and Schlesinger). Both these auto-ethnographic pieces by clinician-anthropologists show how physicians struggled to treat patients with opioid dependence—addictions that often originated with pain prescriptions. Both papers thoughtfully highlight the role of clinicians and clinician subjectivities in navigating treatment refusals taking moral responsibility for patients' suffering.

As Chary and Flood's paper shows, where opioids were once plentifully dispensed (at least to white patients), in recent years, providers and patients alike have been confounded by a shifting nexus of care and harm as regulatory frameworks around opioid prescriptions have become more stringent. Providers are forced to deny palliative care, even when symptom relief is a matter of medical and psychosocial emergency for their patients. Meanwhile, patients, who originally received opioids in clinical settings, experience this withholding as cruelty. Cast adrift and struggling with dependence, they are forced into 'self-care' using street drugs, while their morbidities multiply and worsen. When these patients re-enter clinical settings, they are often referred to, in ambivalent and disparaging ways, as 'iatrogenic trainwrecks'. Chary and Flood's paper shows how treatments gone awry and delayed, denied prescriptions, and comorbidities are not merely the result of individual clinical decisions, but rather, how 'iatrogenesis and moral injury are concomitantly produced through cascades of decision-making and local health systems'. Their paper calls for greater attunement to the ways these forms of iatrogenesis and structures of clinical decision making corrode clinicians' ethical capacities.

While Chary and Flood's paper attends to how providers are subjected to iatrogenic harms as a result of clinical double binds, Textor and Schlesinger's paper demands that providers recognize themselves as active contributors to iatrogenic injury. Through examining access to opioids (Textor) and pre-exposure prophylaxis (PrEP) for HIV (Schlesinger) or lack thereof, their paper spotlights how regimes of risk reduction shape notions of moral responsibility for patients in highly differentiated and unequal ways. In Textor's exploration of pain and dependency, and Schlesinger's (auto)ethnography of men who have sex with men (MSM), patients must demonstrate their clinical and moral suitability to access opioids and PrEP respectively. For instance, Schlesinger describes how notions of 'good' sexuality are reduced to always-prudent sexual practices and the use of condoms especially, irrespective of impacts on desire and pleasure; PrEP is less likely to be dispensed to those who fail to conform to these 'safe' standards. Textor and Schlesinger show how tacit and explicit demands of patient adherence to these biomoral standards produce complications and resistances: patients are alternately defiant, performatively submissive, or sickened by the

self-negation demanded of them by raced, classed and heteronormative conceptions of 'deservedness'. In discussing the resonances between their individual findings, Textor and Schlesinger remind us of the 'avoidable and unnecessary suffering' that follows when 'pleasure and pain, crucial aspects of patients' lived experiences of risk, were eclipsed in the clinical encounter'. Both papers show how risk reduction, far from enhancing patient well-being, becomes a vector of increased surveillance, control, and of individualizing moral responsibility.

Finally, the most heartbreaking example of iatrogenesis on offer is Leah Ashe's auto-ethnography of medical harm and forcible medical confinement, which testifies to the stakes of iatrogenesis beyond clinical accounting.[11] When patients are stripped of their autonomy and rights over sustained periods of time and subjected to coercive and carceral interventions in the name of care, medicine constitutes torture itself. Leah's experience of iatrogenesis was not yielded by medical neglect and abandonment; rather, her body was relentlessly and aggressively worked on, daily, and hourly. From the clinic's perspective, she was a troublesome and 'failed' patient. To survive, Leah had to escape care—an escape which required legal intervention. The long-term effect of her injuries dramatically reduced her life expectancy. Leah passed away in the fall of 2020. Her testimonial, brimming with brilliant, evocative and at times gut-punching language, was critical to her efforts to publicly share and destigmatize stories of medical harm and prise much-needed space for discussions of physician and system-side culpability. In so doing, her writing sets a vital precedent. For when iatrogenesis, like other injuries, stunts our narrative capacities, it requires we craft new expressions, poetic or aphoristic language–as Leah did–that refuse biomedical norms of rationality, linearity, or closure. She did not see this issue come to fruition, though we know how very urgent and necessary this conversation was for her.

Shadowside witnessing

There are several important theoretical and methodological takeaways from our contributors' findings. First, through their frontline witnessing of shadowside medicine, the medical anthropologists and clinicians here explore iatrogenesis' full spectrum, its radiative aftermaths and imperceptible traces from the clinic into everyday life, including the social, psychic, and bodily toll of medical interventions and encounters. Shadowside medicine helps bracket medicine's soteriological justifications in favor of more pressing demands or the other histories that shape it, such as neoliberal logics of scarcity, models of managed care, and racist, militaristic, and carceral impulses. Second, a shadowside approach to iatrogenesis de-singularizes the patient by showing how those affected by iatrogenesis are not just individual bodies and patients, but kin, communities, and providers. Third, by including 'clinical endpoints in their analysis', and making certain their descriptions are clinically anchored (Timmermans and Haas 2008), the contributors remind us of anthropology's power to corroborate our interlocutors' experiences and answer the concerns of our colleagues in medicine and public health. Fourth, and finally, centering the experiences of formerly colonized or enslaved people in our analyses means acknowledging how anti-Blackness and anti-Indigenous logics remain built into, and are not ancillary to, contemporary medicine. As Fanon argued long ago, and several contributors confirm, medicine remains a critical vector of

colonial violence–it was never built to care for certain bodies, but to manage, contain, and in many cases, actively harm them.

Working with our contributors on the special issue while confronting health system collapses worldwide during the pandemic has crystallized some truths for us. Transforming the MIC – and medical anthropology by relation – into liberatory projects will require more than financial resources or mainstreaming structural explanations in medical education. As the MIC searches for answers amid ongoing demands for racial justice in the Movement for Black Lives and Covid-19, even the most progressive medical school curricula reforms—such as introducing 'structural competency' —inadequately address medicine as a vector of racist harm. The 'competency' framework that undergirds medical education effectively shores up, rather than nuances medical expertise, and fails to address how medico-legal processes cover up or absolve medical actors of responsibility.[12] Beyond this, our special issue shows, in troubling ways, that iatrogenic harm often emerges directly *from* medicine's attempts to reform itself, whether in the case of opioid prescriptions or in less interventionist maternal health policies. Time and again, these efforts do not center the experiences of the most marginalized and limit medical harm to legal criteria to what can be statistically measured and counted. We call on providers to expand their understandings of iatrogenesis to include the more long-term and insidious harms that sediment in bodies and spaces, tainting and even defeating care.

By illuminating where change is most immediately needed, shadowside ethnographies possess the political capacity to hold medicine to fuller account and advocate for radical social and racial justice transformations to medical practices and institutions (see Williamson, Granzow, and Liese, Davis-Floyd, Stewart and Cheyney's pieces in particular). Such changes are not providers' responsibility alone. We urge medical anthropologists to center critiques of medicine and iatrogenesis that come from BIPOC scholars within and outside of our field (Davis 2019; Jain 2013; Nelson 2013; Owens 2017; Oyarzun 2020; Sangaramoorthy and Benton 2015; Wailoo 2014; Wallace 2020; Washington 2006) and to integrate anti-racist practices to our work as 'bedside' ethnographers (see Brown and Campelia 2021).

Shadowside ethnography complements abolitionist approaches to the MIC. Abolishing the MIC requires what Ruth Gilmore calls 'presence, not absence', and demands we focus our energies on reimagining and rebuilding systems of care, so that they work for the most vulnerable (see also Gutierrez 2020; The Care Collective 2020; Wallace 2020). This change begins by decentering white, Eurocentric perspectives in medicine in favor of foregrounding the experiences of persons and communities whose stories of iatrogenesis–not just the spectacular but also the mundane– remain hidden or sublimated. Likewise, ethnographers must resist the liberal and elitist impulses of our discipline that pressure us to present certain kinds of truths about ourselves and about medicine, while withholding others (Günel, Watanabe, and Varma 2020; Jobson 2020). Iatrogenic wounds, both visible and invisible, cannot be healed without radical acknowledgement and radical changes in 'politics, in medical institutions, and in narratives about the full humanity of oppressed people' (Ureña 2019, 1643).

We write this with urgency. We write this as Covid patients in India, where we have both worked, die daily in the thousands due to a lack of oxygen, a crisis produced not by a lack of resources, but by structural incompetence and a willful, even genocidal impulse to let die. We write this on the day the trial of Derek Chauvin has ended, when we are

reminded that the conditions that led to the killing of George Floyd—and the killing of Black and brown people—remain in place despite the guilty verdict. The protestors' calls to 'dismantle and rebuild' and 'systems must work for everyone' ring in our ears.

Notes

1. Iatrogenic illness is defined as 'any illness [that] results from a diagnostic procedure or therapeutic intervention that is not a natural consequence of the patient's disease …[These] are most commonly associated with medications, diagnostic and therapeutic procedures, nosocomial infections, and environmental hazards' (Suh and Palmer 2007). Injury, meanwhile, refers to 'tissue or organ damage that is caused by necessary medical treatment, pharmacotherapy, or the application of medical devices and has nothing to do with the primary disease' (Cheng et al. 2019).
2. Following disability justice organizer Mia Mingus (2015), we understand the medical industrial complex as a system of globalized healthcare forged in the crucible of colonialism and capitalism, yet which presents itself as humanitarian and benevolent. The MIC is deeply implicated with eugenics, neoliberal capital, colonization, slavery, immigration, war, prisons, and reproductive oppression, in different ways around the world. As Mingus puts it, the MIC 'is not just a major piece of the history of ableism, but all systems of oppression.'
3. Heartfelt thanks to Susan Greenhalgh for this felicitous phrasing.
4. For example, even though medical injury and harm are important themes in both their individual work, Lock and Nguyen's important volume, *An Anthropology of Biomedicine* (2010), does not include iatrogenesis as a standalone or significant concept. It is also similarly absent from the global health volume, *Metrics: What Counts in Global Health* (2016), in which only one essay references 'injury' as a key term.
5. Ivan Illich identified four categories of clinical iatrogenesis, the first of which include malpractice, negligence, professional callousness; the second, which describes accidents or 'systems breaking down'; the third, which focuses on 'specific risks which are accepted', such as the uses of certain risky technologies or diagnostic tools; and finally, defensive medicine (Illich 1975a, 78–79). Yet, Illich did not limit his analysis to clinical practices and procedures alone; he also outlined social and symbolic iatrogenesis', the latter being the hegemony of the medical industrial complex, 'the most important economic sector after the American war industry' (Illich 1975a, 80).
6. For example, Nazi Germany's genocidal use of public health and biomedicine against Jewish populations, as well as the Roma, homosexuals, the disabled, political prisoners, and POWs, during WWII (see Baumslag 2005; Lifton 1986 [2017]), and the American eugenics movement systematic sterilization of persons deemed undesirable, 'defective', and unworthy of reproduction (see Cohen 2016, Schoen 2005).
7. See for example the recent JAMA 'no physician is racist' controversy (Tanne 2021), the United Kingdom's 2021 "Commission on Race and Ethnic Disparities", which, counter to the government's own data especially during Covid (see Razai, Majeed, and Esmail 2021), rejected 'the common view that ethnic minorities have universally worse health outcomes compared with White people' (Gov.UK 2021, 199), and the doctor who was fired for discussing racism in medicine (Lenzer 2021).
8. Covid outbreaks in hospitals and long-term care facilities impact patients and providers alike, with BIPOC frontline personnel suffering the heaviest share of viral exposure, nosocomial infection, and death (Chaudhry et al. 2020; National Nurses United 2020; Rimmer 2020).
9. The medical diagnostics, algorithms, and technologies on which we are so reliant during Covid are themselves shaped by histories of racism, pulse oximeters serving as but one example (Sjoding et al. 2020; Sjoding, Iwashyna, and Valley 2021; Whitehead-Clarke 2021).
10. See Downe (2020), Phillips-Beck et al. (2020), and Stevenson (2014) for more on colonization's enduring, genocidal presence in contemporary Canadian healthcare.

11. See Susan Greenhalgh's Afterword, "Ode to Leah" (this issue).
12. Instead, we find some hope in trainings that emphasize provider humility (Metzl, Maybank, and De Maio 2020).

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Ethics approval

No ethics approval was required for this Introduction

Disclosure statement

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