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THREE PROPOSITIONS FOR A CRITICALLY APPLIED MEDICAL ANTHROPOLOGY

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Abstract—This paper initiates a discussion of some viable approaches to a *critically* applied as opposed to a *clinically* applied medical anthropology. The old question of the role of the intellectual man or woman is at the heart of this enquiry. Analogies are drawn between the current relations of anthropology to medicine and the history of anthropology's relations to European colonialism. The dilemmas of the clinically applied anthropologists 'double agent' role is discussed and alternatives offered in the form of three separate and to some extent contradictory projects, each of which, however, demands that the anthropologists cut loose his or her moorings from conventional biomedical premises and epistemologies. Ours must be an anthropology of affliction and not simply an anthropology of medicine. Praxis must not be left in the hands of those who would only represent the best interests of biomedical hegemony.

Key words—critical medical anthropology, biomedical hegemony, anthropology as cultural critique, the anthropology of suffering

There is a medical anthropology joke that has been making the rounds among graduate students [1]. On the west coast it first surfaced following a symposium on 'The Anthropology of Sickness' held during the Kroeber Anthropological Society meetings in the spring of 1986 at which several distinguished medical anthropologists were invited to share their ideas and research agendas. The joke goes something like this, although there are several variants, depending on the particular sympathies of the teller.

A doctor and three medical anthropologists—Hans Baer, Michael Taussig, and Arthur Kleinman [2]—are standing by a river. Suddenly they hear the final cries of a drowning man. The doctor jumps into the river and, after battling against the swift current, hauls in and tries to resuscitate the dead man. After a short while another body floats by and the same attempt is made to save it. Another and another comes down stream. Finally it occurs to Hans Baer to head upstream in order to investigate the contradictions in the capitalist mode of production that are responsible for the mass fatalities. Meanwhile Taussig goes off, very much on his own, bushwalking in search of the cryptic message in the bottle that at least one dying man or woman would have had the foresight to send out. Dr Kleinman, however, stays behind at the river bank in order to help facilitate the doctor–patient relationship.

There is a real dilemma that is being posed in this whimsical 'morality tale' (or is it a mortality tale?) for our troubled subdiscipline. It expresses the frustration of those who want to practice an engaged and committed anthropology. It is a frustration that can lead (as this tale would indicate) to cynicism and a return to 'pure' research.

If there is to be any radical alternative to conventional applied medical anthropology [3] what form shall it take? Is there a mediating, third path between the individualizing, meaning-centered discourse of the symbolic, hermeneutic, phenomenologic medical anthropologists, on the one hand, and the collectivized, depersonalized, mechanistic abstractions of the medical marxists, on the other? While ethnomedical microanalyses may be said to reveal *part* truths about *humans*, the medical marxist macroeconomic analysis may be said to reveal part truths about *things*, about systems, while losing sight of the highly subjective content of illness and healing as lived events. To date much of what is called *critical* medical anthropology refers to this later approach: the applications of marxist political economy to the social relations of sickness and health care delivery.

Certainly Taussig's [4] potent socialist-anarchist critique of medicine and the Western world offers an extravagant and heady alternative to the more pedestrian approach on either side of the macro–micro divide. But Taussig's engagement with the poetics of 'epistemic murk' is sometimes infused with a politics of despair (one characteristic of Western radicalism in the post-war years) such that any intervention by committed social scientists or by clinicians would seem banal, hopeless, self-serving, or simply false. Meanwhile, the more conventional political economy marxist critique seems to demand a global revolutionary response in which history, and not mere mortals such as ourselves, will play the leading role. Hence, the role, if any, of the passionate and critical intellectual is unclear, and praxis in medical anthropology has been left in the hands of those content to tinker (endlessly it would seem) with the doctor–patient relationship.

Here I want only to initiate a discussion of what might prove to be viable approaches toward a critically as opposed to a clinically applied medical anthropology [5]. What premises might guide such work? Certainly a notion of praxis is indispensible if one goal is to be that of giving voice to the submerged, fragmented, and largely muted subcultures of the sick (see Ref. [30]). The old question of the role of the intellectual in society as scientist and as

practical man or woman is at the heart of this enquiry. I will take as my spring board and my key text, *Clinically Applied Anthropology* [6], edited by Noel Chrisman and Thomas Maretzki, against which (but with all due respect toward my dedicated colleagues in the field) I will propose a radical alternative, a critically applied medical anthropology.

Analogies can be drawn between the current relation of anthropology to medicine, and the history of anthropology's relations to European colonialism. British and North American social anthropologists who served in the colonies tended to perceive themselves and to act as mediators who tried to prevent the worst ravagings to the tribal world. Although the moral correctness of Western imperialism was sometimes questioned by these 'administrative' anthropologists, the *inevitability* of the whole Western colonial enterprise was largely taken for granted. In the end, with the old colonial empire virtually tumbling before their eyes, a few colonial anthropologists (Bronislaw Malinowski among them) began to switch loyalties and to cast their lots and their support to native liberation movements demanding self-determination.

At the very beginning of his career as an anthropologist and a Victorian gentleman cooly observing the 'savages' at work, sex, and play, Malinowski could write in his infamous Trobriand Island diary that "my feeling toward the natives are [on the whole] tending to 'exterminate the brutes'" [7], an obvious reference to Mr Kurtz's words and reaction to the natives of the Congo in Joseph Conrad's (a fellow Pole and aristocrat), *The Heart of Darkness* [8]. Toward the end of his career, however, Malinowski began to reflect and to write on anthropological loyalties and responsibilities in a very different way [9]. He referred to anthropology as a vocation with a specific 'moral obligation' and he wrote that anthropologists "will have to register that Europeans sometimes exterminated whole island peoples: that they expropriated most of the patrimony of the savage races" and in exchange Europeans withheld from colonized peoples just those instruments of western civilization "...firearms, bombing planes, poison gas, and all that makes effective defence or aggression possible" [9, p. 57]. Among his students at the London School of Economics was young Jomo Kenyatta, whose politically charged *Facing Mount Kenya* [10] was enthusiastically introduced by Professor Malinowski. Malinowski's transformation from a colonialist to a more liberated applied anthropology was, nonetheless, incomplete and ambivalent [11], although the elements for this own critical consciousness-raising were in place.

Today's applied anthropologists serving 'in the clinics', like the early anthropologists serving in the colonies, seem to have defined themselves in the highly circumscribed role of 'cultural broker' [12]. How does this 'brokerage' operate? Chrisman and Maretzki define it in no uncertain terms as the "transaction between anthropological knowledge and the *needs of health practioners*" [13]. We are to put anthropological knowledge at the service of the power brokers themselves. Similarly, Katon and Kleinman have suggested that clinically applied anthropologists might be able to teach a [doctor–patient] "negotiation model of therapeutic relationships" to health care professionals [14]. What these authors mean to imply by negotiation is best summed up in their third stage of the process wherein "often the patient will respond to the doctor's explanations by shifting his or her explanatory model of illness toward the physician's model, and thus *making a working alliance possible*" [14, p. 103]. Is this negotiation or manipulation? We expect scientific language to be precise and to clarify rather than obscure the nature of social interaction.

The 'dilemmas' (I might say contradictions) implicit in this negotiation or broker model are many, and Kleinman lays them out quite clearly. I will take the liberty of quoting at some length from the pertinent essay:

> A large part of the anthropologist's dilemma in the clinical context is to take up a stance that is intrinsically divided, collegial, concerned with the practical resolution of clinical problems and yet at the same time, autonomous, concerned with clarifying an independent anthropological theory of illness and healing that can stand on its own. Constantly shifting between patient and physician perspectives, the clinically applied anthropologist...is an advocate for both....
>
> Nonetheless, it is also this divided stance that is the source of the clinically applied anthropologist's personal discomfort and professional unease. The clinician wonders, 'Whose interests does this professional stranger support?' The patient and family look upon him with equal uncertainty. Each time he intervenes in the making of clinical decisions, the anthropologist feels *the tug of divided loyalties*....
>
> The one member of his tribe in the midst of skeptical members of a tribe with a different world view, how does he learn to best make his points, *remain silent when his words would be seen as useless, threatening, or obstructive, and control his own emotional response to being disvalued and ignored?* When he writes, who is the audience? The divisions go on and on [15].

Dr Kleinman pretends no easy solutions, he has (he writes) "no answer to this dilema" [2] of divided loyalties or what I might refer to as the dilemma of the 'double agent' insofar as the interests and goals of doctors and their patients do not always coincide. Others contributing to this same volume, including the editors, do have suggestions toward 'resolving' the dilemma, specifically, identifying broadly with the goals of the health care professionals so as to avoid being "perceived as strident and personal critics of medical care [lest] we run the risk of simply being ignored because of having been *offensive*" [see Chrisman and Maretzki, 3, p. 21]. Moreover, the editors caution against the anthropologist's natural "desire to identify with the underdog", and they descry the 'naive' medical anthropologist's "romanticized view of the strengths of folk healers", a stance understood as untenable in light of the 'injuries' such par-professionals have visited upon those 'patients' who have defected from orthodox medicine. Such 'courting' of alternative healers can only be viewed as offensive to "our experienced and well traveled practioner colleagues who have seen negative outcomes of folk treatment in their examination rooms" [Chrisman and Maretzki, 3, p. 21]. Presumably, they have not seen the positive outcomes of folk treatments in those same examination rooms, which at least some equally well-travelled and experienced medical anthropologists have observed 'in the field'. Finally,

while the editors acknowledge the problem anthropologists (accustomed as they are to a 'more egalitarian style') encounter when dealing with the rigid and hierarchical nature of interaction and debate in medical settings, still they caution the anthropologist to avoid being a "gadfly" and "to deliver comments tactfully and appropriately".

Such caution is quite extraordinary. Why, as soon as anthropology enters the clinic, are the bywords suddenly negotiation, caution, tact; that is, when we are not being asked outright to 'remain silent' when our words might be viewed as 'threatening' to the powerful interests of medical practitioners? And why, when the medical anthropologists would dare to question the commonsense grounds and assumptions upon which biomedical knowledge and practice is based [a traditional and intrinsic function of our method] are we suddenly cast as emotional and irrational gadflies, troublemakers, hostile to medicine, science the "American [or the 'western'] way"? [16]. Kleinman, for example, refers to certain medical anthropologists who are "deeply hostile to physicians whom they view as patients' jailers" [15, p. 87]. Would Dr Kleinman mean to imply that doctors have never been, or are never to be seen as 'jailers' to their involuntary patients? Are medical anthropologists being asked to ignore their patient informants' explanatory models if and when they are found to contain such unflattering views of physicians? And, would Dr Kleinman mean to describe as 'hostile' the writings of Erving Goffman, Michel Foucault, Jules Henry, and Thomas Scheff [17–20], each of whom tended toward a view of doctors as jailers in certain historical and social contexts?

One has the image of the timid anthropologist—certainly out of his milieux—tip-toeing through the minefields of the modern clinic trying to mediate or to prevent the most potentially pathogenic interactions and miscommunications from hurting vulnerable patients. All of which is necessary and praise-worthy. But, as with the early colonial anthropologists, what is not being called into question is the inevitability (nor the technological superiority) of the whole biomedical health enterprise itself. The oft-expressed professional concerns of clinically applied anthropologists with respect to 'establishing credibility' and 'legitimacy' within the powerful world of biomedicine and the fears of 'marginalization' or, even worse, 'irrelevancy' lead only to compromise and contradiction. This tendency to compromise is, apparently, no less the case when a mature anthropologist enters the profession of medicine, as Melvin Konner's [22] candid story of his mid-life, mid-career entry into medical school painfully documents (see below).

Moreover, the analysis of doctor–patient communications and encounters is not unique to medical anthropology, and the role of 'loyal opposition' to the normative authority (that of the 'traditional intellectual' in Gramsci's [23] schema) is perhaps best filled by those from within the medical profession. Critiques of clinical practice are often most effective and resonant when they are initiated by practicing clinicians contributing essays to traditional medical journals like *Family Medicine*, *The Annals of Internal Medicine*, and the *New England Journal of Medicine* [24], or giving commencement addresses to large medical school classes, or addressing their colleagues at conferences organized in medical schools and centers [25].

However, my dissatisfaction with traditional clinically applied medical anthropology runs even more deeply, and it concerns the failure in much of this literature to grapple head on with the rather basic incongruity between the interpretive ethnomedical and the positivist biomedical scientific paradigms. I refer to the irreconcilability of an anthropological knowledge that is largely 'esoteric' (concerned with 'otherness'), subjective, symbolic and relativist with a biomedical knowledge that is largely mundane, universalist in its claims, concrete, objective and radically materialist. The obvious potential for conflict is avoided (although in no way resolved) by the tendency to reduce the complexity and richness of anthropological knowledge to a few reified and 'practical' concepts (such as 'lay explanatory models', the disease/illness dichotomy, somatization). The result is not only the reification of sickness and human suffering as these are understood by cultural anthropologists, but also the reification of medical anthropology itself. Clinical medical anthropology has become a new 'commodity', carefully sanitized, nicely packaged, pleasant tasting (no bitter after-taste)—the very latest and very possibly the most bourgeois product introduced into the medical education curriculum. ["Exotic cultural patterns are *fun* to know", exhort Chrisman and Maretzki [3, p. 20], and you'd be surprised at how much medical students enjoy the distractions we can offer from their otherwise rigourous studies!] Training in 'cultural sensitivity' is today the mark of the well-educated and sophisticated biomedical practitioner, just as dabbling in enthnology was once the mark of the sophisticated colonial administrator in the tropics. What is compromised in the translation process is anthropology itself.

What is *not happening* in clinically applied medical anthropology today is any radical calling into question of the materialist premises of biomedicine, no (with the possible exception of Taussig [4]) carnivalesque turning of medicine inside out. For, in addition to the role of 'loyal opposition' or 'traditional intellectual', the given social and moral order can sometimes benefit from the role played by the court jester, the 'negative' or 'oppositional' intellectual, the one who turns received wisdoms on their heads, playing off both the normative authority (the 'King') and the 'loyal opposition'. The jester, the oppositional intellectual, works at the margins and sometimes (but not necessarily) from the outside, pulling at loose threads, deconstructing key concepts, looking at the world from a topsy-turvy position in order to reveal the contradictions, inconsistencies, and breaks in the fabric of the moral order without necessarily offering to 'resolve' them. By contrast, conventional clinically applied anthropology produces little or no challenge to the perverse economic and power relations that inform and distort every medical encounter in post industralized and especially capitalist societies [26], and with few exceptions [27], no casting of one's lots occurs with the often disreputable, stigmatized and marginalized patients' rights and self-help groups

or other critical subcultures of the sick, excluded, and confined. Rather, we find a bio-social medical anthropologist-turned-physician who would admit to a process of cathexis through which the patient becomes an object, indeed, even the 'enemy' while [his] "bonds, [his] emotional energy . . . were all with doctors and medical students, and to a lesser extent [but, of course!] with nurses" [22, pp. 365–366].

In conventional applied medical anthropology there are, in short, no epistemic breaks with scientific medicine, analogous to social anthropology's eventual breaks with the colonial world and its hegemony. Worse, clinically applied anthropologists seem to be arguing for an *expansion* of biomedical knowledge and expertise to include some recognition of the nonbiological and social dimensions of sickness. Indeed, this goal may be said to define clinically applied medical anthropology even while it may have disastrous consequences, such as the *medicalization* of every complaint and disorder, including those best managed in other spheres and by other kinds of professionals, or even by nonprofessionals. Alan Harwood suggests (personal communication) that an unanticipated side effect of the popularity of the 'disease'/'illness' dichotomy is that it has created a single discourse for anthropologists and clinicians that has allowed physicians to claim both disease *and* illness, curing *as well as* healing for the biomedical domain. Indeed, this particular message, phrased rather crudely as doctors participating in the mystique and 'legacy' of the 'witch doctor', is being actively disseminated by one clinically applied medical anthropologist in his publications [40], and in his consulting work for the American Hospital Association. Consequently, the social relations contributing to illness and other forms of disease are in danger of being medicalized and privatized rather than politicized and collectivized. Everything from marital discord to poor school performance, from worker burn-out to existential doubt in the nuclear age can be appropriated and *treated* by medicine in new (and improved) therapies.

An alternative and *critically* applied medical anthropology need first of all to disengage itself, dis-identify with the interests of conventional biomedicine. From there I see a multiplicity of possible proposals and approaches—some arguing for radical changes within the structure of clinical medicine and others arguing for changes or alternatives from without. Each can offer much needed challenges to biomedical hegemony. Here I will suggest three *separate* and to some extent, contradictory projects for consideration, reflection, and response. This is an exploratory exercise that does not pretend to exhaust the subject at hand, but merely to stimulate and perhaps ignite. For this reason the proposals are highly schematic. I hope to open a dialogue, not to resolve a vexing set of dilemmas.

One thing I do not hear from my colleagues in medical anthropology, but rather from within some quarters of clinical biomedicine [28] is an invitation to *reduce* rather than *expand* the parameters of medical efficacy, a call for a more humble model of doctoring as 'plumbing', simple 'body-work' that would leave social ills and social healing to political activists, and psychological/spiritual ills and other forms of existential malaise to ethnomedical and spiritual healers. This project derives, in part, from Illich's [29] analysis of the sick-making propensities of an ever expanding sphere of biomedical competence and intervention, and in part from those medical anthropologists calling for a demedicalization of life in modern society *and* a demedicalization of medical anthropology [30]. This project is based on the assumption that scientific biomedicine is not adequate to the tasks of alleviating ontological insecurity in the post-nuclear age, or of responding to women's and men's somatized protests against a sexist social and moral order, or responding to workers' hostility toward and advanced stage of industrial capitalism that treats them as superfluous. And physicians, as they are now trained, are not the best guides for the mortally ill toward their inevitable contract with death. These are ills, to be sure, but ills in the sense that life itself is one long terminal sickness, and one which requires a multiplicity of creative responses.

In this regard, I am mindful of the 'education' of John Sassall, a small time doctor who chose to live and practice medicine among the 'foresters', the residents of a small and remote English village. In a collaborative photographic essay, John Berger and Jean Mohr [31] present a moving and complex portrait of the doctor who begins his career thinking of himself as the 'captain' of a ship, ministering to immediate (physical) needs of his crew. The isolation and 'cultural deprivation' of the community contributes to the doctor's central role and his 'command' of the community. Gradually Sassall expands his roles in the small community from the simple doctoring of cuts and bruises, fevers and infections, births and deaths, to a broader concern with the psychological and even the spiritual needs of his patients. We might say that he was becoming more wholistic in his understanding of medicine. The captain becomes the mentor and the wise counsellor. Then, as Sassal begins to grasp the connections between private troubles and social ills he takes on the role of community activist. He is busy, engaged and so very needed and admired by the foresters. Sassal realizes he is 'a fortunate man'. Nonetheless the gulf of social class, tastes, and education ('breeding') that separates the doctor from his patients means that there can never be any real intimacy between them. A depression follows through which the good doctor confronts the 'falseness' of his overblown ambitions and realizes the dependencies that he is fostering. In his attemps at 'doctoring' to a 'sick' society (rather than to sick bodies) Sassal realizes that he is failing to be true to the ways (humble though they may be) that he can serve his fellow country people.

In the slightly altered words of the Alcoholic Anonymous credo, I would like to see doctors invested with the courage to change the things that can be changed, with the humility to steer clear of those things that fall out of their sphere of knowledge and competence, and with the wisdom to know the difference. Margaret Lock [32] presented the case of a 14-year-old Cree Indian boy, completely mute and profoundly depressed who was flown into Montreal by the Cree Health Service for consultation at a major teaching hospital. The case was handled by an

extremely sympathetic and culturally sensitive child psychiatrist. Following interviews (through an interpreter) with the mother, and attempts at communicating with the young patient, the physician came to accept the boy's mutism as a culturally appropriate response to the culture death of the Northern Cree who had lost their land, their work, and their language. The boy had suffered the losses of his father, two uncles, and a cousin, all resulting from violence of alcohol-related accidents. In addition, the boy was taken from his home and raised hither and yon among the Cree as well as in English and French boarding schools. He had learned fragments of all three languages, but was master of none. Through a combination of words and gestures, the boy was able to communicate to the compassionate psychiatrist his one wish to return home to the North country. Although knowing that she was releasing the boy to a Cree no-man's land and to a probable death by suicide, the doctor accepted that the answer to this boy's pain was *not* to be found in Western medicine or even in Western psychotherapy. She was being true to the limitations of her medical and psychiatric expertise, and she strikes Lock and I as a modal practitioner in her management of this disturbing case.

The second project border on the heretical, but I hope not the absurd. It concerns the development of an anthropological discourse on problematic, nonbiological forms of healing in terms of their own meaning-centered and emic frames of reference, and as possible, indeed valid, alternatives to biomedical hegemony in our own society and for people very much like ourselves. I am referring to what is labeled in the medical literature (and that is when the authors are trying to be kind) 'unorthodox' or 'heterodox' therapies [33].

While, with few exceptions [34] most medical anthropologists have been appropriately pluralistic in their treatment of 'traditional healers' practicing in the non-Western world (and even tolerant of those who would like Michael Harner, attempt to initiate middle class Americans into some of the secrets of Amazonian shamanism), they have not applied these same standards at home where 'unorthodox' medical practitioners may still be labeled 'charlatans' [35]. Although the development of social anthropology hinged upon the cultivation of a methodological agonisticism (i.e. cultural relativism) which is understood as fundamental to the unbiased study of comparative religious systems and magical beliefs and practices [36], medical anthropology and anthropologists still cling to a Western (bio-medical) epistemological orthodoxy (e.g. as in the mind/body, visible/invisible, real/unreal dichotomies) that inhibits our ability to understand paradoxical forms of experience and of healing in particular [37]. Once again, it is sometimes even easier to find this kind of relativist thinking and radical openness from *within* some quarters of clinical biomedicine than from within medical anthropology, as for example, in the writings of Oliver Sacks and Richard Selzer among others [38].

In this regard it might be instructive to reflect on the way that two of our eminent colleagues, Margaret Mead and Gregory Bateson, refused to acquiesce wholly, or in part, to the bio-medicalization of their respective deaths from cancer. Bateson and Mead, teachers all of their lives, continued to teach in the ways they chose to die, much to the chagrin of some of their colleagues and of the scientific community at large.

In a moving essay on her father's last 6 days of dying, Mary Catherine Bateson [39] describes Gregory Bateson's 'death by withdrawal' from pain (and from life) resulting from shingles combined with pneumonia in lungs already badly weakened by his previous bouts of cancer and emphysema. Since his cancer Bateson had been living at the Esalen Institute in Big Sur where he courteously received his far flung friends and their various and well-meaning counsels "spun from different epistemologies, the multiple holisms (writes Mary Catherine) from an unfocused new age" [39, p. 6]. Gegory was open and willing to experiment with a variety of treatments including imaging, megavitamins, and homeopathic medicines, including rather large quantities of wheat grass juice.

When Gregory entered his final crisis, his family left with him from Esalen in a large van heading for San Francisco and for one of two destinations that were debated along the way: the University of California Medical Center Hospital or the Zen Center in Marin County. Mary Catherine describes her father as having chosen (at first) 'knowledge' (i.e. the hospital) over 'hope' (the Zen Center). Gregory wanted a place where his prodigous curiosity about what was happening to his body might be satisfied. He retained to the end, however, "a profound skepticism toward both the premises of the medical profession and the Buddhist epistemology".

After receiving a diagnosis of pneumonia, but no explanation for his pain (later diagnosed as resulting from 'shingles'), Gregory 'negotiated' (Dr Kleinman will be pleased to note) with his doctors at the UC Hospital for large doses of morphine. After several days of pain during which Gregory lapsed in and out of consciousness, he began to ask to be taken home. At one point he came "lurching out of the bed in the middle of the night, asking for scissors to cut the I.V. and oxygen tubes". He asked his son to kill him by hitting him over the head with a large stick, a startlingly patriarchol and biblical request. As his talk turned abstract and 'metaphorical', the hospital nurses tended to discount him, and to respond with cheerful, business-like and soothing mumblings.

Gregory's wife, Lois, finally made the decision to remove him from hospital and to the San Francisco Zen Center where, several days later, Bateson died peacefully with his family members present. M. C. Bateson comments that her father's final choice was not so much between 'holistic' and 'establishment' medicine, a choice between multiplicity (pluralism) and integrity. To the end Bateson maintained his profound skepticism, and in so doing his daughter implies, he remained faithful to the radical relativisms underlying his anthropological epistemology.

Margaret Mead, for her part, died a more solitary and in many ways more conventional death in hospital, except that with her through the final weeks and days of her life was a Chilean folk healer, at her bedside reciting prayers and massaging the diseased parts of her body. In her excellent biography of

Mead. Howard [40] reports that several of Mead's closest friends tried to conceal this information, fearful that Mead's scientific reputation would be damaged were it to become widely known that the famous anthropologist had put *her* faith in a faith healer. In another report of the incident, Rensberger [41] writes:

Word of Mead's impending death spread quickly among Mead's inner circle, and many traveled to her bedside for a last visit. What some of them saw when they entered the hospital room has been hushed up in the four years since. Hovering over the patient who not only had become one of the world's best scientists but was once elected leader of the entire scientific community was a Chilean woman touching, softly massaging . . . Mead's body.

The woman was a *curandera* or, as she would be known in the urban context of New York City, a psychic healer, and Mead had drawn upon her skills for several months preceding her final hospitalization. What Rensberger refers to as 'mysterious rituals' were, for Mead, the equivalent of the shamanic and other healing practices that she had observed in the traditional societies of the South Seas. Whereas one might see in Mead's final days her loyalty to the values of holism, integration, and respect for the knowledge of non-Western peoples that so characterized her career and her legacy as a cultural anthropologist, her daughter expressed the concern in her biography, *With a Daughter's Eye* [42], that Mead was "making herself, by self-deception, vulnerable to deception and exploitation." And, she shared with Resenberger the belief that her mother "had difficulty facing the fact that she was dying" [41, p. 37]. The alternative, that this "facing up to the fact of death" *might* have been what Mead was doing [43] in choosing to have a healer rather than a nurse at her side in her final days seems not to have been considered at all, a testimony to the fierce hold of biomedical premises on our thinking. None the less than Evans-Pritchard's Azande informants locked into their witchcraft beliefs, we *cannot* think that we might be wrong. Yet, if medical anthropology does not begin to raise the possibility of other realities, other practices with respect to healing the mindful body, who can we expect to do so? Medical sociology?

Biomedical clinicians are often criticized by medical anthropologists for their tendency to regard and to treat the human mindful body as two separate entities. They point to the weight of ethnographic evidence indicating that a great many patients are dissatisfied and 'noncompliant' because they continue to hold out for an explanation and a therapy capable of linking their symptoms with their experiences, their lives. One attraction of 'unorthodox' therapies is that these do provide a unifying and therefore satisfying interpretation of pain, sadness, and affliction, and they do so by explicitly locating disorders in their wider social context [44]. Another reason is that at least some of these therapies work for patients. Some degree of biomedical, and certainly medical anthropological, tolerance toward heterodox therapies as valid alternatives to scientific medicine in certain instances is certainly in order.

Finally, at the opposite critical pole, and in marked contrast to the *demedicalization* project or the 'unorthodox' ethnomedical project, is the third proposal that might be explored: the radicalization of medical knowledge and practice, taking (and using) the hospital and the clinic—in Foucault's enlarged sense of the terms—as locus of social revolution. True, we are accustomed in the West to thinking of the asylum, the clinic, the mental hospital as total institutions, closed off from the larger society, as small scale societies in and of themselves [45]. To date much of the critical discourse in medical anthropology has been confined to the analysis of the cancer ward, the leprosy asylum, and the mental hospital as spaces of pain, exclusion, stigma, and confinement. In this regard, the early writings of Jules Henry, Bill Caudill, and Goffman on the distortions in human relations reproduced within medical institutions, homes for the aged, the terminally ill, and the neurologically impaired are paradigmatic and should be reread for their critical insights.

One the other hand, what has not been addressed by critical medical anthropologists are those movements (especially in Europe and North Africa in the post-World War II era) that recognized in the hospital a social space where new ways of addressing and responding to human difference, disease, pain, and misfortune could be explored. In other words, the hospital could be a locus of social ferment, of revolution. There are precedents in the radicalizing practices of Fanon, Memmi and of Basaglia [46–48], all of whom seized upon the hospital as a means for generating a broad social critique, one that begins by linking the suffering, marginality and exclusion that goes on within the hospital with what goes on outside in the family, the community, the society at large. For example, under the leadership of Francois Tosquelles, a psychiatrist and Spanish Civil War hero, the so called Saint Alban group developed a method, later a movement, known as French institutional psychotherapy, which subjected the social dynamics of the mental hospital to a relentless critique. Its goal was the humanization of the hospital and of staff–patient relations by taking account of the social origins of mental suffering. Even more radical, the experiences of Franco Basaglia and his equipe in the cities of Gorizia, Parma, Trieste, Arezzo, Perugia and elsewhere in Italy aimed at the destruction of the mental hospital and its exclusionary logic and the redefinition of the normative toward a greater acceptance of mental differences. Their democratic psychiatry movement led to broad reforms not only in psychiatric care, but also in social legislation, legal sanctions, and welfare reforms. In both cases, the hospital served as the providing ground for a larger social critique, and medicine was transformed into a tool for human liberation.

This final proposition for a critical medical anthropology begins with the recognition that many illnesses that enter the clinic represent tragic experiences of the world. A critical medical anthropological discourse might begin by asking what medicine and psychiatry might become if, beyond the scientific goals and values they espouse, they began to recognize the unmet needs and frustrated longings that can set off an explosion of illness symptoms? We might then begin to have the basis for a truly 'social' medicine and a *critically applied* medical anthropology.

ROLE CONFUSION: COMFORTING THE AFFLICTED OR AFFLICTING THE COMFORTABLE?

Shortcomings in psychiatry, however, are unlikely to be wholly redressed by anthropology. It is far more productive and constructive for us to collaborate with psychiatrists than to attempt to supplant psychiatrists' efforts with notions lacking foundations in human biological substrates. And, should any of us experience mental disorders. Let us hope that the practitioners called on to treat both disease and illness are physicians, not medical anthropologists.

Lex [49]

Nothing in anthropology *per se* qualifies anthropologists as therapists . . . [hence] it is a mystification, and a mischievous one, for [an anthropologist] to advertize himself (sic) as a clinical (in the sence of therapeutic) anthropologist [italics in original]. The movement (sic) to make anthropology a therapeutic discipline is, to my mind, wrong-headed; it will almost certainly provoke substantial resistance from clinicians, who see yet another field in competition with them for limited and shrinking resources.

Kleinman [15].

Thus speaks the clinician. But who are we (clinical, applied medical anthropologist)? Why are we here? Where are we going? Is there really a 'movement' afoot, a conspiracy by clinically applied anthropologists to usurp the power, resources, and privilege of the physician class? Are we mere pretenders to the throne? Surely, most clinically applied anthropologists do not see themselves as comforters of the sick and the afflicted.

Why, then, do physicians persist in viewing the medical anthropologist as an outsider horning in on the limited goods of their secret society? Dr Kleinman writes:

As a late comer to the clinical domain, the anthropologist is viewed with some suspicion by his clinical colleagues, who in an era of scarcity, are protective of turf, time, position and general support funds [15, p. 111].

Are we medical anthropologists so blinded by the aura and charisma of the physician that we have lost our way in the wilderness? Are we suffering from role loss or role confusion? Are we applied medical anthropologists merely doctors manqué? If so, how utterly embarrassing, how humiliating for anthropology, and no less so for ourselves.

What role then would the doctor envision for the applied medical anthropologist? During his heart-felt lecture to medical students at Duke University in 1984, Dr Kleinman suggested that anthropology was the queen of the social sciences, and completing the metaphor in light of his talk, she is a fitting consort to the king, medicine.

What does the critical anthropologist reply to the physician king? Only this: No! No king, no queen, no loyal opposition, but no palace rebellion either (for we are not utterly mad). Rather, let us play the court jester, that small, sometimes mocking, sometimes ironic, but always mischievous voice from the sidelines ('but I say the king does appear a bit underdressed today'!). To the young, up-and-coming medical anthropologist I would say: "Take off that white jacket, immediately! Hang it up, and put on the white face of the harlequin. Don't be seduced; be the seducer! Don't be subverted; be the subverter!" Laughter, as they say is the best medicine, laughter and Rabelaisian love of the absurd, the grotesque, and for the tumbling of received wisdoms, and of privileged epistemologies! There's our role—afflicting the comfortable, living anthropology as the 'difficult science' [50]. In so doing we are exercising to the core what our discipline has always been about, its insistent challenge to commonsense, taken for granted assumptions about the meanings of this diverse and troubled world in which we live.

WITHER CLINICALLY APPLIED ANTHROPOLOGY?

None of these three propositions suggested for critical reflection are particularly new or untested: rather thay have been, until now, very much a subdiscourse, marginal to and neglected by mainstream clinically applied medical anthropology. My intent has been to bring them to the fore, to suggest them as possibilities for the framing of research questions or for the analysis and interpretation of data. However, bear in mind that each project requires 'distance', each requires that the medical anthropologist cut loose his or her moorings from conventional biomedical premises. To do so entails some risk to audience, professional standing, 'respectability' (as conventionally defined), research support and funding, and possibly even professional and career advancement.

The voluntary marginality of which I write does not entail the absolute standard that Virginia Woolf held up to the 'daughters of educated men' who wished to protect culture and intellectual liberty. Women should not enter the corrupting, male dominated professions, Woolf wrote in 1938 [51], unless they "refuse to be separated from the four great teachers of women: poverty, chastity, derision, and freedom from unreal loyalties." By courting derision Woolf meant for women to "refuse all method of advertising merit, and to hold that ridicule, obscurity, and censure are preferable, for psychological reasons, to fame and praise. Directly badges, orders, or degrees are offered you, fling them back in the giver's face!"

As much as I admire the courage and daring of Woolf's challenge, I would not think that it is necessary for critically applied medical anthropologists to decline their postgraduate degrees, nor am I suggesting that they refrain from accepting academic positions or tenure, at Harvard, Chicago, or Cambridge, or that they should "fling back in the face of a startled Sydel Siverman a modest Wenner-Gren Foundation grant!" *But*, the marginality to which I refer might mean that one's real and undivided loyalities may make it difficult for one's research to be funded by the NIH or the NIMH, or for one to be invited to serve as consultant to a governmental agency, on a Presidential Blue Ribbon panel, or to the World Health Organization. And, while the critically applied medical anthropologist might publish in a medical journal or teach in a medical setting, it's doubtful that she would use a journal subsidized by drug companies, or that he would reduce the content of anthropology to make it palatable, 'fun' or inoffensive to medical students. One's undivided and real loyalities may lead to some derision within conventional academic circles, but there are always

alternative arenas of action and spaces of collegiality, just as there are alternative (although certainly more modest) sources of funding to the NSF, NIMH, and NIH.

Nonetheless, with these in mind, I do not expect a stampede of new critical medical anthropologists to follow. Our work as critical anthropologists should be active and committed. Medical anthropology should exist for us as a discipline and as a field of struggle. Our work should be at the margins, questioning premises, and subjecting epistemologies that represent powerful, political interests to oppositional thinking. It is, in short, the work of anthropology turned in upon ourselves, our own society.

I have tried to suggest that a critical discourse can be built either from within a radicalized practice of medicine and psychiatry, or from without via medical heterodoxy. This seems to me of less consequence than the simple imperative to position ourselves squarely on the side of human suffering. Ours must be an anthropology of affliction and not simply and anthropology of medicine. Finally, we cannot allow global analyses of the world system to immobilize us as actors, nor the post-modernist politics of despair to get the best of us so that we end up leaving practice in the hand of those who would only represent the best interests of biomedical hegemony.

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6. See Ref. [3]. I am grateful to Thomas Maretzki for his magnanimity and great good humor in referring to my critique of an approach with which he is associated as "Nancy's '*carnaval*' for the medical anthropologists", following the session of the 1986 American Anthropological Association Meetings where sections of this paper were first presented. The idea of medical anthropology 'taking on' the powerful world of biomedicine is a bit like the proverbial flea on the elephant's back, and can only be seen as somewhat absurd and 'carnivalesque'. I would love to see Dr Maretzki join the carnaval, for I am sure his presence could add great joy to the dancing in the streets!
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16. Horatio Fabrega, for example, in his role as discussant to Lock's and my 1986 American Anthropological Association paper, "Speaking 'Truth' to Illness", referred to our analysis as a "refined but nonetheless virulent attack on medicine and psychiatry".
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26. Despite the fact that, increasingly, those anthropologists working in clinical settings tend to discuss economics and power relations in relation to patient care management and practitioner frustration, the orientation of the vast majority of these studies tend toward the socially, economically, and politically conservative in the sense that it is rare for these clinically applied anthropologists to call for a sweeping restructuring of health care (and of society as a whole) toward socialism, nor do they carry a blanket condemnation of the relations of sickness and health care under capitalism. See, for example, the failure of traditional clinically applied anthropologists to address and confront the links between capitalism and distortions in doctor–patient encounters in the symposium organized by Johnson T. and Wright A. Toward a critical clinically applied anthropology. At the 1987 meetings of the American Anthropological Association in Chicago.
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