



Medical Anthropology: An Introduction

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Chances are you just started taking this course in medical anthropology, and you are not sure what exactly it is going to be about. Chances are also that one of your friends—or your roommate or even your parents—will ask: “Sounds interesting, but what is medical anthropology?” The purpose of this selection is to help you to be prepared to answer that question. As you will see, it is not an easy one to answer. Many medical anthropologists have this problem, for example, at cocktail parties. Part of the problem is that many people—even well-educated ones—do not really know what anthropology is. Therefore, when some people ask the question, they have a preconception that anthropology means only archaeology. In this situation, your challenge is to gently help them out by saying something like this: “Although some medical anthropologists do study the health of prehistoric populations, most medical anthropologists use a cultural orientation to study health and medicine in contemporary populations, especially multiethnic ones like our own.” But long definitions are not always useful. Therefore, to keep the conversation interesting, have a few examples of medical anthropological research at hand. Chapter 1’s selection provides some interesting ones.

Medical anthropology studies human health problems and healing systems in their broad social and cultural contexts. Medical anthropologists engage in both basic research on issues of health and healing systems and applied research aimed at improving therapeutic care in clinical settings or improving public health programs in community settings. Drawing from biological, social, and clinical sciences, medical anthropologists engage in academic and applied research, contributing to the understanding and improvement of human health and health services worldwide.

Medical anthropology is inherently interdisciplinary—meaning that it is not characterized by a single theoretical

paradigm or model. For example, medical anthropology is not limited to the study of exotic, non-Western medical systems, even though the description of religion and healing systems is as old as anthropology itself. The field now also has other areas of research, such as the cultural analysis of biomedicine and the understanding of the globalization of biomedical technologies.

As you read this selection, consider these questions:

- **What do anthropologists mean by *culture*, and how is it related to health and healing?**
- **Why is the distinction between disease and illness important in medical anthropology? Why might this difference not be very important to physicians and other health care providers?**
- **Which of the different approaches in medical anthropology seems most interesting to you? Why?**

Context: The following article, updated by Peter Brown and Svea Closser, was originally provided for this reader by Ron Barrett, Mark Padilla, and Erin Finley. Peter Brown is a professor of anthropology and global health at Emory University; Svea Closser is an associate professor of anthropology and global health at Middlebury College. In the years since the first (much different!) version of this article was written, medical anthropology has grown exponentially, developing into a rich and varied field. It is a measure of the field’s diversity and ongoing evolution that not all medical anthropologists will agree with the structure of the discipline as it is presented here.

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WHAT IS MEDICAL ANTHROPOLOGY?

Medical anthropology is the application of anthropological theories and methods to questions of health, illness, medicine, and healing.

The Society for Medical Anthropology uses a more lengthy definition:

Medical Anthropology is a subfield of anthropology that draws upon social, cultural, biological, and linguistic anthropology to better understand those factors which influence health and well-being (broadly defined), the experience and distribution of illness, the prevention and treatment of sickness, healing processes, the social relations of therapy management, and the cultural importance and utilization of pluralistic medical systems. The discipline of medical anthropology draws upon many different theoretical approaches. It is as attentive to popular health culture as bioscientific epidemiology, and the social construction of knowledge and politics of science as scientific discovery and hypothesis testing. Medical anthropologists examine how the health of individuals, larger social formations, and the environment are affected by interrelationships between humans and other species; cultural norms and social institutions; micro and macro politics; and forces of globalization as each of these affects local worlds. (Society for Medical Anthropology 2015)

This definition can be daunting to someone coming to anthropology for the first time, but its essential point is as we stated: Medical anthropology is the anthropological study of health and healing. Medical anthropology takes the tools of anthropology and applies them to human illness, suffering, disease, and well-being.

To understand what medical anthropology is, then, one must understand anthropology as a whole. Introductory anthropology courses usually begin with some variation of the short and classic definition: “Anthropology is the study of humankind.” Although a bit vague, this definition underscores that anthropology is a holistic and interdisciplinary enterprise that uses many different approaches to understand important human issues. In the broadest sense, these approaches are usually categorized into four major subfields: cultural anthropology, physical or biological anthropology, anthropological archaeology, and anthropological linguistics.

These days, however, introductory courses are often the first and last places where anyone gives much thought to the relationships among these four subfields of anthropology. In recent decades anthropology has gone the way of many academic disciplines. Its subfields have become increasingly specialized, each with its own dictionaries and theoretical orientations. As a result of these increasingly specialized

differences, the academic discussions between the subfields of anthropology have gotten scarce. Such trends are unfortunate, because the compartmentalization of anthropology often undermines the discipline’s greatest strengths: its holistic approach and interdisciplinary nature.

Culture is, of course, a central concept in anthropology—although its definition is contested. One definition of *culture* is “the learned patterns of thought and behavior shared by a social group.” Culture includes not only belief systems but also the economic systems and social structures that affect how people live. Many selections in this book show how culture has profound influences on health.

But because health is influenced not only by culture and social structure but also by evolution and biology (and in fact we argue in this book that biology and culture are inseparable), medical anthropologists often draw on more than one subdiscipline. For example, some selections in this reader show how the biology, growth, and development of human beings are historically and currently shaped by cultural influences. Human biology and culture are intimately related, and so we should adopt a holistic perspective when we are studying human health and sickness.

In regard to the four traditional subfields of American anthropology (cultural anthropology, physical or biological anthropology, anthropological archaeology, and anthropological linguistics), the most common type of anthropologist is a cultural anthropologist. And most practicing medical anthropologists were trained in cultural anthropology. But medical anthropology, a relatively new area of specialization, is not really a subfield, partly because, as we mentioned, subfields of anthropology generally have a central theoretical paradigm. In contrast, medical anthropologists use a wide variety of theoretical perspectives—and they often do not agree on which ones are best. As you will see, medical anthropologists apply a *range* of theories and methods to issues of human health, sickness, and healing.

BASIC CONCEPTS

As is the concept of culture, the notion of health is difficult to define. According to the charter of the World Health Organization, *health* is “a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity” (World Health Organization 2015a).

What constitutes well-being in one society, however, may be quite different from another. The ideal of a lean-figured body—a sign of health in the West—may indicate sickness and malnutrition in sub-Saharan

Africa (Brown 1981). In the fishing villages that line Lake Victoria, the parasitic disease schistosomiasis is so prevalent that the bloody urine of young males is considered a healthy sign of approaching manhood (Desowitz 1987). In the United States, the “elegant pal-lor” and “hectic flush” of consumption (tuberculosis) were often imitated by healthy people at the turn of the 20th century because of the disease’s association with famous writers and artists (Sontag 1983). Any conceptualization of health must therefore depend on an understanding of how so-called normal states of well-being are constructed within particular social, cultural, and environmental contexts.

Core Concepts

Medical anthropologists use two terms to talk about states of ill health: illness and disease. *Disease* refers to the clinical manifestations of altered physical function or infection. It is a clinical phenomenon, defined by pathophysiology. *Illness*, in contrast, encompasses the human experience and perceptions of alterations in health, as informed by its broader social and cultural dimensions.

This distinction helps in understanding many important phenomena, such as interactions between patients and healers. For example, a doctor using a disease model may see the patient’s symptoms as the expression of clinical pathology, a mechanical alteration in bodily processes that can be “fixed” by a prescribed biomedical treatment. From the patient’s perspective, however, an illness experience may include social as well as physiological processes. The physician’s diagnosis may not make sense in terms of the patient’s understanding of her illness, and the doctor’s “cure” may not take into consideration the patient’s family dynamics, the potential for social stigma in the community, or lack of money to follow through with treatment.

Healing practices that humans use range from cardiac bypass surgery, to amulets worn for protection against the evil eye, to conflict resolution between kin groups. Shamans, priests, university-trained physicians, and members of one’s family may assume a healing role at any given time in a person’s life. All of these, including biomedicine, are aspects of *ethnomedicines*, medical systems firmly tied to cultural systems.

A Critical Perspective

In the last part of the 20th century, medical anthropology experienced a significant break from its past. During this period, there were intense intellectual debates

about the approaches sometimes called *critical theories*, including postmodernism and Marxism. In general, these approaches require people to critically examine their own intellectual assumptions about how the world works; the basic idea is that our ideas of reality are shaped by our culture and that sometimes these ideologies conceal complex political relationships.

These debates influenced cultural anthropology in general and medical anthropology specifically. An important outcome was the development of *critical medical anthropology*, a perspective that coalesced in the 1980s and 1990s (Singer 1989). These days, the perspectives of critical medical anthropology are mainstream within medical anthropology. Most medical anthropologists agree with two broad critiques that critical medical anthropology made of earlier work.

The first critique was that many medical anthropologists had incorrectly attributed health disparities to cultural differences without examining the influence of global political-economic inequality on disease distribution. In the past, medical anthropologists had tended to view illness as existing within local cultural systems, and they neglected the larger political and economic context within which these cultures are found. Critical medical anthropologists described how large-scale political, economic, and cognitive structures constrain individuals’ decisions, shape their social behavior, and affect their risk for disease. Readings in this book that exemplify this approach are in Chapter 11 by Paul Farmer and Chapter 14 by Merrill Singer.

One example of this kind of thinking was Meredith Turshen’s analysis of the political-economic dimensions of disease in Tanzania. Turshen described how a history of colonialism drastically affected the country’s nutritional base, altered its kinship structure, and imposed constraints on its health care system. She questioned previous studies’ focus on local culture and emphasized an alternative she called the “unnatural history of disease” (Turshen 1984). Critical medical anthropologists made similar arguments concerning health disparities in wealthier countries like the United States.

Because of their interest in macro-level forces (such as world capitalism), critical medical anthropologists were generally skeptical of health policies that proposed local solutions. Thus critical medical anthropologists not only challenged the local focus of traditional medical anthropology but also criticized the narrow focus of health interventions that did not address the large-scale factors influencing disease (Morsy 1990).

The second critique made by critical medical anthropology centered on the questioning of underlying epistemologies (ways of knowing) and conceptual

categories of medicine and Western culture in general. For example, the 16th-century French mathematician, scientist, and philosopher René Descartes articulated a fundamental cultural model of the separation of mind and body. This is a “culturally constructed” idea that many people take for granted in everyday thought and talk. But your own experiences of emotional states—not to mention recent discoveries in neuroscience—make it clear that the body/mind distinction is not quite true. Similarly, there are many notions embedded in everyday clinical medicine that are culturally constructed and often based on metaphors. For example, low blood pressure is considered a dangerous sign of heart problems in Germany, while in the United States it is considered a marker of excellent health (Payer 1988). The ideas and practice of medicine cannot be separated from culture.

From our perspective, the mainstreaming of the critical perspective within medical anthropology has led to many important developments, including an energetic engagement with social justice and health disparities. Paul Farmer, a physician and anthropologist who also directs the nonprofit organization Partners in Health, has been highly influential in this area. Farmer’s most famous work highlights the impact of global inequality on the emergence of such infectious diseases as HIV/AIDS and multidrug resistant tuberculosis (Farmer 1999, 2004). In providing a critical perspective on global inequalities in health, Farmer and many others have effectively highlighted how socioeconomic and political factors cause profound inequalities in health and disease.

A Practice Orientation

Medical anthropologists engage in research on issues of health and healing systems, as well as research aimed at the improvement of therapeutic care and public health programs. Sometimes these types of research are labeled as “basic” or “applied,” respectively, but because medical anthropologists study human health, most “basic” research has obvious practical relevance, and many of the field’s core theoretical concepts were developed by people actively engaged in clinical and public health work. There is a great deal that we do not know about the causes of sickness and the processes of healing; anthropologists can contribute to the growth of human knowledge in these important areas. At the same time, anthropologists contribute to the design and implementation of programs alleviating complex health problems. This back-and-forth between engagement and reflection energizes the discipline.

Many medical anthropologists, then, have a practice orientation (Inhorn and Wentzell 2012), even as they think theoretically. Unlike other social scientists, medical anthropologists generally think they have an obligation to act to improve human health (Fassin 2012). This belief, however, doesn’t mean that they agree on what action is appropriate. Medical anthropologists’ critical perspectives indicate that they are very aware that the institutional structures of biomedicine and public health sometimes entrench inequalities rather than alleviate them. Most medical anthropologists are constantly reflecting on whose interests their involvement in these structures serves (Singer 1995).

Some medical anthropologists are very actively engaged within biomedical and public health institutions. For a significant period of its history, medical anthropology dealt with the health beliefs and practices of ethnic minorities. Margaret Clark’s *Health in the Mexican-American Culture* (1959) is a good example of such work. Her analysis emphasizes, for example, that it is insufficient simply to translate medical instructions when the patient population has limited literacy and biomedical language (in any language) is unfamiliar to them. Medical anthropologists have often been called to assist in improving communication across both language and cultural barriers between patients and their health care providers. Such problems in communication have been described in Anne Fadiman’s book *The Spirit Catches You and You Fall Down* (1998), which deals with the conflicts between the family of a Hmong child and her American doctors. Some perspectives on “cultural competency” training programs in medical schools can be found in Part II in the section titled “Working with the Culture of Biomedicine.”

Not all anthropologists agree that these training programs are a good thing. Several medical anthropologists have argued that such programs reinforce racial stereotypes rather than dealing with power inequities that are at the root of poor health outcomes (Carpenter-Song, Schwallie, and Longhofer 2007; Gregg and Saha 2006). Such active debate and reflection—both engaged with and critical of practice—is a hallmark of medical anthropology. A critical analysis of such a cultural competency course at Harvard Medical School can be found in the selection in Chapter 35.

Anthropologists working within clinical settings, however, do much more than talk about culture and communication. Anthropologists within the Veterans’ Administration (VA), for example, work on a variety of issues, including the root causes of substance abuse and homelessness in female veterans (Chen et al. 2013; Hamilton, Washington, and Zuchowski 2013).

and the improvement of mental health services for veterans with posttraumatic stress disorder (PTSD) (Besterman-Dahan, Lind, and Crocker 2013; Finley 2013).

In addition to clinical settings, many anthropologists work in public health policymaking, program development, and intervention. Anthropological perspectives are relevant at all levels of the public health process, from the interpretation of disease trends to the design, implementation, and evaluation of programs. For example, medical anthropologists working on the Ebola response did research on topics from the role of informal health workers in the Ebola response to the long-term investments needed for stronger health systems and the reasons why some people might resist interventions aimed at stopping Ebola (Ebola Response Anthropology Platform 2015). They also argued compellingly in international venues that public health agencies should stop conceptualizing culture as a barrier and a source of misinformation and should instead focus on designing responses the desires and needs of recipient populations in mind (Chandler et al. 2015).

Yet other medical anthropologists think that analyzing and writing, often from within the academy, is the best way to create positive change. These medical anthropologists believe that it's hard to think and write critically about health institutions if one is too close to them (or working for them), so they advocate speaking truth to power from outside such structures, often from academic positions.

Through work both practical and theoretical, medical anthropologists contribute to our understanding of issues with life-and-death consequences. They approach these issues from a wide variety of theoretical perspectives, all rooted in anthropology.

FIVE BASIC APPROACHES TO MEDICAL ANTHROPOLOGY

The scope of anthropological inquiry into issues of human health, sickness, and healing is very diverse—so diverse in 2015 that writing this introduction, which characterizes the field, is intimidating. Nonetheless, we've identified five basic approaches to medical anthropology:

1. biological
2. ecological
3. ethnomedical
4. experience-near
5. studies in and of biomedicine.

The first two of these approaches emphasize the interaction of humans and their environment in a way that we consider *biosocial*—that is, with a focus on the interaction between biological/health questions and socioeconomic and demographic factors. The last three of these approaches to medical anthropology are *cultural*—they emphasize the concept of culture (the patterns of thought and behavior characteristic of a group) and how people experience life.

For all the diversity of the field, nearly all medical anthropologists share four essential premises: (1) that illness and healing are best understood in the complex and varied interactions between human biology and culture; (2) that disease is influenced by culture, economics, and politics; (3) that the human body and symptoms are interpreted through cultural filters; and (4) that the insights of medical anthropology have important pragmatic consequences for the improvement of health and health care in human societies.

1. Biological Approaches in Medical Anthropology

Much research in biological anthropology concerns important issues of human health and illness. Many of the contributions of biological anthropologists help to explain the relationships between evolutionary processes, human genetic variation, and the different ways that humans are sometimes susceptible, and other times resistant, to disease.

The evolution of disease in ancient human populations helps us to better understand current health trends, a concept described in more detail in Chapter 8's selection by George Armelagos, Peter Brown, and Beth Turner. For example, the recent global trend of emerging and reemerging infectious diseases, such as tuberculosis and AIDS, is influenced by forces of natural and cultural selection that have been present throughout modern human evolution. During the time of the Paleolithic (about 2,500,000 to 200,000 years ago), early human populations lived in small bands as nomadic hunters and gatherers. The low population densities during this period would not have supported the acute infectious diseases found today; instead, chronic parasitic and insect-transmitted diseases were more prevalent.

The shift toward sedentary living patterns and subsistence based on plant and animal domestication, sometimes called the Neolithic Revolution (about 10,000 B.C.E.), had a profound effect on human health. Skeletal evidence from populations undergoing this transition shows an overall deterioration in health consistent with the known relationship between infectious

disease and malnutrition. New infectious diseases emerged, a result of increasing population density, social stratification, decreased nutritional variety, problems of clean water and sanitation, and close contact with domesticated animals (Armelagos, Goodman, and Jacobs 1991; Cockburn 1964). These changes had a disproportionate effect on women, young children, the elderly, and the emerging underclass, who were most susceptible to infections in socially stratified societies (Armelagos and Cohen 1984).

Currently, great threats to human health come from chronic degenerative conditions. These so-called diseases of civilization, such as heart disease, diabetes, and cancer, are the leading causes of adult mortality throughout the world today. Many of these diseases share common etiological (causative) factors related to human adaptation over the last 100,000 years. For example, obesity and high consumption of refined carbohydrates and fats are related to increased incidences of heart disease and diabetes. Human susceptibility to excess amounts of these substances can be explained by the evolution of human metabolism over millions of years in contexts of relatively large amounts of exercise, seasonal food shortages, and diets low in fat (Konner and Eaton 2010; Weil 2008).

A related theory of “thrifty genes” was proposed to explain relatively shorter-term evolutionary changes that account for genetic variation in the susceptibility to chronic diseases between different contemporary populations (Neel 1982). Some populations have significantly higher prevalences of adult-onset diabetes and hypertension than others. The thrifty-gene hypothesis proposes that genes affecting insulin physiology were selected for, allowing people to adapt to an irregular food supply. This adaptation arose during times of “feast or famine” for certain populations, including some Native Americans, oceangoing Pacific Islanders, and African Americans descended from slaves. In the context of modern diets, however, these genes add to the burden of chronic disease (Lieberman 2008).

But variation in human susceptibility to chronic diseases cannot be accounted for by genetic explanations. Environmental and sociocultural factors play a primary role. Health disparities between ethnic groups in the United States are a result of discrimination leading to poorer living environments and increased stress, among other causes of poor health (Dressler 1996; Williams 1999).

Some biological contributions to medical anthropology critique the misapplication of biological concepts. During the late 19th century, measurements of cranial size were taken of Jewish and Southern European immigrants to the United States and compared with those of Anglo-American residents. The

differences in cranial size between these populations were used to support a theory of racial hierarchy based on hereditary differences in brain size. By careful comparisons between first- and second-generation groups from these immigrant populations, Franz Boas (the founder of American Anthropology) was able to demonstrate that these differences were attributable to environmental influences on body size (Boas 1940). Subsequent analyses have discredited previous studies relating measurements of intelligence to those of cranial capacity (Gould 1981), and categories of human races have been shown to have little validity in the study of human variation (Goodman, Moses, and Jones 2012).

Some biological anthropologists also contribute to the field of ethnopharmacology. Anthropologists in this field consider not only the physiological properties of plant substances but also issues related to their selection, preparation, and intended uses within particular social settings and broader cultural frameworks (Etkin 1996).

Biological anthropology plays a central role in the field of evolutionary medicine, which considers how survival pressures over the course of evolution may have shaped human biology. Health researchers who incorporate an appreciation of the ongoing effects of natural selection on the physiology of people and other organisms may be equipped to develop more sophisticated approaches in their efforts to treat or prevent disease (Nesse and Williams 1996). For example, research on SIDS (sudden infant death syndrome) and children’s sleeping arrangements has shown that despite statements by many officials in the United States that infants should always sleep alone, mother-infant cosleeping (the evolutionary norm) may be the safest choice for babies in particular social and economic contexts (McKenna and McDade 2005). Biological anthropology’s appreciation for the interconnectedness between genes and environment has led to many developments in the field of evolutionary medicine and holds promise for many more. The reading selection in Chapter 3 deals with this topic.

2. Ecological Approaches

Ecology refers to the relationships between organisms and their total environment. Within medical anthropology, the ecological perspective focuses on the interactions between environmental contexts and human health. An ecological approach to medical anthropology emphasizes that the total environment of the human species includes the products of large-scale human activity, as well as “natural” phenomena, and that health is affected by all aspects of human ecology.

It includes attention to how people survive in varying environments, how they find food, how they distribute resources, how they deal with disease, and how the demographics of their population are changing over time (McElroy and Townsend 2014). Pathogens that cause infectious disease, such as the malaria parasite, and factors that affect risk for chronic disease, for example, diet, are closely tied to humans' relationships with their environments. The term *medical ecology* has been used to describe this approach.

Two broad levels of analysis inform this approach. At the micro level, *cultural ecology* examines how cultural beliefs and practices shape human behavior, such as sexuality and residence patterns, which in turn alter ecological relationships between host and pathogen. At a broader level, *political ecology* examines the historical interactions of human groups and the effects of political conflict, migration, and global resource inequality on disease ecology (Brown, Smith, and Inhorn 1996). Many ecological approaches to medical anthropology include some aspects of both cultural and political ecology. Malaria and schistosomiasis provide two useful examples.

Malaria is a disease caused by a microscopic *Plasmodium* parasite that is transmitted to human hosts through contact with mosquitoes of the genus *Anopheles*. These mosquitoes breed and multiply in stagnant pools of water in warm climatic regions of the world. Malaria has a long and sordid history in many societies, and it continues to be a major cause of human morbidity and mortality today (Brown 1997). At a cultural ecological level, adaptations to malaria include highland Vietnamese building practices, in which stilted houses allowed people to live above the 10-foot mosquito flight ceiling (May 1958). In another ecological context, although malaria had been eradicated in the southern Italian island of Sardinia, Brown discovered that many cultural practices functioned to reduce contact with malaria-carrying mosquitoes (Brown 1981; see the selection in Chapter 7). These included settlement and land-use patterns, whereby nucleated villages are located in highland areas and flocks of sheep are taken to the lowlands in the winter, thus minimizing contact with the mosquitoes during peak malaria seasons.

At a political ecological level, however, these adaptive cultural practices were probably motivated by historical threats of military raids and expropriation of land by foreigners. Furthermore, wealthy Sardinians had less contact with mosquitoes because they did not have to leave the safety of the village to work in the fields as did the laborers, nor did they have to stay in the village during peak malaria season when they could afford to take summer vacations abroad. Thus, the example of malaria demonstrates

that multiple ecological variables—biological, cultural, political, and economic—interact to influence the prevalence of particular diseases in a given environmental context. In recent years—marked by the advent of climate change—more areas of the world have become vulnerable to malaria; this is a political ecological phenomenon.

Schistosomiasis, a parasitic disease spread by snails, provides a dramatic example of the relationship between political ecology and disease. For decades, economic development programs throughout the world have often focused on the building of dams to prevent seasonal flooding, improve irrigation, and provide hydroelectric power (Heyneman 1979). Enormous dams, such as the Aswan High Dam on the Nile River, have dramatically altered the ecology of surrounding areas by preventing seasonal flooding and creating one of the largest man-made bodies of water in the world. A byproduct of such changes, however, is an altered relationship between human populations and certain water-borne parasitic infections, such as schistosomiasis. The small snails that carry schistosomiasis thrive in the numerous irrigation canals emanating from the dams, increasing human exposure to the parasites. This exposure has led to an increased risk of contracting schistosomiasis, an infection that primarily affects children, in people that live close to some kinds of dams and irrigation systems. But the way this relationship plays out depends on the larger ecological context of the dam, as well as the socioeconomic status of people at risk (Steinmann et al. 2006).

The story of schistosomiasis demonstrates that political-economic forces, such as dam development programs, can dramatically shape the relationship between host and disease in human populations. Thus, medical ecology's definition of "environment" includes the political-economic consequences of collective human activity. In this globalizing world characterized by out-of-control carbon emissions and climate change that will have serious health effects (Chapter 10), there is no doubt that political-economic policies directly influence local disease ecologies.

3. Ethnomedical Approaches

All societies have medical systems that provide a theory of disease etiology (causation), methods for the diagnosis of illness, and prescriptions and practices for curative or palliative (calming, soothing) treatment. The initial development of medical anthropology derived from anthropological interest in the healing beliefs and practices of different cultures (Wellin 1978). These beliefs and practices related to healing are often referred to as *ethnomedicine*. Anthropological approaches to the

study of ethnomedicine have always included not only understanding how people think about health and disease but also studying the social organization of healing practices (Fabrega 1975). In the simplest sense, all ethnomedical systems have three interrelated parts:

1. a theory of the etiology of sickness
2. a method of diagnosis based on the etiological theory
3. the prescription of appropriate therapies based on the diagnosis.

Health systems, from a cross-cultural perspective, generally fall into two categories:

1. personalistic systems that explain sickness as the result of supernatural forces directed at a patient, by either a sorcerer or an angry spirit
2. naturalistic systems that explain sickness in terms of natural forces, such as the germ theory of contagion in Western biomedicine and the imbalance of humours in many forms of Chinese, Indian, and Mediterranean systems (see the selection in Chapter 16).

At the beginning of the 20th century, anthropological studies of medical systems were confined to ethnographic descriptions of “exotic” practices within non-Western societies. Many of the observations about sickness and therapeutic rituals were analyzed as a window on underlying cosmological beliefs and cultural values within comparative studies of myth and religion. Some aspects of these works have been criticized for a tendency to sensationalize the differences of “primitive” people in comparison to their readership in Western industrialized societies (Rubel and Hass 1996).

The term *ethnomedicine* was first defined as “beliefs and practices related to disease which are the products of indigenous cultural development and are not explicitly derived from the conceptual framework of modern medicine” (Rubel and Hass 1996). In recent decades this arbitrary distinction supposedly “indigenous,” “traditional,” and “nonscientific” medical systems and supposedly “Western,” “modern,” and “scientific” medical systems has been abandoned by nearly all medical anthropologists. Medical anthropologists challenge the idea that biomedicine is an empirical, law-governed science unbiased by cultural premises. They understand that all medical systems are constantly changing, and all are closely tied to their cultural contexts.

In India, for example, many Ayurvedic practitioners receive university training, practice in commercial

institutions, and supplement their ancient therapies with antibiotics, X-rays, and other tools of biomedicine (Nichter and Nichter 1996). Likewise, many Indian physicians trained in biomedicine use Indian categories to explain health issues to their patients. As another example, in her comparison of biomedical systems in Europe and North America, Lynn Payer found considerable variability in the health beliefs and practices that constitute biomedicine (Payer 1988). Because of these issues of cultural diversity even within biomedicine, it is more useful to consider ethnomedicine as the study of any form of medicine as a cultural system. In other words, biomedicine is one of many ethnomedical systems.

Patients often draw on the ideas of one or more ethnomedical systems in their own understanding of illness. They develop an explanatory model (EM), a personal interpretation of the etiology, treatment, and outcome of sickness by which a person gives meaning to his or her condition. Although EMs are personal, they are also learned cultural models, so that an EM shared by a group might be considered a folk model of disease. There is often disparity between the explanatory models of patients and healers, which may lead to problems of communication and nonadherence to prescribed therapies (Brown, Gregg, and Ballard 1997; see the selection in Chapter 34).

While stated health beliefs may influence treatment decisions, explanatory models alone are not good predictors of people’s observed patterns of health seeking—because significant differences often exist between cultural “ideals” (what people say they do) and “real” behavior of observable action. For example, a study of Nepalese patients found that people often sought multiple medical resources for a single illness despite verbal claims to the contrary (Durkin-Longley 1984). Many different factors may weigh on decisions concerning when and where to seek treatment, such as the influence of family members (Janzen and Arkininstall 1982), social networks, and geographic access to health resources (Kunitz 1989; Mumtaz et al. 2013). In many cases, economic resources can severely limit treatment options. Even with great strides made in lowering the cost of antiretroviral therapy, for example, nearly two thirds of HIV-positive people in low- and middle-income countries do not have access to these lifesaving drugs (World Health Organization 2015b).

4. Anthropology in and of Biomedicine

In recent years there has been an increased focus on studying biomedicine as an ethnomedical system of knowledge and social practice. Although this approach has a lot in common with the study of other

ethnomedicines, it has become such a large part of the subfield of medical anthropology that we are giving it its own section here.

One classic example of this approach is an article by Nancy Scheper-Hughes and Margaret Lock (1987). They critically examined the idea that the mind and body are separate entities, a fundamental premise of biomedicine. They suggested that the dominance of biomedicine had made the concept of separation of mind and body so pervasive that people lacked a precise vocabulary to express the complex interactions between mind, body, and society.

The excellent text *An Anthropology of Biomedicine* (Lock and Nguyen 2011) examines the “technologies of the body in context,” including the human transformations (through transplants, and so on) that stretch our moral boundaries. This focus includes an emphasis on biotechnologies such as genetic testing, the use of pharmaceuticals, assisted reproduction, organ transplants, genomics, plastic surgery, and other scientifically derived treatments. In viewing how such new technologies are taken up (or rejected) within existing biomedical systems, we can observe how they come to be associated with different social circumstances across different cultural settings. Reproductive technologies such as in vitro fertilization, for example, may come to epitomize one set of concerns among women in the United States and a very different set among men in Egypt and Lebanon. Chapter 27’s article by Monir Moniruzzaman provides an example of this kind of anthropological work.

The study of biomedicine sheds light on the epistemology of scientific and medical knowledge. Medical anthropologists study the processes by which these forms of knowledge acquire their status as “authoritative knowledge” rather than as “beliefs,” the word often used to describe the knowledge systems of other ethnomedicines. As such, the distinction between knowledge and belief can be seen as arbitrarily reflecting differences in social power and therefore as being highly questionable (Good 1994).

Studying the processes of knowledge creation in biomedicine has provided important insight into how “gold standards” of care and evidence come to be. Medical anthropologist Allan Young, for example, has shown how PTSD became accepted in the late 1970s as a distinct mental illness (Young 1997). It was not a process of psychiatrists suddenly discovering a new disorder. Instead, PTSD came to be included in the *Diagnostic and Statistical Manual for Mental Disorders* (DSM), psychiatry’s official list of accepted diagnoses, when a group of psychiatrists came together and—urged by a vocal lobby of Vietnam veterans and their advocates—agreed that PTSD should be recognized despite a lack of medical and epidemiological research

available to describe it. Chapter 31’s selection by Erin Finley provides an excellent case study of PTSD in the contemporary VA system.

Increasingly, medical anthropologists have examined the cultural and political dimensions of public health and global health bureaucracies. Like scholars who frame studies of biomedicine as a cultural system, anthropologists are increasingly turning their attention to the cultural beliefs, norms, and implicit premises on which public health funding and administration are based (Biehl and Petryna 2013; Chandler et al. 2015; Justice 1986). These medical anthropologists study a variety of public health agencies, from UN agencies to NGOs to governments, and they pay attention to the complex power relations between these entities. Examples of this approach are in the selections in Chapters 44 and 45, which explore the contexts and complex effects of public health programs in Pakistan and Mozambique.

5. Experience-Near Approaches

In 1988, renowned anthropologist and psychiatrist Arthur Kleinman published a book titled *The Illness Narratives*, in which he advocated paying close attention to how people make sense of their illness experiences through narrative (Kleinman 1988). He pointed out that the stories people tell about their illnesses can provide great insight into how they cope with disease and suffering. Since then, what can broadly be called an experiential approach in medical anthropology has become increasingly resonant throughout the other subfields. Anthropologists using this approach frequently put illness-related suffering—whether due to pain, disability, or the awareness of one’s own mortality—at the center of their analysis. They focus on three aspects of illness, in particular: (1) narrative—the stories that people tell about their illness; (2) experience—the way that people feel, perceive, and live with illness; and (3) meaning—the ways that people make sense of their illness, often linking their experience to larger moral questions. For example, in Chapter 23’s selection Linda Hunt considers narratives from two individuals with cancer in southern Mexico; although these two have different cancers and face different life situations, both explain their illness in relation to the disappointments and obligations they have borne in their social lives.

Experiential (experience-near) approaches often explore the links between sickness and problems in the social world. Illness narratives in particular may demonstrate how a symptom is experienced as troubling because of its impact on relationships with others, as when pain or fatigue interferes with a mother’s

ability to care for her children. Narratives may also provide a venue for negotiating the meaning of an illness, particularly in the social space between family members, patients, healers, and so forth. Kohn writes of how care providers treating children with facial disfigurements in Northern California create “therapeutic emplotments”—essentially, complex narratives—that are intended to help the children to feel more comfortable with their appearance. In trying to transform the children’s narratives of themselves and their appearance, the care providers are in fact trying to shift the children’s experience of their disfigurement from one of embarrassment and shame to one of acceptance and confidence (Kohn 2000). Narrative, then, is not just a story of what has happened, or is happening, or might happen. It can also represent an active attempt to negotiate or construct both individual selfhood and social relations amid sickness and suffering.

A central theme in ethnographic descriptions of illness and suffering is stigma. People who are different—either physically, mentally, or in social skills—are often subjected to negative judgments and discrimination from so-called normal people; that is, they are stigmatized. The originator of this idea in medical social science, Erving Goffman (1963), referred to this type of social disapproval as creating a “spoiled identity.” The archetype of a stigmatized disease is leprosy (Hansen’s disease), which despite its terrible reputation is not very contagious at all.

There are both visible and invisible conditions that are stigmatized. With visible conditions, such as being extremely short-statured, people end up being stared at and ostracized; this situation is described in Chapter 36’s selection by Joan Ablon. Invisible conditions—for example, having depression or herpes, or having had an abortion—are usually conditions that people prefer to keep secret; disclosing such a condition is difficult and often socially dangerous. A great deal of medical anthropological research has been done on HIV/AIDS since the beginning of the pandemic. In some ways HIV/AIDS has been an epidemic of discrimination and stigma; however, the availability and antiretroviral drugs has changed this slightly (see Chapter 45).

The experiential approach has been applied most often in the exploration of illnesses that are highly subjective, such as chronic pain and mental illness. These experiences, internal as they are, may be difficult to share or explain. Medical anthropologists attempt to understand conditions such as psychosis from within, interacting closely with and listening to those who might otherwise be ignored because of their difficulties in behaving and expressing themselves in

normative ways (Desjarlais 1997; Jenkins and Barrett 2003). In addition to helping social scientists rethink the cultural boundaries between what is considered normal versus pathological, these studies have the potential to explore the relationship between body and mind in a more holistic way.

Anthropologist Joao Biehl, for instance, has traced the paths by which ongoing socioeconomic changes in Brazil, accompanied by an increasing medicalization of illness and infirmity, have resulted in families leaving their mentally and physically disabled members to live in ragged communities on the margins of society (Biehl 2013). Following this social progression to its outcome at the level of individual experience, he describes how mentally ill individuals in Brazil perceive and make sense of this social abandonment.

The experience of illness is something that evolves in the space between body and mind, and between individuals and those in their social environment; it may change over time as the disease progresses or resolves. In understanding how illness is experienced, medical anthropologists gain insight into how people endure and make meaning in some of the most vulnerable moments of their lives, and thus they can better appreciate how these processes play out in people’s explanatory models, care-seeking behaviors, and coping strategies.

CONCLUSION

Medical anthropology, like its parent discipline, is a holistic and interdisciplinary enterprise. We began this chapter quoting the definition of this subfield offered by the Society for Medical Anthropology. This definition includes so many topics covering such a diverse set of questions that some readers may think that it was written by a committee. In the simplest sense, medical anthropology refers to studies of health and healing from biosocial and cross-culturally comparative perspectives. In this regard, *healing* refers to all medical systems, including modern biomedicine and its sophisticated technologies, as cultural products.

Because there is such a remarkable diversity of theories and methods used in medical anthropology, we can appropriately talk about it as having subdisciplines of its own. In this article, we have outlined five major approaches that medical anthropologists use to better understand issues of human health, healing, and sickness: biological and ecological (biosocial), and ethnomedical, experience-near, and studies in and of biomedicine (cultural). When we explore the specific examples, however, it becomes clear that the five categories overlap.

Part I of this book—the part devoted to *understanding* medical anthropology—contrasts biosocial approaches and cultural approaches; this seems to be a fundamental distinction. Yet on closer examination, even this simple distinction is artificial, because the culturally oriented analyses focus on biological/medical processes, and the biological approaches almost always emphasize the role of human (cultural) behavior. Within all this theoretical and methodological diversity, there are essential commonalities in an anthropological study of health, illness, and healing. These commonalities all stem from an anthropological view of the world.

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