Examining medical anthropological theory as a catalyst for the failure of clinically applied medical anthropology

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Medical anthropological theory may be understood in two ways: first as a set of anthropological concepts and second as the application of these concepts. The theoretical concepts themselves are rarely challenged because they have been fairly well developed. However, the approach to theory and its application has traditionally been underdeveloped and thus requires more thought and practice among anthropologists. This paper asserts that a particularly clear example of the problem with the approach to and application of medical anthropological theory can be viewed in the context of clinically applied medical anthropology (CAMA). I examine two medical anthropological concepts that applied medical anthropologists use in their dealings with clinicians – critical medical anthropology and the culture concept. In doing this, I demonstrate that although these concepts are useful and clinicians need to employ them, there are a number of problems with the theoretical approach. I argue that these problems limit the application of these concepts to CAMA and offer preliminary suggestions to resolve them. In particular, clinically applied anthropologists employing critical theory should work to present a more balanced view of the clinic and physician. In addition, anthropologists working in the clinical setting must update the CAMA literature to ensure a thorough assessment of the current use of anthropological knowledge and concepts – such as culture – in medical schools and clinics.

THE ORIGINS AND OBJECTIVES OF CLINICAL INVOLVEMENT

Medical anthropology has strong therapeutic and clinical roots. As early as 1918, American anthropologist Alfred Kroeber completed psychoanalytic training and study at the Stanford clinic [1] and Gregory Bateson acted as a consultant for understanding personality and psychological problems [2]. Even Margaret Mead viewed anthropology as a clinical skill [3].

Despite these early encounters between anthropologists and western medical clinics, before the 1960s, clinical work in anthropology gained only sporadic attention in the literature. Instead, there was significant focus on the exploration of cross-cultural health phenomena. The increase in anthropological attention to matters of western healthcare systems in the late 1960s occurred in response to social trends. First, there was the shrinking academic job market for anthropologists, which increased anthropologists' desire to be visible and marketable for professional positions. At the same time, health education for practitioners was changing; social science was becoming more important in the medical curriculum than ever before. These trends opened a new space for medical anthropologists and were the eventual impetus for defining a novel medical anthropological endeavour

to be applied in clinical settings [4,5]. In the 1980s, this new subfield, clinical anthropology, or clinically-applied anthropology, became a hallmark of medical anthropology after a number of discussions at professional meetings were published [6].

My definition of the objective of the subfield is in line with that of Chrisman and Maretzki. They contend that CAA's [clinically applied anthropology's] primary goal is "to translate the understandings of anthropology for health professionals so that their service to patients can be more humanistic, holistic and culture sensitive" [7]. Essentially, CAA's unit of analysis is the clinician-patient interaction; the anthropologist acts as a cultural broker, applying medical anthropology theory and research findings to create interventions that teach clinicians to place the biomedical concept of disease into a psychosocial context [8]. I adopt Chrisman and Maretzki's definition, but I use the term "clinically applied medical anthropology" (CAMA), which is current usage [9].

Although the goals of CAMA are robust, they have not been realized. Medical anthropology is still largely ignored in western clinical settings. This is evidenced by a critical examination of the medical anthropological literature over the last twenty years, which shows that the training tools and methods developed by medical anthropologists for clinicians are

considered today to be peripheral in most western clinics [10]. The failure to operationalize medical anthropological concepts and use them in western medical clinics will be explored first by examining the problems with the approach of critical medical anthropology.

CRITICAL MEDICAL ANTHROPOLOGY

Critical medical anthropology, like the political economy of health, strives to understand the potentially unequal distribution of power and wealth in the medical system and its effect on health and healing [11]. To accomplish this goal, critical medical anthropologists often employ a continuum of analysis beginning with the micro-level doctor-patient interaction and extending to the macro-level capitalist world-system [12]. For example, Press demonstrates how ideologies and activities at the level of the macro-capitalist world system, the intermediate-hospital-administration-level, and at the micro-level clinician-patient interaction, come together in his study of an urban general hospital in the United States [13]:

[w]ith cost containment in mind, the hospital has maintained a bare-bones nursing staff...Communication between different ranks and types of staff is poor...In the emergency department, female staff resent the lone male nurse who 'sexist' physicians often single out to discuss an 'interesting' case...In General Hospital, nurses' disdain of unmarried mothers or assumedly sexually promiscuous black teen-aged girls is no less than that of the nurses' nonprofessional friends and relations. Here, this disdain is given clinical relevance as nurses disgustingly inform the physician that the 14-year-old black girl, [who is a rape victim] presenting with sharp abdominal pains, is 'another crotch case'...

This multi-level analysis, which describes the macro-capitalist propensity to drive down costs, the lack of communication between staff at the intermediate level, and the perpetuation of inequalities in gender, class, and race at the micro-level, produces a variegated understanding of the clinical setting. However, this type of analysis is problematic for CAMA. The key concern here is not the validity of the multilevel approach; rather, it is the advocacy position that critical theory expects clinical anthropologists to take. Through its multi-level approach, critical theory can assert that the medical system is a form of social control which necessarily subjugates marginal groups [14]. This position is evident in Press's portrayal of the

hospital physicians as sexist and the nurses as non-empathetic and racist in their interaction with the rape victim.

Medical Oppression

By asserting that the medical system works to suppress marginal groups, critical theory can lead clinical anthropologists to portray biomedicine as a Machiavellian institution. This neglects a strongly held position within anthropology: holism [15]. As noted by Lock, racism or hegemonic beliefs are certainly not the only factors guiding the interaction of staff with patients in clinical settings. For example, although physicians are the usual scapegoats singled out by anthropologists as perpetuating hegemony, most work to protect patients from iatrogenesis. Drawing on her work on the genetics of Alzheimer's disease, Lock shows that physicians can test patients for an allele (ApoE ϵ 4) associated with Alzheimer's disease. However, physicians do not consider genetic testing for ApoE ϵ 4 useful. This is because the specific role of the allele in Alzheimer's disease is not fully understood. Moreover, there is no effective prevention or treatment available for individuals identified to be carrying ApoE ϵ 4 [16]. Here, physicians have concluded that this dead end situation could be a depressing reality for the patient. Lock demonstrates that healthcare workers recognize the diagnostic potential of genetic testing and the potential for psychological harm. In this way, they actually work to prevent the unnecessary subjugation of patients. Because critical theory directly contradicts anthropological holism to highlight mainly the deficiencies in the medical system, anthropologists in a clinically applied medical setting are less likely to adopt other insights provided by theory.

As noted by Hemmings, it is also important for clinically applied medical anthropologists to present the clinical setting in a more balanced fashion to avoid alienating medical professionals [17]. For example, Hemmings asserts that statements promoted by critical theorists such as Nancy Scheper-Hughes, who states, "praxis must not be left in the hands of those who would only represent the best interest of biomedical hegemony" [18] are offending to clinicians. Good and Good's description of medical education and the structure of medical knowledge is relevant here. They assert that as students, clinicians learn an alternative way of seeing, one in which their perception of the world takes on a certain "medical gaze". Here, medical education transforms clinicians to think within the confines of the medical world [19]. Thus, a discussion of the deficiencies of this system in which they are so invested can be seen as an attack on their professional identity. In this way, it is difficult for clinically applied medical anthropologists to be accountable to the

political economy of the medical system that critical theory explores, without compromising their position.

In entering the clinical setting, anthropologists are in a difficult situation; they must be useful to physicians and uphold anthropological tenets. There is not a quick and easy strategy that promotes the maintenance of anthropological holism while simultaneously avoiding the alienation of clinical colleagues. One potential solution will become evident in the following discussion of the problems with a solely “anthropology of affliction” [20].

Limited Understanding of Doctors

Just as problematic as the direct application of the theoretical constructs of critical medical anthropology to CAMA is the biased understanding that critical theory has produced. This too, neglects holism. Critical medical anthropology has focussed mainly on the patient’s perspective rather than that of the doctor. As is common to anthropology, critical medical anthropologists have tended to be advocates for “the victims”. In the clinical setting, these are patients, families or ethnic groups. This is problematic for CAMA on three levels. First, just as critical excess alienates clinicians, so too does their dehumanisation in the anthropological literature. Critical medical anthropology’s tendency to side with patients enhances the patient’s humanity at the expense of the clinician’s in the medical encounter. This can result in physicians being unreceptive to CAMA. Second, when clinicians are alienated, critical anthropologists do not have access to what clinicians actually think. Consequently, when informed by critical theory, CAMA may have little information about the issues most pertinent to doctors and their daily activities. Thus, it is no surprise that when looking through the lens of critical theory, clinically applied medical anthropologists are ill-equipped to develop creative strategies to enhance the clinician-patient interaction. Third, critical theory can lead CAMA to promote the view that only patients are victims, not doctors. However, as Hemmings points out, doctors can also be victims. Their perceived callousness is, in many cases, a strategy developed to cope with the harsh medical environment in which they practice [21].

There have been countless studies that have demonstrated the fundamental power imbalance in the doctor-patient relationship. There is no doubt that this power imbalance exists and that an “anthropology of affliction”, [22] focused on human suffering, is important. However, due to their direct placement in the clinical setting, unlike critical anthropologists, clinically applied medical anthropologists cannot position themselves squarely on the side of human suffering. In order to understand the nuances of the clinician-patient interaction and the potential for

anthropological educational programs, critical medical anthropology needs to be applied with a more balanced approach to appreciate both the doctor and patient perspective.

Stein, based on his work coordinating a behavioural science program for residents at a family medicine clinic, has shown that the ethnographic method can be used effectively to understand clinicians and to create educational programs which meet their needs. For example, through the clear understanding of residents’ lives, as a result of the ethnographic method, Stein has developed strategies to motivate medical residents to read behavioural sciences literature. He suggested readings for the resident’s journal club, which directly correspond with their patient cases. In addition, over time he was best able to understand the clinical setting not by competing in the medical science hierarchy, but rather, by creating an informal position for himself [23].

Perhaps, to address the issues of holism in critical theory, preliminary ethnographic exploration and rapport-building would be most effective—as demonstrated by Stein. Using ethnography, the anthropologist could work with doctors to identify the political and economic issues pertinent to their clinical setting. Such an analysis might show how physicians adopt an altruistic stance towards their patients, but find that time restraints imposed on them by the medical-industrial complex influence the care they are able to offer. This approach to critical theory would serve the patient and would be more representative of the realities of the health system, all while making critiques of this system more palatable to the physician.

Biomedicine as Culturally Constructed

In addition to promoting a multi-level analysis, critical medical anthropology often conceptualizes biomedicine as a cultural system. One typical analysis of the biomedical system by critical medical anthropologists asserts that biomedicine participates in cultural assumptions about the body. For example, biomedicine has been critiqued on its Cartesian separation of mind and body [24]. The criticisms of biomedicine produced through this approach to critical medical anthropology theory are problematic from the view point of the clinically applied medical anthropologist because they create a paradox. The researcher becomes torn between two opposing perspectives, both of which she has a responsibility to uphold. On one hand, the clinically applied medical anthropologist, through her position of vulnerability to illness and as a consumer of medical services, believes that at least part of the truth about the body can be discovered by biomedicine. She sees the importance of biomedical research and western medical care. On the other hand, from the point of her training in medical

anthropology, and perhaps, owing to her embeddedness in critical anthropological theory, the clinically applied medical anthropologist understands that this cultural construction of biomedicine does not always serve in society's best interest. Rather, it can perpetuate categories that are oppressive [25]. Clearly, daily exposure to such a paradox can leave clinically applied medical anthropologists unsure of how to portray the clinical setting.

There are significant consequences for clinically applied medical anthropologists' identification with the biomedical paradigm. The complete rejection of critical theory's understanding of the cultural construction of biomedicine has led anthropologists working in the clinical setting to be criticized as having been co-opted by biomedical hegemony [26]. For example, an initial critique by Taussig, and one still shared by critical medical anthropologists, states that in working under the biomedical system, clinically applied medical anthropologists are making the science of human management all the more coercive [27]. Thus, according to critical anthropology, clinically applied medical anthropologists ought to work under the biomedical paradigm while simultaneously being highly critical of it. This can result in much confusion.

This complex issue has been debated for some time, and there have been few concrete suggestions as to how critical medical anthropologists working in the clinical setting should proceed. Baer argues that clinically applied medical anthropologists cannot avoid being critical, and must question existing medical paradigms, health institutions and the political/economic frameworks in which they are embedded. Consequently, clinically applied anthropologists need to develop strategies to function as critics within biomedical spaces [28].

I am in agreement with Baer; anthropologists must be critical within medical spaces, and with tact it is possible for them to both work within the biomedical paradigm and act as critics of the clinical setting. Take for example Robbie Davis-Floyd, who reports on the problems midwives face in their interaction with Western biomedical workers, and the ways in which attitudes held by clinicians can lead to newborn deaths. Thus, the important point in anthropologists' discussions of the failure in the approach to theory is not whether anthropologists can complete critical clinical work without being co-opted by the biomedical paradigm. Clinically applied medical anthropologists can reach a good position to study the medical system and clinicians critically if they investigate what anthropological strategies are most effective within the biomedical setting. In addition, and more importantly, anthropologists should study whether these critiques of biomedicine as a cultural system are translated into medical practice. If so, how does this incorporation

occur? Many anthropologists have studied up; however whether or not anthropologists' important analyses of the clinical setting have become part of clinical practice is a different question.

TRANSLATING THE CULTURE CONCEPT

An important task of clinically applied medical anthropologists has been to translate the culture concept for physicians. As Kleinman and colleagues demonstrate, many of clinicians' difficult relationships with patients occur across cultural divisions. They demonstrate how divergent models of understanding about health can produce problems in day-to-day clinical practice and assert that these models can be easily negotiated below [29]:

A 33-year-old Chinese man came to the medical clinic at the Massachusetts General Hospital...the patient seemed anxious and looked depressed...During the course of his care, the patient never accepted the idea that he was suffering from a mental illness....He acquired the "wind" disease, he believes in retrospect, after having overindulged in sexual relations with prostitutes, which resulted in a loss of huèi-hèi (blood and vital breath)...He remembered feeling bad about his care at the medical clinic where after the lengthy workup, almost nothing was explained to him and no medicine was given...Whereas his behaviour appeared idiosyncratic and irrational to those unfamiliar with his culture, [my] knowledge of Chinese illness categories rendered his actions understandable and enabled us to negotiate with him a common ground that provided appropriate treatment both for his disease (depressive syndrome) and for his illness (a culture-specific type of somatisation).

It can be seen that a cultural category, like that used by the Chinese patient to understand his illness, is important for clinicians to be able to understand, as it affects treatment at many levels. Here, the cultural understanding of health affected the patient's perception and naming of his symptoms, his treatment expectations, and eventually, the evaluation of the treatment that he received. However, how to approach the translation of the culture concept into a clinician-friendly construct, without promoting a misunderstanding of culture according to its anthropological definition, is a more complicated task than this example suggests. Kleinman, both a physician and a medical anthropologist, works in and understands

both the biomedical and cultural domains. Thus, his negotiation with the patient's cultural model was already informed by an anthropological understanding of, and sensitivity to, culture. This skill was further improved by his ability to move between the ideologically separate domains of biomedicine and anthropology. For the clinical anthropologist without medical training, finding ways to communicate the culture concept to physicians is another matter.

As Von Merring notes in reference to clinically applied medical anthropology and biomedically-trained clinicians, "as a rule, neither professional is well prepared to formulate and explain to the other his or her own distinctive view of their work-a-day worlds. Both function best within their separate cognitive domains as they live out different careers charged by different motivations" [30]. Von Merring's commentary pinpoints precisely the main problem in translating the culture concept: that the ways in which clinicians and anthropologists think about specific phenomena appear irreconcilable. In this sense, the problem with the approach to applying the culture concept in medical settings is a result of the opposing paradigms of biomedicine and anthropology, and not a failure of the approach that has been taken by anthropologist in applying medical anthropological theory.

As Chrisman and Johnson explain, anthropologists are trained to tolerate ambiguity in data, to take the time to explore nuances and to take a relativist position. In contrast, clinicians working under the biomedical paradigm employ a more reductionist way of thinking. Clinicians strive to reduce rather than increase ambiguity in data by relating concepts parsimoniously and packaging them. This is because they are required to make quick decisions based on incomplete data; they need to avoid being paralyzed by ambiguities and uncertainties [31].

It is due to the vast differences in the training of clinicians and anthropologists that developing an approach to translating the culture concept has been so difficult. In translating the culture concept for clinicians, the main problem is negotiating the paradigm in which the educational tool developed for clinicians will be placed [32]. The failed "culture cookbook" approach exemplifies this idea well. Upon entering the clinic to educate physicians about the concept of culture, clinicians only want to understand the clinically relevant characteristics of a particular cultural group. Such an approach can result in a portrayal that reduces patients of a specific cultural background to specific beliefs. This is an essentialization with which anthropologists are rarely comfortable [33, 34]. As Kleinman and Benson note, this kind of "cookbook" approach can misrepresent

cultural groups and portray them as homogeneous and static [35].

On the other hand, clinicians are uncomfortable with anthropologists' broader approach to the culture concept, which usually involves an exploration of various case studies. Clinicians can be overwhelmed by information and have a tendency to disengage with anthropologists [36]. This is mainly because anthropologists believe that all of the nuances explored in cultural case studies cannot be reduced to technical information to be memorized once and then quickly and formulaically applied (like that of other clinical skills). In addition, this broad agenda does not conform to the time-sensitivity which the clinician, in working in the biomedical paradigm, must navigate. The differences between ethnicity, nationality and language—concepts that can be intertwined with culture but are not always linked with it—are difficult to explain and learn in a time sensitive manner. In addition, it is necessary for anthropologists to communicate to clinicians how cultural factors are not always central to a patient case and can actually hinder understanding. This information is similarly time intensive and case-dependent [37].

It has been argued that the difficulties with the culture concept may present an invitation to reduce rather than expand the parameters of medical efficacy. This is not to suggest that the clinically applied medical anthropologist simply admit defeat; rather, the anthropologist needs to approach the translation of the culture, and other anthropological concepts, in a more realistic manner. Scheper-Hughes states that she 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" [38]. This has not only been suggested by medical anthropologists like Scheper-Hughes, but also by some operating within the realm of biomedicine. These individuals contend then, that doctoring should only be concerned with the more humble model of the inner workings of the human body, healing, and the social ills, should be left to alternative/spiritual healers. This is a notion that could result in doctors invested with the courage to change the things that can be changed, and the humility to recognize the limitations of medical expertise. Specifically, these limitations result from dimensions of illness that are not biological, but social and cultural. These, cannot be resolved directly through biomedicine [39]. Thus, according to some authors, medical anthropological theory should be employed by clinically applied medical anthropologists to educate physicians about the varying cultural understandings and responses to disease, and the limitations of the medical expertise to evaluate these conditions. In their

view, this is preferable to expecting inadequately prepared physicians to recall the details of specific cultural cases.

However, I disagree with Scheper-Hughes. It is important to note that despite the perceived difficulties with translating the culture concept for physicians widely reported in the medical anthropological literature, cross-cultural curricula have been readily and successfully incorporated into medical education [40]. In fact, currently, cultural diversity education is a required component of the curriculum of all accredited North American medical schools [41]. Although the cultural training methods used in medical schools have been studied by those in the medical field, [42,43,44] little discussion or evaluation of these methods is evident in the anthropological literature. Research carried out by anthropologists should be focused on ensuring that the current translation of the culture concept in medical schools does not inadvertently reinforce racial and ethnic biases and stereotypes. Anthropologists should work to investigate whether trainees actually use what is taught. Moreover, anthropologists should link cross-cultural curricula to health outcome measures; in this way, distinct pedagogical approaches can be associated with improved quality of care.

CONCLUSION

This paper has argued that although clinically applied medical anthropology is definitely a useful application of medical anthropology theory, it has failed to have an impact in clinical settings. An examination of the approach to critical medical anthropology and the culture concept has revealed that this failure in application is both a result of problems with the approach to medical anthropology as well as the seeming incommensurability of the biomedical and anthropological paradigms. Moreover, it is a result of anthropologists' reluctance to study how anthropological knowledge and concepts are being incorporated into current medical education and clinics. The approach taken by critical theory often portrays the medical system and physicians as perpetrators of patient harm. In order to avoid alienating clinicians and in order to be true to the anthropological value of holism, anthropologists employing critical theory must provide a more holistic view of the clinic and clinician. This can be accomplished through the ethnographic method. In addition, critical theory often studies biomedicine as a cultural system. This can present clinically applied anthropologists with a paradox in which they must both work in and be critical of the medical system. I argue that anthropologists can thrive with this double role. Therefore, they should move from theorizing about the place of critical theory in clinically

applied anthropology and begin studying how critical medical anthropologists can effectively work in clinical settings. In addition, anthropologists should study how important insights from critical medical anthropology can become part of the anthropological knowledge that informs clinical practice. Finally, although the incorporation of the culture concept into medical school curricula is challenging, the culture concept is currently recognized as an important component of medical education. Since these curricula are often developed without the advice of medical anthropologists, it is necessary for anthropologists to begin studying and evaluating these contemporary methods of medical cultural diversity training. This will ensure that the culture concept is being translated effectively and safely.

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