

CHAPTER

I

Medical Anthropology in Disciplinary Context: Definitional Struggles and Key Debates (or Answering the Cri Du Coeur)

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INTRODUCTION

As Scotch noted back in 1963, “Medical scholars have literally for centuries been aware of the social dimensions of health and illness and have, in their research, focused on a variety of social and cultural variables, while anthropology has only lately indulged in similar research” (p.30). Many working outside of anthropology advocated early on for socio-culturally informed approaches, and called for changes in social structure, occupational expectations, and urban environments to defeat certain epidemics (e.g., Bernadine Ramazzini, Benjamin McCrady, Lous-René Villermé, Emil Chadwick, Lemuel Shattuck, Rudolph Virchow, Henry E. Sigerist, and Erwin H. Ackerknecht (Scotch 1963:30–31). If we consider the work of these forebears as well as varied anatomists, physiologists, geographers, etc., who shared early anthropologist’s scholarly interest in the human condition, it becomes clear that medical anthropology exists as the outcome of many lines of intertwined inquiry into humankind, some of which emerged in different fields independently – and some of which provoked further interest in health in anthropology proper.

A Companion to Medical Anthropology, First Edition. Edited by Merrill Singer and Pamela I. Erickson.

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A crucial example of this came with the end of World War II, when medical anthropology received impetus and support from foundation- and government-funded applied work in the arena of international and public health. Data collected by anthropologists in earlier times for simple descriptive purposes proved invaluable; anthropologists helped ensure that social and cultural aspects of health and healing were taken into account in ways that promoted program success. As Foster puts it, this marked a turnaround in which the increased value of ethnological data was driven not by changes on the inside of anthropology but rather by outside interests – those of the international and public health markets (Foster 1974). Anthropology or, more specifically, ethnology, now had direct “technical” (Scotch 1963) relevance.

Indeed, the first review of the field emphasized its practical utility. It was titled, “Applied Anthropology in Medicine” (Caudill 1953). In 1959, an article by James Roney carried the shorter phrase, “Medical Anthropology,” in its title (Roney 1959; see also Weidman 1986:116). But what did this label describe? What tensions did it encompass?

Building on previous historical reviews (including Browner 1997; Claudill 1953; Colson and Selby 1974; Fabrega 1971; Foster 1974; Foster and Anderson 1978; Good 1994; Hasan 1975; Lock and Nichter 2002; McElroy 1986; Polgar 1962; Scotch 1963; Sobo 2004; Todd and Ruffini 1979; Weidman 1986), this chapter examines the historical context of the struggle to define the field. In the 1960s and 1970s, debate centered on then-prominent applied-theoretical and generalist-specialist divides. The contrast between physical (later, biological) and cultural perspectives also made its mark. Later developments related to the evolving definition of culture, the influence of critical (and later synthetic) thinking on the subdiscipline, and the role of extra-disciplinary interaction.

MEDICAL ANTHROPOLOGY TAKES SHAPE

Application or theory?

Good refers to medical anthropology in the 1960s as a “practice discipline” (1994:4), dedicated to the service of improving public health of societies in economically poor nations. Indeed, initial efforts at organizing a medical anthropology interest group – diligently fostered by Hazel Weidman – resulted in an invitation from the Society for Applied Anthropology or SfAA to affiliate in 1968. A full account of this and subsequent developments is offered in Weidman’s important historical review (Weidman 1986).

Although the invitation was accepted by the fledgling medical anthropology community (then called the Group for Medical Anthropology or GMA) as a practical solution to the challenges of maintaining cohesion, the endorsement of and by applied anthropology was “something of an embarrassment” to many (Good 1994:4). Even George Foster, a key founding figure, had to work through ambivalences here. “We were trained to despise applied anthropology,” he once said; recalling that he did not join the SfAA until 1950; until then “I would have nothing of it” (Foster 2000, quoted in Kemper 2006).

As Scotch reported in 1963, there were those who felt that because of its practical bent, “the quality of literature in this area is not always impressive... It is superficial,

impressionistic, and nontheoretical” (Scotch 1963:32). Some felt that those who elected to engage in medical anthropology were “less rigorous than their more traditional-minded contemporaries” (p.33); they were denigrated as mere “technicians” (p.42).

Generalists or specialists? Apprehension also ran high over whether formally organizing as *medical* anthropologists would reinforce an “artificial area of study”; in support of this claim some pointed to “the lack of systematic growth and the failure to produce a body of theory” (Scotch 1963). Some feared that formal organizing might “prove detrimental to the development of theory in anthropology” as it would force the fragmentation of the field (Browner 1997:62).

The American Anthropological Association (AAA) was at that time experiencing growing pains. Its Committee on Organization described “financial and organizational disarray” in 1968 (*Anthropology Newsletter* 9(7)) and noted that while anthropologists in general desired to “retain an integrated professional identity” the profession also faced strong “fissiparous tendencies” (as cited in Weidman 1986:116). Some medical anthropologists felt, accordingly, that focusing on developing the group’s then-nascent newsletter (*Medical Anthropology Newsletter*, or MAN) would be better than assembling as if a faction. This might be termed the “function but no structure” constituency (Weidman 1986:119).

It is helpful here to recall that the AAA did not, at the time, have “sections” as we know them today. Many members believed that research should contribute to anthropology in general, not just some special subgroup. Arthur Rubel, for instance, until his death “would not be pigeonholed as a medical anthropologist... for he always saw health/medical phenomena as human behavior to be understood as anthropologists understood other forms of human behavior” (Cancian et al. 2001).

An uneasy resolution

Partially due to the fear that affiliating with the SfAA, which was independent of the AAA, might distance medical anthropologists from the parent discipline unduly, and because to incorporate independently in another form would be financially costly (Browner 1997), the GMA continued to push the AAA to create a mechanism for organizing as an AAA subgroup. Eventually, largely due to the GMA’s own organizing efforts, this came to pass (see Weidman 1986:121,124) and the SMA received formal status as an AAA affiliate in 1972 (Society for Medical Anthropology 1975).

This move firmly anchored the group within academic anthropology. It also allowed the AAA some control over the shape that medical anthropology took, due to imposed bureaucratic imperatives. However, in part because those *not* interested in direct involvement in the application of their work tended purposefully *not* to identify with the group (cf. Good 1994:4), the influence of applied perspectives remained strong.

Many members retained an affiliation with the SfAA and *Human Organization* (the SfAA’s journal) was a popular publication outlet for medical anthropology. So was *Social Science and Medicine*, founded in 1967. Many SMA members were employed in schools of medicine, nursing, or public health. Others worked directly in the international and public health fields. From the viewpoint of those seeking practical solutions to specific health problems, theory seemed abstract, obstructive, and

sometimes even irrelevant. The authority of biomedical clinical culture, where curative work and saving lives takes precedence, was manifest (Singer 1992a).

What's in a name? There are still those anthropologists who prefer to self-identify as anthropologists interested in health rather than as “medical” anthropologists. In some cases they cling to the old-fashioned academic belief that applied work is *infra dig*. In others, their concern relates to the desire, noted above, to advance the larger discipline or, to paraphrase George Stocking, to guard the sacred bundle (1988). A statement issued by the SMA in 1981 defining medical anthropology addressed this, asserting unambiguously: “Medical anthropology is not a discipline separate from anthropology” (p.8).

But this did not offset objections related to the narrow technical or Western definition of the term *medical*, noted for instance at the GMA’s 1968 organizational meeting. Madeline Leininger suggested the alternate “health anthropology” (which some prefer today as well); “lively discussion followed” (Weidman 1986:119). It is not just that *medical* leaves out nurses and members of the allied health professions. Narrowly defined, it refers only to *biomedicine*. The appellation “medical anthropology” thus has been seen by some as suggesting a biomedical gold standard against which to measure all other healing or curing practices. Other concerns have been the implied focus on pathology and the implicit devaluation of interpretive ethnographic methods and of studies of non-“medical” healing.

Nonetheless, many self-identified medical anthropologists’ work has nothing to do with “medicine” as it is technically defined. For them, and even for many anthropologists working in biomedical settings, the term *medicine* is generic. It is understood to refer to *any* system of curing or healing, no matter what specific techniques are involved.

CULTURAL INTERESTS ASSUME THE LEAD

For better or worse, the subfield moved forward as “medical anthropology.” The SMA’s incorporation in the early 1970s seemed to spur a number of “What is Medical Anthropology?” essays. As Howard Stein noted in 1980, “I have heard the *cri du coeur*, ‘What is medical anthropology?’ (MA) as a recurrent, quasi-ritualized annual event” (p.18). While in its initial phase, generalist-specialist and applied-theoretical tensions had prominence, in this phase the tension between cultural and biological priorities took precedence.

A felt need

Despite physical (now ‘biological’) anthropology’s contribution to the subfield’s growth, beginning with studies of hominid paleontology, anthropometry, and the geographic distribution of certain traits, and later with studies of a more ecological and adaptationist perspective, medical anthropology’s official emergence was largely fostered by culturally oriented scholars, mobilized by their new-found role in international and public health (see Paul 1963; Polgar 1962). This included those affiliated with the “culture and personality” school (e.g., Caudill, who wrote the

aforementioned 1953 review). Thus, Colson and Selby's (Colson and Selby 1974) "annual review" of the field's progress (1974) gives much space over to work on "social pathologies" (p.253), such as drug and alcohol use or addiction, and issues relevant to "ethnopsychiatry" (p.248). A similar pattern infused the earlier review by Fabrega (Fabrega 1971), who noted "the affinity that 'medical anthropology' has always had with psychiatry" (p.186). Even Scotch's 1963 review, organized around the theory-application question, reveals the psychological influence, for instance discussing work relating "modal personality" to certain forms of mental illness (p.43). This distinct focus on "nurture" over "nature" reflects the strength of cultural determinism in early 20th century US anthropology.

The strong presence of cultural anthropologists had a sizeable impact on early efforts to organize the medical subfield. For one thing, while the seven goals drafted by the initial steering committee of the emerging medical anthropology network did refer to "social and cultural aspects of health, illness, and systems of medical care" (Weidman 1986:118), biological aspects received no mention. Further, all of the goals stressed communication (Browner 1997). While physical anthropologists had been working and publishing in and with medicine since anthropology's inception, cultural anthropologists as a whole were still at that time rather new to it and seemed uncomfortable in that milieu. In comparison to their physical/biological counterparts, they generally lacked easy access to it anyhow and could claim little authority within it. Cultural scholars' desire for increased intellectual discourse provided great organizing momentum.

Biological voices In a 1975 "What is Medical Anthropology" commentary published in the SMA's newsletter, MAN, Khwaja A. Hasan, who (along with several others) actually used the phrase "medical anthropology" in print prior to those generally credited for inventing it, took the emerging subfield in general and, more specifically, George Foster himself, to task for neglecting the biological side of the anthropological equation (Hasan 1975). Foster made this omission in a 1974 commentary (also published in MAN) contrasting medical anthropology and sociology (Foster 1974).

Hasan argued that, rather than focusing on the culture-society distinction, which Foster did (as others have: e.g., Paul 1963), Foster should have depicted anthropology as the study of "man" (sic). "Man" is the major focus of medicine, too, wrote Hasan; this, he said, gives anthropology and medicine much more in common than anthropology and sociology. Example after example of the role that biologists and "medical men" played in anthropology's development are followed by more examples of physical/biological anthropologists at work within medicine.

It probably did not hurt Hasan's case that physical anthropology had by this time become more biologically oriented, not only in terms of data types accessed but also in terms of questions asked. In any event, Foster was quite responsive to Hasan's argument: When Foster revised the offending 1974 commentary for use in the first medical anthropology textbook, published in 1978, he and his co-author Barbara Anderson took a more biologically informed position. They included also a reference to Hasan (Foster and Anderson 1978).

Others, too, provided correctives. A key teaching text also first published in 1978 specifically highlighted biological and ecological perspectives (McElroy and Townsend 2004); a 1980 textbook that took a biocultural approach proclaimed in its subtitle to be "expanding views of medical anthropology" (Moore et al. 1980).

Concurrently, while both the introductory undergraduate and graduate “model courses” prepared by Arthur Rubel and published in the newsletter MAN in 1977 and again as part of a “model course” collection (Todd and Ruffini 1979) to aid curricular development for the subfield were short on biology, it did gain representation in Model Course VIII, “Biomedical Anthropology.” This course, prepared by Frederick Dunn, also laments the “limited attention” paid to biological concerns (p.95). Model Course IV, “Nutritional Anthropology” (by Cheryl Ritenbaugh) is quite biological. Having said that, nutritionally oriented anthropologists, who had a very active SMA special interest group from the start, did break away to establish their own AAA section in 1974.

Medical anthropology’s initial culturalism was not so much, then, a prejudice against biological anthropology as it was a simple artifact of the professional activities of many of medical anthropology’s organizationally active founders. And yet, despite the corrective directions taken in the mid-to-late 1970s, science itself had by that time come under scrutiny. The scientific method – the paradigm that biological anthropologists most often worked within – was increasingly seen by those who dominated the field not only as an “establishment” tool. Worse, evolutionary biology was maligned by some because of its potential use by racists (D’Andrade 2000:223).

Finding itself on the “wrong” side of the culture–biology divide that had been thrown up, and upstaged by vocal and morally accusatory opponents of positivism, biological anthropology received less than its fair share of recognition from some corners. This is not to say that biological medical anthropology did not take place; indeed it did, and continues to do, in ways that have contributed greatly to advancing our biocultural understanding regarding, for example, high altitude adaptations, lactose tolerance, breastfeeding, and HIV/AIDS as well as to building a more theory-driven epidemiology. However, such efforts were often rewarded more richly outside of medical anthropology than in it.

‘Function not Structure’ Redux Such goings on notwithstanding, others remained unconvinced of the merit of demarcation efforts. Indeed, Christie Kiefer’s contribution to the definitional debate (Kiefer 1975) bemoans the “irritating question” to begin with (p.1). After outlining a typology of medical anthropologists (“the craftsman, who asks to be spared for his accuracy and thoughtfulness”; “the reformer, guided by a utopian vision”; and “the artist, who would rather be interesting than correct”), Kiefer worries that in trying to delimit the subfield we may cause it to wither on the vine. The quality that makes the field helpful and interesting, he says, is its very disorderliness (1975:1). This only makes us “seasick” he says because “medicine thrives on orthodoxy” (p.1); the quest to define medical anthropology reflects, he suggests, an infection with medicine’s quest for “exactitude” (p.2). Contrasting “certainty on the one hand and meaningfulness on the other,” Kiefer suggests we “stoutly insist” on keeping medical anthropology undefined and indefinite.

Medical anthropology: the official version

Despite this plea, the SMA itself tried to define the subfield with some exactitude in 1975 and again in 1981. The original SMA “What is Medical Anthropology?” statement essentially takes three paragraphs, starting with the bold proclamation, “As the

holistic science of Man, anthropology has since its beginnings pursued the study of both human biology and the behavior of human groups” (Society for Medical Anthropology 1975).

The revision, three times as long, gives notably less attention to the biological arena. In it, we learn that most medical anthropologists “started as cultural anthropologists” (Society for Medical Anthropology 1981:8). The key questions of medical anthropologists, copied in below, do start out with the word *biological* but in the end are culturally oriented:

How are biological processes mediated and modified by the culture? What are the dynamics of maintenance and change common to all curing systems? How are people recruited as practitioners and patients in curing systems, and how are roles learned, carried out and changed? What is the relationship between health beliefs and health behavior? How does the curing system relate to other systems in a culture? What is the relationship between the pattern of life and the pattern of disease?” (p.7).

The essay further states that although the concept of adaptation is incorporated, “the time frame is shorter than that used by physical anthropologists, who are more concerned with evolutionary processes” (p.8).

WHAT IS CULTURE?

From health to sickness

Most early medical anthropologists defined “health” as most still do now: it is a broad construct, consisting of physical, psychological, and social well being, including role functionality. What was new in the 1970s, however, was a distinction increasingly drawn between “disease” – biomedically measurable lesions or anatomical or physiological irregularities – and “illness” – the culturally structured, personal experience of being unwell, which entails the experience of suffering.

The effort to hash out such distinctions was underwritten by the increase in anthropologists taking a meaning-centered focus and the growing use of the emic-etic framework, absorbed through linguistics. “Etic” constructs (such as the temperature represented on a thermometer) are meant to be universally applicable; they are imposed from the outside onto the cultures in question. The problematic assumption of one true empirical reality notwithstanding, etic constructs are opposed to “emic” ideas: ideas (and note the implication there) that cultural insiders have about themselves and their worlds. “Disease” is an etic, a universally applicable and measureable entity. “Illness” (the emic perception) is not. As such, it can refer to a variety of conditions cross-culturally, some of which (it has been argued) do not exist in other cultural worlds.

Thinkers of the day soon realized that, however helpful, the disease–illness dichotomy recapitulates the mind–body dichotomy that biomedicine was, even then, being criticized for “trafficking in.” This view took fuel in part from the burgeoning rift between positivist-minded and interpretive or hermeneutic scholars – a rift often termed the “two cultures” or science–humanities split, à la C. P. Snow (1993 [1959]). In any case, the problem here was that while “disease,” as the dichotomy defines it, is anchored in the body, “illness” is conversely anchored in the mind: disease is thus

attributed (whether it has it or not) a real, concrete, scientific factuality or objectivity that illness, as a subjective category, may be denied (see Hahn 1984).

A second criticism of the dichotomy hinged on the fact that both disease and illness were being located by theorists in the individual. The term *illness* referred, as it still often does, to an individual's social relations, but generally it did and does so only insofar as these were the cause of the illness (e.g., when an offended party places a hex) or as the illness leaves the individual unable to fulfill social or role obligations. Some scholars working in the 1970s wanted to link suffering more palpably to the social order by examining how macro-social forces, processes and events (such as capitalist trade arrangements) could culminate in public health problems and poorly functioning health systems (again, see Hahn 1984). Some recommended using the term *sickness* when larger social processes are being highlighted (see Frankenberg and Leeson 1976).

Studying medical systems

The ultimately helpful work on definitional questions occurred hand-in-hand with efforts that dissembled then-prevalent understandings regarding the nature of cultural systems per se. For instance, a late 1970s contribution to the "What is Medical Anthropology?" conundrum was titled "What Kind of Model for the Anthropology of Medical Systems?" (Kleinman 1978).

In the essay in question, Arthur Kleinman accuses his predecessors of a kind of reductionism. He denigrates the era of "sweeping comparative generalizations" and "ideal-type categorization," which he paints as "superficial" and as couched at "too abstract a level to be relevant" (pp.661–662), arguing instead for a medical anthropology that can "examine health and sickness beliefs as they are *used* in the usually exigent context of social action" (p.661; emphasis in original). While the essay never says so explicitly, it in effect provides early support for the adoption of a process-based theory of culture. It also gives voice to then-emergent concerns about imputing too much systematicity to cultural systems; it questions, quite strongly, "the tacit assumption... that medical systems are more or less homogenous, unchanging, and single" (p.662).

More immediately, however, pointing to the importance of "microquestions" and effectively adopting an anti-universalizing stance, the essay applauds the use made by newer medical anthropologists of the distinction between emic and etic perspectives. Despite the issues raised above, Kleinman and others working in the 1970s found the distinction quite stimulating. Kleinman argued it fostered the growth of promising research in semantic network analysis; at the time of his essay's publication a spurt of medical anthropology work took place in this area.

Referring particularly to the semantic network studies of his institutional colleague Byron Good, Kleinman noted:

Here particular sicknesses are studied, in contrast to their biomedical signification, as culturally constituted networks that link symbolic meanings to physiological and psychological processes and the personal experience of sickness, on the one side, and to social situations, relationships, and stressors on the other.... The upshot is something akin to an ethnomedical epidemiology of *illness* and a sociosomatics of *disease*; a systematic critique is offered of the biological language of medicine and psychiatry and a new

language is proposed for examining the relationships among biology, experience, and meaning in the social construction of sickness as a phenomenon of everyday world (p.663; italics in original).

In short, argues Kleinman, it was time to enter a new era – one in which “complex ethnographic findings... make a shambles of established dichotomies” (p.664). Rather than simply cataloging classifying cultural practices, artifacts, and ideas (part of the archival tradition which did have its merits in anthropology’s early days), much work in this decade was devoted to identifying and understanding the various forces within a given cultural milieu that shape health and health-related experiences, ideas, and actions.

And it wasn’t just semantic analyses that prospered. So did the meaning-centered approach to symbolic analysis, or what was to become known as the Geertzian tradition of interpretive anthropology. Also, a good deal of inquiry (including Kleinman’s own) took place through the study of illness narratives. Theory and methods stemming from discourse analysis supported a good portion of narrative-centered work. Phenomenological ideas, such as those of Maurice Merleau-Ponty and then Pierre Bourdieu were later incorporated by some who emerged from the milieu now sometimes termed “the Harvard School.”

Anthropologists at this time had also come to understand more fully that medical culture was not solely the province of “primitives.” Largely under the leadership of Charles Leslie, now even highly elaborated medical traditions such as Ayurvedic, Unani, and Chinese medicine were subjected to anthropological scrutiny as dynamic cultural systems – and as locally and globally interacting ones too. The role of nationalism in keeping these “great traditions” vibrant also was theorized (see Leslie 1980). The general focus on how health-related experiences are shaped and expressed or given meaning locally was thus now complemented by efforts to examine how forces from without culture did the same.

Working under conditions of explicit change, first under the post-war rubric of “development” and later as part of an acknowledged post-colonial transformation (see Marcus 2005), anthropologists increasingly studied, and created comparative frameworks for making sense of, health seeking, medical pluralism, and medical syncretism. Epistemological questions regarding evidentiary standards and modes of logic in medical decision-making, both emic and etic, were now raised more vociferously; theorists became concerned with the tendency to favor scientific or biomedical standards and the questions of legitimacy this can raise (Lock and Nichter 2002:4–5). Scholars also probed assumptions regarding systematicity itself, arguing that the apparent orderliness of some non-biomedical traditions may be an artifact of modernization, which demands an emphasis on rationality. In this intellectual context, new ideas about culture – and about neocolonial development – were given room to grow.

CRITICAL APPROACHES

Self-criticism

As the 1980s “ticked” into place, anthropology – particularly cultural anthropology – began to respond to changes in global and domestic power relations as well as to feel the heat of other disciplines’ critiques of traditional ethnographic methods: “The

subjects of ethnography could no longer be constituted in as objective terms as previously” (Marcus 2005:680). Definitions of culture, already in flux in the 1970s, grew increasingly “non-essentialist, fragmented, and [came to be] penetrated by complex world historical processes mediating the global and the local” (p.681). They would become more so in the 1990s and early 2000s as so-called postmodernity transmuted into globalization, but the stage was set by the 1980s for the emergence of a critical form of medical anthropology – one that took the lessons of political economy to heart.

Social criticism

Even in the 1970s and earlier, some anthropologists had taken seriously the lessons of historical materialism encapsulated in the works of Karl Marx and Friedrich Engels. Although in the USA an anti-communist bent put dampers on academic excursions into this arena, Eric Wolf’s emigration from Europe during World War II and subsequent changes in the political climate supported the eventual uptake of this line of thinking in US circles. More attention was paid, then, to the works of Ronnie Frankenberg and, through him and others, Italian revolutionary Antonio Gramsci. In this way too, the focus on conflict and reconciliation and the tensions extant between (individual) agency and (social) structure, promoted by the Max Gluckman’s Manchester School, gained new ground on US shores.

As a result, a newly “critical” perspective burgeoned. Proponents denounced past ignorance of social and, more to the point, political economic factors in medical anthropology’s thinking. Systems thinking, most obviously in the form of world systems theory (as per Immanuel Wallerstein) and dependency theory (as per Andre Gunder Frank), were brought into play. Building on work done in the 1970s with regard to “great traditions” and the ways in which they do and do not respond to incursions from what some by then called “capitalist” or “cosmopolitan” medicine, medical anthropology now confronted head-on the impact of hierarchical social relations on people’s health status, knowledge, and action (see, for example, Baer et al. 1986; Singer 1986).

While interpretive or meaning-centered medical anthropology focused on local symbolic significances and networks of meaning, taking ideas as key, critical medical anthropology (CMA) advocates took a materialist approach – one that prioritized the examination of power structures that underlay dominant cultural constructions, and questioned the ways in which power (including the power to frame “reality”) was deployed. In doing so, CMA sought (as it still does today) not only to expose local power dynamics but also to reveal how outside interests, whether regional, national, or global, affect local conditions. Further, CMA argued (as it continues to do) that health ideas and practices reinforce social inequality as well as expressing it.

ANTHROPOLOGY OF MEDICINE, IN POLITICAL AND THEORETICAL CONTEXT

Medical anthropology grew dramatically in the last few decades of the 20th century, partly due to increased opportunities for applied medical anthropologists. But perhaps more importantly, non-applied anthropologists interested in health saw that

they, too, had something to gain by identifying themselves as “medical” anthropologists. The field’s relevance to theories regarding culture had grown more obvious. Further, those who affiliated gained somewhat increased credibility in biomedicine and public health, and easier access to work within such organizations.

The cultural construction of biomedicine and public health itself came under increasing scrutiny now, making manifest the important distinction between anthropology *in* medicine, which many early applied efforts represented, and anthropology *of* medicine (Foster 1974 [after Strauss 1957]:2). Investigations into the medicalization of pregnancy and birth were central to real growth in this area (see Browner and Sargent 2007).

Anthropology of medicine was in part made possible through the growth of employment options in academia, which had begun after World War II. But in the post-Vietnam War era the right (and even obligation) to question authority had become an important aspect of US cultural discourse. Many in certain areas of academia endorsed it gladly. Academic anthropology, in particular, had begun a swing to the “intellectual Left” (D’Andrade 2000:219). Employment within the ivory tower thus supported medical anthropology’s close questioning of biomedicine’s and public health’s established agendas by providing a safe space for – and indeed, a cultural climate encouraging of – contemplations not often safely brought into the workplace. Protected from the need to bring in their own contracts and grants, and invigorated by post-Vietnam “anti-establishment” sentiment, many university-employed anthropologists proclaimed participation in government or corporate sponsored foreign or domestic aid work as retrogressive – as standing in the way of real social progress.

To some extent, the progressive climate fostered within numerous anthropology departments attracted newcomers to the field; some saw medical anthropology itself as a potential “social movement” (Stein 1980:19). Plus, while many went about their work systematically and with rigor, for others science was seen as “part of the military industrial complex” (D’Andrade 2000:221) and therefore needed quashing; “theoretically relevant description” gave way, in some circles, to “moral critique” (p.222). Put off by this tendency where it arose, some scholars more committed to systematic and rigorous research inquiry than hortatory essay writing switched their allegiance to other disciplines, such as epidemiology, genetics, biology, and even sociology.

Associated with cultural anthropology’s general anti-science tendency at the time, a “bias in favor of alternative, heterodox, of non-Western forms of medicine” was noted by Melvin Konner (Konner 1991:80). In his opinion, “Criticism of medicine has become a major academic and publishing industry” (p.81). Admitting that “there is a lot that is wrong with medicine,” he argued that the negative tone taken by some medical anthropologists toward biomedicine was counterproductive: “Modern medicine is not a conspiracy against humanitarianism,” he wrote; “Least of all is it a capitalist plot” (p.81). The “high-minded criticism with no evidence of sympathy for the doctor’s plight” (p.81) that he observed did do some damage to medical anthropology’s reputation in biomedicine – but not much, because generally such critiques were not published in media that many biomedically affiliated professionals read.

Further, many critically oriented scholars still prioritized careful research. Moreover, some made common cause with biomedical insiders who also would critique the industry and its impacts in an effort to improve healthcare. These scholars bridge the divide between an anthropology overfull with hypercritical rhetoric and an

anthropology that is so in tune with the biomedical point of view that it actually had been, itself, medicalized.

As Carole Browner (1999) has explained, medicalized anthropology has lost touch with the discipline's principles; its practitioners "go native" when working within the health services (p.135). Browner respects the anthropologist's need to find a common language with which to communicate with in the healthcare colleagues and to adopt some of medicine's cultural practices to gain credibility in that world. She understands the likelihood that many anthropologists will already to some extent have internalized biomedicine's categories because of their own reliance, at times, on the system. But, Browner warns, one of the grave dangers of being medicalized is the sacrifice of our "critical distance" (p.137).

Complementing a politically motivated objection to work supporting the dominative medical system's imposition was a scholarly one, then: developments in post-modern and feminist theory that led many to question the authority of truth claims in biomedicine and biology on epistemological bases (cf. D'Andrade 2000; Marcus 2005).

Biological influences

Despite the scorn for science promulgated by some in the later 20th century, biological medical anthropologists continued to attract students and quietly made substantial progress. They could afford to be quiet: many journals outside of anthropology gladly accept their work. Importantly, in terms of tenure and promotion, many of the extra-anthropological journals that welcome biological anthropology have higher impact factors than those of the home discipline. They also can "count" more when applications for grants are reviewed, thereby helping assure a steadier source of funding for often-rather-expensive biological research.

In the 1970s, the term *biomedical* had been applied to biologically oriented work with fairly immediate clinical applications or relevance for investigations of universal (albeit perhaps locally expressed) biological or disease processes. As time wore on, political ecology, which acknowledges that power relations affect the ways that human groups handle their natural environments (e.g., water, soil), and documents the health ramifications thereof, was increasingly popular. While its treatment of culture was still rudimentary, the political ecology approach did offer an alternative to the narrower adaptationist perspective.

By the 1990s, some biological anthropologists who had followed developments in critical theory acknowledged the reductionist tendencies fostered even in political ecology and called for a deeper appreciation of the dialectical relationship between culture and biology (see Singer 1996). A more sophisticated biocultural synthesis emerged – one highlighting the complexly interactive roles that social structures and the local and global political economies that support them play in biological outcomes (see Goodman and Leatherman 1998). Some areas of inquiry that have benefitted from this approach are global malnutrition, tourism's impact on host population health, the situational emergence of syndemic clusters of disease or affliction, and even how socio-culturally fostered ecological crises related to pollution, deforestation, soil degradation, and global warming have affected human health. Those on the more cultural end of the biocultural continuum have begun to examine how such "anthropogenic" hazards (including those tied to declared and undeclared

wars) can converge, each having a multiplier effect on the other, and thereby on human well being.

Biocultural explorations have grown in other areas as well. For instance, investigations in regard to culture's role in creating and sustaining the placebo effect led to advances in theory regarding how healing works (e.g., Moerman 2002). Questions regarding the mechanisms whereby culture is embodied enhanced our understanding of "stress" while promoting a more cognitively oriented definition of culture (e.g., Dressler 2005).

MEDICAL ANTHROPOLOGY IN RECENT YEARS

Theory to the center

As the 20th century drew to a close, theoretical and methodological advances made within medical anthropology began to truly inform and inspire the larger discipline. General debates concerning culture, power, representation, social structure, and other issues increasingly reflect advances stemming from medical anthropology. Some examples are seen in recent work on narrative or storytelling in relation to health and healing, identity creation and maintenance, and subjectivity and temporality (especially in relation to stigmatized physical and mental conditions): the role and impact of audit and surveillance systems and authoritative knowledge; healthcare consumerism, pluralism, and syncretism; local and global health inequities, and so on. Much of this work itself, it must be said (and see below), has been influenced by scholars outside of anthropology, such as: Michel Foucault's regarding "governmentality" and "biopower" (e.g., Foucault 1998 [1976]); Anthony Giddens's and Ulrich Beck's regarding "risk" (Beck 1992; Giddens 1984); and, more recently, Johan Galtung's regarding "structural violence" (Galtung 1969; but see also Virchow 1985 [1848]).

The hope for generating generally relevant anthropological theories and concepts always has been there: as noted, some opposed the formation of the SMA because of a fear that structural factioning might contribute unduly to the fragmentation of the field as well as to falsely fence in the subdiscipline, limiting its ability to speak to pan-anthropological concerns. Yet, despite the persistent argument for medical anthropology's broader relevance – a 1974 review of the subdiscipline noted its importance to "issues of interest to the discipline [as a whole, such as] culture contact, the acceptance of innovations, the organization of professional subcultures, and aspects of role theory among many others" (Colson and Selby 1974:254) – and despite exceptions to the rule, much of the medical anthropology conducted through the 1980s drew theory from anthropology's core rather than generating new anthropological theory itself. It was not really until the late 1980s and 1990s that medical anthropology's broader relevance was strongly seen. The reverse in the flow of ideas marks medical anthropology's emergence from the margin into the mainstream of the field (Johnson and Sargent 1990; see also Singer 1992a).

Reinventing wheels?

Medical anthropology has grown to be the largest specialist section membership in the AAA. Degree programs and textbooks are proliferating. However, and perhaps partly as a result of this, much present scholarship is in some ways redundant. There

are at least two reasons for this. For one thing, concepts and new bits of jargon delineated in popular publications are applied or repeated ad nauseum as others seeking to advance follow fashion. Another reason for redundant scholarship in medical anthropology today lies in our apparent abandonment of – or anyhow decrease in – interest in lengthy and thorough literature reviews. The literature is no doubt denser today than it was a generation ago, making total command quite a challenge. Further, submission length limits are shrinking as publishers try to economize (as well as to accommodate shrinking page-length tolerances among many readers). However, scholars today seem increasingly ignorant of important foundational work. Some areas of current medical anthropological interest, despite certain scholars' insistence that they are brand new, have actually been scrutinized by many scholars previously.

Take, for example, hospital ethnography, the focus in 2008 of a special issue of *Anthropology & Medicine* (vol. 15, no. 2) as well as of a special section of *Social Science & Medicine* in 2004 (vol. 59, no. 10). While those involved in these publications stake the claim that anthropologists are only now discovering the benefits of active researchers in hospital settings, Foster and Anderson (who devoted an entire chapter to hospitals in their 1978 textbook and included also a separate chapter on doctors and another on nurses) stated as many years ago that “some of the most important studies of hospitals have been done by anthropologists” (p.164). They went on to note that one of the earliest behavioral science studies of nursing was done by an anthropologist (in 1936) – adding that nurses themselves have done a good deal to advance medical anthropology. A review of medical anthropology published just a few years earlier (Colson and Selby 1974), provides a number of examples of this genre.

This is not to say that aims and approaches have not changed. It is also not to deny that subtle differences can mean the world in terms of what an article or special issue contributes to the field. The heavy institutional pressures on scholars to stake claims of novel research are also not in question (see Sobo et al. 2008). Yet it remains the case that a better grasp of the history of scholarship in a given topical area can support more efficient and effective theoretical advancement. Even this is not a new observation: it was in fact the point of many who, in the 1960s, took medical anthropology to task because “it has not been cumulative” (Scotch 1963:39). Adding to the challenge today are medical anthropology's diverse national traditions (see Sailant and Genest 2007). Scholars may not be aware of, or may be dissuaded for a variety of reasons from reading, the works of those publishing in other countries or tongues. Again, this in itself is not a new problem, but its significance has no doubt broadened as the field has grown.

The periphery's significance?

At the same time, medical anthropology continues to be positioned well to contribute to general anthropology: Its focus, health (etc.), intrinsically lends itself to interdisciplinary collaboration. It has inherent interdisciplinary ramifications, too. This has been seen in work undertaken toward such goals as: improving care for people with HIV/AIDS and other diseases, increasing our understanding of (and ability to address) health inequities, fostering the implementation of cultural changes within healthcare organizations, etc.

George Marcus has in fact highlighted medical anthropology's "interdisciplinary constituencies" while calling it "one of the most energetic and successful of the established subfields" (Marcus 2005:681). He argues that, today in anthropology, "newer topical arenas and theoretical concerns are developed through interdisciplinary discussions... not through studied debates and discussions around products of anthropological research among the community of anthropologists itself" (p.675). Marcus further contends that medical anthropology enjoys "derived prestige in anthropology by dint of this [interdisciplinary] participation" (p.681).

Some of this prestige relates to the push from within the academy to secure more grants and contracts. Financial awards from biomedical research and public health funders are generally "heftier". In addition, they have more cachet outside of anthropology than do awards from within the field. This can be important to scholars seeking career advancement: there does exist a political economy of research (see Singer 1992b; Sobo 2009). But Marcus's argument is not directly concerned with that. Rather, he worries that most "career making research projects" today are, he claims, defined "in terms of social and cultural theory produced elsewhere than in anthropology" (p.676).

Marcus reinforces his overall argument that anthropology has been "cut from its moorings" (2005:673) with a claim that the relationship between its center and periphery has "collapsed" (p.676). With no prevailing "disciplinary metadiscourse" or even simple central tendencies – even the old claim of culture as anthropology's special purview has been challenged, for instance by "cultural studies" – prestige in anthropology must come now from the margins, not the core: "Anthropologists in general tend to be most impressed with their own research initiatives that most impress others" (p.681) – work that garners recognition in extramural "authoritative knowledge creating spheres" (p.687).

This emphasis on work undertaken at the periphery or even within other arenas and then returned to the anthropological fold occurs also in the theme selected for the inaugural SMA-only (versus joint) meeting (held in 2009). The meeting theme, "Medical Anthropology at the Intersections" highlights work in twelve areas: global public health, mental health, medical history, feminism and technoscience, science and technology studies, genetics/genomics, bioethics, public policy, occupational science, disability studies, gender/sexuality studies, international and area studies. These areas build upon those identified in the 2006 SMA presidential statement, in which much like Marcus, Marcia Inhorn notes that "the cutting edges of our field are now found 'at the intersections' of many other disciplines (Inhorn 2007:249). Whether the conference subtitle, "Celebrating 50 Years of Interdisciplinarity," somewhat silences the contributions of those working squarely within anthropology – or at least of those who took an anthropology-first position in the days prior to the 1980s when the core, according to Marcus (2005), imploded – remains an open question.

Authority, passion, practice

Also open to supposition is whether and how interdisciplinarity includes the public at large. Of late, some have sought to carve out an arena termed "public anthropology," which seeks to break free of academic "intellectual isolation," engaging in a

straightforward manner with issues and audiences beyond the discipline's self-imposed boundaries (Borofsky 2000). The University of California Press publishes the California Series in Public Anthropology in support of this mission.

Books in the series to date deal with numerous topics, but many speak directly to issues of concern in medical anthropology, including HIV/AIDS, organ transplantation, sexual health, genocide, war-related trauma, reproductive strategies, and the link between poverty and ill health. Many authors in the series are self-identified medical anthropologists. The prestige of being published in a series with so many important authors and whose books have won so many awards no doubt has attracted more and more medical anthropologists to submit manuscripts for consideration, supporting an efflorescence in this genre – much as the SMA's Eileen Basker Memorial Prize, given yearly since 1988, supported growth of scholarship in the area it addressed: gender and health research. (The New Millennium Book Award was specifically created in 2005 to stimulate growth in more general medical anthropology writing.)

The public anthropology book series no doubt exists to disseminate knowledge and understanding. But it also exists to make money. It unselfconsciously seeks (as per its website description) to compete directly with the success that journalists and scholars from other disciplines have had at repackaging and selling – often at quite a profit – anthropological insights. Notwithstanding, Marcus (2005) specifically sees the call for “public anthropology” as a quest for recognition from the media, which has become “the most prestigious realm” of authoritative knowledge. Marcus attributes this need to the fact, as he sees it, that anthropology is currently paradigm-poor and therefore authority-weak. In this light, public anthropology serves as “a place-holder, an attractive surrogate” and “a source of solidarity” much needed (p.687).

Public anthropology might indeed be a strategy to increase intellectual as well as financial capital. It also reflects – but at present, with its focus more on the expression of passion than praxis or pragmatic engagement (Rylko-Bauer et al. 2006), does not promise to answer – a desire, felt quite strong in today's medical anthropology circles: to have an impact on the world around us. This desire is reflected also in the SMA's “takes a stand” project, initiated in 2002 under president Mark Nichter. It has led the SMA to generate policy statements regarding current pressing issues, beginning in 2006. It is a valiant effort (and one that I should disclose having been part of). However, a thin line separates taking a stand based on careful study, and activism masquerading as academics. Marcus's warning about the need to “rearticulate” anthropology (2005:694) may be overstated but we must certainly avoid further disarticulation by demanding of ourselves – and rewarding – more original, pragmatically engaged, theory-generating scholarship.

The central fact that what Marcus calls a “strong wave of critical thought” (2005:679) ran through the humanities and then into anthropology in the 1980s cannot be denied. It also is the case that many more recent developments in medical anthropology have been greatly influenced by ideas from without the anthropological field. Whether anthropology in general and medical anthropology in particular can claim future kudos as a key generative discipline and subdiscipline rather than accepting relegation to a merely recipient field and subfield remains to be seen. But it does seem that much of today's theory-relevant activity in anthropology is indeed enacted by, and channeled to the parent discipline through, the subfield of medical anthropology.

Methodological developments

Methodologically relevant scholarship, too, is widespread in the medical subfield. I mentioned earlier a concern with medical anthropology's medicalization (Browner 1999). Dissatisfaction with this has increased in the new Millennium; calls for rearticulation here have been vociferous (for fuller accounting, see Sobo 2009). Many condemn the unthinking acceptance of biomedicine's factorial model, which separates health-related situations or experiences into discrete, static units or factors to be counted. Such research pulls experience to bits; it focuses attention on parts rather than the whole and often treats culture as just another factor or variable in a researcher-imposed equation. Instead, a holistic, systems-oriented, comparative approach should be promoted. Researchers should be free to question initial research assumptions, redefine research questions and methods as needed as research moves along, and make sure that various stakeholders standpoints are represented.

It is true today that institutional and structural forces, such as funding streams and the clinical research model so favored in biomedicine, have exerted pressure on the shape of the subdiscipline. However, the above critiques and others like them are gaining an audience not only within medical anthropology but also extramurally, in biomedicine and public health, where experts increasingly recognize the failure of clinical trials-type research to answer all questions and solve all ills. Thus, in addition to contributing various specific data collection and analysis techniques to the general field, medical anthropology has contributed greatly to the nascent growth of a new methodological openness in health research circles.

PERSISTENT DEBASES?

Medical anthropology has been around, as a named subfield, for sixty years now. While debates persist within the subfield, as they should if scholarly progress is to be made, the somewhat spurious oppositions we began with (field-specialist, theoretical-applied, and biological-cultural) have proven bridgeable. The divide between university-affiliated medical anthropologists and those working outside of academia, however, has not been so easily shaken, in part due to organizational factors. A look at the awards offered by the SMA demonstrates this. Practicing anthropologists (as well as academics working in non-PhD granting institutions, where practitioners often prepare) are not well reflected in SMA awards. For instance, there is a doctoral dissertation award, but nothing for a master's thesis. The George Foster Practicing Anthropology Award was instituted in 2004, but all other awards (there are nine in total) concern academic accomplishments. None reward service to the profession, such as Hazel Weidman's history-making organizational work. Not even past presidents of SMA (let alone past board members, etc.) receive present kudos: a list of all former presidents of the society nowhere exists.

How this balance will shift and what, in the bigger scheme of things, any shift may mean for the future of medical anthropology I dare not attempt here to predict. Neither has my research for this chapter prepared me to propose which new tensions will emerge in coming years. I can, however, offer this summary observation: a subdiscipline more attuned to past arguments and achievements might be better equipped for positive future growth.

ACKNOWLEDGMENTS

Numerous individuals supported this effort; this includes particularly our colleagues who previously have written on medical anthropology's history and development and early *Medical Anthropology Newsletter* op-ed contributors (see "References"). I also thank (in alphabetical if no other order) Gene Anderson, Kim Baker, Peter Brown, Carole Browner, Alan Harwood, Tom Leatherman, Robert LeVine, Ryan Mowat, Mark Nichter, Gretel Pelto, Marsha Quinlan, Sharon Stein, and Richard Thomas for specific helpful insights regarding the history of medical anthropology, relevant journals, and the Society for Medical Anthropology. Pamela Erickson and Merrill Singer provided thoughtful editorial guidance, and Mary Bicker helped with the literature review. While the bulk of what I have to say tracks back to others' earlier reports on the state of medical anthropology and of anthropology in general, I alone am culpable for the synthesis herein.

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