

# Medical Anthropology

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Medical anthropology is the study of medical phenomena *as* social and cultural phenomena. “Medical” is an imperious adjective that seems to suggest that medical anthropology is interested in things, thoughts, and practices related to medical science or that it is a branch of anthropology in the service of medicine. It is not; rather, for many medical anthropologists, the opposite applies. “Medical” refers broadly to anything related to health, well-being, sickness, and the treatment of ill-health.

Medical anthropology is first of all social and cultural anthropology – in short, anthropology. It is equipped with all the methodological, epistemological, and theoretical tools and ideas that characterize anthropology as a discipline: contextualization, focus on the emic viewpoint, intersubjectivity, reflexivity; it is explorative, informal in its approach, interpretive, participatory; it prefers guided conversations to formal interviews, narratives to structured questions, seeing (and feeling!) to hearsay, small to large, moving from small inquiries at local sites to the large picture. The theoretical orientations of anthropology are also found in medical anthropology.

Medical anthropology presented itself formally as a branch of general anthropology in the 1960s and “exploded” two decades later into the fastest-growing subdiscipline of anthropology. The explanation for its popularity is threefold. First, medical anthropology offers a wide and fascinating field for ethnography: wide, because there is virtually

nothing that cannot be related to health and sickness; fascinating, because it teases out social and cultural constructions from experiences that appear to be naturally given. The second explanation is that medical anthropology offers the possibility of practicing “useful” anthropology. Insights derived from medical anthropology can be applied in practical work to enhance health and well-being. Useful anthropology is particularly attractive to those who question the morality of an academic enterprise that indulges in the study of human misery without offering anything in return. Third – and perhaps surprisingly – apart from its applied options, medical anthropology is also a fertile field for anthropological theorizing. Its focus on the boundaries of what can be called “cultural” demands new ways of thinking about what constitutes human life. Those boundaries refer to topics such as emotion, subjectivity, intersubjectivity, empathy, morality, suffering, aging, dying, embodiment, sensory perception, and religious experience. Medical anthropology appeals to ethnographers, theorists, and applied anthropologists.

## HISTORY

In the first handbook of medical anthropology, Foster and Anderson (1978, 4–8) point at four predecessors of medical anthropology: physical anthropology, “ethnomedicine,” “culture and personality” studies, and international public health.

Physical or biological anthropologists usually practice within biomedical research and study relations between bodily processes and sociocultural practices such as nutrition,

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migration, work, crime, and violence. In the colonial period physical anthropologists were interested in finding evidence for different stages of physical and psychic evolution among “primitive” populations which confirmed racist ideas and provided justification for the colonial enterprise. Today they are best known for their forensic work in hospitals and laboratories. The overlap between physical anthropology and medical anthropology was most present in the ecological perspective (see further below) of medical anthropology in the 1970s and 1980s.

By “ethnomedicine” (an anachronism), Foster and Anderson mean ethnography focused on “indigenous” beliefs and practices related to health, illness, and healing. The term “indigenous” referred to “non-Western” cultures and excluded ideas and practices within biomedicine. Before medical anthropology was formally launched, such studies usually looked at medical ideas as religious and magical beliefs and at therapeutic practices as rituals. Prominent examples of such ethnographies are Evans-Pritchard’s (1937) study of Azande witchcraft, oracles, and magic, and Victor Turner’s (1967) description and analysis of Ndembu rituals.

W. H. R. Rivers’s published lectures, collected in *Medicine, Magic and Religion* (1924), are widely regarded as the first truly medical anthropological study. Rivers does indeed extensively discuss the *medical* effectiveness and rationality of indigenous practices but the ethnographic quality of his work, derived from observations during some expeditions, is limited. In comparison, Evans-Pritchard and Turner carried out in-depth and prolonged fieldwork before they wrote their ethnographies. The important contribution which earned Rivers the “title” of founding father of medical anthropology was his vision of local medical traditions as an integral part of culture (cf. Wellin 1977).

Foster and Anderson’s third type of predecessor, the “culture and personality” school, thrived during the 1930s and 1940s in American cultural anthropology; examples are Edward Sapir (1884–1939), Ruth Benedict (1887–1948), and Margaret Mead (1901–78). These authors focused on differing personality traits and psychological disorders in various cultures and attempted to account for these variations by linking them to different patterns of socialization and different values in local cultures. It is the theory of cultural production of psychic identities and mental health which provides the overlap with later studies of medical (psychological and psychiatric) anthropology.

Finally, medical anthropology was seen as a development from international public health in which anthropologists advised policymakers and health professionals on local ideas and customs and other factors that might conflict with biomedical principles and thus hinder the introduction of biomedicine-based public health. Benjamin Paul (1911–2005), Charles J. Erasmus (1921–2012), and George M. Foster himself (1913–2006) are prominent examples of this early form of applied medical anthropology.

It seems fair, however, to cast our net further across time and space than Foster and Anderson did and to identify other predecessors of medical anthropology. In nineteenth-century Germany, Rudolf Virchow (1821–1902) was a pioneer in pointing out the link between social and economic conditions and ill-health. Virchow was a medical doctor by training, a leading scientist in cellular biology but also a prominent actor in the founding of cultural anthropology and archaeology in Germany. His concerns about poverty-related disease led him into politics. Virchow was also a prolific writer of books and articles covering the wide field of his interest. He can be seen as an early representative of critical and applied medical anthropology.

One of Virchow's students, Georg Groddeck (1866–1934), argued for a distinction between “disease” (*Krankheit*) and “falling ill” (*Erkrankung*) long before medical anthropologists proposed the distinctive meanings of “disease,” “illness,” and “sickness” (Wolf, Ecks, and Sommerfeld 2007). Somewhat along the same lines, a group of medical doctors and biologists, sometimes referred to as “the Heidelberg School,” began to rethink the biomedical principles of their work. Among them were Viktor von Weizsäcker (1886–1957), Herbert Plügge (1906–73), Thure von Uexküll (1908–2004), and the Dutch physiologist and psychologist Frederik J. J. Buytendijk (1887–1974). In their reflections they criticized various dichotomies that had become commonplace in biomedicine: Cartesian dualism, the separation of theory and empirical observation, and the separation of subject and object. Von Weizsäcker argued against the dominance of biomedicine and its physicalist concept of disease; he saw disease as a meaningful sign of human distress, an expression of unsolved conflicts. He also emphasized the importance of the total context of ill-health. Illness takes place in the pathology of family, marriage, upbringing, and work, as he put it.

The most significant conclusion that can be drawn from this historical sketch is that the first predecessors of medical anthropology were often medical professionals. Doctors who worked outside their own society stumbled on cultural practices that clashed with their biomedical concepts, which forced them to pay attention to these “other” medical ideas and practices. Cultural anthropologists, however, working during the same period in the same cultures, largely overlooked health and medicine as suitable topics for cultural study. They were continuously confronted with disease and attempts to maintain or restore health among the people they studied, but it did not occur to them that those practices could be explored as

both cultural *and* medical. Moreover, early anthropologists were reluctant to tread the field of medicine; after all, anthropology was a discipline that had come into being partly as a reaction against the hegemony of science and biological determinism. At the same time, there was ethnocentrism among anthropologists: indigenous medical practices were not taken seriously. Landy concluded: “the general neglect of medicine by anthropologists betrayed, however unwittingly, an ethnocentric bias toward the very societies with which they were the most familiar” (1977, 4).

That ethnocentrism produced yet another bias. Anthropologists rarely studied their own society until the 1980s, and certainly not institutions and practices that belonged to the field of science. Science was science, not culture. That bias had a paradoxical consequence: critical medical professionals, as we have seen, started to reflect on the social, cultural, and political implications of biomedicine almost a century before anthropologists discovered biomedicine as a field of study. The present interest among anthropologists in medical science and technology, for instance, was preceded by the publications of Virchow, Groddeck, and Von Weizsäcker in the nineteenth century and the beginning of the twentieth.

It is impossible to do justice to the stream of publications on medical anthropology that began to flow during the 1970s when medical anthropology was named and installed as a new subdiscipline in anthropology. Another limitation of this overview is that it does not cover developments in non-Anglophone countries (see Saillant and Genest 2007). Here only some of the key Anglophone publications are mentioned which contributed to the recognition of medical anthropology. These key publications provide excellent – but Anglophone biased – overviews of the work that was carried out in medical anthropology during that early period.

Early reviews which helped to delineate the field included Caudill (1953), Scotch (1963), and Colson and Selby (1974). The first handbooks and introductions into medical anthropology were Foster and Anderson (1978), McElroy and Townsend (1979), and Helman (1984); the last of these, interestingly, was written for health professionals but was widely used on anthropological courses. Charles Leslie's (1976) edited volume about Asian medicine stimulated the comparative study of medical systems. In 1977 Leslie became editor of the journal *Social Science & Medicine*, which around 1974 had opened its doors to medical anthropological work. (Interestingly, the editorial of the first issue in 1967 appeared in four languages, inviting contributions in English, French, German, and Spanish – an initiative that had little effect.) The book that perhaps made the most impact on the establishment of medical anthropology was a voluminous reader collected, edited, and extensively introduced by David Landy (1977). Many of the articles he picked attained a classic status thanks to his selection. John Janzen's book *The Quest for Therapy in Lower Zaire* (1978) was very influential for many years; it stimulated the huge interest in "pluralism" in medical practices and the selective seeking out of care by patients. In 1977 Arthur Kleinman founded the journal *Culture, Medicine, and Psychiatry*, and three years later he published his paradigmatic ethnography about diverse medical practitioners in Taiwan (Kleinman 1980) which heralded a new – interpretive – perspective and confirmed the birth of a new and promising field of study.

## THEORETICAL PERSPECTIVES

It is impossible to present a list of neatly demarcated theoretical perspectives that were or still are employed in medical anthropology.

The picture of theoretical concepts is messy and full of overlapping and crossing (non-existent) "boundaries." This overview will present four theoretical foci that can be discerned in the enormous production of texts in the field of medical anthropology: ecological, interpretive/semiotic, agency, and critical/political-economic.

### Ecological perspective

Ecologically oriented (medical) anthropologists view culture as human adaptation to environment. Health is regarded as the result of successful adaptation to environmental challenges while sickness is the outcome of failure to adapt. The human body is consistently exposed to environmental inputs. Because the organism is slow to adapt to changes in the environment, people devise cultural means to protect their body (wearing clothes, building houses); but cultural adaptation, which often assists, compensates, or replaces physiological adaptation, is also believed to affect genetic adaptation in the long run (cf. McElroy and Townsend 1979).

The ecological orientation in medical anthropology operates in collaboration with demography, epidemiology, biology, and other natural sciences and rarely uses the conventional anthropological tools of participant observation, informal conversation, and empathy. It prefers measurement to qualitative insight, objectivity to intersubjectivity, population to individual. It has, therefore, contributed little to a deeper understanding of experiences of sickness, suffering, and care; its main achievements lie in the field of cultural epidemiology. Ecology-oriented medical anthropologists have shown how diseases are related to pathogenic factors in the environment. A by now classic example is the anthropological contribution to solving the mystery of *kuru*, a neurological disease in Papua New Guinea,

which was found to be related to the practice of cannibalism during funeral ceremonies.

### **Interpretive/semiotic perspective**

Very different from the ecological perspective is the interpretive, experience-near, and semiotic/symbolic approach as practiced by a majority of medical anthropologists from the 1980s until today. Inspired by phenomenology, hermeneutics, and Geertz's plea for a semiotic anthropology, medical anthropologists began to look at health, illness, care, and cure as meaningful experiences. Attention shifted back to the "native's point of view."

An important interpretive contribution by medical anthropology was the distinction between "illness" and "disease," first proposed by Fabrega. The distinction referred to the different perceptions and explanations which doctors and patients advance for sickness. Eisenberg's compact description was: "Patients suffer 'illnesses'; physicians diagnose and treat 'diseases'" (1977, 11). He explicated: "Illnesses are experiences of dis-valued changes in states of being and in social function; diseases, in the scientific paradigm of modern medicines, are abnormalities in the structure and function of body organs and systems." As a tool for tracing other, subtler differences in perceiving and defining sickness, this distinction has proven very useful. Now it is gradually being discarded. It has served a purpose, but also caused confusion. Confusion has arisen mainly from ethnocentric use of the term "disease," which seemed to presume to be "the real thing," that is the professional and Western scientific definition, whereas "illness" was relegated to a label for somewhat naive lay beliefs, where "lay" apparently comprised the thinking of both patients and non-Western practitioners. For the study of the practitioner-patient relationship, however, the distinction between illness and disease has been of great

importance. It has enabled researchers to perceive vast communication gaps between patients and doctors.

Kleinman (1980) suggested the concept "explanatory model" which assumed that different actors in medical encounters develop their own explanations in accordance with their own ideas and concerns. Symptoms of sickness were seen as "symbolic," meaning that they referred to problems and distress that were not directly expressed. Good (1977), in his study of "heart distress" among women in Iran, introduced the tool of "semantic networks." By sorting a wide variety of women's complaints about "heart distress" he was able to sketch the symbolic nature of this illness: "not some disease entity in the 'real world' [but] ... an image which draws together a network of symbols, situations, motives, feelings, and stresses which are rooted in the structural setting in which the people ... live" (1977, 48).

Narratives became a favored tool to get nearer to the existential experience of sickness, pain, and medical treatment, as they provide the patient (but also those involved in cure and care) maximum freedom to tell and illustrate their point of view and their somatic, social, and emotional experience (Good 1984). Narratives are typically performances and "accounts": that is, they not only present but also "defend" and justify the speaker's interests in the matter, as Jocelyn Cornwell (1984) shows in her study of ill-health in East London. Different accounts are strategically used in different social situations. "Public accounts" comply with and confirm the accepted social norms while "private accounts" reveal the personal experiences and further the interests of the speaker. Others emphasized that narratives do not always "exist" in a crystallized form ready for performance but may also be created and improvised in concrete situations.

The relatively invisible and taken-for-granted presence of the healthy body was

another concern of the interpretive trend in medical anthropology. It was in particular the phenomenological work of the French philosopher Merleau-Ponty on the body as a subject (*corps sujet*) and Bourdieu's concept of "habitus" as the "socially informed body" that drew Thomas Csordas's attention to the body as "the existential ground of culture" (1990, 5). Csordas coined the term "embodiment" for the biological incorporation into the body of the social and material world. There is no other way to be in the world and to perceive and sense the world than through our bodies. The body is the nexus of the multiple strings that attach us to the world. It is the "book" that can be read to explore our lives.

In another paradigmatic article, Nancy Scheper-Hughes and Margaret Lock presented a model for using the body as a "heuristic concept for understanding cultures and societies, on the one hand, and for increasing our knowledge of the cultural sources and meanings of health and illness, on the other" (1987, 8). Their suggestion to distinguish personal, social, and political dimensions of the body, each with its own set of experiences and meanings, has been widely followed. The body and embodiment are now central concepts in medical anthropology and cultural anthropology at large. Two outstanding monographs in which the body is presented as a locus of suffering, dependency, and control deserve to be mentioned here. One is the autobiographic "ethnography" of Robert Murphy (1987) about a progressive tumor in his spinal cord which led to disability and ultimately to his death. The other is Emily Martin's (1987) feminist critique of the medicalization of the female body as a children-producing machine. She argues that women are reduced to and locked up in bodies that are dominated by a masculine medical system.

The interpretive/semiotic perspective has been abundantly applied in recent medical

anthropology and it is impossible to provide but a beginning of an overview. In fact, one can hardly think of an issue or theme in medical anthropology which has not been approached from a semiotic point of view: Western as well as non-Western, lay as well as professional, prevention as well as cure, belief as well as practice, health as well as sickness, body as well as psyche, economy as well as culture, public as well as private, repression as well as resistance.

### Agency

The present interest in agency, as social maneuvering or navigating to secure one's interests, was preceded by "transactionalism." Transactionalist theory was originally formulated as an explicit critique of structural functionalism. People were no longer regarded as harmoniously complying with social norms and serving the goals of the community, but seen as self-interested manipulators defying rules, as individuals fighting for their own private or family interests, as "entrepreneurs." Functionalists emphasized continuity in culture, transactionalists change. The former looked at the community, the latter at the individual. Key concepts in the transactionalist perspective were patronage and clientelism, brokerage, network, and the "strong man" – all of which showed ways in which actors can further their personal objectives without openly breaking solidarity.

As traditional societies became more individualized, a transactionalist approach in medical anthropology became more relevant. The penetration of a capitalist economy brought with it more freedom for individuals who used to be highly dependent on their families and local community. New opportunities for the individual included private wages, property, and career, free(er) partner choice, increased personal mobility, and a more individual-oriented ideology. Health

care proceeded accordingly, modulating from largely kinship- or community-based therapy to more private practices. Medical practitioners were seen as entrepreneurs and patients as clients. Modern Western health care proved particularly suitable for meeting the demands of increased individualism. In the first place it was essentially individual oriented (defining disease as an individual problem, and preferring to treat patients in isolation from their community). And in the second place it was “commodified”: everything was for sale. The sale of pharmaceuticals in particular enabled individuals to treat their own complaints without dependence on others (Whyte, van der Geest, and Hardon 2002).

The concept “agency” is usually more used in contrast to “structure” and concepts like hegemony, repression, and structural violence. Agency is then used to demonstrate that people are able to manage their affairs and defend their interests in spite of repression and apparent loss of autonomy. The concept has been particularly fruitful in studies that challenge reports of “victimization” of vulnerable groups. James Scott’s study of “everyday resistance” by Malaysian peasants against a repressive class of rich rice farmers is a typical example. The peasants are apparent losers but they are convinced they have won the struggle over values and reputation. They may be poor but at least they are decent and respected people.

Such agency is particularly well described in ethnographic accounts of women in stressful and repressing conditions. Contributions to an edited volume by Margaret Lock and Patricia Kaufert (1998) show how women respond to medical appropriation of their bodies and other forms of imposed biopower. Their responses are pragmatic within the narrow margins of their situation. Francine van den Borne (2005) describes in minute detail how poor women in AIDS-stricken Malawi calculate their costs and balances

when they engage in multiple partner sex to make a living for themselves and their children. In spite of many constraints and lethal risks they “manipulate norms and relationships to maintain or improve their own position” (2005, 298).

Summarizing, this brief overview of actor-centered perspectives in medical anthropology shows that the early transactionalist studies focused on the agency of the strong who successfully pursue their interests and by doing so transform society, while in the later phase attention was more directed to the weak who manage to eke out a measly existence without changing the “objective” conditions of their life.

### **Critical/political-economic**

“Orthodox” Marxist interpretations of health and health care have always been rare in medical anthropology and have gone out of fashion in general anthropology. But this does not mean that the critical perspective of inequality is not there. The origins and spread of disease have been shown in many instances to be closely related to the working of a capitalist economy. Morbidity and mortality patterns reveal statistical associations with socioeconomic parameters, and qualitative case studies demonstrate how poverty and exploitation constitute enormous barriers for healthy living. Such studies have been carried out both in the industrialized West and in developing countries.

Not only illness but also health care is affected by “modes of production.” Modern Western health care is a product as well as a producer and reproducer in a capitalist tradition. It is part of a system in which profit is a primary aim. That primary aim is realized for example by the “selling” of therapeutic services or by the industry’s deliverance of medicines and medical equipment. On the global and the local

scale, health services are a commodity mainly available for those who can afford to buy them. Higher social classes in the cities of developing countries are better served than the rural poor.

The disparities in health and health care have been exposed incisively by Paul Farmer, who lived and worked for many years in Haiti. Farmer summarizes his views concisely in the introduction to his book *Infections and Inequalities* (2001). The question he raises is why certain people “die of infections such as tuberculosis, AIDS and malaria while others are spared this risk” (2001, 4). The answer lies in social inequality, poverty, structural violence, gender inequality, and racism. His answer is “illustrated” by a multitude of dramatic ethnographic case histories. Farmer accuses his anthropological colleagues of “immodest claims of causality.” By culturalizing the causes they distract attention from the political-economic roots of inequality and from the social interventions that are needed to “cure” people.

In recent decades, local and global inequalities in health have been increasingly addressed and analyzed in Foucauldian rather than in Marxist terms. The focus shifted from what accounts for health inequality to the political force that health and medicine possess. Foucault has pointed out that medicine, together with criminal justice, lends itself *par excellence* as a political instrument to exercise control (“biopower”). Schepers-Hughes and Lock (1987), following Foucault, argued that medicine offers the state the means to exercise control over its citizens. That control appears less brutal than the use of physical violence but is no less effective. Their concept of “body politic” reveals the vulnerability of people in their bodily existence, which needs the care and cure that the state can provide or withhold, or can use to exclude individuals from society.

## APPLIED MEDICAL ANTHROPOLOGY

Mainstream anthropologists tend to be skeptical about applied research. They regard applied anthropology as superficial and divested of theoretical reflection. It is “thin” in order to please the non-anthropological parties that are responsible for policy and practical interventions. Also among medical anthropologists there is uneasiness about anthropology *in* medicine; many prefer to remain anthropologists *of* medicine, critical outsiders.

But critical medical anthropology, as described above, is only credible if it leads to action. Anthropologists owe it to themselves to think practically when they reflect upon their work and position as researchers. Seeing themselves in the web of conflicting interests and contesting parties that constitute their “field,” they cannot afford to shrug off the practical implications of their presence in that field. Rather, concern about those practical implications shows reflexivity and theoretical maturity. Clever reasoning about cultural and political dilemmas and social inequality without rendering an account of responsibilities in the affairs that have been described is not only questionable on ethical grounds but also problematic for reasons of theory. Health inequalities and the appearance of HIV/AIDS in particular have made that insight even more urgent.

In an overview of the anthropology of “global health,” Craig Janes and Kitty Corbett state that “the ultimate goal of anthropological work in and of global health is to reduce global health inequities and contribute to the development of sustainable and salutogenic sociocultural, political, and economic systems” (2009, 169). They mention four areas where anthropologists are well equipped to contribute to this objective: in-depth ethnography which shows how health inequalities work and are maintained in concrete social settings; analysis of the impact of



“global technoscience” on local worlds; critical examination of the role of international health programs and policies; and study of the social and health effects of the proliferation of local private organizations and NGOs.

From the beginning in the 1970s, when George Foster pleaded for anthropological engagement in international health planning, many medical anthropologists have indeed been active in international health as researchers, critical advocates, and internal advisors and as “activists” for human rights, social justice, and ethics. But also “at home” medical anthropologists “applied” their knowledge in medical schools, hospitals, clinics, and community health programs. Practicing anthropology within medicine remains however a delicate balance between distance and involvement.

#### MEDICAL ANTHROPOLOGY TODAY

Today, medical anthropology has grown so enormously and has expanded in so many different directions that any attempt to present an up-to-date overview is bound to do injustice to most of what is being accomplished. One remarkable development that needs to be mentioned, however, is the growing interest and involvement of medical anthropologists in biomedical science and technology. If some of the earlier anthropological approaches to biomedicine were outspokenly critical (e.g., Martin 1987; Lock and Gordon 1988), this is less the case today. Good et al. speak of a “profound fascination with biotechnologies and therapeutics” (2010, 1). Recent work addresses topics like genetics (Sarah Gibbon, Margaret Lock, Gíslí Pálsson), new epidemics (Paul Farmer, João Biehl, Didier Fassin), “biopolitics” (Vinh-Kim Nguyen, Nikolas Rose), “biosociality” (Paul Rabinow), “biological citizenship” (Adriana Petryna), organ transplantation and the

organ trade (Lawrence Cohen, Nancy Scheper-Hughes, Aslihan Sanal), clinical trials (Adriana Petryna), pharmaceuticals (Anita Hardon, Sylvie Fainzang, Mark Nichter), reproductive technologies (Marcia Inhorn, Rayna Rapp, Viola Hörbst, Sarah Franklin), aging (Lawrence Cohen, Mike Featherstone), disability (Benedicte Ingstad, Susan Whyte), HIV/AIDS (Alice Desclaux, Hansjörg Dilger, Fred Le Marcis), death and dying (Sharon Kaufman, Margaret Lock) – and so on.

Research sites are moving to laboratories, hospitals, offices of health organizations and ministries, and pharmaceutical companies. Significantly, two-thirds of a recent reader in medical anthropology (Good et al. 2010) is devoted to studies in the field of biomedical science, technology, practice, and imagination. A recent work by Margaret Lock and Vinh-Kim Nguyen (2010) gives an encyclopedic overview of the work done by medical anthropologists over the past two decades on the impact of biomedicine and biomedical technologies around the world. One section of this book focuses on the importance of recognition of biological variation – the result of the ceaseless entanglement of human biology with evolutionary and environmental forces in addition to historical, political, economic, social, and cultural variables.

The number of journals that accommodate the work of medical anthropologists has increased at least fivefold since the 1980s. Some of the most prominent are: *Medical Anthropology Quarterly* (USA); *Social Science & Medicine* (UK/USA); *Culture, Medicine, and Psychiatry* (USA); *Transcultural Psychiatry* (Canada); *Medical Anthropology* (USA); *Health, Care and the Body* (Netherlands/France); *Anthropology & Medicine* (UK); *Santé et Société* (France); *Curare* (Germany); *AM: Revista della Società Italiana di Antropologia Medica*

(Italy); *Medische Antropologie* (Netherlands); *Kallawaya* (Argentina); *Medicina y Ciencias Sociales* (Spain); and *Viennese Ethnomedical Newsletter* (Austria). Next to these are journals for specific themes within medical anthropology such as children, aging, sexuality, care, science and technology, methodology, and HIV/AIDS. Websites and digital discussion forums abound.

More recent manuals, introductions, and readers in medical anthropology include Johnson and Sargent (1990), Brown (1998), Hardon et al. (2001), Janzen (2002), Baer, Singer, and Susser (2003), Helman (2007), Nichter (2008), and Good et al. (2010).

Teaching courses in medical anthropology can now be found across the globe, including in a growing number of “developing countries.” Job opportunities for medical anthropologists are relatively favorable thanks to the perceived relevance of their specialization for the improvement of human life conditions and the political importance attached to health and health care.

Looking back at the development of medical anthropology over the past half-century, we notice two remarkable shifts. The first is the “homecoming” or de-exotization of medical anthropology: for a long time (medical) anthropologists were preoccupied with “others” and their health-related beliefs and practices and overlooked the social and cultural dimension of medicine in their own society. That myopia has radically changed, as was explained earlier. The old divide between “developed” and “developing” societies seems slowly to be losing its significance. The second major shift is that medical anthropologists who used to be mainly concerned about social and cultural impacts on health and medical practice have now turned about and are exploring how medicine shapes culture and

society. Health and medicine are widely regarded as key values that constitute the quality of life. In studying health in its many ramifications, anthropologists are able to grasp crucial meanings that people attach to their lives.

SEE ALSO: Critical Theory; Health and Culture; Health and Illness, Cultural Perspectives on; Medicine, Sociology of; Qualitative Research Methods; Sick Role

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