Medical Anthropology at the Intersections

HISTORIES, ACTIVISMS, AND FUTURES

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INTRODUCTION | MARCIA C. INHORN AND EMILY A. WENTZELL

Medical Anthropology at the Intersections

The First Fifty Years

In 2009 the discipline of medical anthropology celebrated approximately fifty years of existence. In 1959 one of the first references to "medical anthropology" was made in a publication by a physician-anthropologist named James Roney (1959) titled "Medical Anthropology: A Synthetic Discipline." Roney and Margaret Clark, George Foster, Charles Hughes, Charles Leslie, and Benjamin Paul were among the founders of this nascent field, which blossomed in the 1960s. Through their teaching and programmatic development, these first-generation pioneers spawned a second generation of medical anthropologists, many of whom went on to develop the field in significant new directions. When both George Foster (University of California, Berkeley) and Benjamin Paul (Stanford University) passed away in their nineties in May 2006, medical anthropologists from around the world mourned the "passing of an era" in medical anthropology. This feeling was reaffirmed in September 2009 with the death of Charles Leslie, one of the first medical anthropologists of Asia and one of the founding editors of *Social Science & Medicine*.

This "passing of an era" has caused us to reflect on how far medical anthropology has come as a discipline and on where it is headed. Our goal in this introduction is to sketch briefly the development of the field and the ways in which it has come to intersect with numerous other disciplines. These interdisciplinary intersections are the focus of the book as a whole. However, we provide this overview to orient readers to the field of medical anthropology, noting at the outset that the works cited here represent only a fraction of the huge corpus of scholarship in this burgeoning field.

Since its inception, medical anthropology has been broadly defined as the study of health, illness, and healing through time and across cultural settings (Foster and Anderson 1978; Helman 2007; Nichter 1992). Medical anthropologists study human suffering, as well as the medical systems in place to alleviate that suffering (Hahn 1995; Scheper-Hughes 1992; Strathern and Stewart 1999). Around the world, medical anthropologists analyze the relations among health, illness, social institutions, culture, and political and economic power (Baer et al. 2003; Doyal 1979), combining biomedical perspectives with those that address social and cultural problems through health advocacy and activism (Brown 1998; Singer and Baer 2007). Their work points to the differences in the ways that bodies count: who falls ill and why; who has access to health resources; and where healing is sought. Medical anthropologists have contributed to the study of the production of medical knowledge (Berg and Mol 1998; Lock and Gordon 1988) in fields ranging from reproduction (Ginsburg and Rapp 1995) to international health development (Frankenberg 1980) to the new chronic and infectious diseases (Inhorn and Brown 1990; Manderson and Smith-Morris 2010). They have examined questions of stigma, marginality, and the disabled body (Ablon 1984; Frank 2000). They have probed critical issues of biopolitics, immigration, race, citizenship, and health disparities (Fassin 2007; Good et al. 2011; Harrison 1994). They also look at the intersections of disease and environment (Leatherman 2005) and the structural violence triggered by processes of globalization, neoliberalism, and global capitalism (Farmer 2003; Janes et al. 2006). Amid these macrostructural forces, medical anthropologists have examined the social construction of illness categories, the individual illness narratives used to articulate them, and the social and political hierarchies such categories may produce or maintain (Kleinman 1988; Lindenbaum and Lock 1993; Mattingly and Garro 2000; Good and Good 2008).

On a disciplinary level in North America, medical anthropology is now very firmly entrenched within the larger field of anthropology through its Society for Medical Anthropology (SMA), which has 1,300 members, and its accompanying professional journal, *Medical Anthropology Quarterly*.[1] It is important to note that a similar disciplinary foundation has been set in Western Europe, as demonstrated by the establishment of the European Association of Social Anthropologists' Medical Anthropology Network in 2006.

The practicing side of the profession is also prospering, as seen every two years when the SMA meets with the Society for Applied Anthropology (SfAA), and medical anthropological themes are especially prominent. Given its practice orientation, medical anthropology has often been described as an applied discipline, engaging fruitfully with the allied health sciences (medicine, nursing, public health, bioethics, nutrition, occupational therapy, and social work). Medical anthropology is now well ensconced as a medical social science in universities around the world and in numerous practice settings, ranging from the World Health Organization (WHO), National Institutes of Health (NIH), and the Centers for Disease Control and Prevention (CDC) to numerous private, governmental, and nongovernmental organizations (NGOs) working around the globe.

In addition to its practice orientation, medical anthropology boasts a rich theoretical and empirical scholarly tradition. Many critically acclaimed, medical anthropological ethnographies address topics ranging from embodiment and local biologies to the health problems engendered by structural and political violence.[2] Authors of such work often engage across the social science and humanities disciplines, drawing on history, philosophy, psychology, political science, religious studies, and women's studies perspectives in their ethnographic writing (Good et al. 2010).

With its fifty-year-old foundation solidly in place, medical anthropology is currently expanding outward and interacting in many productive ways across disciplinary boundaries. In her SMA presidential address of 2006, Inhorn described ten key areas of medical anthropological interdisciplinarity (Inhorn 2007a). In 2007 the SMA Executive Board adopted the theme of interdisciplinarity and selected plenary speakers for the first international conference on medical anthropology, which was held at Yale University in September 2009, with Inhorn serving as program chair and Wentzell as co-organizer. More than one thousand scholars from forty-eight countries attended the conference, bespeaking the importance of medical anthropology as a growing global discipline. Many of the founding figures of medical anthropology, who helped to train thousands of students over the years, attended the conference. The conference clearly highlighted the importance of both mentors and students in the social reproduction of the field. In addition to the first generation, many second-, third-, and fourth-generation medical anthropologists attended the

conference, as did members of the SMA's Medical Anthropology Student Association (MASA), who represent the fifth generation and the future of the field in the twenty-first century.

Interdisciplinarity

The goal of this global conference was to examine a number of key fields where some of the most exciting interdisciplinary work is emerging in medical anthropology. In this new millennium, interdisciplinarity is certainly one of the key tropes in the academy. Because medical anthropologists tend to be interdisciplinary in their outlook and training, they are often able to express multiple positionalities within their universities and practice settings. For the next generation of medical anthropologists—including students, who make up one-third of the total membership of the SMA—many of the "cutting edges" of the field of medical anthropology will be found at the intersections of many other disciplines.

Imagining the future of medical anthropology thus requires interrogation of its interdisciplinary history and future possibilities. "Interdisciplinarity" can be defined most basically as one's ability to intersect on a theoretical or methodological level with one or more academic fields. The perceived benefits of interdisciplinarity are many, including improved intellectual creativity and flexibility, the fact that some worthwhile topics of research fall in the interstices among the traditional disciplines, and the reality that many intellectual, social, and practical problems require interdisciplinary approaches (Nissani 1997). As noted by one interdisciplinary scholar, "interdisciplinarians often treat themselves to the intellectual equivalent of traveling in new lands" (Nissani 1997, 201). This practice of traveling across disciplinary boundaries to produce new knowledge resonates well with anthropology's foundational goals, including its commitment to holism and the long-standing anthropological awareness that human cultures, bodies, and experiences are generated relationally, developing at the intersections of histories, peoples, structures, and materialities (Boaz 1982; Jackson 1998; Mauss 1973; Wolf 1982). These insights have led to the development of diverse approaches within anthropology, formalized into the discipline's four subfields, and have paved the way for anthropological adoption of methods and perspectives from other disciplines.

Like any form of knowledge production, interdisciplinary research is a social act, bearing the promise and pitfalls that mark the relational development of new ways of being and thinking. Since research methods encapsulate specific worldviews, which may be differently valorized within and outside the academy, intersubdisciplinary relationships within anthropology have at times generated unease and conflict (Segal and Yanagisaki 2005). The trope of interdisciplinarity has also been critiqued as increasingly "trendy" in the academy but unhelpfully diffuse (Klein 1991) or limited by structural, cultural, and cognitive barriers in the context of academic research and institutional design (Barnes and Jentoft 2009).

Yet, the chapters presented here reveal that intersections between different forms of knowledge production have been formative in the development of medical anthropology itself. All of the authors are among the world's most prominent medical anthropologists, who have made key interdisciplinary contributions to the development of the field of medical anthropology. In each case these scholars were asked to reflect on the intersections between medical anthropology and a related discipline. In the expanded versions of their plenary addresses presented here, these researchers provide models for the practice of interdisciplinarity. Some reveal how forging relationships between disciplines shaped their own careers and anthropological commitments, while others demonstrate the ways that using tools from multiple fields can enrich anthropological analysis and stimulate medical anthropological activism in solving social problems. The contributors offer different understandings of what it means to work and think at the intersections. For example, Lynn Morgan understands these relationships through the metaphor of the "thicket," in which branches intersect both to form an environment and to obscure one's view, while Emily Martin sees them as joined through a process of "grafting."

As a whole, the contributors think through different ways that interdisciplinarity can be achieved in medical anthropology, charting paths for future interdisciplinarity by surveying the field's existing areas of disciplinary intersection. They show that the productive tensions arising when multiple approaches are combined may generate some of medical anthropology's most exciting ways forward. The book's structure provides a model for interdisciplinary engagement. Scholars working at the intersections must first martial existing knowledge produced over the history of multiple fields. Next, they

must question what these intellectual histories and ways of knowing have produced as well as obscured. Finally, they must combine elements of existing approaches in order to ask new questions, generate new answers, and use their knowledge for the solution of human problems. The three parts of the book, "Histories," "Queries," and "Activisms," encapsulate these phases of interdisciplinary research.

It is important to remember that the views of interdisciplinarity presented here developed out of a specific academic and cultural context. The SMA conference attracted scholars from the Global North and the Global South, who presented a diversity of medical anthropological perspectives and approaches. However, the plenary presentations and speakers focused on concerns central to the history of medical anthropology in North America and Western Europe. This book is thus not truly global in scope, nor is it intended as an exhaustive account of all the possible interdisciplinary intersections that have shaped medical anthropology and should inform its future. Instead, it examines nine key intersections, providing a starting point for future interdisciplinary discussions in the new millennium.

Part I: Histories

This section focuses on medical anthropology's intellectual genealogy, including historical antecedents spanning two centuries. The authors demonstrate that early medical anthropology was capacious in its purview, intersecting with physical anthropology, embryology, forensics, museum studies, linguistics, Cold War development studies, and eventually second-wave feminism. As a result, the history of medical anthropology has been crucially shaped by key historical debates on issues of race, class, gender, and empire. As these debates have played out over the decades, medical anthropologists have become increasingly sophisticated in their critiques of inequality and oppression, developing a crucial subgenre known as critical medical anthropology.[3] The chapters in this section artfully blend history and critique in examining medical anthropology's early intersections with three fields: feminist technoscience studies, medical history, and international and area studies.

FEMINIST TECHNOSCIENCE STUDIES

While the early history of a nascent medical anthropology can be traced to the first half of the twentieth century, the second half of the century saw the rise of second-wave feminism, which had major implications for medical anthropology and the discipline of anthropology as a whole. Beginning in the early 1960s, feminist writers and activists began tackling a range of issues, including women's legal rights, work for equal pay, patriarchy and the family, and sexual and reproductive rights. By the 1970s these themes began to be taken up by feminist anthropologists, including feminist medical anthropologists, who launched a major subfield in the anthropology of reproduction (Jordan 1978; Reiter 1975). Over the next decades, many feminist medical anthropologists became interested in reproductive technologies such as contraception and abortion, as well as the potential for overuse and abuse of technologies when applied to women's bodies (Davis-Floyd 1993; Ginsburg 1989; Ginsburg and Rapp 1995; Petchesky 1987; Ragoné 1994; Rapp 2000; Scheper-Hughes 1992). Feminist medical anthropologists' critical insights on patriarchy and biomedicine soon merged with the developing 1980s field of science and technology studies (STS), which also turned the critical lens on the production and reproduction of science, technology, and biomedicine. Like feminist ethnographers, many STS scholars were interested in entering the "backstage" world of laboratories, clinics, operating theaters, pharmaceutical trials, and clinical research sites to offer critical accounts of science, technology, and medicine in the making. By the early 1990s feminist technoscience studies had emerged as an interdisciplinary orientation, championed by a number of major scholars, including Donna Haraway (1985, 1988), Marilyn Strathern (1992a, 1992b), and Sarah Franklin (1995, 2007).

The emergence of this interdisciplinary field is traced by one of the group's early pioneers, Emily Martin. In her chapter, "Grafting Together Medical Anthropology, Feminism, and Technoscience," Martin uses her own biography to trace the history of the intersection between feminist medical anthropology and STS. The chapter shows how the merging of fields continuously provoked new questions and topics of inquiry; in the author's own scholarly trajectory, these topics ranged widely from reproduction to immunology to brain science. The chapter also refutes the notion that scholars work in isolation,

instead showing how conversations between scholars working across fields spurred insights that profoundly influenced the field of medical anthropology. In looking back Martin also looks forward to the future of interdisciplinary work in feminist technoscience studies and medical anthropology as a whole. She argues that medical anthropologists must seek more serious engagement with problems derived from reductionism, make greater efforts to write about science and medicine for public media consumption, and ask fundamental questions about medical technology and materializing practices, guided by the history and anthropology of science. Through these avenues, Martin argues for the importance of interdisciplinary work that is both intellectually and politically significant.

MEDICAL HISTORY

Medical history may be regarded as medical anthropology's "sister discipline" in the humanities. Although medical historians' work is textually based, while medical anthropologists favor person-centered ethnography (Levy and Hollan 1998), medical historians and anthropologists have shared concerns with the history of modern epidemics (Briggs and Mantini-Briggs 2003; Farmer 1992; Ong 1987; Turshen 1989), comparative medicine in a variety of pre- and postcolonial settings (Adams 1998; Comaroff 1985; Farquhar 2002; Hunt 1999; Taussig 1987), and the emergence of new forms of medical technology (Davis-Floyd 1993; Davis-Floyd and Dumit 1998; Lock 1980, 1993). Most medical anthropologists would agree that ethnography is enriched by attention to history and historiography. Indeed, the discipline of cultural anthropology as a whole has been engaged in a "historical turn," a shift toward the humanities, from which medical anthropology has also benefited. Medical anthropologists have an important role to play at the intersection of anthropology and medical history, combining ethnographic and historiographic methods in their work on medicine, health, and the body, especially in contexts of post–Second World War humanitarian aid and development (Escobar 1995; Fassin 2007), the collapse of the Soviet Union (Kligman 1998; Petryna 2002; Rivkin-Fish 2005), and the dirty wars in Latin America, which produced untold amounts of human suffering (Bourgois 2002; Green 1999; Robben and Suarez-Orozco 2000).

In her chapter "Getting at Anthropology through Medical History: Notes on the Consumption of Chinese Embryos and Fetuses in the Western Imagination," Lynn M. Morgan uses historical sources to capture early medical anthropological interest in issues of race, ethnicity, and reproduction. Through a fascinating historical case study of early twentieth-century Chinese embryo collecting, Morgan shows how the discursive categories of "race" and "embryology" were mutually constituted through the practice of racial embryology, which held that exotic specimens might offer definitive evidence of biologically based racial variation. By creating a retrospective juxtaposition between missionaries (with their righteous abhorrence of putative Chinese "dead baby towers"), anatomists (with their blithe anatomical collecting practices), and anthropologists (who were largely oblivious to the violence engendered by their theorizing), this chapter calls for greater acknowledgment of anthropological complicity in a long-standing project to stigmatize and stereotype the Chinese.

INTERNATIONAL AND AREA STUDIES

Morgan's chapter on China also points to the ways in which medical anthropology's history has been critically influenced by the politics of Cold War engagement in international and area studies. Anthropology as a whole has always boasted of a strong area studies tradition. Since the early twentieth century, anthropologists have immersed themselves in the language, culture, history, and politics of other parts of the world. Medical anthropologists have participated in this area studies tradition through research focused heavily on non-Western medical systems, the health effects of poverty and human suffering around the globe, and the concomitant spread of Western biomedicine, technology, and humanitarian aid. Understanding health problems within their social, cultural, political, and economic matrix has required medical anthropologists to be well versed in the languages, cultures, and histories of diverse world regions. As a result, strong area studies traditions exist within the medical anthropology of sub-Saharan Africa (Boddy 2007; Comaroff 1985; Gruenbaum 2001; Janzen 1992; Smith 2004; Turner 1967), Latin America and the Caribbean (Biehl 2005; Brodwin 1996; Dressler et al. 2006; Farmer 1992; Gutmann 2007; Morgan 1993; Scheper-Hughes 1992; Whiteford and

Branch 2008), East Asia (Adams 1996, 1998; Chen 2003; Farquhar 2002; Greenhalgh 2008; Lock 1980, 1993; Kohrman 2005), and South and Southeast Asia (Cohen 1998; Das 1995, 2001; Nichter 1989; Van Hollen 2003).

However, medical anthropology's participation in area studies has not always been value neutral. Over the past fifty years, part of the field's history has been tied to larger Western political agendas, including attempts to "modernize" and "develop" the non-Western peasantry, attempts to "control" their fertility, and, most recently, efforts at "democratic nation building" through various kinds of medical humanitarian projects. In short the history of medical anthropology is tied to Cold War and post–Cold War politics, as well as the politics of war and nation building in the aftermath of September 11, 2001.

In his critical historical chapter, "Making Peasants Protestant and Other Projects: Medical Anthropology and Its Global Condition," Lawrence Cohen ties medical anthropology's emergence as an organized subdiscipline to the context of American Cold War imperatives of "containment." Against this backdrop, Cohen shows how the "culture" concept came to mark the limits of reason of the agrarian peasantry, who were at apparent risk for interpreting their social suffering as grounds to support Marxist insurrection. These imperatives intersected with the midcentury post-eugenic conception of "overpopulation" as the dominant problem facing development planning elites. This chapter argues that medical anthropology's use of culture as an analytic tool is rooted in the relation between these various political imperatives. It shows how subsequent disciplinary conversations—like the putative distinction between critical and interpretive approaches, as well as many present quandaries in the field—can be reframed in relation to the area studies' concept of "culture regions" and their disciplinary legacy.

Part II: Queries

The critical histories presented in part I underpin the questioning of key assumptions within medical anthropology posed by authors in the second part. Chapters in part II raise fundamental epistemological questions about the meanings of accepted notions within three fields: global public health, mental health, and genetics and genomics. The authors of these provocative chapters examine seemingly self-evident terms such as "global," the usefulness

of medical anthropological concepts like "stigma," and the reenactment of the "nature/nurture" controversy in the move toward increasing geneticization. In each case the authors urge medical anthropologists to rethink some of the most basic assumptions within the discipline and those it engages. However, the chapters are also hopeful, charting new research trajectories for the twenty-first century.

GLOBAL PUBLIC HEALTH

Without doubt, medical anthropology has turned toward the "new" field of global public health (also called global health) with special enthusiasm and vigor.[4] Clearly, medical anthropology's passion for this kind of interdisciplinary work reflects the dire need for both compassion and humanitarian activism regarding global health inequalities and the numerous sources of disease and suffering around the globe. Such global health problems are many, including the three "global killer" infectious diseases (malaria, tuberculosis, and HIV/AIDS); maternal and neonatal mortality due to preventable conditions like malnutrition; the globalization of chronic "lifestyle" diseases such as diabetes and certain cancers; and the health problems caused by war and refugeeism. Many medical anthropologists are now undertaking work at the intersections of anthropology and global public health (Hahn and Inhorn 2009). Global health is front and center in today's public health schools, where many medical anthropologists have received dual training. Global health is also at the heart of the work being done by physician-anthropologists such as Paul Farmer and Jim Yong Kim. It is also the major focus of philanthropic initiatives by such notables as Bill and Melinda Gates, Jimmy Carter, and Bill Clinton. The new journal *Global Public Health* is edited by the medical anthropologist Richard Parker, one of the authors in this book. Numerous medical anthropologists are producing scholarship in the area of global health, particularly in response to the worldwide HIV/AIDS pandemic.[5]

In his chapter, "That Obscure Object of Global Health," Didier Fassin questions why global health has become a leitmotiv in the political and academic worlds. While global health has obvious implications in terms of the spread of infectious disease or circulation of medical knowledge, this chapter explores some of the term's less evident meanings and potentials, as well as some of the false commonsense ideas it carries. It does so through examining

a series of empirical cases and posing major questions about the meaning of "global health," asking how "global" global health really is and how "health" should be understood in global health. Contrary to what is often thought, Fassin shows that the concept of global health, as well as the meanings of the terms "global" and "health," are far from clear; they must be problematized but also superseded. Fassin shows that the global meaning of health depends fundamentally on evaluations of the worth of others' lives.

MENTAL HEALTH

Over the second half of the twentieth century, some of the most important early work in medical anthropology focused on mental health and "ethnopsychiatry," or the ways in which mental health problems were expressed and healed cross-culturally (Estroff 1985; Guarnaccia 1993; Harwood 1981; Hopper 1988; Hunt 1999; Jenkins 2003; Kleinman 1980; Rhodes 1995; Rubel et al. 1991; Scheper-Hughes 1978). Medical anthropologists were interested in so-called culture-bound syndromes (Simons and Hughes 1985), as well as whether mental health conditions could be overcome through the "placebo effect" (Moerman 2002). However, in recent years, the attention to mental health within medical anthropology has shifted considerably, reflecting disciplinary concern with broader issues of social suffering (Kleinman, Lock, and Das 1997). The sources of mental illness are now often seen as rooted in conditions of poverty, homelessness, political violence, and other forms of social disruption (Bourgois 2002; Das 2001; Desjarlais 1997; Jenkins 2003; Young 1995). Led by a group of medical anthropologists, the *World Mental Health Report* (Desjarlais et al. 1995) sought to involve the World Health Organization and other global health agencies in recognizing and overcoming the burden of global mental illness wrought by war, refugeeism, genocide, sexual violence, the HIV/AIDS epidemic, and other forms of inhumanity. Given the persistence of so much human suffering in the new millennium, medical anthropology has a clear role to play in understanding and alleviating the global burden of mental health problems.

In his chapter "Medical Anthropology and Mental Health: Five Questions for the Next Fifty Years," Arthur Kleinman, one of the pioneers of this interdisciplinary field, reflects on medical anthropology and mental health's long relationship and its centrality to the development of medical anthropology as

a robust discipline. Kleinman focuses on the future, drawing on the field of global mental health to present the kinds of theoretical, research, and practical policy and programmatic challenges that will be central to medical anthropology over the next fifty years. In doing so, he poses five critical questions, centering on the differences between social suffering and mental health problems; the need to redefine what is at stake in the most severe psychiatric conditions; the paradox of global pharmaceuticals and their over- or under-prescription depending upon social location; the ethics of caregiving in response to mental illness; and the need to reframe the relationship of science and society in the "golden era" of brain research in order to explore the borderland between culture and the "new" neurobiology. Kleinman argues that posing these questions prepares us to reposition medical anthropology, bringing it closer to cultural psychiatry, epidemiology, ethics, and policy in the implementation of global mental health programs. Such programs could especially benefit the poor in the most resource-constrained settings.

GENETICS AND GENOMICS

It could be argued that the "golden era" of brain research has coincided with the "golden era" of human genetics. The Human Genome Project has led to the rapid growth of genetic science and engineering (Palson 2007; Rabinow 1996b, 1999). The development of new forms of genetic technology, such as DNA and haplotype testing, is revolutionizing forensic medicine, as well as producing new knowledge about hereditary forms of risk (Finkler 2000). Assisted reproductive technologies (ARTs) are now intersecting with genetic testing, leading to the development of a field called reprogenetics (Franklin and Roberts 2006; Inhorn 2007b). Medical anthropological interest in new forms of subjectivity emerging through the rise of genetic testing is growing, particularly as anthropologists of reproduction turn their attention to genetic risk assessment within pregnancy (Browner et al. 2003; Rapp 2000; Taylor 2001, 2005).

In her chapter "From Genetics to Postgenomics and the Discovery of the New Social Body," Margaret Lock asks how the biomedical technology of genetic testing, as well as genetic and genomic research, is bringing anthropology's early interests in kinship and the so-called nature/nurture dichotomy back to the fore, demanding reinvestigation of their social ramifications. Lock's chapter opens with a discussion of the concept of "heredity" and its transformation

in the scientific world in the early part of the twentieth century into the discipline of genetics. The era of Mendelian genetics has recently been radically transformed by postgenomics—described by some as a paradigm shift, in that it explicitly recognizes genetic complexity and uncertainty. Lock asks how medical anthropological research on these subjects is increasingly being used in clinical practice, highlighting the repercussions of this scholarship and its application for kinship, human affiliation and biosociality, and new forms of citizenship. The need for recognition of the inseparable entanglement of the material world with socioeconomic, political, and cultural variables is made apparent and meshes with emerging knowledge in the postgenomic era. The chapter explores the research contributions medical anthropologists can make in the understandings of this newly emerging, molecularized, "lively body."

Part III: Activisms

The final section, "Activisms," moves from the conceptual realm of disciplinary genealogies, assumptions, questions, and debates to the realm of action and advocacy. The activist impulse to "do good," "help others," "save lives," and "make a better world" has always been a running theme within medical anthropology. Variously called applied anthropology, clinically applied medical anthropology, action anthropology, and more recently, activist anthropology, medical anthropology that applies research findings to improve health and well-being has been part of the discipline since its inception more than fifty years ago. Although much of the recent advocacy and activism in medical anthropology has focused on global health interventions (Hahn and Inhorn 2009), there are many other domains in which medical anthropologists work for a better and more just world. The authors in the final section highlight medical anthropological intersections with three fields: disability studies; public policy; and gender, LGBT, and sexuality studies, where scholarly activism plays a central role.

DISABILITY STUDIES

Medical anthropology's interest in disability studies grew along with the interest in genetics and genomics described above. Early on, activist scholars, some of them disabled, formed a disability studies special interest group within SMA

and began ethnographic explorations of the lifeworlds of adults whose genetic conditions had led to disability. The topics covered were wide-ranging and included classic studies of adult deafness (Becker 1983), limb reduction defects (Frank 2000), dwarfism and a variety of degenerative conditions (Ablon 1984, 2002), and autoethnography of disability experience (Murphy 2001). The seminal work *Disability in Local and Global Worlds* (Ingstad and Whyte 2007), now in its second edition, proved the importance of medical anthropological ethnography in understanding embodied difference in the lives of the disabled around the world. Still, the potential of medical anthropology to explore the world of disability studies has yet to be fully realized. This will become increasingly apparent with the global expansion of an aging and disabled population.

In their chapter "Anthropology and the Study of Disability Worlds," Rayna Rapp and Faye Ginsburg argue that anthropology has not attended well enough to disability, given that disability is one of the most universally experienced forms of difference. This neglect is apparent in spite of anthropology's foundational claim to study human diversity in all its aspects. The authors ask why anthropology seems relatively averse to focusing on disability. They then challenge medical anthropologists to incorporate disability more centrally into anthropology's canon, arguing for the value of such work on both epistemological and existential grounds. Rapp and Ginsburg also highlight their own work as "activist scholars," who are "engaged" in this field as mothers of disabled children and disability rights activists who are working for change. Their chapter highlights the problem of learning disability (LD) and describes the authors' attempts to develop innovative programs for those with LDs who are no longer children. This case study of scholarship and activism provides an inspiring example for other medical anthropologists whose personal lives can become the fodder for social change.

PUBLIC POLICY

Since the beginning of the new millennium, the official position of the SMA calls on medical anthropologists to "take a stand" against social injustices, particularly those impinging upon human health and well-being. Through its "Take a Stand" initiative begun under the presidency of Mark Nichter, the SMA has urged involvement in matters of public policy and has worked on such pressing issues as U.S. ratification of the child rights and tobacco treaties

(SMA 2006; SMA Study Group 2007) and overturning the global gag rule. Nonetheless, it can be easily argued that medical anthropology is less effective in the policy arena than it should be (Singer and Castro 2004). Perhaps if there were more medical anthropologists trained and ensconced in the policy world, the discipline would have more power to influence vital national and international health debates.

In his chapter, "Medical Anthropology and Public Policy: Using Research to Change the World from What It Is to What We Believe It Should Be," Merrill Singer argues that anthropological involvement in the policy arena has a long but conflicted history. In some areas of disciplinary concern individual anthropologists have successfully influenced public policy in productive and beneficial ways. More commonly, anthropologists have expressed frustration that their research findings, however relevant, have been ignored by policy makers. This occurs because the complex "truths" our research produces are often out of harmony with the official, usually simplistic truths formulated by those with influence in areas of anthropological interest, including health, the environment, welfare, and education. Powerful, well-funded lobbies have gained enormous control over the policy agenda, leaving little opportunity for anthropology's input. In this light, this chapter presents a strategy for expanded medical anthropological influence on health-related policy. The proposed approach involves significantly expanding relations with potential allies in the policy arena, namely community-based organizers and activists. This chapter argues that by promoting and fostering collaboration and coalition building—which are stated goals of the SMA—with the national movement of community-based organizers inspired and trained by Saul Alinsky and his descendants, we can position ourselves to participate in leveling the policy playing field and influencing the development of healthy health policy.

GENDER, LGBT, AND SEXUALITY STUDIES

Gender and health has been one of the most productive areas of medical anthropological scholarship and activism over the past four decades. Perhaps because of the aforementioned feminist movement within medical anthropology, or because of the inspiring existence (for more than two decades) of

the SMA's Eileen Basker Prize for outstanding research in gender and health, medical anthropologists have produced a massive amount of scholarship in this area, including more than 150 ethnographic volumes (Inhorn 2006). By engaging in women's lives, medical anthropologists have contributed considerably to theoretical debates surrounding issues of embodiment, reproductive agency, the intersectionality of oppressions, and women's resistance to health-demoting social relations and conditions. They have also pushed for social change through involvement in feminist movements for reproductive and sexual rights. In recent years these issues and social mobilizations have also been taken up by scholars interested in masculinity (Gutmann 1996, 2003, 2007), LGBT studies (Levine 2008; Lewin and Leap 2002), and sexuality studies in the era of HIV/AIDS (Parker 1991, 1999; Parker et al. 2000). For medical anthropologists working at the crossroads of gender, LGBT, and sexuality studies, "the personal" is often "the professional"; to wit, scholarly engagements may be intertwined with life experiences involving oppression based on gender and sexual orientation. Such engagements, in turn, may produce the activist desire to agitate for greater gender, reproductive, and sexual rights.

The final chapter, "Critical Intersections and Engagements: Gender, Sexuality, Health, and Rights in Medical Anthropology" by Richard Parker, is clearly linked to the first chapter by Emily Martin, creating a kind of medical anthropological Mobius strip of interlinked histories, activisms, and futures. In his chapter, Parker surveys the wide range of intellectual and activist concerns related to gender, LGBT issues, and sexuality, as reflected in work carried out by medical anthropologists for more than four decades. Parker focuses on some of the key historical processes and events that have shaped the development of this work, including the importance of social movements in shaping the context of research and analysis; the impact of the global HIV/AIDS epidemic; the paradigm shift from population control to reproductive health and rights; and the emerging focus on sexual rights. The chapter highlights the author's own long-term activist engagements in the Brazilian HIV/AIDS movement, including his cofounding of the Brazilian Interdisciplinary AIDS Association (ABIA). The history of ABIA presented in this chapter highlights the importance of medical anthropology's activism, offering important lessons and new directions for the field in the new millennium.

The Next Fifty Years

This book traces the histories of key intersections between medical anthropology and a variety of important disciplines, pointing out the possibilities for future scholarship in these arenas and presenting hopes for the real-world consequences of such work. Each chapter offers new ways of understanding questions that have formed the ethical core of medical anthropology over the past fifty years. The book highlights nine key avenues for interdisciplinary scholarship in medical anthropology, which can advance the field as an intellectual enterprise and which can enhance the field's responsiveness to human suffering.

However, the future of medical anthropology's engagements with other fields is by no means limited to these nine interdisciplinary pathways. The intersections highlighted in this book were chosen because they have become central to the field of medical anthropology over the past half-century of existence. But the next fifty years promise a great deal more to come. Based on our thematic reading of some of the exciting new scholarship presented at the Yale SMA conference in 2009, we would like to conclude by encouraging the development of four critical pathways for future interdisciplinarity by the next generation of medical anthropology scholars and activists. Some of these areas already have rich interdisciplinary histories, while others do not. Furthermore, they do not represent the only interdisciplinary trajectories into the future. However, we believe that these four areas are especially important; thus, we would like to stress them as sites of either new or renewed interdisciplinary development for future generations of medical anthropologists.

- *Medical Anthropology and Caregiving* Caregiving, as Arthur Kleinman (2008, 2009a) reminds us in a powerful series of recent essays, is part of what makes us human, and it is essential to twenty-first-century medicine. A medical anthropological focus on care—by kin, community, and clinicians—appears to be an ideal entry point for deepening connections between theory and practice on many levels. Medical anthropology has a role to play in the ethnographic study and analysis of caregiving (Heinemann 2011; McLean 2006; Mol 2008), as well as in facilitating the art of caregiving through clinically applied medical anthropological work in a number of allied fields. Building on existing discussions of decision making surrounding biomedical care (Kaufman 2005; Levin 1990), scholars engaging with this theme might include medical anthropologist-physicians performing primary care, as well as medical anthropologists working at the clinical crossroads of nursing, social work, bioethics, gerontology, occupational therapy, nutrition, and complementary and alternative medicine (CAM). Judging from the papers, posters, and panels at the SMA conference, there are now hundreds of medical anthropologists working at the intersections of these clinically applied fields. Together, they can move medical anthropology beyond the realm of research for research's sake to prove that medical anthropology itself is a caring profession.
- *Religious Studies and Divinity* In a world divided by ethnic and religiously based violence, it is imperative that medical anthropologists continue to be schooled in the world's religions, including their contemporary global forms and movements (Inhorn and Tremayne 2012). Religion and faith are vitally important to health and healing and are the basis for much medical humanitarianism under the aegis of so-called faith-based organizations. Religious traditions also guide the so-called local moral worlds (Kleinman 1995) of patients and healers in many forms of medical decision making, including end-of-life care. Medical anthropology has a future role to play at the intersection of religious studies, which could be undertaken not only by scholars of medicine and religion but also by medical anthropologists who are actually trained in divinity and involved in various kinds of pastoral care, hospital chaplaincies, and faith-based public health interventions.
- *Environmental Studies* The health of the environment is of particular concern in the new millennium. Medical anthropology has a major role to play in examining the health impacts of environmental degradation (Johnston 2007, 2011), including global climate change and environmental pollution. In addition, changing environments are leading to rising waters and disasters that will cause massive population disruptions and "environmental refugeeism" (Hugo 1996). Building on long-standing anthropological study of political ecology and the coconstruction of people and environments (McElroy and Townsend 2008; Turshen 1984), medical anthropology can investigate the relationships between changing environments and human health and well-being. Indeed, the intersection between medical anthropology and environmental studies may be the single most

pressing direction for future scholarship and activism in the twenty-first century. Young medical anthropologists working at this intersection should consider seeking interdisciplinary training in environmental studies and/or environmental health.

- *Biocultural Medical Anthropology* Medical anthropological questions have, and must continue to be, answered with analytic tools from both sociocultural and biological anthropology. In many ways biocultural approaches have been truly foundational in the history of medical anthropology (McElroy and Townsend 2008). Despite the potential of such research to account holistically for issues of bodily change and suffering (Armelagos et al. 1992), the proportionally small amount of biocultural work presented at the Yale SMA conference of 2009 demonstrates that this area of potential subdisciplinary intersection could be significantly enhanced. Scholars working at this intersection continue to urge further development of this approach (Goodman and Leatherman 1998; Wiley and Allen 2008), for example, reminding medical anthropologists of the importance of human ecology (McElroy and Townsend 2008); of the health risks of various forms of adversity (Panter-Brick and Fuentes 2010); of the entanglements among heredity, environment, and social context (Dressler et al. 2005; Gravlee 2009);[6] and of the importance of "local biologies" (Lock 1995) or the delicate interplay of hormones and culture (Bribiescas 2008; Panter-Brick and Worthman 2008). We, too, want to remind medical anthropologists that some of our best interdisciplinary conversations over the next fifty years may take place—indeed, *should* take place—between colleagues in biological anthropology, medical anthropology, and the related anthropological subdisciplines. Creating these intersubdisciplinary medical anthropology dialogues may be as easy as walking down the hall to a colleague's office. This, too, should be a key goal for the future of medical anthropology.

PART I

Histories