The Parallel Lives of Biocultural Synthesis and Clinically Applied Medical Anthropology

Leigh Hayden

McMaster University
Department of Anthropology

Abstract
 In this paper, I give a brief history of the development of the school of critical medical anthropology (CMA) and trace its influences on both biocultural synthesis and clinically applied medical anthropology. I show how CMA has had a profound influence on biological and medical anthropology and how it has shaped our understandings of the relationships between biology and economics. I argue that although a critical perspective of health and well-being has been an important and necessary addition to both biological anthropology and clinically applied medical anthropology, we ought to be careful to trace how rather than simply assert that economics influence biology and health. I also argue that CMA's political economic perspective utilizes a narrow understanding of culture, and that biocultural synthesis could do well to look beyond a materialist view of culture and engage other theoretical schools in cultural anthropology. Finally, I show one such potential line of engagement between the disciplines by paralleling the concept of adaptation in biological anthropology to the concept of complicity in medical anthropology.

Introduction

 Medical anthropology is broadly concerned with human health and well-being, situated within culturally mediated expressions of sickness. Medical anthropologists generally understand sickness as both culturally constructed and an embodied reality. Like the body, illness is an "admixture of discourse and matter, one whose inseparability is a critical, though complex attribute" (Rothfield 1992:99). Debates within medical anthropology often emerge regarding how we can practically understand health as a conglomerate of dualisms: cultural *and* biological, shaped by micro *and* macro processes, and a site of domination *and* resistance

(Dressler 2001). Medical anthropologists (along with a great number of other anthropologists – biological, socio-cultural – and other social scientists) dissatisfied with partial or simplistic understandings of human health are searching for more complex (and hence more valid) models, ones that adequately come to grips with the body as both biological and cultural. However, in practice, it has proven difficult to develop a satisfactory theory that adequately addresses both. Thus, we seem to be "dangling from a pendulum that swings from cultural and psychosocial explanations to anatomical and physiological explanations" (Romanucci-Ross 1991:423).

In this paper, I will trace the development of the school of Critical Medical Anthropology (CMA) and its impact on both biocultural synthesis theory and clinically applied anthropology to show how CMA has profoundly influenced the discipline's desire for a more complex and political understanding of human well-being. I will then outline the problems and possibilities of applying biocultural synthesis theory to clinically applied anthropology. I argue that dialogue between biocultural synthesis and clinically applied anthropology will enhance both disciplines. Such a discourse will introduce a more sophisticated view of culture into biocultural synthesis. Likewise, clinically applied anthropology can gain by incorporating biocultural synthesis's revised concept of adaptation. A true biocultural synthesis, one that obliterates dualisms and finds a new way of seeing, will be possible if we begin approaching research questions from radically different points of view. Perhaps opening lines of discussion between biocultural synthesis and clinically applied anthropology will be one of many radical steps (although this step may not look so radical from outside the discipline) medical anthropologists begin to take.

Critical Medical Anthropology

Baer and Singer, the "Godfathers" of critical medical anthropology, first coined the term in a paper presented at the 1983 American Anthropological Association Conference (Singer and Baer 1983). Their purpose was to call attention to the impacts of the global capitalist system on health and health status, while maintaining an intimate understanding of local customs and conditions. CMA thus orients medical anthropology towards an understanding of the social and political determinants of health (thereby advocating for

the marginalized and oppressed), while maintaining anthropology's expertise.

> While a critical perspective asserts that, in the final analysis, macro-level structures and processes are dominant, and that much past work in medical anthropology has not sufficiently attended to this fact, it also maintains that a thorough understanding of any particular issue requires exploration of micro phenomena. Herein lies the unique contribution of anthropology, a discipline long devoted to close-up examination of local populations and their life ways, worldviews, and motivations for action, to the encompassing holism of the political economic approach. (Singer 1986:128)

This approach stresses the importance of both micro and macro-level analysis, and maintains that a thorough, truthful, rigorous, and ethical approach must link the two. CMA promotes four levels of analysis: (1) macro-social, (2) intermediate social, (3) micro-social, and (4) individual (Singer and Baer 1995). It is a top-down approach, as evident in Singer and Baer's (1995:65) description:

> CMA's understanding of health issues begins with analysis of the impact of political and economic forces that pattern human relationships, shape social behaviours, condition collective experiences, re-order local ecologies, and generate cultural meanings, including forces of institutional, national, and global scale.

To comprehend macro-level phenomena, CMA draws on the political economy of health[1] (Morgan 1987;Singer and Baer 1995), a school which first attracted the interest of medical anthropologists in the early 1970's (Singer and Baer 1995). A seminal conference entitled "Topias and Utopias of Health" was held in Chicago in 1973 and featured health studies by social scientists influenced by political economy. The book "Topias and Utopias of Health" (Ingman and Thomas 1975) that developed out of this conference remained the only major anthropological work using a political economic framework for the next decade (Baer 1990). It was not until years later that Morsy (1979) suggested political economy might be the "missing link" in medical anthropology. At that time, it was felt that medical anthropology lacked a strong unified vision, and Morsy (1996)[2] suggested that political economy would bring medical anthropology out of its fascination with small, isolated communities, and link its studies to larger-scale trends.

CMA advocates have not been consistent or transparent regarding which school of the political economy of health they borrow from

(Morgan 1987). According to Morgan (1987:131) there are three major schools of the political economy of health (dependency theory, orthodox Marxism, and the political economy of health), and most anthropologists under the rubric of CMA have been "heavily influenced by one paradigm – dependency theory – without taking account of the criticisms levelled against it". Dependency theory draws on the works of Arthur Gunder Frank and Emanuel Wallerstein, who argue that in the "world capitalist system" resources flow from "satellite" to "core" regions. According to this school, "medical imperialism occurs through the same channels as capitalist expansion because it extracts trained health workers, creates new markets for drugs, and reinforces class relations" (Morgan 1987:137). Just as prosperity in core countries is made possible through resource extraction from peripheral countries, inequalities in health are due to global forces that extract health and livelihood (in terms of knowledge capital, resources, and infrastructure capacity) from the periphery to the core. Thus, "capitalism" is equated with the world capitalist market, enveloping all countries, regardless of their primary mode of production. Much of Farmer's (2003) work could be classed in this category.

The second school is the orthodox Marxist approach, which argues that the organization of labour under a particular mode of production is a major determinant of health and how health care is organized (Morgan 1987). In the case of capitalism, health is related to one's access to the means of production. Health status is a function of class. The proletariat, who do not have access to the means of production, suffer different types of illnesses and generally have poorer health than the petit bourgeois and the bourgeois. Health care services under capitalism function primarily to expand markets and profit. Gaines (1991) contends that this school does not pay careful attention to Marx's notion of ideology, and uses a simple materialist reading of Marx. Singer's (1986) and Morgen's (1986) work fall into this category.

The third school of the political economy of health is the cultural criticism school. Adherents argue that the culture of biomedicine reinforces gender, race, and income-based inequalities. Followers analyze social relations in terms of unequal power relations but do not use a formal class analysis. This approach seeks to reform biomedicine, whereas the first two schools seek revolution (Morgan

1987). Navarro (1976) critiques medicine under capitalism for individualizing patient-healer interaction and ignoring the context within which conflict occurs. Stebbins' (1986) work on medical services in rural Mexico falls into this category.

Morgan (1987) asserts that critical medical anthropologists need to be both explicit about which school of political economy of health they are using and address its drawbacks. According to dependency theory, all countries that participate in the global market, whether their dominant mode of production is capitalistic or not, are equally impacted by the world economic system (Morgan 1987). Dependency theory does not encourage complex local understandings of the health impacts of particular social relations and environments. As Gaines (1991:229) keenly observes: "it conceals and/or avoids the very real thoughts, experience and actions of people at local levels".

Morgan (1987) suggests that a detailed political economy of health analysis ought to emphasize class in order to highlight both social and economic relations. Scholars under the rubric of CMA have used both an orthodox Marxist approach and a dependency theory approach in their studies, although more CMA writers have started to adopt the orthodox Marxist approach (Morgan 1987). The orthodox Marxist approach is more congenial to CMA studies because it allows for a detailed analysis of social relations and does not assume that capitalism (or biomedicine) is the same everywhere. However, as Gaines (1991) reminds us, orthodox Marxist analysis is historically and geographically situated and applying it indiscriminately is a form of Eurocentrism.

CMA claims to overcome two major weaknesses in "conventional" medical anthropological studies – its medicalization of illness experience, and its inability to consider the health impacts of global socio-economic processes. Medical anthropology has been widely criticized for using biomedicine as the standard for evaluating other health and healing systems and for taking biomedical categories at face value (Bates 1990; Browner 1999;Gaines and Hahn 1985; Lazarus and Pappas 1986; Morgan 1990; Singer and Baer 1995). By understanding other health systems primarily in comparison to biomedicine, medical anthropologists become guilty of ethnocentrism. Moreover, giving priority to Western medicine ignores the social construction of all medical categories.

Secondly, CMA espouses an understanding of health within the "context of the class and imperialist relations inherent in the capitalist world system" (Singer 1986:128). Taking a blend of orthodox Marxist and dependency theory approaches, CMA links health disparity to both class struggle and the pooling of resources and livelihood from satellite regions. This is perhaps the most salient and unique feature of CMA – its encouragement to understand local studies within the context of class and imperialist relations. As Singer (1989:1198) notes:

> While it is a strength of anthropology to never expect uniformity across populations (or even within populations), this strength becomes a weakness if it produces inattention to the unifying effects of phenomena like proletarianization, commodification, and mass advertising.

Singer (1986) maintains that analyzing local level interactions and relations without "reassembling" them to elucidate their interconnectedness falsifies reality. Thus, in this manner, layering a political economy perspective with conventional anthropological studies of small groups is a way of obtaining a *true* perspective of *reality*. Conventional medical anthropologists who do not do this, by corollary, maintain a distorted view of reality and have weaker claims to truth. However, deconstructing abstract phenomenon such as mass advertising is challenging and scholars often assume rather than trace their effects.

It is suspicion of Singer's "unifying effects" that has encouraged some medical anthropologists to develop a sub-field of CMA, known as "critical-interpretive medical anthropology". They argue that supra-individual forces tend to depersonalize medical anthropological studies,

> by focusing on the analysis of social systems and *things,* and by neglecting the particular, the existential, the subjective context of illness, suffering and healing as *lived* events and experiences. (Scheper-Hughes and Lock 1986:137)

Critical-interpretive proponents agree with CMA's critical and oppositional stance toward biomedicine, but believe that a political economic approach does not adequately capture the lived experience of suffering and torment, and prefer to take a more phenomenological and interpretive approach.

> We argue… the most "truthful" way of regarding illness is one that pierces the hidden meanings, the metaphors of illness, the messages in the bottle through which patients, and society at large express their

horror, their repugnance (and their protest) at suffering, illness, and decay. (Scheper-Hughes and Lock 1987:138)

This school shares CMA's perspective that there is a revolutionary component to illness. CMA prefers to focus on the structural violence of illness, whereas the critical-interpretive camp prefers to focus on the "repugnance" of the ill. This camp is concerned with understanding how personal illnesses are metaphors for social and global inequalities and problems (Kaufman 1988; Scheper-Hughes and Lock 1987). Gaines (1991) criticizes Lock and Scheper-Hughes for being prescriptive (like "Marxist" CMA) and synchronic.

However, Singer and Baer (1995) claim that the phenomenologists are re-inventing the analytical wheel, and that CMA aims to do precisely what these critics say it lacks. Singer and Baer (1995:45) argue:

> The examination of sufferer experience, situated in relation to socially constituted categories of meaning and the political-economic forces that shape the contexts of daily life is *central* to the project of critical medical anthropology.

CMA, thus, has all of the strengths and none of the weaknesses of both the political economic studies of health and conventional medical anthropology. It is the ideal theoretical concept, flexible enough to include both the phenomenologists and the medical Marxists. It is my position that Singer and Baer are not only guilty of over-extending themselves, but they incorrectly equate micro-level with interpretive analysis. Trying to situate CMA as the dominant theoretical perspective in medical anthropology, Singer and Baer superficially read their "competitors".

CMA also claims to adequately account for human-environment relationships. Singer and Baer (1995) admit that initially CMA did not adequately focus on ecological factors in health, but this trend has reversed. As part of its Marxist leanings and holistic view, CMA draws from political ecology approaches inspired by both the original works of Marx and Engels and neo-Marxist teachings (Baer 1996). This discourse with political ecology "seeks to transcend the productivist ethic and inattention to the contradictory aspects of society-nature interaction that have characterized much political-economic analysis" (Singer 1998:112). To CMA, political ecology is a matter of political economy, as the very global forces that shape and are shaped by the social environment also shape and are shaped

by the natural environment.

I have argued that CMA has tried to build a theoretical platform based on a variety of disparate theoretical schools (such as dependency theory, orthodox Marxism, and ecology) – bringing together their various strengths in order to create a richer, more holistic, and potentially dominant vision. However, CMA defines itself as much for what it opposes as what it aligns itself with. CMA developed out of a reaction against conventional medical anthropology, and in particular, both older incarnations of biocultural theory (otherwise known as medical ecology) and clinically applied medical anthropology. In the following section, I will outline how CMA's promotion of particular research orientations, and its often-derisive critiques of others, has profoundly influenced both biocultural synthesis as a theoretical school and the field of clinically applied anthropology as an area of research.

Biocultural Synthesis Theory

During the 1992 Wenner-Gren International Symposium entitled "Political-Economic Perspectives in Biological Anthropology: Building a Biocultural Synthesis", leading biological and physical anthropologists met to discuss "fresh, new approaches in which human biologies are understood in broader historical, political-economic, ideological, and sociocultural contexts" (Goodman and Leatherman 1998:5). The goal of the conference was to discuss the possibilities of resynthesizing anthropological specialties. The conference organizers' vision was to develop a "biocultural" theory through combining the schools of ecology, human adaptability, and political economy (Goodman and Leatherman 1998:9).

Biocultural synthesis combines careful studies of human biologies within their particular environmental, historical, and political-economic context,

> to understand how particular local histories shape everyday realities of anthropological subjects, and moreover, how separate communities are connected through larger historical political-economic processes that affect human biologies (Goodman and Leatherman 1998:20).

By understanding conditions such as malnutrition, stunting, and other chronic and infectious diseases as not "maladaptive" but a consequence of unequal access to resources (such as sanitation and fertile land), biocultural synthesis is openly political and committed to human rights.

Like CMA, biocultural synthesis has been profoundly impacted by the political economy of health. Biocultural synthesis draws from the orthodox Marxist school of political economy of health and endeavours to understand the human condition by tracing the connections between social aggregates (Roseberry 1998). These aggregates have no distinct boundaries, and are inextricably connected with others, near and far. Through particular forms of labour, humans develop relationships with each other and the environment, forever shaping each other in the process (Roseberry 1998:79). By focusing on social fields, anthropologists can hope to understand the processes underlying observed data to learn not just *what* health conditions emerged, but how and why.

Biocultural synthesis seeks to understand how local phenomena are connected to wider processes through specific relationships. However, as with CMA, few studies have successfully elucidated these specific relationships (Leatherman (1998) is a noted exception). It is more common to use a political economic approach post facto by overlaying a vague political economic "explanation" over a local study (Gaines 1991; Pelto 1988). I argue that a political economic approach is attractive to biological anthropologists because of its materialist and causal nature. In addition, it is generic enough to apply to most situations. I argue that biological anthropologists (if they insist on using a political economic approach) would be best served by using Roseberry's (1998) framework, simply because it demands intimate layered knowledge of research subjects.

Biocultural synthesis shares a political economic perspective with CMA, and CMA proponents have congratulated these efforts (Singer 1998; Singer and Baer 1995). However, CMA strongly disagrees with the efforts by biocultural synthesis adherents to reconstruct the concept of adaptation to make it more specific and less conservative. Goodman and Leatherman (1998) encourage a "rethinking of adaptation", while Singer (1996) believes that it is a concept that is beyond reform, theoretically repugnant and should be abandoned completely. Other medical anthropologists such as, Romanucci-Ross (1990), are less fervidly opposed to adaptation, but claim it is fundamentally tautological, and therefore useless.

Adaptation became popularized in medical anthropology primarily through the work of McElroy and Townsend, who define adaptation as "changes and modifications that enable a person or

group to survive in a given environment" (1996:11-12). Health, to them, is a measure of environmental adaptation. Adaptation has been criticized by CMA (and others) because it (1) depoliticises (often exploitative) conditions that require "adaptation" (Baer 1990a), (2) blames victims for their inability to adapt, rather than the individuals and groups who instigate the socio-environmental pressure (Singer 1989), (3) promulgates a fundamentally conservative stance, where the "goal" is homeostasis (Singer 1998), (4) incorrectly accepts "nature as a given and separate phenomenon to which human biology is adapted" (Singer 1996:497) and (5) ignores social stratification and social relations (Singer 1989).

Yet biological anthropologists appear reluctant to abandon adaptation. Thomas (1998) has developed a more complex version of adaptation, which understands adaptive processes (which are both biological and cultural) as responses to structural violence and exploitation. Leatherman (1996:479) also supports modifying adaptation to include perspectives from political economy "in order to emphasize a coping process in which the goals, needs, options, and constraints shaping human actions are contingent on changing historical conditions". Landy (1990) on the other hand believes that the problem with adaptation is that it is being used to understand both cultural and biological processes, but it is primarily useful in understanding the latter. Conversely, Alland (1990) believes that it is important to study both biological and cultural adaptation, but one must recognize that they require fundamentally different methods. Biological anthropology's attachment to adaptation is apparent in the emotional and polemic debate between Singer (1989) who offers a scathing critique of adaptation, and Wiley (1992) who valiantly defends the concept. Their prolonged debate (Singer 1993; Wiley 1993) degenerated into a shouting match across sub-disciplines. Debates such as these tend to widen the gap between sub-disciplines rather than shorten it, contrary to the holistic goals espoused by both CMA and biocultural synthesis (Morgan 1993).

Singer feels that efforts of biological anthropologists to "pour new wine into the old wineskin of adaptation" is ultimately fruitless and adaptation should be abandoned because it imposes a Cartesian dualistic notion of human-environment interaction (1996:498). He opposes dualistic thinking and believes that anthropology will continue to spin its theoretical wheels until it sheds itself of such

limiting ontologies. Concepts founded on dualisms are leftovers from the enlightenment project and the colonial enterprise, and therefore anthropology is obliged to eradicate itself of these trappings of European history. Regardless of how well adaptation can be rethought or reformed, it is a fundamentally dangerous notion and must be abandoned.

Even though CMA and biocultural synthesis are highly convergent – they both borrow from the political economy of health perspective to understand and (hopefully combat) health inequalities and they are both interested in how humans shape and are shaped by their environment – they remain unable to agree on the utility of adaptation. However, the congruence between CMA and biocultural synthesis is much stronger than that between CMA and clinically applied anthropology. The debates between these two camps have been less fruitful.

Clinically Applied Anthropology

Medical anthropologists have increasingly turned their gaze towards Western medicine. Some (Hunter 1985) believe that this is a manifestation of the influence of high profile clinician-anthropologists such as Kleinman and Eisenberg, while others (Morgan 1990; Trotter 1997) believe that this trend is a response to job availability. The term "clinical anthropology" was once used to describe anthropological research in a clinical setting. However, debate over the nature of this work – whether "clinical anthropology" ought have a therapeutic aspect, and thus be limited to individuals with both formal clinical and anthropological training (Ablon 1980) – led anthropologists to adopt the term "clinically applied anthropology" to avoid confusion with therapeutic interventions (Chrisman and Johnson 1990). Clinically applied anthropology is simply defined as "the application of anthropological data, research methods, and theory to clinical matters" (Chrisman and Johnson 1990:97).

Clinically applied anthropology is well aware that it is fraught with ethical dilemmas concerning the role of the anthropologist in the clinical setting and his or her relationship with clinicians. Maretzki (1980) believes that the primary goal of the anthropologist in a clinical setting is to document, and the secondary goal to contribute to the therapeutic outcomes of patients. Both of these

goals are problematic. Good documentation of clinical phenomena requires that the anthropologist avoid taking medical categories or medical knowledge as a given (Gaines and Hahn 1985; Kleinman 1985; Kleinman 1977). Medical anthropologists have not been entirely successful at this (Browner 1999; Morgan 1990). I argue that this is because we have internalized many biomedical categories, and because there is pressure in a clinical setting to understand (and thus adopt) technical biomedical knowledge and language. This enables communication and legitimacy, but also is a method of "fitting in".

The flip side to over-familiarization and "medicalization" of clinically applied anthropology is what Toni Tripp-Reimer (1980:21) refers to as the "Robin Hood Syndrome" – the tendency of anthropologists to affiliate with the least powerful and most disadvantaged groups. We *a priori* label the patient as the underdog and not only champion them, but also see ourselves through them (Stein 1980), perhaps because we often share the same culture, background, language and social class (Barnett 1985). Johnson (1995) is concerned with how much unconscious identification with the disenfranchised distort our studies.

Danger of "over rapport" with patients is related to medical anthropology's demonization of both the biomedical model and the imperialist expansion of "biomedical hegemony" (Singer and Baer 1995). Medical anthropologists in a clinical setting must achieve a fine balance between cooptation by biomedicine and romanticization of patients. Lock (1982) once believed that clinically applied medical anthropology could achieve that balance, maintaining integrity as a medical anthropologist "in" medicine.

The second major goal of clinically applied anthropology is to improve therapeutic results. The motivations for improving the efficacy of biomedical therapy is twofold: to improve the health of those who suffer and seek relief (which aligns with applied anthropology's general principle that it must "do" something) and to justify one's research (Browner 1999; Chrisman and Maretzki 1982; Gaines and Hahn 1985). However, when non-clinicians engage in therapeutic work, this can lead to "turf" wars over patients (Johnson 1987; Mathews 1987; Stein 1980). Moreover, conflict may emerge over who can rightfully make claims to improve health care (Johnson 1987; Tripp-Reimer 1980).

Clinically applied anthropology is a complex and sensitive field of work. Due to its proximity to biomedicine and its sometimes-uncritical view of biomedicine, clinically applied anthropology has come under much criticism from anthropologists, primarily those who adopt the CMA label. CMA has two major concerns with clinically applied anthropology: it desires to reform rather than revolutionize biomedicine, and it is too familiar with biomedicine. First, unlike CMA, clinically applied anthropology does not aim to revolutionize biomedicine, merely to observe or improve it. Singer and Baer have been very critical of biomedicine, calling it "bourgeoisie medicine" (1995) due to is "role in the promotion of hegemony of capitalist society generally and the capitalist class specifically" (Singer 1990:183). As such, it is a barrier to emancipation and ought to be revolutionized. Incorporating anthropology into biomedicine further enables it, expanding the medical gaze to non-western regions, and within the western world (Kapferer 1988).

Many CMA adherents assert that by working with biomedical practitioners medical anthropologists are in effect turning their back on the powerless and disenfranchised (in many cases the "sick" are also the "disenfranchised"). Scheper-Hughes accuses clinically applied anthropologists of enabling the "perverse economic and power relations that inform and distort every medical encounter in post industrialized and especially capitalist societies" (1990:191). She encourages anthropologists to desert the establishment of biomedicine and take the side of the "often disreputable, stigmatized and marginalized patients' rights and self-help groups or other critical subcultures of the sick, excluded and confined" (Scheper-Hughes 1990:191-192). The rhetorical appeal of these statements does not go unnoticed by clinically applied anthropologists:

> The great appeal of these assertions about the world of patients, illnesses, and care for anthropologists – who reflexively champion the causes of the disenfranchised everywhere – is obvious. But good practitioners must always question their underlying assumptions about the world, as well as their feelings about the people who are the objects of either study or praxis. (Johnson 1995:107)

Clinically applied anthropologists, aware of their own ambiguous position, urge critical medical anthropologists to keep the same honesty and self-reflection in their own work.

The second major criticism of clinically applied anthropology is that as a field it is too concerned with appearing useful and genial to provide analytic rigour. CMA is fundamentally opposed to biomedical encroachment and imperialism, believes the biomedical model to be reductionist, simplistic, and ultimately dangerous to human betterment as it maintains the status quo. Thus, the idea of anthropologists "tip-toeing through the minefields of the modern clinic" (Scheper-Hughes 1990:191) inserting anthropological analysis where permission is granted enrages many CMA scholars. Translating (and presumably watering down) rich anthropological data to clinicians and health administrators so they can (presumably inaccurately) use it to further their own means seems somehow beneath anthropology (Baer 1993; Singer 1990)

Here I would like to draw a parallel between CMA's absolute rejection of both adaptation and the biomedical model. The rejection of these very different theories is based on CMA's desire to distance itself from the enlightenment endeavour. Both adaptation, by conceiving of a natural world separate from humans, upon which humans act, and biomedicine, which sees disease as a discrete identifiable physiological occurrence, are riddled with dualisms such as human/nature, nature/culture, and mind/body. CMA seeks to rid itself of these dualisms, which are associated with the enlightenment and colonialism. Distancing oneself from colonialism is a rhetorical strategy, implying that one's position is less tainted by the sins of the past and therefore morally sound.

Despite CMA's dismissal of clinically applied anthropology, some clinically applied anthropologists have tried to incorporate a more "critical" analysis into their work. The "critical" movement has infused clinically applied anthropology in two major ways. First, some clinically applied anthropologists are committed to removing the individualism, sexism, classism, and racism inherent in much biomedical practice. They agree with CMA that these unfortunate attributes plague biomedicine, but argue that they are not fundamental to biomedicine, but reflections of wider society (Press 1990). Press (1990) also agrees that biomedicine can and has been used as a mechanism for social control (through normalization and surveillance), and sees this as neither specific to biomedicine, nor inevitable. Biomedicine can be reformed, but this reform must be based on carefully observation and analysis:

If the goal of a critical clinical anthropology, ultimately is change in the biomedical system it is most readily achieved when our analyses and arguments are unassailably comprehensive, and ostensibly objective. (Press 1990:1008)

Clinically applied anthropologists who adopt a more "critical" stance carry this attention to methodological rigour to the other element of the CMA platform they have adopted: multi-level analysis. Press (1990) proposes a multi-level analysis, similar to (but more complex than) the one developed by Singer and Baer (1995). He asserts that a rigorous multi-level analysis will enable the researcher to understand the "*imprecise relationship* between political/economic and medical-interaction factors and… focus our attention upon the *particular manifestations of these values within the clinical encounter*, rather than upon their existence *per se*" (Press 1990:1002, emphasis original). As shown above, the danger of political economy is that it is all too easy to ascribe rather than trace macro-level influences to the micro-level, because tracing the connections is difficult. Press (1990) hopes that a careful and detailed multi-level model will uncover these imprecise relationships.

Despite clinically applied anthropology's attempt to build bridges with CMA, CMA enthusiasts have dismissed the notion of a critical clinical anthropology.[3] Despite CMA's desire to blend theory with practice (Singer 1995), most CMA adherents believe that they ought to do so outside of the clinical setting and develop partnerships with labour unions, self-help groups and women's organizations instead of with clinicians and practitioners (Baer 1990b; Baer 1993; Scheper-Hughes 1990). They believe that working within the medical establishment weakens an anthropologist's ability to critically assess biomedical knowledge and practice. Indeed, one cannot bring down the house one is residing in. The conservative nature of clinically applied anthropology "stems from a perceived need to avoid rocking the boat so as not to be tossed overboard" (Baer 1993:306). Thus, a radical science such as CMA cannot thrive within the borders of the clinic. Morgan (1990) reminds clinically applied anthropologists that to perceive that medicine can't change is to reify it. However, I would add that it will change most readily through coordinated efforts located within and outside of health clinics.

Clinically Applied Anthropology and Biocultural Synthesis: Will Parallel Lives Ever Meet?

The obvious question at this point is; should clinically applied anthropologists employ biocultural synthesis theory? They share a common lineage and common language, and although their methods and research settings are different, could biocultural synthesis be used in the clinical setting? Biocultural synthesis is a broad theory, which in principle can be adopted by a variety of researchers and used in a variety of settings. Moreover, it is a genuine attempt to approach the body and health as both biologically and culturally situated. A biocultural approach could invigorate clinically applied anthropology, which has to date generally focused on the cultural experiences and translations of health and illness, and left the "bio" side to practitioners and "hard science" researchers. However, I am doubtful that understanding human biologies within a political economic framework will accurately account for the translation of illness, organization of health care, and eagerness of the biomedical embrace. I am equally doubtful that this approach will give an adequate understanding of people's motivations, perceptions, and experiences as simultaneously biological and cultural. Clinically applied anthropology can benefit from biocultural synthesis's engagement with adaptation.

I see some parallels between the concept of complicity developing within medical anthropology and biocultural synthesis' attempts to rebuild the adaptation concept. Renovating the adaptation concept is propelled by a desire to understand the decision-making processes of actors who have agency but whose agency is contingent on social factors (both ideological and practical). In the complex worlds we live in, perhaps we (simultaneously biologically, socially, culturally, psychologically) cope, rather than adapt. By understanding these coping strategies, we can understand both the lived experience of our research participants and the immediate forces that constrain them. Some medical anthropologists (Lock 2002; Ning 2005) have begun to look at the complicity of health practitioners, and how their actions and inactions replicate the delivery of a biomedicine that they may not objectively believe in.

By understanding the processes by which both patients and practitioners maintain and naturalize the hegemony of biomedicine (complicity in action), medical anthropologists can get closer to

bridging the gap between so-called "macro" forces and interpersonal relations and dynamics, the so-called "micro" forces. I believe that the concept of adaptation – of coping, coaxing, and sometimes eking through a complex web of social relations – is similar to the notion of complicity, but perhaps with less sinister connotations. It is flexible (both following doctor's orders and being non-compliant can be seen in adaptive terms), but a touch tautological. It seeks not to explain, but rather focuses the researcher on what actors do, under what circumstances, and why. If the goal of both clinically applied anthropology and biocultural synthesis is to aid in the struggle for a healthier, more just world, then I submit the concept of adaptation (or whatever synonym you prefer) will help both camps better understand the context of their research communities, which will help shed light on the factors that catalyze and maintain suffering.

I also believe that biocultural synthesis should expand its cultural horizons. Political economy is just one of many frameworks that can be used to understand human health and suffering. It can be mechanistic and materialistic, which might be appealing to some anthropologists, but will not give them the tools they need to understand lived experience. Biocultural synthesis might familiarize itself with other theoretical schools, such as cultural constructivism (authors such as Geertz (2000), Marcus and Fisher (1986) and Good (1994)). Dressler (2001) has eloquently and convincingly drawn from Bordieu and other cultural theorists to develop a model of "cultural consonance" to understand the relationship between success and blood pressure. Such work attempts to link biology and culture, which are both influenced by macro-level phenomena, but translated and understood locally.

CMA reminds us that biomedicine is a cultural construction, and is but one way of knowing the body. As such, CMA is a valuable critic of the status quo. However, CMA tends to lack self-reflection, and can too easily become a prescriptive analysis. Instead of adopting a more simplistic notion of culture, medical anthropology ought to adopt a more complex notion of biologies. Thus, more two-way conversation with biological anthropologists could help medical anthropology forge new directions. However, it is likely that a non-dualistic, fully-fledged biocultural model will not be developed through friendly academic discourse, but through engaged multidisciplinary practice.

Notes

[1] Morgan defines the political economy of health as: "A macroanalytical, critical, and historical perspective for analyzing disease distribution and health services under a variety of economic systems, with particular emphasis on the effects of stratified social, political, and economic relations within the world economic system" (1987:132).

[2] Morsy continues to use the term "political economy of health", as it is preferable to "critical medical anthropology" because it gives a nod to intellectual ancestors and does less to alienate them (Morsy 1996, 10).

[3] Wiley (1993) has also noted CMA's unwillingness to incorporate any of the wisdom of biocultural synthesis into its own framework, despite CMA's enthusiasm for dialogue.

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