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Contextualising the body: Anthropology, Biomedicine and Medical Anthropology

Ivo Quaranta

Dipartimento di Scienze Antropologiche, Archeologiche e Storico-Territoriali, Università degli Studi di Torino (Italy)

> «It is probably no fluke of intellectual history that a turn toward the body in contemporary scholarship in the human sciences has coincided with the realisation that the post-modern condition is now the uneasy condition of all intellectual activity» (Csordas T, 1994: xi).
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> «... the contemporary discourse on the body has emerged as one of the major manifestations of a crisis in the intellectual politics and epistemology of Western social thought» (Turner T. 1994: 29).
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> «It was agreed that our subject matter is neither simply medicine as an institutional body of scientific knowledge nor the human body as unproblematic product of nature, but rather is a study of the creation, representation, legitimisation, and application of knowledge about the body in both health and illness» (Lindenbaum S. and Lock M., 1993: x).

In this paper I will discuss the contribution of medical anthropology to its parent discipline in terms of the re-conceptualisation of the body as an historical domain and a socio-cultural process. The argument I propose is that such a turn towards a new image of the body would not have been possible without the emergence of an anthropology at home, in the form of an anthropology of biomedicine. Once the body is investigated against the historical practices of its constitution a new horizon, both theoretical and epistemological, opens up for researchers to re-conceptualise their analytical enterprise.

1. Modernity, postmodernity and anthropology at home

Post-modernism represents an epistemological turning point: subjecting the entire Western enterprise to critical scrutiny, it determines the end of a

unitary and universal conception of the self and in turn the death of the "natural", bounded body (Martin, 1992). In this new intellectual landscape the body seems to emerge as a new horizon, allowing a re-orientation of the discipline toward a new view of culture, self and its identity as well.

A new body is playing its role on the stage of social sciences and humanities, moving away from its conceptualisation as a natural, given and bounded entity. Such a shift is to be seen as a consequence of the dissolution of the cultural project in which the previous body was rooted. Only recently appropriate anthropological attention has been paid to modernity in terms of a cultural project. Early anthropology and modernity can be considered as being epistemologically linked to each other: anthropology actually represented the sight of modernity on other cultures (Remotti, 1993). Anthropology contributed in creating a modernist identity, defined against societies conceptualised in opposition as traditional, developing and the like. In such a wave of anthropological thought, modernity has been functioning as an explanatory principle, providing anthropologists with their categorical apparatus, and not as something to be explained or problematised. Thanks to this epistemological position, modernity has hidden itself from anthropological inquiry. In this way an opposition was fashioned between science and culture (body and mind, individual and society, material and ideal, disease and illness, etc.). And it was culture that anthropology used as the conceptual means to represent other societies, and find a reason behind their different practices and beliefs.

It was only when such an organic (epistemological) unity (complicity) between anthropology and modernity broke down that Western enterprise in all its aspects could eventually become the focus of anthropological attention. Such a detachment between anthropology and modernity, in which the latter becomes visible to the former, must be understood in a broader context. As Beck claims, the processes of globalisation and industrialisation have brought about a new modernity, a reflexive one indeed, in which «scepticism is extended to the foundations and hazards of scientific work and science is thus both *generalised* and *demystified*» (Beck, 1992: 14).

Indeed the relation between modernity and post-modernity is best conceived of as an epistemological one. In fact post-modernism does not consist of a specific methodology, of a new style and theory, rather it refers to a modern awareness of itself (Dei, 1993).

It is within such a context that an anthropology at home becomes possible, enabling the researcher to investigate the generative processes of what most of us take for granted about ourselves and our social reality. Among others,

one of the fields that has been undergoing critical scrutiny is certainly the biomedical one, approached now as a local set of practical and theoretical devices for the construction and interpretation of illness and healing. An anthropology of biomedicine in other words emerges from a general process of rethinking the observer's categorical apparatus and history. The anthropological categories themselves, developed after many years of research in different contexts, come to be used upon our own society. The analysis becomes more and more reflexive: the observer's culture and categories become the object of his/her own analysis. The relationship between biomedicine and anthropology then becomes one between a discipline and its object of inquiry.

In order to contextualise this argument I shall now give a brief historical review of the relationships between anthropology and biomedicine.

2. Anthropology and Biomedicine

2.1. Early anthropology and biomedicine

The relationship between anthropology and biomedicine can be seen at different layers and stages. If we think of Evans-Pritchard's study of witchcraft (1937), or Rivers' contribution to ethnomedicine (1924), we can see that the interest in "medicine" is an early one indeed. But, was there already a relationship between these early anthropological analyses and biomedicine? And if there was, what kind of relationship was it? Certainly not one in which biomedicine was an object of anthropological inquiry. It was precisely in such an "absence" that we could detect the presence of biomedicine in early anthropology. In fact it is possible to trace an organic (epistemological) link between the absence of any anthropological inquiry of biomedicine and its use as the implicit background against which anthropology looked at different cultures. Within such studies, science was seen as the ground on which Western societies developed beyond the realm of cultural conditioning. "Culture" instead was the appropriate means for investigating and representing the beliefs and practices of different societies. These became coherent in their terms, but still of a different nature, when compared to the "West".

Absent from traditional anthropology was an awareness of how scientific culture was actually conditioning the very structure of the inquiry (Lock and Scheper-Hughes 1990; Good, 1994; Singer and Baer, 1995; Young, 1982). In this sense, it is possible to identify the very first tie between bio-

medicine and anthropology, the first of which provided the lens for the second to look at other cultural contexts.

2.2. Anthropology and International Health

After the Second World War anthropologists were called to intervene in several programs of International Health (Good, 1994: 26; Singer and Baer, 1995: 24). The relationship between the two disciplines then becomes explicit in so far as anthropologists come to be directly involved in health education and health related issues, but it is still implicit in epistemological (and political) terms. As Foster argues:

> «Quite uncritically the superiority of modern medicine and modern health care delivery was taken for granted, and the task was defined as the study of client groups to determine how modern medicine could be made most attractive to them.» (1980: 849-850).

In other words, Western medicine and values were assumed as universally valid and local cultures as the sources of resistance to be overcome in order to spread scientific knowledge. Biomedicine was therefore working within international health programs as the hegemonic system orienting research and action, and defining the very nature of the problems on the agenda. In stressing the hegemonic dimension of biomedicine, we come to realise that the problem of international health was not of a moral and psychological nature, but rather a structural and epistemological one and, as such, it required the development of a self-critical scrutiny.

It is only in the 70's that medical anthropology comes to complete its process of construction as a legitimated subfield within cross-cultural studies and anthropology. The relationship between anthropology and biomedicine then becomes completely explicit, even though their theoretical positions are different. It is then that we can locate the birth of the cultural study of Western medical systems.

2.3. Toward an anthropologically informed medicine

In the process of debating the definition of medical anthropology's identity, at least two "souls" were engaged. The first one, drawing on the findings of the new cross-cultural psychiatry and symbolic anthropology, is identified with a group of scholars who proposed that the cultural construction of personal experience should be considered as their object of inquiry (Kleinman, Eisenberg, Good, 1978). In other words, medical anthropology had to look at the cultural adaptation of patients to sickness episodes (Kleinman, 1978, 1980).

In such a view, fundamental importance was played by the concept of the Explanatory Model (Kleinman, 1978). With this concept, these authors referred to the different cultural constructions of clinical reality: the ways through which people make sense of their health problems. Central to such an approach was the recognition of the symbolic features of every Health Care System (Kleinman, 1978: 86) – Western ones included – and of the role of effective communication in the healing process. In this project, therefore, the role of the anthropologist was thought of as being that of cultural interpreter, mediating between different cultural constructions of a sickness episode. In fact, patients and doctors are seen as two parties producing different interpretations rooted in their respective socio-cultural context. Disease and Illness (Eisenberg, 1977) come to be represented as different cultural constructions of clinical reality, rooted in the biomedical scientific paradigm of doctors, and in the existential and socio-cultural context of the patient. In such a framework the application of anthropological knowledge was conceptualised at the level of medical encounter. These authors' most famous contributions of the early 80's were precisely concerned with such a level of clinical reality [(1)] and their aim was to create a bio-psycho-social model (Engel, 1977) «that systematically analyses the clinically relevant effects of socio-cultural determinants on sickness and care» (Kleinman, 1980: XII-XIII). In order to achieve such a goal, anthropologists had to enter the clinical setting and, in so doing, it was of fundamental importance not to subvert the established roles of medical professionals and their priority for therapy (Chrisman and Maretzki, 1982). Anthropology, in other words, had to adapt itself to the clinic, and to help medical staff to provide patients with a more humane treatment, by negotiating between the different perspectives involved in the medical encounter (Katon and Kleinman, 1981) and supporting effective communication and mutual understanding.

As far as our discussion here is concerned, it is necessary to stress how these scholars' concern with the cultural construction of illness experience obscured to some an extent the analysis of the constitutive processes of *disease* [(2)].

2.4. A critical approach to biomedicine

The other "soul" of medical anthropology's identity came from a more sociological standpoint and raised issues of a different nature. Biomedicine was always thought of as a cultural system, but in order to be properly examined, it had to be located within its socio-political context. In opposition to the previous approach, the anthropologist's role was seen to be that

of a critical analyst of the social context of culture production, investigating the social interests behind every definition of reality. The biomedical construction of reality is critically assessed, and issues of power and inequality are raised. The very relationship between anthropology and biomedicine then changes its features: from collaboration with and within biomedicine, to the latter socio-political critique.

Within this approach, medical anthropology was trying to define its problems independently of biomedicine, in so far as the very notion of medicine and sickness came to be questioned as ideological, i.e. reflecting social interests. These scholars then proposed that the domain of *sickness*, defined as the social process of creation of medical knowledge and conditions (Frankenberg, 1980; Young, 1982) should be considered as a medical anthropology object of inquiry. Medical anthropology research and action came to be located outside the clinic, in the broader context of sociological analysis and political-economic critique. The relationship with biomedicine becomes a highly critical one:

> «Symbols of healing are simultaneously symbols of power. Specific views of the social order are embedded in medical beliefs, where they are often encoded in aetiologies and beliefs about the sources of healing power.» (Young, 1982: 271)

Biomedicine comes to be thought of as a means of social control. In fact, in the social process of translating signs into symptoms, the human phenomenon of suffering is constructed in terms of biological entities, neutralising any potential negotiation about the meaning of experience and reality (Taussig, 1980). Within a biomedical construction of reality, medical conditions are seen as facts of nature, and the implicit outcome of such a process of medicalization is to prevent people from recognising the social relations embodied in sickness. Biomedicine is seen as reinforcing our self-perception as bio-physical beings, relying on specialist knowledge to deal with our problems, and in so doing contributing to our alienation from ourselves (Comaroff, 1982). According to such a view, anthropology will have to move its focus of attention from an individualising gaze to a socialising one. In this process of re-orientation, the very nature of the field undergoes a radical shift as well, coming to be socialised within the relations between local realities and global processes, and not at the level of clinical interaction (Frankenberg, 1980) [(3)].

If the anthropologists of *Illness* are concerned with the cultural construction of experience and clinical reality, the anthropologists of *Sickness* deal with the social production of cultural meanings and experience, and the clinical construction of reality. The distinction between *Sickness* and *Ill-*

ness, then, is a theoretical and methodological one, concerning the object of medical anthropology, its methodology, its role in society, and fundamental concepts such as those of culture and action. I agree with Hahn (1984) when he suggests that these two approaches be considered in terms of different ideologies trying to shed light on a highly complex phenomenon: that of suffering. Despite the differences between the two approaches, they both share the same shortcoming: by not questioning the *nature* of disease, they confine the body to the realm of its biomedical definition.

2.5. The emergence of a critical-interpretative approach

Along with, and in opposition to, the previous approach, another view of medical anthropology emerged. It was concerned with both issues of political-economy and cultural construction of personal experience. This critical-interpretative approach, put forward by Lock and Scheper-Hughes (1987), fully realises the process of detachment from biomedical epistemology and ontology. These authors' definition of sickness is grounded on a critical phenomenology focused on the body as generative actor within the process of cultural production, reproduction and negotiation. Within this approach, the body emerges as the very specific object of medical anthropology: neither the cultural construction of personal experience, nor the social process of production of medical knowledge and conditions, but rather both of them now located in the new context of the body. This approach clearly put forward a strong critique of every essentialism: the very notion of a physical body is questioned, for it never occurs outside the nexus of cultural and socio-political forces located within a historical context.

Only by drawing on such an historical and phenomenological conception of the body is it possible to completely found a *bio-free* medical anthropology. Although the previous approaches had been critical (in different ways, and to different extents) of biomedicine, they were not making an explicit critique of the ideological construction of the "physical" body, so they risked implicitly sharing the same assumptions as biomedicine.

It is only from a re-conceptualisation of the body that we can reach a broader understanding of sickness without reproducing biomedical epistemology and ontology. The body now becomes the most proximate context in which to look at the interplay between personal experience, cultural discourses and socio-economic forces. It becomes the process through which experience, culture and society are reproduced and negotiated. In

this framework, Lock and Scheper-Hughes define sickness as:

> «a form of communication – the language of the organs – through which nature, society, and culture speak simultaneously. The individual body should be seen as the most immediate, the proximate terrain where social truths and social contradictions are played out, as well as a locus of personal and social resistance, creativity, and struggle.» (Lock and Scheper-Hughes, 1990: 71)

Such a formulation makes it possible to think of sickness in non-biomedical terms, helping us to focus on the socio-cultural processes within which experience is embedded and symptoms come to be articulated as metaphors of distress and resistance.

2.6. Anthropology from the body

It is against such a background that a new paradigm for anthropology emerged, namely embodiment, and a new trend in ethnography became popular, concerned at the same time with phenomenological accounts and issues of political economy [(4)].

The body is certainly not a new object for anthropology: Marcel Mauss and Mary Douglas' studies gave it a legitimate status within the discipline. However central, past analyses of the body were carried out within a taken-for-granted opposition between nature and culture. Although its meanings were seen as belonging to society (like every other classification), its deep nature was still seen as rooted in biological processes. Such processes were thought to be «good to think with» (Douglas, 1970) in the production of social meanings, but certainly the body was not conceptualised as playing an active role in such a meaning-building activity.

Contemporary analyses of the body, however, depart from a different ground and view of the body. The body is now neither just the target of cultural conditioning (Mauss, 1973 [1934]), nor the source of metaphors about society (Douglas, 1970). Neither is it simply defined by disciplinary practices and discourses (Foucault, 1975). Rather it is seen in a phenomenological fashion as playing an active role in the process of meaning production, in the process of decision making, in the transmission of knowledge, etc. Post-modernism, with its stress on deconstruction, has seen the death of a passive objectified body and the rise of an active process of historical analysis.

The deconstruction of the biomedical body paves the way to the study of the historical and cultural devices of constructing the body. Body symbol-

ism and representations become appreciated in their local historicity, less as cultural means of representing the human body *as it is given in nature* (as biomedicine puts it), rather as devices for the very construction of its nature, now of an historical kind (Feher, M.; Naddaff, R. and Tazi, N. 1989; Crary, J. and Kwinter, S. 1992). The historical and situated nature of the body helps us to understand the bias in «the assumption that whatever nature makes is a natural kind» (Dennett D.1991: 381). To acknowledge the historical nature of corporeality leads us to the investigation of the process of its construction, of the cultural creation of its naturalisation. It is in this sense that the problem of the body becomes one of social ontology and the generative process of body and sociality appears far from being independent.

Such a process of reconfiguring the body within medical anthropology reflects broader and general concerns of the discipline as a whole, and at the same time it has offered anthropology useful means to redefine its theory and practice. On the one hand the appearance of the concept of embodiment is in fact very much linked to the emergence of a new concept of culture as:

> «... under continuous creation – fluid, interconnected, diffusing, interpenetrating, homogenising, diverging, hegemonising, resisting, reformulating, creolising, open rather than closed, partial rather than total, crossing its own boundaries, persisting where we do not expect it to, and changing where we do.» (Sanjek, 1991: 622. In Borofsky, 1994: 313).

On the other hand embodiment offers anthropology a point of entry in the generative processes of the cultural process that emerges from the relationships between body, self and society within a specific, but not bounded, historical context.

3. Medical Anthropology and Anthropology

3.1. Fragmented hegemonies, embodied resistance: illness as a heuristic device for the study of culture

The deconstruction of the biomedical body allowed by the previous approaches paved the way to the study of the historical and cultural devices of constructing and naturalising the body. Within this analytical landscape, the anthropological study of illness offers the discipline as a whole a precious analytical context.

To underline the social nature of the body and the bodily basis of culture is not to talk of the relationship between the two levels in mechanical terms. Despite the fact that the dialectic process between the two is constitutive, it is also emergent, processual, and indeed contradictory, as well as open and indeterminate, susceptible of being negotiated, questioned and rejected. As Frankenberg states:

> «The body is not merely [...] a symbolic field to mirror or reproduce dominant values and conceptions; it is also a site for resistance to, and transformations of, imposed meanings. [...] Cultural meanings are not only shared and given, they are fragmented and contested. Social life is divisive as well as cohesive. The body makes, and is made, by, a fractured social world.» (1992: xvii)

It is precisely because of the emergent, processual and fragmented relationship between social reality and experience that the body can elude the pervasiveness of social necessity, establishing dimensions of critique and resistance. Our acknowledgement of the body's role in the emergence of culture and experience (Csordas, 1990; 1994) allows us to understand why illness does not require a different positioning of the sufferer in the world. It also produces a different existential mode of being in the world (Williams, 1996). In so doing, the illness experience opens up a space for critical thinking through which the very partial and arbitrary as well as precarious character of our ontological and existential referents are brought to light, forcing us to negotiate them anew (Garro, 1992; Good, 1994; Scarry, 1985). «In sickness we confront the inchoate. Bodily suffering distorts the landscape of thought, rendering our previous construction incoherent and incomplete» (Kirmayer, 1992: 329).

The creative power of illness, as well as its methodological contribution to anthropology becomes clear with this last assertion. The body is not a marginal element in the process of challenging and consolidating the social order and its 'givenness'. On the one hand it is in fact through inscription in the body that knowledge and the social order become hegemonic: in entering the lived experience, they disappear from awareness. It is through such a process of embodiment that the dominant order becomes 'natural', and the socio-political processes that sustain it come to be obscured in the immediacy of the lived experience. On the other hand, bodily distress articulates a form of "*dis-ease*" with the social. Both these processes are performed in the depths of our intimate existence.

Illness brings to light the process of being in its *negative* mode, and in this sense it must be looked on as a 'change' in the embodied process of being-in-the-world. Illness is itself a process, whose peculiarity lies in the rupture

it engenders regarding the previous pre-existing relationships between body, self and society [5].

3.2. Reflexivity, anthropology and biomedicine

The body then emerges, as H. J. Jung puts it, as the umbilical cord to the social: «To be social is first and foremost to be intercorporeal. [...] The body is our *social placement* in the world. [...] The world, as Merleau-Ponty has it, is made of the same stuff as the body presumably because we relate ourselves to the world by the medium of the body, which is the lived field of perception. Since we are always already social, the body cannot be the 'origin' but, more properly, [...] the ambient medium of the social» (Jung, 1996: 5).

The body, then, is a generative agent of meanings and experience. However, the body is never given outside the game of culture, it is always socially located (Bourdieu, 1979, 1990) and historically informed (Feher M., Naddaff R., Tazi N., 1989; Mellor and Schilling, 1997). The body, then, is at the core of the ongoing process of perception and objectification (Csordas, 1990; 1994), as much as it is the engine of the process of inscription and projection (Frank, 1998), an object of construction (Foucault, 1975) and a generative agent (Merleau-Ponty, 1945). It is at once a natural entity and a cultural process, individual and collective, personal and social.

So, embodiment seems to allow for the collapse of the antinomies sustaining modernity as a cultural tradition. An anthropology oriented towards the generative process of coming into being of culture and experience must be rooted in an epistemological critique of modernity, and allow this critique to become methodologically operational within anthropology as a whole. The body, then, plays a central role in socio-cultural theory:

> «The theoretical implications of the scholarly discovery that the body has a history and is as much a cultural phenomenon as it is a biological entity are potentially enormous. Also, if indeed the body is passing through a critical historical moment, this moment also offers a critical methodological opportunity to reformulate theories of culture, self, and experience, with the body at the centre of analysis.» (Csordas, 1994: 4)

Medical anthropology offers anthropology specific contexts to enter the realm of the constitutive process of givenness, the very core of the process of naturalisation and objectification, i.e. the very process that brings into existence the world and the human agent as a positive presence in a meaningful landscape.

Such a transformation would not have been possible without a critical approach to the biomedical construction of the body, thorough a critique of modernity and the development of an anthropology at home.

If it is of vital importance on the one hand to found medical anthropology outside the biomedical domain, on the other hand I do believe that a relation between the two will always be necessary. In my view, medical anthropology needs to hold a relationship with biomedicine not only in terms of a critical study of it, but also in its reflexive process of self-definition.

In so far as anthropology and biomedicine share the same socio-cultural context, they do share, to a certain extent, an *implicit anthropology* as well. The difference between the two disciplines lies precisely in the relationship they hold with such an implicit anthropology. Anthropology defines itself as a discipline that is epistemologically aware of its own theoretical assumptions, while biomedicine produces its own reality and knowledge by drawing on the dominant scientist ideology, without epistemologically reflecting upon it.

In such a self-reflexive scrutiny anthropology will always face biomedical assumptions, in so far as they play a fundamental role in sustaining such an implicit anthropology, providing it with a criterion of reality and a measure of truth (the biomedical body). In this sense, anthropology must always start any analysis by critically reflecting upon the hegemonic biomedical definition of the body.

The self-reflective process of deconstructing the biomedical definition of the body is nothing more than its re-construction according to the cultural practices of its constitution as a naturally given individual entity. In other words, medical anthropology rests on the very practice of uncovering the implicit background of every anthropological comparison, i.e. the implicit (because they are embodied) limits of our explicit reasoning and more generally of our socio-cultural mode of being-in-the-world. Among others things, what medical anthropology has to offer its parent discipline is the possibility of conceptualising in reflexive terms not only biomedicine (i.e. its own cultural context), but its own analytical enterprise.

4. Bridging levels of analysis

Such a self-reflexive attitude, now identified as the epistemological specificity of medical anthropology against biomedicine, is the very cornerstone of anthropology in general. In fact I do not believe there is any substantial difference between anthropology and medical anthropology (see Comaroff, 1981). The task and methodology that medical anthropology pursues are

the same as those of anthropology in general. To be specific to medical anthropology is the context in which they are located, be it the body or the emerging concept of suffering (see note 4).

To be specific to medical anthropology and useful for anthropology in general is medical anthropology provocation «to inquiry the historical processes whereby biological and cultural phenomena are mutually determined» (Lindenbaum and Lock, 1993: xiv) [6].

Moreover in so far as to be 'critical' in anthropology has become more and more a matter of being able to bridge different levels of analysis [7], the body seems once more good to think with. Once it is conceptualised as an active player in the game of structure and agency, culture and experience, hegemony and resistance (and so on), we realise how personal distress goes beyond the individual experience, to become rather the embodied trace of broader socio-political processes of a an historical nature. In this context, the concept of embodiment seems to appeal to a very felt need in the academic world: namely the necessity of mediating between individual lived experience and broader socio-economic processes, between phenomenology and political economy.

It is then obvious that medical anthropology must define its problems independently of biomedicine if it does not want to get trapped in reductionism and epistemological naiveté. But it is even true that to define its own problems independently of anthropology in general would be naive, noxious and misleading:

> «A way of thinking about our subfields is to see them as providing opportunities to grasp major topics in general anthropology and to examine them in highly specific contexts. [...] Thus, subfield proliferation could be viewed as a chance to bring new energy to old anthropological questions. [...] Seen in this way, anthropological subfields like medical anthropology contribute to the reformulation and expansion of the searching questions that give anthropology its distinctive strength.» (*American Ethnologist*, 1988 vol. 15, num. 1, p. 2)

Notes

[1] See Del Vecchio Good and Good, 1982; Eisenberg and Kleinman, 1981; Good and Del Vecchio Good, 1981a, 1981b; Katon and Kleinman, 1981; Kleinman, 1981, 1982.

[2] It must be said that these very same scholars have been among the best critics of themselves in their more recent publications, moving away from the biomedical reductionism that characterised their early work (Good 1994; Kleinman 1995).

[3] Following this approach a group of scholars launched the term *Critical Medical Anthropology* (Singer and Baer 1982 Meeting of the *American Anthropological Association*). Such an approach

emerged as a direct challenge to previous conceptualisations of medical anthropology, and was meant to correct their shortcomings: it is in this sense that these authors chose the term 'critical' to define their approach. Singer and Baer put it: «adoption of the term *critical medical anthropology* was intended to reflect a two-sided approach involving the criticism of conventional medical anthropology for its narrow perspective; and social criticism, in the tradition of Marx, Mills, and other socially critical thinkers» (Singer and Baer, 1995 Chap.1: 42). The shortcomings they identify in conventional medical anthropology are, according to them, very much the outcome of the uncritical acceptance of the socio-cultural context in which the discipline is rooted and the lack of a macro-understanding of social and medical processes. These authors stress how their work developed in response to a growing recognition that «medical anthropology needs a critical analysis of the socio-medical context in which it has emerged» (Singer, Baer and Johnsen, 1986: 95). The context they mean is a particular moment within the capitalist world's economic and medical system. They sustain that such a context has affected conventional medical anthropology in both theory and practice, leading it to incorporate Western ideological medical assumptions. Their task is not just a critique of the traditional anthropological approach to medicine, but a study of the latter "in the context of the capitalist world system" (1986: 96).

(4) This is testified by the new focus on social suffering and structural violence that has captured scholars attention (See for example the triptych of volumes edited by: Kleinman, Das, Lock, 1997; by Das, Kleinman, Ramphele, Reynolds, 2000; and by Das, Kleinman, Lock, Ramphele, Reynolds, 2001).

(5) «Breakdowns play a central role in human understanding. A breakdown is not a negative situation to be avoided, but a situation of non-obviousness, in which some aspect of the network of tools that we are engaged in using is brought forth to visibility [...] A breakdown reveals the nexus of relations necessary for us to accomplish our task» (Winograd In Haraway, 1993: 381). This is probably the reason why medical anthropologists have focused their attention much more on sickness than on health.

(6) See for example cultural studies of science and biotechnology (Martin, 1994; Lock, Young, and Cambrosio, 2000; Young, 1995), emotions (Desjarlais, 1992; Pandolfi, 1991; Williams, 2001), narratives of experience (Frank, 1995, 1997; Radley 1995, 1997; Good, 1994; Mattingly, 1998; Mattingly and Garro, 2000), political and structural violence (Kleinman, Das and Lock, 1997; Das, Kleinman, Ramphele and Reynolds, 2000; Das, Kleinman, Lock, Ramphele and Reynolds, 2001), industrialisation (Ong, 1987), colonialism (Comaroff, 1985), reproduction (Martin 1987), religion (Csordas, 1990) and others. All these examples are topics belonging to general anthropology. They become specific to medical anthropology when their analysis comes to be located within their relationship with the body.

(7) See Massé's contribution in this volume.

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