at such a level of abstraction that we can see these interconnections and processes, we might assert without too much dissention that medical anthropologists need to be taught both clinical and epidemiological, qualitative and quantitative, research skills along with computer applications for both types of data. They need to be shown, also, the research/service/training/policy/theory-building processes involved in anthropological application that are linked to both anthropology and, to whatever component of the health enterprise within which they work.

Medical anthropology training programs which utilize such an explicit interlocking paradigm could prepare graduates for any assignment within the health field. Solid anthropological training, the holistic/interlocking paradigm for applications in the health field, exemplary methodological strengths (both quantitative and qualitative), conceptual agility and behavioral flexibility should provide entrée into the job market related to national and international health as well as to academia. It may be necessary, however, for graduates of such programs to generate their own opportunities for employment in the health field. Health professionals are learning how to collaborate with anthropologists, but many have not yet had sufficient exposure to grasp the benefit of such an alliance. That issue requires more attention by medical anthropologists.

Author's Reply

by ROBERT T. TROTTER, II

The dichotomy between patient care and public health may be formulated as a debate over training anthropologists to focus on health care processes research, or public health issues. A parallel concern in medical sociology dichotomizes the debate as the difference between sociology *in* medicine versus sociology *of* medicine. We need both in anthropology. However, the debate is useful in getting anthropologists to think about the utility of anthropology in both areas of focus, and also helps clarify what methodologies need to be taught. The end result may be to decide that both approaches are needed in all programs.

In a debate of this type, scholars may tend to set up polar extremes, leaving reality somewhere in the middle. The other key element left in the middle is the individual student. In order to take advantage of a difficult and changing marketplace, students need the most flexible training possible. If they receive the orientation, education and training to move in either direction, depending upon circumstance and personal preference, then they are getting the best possible preparation for being medical anthropologists. One formula for medical anthropology education is to first provide sound and broad-based training in basic anthropology (including exposure to all of the four subdivisions: cultural anthropology, physical anthropology, archaeology and linguistics). Then, illustrate how anthropological theories and concepts have been related to concepts of health, illness, healing and health care delivery systems. After helping students discover that they can create niches for themselves in this area, turn them loose to find a position.

Whichever of the two directions students initially take, if open to innovation they may eventually pursue both. Each new project benefits from the last, regardless of whether it is anthropology *of* medicine, or anthropology *in* medicine.

Author's Reply

by MARK NICHTER

A concern which may be raised in social science is that the kind of applied-social-science-in-medicine role suggested runs the risk of supporting the medical power structure by assisting clinicians better manipulate, if not control, patients. The therapy facilitator role developed had as a prime objective the enhancement of clinician-patient communication such that a negotiation of ideas, images, concerns, needs (felt as well as professionally determined) and courses of action could be engendered leading to therapeutic alliance and adherence, not compliance with therapy. The therapy facilitator served as both a patient and a clinician advocate, but not as an advocate for one interest group in deference to another.

The therapy facilitator aided clinicians in managing patients only to the extent of helping patients understand the possible "whys" of institutional rules and regulations, the repercussions of their immediate behavior within the hospital as a social system, and the extent to which clinicians were as bound by institutional constraints as were patients. The anthropologist's unique position of "relative neutrality" in relation to patient control enabled dialogue with patients about a wide range of control issues relating to their interaction with clinicians as well as family members. Dialogue about the latter revealed new dimensions of patients' illness experiences addressed in the training context of the teaching hospital during case conferences and through the evaluation/development of care plans.

An ethnographic approach and application of social science evaluation methods enhanced clinicians' efforts to assess those factors influencing a patient's ability to adapt to a given environment. The sociocultural environment explored by the anthropologist was considerably broader than that normally considered by most clinicians. An emphasis on this larger environment drew attention to, and challenged, the contextual relevance and adaptative value of specific therapeutic efforts for individual patients.

Clinically applied medical anthropology draws upon two interdependent social science perspectives: the type of social science in medicine perspective, underscoring sociocultural patient assessment; and a complementary social science of medicine/health perspective, prompting assessment of the hospital as a social system and of the medical system as a social institution. While therapy facilitation directly applied social science in medicine, it incorporated the latter perspective at strategic interfaces where the institutional socialization of disease, or illness, as sickness can have negative effects on a person's well-being. The interrelationship between social structure, the reproduction of health/sickness in a socially stratified society, and the role of medical institutions in maintaining social control may be appreciated by clinicians, outside the immediacy of the ward. There they may be better able to reflect intellectually and emotionally on problematic aspects of their roles.