

COMMUNITIES OF PRACTICE AND  
ANTHROPOLOGICAL IMAGINATIONS:  
REFLECTIONS ON TEACHING AND LEARNING ANTHROPOLOGY  
IN A POSTGRADUATE GENERAL PRACTICE PROGRAMME

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ABSTRACT

*Learning to be an anthropologist involves developing an anthropological perspective or way of seeing. This anthropological imagination is the key feature of the anthropological task of cultural critique. In this paper, I reflect on my experiences teaching anthropology in the context of a distance taught general practice postgraduate course in New Zealand. In this context, students begin to develop an anthropological perspective by practicing within academic and anthropological communities of practice. The model of legitimate peripheral participation within communities of practice (Lave and Wenger, 1991; Wenger, 1998) provides useful insights for exploring the teaching and learning of anthropology in this context.*

INTRODUCTION

Students have a lot to learn when they begin to study anthropology. Aside from learning about the history, research methods, key theorists, and debates within the discipline, one of the key practical outcomes is that students develop the ability to see and think anthropologically<sup>1</sup>. Of course, students' level of engagement with the discipline depends upon their own motivation and intention as well as their background. It is perhaps self evident that learners bring their previous life experiences as well as their previous experiences of learning to new learning settings and environments (Boud, 1993). These personal experiences and histories provide the starting point for students' learning experiences in anthropology but also guide or frame the interpretation of these experiences and their engagement with the discipline (Barnes, 1992; Segal, 1992).

In this paper I share some of my own experience as an anthropologist teaching medical anthropology within a postgraduate programme in general practice taught from the Department of General Practice at the Dunedin School of Medicine (DSM) in New Zealand. This programme can only be undertaken on a part time basis, is distance taught, and restricted to those with medical qualifications - specifically those who are general practitioners. There are three Schools of Medicine associated with the University of Otago, each contributing courses (24 in total) to a Diploma in General Practice (Dip GP) but the courses contributed by the Department of General Practice at the DSM are distinctive with their emphasis on the critical reflection on the praxis of general practice. This rationale includes an examination of the philosophy, teaching, ethics, and practice of general practice, as well as developing the critical appraisal and research skills specific to the discipline. The medical anthropology components of the programme have an explicit critical interpretive theoretical framework that is consistent with this rationale.

The enrolment criteria result in relatively cohesive cohorts of students who share common membership in the culture of a medical specialty (or generality, depending on perspective) and have undergone the process of doctor-making known as medical training. There are several situational limitations because the programme is distance taught. The primary structural feature is that each course begins with an intensive two day live-in Residential comprising workshops and seminars, with subsequent live discussions in telephone audioconferences, and asynchronic discussion through websites and email. The programme is entirely internally assessed, and the average class size across the Dip GP is relatively small, each course within the DSM Department of General Practice attracting an average of between five and ten enrolments each year.

Students participating in these courses are usually experienced general practitioners in either full time or part time practice. Sometimes they are also medical educators in general practice and academic settings. They bring with them their experiences of being general practitioners and teachers in various health care settings, and participants in various social and cultural contexts – families, churches, local and medical communities. They are sometimes motivated to enrol in the DSM Dip GP programme because they have become disillusioned about, or ‘stale’ in their practice of medicine, desire to learn practical and reflective skills in clinical teaching and conducting research, and also because enrolling in the Dip GP is one means of gaining their annual quota of CME (Continuing Medical Education) points, necessary for continued accreditation by the Royal New Zealand College of General Practitioners.

The Dip GP learning outcomes are carried into clinical practice and particularly into the patient-doctor consultation, into medical education and academic settings where the teaching and research skills gained are put into practice, as well as into the professional bodies that administrate and regulate general practice in New Zealand (including the Royal New Zealand College of General Practitioners and the New Zealand Medical Council).

This paper reports my retrospective reflection upon my experiences in teaching these classes – supported by my own journal fragments, student assignments, internet class discussions, and course evaluations. The associated processes of learning anthropology and becoming an anthropologist have not yet been well researched if the higher education and anthropology literatures are any indication. Yet the process of learning anthropology raises important questions both about the nature of learning and the nature and goals of anthropology.

I propose that Lave and Wenger's (1991; Wenger, 1998) articulation of situated learning and legitimate peripheral participation within communities of practice provides useful insights for theorizing the learning of anthropology in the context described here and perhaps for the learning of anthropology in other settings. In particular, I suggest that it is through participation in anthropological communities of practice that students learning anthropology begin to frame their observations within anthropological lenses and to imagine anthropologically.

#### COMMUNITIES OF PRACTICE AND LEGITIMATE PERIPHERAL PARTICIPATION

Within learning theories a broad distinction can be made between cognitive and sociocultural pathways to 'expertise' (Billett, 1996), or 'full participation' (Lave and Wenger, 1991). While cognitive approaches suggest that expertise is gained by acquiring procedural and conceptual knowledge, sociocultural perspectives associate pathways to expertise with immersion within particular social situations or communities of practice over time. Skilful knowledge is one prerequisite for gaining expertise, but so too is the ability to engage successfully in the discourses and repertoires of the particular community of practice. A community of practice is defined as 'a set of relations among persons, activity and world, over time and in relationship with other tangential and overlapping communities of practice' (Billett, 1996: 266). Situated learning within communities of practice is grounded within a process of legitimate peripheral participation where learners start with practicing on the peripheries of the community and move toward full participation as they gain experience

and competence in the community's repertoires.

The communities of practice described by Lave and Wenger (1991), and Billett (1996) tend to be relatively well defined trades such as tailoring, weaving, and hairdressing, with an organizational structure that includes apprenticeship. While sidestepping any attempt to define anthropology, I propose that the highly complex discipline of anthropology can also be viewed as constellations (a term used by Wenger, 1998:126) of interlocking communities of practice sited in academic departments, research and development organizations, and various other applied settings. Within these anthropological communities of practice, or perhaps, communities of practicing anthropologists, one finds 'old timers' and experts in various fields, as well as those who could be considered novices – undergraduate and postgraduate students for example. It is also possible to identify members positioned near the hubs of anthropological communities of practice, and members who practice on the peripheries of the same communities either through choice or marginalization.

Wenger (1998:154) acknowledged that there are many trajectories associated with ongoing participation within communities of practice, some of which lead to full participation and some that do not. These include peripheral trajectories that might never lead to full participation and boundary trajectories where membership spans several different communities of practice. He uses the notion of alignment to describe the ways in which communities of practice and participating individuals come to share common repertoires and identities (Wenger, 1998:195). Alignment is never secured but rather is always under constant renegotiation by members of communities of practices and the communities themselves.

Wenger (1998:153) suggests that practice defines a community in three ways; through mutual engagement, joint enterprise and a shared repertoire. A full member of a community knows how to be competent (and what constitutes competence), understands the repertoire, and also knows how to engage with others in the community. For example, novice anthropologists, as they move through their graduate and postgraduate study and into applied and academic positions learn the repertoires and discourses of anthropology as a discipline through coursework, fieldwork, working as research and teaching assistants, and participating in seminars and conferences. I suspect that the nature of the discipline is that practicing anthropologists are always 'practicing' anthropology in the sense of continually developing and exercising skills. In this sense the practice of anthropology is perhaps similar to the process of learning anthropology.

Although the pedagogy of anthropology is not well developed, it has attracted some attention. For example, Jacobson (1996) writes about the processes involved in learning a new culture – he refers to immigrants but it also applies to people who are doing fieldwork (Wolcott, 1982) or learning to be critical about their own society. In each situation, learning can be defined as a process of entering a cultural meaning system or sphere, to become enculturated within the community in which the knowing and learning have meaning. This understanding leads de Roche and de Roche (1990) to describe students as ethnographers in the sense that they are exploring the sub-culture of academic social science community. They suggest that courses in anthropology are exercises in fieldwork acculturation where students study the work of us natives. In other words we, as teachers and practitioners, are their key informants.

These ideas have some resonance with Lave and Wenger's (1991; Wenger, 1998) framework, specifically that learning is an integral part of generative social practice within the lived in world. They are explicit that learning is always about shifting identities and selves within a dynamic and increasingly complex postmodern world. Their argument is implicitly framed within a holistic paradigm of embodied praxis. Persons engage with their communities of practice as embodied selves (Lave and Wenger, 1991; Wenger, 1998). In this sense learning and practice are neither separated nor distinct.

As noted, one feature of this model is that individuals participate in constellations of overlapping and perhaps indistinct communities of practice at any one time. For example, students who participate in my courses are already practicing as experienced members within the well defined communities of general practice and medicine and some are also experienced medical educators in the interlocking communities of academic general practice.<sup>2</sup> However, for most students, participation in the Dip GP programme, and in the medical anthropology option, constitutes peripheral participation within communities of medical academia and medical anthropology. This peripheral participation, as novices, is legitimated by their institutional student status in the first instance and via both internal and external research and ethics committees as novices begin to conduct their own research for course assignments, research essays, dissertations, and theses. The trajectories of these courses do not lead to full participation within anthropological communities of practice, but are best described as boundary trajectories where students' engagement with the discipline and its repertoires, including the art of seeing or imagining anthropologically and ability to access anthropological resources, are drawn into their participation within other communities such as general practice,

medical academia, and medical education.

#### TEACHING AND LEARNING ANTHROPOLOGY IN GENERAL PRACTICE

In 2001, postgraduate students in the distance taught Dip GP programme at the Dunedin Medical School (DSM) Department of General Practice enrolled in an inaugural introductory course in medical anthropology. A more focused course exploring the anthropology of biomedicine was added to the programme in 2002, and an advanced special topic in medical anthropology became available in 2003 for students wanting to explore in depth a chosen topic of interest within a medical anthropological framework.<sup>3</sup>

Teaching anthropology in this context provides unique challenges. The importance of context cannot be underestimated in any teaching objective. Just as pedagogy must be student-centered, in that it is based on understanding and addressing students' perspectives and cultural understandings, similarly teaching is about highly contextualized instances rather than universally applicable approaches. This means that teachers must pay great attention to the immediate socially constructed settings, the nature of interactions between learners and teachers, tasks and resources, cultural meaning and the larger cultural, historical and institutional settings as well as to students' learning styles, and levels of understanding (Jacob, 1995; Wilson *et al* 1987). For example, teaching mature professional GPs with little or no grounding in social science is different from teaching undergraduate anthropology students. The majority of Dip GP students have an ontological perspective (gained and/or reinforced during medical training) that can best be described as positivist. That is, truth and fact are synonymous and seen to exist universally and absolutely, independent of time and space. This reality can be measured using experimental (primarily quantitative) methods that presuppose a researcher stance of neutrality and objectivity (Gordon, 1988; Guba and Lincoln, 1998). Correspondingly, these students generally begin learning anthropology with little appreciation or comprehension of the socially constructed and relativist nature of reality – a perspective explicit in critical interpretive medical anthropology. Lock (1993) also alludes to this; in her experience students who have studied anthropology prior to medical or nursing training more easily comprehend the implications of cultural difference in health care settings.

Students enroll in the Dip GP for both personal and professional development. Medical anthropology courses are optional. This means that students who enroll in them are motivated primarily by interest. For some, this interest has been kindled by exposure to the therapeutic modalities of non-western

cultures and societies. For example, one student had lived in China learning acupuncture, which she has since used in conjunction with her conventional biomedical practice. Another immigrant student was practicing in an isolated rural town with a large Māori population and attempting to understand the complex cultural issues peculiar to New Zealand. Some students are interested in better understanding patients' health and illness behaviors, and improving their relationship with patients, while others are interested in exploring aspects of biomedical praxis such as professionalism among physicians.<sup>4</sup>

In the context of teaching and learning sociology, Eckstein *et al.* (1995) suggest that learning about the discipline of sociology is very different from learning to use a sociological perspective. The same is true of anthropology. Although it was intended that the medical anthropology courses of the Dip GP programme prove useful to students in their professional practice as general practitioners and teachers of undergraduate medical students, it was unrealistic to expect that students' participation in these introductory courses in medical anthropology would result in anything more than limited competence or familiarity with the discipline – historically, methodologically, or theoretically. Therefore, these courses were designed to encourage students to engage with anthropology as a discipline, and, in doing so, to develop the ability to problematize and critique the medical cultures and healthcare systems in which they participate as professionals. Thus, it seemed that a realistic teaching and learning objective was that students develop and exercise the ability to *see* anthropologically.

In the introductory medical anthropology course, students are introduced to the discipline of medical anthropology through its dual historical origins in public health and early ethnomedicine (Ackerknecht, 1943; Evans-Pritchard, 1937; Paul, 1955; Rivers, 1924). The organizing principles are the concepts and critique of culture and society, health, and embodiment. These are key framing concepts within critical interpretive medical anthropology but also provide a critical framework for discussions of readings and examples from practice with which students illustrate their reflections and contributions. Within this framework students are expected to learn how to recognize broad theoretical and paradigmatic flavors in anthropological literature (for example, interpretive, critical, structuralist and functionalist), and to demonstrate understanding of a) the ways illness and healing behaviors, and therapeutic modalities are socially constructed and embedded within cultural contexts; and b) the relativist positioning of biomedicine as a cultural and social construction in relationship to other therapeutic praxes and modalities.

Specifically, the learning objectives in the introductory course are that upon completion students: be *a)* familiar with anthropological concepts of culture and society; *b)* able to critically discuss the cultural context of medicine; *c)* familiar with theories of illness/health seeking behavior; *d)* able to critically analyze biomedicine as a cultural system; *e)* able to analyze the interface between biomedicine and other medical systems in the delivery of health care; and *f)* have developed an 'anthropological imagination' or way of seeing. The learning objectives for the follow on course examining the anthropology of biomedicine are that students will: *a)* gain experience in the use of ethnography as a research method; *b)* be able to critique biomedical praxis; and *c)* be able to critique anthropological and sociological discourses on biomedicine.

The process of learning to *see* anthropologically for participants in these courses begins with reflection upon their own professional and clinical experiences. One way that this is encouraged in the introductory course is through the use of journalling<sup>5</sup> which facilitates the development of analytical distance or a critical perspective. While students are not asked to submit their journal, it provides the basis for their assignments. Journalling has proved to be an intense experience for some participants. For example, in audioconference discussions, one student talked of the ongoing emotional work she found herself facing as she reflected upon her clinical consultations over the duration of the course. In a discussion of the placebo effect, she shared her perception that the opposite, the *nocebo* effect (Hahn and Kleinman, 1983), could result from talking with patients about symptoms, diagnosis and prognosis. Already sensitive to communication issues between patients and doctors, this led to a heightened sense of responsibility for the manner in which she talked with patients about their symptoms, diagnosis, management and prognosis. The following is an excerpt from her final assignment.

Most doctors are not aware of the powerful negative suggestions they may make, or of the fact that, because they are in a position of authority, even if they were exerting no measurable treatment effect, they could still produce healing or harm via their unconscious use of language that may create placebo or nocebo effects.

This emphasis on demonstrating the practical application of an anthropological imagination rather than knowledge about anthropology is reflected in the workload of these courses which could be considered relatively light in comparison with postgraduate papers in traditional anthropology programmes.<sup>6</sup> In situations where course aims intersect with vocational practice, the reflective work generated by this intersection constitutes legitimate course work



– hence the focus on journaling and field notes which draw observation and experience into critical analysis. Assignments certainly provide evidence of students' engagement with key critical anthropological problematics. In particular, these assignments (which take the form of written essays) demonstrate students beginning to construct and frame complex and critical articulations of coursework, clinical practice, and participation in medical culture and the New Zealand health care environment within medical anthropological frameworks of embodiment, cultural critique, and the social construction of health, illness and medicine. For example, one student explored the phenomenology of general practice within a critical interpretive medical anthropological framework, drawing upon the work of Good (1994), Gordon (1988), Kirmayer (1988), and Scheper-Hughes and Lock (1987) to explore the intersection of conflicting professional and personal demands upon the person of the GP. The following is an excerpt from her final assignment.

As we (GPs) become aware of our existential pain... we may eventually learn the paradox of living within the current socially constructed worlds both of our dominant modern biomedical paradigm and of the post-modern world which is still unfolding... Learning this art may in turn bring a deeper healing to ourselves (as GPs) that may eventually extend out towards our patients, our profession and our society.

#### IMAGINING AN ANTHROPOLOGICAL IMAGINATION

Kain (1999) writes that disciplines represent ways of knowing, seeing and interpreting the world. The perspective that biomedical training provides has been described in detail by various social scientists (Becker *et al.*, 1961; Cassell, 1998; Good, 1994; Kleinman, 1980; Konner, 1987; Lock, 1993; Sinclair, 1997). In particular, those who undergo medical training learn to *see* via the utility of a medical or clinical gaze (Foucault, 1973; Good, 1994: 65–87). Good (1994: 65–87) argues that gaining the skill to *see* medically requires an extraordinary amount of cultural work by students; a process that begins in anatomy classes and cadaveric dissection and continues as medical students learn the skills of history taking and case presentation (Atkinson, 1995; Good and Delvecchio Good, 2000; Hunter, 1991). The acquisition and development of this professional competency accompanies the transition from legitimate peripheral practice into full participation within communities of medical culture and practice as students move through the medical curriculum.

Similarly, an important task facing the novice anthropologist is learning to *see*

anthropologically. Like the clinical gaze, learning to flex an anthropological imagination requires work by novice anthropologists as they learn to identify different viewpoints and the politics of competing and contested social discourses. Teachers of sociology have written much on the subject of facilitating the development of a *sociological* imagination in their students (see for example, Bengston and Hazzard, 1990; Crowdes, 2000; Eckstein *et al*, 1995; Kaufman, 1997; O’Flaherty, 1992; Schopmeyer and Fisher, 1993). In classical sociology this term described the special insight and frame of mind that sociologists needed to acquire in order to explore and interpret the social world (Wright Mills, 1999 [1959]). More recently, it has been defined as an attitude of critical reflection about common sense (Bengston and Hazzard, 1990).

Teachers of anthropology appear not to be so overtly concerned with teaching the anthropological imagination, and yet the anthropological imagination is a central concern for the discipline (Clifford and Marcus, 1987; Dimen-Schein, 1977; Geertz, 1973; Keesing, 1981; Marcus, 1999; Strathern, 1987). Within critical and interpretive anthropology the definition or description of an anthropological imagination is premised upon the central endeavour of anthropology as cultural critique (in a broad sense), and underpinned by the understanding that all culture is humanly constructed (Nanda, 1997). In medical anthropology the anthropological imagination orients around the critique of medicine and medical practices, health, subjective illness experiences and the articulations of these within cultural, political, ecological, and societal contexts (Scheper-Hughes, 1994).

Wolcott (1999) frames anthropological critique in terms of the difference between looking and seeing. Specifically, reflexivity and engagement are key characteristics of the latter kind of vision. Learning has been described as a transformative process where adults re-image self and the world (Hobson and Welbourne, 1998) - similarly the anthropological imagination is also about imagining radically different human possibilities (Barnes, 1992). The nature of engagement in imagining anthropologically involves exposing oneself and understandings of the world to critical analysis. Inherent in this exposure is the potential for transformation. In this sense, learning can be characterized as risk. Certainly, in learning to see anthropologically, the ordinary and taken-for-granted become problematic. One’s own life is no longer ‘sensible’ but peculiar and unique – the result of global and local, historical, political, and economic processes. In meeting the challenge to explore the peculiarities of one’s own culture (and by association, oneself), there is the risk that the explorer becomes transformed in the process. Giddens (1991) describes the late modern age as a secular risk culture where individuals are constantly

confronted with change and uncertainty. He suggests that reflective engagement with the social world is one way in which individuals can exercise some degree of control over the highly fluid and constantly shifting sands of this environment. Maintaining ontological security in this environment is challenging in an existential sense. Similarly, intentional learning is risk because it involves opening oneself to transformation, particularly so because it is impossible to foresee the endpoint of such transformation. Schön (1983) suggests that, for practitioners, reflective practice is like an iterative and reflective conversation with the practice situation. By becoming self aware, practitioners open themselves to the possibility of alternative ways of conceptualizing the reality of practice. For example, one student who completed the introductory course in medical anthropology wrote her final assignment about menopause and embodiment within the context of the consultation framed by cultural ideas about women and bodies. She commented:

In writing this assignment, I have had a sense of the great possibilities, both philosophical and practical inherent in applying anthropological ideas to daily practice... For me the exercise has brought a new understanding of the enormous complexities and necessary limitations of any work that takes the body as its focus. How has general practice been able to ignore these issues for so long?

Teachers of anthropology have experimented with ways of encouraging students to engage with anthropology and to develop an anthropological imagination (de Roche and de Roche, 1990; Segal, 1992). Barnes (1992) postulates that self-conscious study of anthropological theory allows students to perceive the social construction of their own thoughts and beliefs. In the process of exploring how others interpret what we take for granted, students begin to question what they consider to be normal and ordinary (Schopmeyer and Fisher, 1993). Others stress the importance of understanding the notion of culture as a medium for developing an anthropological imagination (Lock, 1993; Newman, 1990; Peacock, 1986: 99). Lock (1993), for example, suggests beginning this process with health care professionals by discussing the possibility that concepts such as family, health, death, life, individual, and illness are cultural constructs. Segal (1992) suggests that students keep a journal on some aspect of their own society and encourages them to move from a descriptive to reflective perspective. He describes the core social anthropological methods of participant-observation as a dialogue between students and their environment. A critical aim of his course is to encourage students to begin having this conversation. Caughey (2000) asks students to construct a self-ethnography by comparing their own life history with that of an informant with a

slightly different background as a device to encourage students to critically reflect upon their own cultural understandings. Spindler and Spindler (1990, 1997) suggest that students must learn how to think anthropologically by *experiencing* the process of thinking anthropologically, and suggest cultural case studies as a means of doing this. In true anthropological fashion they argue that this process allows for open-ended discussion where there is no finality, no resolution, and no absolutes.

Learning always begins with where a student currently 'is'. It is important that students are explicitly encouraged to relate what they are learning to what they already know (Biggs, 1999: 11–32). My own experience over seven years of teaching anthropology to GPs has demonstrated how difficult it can be for them to begin with critiquing their own biomedical culture as insiders before developing critical skills as an outsider to other cultures. Their embeddedness within the sociocultural niches of biomedicine and general practice makes it difficult to examine the social and historical construction of the 'ordinariness' of their everyday lived professional practice and the discourses embedded therein. In one Residential session at the beginning of the introductory course an invited sociologist discussed a highly publicized case involving a GP who was struck off the medical register by the NZMC after an investigation following a complaint from a patient about his use of alternative therapies in conjunction with his biomedical practice. Although the class strongly contested the sociologist's presentation of the specifics of the case, they later commented on the analytical orientation around contested discourses of power and resistance between biomedicine, complementary and alternative medicines (CAM) and the State in New Zealand as CAM practitioners struggled to organize and legitimate their therapeutic modalities. Some of the class practiced acupuncture in conjunction with their biomedical practice, while others utilized CAM for themselves. The critical examination of discourses of power and resistance across historical, social, political, and cultural settings is a key feature of critical interpretive medical anthropology. Here students were beginning to make connections between their own experiences and theoretical explanatory frameworks for these experiences. In the process they were also making connections between the highly eclectic discipline of general practice and the discipline of medical anthropology.

Ramsden (1992) suggests that while there are many ways of organizing or presenting content, it should proceed from known and everyday experiences to the abstract and then back again to practical application of theoretical knowledge. Similarly, anthropologists use an interpretive process moving from descriptions on local, or micro levels to connections and theorizing on an

abstract or macro level in both a hierarchical and a horizontal sense before moving back to look critically at the local case in light of theory. Barnes (1992) argues that the most impressive and breathtaking developments in students' thinking often happens as they move back and forth between individual experience (their own and that of unfamiliar people and remote places) and structural analyses or theories. This process was evident during a field exercise at a local museum during a Residential for the introductory medical anthropology course. The brief given to the class was that in pairs they were to imagine that they are cruise ship visitors from another country who have never travelled to New Zealand before and this is their first stop. What impressions do they form about the culture(s) of New Zealand from their museum visit? In the following debrief session, they were critical of this brief. It was difficult, they noticed: a) to imagine oneself in someone else's cultural shoes, and b) to bracket one's own emotional engagement with the iconography of 'Kiwiana' in attempting to gain critical distance from one's own culture(s).<sup>7</sup> In fact, this was the teaching and learning objective of the exercise; to arrive at these anthropological problematics. From this point the discussion moved on to consider the difficulties of conducting ethnographic research in exotic societies and of doing anthropology at home which, in turn, led to discussion on the task of anthropology as cultural critique and the politics of representation. In the process, students moved from pondering their own anthropological imaginings to pondering the imaginings of other anthropologists to framing these within a critical interpretive perspective and reconsidering their own anthropological imaginings accordingly. I have seen this process repeated many times as course readings stimulate class discussion on health and illness knowledges and behaviors within different therapeutic modalities and cultural settings and the anthropological theories that attempt to explain them. Often these discussions move back to consideration of specific consultations or examples of patients of whom students now have greater understanding. For example, one student who was frequently asked by government welfare sickness beneficiaries to certify their illness in order to have their benefits continued submitted the following question in an audioconference discussion.

If we accept this sick role to have four components, according to Parsons (1952), and the fourth component is the patient's obligation to seek technically competent help: *a*) does this help include alternative medicine even if the dominant culture doesn't accept their certification ability; *b*) if the patient does not agree with one GP's assessment he/she needs to seek opinions until the sick role is confirmed; *c*) if he/she doesn't fit the criteria for sick role acceptance,

are they no longer sick or because the sick role is patient orientated, they are sick by proxy?

One practical application of developing an anthropological perspective or imagination is that it provides a framework that facilitates comprehension, if not resolution of situations commonly encountered in clinical settings and in the context of patient care. In attempting to understand others, GPs also learn about their own cultural lenses (Keesing, 1981), problematizing aspects of their own experience and practice, and the culture of biomedicine (Carrese and Marshall, 2000). A discussion of female circumcision or genital mutilation based on the work of Gruenbaum (1996) in one Residential session on ethno-ethics illustrates this. None of the students had any professional experience with patients who had suffered the procedure. The case study raised issues of cultural identity, power and resistance, embodiment, gender and health. It also developed into a debate on personal and professional relativism and cultural critique. Upon what grounds do anthropologists critique the cultural practices of others? Here I identified my own stance which is that the practice of female genital mutilation in its extreme expression of pharaonic circumcision (characterized by the total excision of the external female genitalia, and sewing shut most of the vaginal opening) should be discouraged. From here, the discussion moved to the social construction of human rights and the ethnocentricity of western human rights discourse, and to the juxtaposition and justification of professional and personal values in the practice of anthropology. Through their participation in this and other debates, students learned about the dilemmas encountered in medical anthropology, and in doing so were also participating (and practicing) legitimately on the peripheries of anthropological communities of practice. The class itself constitutes a community of 'practice' where students tested their nascent anthropological imaginations, discourses, and theories on each other, and on their teachers. Interestingly, in evaluations of these courses, students have explicitly commented on the role that I, guest lecturers and resource people, as practitioners, play in modeling both academia and anthropology for them. They are also often intensely interested in reading and discussing the work of physician-anthropologists such as Helman (1994, 1978) and Kleinman (1988).

Making the cross-over from seeing medically to seeing anthropologically can be challenging. Although the two visions are similar in that they are acts of interpretation and social construction, there are practical and paradigmatic differences. In the process of translating symptoms into clinical signs, the medical gaze in modern biomedical praxis constructs quantifiable medical facts that, accounting for natural human variation, can be mapped onto dis-

ease profiles and managed according to existing clinical guidelines for best practice. The clinician is an expert who is detached from the person of the patient and the medical gaze is primarily exercised upon the organic physical body of the patient. When symptoms resist the medical gaze, or when they cannot be translated into recognizable and quantifiable signs, they are defined as idiopathic or as psychosomatic. While the former term connotes a yet unrecognized and quantified disease process, the latter de-legitimizes the lived experiences of illness for patients. Social scientists have argued that despite the positivist paradigmatic framing of medical vision, the medical gaze is inherently a socially constructed and qualitative process (Atkinson, 1995; Foucault, 1973; Good and Delvecchio Good, 2000; Hunter, 1991). However, the reflective awareness, outlined by Schön (1983), which develops through clinical experience, does not necessarily challenge the practice of the medical gaze, nor its paradigmatic praxis.

Learning to *see* anthropologically is an explicitly qualitative and interpretive process. In learning to exercise this vision, GPs have to imagine themselves as anthropologists, and learn to locate themselves critically and reflexively within their anthropological imaginings. Within the dispersed and reflexive discourses and praxis of postmodern anthropology there are no clinical guidelines, only the experiences, interpretations, and critical theoretical reflections of other situated anthropologists, working within various research settings, fields and traditions in interlocking communities of practice. One student reporting on her ethnographic exercise for the follow up course commented on her experience of practicing an anthropological imagination:

I found it hard to get out of my own way... To put aside present conceptions and ideas to allow new insights to form proved difficult... How does one integrate observations with comments and interpretations of them...? Pursuing this project has taught me a number of things. The learning stretches beyond the rudiments of ethnography to the consciousness of observation and reflection... I am reminded again how integral oneself is to observation and encounter in any environment and this can never be completely controlled for.

## CONCLUSION

Developing the ability to see anthropologically is intrinsic to the process of learning anthropology. In the teaching and learning context described here, it is the culture and practice of medicine that constitutes the primary focus of anthropological imaginings. Dip GP students' development of this criti-

cal faculty takes place as they participate in the intersecting communities of their own professional practice and their academic study. While they do not become experienced or skilled anthropologists after completing one or two courses in medical anthropology, by the time they complete the introductory course there is evidence that students are developing and flexing their fledgling anthropological imaginations. This engagement is even more pronounced as students complete the second course where the assessment is based upon an ethnographic exercise.

What can a model of situated learning and legitimate peripheral practice within anthropological communities of practice offer a discussion of teaching and learning anthropology? Wenger (1998) developed this model investigating the ways in which practices arise and learning occurs within organizations, and it has also proved useful in examining the situated learning that occurs in trade apprenticeships (Lave and Wenger, 1991; Billet, 1996). I have found that this framework has a high degree of resonance for the teaching and learning of anthropology in the context described here. While I am reluctant to generalize from my own experiences of teaching anthropology to other educational settings where anthropology is taught, I contend that Lave and Wenger's (1991; Wenger, 1998) concept of legitimate peripheral participation within communities of practice also offers insights that are useful in examining the teaching and learning of anthropology within other contexts. In the first instance, the notion of constellations of communities of practice is appealing as a means of describing the multiple sites, practices, sub-disciplines and fields that constitute anthropology. With regard to teaching and learning, the model also accounts for the 'situatedness' or context of learning – this has particular application to students who are continuing education while participating within work-based communities of practice. The notion of legitimate peripheral participation helps explain the processes by which students learn the discourses and repertoires of the discipline, and begin to practice anthropologically. The notion of trajectories helps explain students' (and practitioners') positioning vis-à-vis anthropological communities of practice – whether their pathways lead toward full membership or toward boundaries of anthropological communities of practice.

As teachers, anthropologists have been slow to problematize teaching and learning at a tertiary level within their discipline. As a result there is an undeveloped pedagogy of anthropology. Consequently, there are many questions yet to be explored concerning the process of becoming an anthropologist across various settings and communities of practice. For example, when do anthropology students begin to identify themselves as anthropologists rather



than students? What does this process involve? What does *learning* mean within various anthropological settings? How is the task of learning to see anthropologically specifically accomplished? Why do some students fail to develop an anthropological imagination? Further exploration of these issues across various anthropology teaching and learning environments will greatly assist anthropologists in developing courses and programmes in a range of settings.

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#### NOTES

- 1 I use the terms seeing and imagining anthropologically interchangeably throughout this manuscript. Current theorising around embodiment within the field of critical interpretive medical anthropology (see Jaye, 2003) would suggest that it is questionable whether the processes of seeing (as a sensory process) and imagining (as a cognitive process) can be distinguished from one another.
- 2 Being a GP medical educator can mean several things. At one level are the salaried academics who work within the medical school setting, teaching at either an undergraduate or postgraduate level as well as conducting research. Another level comprises those GPs who are contracted to teach in specific undergraduate courses within the medical school setting, while another level consists of those GPs who supervise undergraduate students doing general practice attachments or rotations within community clinical settings.
- 3 I am responsible for the development and teaching of these courses.
- 4 I have already noted that the critical rationale of the medical anthropology stream is consistent with the critical rationale of the DSM DipGP programme. In particular, within the compulsory DipGP course, Core Studies in Medical Practice, previously completed by the majority of participants in DipGP medical anthropology courses, students learn that medical praxis is always situated within particular sociocultural settings. They also learn to recognize and ex-

amine the paradigmatic principles of positivism that underlie modern medical praxis and general practice as well as recognizing the social and cultural influences on patients' illness experiences. This prepares students well for the introductory medical anthropology course and several students commented on this.

- 5 The follow on course has extended this into an ethnographic exercise that involves keeping field notes.
- 6 There is evidence that courses that are overloaded with content can encourage surface rather than deep learning approaches (Ramsden, 1992).
- 7 Kiwiana is the term used to describe the nostalgic popular material representation of New Zealand's cultural and historical heritage.

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