Radical Applied Clinical Anthropology

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The structure of biomedicine and healthcare delivery is not designed to be patient-centered and will require a radical redesign that drastically shifts the clinical gaze. The shift in gaze will require an implementation of a new applied clinical medical anthropology to identify, describe and resolve the current entanglements that make care delivery so complicated. Those entanglements must be pulled apart and laid bare by utilizing direct observations of patients, providers and healthcare experiences to create new assemblages. A focus on ethnographically informed models is the pathway to shifting the clinical gaze.

MICHEL FOUCAULT (1973) first described the clinical gaze, linking the origin of the concept to the implementation of anatomy-based physician education that led to insider knowledge and asymmetric power relationships between healthcare delivery and healthcare recipient. Anatomy-based education furthered pathophysiological understanding of organic disease concepts, broadening the distance between disease and illness. Others have attempted to find cultural remnants of folk medicine as well as ways to better unite disease/illness concepts, perhaps returning us to some imagined "before", pre-gaze state (KLEINMAN, EISENBERG & GOOD 1978). However, the complexity of modern healthcare systems in the United States are strongly rooted and engrained in a broader capitalism, highly structured, and almost autonomous given the millions of companies, medical supplies, billers, buildings, providers, and patients that reify the system on a daily basis. If there is a cultural context, a cultural system, then it is this neoliberal structure reproducing validity of specific disease definitions and care pathways based on reimbursement strategies that define medical deservingness (RATNA 2020) – who is seen in care pathways and who is not, who has legitimate disease and who goes unnoticed (HOLMES, CASTAÑEDA, GEERAERT, CASTAÑEDA, PROBST, ZELDES AND WILLEN 2020; SHER 1983). The clinical gaze is a lens magnifying this complex network that defines healthcare. This gaze sees what the lens is designed to visualize, not necessarily what diseases patients have or where patients suffer and need clinical pathways of care. The gaze is able to see patients deemed by the healthcare delivery structure as deserving while staying blind to the non-deserving. How can we shift this gaze to be patient-centered?

Applied clinical anthropology is not a new concept but the idea lay dormant for 3 decades (CHRISMAN & MARETZKI 1982; KLEINMAN, CHRISMAN & MARETZKI 1982). NOEL CHRISMAN introduced the idea that anthropologists could navigate the space between disease and illness directly to increase patient compliance (CHRISMAN & MARETZKI 1982). These clinical anthropologists could liaison biomedical care plans to treat disease with patient culture and folk beliefs that made up their illness, largely following the disease/illness paradigm and ethnomedicine concepts being explored at the time (KLEINMAN, EISENBERG & GOOD 1978). That space in between disease and illness or between biomedical culture and local culture/ethnomedicine, it was thought, might be responsible for care plan non-compliance and perpetuation of disease. The assumption that patients chose not to participate in medical care secondary to different belief systems may partially explain small aspects of the variation in compliance but was grossly overstated, leaving out marginalization of asymmetrical power structural determinants of care and care access (SCHEPER-HUGHES 1990; FARMER 2006).

Much of medical anthropology turned to broader, and necessary, critique of the healthcare system, working mostly to identify how power asymmetries, racism, colonialism and gender inequity results in an uneven distribution of healthcare outcomes (Scheper-Hughes 1990). These are necessary critiques but move too far away from the direct patient experience to actually improve human lives.

While anthropology has moved away from static definitions of culture (de Castro 2011), hospital patient experience departments perpetuate "cultural competencies" (Aha 2013) assuming that the reason why the patient does not take her medicine or doesn't always arrive at her appointments is because she is a member of a non-dominant religion, views time differently based on origin stories in her family heritage, doesn't wear jeans to clinic and prefers to not shake hands and to have her husband in the room. These attributes of 'culture' are used to explain, or even justify, observed inequities in care and creation of disparate care delivery (AHA 2013). These explanations and justifications ignore racism, undocumented-status, inability to access health insurance when unemployed, lack of transportation to clinic, family work schedules, domestic violence, misogyny both in her own neighborhood and home, and teetering food insecurity during a pandemic.

We suggest that a radical reconsideration and implementation of an applied clinical anthropology can transform healthcare delivery by directly engaging in the patient-physician interaction and the acute medical encounter. The key to this applied approach is integration of the anthropologist as an actual member of the healthcare team with stated role to consider culture and structural vulnerabilities across current care pathways that contribute to unmet healthcare needs of patients and differential healthcare outcomes. Reimagined applied clinical anthropologists see patients, work with staff and the broader community outside of the hospital or clinic, improve patient centered care models that expand deservingness, link disease and illness, and improve healthcare outcomes. This clinical anthropologist uses these ethnographic observations to inform new pathways, to consider broader assemblages, and to unentangle webs of unaligned incentives across the modern biomedical care delivery space. Clinical operations and direct patient contact are key elements of our new approach that integrates the broad category of forces that explain health inequities outside of pharmaceuticals and surgeries (social determinants of health) includes issues such as food insecurity, education, sex and gender, geographic residence, homelessness, co-occurring mental illness or substance use (Williams & Sahel 2022).

How can social determinant approaches before integrated directly into clinical practice? A neoliberal healthcare system distributes patient care, and patient outcomes, through a hodgepodge conglomeration of drug, device, and procedure delivery, all emphasized through un-aligned incentives (Ratna 2020).

Multiple forms of exploitive, or unchecked, capitalism have been described previously. While capitalism itself may just relate to private business trade and industry operating to produce profit, neoliberalism describes an extreme form of the concept, reducing most government regulations to create supposed free market attributes that allow private entities to further maximize revenues with few barriers. Neoliberalism may have an underlying assumption that creation of profit for the sake of profit creation leads to human progress and should not be inhibited. We are most interested in a related concept of salvage capitalism. Essentially salvage capitalism is the identification of potential profit, potential revenue generation out of human activities that may be taking place for other reasons or in absence of a formalized market. A human illness relates to a narrative during a healthcare encounter. In the United States, that narrative is ultimately packaged into a revenue generating unit called an ICD-10 code (e.g. "Acute Chest Pain" R07.9).

Salvage capitalism (Tsing 2009) threads together ways of elevating visibility to some patient populations at the expense of others who go unseen or remain undeserving of care. ICD-10 codes, third party payors, and compliance guideline organizations salvage these revenues creating the illumination of clear pathways in modern healthcare strung along precarious patches of disease and illness. Broadly, this coalition of capitalist forces produce incentives that reify improved care for some patients over others. Over time, reproduction and reification along un-aligned incentives form stochastically entangled care paths that are difficult for patients and providers to navigate but easier for payers and compliance organizations to recognize.

A new clinical anthropology places emphasis on the emergence of pathways of possibility that create newly visible and deserving patient populations such as those with Sickle Cell Disease (SCD), Opioid Use Disorder (OUD), and Hepatitis C Virus (HCV). Pathway development utilizes co-located treatment models that recognize both syndemic and co-occurring diagnoses when present. This anthropology takes into account the broader structure of healthcare delivery as well as the challenges and incentives facing patients, providers and payors. Specifically, our clinical anthropology has been implemented in two broad ways: 1) patient experience, patient shadowing and medical education and (2) creation of care pathways that bring visibility to unseen and vulnerable populations.

Patient experience, shadowing education

An applied clinical anthropology can extend disease-illness gap concepts that may diminish the patient experience of care. Kleinman and colleagues recognized that explanatory models of disease were based on organic precepts and goals of correcting an underlying pathophysiology informed by biomedical and natural science education, while an illness paradigm of many patients focused on symptoms and was likely made up of both ethnomedicine and folk concepts of sickness (Kleinnman, Eisenberg & Good 1978). Perhaps, by narrowing the gap between explanatory models (disease and illness), patients may have a better experience with the healthcare system.

A modern version of this approach is more complicated, owing to the structural layers that have been added to American healthcare over the past 40 years (healthcare teams, third party payors, attempts to control spending, increased administrative/administrator influence, multiple parties involved in a patient encounter including not just physicians and nurses but also physician assistants and other advanced practice providers and ancillary staff). Patient centered care is now part of the decade old Triple Aim model (a broad set of concepts aimed at improving health, quality, and the patient experience) (IHI, n.d.). How can anthropologists utilize ethnographic methods to inform and apply interventions in medical education, care delivery and continued process improvement that fill the gaps between current state and the vision of Triple Aim implementation.

Hospital Care Assurance Programs (HCAP) and Press-Ganey surveys (Press 2006) are used to track the patient experience across time and across institutions and providers by measuring patient satisfaction (part of the Triple Aim). Percentile differences across institutions result in Centers for Medicare and Medicaid Services (CMS) financial penalties or rewards. More recently, similar data has been tied to individual physicians, affecting their specific Medicare reimbursement rates. While much effort is put into improving facility scores, very little change in those scores becomes persistently hardwired. Most hospitals now have C-suite level Chief Patient Experience Officers and large budgets to employ staff to script and coach providers on potential ways to improve their own satisfaction scores (greet patient, introduce yourself, sit down, wrap up main points with a summary, ask if there are questions).

Our initial attempts to radicalize clinical anthropology were built on this foundation almost 10 years ago when a physician (JW) joined with a medical anthropologist (RB) to invest in a long game strategy aimed at transforming the care experience through medical education and patient shadowing (Wilson, Baer & Villalona 2019; Wilson & Baer 2022). In ongoing work, we began teaching an undergraduate course to highly talented students that expressed a desire to attend medical school. Our goal was to reposition patient experience to a front and center process instead of an afterthought in mid-career. To do this, we taught Kleinman, Eisenberg & Good (1978), Hahn (1996), and other models of culture differences between lay people, biomedical providers and the healthcare system. While we introduced important elements of structural competency evaluation and the impact of structural violence in the clinic, the focus was on gaps in explanatory models and communication issues that explain differences in how a patient and provider view the same encounter very differently. The cornerstone of this model was patient shadowing. Patient shadowing represents the early implementation of ethnographically informed care. Essentially, we re-labeled participant observation as "patient shadowing" to match the nomenclature of premedical students and an academic hospital and then sent our students to sit with multiple patients for the entire patient encounter (WILSON & BAER 2019). Students always remark that they are nervous going into the experience but come out finding this to be the most valuable experience in their education as each student exits the experience with a firsthand knowledge of how care gaps arise, able to witness the culture of medicine, the culture of patients, and the culture created during the physician-patient encounter.

Observations, semi-structured interviews, and quotes from patient shadowing experiences and waiting room observations were thematically coded leading to an ethnographically informed patient-leaflet, laying out what people should expect during a hospital emergency department encounter (WILSON & BAER 2022). Later, we were invited to do a similar seminar for internal medicine resident physicians. After patient shadowing, the medical residents requested that the hospital stop the routine practice of early morning (4am) daily patient blood draws. The practice of 4am blood draws is physician-centered in an attempt to have lab results ready for morning rounds which often begin around 7am. The medical residents noted that daily results rarely impacted clinical outcomes across most patients and the practice of early morning interruption in sleep was not patient centered. We also began to offer patient shadowing and patient centered ethnographic experiences to current medical students during their first year "Doctoring" course and earlier work with premedical students continues through longitudinal cohort surveys as our prior students progress through their medical training and initiate professional life. Will these early experiences shift the clinical gaze over time, integrating patient centered care into the DNA of new physicians?

Healthcare delivery pathways

We cannot just train future healthcare workers to better consider the patient experience while seeing patients. A restructuring of healthcare must occur. Models of sick/not sick, deserving/not deserving must fade away for patients to decide what and where disease and illness are treated as a guiding design of healthcare delivery. Participatory action by those involved in direct patient care and healthcare system design is needed, along with changes to medical education. The goal here is not to improve patient compliance with biomedical care plans but, instead, to reconsider with patients what care plans should be developed and hardwired into healthcare.

The patient encounter that happens over and over again each day in every clinic, hospital and virtual visit, is the level of cultural production and the space where new ways of being for patients, physicians, medical staff and the healthcare system at large are seen or not seen, affirmed or ignored, produced, assembled or disassembled. Here is where we envision situating the applied clinical anthropologist as an active member of the healthcare team, positioned in the liminal spaces where the production of healthcare occurs. The reproduction and performance of these encounters is an ontological transcendence in which disease is made real or not real while patients are made to belong or dismissed, drastically altering healthcare outcomes and mortality.

In this space, the anthropologist can identify and conceptualize the production of culture taking place in patient-physician encounters, the way that healthcare delivery is designed, structured and delivered and the ways in which patients experience that care. How do those encounters embrace potentialities that can either go unrecognized, affirmed, or enhanced to create new patient care pathways? Creation of patient care pathways represent new ontologies in a world of salvage capitalism (TSING 2017). This salvage capitalism is represented by predetermined diagnosis related groups (DRG), reimbursable current procedural terms (CPTs), and international classification of disease (ICD). DRGs, CPTs, ICDs make or break reality of medical disease and patient belonging in the current biomedical model driven by reimbursable visits and the examination and auditing of outside compliance organizations constantly abstracting specific codes. These three letter codes are the reality of practice. A radical anthropology reimagines the design of a healthcare system based on the diseases that patients have and the illnesses they experience, not a response to the designated reimbursable codes. Imagine an emergency medicine physician training curriculum based on the frequency of each complaint for which patients seek care (substance use, mental illness) instead of those that are socially acceptable and deemed deserving of care, both highly reimbursable and monitored for process improvement (heart attack, stroke, sepsis).

But to make visible those diseases, there are complex steps to map out entangled webs of disease-illness, structural vulnerabilities, and use of other codes that hide reality (e.g., abdominal pain for patients with depression, or repeat visits to emergency departments for benign conditions masking food insecurity, mental illness and homelessness or other disease hidden in expression of entangled symptoms). The radical applied clinical anthropologist works in the medical space producing an ethnographically informed care (HENDERSON 2022, WILSON & BAER 2022). While psychological models dominate current care approaches (e.g., trauma informed care) and do add value, that value is based in the approach to the individual patient or an understanding of how individual patients experience disease (BROWN, ASHWORTH, BASS, RITTENBERG, LEVY-CARRICK, GROSSMAN, LEWIS-O'CONNOR & STOKLOSA 2022). Ethnographically informed care does not stand as a mutually exclusive approach to trauma informed care but is useful for broader attempt to reimagine healthcare delivery through collective observations of patient-physician encounters, interviews with patients, interviews with providers and deep knowledge of contextual circumstances driving the presence or absence of established care pathways (WILSON & BAER 2022; HENDERSON 2022). We utilize this approach in our clinical work at an emergency department to develop new ways of improving the patient experience, educating medical students and residents, and treating patients with sickle cell disease, opioid use disorder, HIV and hepatitis, diabetes, firearm violence and, most formally, opioid use disorder. Examples of that work are briefly discussed below.

Ethnographically informed care

Can a critical, clinically applied anthropologist find new ways of working that can bring together the golden triad of patient-centered value, healthcare provider value, and healthcare system value in a way that does not compete to find meaning and purpose in the clinical landscape but instead makes the meaning and purpose of their work obvious to other clinical stake holders, integrating fully into the clinical team. Our applied clinical anthropology is a praxis where research may take place or be generated as a way to demonstrate model success but not as primary end in itself. The goal at the outset for our applied clinical anthropology is to build a new healthcare system, visualizing unseen gaps, assembling and aligning people and systems, and unentangling complicated mixes of training, payer and compliance inertia that guides regular clinical practice for physicians. We envision a radical anthropology in the clinical space with the applied clinical anthropologist moving between roles as interlocutor with multiple groups that must be engaged to reconsider health: physicians, staff, patients, administrators. Think of the disease-illness gap described by KLEINMAN, EISENBERG & GOOD (1978) in the 1970s but made more complex by considering the broader structure of third-party payors, compliance bodies, and collected stories of lived experiences of not just patients but also physicians and others working within the current system.

What does it mean to create ethnographically informed pathways that unentangle and reassemble current clinical realities? Our work to improve care of patients in the emergency department with sickle cell disease, opioid use disorder (OUD), and Hepatitis C Virus (HCV) are all representative of our approach to ethnographically informed assemblage formation (Wilson and Baer 2022). Theoretically, the work of philosophers Delanda, Deleuze and Guatarri, as well as the anthropology of Tsing and Nading, specifically inform our work in their attempts to define and describe assemblages (Delanda 2006; Deleuze Guatarri 1987; Tsing 2017) and complex entanglements (Nading 2019). Methodologically, we extend the descriptive concept of syndemics (two biological disease states linked by same social phenomenon) (Singer, Bulled, Ostrach, and Mendenhall 2017) to an applied treatment approach of co-locating care for co-occurring disorders (HCV and OUD).

To be critical, clinical and applied, the anthropologist can parlay healthcare observations to first unentangle existing structures (Nading 2019) while searching for the precipice of newly forming assemblages. Those assemblages can be formally built out into new and tangible patient care pathways. Extending Tsing's concepts of salvage capitalism (Tsing 2017) in the critique of medical coding to generate charges and revenue that create precarious patches (spots where reimbursement leads to semi-permanent care pathways) across a capitalism landscape, new connections can arise to bring those patches together in ways that were not there just a moment ago – providing visibility to patient populations that were unrecognized in the current entanglement. In the past, our ED would follow the CDC guidelines (Branson, Handsfield, Lampe, Janssen, Taylor, Lyss, Clark, and the Centers for Disease Control and Prevention 2006) for HCV testing and miss new diagnoses of HCV in patients that inject drugs. While we now see these patients and offer them treatment, most clinical spaces continue to follow the existing algorithm or do not screen for HCV at all, perpetuating spread and missing opportunity for cure. A decade ago, people who use drugs were offered no medical treatment or specific community linkage while now, physicians in our ED initiate lifesaving therapy (buprenorphine) and participate in 'warm hand-off' processes that ensure patients are not lost after ED discharge. Much of this work involves finding connections between those patches of patient-centered care to broader healthcare system and provider incentives or motivations to hardwire new routes of improved outcomes.

Consider first a patient with a myocardial infarction, stroke, or sepsis. In the current healthcare system, provider education, prehospital/EMS, primary care/prevention, pharmaceuticals, compliance organizations (e.g., goals set in the United States by the National Quality Foundation), payment structures (Center for Medicare and Medicaid Services) and reimbursement to individual providers and facilities all align to drive care with less variation from encounter and a common set of expectations among providers and healthcare systems across the United States. These are formalized pathways of care, highly entangled assemblages with patient, provider, administrator incentives aligned. Alignment in healthcare is not a common feature in the United States secondary to different payment sources and associated quality goals for providers and facilities and providers and staff (e.g., nursing). Acute coronary syndrome/coronary artery disease alignment leads to assemblage stability across preventive care, prehospital care, primary care, the emergency department, and the cardiology teams. Patients with a ST-Elevation Myocardial Infarction (STEMI) receive high quality, low variability care across hospitals in the United States.

Patients with Sickle Cell Disease, on the other hand, often receive care below best practice recommendations that is highly heterogenous. In 2016, we recognized our emergency department was delivering highly variable care to patients with SCD Veno-occlusive Crisis (VOC). SCD VOC is a painful condition where sickled cells impede regular blood and microinfarcts in soft tissues and bones occur. As patients with SCD live longer secondary to advances in medical management, they undergo more episodes of these painful conditions and, often, develop a physiological opioid dependence from treatment. The distribution of SCD worldwide is based on evolutionary processes that promote selection of the sickle cell trait which is protective from malaria across geographically affected areas near the equator, including parts of Africa.

In the United States, SCD is structurally distributed with high prevalence in the South secondary to historical enslavement of African people (CDC 2020). Institutional racism and implicit bias of healthcare providers in the south have contributed to uneven care delivery to mostly black patients with SCD VOC. Students conducted participant observation and semi-structured interviews with SCD VOC patients in our hospital, seeking to create a more just, equitable, and evidence-based system of care (Wilson and Baer 2022). Through these ethnographically informed approaches, our hospital has now hardwired utilization of patient-controlled analgesia (PCA) and emphasizes early pain medication delivery after ED arrival. PCA utilization and early drug delivery are WHO/NHLBI best practices (Yawn, Buchanan, Afenyi-Annan, Ballas, Hassell, James & Jordan 2014) that have resulted in improved patient experiences and decreased hospital admissions by over 10% (Osorno & Wilson 2018). The long length of stay (LOS) associated with SCD VOC admissions and the "poor payor mix" (a term representing the connection between SCD VOC patients and the likelihood of lower reimbursing Medicaid state/federal insurance), has aligned neoliberal healthcare goals (reduce length of stay on this poorly paying DRG in order to lose less money) and patient care goals, while also removing the opportunity for repeated microaggressions of provider-patient judgement encounters where deservingness of treatment could be decided at the moment of care delivery.

Assemblage formation

A prior graduate student produced an ethnographically informed medication for opioid use disorder (MOUD) pathway that represented roots of new assemblage formation (Henderson 2022). 10 years ago, patients that presented to our ED with OUD were given no treatment and few resources. Their mortality at 1 year was higher than that of a person presenting with heart disease (Weiner, Baker, Bernson & Schuur 2020). Henderson, Wilson & McCoy (2021) constructed the ED BRIDGE to provide buprenorphine to patients with OUD along with a warm hand-off to a community provider (Henderson, Wilson & McCoy 2021). This process required physician engagement and new, two-way relationships with community partners.

The assemblage has more fully begun to form as other work on infectious disease is more clearly linked to OUD pathways. In 2016, JW initiated HIV and HCV non-targeted screening in the ED based on CDC guidelines (2006). Patients with newly diagnosed HCV were difficult to link to care, even though new direct acting antivirals (DAAs) that offered HCV cure in 95% of patients within 12 weeks were available beginning in 2015 (Feld, Jacobson, Hézode, Asselah, Ruane, Gruener, Abergel 2015). The traditional demographic of HCV patients shifted from age-cohort ("baby boomers" born between 1945–1965), well-funded (Medicare) people to a non-age-cohort ("millennials" born after 1980) with active or recent drug use and less likelihood of having any third-party insurance or having lower reimbursing state/federal funding (e.g., Medicaid). People who inject drugs (PWID) are also less likely to engage in HCV treatment given the lack of obvious systemic symptoms in the early disease course. Left untreated, those with HCV can develop liver failure or liver cancer. In addition, HCV is highly infectious via injection drug use secondary to the ability of viral particles to remain active on drug paraphernalia.

HCV and OUD are a syndemic created secondary to the biology of HCV (virulent and highly infectious during injection), opioid use disorder (often progresses to injection drug use as physiological dependence develops) and social determinants, social policy and structural causes of drug use. A combination of lower wages, lower education obtainment, less positive outlook for future life happiness, pharmaceutical marketing, federal laws restricting safe injection sites and oral medication supply (both opioids and treatments for opioids) have all combined to place us in a opioid current epidemic that began in the mid 2000s with prescription drug misuse, escalated to injection heroin use and is now best defined by fentanyl. Co-occurring mental health disorders (documented in 80% of our participants) is also an important component of this syndemic.

The classic syndemic description by Singer connected HIV, drug use and domestic violence (Singer, Bulled, Ostrach, and Mendenhall 2017). Other anthropologists have extended syndemic descriptions to diabetes and obesity (Mendenhall, Kohort, Norris, Ndetei & Prabhakaran 2017). The expansion of syndemic models into public health has led to the expansion of the descriptive technique to consider the linkage between social determinants and multiple other acute and chronic disease states and biological conditions. Our clinically applied anthropology extends syndemics from a descriptive model to treatment model, using a syndemic methodology to consider emerging assemblages (OUD programs, HCV linkage and treatment programs) and to design care pathways that manage co-occurring disease. We first implemented the MOUD program in our ED and found that 78% of patients we started on buprenorphine and linked to care also had HCV. Previous to this pathway, our linkage to care rates for HCV were under 30% and only 3% of patients were started on DAA. By co-locating downstream OUD and HCV care (prescription of buprenorphine and DAAs at same site), we established the largest HCV management program for patients in OUD recovery with an over 40% DAA treatment initiation. Our syndemic treatment pathway led to management of OUD and cure of HCV in patients that otherwise would have had no care, a 5% one-year mortality and continued spread of HCV in the community.

Finally, we expanded our newly forming complex assemblage by expanding the territory and scope of our pathway after recognizing that some patients in the ED with HCV were not yet ready to stop using injection drugs in order to start OUD treatment. Those patients attend a syringe exchange program where they undergo onsite testing for HCV. If positive, patients are able to receive DAA treatment at the exchange in a one-of-a-kind program that has the highest rates of HCV treatment in patients still using drugs (an important action to stop the transmission of HCV).

The time is right to reconsider applied clinical anthropologists as direct agents within the healthcare delivery space. This disruption challenges patient experience departments, healthcare providers and social workers to reconsider understanding of social determinants and the role the healthcare system can play in overcoming these burdens to delivery high quality patient-centered care. Those perceived social determinants are neither static burdens to overcome or arbitrarily objective items to be separated from the lived experience of disease. Just as prior concepts of applied clinical anthropology were given up in favor of a critical focus that first examines structural violence and power within relationships between people and institutions, abandonment of cultural competency concepts to are moved past, instead, focusing on ontological emergences within replicated healthcare encounters.

This does not mean that culture does not explain any differences in how patients consume healthcare, how healthcare is accessed or why there are broad disparities across human groups in healthcare outcomes even within local regional space. We are also not suggesting that simply studying structural realities, economic differences, or static demographics will lead to resolution of new disparity formation or solve inequity. Our model of an applied clinical anthropology shifts the lens to the ongoing reproduction and formation of those disparities, suggesting that this is the liminal and hard to see space that the anthropologist must find and magnify as the interesting place for study, healthcare contribution, and improved patient care. Chenhall and Senior (2017) have argued to abandon the static social determinant of disease concept in favor of the dynamic assemblage theory which focuses on disease emergence. While we do advocate for assemblage theory as the guiding theory to examining, unentangling, and creating new patient care pathways, we actually do not advocate full abandonment of the Social Determinants of Health (SDOH) since this is a language medicine speaks dating back to Virchow who posited that medicine is really social science. Instead, we suggest clinical anthropologists adopt the SDH framework in discussion with medical colleagues but utilize the ontological approach of assemblage formation as a guiding strategy to implement SDOH solutions into healthcare delivery approaches. Traditional anthropological methods relying on participant observation and collection of qualitative data through semi-structured interviews is able to capture lived experiences of patients, providers, and other healthcare stakeholders. Utilizing those insights allows for design of novel care pathways and positions the anthropologist directly into the clinical space. This ethnographically informed care is a radical new clinically applied medical anthropology that can transform the patient experience by shifting the clinical gaze through a shared formative approach to care.

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