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INTRODUCTION

Clinical Ethnographies of the Politics and Poetics of the US Healthcare Crisis

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Introduction

The confluence of the COVID19 pandemic, the Supreme Court's overturning of *Roe vs Wade,* the televised murder of George Floyd, and the rise of populist hate-speech under Donald Trump highlights how political ideologies, racism, and social structural inequities negatively impact health and medicine. As US-based medical providers, scholars, and advocates, we are keenly aware of the ways in which policies and social forces influence bodily well-being. COVID-19 continues to lay bare the divisions between haves and have-nots. High death rates in the U.S. compared to similarly wealthy countries (Bilinski et al., 2023), a monetized for-profit health system that disproportionately affects poor and racialized communities (Dranove & Burns, 2022), and a deeply polarized political climate all harm health and well-being.

Numerous domains of medical practice mirror increasingly national trends, with providers caught in the turmoil. Examples abound: partisan defunding of the federal Office of Pandemics and Emerging Threats (Schismenos et al., 2020),

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prohibitions against gender-affirming healthcare (Cahn, 2022; Hughes et al., 2021; Mercer, 2022), and the United States court system's evisceration of reproductive rights (Schreiber et al., 2023; Williams et al., 2022). Social media also plays an increasingly expanded role. During the COVID-19 pandemia, viral messaging discouraged people from getting vaccinations which put the lives of physicians, their families, and the general public at risk (Conklin, 2022; Klitzman, 2022)—and such levels of poor health information quality persist, particularly for life-threatening conditions like cancer and diabetes (Afful-Dadzie et al., 2023).

In recent decades, there have been more calls for providers to recognize the confluence of structural forces of sickness beyond the doctor–patient clinical encounter (Bourgois et al. 2017, Metzl & Hansen, 2014; Neff et al., 2020). Clinicians who are attuned to the ways in which powerful structural determinants influence sickness and health can perform their professional missions more effectively and humanely (Holmes et al., 2020; Metzl & Hansen, 2014; Stonington et al., 2018), as patients suffer from higher burdens of disease and reduced access to quality care (Crear-Perry et al., 2021; Waldron, 2010). One of the most damaging structural forces entering the healthcare arena are private equity firms, whose regional monopolization of labor forces decrease physician autonomy and healthcare access, harming patients and raising costs. While the corporate practice of medicine is not new, the influx of private equity has skyrocketed in the past two decades with firms raising their annual investments from $5 billion in 2000 to $100 billion in 2018 (Fuse & Hall, 2024; Scheffler et al., 2023).

These contemporary politico-economic challenges demand a broader understanding of healing—one that does not remain ensconced in conventional scripts of biomedically reductionistic practice. Recognizing the ever-changing conditions of our complex world and its impact on care, we need novel ways to make sense of it. A promising development within our field is the demographic shifts of clinical formation, as more women and people of color become health professionals. Trainees increasingly call for diverse clinical experiences and greater focus on justice, social responsibility, and awareness of local and global health inequities. Given this rapidly evolving context, clinical ethnography becomes a means to identify ethnographically urgent emerging problems and pathways to reshape medical practices. As a "clinically informed self-reflective immersion in local worlds of suffering, healing and well-being," (Calabrese, 2013, p. 51) ethnography offers tools for documenting experiential understandings of how structural forces and power inequities impact sickness and health. Tasked with interpreting the "local moral worlds" (Kleinman & Kleinman, 1991, p. 279) in which we work, our embroiled professional/methodological subjectivity prompt critical reflexivity on our positions within these fields of power. This dialectic of reflection and participant-observation aims to chart a more hopeful and humbler path toward solidarity with patients and allies to promote change from within and beyond the healthcare system.

This special issue offers an ethnographic snapshot and critical archive of the era's turmoil since COVID-19. Composed of health practitioners and researchers who are also social scientists and humanist observers, the authors in this special issue draw on ethnography to address the poetics and politics of intimate spaces of healing.

This engaged scholarship builds on interdisciplinary traditions at the nexus of anthropology and medicine.

Ethnography and Structural Attunement

Running parallel to the rise of clinical ethnography is narrative medicine, which is a humanities-inspired field that emerged to help practitioners recognize patient illness narratives. It strives to foster therapeutic alliances and compassionate ethical care by the provider accompanying the patient emotionally through the illness ordeal (Charon, 2008). The method of clinical ethnography builds on narrative medicine's impetus by adding providers' reflections and systemic attention to structural constraints. It uses similar techniques "to observe, to document, to understand, and … to write about [patients'] lives and their pain as fully, as truthfully, and as sensitively [as possible]" (Scheper-Hughes, 1995, p. 410). Documenting subjective realities is not enough, however. As public medical anthropologist Nancy Scheper-Hughes insisted in 1995, there is a moral imperative to go further by taking a critical stance, drawing connections to harmful structural forces, and staking a political commitment to alleviate social suffering (Scheper-Hughes, 1995).

Clinical Ethnography: History of the Term

Early in the twentieth century during the British imperial era, the multidisciplinary anthropologist, neurologist, and psychiatrist W.H.R Rivers generated popular interest in what might now be called "clinical ethnography" by publishing his clinical notes including his autobiographical self-reflections on treating "shell-shocked" patients. In particular, many of Rivers' reflections revolved around two of his young war hero patients, Sasson and Graves, who were traumatized by their experiences, but went on to be pacifist heroes and literary stars. While Rivers had personal allegiances to the military, his reflections on their process of healing from the war ultimately led him on the path of promoting pacifism (Rivers, 2013; Wilson, 2017). Such reflexivity is core to clinical ethnography and shines light on the way in which the method produces knowledge but also leads to personal transformation for many ethnographers.

Almost a century later, beginning in the 1980s, scholars began to use the actual term, "clinical ethnography." For some, the term "clinical ethnography" referred to an anthropology of clinician formation (Davenport, 2000); for others, it referred to clinicians practicing ethnography (Calabrese, 2013; Ewing, 1987; Herdt, 1999; Jain & Jadhav, 2009) and, by extension, to a non-clinician's critical interpretation of the clinic (Good et al., 1985). The prolific psychiatrist–anthropologist, and social medicine scholar Arthur Kleinman did not ostensibly use the term "clinical ethnography," but his work developed key concepts that are foundational to the method, including "patient illness narratives," "cultural construction of clinical reality," and ethnographically informed practitioner reflexivity on medicine and

the human experience (Kleinman, 1988, p. xviii; Kleinman et al., 1978, p. 251; Kleinman & Kleinman, 1991).

Like Rivers and Kleinman, many early clinical ethnographers were psychiatrists and therapists. By the late 1980s, however, a wave of social scientists and psychoanalysts theorized increasingly complex and experimental ethnographic accounts of clinical encounters (Crapanzano, 1992; Ewing, 1987; Herdt & Stoller, 1990) facilitated by psychoanalytic insights (like Rivers) with an attention to transference and countertransference. A subset focused critically on "culture-bound syndromes" (Hughes, 1985; Kleinman, 1980; Simons & Hughes, 1985) or "popular illnesses" (Good et al., 1982; Guarnaccia, 1993), ranging from Puerto Rican *ataques de nervios* (Guarnaccia et al., 1989) to *kamidaari* in Japan (Shimoji & Miyakawa, 2000). Several of these cultural-bound discussions were both meaning-centered and critiques of social structure, combining psychoanalysis and political economy. They identified harmful actors and societal forces perpetuating patient pain and distress (Guarnaccia et al., 2010; Gherovici, 2018; Bourgois, 2003). This mutual imbrication of anthropological and psychoanalytic traditions was an important throughline in the development of clinical ethnography.

An early formal definition of "clinical ethnography" comes out of a 1985 article "Reflexivity, Countertransference and Clinical Ethnography," in which the authors collaborated on an interpretive analysis of a cultural consultation service in a psychiatry clinic (Good et al., 1985). Through the process of participant-observation and interdisciplinary collaboration, Good and colleagues showed how their ethnographic work influenced the practices of the clinical psychotherapists (who were also taking fieldnotes), while the clinical content, in turn, was influencing the ethnographers' interpretation of the medical professional field (Good et al., 1985). Anthropologist Herdt and psychiatrist Stoller were also early adopters of the term, valorizing clinical and ethnographic expertise in their study of erotic experience and gender identity in Papua New Guinea (Herdt & Stoller, 1990). The physician–anthropologist Melvin Konner used clinical ethnography in his critical interrogations of medical training and its limitations, providing an early example of first-person commentary on the process of professional socialization (Konner & Shostak, 1987).

More recently, Calabrese clinical ethnography in *A Different Medicine* (2013) follows two parallel lines of inquiry investigating different approaches to adolescent substance abuse—one based on the consumption of the psychedelic Peyote cactus in the Native American Church and the other by a community clinic using conventional therapies. Drawing on his dual expertise in anthropology and clinical psychology, Calabrese interrogates cognitive frameworks to explore the unknowns of the human mind, while laying bear inherent contradictions in U.S. national drug policies (Calabrese, 2013).

Clinician–anthropologists Rebecca Lester and Elizabeth Fein further develop the method in their auto-ethnographies in *Famished for Care* and *Living on the Spectrum,* respectively. Be it commentaries on the "lived experience" of anorexia nervosa or autism, both authors expand on the limits of ethnography to redefine popular and professional understandings of "neurodiversity," "eating disorders," and personhood within the context of the corporate practice of medicine (Fein,

2020; Lester, 2019) Like these earlier scholars, this special issue's authors draw on their fractured positionalities and emotional/professional allegiances to reveal how complicity operates in medical practice and use ethnography to upend conventional understandings of sickness and health.

The Scholarly Value of an Epistemologically Fractured Habitus

The majority of the clinician–scholars who contributed to this special issue are not psychiatrists or psychotherapists, but they share a commonality across practice disciplines due to their positionality straddling the "epistemiologically incommensurate" fields of medicine (or public health) and the social sciences (Wendland, 2019, p. 198). In total, the contributors consisted of four medical students, one emergency medicine physician, three internists, one family practice doctor, one public health practitioner, and one obstetrician–gynecologist. With intention, we included medical students and seasoned providers together to highlight the ongoing processes of subjectivation, socialization, and serendipitous pre-conscious biases that develop during training and practice. Drawing on Bourdieu, we value the embodiment of a fractured professional habitus as clinician–ethnographers in formation/maturation (Schlesinger et al., 2021). The distinct particularities of our clinical demands and hierarchical locations within medicine allow us to explore vexing methodological and humanist questions: What does it mean to be a clinician critiquing medical practices while simultaneously providing care? How do clinician interpreters balance multiple obligations, and which takes precedence?

The special issue contributors see this hybrid practice's potential to reveal power hierarchies and improve caregiving and solidarity, but only when one is aware of how research priorities may harm or distract from one's caregiving imperatives. As clinicians—across the spectrum of training—who are also anthropologists and philosophers, they take on key issues within the practice of medicine, focusing on two core topics: critiques of imbalances of power and the formation of clinical subjectivity. These ethnographic observations sharpen therapeutic skills by recognizing the meaning-making and pathophysiological structural forces harming bodies and hopefully generate a humble awareness of the limits of theoretical knowledge and methodological innovation. The dialectical utility of contradictions ideally cuts both ways: ethnographic data, critical thinking, and fragile biomedical expertise enriches both the multidisciplinary clinician and the social scientist.

Clinical ethnography also has the potential to cast a critical lens on routinized actions cultivated over years of repetitive training and practice. As Herdt writes, "What distinguishes clinical ethnography from anthropological ethnography in general is the application of disciplined clinical training to ethnographic problems" (Herdt, 1999, p. 106). For Herdt, one does not have to be technically trained to perform clinical ethnography, just generally familiar with the therapeutics taking place in the field of study (Herdt, 1999). As it pertains to the ethnographies in this special issue, however, the fact that we are trained practitioners presents a different way of knowing that arises from our capacity to critique ourselves and our disciplines from within.

Multiple positionalities and emotional/professional allegiances also reveal how our confessions of complicity in the systems we critique give rise to a moral responsibility toward radical emancipation to counter the quotidian social suffering we witness while working. Such a searing recognition resonates with Scheper-Hughes' assertion that ailing bodies manifest oppressive social structures wordlessly and intimately. Clinicians' proximity to the suffering and affliction of patients offers them a choice: Limit engagement to a palliation of individual patient pain, thereby maintaining the status quo, or pursue a more utopian "liberation medicine" (Scheper-Hughes, 2023, pp 213–215). She urges physicians to accept the moral responsibility tied to their privileged position, listen to their patients and their bodies, and work together to counter the political forces devastating the poor and disenfranchised (Scheper-Hughes, 2023). The authors in this special issue attend to this call through critical interpretations of the contexts enveloping therapeutic practices. Through their re-configuration of the relationship between the body and social pathology, they enrich a broader structural and meaning-centered understanding of the social determination of health (Harvey et al., 2022).

As social scientists, the authors attempt to unpack unquestioned variables underlying public health metrics, such as race, socioeconomic status, gender, and normativity. Through the evocative ethnographic vignette-cum-medical-and-social science case study format, many explore theoretical insights informed by political economy, critical phenomenology, psychology, and symbolic analysis. Their vocation facilitates entry into fraught social worlds and non-transparent bureaucratic interstices of health systems, enabling documentation and ethical reflections which potentiates care and hopefully humility rather than hierarchy.

Witnessing and the Clinical Gaze

Good clinical ethnography strives for an ethic of purposeful witnessing and practicing alongside people who are suffering and in the midst of acute vulnerability. This is the essential premise for human and civil rights. In "The Primacy of the Ethical," Scheper-Hughes distinguishes observation from witnessing whereby "witnessing" is a practical stance in contrast to the academic researchers' detached observations. As anthropologists "who are privileged to witness human events" up close and over time, she believes they have an obligation to "identify the ills in a spirit of solidarity." (Scheper-Hughes, 1995, p. 411, 419). Doctors also have an obligation beyond treating patients to speak out about the social ills they witness routinely. The method of enmeshed engagement demands practical advocacy, a purview that extends beyond the clinical encounter, and an insistence on the "common sense" of the human right to care.

The practice of medicine as a symbolic form is a productive starting point to consider how providers and trainees grapple with attending to the physiology of ailing bodies (Good & Good, 1993) and remain committed to structural change. At a clinic for the Campaign on Homelessness in Angel Bay, medical anthropologist Beverly Davenport documents how this tension subjectivizes students by unintentionally squashing their commonsense witnessing ethic, reinforcing doctor/

patient hierarchy (Davenport, 2000). Holmes (this issue) echoes this affective tension between wanting to treat patients with dignity as whole, social persons versus the institutional pressure to objectify patients to meet professional expectations and gain normative biomedical competencies (this issue). Insights on "moral injury" gnaw at US practitioners inside-out during clinical encounters and manifest euphemistically in a surge of literature about healthcare worker "burnout" (Dean et al., 2019; Talbot & Dean, 2018), "moral distress" (Jameton, 1984), and "moral stress" (Buchbinder et al., 2024; Cribb, 2011). Consensus invariably shifts regarding what "doing right" means for individual clinicians, but the US Trump-mobilized 'post-truth' era of rising "predatory accumulation" and "necro-governance" reflects the current hegemony of for-profit medicine (Bourgois, 2018).

In short, our vocation gives us logistical access and also facilitates entry into the fraught social worlds and non-transparent bureaucratic interstices of health systems, allowing us to document and reflect on patient–practitioner miscommunication and conflict, as well as mutual empathy and care. Holding professional frameworks in balance with a critical awareness of structural constraints and fallible expertise offers a novel take on the complex assemblage of modern-day medicine.

Mapping the Special Issue's Arc

The US healthcare system is fractured, unequal, and abandons too many sick people. Each of the articles highlights the need for radical change and the constraints on ethical practice.

Within the realm of witnessing and pragmatic solidarity, the contributions by physician–anthropologists Carolyn Sufrin, Kim Sue, Liza Buchbinder, and Jeremy Levenson, as well as physician–scholar activist Shamsher Samra (this issue) all examine healthcare in large urban jails. They demonstrate medical anthropology's centrality to the fledgling but rapidly growing discipline of carceral studies (Parker, 2023). All four accounts document non-transparent realities, where the importance of a human right to healthcare is nowhere more visible than behind bars.

Their insights confront us with the fundamental contradictions between the security/punishment priorities of carceral institutions and the rehabilitative/lifesaving priorities of clinicians. In "Complicity Consciousness: The Dual Practice of Ethnography and Clinical Caregiving in Carceral Settings," Sufrin writes as an obstetrician–ethnographer veteran of a jail medical ward (Sufrin, 2022). After learning that a close friend and patient struggling with addiction died in childbirth, she invokes her hierarchical authority and habitus to advocate for the deceased's grandmother's right to adopt her newborn orphan grandchild. The tragedy she documents demonstrates the desperate need for human connection and care in such a brutal setting. Sufrin insists on a tenacious hyperawareness of the ethics and challenges of being a jail-based healthcare provider. Caregiving in carceral contexts is therapeutically transformative and could have saved her patient's life. Her structurally informed self-consciousness enabled her to provide partial help for the orphaned newborn so that a loving grandmother could adopt her, which unfortunately was too little too late.

Sue writes from the point of view of a jail internist–anthropologist, specifically at New York City's Riker's Island jail during COVID-19. Persuasively, she is "ethically obliged" to sign "health clearance forms" that permit guards to taser or pepper spray her patients during "cell extraction"—some of whom are in florid psychosis—to prevent them from being subjected to the alternative uses of force, such as brutal baton-battering (Sue, this issue). Embedded in the nitty-gritty chaos of COVID's historically unprecedented public health crisis behind bars, the carceral system institutionalizes brutality legally through the creation of a box at the bottom of a form to authorize use of force. Striving to deliver humane care the carceral bureaucracy reduces Sue to a cog oiling the quintessential structural violence of US mass incarceration. Sue engages theoretically and emotionally with the double-bind of an institution saturated with punitive social suffering. Despite these impossible contradictions, she argues for clinicians to go to jail to defend and embrace the right to healthcare and the need for transparent social criticism of institutionalized injustices.

Levenson and Samra's article provocatively re-defines the term "engaged clinical ethnography" by exploring their role as ethnographers and activist–advocates in social movement organizing. They harness their "ethic of commitment" to link state violence to the national epidemic of police shootings on segregated streets and private homes of people experiencing mental health crises outside and inside jails. In an era of rising homelessness and decreasing access to community—and hospital-based mental health services—the effect of increased spending on incarceration and court oversight has been particularly repressive for individuals with psychosis (Levenson & Samra, 2023). Moreover, a proportional increase in access to community-based mental healthcare and supportive public housing has not accompanied the deinstitutionalization of state psychiatric hospitals. They draw on physician–anthropologist–public intellectual Paul Farmer's concept of "pragmatic solidarity," in which physicians express personal outrage over injustices while practically leveraging their credibility as healers. They advocate for the rights of all detainees, thereby operationalizing their practical commitment to justice and quality care for all "by any means necessary." (Levenson & Samra, 2023)

Buchbinder's firsthand account caring for inmates in a large county correctional facility echoes these concerns and her hospitalist medical expertise allows her to deliver remedial high-quality care to sometimes violent and often floridly distressed patients in the jail. Security mandates during COVID imposed physical barriers, onerous protocols, and bureaucratic-inmate-processing-rules-turned-routine-clinical procedures into insurmountable tasks justifying timely transfers to the hospital to prevent interrupted treatments that could lead to sickness and death. She notes that as municipal and state legislatures vote for greater expansion of jail medical wards, these decision-makers must recognize that jails are inherently unhealthy spaces. In short, the sick do not belong in jail or court. Fundamental contradictions between punishment and care permeate carceral clinical interactions and impose moral injury bearable as a physician only because failing to provide desperately needed care is a worse human rights violation.

The second set of selections focuses on how the COVID-19 pandemic and assaults on reproductive rights following the US Supreme Court's overturning of

Roe v Wade reshaped the US healthcare system. This section also addresses how previously sacrosanct aspects of medicine, such as the collection of personal information for abortion care and the surveillance of medication-assisted treatment for opioid use disorder, were upended for the sake of containing the virus. In their piece for this special issue, family practice doctor and historian Karlin and MD/PhD medical and anthropology student Hodge turn the hands-on medical model on its head. Their timely, evocative article on the urgent need for medication-assisted abortion describes the simplicity of a hotline in which volunteer providers remotely advise women requesting self-management of medication-assisted abortions. Volunteer doctors deliver care by talking callers through the self-administered pill-enabled abortions step-by-step. These emergent clinical encounters—remote but empathetic—foster new forms of intimacy and collectivity in medicine.

Public health practitioner and anthropologist Knight reimagines care for patients at risk for opioid overdose in two U.S. cities during three co-existing crises: the COVID-19 pandemic, the opioid epidemic, and the racial justice mobilization following George Floyd's murder. Counterintuitively, surveillance of medication-assisted treatment for opioid use disorder was suspended to contain Covid-19 and naloxone dispensing machines were made available to everyone. This led some California jails to decrease skyrocketing overdose deaths among newly released inmates. Through two long-term qualitative studies—one in a San Francisco primary care clinic and the other in an outpatient methadone treatment program—she reveals the logic of the carceral state's surveillance practices that shape medication-assisted treatment (MAT) for opioid use disorder. By chance, the clinics' COVID-19 infection-control protocols dramatically transformed the methadone clinic, permitting take-home MAT. While not supported by strong evidence, the prevailing belief within the medical establishment was that take-homes increase overdose risk, but the pandemic squelched that concern in the interest of public safety. Harkening back to Karlin and Hodge's invocation of the urgency for "care with nothing in the way," Knight identifies how racism, stigma, and mistrust decreased access to drug treatment since the early 1900s. The collective fear of COVID-19 led to this liberalized methadone (and naloxone) dosing and the "emancipation" of addiction and overdose treatment. In this moment, pandemic health pragmatism was the collective expression of solidarity for people with substance use disorders, decreasing the alienation of previously punitive surveillance practices.

In "Meaning in Psychosis: A Veteran's Critique of the Traumas of Racism, Sexual Violence and Intersectional Oppression," Kalofonos documents the capacity and insights that people experiencing distressing psychosis have when narrating their psychological state and seeking care. Kalofonos' psychoanalytic and critical approach is collaborative. Above all it decreases the social isolation and distress of his patients by finding meaningful critique and a pathway to care by taking psychosis narratives seriously. Through his empathetic practice and anthropological vantage point, Kalofonos identifies the for-profit reductionism promulgated by pharmaceutical corporations. He shows how the deskilling of caregiving in mainstream psychiatry dismisses narratives of psychosis as irrelevant "noise" to be cured with often toxic mood-altering or soporific medications that exacerbate patients' social isolation. Kalofonos draws on multiple theoretical

frameworks bringing user-survivor writings and meaning-centered cultural psychiatry into dialog with Fanon's "sociogeny" to link both traumatic life experiences and social structures in his patient's narration of psychosis. His article critiques de-pathologizing psychosis by emphasizing its structural roots. Thinking structurally, his interlocutor's psychotic speech becomes intelligible and opens up possibility for a mission-oriented, "no-snitch" solidarity and commitment to caring for persons experiencing serious mental illness. Insights from this approach have enabled Kalafonos to co-develop a pathbreaking outpatient Veterans Affairs intervention that is currently expanding outpatient access to a peer-facilitated psychoanalytically informed therapy of "hearing voices." (Kalofonos, 2023).

The final thematic grouping of articles within this special issue addresses subject formation and uncertainty in medical training and hospital practice. The articles by Holmes, Aboii, Stonington, Livne, and Boudart utilize ethnography to render visible disciplinary subjectivation through the contradictions of caregiving in their clinical training and professional work.

Holmes reveals how early medical training teaches students to unlearn their empathic connection with patients. While practitioners discovered how to "perform" empathy (in the language of medicine), the intersubjective affective work between patient and physician is "trained out" of them during their years of schooling. Drawing on language socialization theory, his long *durée* autoethnography as a medical student twenty-five years prior, and interviews with pre-clinical medical students, Holmes explains how the "verbal, textual and bodily language of medical practice" (Holmes, this issue) creates harmful divides between physicians and patients. He also shows how solidarity, health equity, and policy advocacy are effectively off-limits for ambitious doctors. This "hidden curriculum" cultivates empathy as a performance skill, with the ultimate aim of accelerating patient processing, rather than as a "multi-faceted capacity to develop within oneself" in the name of better patient care (Holmes, this issue). Holmes calls for revamping training by valorizing affective work within a social medicine/medical humanities framework. This shift promotes the caregiver's commitment to building solidarity, augments better understandings of patients' social worlds, and extends Holmes' vision for advocacy and structural reform.

In "Corpses in Clinical Space and the Preposterous Temporality of Pandemic Care," Aboii steers clinical ethnography in an entirely new direction, unpacking the "preposterous temporality" of pandemic care by interrogating the symbolic weight of the corpse within clinical spaces. As an MD/PhD medical and anthropology student, Aboii writes about her engagement with a corpse who had replaced a patient on the ward, prompting an exploration of how corpses disrupt narratives in medicine. Evoking various literary and theoretical works, such as Ionesco's play "Amédée," Glissant's critique of the tragic heroine, and Marriott's theorization of blackness as corpsing, Aboii conceptualizes how corpses could reconfigure clinical spaces when temporal boundaries are blurred. The article challenges the notion that the COVID-19 pandemic was unique by examining the continuities that exist before and after moments of pandemic crisis. By analyzing the corpse as a figure that prompts a reconsideration of ideal and failed care, she argues that the presence of corpses in clinical spaces serves as a critique of the dominant narrative arc, which

centers the medical provider as the imagined quasi-omnipotent hero/heroine who commands control of the medical crisis and public health tragedy.

Stonington (internist-anthropologist), Livne (sociologist), and Boudart (MD/PhD anthropology student) also examine how medical crises unfold by combining Stonington's ethnographic account of providing healthcare in Michigan during the early months of COVID-19 combined with testimonies from over forty doctors caught in the COVID-19 turmoil. The testimonies are powerful, but Stonington's autoethnography becomes a backbone for the collaboration's arguments. For Stonington, Livne, and Boudart, timing was critical. They captured providers' thoughts and feelings at the pandemic's inception to explore a knowledge practice they call "hallucination," exposing the cognitive dissonance of working during an unprecedented medical panic and inadequate US public health infrastructure. Despite medicine's assumption that evidence-based treatment protocols do not change in the varying contexts of clinical practice, the pandemic revealed a "pseudo-scientific" imaginary that spatialized clinical epistemologies as hallucinatory virions. Such imaginaries shaped behavior as the authors describe a doctor basing clinical decisions on hallucinatory visualization of virus particles in a patient's room. Echoing several of the authors in the special issue, they suggest that "emergent imaginings" during the pandemic proliferated, offering a window into the fallible knowledge practices of clinicians even during calmer times of routinized certainty (Stonington, Livne, and Boudart, this issue).

Somatic Solidarity and Utopian Pragmatism

Caregiving and training obligations are natural sites for the anthropological method of self-reflective participant-observation (Calabrese, 2013; Fein, 2020; Good et al., 1985). Such acts of affective immersion can powerfully improve a clinician's practice, but as Holmes, Levenson, Samra, and others (this issue) argue, the method can also serve as a vehicle for political activism and policy reform. In the early 2000s, medical anthropologist Adrienne Pine envisioned the role of an "observant-participant" as an embodied one rooted in a solidarity with her interlocutors' struggles for social change. She worked alongside Honduran nurses caring for wounded protestors resisting a coup that led to a series of neoliberal austerity measures at the expense of everyday Hondurans. Pine's method of observant-participation was akin to a somatic form of ally-ship. As she wrote in a 2013 article chronicling this moment of popular uprising, "It was the somatic solidarity of the body politic: common material processes of subjectivation (not to be confused with common subjectivity) that brought me closer to my interlocutors in an ever-shifting community of embodied indignation, with potential for radical anti-capitalist mobilization" (Pine, 2013, p. 150). Similar to the nurses who were straddling patient care and their political convictions, Pine found a dialectical interplay between ethnography and her activist commitments, with the two allegiances informing each other.

In a similar vein to Pine, Seth Holmes and Jorge Ramirez-Lopez consider the best ways to show solidarity with their interlocuters—Triqui farmworkers in

Washington state and California—in their struggles for labor protections, political recognition, and access to decent housing and healthcare. Holmes and Ramirez-Lopez wrote in the second edition of the ethnography *Fresh Fruit, Broken Bodies* that we should "Learn what kind of solidarity they seek (and also learn what may not be helpful, even if it is well intentioned)….What kind of support would they like from us? If you are in health care, seek out frameworks and practices that counteract the lenses that individualize and naturalize health inequities or represent certain categories of people as undeserving" (Holmes, 2023a, 2023b, p. 232). As clinicians, this sensitivity is cultivated by methods, such as clinical ethnography, and operationalized through concepts, such as "social medicine" and "structural competency." Drawing on Pine, Holmes and Ramirez-Lopez's work as well as the work of other authors in this special issue, we see the ways in which clinician ethnography can serve as a tool for not only enhancing one's practice, but also for solidarity with social movements advocating for meaningful change. Medicine is mired in harmful structural forces and special interests that too often implicate clinicians by preventing them from doing—or recognizing—what is right for patients, resulting in moral distress and negative patient outcomes. Clinical ethnography allows for the questioning and relationship-building needed to reveal the complex issues shaping medicine today. More importantly, it enables the participant-observer, who is also an observant-participant, to connect with and lend support to others who are organizing, advocating, and fighting for positive change.

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