

nudge our scholarship and activism toward a more holistic anthropology regardless of what we call it.

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I have nothing against a new name for medical anthropology; I may even like “health anthropology.” But I wonder if it makes a difference, and moreover, is it possible and prudent to change an established name? Only absolute monarchs seem to be able to impose new names, but even in their case, the renaming may be undone after their death. Susan Sontag (1983), in her renowned essay “Illness as Metaphor,” called for a language change: the abolition of illness metaphors that disqualify people. Her book was widely acclaimed, but people’s speaking habits did not alter, of course.

My main concern with “Rebranding Our Field?” is, however, that the new name will make little difference. The reasons that the authors present for their proposal contain some hidden contradictions and—worse—are based on a doubtful, if not incorrect, reading of the history of medical anthropology. Let me start with the history.

The authors assert that the beginning of medical anthropology as a (sub)discipline was enmeshed in biomedical science and that the adjective “medical” confirms this early alliance. It is true that biomedical professionals were often the first to take an interest in the social, cultural, political, and economic aspects of health and illness, but by doing so, they rather distanced themselves from their own biomedical discipline. The reason that biomedical professionals were the pioneers of medical anthropology was the fact that, in their work, they stumbled on the complexities and wider contexts of health and illness that conventional biomedicine tended to overlook. The questions that were raised by this confrontation led them to investigate these complexities and become self-styled anthropologists.

Professional anthropologists, however, who worked almost exclusively in non-Western communities, kept away from the issue of health and illness as a research object; they considered it to be outside of their anthropological realm. In addition, many anthropologists were allergic—to use a medical metaphor—to physical issues that reminded them of unfortunate coalitions between anthropologists and racist research around the beginning of the twentieth century. The few ethnographies in that period that did touch on health and illness (the most prominent was Evans-Pritchard’s [1937] Azande study) focused on “safer” themes such as religion, ritual, divination, and modes of thought. They did not use the term “medical.”<sup>1</sup> Medical was, for them, what happened in doctors’

1. But Evans-Pritchard did use the term “medicine” for Zande herbal concoctions.

consulting rooms, clinics, and hospitals. In other words, the neglect or avoidance of health and illness as a research object was rooted in ethnocentric assumptions among anthropologists in that period.

Ironically, it was biomedical “tropical doctors” who drew the attention of anthropologists toward local experiences of health, illness, and healing as a research-worthy aspect of culture.<sup>2</sup> By calling this new research focus “medical,” they did not limit the domain to biomedical definitions but rather extended “medical” to include anything that people anywhere perceived as relevant for their health and well-being. Moreover, it should be emphasized that in an overwhelming majority of medical anthropological research between 1950 and 1975, biomedicine was absent. The best proof for this claim are the first two readers in medical anthropology (Landy 1977*b*; Logan and Hunt 1978), which present the state of the art of medical anthropology at that moment in time.<sup>3</sup> Landy’s reader (containing 57 articles) does not include one single ethnographic contribution that focuses on biomedical science, work, or institutions as cultural phenomena. Furthermore, no ethnographic text is located in a Western setting. It is only in more theoretical, historical, and epidemiological articles that biomedical concepts are mentioned, mostly in comparison with or in contrast to local, nonbiomedical concepts.

The same applies to the reader by Logan and Hunt (with 39 contributions), but with one interesting exception: five ethnographic contributions are situated in a Western society, but in all of these five cases, the real focus is on ethnic “others” who live in that society and on their nonbiomedical ideas and practices. Furthermore, a few contributions in both readers have a link with biomedicine in the sense that they study local cultural ideas and practices as possible obstacles to the introduction of biomedicine.

State-of-the-art reviews in the 1960s and 1970s (Colson and Selby 1974; Fabrega 1971; Lieban 1973; Scotch 1963) sketch grosso modo the same situation. Fabrega (1971) remarks that his overview places primary emphasis on studies “in non-Western settings . . . that rely on the concept of culture” (167; which seems to me to imply that studies in Western settings are less likely to be “cultural”). Three years later, Colson and Selby (1974) apply a similar restriction but at the same time allow for an extension of the field: “Work was

2. Scotch (1963) observed that “it is ironic that medical scholars have literally for centuries been aware of the social dimensions of health and illness and have, in their research, focused on a variety of social and cultural variables, while anthropology has only lately indulged in similar research” (30).

3. Although Pearsall (1978), in a review, complains that Landy’s reader “is not a satisfactory textbook for introducing medical anthropology as a comprehensive and truly comparative search . . . about human health, disease, and medicine at all times and in all places.” Pearsall concludes her review by calling the reader “a brilliant illumination in one of the *more traditional corners* of medical anthropology” (15; italics added for emphasis).

considered for inclusion in this review if characterized by concern with health and disease in non-Western settings or the use of anthropological concepts and methods in the exploration of health and disease regardless of cultural or geographic setting” (246).

There is, however, at least one formidable testimony that seems to contradict my argument about the exotic bias and exclusion of biomedicine in early medical anthropology—that is the first medical anthropology handbook, by George Foster and Barbara Anderson (1978). This was a revelation when I recently picked up the book from my shelves. After an introductory chapter on the origins and scope of medical anthropology, the book deals with the non-Western world (chapters 4–7) as well as the Western world (chapters 9–11). It ends with five chapters that delineate roles for medical anthropologists, mostly in collaboration with biomedicine. The book was a revelation in the sense that I realized that in the early 1980s, when I used it in my own teaching, I focused almost entirely on the first seven chapters and largely ignored the rest; I was clearly part of the non-Western bias of that period.

Reading the second half of the handbook more closely, I discovered an almost prophetic plea for the de-exoticization of medical anthropology. Drawing mostly from medical sociological sources, the authors sketch an anthropology of “Western” illness behavior, hospitals, and biomedical professionals, including doctors and nurses. The closing five chapters outline the roles that medical anthropologists can play, not only as “embedded” researchers in biomedical projects but also as researchers of biomedical concepts and practices. I found the suggestions for the anthropological study of nutrition and bioethics (concerning birth, old age, and death) particularly visionary. Their broad vision of medical anthropology was not widely appreciated, however. One reviewer in the official newsletter of medical anthropology wrote: “The scope of the book is wide, indeed, so wide that one could plausibly argue it is not so much an overview of ‘medical anthropology’ as it is an overview of many aspects of the behavioral sciences in medicine and health care” (Hughes 1979:21). Not much later, the anthropological focus did shift toward biomedicine, without much reference to Foster and Anderson’s (1978) plea. In summary, the second half of their handbook did not—at the time—reflect a general opinion of what medical anthropology was or should be.

There is no doubt that the interest of medical anthropologists until approximately 1975 lay almost entirely in medical issues in a very broad sense (anything connected with health, illness, and treatment) but with the exclusion of biomedicine. The fact that during that period the adjective “medical” referred to anything that people emically considered relevant to their health and well-being is significant. The term “medical” is clearly different (much more comprehensive) than “biomedical.” It confirms what Logan and Hunt (1978) propose as a definition of medical anthropology: “the comparative and holistic study of culture and its influence on disease and health care” (xiii). Taking the adjective “medical” as an indication of

medical anthropology’s early alignment with biomedicine, as the authors of “Rebranding Our Field?” do, is what I have called a doubtful if not incorrect reading of history.

Somewhat paradoxically, the initial exclusion of biomedicine from medical anthropology must be seen as the consequence of the ethnocentrism that pushed anthropologists to study “other cultures” (which was then the title of a popular handbook in anthropology by Beattie [1964]). That push was particularly strong for medical anthropologists: medicine at home was not a suitable study object because it was science and not part of “culture.”

This ethnocentrism was particularly strong in my own country, the Netherlands. At the time US anthropologists began to work more closely with biomedical colleagues (anthropology *in* medicine), Dutch anthropologists were still virtually absent in biomedical institutions of research, care, and teaching. The same applied more or less to the anthropology *of* medicine. Dutch anthropologists were reluctant to choose their own biomedical tradition as a field of research (for reasons mentioned above). In addition, biomedical institutions were not particularly eager to become objects of anthropological research. Becoming a cultural study object seemed a threat to their scientific status, and moreover, anthropological studies of biomedicine that had been published abroad were less than flattering (e.g., Hahn and Gaines 1985; Lock and Gordon 1986; Wright and Treacher 1982).

Although the speed of the “rapprochement” between anthropology and biomedicine (in both senses: *in/of*) varied in different places, it can be said that it started nowhere in earnest before the 1980s. This reluctance to take on biomedicine (medicine at home) was, in fact, the weakness and myopia of medical anthropology until recently. Hahn and Gaines (1985) wrote in the blurb for their book: “In neglecting to study Biomedicine itself, anthropologists may have accepted a central biomedical assumption: that it is scientific and beyond the influence of culture. Thus it is thought, ‘they’ have ethnomedicine while ‘we’ have medicine.” I fully agree with Saillant and Genest (2007a), cited in “Rebranding Our Field?,” that the critical study of biomedicine helped to “rescue [medical] anthropologists from exoticism, folklorism, and the ethnography ad nauseam of all the ethnomedicines of the world” (xxiii). It took medical anthropology a long time to grow up and free itself from exoticism and join the repatriation wave of general anthropology (cf. Peirano 1998). Notably, Saillant and Genest (2007a) continue the above citation as follows: “They [anthropologists] are now free to study biomedicine as any other medical system with its share of ‘beliefs’ and irrationality. But there was an undesired and undesirable effect to that: medical anthropology was linked all the more closely to the study of ‘Medicine’ [capital in original] making it appear more ‘medical’ than ever.” But all this happened only at the end of the 1980s and thereafter. Judged by its 40 contributions, one of the latest readers in medical anthropology (Good et al. 2010) suggests that medical anthropology is now overwhelmingly concerned with biomedical science and practice.

In conclusion, it is unlikely that medical anthropology's adjective was associated with biomedicine when it first became a recognized subdiscipline in anthropology. This does not, however, gainsay that today the term "medical" could lead to a misunderstanding of its mission and field of research, certainly among nonanthropologists in the modern world for whom there is only one type of medicine: biomedicine. I agree, the "medical" in "medical anthropology" is a somewhat imperious adjective that seems to suggest that medical anthropology is interested in things, thoughts, and practices related to medical science or that it is a branch of anthropology in the service of medicine. It is not; rather, for many medical anthropologists, the opposite applies (Van der Geest 2014:1).

Would "health anthropology" solve the problem? I wonder. How would those misunderstanding "medical" as "biomedical" understand "health"? The answer seems obvious: as biomedical health. In other words: if the medical anthropology community, in a rare state of unanimity, would decide to adopt the new name, the same confusion would persist. I agree, "health" is a softer, more friendly, more holistic-sounding qualification, but the effect of such an operation would remain mainly cosmetic. Everything that was before in "medical" (including—to cite the authors of "Rebranding Our Field?"—such seemingly unmedical events as dying, birth, building a house, or digging a well) will then move to "health." Will the renaming be worth the effort?

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## Reply

The point of writing this article has been to stimulate engagement with and discussion of the labeling of our discipline. While we are not arguing for an immediate, uncritical embracing of a new label, we are concerned enough about our current "branding" to feel the need to engage in a critical exploration of it. The thoughtful responses from the commentators have more than vindicated our initial motivation. We hope that this is just the beginning of a rich and robust conversation.

Finkler comments that the article left gaps in the history of the subdiscipline and proceeds to fill some of those gaps. Her contributions are further extended in the commentaries from Janzen and van der Geest. While it was not the intention of the authors, nor is it within the scope of the article, to provide a comprehensive history of medical anthropology, the range and variety of the history narratives discussed in both the article and the commentaries are not currently available in one source and thus point to the need for an inclusive review article or even a volume on the fragmented, complex, and fascinating history of our subdiscipline. Van der Geest's reflections on his use of Foster and Anderson's (1978) text in

the years when he was pioneering the teaching of medical anthropology in the Netherlands offer an insightful example of what we now see as ethnocentric blinkers.

Both Finkler and Janzen raise the matter of "holism," an obviously central concept in anthropology but one subscribed to by many other parties today, including within healing circles under the guise of "holistic health" or "holistic medicine." Generally, within anthropology, holism refers to viewing specific aspects of the human condition (e.g., health behavior, religious behavior) within a broader social, environmental, cultural, and historical context. Whereas Janzen concedes that the term "health anthropology" has a more holistic ring to it than "medical anthropology," Finkler suggests that referring to medical anthropology as "holistic anthropology" instead of "health anthropology" might be more appropriate. However, if medical anthropologists were to do so, they undoubtedly would find the vast majority of other anthropologists, not only sociocultural anthropologists but also physical anthropologists and archaeologists, also objecting that health anthropologists were attempting to monopolize a concept that more or less belongs to the entire discipline of anthropology.

Cheyney suggests that it is important to acknowledge what we might lose in a change of discipline labeling. Long, who undertakes most of her research in hospital environments and, like Cheyney, has researched in obstetrics and midwifery, shares some of her concerns, acknowledging that ethnographic research in hospitals can be fraught with issues of gatekeeping. Losing the status that comes with the label "medical," anthropologists may complicate access to clinical spaces for health/medical anthropologists who, like Long, do not have clinical backgrounds. While we appreciate Cheyney's concerns with the co-option of health into the medical-industrial domain, this does not take away from the capacity of the term "health" to be potentially more inclusive of nonbiomedical epistemologies of well-being and/or illness. Further, it is not clear that Cheyney's concern would bear out: would the term health anthropology turn off clinical practitioners?

Janzen, on the other hand, argued the costs of not rebranding. In exploring the background to "the preeminence of the medical in anthropology" and the dominance of the "curriculum high priests" of medical schools, he suggests that anthropology's integration into medical education has come at the cost of "forging a true anthropology of health." The first three PhD programs in medical anthropology, namely, the ones at the University of Connecticut (which issues general degrees in anthropology across several subfields), University of California at Berkeley–University of California at San Francisco, and Michigan State University, were closely affiliated with biomedical schools and, in the case of the latter, also with an osteopathic medical school. Physician-anthropologists such as Arthur Kleinman and two of his students, Paul Farmer and Jim Kim, became key figures in US medical anthropology. While Kleinman eventually moved into the anthropology of suffering, his initial commitment was to a clinical mandate for medical anthropologists, thus fostering clinical anthropology, particu-