Introduction

Ethnocentrism and medical anthropology

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> *'Nuer think that they live in the finest country on earth....'*
> E.E. Evans-Pritchard

Medical anthropology's ambition is to describe and interpret human suffering in 'experience-near' concepts and categories. Following Geertz's cue, Kleinman and Kleinman (1998: 201) call upon their colleagues to orient their research around the question of *what is at stake* for people in particular situations, and interpret their suffering starting from that central perspective. Such an orientation, they write, will lead the ethnographer to a more valid understanding of people's moral world than medical, psychological or sociological approaches will. Yet, they continue, anthropologists are unable to realise that ambition. They too cannot shake off their professional preconceptions and are bound to reduce the full experience of human suffering to the cultural categories of their discipline. 'Anthropologising' is as alienating as medicalising or psychologising; all betray the patient's experience.

The Kleinmans critically examine the main dilemma of medical anthropology, which in this book we address with the term 'ethnocentrism': the inability to think of and value other people's lives in any other way than in our own categories. The essays in this book describe the authors' attempts to escape from ethnocentrism *and* their simultaneous resignation to it as the only reasonable way of understanding others.

Anthropologists and ethnocentrism

Anthropologists have a complex and confusing relationship with 'ethnocentrism'. First of all, they consider ethnocentrism as intellectually naïve, morally despicable and politically dangerous; they see as one of anthropology's missions to criticise and fight ethnocentrism. At the same time, they acknowledge that ethnocentrism is an indispensable part of each culture and that no culture could

survive without at least some degree of it. Secondly, anthropology is itself the child of a history of ethnocentrism and is unable to rid itself of its heritage in its own work. Thirdly, and finally, ethnocentrism is an epistemological necessity.

Before we focus our attention on these three contradictory aptitudes in anthropological thought and work, we must briefly pause at the term and concept of 'ethnocentrism'. It is one of those terms that have found their way from social science publications into popular language. The term has cognitive, moral and even stylistic connotations. Its precise meaning, however, has never been coined in a definitive way and the authors in this book also use the term in various, often provocative meanings.

The word was probably first used in 1900 by an American anthropologist, W.J. McGee, in a discussion about 'primitive thought'. McGee placed 'ethnocentrism' in an evolutionary list of centrisms, which climbed from egocentrism to heliocentrism. He regarded the evolution of the human reason as a steady expansion of the human perspective. The following quotation sums it up:

> Science shows that the solar system hurtles through space, presumably about an unknown center; it showed before that the sun is the center of our system; but the heliocentric system was expanded out of an antecedent geocentric system, itself the offspring of a democentric system, which sprang from an earlier ethnocentric system born from the primeval egocentric cosmos of inchoate thinking. In higher culture the recognized cosmos lies in the background of thought, at least among the great majority, but in primitive culture the egocentric and ethnocentric views are ever-present and always-dominant factors of both mentation and action (McGee 1900: 831).

It is interesting that McGee considered ethnocentrism as an early step in the evolution of the human mind, implying that his own society, the USA, around the turn of the 19th century was not ethnocentric. In our view, this opinion was, of course, convincing proof of his intellectual naïveté, i.e. ethnocentrism.

Most consider William Graham Sumner as the one who stamped the concept of ethnocentrism. He defined it as: 'the technical name for this view of things in which one's own group is the center of everything, and all others are scaled and rated with reference to it' (Sumner 1907: 113). He illustrated this with ethnographic examples of his time, and briefly discussed two related concepts: 'patriotism' and 'chauvinism'. For Sumner, ethnocentrism had a much wider meaning than for McGee. In their study of ethnocentrism Levine and Campbell remark that:

[E]thnocentrism is not simply a matter of intellectual functioning but involves emotions that are positive and negative. Symbols of one's own ethnic or national group or of the values shared by that group (or both) become objects of attachment, pride, and veneration; symbols of other groups or their values become objects of contempt and hatred. Furthermore, groups develop collective symbol systems that arouse ethnocentric emotions shared by individuals in a population (Levine & Campbell 1972: 1).

Levine and Campbell systematically examine and compose facets of Sumner's ethnocentrism and 'test' them, as it were, using ethnographic and theoretical literature. To cut a long story (their book counts 245 pages) short, they conclude that 'social science theories about ethnocentrism represent convictions of an axiomatic nature that go beyond the realm of empirical research'(ibid.: 211).

Ethnocentrism may not be a well-defined concept (as most concepts in anthropology) but it has proved an effective tool for reflecting on anthropological praxis: ethnographic data, methodology, ethics and interpretation. This collection of essays demonstrates this with regard to medical anthropology. But let us first direct our attention to what we have called the three contradictory aptitudes of anthropology.

Cultural anthropology could be described as a 'negative' science. Its objective was and still is to question the taken-for-grantedness of one's own culture. André Köbben, once the chair holder of anthropology at the University of Amsterdam, used to say that the anthropologist shows alternatives to the ways of thinking and acting that we have learned to consider as 'natural' (*Antropologie laat zien hoe het ook anders kan*). Anthropology could therefore be called a science (or 'art') of 'denaturalisation'. Its historical roots lie in two types of denaturalisation, one literal, the other figurative. Boas and his students set out to demonstrate that biology alone does not determine human behaviour but that unique cultural and historical contingencies should also be taken into account. His concern was directed towards the biological determinism of his time, which was only a short step away from racism.

The second type of denaturalisation was the 'alternative view' mentioned above (Köbben). 'One of the primary missions of anthropology,' Levinson (1996:404) writes, 'has been to combat ethnocentrism by documenting the rich variety of human behaviour and culture around the world and by pointing to the appropriateness of different behaviours and customs, in different social, political, economic and environmental circumstances.' That 'mission' of anthropology recurs in nearly all anthropological handbooks and introductions, most explicitly in Herskovits'(1948) classic *Man and his Works.*[2] Herskovits'

weapon against ethnocentrism is cultural relativism, i.e. respect for the values of other cultures. Its principle is that 'Judgements are based on experience, and experience is interpreted by each individual in terms of his own culturation' (Herskovits 1954: 351). Once a person has become aware of the fact that his appreciation of the value of his own culture and other cultures is – at least partly – the product of his own cultural upbringing, cultural relativism enters. Anthropology, in Herskovits' as well as many others' view, is a continuous endeavour to drive this awareness home. In Herskovits' words, cultural relativism:

> [G]ives us a leverage to lift us out of the ethnocentric morass in which our thinking about ultimate values has for so long bogged down. With a means of probing deeply into all manner of differing cultural orientations, of reaching into the significance of the ways of living of different peoples, we can turn again to our own culture with fresh perspective, and an objectivity that can be achieved in no other manner (Herskovits 1954: 366).

In one of the most thorough discussions on ethnocentrism and cultural relativism (never translated into English), Ton Lemaire (1974: 166) points out that cultural relativism does not remove ethnocentrism but only establishes its inevitability. Herskovits himself had acknowledged this when he observed that some degree of ethnocentrism is inherent in each culture. It need not be an aggressive type but it nevertheless exists. The usual form of ethnocentrism is 'a gentle insistence on the good qualities of one's own group, without any drive to extend this attitude into the field of action' (Herskovits 1954: 357). Sociobiologists go to the extent to claim that ethnocentrism is a survival mechanism in response to external threats (Reynolds et al. 1987). Though the opinions about the presence of ethnocentrism may vary, all seem to agree that a degree of it is indispensable for cultures to exist, in the same way that some amount of egocentrism (and egoism) is needed for the survival of an individual. Thus we arrive at the first contradiction: anthropologists combat what they consider indispensable.

Another contradiction emerges if we take into account the historical roots of cultural anthropology. Several authors have pointed out that anthropologists, like Christian missionaries, are the product of the colonial period, which could be characterised as a political condensation of European ethnocentrism, or for that matter, Eurocentrism. That anthropology is the child or daughter or handmaiden of colonialism is by now a cliché according to Blok (2002: 14). Lemaire (1974:174) is one of many who have argued that anthropologists played an essentially conservative role in the colonial period by portraying indigenous cultures as integrated functioning systems. Their 'respectful' ethnographies contributed to the tendency to keep these societies in tact, which largely overlapped with the goals of colonial policies. If anthropologists criticised the colo-

nial regime, it was rarely the system itself, but rather specific practices. The 'outlawing' of anthropology in African universities after independence was the logical consequence of this past: they wanted to shake off the most blatant symbols of the colonial spirit. Ironically, preserving African cultures as well as trying to change them were considered as proof of anthropology's ethnocentrism.

The colonial roots of anthropology, however respectful of local cultures, led to yet another type of ethnocentrism, an inverted ethnocentrism, one might say: exoticism. Anthropology, almost by definition, occupied itself with *other cultures*. Beattie's introduction to anthropology, published in 1964, bore exactly that title. Anthropology was, and in a sense still is, the study of difference. The ultimate objective of studying difference may be, as indeed Herskovits observed, 'to turn to our own culture with fresh perspective'. But it could not avoid signalling another message: that other cultures had more 'culture' than our own, that is to say, the contingency or arbitrariness of a society's beliefs and values was more easily observed outside than within one's own world.

Idealising and romanticising descriptions of other cultures, as in the Orientalist tradition, similarly produced such suggestions. Mason (1998) speaks of the 'infelicities' that result from this form of exoticisation. Exotic objects, customs and institutions are set apart for the pleasure of the Western eye and – out of their context – are completely misunderstood. The ethnocentrism underlying this exoticisation is obvious. Other cultures are reduced to meanings determined by the western observer. What at first presents itself as the opposite of ethnocentrism – admiration and respect – turns out to be just another variation of it.

But should we be surprised? Anthropologists insist that they are their own research instruments. While this applies to some extent to researchers in all sciences, anthropologists are nearly alone in cherishing this given as a desirable attribute. Subjectivity, a curse in most science traditions, is almost heralded as an inroad to delving more deeply into understanding people. Recalling Herskovits' remark that people experience and judge others in terms of their 'own culturation', we should acknowledge that some degree of ethnocentrism is indeed an epistemological necessity. We cannot think except with the concepts and categories we have picked up during our life. Scores of philosophers, while trying to divest themselves from the limitations of their intellectual culturation, have implicitly or explicitly confirmed the inevitability of thinking through the thoughts one has inherited from parents and teachers. Even radical departures from the traditional patterns of thought are derived from these very same traditional patterns.

Stating that the anthropologist is his own research instrument is, therefore, more than 'making a virtue out of necessity', it also takes advantage of the affin-

ities that lie beneath the apparent cultural differences. Exploring and using subjectivity opens the way to intersubjectivity. To borrow Bode's (1995) phrase, being 'ethnocentric in an enlightened way' is the only option a researcher has. It is only anthropologists who welcome this epistemological bind in doing research. The third – ironic – contradiction is that those who condemn ethnocentrism acknowledge that they cannot avoid it, and, moreover, cultivate it to enhance their research and make it more convincing.

Medical anthropology facing ethnocentrism: five comments

I am going to make five comments on medical anthropology and on practices of policy, care and research. All have the same starting point, namely that both the object of our study and the study itself are cultural phenomena. They share the blessings of culture but also the risks, and it is especially the latter to which my comments refer. As paradoxical as it may seem, the biggest danger of culture lies precisely in what its members regard as a blessing; I am referring to their belief in their own excellence and superiority. In the culture of practising science and research this may lead to pedantry and academic dogmatism.

I will discuss five kinds of ethnocentrism: (1) of medical professionals versus so-called lay-people, (2) of medical scientists versus anthropologists (and vice-versa), and (3) of cultural anthropologists versus their colleagues in medical anthropology. The fourth (4) is a reversed type of ethnocentrism that has marked the development of cultural anthropology in general and medical anthropology in particular: exoticism. The fifth (5) concerns the contempt by anthropologists for applied anthropology. Positively put, I will subsequently argue that we should take the lay perspective in health care seriously, and plead for interdisciplinary co-operation, for a more imaginative appreciation of medical anthropology, for a de-exoticisation of medical anthropology and for a meaningful application of medical-anthropological views.

The lay perspective

Professional pedantry is rarely more clearly demonstrated than in medical circumstances: in doctor-patient relations, in health care information, and in making health care policy. Markedly contradictory was (and is) the conviction of knowing opposed to not-knowing in 'Primary Health Care'.

Primary Health Care in the 1970's could be described as a new philosophy in health care, the dawning of the understanding that health care is in the first place the care of the people, and that they know best how to take care of them-

selves in daily life. In that view, medical expertise is only needed when the problems have become too serious for the care of ordinary people. In other words, Primary Health Care was a plea for self-reliance and self-empowerment, a world-wide movement against medicalisation.[3]

This plea for self-reliance, however, did not originate from the people who were supposed to become self-reliant, but was launched by higher authorities, on behalf of them. Local communities were seldom consulted on how they viewed their situation, especially in the field of health care, and how they thought to cope with the occurring problems. Added to this came a second contradiction that partially 'neutralised' the first one. In practice, health policy-makers seldom were serious about the self-reliance philosophy. They continued their business as before, with top-down medical care, but called it Primary Health Care.[4]

Between 1987 and 1991 Anja Krumeich carried out anthropological research on the Caribbean island of Dominica on the ways in which mothers took care of their small children. She found that mothers had clear ideas about childcare, with respect to both preventive and curative treatment, but that those who were in charge of PHC thought that this knowledge was irrelevant. PHC workers tried to persuade the mothers to use 'real' health care, though they had no knowledge about what the mothers viewed as 'real' and trustworthy care. At the end of her research, Krumeich organised a 'seminar' together with the mothers in which they exposed the disregard of their knowledge by professional health care providers in short drama sketches. Krumeich not only concluded that this disregard of local ideas was contradictory to the concept of PHC and implied a waste of knowledge capital, but also that there could be no dialogue between the mothers and the health care workers because the latter did not take the former seriously. Her study was an observation of local knowledge which did not get through to the professional health care workers (Krumeich 1994).

This example is typical of the kind of research that the Medical Anthropological Unit supports: to make the ideas heard which are drowned out by dominant views, mainly of Western origin. This interest in unheard or silenced knowledge does *not* originate from the wish to better understand a certain community with a view to change their minds more efficiently; anthropology is not a tool to 'crack the secret code'. The main motive for studying the 'lay-perspective' is that what these people think and say has a value in itself. The 'ideal' anthropologist does not view himself as a scientist who looks at his research object from a superior position, but regards himself as a student who tries to understand another culture and is taught and helped by his informers. I am reminded of a proverb which people used to both correct and comfort me during my first research in Ghana, 'The stranger is a child'. The anthropologist is an outstanding example of a child. My gradual introduction into the lan-

guage and culture of the community was a personal enrichment, one that helped me to grow in many ways. Moreover, the introduction into another culture leads to a better, more mature knowledge and appreciation of one's own culture.

That the ideas of 'others' are worthwhile is perhaps nowhere more true than in health care. However, there probably is no other place where this will be more denied, because usually only scientific medical knowledge is regarded as relevant. It is often overlooked that the patient is an expert in the field of his own body. Much of what he knows and feels remains difficult to discover for the doctor, who may rather resort to 'safer' interpretations. A more recent research illustrates this in another way. Van Duursen et al. (2002) described how Dutch gastroenterologists, when faced with the complexities of chronic abdominal complaints, used ethnocentric schemes for diagnosis and treatment. They approached women with standard ideas of psychological causes, and migrants with stereotypical ideas about cultural differences. Kuiper, a Dutch professor in social medicine, said it strikingly: 'The patient is always right', and Kasanmoentalib (1983: 11) wrote, 'From an existential point of view', the doctor is 'inferior to the patient'. The challenge is to listen more carefully to the patient.

Interdisciplinary relations

Ethnocentrism has just been described as an underlying mechanism that obstructs communication between professional health care workers and 'ordinary people'. Ethnocentrism also plays a part in the (lack of) communication between scientists from different disciplines. Indeed, it is clarifying to regard scientific disciplines as cultural traditions with which one identifies oneself, not only socially but also 'religiously'. That is to say that the basic ideas of the scientific field assume the air of statements on reality, of doctrines with far-reaching, meaning-giving implications. The belief in those doctrines is, among others, preserved by shutting off the 'messages' from other disciplines or showing contempt for scientific work outside of one's own field.

If culture, and religion in particular, have the character of a model – a model *of* and a model *for*, as suggested by Geertz – one might expect that ethnocentrism will mainly reveal itself in condescension about the worldview and ethical principles of others as 'superstitious' or backwards or dubiously behaved. Characteristics of such mutual disapproval are also found among practitioners of anthropology and medical science. Anthropologists reproach physicians for their reductionism; conversely, the physicians find the long stories of anthropologists 'soft' and 'unscientific'.

Köbben (1991) calls biologism the biggest taboo in social science and he refers to a few commotions around researchers who tried to explain mental or cultural phenomena in a biological way. Examples of these were the criminologist Buikhuizen, who suggested biological grounds for criminal behaviour, and the neurobiologist Swaab, who did the same thing for homosexuality. Biological determinism is soon linked with fascism and other unfavourable movements. The bitter reactions to sociobiology originated from the same abhorrence of biological reductionism.[5]

There also exist moral objections between physicians and anthropologists with regard to each other's work. Anthropologists may 'claim' that they make a stand for people, but many physicians think that in actual fact they do not. Anthropologists, with a mixture of disdain and irony sometimes call their profession 'the art of hanging around'. Indeed, health workers point out, when people approach them (anthropologists) with practical problems, they just hang around and excuse themselves while practising 'non-intervention'. Conversely, anthropologists criticise physicians for the objectifying ways in which they treat their patients. Of course this is gross stereotyping, but that is how crude ethnocentrism works.

'If there is one field in life where taboos do not belong, it is science', Köbben starts his 'tongue in cheek' argument. Of course, there *are* taboos in science. Denying this would place science outside of human culture. Meanwhile, it is obvious that I view science as a cultural phenomenon par excellence, with social obligations, etiquette, exercises of power and also with taboos. That is why interdisciplinary co-operation is such a difficult task. One has to leave the safe ground of one's own culture. This arouses fear in the 'transgressor' and aggression or derision in those who stay 'at home'. If science were really scientific, interdisciplinarity would be self-evident.

There is irony in the anthropological fright for everything that has a shred of biology. Anthropologists, while fighting ethnocentrism 'abroad', practise it at home. One would expect that, with their keen eye for the functioning of culture, they would perceive the cultural characteristics of their own discipline. Why do they stay so anxiously on their own disciplinary territory, when it is their intention to cross the borders of their own culture? Obviously, to cross one's cultural borders, in the ordinary sense of the word, is less threatening than to leave the safe ground of one's discipline. Ethnocentrism presents itself as a strategy for survival, even for anthropologists. It relieves people of the necessity to seriously think about alternative worldviews; cultural convictions become blinkers to keep life simple. Crapanzano's (1980: xiv) call for anthropology to question assumptions instead of confirming them is only partly responded to.

Interdisciplinarity is not easy eclecticism or scientific hodgepodge, but an exploration of the limits of one's own explanatory model. It requires imagination and a receptive mind for other models. Disciplines are cultural tools with which people try to understand and explain reality. No discipline can claim to have the final word. The anthropological approach concentrates on meaning and reaches this by studying the phenomena and placing them into a context. Medical scientists will often be inclined to do the reverse. They will temporarily exclude the context to concentrate on the biological or chemical aspects of the problem they are studying. Eventually, however, the illness will have to be brought back to its 'natural' place: a patient in a specific cultural and physical condition. The cultural interpretation holds a task for the medical interpretation and vice versa. The anthropological view does not contradict the medical view, but formulates questions and suggestions for the natural scientist to work on. One could also say that biological statements form a challenge to anthropologists. Finally, the medical scientist is confronted with the social and cultural complexity of illness and health, and the anthropologist with the hard natural scientific facts. One could say that every interdisciplinary undertaking is an attempt to bridge the various dualities in our culture, a perilous undertaking as is shown in the work of Merleau-Ponty and Buytendijk. Interdisciplinarity is the logical result of seeing that reality itself is 'multidisciplinary'.

An example of *successful* interdisciplinary research was the 'Leiden 85+ Project' in which medical and anthropological researchers co-operated. The aim of the study was to describe the oldest of the old in terms of successful ageing, to look for determinants and preventable causes of unsuccessful ageing and to explore possibilities to invest in successful ageing. The quantitative part of the study was carried out by medical researchers who measured the quality of the old people's physical, social and psycho-cognitive functioning and their general state of well-being. For all four measurements they made use of existing tests and scales. Their assumption was that 'successful ageing' was a compilation of all four scores, showing an optimal state of functioning and subjective well-being. In total, only ten percent of the 599 participants satisfied all criteria and were classified as 'successfully old'.

The anthropologist in the team confined her research to 27 people with whom she had several open conversations. She also visited them informally to observe the daily routines in their lives and occasionally meet their relatives. One of the objectives was to investigate how the elderly themselves looked upon their situation and what they regarded as 'successfully old'.

The qualitative and quantitative research proved a fruitful combination, as did the linking of emic and etic views on being old and 'successful.' Team discussions were held between researchers of both disciplines to reach a better

insight into the meaning and validity of the collected data. An important outcome of these interdisciplinary meetings was that 'successfully old' revealed its shifting meanings. For policy-makers it was primarily a state that could be measured, showing the extent to which an older person was able to function independently. That, obviously, depended on physical and cognitive conditions. The elderly themselves, however, held a more dynamic view of success and insisted that optimal physical and cognitive functioning could not be regarded as success. In most cases, it was merely a matter of luck. Success at old age, they argued, showed itself foremost in a person's ability to attract other people and have a socially satisfactory life. A person is rewarded or punished for the kind of life he has led. Good company in old age is an indication of success; loneliness is evidence of a life of failures. The anthropological contribution thus provided a more nuanced interpretation of the quantitative data. Conversely, the figures and scores of the medical research helped the anthropologist to establish the relevance and representativeness of her information (Von Faber et al. 2001, Von Faber 2002). Another example of successful interdisciplinary research is the study by Eric Vermeulen (2001) in two neonatal intensive care units in Belgium and the Netherlands. The linkage of medical and anthropological expertise evolved both in the ward (between the researcher and the staff) and within the researcher who had a medical as well as an anthropological background.

I view interdisciplinary co-operation as practising respect for 'dissidents' and abandoning scientific self-satisfaction.[6] We should dedicate ourselves to an interdisciplinary medical anthropology, as this will lead us to progress in scientific understanding.

The anthropological fascination for medical phenomena

Between 1985 and 1987, Robert Pool carried out research into social and cultural factors, which were connected with kwashiorkor in a village in Cameroon. At least, that was his intention. 'Kwashiorkor' is described in biomedical literature as an illness that mainly occurs in children. Symptoms mentioned are, among others: lack of growth, loss of weight, oedema, discoloration of the hair and apathy. The illness had a high occurrence in the village, even though there was no food shortage; it was reasonable to suspect that certain customs caused the malnutrition. However, during his research Pool became more and more confused. From conversations he had with the villagers it appeared that there was no question of malnutrition, but that the illness was caused by moral faults of the parents or ancestors, for instance: incest, murder or suicide. Others blamed witches for the illness. 'Kwashiorkor' was an imported term and an explanation used by health care workers. For the people in the community it was all much

more complicated. Treatment in the clinic or the hospital had little result, whereas local healers who removed the fault with rituals were successful. His research is a striking example of an anthropological comment on a biomedical 'fact'. During talks about the illness members of the community indicated what they viewed as the biggest threats to their existence and how they tried to protect themselves against these threats. For this reason Pool's research was not only a cultural interpretation of an illness, it also was an ethnographic essay with illness as a starting point but by no means as an end point (Pool 1994). It illustrates that it would be wrong to consider medical issues culturally uninteresting.

Maarten Bode's analysis of Ayurvedic and Unani pharmaceuticals in India shows another example of the cultural significance of *materia medica*. He argues that the industrial production of traditional medicines provides people with a vehicle for expressing both modernity and adherence to ancient national traditions (Bode 2002).

There are at least two reasons why anthropologists should be – and *are* – fascinated by medical phenomena. The first is that it gives them much intellectual satisfaction to show the cultural composition of a phenomenon which one at first located outside the domain of culture and, therefore, outside the authority of the anthropologist. The second reason is that there is scarcely another subject around which more culture has been spun than illness and health. Views, practices and experiences of illness and health are linked with every part of culture. In illness, health and health care we are confronted with the central and most cherished values and views of a culture; they are a 'treasury' for anthropological research.

Illness is a cultural product in the sense that it is impossible to think of it in such a way that it is totally unrelated or meaningless to the life of the patient. Nature seems to go its own way; 'seems'…, but on closer consideration we discover more and more cultural characteristics of the phenomenon of illness. Illness is a social event; the pain and the symptoms are made known to others in a socially acquired way. A patient who does not abide by cultural rules runs the risk of being misheard and will not receive the support and sympathy that he hoped for. One could say that health problems and symptoms of illness are *not* so much biological phenomena which occur in the body and are subsequently told to others but that they are events that occur *between* people. Problems and symptoms are communication. They form the message with which someone presents himself to others, establishes his position, and makes his temporary identity known.

The explanation of the illness can also be nothing but a cultural act. The 'pool' from which healers, patients and acquaintances draw when looking for an acceptable explanation is, by definition, a cultural reservoir. No one can

think of a cause, which has not been handed to him by tradition, so it is to be expected that dominating concepts of a culture recur in the most common explanations of illness. In a society where people live very close to each other and follow each other's movements very carefully, it is obvious to think of social causes, such as jealousy, which shows itself as witchcraft or the evil eye. Where science controls social life, as is the case in my culture, one will find this scientific view in the explanation of illness. Moreover, the explanation of illness is a distinct social act, for via this explanation, judgement is passed: the patient can either be accused or acquitted. Illness is a unique opportunity to set things right socially. It offers possibilities for spiteful blame and hostility, but also for reconciliation.

If illness is so pervaded with culture, then it will hardly be surprising that the illness-experience is also a cultural artefact. What the patient feels is not biologically determined but is situated in a web of social-cultural and psychological meanings. Symptoms, to which one did not pay much attention at first, feel different after a diagnosis has been made. An infected foot does not mean the same thing to a rice-peasant in Vietnam as it does to a civil servant in the Netherlands. An infection of the bronchial tubes of a child can be perceived as a short-lasting ailment to one mother, whereas it can be a serious threat to another mother, because she suspects it has been caused by a jealous person who wants to kill her child. For one person, the greatest pain is the social isolation connected with illness, whereas for another, the extra attention of being ill creates an agreeable feeling (cf. DelVecchio Good et al. 1992). It may not be possible to *prove* the cultural construction of illness-experience, but it can be made plausible.

The second reason that medical phenomena are fascinating for the anthropologist is that they are a junction of social interests and cultural meanings. Nowhere else can one capture what moves people and what they believe in as directly and as true to life as in the thinking and acting connected to illness and health. In these realms people demonstrate how they explain reality, how they relate to each other, who has power and what is regarded as valuable. Additionally, in our own culture, health has climbed to the highest values. It has gained an inviolable position, which can only be compared to the position of religion in former years.

Rolies (1988) cites a survey done among the Dutch which shows that one fourth of the Dutch consider health as the highest value, and half of the Dutch rank health as one of the three highest values. This means that, for many people, health has obtained a religious importance. Health gives meaning to their life; they derive rules for good behaviour from it as they once did with Christian values. When health is the highest good, it is necessary to do anything for it. Most religions hold ideas to eliminate death in one way or another. When

death has thus lost its sting, health has a relatively lesser value. But the importance of health increases when the certainty of a defeat of death no longer exists. Good health will not keep death at bay, but it is nevertheless the best guarantee for a long delay. It is no wonder that, for many, health has obtained an ultimate value.

The inviolable value of health is also expressed in the way it can be used to obtain social dispensations. One can be excused from all kinds of obligations on medical grounds. Questioning the sincerity of a claim of illness is regarded as inappropriate and a new form of 'blasphemy'. In short, illness and health are also fascinating for religious and political anthropology and for anthropology in general.

The study of illness, health and health care is based on a dual tradition in anthropology. On the one hand, medical issues, in their broadest sense, have always taken a central place in ethnographic work. On the other hand, biologically interpreted phenomena are especially attractive to anthropology because they form a test case for its ability to produce cultural interpretations around the 'convolution' (I have no better, non-dualistic term) of matter and mind.

'De-alienation'

Ethnocentrism is hidden in the strong predilection that anthropologists have for research in 'foreign' cultures. The implication of this exotic preference is that a foreign culture is better suited for cultural analysis than one's own culture is. Even if this preconception would not really exist among anthropologists, the abundance of foreign cultures in their work inevitably creates that impression. When Malinowski wrote a new foreword to the third edition of *The Sexual Life of Savages* he expressed his disappointment at the way his book had been received. Readers, he complained, had ignored its theoretical and methodological innovation and had only been interested in its sensational details: 'the notorious ignorance of primitive paternity, the technicalities of love-making, certain aspects of love-magic (a subject unquestionably attractive), and one or two eccentricities of the so-called matriarchal system' (Malinowski 1932: xxi). It is hard to believe that he had not foreseen this reaction. Anthropologists are expected to return with exotic, eccentric and extraordinary stories. Keesing (1987: 168) called them 'dealers in exotica'.

In recent years, however, one can speak of a 'homecoming' of anthropology. A growing number of anthropologists have decided to carry out research in their own society, though it is still seldom that the research takes place in their own community or subculture. Often they still give preference to exotic groups within their own society: nuns in an enclosed convent, chimney sweepers, bank

robbers, prostitutes, junkies, lion tamers and synchronised swimmers. The arrival of three Asian anthropologists to study lives of older people in the Netherlands made us more aware of our own 'foreignness'. Klaas van der Veen (1995) was closely involved in this fascinating research exchange.

Oddly enough, the turn towards one's own society is hardly noticeable in Dutch medical anthropology though it is in many other countries. It is striking that many publications from the United States are based on research in institutions and among population groups in their own country.[7] Out of 23 articles published in the leading journal *Culture, Medicine & Psychiatry* in 1993, fifteen dealt with research in the author's own society. In 2001, twelve out of fifteen articles in the same journal dealt with the author's own society. A similar tendency occurred in another important journal, *Medical Anthropology Quarterly.* Some years ago I read more than forty medical-anthropological theses from an English university; only one of them took place outside of Great Britain.

I do not have an explanation for the scant involvement of Dutch medical anthropology in health and health care in their own society. In the past things have happened from which one could deduce that the medical world does not have much appreciation for social science research. A notorious example was the interdiction of the publication of a book about research in a cancer hospital. The book had to be withdrawn from the market because the hospital authorities disagreed with the contents (Van Dantzig et al. 1978, De Swaan 1983b).[8] More recently, there have been several positive experiences, for example by Els van Dongen (1994) in a psychiatric hospital (see also elsewhere in this book), Margaret von Faber (2002) whose research was briefly discussed above, Anne-Mei The (1997) and Robert Pool (2002) on euthanasia in Dutch hospitals, Ria Reis (2001) on images of epilepsy and the role of professionals in the creation of new stereotypes, and Eric Vermeulen (2001) on decision-making in the neonatal intensive care unit of a Dutch and Belgian hospital. More openness does now exist, but it would be premature to speak of a complete change of climate. Medical institutions and funds in the Netherlands still have their reservations about anthropological research. They think that it is too vague, too general and too little geared to practical problems and solutions. My fifth observation will deal with this aspect.

Whatever the explanation, the majority of medical-anthropological research is still carried out outside the Netherlands and thus feeds the old ethnocentrism: the view that medical practices in other societies are 'cultural' but that biomedical science stands outside and above culture. Reflecting on their 'exotic' data, anthropologists *have* extended their opinions to health and health care practices in their own society, but there is still little ethnographic research about their country's health care. Such research would not only be enriching for

anthropologists, but also for patients and those working in a medical environment.

Highlighting the cultural dimension of medicine does not imply criticism but rather displays an unknown potential in therapeutic work. The general practitioners' social, political and symbolic dimensions of thinking and acting, for example, form an intrinsic part of their efficacy. Awareness of this 'secret power' is in their own advantage. The de-exoticisation of medical anthropology, therefore, will benefit both anthropology and medicine.

Usefulness and uselessness of medical anthropology[9]

The culture of medicine is, in the first place, practical. Health workers are expected to find concrete solutions to concrete problems. The awareness that time is expensive is tightly linked to this. Many operations have to be carried out immediately, before it is 'too late'. A third element of their culture is that doctors judge their success from the health of their patients. The preservation and recovery of physical well-being is the *raison d'être* of their profession. According to Glasser (1988) they are accountable to people. If their work does not result in a better health, they have failed and deserve criticism.

The main ingredients of the culture of anthropologists are almost the opposite. The 'average' anthropologist today is theoretically, even almost philosophically inclined. The anthropological productions that are most admired are descriptive, interpretative and reflexive, and preferably make use of a literary style. Many anthropologists consider applied anthropology a dilution of their profession, a dubious concession to non-anthropological 'others'. Moreover, if it is done for money, and this is usually the case, it reeks of intellectual prostitution.[10] The idea that a 'proper' anthropologist should not concern himself with the practical application of the results of his research still occurs.

It is not surprising, therefore, that anthropologists are usually in no particular hurry to write down their findings. Their contempt for practical matters is also revealed in the slow production of their publications. Many anthropologists claim that their views and interpretations need time to ripen. It is not exceptional when an anthropologist publishes about research he carried out twenty years ago; I have done so myself.

To the average anthropologist, the completion of his task does not lie in the improvement of the living situation of those among whom he did research, but in the production of texts about them. While a physician finds satisfaction in the recovery of his patient, the anthropologist finds it in a favourable reception of his publication. He is, first of all, accountable to his colleagues and managers, who may not read his publications but will certainly count them. He feels less

accountable to the people among whom he did research, and who often are *de facto* co-authors of his work, although this is now changing gradually.

That the 'use' of anthropological research is limited, is obviously connected with its 'holistic' character. When one involves 'everything', one does not know where to begin. The long and comprehensive descriptions of anthropologists often have a discouraging and paralysing effect on policymakers. They do not offer concrete suggestions; they do not simplify the problem (which is the objective of medical research) but rather complicate matters. And when they formulate recommendations it is usually something like 'on the one hand such, on the other hand so'; or worse still, they may conclude that more research (anthropological of course) has to be done. Doctors often have the impression that anthropologists will only let themselves be enticed to make concrete statements *post mortem*. After the horse has bolted, they come and describe how this could have happened; they do not even lock the stable door.

The challenge to medical anthropologists is to bridge the gaps between anthropology and medicine. One could, and even must, expect of them that they will now and again dare to speak out on practical problems without abandoning their anthropological principles. In his inaugural lecture some years back, Pieter Streefland (1990) pleaded for a real interdisciplinary and problem-oriented medical anthropology, an improvement of its image among doctors and policymakers and more alertness in the initiation of applied medical-anthropological research. Richters (1991) also called for a rapprochement between doctors – in particular psychiatrists – and anthropologists. Furthermore, she criticises her fellow anthropologists for not paying enough attention to social and political factors that cause and perpetuate illness.

Such a shift of emphasis in the work of medical anthropologists would indeed be a defeat of the ethnocentrism that has crept in. It would mean that in our work we are not just after the applause of colleagues but that we also try to gear it to the taste and needs of others, such as policymakers, health care workers and, above all, the local population. We should be able to do so, thanks to the anthropological imagination to which we appeal: the ability to put ourselves in the position of others.

A good example of such applied research is that which Anita Hardon conducted in two poor areas in Manila. She tried to discover how the people in those areas defend themselves against illness, especially by means of self-medication, and how their situation could be improved. The naiveté of much so-called applied research is that it is carried out as a service to the least privileged but that the results and recommendations are subsequently offered to the most privileged, those who have ample reason to leave everything as it is. Her research, however, was a continuing dialogue with those directly affected by

problems of ill health and poverty, resulting in attempts to find concrete solutions for those problems. Philippino social groups were involved in the research from beginning to end. They published the report, disseminated it throughout the Philippines and used it in political and practical activities for the improvement of health in the areas (Hardon 1989).

Another example of policy-oriented research is the study carried out by Winny Koster on induced abortion among Nigerian women. She combined her fieldwork with 'teaching' young people how to prevent the hazards of unwanted pregnancies and abortions (Koster 2003). The work of Corlien Varkevisser, who retired in 2001, has always been marked by an explicit orientation on practice and policy. Throughout her career she worked in close cooperation with health workers and policy planners (Mwaluka et al. 2001, Idawani et al. 2002, Alva et al. 2002).

Anthropologists love to talk about dialogue, but their dialogues are often unintelligible to the intended discussion partners. When medical anthropologists succeed in engaging in a real dialogue with non-anthropologists, such as health care workers and members of local communities, they will accomplish something many of their colleagues can only dream of.

In conclusion

This introduction focused mainly on the negative side of ethnocentrism. I considered situations in which people unreflectively take their own knowledge and values as objective reality, and automatically use them as the context within which they judge less familiar objects and events, to paraphrase Levine and Campbell (1972: 1).

The five situations which were discussed in more detail all concerned some kind of communication: between medical professionals and 'lay people', between medical and anthropological researchers, between cultural anthropologists and their colleagues in medical anthropology, between medical anthropologists and those they study, and between theory- and policy-oriented anthropologists.

I have tried to sketch the pitfalls of ethnocentrism for medical anthropologists and suggested ways to avoid and overcome these, using examples of research carried out by some colleagues of the Amsterdam Medical Anthropology Unit. In the opening paragraphs of this introduction I suggested that it is the mission of cultural anthropology to expose and critique unreflected (or 'primitive') ethnocentrism and to argue about how to deal with the inevitability of ethnocentrism in a respectful and enlightened way. It is the task of medical

anthropology to do the same in the field of health and medicine and with regard to the cultures of disciplines which study health and health care. Cultural respect is not only a moral imperative but also a methodological condition both for anthropological fieldwork and for interdisciplinary co-operation.

Notes

1 Part of this text has been derived from my inaugural lecture *"Hoe gaat 't?" Vijf opmerkingen over medische antropologie en etnocentrisme* (Van der Geest 1995a), which was held on May 22, 1995 at the University of Amsterdam. I thank Trudy Kanis for the translation of the Dutch text and Sonja Zweegers and Sera Young for editing the translation.

2 I quote from the abridged and revised version, which was published under a new title (Herskovits 1954).

3 Primary Health Care (PHC) reflected the spirit of its time. With his book *Pedagogy of the oppressed* Paulo Freire (1972) had raised the consciousness of oppressed people and pointed at the possibilities to release themselves from their situation. Ivan Illich (1976) wrote a best-seller on medicalisation and the 'sick-making' effects of medical science. The literature on PHC can fill a library. The WHO itself presented PHC as a new policy in the so-called Alma-Ata document (WHO/UNICEF 1978). One eloquent and influential pleader for PHC outside the World Health Organisation was David Werner (1977, 1981) who viewed PHC as an outspoken political affair and who translated Freire's ideas into health care practice.

4 For an explanation of these shifts in meaning of 'Primary Health Care' from a multi-level perspective, see Van der Geest et al. 1990.

5 Richters (1991: 404-12) describes the resistance against interdisciplinarity between anthropologists and psychiatrists from the same point of view. Although they sometimes work together they keep entrenching themselves behind their barricades, they do not read each other's work and do not take each other's views seriously. She concludes: 'They each keep weeding their own garden and deciding what are weeds'.

6 In a probing review of a medical-anthropological study on pain Menges (1993) airs his feeling about the self-importance of the authors in the following way: '(It) strikes me how well these medical anthropologists know it all… There is a certain hidden arrogance in the way non-enlightened spirits in the clinic are placed opposite those who, like the authors, have seen the light. In this one-sided approach, the often desperate struggle practitioners and other social workers are having to 'understand' chronic-pain patients is ignored' (our translation).

7 I think, among others, of the work of Kleinman, Good, DelVecchio Good, Stein, Lock and Martin.

8 The most important thoughts of this study have, however, been published in a later book by De Swaan (1983a).

9   Parts of my fifth comment have been mentioned earlier in an editorial for the jour-
     nal *Social Sciences & Medicine* (Van der Geest 1995b).
10   See Pouwer (1987) and De Ruijter (1988) for a (Dutch) mini-debate about the loss of
     the 'purity' of anthropology due to the evil temptations of money.

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