INTRODUCTION

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It is difficult to imagine anything more precious to human kind than good health. People, all over the world, have always been concerned about their state of health and have so developed the means of surviving threats to their life and increasing their well-being. At the same time, however, people continuously contract diseases as a result of their own actions. The relationship between behaviour and state of health, studied from a cultural (or social) anthropological point of view, forms the basis of 'medical anthropology'.

1. The field of medical anthropology

Although the general definition of medical anthropology is clear enough, the precise demarcation of its field of study is not easy. Concern about health, because it is so basic to human life, affects every activity in the in the socio-cultural domain. Almost every anthropological variable is in some way linked to health or disease. One could almost substitute the term 'anthropological anthropology' for 'medical anthropology'. The division of topics in anthropology, generally, is equally applicable to the distinctive areas in the field of medical anthropology: economic systems, marriage and kinship, social stratification and religious beliefs are all clearly related to questions of health and sickness.

Lieban (1974) divides the field of medical anthropology into (1) ecology and epidemiology, (2) ethnomedicine, (3) medical aspects of social systems and (4) medicine and culture change. In (1) he relates the incidence of disease to human adaptations to physical environment and to differences in age, sex, occupation, social stratification and other variable factors. Ethnomedicine (2) - essentially the study of indigenous medicine - includes also the classification of disease and the religious beliefs involved in its diagnosis and treatment. The term 'ethnomedicine' is itself somewhat ethnocentric, in that it does not apply to western medicine. This seems to imply that western medicine is not to be thought of as 'indigenous', nor as being subject to cultural beliefs, at least not to the same degree. The fact that very few anthropologists subscribe to this un-anthropological approach (see for example Van Binsbergen and Bleek in this volume) demonstrates

that the concept of 'ethnomedicine', as it is commonly used, is ill-suited for defining one particular area of study in medical anthropology.

In 'Medical aspects of social systems' (3) health (or its absence) is treated as an independent variable. Under this heading fall studies of social and cultural phenomena related to questions of health and sickness. This third category is somewhat imprecise, and that is mainly for two reasons. The first is that its subject matter is so wide as to embrace almost any socio-cultural phenomenon. In this context Lieban discusses beliefs concerning sanctions, deviancy and illness as symptoms of a society's deficient functioning.[2] But economic activities, residence patterns and kinship relationships are also influenced by the presence or threat of disease. The second reason is that in relation to health factors the distinction between dependent and independent variables is often purely theoretical. Moving one's residence from an infected area, for example, may be regarded as 'dependent' on the prevalence of disease but it may also be seen as a step towards health. To give another example, witchcraft accusations may occur as a result of disease but they can, at the same time, assume diagnostic and therapeutic functions. Lieban's fourth (4) heading reminds one of the last chapter in classical handbooks which treats the phenomenon of change as a subject in its own right. Lieban is concerned not only with the introduction of western medicine into non-western societies, but also with the influence of other forms of social change on matters of health. The latter would fall better under 'epidemiology' while the former might better be treated as an aspect of 'ethnomedicine'.

Lieban's is not the only survey of medical anthropology. Other surveys such as those made by Polgar (1962), Fabrega (1972) and Colson and Selby (1974) are also characterized by a remarkable lack of logical consistency. The definition of research areas is based upon unequal criteria and there are considerable overlappings and gaps. The field of medical anthropology is mainly delimited in pragmatic terms, and medical anthropologists have yet to come to grips with their own field of studies.

This is not surprising, seeing that medical anthropology is a young and rapidly growing branch of social science. A recent reader (Landy 1977) mentions no less than thirteen topics as belonging to the field of medical anthropology: paleopathology; ecology and epidemiology; medical systems; divination and diagnosis; sorcery and witchcraft; public health and preventive medicine; anatomy, surgery and medical knowledge of preindustrial

peoples; obstetrics and population control; pain, stress and death; emotional states and cultural constraints; status and role of patient; status and role of healer; socio-cultural change in medicine. This shows the rapid growth of medical anthropology. Yet, according to one reviewer (Pearsall 1978), Landy's reader still leaves out many relevant topics.

I have two suggestions for a more logical and consistent organization of medical anthropology. The first is that it should be confined to studies which have as their subject matter ('material object') people's state of health. The relevance of the subject matter of a given study may depend on an implicit understanding that it is related to problems of health. A study of the doctor-patient relationship for example is relevant because of the implicit understanding that its character affects the therapeutical process. It must be realized, however, that different opinions exist on the question of relevance. Consensus about the relevant socio-cultural factors can only be reached gradually. The range of relevant factors is, in any case, much wider for anthropologists than for medical specialists. The restriction of the subject matter to people's state of health excludes studies in which health and sickness are treated as independent variables. To give one example, a study of the economic or demographic consequences of leprosy is not a part of medical anthropology, since its subject matter is respectively economic or demographic. However, many studies in medical anthropology are not quite so restricted and - somewhat ambivalently - take into account the possibility of a two-way interaction between cause and effect.

The second suggestion is to divide the field of medical anthropology into two very broad areas. One, 'the anthropology of disease', would be concerned with ill-health as the direct or indirect result of socio-cultural behaviour. The other, 'the anthropology of health', would be concerned with the study of health (or the quest for health) as a socio-cultural phenomenon. Such a division also follows the conventional organization of medical science in three broad areas, physiology, pathology and medicine. 'Anthropology of disease' roughly corresponds with pathology and 'Anthropology of health' with medicine. The 'anthropology of disease' would include such subjects as paleopathology, ecology and socio-cultural epidemiology, with regard to both physical diseases and psychic disorders. Under the 'anthropology of health' fall both the study of non-western medical care (commonly termed 'ethno-medicine') and that of western medicine. The study of medical belief

systems, patient-healer relationships, classification of diseases, to mention a few important subjects, also belongs to this category.

2. Medical anthropology versus medical sociology

Another aspect of the problem of identity of medical anthropology is to be found in the definition of its boundary with the medical sociology Attempts at clarification have recently been made by both an anthropologist (Foster 1974) and a sociologist (Olesen 1974), but neither succeeds in establishing a demarcation line based upon firm methodological principles or differences in subject matter. All that can be said is that both medical anthropology and medical sociology are defined according to the chosen profession of their practitioners. Such differences as there are between the subjects studied by medical anthropologists and those studied by medical sociologists (both Foster and Olesen give some useful examples) are not explicable on the basis of differences between the two disciplines, but are rather the result of historical development. One instance of this process is to be found in the different locations of sociological and anthropological fieldwork. The fact that anthropologists often conduct fieldwork in areas where western medical care is not easily available influences the character of much anthropological research (as is shown by some contributions to this volume). These differences between medical anthropology and medical sociology are, however, fortuitous. There is no other explanation for the fact that anthropologists tend to be interested in indigenous (non-western) medicine, cognitive aspects of health and disease, cultural epidemiology, etc. and prefer to carry out participant observation in small groups outside their own culture while sociologists tend to be interested in medical practices within their own society, role relationships between doctors and patients and make more use of survey techniques. Foster's contention that anthropologists tend to identify more with the sick and sociologists more with the medical establishment is no more than professional chauvinism. Fox (cited, with disapproval, by Foster 1974: 1) is not the only one who finds the attempts to justify the disparateness of sociology en anthropology almost comical'.

An example of such 'almost comical' justification is the following quotation from Olesen (1974: 8):

> "For instance, two fieldworkers from these subdisciplines, both analysing the labor and delivery room with data gathered via participant observation would group their analysis in the views of their respondents or informants rather than testing derived hypothesis from theory. Both, if they were well trained fieldworkers, would carefully attend to their own participation in the setting and the meaning of that participation to the data gathering processes. However, the concepts of the parent discipline might well separate their eventual reports to their colleagues, to health care professions, or to patient groups: the sociological fieldworker might well develop emergent concepts which were influenced by such sociological work-horses as 'role'; Goffman's dramaturgical concepts of 'front and back stage', 'presentation of self', 'stress', 'hierarchy'; while the anthropologist observer might want to entertain concepts of 'kinship', 'ritual', 'purity and danger', 'contagions', 'mythic properties of birth'."

Goffman's ideas both about the dramaturgical aspects of social behaviour and about hierarchy have had a great impact on both 'sociologists' and 'anthropologists'. Conversely, the emphasis on kinship, ritual and belief which Olesen attributes to anthropologists is not so much related to the researcher's discipline but rather to certain characteristics of his research population.

3. Anthropologists and medical aid

Anthropologists who conduct fieldwork in an area at some distance from western medical service are often involved in problems of health, whether they like it or not. Their confrontation with sickness takes place in two different ways. In the first place they may themselves become sick. Unusual conditions, regarding climate, food, hygiene and accommodation, make them more succeptible to disease than they are at home. Concern about possible sickness may also have a negative influence on their state of health. Fieldworkers can also contract a disease because sick people seek their help. Many fieldworkers, for that reason, have their own supply of medicine. Pelto and Pelto (1973: 263-4) note that several fieldworkers have been prevented by illness from finishing their work, citing the examples of Holmberg (1969), Whitten (1970: 396) and Maxwell (1970: 474-5). Many readers will know of other examples.[3] In the present volume, Van Binsbergen records how both he and his wife were troubled by sickness at a very crucial moment in their research in Zambia. Their sickness had some grave consequences for them and for their respondents.

More crucial however, is the fieldworkers' confrontations with sick people around them. People living in the neighbourhood of fieldworkers are likely to appeal to them for help when they are sick. Fieldworkers usually have their own medical supplies and, besides, they are often identified with physicians, many of whom are still whites and foreigners, particularly in rural areas. Barnett (1970: 25), writing about his fieldwork on a Pacific island, relates: "I found it almost impossible to explain to them that although I am a 'doctor' I really am not". Anthropologists are often not unwilling to provide some medical services, if only to give something in return for the information they have received. Help of this kind may be comparable with other small services which fieldworkers render, such as providing transportation, distributing gifts, taking photographs or using their influence to mediate for their informants. Giving medical care also helps a fieldworker to become an accepted member of the community. Read (1965: 79-89), who did research in Papua New Guinea, notes how he gained the people's confidence after a successful medical intervention.

Van Binsbergen's presence in a Zambian village was justified by the medical help he was able to give. Both he and his wife even felt that they were more exploited by the people than the people by them. A similar picture emerges from Schenk's contribution to this volume, in which she describes how she and her husband became involved in the medical problems of a young Indian boy.

A fieldworker has, in general, an obligation to do his best to help sick people who appeal to him, unless professional medical services are locally available, as is clear from examples from the anthropological literature. During his fieldwork among the Lugbara in Uganda Middleton (1970: 22-3) provided medical aid every morning from seven to eight, and later organized a dispensary which was open during markets. Both Bohannan (Bowen 1964: 36-7) and Powdermaker (1967: 77) also provided medical aid at fixed times and Saberwall (1969: 56-7) provided transport for taking people to the hospital, as countless other fieldworkers have also done. Alland (1976: 86, 99, 107), writing about his fieldwork in Ivory Coast, tells us that he spent a great deal of time on providing first aid, especially treating children's tropical sores, and taking the more seriously ill to the hospital. Gould (1965), who had had some medical training before becoming an anthropologist, became a popular 'doctor' in the Indian community where he conducted his fieldwork. Many people preferred him to the professional

doctors because of his personal interest in them; others asked him to take them to doctors whom he knew personally. Lewis (1955) helped to establish a medical post with a doctor in Tepoztlán. Van Binsbergen is presently mobilizing people and funds for a self-help clinic in his area of research.

Some authors have reported on their failure to intervene in medical affairs. Laura Bohannan (Bowen 1964: 181-95) describes how she watched a woman, who had become very dear to her, die. Unable to do anything to help the woman, she had at first expressed her confidence in traditional medicine. When the illness became critical, she tried to persuade the woman's relatives to allow her to take her to a hospital, but she failed to do so and the woman died.

To summarize, the personal involvement of an anthropologist in the medical problems of his informants can be viewed, negatively, as a breach of the code of non-intervention. It can also be seen as a strategic means of propitiating informants, to the point of real participation in their lives. The participatory aspect of the so-called 'participant observation' of fieldworkers usually leaves much to be desired. The inmense gap between the fieldworker's and his informant's economic status and interests makes it difficult for both of them to share fully in each other's lives. There are, however, a few common interests. Of these health is the most prominent and although, in case of sickness, differences in wealth can be decisive, true sharing is still possible. Two quotations from contributions to this volume illustrate this point:

> "Utterly shocked by this humiliating confrontation with the health agency whose excellency he had always advocated among his people, and to which he was now applying as a last resort, Muchati rushed out of the ward, to the parking lot where I was waiting. For the first time in all the years that we had worked together, he cried out my first name, without the usual titles of address: finally he was an equal who in his distress appealed to his friend." (Van Binsbergen)

> "We waited for hours in the corridor of the hospital. A nurse asked why I was waiting. I told her the story about the boy. She confirmed the director's instruction and said: "Who will take the responsibility if something happens?" She told me that it would be no better the next day because it would be Good Friday. When she saw my despair she asked if I was a Roman Catholic. I lied and said: "Yes". She then promised to try and get hold of the doctor in charge. After a while a young woman doctor came into the corridor to see me. I recounted the case history of the boy once again. She

asked: "Is he your servant?". I said: "No", and saw that she was astonished. Then she said: "We can only admit him when he is dying"." (Schenk)

Such moments are precious both from a humanistic and an ethnographic point of view. In the latter case they allow the anthropologist, as an outsider, to gain an inside view and to describe the observed process with rare insight.

Unfortunately, few anthropologists have described such moments. This is not surprising, because these are precisely the moments that fieldworkers stop being observers and become personally involved. A passage cited from Bohannan (Bowen 1964: 185) applies here well: "What is one to do when one can collect one's data only by forming personal friendships? It is hard enough to think of a friend as a case history." It clearly illustrates the paradoxical character of participant observation: the observer does not participate and the true participant does not observe. I used the term 'paradoxical' and not 'contradictory' because I believe that by a special effort moments of true participation can afterwards be described and analysed.

This volume includes two admirable attempts (Van Binsbergen and Schenk) to describe and analyse personal involvement with the well-being of informants. Both give a very detailed account of the dramatic events in the pathological history of a young boy. They give the reader not only a theoretical understanding of the health problems at issue but also a feeling of the emotions which accompany them, without which the problems arising are only half understood. Desperation, anxiety, insecurity and fatalism all play a part and contribute to the vicious circle in which the patient is caught.

Van Binsbergen describes the first years in the life of Edward, the son of his servant and research assistant in Zambia. Following a difficult birth, the baby is often critically ill. Because of their relationship with the father, Van Binsbergen and his wife do their utmost to save the boy's life. Sometimes they are expected to play an active role, for example by giving the boy medicine or taking him to the hospital. At other times, when local medicine or rituals are considered to be more appropriate, they have to remain passive. The merits of the essay are twofold. In the first place, this extended case shows the very complex character of people's health behaviour and lends itself to an analysis of

its crucial components. In the second place, a fieldwork situation, in which human and scientific values instead of clashing with each other prove to have some common ground, is vividly described. The question, which then arises, as to whether ethical and methodological aspects of fieldwork have not much more in common than has been realized up till now, is not dealt with.

Schenk describes her and her husband's involvement in the misery, caused by the sickness of a twelve year old boy in the Indian town of Valsad. Caste differences, combined with extreme poverty, deny the boy access to existing medical services, at least until the two fieldworkers act on his behalf. Their attempts to intervene in this boy's and other people's health problems probably constitute their most intensive participation in people's lives. They further tried to help, by writing letters and making loans, when people were dismissed from their job or chased out of their houses. However, the only time their intervention had some success was in the case of the sick boy. Other areas of life, especially those pertaining to politics, caste, poverty and social inequality, which were the focus of the research, proved to be closed to such participation. (Schenk: personal communication). It is reasonable to assume that involvement in problems of health turned out to be particularly important to Schenk and her husband, both emotionally and scientifically.

4. The essays

Five of the six essays were written by social scientists, and one (Van Enk) by a medical specialist. Four essays are based on African data (three Ghana, one Zambia) and two on data from India. Leaving aside, for the moment, Van Enk's essay, we see that in the three remaining essays on African topics the main concern is the options people have in selecting medical treatment, whereas that of the essays on Indian topics is a discussion of western medicine in Indian society. This difference in approach cannot be explained by the absence of options in the Indian situation. There are any number of options, especially in the fields of Ayur-Vedic and Unani medicine, which belong to the age old Hindu and Muslim medical traditions. The fieldwork was, however, concerned with western allopathic medical care. This is, in contrast to most African nations, comparatively easy to obtain in India, where there is a large number of Indian allopathic

trained doctors in practice. But as the essays show, there are both structural and cultural barriers to the availability of this type of medical aid.

A theme common to all six essays is the doctor-patient relationship,[5] hardly surprising seeing that social relationships are the basic subject matter of anthropology. In this sense, all six essays fall under 'medical anthropology'. On the basis of my own definition of medical anthropology these essays can be considered as exercises in the 'anthropology of health', because they are concerned with anthropological implications of health care. It is probably no coincidence that none of them falls into the category of 'anthropology of disease'. If this is defined as the study of poor health as a direct or indirect result of socio-cultural behaviour, professional competence in pathology is necessary to judge whether particular socio-cultural factors are related to the incidence of certain diseases. The only medically trained contributor to this volume deliberately restricts himself to matters, which in his original study of stomach resection, were only mentioned in passing. A multi-disciplinary approach is needed in the anthropology of disease, as much as in the anthropology of health. Unfortunately none of the contributors to this volume have received the integrated socio-medical of medico-social training, which this would require.

Van Binsbergen attempts to find out why cosmopolitan medicine is resorted to on one occasion, and indigenous medicine on another. He rejects the thesis that such decisions are made primarily on the basis of cognitive factors relating to health and disease, for health behaviour is essentially social behaviour which can only be understood in its social context. The Nkoya are characterized by residential groups which are remarkably unstable, the power of elders, continuous movement between town and country and marginal participation in the capitalist economic system. In an extremely complex pattern of social relationships individuals, in their search for health and general well-being, rally as much support as possible. This is to be found in the political, the economic, the religious as well as in the medical field. When the traditional sector looks more promising, that is where medical aid will be sought.

Van Binsbergen rejects all facile predictions of people's medical behaviour, for which there is little scope in a complex situation not open to any simplification. In the last analysis health and medicine in Zambia have a political character. Indigenous medicine, even if technically inferior to cosmopolitan medicine in the treatment of somatic-pathological conditions, will remain indispensable as long as the present social and economic insecurity continues to exist. This essay reveals a certain ambivalence towards both traditional and western medical systems. This ambivalence is found in the work of many anthropologists. On the one hand they defend the traditional culture, on the other hand they are concerned with the promotion, wether direct or indirect, of western medical care (cf. references in the previous paragraph: Middleton, Bowen, Powdermaker, Saberwall, Alland and Gould). Bohannan's (Bowen 1964: 101-95) reaction to the sickness of her friend is particularly significant. At first she trusted in traditional medicine, but then, when the condition became critical, she 'relapsed' to western medical help. Two factors explain this ambivalence. The first is a lack of medical knowledge which encourages superficial involvement in any medical practice. The second is the anthropologist's position as a relative outsider. When either of these two factors does not apply, an anthropologist may well take a less equivocal stand on the desirability of a particular medical practice, as the essays of this volume indicate. Two authors (Van Enk and Tijssen) are directly connected with providing western health care and three others (Van Binsberge Schenk and Van der Veen) are very much involved in it, if for different reasons. Bleek, who is the least involved in western medicine, is probably the most ambivalent on this point.

An important question which Van Binsbergen fails to answer, concerns the influence of cognitive factors upon the complex Nkoya behaviour in search of health. If, as Van Binsbergen suggests, cognition is not a primary factor, it still cannot be entirely neglected in the final analysis. Van Binsbergen does not entirely ignore Nkoya conceptualizations of illness and health, which as he himself admits, are essential to an understanding of people's health behaviour. One might well ask whether his conclusions should be modified in the light of the cognitive element. Although cognition cannot be considered apart from a patient's social situation, it should be noted that, in analytical terms, the cognitive explanation is the counterpart of the socio-political explanation. Van Binsbergen's failure to include the cognitive framework in his analysis constitutes the major weakness in this otherwise excellent essay.

Bleek contrasts two types of healers, as they are perceived by school pupils in rural Ghana. His purpose was to test the somewhat ethnocentric assumption that modern doctors are considered as more 'scientific' than herbalists. He failed in this purpose because the pupils used terms (and perhaps also concepts) which did not allow for a distinction between 'scientific' and 'magical' thinking. The investigation does however lead to the important conclusion that the pupils have considerably more confidence in western than in traditional medicines, but that this does not extend to a preference for western over traditional doctors. This probably explains the wide distribution of western medicines through unqualified channels, which threatens to become one of the most serious medical hazards in Ghana and many other developing countries.

Van Enk's contribution is a report of an interesting experiment in which former patients of a Ghanaian hospital were invited to come back for a re-examination. The re-examination took place in the course of research into the epidemiology of peptic ulcer, carried out by the author for his Ph. D. (Van Enk 1976). The re-examination was surprisingly successful, seeing that in Ghana the relationship between western-trained hospital doctors and patients is usually superficial and short-lived (as it is in many other African countries) whereas contact with traditional healers is usually [6] long-lasting and comprehensive. Moreover, it was believed that 'shopping around' by patients, transport difficulties, frequent transfers of medical personnel, and a host of other factors, rendered follow-up care extremely difficult. It is not altogether clear what explains the success of the experiment. Van Enk thinks primarily in terms of hierarchy: a superior summons an inferior. One may also think of the durable character of traditional health care as an explanation of the enthustiastic response to the doctor's invitation. Whatever is the right explanation, the outcome of the experiment is extremely important for those involved in providing western health care in African countries. Seeing the different conclusions reached by Bleek and Van Enk with regard to the image of the western trained doctor in Ghana, more research in this field is called for.

Tijssen is also concerned with the choice between modern or traditional medicine. She spent two years in Ghana where her husband worked in a

hospital as a medical doctor during which period she conducted research, in the hospital, directed to gaining more information about the patients and their behaviour during illness. An M. A. Thesis was based on this research (Bollen-Tijssen 1978), in which (p. 89-90) the various explanations for the choice of either traditional or modern medicine were presented in the form of three alternative hypotheses. The choice is determined/ influenced by:

a. patients' individual characters (e.g. educated versus illiterate, urban versus rural, etc.)
b. type of disease (e.g. 'natural' versus 'supernatural', short versus chronic, etc.)
c. characteristics of the medical system (e.g. geographical and financial barriers, etc.).

The conclusion - in contrast to that reached by Van Binsbergen for the Nkoya - is that the nature of the sickness is the primary factor determining people's choice of medical help.

It seems to be generally true that chronic disease and psychiatric disorder, which require long and individual attention, are likely to remain the field of traditional healers, whereas diseases requiring shorter and more technical treatment are likely to be referred to modern doctors. Tijssen presents one interesting exception to this rule: fractures are treated preferably by traditional healers. This practice has also been reported by other students of African medical systems but never in such detail. The explanation suggested for it leads to a number of practical suggestions for the modern treatment of fractures.

A comparison of the opposing views of Van Binsbergen and Tijssen (in her thesis) suggests that there is a link between the type of research and the type of explanation. Van Binsbergen's research, based on intensive participation in the lives of informants, yields a very complex set of factors which probably reflect the character of his fieldwork relationships. Tijssen's questionnaire approach, in contrast, was such as to yield clear-cut - and probably simplified [7] - 'parameters'. A combination of both research techniques seems indispensable.

The two remaining papers are about health care in India. Schenk's presentation of extreme poverty, caste differences and a shockingly ineffective medical system, leading to a situation in which people are

denied access to the health care which is intended for them, is very straightforward. An extended case study shows the utter hopelessness of the situation. The paper suggests that statistics about the position of health care are extremely deceptive, if it is not known how this actually works. But for the influence and personal interest of the fieldworker the boy would have had no chance of survival.

The last paper, by Van der Veen, provides a socio-cultural explanation for the under-utilization of the state health services in India. This is to be explained primarily, by the type of relationship which exists between western-trained doctors and their patients. If, at first sight Van der Veen seems to be far removed from Schenk, (who emphasizes other structural reasons for the lack of health care), his analysis helps none the less to understand Schenk's material. According to Van der Veen, medical aid, as any type of aid, depends upon the existence of a many-stranded relationship. This personal bond, based as it is on the principle of reciprocity, cannot easily be established by people who live in a state of extreme poverty, which is further justified by religious rationalisations. This may explain why the poor are unable to get adequate medical treatment (as Schenk shows), and why a western and bureaucratically organized medical system, which neglects the personal bond, is bound to fail in India (as Van der Veen shows).

The above summaries do not do full justice to the six essays in this volume. The purpose of the introduction is not to deflect interest from the essays themselves, but to point out a number of salient points of agreement and conflict. A remarkable point of agreement is the discussion, common to all six authors, of the role of western medical care in a non-western setting. There is more to this than an ethnocentric preoccupation on the part of the authors. Without making any value judgement one may safely say that the western model of health care has reached the most diverse societies, and that no comprehensive study of health behaviour, wherever made, could exclude its influence.

NOTES

1) I am grateful to Klaas van der Veen, Thomas Crump and Wim van Binsbergen who commented on an earlier version of this Introduction. Van Binsbergen's comments were so extensive that he would almost count as a co-author.

2) This last topic belongs rather to the area of social epidemiology, since illness is not treated here as an independent variable influencing social conditions, but as a variable dependent upon social conditions.

3) A curious example, reported by Wagley (1960: 402), arose during his fieldwork among Indians in Brazil: "My illness proved to be a boom for ethnographic research. People were more patient with the sick anthropologist than with the well one. They told stories, not only for my benefit, but also to entertain each other.....".

4) For a brief discussion of the 'economics of health', see Illich 1977: 239-46.

5) It remains, however, an intriguing question why anthropologists focus their attention so exclusively on the doctor-patient relationship and not on other relationships which also play a role in the healing process, e.g. patient-sponsor, patient-nurse, nurse-doctor, doctor-(rival)doctor, etc.

6) It seems that some 'traditional' healers also have anonymous, short-lived relationships with their clients. Such superficial relationships are probably best regarded as the result of a 'rationalization" of traditional healing in a <u>modern</u> setting.

7) A possible example of such simplification is the classification of urban-rural, under the heading personal characteristics. As is well-known, people in many African societies, and certainly in Kwahu, continuously cross the border between both settings. Similar objections can be made to other classifications, e.g. those referring to educational level, financial status and the 'natural' - 'supernatural' character of disease.

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