Remembering Klaas Willem van der Veen (1930–2016)

Sjaak van der Geest

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On Monday, 30 May 2016, Klaas van der Veen died after a long period of vascular dementia. Until his retirement in 1995, Klaas had been employed as an assistant and later associate professor in the Anthropology Department of the University of Amsterdam. In 1978 we cofounded the medical anthropology section of that department, after which we worked closely together for seventeen years. Klaas was a perfect colleague and a much-loved teacher. His popularity can be concluded from the fact that twice in his life colleagues presented him with a *liber amicorum*, first in 1980 at the twenty-fifth anniversary of his appointment at the university and again in 1995 upon his retirement.

Klaas was born in 1930 in Makassar, Indonesia (then the Dutch East Indies). His father was a machinist at the Koninklijke Paketvaart-Maatschappij (KPM) who sailed between the various islands. Eighteen months after his birth, the family moved to the Netherlands when his father retired at the age of forty-five. Around 1950 Klaas began his study of human geography (*sociale geografie* in Dutch) at the University of Amsterdam. Anthropology did not exist at that time as a department in Amsterdam and the first generation of anthropologists originated almost entirely from the Human Geography Department. In 1955, Klaas became a student assistant to the first Amsterdam anthropology professor André Köbben. In 1963,

Köbben became his *promotor* (supervisor) for his PhD research about hypergamy among Brahmin families in Gujarat, India (hypergamy refers to the 'marrying up' of wealthy low caste women with men from a higher but impoverished caste).

His doctoral dissertation (1969), published two years later under the title 'I Give Thee My Daughter', outlines the ideas and interests that would occupy him for the rest of his academic – and personal – life: the ambiguity of marriage and kinship as a principal determining context of human relations. Out of this work rose concepts like gift giving and reciprocity, multi-stranded relationships, hierarchy and inequality, and human ambivalence.

For his whole active life, Klaas remained focused on India. His love for India resembled the love in an arranged Indian marriage: he never chose this country. Originally he and a few other Dutch co-researchers were assigned to carry out research in postcolonial Indonesia, but due to political tensions between the Netherlands and Indonesia and the latter's refusal to give the team visas, the research venue was relocated to India. From that moment on, his love for the country began to grow. What had been arranged for him became his life-long fascination.

As part of his teaching, Klaas got involved in creating a 'field station' in Tunisia for students doing research for their master's theses. Two teachers introduced five to ten students to the field and supervised them on location. The experiment began in 1965 and lasted approximately five years. Douwe Jongmans, initiator of the station and a Tunisia expert, and Klaas wrote an account of their experiences in what was then called the *Sociologische Gids* (1968).

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After completing his doctoral dissertation on marriage and hierarchy, he became interested in social and cultural aspects of health, such as the relationship between doctors and patients and problems in tuberculosis (TB) control. As a social scientist, Klaas found himself too far removed from the medical professionals he met in his research, so he decided to study medicine. After a year, he realized that this was too ambitious and so switched to a one-year nursing training at the Naval Hospital (Marine Hospitaal) in Overveen, where he lived. He combined this training with a part-time appointment at the university.

In his studies of TB treatment in India (1982 and 1984), he pointed out that the coexistence of private profit-oriented treatment centres and free public TB centres had an 'extremely harmful' effect on the quality of treatment in general. Private practitioners took advantage of the – erroneously – bad reputation of the state health centres to attract patients. Since TB treatment needs to be long and continuous, most patients could not afford a private doctor's full treatment and thus stopped after a short period when the symptoms diminished.

Advanced cases of TB were, however, rejected by the private clinics and referred to the public ones that thus 'earned' their bad reputation as places where people would die.

A more than hundred-page report on 'cultural codes and the doctor-patient relationship' (1982) best represents Klaas's perspective (all of the following quotes come from this text). His views and findings concerning Indian kinship and marriage became the key to unravelling the doctor-patient relationship:

> The multiplexity . . . of exchange relationships in India found to be characteristic for sharing and giving (Vatuk) in the context of family and 'household' (Das & Nicholas) and in agrarian production (Ludden & Rudra) is also a major component of the doctor–patient relationship. Not only in, what is generally called, the traditional Indian health care but also within the allopathic, state organized medical services. (p. 1)

Four concepts – busily discussed in sociology in the 1970s – took a central place in his argument analysing the contrast between Indian and biomedical practices: (1) ascribed (vs. achieved) roles, (2) the multi-stranded (vs. single-stranded) character of relationships, (3) the diffuse nature of goal differentiation (vs. specific task orientation), and (4) a hierarchical (vs. egalitarian) interpretation of relationships. Klaas argued that the interpretation of human relationships in terms of belongingness and multi-strandedness hampered the effectiveness of state-organized health care in the country. The complexity of the situation is strikingly expressed in the following quote from one of his informants:

> It has to be admitted that the medicines of the government clinic are effective. Only, we are embarrassed because we are poor. People say that because the bloody bastard is poor he has landed in the government clinic. If a well-to-do patient goes there to save money, no one says anything but if we go they say that because we are poor we have come for free medicines. That is why we are ashamed. (pp. 41–42)

But going to a government health centre is not only a sign of poverty, 'it is also a proof that one has not been able to find someone (a relative, friend or patron) who was willing to pay the fee "to go to a really good doctor"' (p. 46).

When people want to consult an allopathic doctor they have reasons for that. And the technical skill of the doctor is obviously an important one. Which allopathic doctor will be consulted is, however, also dependent on the question [of] which doctor can be approached by virtue of some sort of an ascriptive relationship. Even a note (*chithi*) from someone who has an ascriptive relationship with the doctor may be a decisive factor for the choice. (p. 48)

He concludes: 'The ideal-typical, western interpretation of a doctor–patient relationship is cast in terms of single-strandedness, while the Indian interpretation puts most emphasis on many-strandedness. In the first, (supposed) technical competence and affective neutrality are given precedence, while the second is characterized by an emphasis on particularistic claims as the justification why the doctor should take interest' (pp. 74–74a).

These 'categorical' conclusions may sound too apodictic and generalizing in present-day anthropology, which excels in profound nuancing and rejecting 'dichotomies'. I am, however, inclined to read Klaas's contrasting concepts as distinctions that deserve our attention as heuristic devices and that enable us to look for nuances at a deeper level.

In his final observation in the report, he wonders to what extent the multi-stranded interpretation of the doctor–patient relationship hampers the development of a bureaucratized health care system and makes the following provocative remark: 'At the same time the question is raised, though not answered, whether a bureaucratized system . . . will be the best solution for the problems of health care in India' (p. 74a).

These observations still seem valid twenty to thirty years later (see Bhat 1999; Fochsen et al. 2006). Indian health care is still facing a kinship-like configuration of multi-stranded relations that are exploited to the benefit of doctors and some patients, but which exclude those who lack the financial and social capital to choose what they need.

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In 1978, the Anthropology Department of the University of Amsterdam was invited to establish a medical anthropology programme. That request was based on the presence of three Amsterdam colleagues who had carried out medical anthropological research: Klaas van der Veen, Marie Lou Creyghton, and myself. Marie Lou Creyghton left around that period, but Klaas and I began to develop an intensive course in medical anthropology that attracted a lot of interest, both within and outside anthropology. The new specialty proved successful and has since expanded enormously. The charisma and dedication of Klaas undoubtedly contributed to this success.

In 1986, Klaas and Veena Das launched a research project on the living conditions and care of older people in the Netherlands. The project was part of the Indo-Dutch Programme for Alternatives in Development. The researchers were anthropologists from India and Nepal: Roma Chatterji, Sanjib Datta Chowdhury, and Rajendra Pradhan. Fieldwork was conducted in a rural community (Pradhan), in a retirement home (Chowdhury), and in a nursing institution (Chatterji). Unfortunately, apart from some articles and a documentary film, the findings of this original 'reverse' investigation received little publicity. The three studies have

not been published and a joint final report, 'The Welfare State from the Outside: Aging, Social Structure and Professional Care in the Netherlands' (1991) is not even available at the University of Amsterdam's library (I was told that grey literature is not accepted by the library). Klaas's extensive introductory contribution, titled 'Who Cares and Why? A Comparative Discussion of Cultural Codes and Social Support', thus underwent the same fate.

The most striking observation by the three Asian researchers regarding elderly care and living conditions in the Netherlands was the paradox of privacy (see, for example, Chowdhury 1990; Chatterji 1991, 431). Privacy – closely related to the wish for independence – proved an urgent concern for ageing people who were increasingly facing the loss of these two cherished values. Klaas summarized this observation in the closing sentence of his introduction: 'The privacy defence . . . seems to be one of the major stumbling blocks in the social support for the elderly, while at the same time it is one of the most cherished cultural codes in the western world' (Van der Veen 1991, 65).

His involvement in this study of Dutch elderly by non-Dutch researchers led him to reflect more explicitly on ageing and care in his own society, looking for similarities as well as contrasts between his Indian experiences and culture 'at home'. The (translated) article following this obituary is a fascinating example of this East–West shift.

The second *liber amicorum* that he received, 'Ambivalence / Ambiguity: Anthropological Notes' (Van der Geest 1995), referred to his persistent focus on the contradictory nature of human relationships, both on what people *say* about their relationships and what they *do*. He especially liked to poke at people's claims of autonomy. One of his favourite sayings was '*Mensen zitten aan elkaar vast*' (People are stuck together), however loud they shout that they go their own way. Linking Dutch and Indian observations had led him to that insight. He liked the term 'cultural codes', as a code is a language that says one thing and means something else. Culture in this instance allows people to maintain their illusions of autonomy.

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Several years after his retirement Klaas had a stroke from which he never recovered. His health deteriorated gradually and vascular dementia affected his thinking and behaviour. Three years ago he moved into a nursing home in Haarlem, close to his wife Jenny and his three children, Aale, Maria, and Frans. It is ironic that due to his disease he was unable to 'benefit' from this opportunity for full participant observation in the institutional care of fragile older people in the Netherlands, about which he had been writing so incisively at the

closure of his anthropological career. With gratitude I remember him as a dear friend and loyal colleague.

Published and unpublished work by Klaas W. van der Veen

Much of what Klaas van der Veen wrote is hard to find. Conference papers, unpublished reports, and papers that appeared in 'grey' series are rarely available in a digital form. The same applies to contributions to edited books. He also wrote some personal reflections that were only shared with a few close friends and colleagues (and have been excluded from this list). It may sound strange to us today, but he only published two articles in international journals. We hope, however, to make all of the writings listed below digitally available in the near future. For further information, contact me at: s.vandergeest@uva.nl.

1966. 'Unilaterality in Hindu Society: An Attribute of the Mother-Son Relationship or the Expression of a Fundamental Human Need'. Paper presented at 'Kinship and Culture' symposium, Burg Wartenstein, Austria.

1968. 'Het Leeronderzoek in Tunesië', coauthored with Douwe Jongmans. *Sociologische Gids* 16, no. 3: 175–83.

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