

Conclusion

Ria Reis & Sjaak van der Geest

The issue of ethnocentrism is at the heart of cultural anthropology. If anthropology's study object is culture, so is anthropology itself. Asking an anthropologist to completely shed ethnocentrism, therefore, is misunderstanding the issue. There is probably no field in anthropology where the ethnocentric paradox presents itself as openly as in medical anthropology. 'Western' ideas of health, disease and health care have assumed the status of absolute truth. Robert J. Priest has raised the issue of ethnocentrism in connection with missionaries. Before questioning the stereotypical image of missionaries among anthropologists he presents that image:

[I]f the key anthropological virtue is respect, then the primary sin is to evidence a lack of respect by crossing boundaries with a message implying moral judgement – in a word, to be ethnocentric. And if 'the anthropologist's severest term of moral abuse' is 'ethnocentric' (Geertz 1973: 24), then perhaps the anthropologist's clearest example of ethnocentrism is the missionary (Priest 2001: 34).

It does not seem far-fetched to look upon doctors and other health workers as 'missionaries of medicine'. The gospel of biomedicine has been successfully preached all over the world. In the same vein that Christian churches are now the leading religious (and political) institutions in many countries in Africa, America and Australia, biomedicine is now the dominant medical (and political) system in all countries of the world.

Medical anthropologists have trodden carefully into this field of overt medical ethnocentrism. On one hand they have exerted themselves in describing – to the extent of defending – 'the "natives" point of view' with regard to illness and health care. On the other hand, they rarely are willing to 'compromise' biomedicine in the light of other medical beliefs and practices. As a matter of fact many have firmly participated in preaching the good news of Western medicine. That fine line between respecting and rejecting local cultures of medicine is also found in the research programme of the Medical Anthropology Unit of the University of Amsterdam:

The Unit's general areas of research can be summarised as follows: how do people define and experience health problems; how do they strive to improve their health and well-being; and what are their responses to health care interventions?

Medical-anthropological research carried out by the Unit is generally conducted in settings where people are confronted by health care interventions designed to improve their general state of health or to influence patterns of behaviour which may be detrimental to their well-being. Consequently such research is dynamic in nature. Topics of investigation are not limited to the patients' subjective experience of, and response to, such interventions but also include the activities and culture of the institutions undertaking the health care interventions. The topics of investigation are further related to the broader socio-cultural and political-economic context.

The Medical Anthropology Unit of the University of Amsterdam attempts to create a balance between applied medical-anthropological research and research of a more reflective and theoretical nature. The Unit regards these two types of research as complementary (MAU 1997: 1).

Two concepts in this quotation need clarification. 'Confronted by health care interventions' refers, in ninety percent of all cases, to biomedical interventions. In other words, researchers of the Medical Anthropology Unit are particularly interested in the 'confrontation' of members of local cultures with biomedicine. Studying that confrontation confronts the anthropologist with his own medical ethnocentrism. All ambiguities and contradictions discussed in the introduction return here in their most acute form: intellectually, politically and morally. On one hand, they want to capture and present the emic point of view vis-à-vis the dominant presence of biomedicine; on the other hand, they do not want to renounce their faith in biomedicine. On one hand, they show respect for the local views and practices; on the other hand that seems hollow in the light of their refusal to take part in the local medical practices. Finally, the epistemological basis of their study of local medical traditions remains firmly embedded in biomedicine and raises doubts about their claim of emic interpretation.

These dilemmas of medical-anthropological research become even more pungent if we consider the second concept in the above quotation on the research programme: The Unit attempts to create 'a balance between *applied* medical-anthropological research and research of a more reflective and *theoretical* nature'. By engaging themselves in health policy and health activities, medical anthropologists become indeed nearly 'missionaries', the stereotypical epitome of ethnocentrism.

The contributions to this volume showed how the various authors have grappled with the contradictions and dilemmas of their discipline. Indeed all

contributions focus on the confrontation of members of local cultures with biomedicine.

Chris de Beet took us back in time to the origin and history of the West African state of Sierra Leone. He presented and discussed three cases of Eurocentrism among colonial administrators. In all three, notions about disease and disease prevention were applied for political purposes. The cases illustrate what several medical and historical anthropologists have argued, that biomedicine proved an effective tool for building and expanding colonial presence. Medicine is politics in disguise.

Kodjo A. Senah addressed Ghanaian doctors' contempt of lay views which blocks communication between patient and doctor and thus harms the quality of health care in his country. The lack of trust and respect between patients and physicians seriously hampers diagnostic and therapeutic activities. Doctors do not seem to care much about the low quality of their work and 'cocoon' themselves in their belief that they are doing a good job. Patients and their relatives, however, become desperate and cynical. The author appealed to doctors to wake up out of their dream of complacency.

Like the previous author, Els van Dongen carried out research in her own society, albeit in a subculture that radically differs from 'ordinary Dutch life'. She did fieldwork among schizophrenic people in a psychiatric hospital. The article discussed the contested nature and the reality of the mental problems as defined by psychotic people and psychiatric professionals. That contest, however, is an unequal fight, and professional claims that what the patients say does not belong to the world of reality, eventually silence the claims of the 'psychotics'. Her description and analysis of this conflict aimed at making professionals more aware of the patients' entitlement to reality.

Annette Drews described and compared local and biomedical concepts of pregnancy and birth in a Kunda community in Eastern Zambia. As an anthropologist and partner of a Dutch physician, she was literally caught between two medical traditions, which proved extremely critical of one another's performance, particularly with respect to delivery. She provided the reader with a detailed account of a 'traditional' birth including extensive transcriptions of conversations within and outside the birth hut. After criticising the cold and dehumanising atmosphere in the hospital's labour ward and commending the Kunda approach to childbirth, she concluded that the ethnocentrism of the hospital workers not only harms the community members but also the workers themselves. They would benefit a great deal from 'allowing the patients to contribute their ideas, morals and values to the medical encounter (...). Both patients and professionals would gain from a true dialogue.'

In the last contribution, Sonja Zweegers discussed the misunderstandings and clashes that occurred during her research about ideas of hygiene and dirt in a Vietnamese community. She focused on two types of ethnocentric bias that cropped up between her and her Vietnamese interpreter, who also was a medical doctor. The first problem originated from the opposing views that she, an anthropologist, and he, a physician, held with regard to people's concepts of hygiene. The second disagreement arose from his status as an insider of Vietnamese culture and her being an outsider, unable even to speak the language. Looking back, she realised that she could have benefited from her interpreter's 'ethnocentrism' if she had come to grips with her own bias and arrogance.

Medical anthropology's classical quest emerges from these essays. In the introduction, Sjaak van der Geest described five types of ethnocentrism that anthropologists face and have to resolve. Although the contributions by Kodjo Senah and Els van Dongen are examples of 'medical anthropology at home', the various contributions did not discuss exoticism in medical anthropology as such, nor the tensions between cultural anthropologists and their colleagues in medical anthropology, nor the anthropologist's contempt for applied anthropology. All authors focus on the first type of ethnocentrism that was described in the introduction: the ethnocentric attitude of medical professionals to 'lay-people'. Chris de Beet analyses medicocentrism from a historical and political perspective as part of the colonial enterprise in Africa. Kodjo Senah, Els van Dongen and Annette Drews describe how the disregard of or even contempt for their patients' viewpoints obstructs the very thing that health workers strive for: an improvement of the health and well-being of their patients. Sonja Zweegers takes the issue one step further by discussing how in turn the anthropologist's contempt for the ethnocentric attitude of physicians hampers the communication between health-worker and anthropologist, the second type of ethnocentrism described in the introduction.

The 'bias' towards the first field of ethnocentrism is no doubt caused by the editors' request to the authors to reflect upon their own research projects. All but one project had the understanding and description of emic views as one of their aims. But medical anthropology's focus on and support for the 'entitlement to reality' of patients, to adopt Van Dongen's eloquent expression, immediately follows from the anthropological enterprise itself. It results not so much from a morally superior attitude to support the less powerful, but from the epistemological stance that one cannot describe and understand cultural phenomena without taking into account all voices, including those under-represented in dominant views. When studying medical encounters between professionals and so-called 'lay people', the anthropologist has to pay special

attention to emic perspectives and the mechanisms that silence and defuse them. But this enterprise seldom leads to a rejection of biomedical ideas and practices. On the contrary, anthropological writings more often than not mean to 'educate' the doctor about his ethnocentrism, so that the quality of the medical encounter may be improved to the benefit of both patient and doctor. And the more engaged in the medical enterprise, the more contempt medical anthropologists have to face from their colleagues in cultural anthropology.

However, there might be a degree of complexity to the field of medical anthropology that is missing in mainstream anthropology. In the research program of the Medical Anthropology Unit at the University of Amsterdam, the health care interventions that people are confronted with and that are worthy of anthropological study are described as being 'designed to improve their general state of health or to influence patterns of behaviour which may be detrimental to their well-being.' In other words, what health workers think and do, in short, biomedicine, has to answer the patients' needs. Doctors are accountable to people. In the confrontation between doctors and patients, the problematic reality discussed is the reality lived by the patient. In that sense, contrary to the doctor's manifest dominance, there is a quintessential dependence on the patient, who has to be willing to seek out the hospital for help, to comply with the doctor's preventive or curative methods and to change his perception and behaviour. Despite all of the differences and contradictions, the medical encounter itself is a reality shared by medical professionals and the 'lay people' seeking their help. In the final analysis, what is at stake for the patient is also at stake for the doctor. The anthropologist's inability or refusal to become involved in that encounter and contribute to the alleviation of the patient's suffering could be regarded as a kind of professional ethnocentrism. Indeed, studying the confrontation between members of local cultures and biomedicine confronts the anthropologist with his own medical *and* anthropological ethnocentrism.

In the introduction Sjaak van der Geest described three dilemmas in ways of dealing with ethnocentrism in anthropology. They carry three lessons to be learned for medical anthropology. Like anthropology, medical anthropologists combat what they find indispensable. Without medicocentrism, doctors would not be sought out by patients. Within the clinical encounter, where doctors and patients, however laboriously, try to come to a shared definition of what is at stake, there is no easy solution for the anthropologist between taking part in medical activities and refusing complicity. The second dilemma between recognising and admiring otherness on one hand, and by describing it and keeping it from change on the other, addresses the pitfalls of conservatism and exoticism. Medical anthropologists face this dilemma, not only when they study medical

traditions elsewhere, where 'otherness' is overtly present, but also when they study the 'otherness' of marginal groups or categories of people, such as patients, in their own society and reduce them to anthropologically interesting meanings and topics of academic discussion. Finally, the contradiction that intersubjectivity can only be discovered by exploring subjectivity is also at work in medical anthropology. It applies to the study of suffering, probably one of the most individual experiences that people go through. Anthropologists are their own research instrument. Having partaken in suffering does not exclude one from studying it. On the contrary, some of the most enticing and insightful studies in medical anthropology have been written by authors who suffered from the very affliction they studied.

To conclude we resume Lemaire's (1976) observation that anthropology is not able to remove ethnocentrism but *can* point out and articulate its inherent existence in any cultural endeavour. Every form of bias is some kind of ethnocentrism, whether it is androcentrism, scientism, hodiecentrism or anthropocentrism. The point is not to drive it out but to become aware of it, and by doing so, turn it to our advantage. This awareness will enable us to come closer to those who may seem far away. It will reveal congruence between apparently distant partners in the culture of health, illness and medicine.

References

- Geertz, C.
1973 *The interpretation of cultures*. Chicago: University of Chicago Press.
- Lemaire, T.
1976 *Over de waarde van kulturen: Een inleiding in de kultuurfilosofie. Tussen europacentrisme en relativisme*. Baarn: Ambo.
- MAU (Medical Anthropology Unit)
1995 *Research by the Medical Anthropology Unit, University of Amsterdam. An overview of projects (1993-1997)*. Amsterdam: Het Spinhuis.
- Priest, R.J.
2001 Missionary positions: Christian, modernist, postmodernist. *Current Anthropology* 42 (1): 29-68.