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EDITORIAL

OVERCOMING ETHNOCENTRISM: HOW SOCIAL SCIENCE AND MEDICINE RELATE AND SHOULD RELATE TO ONE ANOTHER

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A moderate dose of ethnocentrism is healthy, according to Herskovits, a pioneer of cultural anthropology:

> Ethnocentrism is the point of view that one's own way of life is to be preferred to all others. Flowing logically from the process of early enculturation, it characterizes the way most individuals feel about their own culture, whether or not they verbalize their feeling [1, p. 356].

Ethnocentrism does, however, become a problem when people from different cultures meet and interact. It prevents people from understanding the other, let alone taking the other seriously. The views of others are judged by standards of one's own culture. Keesing, in his handbook of cultural anthropology:

> To view other people's way of life in terms of our own cultural glasses is called ethnocentrism. Becoming conscious of, and analytic about, our own cultural glasses is a painful business .... Although we can never take our glasses off to find out what the world is 'really like', or try looking through anyone else's without our's on as well, we can at least learn a good deal about our own prescription. With some mental effort we can begin to become conscious of the codes which lie hidden beneath our everyday behavior [2, p. 69].

Spradley points out that there are many ethnocentric descriptions in anthropology. They make hardly any use of local language and ignore the *meaning* of the things they describe. They tend to use stereotypes [3, p. 22].

One of the most telling products of ethnocentrism is the image of the 'barbarian', the uncivilized other, 'uncivilized' being a convenient term for having-another-culture. 'Barbarian' is an onomatopoeia invented by the ancient Greeks for anybody speaking an unintelligible (i.e. non-Greek) language ('bara bara bara'). Stereotyping the non-Greek as barbarians was indeed convenient. It made the inability to communicate with them a matter of no importance. After all, they were uncivilized. What they were saying was probably mistaken, at most amusing.

The term 'barbarian' has retained its popularity down the ages and has spread over many languages. As abuse in political rhetorics it was particularly well-liked by some recent American presidents. The South African author Coetzee [4] remarked that the non-barbarians are the real barbarians. They deny their own barbarism by calling the others barbarians. A similar aphorism was suggested by Lévi-Strauss [5]: "The barbarian is, first and foremost, the man who believes in barbarism". I like the boomerang capacity of the term, but it may be wiser to do away with it altogether.

For anthropologists, ethnocentrism is about the worst of all evils [6]. They see it as their task to eliminate ethnocentrism. They want to be interpreters between cultures, to make the ideas of one culture intelligible and acceptable to people in another culture (and vice-versa), Their 'tool' is cultural relativism, which, according to Herskovits, does not only teach us to respect other people's views, but throws a new light on our own culture as well:

> ...this position gives us 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 different peoples, we can turn to our own culture with fresh perspective, and an objectivity than can be achieved in no other manner [1, p. 366].

It may be enlightening to look at social science and medicine as two different cultures, into which people gradually are enculturated and taught to view and explain the world in a particular way. The often difficult relationship between social and biomedical scientists can then be viewed as a form of mutual ethnocentrism.

If culture is a system of shared meanings, as most anthropologists today seem to agree, what are the ideas and ideals that social scientists on the one and medical practitioners on the other hand share?

The culture of medicine is, first of all, practical; it is problem-oriented. Doctors are supposed to find concrete solutions to concrete problems. A second, closely connected, element of medical culture is that there is no time to lose. Interventions have to be carried out promptly, before it is 'too late'. A third element is that medical doctors measure their success by people's health. The maintenance and restoration

of physical well-being is the *raison d'être* of their profession. They are, to use Glasser's term [7], accountable to people. If their intervention does not yield effects in terms of better health, they have failed and deserve criticism.

The chief ingredients of social science culture are almost directly juxtaposed to those of medicine. Since there are several 'sub-cultures' in social medicine, I shall focus on the culture I know from personal experience: cultural anthropology.

Present-day mainstream anthropology has a dominantly theoretical, somewhat philosophical character. The type of anthropology which carries the most prestige is descriptive, interpretive and reflexive. Applied anthropology is regarded by many as a dilution of true anthropology, an almost scornful concession to non-anthropologists, the others. Moreover, if it is done for money—and it usually is—it reeks of professional prostitution. One could almost say that an anthropologist who wants to be respected by his colleagues should not worry himself about the practical application of his research. This constitutes a radical change from the trend of 20 years ago when it was *bon ton* to question 'pure' anthropology and to urge anthropologists to place themselves at the service of the unprivileged.

Consequently, the average anthropologist is in no hurry to finish his research and write up his data. The disdain for practical matters reappears in the slow production of publications. Anthropologists claim that their insight and interpretations need time to 'ripen'. In a reflection on her research about witchcraft beliefs in rural France, Favret-Saada wrote that it took her some time before she was able to understand the deeper implications of her field notes [8]. There is nothing unusual in an anthropologist writing about field work conducted more than 20 years earlier. I have been doing it myself.

For an anthropologist the fulfilment of his task does not lie in an improvement of the lives of the people studied, but in the production of texts about them. An anthropologist who does not publish must indeed perish. If a medical doctor finds satisfaction in the recovery of a patient, the anthropologist derives happiness from a publication which is well received by his colleagues. His accountability is first and foremost to his colleagues who literally 'count' his publications, possibly even the number of times they have been cited by others. His accountability to the people among whom he carried out the research is minimal, although this is gradually changing.

It is no wonder that these two cultures which, in many respects, are diametrically opposed to one another, have an uneasy relationship, interspersed with ethnocentrism. For many, on both sides of the dividing line, 'medical anthropology' and 'medical sociology' are oxymorons. Medical anthropologists, for this matter, are viewed as apostates by some of their orthodox colleagues. It is surprising that there exist any good relations and fruitful cooperation between medical practitioners and anthropologists.

Streefland [9] sums up a few grievances which health practitioners have against anthropologists. They follow logically from the above described cultural features. Anthropologists, they say, seem hardly concerned about the well-being of people and do not attempt to help them to solve their problems. What they find particularly annoying is that anthropologists refuse to offer positive suggestions for the improvement of people's life conditions, but are quick to criticize and ridicule the attempts of medical doctors and health planners. They also complain that anthropologists take too long doing their research and publishing the results. And, finally, they do not understand nor appreciate, the theoretical bent in the work of anthropologists. Many medical scientists and practitioners find the long and wordy treatises by anthropologists esoteric 'babble' ('bara bara bara'), no real science.

Anthropologists, on the other hand, look down upon the reductionist biologistic views of medical scientists. Anthropologists have a long tradition of allergy (we do like medical metaphors) to natural science, and to biological explanations in particular. The origin and growth of anthropology can succinctly be described as a persistent reaction against the waves of scientism, in the history of western civilization. This is particularly true for anthropology in the United States with people like Edward Tylor, Franz Boas, Ruth Benedict, Margaret Mead, Melville Herskovits, Edward Sapir and now Clifford Geertz. The optimism of natural scientists who claim that they can predict human behaviour and change (improve) the world shows their naïveté. Among anthropologists pessimism is more fashionable. Others call it defeatism.

There are two remarkable ironies in this exchange of ethnocentric stereotypes. The first refers to the involvement with people. Anthropologists, who claim expertise on human beings, as reflected in the name of their discipline, are accused of not being concerned about people. They practise participant observation, live with people, share their lives, and yet they seem more interested in texts on dead paper than in living human beings. They are even suspected of withholding normal human assistance in order not to interrupt the 'natural' course of events. Non-intervention is another feature of anthropology which contrasts starkly with medicine's basic intervention-directedness [10].

It has been noted that medical doctors are in a better position to win people's trust and friendship than anthropologists. Their involvement with people's suffering serves a purpose which the patient understands and appreciates. They are not inquisitive priers asking irksome questions as anthropologists may do. Doctors, one could say, are a more natural part of the social situation of a sick person and, as such, better able to practise participant observation

[11]. This provocative statement may need considerable nuancing (e.g. How many doctors do indeed get personally involved with their patients? And are not anthropologists better equipped for participating in people's daily life, which always is the context of health problems?). But there remains enough truth in it to disturb anthropologists.

The second irony is that anthropologists, who have embarked on the extermination of ethnocentrism, practise this very habit at home. One would expect that with their sharp eye for the working of culture, they would be more conscious of the cultural features of their own discipline. If it is their objective to transcend the boundaries of their own culture and to immerse in the world of others, why stick so timidly to the safe territory of their discipline? Apparently, crossing cultural boundaries, in the ordinary sense of the word, is less threatening than switching those of their own discipline. The former is more gratuitous and can be done—and described—without deep personal consequences. The latter could affect the basis of their professional existence. Here we see the flight to ethnocentrism in its primitive stage, as survival strategy: people regard "their own cultural values as the only valid ones" [12, p. 56]. It prevents epistemological and ethical doubts and relieves people from thinking about alternative world views. "Anthropology should . . . lead us to question, not to confirm out own presumptions", Crapanzano writes [13, p. xiv]. Indeed: "Should".

Several social scientists have brought forward proposals how anthropologists and medical practitioners could come closer to one another. Foster's [14] well-known suggestion limits itself to contributions which anthropologists could offer to the medical world. In the first place, cultural relativism which will enable them to take other health views (e.g. the layman's) more seriously; second, anthropology's holistic perspective on health, illness and healing; and third, the anthropological research approach of empathic participant observation. However reasonable, his suggestions appear somewhat facile in the light of the above discussion on mutual ethnocentrism.

Streefland [9] concludes his brief overview of disputes between social science and medicine with three suggestions: building up a medical anthropology which is truly interdisciplinary and problem-oriented; an improvement of the image of social science in the eyes of medical doctors and policy-makers; and a more active attitude of medical anthropologists initiating applied health research.

Richters' [15] voluminous dissertation is an attempt to inform medical doctors and psychiatrists about the objectives and methodologies of medical anthropology. At the same time she criticises her fellow anthropologists for paying insufficient attention to the social and political factors that cause and perpetuate disease and suffering.

Chrisman and Johnson [16] hold a warm plea for a 'clinically applied anthropology'. They, too, emphasize the wholesome contribution of anthropology to medical practice, through its theoretical and ethnographic concepts. They believe that "an anthropological approach changes health care delivery in a positive way". They, too, mention ethnocentrism and cultural relativism as key concepts:

> A useful way to operationalize the concept of cultural relativism (or the avoidance of ethnocentrism) is the notion of eliciting patient perspectives .... Unfortunately, much of what the patient says is considered to be subjective, with the connotation of 'not real' or not as important as 'objective' data such as findings from physical examination or laboratory tests. Demonstrating that eliciting patients' perspectives on their symptoms can provide equally valuable data makes sense to most clinicians and is usually accepted [16, p. 109].

I am less optimistic. All suggestions for more and better cooperation in the field of social science and medicine should be preceded by recognition—and confession—of profound ethnocentrism by both sides. If the adherents of both disciplines do not give up their *extra ecclesiam nulla salus* stand and shed their belief that their views are the only valid ones, all attempts to reach interdisciplinary cooperation will fail or remain marginal.

Interdisciplinarity is not only a long and difficult word, it is also a long and difficult road. It is more fashionable as lipservice than actual practice. Clinging to one's own discipline is probably nowhere as tight and desperate as in so-called interdisciplinary projects.

But disciplines are merely human designed (cultural) tools to study and interpret/explain reality. No discipline is all-embracing or has the final word. The anthropological approach focuses on the meanings of human phenomena. It achieves this by studying the phenomena in their wider context. The medical scientist is rather inclined to isolate his study object. He will temporarily exclude the context to concentrate on the biological and chemical properties of the problem at hand, but eventually the disease will be brought back to its 'natural' place, the patient in his specific social and cultural context and psychological position. The cultural view needs the medical one and gives meaning to it. Conversely, the biomedical expert cannot neglect the cultural complexities of disease.

Interdisciplinarity only has a chance if those who belong to the culture of social science and those of the culture of medicine give up their ethnocentric fear of dissenting beliefs and accept the practical consequences of the conviction that reality itself is 'multidisciplinary'.

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