

Chapter 9

THE NETHERLANDS

A Cultural Fascination with Medicine: Medical Anthropology in the Netherlands

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It is said that the Netherlands has the highest density of anthropologists in the world. It could well be true and seems to dovetail with two other “records,” equally based on impression. During the heydays of missionary activity, the country produced an incredibly large number of Christian missionaries who could be found all over the world, particularly in Africa and in Indonesia, previously a Dutch colony. In the wake – and forefront – of the preaching missionaries were large numbers of doctors and nurses who spent a few – and some, many – years of their life in what later came to be called developing countries. Some of these medical “development workers” worked on government contracts but many of them were attached to a missionary organization. The origins of medical anthropology in the Netherlands are thus closely linked to the activities of missionaries and medical workers in developing countries.

The most elaborate discussion of past and present Dutch medical anthropology is – perhaps not surprisingly – from an outsider: the Italian anthropologist Diasio (1999, 2003), who studied medical anthropological traditions in four European societies, namely France, Great Britain, Italy, and the Netherlands. She writes that Dutch anthropologists are over-modest, and downplay their own anthropological merit. They do not seem to think that they have made a significant contribution to the discipline and see themselves as a mixed breed of foreign and interdisciplinary influences. I agree with her thesis on the mixed provenance of Dutch medical anthropology, but I do not downplay its contribution to the development of this subdiscipline.

“Alien” Origins

The first Dutch study that explicitly referred to “medical anthropology” appeared in 1964. It was a dissertation by a medical doctor, Vincent van Amelsvoort, on the introduction of “Western” health care in the former Dutch colony of New Guinea (now an uneasy province of Indonesia). It was only one year after Scotch had delineated medical anthropology as a formal field of research and teaching and as

a subdiscipline of cultural anthropology.¹ Van Amelsvoort's study focused on the clash between two entirely different (medical) cultures (Van Amelsvoort 1964a). In that same year he (Van Amelsvoort 1964b) published a short note on the new field of medical anthropology in a Dutch medical journal. Discussing the origins of the new subdiscipline, Van Amelsvoort referred mainly to social scientists and health professionals who had worked in the field of health development (as he had done himself) and had analyzed the relationship between culture, health, and health practices, such as Erasmus, Wellin, McDermott, and Carstairs. Seeing medicine as a part of culture, he wrote:

Medicine consists of a vast complex of knowledge, beliefs, techniques, roles, norms, values, ideologies, attitudes, customs, rituals and symbols, that interlock to form a mutually reinforcing and supporting system. . . . In its totality this system is functioning to solve a universal major problem of every society: disease. (Van Amelsvoort 1964a:13)

Van Amelsvoort was a "tropical doctor" with a keen interest in culture. That interest was thrown upon him during his work as a colonial doctor in New Guinea. Later on he became professor of health care in developing countries in the Medical Faculty of the University of Nijmegen.² The biographical background of his work in medical anthropology typifies the "alien" origins of the discipline in the Netherlands. "Alien" refers to both disciplinary and geographical territories. Medical anthropology in the Netherlands started far from home, in tropical areas, and those who initiated it were not anthropologists but medical doctors.

Medical Initiatives

I can think of mainly two reasons why physicians and not anthropologists took up the issue of culture and medicine. The social and cultural character of health problems manifests itself much more prominently in medical practice than in anthropological research. In their attempts to improve health conditions, tropical doctors continuously encountered "cultural barriers." It forced them to think about the nature of these barriers and to reflect on their own mission. Whatever opinion they developed about the practical implications of cultural barriers, many of them at least realized that it was crucial to learn more about them. There was a need for knowledge about local cultures, particularly medical cultures.

This awakening of cultural interest among Dutch tropical doctors can be observed in the work of some early physicians in the Dutch colony of the Dutch Indies. J. P. Kleiweg de Zwaan (1910) published a study about indigenous medicine among the Menangkabau people in North Sumatra, J. M. Elshout (1923) did the same for the Dayak people in Borneo, and J. A. Verdoorn (1941) wrote a study about indigenous midwifery in various ethnic groups of the colony. Another colonial precursor of medical anthropology was F. D. E. van Ossenbruggen, a lawyer who studied general aspects of local Indonesian cultures and was particularly interested in how illness and health practices were embedded in the general culture. His work includes a comparative study of rituals against smallpox among different

populations (Van Ossenbruggen 1916; see also Diasio 2003; Niehof 2003). Van Amelsvoort's dissertation in 1964 followed the tradition of colonial doctors, as did a study by G. Jansen (1973) on doctor–patient relationships in Bomvanaland (South Africa). Jansen had spent 11 years as a missionary doctor in Bomvana society. It was around that period, in the 1970s, that Dutch anthropologists became interested in the cultural identity of health and medicine and “took over” the job of medical anthropology from their medical colleagues.

The medical (applied) purpose of medical anthropology remained strong after anthropologists became involved in the work. Many of the first *anthropological* medical anthropologists in the Netherlands worked in close cooperation with – or in the service of – medical projects. The anthropologist Douwe Jongmans, for example, moved from the University of Amsterdam to the health section of the Royal Tropical Institute and did research among North African immigrants. His main contribution lies in cultural perceptions and practices around fertility and birth regulation (Jongmans 1974, 1977).³ Several other anthropologists continued – in varying degrees – to practice “anthropology *in* medicine,” abroad, but also increasingly in the Netherlands among migrants (Van Dijk 1981, 1987).

A second explanation for the “failure” of anthropologists to grasp the opportunity of medical anthropology at an early stage might have been their weariness of applied anthropology, which dominated the postcolonial era of anthropology. In the 1950s and 1960s, most anthropologists fostered the principle of – as much as possible – nonintervention. “Proper” anthropologists, it was believed, should not get their hands dirty on government- or mission-initiated development projects. Problems of illness and death were first of all to be studied as occasions for social conflict and religious ceremony. Illness and death as a subject did not really interest them. Only when they occurred in their immediate environment and touched them personally were they likely to become more actively involved. Many anthropologists, for example, distributed medicines to members of “their family” and to neighbors and helped them in other ways. Some anthropologists were known to “play doctor” and even held “consulting hours.” Such activities remained however entirely separated from their scientific work and did not lead them to anthropological reflection. They were not only activities that fell outside the scope of their research, they were even in conflict with the “rules” of proper anthropological fieldwork: nonintervention and participant *observation*, with the emphasis on the last word.

The “classic” anthropological allergy to biology probably contributed to anthropologists' reluctance to get involved in medical issues. It was only in the 1970s that anthropologists “discovered” body and biology as cultural phenomena and became fascinated by medical topics. It was at this moment that medical anthropology in the Netherlands – as in many other countries – became a recognized and popular field of study within cultural and social anthropology.⁴

Xenophilia

The other type of alienage during the first years of medical anthropology in the Netherlands was geographical. The research that was recognized as “medical

anthropology" had always taken place far away, on foreign territory. This is no surprise, since at the time anthropology was seen as the study of "other cultures," as Beattie (1964) confirmed in the title of his handbook on anthropology. With some exaggeration one could say that it was not the topic but rather the *topos* that made a study "anthropological." Studies on social and cultural aspects of health, body, mind, emotion, and well-being that would now be considered as typically anthropological but which took place in Dutch society were automatically excluded from the anthropological library (to be more precise, not only were they never considered for inclusion or reference, they were never even noticed). Conversely, work done under the tropical sun was embraced as anthropology or anthropologically relevant, even if it was rather far removed from anthropology in theoretical and methodological respects.

The following two examples illustrate my point.⁵ The first concerns the pioneering studies of the physician, biologist, psychologist, and philosopher F. J. J. Buytendijk (1887–1974), who is hardly ever referred to in the publications of the early Dutch medical anthropologists. Buytendijk's main concern can be characterized as a consistent attempt to overcome the body/mind dichotomy, a theme which some thirty years later became the inspiration for one of the most influential publications in medical anthropology (Scheper-Hughes and Lock 1987). Using data from physiology and ethology, Buytendijk tried to render the French philosopher Merleau-Ponty's (1908–61) ideas about the body-subject plausible and acceptable to a forum of hard scientists. He argued for an "anthropological physiology": a physiology that – as Merleau-Ponty suggested – reacted meaningfully to human experiences. He applied his views to bodily reactions such as sleeping and being awake, pain, being thirsty, blushing, sweating, and fainting. Buytendijk felt closely affiliated to the Heidelberg group in Germany where Viktor von Weizsäcker, Herbert Plügge, Thure van Uexküll, and others worked for a nondualistic brand of medicine.⁶ Buytendijk, whose work has been translated into English, shows that there is subjectivity and meaningful reaction in physiological processes. Just as the body is a cultural product, bodily dysfunction is a meaningful and cultural act, a form of being human (Buytendijk 1974). As I said before, Buytendijk's publications were not thought to be relevant to cultural anthropologists. The negligence was indeed mutual. Buytendijk took his inspiration and data from biology and psychology, from humans as well as from animals, but never referred to studies of people in other cultures. It is doubtful that he read anthropological work, an amazing omission in hindsight.

A similar story could be told about the Dutch psychiatrist Van den Berg. Outside the Netherlands Van den Berg is best known for a brief treatise on the psychology of the sick-bed, which has been translated in many languages. Within his own country he drew considerable attention through his book "*Metabólica . . .*" (1956), a study of societal changes in a historical perspective. Some years later he published his monumental study of the human body from a "metabolic" perspective (Van den Berg 1959, 1961). His main thesis was that the human body has changed through the ages (his study takes the reader back to the 13th century). He does not only argue that the *meaning* of the body has been changing all the time but that the body itself, "in its materiality," has changed. Van den Berg's style of

reasoning does not fit in any conventional discipline and one could characterize him best as a “postmodernist *avant la lettre*.” His argument follows unpredictable associations, from paintings by Brueghel, Rubens, and Picasso, to a mystic’s vision, a book of devotion, a scientific study of the heart, a paper clipping about the rescue of a drowning person, a collection of lyrics, an X-ray photograph, and a building by Le Corbusier. The body, Van den Berg writes, reflects the ideas and politics of its period. As with Buytendijk, this viewpoint is busily discussed by anthropologists today, but unnoticed by them at the time. Conversely, again, it should be noted that Van den Berg showed no interest in anthropologists’ descriptions of human bodies in other cultures. The xenophilia of the anthropologists paralleled the “xenophobia” of the other disciplines that occupied themselves with body, culture, and society.⁷

I have pointed out the divergent origins of Dutch medical anthropology. The subdiscipline’s mixed historic and cultural identity is the result of a unique interplay of inclusion and exclusion of outside influences. Using hygienic, almost medical, language, Diasio (1999) speaks of an “impure science,” a purposely unfortunate adjective, as no cultural phenomenon can remain “pure.” Continuing her medical metaphor, “purity” would indeed imply sterility. One could also propose the anthropological metaphor of exogamy for the geographical and disciplinary vagaries of Dutch medical anthropology.⁸

Current Affairs

Describing the present situation of “medical anthropology” in the Netherlands is not much different from writing about multicultural society. People switch identity according to situational needs and interests. Sociologists and psychologists may decide to call themselves (medical) anthropologists if they regard this as being advantageous in their work or academic situation. Conversely anthropologists may call themselves something else for the same reason. A growing number of people with training in a (para)medical profession decide to study medical anthropology, then return to their original profession, without professing their anthropological identity. I estimate that at present about fifty medical anthropologists work in different areas of health care, social work, and health policy, though they are hardly identified as such. This elastic character of “medical anthropology” should be taken into account while reading the remainder of this article.

Chairs in Medical Anthropology

By now, medical anthropology is a well-established academic discipline in the Netherlands. And though it is taught at various universities, the center of medical anthropological teaching and research is no doubt the Medical Anthropology Unit at the University of Amsterdam. Over the past decade the University of Amsterdam has appointed five professors to chairs in medical anthropology or closely related fields.

In 1990 Pieter Streefland was appointed as professor of applied development sociology, in particular with regard to health. In 1994 the University of Amsterdam established the first “proper” chair in medical anthropology in the Netherlands with Van der Geest as its occupant (Van der Geest 1995a). In 1995 Corlien Varkevisser became professor of interdisciplinary research in health and development,⁹ and in 2000 Stuart Blume, professor of science and technology dynamics, joined the Medical Anthropology Unit. In 2002 Anita Hardon was appointed professor of the anthropology of care and health.

At the University of Leiden, Annemiek Richters holds a chair in culture, health and illness in the Medical Faculty. She has degrees in medicine, anthropology, sociology, and philosophy and has specialized in gender issues, trauma, and human rights. At the Free University of Amsterdam, Ivan Wolffers holds a professorship on health care and culture in the Medical Faculty and Joop de Jong is professor of transcultural psychiatry in the same faculty. In Utrecht David Ingleby is professor of intercultural psychology. At the University of Nijmegen, Frank Kortmann is professor of transcultural psychiatry (his favorite adage being “All psychiatry is transcultural”).

*Teaching*¹⁰

Since 1978 an introduction into medical anthropology has been offered – initially by Klaas van der Veen and Sjaak van der Geest – at the University of Amsterdam to both anthropology students and students from other disciplines. Later on others joined in: Anita Hardon, Anja Krumeich, Cor Jonker, Els van Dongen, Ria Reis, Maud Radstake, Marian Tankink, and Diana Gibson. Over the years other courses were added to the introduction, such as Health and Development (Corlien Varkevisser, Trudie Gerrits, Winny Koster), Anthropology and Psychiatry (Els van Dongen, Han ten Brummelhuis), Gender and Reproductive Health (Anita Hardon, Jeanet van de Korput, Trudie Gerrits, Lia Sciortina), Medicine and Science Dynamics (Stuart Blume, Anja Hiddinga, Olga Amsterdamska), Anthropology of Aging (Sjaak van der Geest, Els van Dongen), Anthropology of Infectious Disease (Pieter Streefland), Anthropology and Epidemiology (Anita Hardon and Walter Devillé), Anthropology and Children (Ria Reis, Anita Hardon), and three courses on the regional aspects of Ethnographies of Health and Health Care in Africa (Sjaak van der Geest, Ria Reis), Asia (Han ten Brummelhuis, Pieter Streefland, Leontine Visser, Maarten Bode), and Europe (Els van Dongen).

In 1997 the Amsterdam Unit started an international master’s in medical anthropology, the “AMMA.”¹¹ The course attracts between 15 and 20 students yearly from all over the world. From 2003 onwards the unit offers a Dutch master’s in medical anthropology and sociology.

In addition to the University of Amsterdam, courses in (or closely related to) medical anthropology are taught at three universities. At the Free University of Amsterdam two courses are offered to medical students: Culture and Health, and Health and Development.¹² Anja Krumeich, at the University of Maastricht, teaches an Introduction in Medical Anthropology.¹³ Several courses are taught at the

University of Leiden, one of them being Medical Sociology for Developing Countries. This course started as early as 1971. The first organizer was Willem Buschens,¹⁴ one of whose concerns was to bridge the gap between medical professors and sociologists/anthropologists in the context of health development. After his death the course was continued by Hans Speckman¹⁵ and Jan Slikkerveer. Other courses at the University of Leiden fall under the responsibility of Annemiek Richters. They are taught in the Medical School and focus on health and human rights and multicultural medicine.¹⁶ At the University of Utrecht David Ingleby organizes courses in the field of intercultural and cultural psychology.¹⁷

*Research*¹⁸

It is not possible to do justice to all medical anthropological research activities in the Netherlands and I apologize beforehand for the many omissions in this brief overview. Most research which can be characterized as "medical anthropological" has been carried out by the research group at the University of Amsterdam. Over the past 25 years an estimated 20 doctoral dissertations and a hundred master theses have been produced by and under the supervision of members of the Amsterdam Unit. Together with other research projects they cover almost any imaginable topic, but six main themes may be distinguished among all of this diversity.

The first theme covers perceptions and practices concerning health and illness. Seeing health and illness and people's responses to them as social phenomena embedded in cultural conventions has been the starting point of a wide variety of explorations in medical anthropology. This perspective of health and illness has inspired research in the Unit, which deals with cultural variations in the conception and treatment of specific diseases such as malaria, tuberculosis, HIV/AIDS, nutritional disorders, and chronic diseases such as epilepsy and diabetes. Other projects focus on therapeutic traditions, and concepts of sanitation and prevention.¹⁹

The next theme is medical knowledge and technology, including pharmaceuticals and immunization. For more than twenty years, the Unit has played a pioneering role in the anthropological study of pharmaceuticals. Another facet of medical technology that has been studied by the Unit is the social, cultural, and historical context of immunization. This comparative research project has been carried out in seven different countries. Most recently the history of the production of medical science and technology has been added to the Unit's research program.²⁰

A third theme relates to gender, reproductive health, and population policy. Projects on this theme aim to gain an understanding of the way in which men and women regulate their fertility and how they experience their reproductive health. The projects hope to contribute to gender-aware and culturally acceptable reproductive health interventions. Particular attention is paid to the influence of population policy on the quality of family planning services. Although much has been written on the violation of reproductive rights of women in developing countries, until now little research has been directed towards how women and men themselves could be given a voice on this issue. One study, which was carried out in

seven countries, centered on the development and functioning of family planning programs as well as the advances in fertility regulating technologies.²¹

A fourth theme covers chronic illness and aging, including long-term care and the "unending work" of the afflicted themselves. The anthropological and sociological study of chronic illness, the life of the elderly, and long-term care arrangements reflect both changing trends in morbidity and mortality and a current concern in health-care policy at large. Care for the chronically ill and the aged, which often takes place in the home, requires a growing amount of effort and financial investment. The Unit explores the social and cultural variations of this type of care but also focuses on how older, chronically ill, and disabled people "care" for and present themselves in public life. The "public appearance" of older and chronically ill people is another research theme of the Unit. The research aims to formulate suggestions for adequate policy in this field.²²

As a fifth theme, the Unit conducts research on mental health. The burden of mental health problems is likely to become heavier in the coming decades and will raise obstacles to global development and human emancipation. Important issues in this area are migration and mental health, violence and trauma, the "graying" of society, substance abuse, oppression, poverty, identity formation, and social memory. Medical anthropology explores the social and cultural variations of dealing with mental health problems and tries to formulate suggestions for action. It also contributes to the development of theories that can enable cross-cultural comparison.²³

Finally, the Unit focuses on health-care policy and management. Community-based health care holds a special attraction, as it is a consistent attempt to put health care into the hands of those to whom it matters most. With its focus on the layperson's perspective, anthropology has a logical interest in how health care functions at the community level as well as at other levels of the sociomedical organization. Special attention is given to the way it endures the pressures of structural adjustment. The social implications of policies of health reform, for example through cost-sharing, are also a matter of interest.²⁴

Of all these themes, the anthropology of medicines has probably attracted the most international attention. In 1991 the Amsterdam Unit organized an international conference on this topic in cooperation with the University of Copenhagen. In addition it published several books and articles that have become trendsetters in "pharmaceutical anthropology" (Etkin and Tan 1994; Hardon 1989; Senah 1997; Tan 1999; Van der Geest and Whyte 1988; Van der Geest et al. 1996; Whyte et al. 2002). Other themes to which the Amsterdam Unit has made substantial contributions are the study of immunization (Blume and Geesink 2000, Streefland 2001, Streefland et al. 1999) and reproductive health (Hardon 1998; Hardon and Hayes 1997).

The leading research position of the Amsterdam Unit is also reflected in other activities. The Unit is the publisher of a Dutch/English journal *Medische Antropologie* and three book series: *Health, Culture and Society*, *Current Reproductive Health Matters*, and *Community Drug Use Studies*.

Research activities by Annemiek Richters and colleagues at the *University of Leiden* deal with a variety of topics including: gender violence, trauma, health and

healing; the quality of reproductive health care for migrant women in the Netherlands; Western medicine and the body politics of women in the context of globalization; health and human rights; and HIV/AIDS in a cultural perspective. The main focus of the research is the effect of globalization on gender identities and gender violence (Hof and Richters 1999; Richters 1998, 2001). At the same university Jan Slikkerveer has for many years worked on local knowledge systems, including medical knowledge (Slikkerveer et al. 1993; Warren et al. 1995).

In the Medical Faculty of the Free University of Amsterdam, Ivan Wolffers leads a research project on AIDS and migration in a few Asian countries. This program includes several research projects that focus on understanding the factors that lead to vulnerability in migrants. The research is aimed at empowerment and concentrates on interventions and tools for advocacy (Wolffers et al. 2002). A spinoff of this project is research on the health hazards of sex work in several Asian countries. At the same university, Joop de Jong is involved in research on war violence and mental health in Africa, Asia, and Europe, and Arko Oderwald on philosophical and ethical aspects of health and health care. Oderwald has published extensively on issues of health and illness in literary imagination and ego-documents (Oderwald 1994, 2001).

At the University of Maastricht Bernike Pasveer and colleagues are heading a research project on "The Mediated Body." They study the historical and contemporary medical, artistic and philosophical angles arising from the project's conjecture that medical knowledge of the human body as well subjective experience of the body are phenomena affected by the mediating procedures and instruments with which bodies are studied and represented. Rather than assuming that medical instruments of visualization are transparent windows onto a given body, the hypothesis is that what is known of the body, as well as the ways people experience their body, is mediated through/results out of the very instruments used to produce and represent knowledge.

Somewhat in the same vein, Annemarie Mol, medical philosopher at the University of Twente, studies the social and cultural contingencies of biomedical science and practice. Her publications deal with issues of gender, the body, technology, and texts. The ethnography of one of her books (Mol 2002) is situated in a Dutch hospital.

At the University of Nijmegen, Fenneke Reysoo is involved in research on the social processes of sex and reproductive choice. The focus is on socioeconomic determinants (marital status, family structure, housing conditions, rural-urban divide, religion, secularization, exposure to mass-media, and purchasing power), as well as on meaning systems of gender, love, honor and shame, marriage, reputation, power, and property. Part of the research is based on the ethnographic literature of various countries, another part on ongoing data-collection in Morocco.

Administrative Matters

Research projects by Dutch universities are usually registered in large research schools that accommodate both senior and junior researchers, including Ph.D.

candidates. Most of this research is funded by the universities, by Dutch ministries, and by sponsors such as WHO, the European Union, commercial funds and NGOs. The research schools are evaluated by external commissions.

Most of the research mentioned in this overview is part of the Amsterdam School of Social Science Research (ASSR), the Research School for Resource Studies for Development (CERES), and Science, Technology and Modern Culture (WTMC).

Theoretical and Ethical Considerations

The variety of research themes in Dutch medical anthropology equals that of the theoretical concepts and perspectives they explore. If we push things just a little, we may, however, discern a few more or less central foci of theoretical discussion. Six theoretical concepts deserve special mention: the symbolic potential of medical phenomena; the power aspect of medical thinking, acting, and technology; the globalization and localization of medical knowledge and practice; the relationship between biology and culture; the agency of patients; and the applicability of research. They cut across the themes and topics presented above. Ethical considerations are intertwined with all these concepts but particularly with the last two.

Symbols and the Social Experience of Health and Illness

Symbols are the "stuff" of human thinking and acting. Culture is increasingly regarded as a universe of shared symbols. Through symbols people communicate social relations and cultural experiences. If illness and health are at the center of culture and society, it is not surprising that the domains of ill health and wellness and of fortune and misfortune are some of the most important providers of metaphors and metonyms that people use to order their existence, attach meaning to it, and communicate with others. Consequently, the body as primary experience stands out. Thus, the sick body becomes the "topos" of vulnerability in a hostile or indifferent environment, the body afflicted by chronic illness represents the chronic ailments of society and the aging body becomes a metaphor for a world that has lost its appeal. The AIDS epidemic worldwide is perhaps the most defeat- ing example of this symbolism of destructiveness.

The able as well as the sick or disabled body is the intimate point of reference from which and through which people explore the world. The immediacy of the bodily experience infuses bodily symbols with special rhetorical force. These symbols enable people to make contingent situations "self-evident" and to render diffuse experiences concrete. Medicalization and somatization are not only part and parcel of professional medical practices, they are also constituents of the everyday life of ordinary citizens.

The anthropological approach to illness and health illuminates the way people produce culture and society and, in turn, are “products” of social and cultural processes. Medical phenomena as carriers of connotations (“good to think with”) constitute a crucial study area for Dutch anthropologists.

Medical Hegemony: Acceptance and Resistance

If medical phenomena occupy such a central place in the production of symbols and the maintenance of social relations, then it is also understandable that they lend themselves easily to the exercise of power. Medical discourses contribute to the construction of others as beings who need help and control; medical services are political means by which that control is achieved. Introducing the concept of “bio-power” (the power to heal instead of the power to kill), Foucault was one of many to draw attention to the political dimension of medical phenomena. Some Dutch anthropologists apply another concept, “naturalization,” to this dimension of medicine. In medical practice the social is declared “nature” and presented as self-evident.

Medical knowledge and health care are not only the products of a state authority that takes care of its civilians. They also give that state the right to exist and facilitate the exercise of political power. Tropical medicine, for instance, made an essential contribution to the implementation of colonial regimes, being used to legitimate these regimes. Public health in Dutch society has the same effect. Conversely, failures in the provision of health care bring governments into great political jeopardy.

Power and politics are connected to the “medical” in still many other ways. Epidemiological research shows that social and economic inequalities are the best predictors of health and access to health care. Poverty in an economic sense usually implies a lack of control about one’s own body and health. The professionalization of health care and the monopolization of control over medical technology are yet other examples of the interweaving of power and the medical.

Finally, research on the configuration of psychiatric care and power shows that culture is not only a binding force but also a manipulative system that marginalizes, excludes, labels, and punishes people. The marginalization of older people in society demonstrates how closely physical and social “weakness” are related.

Globalization and Localization of Health-care Arrangements

The force of medical symbolism expresses itself vividly in processes of globalization and localization, that is, in the diffusion of bioscientific medicine and in local reinterpretations or resistance against this encroachment. Research on the execution of vaccination campaigns and the distribution, perception, and use of pharmaceutical products, including contraceptives, puts this global development into sharp focus. World-wide processes of expansion and adaptation are also exemplified by research on the social history of the production of medical knowledge and technology.

In the context of an international policy to reduce population growth, contraceptives are disseminated even to the most remote corners of the world. The "life cycle" of contraceptive technologies, from inception through production to application, demonstrates clearly the tension between globalization and localization. Research on contraceptive practices addresses this issue at the global as well as at the local level and shows how consumers and producers of these techniques influence each other.

The ambiguity of globalization vis-à-vis localization presents itself in the uneasy encounter between imported and indigenous medical traditions. In India, for example, the hegemony of Western pharmaceuticals has met with the opposition of Ayurveda. Ayurvedic pharmaceuticals provide Indian cultures with a concrete and evocative symbol for expressing their own identity in contrast with Western images (Bode 2002).

The study of the perception and actual use of pharmaceuticals shows how the globalization effect of the dissemination of pharmaceuticals is mitigated by the cultural reinterpretation that these products undergo. They acquire new local meanings that may deviate drastically from their "global" biomedical definition (Whyte et al. 2002).

Globalization also plays a role in research on perceptions and practices concerning vaccination, for example with respect to prevailing views about the prevention of illness and the protection of health. Studies using a multilevel perspective show how international goals translate into national and local programs and practices. These often substantial shifts in the contents of goals can cause miscommunication between different levels of organization and constitute considerable policy problems.

The Coproduction of Biology and Culture

Anthropology has had a lifelong fascination and feud with biology. It arose partly as a critique against biologism and scientism and was shaped to a considerable degree by this opposition. Unfortunately, the discussions have often led to irreconcilable viewpoints that are both deterministic in nature: cultural against biological reductionism. Anthropologists should avoid these fallacies of exclusive thinking. They should study both the cultural character of biology and the biological features of culture. The repeal of dualistic thinking is one of the main issues and aims of medical anthropology.

The inseparable unity of the "body-subject" (Merleau-Ponty's term) can hardly be observed and described better than in the experience of being ill and becoming well. At the level of the body, the physical implications of meaning-making are undeniable and illness and well-being show themselves as "co-productions" of nature and culture. It is impossible to make sense of the cause, the etiology, the expression, and the experience of health complaints without placing these in a social and cultural perspective.

In anthropology the body is not only seen as the arena where battled is waged over meanings of "nature" and "culture" but also as the place where reconciliation

is possible. The human body itself is a convincing demonstration of the untenability of the Cartesian dichotomy.

Agency of Patients

Anthropological studies of health and illness often portray patients as "patient" and "passive" recipients of care designed and executed by others, such as professionals and relatives. Publications discuss institutions and arrangements of care and medical intervention but pay little attention to the "never-ending work" (to paraphrase Strauss) that patients carry out themselves. Health care does not simply exist in institutions and professional expertise, but is a continuous process of "being done" and "being made." Studies of health-care activities focus on their *interactional* (what patients do in reaction to what others do to them, and vice versa) and *transformational* (how do health arrangements and patients change as a result of that interactional process) effects. Dutch anthropologists want to focus more on patients as central actors in and around the provision of health care, but also in and around the production of new biomedical knowledge and new diagnostic and therapeutic tools. Under certain circumstances, patient groups succeed in influencing the development of biomedical science (Blume and Catshoek 2002). Anthropologists promote a greater influence for patients with regard to what and how health research should be conducted.

Applicability

Application of research results is a constant practical and theoretical challenge. How to put anthropological research results to use has indeed proven to be a thorny question. Often the improvement in our understanding of how and why certain phenomena operate paralyzes rather than invites the search for concrete solutions. If everything relates to everything, as anthropologists often claim, then how can one take action? The result is that practically inclined disciplines often do not wish to engage themselves in anthropological research and that anthropologists hardly bother to ask what is or could be done with their research.

This gap between theory and ethnography on one side and practical work on the other needs to be bridged. Anthropological research should also lead to practical conclusions. The application of research is an essential part of the anthropological quest. The practical application of the insights gained implies seriously considering the ideas and interests of "others." Moreover, focusing on applicability implies a victory over academic ethnocentrism and widespread disciplinary encasing (Van der Geest 1995b).

One of the main problems of applied research is that its results are often least accessible to those who are most entitled to it. It is regularly the case that the outcome of research that is carried out as a service to the least privileged is presented to the most privileged, who have a vested interest in everything remaining the same.

The focus on applicability as an objective and theoretical challenge can be traced in many research projects presented in this overview. Studies of "community drug use" try, on the one hand, to formulate recommendations for the improvement of medicine use, and, on the other, to seriously consider the ideas of those who use these medicines "wrongly." A similar task is confronted in the research on various aspects of reproductive health that reveals notions and practices that may be harmful from a biomedical point of view but are of great value in the local culture. The ways in which people deal with diseases such as tuberculosis and HIV/AIDS confront the anthropologist with a similar problem and require a great deal of creativity on her/his part to formulate respectful and culture-sensitive recommendations for change.

Cultural respect is not, however, a blind kind of respect devoid of criticism. In the final instance, respect for culture must be rooted in respect for *people*, the ones who live in that culture. Defending cultural traditions which the members of that culture experience as oppressive would become a new form of cultural imperialism, a reversed ethnocentrism. Taking this into consideration, medical anthropologists should look for respectful solutions that receive the approval and support of those who are immediately affected by them (Van der Geest and Reis 2002).

Prospects

It is hard to predict medical anthropology's future in the Netherlands, but two related developments are likely to take place. The first one leads us back to the opening paragraphs of this article. Medical anthropology will distance itself more and more from its "alien" beginnings and come "home." The Amsterdam Unit actively promotes research in its own society as is shown in its involvement in three international conferences on Medical Anthropology at Home (1998, 2001, 2003).

The home-coming of Dutch medical anthropology is further stimulated by the changing epidemiological scene. Chronic disease and old age are gaining an increasing amount of attention. The emphasis is shifting from active medical intervention to care and social attention. The role of the social and cultural context is becoming more important, as is the study of this context by anthropologists.

The growing number of citizens of foreign origin with different cultural perceptions of health and medicine constitutes a third factor that will increase the need for anthropological research in Dutch society. Anthropologists are drawing attention to the "culturalization" of health problems among migrant citizens (Van Dijk 1998) and to policies of exclusion in health care. A large number of initiatives (both research and training courses) have been taken to address the interculturalization of health and health care.²⁵

All three reasons for this "home coming" imply more cooperation between anthropologists, health-care professionals, and patients. Medical anthropologists will be pushed out of their safe haven of "pure" anthropology. The old medical roots of medical anthropology will be revitalized, but the picture will be more complex than before.

Acknowledgments

Writing an overview of such a diverse field as medical anthropology in the Netherlands is a precarious undertaking, especially if one is strongly immersed in it, as is the case for this author. I thank the many colleagues who helped me in collecting the information (especially Annemiek Richters and Rob van Dijk) and apologize for omissions and (Amsterdam) "biases." I quoted liberally from a document, which I wrote for my own research unit at the University of Amsterdam (Medical Anthropology/Sociology Unit (MASU) 2003). Other overviews that I consulted were: Diasio (2003), Richters (1983), and Streefland (1986).

Notes

1. A birth date of medical anthropology does not exist but 1953 was without doubt an important year. In that year, Caudill, by training a psychiatrist, wrote a contribution to Kroeber's *Anthropology Today* about "Applied anthropology in medicine" (Caudill 1953). Ten years later, Scotch published his overview of medical anthropological work, which he started as follows: ". . . In every culture there is built around the major life experiences of health and illness a substantial and integral body of beliefs, knowledge and practices" (Scotch 1963:30). It was one of the first attempts to define the study object of medical anthropology.
2. Vincent van Amelsvoort died in 2001. For brief biographies of his life, see several contributions to the Festschrift for his retirement (Braakman 1986) and his (Dutch) obituary (Van der Geest and Hamel 2001).
3. In 1983 Douwe Jongmans became professor of the "Intercultural Study of Human Fertility" at the University of Utrecht. He retired in 1986. More information on his life and work can be found in a Festschrift made for him at his retirement (Hoogbergen and de Theije 1986).
4. I suspect that medical anthropology developed along similar lines in other countries. The most prominent ancestors of medical anthropology in Britain, for example, were physicians (Rivers, Lewis, Loudon) and the same goes for the United States (Ackerknecht, Paul, and Kleinman). For the medical roots of British medical anthropology, see Diasio (1999:44–122).
5. Another, much earlier, example (not included in my brief overview) would be the work of Dutch Hygienists in the 19th century, in particular that of Pruys van der Hoeven, who emphasized the social and political nature of health and disease. Richters (1983) and Diasio (1999, 2003) discuss the Hygienists' (unrecognized) link with medical anthropology.
6. In Heidelberg the term "medical anthropology" (*medizinische Anthropologie*) was used long before the word was introduced in the Anglophone world, but it had another meaning: the philosophical reflection on illness, health, and healing (Von Weizsäcker 1927). As a consequence, German medical anthropologists were unable to adopt the term, as it already had another destination. They are still struggling to give a decent name to the discipline which their colleagues outside Germany term "medical anthropology."
7. The anthropological predilection for "things from far," exoticism in brief, was of course an inverted type of ethnocentrism. See for example Van der Geest (2002a).

8. One could perhaps say that Dutch medical anthropology is in yet a third way alien-oriented. The literature read in university courses is overwhelmingly foreign, demonstrating an extreme form of nonchauvinism. Dutch authors are hardly mentioned in the most popular handbooks and readers of medical anthropology. The most ambitious study on the foundations of medical anthropology written by a Dutch author is entirely devoted to a debate with the American school of Kleinman and hardly touches on the achievements of the "Dutch school" (Richters 1991). For an English summary and review of this study, see Marezki (1994).
9. She held her inaugural lecture in 1995 on Health Systems Research (Varkevisser 1996).
10. An elaborate – but now partly outdated – overview of courses in medical anthropology in the Netherlands was published some years ago in *Anthropology and Medicine* (Van Dongen 1997).
11. Extensive information on the AMMA (Amsterdam Master's in Medical Anthropology) can be found on the website (<http://www2.fmg.uva.nl/amma/>). A brochure can be requested from the secretariat (amma@pscw.uva.nl).
12. Information: Anke van der Kwaak (a.van_der_kwaak.social@med.vu.nl).
13. Information: Anja Krumeich (A.Krumeich@ZW.unimaas.nl).
14. Willem Buschkens, who called himself a "non-Western sociologist," worked in Suriname, Ethiopia, and Somalia. He died in 1991. For a brief biography, see Speckmann (1991).
15. Hans Speckman specialized in the social and cultural aspects of family planning. He did research and taught in Suriname, Indonesia, and other countries. He died in 1997. For a brief biography, see Van der Geest (1997).
16. Information: Annemiek Richters (j.m.richters@lumc.nl).
17. Information: D.Ingleby@fss.uu.nl.
18. Research activities and publications in the field of medical anthropology are too numerous to be mentioned here. For an overview of research and published work by members and affiliated researchers of the Amsterdam Medical Anthropology Unit from 1993 to 2002, see Medical Anthropology Unit (MAU) (1997) and Medical Anthropology/Sociology Unit (MASU) (2003).
19. Publications in this field include: Nijhof (2002), Reis (2001), Van Dongen and Fainzang (2002), Van Duursen et al. (2002).
20. Some of the publications on this topic are: Adome et al. (1996), Amsterdamska and Hiddinga (2000), Blume (1997, 1998, 1999, 2000, 2002), Blume and Geesink (2000), Bode (2002), Gibson (2001), Streefland (1995, 2001), Vermeulen (2000), Whyte et al. (2002), Zaman (2004).
21. Publications related to reproductive health include: Gerrits (2002), Hardon (1998), Hardon and Hayes (1997), Koster (2003), Krumeich (1994).
22. Publications on old age, long-term care, and chronic disease include: Nijhof (2002), Van der Geest (2002b), Van Dongen (2002a) Von Faber (2002), Von Faber et al. (2001).
23. Publications on mental health include: Van Dongen (2000, 2002b, 2002c, 2003), Van Dongen and Van Dijk (2000).
24. Some publications focusing on health policy and intervention are: Arhinful (2003), Streefland (1998), Vulpiani et al. (2000).
25. Dutch medical anthropologists are taking part in a large European study about the exclusion of migrants from national health care in nine European countries (see Vulpiani et al. 2000). Likewise, there is an intercultural mental-health center of

expertise in the field of ethnic and cultural diversity (MIKADO). Its main objective is to improve mental health care by improving the transfer of knowledge, promoting intercultural expertise, and initiating research. For information: n.sonmez@mikado-ggz.nl; website: www.mikado-ggz.nl, accessed June 2004.

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