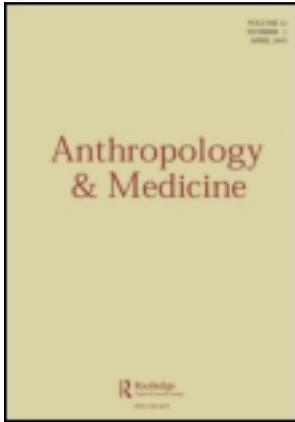


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Alien origins: xenophilia and the rise of medical anthropology in the Netherlands

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Alien origins: xenophilia and the rise of medical anthropology in the Netherlands

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The beginnings of medical anthropology in the Netherlands have a 'xenophile' character in two respects. First, those who started to call themselves medical anthropologists in the 1970s and 1980s were influenced and inspired not so much by anthropological colleagues, but by medical doctors working in tropical countries who had shown an interest in the role of culture during their medical work. Secondly, what was seen as medical anthropology in those early days almost always took place in 'foreign' countries and cultures. One can hardly overestimate the exoticist character of medical anthropology up to the 1980s. It was almost automatic for anthropologists to take an interest in medical issues occurring in another cultural setting, while overlooking the same issues at home. Medical anthropology 'at home' started only around 1990. At present, medical anthropology in the Netherlands is gradually overcoming its xenophile predilection.

Keywords: medical anthropology; history; the Netherlands; tropical medicine; xenophilia; exoticism

The first Dutch study that explicitly referred to 'medical anthropology' appeared in 1964.¹ 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 came only one year after Norman Scotch had delineated medical anthropology as a formal field of research and teaching, and as a sub-discipline of cultural anthropology.² Van Amelsvoort's (1964a) study focused on the clash between two entirely different (medical) cultures, and it was quickly followed by the publication of a short note on the new field of medical anthropology in a Dutch medical journal (Van Amelsvoort 1964b). Discussing the origins of the new sub-discipline, Van Amelsvoort referred mainly to social scientists and health professionals who (like himself) had worked in the field of health development and had analysed the relationship between culture, health and health practices: Charles Erasmus, Edward Wellin, Walsh McDermott and G. Morris Carstairs. Van Amelsvoort was a 'tropical doctor' with a keen interest in culture, thrust upon him during his work as a colonial doctor in New Guinea. Later he became professor in 'Health Care in Developing Countries' in the medical faculty of the University of Nijmegen. The biographical background of his work in medical anthropology typifies the 'alien' origins of the field in the Netherlands, referring to both disciplinary and geographical territories. Medical anthropology in the

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Netherlands started in tropical areas far from home, and those who initiated it were not anthropologists but medical doctors.

Medical initiatives

There are at least three reasons why physicians and not anthropologists took up the issue of culture and medicine. First, 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 those cultural barriers, many of them at least realised that it was crucial to learn more about them. There was a need for knowledge about local cultures, particularly medical cultures.

That awakening of cultural interest among Dutch tropical doctors can be observed in the work of some early physicians in the Dutch Indies (later Indonesia). 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 about 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 was particularly interested in how illness and health practices were embedded in the general culture of local Indonesian groups. 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 the study by Gerard 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 time, 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 applied purpose of medical anthropology remained strong, however, 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 focus was on cultural perceptions and practices around fertility and birth regulation (Jongmans 1974, 1977). Several other anthropologists continued (in varying degrees) to practice ‘anthropology *in* medicine’ – mostly abroad, but increasingly also in the Netherlands, albeit mainly among migrants.

A second explanation for the ‘failure’ of anthropologists to grasp the opportunity of medical anthropology at an earlier stage could be their weariness of so-called ‘applied anthropology’, which dominated the post-colonial era of anthropology. In the 1950s and 1960s, most anthropologists fostered – as far as possible – the principle of non-intervention. ‘Proper’ anthropologists, it was believed, should not make their hands dirty on government- or mission-initiated development projects. Problems of illness and death were to be studied primarily as occasions for social conflict or

religious ceremony. Individual cases of illness and death *per se* did not really interest them. Only when they occurred in their immediate environments 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 neighbours, and helped them in other ways. Some anthropologists were known to 'play doctor' and even held 'consulting hours'. Such activities generally remained separate from their ethnographic work, however, and did not lead them to anthropological reflection. Not only did these activities fall outside the scope of their research, but they were also in conflict with the 'rules' of proper anthropological fieldwork: non-intervention, participant *observation*, with the emphasis on the second word.

Evans-Pritchard is a well-known example of an anthropologist busily engaged in medical activities, but he was also an exception. In his Azande study, Evans-Pritchard (1937, 506) writes that he was 'constantly associated with every kind of sickness.' When his medical work became more cumbersome and took him two hours every morning, he arranged for assistance; someone else came to dress wounds and dispense medicines for him. It had not been a waste of time. He writes:

When...I generalize about Zande notions of disease, I do so on a fairly wide experience. I have invariably found that when a Zande is struck down by general and acute sickness, with sudden and severe symptoms and rapid course, as in certain types of fever, pneumonia, cerebrospinal meningitis, influenza, &c, his relatives and neighbours straightaway connect his collapse with the primary cause of witchcraft or sorcery... (Evans-Pritchard 1937, 506)

His reflection on the mundane work of treating sick people enabled him – as an anthropologist – to write the first major work in medical anthropology, decades before medical anthropology emerged as an academic discipline.

Finally, it must be remembered that the birth of anthropology around the turn of the nineteenth into the twentieth century was partly a reaction to the growing hegemony of biology and its excrescences into flat evolutionism, racism and eugenics. This 'classic' anthropological 'allergy' to biology probably added to anthropologists' initial reluctance to get involved in medical issues. It was only in the 1970s that anthropologists 'discovered' the symptoms of bodily dysfunction as cultural phenomena and became fascinated by medical topics. That was the moment when medical anthropology in the Netherlands – as in many other countries – became a recognised and popular field of study within cultural and social anthropology.³

Xenophilia

The other type of alienism during the first years of medical anthropology in The Netherlands is geographical. Research that was recognised as 'medical anthropology' had always taken place far away, on foreign territory. This is not surprising, because at that time anthropology was seen as the study of 'other cultures' (Beattie 1964). With some exaggeration one could say that not the topic but the topos made a study 'anthropological'. Studies on social and cultural aspects of health, body, mind, emotion and well-being, which were situated in Dutch society were not considered 'anthropological' *because* they dealt with Dutch issues; they were not even noticed by anthropologists. 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.

Two examples illustrate this point.⁴ The pioneering studies of the physician, biologist, psychologist and philosopher F.J.J. Buytendijk (1887–1974) is hardly ever referred to in the publications of the early Dutch medical anthropologists. Buytendijk's main concern can be characterised as a consistent attempt to overcome the body/mind dichotomy, a theme which, about 30 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 make the ideas of the French philosopher Merleau-Ponty 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 – was shown to react meaningfully to human experience. 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 attempted to develop a non-dualistic brand of medicine.⁵ Buytendijk, whose work has been translated into English, shows that there is subjectivity and meaningful 'behaviour' in physiological processes. The body is a cultural actor, and bodily dysfunction is a meaningful cultural act (Buytendijk 1974). As stated above, Buytendijk's publications were not thought to be relevant to cultural anthropologists. In fact, that negligence was mutual. Buytendijk took his inspiration and data from biology and psychology, about human beings as well as animals, but never referred to studies of people in other cultures. It is doubtful that he read anthropological work. This may look an amazing omission with hindsight, but we should realise that at that time anthropologists offered little on embodied processes that could have interested Buytendijk.⁶

A similar story can be told about the Dutch psychiatrist J.H. van den Berg. Outside the Netherlands, Van den Berg is best known for a brief treatise on the psychology of the sick-bed (Van den Berg 1966 [1954]), which has been translated into many languages. His phenomenological description of the experience of the bed for a sick person is surprisingly anthropological. The bed is a safe haven for a healthy person, an intimate place where he can rest, recharge his energy, be alone or make love. It is a place full of promise. But for the sick person the bed may become a prison, the place that he wants to leave but cannot. For the chronically ill person in particular, the bed becomes the symbol of a life without future. The sounds that reach him from the street remind him of the world that he lost. This beautiful emic capture of the illness experience was eagerly read by generations of nurses throughout the 'Western' world, but remained unnoticed by anthropologists for a long time.

Within his own country, Van den Berg drew considerable attention through his book *Metabletica* (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).⁷ His main thesis was that the human body has changed through the ages (his study takes the reader back to the thirteenth century). He not only argues that the *meaning* of the body varies over time, but also 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 characterise him perhaps 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. Again, this is a viewpoint busily discussed by anthropologists today, but it went 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 other disciplines that occupied themselves with body, culture and society.

One could perhaps say that at present Dutch medical anthropology is alien-oriented in yet a third way. Literature read in its teaching courses is overwhelmingly foreign, demonstrating an extreme form of non-chauvinism. 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).

In sum, the origins of Dutch medical anthropology are in two respects 'alien', in a disciplinary and in a geographical sense. The latter is the dominant alienation. One cannot overestimate the exoticist character of anthropology – and medical anthropology in particular – up to the 1980s. It was almost automatic for anthropologists to take an interest in anything happening in another culture and to overlook anything happening at home. This predilection for 'things from far', exoticism in brief, was of course an inverted type of ethnocentrism: 'culture', the object of anthropological scrutiny, was only to be found among the 'others', while at home they had science, medicine and the Christian faith, untainted by the relativist adjective 'cultural' (see further: Van der Geest 2002). The only things occurring in another culture that did not interest them were events or institutions that reminded them of home and did not fit their conception of 'culture'. Schools, Christian churches, western-type hospitals and health centres were skipped or blotted out of their ethnographic work; they did not observe them nor participate in them (Van der Geest and Kirby 1992).

If Buytendijk had written his treatise on phenomenological physiology in Borneo, anthropologists would have embraced him as a colleague. If Van den Berg had written about the sickbed of patients in Congo, the same would have happened.

Medical anthropology in the Netherlands today, following mainstream cultural anthropology, tries to overcome its 'alien' beginnings and come 'home' (on *Medical Anthropology At Home*, see the vignette by Sylvie Fainzang). This trend is probably stimulated also by the changing epidemiological scene in its society. Chronic disease and old age take an increasing amount of attention. The emphasis shifts from active medical intervention to care and social attention. The present popularity of medical anthropology among students has been surprising. The author's impression is that medical anthropology caters for two types of students. It continues to be a branch of anthropology that 'matters' in the sense that it can be applied in practical medical and paramedical work. But medical anthropology also has become a major domain of theorising about culture. Health and illness, body and food, care and violence, anatomy and genetics, medical science and medical hegemony constitute excellent cases to explore the 'work of culture'. This 'double identity' (applied and theorising) typifies medical anthropology as it is presently practiced in the Netherlands and at the University of Amsterdam in particular.

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Conflict of interest: none

Notes

1. 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 (France, Great Britain, Italy and The Netherlands). She writes that Dutch medical anthropologists see themselves as a mixed breed of foreign and interdisciplinary influences. This paper supports her thesis on this mixed provenance.
2. A birth date of medical anthropology does not exist, but 1953 was undoubtedly an important year for the contribution by Caudill (a psychiatrist by training) to Kroeber's *Anthropology today* about 'Applied anthropology in medicine' (Caudill 1953). Ten years later, Scotch published his overview of medical anthropological work, which began with the premise that '...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 object of study of medical anthropology.
3. 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 USA (Ackerknecht, Paul, Kleinman). For the medical roots of British medical anthropology, see Diasio (1999, 122–44).
4. Another much earlier example is the work of Dutch hygienists in the nineteenth century, in particular that of Pruys van der Hoeven, who emphasised the social and political nature of health and disease. Richters (1983) and Diasio (1999, 2003) discuss the hygienists' (unrecognised) link with medical anthropology.
5. 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 (cf. 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 for a decent name to the discipline which their colleagues outside Germany term 'medical anthropology'.
6. A good overview of work produced by the Dutch phenomenological school is Kockelmans (1987).
7. See also Van den Berg (1987).

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Vignette

Medical anthropology at home

MAAH is an international network of medical anthropologists who do research in their own societies. It was born in 1998, after the first European Conference on 'Medical Anthropology at Home' held in the Netherlands, at the initiative of the University of Amsterdam. It stemmed from the belief that medical anthropology had for too long neglected the study of our own societies, towards which anthropologists had turned only recently, and that it would be fruitful to promote a collective thinking about the theoretical and methodological implications of research in this context. Its broader aim is to bring together medical anthropologists in order to discuss theoretical, methodological and practical issues in relation to health and culture, and to reinforce the position of medical anthropology in Europe. Although most of its members belong to European societies, it also welcomes researchers from other continents, with about 15 countries represented. The network organises regular conferences in various countries, during which research is discussed on themes such as the body, reproduction, drug use, doctor/patient relationships, chronic illness, health systems, medical pluralism, multiculturalism, migrations, and political engagement. But MAAH events also allow for discussions of methodological and epistemological issues connected to the choice of working in familiar settings, and they have encouraged reflection on the relationships between anthropology and medicine. These conferences give rise to collective publications of books and special issues of journals (including *Anthropology & Medicine*, *Antropologia Medica*, Aarhus Press, URV Publications), which echo these exchanges. The network has an international scientific Advisory Committee and a mailing list [see <http://www.vjf.cnrs.fr/maah-france/>].

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