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Editorial. Medical anthropology at home: creating distance

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Changing fields

The time that medical anthropology only focused on health, sickness and health care in cultures other than those of the researchers belongs to the past. Worldwide, medical anthropology has developed a recent and growing interest in studying health issues 'at home', and the discipline shares its reasons for homecoming with general social and cultural anthropology. First, for Western anthropologists there are 'mundane' reasons such as the end of the colonial era and a suspicion by many African and Asian states of neo-colonial intellectual imperialism. Second, decreased funding and increased student numbers (especially from medical professions and other disciplines) pull anthropologists 'home'. Third, there are theoretical and methodological reasons: enhanced critical awareness has exposed the bias in anthropology, which studied 'others' as 'cultural' beings, but overlooks its own cultural foundations and the cultural dimension of 'home'. This awareness laid bare unknown domains. What has always been taken for granted is now questioned.

The methodological and theoretical implications of the changing fields are complex and paradoxical. The anthropological literature suggests that this field of research has its specific problems and challenges (Ahmed & Shore, 1995; Jackson, 1987; Moore, 1996). The main obstacle is probably the lack of distance needed for analysis and reflection. Working at home forces medical anthropology to confront its limits and traditional interests as culturally constructed. It also reveals the value of the anthropological 'voice'. It is in this context that anthropology at home came into particular focus at the European conference 'Medical Anthropology at Home', organized by the University of Amsterdam in the Netherlands in April 1998.

Among the themes discussed at the conference, the most important was the very expression 'at home'. 'Home' has many meanings. Anthropologists use this idea to designate a country, Europe, Western societies, a culture, an institution, an activity, an illness, and so on. If we try to summarize the various contents attributed to home, we find two main themes: home as a shared 'culture' or as a shared 'experience'. However, the question remains whether it is not disregarding of the social and cultural setting to consider only the shared experience

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since, for most anthropologists, working on topics (whatever they are in a Polynesian or an African village) would not be considered working at home. Besides, if we start with 'home' as one's culture, the problem remains that of cultural boundaries, and the relativity of home. The different ways of doing medical anthropology at home are another point: one is at home, works at home and feels at home. Some suggest that anthropology at home has no special epistemological position compared with anthropology abroad, though there may be differences at the practical level of fieldwork and publishing. One could also challenge the notion 'at home' as suspicious in that it may lead us in an unfavourable direction, if it is predominantly used for Western contexts. This would exclude non-Western anthropologists working in their 'homes'.

So, 'at home' is a changing and fluid notion. Yet, it is very useful in expressing a particular kind of situation that challenges traditional settings of anthropological research. It could facilitate re-examination of such research by focusing on the domestic nature and the medical dimension of anthropology.

Closeness, otherness and creating distance

One problem of homeness is that of defining closeness and otherness. Here we have contrasting points of view: some consider sharing an experience of illness with informants as being at home, while others think of health as home and sickness as otherness. Besides, the researcher may be placed in the difficult situation of having to present sickness or sick persons as others and of wishing to avoid this stigmatization. It puts the anthropologist in a rather double-bind position.

As far as the notions of closeness and otherness are concerned, there are several ways of considering them. Anthropological research at home might have emotional problems involved in overcoming 'insiderness'. Shared history and personal experiences may cause unconscious attitudes to one's informants, such as forceful identification with an informant. Although this is not specific for 'working at home', the chance that one is confronted with this emotional involvement and its painful consequences is considered greater in anthropology at home than abroad.

Anthropologists feel they need distance to analyse their data and write their ethnographies, but even the things to which they choose to keep a distance vary. So do the objects with which the researcher feels familiar. The notions of closeness and otherness are sometimes applied to the objects or themes studied, and sometimes to the epistemological posture of the researcher facing the constructed objects. The variety of the things to which anthropologists wish to keep a distance testifies to the richness of the problems of anthropology at home. It testifies to the relative character of these notions, which is the result of a construction. If this relative character allows many plays around the very idea of homeness (we can speak of the 'true insiders', or of those who are at times inside somewhere and outside somewhere else, or of being outside the inside), these are not only plays with words. They keep stressing the important problem of

boundaries. Moreover, these notions have proven they have in a way to be de-sacralized in the sense that, *just as distance is not a guarantee of objectivity, familiarity is not knowledge.* As the medical anthropologist at home becomes aware of the problem with these notions and their impact on knowledge production, we can examine the contribution of medical anthropology to the theory and methodology. What is the purpose of this intellectual resource? Who will benefit from medical anthropology? Can universals be re-established without losing track of their origins in diversity?

Medical anthropology and comparison

We cannot think about medical anthropology at home without raising the question of comparison. Comparison must focus not only on differences but must highlight similarities too. The question is: what is compared? What boundaries and what referents are chosen for comparison? Do we compare the differences between cultures or within those cultures (Moore 1996)? Meeting another, different reality is a condition for reflexivity. This, in turn, militates in favour of comparison. Then, we can systematically compare research on the same subject in different cultures.

Even if this comparison is not always made by going on different and various fields by all the researchers, at least they may (and they have to) turn to the existing ethnographic literature on various societies across the world, a literature which has been enriched by fieldwork at home. Any tendency to construct African knowledge, for example, as simple reversal of European knowledge could be avoided and prevent the anthropologist from slipping "too easily into unthought dialectic of opposition that is the negativity of difference" (Moore, 1996: 6). We should include multiple difference in our analyses, rather than starting with cultural ones.

Comparison must not be a profession of faith. It must objectify or materialize by a resort to an explicit use of comparison, with the purpose of distinguishing between common sense knowledge and anthropological knowledge.

Returning of the results

The return to the informants of the results of their work by making available their publication is one of the difficulties that anthropologists come across at home. By returning them, we confront ourselves with various kinds of reactions that constitute feedback such as contradiction, anger, etcetera. And it is a test of validity of the research. If some choose not to write certain things to protect their own and their informants' interests, others have found it useful and fruitful to seek these reactions for validating the research process. In any case, the possibility of being read by one's informants is a new dimension to tackle for anthropologists at home. As a consequence, this could mean a revision of the role of the academic anthropologist and a re-evaluation of the informant's point of view. The nature of medical anthropology at home stresses questions like:

who owns the knowledge obtained, what is medical anthropology at home for, and whose needs are being met?

The papers

The problems and challenges of doing medical anthropological research at home are often overlooked in the present research settings. The papers that follow offer insights and experiences from the field. They demonstrate that reconsideration of the problem of involvement and detachment is important, for this reconsideration might lead to defamiliarization of the familiar. This, in turn, would deliberate the others 'abroad' from 'exoticization' and 'objectification'. The fragile balance between involvement and detachment, with its emotional, sometimes painful or humorous consequences, lends the anthropological perspective its special flavor (van Ginkel, this volume). The papers demonstrate that medical anthropology at home does not have a special epistemology compared to medical anthropology abroad.

That this is so is documented in van Ginkel's paper. The author discusses the repatriation of anthropology, stimulated by political, economic and academic developments. Van Ginkel is not a medical anthropologist. His interest in 'endogenous anthropology', as he names anthropology at home, stems from 12 years of research experience in the Netherlands, his native country. He describes the more general problems anthropologists face when conducting fieldwork in familiar settings. They can be used by medical anthropologists to 'bounce against'. He discusses theoretical and epistemological implications of endo-ethnography. He warns us not to over emphasize the differences between anthropology at home and abroad in an absolute way. He concludes that it is only at the practical level of fieldwork and publishing, and not at the analytical level, that differences between anthropology at home and abroad may exist. For van Ginkel, the crucial point is not where anthropologists hail from, but how they perceive and interpret the reality they confront.

Sylvie Fainzang's paper addresses the comparison of research on the same subject in different cultures. She argues that, though the methodological, epistemological and theoretical research traditions developed by anthropologists working abroad could be a problematic heritage for medical anthropology at home, its contribution to medicine and anthropology as a whole is of great significance. Fainzang offers us insight in the formulation "in new terms fundamental questions concerning behaviour of individuals in society" by systematically comparing her research in Burkina and different parts of France.

Comparison of different research settings also is a main theme in Ria Reis' paper, which explores the differences between anthropological research on epilepsy in Swaziland and the Netherlands. Reis argues that the balance between distance and proximity is not only problematic on the cognitive level, but also on the emotional level. Doing research at home *feels* different. The author illustrates her argument by an interview with the mother of a retarded son with epilepsy. Having intimate knowledge of her life with a physically and cognitively

handicapped daughter, she had a forceful identification with her informant. Although such events are not specific for medical anthropology at home, they alert the researcher more forcefully to socio-cultural core issues than is the case abroad. The methodological consequences of such events must be recognized and dealt with by reflexion and introspection.

Els van Dongen's discusses the notions of closeness and otherness in medical anthropology at home. By reflecting on fieldwork in a mental hospital in the Netherlands, van Dongen illustrates how the anthropologist, patients and staff members 'make' each other, despite sharing the same geographical, historical and social background. The making of the other means that the anthropologist becomes involved in an arena in which moral claims are contested, because the researcher is not fully considered a stranger. The consequence, as the author views it, is that ethnographic writings become a social and ethical practice in which the informants can play an important role in giving feedback, which in turn sets in motion the reflections of the anthropologist. Therefore, fieldwork is a long-term and ongoing process.

The usefulness of 'at home' as a programmatic concept is investigated in Bernhard Hadolt's paper. The author leaves aside the many dimensions of the notion of 'home' and questions it as a metaphor which refers to research being done by Western medical anthropologists in Western settings. To address the question of where and how the concept of 'at home' locates the difference between at home and not at home, Hadolt uses Moore's elaboration on 'differences between' and 'differences within'. For the author, 'at home' echoes the distinction between 'we' and 'the other' and thereby shares its shortcomings. Hadolt's conclusion is that 'at home' is a useful ethnographic category, but that it suppresses the interconnectedness and the relationships between 'we' and 'the others' other forms of difference than cultural ones and similarities that cut across the we–other and home–abroad division.

Conclusion

The papers presented in this special issue explore a range of experiences of medical anthropologists at home. They demonstrate that this field can challenge the idea that 'real' anthropology has to be done abroad. A number of questions set by the practice of medical anthropology at home are identified, so that one is able to think over one's practice, and give the field more consistency.

It might be unusual to publish a series of reflexive and self-examining papers on medical anthropology in an interdisciplinary journal which expands upon the growing theory and research linking anthropology with medicine. However, these glimpses behind the scenes show by their reflections on differences within Western societies the cultural nature of health practices and beliefs. When the suggestion is correct that anthropology itself cannot inform others, for example, people in the field of health care, about its enterprise very clearly (Shore, 1996), these papers show the reader how medical anthropologists work; how they experience their own culture and society through their informants. They show

successes and failures. They might bring complementary and useful perspectives on health, illness and health care, and culture and society.

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