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# *Closing notes second meeting Maah, Tarragona April 2001*

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My final comments are not going to last an hour as is announced in the programme, don't worry. I perfectly understand that we are tired. I will give my short endnotes and then we will discuss some practical matters, like the third meeting of our network. But let me start with some final remarks about this meeting.

I begin with a short quotation by Anatole France. As a tribute to the participants who have made so much effort to make their presentations in English, I shall quote in French:

> «La vérites découvertes par l'intelligence demeurent stériles. Le coeur est seul capable de féconder ses rêves. Il verse la vie dans tout ce qu'il aime.» (Anatole France. *Le opinions de M. Jerome Coignard*. Paris: Calman-Levy, 1923).

Why am I saying this? Because I believe that the "truths" that we have discovered during the three days of the meeting are not sterile. Times have changed. We have discussed the many issues and questions not only with intelligence but also with the dreams we have about good and valuable medical anthropology at home.

Two themes were central to the meeting: the contribution of medical anthropology to anthropology in general, and the liturgy of health and health care. Let me return to the original texts, which are sent via the mailing list of the MAAH.

The first theme was described as follows:

«Discussions about the use of medical anthropology are dominated by its applicability in medical science and practice, leaving its contribution to general anthropology in relative obscurity. The second conference on med-

ical anthropology at home will redress this imbalance by bringing into focus the position of medical anthropology within cultural anthropology.»

The question is: did we succeed in discussing the position of medical anthropology within cultural anthropology? I think that we have tackled both issues: the applicability in medical science and practice and the position within cultural anthropology.

There seemed to be a little Babylonian confusion about this theme at first. Some of us might have thought that this theme was defensive, as if we had to find a reason for our existence vis-à-vis medicine. However, the arguments made in the papers on the first day made it very clear that medical anthropology can contribute to a better understanding of what it means to be human and cultural beings, precisely because the focus on illness allows us to obtain knowledge about symbolic logic in a society, the various institutions, the social relationships, and so on and so on. The importance of the contribution of medical anthropology to cultural anthropology was very well illustrated by the papers on the body and embodiment. In the discussion it became clear that medical anthropology has brought the body into cultural anthropology. Furthermore, several theoretical issues were discussed. The question was raised whether we can speak of reflexivity if we make an anthropological analysis of biomedicine. Another interesting point was made on complementarity. Is medical anthropology as a critical science the "consciousness of medicine"? What exactly do we mean by embodiment? Should we consider this concept within the framework of semiology, or is it an interplay between the lived experience of individuals and socio-political forces? Or do we use the concept in the sense of incorporation (my thanks to the chair of this session for giving me her notes!). Another example of the contribution of medical anthropology to cultural knowledge is the discussion on ethics. It became clear that concepts like autonomy, which is so central in ethics, has to be reconsidered because anthropological research shows that this concept may hide the true reasons for the existence of ethical codes. It was also stated that we lack the knowledge of how patients think about autonomy, for example.

We came very close to anthropological reflexivity when we spoke about migration and health and the issue of obtaining permission to do anthropological research in medical settings. The presence of migrants in European societies forces us to rethink the possibility of obtaining knowledge of what we are. The discussion reflected on the willingness of medical anthropology to start a democratic debate – by the way, this issue was put forward in other papers as well – because in this case we are dealing with people

who often cannot resist being studied. We will have to reflect on our stance, because anthropological knowledge can be used against them by the powers that be. However, we had discussions which showed that there are also people who can resist being studied in a powerful way.

Important issues were also the various "de-'s" and "re-s", as I would like to name them. By 'de-s" I mean: de-medicalisation, de-exotisation, de-pathologisation. The first one – de-medicalisation – was understood in different ways and on different levels. We spoke about the de-medicalisation of anthropology, meaning that medical anthropology should not become a handmaiden of medicine. Or did we want to say that societies need to be de-medicalised? Or do we mean that we should de-medicalise concepts such as risk or compliance? And is medicalisation always an advantage? The South African case made clear that we have to look at both sides: the negative and the positive impact of medicalisation on people's lives.

The second "de", de-exotisation, brought us to the concept of 'at home'. It is perhaps meaningful that there was no single reference to the -European- special issue of Anthropology and Medicine (1998) which was the result of the first meeting, edited by Sylvie and myself, and which discussed all the issues that were at stake in this second meeting in several good quality articles. . What is this 'at homeness'? Maybe, paraphrasing Tullio, Europe is our home, even if we come from abroad. Before discussing the "re-s", I would like to digress a little Reading through the forty papers of this meeting and looking at the references at the end of each paper, I saw that most of the references were not European but North American. I have nothing against this, because many of the works cited are of the highest quality, but I believe that if we want to learn about medical anthropology at home in Europe, we should read our own works in order to understand each other's scientific thoughts and ethnographic projects. Of course, there is the issue of different languages; a sensitive problem, but also a challenge, which will have to be discussed more extensively in the future. The English that we have spoken these days is not the English spoken by native speakers. The native-speaker English has undergone a transformation to become, in a sense, our English. At least, language issues have to be taken seriously. Now I come to the "re-'s". By "re-s" I mean re-anthropologisation, re-enchantment, re-exotisation; issues which made clear that medical anthropology, especially medical anthropology at home, can indeed make a contribution to cultural anthropology. The first – re-anthropologisation – means that in this meeting and in many papers there was a plea to bring back into medicine the focus on human suffering and misery from a non-pathological perspective. Or, if you wish, as one participant pointed out on the first

day: «We spoke all the time about medicine, but where are the people. I feel closer to a doctor who is working with people, than to an interpretative anthropologist.» And this tackles the problem of the question of anthropology as an applied science or as an intellectual enterprise again, as our guest from Canada noticed. The discussion of the double role of an anthropologist and an action researcher made this clear once again.

The second theme – liturgy – revealed that medical anthropology at home may re-enchant the world at home, because it examined the religious and ritual nature of the European medical traditions. It was said in the announcement of the second meeting that anthropology often likened medical ideas and practices observed in distant societies to religion and ritual. I believe we have reversed this ethnocentric view by speaking about the magic, ritualistic and religious nature of biomedicine's practices and people's health-seeking behaviour. However, this issue often remained implicit in the sessions on liturgies. It was obvious that in the diverse medical systems, whether they are pentecostal, charismatic, tarantistic, or focused on saintity, these seemingly exotic practices seem to belong to humanity and, thus, they also belong to European cultures. The papers made clear that what we studied abroad persists today in Western societies. The discussions on liturgy, ritual and magic in biomedicine made it even clearer. They show that the idea of a disenchantment of the world is simply not true. The question is, however, what do we gain by such a view? What does it contribute to our understanding of cultures? During the discussion we had our doubts about the usefulness of liturgy in medicine, but we should distinguish the scientific and practical level of medicine.

However, there is a danger of re-exoticising human life, i.e. medical practices. The resistance to the idea of magic, ritual and liturgy applied to biomedicine can sometimes be very strong in biomedicine, as a colleague told me. Besides, it may reinforce anthropological stereotyping. On the other hand, it can also reveal the strong performative nature of medicine and force us to reflect on our performances at home.

Another aspect that was stressed during the meeting was history. We all agreed that the historical dimension has to be included in our research. Some papers showed that sometimes the echoes of the past are very important in explaining people's ideas about illness and health in the present and to get an idea of the fundamental processes linked to health and health care in the future. The merging of medicine and religion is not new. Here, history is also important, as Josep showed us. We may conclude – in the words of one participant – that we will have to put history at home. The question is how do we view history? As something static or dynamic?

The issues that were discussed are too numerous to speak about in this closing session. We talked about the problematisation of concepts as risk, the fact that healthy people are sometimes transformed into sick people, the political stance of medical anthropology, concepts of the self in relation to agency, gender, auto-ethnography as real anthropology at home, comparison, the importance of narratives, etc. etc. The critical dimension of anthropology was stressed many times. One of the tasks of medical anthropology is to study the links between the different levels: macro, meso and micro. Power is an important concept, although some of us have asked if we should focus only on issues of power and hegemony. However, according to Tullio, we will have to establish a relationship with a powerful other: biomedicine.

In conclusion, what medical anthropology can contribute to cultural anthropology is to ask what the relevance of this sub-discipline in our world is, vis-à-vis other disciplines such as journalism, media and medical history. One important thing is the presentation of ethnographic material, which has remained implicit in this meeting. It became clear that medical anthropology at home may illuminate anthropological theory and practice in several ways:

a. Biomedicine affords a subject for the study of power.

b. Medical anthropology at home contributes to the ethnography of our own societies, its symbolic systems, its practices and beliefs.

c. Medical anthropology makes it possible to reflect on anthropological practices.

d. Medical anthropology shows the human condition and arenas in which we can explore fundamental questions.

e. Medical anthropology challenges methodological issues because the silent point of reference – biomedicine – is made explicit.

f. Medical anthropology has to discuss a possible breakdown in the distinction between applied and non-applied science.

g. Medical anthropology is critical.

I am convinced that I have not covered the whole richness of the discussions of the second meeting. Many of the themes, issues, problems and items that we have discussed are not entirely new, but they are still current and important. I apologise if I have left out important remarks, comments and contributions. However, we will do justice to the richness of the arguments and the ethnographic work of medical anthropology by publishing the contributions.

I must say that having a central theme, or in this case two themes, is a good thing. It has forced me and many others, I think, to approach the material from a different angle.

I would like to end these closing remarks with something that is as colourful as the contributions of this meeting, but which is not meant to contribute to theoretical and methodological debates. I believe that I speak on behalf of all of you when I say that we have to thank Josep and his staff for the organisation of this meeting. I believe that we can say that there is still a lot to think about and a lot to work on, but that we owe our inspiration to go on to Josep and his Spanish colleagues.