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Epilogue

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One of the aims of the Second Conference on *Medical Anthropology at Home*, held in Tarragona (Spain) in April 2001, was to discuss the contribution Medical Anthropology has made to Anthropology. Both European and non-European medical anthropologists who work in the same cultural environment attended the conference. This theme was almost compulsory for us and we were unaware at the time that our conference shared its name with one held at the Annual Meeting of the American Anthropological Association in the year 2000. Some contributions to this conference have been published recently (Guarnaccia, 2001). I find it strange that North American and European anthropologists share this interest now, a quarter of a century after the institutionalisation process making medical anthropology a specific field of study and its development as a profession. It is now the first, quantitatively speaking, of all the leading anthropologies. Why is there such an explicit need for medical anthropology to justify itself in front of the mother discipline? When the contributions of one of the disciplines are laid on the table, its relative merits are discussed and justification is sought. Just seven years ago, Kleinman (1995) and Hahn (1995) both attempted in their own way to justify themselves before the anthropological profession.

Forty years ago, when modern medical anthropology was founded, the states of the art did not seek so directly to do this. William Caudill (1957), for example, directly proposed a *clinical anthropology* that focused on the study and evaluation of the changes that were taking place in the American health sector after the Second World War. It was a sort of invitation to anthropologists to do research in the field of health and a rationalisation of why they should do so. Benjamin Paul (1955) compiled a now classic

volume that combined the, shall we say, «classic» stage of Anthropology (ethnomedicine), with studies of «complex societies» and evaluation studies with implications for action.

The well-known article by Scotch (1963), in which this field was first termed «medical anthropology» seemed to be limited to contributions from anthropologists in non-western countries. These were more from the ethnomedical perspective than from the perspective of Paul's *Health, Culture and Community* (1955) or the state of the art perspective of Polgar's *Health and Human Behavior: Areas of Interest Common to the Social and Medical Sciences* (1962). These last two concentrated much more on a bibliography without borders, open to every health phenomenon.

The states of the question much discussed in Anglo-Saxon medical anthropology at that time ignored the little European experience in this area. They included experiences from Africa, Latin America and Asia, but not from Europe. Although many North American anthropologists found their way to southern Europe, the fundamental contributions of the group led by Ernesto di Martino were ignored, while significant studies such as those by Favret-Saada and Françoise Loux found it difficult to cross the Atlantic.

This does not surprise me in the slightest. The construction of the Welfare State in Europe during what the French call the «*trente glorieuses*» (1945-1975) required a revolution in the organisation and structure of the health care facilities of all European countries. So the research and debate about, were juridicopolitical in the hands of economists, quantitative sociologists and epidemiologists, and the discussion and evaluation was essentially quantitative. At the same time, and by the same principle, the Welfare State, which is a product of an individualistic conception of citizens' rights, favours clinical case-based research – a qualitative technique – more than preventive policies based on overall qualitative variables. For this reason, clinical doctors, psychiatrists and psychologists have dominated qualitative research in the European health sector. On this stage, the Welfare State was born from a political ideology based on a materialistic conception of human inequalities, not from a relativist-based idea of cultural diversity. In Europe, therefore, the health sector is not very interested in social or cultural variables. This is why medicine's anthropological road is long and dismal [(1)].

It should be of no surprise that, at the dawn of medical anthropology in Europe, the stage should be *at home* and that it should demand an explicit or implicit debate of medicalisation. Until recently the circumstances in Europe did not allow a domestic space for research in social sciences to

develop, except in quantitative sociology or in a few historiographical trends. There are a huge number of publications in Europe, however they aimed to construct ethnographical referents have remained within the strict limits of the medical folklore practised by folklorists, ethnographies written by doctors themselves (confined as they are within the matrices of *Airs*, *Waters* and *Places*), or the thousands of generally forgotten reports with which doctors and psychiatrists. All that is disconnected from the development of anthropological or social theory attempted to evaluate the social problems that are associated with inequalities of health.

In my opinion, this is why an applied field of work for anthropology was late in developing and subsequently why medical anthropology, except in Italy, was also late in developing. So, although working «at home» is, I dare say, predominant in international medical anthropology today, in Europe it is still relatively «new» in social anthropology, where it must justify itself both as an area of research and reflection and as the logical labour market for future generations of professionals. Compared with the large numbers of North American medical anthropologists, we Europeans are in the more modest business of trying to make our colleagues appreciate an emerging reality that in Europe, and indeed in any country with a well-constructed welfare state system, presents a research context that is totally unlike that of traditional research in international health or the studies of ethnomedicine and ethnopsychiatry.

To be fair, the call for anthropology «at home» following the two conferences of the group (the first in Zeist in 1998 and the second in Tarragona in 2001) also responds to the clear maturity of this anthropological field and its increasing presence on both the «national» and «European» stages. This maturity, however, has not been reached without two forms of resistance having to be overcome. One of these comes from a sector of academic anthropology that had legitimately built its identity on anthropology «abroad» and feared –as it still does– the break-up of anthropology «at home» within a magma comprising sociology, history, *science and cultural studies* and feminist and disability studies. Too often I feel that «our» subjects continue to surprise more than a few of our colleagues and that our usual interlocutors are no longer anthropologists, but sociologists, health professionals, legal professionals or politologists. For these academics, our profile is clearly anthropological, but to our colleagues it sometimes appears as if we have «strayed».

Second, In Europe, however, claiming a space for the anthropologist in the field of health is still something of an apostolic mission. The vocation of the second volume from this conference (Comelles, Van Dongen, 2002),

therefore, which is much more theme-oriented, is to open up to the health sector. It is true that the health sectors in Europe are putting up resistance – not professions such as nursing or social work, which are used to including anthropology as part of their training, but biomedicine, which is sometimes more biomedical and monolithic than its American counterpart. A North American colleague once criticised my over-emphasis on the power of doctors. I replied that in the United States doctors could, by the judicialisation of medical practice, earn money in exchange for giving up power. European doctors, the majority of whom are on a salary, have been left with only a little «slightly sacred» power. It is resistance to losing this power of control over the profession as a whole that makes it difficult in Europe to create an atmosphere of evaluation or qualitative study. For years they monopolised it. Today they have given some of it to quantitative methodologists, clinical epidemiologists, pharmacologists and economists, but resist qualitative evaluation because, as clinicists, they are quantitativists themselves. This is why, in such a corporativist academic and professional model as the European one, the limited resources spent on programmes in which the qualitative methodologies and social or cultural variables have a role are less likely to be derived from transdisciplinary research.

Eppur si muove. In Europe in the 1990s there was an increasingly clear awareness, and in the academic and scientific world I would say that there was a strong awareness, of the need to increase our communication links, which until then had been locked away in the frontiers of states and the frontiers of disciplines. The effect of globalisation is not only the destruction of the old system of frontiers that had existed since 1919, but also the destruction of the mental frontiers of the tree of science. After two centuries of centrifuges, complex disciplinary identities and the imperious need for multidisciplinary to understand any cultural process today seem inevitable. But this is something new in Europe too. The many relationships that have developed in the last ten years have shown that we could discover more about each other than we do from tourism and that we could understand each other from an equal relationship, without the need to impose any form of domination. We have also discovered that the problems that in part drive us are not unlike those that may emerge from the dominant, i.e. North American, and medical anthropology. Actually, though, they are different because the context of health in Europe and in some non-European countries is strongly determined by the Welfare State. This not only supposes that there are different ways of understanding and managing health but that there is an *embodiment* by the population of what Welfare State facilities means. This is a fundamental point: although the

Welfare State obeys the development of a certain political culture (with different periods and rhythms), around the world it is extremely diverse and, on some stages, models drawn up in contexts other than this must be completely re-thought.

There is, however, a common space that makes it possible to understand the whole and, although we may not like it, it is the first stage of globalisation i.e. the process of medicalisation. The point is that medicalisation is one of the constituent features of our political culture and is itself *embodied* in us. So when I read the contributions of this book, I find that what constructs the object of study in this particular field of anthropology, in the margin of the margin, is not health and illness, or medical systems or biomedicine, but rather the process of medicalisation and the hegemony of biomedicine linked to the dominance of politics, society, economics and culture. At the side, a fascinating, enormous diversity of subaltern cultures and practices, rich in solutions and in imagination, but very bad known Today nothing is detached from this phenomenon. Nothing escapes from it. The problem is that what we call medicalisation is not a *fact* but a *process*, and as such it affects us all our lives. It is our experience in this respect that contributes to its reformulation, criticism, or acceptance without resistance.

I feel it is important to speak in these terms because biomedics, or biomedical or health researchers, can never have the detachment they need to be able to distance themselves from their own internal experience. They, like us, are involved in the same process, but from the inside it is much more difficult to understand the impact the process has on oneself. It is therefore difficult for the professional to understand the logic of those on the outside. Anthropological distance is crucial, therefore, because it allows one, from the outside, to theorise and conceptualise the context and establish regulations on research that contextualise the information correctly. That the anthropologist is on the outside does not mean, however, that he or she is outside the health sector's compromise to society. This is sometimes forgotten. Even the most theoretical contribution of the most theoretical medical anthropology can influence the health sector, whether in the short term or in the long term. A medical anthropology exclusively for anthropologists is unthinkable. So is an anthropology at the service of biomedicine. Neither one nor the other. In the health sector, cholera, yellow fever, dengue fever and senile dementia are not metaphors. And pain is not a word to help speakers lecture at an academic conference. The distinction between a Social Science *in* Medicine and a Social Science *of* Medicine can no longer be sustained. Ethnographical experience in the health sector always involves assuming one has the ability to intervene.

This book is therefore a collection of the «most political» contributions or issues. This does not mean that the other contributions were not political. They are the «most political» in the most superficial sense of the word. Basically, this book champions our right to space in the fields of medicine and anthropology. It opens the door to political debate on cultural diversity, searches for answers to the «why» questions of biopolitics by dealing with the body, and discusses ethical problems. The contributions attempt to determine the social uses of Anthropology. It reflects on the fact that in Europe anthropology cannot limit itself to being the defender of marginal or minority groups. It must also tackle the ideological, cultural and social problems of countries that have, and *have embodied*, the Welfare State. It is absurd to believe that to do this is to investigate some sort of paradise. Clearly, the indicators of quality of life in Europe are, along with those of the Japanese, the best in the world. But the reality that sustains them is fragile: it is a delicate freshly grown flower that some would already like to crush. Though the situation is generally enviable, qualitativists find cause for concern in the microsocial and microcultural that stops them from looking away. For this reason the book ends with discussions and debates on ethics, concepts and the Welfare State. If the European identity is the link between extreme cultural diversity and a principle of citizenship whose objective is to iron out inequalities, I believe that we, as medical anthropologists, will play a crucial role in the future.

Notes

(1) See Comelles and Martínez (1993) and Comelles and Orobitg (2000); also Diasio (1999), who compared the cases of Italy, France and the Netherlands.

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