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Reflections and future paths

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> «Anthropology would make a difference because relationships make a difference» (Carrithers 1992)
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> «Some believe that ethnologists, homeward bound now, might as well surrender themselves to the sirens of disenchantment. But the ethnologist never comes home» (Augé 1999)

This volume offers a bouquet of anthropological studies about suffering and illness. These contributions show that medical anthropology is at home domestically, and that anthropologists have been able to maintain their wonder about the cultural richness 'right under their noses'. We must realise that it is only several decades ago that medical anthropologists began to take an interest in their own societies and cultures (though there are of course exceptions, like the Italian anthropologist De Martino, who have always worked 'at home'). Given the short time that medical anthropology has studied what is under our noses, the work that the papers in this volume do to show that anthropology is a discipline which transforms the taken-for-granted realities at home into questionable cultural processes is all the more impressive. Again and again we see that anthropology's methodology and theory can be applied everywhere. The themes of the volume have 'produced enduring answers', which – in my opinion – can be seen «as ways of formulating questions» (Frankenberg 1995). New themes and issues have emerged from this volume. Each part, in turn, invites us to rethink our methodologies and approaches and challenges us to question what we have found.

The papers have made clear that narratives and narration are central focuses in anthropology. With stories, people try to shape their pasts and futures. «To tell a story is to take arms against the threat of time ... the telling of a story preserves the teller from oblivion», Portelli wrote in 1981. Anthropologists agree that a story, a narrative, is more than a recital of events. A narrative organises experience, gives coherence to someone's life, reveals some of the elements of one's identity, and makes sense of

one's life and many other things. Through stories, culture "speaks"; culture is reproduced and (re)created by the teller and the listener. Narratives and stories have charm. They move, evoke worlds of the past, they reveal dreams and fantasies, and they are sometimes about the 'poetics of suffering'. Of course, words are indispensable in anthropological work but, sometimes, I wonder if anthropologists have focused too much on words. Talk is just one practice among many others. It is interesting that anthropology's recent interest in the 'body' and embodiment (Van Dongen and Comelles [i.p.]) has hardly tackled the critical methodological problem of representation (through words) and 'being-in-the-world' (through sensing). The exploration of «experience in all its sensual modalities» (Good 1994: 123) still largely relies on narrativisation of the worlds of our informants, through which they represent their bodies and the world of 'the flesh'. Many would argue that one couldn't really study experience because experience is always mediated by language. Yet I would like to argue that a methodological standpoint capturing the immediacy of bodily experience – 'radical empiricism' as Stoller in 1989 termed it – enables the development of a 'sense-itive' anthropology. The focus on narrativisation leads me to the question: What exactly has happened to 'participant observation' and ethnographic writing in Medical Anthropology at Home? It seems that, because it is sometimes impossible to do long-term research in one's own society [(1)] and because it is hard to find time to 'hang around', we might have lost our 'taste of things'. I am not saying that medical anthropology at home has become 'scientistic' or has narrowed itself to the 'intelligible', the 'intellectual' or the 'cognitive'. Some of the papers in this volume are 'leaning against the wind' and show how impressive the knowledge obtained by this 'sensing' (and moving) can be. However, in future research, these other dimensions of ethnography and anthropological fieldwork may be more extensively discussed in the network of medical anthropologists who work at home, so that the 'charms' of anthropology at home can be fully revealed.

In medical anthropology, there is also a tendency to focus on biomedicine. Of course, biomedical thinking and practices merge deeply into people's lives and into their illness explanations. The many existing and excellent studies within medical anthropological research at home may have suggested that biomedicine is 'all that matters' for people. In this volume, it becomes clear that biomedicine is but one of the paths people follows when they suffer. The papers show for example, how religion and suffering are closely linked. Religion is important to curing, but also has a broader scope; saints are "used" as social instruments of healing. Collective mental and

social structures of long duration (Braudel) play a role in issues of health and suffering; everyday life theories and history are brought to life by ethnographic research. There seems to be a link between these studies and the geographical area of "home". Why is it that folk-life studies or studies of 'collective and mental structures of long duration' are an important part of medical anthropology at home in Scandinavian and Mediterranean countries and do not have (or rarely have) such a position in other parts of Europe? (2) Jackson (1987) has already taken up this issue for anthropology at home in general. He argues that the reason is that these studies express a strong concern with separate identities. In the same volume, Ardener (1987) discusses 'remoteness' in relation to the interest in 'folk-life'. Remote areas, Ardener argues, are event-rich or event-dense, which is the result of «the weakening of [...] the maintenance of a self-generated set of overriding social definitions [...] thus rendering possible the 'disenchantment' of individuals ...» (p. 59-50). Then, how might anthropology study 'folk-life' in relation to illness? Historically, folk-life studies were also part of ethnology, because they could help ethnologists to understand the use of objects and to trace the diffusion of tales and myths (Jackson 1987: 4). Also the use of concepts like magic and miracles, liturgies and rituals provide us with a lively understanding of how the different 'compartments' of social life are interwoven and how people act upon suffering. The distinction between 'enchanted' and 'disenchanted' worlds can be misleading, as Reynolds Whyte (1997) correctly points out. Illnesses are also associated with uncertainties of human relationships. Biomedicine has so far failed to live up its promise of miraculous cures and magic bullets. People turn towards other possibilities. In this sense, medical anthropology could study 'folk-life'. It would help medical anthropology to trace 'deep' health beliefs and behaviours that are grounded in history and still echo in people's health behaviour. On the other hand, to find new ones that come with the many who have entered the different regions of 'home'. For example, within Europe complementary medicine is the subject of policies and regulations in many countries. It is often overviewed that 'complementary medicine' contains many elements of historical sorts of health practices from home and elsewhere, and that it is firmly rooted in the history of cultures. Historical-cultural health practices and beliefs are also still alive in biomedical practices. The consequence is that biomedicine has a non-universal status. Different 'biomedicine's' exist. They are grounded in beliefs about social relationships, the body, religion and worldviews. Medical anthropology would allow the 'differences within' the homes to be viewed (Moore 1994), but the papers in this volume also offer possibilities for explicit comparison between the different homes. This issue may be taken up in the future

in medical anthropology at home, so that the anthropological science can bring about «the essential sameness of the human being as a social being» (Fainzang 2000) and the essential processes and elements that underlie illness behaviour at home and elsewhere.

The relationship between medicine (and other disciplines) and medical anthropology is still opaque. Anthropologists often have to say how the understanding and knowledge could be applied or is "of use". There are many answers to give and even more questions to ask, but the papers in this volume show that biomedical therapies reach far beyond the illness. They are also 'tools' to shape human relationships. Medical anthropology shows that biomedicine is not a 'cool-hearted' way of healing. It is soaked with culture and therefore human. Besides, anthropological knowledge may empower people and even offers the natives ethnographic understanding to revitalise practices and discourses of old structures and healing activities in the local politics of culture.

Ethnographic writing is much criticised – by anthropology itself and by others – but it will be precisely ethnographic writing that will raise new questions for further investigation.

Notes

(1) I will not discuss the reasons and causes of this process. See Clifford and Marcus 1986; Jackson 1987; Stoller 1989.

(2) Except Germany and those regions that have great interest in folk-life studies (Celts, Bretons, Irish, Welsh, etc.).

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