REALDI COLVMBI
CREMONENSIS,
In almo Gymnaſio Romano
Anatomici celeberrimi,
DE RE ANATOMICA
LIBRI XV.

AM *Rivista della Società italiana di antropologia medica*

Direttore Tullio Seppilli (*presidente SIAM*, Università di Perugia)

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AM

RIVISTA DELLA SOCIETÀ ITALIANA DI ANTROPOLOGIA MEDICA

Medical Anthropology and Anthropology

Contributions of Medical Anthropology at Home to anthropological theories and health debates

edited by
ELS VAN DONGEN AND JOSEP MARIA COMELLES

11-12

ottobre 2001

Fondazione Angelo Celli per una Cultura della Salute – Perugia

ARGO

Frontespizio del volume *De re anatomica libri XV* di Realdo Colombo (Cremona, tra il 1510 e il 1520 - Roma, circa 1559), stampato a Venezia nel 1559.

Frontispiece of the book *De re anatomica libri XV* by Realdo Colombo (Cremona, between 1510 and 1520 - Roma, ca. 1559), printed in Venice 1559.

Il logo della Società italiana di antropologia medica, qui riprodotto, costituisce la elaborazione grafica di un ideogramma cinese molto antico che ha via via assunto il significato di “*longevità*”, risultato di una vita consapevolmente condotta lungo una ininterrotta via di armonia e di equilibrio.

The logo of the Società italiana di antropologia medica here reprinted is the graphic elaboration of an ancient Chinese ideogram which progressively assumed the meaning of *“longevity”*, the outcome of a life consciously lived following a never-ending path of harmony and balance.

AM
Rivista della Società italiana di antropologia medica

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La Direzione e il Comitato di redazione di *AM* hanno accettato la proposta fatta dai Curatori degli atti della Seconda sessione di *Medical Anthropology at Home* di pubblicare su questa rivista il risultato del loro lavoro.

Medical Anthropology at Home è una rete, prevalentemente europea, di antropologi medici che svolgono larga parte delle loro ricerche nel proprio paese. Una attività di ricerca dunque, condotta nel medesimo contesto territoriale in cui il ricercatore vive la sua "normale" vicenda personale e professionale: una condizione, perciò, in cui sia il ricercatore sia coloro sui quali egli indaga sono radicati in un unico e medesimo contesto sociale, insieme ai problemi da cui la ricerca nasce, ai poteri che la promuovono, alle ricadute concrete che ne risultano, alle attese che essa suscita e a una conseguente responsabilizzazione del ricercatore, che giorno dopo giorno gioca nel suo stesso ambiente la propria credibilità. Una condizione ben diversa, occorre dirlo, dalle pratiche di ricerca *abroad*, lontane cioè dalla vita quotidiana del ricercatore, in cui il "suo ritorno a casa" rompe più o meno definitivamente ogni rapporto con coloro cui l'indagine è stata rivolta.

La rete *Medical Anthropology at Home* ha preso avvio a Zeist, in Olanda, nei giorni 16-18 aprile del 1998, in una prima sessione organizzata dalla Unità di antropologia medica della Universiteit van Amsterdam. In merito se ne può vedere un lungo resoconto di Ivo Quaranta su questa stessa rivista, alle pp. 300-308 del numero 5-6, ottobre 1998.

La Seconda sessione di *Medical Anthropology at Home* ha avuto luogo nei giorni 19-21 aprile del 2001 a Tarragona, in Catalogna, Spagna, organizzata dal Departament d'antropologia social i filosofia della Universitat Rovira i Virgili. In questa Seconda sessione, in riconoscimento del contributo che l'Italia ha dato sin dagli anni '50 ai moderni sviluppi della antropologia medica *at home*, la città di Perugia è stata indicata come sede per la Terza sessione della rete, nel 2003.

Peraltro, va sottolineato che a differenza di altri paesi occidentali nei quali le ricerche che oggi definiremmo di antropologia medica hanno avuto un esordio essenzialmente "coloniale", rivolto dunque a sistemi di cura esotici, in Italia gli studi di antropologia medica si sono sostanzialmente sviluppati sin dal secolo XIX e per tutto il '900 all'interno del paese: l'antropologia medica italiana, con la sua precoce articolata ed estesa tradizione di studi, è sempre stata, appunto, in larghissima misura una antropologia medica *at home*.

I Curatori degli atti della sessione di Tarragona, Josep María Comelles e Els van Dongen, hanno attentamente raccolto tutte le relazioni presentate in quella sessione, le hanno riorganizzate secondo una coerente articolazione tematica e ne hanno ricavato due ampi volumi, ciascuno dei quali munito di un titolo particolare che in qualche misura rappresenta una possibile sintesi dei temi che vi sono trattati: *Medical Anthropology and Anthropology. Contributions of Medical Anthropology to the theory of Health Studies* e *Themes in Medical Anthropology. Medical Anthropology at Home contributes to Health Studies*. I contributi vengono tutti presentati in inglese, la lingua ufficiale in cui si sono svolti i lavori a Tarragona, e i relativi testi sono stati sottoposti, prima della loro pubblicazione, a una revisione condotta sotto la responsabilità dei Curatori da una équipe di esperti di madrelingua. Non è di scarso significato per gli sviluppi della rete, tuttavia, che proprio a Tarragona, su proposta della delegazione italiana – a garanzia di un maggiore equilibrio fra le grandi aree linguistico-culturali europee e al fine di evidenziare la ricchezza e le numerose specificità di quella che potremmo definire una antropologia medica "latina", dall'Italia alla Spagna, dal Messico al Brasile – la rete ha riconosciuto da allora in avanti come propria lingua ufficiale, accanto all'inglese anche lo spagnolo. E così sarà già dalla sessione di Perugia.

Il vastissimo materiale costituito dai due volumi messi a punto dai Curatori ha reso necessario che anche *AM* dedicasse due dei propri volumi alla pubblicazione degli esiti della sessione di Tarragona: così i volumi di *AM* 11-12 (2001) e 13-14 (2002) escono assieme e verranno presentati a Perugia nel corso della Terza sessione della rete.

Dobbiamo agli abituali lettori di *AM* almeno due altre precisazioni. Conformemente alla prassi della rivista, tutti i contributi dovrebbero recare il relativo riassunto (italiano, francese, spagnolo, inglese) e una scheda sull'Autore. Per ragioni tecniche del lavoro di curatela, ciò è risultato impossibile e ci si è dovuti limitare alle qualifiche degli Autori indicate accanto al loro nome sotto il titolo dei contributi. Parimenti, le convenzioni per i riferimenti bibliografici, definite "ab origine" dagli Organizzatori della Seconda sessione e ribadite poi dai Curatori del volume non prevedono alcuni dati da noi normalmente richiesti e non corrispondono comunque esattamente a quelle adottate dalla nostra rivista. Ma ovviamente, sarebbe stato pressochè impossibile e illegittimo, dopo la decisione di pubblicare gli atti su *AM*, richiedere a posteriori agli Autori il riesame dei loro contributi per un adeguamento a convenzioni inizialmente non prescritte.

Questa pubblicazione è stata resa possibile dai contributi finanziari della Universiteit van Amsterdam, della Universitat Rovira i Virgili (Tarragona), della Fondazione Angelo Celli per una Cultura della Salute (Perugia) e della Società Italiana di Antropologia Medica. A queste istituzioni, oltreché naturalmente ai Curatori e a tutti gli Autori che hanno partecipato a questa impresa, va il nostro ringraziamento.

Tullio Seppilli, direttore di *AM*

A los lectores

La Dirección y el Comité de redacción de *AM* han aceptado la propuesta de los Compiladores de las actas de la Segunda sesión de *Medical Anthropology at Home* de publicar en esta revista el resultado de su trabajo.

Medical Anthropology at Home es una red, por lo general europea, de antropólogos médicos que desarrollan gran parte de sus investigaciones en su propio país. Una actividad de investigación conducida en el mismo contexto territorial en el cual el investigador vive su "normal" situación personal y profesional. Sea el investigador que quienes son objeto de su investigación se encuentran en un mismo y único contexto social, junto a los problemas de los cuales la investigación nace, a los poderes que la promueven, a las recaídas que de estos resultan, a las expectativas que suscita y a una consecuente responsabilización del investigador, que se juega día tras día su propia credibilidad dentro su mismo ambiente. Una condición bien diferente a las prácticas de investigación *abroad*, o sea lejos de la vida cotidiana del investigador y que, además, rompe en su "regreso a casa" más o menos definitivamente toda relación con quienes fue hecha dicha investigación.

La red *Medical Anthropology at Home* empezó en Zeist (Holanda) los días 16-18 de abril 1998, en una Primera sesión organizada por la Unidad de antropología médica de la Universiteit van Amsterdam. Se puede leer una larga revisión del encuentro por parte de Ivo Quaranta en esta misma revista, pp. 300-308 del numero 5-6, octubre 1998.

La Segunda sesión de *Medical Anthropology at Home* se llevó a cabo del 19 al 21 de abril 2001 en Tarragona, Cataluña (España), esta vez organizada por el Departament d'antropologia social i filosofia de la Universitat Rovira i Virgili. Durante esta Segunda sesión, en reconocimiento a la contribución que Italia ha dado desde los años '50 al desarrollo de la antropología médica *at home*, la ciudad de Perugia fue indicada como sede para la Tercera sesión de la red.

Hay que subrayar, por otra parte, que a diferencia de otros países occidentales en los cuales las investigaciones que hoy definiremos de antropología médica tuvieron un exordio esencialmente "colonial", dirigido a sistemas de cura exóticos, en Italia los estudios de antropología médica se desarrollaron sustancialmente desde el siglo XIX y durante todo el siglo XX al interno del país: la antropología médica italiana, con su articulada y extensa precoz tradición de estudios fue siempre en amplia medida una antropología médica *at home*.

Los Compiladores de las actas de la sesión de Tarragona, Josep María Comelles y Els van Dongen, reunieron atentamente todas las ponencias presentadas en dicha sesión, las reorganizaron según una coherente articulación temática y obtuvieron dos amplios volúmenes, cada uno con un título particular que, hasta cierto punto, representa una posible síntesis de los temas que fueron tratados: *Medical Anthropology and Anthropology. Contributions of Medical Anthropology to the theory of Health Studies* e *Themes in Medical Anthropology. Medical Anthropology at Home contributes to Health Studies*. Las ponencias son presentadas en inglés, el idioma oficial de la sesión de Tarragona, y sus relativos textos estuvieron sujetos, antes de su publicación, a una revisión por parte de un equipo de expertos de lengua materna bajo la responsabilidad de los Compiladores de las actas. No es de poca importancia para el desarrollo de la red que a Tarragona, bajo propuesta de la delegación italiana – para garantizar un mayor equilibrio entre las grandes áreas lingüístico-culturales europeas y para evidenciar la riqueza y los numerosos distintivos de una antropología médica "latina": de Italia a España, de México a Brasil – la red reconoció al español, desde ese entonces, como idioma oficial junto al inglés. Y así será en la sesión de Perugia.

El vastísimo material incluido en los dos volúmenes antes mencionados ha hecho necesario que *AM* también dedicase dos volúmenes a la publicación de los resultados de la sesión de Tarragona: así, los volúmenes de *AM* 11-12 (2001) y 13-14 (2002) son publicados al mismo tiempo y se presentarán en Perugia durante la Tercera sesión de la red.

Debemos a los lectores habituales de *AM* al menos otras dos precisiones. Conforme a la praxis de la revista, todas los textos deberían tener su relativo resumen (en italiano, francés, español, inglés) y una ficha sobre el Autor. Por razones técnicas del trabajo de compilación nos fue imposible inserirlos en la publicación y nos tuvimos que limitar a indicar las calificaciones de los Autores indicadas junto al nombre, abajo del título del texto. En cuanto a las referencias bibliográficas, definidas "ab origine" por los Organizadores de la Segunda sesión y reafirmadas por los Compiladores de las actas del volumen, no prevén algunos datos que normalmente solicitamos y no corresponden exactamente a las normas utilizadas por nuestra revista. Obviamente hubiera sido imposible e ilegítimo, después de la decisión de publicar las actas en *AM*, pedir "a posteriori" a los Autores la reexaminación de sus textos para una adaptación a convenciones inicialmente no prescritas.

Esta publicación fue posible gracias a la contribución de la Universiteit van Amsterdam, de la Universitat Rovira i Virgili (Tarragona), de la Fondazione Angelo Celli per una Cultura della Salute (Perugia) y de la Società Italiana di Antropologia Medica. Agradecemos a estos institutos, a los Compiladores y a todos los Autores que han participado a esta empresa.

Tullio Seppilli, director de *AM*
[traducido del italiano por Corinne Meléndez]

To our readers

The Editor and Editorial Committee of *AM* are happy to accept the proposal of the Editors of the proceedings of the Second Session of *Medical Anthropology at Home* to publish the proceedings in our review.

Medical Anthropology at Home is a mainly European network of medical anthropologists who carry out a great part of their research in their own country. This is, then, research that is carried out in the same territorial context as the researcher lives his/her own normal personal and professional life. It is thus a condition in which both the researcher and those being researched find themselves within one and the same social context, together with the problems that give birth to the research, with the powers that promote the research, with the concrete spin-offs that result from it, with the expectations that it gives rise to and with the consequent taking on of responsibility by the researcher who, in this self-same environment, has day-by-day to put his/her credibility on the line. One must therefore say that this is a very different condition from research practice *abroad*, in other words far from the daily life of the researcher, for whom the "return home" represents a more or less final break in relationships with those who were object of the study.

The *Medical Anthropology at Home* network began life in Zeist (Holland) on 16-18 April 1998 at the first conference organized by the Medical Anthropology Unit of the Universiteit van Amsterdam, on the subject of which readers of *AM* may find an summary article by Ivo Quaranta on pp. 300-308 of the double number 5-6 (October 1998).

The second conference of *Medical Anthropology at Home* took place on 19-21 April 2001 at Tarragona in Catalonia (Spain) and was organized by the Department of Social Anthropology and Philosophy of the Universitat Rovira i Virgili (Tarragona). In recognition of the contribution to medical anthropology at home that Italy has made since the 1950s, the second conference chose Perugia as the city for the network's third (2003) conference.

It must moreover be emphasized that, different from other Western countries in which research that we should now define as medical anthropology had an essentially "colonial" beginning, and was therefore focused on exotic medical systems, medical anthropology studies in Italy in substance developed in the nineteenth and throughout the whole of the twentieth century within the country. Italian medical anthropology, with its early articulated and extended tradition of study has always, then, been to a very large extent a medical anthropology "at home".

Josep María Comelles and Els van Dongen, the Editors of the proceedings of the Tarragona conference, have with great care collected together all the contributions there presented, reorganizing them thematically and have thus produced two substantial volumes, each of which bears its own specific title reflecting the contents in summary form. The two volumes are: *Medical Anthropology and Anthropology. Contributions of Medical Anthropology to the Theory of Health Studies* and *Themes in Medical Anthropology. Medical Anthropology at Home Contributes to Health Studies*. The contributions are all in English, the official language of the Tarragona conference, and the corresponding texts have all been revised by a team of mother-tongue experts working under the direction of the Editors of the conference proceedings. It is of no little significance for the development of the network, however, that at Tarragona an Italian proposal was accepted to adopt Spanish as an official language alongside English. This guarantees a better equilibrium among the great cultural-linguistic areas of Europe with the aim of also bringing out the richness and numerous specificities of what might be termed a "Latin" medical anthropology, going from Italy to Spain, Mexico and Brazil. This will take effect as from the conference in Perugia.

The vast material that constitutes the two volumes produced by the conference Editors has made it necessary for *AM* to devote two of its double numbers to publishing the proceedings of the Tarragona conference and thus numbers 11-12 (2001) and 13-14 (2002) of *AM* will come out simultaneously and be presented at Perugia during the third conference of the network.

At least two guidelines must be made clear to readers of *AM*. As is established practice with *AM* all contributions must provide an abstract in Italian, French, Spanish and English, together with note about the Author. For technical reasons this was impossible for the Editors of the Tarragona proceedings who had to be content with more generic information regarding the professional status of the Authors, included under the title of their contribution. Likewise, the bibliographical conventions, defined "on the spot" by the Organizers of the Tarragona conference and confirmed by the conference proceeding Editors, do not include certain data that we normally require and in any case do not conform exactly to those adopted by our review. After the decision to publish the conference proceedings in *AM* it would obviously however have been almost impossible, as well as not being legitimate, to have asked Authors to revise their contributions to bring them into line with conventions that had initially not been laid down.

The current publication has been made possible thanks to the financial contributions of the Universiteit van Amsterdam, of the Universitat Rovira i Virgili (Tarragona), of the Fondazione Angelo Celli per una Cultura della Salute (Perugia) and of the Società Italiana di Antropologia Medica. To these institutions, as well of course as to the Editors and all the Authors who have taken part in this undertaking, go our heartfelt thanks.

Tullio Seppilli, editor of *AM*

[translated from Italian by Derek Boothman]

Presentation

Els van Dongen and Josep Maria Comelles

This is the preface to a collection of ethnographic papers. The volume grew out of the Second Meeting of Medical Anthropology at Home in 2001 in Tarragona, Spain. When the meeting ended, we decided to revise and rewrite our contributions. The lively discussions during the meeting provided all of us with enough comments and new inspiration to do so.

Those who are inclined to the challenge of medical anthropology at home will get a good idea about the work of anthropologists who have studied their own societies for many years. The volume has four main themes – the influence of medical Anthropology within anthropology, the Body, migrations, and commitment, ethics and applied anthropology and within those broad themes the reader will find a wide variety of sub themes. The studies cover a wide geographical area; from the North of Europe to the South and from the West to the East.

The papers generate rich and detailed data about health and illness in a European context. They attempt to show the relevance of medical anthropology in Medicine and Anthropology today, particularly in the context of the welfare state. The papers also show the 'differences within' European diversity and discuss the problems of conceptualisation and comparison.

We are grateful for the many contributions to the conference and – subsequently – to this volume, the first to come out of the meeting. We would also like to thank our Italian colleagues Tullio Seppilli and Pino Schirripa who offered a 'home' for our papers and made this publication possible. We thank the University of Amsterdam, the Medical Anthropology Unit, the University Rovira i Virgili, the Fondazione Angelo Celli in Perugia and the Società italiana di antropologia medica for providing technical and financial support.

AM
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Medical Anthropology "at Home": a conceptual framework and the Italian experience

Tullio Seppilli

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1.1.

As our present Conference in Tarragona shows, the consolidation of the project to hold periodical European encounters of a *medical anthropology* defined as *"at home"* requires in my view further examination of what this formula means.

Everyone knows that the question was discussed during the inaugural day of the preceding Conference, the first one, held in Zeist (The Netherlands) between 16th-18th April 1998 (1): already on that occasion there emerged extremely heterogeneous positions, stemming moreover from heterogeneous reference parameters. So we were uncertain about the suitability of keeping the term in use and, therefore, of conceptually maintaining the opposed coupling that distinguishes between an anthropology "at home" and an anthropology "abroad".

Indeed, the specification "at home" is often used to refer to research carried out in what were once called the metropolitan countries, namely the European or more generally the Western industrialised ones. In those countries anthropology was born and for a long time produced the greater part of ethnologists and social and cultural anthropologists, trained to do in research largely "elsewhere" in "other", different contexts, in areas of the world defined as "exotic", "primitive", "pre-industrial" or, more explicitly, in the "colonial" or (today) the "developing" countries. As against this, anthropology "at home" should be related to the modern industrialised world in which most anthropologists live, i.e. the European or more generally the technologically advanced Western world, in so far as this is a particular research field characterised in effect by several specific common features. This is, therefore, a sphere of anthropological research defined by its specific *object* (a certain type of society) and at least to some extent by a specific territorial reference point. We should talk, in this case, of a *[medical] anthropology concerning European societies* or, in general, *concerning "Western"* or *industrialised* (or *highly technologically advanced*) *societies*.

As we know, this anthropology, both medical and (more generally) socio-cultural too, dedicated as it was to the study of the institutions and cultural dynamics of industrialised societies, developed very little until a few decades ago. The field was partially covered by sociological research, on the implicit assumption that anthropological disciplines, to a certain extent, should concern themselves only with "primitive" or "other" societies and not "Western" ones (2). In an essentially evolutionist perspective, the only aim assigned to anthropology with reference to these "Western" societies was to reconstruct in the "backward folkloric" areas the impoverished survivals of previous more ancient periods of civilisation (3). As a consequence, anthropological attention was focused at the beginning on the knowledge and practices of health/sickness processes almost exclusively on the medical traditions of "primitive" or in any case extra-Western peoples or on folk medicine in the West. Anthropology focused on knowledge and practices that were classified as "superstitions" and that were considered essentially irrational and ineffective. The aim, then, was, certainly, to document but above all to extirpate.

I have already underlined the importance of such limits, that involve at the same time both theory and object of study. «Maybe the most incisive quality jump, the one which radically released and transformed the *whole* disciplinary framework of medical anthropology, and which greatly extended its critical dimension, modifying its relationships with other research fields and changing its operative directions, consisted in the resolute widening of its sphere. When medical anthropology overstepped the study of a mere 'alterity', that is to say the study of European folk medicine or of the non-Western or in any case "heterodox" medical systems, and began increasingly to face up to official Western medicine, studied therefore as just *one* of the many different medical systems that have existed in the world. Western medicine appears as different, because it is based on the scientific method (with all the presuppositions and implications it involves), but it is also, like other systems, a *social institution* and a *power structure* and, in any case, like the other it is a *historically-determined cultural-ideological and organisational apparatus*» (Seppilli, 1996:XIV-XV) (4).

In this perspective, much of the research carried out in recent decades has focused on the anthropological study of biomedicine, that is the medical system we must consider, in the West, hegemonic and therefore "conventional".

However, is it meaningful today for us, as anthropologists, to define "at home" as a research sphere only because it focuses on realities in the West or, in any case, in industrial societies? For we are dealing with realities to which not only Western researchers but those from elsewhere are turning their attention, others who were trained in the West and stayed on to work there, or who were even trained elsewhere, given the well-known growth of training centres and institutions of professional anthropology outside its original boundaries. In such cases what sense would there be in defining this type of enquiry as having been done "at home"? And moreover is it still legitimate and heuristic in the framework of the current processes of planetary interactions, to distinguish anthropological research concerning the West from anthropological research carried out "elsewhere"?

1.2.

I believe, instead, that the indication "at home" should stand for something more profound, namely not simply an *object* but a *condition* which can actually occur not only in Europe or throughout the West (or at least in a specific part of the world or in a particular kind of society), but in any area of the world. In other words the fact *the researcher and the object of research* (and therefore also the problems that give rise to the research and the social consequences that its results pursue) *are rooted in one and the same social context*. Medical anthropology "at home", then, is *research carried out by medical anthropologists in their own country* (and if we want to specifically refer to Europe, as *research carried out by European medical anthropologists in their own country*).

What implications does a definition of this sort have? What does it mean, for an anthropologist, to do research – "fieldwork", in particular – *in their own country [at home]* rather than in a context that is "different" from the daily one in which they live? What is the substantial difference when in the research field the person who investigates and the one investigated are rooted in the same context?

Let us look at some preliminary answers to this question. We are dealing with the question of research carried out by anthropologists in contexts which are at least partly the same as those of their own daily life. Certainly the anthropologist has first acquired a specific professional knowledge/approach. But in any case, life horizons and the cultural system on which points of view, references to the past, hierarchies of values and a wide set of codes and conventions are based, are mostly the same – or quite similar –

for both the poles of the research (the anthropologist and his object of enquiry). As we know, all this allows the researcher to take advantage of a useful general framework of knowledge and of valid readings of the reality being studied but, at the same time, it masks as apparently "obvious" several manifestations and connections that an outsider observer would immediately see as glaring. And in some way, it also involves the researcher, even subjectively, in the network of judgements and tensions that characterises relationships and reciprocal images between the various social groups of his/her own context. What follows, then, for the researcher, is an approach to the reality investigated that is concisely indicated, as we know, by the expression "view from within", in contrast to the "view from afar" of researchers studying cultures and societies in extraneous contexts. To this there must be added that, once the work has come to an end, when the researcher lives in the same place in which he does fieldwork – as usually happens in "at home" researches – a situation of a persistent responsibility emerges. There is a state of "indebtedness" of the researcher, and equally of "expectation", on the part of those who have been the object of the research, who expect some subjective or objective "benefit" (caused or not by the aims of the project or the researcher's intentions). This situation, even beyond its ethical-deontological values, ends up by affecting the processing and diffusion of the data gathered, the operating results that the research eventually gives rise to, and the future possibilities of working "at home" for the researcher himself. All this obviously happens to a very minor extent when the researchers, at the end of his fieldwork "abroad", calmly (cynically?) returns to their own country, where the only concrete "dependence" is the one that may join them to those who "commissioned" the research.

If we want to proceed, we must first of all "dismantle" any possible residual representation of the anthropologist as abstracted from their material and cultural context, from its internal contradictions and from the hegemonic and power processes that take place within this context. We must do so because the anthropologists themselves are "historically/socially determined" persons and cannot but share, at least in part, the conception of the world and a certain hierarchy of values of their society (although in a critical and sometimes opposed form). Also, because they are intellectuals (and more specifically because of their scientific knowledge of social realities), the operational outcomes of their work must to some extent influence the mechanisms and equilibria of the social system of which they are part, or in which they have to operate professionally. With regard to such equilibria, in fact, the social use of the results of the research, and the specific choice of the object of enquiry, are not at all socially "neutral": they largely depend on powers external to the anthropologist's merely "technical" field. This is why in stratified social systems anthropologists have (partly, at least, and more or less consciously) the "organic" function of providing specialist support to the goals and strategies of a specific social class, or in any case of a specific power formation. They furnish cognitive platforms about the social realities in which such a formation intends to operate and help create and increase the awareness and efficacy of its planning strategies and act as a producer of themes and as a cultural mediator within the processes of hegemony and circulation of ideas by which this formation develops its policies of social control (5). However, even in this field, (medical) anthropologists who operate "at home" and those who operate "abroad" seem to work in largely heterogeneous conditions, on which it would be opportune to conduct a more detailed analysis. What are the power formations power involved and in what perspective? What are the effective strategies of intervention in which the research is situated and what are the social groups and, in their different ways, the environmental contexts involved? When and in what professional conditions is research carried out; to what extent and with what methods and mediations are the research results used and, realistically, what are thus their operational applications?

1.3.

Finally, it may be opportune here to refer to an epistemological question which involves the very bases of medical anthropology and which clearly reveals itself when the object of anthropological research is biomedicine, for us Europeans *our* hegemonic medicine.

Certainly biomedicine has to be examined just like any other medical system, as a historical product rooted in a concrete and specific typology of society and culture. Besides, we have already emphasised that biomedicine is *also* a social institution, a power structure, and an ideological-cultural and organisational apparatus. In any case, the paradigm of biomedicine, and the criteria by which it characterises and classifies pathological states, establishes their etiopathogenesis and constructs the very concept of "illness". For medical anthropology all this has the value of one "emic" model on an equal footing with those formulated by other medical systems.

However, at the same time, biomedicine necessarily assumes a particular value for medical anthropology which derives from its own status and is traceable to the common matrix of both their epistemological bases, i.e. in essence to the general bases of “scientific thought”. What I mean here is that the parameters within which biomedicine studies the factors of a certain syndrome, or the action mechanisms of a given drug (or those within which it evaluates the efficacy of that drug) are found on a methodological horizon which is undoubtedly historically determined but which just because of certain of its rules appears to guarantee with a certain degree of approximation the “reliability” of even the conclusions, provisional and partial as may be, that we call “scientific constructs”.

Therefore, apart from the evident heterogeneity of the methodological construction of “natural sciences” on the one hand and “socio-historical sciences” on the other – which it is not the case to go into here – biomedicine and medical anthropology share a common general epistemological basis, which is the “scientific conception of the world”.

In such a framework, if biomedicine often possesses an image of pathology which is limited biologistically just to *disease* – a well known theme, for us – the “cognitive deficit”, which stems from it and which corresponds to an ideological and practical limit on its own scientificity, clearly indicates that the discipline is insufficiently open while, however, not annulling the substantial reliability of its conclusions in the strictly biological field. Further, it is precisely this limit on biomedicine that anthropological research contributes to overcoming by an examination (which equally aims at being scientifical) of *illness* and *sickness*, that is to say the dimensions of pathology constituted by its subjective experience and its socio-cultural correlations.

But here we are dealing with the convergent perspectives, in the light of a more comprehensive (and therefore more “correct”) scientific representation of an object, pathology, to which both approaches contribute to investigating *by intertwining with each other*. Here it should be clear that the tendency of some medical anthropologists to exclude any reference to the biological reality of pathology as something radically extraneous to the anthropological approach, which should just concern itself with pathology in so far as it is *culturally perceived*, is a very serious theoretical and practical mistake. It is akin to asserting that an enquiry into how the various medical systems interpret and deal with, for example, plague epidemics, and with what success, does not need “to know” what the “real” etiopathogenic mechanisms are. That is to say, it does not need “to know” if the “real” correlation is with the wrath of God, or with a biological bacterium-flea-rat sequence, linked to particular events and environmental and socio-historical situations.

Thus, when medical anthropology investigates biomedicine – or, if one likes, the biological paradigm which is its cognitive basis – it studies an "emic" object which, at the same time, represents a very particular "case". In essence, then, the "anthropological knowledge" of the researcher and the "biological knowledge" which constitutes one of the characteristics of the object investigated, both to a large extent participate in one single epistemological basis and, at least in principle, cannot but integrate to constitute an "etic" point of view. In any case the one is existentially doubly bound to the other.

2.1.

Bearing in mind what has been said above, it seems to me of interest to examine the trends of development, the main topics and problems of a "national" medical anthropology such as that of Italy. This is an interest which is not only to be defined in its overall, early and in some ways original contribution to the growth of our studies but above all – and this is what we are most concerned with – in the fact that, different to what has happened elsewhere, Italian medical anthropology has in fact to a large extent been developed "at home", as a long and articulated succession of stages of research carried out by Italian researchers within their own country (6).

In this respect, it would be opportune to define briefly the steps of this research tradition whose historical development, while today definable in terms of "medical anthropology", have each had their own and in some senses autonomous methodological, thematic and operational configurations, and their own specific goals, ideals and socio-political horizons.

(*a*) The first phase, which we could define as pre-anthropological, concerned public investigations from which significant information emerged about orientations and cultural patterns relative to health in particular areas or particular social strata. I am here talking, for example, about the medical-epidemiological surveys, contained in detailed "reports", commissioned by the Health Judiciary of the Florentine State (Grand Duchy of Tuscany) in the early 16th century, and which provided precise detailed information regarding the Tuscan peasants' mistrust of medical examinations by the official physicians.

(*b*) The second phase is due to the Enlightenment and was therefore centred on the so-called "Napoleonic surveys or *statistics*", carried out in the various Italian States under French hegemony or direct French occupation in the first fifteen years of the 19th century. In that period, very long, detailed and systematic surveys were carried out at successive levels, from the municipal to the provincial level to arrive at a synthesis at the State level. These surveys took into account many aspects of the territory and society, conditions of health and so-called "superstitions", with the aim of constructing a useful knowledge base so that well-grounded policies of "good government" could finally be put into effect. Let us give an example. Among the numerous and detailed information requested by the five weighty "questionnaires" carried out in 1811 throughout "napoleonic" Murat's Kingdom of Naples, there figured the gathering of data regarding prejudices against smallpox vaccinations (at that time rampant). The aim of this was to strengthen an intensive mass campaign of health education in the entire territory to support the practice of vaccination.

(*c*) After the fall of the Napoleonic States, Italy underwent a contradictory period of socio-political involution. At the same time there was a slow renewal of a unitary national identity, shown in the intellectual field by the ideals of Romanticism, and then by a progressive philological sensibility which was later to develop during the positivist period. At this time, in the context of a growing interest in "popular literature", the only significant contributions to medical anthropology in this domain are proverbs, the "living voice of the people", which are testimony throughout all parts of Italy, to the strong attention paid by the people to health matters and to their correlations with doctors and medicines, with nutrition, with lifestyle, and with the human life cycle.

(*d*) However in a certain sense the great explosion in research that we would today define as "medical anthropology" took place during the age of positivism, more or less between national Italian unity (1870) and the conclusion of the First World War. This was a time of great productivity in the sphere of human sciences, which may very briefly be characterised by:

(i) a strong secular orientation and open hostility to all "superstitions" and all forms of "obscurantism";

(ii) an intense promotion of science and its role in future human progress, and widespread confidence in the possibilities of a scientific approach to knowledge of man and his vicissitudes. This approach was however closely identified, as a consequence of Darwin's revolutionary discoveries and the progress of medicine, with the paradigm of the biological disciplines, hence a tendency, albeit with different emphases given to it by different authors, to attribute to biological factors a great number of phenomena determined in actual fact by socio-historical conditions ("social Darwinism"), with serious theoretical and political consequences;

(iii) careful attention to the most varied psychic and/or behavioural styles linked in whatever way to what much later would be included under the heterogeneous "deviance" heading (madmen, criminals, bandits, rebels, anarchists, visionaries and religious reformers, and prostitutes etc.). They were carefully analysed but very often interpreted in biological terms such as "atavism" or "degeneration", and in any case grouped together in a limbo of some supposed "social danger" (even compulsorily and therefore blameless), which was defined in opposition to a "normality", which was identified with the operating parameters of a bourgeois society considered to be at the peak of evolutionary process;

(iv) the project to assign anthropologists, as "organic intellectuals" of the new political ruling class of a recently unified Italy, to construct innovative policies of social control and cultural homogenisation and modernisation.

In this perspective, and with the limits generated by the heavy biologistic distortions, the contribution of positivistic anthropologists to stimulating reflection and empirical research in every field of medical anthropology was truly enormous. They compiled the corpus of knowledge and practices of popular medicine in entire regions, areas or particularly interesting zones (7). There was assembled one of the greatest European collections of protective amulets (8). There was produced – despite the biologistic bias we pointed out above – a very wide documentation about madness (9). Hypnosis and suggestion mechanisms, mediumistic states and other "altered" states of consciousness were investigated (10). They raised the question of the real and contradictory social incidence of hospitals (11). In correlation with, among other things, legislative operations that tended to centralise every health care activity under the exclusive aegis of biomedicine, data were gathered from all municipalities in Italy on the possible presence of health workers whom we would define today as "non-conventional", in the context of a wide State-promoted survey of the "health and sanitary conditions in the municipalities of the Realm" (1885).

(*e*) In the following period, under the Fascist regime, anthropological production – for evident reasons of social control – came to an almost total halt, above all as far as fieldwork was concerned. For the same reasons, only two lines of research were encouraged. The first of these was a limited colonial ethnography, which also made some mention of Ethiopian medicine. The second, within the country, was folklore research directed at those aspects of the "popular arts" – above all of rural tradition – whose emphasis was functional to the ideological-cultural policies of the dictatorship (the myths of "rurality" and "race"). Therefore, in this framework there was little room for surveys that today would be considered as belonging to the sphere of medical anthropology "at home". However, we must mention the beginnings of the vast and systematic enquiry into popular beliefs and practices concerning pregnancy, birth and nursing, which Antonio Scarpa conducted throughout the entire country. This made use of the organisational structures of the National Organisation for Maternity and Infancy (*Opera Nazionale Maternità e Infanzia [ONMI]*), created by the Fascist regime itself in support of its intense policy of demographic increase. The investigation began at the end of the thirties but was completed and published only in the post-war period (1952, 1969). Equally, it is important to remember that in the second half of the thirties a scholar coming from the field of the history of medicine, Adalberto Pazzini, put together a wide-ranging collection of information, published and unpublished, regarding popular Italian medicine. After the publication of a first *Saggio di bibliografia di demoiatrica italiana* (1936) he published two wide-ranging volumes, the first during the Fascist period, and the latter after the end of the Second World War (1940 and 1948).

(*f*) With the fall of Fascism and the end of the Second World War, there began to develop a large movement to discover social reality and the great unresolved problems of the country, such as the so-called "Southern Question" and the persistent poverty of large masses of the people. With the help of broad combative political and trade union organizations, an extensive movement in the literary, artistic and cinematic fields, well-known as neorealism, was developed. In this ideologically complex and to some extent contradictory context, the social sciences and anthropology itself were reborn even though, for a number of reasons, the development of anthropology ended up by being quantitatively lesser than, for example, those of sociology and psychology. In this development, various influences came into play. On the one hand there was the influence exerted by United States cultural anthropology; on the other, there was the expansion of a cognitive approach to social reality produced in Italy by a renewed tradition of Marxist studies. And there was also in general an impetuous process of "updating" which came about thanks to scholars and publishers with regard to what, under the dictatorship, had been produced abroad in the whole sphere of human sciences. But undoubtedly, as far as anthropology and medical anthropology are concerned, the work undertaken by Ernesto de Martino (1908-1965) up to the time of his premature death is fundamental. He carried out an extremely extensive theoretical and empirical research work, in which his origins in Benedetto Croce's historicism became increasingly more closely intertwined with methodological and thematic threads borrowed from psychoanalysis, from existentialism and phenomenology and, above all, from a Marxism greatly enriched by the contribution of Gramsci. His vast research activity, that as regards empirical fieldwork was to a large extent carried out in Southern Italy, was characterised by dissolving and overcoming of the old and narrow positivistic folklore methodology in a new perspective of wide historical horizons, with great attention paid to the dynamics of cultural circulation processes, to the network of class, hegemony and power relationships, and to the complex rooting of individual and collective subjectivities within the material conditions of existence in which humans live their life. In this context, the preceding interpretative patterns concerning magic, states of consciousness and popular therapies, were integrated with psychoanalytic and psychiatric contributions above all of a phenomenological nature, without however losing the concreteness of the socio-cultural framework in which the historically analysed objects are produced. Moreover, great attention was paid to the researcher's subjectivity and his reference contexts, to the need for making this explicit, and to its consequence and its constitutive meaning within the relationship between the researcher and whoever was in some way the object of the research itself. An "encounter" that must – on pain of the research losing its heuristic value – set itself the goal of achieving a new common perspective of awareness and deliverance. The main cornerstones of such a complex "methodological revolution" are the reflections regarding the meaning and the psycho-cultural function of the historic institution of magic (*Il mondo magico,* 1948, and *Magia e civiltà*, 1962), the enquiries into funeral laments (*Morte e pianto rituale nel mondo antico: dal lamento pagano al pianto di Maria*, 1958) and on the popular healers of Lucania (*Sud e magia*, 1959), historical-ethnographic research on tarantism (*La terra del rimorso*. *Contributo a una storia religiosa del Sud*, 1961) and the posthumous volume *La fine del mondo. Contributo alla analisi delle apocalissi culturali* (edited by Clara Gallini, 1977), to mention only the main volumes. And we can consider that such cornerstones are also fundamental reference points of current Italian medical anthropology and, so to speak, of its specific "national tradition". And the same book *La terra del rimorso* undoubtedly constitutes the moment of the birth of ethnopsychiatry in Italy, in the same years in which it was born in France and West Africa with the School of Dakar, in Canada and in the United States (12).

(*g*) We have now reached the present day and the new Italian medical anthropology – despite a number of significant researches and interventions in Africa and Latin America – still seems to be mainly concentrated "at home", where it is developing with at an increasing pace, and its empirical research already covers numerous areas of the national territory (13). Today de Martino's theoretical framework is being used, to a greater or lesser extent, by almost all the Italian medical anthropologists and, in the meantime, the methodological processes of many once separate research lines have been integrated (under the now acknowledged definition of "medical anthropology"). Some of the steps in this process may be considered the National Conference on "Health and pathology in the traditional medicine of the popular classes in Italy" ("*Salute e malattia nella medicina tradizionale delle classi popolari italiane*", Pesaro, 15-18 December 1983) and the special issue on *La medicina popolare in Italia*, linked to this Conference, in the journal *La Ricerca Folklorica* (October 1983); the constitution of the Italian Society of Medical Anthropology (*Società italiana di antropologia medica [Siam]*) (Perugia, 18-19 May 1988); the publication of the collective book *Tradizioni popolari italiane. Medicine e magie* (1989); the first number of the periodical *AM. Rivista della Società italiana di antropologia medica* (October 1996); and the publication of the first volume of the "Series on medical anthropology" (*Biblioteca di antropologia medica*) (November 2000). I cannot but underline the impetus given to each of these initiatives by the so-called School of Perugia (14), in which de Martino's heritage may appear today more explicitly, integrated in the course of time by the main contributions elaborated in other countries. Starting from the mid-fifties, this school has confronted almost all the themes of medical anthropology 'at home'. These, certainly, were directed at comprehending contemporary processes, but at the same time were open to the exploration of more ancient historical periods. These fields have ranged from investigations of popular medicine, traditional healers in both the countryside and in the urban contexts, sacral thaumaturgies and therapeutic sanctuaries, to the recent expansion of "non-conventional medicines", from studies on amulets and apotropaic formulas to the cataloguing of ex-votos, from collecting proverbs which codify and transmit "popular knowledge" aimed at guaranteeing well-being and longevity to the critical examination of training courses for "official" medical personnel, from the ways in which health is dealt with within the home (the *autoatención* of Spanish language scholars) to the observation of the ways in which "therapeutic itineraries" are followed and of social relations within the hospital, from research into madness and its cultural perception to the so-called "writings from the asylum" to those about life in total psychiatric institutions and long-stay hospitals, from the analyses of health and medicine patterns propagated by the mass-media to the cognitive contributions aimed at health education, from surveys about professional styles of therapeutic figures and about relations between patients and physicians, as well as between the health institutions and their users, to the evaluation of how the health services respond to the health requests of recent immigrant groups.

It is perhaps to this activity that I owe the invitation from the Scientific Committee of our Second Conference on Medical Anthropology "At Home" to give this introductory lecture. For this invitation I am very grateful and deeply honoured.

Notes

(1) See the extensive and very precise report that Ivo Quaranta wrote about the Conference: "Medical anthropology at home. A European Conference". *AM. Rivista della Società italiana di antropologia medica*, num. 5-6, 1998, p. 300-308.

(2) See Mariza G. S. Peirano ("When anthropology is at home: the different context of a single discipline". *Annual Review of Anthropology*, vol. 27, 1998, p. 105-128) for the complex and tortuous path through which anthropologists, little by little, went beyond the practice of doing research by exclusively focusing on the study of "exotic" populations, starting to direct their attention toward the Western world in which, moreover, anthropology itself developed as a discipline.

(3) Even today the never extinguished *querelle* regarding the field of the anthropological disciplinary corpus, regarding its internal partitions and their respective denominations – differently developed in different countries – is made more complex by the fact that when anthropology pays attention to the extra-European societies, it is generally understood as a "global" discipline, directed therefore to the whole social system examined as a global social setting of civilization – from its economic bases to its social and power structures, and thence to its symbolic and ideological constructs. Whereas when it turns its attention to societies improperly defined as "complexes", such as the European ones, anthropology is generally understood as being directed at focusing uniquely on the set-up of the institutions and cultural processes, and must therefore correlate with and integrate itself into a framework in which other socio-historical disciplines also converge.

(4) Tullio Seppilli, "Presentazione". In Donatella Cozzi and Daniele Nigris. *Gesti di cura: Elementi di metodologia della ricerca etnografica e di analisi socio-antropologica per il nursing*. Paderno Dugnano: Colibrì, 1996, p. XI-XXIII.

(5) About the notion of "organicity" see Antonio Gramsci, *Gli intellettuali e l'organizzazione della cultura.* Torino: Einaudi, 1949, p. 3-7 (Opere di Antonio Gramsci).

(6) The lack of development of an Italian overseas medical anthropology is not surprising. The main reason was the weak and late colonial policies of a State which was unified as a nation only in 1870 and which had only a few, unfortunate colonial vicissitudes.

(7) Antonio De Nino for the Abruzzi and Molise [1891], Zeno Zanetti for Umbria [1892], Giuseppe Pitrè for Sicily [1896]. Also Carolina Coronedi Berti for the territory of Bologna [1877], D. G. Bernoni for the city of Venice [1878], Giovan Battista Bastanzi for the Venetian Alps [1888], Caterina Pigorini Beri for the Apennine part of the Marche [1889 e 1890], Paolo Riccardi for Modena [1890]. For specific topics, see Angelo De Gubernatis, Paolo Mantegazza, Alfredo Niceforo, and many others.

(8) Giuseppe Bellucci [1870 to 1920].

(9) Cesare Lombroso, Enrico Morselli.

[10] Giulio Belfiore, Leonardo Bianchi, Cesare Lombroso, Enrico Morselli, Salvatore Ottolenghi, Pasquale Rossi, Giuseppe Seppilli, Scipio Sighele, etc.

[11] G. Vadalà-Papale [*Il darwinismo e gli ospedali*, 1884].

[12] Within this Italian ethnopsychiatry "at home", under de Martino's influence, research was carried out by numerous students: by anthropologists such as Vittorio Lanternari, Alfonso M. Di Nola, Mariella Pandolfi and Donatella Cozzi and by psychiatrists such as Giovanni Jervis, Michele Risso, Piero Coppo, Sergio Mellina, Roberto Beneduce, Giuseppe Cardamone, Salvatore Inglese and Virginia De Micco.

[13] Notwithstanding the heterogeneous nature and the different research directions, which cannot possibly represent in any way a large census of Italian medical anthropological production, we may cite Clara Gallini, Luisa Orrù and Nando Cossu for Sardinia, Elsa Guggino for Sicily, Luigi M. Lombardi Satriani for Calabria, Giovanni Bronzini, Miriam Castiglione and Annamaria Rivera for Puglia, Alfonso M. Di Nola and Emiliano Giancristofaro for Abruzzo, Mariella Pandolfi and Italo Signorini for the Campanian Sannio, Paolo Apolito and Gianfranca Ranisio for Campania, Gioia Di Cristofaro Longo for Lazio, Fabio Dei for Tuscany, Giancorrado Barozzi and Roberto Roda for Emilia-Romagna, Gian Luigi Bravo and Piercarlo Grimaldi for North-Western Italy, Glauco Sanga and Italo Sordi for Lombardy, Dino Coltro and Daniela Perco for the Veneto, Emanuela Renzetti for Trentino - Alto Adige, Gian Paolo Gri and Roberto Lionetti for Friuli - Venezia Giulia.

[14] I may be said to have set up this "school" shortly after beginning my academic work when, on coming to Perugia, I was able to establish in the local university the Institute of ethnology and cultural anthropology (*Istituto di etnologia e antropologia culturale*) (1956), which I was to direct until the end of 2000. My first writings – "A Contribution to the formulation of the relations between public health practice and ethnology" [*Contributo alla formulazione dei rapporti tra prassi igienico-sanitaria ed etnologia* (1956)] and "The Contribution of Cultural Anthropology to Health Education" [*Il contributo della antropologia culturale alla educazione sanitaria* (1959)] – date back to these initial years as do my first investigations about popular healers and folklore medicine and the organization, in Perugia and Rome (1958), of the exhibition of photographic documentation of the research into Lucanian healers directed in 1957 by Ernesto de Martino, to all intents and purposes my teacher. Ever since then, even while carrying out research in several other fields, I have continued to devote almost uninterruptedly my attention to medical anthropology, to the reflection on its epistemological basis and on its operational implications, to its teaching and to its instruments of scientific and professional organisation and, above all, to a great number of its own research objects, with particular reference to Italy. Since the beginning of 1999, the Institute of ethnology and cultural anthropology has become the Anthropological Section of the new and broader Department of Man and the Environment [*Sezione Antropologica del Dipartimento Uomo & Territorio*]. Moreover, for some years now our medical anthropology activities have been principally located in the Angelo Celli Foundation [*Fondazione Angelo Celli per una Cultura della Salute*], constituted by my father, a professor of public health, in 1987 and of which I am now president. The Foundation is also situated in Perugia, where the *Italian Society of Medical Anthropology [SIAM]* has its national headquarters. In this by now long journey through the disciplinary field, I have been supported by a growing group of pupils and collaborators of various "generations", the names of whom, at least, I would like to cite here: Alessandro Alimenti (†), Giancarlo Baronti, Carlotta Bagaglia, Paolo Bartoli, Andrea Caprara, Paola Falteri, Sabrina Flamini, Grazietta Guaitini, Lara Iannotti, Laura Lepore, Cristiano Martello, Massimiliano Minelli, Cristina Papa, Caterina Pasquini, Maya Pellicciari, Enrico Petrangeli, Giovanni Pizza, Chiara Polcri, Roberta Pompili, Riccardo Romizi (†), Pino Schirripa, César Zúniga Valle. Without them, very little of what has been done could have been brought to a successful conclusion.

PERSPECTIVES
ON MEDICAL ANTHROPOLOGY

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Introduction

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The first four papers of these proceedings address a crucial issue in discussions about the mission of medical anthropology. To phrase that mission in negative terms, both Raymond Massé and Sylvie Fainzang argue for a de-medicalisation of medical anthropology. In their view, medical anthropology should not accept the biomedical concepts and categories as 'facts' on which anthropologists may comment from a social and cultural point of view. Such a medical anthropology would disqualify itself as only 'writing in the margin' of true science. It would become merely *an* anthropology *in* medicine, a handmaid helping to implement the facts of science in society. A de-medicalised medical anthropology, however, looks at health, illness and medicine and inherently social and cultural phenomena with their own meaning and momentum.

Raymond Massé describes the outlines of a critical medical anthropology focusing on social suffering. His view is based on the complementarity of phenomenological, economic and political perspectives. Medical anthropology, he writes, should be occupied with a comprehensive understanding of disease, taking into account the multi-layered character of both context and experience.

Similarly, Sylvie Fainzang follows Marc Augé to emphasise that practices relating to illness are indissociable from the social and symbolic system. "Illness, as a paradigmatic example of misfortune, reveals the nature of social relationships." She continues: "The medical field is but one social field among others, even if the questions it raises are exacerbated by the radicality of what is at stake, such as life, death, sexuality."

The other two papers provide excellent cases to illustrate the general argument of the first two authors. Oriol Romaní focuses on drug use, not as a pathological condition but as a "potent analyser" of contemporary society. By understanding drug use we will eventually also better understand the society in which it occurs.

In the same vein, Rosario Otegui Pascual argues that the anthropological study of AIDS should lead us to an analysis of processes of social inequality. The socio-symbolic status of AIDS is linked up with the construction of identity, stigmatisation and ‘distanciation’.

The discussion that followed the presentation of the papers focused again on the identity and state of medical anthropology. The term ‘de-medicalisation’ was criticised for two reasons. First because it sounded too defensive, implicitly recognising the domination of medical science and practice over anthropology. Secondly, it sounded unnecessarily hostile towards biomedical practice whereas we should simply recognise the difference in perception or paradigm. That difference, however, should not be regarded as incommensurable but rather as complementary. As a matter of fact that complementarity was embodied in the persons of several participants at the conference.

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Contributions and challenges of Medical Anthropology to Anthropology.

Integration of multiple dimensions of social suffering and medicalization of Medical Anthropology

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Introduction: importance of medical anthropology as a sub-discipline

Medical anthropology has become one of the most prominent sub-disciplines in anthropology. The significant number of graduate students, research programs and researchers it attracts, as well as the credibility it has acquired as an applied science in national and international health development programs, has given credibility to the discipline among social scientists as well as among managers in public institutions.

The reasons for the success of this sub-discipline are numerous. In developed countries, the 1980's were marked by the emergence of problems which revealed determining social and cultural factors related to health problems (AIDS, drug addiction, teenage pregnancy, eating disorders), and dramatic changes in consumer confidence in biomedicine. In particular, the twin epidemics of AIDS and substance abuse that mushroomed in the 1980's urgently called for a participation of anthropologists in multidisciplinary public health teams. On the international scene, anthropologists were invited to play a significant role in the planning and the evaluation of programs related to diarrhoeal disease, tropical diseases or AIDS. The topical breadth of contributions of medical anthropology to the socio-cultural analysis of infectious diseases (Inhorn and Brown, 1997), or to public health programs (Halm, 1999) have been abundantly debated.

It seems obvious that one of the first contributions of medical anthropology to anthropology is the popularisation of the anthropological discipline among the administrators of public institutions, other social science disciplines and the general public. More than any other sub-discipline, medical anthropology will contribute to position anthropology as a major discipline among social sciences. Anthropology is no longer seen as a fundamental field of research on exotic cultures or minority cultures in pluriethnic societies. From now on, it will be known to the general public as an applied social science applicable to the solution of concrete problems. Associated to "soft" methodologies, henceforth, it will be known as an innovative discipline in qualitative methodologies and as a discipline known for its flexibility (for example: *Rapid Ethnographic Assessment Methodology*). The image of the isolated individualistic field anthropologist will be replaced by the image of a helpful and credible anthropologist as part of multidisciplinary teams.

In brief, medical anthropology, more than any other sub-discipline, will contribute to building a scientific credibility and a positive social image of anthropology. This new credibility will open the doors for anthropologists to national institutions of public health (i.e. *Centre for Disease Control*, public health administrations, community health programs) and numerous international public and private organisations, working in public health. This relative abundance of employment offers for medical anthropologists, coupled with the intrinsic appeal of a sub-discipline which harmonises practice and theory, will ensure that the student clientele of Anglo-Saxon university departments of anthropology will stabilise and, possibly, even increase. Furthermore, the European counterpart will experience the same trend.

Contributions to classic fields of research in anthropology

Of course, contributions of medical anthropology are not only restricted to this marketing function, which has established the credibility and the popularity of anthropology. Fundamentally, it has allowed a deeper analysis to be made of several fields of classic research in anthropology. We will only give some examples here.

1) Medical anthropology has allowed the confirmation of the importance of the holistic approach, which is systemic in anthropology. Since the classic works of Clements (1932) and Rivers (1924), ethnomedicine has become one of the essential dimensions of culture to be investigated. As suggested by Rubel and Hass, in a functionalist perspective, "one of the most prominent ways in which ethnomedicine contributed to the development of theory and method in socio-cultural an-

thropology was to show the functional integration of the components of health care institutions within society's cultural matrix, its social organisation, or political system" (Rubel and Hass, 1990; 116).

2) Through its analyses of the introduction of biomedicine in traditional societies, medical anthropology has become one of the most privileged fields of studies of acculturation mechanisms and local reinterpretation processes of knowledge and foreign practices. The anthropology of biomedicine is becoming a privileged research field of sub-development and of the globalisation phenomenon through the study of internationalisation processes of knowledge and biomedical care practices.
3) Ethnomedicine studies will become one of the privileged fields for the analysis of alternatives to biomedicine and strategies of local resistances to new forms of powers, namely the ones associated to biopower in a critical anthropological perspective (Baer, Singer & Susser, 1997, Berche, 1; 1999).

In fact, the list could be longer to cover more or less all the problems covered by modern anthropology (feminist studies, immigration, identity, cultural and ethical relativism, public policies and so on), all the problems which have been discussed, more precisely, by means of studies on health and disease.

Production of new concepts and theories

The contributions of medical anthropology are not limited to dynamisation and the renewal of the research traditionally associated to anthropology. Questioning the role of cultural and social factors in the analysis of the causes of disease and its unequal distribution through time and space has contributed to the renewal of ecological and theoretical models on the role of environment and to a reorientation of traditional physical anthropology. The analysis of the socio-cultural construction of illness has stimulated the refinement of the cognitive and interpretative theoretical models. In the early 1970s, in reaction to criticism of its lack of theorisation and a descriptive tendency, the sub-discipline shifted ground. «The 1980s were a time of ferment in academia, marked by debates between advocates of critical theory, feminism, and postmodernism; [...] studies of cultural knowledge structures and embodied knowledge; [...] a time of theory posturing» recalls Nichter (1991:1). Many important concepts, models and theories were suggested that focused on either the semiotic and interpretative (i.e. concepts of idioms of distress, semantic networks, the illness explanatory model), economic-political (theories on resistance or biopower in critical medical anthropology), or phenomenological (i.e. concepts of existential fields of illness, embodiment) dimensions of the illness experience. The production and refinement of these concepts and theories can be seen as one of the most important contributions that medical anthropology has made to the discipline.

However, in the next pages, I will put emphasis on what I consider the two major challenges which medical anthropology will have to face in the coming years. In my opinion, these challenges must be faced by the discipline of anthropology as a whole. If medical anthropology succeeds in taking up these challenges it will have significantly contributed to the evolution of anthropology as a social science, as much on the theoretical level as on the level of applied anthropology. The first challenge is the articulation between the multiple dimensions of the illness experience. More specifically, and this difficulty is a challenge for all of the sub-disciplines in anthropology, the theoretical endeavour will have to bear on the analysis of the interrelationship between three dimensions of illness: The *individual dimension* (1), the *socio-cultural dimension* (2), and the *economic-political dimension* (3). The theoretical challenge is that of complementarity between phenomenological, interpretative and critical perspectives, and that of the articulation between micro and macro-analysis. The second challenge is that of denaturalising the anthropological in medical anthropology, through the menace of a medicalization of anthropology. If medical anthropology has contributed to the renewal and to the dynamisation of research in several classic problems in anthropology, if it has promoted the development of concepts and theoretical models that have enriched the parent discipline, an excessive medicalization of medical anthropology could also have negative impacts on anthropology. If it permits anthropology to consolidate its scientific credibility and gain prestige in the competitive field of social sciences, a possible denaturalisation of medical anthropology risks denaturalising anthropology itself. Insofar as it will be able to accept these two challenges, medical anthropology will contribute to discussions on the nature and the place of anthropology in the field of social sciences.

The challenge of the commensurability of phenomenal, interpretativist and critical analysis of illness

Few concepts and theories have been dedicated to the explanation of the inter-relationship of the illness experience with the multiple dimensions of reality and the interface between the multiple layers of the illness experience. Yet, I think, it is at this level that the major challenge exists for contemporary medical anthropology. We will briefly summarise these concepts and theories in three approaches that now coexist within the discipline.

- *Ethnographic works which have described folk beliefs associated with nature and illness causes, beliefs conceived as being organised in coherent systems.* This approach, described by Good (1994) as empiricist, by default considers beliefs as well-defined statement, easily identifiable concrete entities, which are, therefore, modifiable by health education programs. Such a reification of both beliefs and culture considered as a cultural system has been attractive for those health professionals looking for concrete cultural targets for public health programs and for those relying on psychosocial predictive models such as the Health Belief Model (see Massé, 1995.130-141). This empiricist paradigm is also based on "rationalist theories of medical beliefs, the ecological theories of ethnomedical systems as essentially adaptive and analytic primacy of choice in studies of illness behaviour" (Good, 1994.44).
- *The analysis of illness representations as culturally constituted realities.* Illness is no more seen as a biological entity but as a semantic network, an idiom of distress or an explanatory model. This approach has sensitised health professionals to the importance of a cultural construction analysis concerning the meaning of illness for a given population. It favoured an analysis of popular symbolic structures and processes through which illness is linked to fundamental cultural values.
- *The Anglo-Saxon critical medical anthropology* is characterised by emphasis on the structural, political and economic causes of illness, the asymmetric power relations (gender, ethnic, class) which characterise practitioner-patient relations and the reproduction methods of the hegemonic position of biomedicine in comparison with ethnomedicines. It pays particular attention to the influence of the world economic and political system on the distribution of illness and care (Frankenberg, 1980, Baer, Singer and Susser, 1997). This approach postulates that the principal, but latent, function of ill being medicalization, would be the resolution of social conflicts (Swann, 1989:1169) giving advantage to dominant economic and political classes.

In its response to these biomedical and cultural deviations, critical medical anthropology divides itself into two tendencies. Firstly, a political economy which focus its attention on a macro-analysis of the effects of international policies on health causes and treatment. This approach, which is considered as the missing link of medical anthropology (Morsy, 1979), puts the emphasis on the link between local socio-cultural dynamics and historically determined national, international, political and economic processes (Morsy, 1996). It dedicates dependency relations between rich and poor countries (Morgan, 1987). Secondly, a critical interpretative anthropology (Lock and Scheper-Hughes, 1996), which resembles a radical phenomenological approach. For Lock and Scheper-Hughes (1996), the meaning of suffering continuously evolves to the confluence of the three bodies. That is to say, under the influence of lived experience by the person (*em-*

bodiment in individual body), the symbolic representations held by the society (*social body*) and the political control and discipline of individuals (*body politic*).

In our opinion, the issue that constitutes one of the major challenges of medical anthropology at the beginning of the 21st century, is one of the articulations between these interpretative and critical perspectives. If the approach of radical phenomenology advocated by Nancy Scheper-Hughes, among others, partially succeeds in conciliating explanation and interpretation of illness, the political economy approach of health keeps us away from such an arrangement. This approach was criticised (Morgan, 1987), among other things, for an excessive transcultural application of Western concepts about gender and class relations, and for the evacuation of ethnomedicine as a form of local resistance to biomedical hegemony or as the expression of creativity of dominated cultures. The absence of analysis of economic development impacts on the population's health. However, it is not easy to achieve this complementarity of approaches without falling into the trap of over-determining the meaning of suffering and delegitimizing discourses and local methods of health taken in charge (Kleinman, 1992).

This challenge of objectively reconciling the international political and economic macrostructure and the analysis of local health interpretations – a priori a difficult task – requires the articulation among various health relations to be modelled. Singer and Baer (1995) have proposed a model for analysing behaviours linked to health, integrating four levels from a macro-social level. They refer to the world capitalist system, to international economic corporations and institutions. However, they include: A social intermediary level, which reveals the role of biomedical and ethnomedical care institutions. A micro social level, which reveals interactions between patients and medicine-men, and finally an individual level linked to relations that an individual maintains with his social network, his lived illness experiences and his personal psychological and physical system. Bibeau (1996) proposes a three dimensional analysis model, which puts the emphasis on interfaces between the macro-sociological forces that determine the semiologic patterning of reality, the historical context and power relations. In this context, cultural values have been developed. However, the model takes mediating categories into consideration. The cultural codes are articulated to the macro-social context and to the usage people make of it during their daily experience. The new medical anthropology will be constructed, according to Bibeau, on the clarification of intermediary levels between outside forces and local socio-cultural organisations, and on the analysis of the interfaces between the multiple dimensions of reality in order to make a comprehensive conceptual framework that bridges the gaps created by the tendency to counterbalance the post-modern-literary and politico-economic drifts in anthropology. Anthropology should remember its ultimate goal and mission, which is to produce a comprehensive, multidimensional, encompassing interpretation of human experiences in a world in constant evolution.

However, although the theoretical importance of combining these various interpretative and critical levels of analysis is commonly recognized, the ethnographic works published in medical anthropology do not do so, or even attempt to do so (4). The challenge that must be faced, then, is that of an interpretative anthropology of suffering, sensitive to the historic local and individual consequences and to its economic and symbolic power relations (Farmer, 1988:80). In particular, I believe that the concept of social suffering makes such a contribution. In the context of a quest for a comprehensive framework this concept could bridge the gaps between these multiple readings of reality. It would also deepen the analysis of the interconnectedness among political-economic, socio-cultural and phenomenological dimensions of suffering. This is what I have tried to explain in a recent paper (Massé, 2001), by describing the outlines of a critical ethnoepidemiology of social suffering in the French Caribbean based on the explicit goal of complementarity between phenomenological, interpretative and economic and political perspectives.

We are conscious that such a challenge is at the very heart of the whole discipline of anthropology (and maybe of all social sciences), in particular in the issues of economic globalisation, post colonialism and sub-development. However, we also believe that this challenge concentrates on the health and illness field. If it is obvious that social and economic inequalities, as much on a national as on an international level, explain the over exposure of some populations to risk factors and unhealthy living conditions. Then, it is also true that the illness experience is a privileged field of study of the role of cognitive and symbolic structures in the socio-cultural construction of meaning and the domain of deeply intimate human experience. Must we renounce this challenge and conclude that these levels of analysis are incommensurable? Or must we make it one of the conditions of the evolution of medical anthropology and of the whole discipline? I believe, for my part, that medical anthropology has no other choice than accept the challenge. To confine oneself to the analysis of health cultural representations is to condemn oneself to the marginal status of cultural fact specialists and to the label of exotic specialist. By changing for a political economy of health, you condemn yourself to managing without the expertise of the fieldwork and of the emic analysis of illness interpretations and experiences. Anthropology has no other choice but to return to its preoccupation with a comprehensive understanding of disease. However, two related challenges will have to be accepted if we wish to conciliate these multiple analysis levels: the redefinition of the notion of context and the abuse in the anthropological interpretation of illness experiences.

The concept of context

The definition of context, which has to delimit the perimeters of the anthropologic fields, is becoming increasingly complicated. The exotic ground is not the only pertinent study framework in the context of the globalisation; it is the whole planet, which gives a meaning to local ground. However, an anthropology of globalisation must not move the anthropologist away from his concern for local culture. Nor he must not practice an anthropology "at home". Returning home must be a step to an expansion, a release from the inside, a project which must be guided by the observation of world history which is now taking place world-wide (Copans, 2000: 31). Do the internationalisation of fieldwork via an anthropology of internationalisation and the fallback position on an anthropology at home constitute the two opposite dimensions of a single phenomenon of relocation of anthropology? These are some of the related issues that raise the question of the context of analysis.

In the framework of a vigorous defence for a return to what is unique in ethnographic methods – their reflexivity, which gives subjects the authority to determine the contexts of their beliefs and practices –, Englund and Leach (2000: 225) are afraid that the cult of meta-narratives of modernity in contemporary anthropology give anthropologists readymade speeches on the largest context or the local context. As Gupta (2000: 240) underlines: «The central point here is that one cannot assume, as anthropologists have been wont to do, that the local is its own universe, a geographically circumscribed space where meanings are made, where the most important social interactions occur, where economic and affective life is lived, and where social structures are reproduced». The fundamental question here, in the analysis of ethnomedicines and local reinterpretations of biomedical knowledge and practices, as Appadurai (1996) says, is the following: does the larger-scale perspective yield more knowledge about the narrower context than the focus on the local context itself? I agree with Abelès (1996) that «anthropology must be careful in its dealings with the fetishist trap of the microanalysis, and not accept at face value the illusion that proximity generates, quasi mechanically, a better knowledge of the object» (Abelès, 1996:99). Deconstruction of macro-analytic categories risks condemning ourselves to an epistemological powerlessness. On the other hand, macro-analytic generalisation approaches, and the resort to reified models and concepts, are responsible for oversimplifications, which have serious ideological and political consequences (Lévi, 1996:188). Personally speaking, I believe that, in medical anthropology as well as in the anthropology of other modernity problems, we should look for a mid-term between macro-analysis of the 'world-system' and the classic analysis of exotic local ethnomedicine. The 'ethnography of middle-range' suggested by Comaroff (1993) seems to be a reassuring alternative here. However, it entails a deconstruction of the concept of context itself. We do not say that a wider context does not exist, but we suggest that anthropology should find a middle-way between inductive, emic approaches based on the micro-analysis of meaning constructions and lived experience and macro-analysis using deductive approaches through concepts and theories that reflect preconceived views. The risk is to be disengaged from a 'reflexive knowledge production'.

The abuse of interpretation

In fact, beyond the definition of an intermediary level of analysis between micro and macro society, the question posed by these meta-narratives of modernity is that of over-determination of the meaning of illness or, more precisely, that of imposition of analysis charts (concepts, theories) outside local realities interpreted by the anthropologist. Examples range from the efforts of Horton to demonstrate the rationality, and even scientificalness, of magical practices, to the comments of Comaroff (1993) on the fundamentally 'magical' bases of beliefs and practices in Western modernity.

The concept of 'resistance' is one of those theoretical categories that are candidates for the status of total deconstruction of illness. For Kleinman it refers to «resisting the imposition of dominating definitions (diagnoses), norms defining how we should behave (prescriptions), and official accounts (records) of what has happened. We resist, in the micro political structure, oppressive relationships. Such resistance may take the form of active struggle against dominant forces or a more passive form of non-compliance» (Kleinman, 1995: 126). As applied to human suffering and to ethnomedicines defined as local forms of resistance to the globalisation of biomedical care, techniques, and values, this concept gives primacy to the search for political meaning over intersubjective and situational meaning with the experience of suffering.

> «The interpretative requirements of suffering for theodicy – namely, the struggle of rebuilding a coherent account of why misery should exist in the world –, are viewed by many anthropologists as the core reality of suffering. [But] the intersubjective experience of suffering is so various, so multileveled, so open to original inventions, that interpreting it solely as an existential quest for meaning, or as disguised popular critique of dominant ideology, notwithstanding the moral resonance of those foci, is inadequate. It may distort this most deeply human conditions» (Kleinman, 2000:145).

In such a perspective, Englund and Leach (2000) denounce the dangers associated with the meta-narratives of modernity such as those of individualisation, multiple modernity, and ruptures between tradition and modernity. For example, to see the belief in the healing powers of the Holy Spirit among Pentecostalists, or the beliefs in the evil nature of 'black people's medicine' as part of the global counter-movement against 'disenchantment' subordinates the ethnographic data to interpretation «guided by a pre-given meta-narrative rather than close attention to the interaction between the ethnographer and his or her interlocutors in the production of anthropological knowledge» (Englund and Leach, 2000:236). We agree with Sabgren that these theories of renunciation «contribute to locating all effective historical agency or causation in metaphysically conceived wider forces like 'individualisation', 'commodification' and 'globalisation'. This essentialisation of what constitutes the anthropologically 'relevant' becomes not only a cover for 'ethnographic ignorance' as they argue, but also (it seems to me) a warrant for theoretical ignorance» (Sangren, 2000:243). Therefore, medical anthropology will have to be careful with concepts and meta-narratives which incorrectly simplify the lived complexity of illness and do violence to the personally idiosyncratic and situationally particular.

The challenge of the non medicalization of the anthropology of health

Another contribution of medical anthropology to anthropology is, in my point of view, a reminder of the risk of disciplinary dissolution and denaturalisation, in the context of abusive and clumsy borrowing from other social science approaches to human experience. This contribution can be illustrated by analysing the tendency toward a "medicalization of medical anthropology" that characterises Anglo-Saxon anthropology.

In the 1970's and 1980's, a certain passion for finding new places for complementarity between anthropology and epidemiology surfaced. The objective was to propose methods, which allowed the prevalence of health problems to be measured, particularly mental health, and to analyse their distribution through time and space. The epistemological issue had just found a middle-ground position between the universal pretensions of the occidental psychiatric nosographies and the documentation of culture-bound syndromes that referred to sicknesses specific to certain cultures. In both cases (as in several other fields of application of health anthropology) anthropologists associated with cultural factor specialities were encouraged to intervene to facilitate biomedical interventions, improve results and facilitate expansion. Evidently, criticism came swiftly from anthropologists sensitive to the ethical issues masked by such collaboration. Several reminded the anthropologists that the application of medical anthropology could not support the imperialist enterprise of biomedicine, which was both cultural and economic; nor could it accept the folklorization or the marginalisation of ethnomedicine. Nancy Scheper-Hughes, for example (1990: 192), called for a medical anthropology that must obligatorily «disengage itself with regards to medicine and demarcate itself from conventional biomedical interests». The issue here is that of the risks of anthropological biomedicalisation, in particular of mental health or, more precisely, the risks of subordinating the possible contributions of Anthropology to the epistemological postulates and the agenda of Medicine.

Such a warning against the medicalization of anthropology was recently voiced by the American Carole Browner (1999), who perceives a strong tendency among anthropologists to retain biomedical entities conceptualized by medicine as objects of research. She sees in this a form of anthropological acculturation which she describes as "going native", that is, becoming "medical natives" by adopting the language and the scientific practices, in short, the scientific culture. What I am advancing here is that the risks of medicalizing health anthropology must be analysed on two levels. Firstly, on the epistemological level, the level of the risks of empiricist deviation through the abusive usage of diagnostic categories in the definition of the sickness. And, secondly, on the methodological level, through recourse to qualitative methodologies borrowed from social science which tend to marginalise the field approach.

The risks of deviation towards an empiricist epistemology: the example of the abuse of psychiatric diagnostic categories

A reading of the recent issues in the major medical anthropological journals, particularly Anglo-Saxon ones, attests to a certain withdrawal of anthropologists from illnesses as biomedical diagnostic entities. On the physical level, there is a plethora of articles dealing with respiratory and urinary troubles, cancer, menopause, AIDS and so on. On the level of mental health, papers deal with Alzheimer, depression, schizophrenia, pre-menstrual syndrome or post-traumatic stress. These illnesses are becoming the starting point for analyses aimed at identifying the cultural dimensions linked by each culture to these medical diagnostic entities. The risk of medicalizing anthropology is that of reorienting research on diagnostic categories and seeing diseases as reified nosographies delimitable and definable by means of symptomatologic configurations. In other words, there is a risk of an empiricist drift.

From this standpoint, retaining “folk illnesses” or “culture-bound syndromes” as objects of research does not constitute an alternative to this empiricism. It only renews the perspective which confines psychological problems to reified categories (this time by means of popular knowledge) which is always defined according to somatic, affective, cognitive, or behavioural manifestations.

In 1989, Mirowski and Ross severely criticised the use made by epidemiology and psychiatry in particular of diagnostic categories, as is the case with the DSM or the CIMIO. They maintained that having recourse to diagnostics such as mental health measurement tools hinders an in-depth comprehension of the manifestations and the causes of psychological problems largely because diagnostics do not take into account the structure of the relationships of causality which link the variables. This report groups the causes, the symptoms, the consequences and the random associations existing between the symptoms into one shapeless mass (Myrowski and Ross, 1989:19). Byron Good (1992), for his part, criticises the diagnostic categories because they consider the disorderly categories as tangible and mutually exclusive discrete entities but disregard the logic of classification based on the nuances and of gradations based on the distress level and the severity of symptoms or causes.

However, psychiatric anthropology’s response to this risk of empiricist drift does not constitute a true epistemological break. Kleinman (1997) suggests that psychiatric anthropology make a critical analysis of the nosographic classifications of universal pretensions. Furthermore, he recommends that psychiatric anthropology open itself to a ‘creolization’ of psychiatric practices or a ‘colonisation’ of psychiatric diagnoses by way of an open discussion on cultural pluralism. Therefore, the issue would be to reaffirm the importance of «projecting the local amid the global while taking very seriously into consideration the local terms for disease identification» (Kleinman, 1997:75). Thus, in our opinion, to the extent that the focus is the categorical classification of sickness, even if it integrates some local cultural components, it is still a form of subordination of anthropology to epistemology and to the agenda of psychiatry. Although this objective is very commendable and most certainly inevitable it must not, however, summarize the essential components of anthropology to the analysis of mental illness.

From this same perspective, another path of major collaboration between anthropology and psychiatry is that of the promotion of sensitivity to DSM-IV with regards to the influence of culture on categorisations of mental "disorders". In the introduction to Volume 35 (3) 1998 of the journal *Transcultural Psychiatry*, Laurence Kirmayer writes a rather negative assessment about the results of the work group on *Culture and Diagnostic*. Although anthropological research presents popular parallel nosographies and even local idioms through which different peoples express and explain the numerous forms of mental health, the work group responsible for the DSM-IV only includes the following elements in the final version: a brief commentary on the importance of culture, some sections about cultural considerations, age and gender which accompany the texts linked to certain psychiatric categories, an annexed glossary containing some 25 culturally conditioned syndromes and a user's guide for the formulation of the cultural conditions of a diagnosis.

The introduction to the summary volume for the DSM-IV did not take into account the suggestion of integrating a definition of culture, race and ethnicity prepared for this purpose. No room was allotted for constructive criticism which stated that the division in cathegories of somatoformic, affective, distress and dissociative disorders did not respect the natural covariations of the forms of distress which were observed in trans-cultural studies. Throughout the manual, culture was presented as a bias capable of leading one to erroneous diagnoses, rather than as a component of the definition of mental illness as a construction that is as cultural as it is professional. There was a brief outline of the cultural formulation of psychiatric disorders but it was an annex and not placed directly after the introduction to underline the importance of taking cultural and social contexts into account.

Evidently, communication between psychiatrists specialising in epidemiology and anthropologists required them to share at least a common language. This common language was that of empiricism where all concerned looked for recurrent characteristics and patterns founded on reified symptoms for the purpose of defining pathological entities, and describing and delimiting disorders. Here again, the price that anthropologists pay is the risk of losing sight of what constitutes their originality and their strength: that is, the analysis of the influence of individual, social and political contexts of suffering. Such collaborations risk marginalizing anthropology of the experience of suffering, individually lived but socially, politically and culturally built. In fact, the leitmotif of psychiatric anthropology over the last two decades has been to criticise the validity of the diagnostic categories while the task of epidemiology has been to increase reliability. While the DSM's working groups' papers aimed to ensure the internal coherence of the criteria of diagnostic definitions (e.g. the stability of factorial constructs between one social sub-group and culture and another), anthropology questioned the validity of the established roles and categories. But even this critical approach confirms anthropology's subordination to the medical agenda. Paradoxically, it strengthens the epistemological paradigm that it believes it is denouncing.

Methodology and field work

The medicalisation of anthropology, a trend confirmed in the specialised journals (see infra. Hadolt), expresses itself either through interviews, sometimes completed by direct observations done in decontextualized sites (operating rooms, hospital emergency waiting rooms), or through methodologies based on narratives of lived episodes of sickness. In the 1980s, health practitioners called upon anthropologists to develop rapid ethnographic assessment procedures to assist them in the collection of data related to knowledge, beliefs, and values about diseases. Generally, we note the absence of long-term fieldwork, and also the absence of narratives being integrated into social and global political contexts.

Let's be clear here. Such new data analysis methodologies as iterative content analysis, discourse analysis or grounded theory, as well as the increasing use of analytic textual data software, represent a jump-start for anthropology. Not only do I personally teach them in my department but also I have also widely used them within the framework of different research projects in Quebec. I consider that these methods and techniques help to reinforce the validity and credibility of research in the anthropology of health and to make the construction of conclusions less impressionistic, more explicit and more systematic. Far from renouncing these methods, anthropology, like all the other social sciences, should draw inspiration from them. However, the price to pay may be too high. Anthropology risks losing sight of the discipline's global perspective, which depends on contextualizing the steps of sickness in the social, political, economical and global cultural framework. In fact, the fundamental issue here is that of a marginalisation of the terrain of the anthropology of health. Englund and Leach state that the biggest threat to anthropology is not the problem of funding but «the factory conditions and audit practices which now structure the academic work» (2000: 238), as well as the pressure to feed the proliferation of journals, book series, and conferences. This does not fit in with the reflection of "a slow and unpredictable activity by its very nature". «Under such conditions, the doctoral project is becoming the only period of sustained and long-term fieldwork in a scholarly career. Not surprisingly, perspectives which require a minimum of fieldwork, perspectives which demand instant ethnography to illustrate aspects of a metropolitan meta-narrative, hold increasing appeal» (Englund and Leach, 2000: 238-39). Hence, the recourse to meta-narratives and vast theorisations of post-modernism serves as an alternative to a "realist reflective ethnography", which rests on a real commitment, founded on the experience that the researcher shares with the local population.

Two tendencies counterbalance this move toward the marginalization of the field and the decontextualisation of analysis. First of all, we can note with Kleinman (1995) a return to an in-depth ethnography in medical anthropology's publications. There have been more detailed monographs published in book form since the end of the 1980s than in the previous forty years. There seems to be a pendulum effect in the publication of hundreds of essentially theoretical studies. Kleinman (1995:194-197) sees that these ethnographic monographs challenge the basic conventions of health research. In the depth of their analysis, their attention to detail, and their sensitivity to the plurality of constructions of the significance of sickness, ethnographic books are an alternative, which is situated in a no man's land between science and humanities. But foremost, ethnographic books provide the most faithful representation possible of the phenomena that are marginalised by medicine, such as common knowledge, alternative practices, the phenomenological dimensions of the experience of sickness, and the socio-political causes of sickness. At the beginning of the 1970s, an important phenomenological current began to develop in Anglo-Saxon medical anthropology around the ethnographic concept of the real life experience of suffering and sickness. This is an important contribution that risked a methodological drift, which could have led to the decontextualisation of sickness from the biographic framework in which it exists. In this last example, however, there is always the risk of confining the analysis of social and mental suffering to the macro level.

In the framework of my own research on psychological distress in Martinique and in French Canada (Québec), I had initially planned to produce diagnostic tools that were sensitive to local idioms of identification, expression and explanation of mental suffering. I could have done this using case studies of depressed patients, open interviews with sick people or with people close to the patient, or diagnostic charts to which a few ‘local’ symptoms would have been added. However, each of these approaches restricts the analysis to a person outside the context of the family, community and social surroundings in which he is evolving. Only a hands-on, long term approach, built on observations of the different life surroundings where this psychological distress develops, allows us to grasp the work of culture on suffering and to grasp the richness of meanings brought out by the local idioms used to describe distress. For example, the observation of constant tension between spouses, between parents and children, between grand-parents and grand-children have confirmed that, while it is sometimes a nest of security and stability, the family environment is the first place where stress, anxiety and frustrations burst out. In a Caribbean context, an anthropology of depression has a lot in common with the family and inter-family relationships, marked by an accelerated destructuralisation of the family and the difficult relationships between the traditional Caribbean man and the new Caribbean woman. Also, anthropology of social suffering must take into consideration different mediatorial observation spaces. For example, political assemblies or unions are extremely interesting surroundings in which to analyse the social and racial tensions that serve as a backdrop to a tense and frustrating climate. Small group meetings and prayer meetings organised by the members of Fundamentalist churches, which take place in the homes of sick brothers and sisters, allow us to explain the importance of the church as a place for rebuilding lives and overcoming depression. An analysis of the pastor’s sermons allows us to understand the place that Satan and sin occupy in the people’s explanation of sickness. It also allows us to understand the origin of many sick people’s re-interpretation of alcoholism and drug abuse, as well as dancing and sexual liberation as demonic manifestations that bring depression. Just as important are the direct observations of suffering within the daily life of unemployed people who wander around the capital’s streets or tourist beaches, or the analysis of what is conveyed in the newspapers, radio, television, political assemblies, and which it is possible to understand with a sustained fieldwork approach.

There is no need to lengthen such a list with more examples for an audience of anthropologists. However, the present pressure for an applied anthropology, which is complementary to medicine, reminds us of the importance of being sensitive to the social life of individuals on whose behalf anthropologists want to express themselves. The contributions of Anthropology must go beyond the framework of a culturalisation of diagnostic categories, be they popular or medical, which will include different forms of expressing psychological distress.

Conclusion

This tendency to medicalise the anthropology of health is seen to be more significant in Anglo-Saxon countries than in France and Europe in general. The reasons are complex. In the United States, Canada and Australia, in particular, not only has this sub-discipline been established since the beginning of the 1980's, but also in the last two decades, several thousand graduates in medical anthropology have found jobs in governmental agencies, community health centres, multiethnic organisations, public health agencies, research centres in epidemiology, insurance companies, and in other institutions far removed from the preoccupations of fundamental research. In no way do I believe that we must refute this tendency towards tangible and practical applications of anthropological knowledge to Health Care and to the management of health policies. Having myself worked for several years as an anthropologist within a governmental agency of public health, I can attest to the importance and to the pertinence of such a contribution. However, it is clear that an applied medical anthropology will not be able to maintain its credibility unless it is systematically nourished by sustained fieldwork that allows the inter-relationship between diverse illness dimensions to be analysed. These risks are linked to the reification of diagnostic categories, to the division of social and cultural factors and to their division in decontexualized variables that conceal the influence of economic and political structures.

In fact, what I have dealt with in this presentation are the limits of complementarity between medicine and anthropology and, more particularly, the incommensurability between these radically different perspectives. I maintain that even though medical anthropology and medicine (or epidemiology) share the same concerns methodologically and epistemologically speaking, they are nonetheless perfectly incommensurable ontologically speaking, be it on the level of the target objectives, or in the ultimate finalities. There is incommensurability between the finalities of comprehension and the objectives of health measurement; between the objectives of reconstructing the numerous layers of the meanings of suffering and the objectives of producing culturally adapted definitions of illness categories which will serve as a springboard to comparative transcultural investigations. Finally between the objectives of relocating meaning in the numerous levels of context versus the objectives of delimiting diagnostic entities by presenting transcontextual validity.

The search for zones of complementarity between, on the one hand, an anthropology of health and, on the other hand, epidemiology, medicine and psychiatry must remain a major anthropological challenge during the coming decades. Increased rigor in qualitative research methods, the development of a common epistemological vocabulary and the search for common methodological ground between these approaches is a necessary, but not sufficient, condition. Anthropology must, however, assume the responsibility that it is radically marked out on an epistemological and ontological level both in regards to fundamental beliefs about the nature of the reality studied and in regards to the ultimate finality of the research (Massé 2000). It will have to assume without complexes and in a creative way the incomensurability of ontological paradigms.

Notes

(1) The individual dimension is related to an analysis of the daily personal experience of illness and of the physical and social environment in which the disease is experienced.

(2) The socio-cultural dimension refers to the sociological and cultural characteristics of the society and the ethnic group concerned.

(3) The economic-political dimension refers to the organisation of the care system, to political causes concerning inequality in care and health, to asymmetric power relations between caregivers, administrators and patients and between rich and poor countries.

(4) We can mention some examples such as Kleinman (1986) on the social origin of distress in China, or Farmer (1996) who, in his study on Aids in Haiti, calls for an anthropology which will go beyond the search for cultural meaning, the eternal object of research on ideas and symbols. This anthropology will see that AIDS in Haiti is clearly in keeping with a political and economic crisis which is itself rooted in the social and economic structures inherited from the colonial time.

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Symptoms, epistemes *and poaching anthropologists*

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Despite the great diversity of theoretical approaches, ethnographic orientations and specialities in contemporary anthropology, nowadays many things seem to be becoming homogenous and recurrent in our field. One of them, perhaps the most evident, is the continuous conquest of new fields of research. In a short time, topics of interest, which would have been strange to our ethnographic gaze just a few years ago, have become the usual subjects of everyday anthropological writing. This phenomenon has probably been more pronounced in the anthropological specialities which have developed over the last thirty years. Obviously, creating a new speciality always involves an effort of scientific imagination to delimit the borders and belongings of the new territory. For instance, in medical anthropology it is well known that after an intellectual struggle with Western scientific medical tradition diseases, therapies, symptoms, syndromes and even biomedical knowledge have become objects of critical reflection and ethnographic analysis.

Nevertheless, anthropologists have not reflected about the way some topics become relevant to our own "scientific culture". We have, in this scepticism of reason that is post-modern American anthropology, good (and now classic) examples of reflexivity about ethnographic encounter (Crapanzano 1980; Rabinow 1977) and ethnographic authority (Clifford 1983). We have, in contemporary anthropology, interesting incursions into the study of reason, rationality and science (Lock and Gordon 1988; Rabinow 1996) and also good historiographical and genealogical accounts of past theories and practices in our own discipline (like Stocking's books). However, we do not have the routine of self-reflection about how we incorporate new subjects and what epistemological or ideological conditions are necessary for this kind of activity.

In this paper I analyse the way medical anthropology began to study the subject of symptom approximately twenty years ago. In spite of focusing on this particular subject, however, my intention here is more general and theoretical and I do not limit myself exclusively to the field of medical anthropology.

The anthropology of symptom and the symptom of anthropology

That symptom is a relevant object of study for medicine, psychiatry and even psychology is an unquestionable fact. Behind a symptom we expect a pathophysiological or psychopathological reality, natural evil in its wide variety of manifestations. However, in the last twenty years symptom has also become a subject of research for some specialities, such as medical anthropology, which are not directly involved in the clinical intercourse. In a short time, what traditionally had been understood to be a pathophysiological, or at least a psychopathological, reality has been understood to be a cultural manifestation, a highly suggestive metaphor, a symbol which condenses social and political-economic contradictions. I believe that in spite of the disparity of opinions in medical anthropology most authors will agree with this, from Byron Good and Mary-Jo DelVecchio Good (1981:165) to Margaret Lock (1991:87), from Arthur Kleinman (1988a: 10) to Scheper-Hughes (1992:181), from Mariella Pandolfi (1990:255) to the caustic Michael Taussig (1980:3).

Anthropological attention to this new object can in turn be interpreted as another example of the discursive indeterminacy that characterises the refiguration of social thought so neatly captured in Geertz' concept of "blurred genres". Suddenly, literary critics are writing about anthropology (Clifford 1983) and anthropologists are behaving as literary critics (Geertz 1988), not to repeat the entire litany of examples of blurred genres cited by Geertz. It even seems that this phenomenon has also affected medical anthropology. What is Kleinman – an anthropologist who talks about medicine, a psychiatrist or a physician? What does Good do – a semeiology of symptoms, an anthropology of affliction, a critique of biomedicine? What is Taussig – an anthropologist, a physician or a reader fascinated by the works of Benjamin and Luckács? What is more, could not the fact that anthropologists interpret symptoms be understood as a new "symptom", but this time of anthropological knowledge itself?

Certainly, we are faced with a continuous, maybe chronic, refiguration of established authorial definitions and of the limits of anthropological knowledge. As well as the traditional subjects there now seem to be new potential worlds of ethnographic practice and speculative thought. Geertz evoked this phenomenon when he pointed out the relevance of Kluckhohn's affirmation that «anthropology is an intellectual poaching license» (1983: 21).

But intellectual poaching activities are never accidental facts. They depend on specific predispositions and "conditions of possibility" of the branch of knowledge in which the "captured" topics are to be implemented. In other words, there are no poaching activities without the epistemological conditions that make it possible for anthropologists to go hunting in new intellectual territories.

Canguilhem teaches us something in this respect. He tells us that the exchange of ideas between scientific specialities – and I say exchange so as not to abuse cynegetic metaphors – is a more frequent phenomenon than the traditional distance between specialities suggests. For instance, the history of the concept of "biologic regulation" in the 18th and 19th centuries is also the history of the relationship between theology, astronomy, medicine and even Comtean sociology. Moreover, the emergence of bacteriological theories and their therapeutic applications in the 19th century is indebted to the development of chemistry and the chemical industry:

> «C'est l'extension des examens microscopiques de préparations cellulaires et la pratique des decolorations à base de derivés synthétiques de l'aniline, industriellement fabriqués en Allemagne à partir de 1870, qui devaient aboutir, pour la première fois dans l'histoire de la mèdecine, à une thérapeutique aussi efficace que libre de toute théorie médicale, la chimiothérapie, inventée par Paul Erhlich (1854-1915)». (Canguilhem 1993:69) (1)

Subsequently Canguilhem points out: *Pas de chimiothérapie sans une certaine société scientifique, sans une certaine société industrielle* (1993: 72), and also no chemotherapy without the scientific view moving from the simple idea of "extraction" of substances to the idea of the massive and industrial "production" of these substances (1993: 72). The emergence of chemotherapy owes more to synthetic aniline stains than Lévi-Strauss to structural linguistics or Clifford Geertz to European hermeneutic philosophy.

Canguilhem builds up an epistemological method, which is useful for analysing the process of appropriation of ideas. This method oscillates between astonishment and perplexity at scientific loans and the study of the "conditions of possibility" of scientific knowledge. It also finds in the "concept" the main referent for relating loans to epistemological conditions. But a concept is not a word. A word can cover different concepts. A concept is a notion that suggests a particular problem in the framework of a science. Defining a concept, therefore, involves delimiting a problem (Canguilhem 1955:5-7, 1989:177; Lecourt 1971:XV). But that's not all. A concept can only be introduced into an intellectual or scientific context if it is coherent with and relevant to existing concepts, theories and hypotheses in this context.

In *La formation du concept de réflexe aux XVII^{e} et XVIII^{e} siècles* Canguilhem shows in an exemplary fashion the potential of his conceptual epistemology. He proves that the traditional common sense that attributes the paternity of the reflex concept in medicine to Descartes is only an illusion. The French epistemologist shows how in Descartes' works the nervous system was understood only in one potential direction: from the centre to the periphery and not from the periphery to the centre. On the contrary, the notion of reflex in modern medicine involves the possibility of both directions: from centre to periphery, but also from periphery to centre. So this evidence clearly invalidates Descartes' claim to the paternity of the medical concept of reflex. In fact, only when physiology was able to understand that the relationship between centre and periphery in the nervous system was double faced, could the concept of reflex be introduced in Western medicine. This was a medical appropriation of the optical idea of light reflection that was made possible by a curious medical identification between life and light (Canguilhem 1955: 51-96).

In short, Canguilhem's studies show that anthropologists are not the only poachers in the intellectual domain and, also, that this kind of activity cannot be undertaken without previous epistemological conditions. Neither is it absurd to think that we can apply the epistemological and conceptual approach that Canguilhem developed for the study of biological sciences to our field; for instance, the appropriation of the concept of symptom by medical anthropology.

The concept: signs versus symptoms

Most medical dictionaries provide a single, well-known distinction between two terms: sign and symptom. The former is usually understood to be objective evidence of disease that can be perceived by a professional. The latter, on the other hand, is understood to be a more ambiguous, uncertain manifestation derived from the perception and expression of the patient themselves. Stone (1988), for example, gives the following definition in his *American Psychiatric Glossary*:

> «Sign: objective evidence of disease or disorder. See also symptom.»

And:

> «Symptom: A specific manifestation of a patient, condition indicative of an abnormal or mental state or a subjective perception of illness.»

It should be noted that "sign" and "symptom", in their most divergent senses, denote completely different orders of reality. Signs, as defined in psychiatric and biomedical terminology, are closely connected to what has been understood in semiotics as indices or natural signals. In the same way that we infer the presence of fire when we see smoke, disease can also be inferred from medical signs such as fever. Neither fever nor smoke (at least not usually in the latter case) is a meaningful creation based on semiotic or cultural conventions; rather, they are both natural occurrences. Signs, then, are characteristically a part of a natural and self-evident reality which, like the tip of an iceberg, only enter the domain of semiosis or signification to the extent that they are interpreted, as a particular disease is inferred from the presence of fever.

In contrast, symptoms refer to a "patient's self-report," to "a subjective perception." Without going any deeper into what is meant here by the word "subjective," we can say that symptoms are the patient's interpretation of a series of bodily, psychic and emotional sensations: "I've got a headache," "I feel depressed," "I'm a bundle of nerves". Symptoms are thus verbalised or mimed and, therefore, their construction reflects the expressive needs of the speaker. So they arise not as part of a physical reality or the visible effect of a cause, but as a human expression or complaint that embodies meaning.

There is a world of difference between a case of eczema and a statement such as "My heart is upset." It is no accident that symptoms have constituted a problem of immense proportions in psychiatry and medicine. Eczema is always eczema, but a complaint of heart distress is not the same when expressed by an Iranian woman, a character in a European romantic novel, a patient from Barcelona with coronary heart disease, or a Nahuatl native from Hueyapan. For the Iranian woman, the heart is a physiological organ that is vulnerable to the oppression of daily life and the problems of feminine sexuality (Good 1977: 41-51). For others, however, it may be the (symbolic) centre of emotional life (romantic characters), an organ that does not function as it should (Barcelona patient), or an organ necessary for the digestion of food (the Nahuatls) (Alvarez 1987: 89-90) (2).

The distinction between sign and symptom is of greater importance in clinical knowledge and practice than has generally been recognised. Psychoanalysis, for example, has even semioticized some physical signs; that is to say, what at first seemed to be a sign is understood as a symptom. Here I am thinking of the meaning of “simulation of childbirth” which Freud attributes to Dora’s fever and perityphlitis in *Fragments of an Analysis of a Case of Hysteria* (1988:87). I am also thinking of Freud and Breuer’s interpretation of Anna O’s *tussis nervosa* in *Studies of Hysteria* (Breuer and Freud 1985: 48). It is even reasonable to state that any psychoanalyst will understand both fever and eczema to be something more than mere pathophysiological signs (3). Nevertheless, contemporary psychiatry and biomedicine have more often than not adopted the opposite view. That is to say, symptoms are objectified as if they were physical signs that bespeak a natural, universal and biographical reality

A few years ago Stanley Jackson pointed out the problems generated by this biomedical orientation in a penetrating paper entitled *The Listening Healer in the History of Psychological Healing* (1992). After enumerating the successes in molecular biology, pharmacology and medical technology during the previous years, Jackson argues that, paradoxically, this success is distancing health professionals from their patients. As he says: «While seeing more we [they] are often at risk of hearing less» (1992: 1630).

The hegemony of seeing over hearing is not new in Western medical tradition but is reminiscent of the origins of modern medicine or biomedicine. For instance, in *Naissance de la clinique*, Foucault shows how modern medicine arose from what he defines as a modification of the clinical gaze. The turning point that gave rise to positivistic medicine is revealed by comparing Pomme (4) and Bayle’s descriptions (5). In a span of less than 100 years, medical science underwent such a transformation that the quasi-botanical classification of disease entities was overturned by this penetration into the interior of the body. The resulting reorganisation of medical knowledge replaced the old «botany of symptoms» with a new «grammar of signs», the prior emphasis on nosological classification with a study of the sequence of events which give rise to diseases, and the pre-modern doctor’s first question – «What is the matter with you?» – With «Where does it hurt?» (1972:XIV)

The features outlined by Foucault in his description of the newly formed “positive medicine” can be found in the characteristics of contemporary biomedicine. If this emergent science was still a long way from Henle-Köch’s bacteriological paradigm, which provides Western medicine with a model for understanding and eradicating infectious diseases, and from the clinical experimentation method introduced in 1865 by Claude Bernard, it was nonetheless very close to achieving the epistemological conditions that would bring it into being through Bichat’s work in pathology and Broussais' physiological approach (Laín Entralgo 1947; Canguilhem 1966; López Piñero 1985). Neo-Hippocratic medicine was already being transformed into a science capable of identifying pathological processes through the penetration of the physician's gaze into the silent and natural universe of the organs.

At first, the paradigm of the clinical gaze was to be the dissection of cadavers, but subsequently there were innovations such as the introduction of radiological examination and laboratory tests at the beginning of the century (Jackson, 1992). The ability to localise abnormality would establish the pre-eminence of seeing over hearing and, as a result, the analysis of the signs of disease over the interpretation of symptoms. This is the hallmark of a fully formed biomedical model from which, as we can deduce from Jackson's words, we have not yet emerged.

The role of the symptom in this positivistic and biomedical *episteme* is certainly curious. The medical definition of symptom refers to a reality that is not physical but cultural and linguistic. It is, also, non-specific from the point of view of its localisation in the body, because the patient's complaint is not in itself pathologic. With some exceptions, like aphasia or delusion, the pathological dimension is not part of the discourse, but part of the object that this discourse refers to. For this reason, it is first necessary to interpret the patient's code, the native or emic sense that will indicate the pathological dimension.

It seems that interpretation of patient complaints turns into a necessary activity for the clinician. The symptom's cultural context needs to be taken into account if potential misreadings in the clinical activity are to be avoided. Nevertheless, the history of symptom in biomedical knowledge is clearly the history of a recurrent misreading due to the omission of the meaningful dimension of illness (6). The predominance of seeing over hearing in clinical activity has led to this kind of situation.

At first glance, the predominance of sign over symptom in biomedical knowledge may not seem to be relevant to anthropological interest. We may even think that this subject is more exotic than those that created the original anthropological concern are. How can the fact that biomedicine does not take symptom into account affect anthropology? What is the importance of the biomedical process of reifying symptoms and affliction? The biomedical reification of illness complaints seems to be tangential to theoretical anthropology and ethnographic knowledge. However, it is also true that the anthropological appropriation of the concept of symptom is largely due to the vacuum produced by a medical gaze that ignores discourse and focuses on a world of bones, viscera's and pathophysiological realities. In fact, one of the more effective strategies in contemporary medical anthropology is to demonstrate how illness complaints condense a local world of meanings, values and political and economic processes. And this supposes not only that symptom is appropriated but also that it is reformulated. For instance, in anthropology, the relation of symptom to pathological reality is clearly irrelevant. If there is something that clearly separates the anthropological from the biomedical view of symptoms it is precisely the absence or presence of criteria for distinguishing the normal from the pathological.

But neither conceptual appropriation nor conceptual transformation would be possible without certain epistemological conditions of possibility. As Foucault states in *Les mots et les choses* (1966), the *episteme* not only creates the limits of possibility of our knowledge but also the sense of coherence between the new subjects and the old. And even though an *episteme* can introduce coherence between the more disparate elements it also can deny the most "obvious" relationship.[7] For this reason, we must ask ourselves not only about the vacuums in biomedical knowledge, but also about the epistemological modifications that have led to symptom being introduced into medical anthropology as a concept and as a relevant subject.

Epistemological conditions: from behaviours to meanings

In the same paper where Geertz evokes the idea that anthropology is an intellectual poaching license, he also talks about one thing he thinks is true in contemporary social science. I am referring to the well-known assertion that:

> «Many social scientists have turned away from a laws and instances ideal of explanation toward a cases and interpretations one, looking less for the sort that connects planets and pendulums and more for the sort that connects chrysanthemums and swords.» (1983: 19)

This statement is quite a good definition of one of the most polemical epistemological changes in anthropological knowledge: the shift from the dream of a scientific explanation (*Erklären*) of culture and society to an interpretative research of senses and meanings (*Verstehen*). And this epistemological change has also affected the way medical anthropologists understand their work.

Since the seventies, and in spite of the diversity of approaches in contemporary medical anthropology (8), we can speak about an interpretative anthropology of illness, which, with greater or lesser critical intent, has approached symptoms as expressive forms that reflect local worlds of meaning (9). The ethnographic task here has been to gain access to the cultural domain within which illness and symptoms are experienced, understood, and interpreted. This approach clearly reflects the influences of European hermeneutic philosophy (Gadamer 1960, Ricoeur 1969) as well as those of the leading authors of the symbolic and interpretative cultural anthropology of the 1960s and 1970s such as Victor Turner and Clifford Geertz. But we can still say something else on the subject: only when anthropology developed an interest in "meanings" and "significations" did the concept of symptom acquire anthropological relevance. But let us begin at the beginning.

Ethnography I: behaviours

In 1964 Philip Newman (10) described with considerable precision the behaviour of an individual suffering from "wild man" – also known as *Wild pig*, *AhaDe idzi Be* or *longlong* – among the Gururumba of New Guinea (1964).

Gambiri, the name by which Newman calls the person in question, had refused to give food to the children who were playing in the village. As the ethnographer had observed many times previously, this was a game of demands and negotiations characterised by the insistence of the youngsters and the apparently patient and calm response of the adult. However, this daily scene gradually began to acquire a strange tone. Gambiri wanted to be given back a bowl that one of the children had snatched from him and, clearly mistaken, accused the ethnographer of having taken it. Then, Gambiri found a plastic pot used as a toilet by the ethnographer's children and said, «There is my bowl. I can take it and throw it away in the forest. It is not heavy». Gambiri's sentence contained a conventionalised message: the moral career of the wild man had begun.

While Newman watched, the villagers began to gather around Gambiri, saying, «*Gambiri ahaDe idzi Be* Gambiri has turned into a wild man». To the ethnographer, this situation seemed to be not unlike a theatrical production in which the actor plays his part and the audience hangs on his every word and gesture. Apparently, however, the relation between actor and audience was in this case even closer. Newman writes, «When Gambiri made threatening gestures toward them they ran off laughing or screaming in mock terror» (1964: 2). In one of these intermittent and contrived rushes, the wild man managed to grab hold of a young girl and take a net bag that she was carrying. Then, in the ethnographer's words:

> «Gambiri sat down on the ground, removed the contents of the bag, found a piece of soap, which he gave to an onlooker, and a small knife, which he gave to me, saying that it had been given to him by an Australian Patrol Officer for being a good worker on the government road. After gathering up the contents of the bag he then made a series of demands on me, asking for a loin cloth, a tin of meat, and some tobacco. Each denial was answered with a shouted "Maski" [Neo-Melanesian for 'no']... This particular episode was ended when he again accused me of stealing his bowl and was then told by an onlooker that a young boy who happened to be passing by at the moment had taken it. The onlooker also suggested that Gambiri ought to shoot the boy, a suggestion he took up with gusto as he put an arrow to his bow and ran after the intended victim.» (1964: 3)

Following the account of this performance, Newman describes Gambiri's subsequent behaviour during the following two weeks: he visited nearby villages where he stole a number of small items, which he considered to be gifts from imaginary people. He was always aggressive and defiant. He shot arrows at people who were too far away to be wounded. He collected numerous objects, he travelled to more distant villages which did not belong to the area of his own subclan; he disappeared into the jungle, where he scattered the objects he had acquired; and finally he returned to the village and, surprisingly, to everyday normality. His extensive repertoire of "bizarre", strange behaviours were also, nevertheless, conventionalised forms of deviation which enable Newman to speak of a wild man pattern among the Gururumba.

Newman's description is not new. The ethnopsychiatric literature is full of references to deviant behaviours, patterns of misconduct, folk mental illnesses, culture-bound syndromes or similar phenomena otherwise named. However, some elements of Newman's description and analysis of the wild man are particularly striking. At first, the wild man process is initiated with a phrase which is complemented with a «*Gambiri ahaDe idzi Be*» from the onlookers. This sets off a whole chain of behaviours, forms of expression and attitudes, which the ethnographer reconstructs, focusing especially on the analysis of behaviour and behavioural sequences. Although present in Newman's description and analysis, Gururumba forms of expression are clearly of secondary importance compared to Gambiri's behaviour: the collection of objects, petty thefts, return to the village, etc. Newman's article emphasises these behaviours at the expense of Gururumba discourse. Ethnographic observation seems to be more important than listening to his informants. The transcription of behaviour emerges, then, as paramount, and the words of the actor and his audience are relegated to a merely supporting role when the wild man disturbs the calm of village life (which is not, however, without its tensions). Newman rarely analyses the complaints and questions that are the wild man's typical forms of expression, but focuses primarily on the behaviours and behavioural sequences that take place in a perfectly orchestrated fashion for 16 days. In short, the message of Newman's ethnography is that the principal object of study is behaviour. This behavioural focus is so all-consuming that it tends to behaviouralise the game of questions and answers; that is to say, local discourse.

In Newman's analysis, behaviour is seen as the result of a combination of social, cultural and psychological determinants. Newman traces this idea back to North American Culturalism, acknowledging his intellectual debt to Kluckhohn's analysis of Navajo witchcraft (Newman, 1964:8). The author thus places himself in the Culturalist tradition, although this does not prevent him from asserting that the case of the wild man, like any other deviant behaviour, is not only the mechanical result of "culture using man" but also of "man using culture". What is of interest here is that the reciprocal relation established by the author between the categories of "culture" and "the individual" is determined by the dynamics of the interaction between cultural patterns and behaviour.

Newman reconstructs the complexity of the cultural system in which the action unfolds. In great detail he describes the obligations of a Gururumba married couple, he speaks of the social pressure on thirty-year-old males (who are also the individuals affected by the wild man syndrome) and of their desire to acquire power and prestige. Gambiri, he says, is in an awkward situation: he hasn't paid the bride price and the deadline has been and gone. What is more, his wife is expecting their second child and he will soon have to remunerate his affines for the new offspring in accordance with the traditional obligations of the Gururumba. Gambiri's outburst, therefore, seems to be the result of exogenous, but extremely powerful, forces which overwhelm his capacity of absorption: he only has one pig with which to pay off his increasing debt.

The ethnographic description of the wild man belongs to the anthropological strategy that seeks to locate the essential element of observation – here Gambiri's bizarre behaviour –, in a socio-cultural context that provides meaning and enables an explanation (in its sense of natural explanation), by means of a holistic reconstruction of the situations. At the time in which Newman was writing there was a tradition which endorsed his procedure, as well as a set of key words or concepts which gave meaning to these ethnographic descriptions which were not limited to translating but also attempted to provide an explanation of what was happening. Benedict had already located the criteria for abnormality in the context of culture in her controversial *Patterns of Culture* (1934). Boas (the last Boas) had already defined a model in which concepts such as individual, culture and behaviour were essential to the anthropological task. As Boas stated, it was:

> «A vain effort to search for sociological laws disregarding what should be called social psychology, namely, the reaction of the individual to culture. They can be no more than empty formulas that can be imbued with life only by taking account of individual behaviour in cultural settings.» (Boas 1966: 258-9)

This was a preview of the interests of the Culture and Personality School, from Benedict to Linton and from Mead to Kardiner: the relation between culture and individual through the duality cultural pattern vs. behaviour; the importance of psychological and psychoanalytical theories and the attempt to explain culture by means of a processual approach that is not based on a historical dimension, but on this constant feedback by which individual behaviours reproduce traditional guidelines through the so called process of socialisation. Briefly, this is what Newman understands as the process of culture using man.

Although Newman attempts to find a cultural and psychological explanation for the wild man behaviour, in the final analysis he can only suggest some relationships between cultural patterns, social conditions and psychological structures. The reason is that it is difficult to answer the question, "Why do some individuals within a group opt for this sort of behaviour and others do not?" It may be thought that social pressure is more intense in some cases than in others or that there are some situations that are more inclined to trigger the wild man pattern. However, the final answer to this question belongs to a dimension that is a feature of the temperament, constitution, hypothetical intrapsychic conflicts or previous characteristics of the personality of the affected individuals. The Culturalist and behaviourist model seems to be at full stretch here: it introduces the reproduction of the context and of the variables that interact but it scarcely mentions the possibility that the phenomenon can be completely explained.

But what is interesting here is that within Newman's theoretical and ethnographic approach the notion of symptom has neither a sense of coherence nor a sense of relevance. In fact, Newman does not use the concept of symptom but other concepts, such as "behaviour", "function", "cultural patterns" or "bizarre behaviour patterns", which are coherent with and relevant to the culturalism of the age.

This is not to say that the word *symptom* was not used on occasion in ethnographies from Newman's time. Some studies from the sixties spoke specifically about *symptoms* (see Parker 1962: 62; Schooler and Caudill 1964: 172). In these cases, the term is neither a construction of meaning nor an anthropological notion. In Seymour Parker's study of Inuit psychopathology, two years before the publication of Newman's work, the author states:

> «Symptoms will be viewed not simply as a reflection of socio-environmental pressures, but as they function in the personality and social systems in which they appear.» (Parker 1962: 76)

"Function" and "personality" emerge here as key elements to which another extremely important variable must be added: "social systems". What exactly does Parker understand by symptoms? And what do other authors such as Schooler and Caudill understand by symptom in their well-known comparative study of the symptomatology of Japanese and North American schizophrenic patients (1964: 172)?

When these authors use the term *symptom*, they have in mind a conventional psychiatric category in use at the time. Thus Parker says, «the most frequent psychopathological symptoms are morbid depressions, anorexia, and obsessive and paranoid ideation» (1962: 77). In Schooler and Caudill's case, the word *symptoms* refers to "withdrawn", "sleep disturbance", "emotionally labile", "euphoria", "apathy", etc. (1964: 173). That is to say, symptoms are neither constructions of meaning nor forms of expression used by the patient, but psychiatric and biomedical generalisations. There is no conceptual reformulation or emic analysis of symptoms, only a dovetailing of disciplinary interests. Here symptoms have no meaning.

Ethnography II: meanings

Almost thirty years after Newman described the behaviour of the Gururumba wild man, Etsuko Matsuoka (1991) approached a case of *Kitsune-Tsuki* (fox possession) in Japan in a markedly different manner.

Michiko, Matsuoka's informant, began to hear strange voices after the death of her parents. These became more frequent after she visited the "spiritual mountain" where she had attempted to communicate with them through a shaman. The voices became so insistent and loud that she sought help at a psychiatric hospital. However, her seven-month stay in the hospital did not solve her problem because, according to Michiko, «the medicine was no help, but it's natural that spirits can't be cured by medicine and doctors would never understand spirit possession» (1991: 456).

Subsequently, Michiko turned to several different shamans – seven in all – who suggested a variety of possible diagnoses and treatments. Depending on the version, she was possessed by a snake, a mountain spirit, or a fox. The last interpretation seemed to Michiko to be the right one, to the extent that she identified the source of the voices as being the spirit of a fox killed by one of her ancestors. The special feature of this spirit was that it provided her with true information about the world and about her past. «I'm not cheating you, so listen carefully»; the fox told her before proceeding to recite her life story. The fox informed Michiko that she was of aristocratic origin, and that some of her ancestors were even connected to the imperial family. He also told her about matters that were not part of her personal history. For example, that the Chernobyl nuclear power disaster had been caused by a curse placed on the Soviet Union for shooting down a South Korean plane, and that Ronald Reagan had put a bomb on another plane, a Japanese plane, which caused a terrible accident. But the voices mainly spoke of unexplained incidents from Michiko's past: the fire that burned down her parents' house, the suspicion that their neighbour might have been involved, and the family's subsequent economic difficulties. According to Michiko:

> «The fox says that it will not go away until I prove the arson, because it has possessed me to let me know the truth. It is not an ordinary fox but a box fox. And the fox is a follower of the fox deity, so it should know everything.» (1991: 457)

Over the years, the voices did not disappear, but Michiko experienced a change of great significance. After several failed attempts, she became a shaman in a Buddhist sect (*shugendo*) in a desperate attempt to cure her. In her own words:

> «I finally had the first client. A brother or a sister of a friend of my colleague suddenly disappeared. The spirit behind me told me to search for him/her. So I guessed the place. I didn't receive any money because he or she is not yet found... I still work on religious practice every day. I'll keep on doing it because it has made me what I am.» (1991: 459)

Matsuoka's account of this case is important not only for its portrait of Michiko's experiential universe, but also for the way it is presented in an ethnographic context. Articles of this kind – like Newman's, which opened the previous section – are not unusual in anthropological literature. However, when Matsuoka's analysis is contrasted with Newman's, some interesting divergences in their ethnographic styles emerge. For instance, Michiko speaks extensively in the first person, whereas Gambiri tells us hardly anything in his own words. In fact, these two articles construct affliction in markedly different ways. Whereas Newman behaviouralizes Gambiri's discourse, Matsuoka discursivizes Michiko's behaviour. In Matsuoka's article, in fact, the patient's narrative is at the core of the ethnographic analysis. The central issue is not behaviour and sequences of behavioural response, but the significance of indigenous discourse, to such an extent that behaviour is accessible only through the informant's narrative. This not only affects the transcription of Michiko's narrative, but also the analytic concepts that the Japanese ethnographer uses to unravel the case and develop a coherent interpretation of it. Matsuoka does not speak in terms of patterns of misconduct, ethnic disorders, the ethnic unconscious, social deviance, or folk taxonomies, instead treating Michiko's illness as a metaphor with a number of possible interpretations: shamanic, psychiatric, and anthropological (which includes the sufferer's narrative).

This range of possible interpretations does not reproduce Newman's analytic strategy using different variables. Matsuoka's aim is not to construct a definitive explanation, but simply to juxtapose different readings of the same case. Of course, this juxtaposition is not gratuitous; she means to show us that one of these readings is more likely, a strategy to shed as much light as possible on the curious case of *Kitsune-Tsuki*. A causalist or etiological model, she observes, is much less productive than an interpretative approach, which gives the informant's symptoms their "metaphoric" and polysemic nature. In other words, she does not attempt to explain away possession as a pathoplastic form of a disease – which in this case could easily be schizophrenia – but ventures into the domain of meaning, placing the informant's illness narrative in relation to a larger frame of reference. And what she finds, first of all, is a plural universe of meanings, which Michiko uses alternately, and even simultaneously, reflecting a context in which different medical systems coexist. Second – and more importantly for my purposes – she also finds that fox possession is a reflexive symbol that provides Michiko with an opportunity to think about her genealogy and ancestors. This symbol – which is also a symptom – turns the fox into a liminal agent which voices the truth of a life, a local, cultural instrument for reflection.

Everything suggests that Michiko's symptoms are like representations, which cannot be understood outside the cultural context in which foxes and the memory of ancestors acquire meaning. But what is less clear, although also true, is that Matsuoka's text cannot be understood outside the universe of knowledge in which it has been produced. That is to say, in the framework of an interpretative medical and psychiatric anthropology which investigates the meaning of illness and symptoms through such concepts as symbol, metaphor, narrative, semantic networks, idioms of distress and so on (Kleinman 1980; 1988a; 1988b; Good 1977; Good and Good 1981; Nichter 1981). This approach, unlike Gambiri's ethnography, speaks not of behaviours, functions or patterns of misconduct that must be explained, but of meanings and expressions that must be decoded.

The turn toward an interpretative perception of symptoms is the result of a succession of influences such as hermeneutic philosophy, symbolic and interpretative anthropology, and interpretative medical anthropology. Particularly important in this last case is the work of scholars such as Kleinman, with his precocious ideas about the meaning of illness and suffering (1980), and Byron Good, with his concept of semantic illness networks. This concept formulated in the well-known article *The Heart of what's the Matter: The Semantic of Illness in Iran* (Good, 1977) considers illness and its expressions as a dominant symbol which condenses emotions and feelings, meanings and situations, afflictions and social rules. Applying it to interpret a complaint such as the "*narahatiye qalb*", present in the Turk-speaking people in the East Azerbaijan province in Northwest Iran precedes the interpretative elements present in Matsuoka's article: the hermeneutics of the emic dimension of illness by immersion in its symptoms and its narrative and text analysis, the use of linguistic and semiotic models, and the critics of biomedicine.

But the most evident appropriation and reformulation of the concept of symptom is, without doubt, a subsequent article by Byron and Mary-Jo DelVecchio Good entitled *The Meaning of symptoms*, in which the authors show how to deal with this new object: the symptom as a condenser of meanings. Whereas the biomedical model searches for somatic or psychophysiological lesions, the hermeneutic model investigates the constructions of meanings: «the illness reality of the sufferer» (1981: 179). Whereas the former proceeds clinically and with the support of organic evidence, the latter decodes the semantic networks. Whereas the biomedical model «dialectically explores relationships between symptoms and somatic disorder», the hermeneutic model interprets symptoms as texts in their relation with the semantic networks as a context. In short, while one operates in the explanation mode (*Erklärung*), the other opts for the understanding mode (*Verstehen*) (1981: 179). In this context the following statement makes sense:

> «Symptoms do not reflect somatic abnormalities in any simple way and the relationship among symptoms does not mirror a set of mechanistic or functional physiological relationships. Symptoms are irreducibly meaningful. Illness and symptoms are experienced as realities and are thus integrated, logically and meaningfully.» (Good and Good 1981:191)

Such an evident identification between symptom and meaning is only possible within an interpretative anthropology of illness. The notion of symptom is appropriated in both a critical and furtive manner since while Good and Good point out the vacuums produced by an excessive biologization of medicine they also suggest new ethnographic territories. Thus, symptom is transformed into a relevant concept for anthropology. We are now immersed in the *episteme* within which symptom and meaning meet, in the same manner, perhaps, that according to Foucault the umbrella and the sewing machine are found together on the operating table. Now symptoms mean.

Notes

(1) «It was an extension of microscopic techniques for the study of cell preparations and the use of synthetic aniline stains (manufactured in Germany after 1870) that led, for the first time in the history of medicine, to a therapeutic technique that was both effective and unrelated to any medical theory: chemotherapy, invented by Paul Ehrlich (1854-1915)».

(2) Even "heart" can mean different things for physicians of different national traditions, as Thomas Ots has pointed out in his article *A heart is not a heart is not a heart is not a heart* (1993: 397).

(3) This is generally true for European psychoanalysis; for example, the Lacanian School, which is closer to the humanities than to biomedicine and biomedical psychiatry. This is evident from a glance at Lacan's *Écrits* (1966) and at his *Séminaire*.

(4) An 18th Century clinician who tried to cure a case of hysteria with ten to twelve hours of baths a day for ten months.

(5) The first 19th Century doctor who observed and described the encephalic lesions of general paralysis of the insane (GPI) or paresis (1972: V).

(6) For an in-depth review of this topic, see Martínez-Hernáez (2000).

(7) I am thinking of Borges' curious animal taxonomy that Foucault uses in the preface to *Les mots et les choses* and of the famous couple (introduced previously by Lautréamont) formed by the umbrella and the sewing machine on the operating table outlined in the same preface.

(8) The labels are *Clinically Applied Anthropology* (Chrisman and Johnson 1990), *Critical Medical Anthropology* (Baer, Singer and Johnsen 1986), *Critically Applied Medical Anthropology* (Scheper-Hughes 1990), *Critically Interpretive Medical Anthropology* (Lock and Scheper-Hughes 1990), *meaning-centered approach* (Good 1994), *embodiment paradigm* (Csordas 1994), etc.

(9) See Kleinman 1980:119; Good 1977: 27: Good and Good 1981: 165; Good 1994: 92; Scheper-Hughes 1992: 167; Lock 1990: 237.

(10) Here we have used Newman's work. However, any article of the period would have a similar approach. See particularly Harris (1957), Mischel & Mischel (1958), Langness (1965) and Parker (1960).

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Medical Anthropology, a tool for Social Anthropology

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Medical Anthropology, a tool for Social Anthropology

The specialisation and the division of Anthropology in sub-fields or subdisciplines, which led among other things to the constitution of medical anthropology, implies a focus on a particular object related to illness and medicine and supposes the elaboration of specific problems induced by the object itself. However, any reflection on what medical anthropology contributes to general social and cultural anthropology, includes a reflection on what makes such a contribution possible. I propose to examine here the conditions under which the type of research we do in medical anthropology can contribute to general anthropology, and to show that these conditions are the result of the alchemy between the problematisation and the construction of the object.

The aims of the research

Medical anthropology is characterised by two main research orientations that have different purposes and are based on two distinct postulates:

1) The first postulates that examining the problems connected with health and illness from an anthropological perspective can contribute to enrich medical research.
2) The second postulates that the problems raised in the fields of social and cultural anthropology find a privileged field of reflection in medical anthropology.

Despite the apparent similarity of these two postulates, we can see, on close examination, that they cover two completely different positions. In the first case, anthropology is applied to the medical field. In other words, the point is to use anthropology to enlighten medical practice, through knowledge of the cultural facts. A great number of contemporaneous works, mainly American, testify to this perspective, the aim of which is to improve knowledge of the cultural factors that determine the behaviours of sick people, and thus increase the usefulness of medical programs. In this perspective, the anthropologist must work in conjunction with medical doctors, contributing method and data, in so far as cultural or ethnical factors can help to understand the causes, characteristics and consequences of an illness, as well as the behaviours of patients.

This perspective has probably been at the origin of a certain misunderstanding about the nature of this new knowledge constituted by medical anthropology. The misunderstanding is that this discipline as a branch of the medical sciences, which focuses on the cultural conceptions of illness in order to help health professionals in their task. Such a misunderstanding leads to medical anthropology being situated on the fringe of social and cultural anthropology.

In the second case, illness is considered as a domain of social anthropology. This tendency has asserted itself in France with Marc Augé (1986) who postulated that the practices relating to illness are indissociable from an articulate symbolic system. He also questioned the very existence of a constituted field of medical anthropology with definite frontiers. The idea is that social anthropology is a unified whole; that is to say, that there is only one anthropology, which focuses on distinct empirical objects, and that these constitute *one* object of analysis which must not be fragmented. Illness as an object is, in this perspective, an opportunity for enriching anthropological problems. The detour through representations of illness becomes an advisable itinerary (or even a necessary one) for the anthropologist who wishes to analyse the systems of thought and behaviours in such and such society. In these conditions, the study of the phenomena related to illness becomes a necessity if social life is to be understood. The first aim of medical anthropology is, therefore, not to conceive finalised research on a biomedical target, but to access the knowledge of society through one specific gate. In this perspective, medical anthropology is a privileged path towards this knowledge.

Therefore, the French school has developed a perspective that focuses on the medical field but which insists that medical anthropology should not be separate from the other fields of anthropology. It is, then, necessary to connect the data collected in the medical sphere to the other spheres: politics, religion, genders, kinship, etc.

In keeping with this last perspective, one of the conditions that enables medical anthropology to make a useful contribution to general anthropology is that the object is constructed with a centrifugal perspective. In other words, if we are inspired by the globalizing approach that social anthropology has taught us to have, we must connect the object we choose to study to the other spheres of social life, by identifying the systems of meanings between different registers. This means that we must attempt to link elements that belong to different areas and which the cutting up into various fields has sometimes artificially disjointed. In short, we must not "cut out" the object but, on the contrary, "re-stick" it.

To give an example, the symbolic numeric system which prevails in some African societies and that organises care (according to which a treatment is codified along the line which attributes number 3 to men and number 4 to women) has to be analysed in the light of the place these numbers occupy in other spheres (namely the rules of residence and the rules of transmission). Indeed, among the Bisa of Burkina, for instance, the number 3 refers to the three parts which constitute the *nyi* (the main component of the person) in a man, and the number 4 refers to the four parts constituting the *nyi* in a woman. The three parts of the male *nyi* are: one part of his father's *nyi*, one part of his mother's *nyi* and one part is his own individual *nyi*. The *nyi* of a woman is made of these three parts, to which must be added one part of her husband's *nyi*, meaning that she acquires the complete status of a person only once she gets married. The centrifugal approach shows that this technique of care giving and treatment is connected to the relationships between men and women, and to the inscription of the person in the social space (Fainzang, 1985). In the present case, not only does it allows the basis on which the perception of the efficacy of a treatment is built to be understood, but also the way human societies naturalise and thus legitimise social relations by founding them on the definition of the person.

Thus, to contribute to social and cultural anthropology, medical anthropology must, as general anthropology, take part in this work of weaving the various social levels. Now, this weaving has to do with the content we assign to the notions we use and with the way we construct our object, that is to say, with the tools we handle.

The tools of Medical Anthropology

I have already stressed the importance of dissociating medical anthropology from medicine (Fainzang 2000 [1989]). In this respect, I have underlined the need for medical anthropologists to maintain their identity as anthropologists and not medical doctors (cf. Fainzang 1998). It seems to me that medical anthropology can make a useful contribution to general anthropology only if it keeps its identity as a discipline of social science. That is to say, medical anthropologists must construct themselves through their difference with medical doctors. The proximity between medical anthropology and medicine is widely discussed today (see Browner, 1999, who speaks of the "medicalisation" of medical anthropology). However, there are many anthropologists who, while they defend the idea of a necessary "demedicalisation" of the discipline, tend to construct their researches with the tools borrowed from medicine and with medical problems. This medicalisation of medical anthropology tends to leave it on the fringe of social anthropology only because medical anthropology is excessively inclined to building its objects within the lines of medical problems.

The first difficulty arises from the use that many anthropologists make of the notion of illness itself, within what is intended to be a clarification of concepts. The problem with the term « illness » is that it claims to have a large consensus among medical anthropologists but it is far from being commonly used and from having similar epistemological implications. All medical anthropologists have found cases which do not correspond to the medical definition of disease but which are nevertheless regarded as illness by the subjects. Yet many anthropologists, while rightly distinguishing the concepts of disease, understood as a bio-medical reality, and of illness, as a personal experience, still tend to regard illness as a *response* to disease and, therefore, never conceive of it as a separate and independent phenomenon. They still follow the point Kleinman made long ago that "illness includes secondary personal and social responses to a primary malfunctioning (disease) in the individual's physiological or psychological status (or both). Illness is the shaping of disease into behaviour and experience. It is created by personal, social and cultural reactions to disease" (1980:72). If Kleinman succeeded in transcending some of the notions he used at first and in particular the notion of medical systems which he enlarged to the political and the moral dimensions of the systems of health (1995), many anthropologists still give a reductionist content to the notions and concepts used.

Yet what anthropologists should be interested in, and what should govern their theoretical construction of the object "illness", is not only the feelings which the subjects have about the reality of a disease and the analyses which they make of it, but also everything they consider as illness. This means that illness should not necessarily be dependent on its phenomenological reality or, at least, on the way biomedicine defines this reality. There can be representations and even identifications of illness without there being any diseases in the bio-medical sense, and without any implications of psychic disorder. They are anthropologically important, for it is the way in which people perceive and interpret their condition as illness that determines their recourse to therapy and many other kinds of social practices. That's why I suggested that the category of illness should be taken as an "empty" category, to be filled by people in the light of their own social position, history and culture.

What is striking here is that a concept, which aimed to create some distance from the medical perspective has paradoxically reinforced this perspective!

In the same vein, anthropology must consider the ethnographic materials and the notions that are related to them without depending on the biomedical perspective. I showed that people have certain notions of prevention, contagion and efficacy and the content of our group study is often quite different from that which health professionals give them. They have, therefore, an anthropological content, which may be different from their medical content. That's why I argued that medical anthropology should question the content of all the notions used in the domain of health and illness (Fainzang 1998).

In an attempt to bring fruitful elements of reflection to social anthropology, medical anthropology must renew the approach to these notions by relativising, shifting or enlarging the bearing and the meaning of its objects. For example, the complex and stormy debates that health professionals have about the issue of knowing whether Aids is a «contagious» or a « transmissible » disease is not only a purely technical question. The use of these notions of contagion and transmission is in itself an object for anthropology since they have social reasons and social implications.

Even a term such as «risk» must be questioned and rebuilt by medical anthropologists. By analysing the perception of risk, medical anthropology must admit that people's dealings with risk involve many social processes and dimensions (economic, symbolic, relational, etc.) other than the purely medical way of considering risk in its sanitary dimension. Indeed, anthropologists cannot content themselves with noting that there is an important gap between scientific knowledge and lay perceptions of medical risks, and with accrediting the opposition which actors of Public Health and epidemiologists make between "real risk" and "perceived risk". Admittedly, anthropologists have a role to play in understanding the way in which these risks are perceived and managed by the population. Their role is also important in the apprehension of the whole context in which they fit, in order to connect the perception of risk with this context. However, they also have a particular role to play in the deconstruction that must be carried out if risk, and how it is built, is to be understood. Although it is clear that risk belongs to a given social context, and that the way this risk is dealt with is in keeping with this context, anthropology has underlined the social constructions of risk which hide behind the apparent objectivity of its medical or epidemiological definition. The construction of risk depends partly on social institutions, as Douglas showed (1992). In her approach, the reality of the dangers does not determine the perception of risks: what prevails is the way in which risks are considered as serious and are judged acceptable or not, in relation to a given context. According to Douglas, the concept of risk is a way of satisfying a goal: that of moralising and politicising the dangers within an industrial society. The hierarchy of the risks formulated by the medical institutions or the media is thus related to an arbitrary culture, which makes it possible to speak about the "social uses" of the epidemiological concept of risk.

The field of AIDS research has prompted greater reflection on the issue of risk. Many studies have aimed to highlight the social factors that explain or determine why people adopt behaviours with risk. Several authors have shown that behaviour with regard to the condom can represent, according to the partners, a usable resource for constituting the relation. To refuse explicitly to use it may be a way of expressing confidence and attachment to the other person. On the other hand, attempting to impose it, may be a way of marking a certain distance and a desire not to commit too much to the relationship. Research in Africa came to the same conclusions: accepting the condom may mean that the relation is weak; refusing it may mean that the relation is strong. The logic of protection is the logic of positioning vis-à-vis the partner in a relation. On the whole, the stakes of health are integrated like resources for the benefit of relational stakes. In addition, the risk of contamination coexists (or competes) with other risks. These are biological and social risks (1). Under these conditions, the risks of transmission are often regarded as lower than the family or social risks of rejection.

As we can see, risk-taking has nothing to do with unconsciousness or ignorance: it is, in a way, rational, since it is a means to an end in the relational field. Risk-taking can bring important relational benefits compared with which the concerns for health can appear derisory. Therefore, it seems clear that if some individuals adopt risky behaviours, it is not because they ignore these risks, but because they respond to a second stake that competes with the first. The risk, then, is clearly not only sanitary and taking a risk is a response to stakes that are not necessarily those of prevention. Besides, when the risks of transmission are regarded as less important than the risk of exclusion and when dealing with risks leads the individual to choose in favour of the least important, this dealing is made according to the personal (and collective) appreciation of a risk vis-à-vis other risks. In this respect, rather than speak of dealing with risk, we could speak of calculating risks. For example, a woman who does not procreate considers that the risk of endangering her social recognition is less important than the risk of losing her health.

If it can be agreed that there is a bond between risk evaluation and the choice of taking a risk, it must be admitted that the question is not so much one of taking a particular risk as of refusing to take another. Therefore, anthropology's contribution is that it can focus on the social context in which this "calculation" of risks takes place, and on the very deconstruction of the medical concept of risk. From this point of view, the opposition between "real risk" and "perceived risk" does not hold because the perceived risk of being socially excluded is just as real as the "real" risk of being contaminated by AIDS. One can have a judgement, as a doctor, an epidemiologist, or an actor of public health, on the gravity of one risk compared to another (if one starts from the criterion of health), but this must not be the approach of the anthropologist. If for the actors in public health it is perfectly reasonable to make a choice, for anthropologists it is not. Anthropologists must not decide the primacy of one risk over another. That is why anthropologists must reappropriate the notion of risk which has been, in a way, confiscated by the medical perspective, in order to understand the various dimensions which compete with the sanitary one and which are the ground for people's behaviours.

Yet admitting to the relativity of such concepts and categories as the normal and the pathological must not lead us to cultural relativism. These notions must not be seen as fixed, as categories that are given forever, but as social constructions, within a society, subject to the variations of the social contexts in which they have been elaborated. If their social and historical bearing are to be discovered, it is indispensable to think about the notions generally used in public health in a new way, and to free them from the content that medical sciences assign to them. This epistemological course is a prerequisite to the contribution of medical anthropology to anthropology.

Now the notions and concepts themselves are part of the way of constructing the object, and the latter is connected with the way of problematising the research.

From the problem to the problematisation

Strictly on the level of the problems it raises, medical anthropology makes a decisive contribution to social anthropology by the exemplary character of illness. For instance, illness, as a paradigmatic example of misfortune, reveals the nature of social relationships. In this respect, many questions can be asked by the field of medical anthropology which directly interest social anthropology (namely: what do perceptions of illness and therapeutic recourses reveal about the relationships between individuals and between groups? How are these practices and representations articulated with the cultural specificity of the various groups? Do representations of illness produce specific social practices? What social logic do they refer to?). Medical anthropology may be useful for social and cultural anthropology in so far as the way people think and deal with illness teaches us a lot about the relationships of people to society. For example, the kind of interpretation they have for explaining the occurrence of their sickness, and the possible modes of blaming someone else for being responsible for their condition, implies a certain way of thinking about one's inscription in the world and in the social network. The relationship to illness reveals the social relations and the symbolic systems that prevail in a society, and it functions as a grid for understanding these relations and systems. (Fainzang, 2000 [1989])

But the particularity of this domain is that it is the specific place of the body and suffering. Illness activates representations of the organs, the substances and fluids, the person, the sexes, etc., the deciphering of which is a privileged way of studying symbolic logic's governing life in society, one of the main purposes of anthropology (cf. Sahlins, 1976). Besides, the very discourse about the body is a kind of lexicon of social relationships. For instance, the study of the representations and practices associated to the issue of nerves and nervous illnesses has shown that they largely refer to the construction of the relationships between genres (Cayleff, 1988). The study of the causes of alcoholism and of the consequences of over-consumption of alcohol on the body, as perceived by alcoholics, shows how far the symbolic connections they make and their motivations to consult a medical doctor are related to their adherence to the schemes resulting from the social construction of genres (Fainzang 1996). The medical field is but one social field among others even if the questions it raises are exacerbated by the radicality of what is at stake, such as life, death, and sexuality.

There are of course many ramifications of the questions raised by suffering (see for instance Kleinman's new perspectives on the political dimensions of suffering in Lock & Das 1997). In this regard, medical anthropology has made an important contribution to the development of critical anthropology and its political implications in the fight against injustice and social sufferings, and has also allowed us to sharpen our look, even in a less militant vein, on social realities (inequalities, conflicts, etc.).

In any case, medical anthropology may enlarge our understanding of social life, thanks to a remodelling of the problems. This remodelling assumes that the problems themselves must be studied from a perspective other than the medical one and in the light of other spheres of social life, and of other social and cultural settings.

For instance, there is much to be gained by examining the issue of anonymity, which divides some associations of ex-alcoholics, in the light of the spheres of ritual and political life in various cultural settings. Not only will such an examination allow us to understand the deep significance that anonymity has in the frame of the theories of illness and recovery of these associations, but it will also allow us to enrich our understanding, in general anthropology, of the issue of the person and identity. Of course, one could be satisfied by studying the meaning of anonymity within the frame of associations for ex-drinkers, by saying, as many social scientists do, that it is limited to the case of Alcoholics Anonymous, and that anonymity is either a means of attracting members who feel too guilty or who fear the social consequences of recognised alcoholism, or a means of lessening the individual differences among the members of the group, by promoting mono-morphous histories, fighting attempts at self-promotion and encouraging self-sacrifice, or even as the condition of the constitution of an alcoholic identity, itself a condition of the efficacy of this type of group. However, a group of former drinkers like *Vie libre* rejects anonymity: here, the individual is asserted, patronymics are known, and the ex-drinkers' stories are not monomorphs. The unity of the group is not achieved at the price of silence over personalities or individual stories. Everyone knows quite a bit about the others: their names, their addresses, their professions, their life histories, their families, and their work places (Fainzang 1996). Therefore, we must go beyond the single explicit discourses of these associations on anonymity to understand what is really at stake. We must also try to push the analysis usually made by social scientists and psychiatrists further if we want to explain the therapeutic role of anonymity. Anonymity refers to something other than a technique that allows people to come and remain in these types of groups.

To this end, we can fruitfully compare our materials to data collected in quite different cultural and social settings, namely to data drawn from two examples of African societies.

1) Describing a nomination ritual for a sovereign chief amongst the Ndembu in Zambia, Victor Tumer (1990 [1967]) mentions that the chief, during the period of liminality, shares the name of *mwadyi* with his wife. This name is equally given to boys going through initiation. It is a sign of the anonymous condition of the candidate, explains Turner. Here, although the context is not that of sickness, anonymity is what marks the state before a passage.

2) Among the Bisa of Burkina-Faso, a sick man is not spoken of by his name. He is spoken of as "the sick man". The sick man's anonymity can be explained because he becomes excluded from all forms of transaction, from all alliances, from all collective rituals (other than therapeutic ones), and because he does not exist socially as an individual integrated in a network (of kinship and production, for example). Being sick means being excluded from social relationships; recovering means being able to enter exchanges and relationships.

The wider significance of anonymity in both these situations allows the issue of anonymity in ex-alcoholics' associations to be reconsidered. If we compare them with what happens in *Vie libre*, we find that there are common points with the way that this movement deals with the issue of identity. These points appear when we study a particular ceremony (the presentation of the pink card). This ritual is held at the end of a period of six months of abstinence from the time the member joined. It is the moment when the ex-drinker is integrated into the group of pink cards and into the large *Vie Libre* family. From this moment on, the term «pink card» or «cured drinker» designates him, after his own name. During the ceremony, which refers to the belief in the alcoholic's cure, a paragraph is read from the Association's charter that stipulates the rights and duties of pink cardholders. The designation ("pink card" or "cured drinker") is not an individual identifier; it does not single out the individual: it integrates the person into a family-like structure. The individual's new identity is, therefore, like a second patronymic or like a lineage name that bestows specific rights and duties. We notice that *Vie Libre* does not fully include alcoholics into social life until they are "cured drinkers," in other words while they are still sick; they cannot take part in elections; they cannot carry out militant action. The state of sickness renders the subject sociologically anonymous. In *Vie Libre*, the passage to the state of "cured drinker" is equivalent to regaining an identity that grants the right to act within the group. The cured drinker becomes active; the member of a network, a militant, and a person qualified to take responsibilities and to have say.

The light that these African examples shed on the problem gives us a different understanding of what anonymity means and implies in the ex-drinkers' association. The fact that the members of AA remain anonymous and grant the subject the sole identity of "alcoholic" means that the individual remains at the stage of a sick person and that there is no passage. Indeed, AA assumes that the individual remains an alcoholic forever. On the contrary, the *Vie Libre* movement allows the individual it considers cured to acquire a new identity. By bestowing the identity of cured drinker on a specific individual, *Vie Libre* demonstrates that it refuses to leave the sick person in that state. Furthermore, this cross-cultural approach to the problem allows us to see how far dealing with anonymity plays a part in the constitution of the person. A joint reflection on the place that anonymity has in self-aid groups and in quite different cultural and social groups or settings helps us to understand the deep significance anonymity has in the construction of the link between the person and his/her inscription in the world. If such an approach clarifies the motivation behind *Vie Libre's* rejection of anonymity and leads to the proposal of a new interpretation of anonymity in Alcoholics Anonymous (2), it also provides new insight into the general issue of anonymity versus identity in social anthropology.

Therefore, another condition for the contribution of medical anthropology to general anthropology is to model the problem set by the research in medical anthropology so as to give it a shape other than that given by medical doctors. I shall illustrate this point with another example: the issue of the use of medicines.

In a study about the social uses of medicines and prescriptions among patients, I was struck by the fact that doctors could not understand what I was attempting to study if it was not the issue of compliance. Yet it is obvious, from an anthropological point of view, that the question of knowing what the patients do with their prescriptions and their medicines is not the same as the question of knowing if they do what the doctor prescribes that they should do.

As some authors have shown, the issue of compliance creates difficulties for the social anthropologist because it implies studying the phenomenon from the perspective of medical doctors. In fact, compliance is defined as the measure in which the behaviour of the patient coincides with the medical advice (Haynes *et al.* 1979). In this respect, Trostle (1988) proposes that the idea of «compliance» should be considered as an ideology which settles and justifies the authority of medical doctors. Trostle also shows that the importance of the debate on compliance is linked to the fact that it refers to an ideology of the authority of doctors and health professionals. According to him, the whole literature devoted to this issue, though it pretends that it is concerned with the improvement of health, is in fact a literature on power and control. He denounces, with reason, the fact that the social sciences that study this problem adopt the vision of the world of health professionals. The issue of compliance reduces the problem of the *use* of medicines to that of the *conformity* of the use of medicines to medical prescription. Conrad (1985) goes so far as to question the anthropological relevance of studying compliance, in that this issue creates the suspicion that the anthropologist is working *for* medical doctors.

The point, therefore, is the following; anthropologists should not give way to the normalising temptation of the problems defined by medicine, such as the problem of compliance, or submit our studies to some form of medical reductionism. In the use of medicines and prescriptions, this means that we must be cautious in our attempts to understand the representations and behaviours induced by prescriptions and all the social relationships built around medicines (3), and and we must not satisfy ourselves by studying who the good and the bad compliant patients are. When studying the social uses of medicines, the point is not only to find out how drugs are used but also, more importantly, to find out what drug use can reveal about individuals and society (Fainzang 2001).

This example illustrates the last point I wish to make here, which is to distinguish between the problem and the problematization. It seems necessary to transcend the formulation of a medical problem in order to set it in anthropological terms and with an anthropological purpose; that is to say, the problem set by medicine needs to be deconstructed and then reconstructed in accordance with anthropological questions. Demedicalisation, which is a prerequisite if medical anthropology is to make a contribution to social anthropology, passes along a new path of problematizing.

Finally, the work advocated here on concepts, the construction of the object and problematisation argues in favour of using medical anthropology, not as an aim in itself, but as a tool, in the service of social anthropology.

Notes

(1) Morbidity and mortality are linked to pregnancy and childbirth in many African countries. Women who fail to get pregnant or who refuse non-protected sexual relationships, which would be interpreted as sterility or a refusal to procreate, risk being socially excluded and withdrawn from the institution of the levirate.

(2) For a more detailed presentation of this issue, see Fainzang 1994.

(3) For example: the relation to writing expressed through the perception of the prescription as a material object, the relation to time expressed through the use of a medicine in the long or short term, or the relation to power, expressed through the way of behaving towards medical doctors, etc.).

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“Drugs”, an analyser of contemporary societies

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Introduction

In this paper, I take for granted that the different uses of drugs are a structural phenomenon in human societies, which explains why studying them can serve as a very interesting way of making a comparative analysis of the basic aspects of human behaviour. Their study can provide very valuable information not only to the field of Medical Anthropology, but also to the field of Anthropology in general.

From this perspective, my proposal here is limited to the concept of “drugs,” as a product of Western 20th century culture and, more concretely, as a product of the social construction of the “drug problem.” In this sense, I believe that it can be useful to consider “drugs” to be a potent analyser of contemporary societies.

By “analyser,” I mean a phenomenon or device, formed by a group of processes. This group of processes is considered to be equivalent to the constitutive processes of the society in which they are found. The do not stand purely as a formal device; rather they deal with a phenomenon that occupies a strategic position within the society in question, a “total social phenomenon,” in Mauss words.

To see how this analyser functions, I suggest looking at two specific and very relevant aspects of the Western model of “drugs.” These aspects include the “discussion on drugs” as a form of meta-language, and the identification of “drug dependency,” as a form of referring to a constitutive factor of the human being, from a specific, cultural perspective.

Part I

1.1. Some initial points

With the aim of conceptually defining the principal terms used, we encounter our first problem: we are guided by the definitions, or rather by the specific uses, which distinct authors have made regarding these concepts. As stated by Menéndez (2000: 163), «definitions usually express what the categories should be and not their actual uses, even those, which consider the concepts to be provisional and/or group instruments. The meaning of [...] any concept should be looked for in the description, analysis, interpretation, and/or in the intervention of specific processes.»

For the concept of drugs, analysed from the transcultural point of view, I believe that an instrumental definition can be proposed. This definition would be based on their real uses, which are dealt with in different studies of the concept (1). Moreover, as from the end of the forties and following the sociological orientations derived from the School of Chicago, ethnographic and socio-anthropological studies began to appear about the distinct "world of drugs" in urban/industrial societies (2). Some researchers have continued the discussion on drugs from different theoretical perspectives (3), and the states of the art by Edwards and Arif (1981), and the European repertory presented by Fountain and Griffiths (1997) (4) are seminal references even from the point of view of social intervention.

May be all human societies have been familiar with and continue to use very different substances to attain various states of stimulation or sedation. These substances are used for pain relief, at social gatherings, for the experience of pleasant sensations, mood alterations, changes in one's field of sensory perception, and for the attainment of some forms of knowledge, which are out of the ordinary, etc. That is to say, in all of these examples, chemical substances that can modify such functions of the human body as perception, behaviour and motor functions are introduced into the organism (normally in small amounts). The effects of these substances, their consequences and functions are conditioned, above all, by social, economic, and cultural definitions, which are generated by the social groups that use them.[5] In other words, the use of drugs is not so much a chemical phenomenon (although it is this, too), but rather a socio-cultural phenomenon in which the handling and the effects of the chemical components is somehow based on the dominant social representations existing in the group using them.

When we make a historical analysis of the construction of the "social drug problem", we observe that it has been gradually building itself up throughout the 20th century. We can see that this transcultural definition lends itself only to some of the substances defined as drugs, while others are left out. If we look for a definition of "drugs" from the point of view of the prohibitionist paradigm, it can be found at the root of the principal management models of drugs in modern-day society. If we look at the criminal model and the medical model (principally the former) (6), we can immediately verify that the term "Drugs," (as such, and in capital letters), in the most orthodox of discussions, refers indistinctly to a whole group of heterogeneous, illegal substances. These include cannabis, heroin, cocaine, hallucinogens, ecstasy, etc., while alcohol, tobacco, hypnotic drugs, sedatives and tranquillisers are not included. The justification, at least from the point of view of the 1961 Vienna Agreement, is focused on defending public health. As such, using the same scientific rationale that put together the previous definition, we find considerable inconsistency in this objective, not only in the method (the repression)[7] but also in those substances that are inside and outside the boundaries of "Drug." Such is the heterogeneity of the characteristics, which exist on both sides of the established limits. So, it is difficult to find coherence between the concept of "drugs" and their (supposed) empirical references, beyond the fact that the term, "drugs" refers to all those substances that are on the corresponding lists in the international treaties.

Actually, apart from the prohibitionist arguments, which hide behind their scientific appearance and try to affirm the contrary, this is not at all important. What stands out, once the previous corroboration has been made, is that drugs are a symbolic construct with several meanings, which revolve principally around themes such as desire, pleasure, performance, anxiety, addiction, sociability, risk, exploration, the unknown, the forbidden, pain or death. Its basic empirical references would be various designations, which carry the image of (implied) substances, above all heroin and marijuana. Some of these designations carry the image of activities such as "smoking" and "shooting up," as well as the ambivalent figure of the "drug addict." It is important not to forget that this symbolic construct also constitutes a material reality throughout the social processes in which it is involved.

1.2. "Drugs," a total social phenomenon

As pointed out in the introduction, drugs have become a total social phenomenon within our contemporary societies. I believe that they are sociocultural phenomena, which allow anthropologists privileged access to the societies they study (much in the same way as sacrifice for Mauss (1968), persona for Leenhardt (1995), or religion and relationships for many other anthropologists). In this way also, the concept of drugs is useful for studying our societies. They are so situated that the analysis of social practices and the discussions revolving around them (and particularly the interrelationships between them) are a way of attaining information. This analysis allows us to reach the central aspects of contemporary societies, as they are forms of construction, erected by the subject. These constructions are also the result of social control and its institutionalisation, economic and political domination, social communications, as well as the basic, cultural orientations and values of a society, such as the myths that revolve around pleasure or death, etc.

Thus, it is a total social phenomenon, «... which is manifested, not only through opinions, but also through attitudes and behaviours, which influence the intervention of diverse institutions in our society. These interventions by executors (parents, medical experts, etc.) cause an uncountable number of problems in questions such as personal and family relationships, learning, health, adaptation, or to get basic needs» (Comas, 1986: 4).

From a methodological point of view, the discussions on the social representations on drugs, have been hegemonic untill now. These discussions talk of the "drug epidemic," which is invading our society, and involve related feedback and social practices (police actions; judicial, educational, sanitary and social interventions; informal social interactions, etc.). On the other hand, there is the actual practice of using drugs, the real use of drugs by specific individuals, which is a different phenomenon from the above-mentioned point (although with some areas of contact in evidence). These concrete uses are in some way also influenced by these discussions. The "drug problem," therefore, involves basic, distinct levels of reality, which grant it significance and help to culturally direct social interaction in one direction or another.

1.3. Strategic social processes, drugs and "Drugs"

I will now point out some of the basic levels at which "drugs" are strategically placed. For expository reasons, I will refer to each one separately, however, it is important to remember that they are inter-related by a series of dynamic processes. In addition, I will refer to drugs using the transcultural (scientific) concept, whenever necessary, but in places I will refer to the concept of "drugs."

At a personal level, many uses of drugs, which are assumed to have been established by the social conditions of existence, represent a form of subjective adjustment,. This is so at both the individual and social level, when dealing with either institutionalised uses or non-institutionalised uses. These are often enveloped in a certain mythology (though sometimes negative) created around the substance being used or the practice being carried out (8). Varied uses of drugs are involved in social relationships, both instrumentally and symbolically. As such, it is possible to identify oneself by using a substance, which has some sort of prestige and is found to be useful for an established relationship or for a relationship in the process of being established. The construction of specific associations, linked to how some (non-institutionalised) drugs are circulated in our societies (9)), has had negative social consequences for many people and social cohesion itself. These negative associations have resulted in the over-exploitation and the "criminalization" of groups that occupy subordinate (or already marginalised) social positions. We should also note the "marginalization" of individuals and groups from social sectors that are initially "better off" than those mentioned above. On the other hand, the people suffering the consequences of drug use have prompted various pressure groups to be created, some of which have sufficient power to be noted at the world level.

From an economic point of view, the businesses that deal in drugs (e.g., pharmaceuticals, tobacco companies, wineries and illegal traffickers) generate a considerable volume of direct and indirect profits. These businesses are of such importance within the sphere of the world's economy that their capacity for power and influence is not to be scorned. In this "package" we should also include the softening effects that the middle and lower levels of production and illegal trafficking often have on the economic crises within the framework of the informal economy. There is also another sector that cannot be forgotten: the professions related to the drug culture in the broad sense of the term. Perhaps it may not be as economically powerful as those mentioned above, but the decisions taken by this sector can interfere to a certain extent in the dealings of the other groups. These professions include bureaucrats and the administrators of control organisations, police, lawyers and judges, sanitary workers and researchers, etc. In addition, we should also mention the dividends, which the "drug businesses" can provide for other industries, such as agents, record companies, or "show-business," in general.

At an ideological level, drugs are involved in various processes of rationalisation, and in particular politics. These processes create certain visions of the world, which revolve around the "drug question," and ideological illusions and political manipulations, which can distort and disguise other, more fundamental problems and, therefore, be more compromising for the maintenance of the "status quo" at certain critical moments. Also to be noted is the authorisation of forms of social control, using the "drug question" as an excuse. (The relations between the United States and Latin America in the eighties, and in particular the Colombia Plan, would be a good example of this). The "repressive pretext" offered by "drugs," with respect to certain socio-political dissidence or the great political/electoral profitability of the subject, is also notable. To sum up, the drug discussion provides a series of arguments and explanations, which help people and groups to decide to act in one way or another. All of this occurs from more elaborate positions (where the previously mentioned conduct is more or less explicit, though not overtly stated, since the participating parties would lose their capacity for influence), as well as from much more experienced and direct positions.

1.4. Social representation and drugs

In keeping with the above (principally with the last point), we can deduce that the social representations of drugs are a constitutive and fundamental part of the same phenomenon. In fact, we can consider them to be a nuclear element (10).

The social representations tell us what drugs are, what they are used for, and what their qualities are. They tell us what effects they have, how they should be taken, whether they require special preparation and when they should be taken. They provide us with techniques for ingesting the drugs, the necessary doses, etc., and tell us which drugs are the most appropriate. Finally, they tell us what their origins, history and social considerations are. These representations should have a minimum of congruency with the socio-economic base and the cultural inheritance of the society being dealt with (in spite of the fact that the relationship between these two elements is never mechanical). Thus, the tendency towards this congruency means that the social representations of drugs are different in different societies, where their use is a required step (at least at a ritual level) for the population in general and where their management is reserved for only a small group of prestigious specialists. In this type of society, only some drugs enjoy this generalised social statute of necessity, while access to others is complete taboo.

Currently, in almost all societies the model of drug perception and management is based on two fundamental paradigms: the legal model and the medical model. That is to say, there are some international laws, which are reflected with greater or lesser precision, in the regulations and organisation of drug control in the different states. However, at the same time, there is also a complete line of thinking and behaviour, which places drugs in the field of illnesses. All of this produces a set of ideas about what drugs are and what their place in life should be. It takes into account the influences of the world view, and also carefully weighs the moral aspects of drugs (in association with what they should or should not be), as well as the set of social devices for managing their appearances, effects, etc.

I believe that it is no longer necessary to discuss, at a general level, the nuclear role of social representation in the drug phenomenon, especially because we have considered it to be a total social phenomenon from the start. However, to finish up, I believe it would be interesting to verify its importance by analysing a specific case.

1.5. The Spanish case

I am interested in showing how the social representations of drugs have affected the group of social representations that have existed in Spain for last twenty-five years and their evolution. Perhaps at one time or another this has also happened in other Western countries, but I believe that the specificity of Spain's case lies in the fact that this occurred in the context of a political transition into democracy. The so-called "drug problem" constitutes a social problem that built up in Spain from the end of Franco's dictatorship (mid seventies) to the end of the eighties. At that time, drugs were already part of the repertory of basic problems in our society. In reality, during the fifteen years between 1975 and 1990 the problem developed around what would end up being the drug paradigm; that is to say, the personal and political conflicts, which would be protagonised by heroin and heroin addicts.

More concretely, after 1973-74 heroin began to circulate throughout Spain and it travelled through the social networks, where cannabis products were already predominant (forming part of the old counter-culture core). It then began to spread and in 1979-80 it reached the young sectors of the general population. Among these young people, the older ones had already had social, militant and/or political experiences (from the end of the Franco regime to the transition). However, these young people were still outside the game, in the new situation that was consolidating, and other even younger people were plainly beginning to develop what we call, in classical terms, "deviated" practices of socialisation. They were on the outskirts of their schools, experienced difficulties in entering and keeping jobs, had problems with their families, and became progressively immersed in delinquent activities. They practised using drugs other than cannabis and alcohol, such as amphetamines and intravenous routes (see Comas, 1985, Funes and Romaní, 1985, and Gamella, 1990).

Until that moment, the "drug problem" had been secondary to the big questions raised by the end of Franco's regime and the development of democracy. But once the eighties had begun, this social problem became one of the heavy "leit-motifs" in the social conscience, and it accompanied and contributed to the consolidation of the democratic system that we are familiar with today.

In effect, the drug problem always appears at the top of the general opinion polls, as well as the polls regarding victimisation, sharing importance with unemployment and terrorism. Moreover, in 1983-4, there was great political conflict surrounding a small reform in the Penal Code instigated by the Minister of Justice of the then new socialist government, which had the "drug question" at its epicentre (11). Later, there was a certain institutional reaction with the creation of the *National Plan on Drugs* in 1985, and the progressive extension of socio-sanitary services during the second half of the decade. This phase, where drugs were the great protagonists, ended around the beginning of the nineties, at a time when "anti-drug" citizens' movements began to take shape, with considerable media impact in numerous neighbourhoods of our cities (about the time of the municipal elections in 1991) (Romaní, 1999).

I believe that this historical picture illustrates the fact that the predominant social representations in the Spain of the eighties came close to its vision of the world, where "drugs" occupied a central place. A place that, right now, «forms a part of the basic cultural heritage, which allows contemporary Spaniards to communicate and to act, thus allowing them to orient themselves within the social context of where they live, rationalise their actions, explain relevant events, and defend their identities.» (Megías, 2000:7).

Part II

2.1. "Drugs" as a meta-language: a metaphor for society

In order to ensure their own continuing existence, various social groups and society at large continuously define reality using mechanisms that strive to reconstruct this reality both socially and dynamically.This reconstruction consists of cultural images and stereotypes, some of which, within the broader context of the social representations, have managed to symbolise, either actively or passively, the basic aspects of our social life.

The socio-cultural phenomenon of drugs has been built up in such a way that it contains a series of stereotypes that refer to the nuclear aspects of our existence. We refer to specific ancestral fears, related to our own social and natural natures, to the difficulties we experience in controlling our emotional bases, difficulties we have in understanding ourselves and in accepting our places in a continually changing world, etc. It may be thought that the popular success of the social construction of "drugs" is based on the prohibitionist paradigm (one of the elements that permitted the consolidation of this construction to become the dominant perception and management model that we are familiar with today). This was not only due to the fact that the prohibitionist paradigm knew how to integrate various (more or less powerful) interests into its model. It was also because it knew how to manipulate the flow of information, in such a way as to permit it to mobilise the deepest emotions of broad sectors of the population.

It was not the act of taking some type of drug. And, in particular, it was not these aspects that were behind the intense movement for control over drugs. Rather, it was the fact that there was a kind of emotional contamination, which made this topic one of mixed and extremely powerful sentiments. People were afraid and frustrated because they perceived that their vision of the cosmos and social world were being threatened (see Cloyd, 1985).

The effects of drugs, from the point of view of their instrumental and expressive uses, can be considered to be an extension or a prolongation of our own bodies. In this way, controls over drugs would be justified as necessary to preserve our own "selves" (since many of the effects, or potential effects, of different drugs can induce states beyond the known limits of our reality and cause the non-differentiation between ourselves and our environment). In this respect, they become vehicles of contamination, precisely because they do not define their own limits (see Douglas, 1991). The "drug problem" carries all of these fears and anxieties, which focus mainly on the fear of the unknown, or what is thought to be uncontrollable. They become what they embody, the "outsider," and in this sense, they become a concrete, historically collective variation on a basic structural-kind of theme. They have other homologous manifestations, which are often encouraged, such as certain kinds of sexual taboos or xenophobia and racism. To sum up, the social construction of the drug problem has created another "Judas goat."

“Drugs” and the discussions they generate have become a metaphor – with all its ambivalence – which allows us to understand reality and intervene in a specific way. This allows us to manage the real problems to a certain extent but the problems still remain hidden. The fact that the “drug myth” occupies a central position in our society means that everything related to it becomes the object of attention almost immediately. There is a whole series of problems, many of which are structural, at the root of the difficulties and existential anxieties of large groups of the population. These remain “unspoken,” due to the difficulty of finding a language to explain them: e.g., permanent unemployment, generation conflicts, the redefinition of distinct gender roles and life together in domestic groups. Also to be noted are the difficulties that many young people experience when they enter the social world (as well as those experienced by older people), socio-economic instability and the tensions created in urban environments, which have arisen as a result of human necessities. Migrations and the difficulties generated by inter-cultural relationships, as well as the impotence provoked by established routes of conflict resolution, are also some of the anxieties that the population experiences. So “drugs” (a fundamental part of the broader framework on “discussions regarding security”), through simple and overwhelming stereotypes, is a way of “explaining away” these problems and, above all, a way of behaving and calling attention to oneself. However, paradoxically the “solutions” adopted under this perspective leave the system at the root of all the untouched conflicts (including the problem with the drugs themselves!) In addition, the system prevents political and technical measures from being adopted to resolve these problems more effectively (12).

2.2. “Drugs” as dependence: a metaphor for life

The current configuration of the “drug problem” reveals the principal contradictions in the role assigned to general addictive behaviour within consumer societies. That is to say that there are cases of encouraged consumption, which are presented as desirable and even necessary if we are to achieve balance in our personal lives and success in our social undertakings. On the other hand, there are also certain kinds of consumption, which are restrictively regulated and also censored. Transgressions in these regulations (formal and/or informal) can end up having serious consequences for those who participate in violating them.

What is conflictive about this situation is not so much the relative arbitrariness of the regulations themselves (which is a constitutive element, either large or small, in all aspects of social life). Rather, it is the fact that from the point of view of the socio-cultural heterogeneity that characterises contemporary societies, the areas of arbitrariness of the regulations are at times perceived to be just that – arbitrary. Different social sectors perceive these regulations to be arbitrary and, therefore, they are seen to be impositions, put upon them by other, specific social groups. That is to say, there is no consensus regarding these regulations. The conflict provoked by this situation should not be surprising, bearing in mind the importance which "consumption" has acquired in our societies, not only from a strictly economic point of view, but also from a cultural one (as an element of identity).

From the prohibitionist paradigm a key element in the dominant discussion on "drugs" is the identification between "drugs" and "dependence." It is said that the mere contact with drugs will leave an individual a prisoner to them. If the criminal model is stressed, then the criteria for discerning this illicit step are established using legality. So, the first "joint" opens the door to heroin or crack addiction, without entering into digressions regarding patterns of alcohol or tobacco consumption, for example. These may or may not make access to other drugs easier, and pose many other possible questions. What is important is that the limit of "forbidden" has been crossed, which leads inexorably to addiction. Of course, at this level, it becomes more and more difficult to find developments, which so explicitly define the questions (in the manner in which I have summarised here). However, in keeping with the specific uses that, along with Menéndez, we have pointed out in our introduction, this focus can still be found in the official documents of the International Committee on Narcotics Control of the United Nations (13).

If the focus stressed is that of the medical model, we must bear in mind the absolute hegemony of the biomedical perspective. When the use of a substance by an individual is analysed, what can be noted are the effects of that substance on his/her conduct. That is to say, the interpretation of his/her conduct will be reduced to and explained by a sort of manufactured argument – based on a specific, standardised clinical practice – about the pharmacological effects of a substance on the central nervous system.

Whether the option is criminal or medical – or different combinations of the two – they are both destined to the fatality of dependence, expressed by the metaphor "drug slavery," which points towards a certain kind of determinism. In one case, this would have to do with bad will perversion or the social conditions that lead a subject to deviation. In the other case, the determinism is attributed to pharmacology. But in both cases, and under different guises, what exists in reality is a negative moral assessment of the conduct of that individual, of his/her values, or in other words, to certain hegemonic interpretations that deal with socially accepted values. He who has strayed from the path will not, supposedly, acquire either liberty or health for himself. These qualities represent the great values of the game, in this case. For this reason, the individual should be treated by correctional facilities, until he demonstrates the ability to re-enter society and, even then, the shadow of the stigma will hang over him for the rest of his life.

This way of looking at things omits what, from a socio-cultural perspective, is a basic, methodological element: that in order to realise the complexity of reality, we must bear in mind the multiple, varied and sometimes contradictory relationships among the contexts, the subjects, and the drugs. In this theoretical framework, it is possible to verify that there are in fact positive uses of drugs for the subject and/or for the group, of which the subject may form a part. There are other uses, which the subject/group attempts to manage to the best of their ability, and by promoting some uses they have to hold back on others. And, of course, there are other uses, which are frankly negative, for the subject and/or the group. (And the interests of the two and/or the evaluation of the conduct do not always coincide.)

It is clear, then, that an important element in the field of drugs is drug dependence, which I defined, inspired by Cancrini (1982), in another text. I stated that, «it consists of a group of processes, through which certain uneasiness, either of a serious or not very serious nature, is expressed, and which may have diverse causes (as well as other manifestations). However, its principal symptom would be the organisation, by an individual, of the complete group actions in everyday life around the rather compulsive, consumption of determined drugs. It can be confirmed that as a social phenomenon relevant to society, drug dependency appears in a characteristic form within central, contemporary urban/industrial societies. It also appears to be due to the influence and/or imposition of the same, in generally sub-alternate (though not necessarily) societies, associated with the processes of urbanisation, as only in these do the conditions which allow this to occur arise» (Romaní, 1999).

In some drug users these circumstances of drug dependency can be seen to depend on the combination of the three basic, cited factors. But this is what the prohibitionist paradigm does not admit: from its perspective, the equation “drugs equal drug dependency” is unquestionable and a given universal (such as all of the positivistic principals on which it prides itself). What we can understand, using this equation, is a determinist idea of human life which, in order to be socially fruitful, should adapt to those requirements that have been discovered by positive science in either its legal/criminal version or in its neurological one. Certain tendencies, impulses, actions, etc., promoted by drugs (or those which are induced by them) should be corrected, also scientifically, in order for the individual to be able to develop his or her life, according to the hegemonic, cultural models that society does not question.

This suggests another equation, that of "dependence equals pathology," under which we can perhaps find the negative result of recognising certain limits to human life. Positivism began to believe that these failings could be scientifically controlled. I am referring to the "modern-day Utopia," which offers a better life through scientific planning, through the intervention of the corresponding professional specialists (14). This has not turned out to be as easy as was expected. And, from there, contemporary science has continued to build its distinct, epistemological reconsiderations. However, sticking to the concept of dependence, what paradoxically appears not to be tolerated are limitations to "free will." This concept was derived from Cartesian rationality, a model that turns out to be too rigid to work with all of the complexities that we now know constitute the principal characteristics of life (15).

To sum up, what the model does not seem to include is the role of dependency in human life, in general, and in drugs, in particular (16). This role has been cited previously in the text, and I shall summarise here, by stating that «man is a dependent being by nature, and I say by nature, not only as an expression, but in a precise manner, for his biological constitution. Man is an animal with open genetic programming, and with a very general orientation towards his instincts, who is moulded in a decisive manner by his culture. He then incorporates this culture into himself ("embodiment") through social interaction and learning. This is due principally to the long period of growth time, which characterises him. This dependence on his socio-cultural environment is a radical aspect (also in the strict and strong sense of the word) of his life. For this reason, what would seem more sensible (and surely, more effective) is to consider how to manage, in the most positive way possible for the individual and the society, the little and not so little dependencies, which make up part of our everyday lives as human beings.

Of dependencies "with a name", there are many. There are dependencies to drugs, gambling, work, order, sex, etc., which for some individuals and in determined conditions, we can define as pathological. And, what doubt can there be, from our current level of knowledge, when we can confirm that certain medicines can precipitate, enable, fix, etc., these pathological processes of dependence. Therefore, I believe that it is more appropriate, in spite of all of the limitations, to approach dependence in relation to what we call a determined "lifestyle." We should do this, above all, in order to point out that it does not only and principally have to do with the pharmacological effects of a substance over an individual. Rather, it is that we are faced with a socio-cultural construction, in which processes of identification, construction of the self, strategies of interaction and the negotiation of roles come together. That is to say, it is a complete framework of social relationships and cultural expectations that contribute to the construction of the subject, and through which the subject can direct his existence (although in this case it might be in the middle of substantially conflictive areas). These are situations, of course, where the pharmacological world plays a role, but where it cannot be considered a causal factor of these same situations (as the biomedical model has tended to do in a simplistic manner). But rather, it must be articulated to the rest of the levels, which make up this phenomenon» (Romaní, 1999:59-60).

Notes

(1) As basic references, I recall the first work done on modern synthesis (Lewin, 1927-1970), the ethnographic and historical works on alcohol (Heat, 1975, Menéndez, 1990 and 1991, Cottino, 1991, and Campos, 1997), and the anthropological monographs, which focused mainly (although not exclusively) on hallucinogens and the shaman complex, developed in the seventies (Levi-Strauss, 1979, Harner, 1976, Furst, 1980, and Reichel-Dolmatoff, 1977).

(2) See Lindesmith, Becker, Finestone, Hughes, Blumer, *et al.*, etc. See the analysis and the references of Dan Waldorf, 1980.

(3) Among others, Agar, 1973, Rubin, 1975, Hugues, 1977, Romaní, 1983, Adler, 1985, Biernacki, 1986, Parker, *et al.*, 1988, Bieleman, *et al.*, 1993, Bourgois, 1995, Pallarés, 1996, Díaz, 1998, Fernandes, 1998, MacRae, *et al.*, 2000, and Gamella, *et al.*, 2001.

(4) For empirical support to this paper, see section b) monographs on drugs, and a more extensive list of works in the final bibliography.

(5) Menéndez (1990) inspires the last part of this definition.

(6) In the criminal model, drug = crime, and in the medical model, drug = illness. The medical model, with its biological and positivistic orientation, does not question prohibition, but rather has continued, over the course of many years, to work in an articulated manner towards its premises. For an analysis of these models and their relationships, see Romaní (1999).

(7) Even though in progressive agreements, international meetings and similar accords, assistance and educational aspects are now being added, they are always in keeping with the repressive prohibitionist paradigm. This only serves to increase the inconsistencies cited.

(8) Examples of this can be seen in the iatrogenic use of hypnotic drugs and tranquillisers, induced by confidence in doctors, or in the intravenous use of heroin, in the context commented upon by Lou Reed in his song, "Heroin".

(9) I refer to its cultivation and/or manufacture, as well as its trade through the structure of the so-called "Black Market."

[10] Here I take material published in a collective book edited by Megías (2000).

[11] The Ministry of Justice attempted to make changes to Spanish Penal Code about drugs, to adapt it to the most elementary demands of constitutional democratic guarantees. However, there was a social reaction within the country and in international circles against it. In 1987, the Spanish government gave in to all of these pressures. They proposed a counter-reform, which meant returning to the arbitrariness, which had characterised the laws on drugs before. See "Legal Aspects", by Carlos González, in Grup Igia (2001).

[12] For a more extensive analysis on this point, see the last chapter of Romaní (1999).

[13] See the annual reports of the ICNC (1997, 1998, and 1999), "literary jewels" of Western scientific, legal fundamentalism.

[14] I recall here some of the characteristics of modern life, with relation to the development of rationality and the processes of bureaucratisation, specialisation, and professionalisation, according to Weber (1992).

[15] We also know this, at least in part, thanks to distinct contributions in positive science.

[16] For this reference, it is worth looking at the article by Peele (1990).

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Social Anthropology and Aids

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For Alberto Cardin, master in heterodoxy.
In memoriam.

In 1981, in the United States, the epidemiological bulletin of the *Centre of Disease Control* in Atlanta announced that in New York and California there had been a dramatic increase in non-habitual illnesses linked to subjects with defective or depressed immune systems (normally children being breast fed, old people and patients receiving immunosuppressive treatments for pneumocystosis or Kaposi's sarcoma). The latest news was that the infected subjects – 5 cases in Los Angeles and 26 between New York and San Francisco – were young men who had nothing in common except their sexual preferences: they were all homosexuals. They had all previously been healthy but their analyses showed a decrease in their immune systems. At the beginning of 1982 there were more than 200 cases throughout the country; all the infected subjects showed an important drop in lymphs and especially T4 lymphocytes (Arrizabalaga, 1995). Aids introduced itself to the world.

By the year 2000 the Aids pandemic had shortened 19 million lives and produced 13 million orphans. Thirty-four million more people live with HIV which causes Aids; practically all of them will die. Although the disease was first identified in the USA it is now concentrated in the third world: 25 million people in Africa are infected and 6 million in Asia. In parts of Southern Africa more than 20% of all adults are infected (1). For the almost two decades during which we have lived with Aids, numerous things have changed: the Eastern Block has been dismantled, conservative ideologies have increased and consolidated, neo-liberalism has been established and the free market strongly defended, the economy has become global, the new technologies have undergone spectacular development, and there have been important discoveries in the fields of genetics and biomedical technology. But Aids continues to escalate bringing death and massive destruction, serving as a real and metaphorical reference to the hidden face of this “supposed” planetary development. The breakdowns in the system, with its increasingly important flaws, become clear from the socio-epidemiological data about Aids. Poverty, dependency, death and illness increasingly highlight the inequalities between rich and poor countries. The most excluded and vulnerable groups are hit hardest by the illness. Aids, like many other illnesses, reveals the economic, political and social processes of inequality and power, with blinding clarity.

It is hardly surprising, then, that since the inception of the epidemic, Aids has been continuously and thoroughly studied. It has been analysed by numerous social scientists from three different standpoints: its socio-historical construction as a morbid entity, the demarcation of the processes of vulnerability of the affected subjects and the processes of individual and collective identity. Likewise, it should be pointed out that the characteristics of Aids, like no other illness, have meant that the Social Sciences in general and Anthropology in particular have had to come to terms with the need for some of their researchers to get involved in the processes of health intervention, above all prevention and education.

All this has undoubtedly considerably enriched the debates, many of which have a long history in social anthropology, about the future of our discipline in the 21st century. In the paragraphs below I shall try to outline some of the main issues and problems that the analysis of Aids has helped to develop in Social Anthropology, and more specifically in Medical Anthropology (2).

Anthropology and Aids: the story of an encounter

From the mid 1980s, and particularly from the end of the decade to the present day, the number of anthropological projects researching into Aids has grown and exponentially increased the discipline’s knowledge about health and sickness more than any other morbid phenomenon in recent history (3). Anthropology soon became an active part of the academic and political agendas on public health in the rich countries and subsequently in the poor ones. There are several reasons for this development.

First and foremost among these reasons are the specific characteristics of the sickness. It is a contagious infection; it is transmitted by sexual contact and through blood, which meant that it was initially associated with the behaviours and lifestyles of "risk groups" characterised by particular sexual conducts or drug addiction; it is incurable; and it has a high death rate. Added to the fact that at present there is no vaccination, the health sectors and those in charge of public health policies have felt obliged to request the collaboration of social anthropologists since everything seems to suggest that, in the absence of other remedies more in concordance with the hegemonic biomedical model, the only chance of halting the epidemic is through preventative and educational policies. These, it is thought, should be based on knowledge of sexual practices and, in particular, the "*risk practices*" of individuals in the groups that have been epidemiologically defined as the most vulnerable, "*risk groups*" and "*high-risk groups*". Aids develops as a disease if a person is infected with HIV (Human Immunodeficiency Virus), which is transmitted sexually or through the blood, and from the very beginning the infection has been defined as deriving from sociocultural behaviours. Anthropology, then, seems to be a good ally in policies of prevention and education despite the fact that, as we shall see later, some anthropological research projects questioned the concepts of "risk groups" and "risk practices" as being ideological.

Secondly, in my opinion the demand for the collaboration of anthropological studies is growing because the Aids pandemic, according to medically established epidemiological profiles, seems to affect populational subgroups that are characterised as being "carriers of cultures". The scientific and popular images that form the social constitution of the Aids phenomenon –normalising, normativising and legitimising– portray homosexuals, drug addicts, Afro-Americans, prostitutes, poor women and Africans, to name but a few examples, as belonging to marginal groups, groups that are different and which have "exotic" behaviours. These behaviours are supposedly consolidated because they share sexually specific cultures – for example, Grundfest (1995) denounced the construction of "an African sexuality"– or they have lifestyles that for society as a whole, of which the medical-health groups are a part, are the cause of, and the explanation for, the parameters of epidemiological transmission. In this respect, the "oblivion" to which those infected by blood transfusions have been condemned is significant (see Glucksmann, 1995, for the situation in France and Scheper-Hughes, 1994, for the situation in Brazil). In short, the phenomenon of Aids is constructed on what Crawford (1994) has rightly called "fantasy groups", whose main characteristic is otherness. Aids *is* in "the others" and at the same time, since it threatens hegemonic normality, "the others" are Aids. These others, however, represent the limits of marginality and subalternity. Their otherness, therefore, is stigmatised, which the disease then overstigmatises because it uses as an element of morbid naturalisation what has socially and historically been described as loathsome. As some anthropological research has pointed out (Lindenbaum, 1992; Crawford, 1994; Gatter, 1995 and Grimberg 1997) the ideological and political articulation of Aids as a looming menace inscribed –fortunately? – in the bodies of "others", has bestowed considerable protagonism on anthropological investigations ever since the beginning of the pandemic because, of all the Social Sciences, Social Anthropology has historically been responsible for studying "other cultures".

Thirdly, the numerous, and in many cases excellent, anthropological investigations into Aids reflect the theoretical and methodological power and maturity that Anthropology has acquired in the analysis of processes of health and sickness (4). A particularly buoyant period in the long history of Medical Anthropology was the 1980s, when investigators began to make incursions into hitherto uncharted territory: biomedicine as an ethnomedicine of the Western societies, illnesses and health problems that were not exclusively "folk", the need to analyse health, illness and care processes in the framework of political and economic historical contexts that provide them with explanatory coherence. This discipline, therefore, is in a perfect position to make a thorough, critical study of the Aids phenomenon and this is precisely what some of its leading specialists are doing: among others Frankenberg, Singer, Parker, Lock, Grundfest, Bolton, Lindenbaum and Scheper-Hughes. Most of these researchers have proven experience in the study and analysis of the problems health, illness and care and they consider research into Aids as a challenge. In their choice of themes and epistemological proposals, as we shall see below, they reflect the debates that take place within medical Anthropology as a whole

Fourthly, the connection between academic knowledge and its practical application plays an important role in the increase in anthropological investigations. Medical Anthropology's long tradition of developing projects from Applied Anthropology should not be forgotten. In the case of Aids, once again, some anthropologists are required to carry out interventions aimed at prevention and education. On most occasions the challenge is accepted, but previous experiences (5) mean that the specific ethnographic work leads to new proposals that are more critical with the processes and the forms of the intervention. This gives rise to a highly interesting anthropological production about models of social intervention.

And last but not least, it should be pointed out that in this story of the encounter between Social Anthropology and Aids, the extensive, but of course never sufficient, private and public funding for anthropological research into Aids plays a fundamental role, as is usually the case. In fact many projects on particular groups or morbid processes, which would otherwise never receive funding, have more chance if they are presented and redesigned to apply to the Aids environment.

As Arrizabalaga quite rightly points out (1995), 42% of the world's population is potentially at risk of malaria, mainly in the poor countries and funding is minimum in comparison with other less important morbid processes. This is a counter example which makes it possible to state that Aids, as well as being "the plague of the 20th century", "the most significant epidemic" and "the illness of post-modernism", has characteristics and complexities that highlight sociocultural and sociohistorical forms of being sick in all its multiple meanings (6), and represents a breakdown in the discourses of hegemonic biomedicine.

Anthropology of Aids

From the analysis of the anthropological production on Aids, we can deduce that the problems approached can be divided into four main groups:

- **The construction of medicoscientific concepts.** This group includes those studies that make a critical analysis of the languages and practices of medicine, epidemiology and anthropology itself to show that the ways in which scientific concepts and care practices are constituted are subject to social and historical processes of reaffirmation and/or concealment of political and social relations.
- **Social inequality in processes of health, illness and care.** This group consists of all those investigations that, from the perspective of Critical Medical Anthropology, analyse how the processes of social inequality connected to Aids are constituted. These projects analyse Aids as a morbid entity, the particular characteristics of which make it possible to study the unequal relations of class, gender and ethnic group as well as the structural processes of domination that are assessed as they intersect with the microsocial level in which they are interwoven.
- **Aids as a major illness.** Theories derived from interpretative Anthropology and symbolic interactionism give rise to a wide range of investigations which emphasise the need to analyse the meaningful and symbolic contents that take shape around the Aids phenomenon. Anthropologists focus on deciphering the symbolic elements that exist alongside Aids: blood, semen, the sick and healthy body, the individual and collective crisis of identity, the reconstitution of new forms of personal and collective identities, and the breakdown of frontiers and their re-establishment are just some of the main issues in these analyses. Many of the studies on the homosexual universe belong to this group.

- **Commitment to Intervention.** Some researchers call for anthropology to have a critical, ethical and political commitment to the subjects being studied. Faced with the suffering and death that the Aids pandemic means for so many people these researchers have suggested experiments of intervention both in prevention and health education. The applied work of some feminist anthropologists with poor women in both first-world countries and poor countries, proposals for intervention in collaboration with affected groups and work carried out directly with non-governmental organisations recuperate the problem of the possibility of an anthropology committed to social change. This work opens up old debates at the heart of first-world anthropology –debates that had never finished for the anthropologists from poor countries who study and analyse their own reality. This is particularly so in the case of Latin-American anthropology.

1. The construction of medicoscientific concepts

Aids, and the crisis that it has produced in the Western world on a number of levels, has generated a considerable number of studies in Social Anthropology, the History of Science and Sociology. They focus with great detail and precision on the connections between the constructions of concepts and medicoscientific practices and the social, economic and political structures and processes. They underline the lack of neutrality of the scientific concepts, and the ethical and political implications that are derived. Many investigations (Wallman, 1988; Treichler, 1992; Glick, 1994; Fee & Krieger, 1993; Frankenberg, 1993; Arrizabalaga, 1995; Singer M., 1994 among others) have pointed out the need to focus critically on the concepts and constructions that have come from the discourses of medicine, particularly from epidemiology, but also from the social sciences themselves.

As an infectious disease that affects the developed world, Aids opened up a crisis at the heart of biomedicine at a time when the dominant discourse was that infectious diseases had been almost definitively eradicated. Arrizabalaga evokes this crisis very well when he points out: *«The unexpected and spectacular outbreak of Aids took place within the atmosphere of exultant health optimism that twenty years ago radiated from the international community. It came as a complete shock… It should be stressed that that it is the first pandemic to strike the First World, that is to say the population of the United States and Europe since the influenza of 1917-18»* (1995: 8). As Arrizabalaga states, Aids erupted at a time when the WHO had announced that smallpox had been eradicated throughout the world (1977), the declaration of Alma Ata had been circulated *"Health for all by the year 2000"* (1978) and the first pathogenic human retrovirus had been identified and isolated, which opened the doors to investigations into cancer, slow viral infections and the so-called autoimmune diseases.

Although on the one hand medicoscientific knowledge was sufficient to identify Aids as a specific pathology as Grmeck pointed out – *«such a pathological state could not even have been conceived as a specific disease without certain conceptual and technological instruments which had only very recently started to be used in the health and life sciences»* (Arrizabalaga, 1995) – the reality of the ferocity of the infection meant that a historically constructed, sociomedical discourse soon took shape. This discourse contained a considerable charge of appraisals, representations and ideologies, to which the social forms of constructing reality were added either explicitly or implicitly. In this respect, the history of the medicoscientific paradigms about Aids is highly revealing.

During the two decades of Aids, three paradigms have been constructed about the pathology. They involve, as Fee & Kreiger (1993: 1477) have pointed out, various points of view about etiology, pathology, prevention and treatment. Likewise, they have different conceptions of the search for responsibilities –"*the blame*"– with reference to the relation between individual and society.

Aids as the gay plague is the first of these paradigms. Epidemiology is the discipline responsible for pointing out the disease's preference for young male homosexuals, linking its transmission to supposed group 'lifestyles' such as "*promiscuous*" behaviour, inhaling *popper* – amile nitrite – as a sexual stimulant and anal sex. At the moment, the disease is defined as a syndrome and the "first *risk group*" is constructed. The epidemiologists' fascination with constructing this risk group and the others that make up the "plague of the 4 Hs" – homosexuals, Haitians, haemophiliacs and heroin addicts – led them to ignore the fact that, as early as December 1981, the director of the Division of Allergies and Immunology of Albert Einstein's Medical College, Dr. Rubinsein, warned that his work with Afro-American children from the Bronx suggested that they were suffering from the same disease as homosexual males (Singer, 1994: 941).

The concept of a risk group with specific practices that link all the its individual elements to a particular "lifestyle" is the first paradigm. It claims to be empirically neutral and entails highly stigmatising and unifying social forms of group configuration. Prevention is organised in terms of modifications to lifestyles, which are regarded as being a set of behavioural features and forms that are mistaken and negotiable. The responsibility for modification lies mainly with the individuals themselves. The idea is that although lifestyle is social in shape, the subjects in which a particular lifestyle is "embodied" have the individual capacity to change it: the victims are presented as having brought the disease on themselves (7).

Although Critical Medical Anthropology undertakes the important task of questioning the concept of risk group (Glick *et alii*, 194; Singer, 1994; Leap; Parker, 1994 i Brumelius & Herdt, Kate & Mason, Abramson, 1992 in Herdt & Lindenbaum among others), the fact is that Social Anthropology itself has also helped to "reify" the concepts of lifestyle and risk group by providing them with a coherence that is determined by the supposed unity of individuals who belong to a "subculture"; that is to say, the world of "drugs", gays African sexuality, etc. It is this unity on which the epidemiological profiles of the transmission and location of Aids are based.

In 1983 HIV – the Aids virus – was identified and from this point on the disease was no longer considered to be syndrome but an infectious disease produced by a virus, which is found in body fluids. The image of the dangers of casual transmission, the old popular idea of "bad blood" (Fee & Krieger, 1993), became part of the scientific and popular discourse. The virus was identified as an insidious "little bug" –undoubtedly helped by some of the publicity campaigns (for example, the Spanish campaign "*si-da, no-da*"– and was no longer limited to the risk groups. It was a threat to one and all but its transmission was conceptualised in the so-called "*risk practices*". The concept of risk conducts linked transmission of the virus directly to individualised, desocialised and ahistoric behaviour, which led to a campaign of prevention that encouraged the use of condoms and disposable syringes. The creation of "risk groups" had been fiercely contested by activists, mainly homosexuals, because they were policies of exclusion and collective marginalisation. However, the construction of the concept of "risk practices", apparently more universalist, ended up by disarticulating the individual not merely in its dependence on the social, but even in its own right as an overall entity. Considered in this way, the individual is the bearer of "good" and "bad" practices and the prevention and/or education must only aim to eradicate the latter, previously defined by medicine's discourse on "risk". This construct is, suspiciously, highly similar to the hegemonic biomedical discourse which is based on the concept of a compartmentalised biological body. This concept excludes the aspects that historically constitute health and illness because it considers them to be mainly social "facts", interwoven in the social forms of inequality in the production of morbid states. The doors have been opened for the consolidation of the second paradigm.

The reconceptualisation of Aids as a chronic infectious disease highlights a medical model based on pathology and treatment. In this second approach, the main budgetary efforts focused on biomedical research to improve the pharmacological treatments and to decipher the internal mechanisms of the virus so that a vaccination could be developed. The preventive framework considered that it was fundamental to carry out massive campaigns, the aim of which was to produce behavioural changes in the general population. These campaigns were based on the individualist concept of biomedicine and on the political and economic concepts of liberalism, which consider social subjects as individual entities characterised by their "freedom" and "capacity for choice". This standpoint, still a hegemonic one, considers *«the populations and subgroups of these populations – including the 'risk groups' – as being made up of the sum of its individuals, which exist without culture or history»* (Fee & Kreiger, 1993: 1483).

The third alternative and critical paradigm, which has various denominations – «a collective chronic infectious disease and persistent pandemic» (Fee & Krieger, 1994) or "syndemic" (Singer, 1994) – defines the disease as *essentially social*. This basically means that Aids can be articulated and explained by analysing the historical and social construction of the processes of health, illness and care. In short, the complexity of the location, transmission and prevention of Aids, like many other diseases, cannot be understood without bearing in mind the political and economic processes which constitute the inequalities of health in their relation to the inequalities per social class, ethnic group and gender. We shall discuss below the problem that this perspective raises and which the Anthropology of Aids has to face.

2. *Inequalities in the processes of health, sickness and care*

Since the beginning of the 1990s numerous ethnographic studies carried out on collectives by anthropologists have stressed the need to use concepts from Critical Medical Anthropology in the study of Aids (8). As Singer rightly pointed out (1994: 937), Aids emerges as an opportunistic disease in that its location and forms of transmission reinforce social divisions and structural inequalities that take shape in terms of social class, ethnicity and gender. In the case of the United States, studies by Singer (1994), Waterston (1997), and Bolton (1995), among others, focus on the analysis and conceptualisation of the new "*centres of poverty*" of the "*marginalized urban zones*" and on the increase in the distance between the levels of health and sickness between the different social classes that the neoliberal paradigm is providing. These inequalities are made even more complex by ethnic and gender variables. After working for 10 years in the marginal districts of Hartford. Singer confirmed the growth in infant mortality rates and in the levels of infant malnutrition among the Afro-Americans and Hispanics – habitual neighbours in these areas – as well as the continuous rise, in "these hidden cities", of cases of contagious infections – gonorrhoea, syphilis, chancre, etc. In the case of Aids, national statistics show that in New York City drug addicts that use syringes – a possible means of infection if they are shared – were 38% Afro-Americans, 38% Latins, and 23% whites. In NYC the general population is 52% whites, 24% Afro-Americans and 20% Latins. The national data about the number of people infected with Aids confirm the social inequalities: of the total number of people diagnosed with Aids in the United States, 30% are Afro-Americans and 17% are Latins. «Whereas these two ethnic groups represent 28% of the population of the USA, they have 47% of the Aids cases. Significantly, the average time of survival for the individual cases diagnosed with Aids varies according to the ethnic group. In Connecticut, for example, the average survival is 11.2 months for whites in contrast to 7.7 for Afro-Americans and 10.2 for Latins. These figures reflect the differences in general health of these collectives and the unequal access to health services of the different populations» (Singer: 1994: 936).

It should be pointed out that the figures above cannot be understood exclusively in terms of ethnic subcultures. They must be seen in relation to the social conditions of discrimination, power, unemployment, the precarious nature of employment and frustrated expectations that are an integral part of the ethnic minorities only if these minorities are interrelated with the structuring processes of the social classes. This clearly shows that there is a tendency to "*ethnicize*" these groups and convert them into "exotic isolated tribes" in the heart of the city when the analysis should focus on the processes of inequality and social discrimination in the relations between social classes. If the interrelations between poverty and ethnicity are not studied, policies of care and prevention will merely obscure and mask social divisions; as life and work conditions improve, structural changes will be prevented from making real changes to the "real processes of risk".

Wallace expressed himself in the same fashion (1990) when he studied the problems of social disorganisation of the working classes in the poor districts of New York in relation to the sociosanitary and economic policies of the municipal services. Waterston (1997) also adopted a similar tone when he worked in a residence in Manhattan (Woodhouse) for tramps, the mentally handicapped and minority women who had unusually high rates of Aids.

Moreover, much critical anthropological research about Aids is being carried out in the context of poor countries and/or by critical feminist anthropology. The studies by Farmer on Haiti, Schoep and Grundfest on Zaire, Baldo & Cabal on Sub-Saharian Africa, Parker and Paiva on Brazil and Lim Tan on the Philippines, for instance, show how important it is to see Aids and its distribution in the poor countries as the result of political and economic factors, among which should be included those problems derived from colonialism and post-colonialism. As Baldo & Cabral point out for Sub-Saharian Africa, the exponential increase in Aids can only be understood by LIW (low intensity wars) analysis. The low intensity wars that have been lashing the continent in recent decades are responsible for the important economic changes which have forced large groups of population to leave the conflict zones and head for urban areas. This has generated poor settlements and marginal circles – with new phenomena such as prostitution or street children – which provide an excellent environment for the development of infectious diseases, including, of course, Aids (Baldo & Cabral, 1990: 40). The correlation between economic policies and health inequalities is also highlighted, in this case from the feminist perspective, in the excellent studies by Grundfest (1992, 1995) on poor women in Zaire. In her twenty years of work in Zaire, she has analysed the construction of a – mainly feminine – Central African sexuality, based on information received from missionaries which, in agreement with the cultural and social discourses of many African males and spiritual leaders, reinvent an "African woman". This figure is portrayed as being sacrificed by tradition, having no freedom and being highly submissive; the fact that there are important realities and feminine practices in Africa that resist male domination is concealed (9). She explains that, for many African women, AIDS stands for "Insufficient Salary For Years" or "Difficult to Earn an Individual Salary" (10) and makes it clear that many African women are obliged to work in the sex market and/or have various sexual partners because of the socioeconomic conditions of poverty and lack of protection for women. She also shows that the clients – mainly Westerners who are prepared to pay between $ 50 and $ 150 a night– make their sexual demands because of the supposed "voluptuous sexual practices" of African women. In fact, it is precisely this demand that is creating these practices (1995: 37), which are a source of possible infection for women.

Investigations such as the ones mentioned above, which stress the important connections between the economic and political forms that articulate the inequalities and the impact of Aids, try not to separate this disease from other general processes of health and sickness. Aids, therefore, is analysed as an infectious disease that, like others, can be used to analyse unequal social processes. This approach differs, to some extent, from other anthropological studies in which Aids is dealt with as a sociosymbolic construct whose meanings have to be unravelled.

3. *Aids as a major illness*

This perspective includes most of the ethnographic investigations about "homosexuality" and sexual identities. They work from theoretical, symbolic and interpretative approaches in an attempt to understand the "sense worlds" that Aids gives rise to. Although this perspective does not hesitate to point out that the Aids epidemic is inscribed in an important social crisis, its main concern is to show the need to understand and interpret it as a "major epidemic (Treichler, 1988; Wallman, 1988; Crawford, 1994; Gatter, 1995 among others). Aids as "a metaphor" of the general crisis of the end of the century creates its meaningful universe around the collective and individual crises of identity. As Gatter (1995: 1525) states, interpretative studies underline the importance of examining how subjects within cultural constructs build and rebuild their sexual identities and the associated practices in specific universes of meaning. These perspectives, which consider human culture to be essentially meaningful, defend that sexual identity in its sociohistoric construction has become a central element in the Western constitution of the "self" and of "the others" and that HIV, with its initial focus on homosexual collectives and/or sexual practices, has helped to reflect on the main cultural mechanisms that define sexual frontiers and how they can be crossed. Similarly, these studies and their painstaking ethnographic analyses of "gay" populations (Bolton 1992, 1995) defend the need to further complicate the collective concept in favour of the idea of diversity; in this way they could do away with stereotypes that use homophobic prejudices to reify the existence of a united "subculture" which gives sense to supposed gay practices. It is not surprising that the categories begin to take shape and people begin to speak of "men who have sex with men" from a heterosexual identity or of sexual partners who inject drugs. These categories are again relativised to convert the very concept of "risk" into an element of discussion as a constructor of realities and reinforcer of the processes of "empowerment" and "embodiment".

What is more, this situation and the fact that some authors connect it to the approaches of symbolic interactionism saves the study – in the best tradition of Goffman – from the processes of stigmatisation and the reconstitution of identities that takes place in the people that have to live with HIV. Cawford (1994:1348) pushes the analysis further by proposing that it is impossible to understand sociosymbolic constructions if we do not interconnect them with four important aspects:

1) *The central nature of the concept of health in the shaping of modern Western identity*. The meaning of being healthy surpasses biological limits to become a significant referent of "being a responsible and respectable person", and this meaning of morality is related to images about class, race and sexuality.
2) Since the middle of the 1970s, attaining health has become highly valued and is crucial if we are to understand how contemporary personal identity is constituted.
3) The healthy "self" is built on sick "others", and constructs "imagined" othernesses, on which Aids confers the particular power of distance.
4) The practices of stigmatisation and the perceptions on which they are based make it possible to study the meanings of health in the construction of the "self" and of others as practices and perceptions based on domination. Not in vain does the social construction of the concept of health respond to the needs and imperatives of the urban middle class. Therefore, the concept of health and its corollary, sickness, are configured as powerful meaningful elements for "distinguishing" social classes.

As we can see, the approaches that attempt to decipher the symbolic universes and the sociocultural constructions of the Aids phenomenon do not abandon the critical spirit characteristic of Medical Anthropology in recent years. I believe that this is partly due to the fact that on most occasions, faced with the terrible suffering that Aids inflicts on people, many researchers who work on one or other of the problems described above have become committed to the intervention.

4. *Commitment to intervention*

If particular investigations and studies agree on one thing in prevention and health education in an Aids environment, this is their denouncement of the inefficiency and social irresponsibility of public health policies, which are based on the hegemonic conceptualisation of biomedicine. Because biomedicine highlights the need for behavioural changes that biomedicine itself defines as being of risk, the social forms of the behaviours are individualised and social subjects are conceived as individuals with a capacity to choose their habits, supposedly "freely", and negotiate their social practices with themselves and with others (11). Waterston (1997), Grundfest (1995) and Bolton (1992, 1995) show the importance that the connection between the *macro* and *micro* levels acquires in intervention. The former levels are the ones that in the public sphere must promote structural changes for developing equality and eliminating the processes that increase social inequalities. The latter, on the other hand, promote particular and immediate strategies of care and protection for the most underprivileged groups. They include the proposals for research-action by Grunsfest with poor women in Zaire. By creating small discussion groups, the women "speak" about their problems with Aids, about the possibilities and impossibilities of negotiating with their partners and about sexual practices. They recover some of the possible strategies of resistance that have traditionally allowed them to resituate themselves within the forms of gender discrimination and, likewise, take advantage of the new images that Aids and its dangers have constructed in the males with whom they have sexual relations. For their part, Waterston and Singer's model (CCP, community-centred praxis), which is also based on the idea of research-action, emphasises the importance of knowing the needs of the community at all levels, including infrastructure, and organising and consolidating through various social actors awareness policies that will help to solve community problems, particularly those that affect health, sickness and care. All these models are reminiscent of the transforming experiences that the Experimental Centre for Health Education in Perugia (Italy) has been carrying out for years, with the considerable involvement of social anthropologists.

I would like to finish by pointing out that the problems of Aids that Social Anthropology has mainly investigated are a good example of the centrality that Medical Anthropology has acquired in the anthropological discourse. On analysing the problems of suffering of the social subjects, Medical Anthropology is driven to commit itself to a socially relevant discipline that is critically committed to the subjects it studies. Without a doubt, in this respect it coincides with the best historical tradition of the Social Sciences.

Notes

(1) Sachs J.D. "The Director of the International Centre for Development, University of Harvard", in *El País*, *Negocios*, July, 2nd, 2000, p. 3.

(2) There is a long bibliography at the end of the text that contains the main contributions to the issues that I am going to deal with. Of course the bibliography is in no way exhaustive, given the extent of anthropological production on Aids. It focuses on work done in the Anglo-Saxon world and provides a brief sample of material produced by Spanish researchers. I would also like to point out that in recent years in our country several doctoral theses have been completed or are in the process of being completed, that analyse the problems associated with Aids from different perspectives. For example, the Ph.D. dissertation by José Fernández-Rufete focuses on a care centre for people with Aids, Fernando Villamil studies homosexuality and Aids and Purificación Heras writes about temporality in people infected with HIV.

(3) In 1992, Price questioned this growth and development. He pointed out that to a certain extent anthropologists would be nothing more than mere participants in a new research industry. In this case, the industry of research into Aids (quoted in Waterston, 1997).

(4) Comelles, J. M. and Martínez, A. (1993) have made a very complete study of the principal landmarks and paradigms in the development of medical anthropology from its beginnings to the present day.

(5) The debates and criticisms at the end of the 1960s about the collusion of Social Anthropology with colonialism undoubtedly had an effect. So, in some of these practical applications we can trace the responses back to the criticisms and questions that these debates raised. For example, how could “exotic peoples” be studied without taking into account that they were submitted to the colonial system’s structural conditions of domination and dependence, particularly when the anthropologist belonged to this colonial system, which was the case on most occasions? To what extent do anthropological investigations contribute with their ethnocentrism and androcentrism to reproduce and consolidate existing inequalities? For an assessment of the present situation, see Gledhill, J. 2000. *El poder y sus disfraces*. Barcelona, Bellaterra, particularly chapters 4 and 9, which are splendid. Without discounting the idea that the “passion” for intervention may be the result of a somewhat “uneasy conscience” with respect to the subjects investigated and to whom we owe so much – which may explain the harshness of some of the criticisms of the anthropological “distance”–, see Scheper-Hughes, 1997. *La muerte sin llanto: violencia y vida cotidiana en Brasil*. Barcelona: Ariel.

(6) M. Singer, 1994, put forward the term ‘syndemic’ to conceptualise Aids – as opposed to epidemic or pandemic. It highlights the set of inter-relations and complex links that Aids creates between health and social problems, with reference mainly to poor urban populations. He also points out, from a theoretical perspective of Critical Medical Anthropology, that Aids should be reconsidered in the light of three important social dimensions: it’s social construction, social transmission and social position (1994: 941).

(7) For the epidemiology of Aids and a general discussion about how Social Anthropology and Epidemiology handle the concept of lifestyle, Frankenberg (1993) and Menéndez (1998) point out the shortcomings of the latter discipline to work with a concept that owes its originality and richness to the Social Sciences. As a theoretical instrument for organising processes and structures, micro and macro levels, and individual and social levels, it is dehistoricised and disarticulated by the use that Epidemiology makes of it.

(8) Marxist writers, Gramsci and Wolf, among others – can be seen to have an active influence on some of these authors, although nowadays it is not very “politically correct” to say openly that one is a Marxist. For this reason I believe that the term “Critical Anthropology” is a convenient label under which to include a whole range of investigations that are central to Medical Anthropology but which still have a marginal role in Social Anthropology in general.

(9) The concept of resistance refers to an interesting debate in Social Anthropology in which popular cultures lose their folk and isolated nature, and become part of the domain of the concepts of hegemony and subalternity. This concept thus articulates the historical relationships between the cultural forms of the various social classes. Gramsci, Wolf, Fanon, De Martino, Seppilli and Menéndez, among others, are researching into this conceptual framework.

(10) Translator’s note: This is a play on words using the Spanish initials for Aids, *SIDA,* which they say stands for *Salario Insuficiente Durante Años* or *Salario Individual Difícilmente Adquirido*.

(11) In a future article, which I am currently preparing, I reflect on different models of prevention and health education. I distinguish between those that can generate social change and those that reproduce inequalities in health. Some of the content appears in Otegui (2000) “Health Education and Anthropology. A case of misunderstanding: hypertension”. *Jano*, June-July.

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Medical Anthropology's 'ownership of the body' and the medicalisation of Social Anthropology

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Introduction

One of the most central fields both of enquiry and of theoretical output in medical anthropology concerns the 'body' and related concepts such as 'embodiment'. Some authors even go so far as to suggest, «that it is medical anthropology's 'preferential option' for the body that represents this subdiscipline's unique vision as distinct from social and cultural anthropology (where the body is largely absent), and from physical anthropology and the biomedical sciences (where the body is present but silent).» (Scheper-Hughes 1994; see also Scheper-Hughes' & Lock 1987 programmatic article about the 'mindful body')

As Lock's (1993) and Csordas' (1999a) excellent review articles about the body in anthropology show, medical anthropology is not alone in its interest in the body. What came to be referred to as the 'anthropology of the body' (Blacking 1977) has also been developed by contributions from other sub-fields of social and cultural anthropology: maybe the most particularly feminist anthropology, but also cognitive anthropology, the anthropology of science and technology and the anthropology of the senses, to mention a few. And of course, the academic interest in the body does not stop at the disciplinary boundaries of anthropology, but rather permeates all social sciences and the humanities, a fact which Lyon & Barbalet (1994) referred to as the "somatization of social theory".

However, it is often claimed that medical anthropology has a somehow privileged view on of the body, because it is engaged with the suffering body. This is the terrain where, in the context of the physical, social and emotional breaches caused by illness and suffering, the basic contradictions of human existence come to the fore and where established social and cultural orders are called into question (1). This argument echoes the similar one that the study of illness and suffering offers a privileged window on to the inner workings of social life (Frank 1961, Good 1977, Kleinman 1980, Taussig 1980, Turner 1967). The relevance of the 'body' focus – not only for medical anthropology, but also for anthropology in general –, relies on the fact that it provides the key for cross-cutting problematic dichotomies such as *nature-culture*, *self-other and body-mind*. All them of these are associated at with the fundaments of the discipline as a whole (Csordas 1990, Frank 1986, Lock 1993, Ots 1990, Sharma 1996, Strathern 1996, Synnott & Howes 1992). In Csordas' view of a cultural phenomenology, taking the body and embodiment seriously would eventually lead not merely to anthropology *about* the body, but also *from* the body. (1994b:xi).

Against this backdrop, the guiding question for this text is if and how the call "to bring the body in" has resonated within wider anthropology and how prominent the body and related concepts such as embodiment are in anthropology. In particular, I am interested in the "political" effects that the 'body' had within anthropology as a discipline in terms of competition between and relevance of anthropological subdisciplines for anthropology in general. For it is this issue that accounts for my feeling of that something is missing in the available literature reviews on the anthropology of the body (Lock 1993, Csordas 1994, 1999a, 1999b, Strathern 1996 and Synnott & Howes 1992 to some extent). These reviews are excellent in that they sharply analyse and elaborate on the history of ideas regarding the 'body' in anthropological theory and how these ideas were have been used in ethnography. However, they virtually ignore how the research on the body has changed the academic landscape of anthropological disciplines and its fields of works; they leave out the question of the "ownership" of the body in anthropology.

In tracing these questions I draw on bibliometric methods (2), which I also use as a means for a (preliminary) operationalisation of the question of what 'general anthropology' should be. This text, then, is not a literature review in the usual sense. By studying the numbers and figures of a publication count and looking at who has published *what*, *where* and *when* under the 'body' label, I have tried tries to raise critical questions about medical anthropology's claims of competence and research fields, its stance among other anthropological sub-disciplines and work fields, and its not always welcomed contributions to anthropology. Although this turned out to be more difficult than I expected and that a sound interpretation is more limited than I had thought, this approach nevertheless allows to make some relevant observations to be made and conclusions to be drawn.

Searching 'General Anthropology'

Technically speaking, what follows in the next sections is an ex-post evaluation with a descriptive kind of question (Bussman 1995). The basic question is, if and whether the usage of the concepts of 'body' and 'embodiment' in anthropology has changed in terms of frequency as manifested in a range of anthropological journals during the last two decades. And if so, how has it changed? As such it is a 'black box evaluation', because this kind of evaluationit cannot causally explain why this change was brought about.

For this study I used *Sociological Abstracts* (SA), the former *Sociofile*, produced by Sociological Abstracts, Inc., and the *Social Sciences Index* (SSI), which is a smaller version of the *Social Sciences Citation Index* (SSCI*)*, which are both provided by the Institute for Scientific Information. The SSCI and SA count as the most often used bibliographic databases in the field of social sciences (3). For the SSI, there was available one database available, the *Social Sciences Index 2/83-9/99.* The SA I had access to be divided into two databases, *Sociological Abstracts 1986-1999* and *Sociological Abstracts 1963-1985*. Since some of the journals I was interested in were included in one database but not in the other and the reverse, I used both SSI and SA.

What I basically did in my first step was to search the above databases for the terms 'body' and 'embodiment'. For the search string 'body', this resulted in a list of 4.237 entries in the SSI and 4.119 in both the SA databases. The search for 'embodiment' resulted in only 32 hits in the SSI and 383 hits in the SA. On the basis of the resulting sets of bibliographic entries I then identified those records hits that were associated with anthropological journals and any others journals I considered to be relevant for to the topic. Since after this step the set of records hits for 'embodiment' shrank to merely 11 entries in the SSI and 22 in the SA, I decided not to follow this strand line of enquiry further. The 445 hits in SA and the 140 hits in SSI for 'body' were more promising. In a second step, I searched the databases for the names of the identified journals and retrieved all available bibliographic entries for each of those journals. With these latter sets I crosschecked the relevant results from the first search of 'body'-records. In a third step, I finally imported the downloaded lists of results into *Atlas.ti*[4] and processed them further by coding the entries by year and by journal.

Following a principle of bibliometrics, I 'resolved' (or circumvented) the problem of how to define '*general anthropology*' by simply assuming that anthropology is what anthropologists publish in their journals. Strictly speaking not even that, because it is merely the compilation of words in the titles, abstracts and keywords which that makes up a record in the consulted databases. However, I operationalize '*general anthropology*' as being constituted by the bibliographic records of four major anthropology journals. These are *American Anthropologist*, *American Ethnologist*, *Current Anthropology* and *Man* and the *Journal of the Royal Anthropological Institute* respectively (for convenient shorthand I refer to these as '*The Fantastic Four*')(5). However, leaving aside the profound anglophone bias (also to be found in the consulted databases consulted and which itself would deserve a closer examination in terms of the centres and peripheries of knowledge production within anthropology) I see can justify this operationalization justified for the following reasons:

1) These journals are certainly the ones that are most often found in anthropology departments around the world.
2) They are the ones with the largest output of articles.
3) They are perhaps also the most prestigious ones among anthropologists.

Besides limiting myself to '*The Fantastic Four*' there are a number of other important points to be taken into account when interpreting the search results. These are of a technical, methodological and/or epistemological nature:

- SSI and SA covered a different set of journals. While both covered e.g. *American Anthropologist* and *Current Anthropology*, SA did not include *American Ethnologist* and or *Man / Journal of the Royal Anthropological Institute*. SSI, on the other hand, did include *Man*, but did not include many of the journals relevant to Medical Anthropology. In addition, even concerning one and the same journal the matches for some journals in SSI were sometimes quite different than for those in SA (as will been shown in a later figure). Where I found it possible I took this into account in the presentation and interpretation of the sometimes-puzzling results. I will specify discuss this later below.
- SSI and SA also diverge at to in the periods of time they covered: *Social Sciences Index 2/83-9/99* – contrary to what its name indicates – showed bibliographic records from as early as 1981 to 1999. *Sociological Abstracts 1986-1999* included records from 1981 to 1999 and *Sociological Abstracts 1963-1985* included records from 1960 to 1985. In addition, for both SSI and SA the number of entries for the years 1999 and 1981-1983 was much smaller than for the other years; apparently these years are incompletely covered and where this became relevant significant I restricted the results to the years 1984-1998.
- Since the records in SSI and SA overlap in their content due for the above reasons, the sum of total hits therefore cannot be equated with the actual number of articles in the respective journals.
- As the databases include different sorts of publications, the hits are to be specified by their type: besides articles, also relevant here are book reviews and comments on other articles. It turned out that some journals' 'body'-records consist predominately of book reviews or comments while others included more genuine articles.

- The search machines of the databases use strings of letters. The search string 'body' thus shows all records where this string is found, also including titles which talk about a certain "body of literature" or which call for an EU- wide 'body' to regulate security. At least regarding the subject 'body' the keywords were more reliable (although sometimes keywords such as 'body-armour' and 'body-shop' showed up). Nevertheless: the search string 'body' is not to be taken as indicating that the 'body' is used as a concept or topic, because the search string does not specify the occurrences. I tried to correct the biggest errors in this regard.
- Finally it cannot be necessarily be assumed that all articles that talk about the body also have the word 'body' in their titles, abstracts or keywords. Such prominent articles as Boddy (1988), Farmer (1998) and Ong (1988) did not show up in the search, because 'body' is not used in the title, abstract or keywords. The results, therefore, do not exhaustively include all records directly relevant for anthropology of the body.

With these points in mind let us turn to some of the results.

Results I: Figures and Numbers

As already mentioned the first search for 'body' produced a list of 4.237 records in the case of SSI and 4.119 records for SA. Figure 1 shows the hits in these lists by the year of publication. The entries for 1999 and the years before 1984 are left out, for the reasons described above. A number of The records also showedthat had no publication year and therefore are not included either.

Figure1. Total matches for the search string 'body' by year

1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	Total
221	286	257	230	255	275	258	341	362	382	569	617	761	762	625	6.201

[Databases: *Social Sciences Index 2/83-9/99, Sociological Abstracts 1986-1999, Sociological Abstracts 1963-1985*; no restriction of journals]

Interestingly the number of matches steadily grows over the years, and in 1997 reaching a number more than the total was three times bigger that the matches that of 1984. This increase may be partly due to a larger output of journal contributions in general. New journals may have been founded (such as *Body & Society* which is highly relevant for our topic), or and other journals may have become more extensive (see figure 6, which also shows the increase in total hits for one and the same journals over the years). However, it also seems to support the often – voiced argument that the body has become more and more prominent in the social sciences as a whole during the last fifteen years or so (Lyon & Barbalet 1994, Martin 1990, Csordas 1999a). Whether the decrease in hits in 1998 after a peak in 1997 indicates that the body's prominence in the social sciences has already started to go down again cannot definitely be determined. More evidence for this trend from the following years would be needed.

Figure 2 lists the anthropology journals and some other journals important for medical anthropology which figured prominently in the results of the 'body-search' and which I found particularly relevant to my purpose. The list does not include other anthropology journals such as the *Journal of Anthropological Research, Critique of Anthropology* and *Anthropological Quarterly*, which only showed some single hits in the 'body-search'. Figure 2 also

Figure 2. Relevant journals covered in the databases Sociological Abstracts 1986-1999 and Social Sciences Index 2/83-9/99

	Sociological Abstracts		**Social Sciences Index**	
	Covered	Total matches	Covered	Total matches
American Anthropologist	yes	1.238	Yes	5.230
American Ethnologist	no	–	Yes	2.968
Annual Review of Anthropology	yes	121	No	–
Anthropos	yes	388	No	–
Body and Society	yes	110	No	–
Cultural Anthropology	yes	180	Yes	+
Culture, Medicine and Psychiatry	yes	187	No	–
Curare	yes	240	No	–
Current Anthropology	yes	344	Yes	2.801
Ethos	yes	175	No	–
Man/Journal of the Royal Anthropological Institute	no#	–	Yes	3.561
Medical Anthropology	no	–	No	–
Medical Anthropology Quarterly	yes	56	No	–
Social Anthropology	yes	100	No	–
Social Science and Medicine	yes	2.657	Yes	*
Sociology of Health and Illness	yes	1.142	No	–
Total		6.938		14.560

* Not ascertained

Man until 1975

shows whether a journal was covered or not in the two databases (*Medical Anthropology* was unfortunately not included in either SSI or SA), and under the header "total matches" it lists the total number of matches when the databases were searched for the journal names in the second step as described above.

It should be noted, though that the considerable differences in the number of matches for *Current Anthropology* can only partly be explained by the fact that SA did not show comments as original records. Apart from this, I cannot offer an explanation for the difference in the total matches for *American Anthropologist* and *Current Anthropology*. However, figure 2 serves as background information for the numbers of matches presented in the following figures. They give a rough idea about "out of how many?"

Figure 3 indicates the matches in the 'body-search' for each identified journal in SSI and further specifies them by the type of publication (articles, book reviews and comments). Figure 4 does the same for SA, with the restriction that only *Sociological Abstracts 1986-1999* is considered so that a comparison can be made with SSI (however problematic this may be).

Given the large number of total 'journals-matches' as presented in figure 2, the scarce number of relatively few 'body-matches' in the general anthropology journals is striking at first viewsight. Taking the results for both databases together with the total number of 'body-matches' for 'The Fantastic Four', there are only 120 (including of which book reviews and comments, which – summing up to account for 75 hits, – account for more than half of them) out of a total number of 16,142.

However, in order to qualify the prominence of the 'body' in the 'The Fantastic Four' to some extent I also searched the sets of journal-records for other 'central anthropological concepts' of a similar order and specificity as 'body'. Figure 5 shows the results:

The number of matches for other anthropologically 'central concepts' in the 'The Fantastic Four' provides a more contextualised picture of the prominence of the 'body'. In comparison to the 16,142 total 'journal-hits', any the 'central concepts' hardly seems exist in the 'The Fantastic Four'. In comparison to the other concepts as listed above, the 'body' figures is in the middle range of frequency with 'identity' and 'power' at the top of the list followed by 'rite', 'ritual' and 'representation'. 'Body' has about the same number of matches as 'discourse', 'experience' and 'self'. 'Performance', 'agency' or 'hegemony' – and 'embodiment' – are at the lower end of the count. However difficult it may be to interpret such a 'ranking', in my view it seems reasonable to say that – compared to other concepts – the

Figure 3. Results for the search term 'body', database Social Sciences Index 2/83-9/99

Total number of matches (without restriction of journals): 4,237

	Covered	**Articles**	**Book reviews**	**Comments**	**Total**
American Anthropologist	yes	10	15	–	25
American Ethnologist	yes	12	16	–	28
Annual Review of Anthropology	no	–	–	–	–
Anthropos	no	–	–	–	–
Body and Society	no	–	–	–	–
Cultural Anthropology	yes	5	–	–	5
Culture, Medicine and Psychiatry	no	–	–	–	–
Curare	no	–	–	–	–
Current Anthropology	yes	6	1	25	32
Ethos	no	–	–	–	–
Man/Journal of the Royal Anthropological Institute	yes	10	8	–	18
Medical Anthropology	no	–	–	–	–
Medical Anthropology Quarterly	no	–	–	–	–
Social Anthropology	no	–	–	–	–
Social Science and Medicine	yes	25	7	–	32
Sociology of Health and Illness	no	–	–	–	–
Total		68	47	25	140

body is not as "absent" in general anthropology as Scheper-Hughes (1994) suggested. However, that fact that 'embodiment' hardly got any matches indicates that this aspect of 'body' is indeed more or less missing in 'general anthropology'.

What is also important is the question, of whether the body has become more prominent since the middle of the 1980's. Figure 6 tries to answer this by showing the body's occurrence by year and again compares the respective number of matches with those of some of the other 'concepts':

Judging from the total numbers of matches, the body has become increasingly prominent. At the same time, however, the number of the total publication output in the 'The Fantastic Four' rises significantly too – as do all other compared concepts. So whether the body has become more significant in relation to other concepts cannot be decided from the low number of matches by year. When we take into account the publication lag, the

Figure 4. Results for the search 'body' in the database Sociological Abstracts 1986-1999

Total number of matches (without restriction of journals): 2,396

	Covered	**Articles**	**Book reviews**	**Comments**	**Total**
American Anthropologist	yes	3	7	–	10
American Ethnologist	no	–	–	–	–
Annual Review of Anthropology	yes	5	–	–	5
Anthropos	yes	4	2	–	6
Body and Society	yes	86	24	–	110
Cultural Anthropology	yes	10	–	–	10
Culture, Medicine and Psychiatry	yes	22	3	–	25
Curare	yes	22	–	1	23
Current Anthropology	yes	4	–	3	7
Ethos	yes	6	–	–	6
Man / Journal of the Royal Anthropological Institute	no	–	–	–	–
Medical Anthropology	no	–	–	–	–
Medical Anthropology Quarterly	yes	34	6	7	47
Social Anthropology	yes	3	–	–	3
Social Science and Medicine	yes	72	4	–	76
Sociology of Health and Illness	yes	25	24	–	49
Total		296	70	11	377

Figure 5. Prominence of 'concepts' in anthropology

Search string	**matches**
body	120
embodiment	16
agency	23
discourse	149
empowerment	7
experience	118
globalisation	52
hegemony	24
identity	412
ideology	126
performance	94
power	445
reflexivity	13
representation	265
resistance	69
rite	289
ritual	259
self	138

[Databases: *Social Sciences Index 2/83-9/99* and *Sociological Abstracts 1986-1999*; covered Journals: *American Anthropologist, American Ethnologist, Current Anthropology and Man / Journal of the Royal Anthropological Institute*]

Figure 6. Comparison of matches for 'body' and other 'concepts' by year

	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	Total
Total	749	851	936	865	864	886	897	904	1087	1004	1239	1267	1269	1295	1284	15397
Body*	0	6	5	1	5	4	1	3	16	5	10	12	31	28	9	136
Representation	3	6	13	9	7	9	11	18	10	14	19	16	53	54	23	265
Identity	7	8	11	8	7	19	11	11	25	22	45	29	59	89	61	412
Discourse	0	4	10	8	11	9	10	10	8	13	13	8	5	20	20	149
Power	7	11	26	25	30	22	26	25	31	24	29	64	64	39	22	445
Self	3	2	12	12	5	11	6	4	2	7	13	12	33	8	8	138

* Also includes the search terms 'embodiment' and 'embodied'

[Databases: *Social Sciences Index 2/83-9/99, Sociological Abstracts 1986-1999;* covered Journals: *American Anthropologist, American Ethnologist, Current Anthropology and Man / Journal of the Royal Anthropological Institute*]

figures, however, seem to support Csordas' statement that the 1990 *American Ethnological Association Annual Meeting* dedicated to the topic of the body in society and culture topic, was the "culminating event in the turn to the body" for anthropologists (1994b:xi).

Let's move back to figure 1 and compare the increase of in 'body-matches' for 'general anthropology' with the increase of 'body-matches' for the social sciences in general. The results indicate that the body's prominence in anthropology grew faster than in the social sciences in general.

Summing up so far, we can draw three conclusions. First, that the body played a considerable part in 'general anthropology' and is in the middle range of other 'central concepts'. Second, there has been a significant increase in the interest in the body in 'general anthropology', in particularly since the beginning of the 90's. Third, that the interest in the body in anthropology has been growing faster than in the social sciences in general. So, what is happening in medical anthropology?

As figures 3 and 4 impressively show medical anthropology journals have a much higher proportion of 'body-matches' than 'general anthropology'. '*The Fantastic Four*' have "only" produced 45 original 'body-articles' (and 75 book reviews and comments respectively) out of more than 16,000 entries. In contrast, *Culture, Medicine and Psychiatry* and *Medical Anthropology Quarterly* alone – which are only covered in SA – together yield 63 matches (and 9 book reviews) out of 243 total 'journal-matches'. *Medical Anthropology* is not even covered and the many publications of medical anthropologists in journals such as *Social Science and Medicine* and *Sociology of Health and Illness* are not taken into account either. Medical anthropology journals clearly exceed general anthropological journals as far as the quantity of output about the 'body' is concerned in terms of quantity (and if we believe some medical anthropologists also in terms as far as quality of output is concerned). Before dealing with the question about what all this means let me very briefly say something about the authors and their topics.

Results II: Authors and Articles

Thus far the question of authorship has been left to one aside, but it is rather obvious that journals and the fields of research they cover are one thing, and authors and their fields of research are another. In effect, in a (sub) discipline both journals and authors/articles play an overlapping part and to some extent constitute each other. The former do this via the scope of subjects they cover and the (sub) discipline they belong to and the latter via the content they present and their (perhaps multiple) disciplinary identity. The extent of a journal's range of subjects and fields of research, however, is crucial here. Like general anthropology journals and unlike journals more specifically designed for anthropological subdisciplines, they present an extended range of topics and approaches stemming from all sorts of subdisciplines in anthropology. At this point at the latest the relation between general anthropology journals and general anthropology becomes highly questionable: general anthropology journals indeed are full of not so ”general” articles. Whatever else the big anthropology journals may be, therefore, they are also an important arena for the negotiation of what counts as relevant for “general” anthropology (which means what is relevant for other subdisciplines) beyond the specificity of the subdiscipline and/or field of research an author/article comes from. In this sense, articles that are necessarily specific to their field and discipline may also represent “general” anthropology when published in general journals.

Regarding the 'body-records', a number of articles can be found, which can be seen as “belonging” to medical anthropology when skipping through the 'The Fantastic Four'. Among these are Bastien (1985), Cassell (1996), Green (1998), Konrad (1998), Martin (1992) and Ong (1990). Other 'body-articles' are associated with physical anthropology, psychological anthropology, the anthropology of religion and so forth. This shows the range of subdisciplines and fields of research, which contribute to the literature on the body.

This crosscutting of (sub-) disciplinary boundaries applies to a much lesser extent to the more specific medical anthropology journals. There are some ‘body-records’ in these journals, which one perhaps would not necessarily recognise as falling into the area of medical anthropology in the first place (Olujic 1998). Most articles though can easily be identified as “belonging” to medical anthropology. Interestingly, the records also show that many medical anthropologists publish in journals akin to medical anthropology journals such as *Sociology of Health and Illness* and *Body and Society*, but the reverse seems rather unusual. In the ‘body-records’ for *Medical Anthropology Quarterly* and *Culture, Medicine and Psychiatry* I have found only one example of an article from a sociologist (Conrad 1994). Well-known sociologists of the body such as Bryan Turner, Chris Shilling, Mike Featherstone or Deborah Lupton do not appear even once in the medical anthropology ‘journal-matches’ (though reviews about their books do).

However, taking the anthropological ‘body-records’ together as a whole show that the academic field of interest in the body spans general anthropological journals and medical anthropology journals. The main output of articles in this field is published in the area of medical anthropology (both in terms of journals and authors).

So What?

In her well known paper about how patient’s experience the long-term consequences of stroke, Kaufman (1988) pointed out that biomedicine is in a paradoxical situation. On the one hand, a “holistic” medicine is called for, which treats the whole person and not just a passive body by considering people’s life circumstances. On the other hand, biomedicine is criticised for its tendency to incorporate more and more dimensions of everyday life, which is discussed at length under the headinger of “the medicalisation of life” (Illich 1977, Conrad 1992, Lock & Kaufert 1998). Against the backdrop of the bibliometric results presented here, the question, which I am asking is whether medical anthropology to some extent faces the same dilemma as biomedicine. Is medical anthropology not also split between the demand for holism in order to do justice to people’s specificities of life on the one hand and contributing the demand for the medicalisation of life on the other? Or to focus on the question of the relationship between medical anthropology and anthropology, is medical anthropology not a way of medicalising anthropology in general?

Browner (1999:135) has recently cautioned us not to let medical anthropology be "medicalised" by studying entities as they are conceptualised by biomedicine such as cancer, stress or postpartum depression as they are conceptualised by biomedicine. She rightly pointed out that this has unfavourable substantive and methodological consequences and suggested that we rely on a more "holistic" approach instead, which includes all aspects of social reality. However, the other side of the same coin is that we bring ever more phenomena into the "medical anthropological gaze" (Scheper-Hughes 1994:230). By doing this we predefine what we consider to be relevant. This may have consequences for how people understand the phenomena we are studying. However, it also has consequences for what kind of phenomena medical anthropology claims to be competent for and entitled to deal with. In other words, what is the *domain* of medical anthropology? In what topics is medical anthropology "domaining" (Strathern 1993)? Paradoxically, the very endeavour of not medicalising medical anthropology that Browner is calling for seems to contribute to a medicalisation of general anthropology. For as the bibliometric results presented here indicate, the field of anthropology has been growing as a whole in the pastrecent decades; medical anthropology, however, has been growing faster and has considerably extended its domain in anthropology. And the question can be rais, at whose cost?

Some ten years ago Reynolds White (1989) proposed that there be a shift in the anthropological conceptualisation of misfortune in Africa: at one time misfortune was discussed within the anthropology of religion, whereas now it belongs to medicine and medical anthropology. If this observation is true, what consequences do shifts such as this one have for the anthropological understanding of the topics concerned, for the subdiscipline which once had been regarded as competent for a topic and finally for medical anthropology itself?

The case of the body may be understood as a salient example in this regard. As Synnott & Howes (1992) have argued, the body has always been implicitly present in anthropology. Together with feminist anthropology, though, it was medical anthropology that played the principal part in making the body explicit. The study of biomedicine and in particular the critical assessment of the biomedical conceptualisation of disease and the body has played a central role in this (Hadolt 1998). In my view this also accounts for the undeniable success of medical anthropology within anthropology. However, as supported by the bibliometric findings, medical anthropology is dominantting in the field of the body. This is not only relevant as such, but as the body intimately permeates all aspects of life it also provides an important link to other fields of social life. It is not least this very reason which – under different headingsers and with different effects – accounts for the success of biomedicine in the medicalisation of life. As such the body offers medical anthropology a potent way of expanding its domain into other fields of research. Consequently, some of my colleagues are already calling to reclaim the body from medical anthropology and propose a "de-medicalisation of the body" in anthropology.

More evidence for medical anthropology's tendency to expand its domain also comes from the study of suffering. This line of interest has been recently pushed forward by the development of the concept of *social suffering* (Kleinman, Das, Lock 1996), which addresses suffering resulting from structural violence such as war, hunger or political oppression. This concept explicitly seeks to envision suffering beyond its individualised form and beyond established categories both of kinds of suffering (disease, unemployment, poverty, etc.) and their allocation to distinct agencies of responsibility for it (medicine, social welfare, development agency). This way of conceptualising suffering has begun to produce new agendas for medical anthropology such as a "medical anthropology of political violence" (see the special issue of *Medical Anthropology Quarterly* edited by Linda Green 1998). While I certainly sympathise with the general idea of social suffering, the concept clearly extends the possible scope of medical anthropology's domain and as such it faces difficulties similar to those of the preoccupation with the body.

I am not suggesting here, that we as medical anthropologists should abandon the body project or return to the study of disease and illness. Exploring new fields, asking innovative questions and expanding one's view are indeed vital for any field of research. Thus the boundaries of a discipline can never be fixed. Tracing the history of ideas, developing new concepts and analysing theoretical questions, however, is not enough. What also needs to be done is to critically analyse the political and academic conditions and consequences of how we choose our objects of research. Medical anthropology has been aware of this issue in relation to biomedicine, even though the implications have been voiced more at in the epistemological dimension than at in the political one. What is still missing though, in my view, is that we must also come to terms with what doing medical anthropology means to and costs for other subdisciplines in anthropology and the price that they have to pay for it. We cannot automatically assume that medical anthropology's contributions to anthropology are always "positive". It might turn out, that some anthropologists working in other subfields, for may have good reasons may for not seeing medical anthropology as positively as most of its protagonists do.

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Notes

(1) See Comaroff 1982, Csordas 1994a, Good 1994, Kirmayer 1993, Kleinman 1995, Scheper-Hughes 1994, Scheper-Hughes & Lock 1987, Strathern & Stewart 1999, Taussig 1980.

(2) Melkers (1993:44) defines bibliometric as «the study and analysis of scientific output with the use of publication-based data.» Usually bibliometric is used as a tool to evaluate the "output" of research activities, in particular topical areas or institutions and the "impact" of scientific journals or particular articles by means of publication counts, citation counts, co-citation analysis or scientific mapping (see Melkers 1993 and Hornbostel 1997 for an overview).

(3) The more comprehensive SSCI was not available in Vienna, so I had to restrict my search to the SSI. For more information about covered journals, searchable fields etc. see http://www.isinet.com/isi/ (SSI) and http://www.ovid.com/products/databases/soc-page.cfm (SA)

(4) *Atlas.ti* is a software programme for qualitative data analysis based on the principles and coding paradigm of Grounded Theory, but it also works well for simple quantitative analyses such as mine.

(5) I hasten to add that I do not suggest that these four journals are the most important ones in anthropology as far as their scientific output and impact are concerned. To judge this depends too much on the specific interest of individual anthropologists, their topical and regional area of work and their institutional affiliation.

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THE BODY

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Introduction

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A conference on medical anthropology cannot be held without granting some space and time of reflection to the issue of the body. Medical anthropology, through its focus on illness, has a particular interest in the human body and all that relates to it (its organs, its substances, its functions), in that it questions the relation of illness with physical experience and pain. For the patient who suffers, the body is an «essential part of the self», said Good (1994).

If the body is a central object for medical anthropology, it is also central for general anthropology. As stressed above (Fainzang, in the present volume), the study of the body and of its representations is fundamental to anthropology insofar as it allows to unveil some of the symbolic logics governing life in societies, which is one of the main purposes of anthropology. But the study of the body is also important because it means focusing on suffering and on the lived experience of people, which is another way of understanding and analysing social realities.

Yet there are different ways of seeing and conceptualising the body, which play a part in the kind of relations medical anthropology has with biomedicine and with anthropology in general. The issue of the body brings us to the way the body is perceived and conceived both by anthropologists and by informants. It is examined here on various levels and the discussions concern:

- the image of the body,
- the conceptualisation of the body,
- the status of the body (especially as an object or a subject, an agent of experience and narratives),
- the role of the body, namely as a vehicle, through signs and symptoms.

In this regard, the papers also examine what is at stake with the body in medical anthropology and the relationship between the body, anthropology and medicine.

The papers in this chapter raise quite a number of heterogeneous questions. Some take the body as a means of deciding on the place of it in medical anthropology studies; others take the body as an object of reflection *per se*. They all address, however, a certain number of questions, which concern the question of the relationships of anthropology and medicine, and the contribution of medical anthropology to anthropology.

The issue of the body is all the more important as it refers to the notion of embodied experience. A few years ago, Good (1994) noted that literature on representations was important but that accounts of illness experience were largely absent. This gap has been largely filled thanks to interpretative studies: nowadays, many authors plead for an anthropology of experience (Kleinman & Kleinman, 1995). Likewise, the papers in the present chapter largely speak of embodied experience.

However, it seems that the issue of the experience of the body is somehow seen as the opposite of the issue of representation. There is a focus here, as in interpretative anthropology, on embodied experience as the grounds of illness representations, which stress the primacy of bodily experience. The result is a concern to give accounts of bodily experience rather than to give cognitive renderings of illness, as the opposite course of what Good noted concerning the context criticised by anthropologists in the interpretative tradition, simply reversing the order of priorities. The body is seen as subject of knowledge, and experience is seen as prior to representation. This requires some comments to be made:

1) What is striking is that the distinction between the study of representations and the study of bodily experience is a distinction between cognitive and experience-related categories. That is to say, it is a distinction, which reifies the split between body and mind, whether it is by taking one or step or the other.
2) One question is how far the actual focus on embodied experience and the notion of embodiment contributes to general anthropology? This question relates to the true anthropological issue of the relationships between body and knowledge.
3) There is, in this field of research on the issue of the body and embodiment, a consensus that embodiment rests on the phenomenology of illness experience. But the notion of embodiment seems to have different contents and implications for different people. Some base knowledge on the experience of the body, while others find that the body expresses what comes from social and personal life experience, seeing the body as a reading grid of life and of the self, or as the locus of the cultural construction of personal experience.

So it seems that we confront some major problems here. Finally, we can wonder whether we do not have, with body and illness, the same type of relationship as in the story of the chicken and the egg: which came first? Which depends on the other? Can we make any sense of the separation between them?

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Contextualising the body: Anthropology, Biomedicine and Medical Anthropology

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> «It is probably no fluke of intellectual history that a turn toward the body in contemporary scholarship in the human sciences has coincided with the realisation that the post-modern condition is now the uneasy condition of all intellectual activity» (Csordas T, 1994: xi).
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> «... the contemporary discourse on the body has emerged as one of the major manifestations of a crisis in the intellectual politics and epistemology of Western social thought» (Turner T. 1994: 29).
>
> «It was agreed that our subject matter is neither simply medicine as an institutional body of scientific knowledge nor the human body as unproblematic product of nature, but rather is a study of the creation, representation, legitimisation, and application of knowledge about the body in both health and illness» (Lindenbaum S. and Lock M., 1993: x).

In this paper I will discuss the contribution of medical anthropology to its parent discipline in terms of the re-conceptualisation of the body as an historical domain and a socio-cultural process. The argument I propose is that such a turn towards a new image of the body would not have been possible without the emergence of an anthropology at home, in the form of an anthropology of biomedicine. Once the body is investigated against the historical practices of its constitution a new horizon, both theoretical and epistemological, opens up for researchers to re-conceptualise their analytical enterprise.

1. Modernity, postmodernity and anthropology at home

Post-modernism represents an epistemological turning point: subjecting the entire Western enterprise to critical scrutiny, it determines the end of a unitary and universal conception of the self and in turn the death of the "natural", bounded body (Martin, 1992). In this new intellectual landscape the body seems to emerge as a new horizon, allowing a re-orientation of the discipline toward a new view of culture, self and its identity as well.

A new body is playing its role on the stage of social sciences and humanities, moving away from its conceptualisation as a natural, given and bounded entity. Such a shift is to be seen as a consequence of the dissolution of the cultural project in which the previous body was rooted. Only recently appropriate anthropological attention has been paid to modernity in terms of a cultural project. Early anthropology and modernity can be considered as being epistemologically linked to each other: anthropology actually represented the sight of modernity on other cultures (Remotti, 1993). Anthropology contributed in creating a modernist identity, defined against societies conceptualised in opposition as traditional, developing and the like. In such a wave of anthropological thought, modernity has been functioning as an explanatory principle, providing anthropologists with their categorical apparatus, and not as something to be explained or problematised. Thanks to this epistemological position, modernity has hidden itself from anthropological inquiry. In this way an opposition was fashioned between science and culture (body and mind, individual and society, material and ideal, disease and illness, etc.). And it was culture that anthropology used as the conceptual means to represent other societies, and find a reason behind their different practices and beliefs.

It was only when such an organic (epistemological) unity (complicity) between anthropology and modernity broke down that Western enterprise in all its aspects could eventually become the focus of anthropological attention. Such a detachment between anthropology and modernity, in which the latter becomes visible to the former, must be understood in a broader context. As Beck claims, the processes of globalisation and industrialisation have brought about a new modernity, a reflexive one indeed, in which «scepticism is extended to the foundations and hazards of scientific work and science is thus both *generalised* and *demystified*» (Beck, 1992: 14).

Indeed the relation between modernity and post-modernity is best conceived of as an epistemological one. In fact post-modernism does not consist of a specific methodology, of a new style and theory, rather it refers to a modern awareness of itself (Dei, 1993).

It is within such a context that an anthropology at home becomes possible, enabling the researcher to investigate the generative processes of what most of us take for granted about ourselves and our social reality. Among others, one of the fields that has been undergoing critical scrutiny is certainly the biomedical one, approached now as a local set of practical and theoretical devices for the construction and interpretation of illness and healing. An anthropology of biomedicine in other words emerges from a general process of rethinking the observer's categorical apparatus and history. The anthropological categories themselves, developed after many years of research in different contexts, come to be used upon our own society. The analysis becomes more and more reflexive: the observer's culture and categories become the object of his/her own analysis. The relationship between biomedicine and anthropology then becomes one between a discipline and its object of inquiry.

In order to contextualise this argument I shall now give a brief historical review of the relationships between anthropology and biomedicine.

2. *Anthropology and Biomedicine*

2.1. *Early anthropology and biomedicine*

The relationship between anthropology and biomedicine can be seen at different layers and stages. If we think of Evans-Pritchard's study of witchcraft (1937), or Rivers' contribution to ethnomedicine (1924), we can see that the interest in "medicine" is an early one indeed. But, was there already a relationship between these early anthropological analyses and biomedicine? And if there was, what kind of relationship was it? Certainly not one in which biomedicine was an object of anthropological inquiry. It was precisely in such an "absence" that we could detect the presence of biomedicine in early anthropology. In fact it is possible to trace an organic (epistemological) link between the absence of any anthropological inquiry of biomedicine and its use as the implicit background against which anthropology looked at different cultures. Within such studies, science was seen as the ground on which Western societies developed beyond the realm of cultural conditioning. "Culture" instead was the appropriate means for investigating and representing the beliefs and practices of different societies. These became coherent in their terms, but still of a different nature, when compared to the "West".

Absent from traditional anthropology was an awareness of how scientific culture was actually conditioning the very structure of the inquiry (Lock and Scheper-Hughes 1990; Good, 1994; Singer and Baer, 1995; Young, 1982). In this sense, it is possible to identify the very first tie between biomedicine and anthropology, the first of which provided the lens for the second to look at other cultural contexts.

2.2. *Anthropology and International Health*

After the Second World War anthropologists were called to intervene in several programs of International Health (Good, 1994: 26; Singer and Baer, 1995: 24). The relationship between the two disciplines then becomes explicit in so far as anthropologists come to be directly involved in health education and health related issues, but it is still implicit in epistemological (and political) terms. As Foster argues:

> «Quite uncritically the superiority of modern medicine and modern health care delivery was taken for granted, and the task was defined as the study of client groups to determine how modern medicine could be made most attractive to them.» (1980: 849-850).

In other words, Western medicine and values were assumed as universally valid and local cultures as the sources of resistance to be overcome in order to spread scientific knowledge. Biomedicine was therefore working within international health programs as the hegemonic system orienting research and action, and defining the very nature of the problems on the agenda. In stressing the hegemonic dimension of biomedicine, we come to realise that the problem of international health was not of a moral and psychological nature, but rather a structural and epistemological one and, as such, it required the development of a self-critical scrutiny.

It is only in the 70's that medical anthropology comes to complete its process of construction as a legitimated subfield within cross-cultural studies and anthropology. The relationship between anthropology and biomedicine then becomes completely explicit, even though their theoretical positions are different. It is then that we can locate the birth of the cultural study of Western medical systems.

2.3. *Toward an anthropologically informed medicine*

In the process of debating the definition of medical anthropology's identity, at least two "souls" were engaged. The first one, drawing on the findings of the new cross-cultural psychiatry and symbolic anthropology, is identified with a group of scholars who proposed that the cultural construction of personal experience should be considered as their object of inquiry (Kleinman, Eisenberg, Good, 1978). In other words, medical anthropology had to look at the cultural adaptation of patients to sickness episodes (Kleinman, 1978, 1980).

In such a view, fundamental importance was played by the concept of the Explanatory Model (Kleinman, 1978). With this concept, these authors referred to the different cultural constructions of clinical reality: the ways through which people make sense of their health problems. Central to such an approach was the recognition of the symbolic features of every Health Care System (Kleinman, 1978: 86) – Western ones included – and of the role of effective communication in the healing process. In this project, therefore, the role of the anthropologist was thought of as being that of cultural interpreter, mediating between different cultural constructions of a sickness episode. In fact, patients and doctors are seen as two parties producing different interpretations rooted in their respective socio-cultural context. Disease and Illness (Eisenberg, 1977) come to be represented as different cultural constructions of clinical reality, rooted in the biomedical scientific paradigm of doctors, and in the existential and socio-cultural context of the patient. In such a framework the application of anthropological knowledge was conceptualised at the level of medical encounter. These authors' most famous contributions of the early 80's were precisely concerned with such a level of clinical reality (1) and their aim was to create a bio-psycho-social model (Engel, 1977) «that systematically analyses the clinically relevant effects of socio-cultural determinants on sickness and care» (Kleinman, 1980: XII-XIII). In order to achieve such a goal, anthropologists had to enter the clinical setting and, in so doing, it was of fundamental importance not to subvert the established roles of medical professionals and their priority for therapy (Chrisman and Maretzki, 1982). Anthropology, in other words, had to adapt itself to the clinic, and to help medical staff to provide patients with a more humane treatment, by negotiating between the different perspectives involved in the medical encounter (Katon and Kleinman, 1981) and supporting effective communication and mutual understanding.

As far as our discussion here is concerned, it is necessary to stress how these scholars' concern with the cultural construction of illness experience obscured to some an extent the analysis of the constitutive processes of *disease* (2).

2.4. *A critical approach to biomedicine*

The other "soul" of medical anthropology's identity came from a more sociological standpoint and raised issues of a different nature. Biomedicine was always thought of as a cultural system, but in order to be properly examined, it had to be located within its socio-political context. In opposition to the previous approach, the anthropologist's role was seen to be that of a critical analyst of the social context of culture production, investigating the social interests behind every definition of reality. The biomedical construction of reality is critically assessed, and issues of power and inequality are raised. The very relationship between anthropology and biomedicine then changes its features: from collaboration with and within biomedicine, to the latter socio-political critique.

Within this approach, medical anthropology was trying to define its problems independently of biomedicine, in so far as the very notion of medicine and sickness came to be questioned as ideological, i.e. reflecting social interests. These scholars then proposed that the domain of *sickness*, defined as the social process of creation of medical knowledge and conditions (Frankenberg, 1980; Young, 1982) should be considered as a medical anthropology object of inquiry. Medical anthropology research and action came to be located outside the clinic, in the broader context of sociological analysis and political-economic critique. The relationship with biomedicine becomes a highly critical one:

> «Symbols of healing are simultaneously symbols of power. Specific views of the social order are embedded in medical beliefs, where they are often encoded in aetiologies and beliefs about the sources of healing power.» (Young, 1982: 271)

Biomedicine comes to be thought of as a means of social control. In fact, in the social process of translating signs into symptoms, the human phenomenon of suffering is constructed in terms of biological entities, neutralising any potential negotiation about the meaning of experience and reality (Taussig, 1980). Within a biomedical construction of reality, medical conditions are seen as facts of nature, and the implicit outcome of such a process of medicalization is to prevent people from recognising the social relations embodied in sickness. Biomedicine is seen as reinforcing our self-perception as bio-physical beings, relying on specialist knowledge to deal with our problems, and in so doing contributing to our alienation from ourselves (Comaroff, 1982). According to such a view, anthropology will have to move its focus of attention from an individualising gaze to a socialising one. In this process of re-orientation, the very nature of the field undergoes a radical shift as well, coming to be socialised within the relations between local realities and global processes, and not at the level of clinical interaction (Frankenberg, 1980) (3).

If the anthropologists of *Illness* are concerned with the cultural construction of experience and clinical reality, the anthropologists of *Sickness* deal with the social production of cultural meanings and experience, and the clinical construction of reality. The distinction between *Sickness* and *Ill-*

ness, then, is a theoretical and methodological one, concerning the object of medical anthropology, its methodology, its role in society, and fundamental concepts such as those of culture and action. I agree with Hahn (1984) when he suggests that these two approaches be considered in terms of different ideologies trying to shed light on a highly complex phenomenon: that of suffering. Despite the differences between the two approaches, they both share the same shortcoming: by not questioning the *nature* of disease, they confine the body to the realm of its biomedical definition.

2.5. The emergence of a critical-interpretative approach

Along with, and in opposition to, the previous approach, another view of medical anthropology emerged. It was concerned with both issues of political-economy and cultural construction of personal experience. This critical-interpretative approach, put forward by Lock and Scheper-Hughes (1987), fully realises the process of detachment from biomedical epistemology and ontology. These authors' definition of sickness is grounded on a critical phenomenology focused on the body as generative actor within the process of cultural production, reproduction and negotiation. Within this approach, the body emerges as the very specific object of medical anthropology: neither the cultural construction of personal experience, nor the social process of production of medical knowledge and conditions, but rather both of them now located in the new context of the body. This approach clearly put forward a strong critique of every essentialism: the very notion of a physical body is questioned, for it never occurs outside the nexus of cultural and socio-political forces located within a historical context.

Only by drawing on such an historical and phenomenological conception of the body is it possible to completely found a *bio-free* medical anthropology. Although the previous approaches had been critical (in different ways, and to different extents) of biomedicine, they were not making an explicit critique of the ideological construction of the "physical" body, so they risked implicitly sharing the same assumptions as biomedicine.

It is only from a re-conceptualisation of the body that we can reach a broader understanding of sickness without reproducing biomedical epistemology and ontology. The body now becomes the most proximate context in which to look at the interplay between personal experience, cultural discourses and socio-economic forces. It becomes the process through which experience, culture and society are reproduced and negotiated. In this framework, Lock and Scheper-Hughes define sickness as:

> «a form of communication – the language of the organs – through which nature, society, and culture speak simultaneously. The individual body should be seen as the most immediate, the proximate terrain where social truths and social contradictions are played out, as well as a locus of personal and social resistance, creativity, and struggle.» (Lock and Scheper-Hughes, 1990: 71)

Such a formulation makes it possible to think of sickness in non-biomedical terms, helping us to focus on the socio-cultural processes within which experience is embedded and symptoms come to be articulated as metaphors of distress and resistance.

2.6. Anthropology from the body

It is against such a background that a new paradigm for anthropology emerged, namely embodiment, and a new trend in ethnography became popular, concerned at the same time with phenomenological accounts and issues of political economy (4).

The body is certainly not a new object for anthropology: Marcel Mauss and Mary Douglas' studies gave it a legitimate status within the discipline. However central, past analyses of the body were carried out within a taken-for-granted opposition between nature and culture. Although its meanings were seen as belonging to society (like every other classification), its deep nature was still seen as rooted in biological processes. Such processes were thought to be «good to think with» (Douglas, 1970) in the production of social meanings, but certainly the body was not conceptualised as playing an active role in such a meaning-building activity.

Contemporary analyses of the body, however, depart from a different ground and view of the body. The body is now neither just the target of cultural conditioning (Mauss, 1973 [1934]), nor the source of metaphors about society (Douglas, 1970). Neither is it simply defined by disciplinary practices and discourses (Foucault, 1975). Rather it is seen in a phenomenological fashion as playing an active role in the process of meaning production, in the process of decision making, in the transmission of knowledge, etc. Post-modernism, with its stress on deconstruction, has seen the death of a passive objectified body and the rise of an active process of historical analysis.

The deconstruction of the biomedical body paves the way to the study of the historical and cultural devices of constructing the body. Body symbolism and representations become appreciated in their local historicity, less as cultural means of representing the human body *as it is given in nature* (as biomedicine puts it), rather as devices for the very construction of its nature, now of an historical kind (Feher, M.; Naddaff, R. and Tazi, N. 1989; Crary, J. and Kwinter, S. 1992). The historical and situated nature of the body helps us to understand the bias in «the assumption that whatever nature makes is a natural kind» (Dennett D.1991: 381). To acknowledge the historical nature of corporeality leads us to the investigation of the process of its construction, of the cultural creation of its naturalisation. It is in this sense that the problem of the body becomes one of social ontology and the generative process of body and sociality appears far from being independent.

Such a process of reconfiguring the body within medical anthropology reflects broader and general concerns of the discipline as a whole, and at the same time it has offered anthropology useful means to redefine its theory and practice. On the one hand the appearance of the concept of embodiment is in fact very much linked to the emergence of a new concept of culture as:

> «... under continuous creation – fluid, interconnected, diffusing, interpenetrating, homogenising, diverging, hegemonising, resisting, reformulating, creolising, open rather than closed, partial rather than total, crossing its own boundaries, persisting where we do not expect it to, and changing where we do.» (Sanjek, 1991: 622. In Borofsky, 1994: 313).

On the other hand embodiment offers anthropology a point of entry in the generative processes of the cultural process that emerges from the relationships between body, self and society within a specific, but not bounded, historical context.

3. Medical Anthropology and Anthropology

3.1. Fragmented hegemonies, embodied resistance: illness as a heuristic device for the study of culture

The deconstruction of the biomedical body allowed by the previous approaches paved the way to the study of the historical and cultural devices of constructing and naturalising the body. Within this analytical landscape, the anthropological study of illness offers the discipline as a whole a precious analytical context.

To underline the social nature of the body and the bodily basis of culture is not to talk of the relationship between the two levels in mechanical terms. Despite the fact that the dialectic process between the two is constitutive, it is also emergent, processual, and indeed contradictory, as well as open and indeterminate, susceptible of being negotiated, questioned and rejected. As Frankenberg states:

> «The body is not merely [...] a symbolic field to mirror or reproduce dominant values and conceptions; it is also a site for resistance to, and transformations of, imposed meanings. [...] Cultural meanings are not only shared and given, they are fragmented and contested. Social life is divisive as well as cohesive. The body makes, and is made, by, a fractured social world.» (1992: xvii)

It is precisely because of the emergent, processual and fragmented relationship between social reality and experience that the body can elude the pervasiveness of social necessity, establishing dimensions of critique and resistance. Our acknowledgement of the body's role in the emergence of culture and experience (Csordas, 1990; 1994) allows us to understand why illness does not require a different positioning of the sufferer in the world. It also produces a different existential mode of being in the world (Williams, 1996). In so doing, the illness experience opens up a space for critical thinking through which the very partial and arbitrary as well as precarious character of our ontological and existential referents are brought to light, forcing us to negotiate them anew (Garro, 1992; Good, 1994; Scarry, 1985). «In sickness we confront the inchoate. Bodily suffering distorts the landscape of thought, rendering our previous construction incoherent and incomplete» (Kirmayer, 1992: 329).

The creative power of illness, as well as its methodological contribution to anthropology becomes clear with this last assertion. The body is not a marginal element in the process of challenging and consolidating the social order and its 'givenness'. On the one hand it is in fact through inscription in the body that knowledge and the social order become hegemonic: in entering the lived experience, they disappear from awareness. It is through such a process of embodiment that the dominant order becomes 'natural', and the socio-political processes that sustain it come to be obscured in the immediacy of the lived experience. On the other hand, bodily distress articulates a form of "*dis-ease*" with the social. Both these processes are performed in the depths of our intimate existence.

Illness brings to light the process of being in its *negative* mode, and in this sense it must be looked on as a 'change' in the embodied process of being-in-the-world. Illness is itself a process, whose peculiarity lies in the rupture it engenders regarding the previous pre-existing relationships between body, self and society (5).

3.2. Reflexivity, anthropology and biomedicine

The body then emerges, as H. J. Jung puts it, as the umbilical cord to the social: «To be social is first and foremost to be intercorporeal. [...] The body is our *social placement* in the world. [...] The world, as Merleau-Ponty has it, is made of the same stuff as the body presumably because we relate ourselves to the world by the medium of the body, which is the lived field of perception. Since we are always already social, the body cannot be the 'origin' but, more properly, [...] the ambient medium of the social» (Jung, 1996: 5).

The body, then, is a generative agent of meanings and experience. However, the body is never given outside the game of culture, it is always socially located (Bourdieu, 1979, 1990) and historically informed (Feher M., Naddaff R., Tazi N., 1989; Mellor and Schilling, 1997). The body, then, is at the core of the ongoing process of perception and objectification (Csordas, 1990; 1994), as much as it is the engine of the process of inscription and projection (Frank, 1998), an object of construction (Foucault, 1975) and a generative agent (Merleau-Ponty, 1945). It is at once a natural entity and a cultural process, individual and collective, personal and social.

So, embodiment seems to allow for the collapse of the antinomies sustaining modernity as a cultural tradition. An anthropology oriented towards the generative process of coming into being of culture and experience must be rooted in an epistemological critique of modernity, and allow this critique to become methodologically operational within anthropology as a whole. The body, then, plays a central role in socio-cultural theory:

> «The theoretical implications of the scholarly discovery that the body has a history and is as much a cultural phenomenon as it is a biological entity are potentially enormous. Also, if indeed the body is passing through a critical historical moment, this moment also offers a critical methodological opportunity to reformulate theories of culture, self, and experience, with the body at the centre of analysis.» (Csordas, 1994: 4)

Medical anthropology offers anthropology specific contexts to enter the realm of the constitutive process of givenness, the very core of the process of naturalisation and objectification, i.e. the very process that brings into existence the world and the human agent as a positive presence in a meaningful landscape.

Such a transformation would not have been possible without a critical approach to the biomedical construction of the body, thorough a critique of modernity and the development of an anthropology at home.

If it is of vital importance on the one hand to found medical anthropology outside the biomedical domain, on the other hand I do believe that a relation between the two will always be necessary. In my view, medical anthropology needs to hold a relationship with biomedicine not only in terms of a critical study of it, but also in its reflexive process of self-definition.

In so far as anthropology and biomedicine share the same socio-cultural context, they do share, to a certain extent, an *implicit anthropology* as well. The difference between the two disciplines lies precisely in the relationship they hold with such an implicit anthropology. Anthropology defines itself as a discipline that is epistemologically aware of its own theoretical assumptions, while biomedicine produces its own reality and knowledge by drawing on the dominant scientist ideology, without epistemologically reflecting upon it.

In such a self-reflexive scrutiny anthropology will always face biomedical assumptions, in so far as they play a fundamental role in sustaining such an implicit anthropology, providing it with a criterion of reality and a measure of truth (the biomedical body). In this sense, anthropology must always start any analysis by critically reflecting upon the hegemonic biomedical definition of the body.

The self-reflective process of deconstructing the biomedical definition of the body is nothing more than its re-construction according to the cultural practices of its constitution as a naturally given individual entity. In other words, medical anthropology rests on the very practice of uncovering the implicit background of every anthropological comparison, i.e. the implicit (because they are embodied) limits of our explicit reasoning and more generally of our socio-cultural mode of being-in-the-world. Among others things, what medical anthropology has to offer its parent discipline is the possibility of conceptualising in reflexive terms not only biomedicine (i.e. its own cultural context), but its own analytical enterprise.

4. Bridging levels of analysis

Such a self-reflexive attitude, now identified as the epistemological specificity of medical anthropology against biomedicine, is the very cornerstone of anthropology in general. In fact I do not believe there is any substantial difference between anthropology and medical anthropology (see Comaroff, 1981). The task and methodology that medical anthropology pursues are the same as those of anthropology in general. To be specific to medical anthropology is the context in which they are located, be it the body or the emerging concept of suffering (see note 4).

To be specific to medical anthropology and useful for anthropology in general is medical anthropology provocation «to inquiry the historical processes whereby biological and cultural phenomena are mutually determined» (Lindenbaum and Lock, 1993: xiv)(6).

Moreover in so far as to be 'critical' in anthropology has become more and more a matter of being able to bridge different levels of analysis(7), the body seems once more good to think with. Once it is conceptualised as an active player in the game of structure and agency, culture and experience, hegemony and resistance (and so on), we realise how personal distress goes beyond the individual experience, to become rather the embodied trace of broader socio-political processes of a an historical nature. In this context, the concept of embodiment seems to appeal to a very felt need in the academic world: namely the necessity of mediating between individual lived experience and broader socio-economic processes, between phenomenology and political economy.

It is then obvious that medical anthropology must define its problems independently of biomedicine if it does not want to get trapped in reductionism and epistemological naiveté. But it is even true that to define its own problems independently of anthropology in general would be naive, noxious and misleading:

> «A way of thinking about our subfields is to see them as providing opportunities to grasp major topics in general anthropology and to examine them in highly specific contexts. [...] Thus, subfield proliferation could be viewed as a chance to bring new energy to old anthropological questions. [...] Seen in this way, anthropological subfields like medical anthropology contribute to the reformulation and expansion of the searching questions that give anthropology its distinctive strength.» (*American Ethnologist*, 1988 vol. 15, num. 1, p. 2)

Notes

(1) See Del Vecchio Good and Good, 1982; Eisenberg and Kleinman, 1981; Good and Del Vecchio Good, 1981a, 1981b; Katon and Kleinman, 1981; Kleinman, 1981, 1982.

(2) It must be said that these very same scholars have been among the best critics of themselves in their more recent publications, moving away from the biomedical reductionism that characterised their early work (Good 1994; Kleinman 1995).

(3) Following this approach a group of scholars launched the term *Critical Medical Anthropology* (Singer and Baer 1982 Meeting of the *American Anthropological Association*). Such an approach

emerged as a direct challenge to previous conceptualisations of medical anthropology, and was meant to correct their shortcomings: it is in this sense that these authors chose the term 'critical' to define their approach. Singer and Baer put it: «adoption of the term *critical medical anthropology* was intended to reflect a two-sided approach involving the criticism of conventional medical anthropology for its narrow perspective; and social criticism, in the tradition of Marx, Mills, and other socially critical thinkers» (Singer and Baer, 1995 Chap.1: 42). The shortcomings they identify in conventional medical anthropology are, according to them, very much the outcome of the uncritical acceptance of the socio-cultural context in which the discipline is rooted and the lack of a macro-understanding of social and medical processes. These authors stress how their work developed in response to a growing recognition that «medical anthropology needs a critical analysis of the socio-medical context in which it has emerged» (Singer, Baer and Johnsen, 1986: 95). The context they mean is a particular moment within the capitalist world's economic and medical system. They sustain that such a context has affected conventional medical anthropology in both theory and practice, leading it to incorporate Western ideological medical assumptions. Their task is not just a critique of the traditional anthropological approach to medicine, but a study of the latter "in the context of the capitalist world system" (1986: 96).

(4) This is testified by the new focus on social suffering and structural violence that has captured scholars attention (See for example the triptych of volumes edited by: Kleinman, Das, Lock, 1997; by Das, Kleinman, Ramphele, Reynolds, 2000; and by Das, Kleinman, Lock, Ramphele, Reynolds, 2001).

(5) «Breakdowns play a central role in human understanding. A breakdown is not a negative situation to be avoided, but a situation of non-obviousness, in which some aspect of the network of tools that we are engaged in using is brought forth to visibility [...] A breakdown reveals the nexus of relations necessary for us to accomplish our task» (Winograd In Haraway, 1993: 381). This is probably the reason why medical anthropologists have focused their attention much more on sickness than on health.

(6) See for example cultural studies of science and biotechnology (Martin, 1994; Lock, Young, and Cambrosio, 2000; Young, 1995), emotions (Desjarlais, 1992; Pandolfi, 1991; Williams, 2001), narratives of experience (Frank, 1995, 1997; Radley 1995, 1997; Good, 1994; Mattingly, 1998; Mattingly and Garro, 2000), political and structural violence (Kleinman, Das and Lock, 1997; Das, Kleinman, Ramphele and Reynolds, 2000; Das, Kleinman, Lock, Ramphele and Reynolds, 2001), industrialisation (Ong, 1987), colonialism (Comaroff, 1985), reproduction (Martin 1987), religion (Csordas, 1990) and others. All these examples are topics belonging to general anthropology. They become specific to medical anthropology when their analysis comes to be located within their relationship with the body.

(7) See Massé's contribution in this volume.

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Embodied anthropology: Anthropology from oneself(1)

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I have been doing research on health and the body from a feminist perspective for twelve years; for the last eight years I have focused on the issue of body image. One of the definite aspects for this has been the fact that the subjects, orientations and questions that have guided my studies are closely articulated with my own circumstances and experiences, of which I have been aware all these years (2). I would not say that in my case both life and research have always been in agreement, but they have been closely connected and the achievement of the target of my research includes implicitly being able to understand the darkest parts of my own sexual, bodily, emotional and intellectual experience. I have never written about such links between life and the research process: I have only stated so during oral presentations of my work, always taking into account the audience I was facing. There are several reasons for this silence: self-consciousness when talking about myself, feeling naked in front of the audience, the risk of being misunderstood or rejected. And besides, we must bear in mind that I was a beginner in anthropology, that I came from another professional area and that my research had been around anthropology, and not anthropology itself.

But if the articulation between life and anthropology has been a general feature in all my research it is stronger when related to body image issues. The influence of what one has lived upon what one has written is so important that a few months ago I realised that if I wanted to carry on with my research in this field I had to focus on the connections between my own experience and my anthropological work. I think it is about time to make it explicit and to contribute to a minor but necessary discussion in our area. Thus, the main goal of this article is to reflect on how my research work upon body image shows interactions with my own experience. Furthermore, at the end of the article I will refer to the relationship between self-ethnographies, mostly those coming from medical anthropology, and anthropology at home.

As far as my body experience and identity are concerned, there are three key elements:

- the direct influence of contemporary Western culture on the body;
- specific symptoms and problems;
- the intersections produced in my own personal, social and professional identity, the multiplicity of selves that I have embodied as a woman, a feminist, a women's doctor and anthropologist, all of which have a tension between them, and something specific and converging around the subject-matter of the body.

I must say that I owe a great deal to feminism for making me understand that what is corporal is never natural, but always socially and politically constructed. And, mostly, I have to thank feminism for having given me the opportunity to understand the idea that the body is not only a place for discrimination but for resistance and confrontation as well. However, both my professional training and practice in a peripheral and alternative field within medicine, such as family planning is, have allowed me to make a "cultural break" and acquire an "anthropological sensibility" before getting in touch with anthropology as such, this being a positive influence on my further work. Only lately have I approached the body from an anthropological point of view, but, no doubt, it was a good final point for a process that started as early as the age of eighteen. Anthropology has been a first rate ingredient in this process. It allowed me to reveal some aspects related to my personal experience which were hidden up until then and to find alternative forms of approaching and facing them so as to understand the body culture in which we are immersed. Furthermore, it has been an incentive to value and legitimate a space for our own analysis, that is, an alternative analysis that is sometimes set against the dominant perspectives in other reference frames.

The fact of consciously and explicitly interconnecting one's own body experience and the research I will tackle later on is referred to as "embodied anthropology" by means of which I try to claim an anthropological exercise which takes into account this twofold dimension:

The first one is articulated with the analysis starting from the concept of *embodiment* (3) (*corporización* (4) in Spanish). A concept which brilliantly integrates the tension between individual, social and political body (5) .

The second one referring to the "self" (self-observation, self-analysis) (Hernández, 1999), the relevancy of departing from oneself in order to understand the others, mostly when "we have gone through the same things".

An anthropologist faced with her self-analysis

In 1993 I started a study on body image that was within a European project but basically located in Spain (6). I studied various phenomena with a certain general view, mostly on European grounds, such as regulation of food through diets or exhibition of the body and catwalk modelling, and advertising (7). The main research techniques were: interviews with men and women who had significant experience related to their image (due to job, main activity or sexual orientation); active observation of various contexts (surgery rooms of various specialist fields; fashion-related venues and events, women and mixed groups, feminist forums, etc.) as well as national and international publications related to image and fashion.

However, I began to be interested in this subject when I finished secondary school as my body went through a radical change: suddenly I put on 15 kg and started to suffer hirsutism, which still prevails, although it has started to fade away thanks to electrolysis. From such significant changes as overweight and hirsutism, shame, guilt, and the routine of diets became part of my life for a long time. I kept the shame and guilt secret and, consequently, did not have the relief of confession (8).

Hirsutism, or the excessive growth of hair on a woman's face, especially when it takes place in the middle of youth, puts one in a rather ambiguous and painful situation. On the one hand, culturally it brings up the image of the "bearded woman" who is taken from fair to fair as a paradigm of error, horror, deformity and otherness. Besides, it symbolises sexual non-definition at an age when one is supposed to be building social and sexual identity in a society that is not prepared to accept or tackle ambivalence. It all produces negative feelings and reactions, which can be different as well: one can feel insecure, ashamed, powerless, enraged whereas the others can feel commiseration, pity or uncertainty towards you. They can also be cruel. In most cases, silence and a certain isolation builds up around you so that you remain under the other's gaze with no right of reply and you end up fixed, enchained and suffocated by their, sometimes, evasive gaze (9). But this general reaction has nothing to do with the search for solutions. I mean that even though today there are rather efficient treatments, both my private and professional experiences make me think that young women suffering from hirsutism today are “left to their own devices” at an age when they have hardly started to make their own decisions. Their families and social background overlook them, even the health system underestimates the issue and considers it a second rate medical problem. Everything related to image has does not have the same social or professional consideration, but these discomforts are absolutely hierarchic, whatever one’s own perception, experience or suffering are.

The case of being overweight, however, is quite different. Ideal thinness is so imperative that the danger of putting on kilograms has a disproportionate consideration and people are systematically pushed to going on a diet. By the way, this is also an option when one is not overweight, because what lies under it is an encouragement to discipline and self-regulation which, in the end, is an effective and sophisticated form of social and ideological control so typical of our society.

Diet became a substantial part of my living pattern, of my life. There were two main stages intertwined by means of transitional intervals:

- “Personal and social success”, where I used to lose weight and reconcile myself with my body, taking great care of my appearance;
- The image of failure reflected in the mirror when my main goal was to erase my body definitely, trying to conceal it, for instance, under baggy clothes. In both cases, the role and valuation of others were crucial, shifting almost automatically from praise to silence, or to recrimination for “neglect”.

The continuous alterations in weight made me eat compulsively and I suffered from bulimic attacks, as often happens in these cases (10). As a result of this, I became gloomy and introvert at an age when I was starting to have my first love and sexual experiences and was wondering what on earth I was to do with my medical studies and professional career. Then, I got in touch with a group of feminists in my hometown, which is an industrial town. As often happened back then, what we called “the Basauri women’s group” was to create a family planning centre (11) where, years later, I started to work as a doctor.

Suddenly my body became the main character and was enormously visible, both for me and for the others, going through a process of absolute hyper-objectivation and becoming the prism through which the me and the others valued what was going on within me. My “being in the world”, my “existing in the body” was made into the visible, the external body (12), and the seen body (13). What I lived or perceived beyond my appearance did not matter, but what did not match the social ideal did. For a long time I strongly felt that I was a victim. What had happened to me and the social stigma it carried with it, because, as I have said before, ugliness and deformity are otherness par excellence (Chapkis, 1988). I was also a victim of silence and isolation: thousands of talks on weight, body and image, made by experts and non-experts alike, make up for a great deal of time and space in Western societies; but, generally speaking, they are mechanical, repetitive and stereotyped to the point of satiety (14). People are worried about weight lost or put on, about firm, protuberance-free bodies (Bordo, 1990). People are worried about the body's social success or failure. That's it. Besides, the fact that either losing or putting on weight is not a serious illness and that there has not been a trend towards creating associations or regulating self-help practice, except for serious cases, makes it difficult to find real advice or help (15).

What was my family's role in all this? I think that the main point is the fact that I was socialised in a middle class background and that my parents were teachers. Like all the teachers of their generation my parents had a rather complex professional status during the Franco era, with social prestige, especially in rural areas, on the one hand, and a precarious socio-economic level which improved later on, on the other. They had a strong perception of their responsibility as educators and keepers of the social order. In my family, mind has always come before body and in this order the daughter's sex was of no importance (I have no brothers). So my family background was characterised by avoiding and silencing sex. This was characteristic not only of a given historical moment in Spain but of a given social class as well. And this does not speak for a good experience of the body. However, the gender neutrality has positive and negative dimensions. Positive because I have been allowed to grow an androgynous mind and intellect, which are really valuable for me; and negative, because I had to unlearn and learn many questions related to managing the emotional, the bodily and the feminine by myself. Being aware of the specificity of my own familiar and social locus has helped me to always bear in mind that the cultural dictates on the body have to be analysed in their historical and geographical contexts, at micro-experience level, but also at the social, political and economic macro-process levels.

The negative part of this personal journey has been the suffering I went through for many years, the feeling of having made a mistake, not only as a woman, but as a human being as well, in something I was not able to see but could intuitively tell as definitive. I thought that I had neglected myself, that I was in danger; because that is the way our society sees lack of control. Accumulated doses of resentment (16) have also been positive and negative. I felt resentment against those who daily reminded me of my "error" or went on about other people's errors; and this resentment was aimed at the social system as well. But my targets were well defined: one was against my colleagues from the health system, who give overweight an importance that is out of proportion. The medical class, as I said before, tend to overlook other body issues, even aesthetical ones, that sometimes determine their patients' health and do not take into account positive and alternative elements underlying "other corporalities". Being as they are in a medical and social model "possessing the truth" and acting as a "roller", they are unable to see and hear things in perspective, from a suitable distance.

Other specific objects of resentment were my feminist colleagues (except for many good and valuable people) who usually barely scratched the surface of this issue and had great difficulty in applying the same criteria they used on issues that are of equal or greater importance, such as motherhood or work. However, the women's movement was able to use the body issue as a political weapon and an alternative and counter-cultural identity tool, especially during the 70's and 80's. Belonging to this family has allowed me to look closely at personal and collective contradictions, which has not always been pleasant. Nevertheless, there has been a positive dimension in all this: the urgent need to understand why it was so and the obligation to think about something over and over again until you see the light. It has given me the chance to improve my ability of looking at things, of looking at others, and myself and to undergo compulsory "training" which has proved a useful process of learning about research.

Moreover, some theoretical and bibliographical references were absolutely healing from a personal point of view and really encouraging from an intellectual perspective. I should mention three of them. The first is *Tu cuerpo, tú misma* by Susie Orbach (1987)(17), which is set against the background of a therapy with women and weight problems. Orbach poses a question which for me was thought-provoking and new: the relationship of obesity with issues other than eating and the pleasure of eating and the benefits of a body not recognised by society. A body that, despite not being normal, can provide distance and shelter against other cultural imperatives such as beauty, aesthetics and sexuality, which women in particular pay a price for. It is a book I have read and reread many times and which I have kept within the file of key readings. Another basic theoretical reference is Janet Polivy and Linda Thomsen's article "Los regímenes y otros transtornos de la alimentación" (1992) ("Diets and other eating disorders") warning against the physical and psychological dangers of dieting, mostly when it becomes a constant habit. After reading it, I became anti diets and controlled eating, even though I have varied this position over the years. Finally, I must mention Susan Bordo's (1990) theoretical argument on body regulation in Western societies. Bordo argues that in our society there is a twofold and apparently contradictory principle that urges us to consume and overvalues self-control. Besides, she makes a precise diagnosis of gender implications in advertising, fashion and mass media, taking into account changes that have occurred for both men and women.

Some conclusions from within myself

More than twenty years have passed since I first embarked on this experience and I look back serene and satisfied. The most important symptoms and discomfort have disappeared, although new ones arise as I get older. I think that I see my experience around the body as the management of my own life, varying and combining diverse meanings and techniques. Discovering and learning to value the "power of the physical" (18) within myself has been very important. This power has sometimes been influenced by gender, but many other times it has been totally neutral. I must underline the significance of understanding that my appearance, rather than being an addition to my ability to think, was the union of the two and that the external appearance could be the centre whenever I wanted, without the other suffering any disability. It was always myself.

In this elaboration and reconstruction of my own process many different issues and protagonists have taken part. Particularly important for me was the fact that I lived within a social context that has continuously revised its cultural canons, as regards esthetical ideas, sexual practices and ways of being a man or a woman. Being a feminist with a leftist background with many contradictions regarding the body, has been very important, and enjoyable, for me was to set my body working in very different ways both within and beyond cultural conventions. Also very important was the fact that I worked for a decade as a doctor in a family planning centre, a privileged laboratory for personal, sanitary and political work and reflection.

Therefore, the general argument has been the construction of my own self as an adult. Later, this led me to make the image issue my anthropological object of study, a process with different stages, contents and questions. For example, I was a vegetarian for a long time and this allowed me to accept my body in a more autonomous way and to strengthen my critical position towards the official medical system. However, later I realised that naturism has the main characteristics of our culture as far as the body is concerned:

it contributes to the above mentioned hyperobjectivation of one's own body, and shares the same trend that urges us to consumerism and self-discipline. So, it is another version of the Western regulation of life through the body.

Not long ago I spent some time in Leon (Spain) and went through a meaningful experience with a group of cover girls. They were very young and rather dependent on their interaction with men (an experience I lacked when I was their age) but willing to find their equality space in society. The experience made me think about youth, image, being a man or a woman, womanhood, masculinity and neutral sexuality and, personally speaking, I reflected upon my appearance, my desires and/or my difficulties for exhibitionism, that is, seduction and interaction with others. Besides, I had the opportunity of trying out different roles, skills and images in a city where nobody knew me, which was a lot of fun. It also allowed me to come into contact with a wide business and commercial world, where models are just one element, even though sometimes the most visible: a stage with male and female characters, individual and collective, multiple and different, with diverse responsibilities for keeping a certain body culture.

I will mention one significant episode. The Leon girls taking part in beauty or modelling contests told me that during the interviews they were asked about the fashion shops they liked best. It seems that their answers were important for the contestants' final scores, so they answered carefully. This, and other facts, made me realise that in practice what there is at stake around the image issue is not only a question of gender ideology but a wider one, where a certain political and economic model is asserted and where gender speaks for a whole social system.

I cannot say that in my case research has been exactly a form of therapy, and, though "healing", it has been a form of redemption or expiation (19). But it is clear that the elaboration and reconstruction of my own process have found a final projection in anthropological work. Although on a very primary level, I have seen some of the current dilemmas on body analysis clearly reflected in me. Now, I can easily place and rebuild on me this "post-structuralist body" that Terence Turner defines as «abstract, singular, intrinsically self-existing and socially disconnected, individual» (1994: 46) and which is associated with passively determined (disembodied) social behaviour, personal identity and cultural significance by authorised power discourses (ibidem). But, simultaneously, feminism has taught me to understand the body as subjective and objective at the same time, full of material, personal and social significance, an agent receiving and producing discourses (ibidem).

If this is what I perceive and experience, why should I not think that other women – even those who are most “exposed”, those who “risk their bodies” (models, prostitutes) – bear the same contents, contradictions and tensions? Why don’t we start out from the idea that making an in-depth study of these women is one of the keys for anthropological study of the body because it will make us understand that we can change our culture? As Turner argues, in contemporary capitalist societies the body is the locus for social inequality, but also for empowering (1994). And I think that in me and other men and women those two components are confronted and it is easier to speculate about them than to analyse them. We are worried about the analytic difficulty that this tension carries, but we should be even more concerned about not being able to guess what the future outcome of the struggle will be. Therefore, it is necessary to revise what it means for men and women to be both social agents and agents of their own life by means of the body (20). And this implies alternative analytical approaches (21).

Anthropology of the body has developed a lot during the past decade. However, I always wonder whether we are empirically demonstrating a mere passing wave or speciality, or whether we are really attempting a new way of thinking about, of tackling, the human being/experience, which is something that should turn the discipline upside down.

I am arguing in favour of putting to one side excessively linear anthropological analyses and of going more deeply into the complexity of processes and the variety of contexts and experiences. Anthropology can be very valuable for understanding and tackling situations in which there are high levels of social suffering by discovering all the cultural, social and political factors that are part of a given situation. I think it is also necessary to reconsider how anthropology focuses on cultural diversity. Whenever we speak about body or image we tend to consider our culture as uniform (Becker, 1994) so it is necessary to mention which collectives we are referring to and distinguish between ideal and real levels of experience. I also think that the difference established between cultures is excessive. It is true that relationships between self and body vary in different societies and that in Western societies there is an individuation of the self and consequently of body experience not found in other contexts. But the new theoretical approaches to the body insist on making the dominant vision on the identity construction and the individuation and personification processes more complex and diverse. These should help us to make more precise analyses and to be more aware of the historical changes and inner variability of each social group.

My stance has not always been as welcome as I should have liked in the different backgrounds I work and live. The argument that in the world of body exhibition, especially in modelling, there are ambiguous and complex, positive and negative elements, as well as changes for women, has been the most controversial issue (22). In my opinion, both social sciences and feminism tend to make a restrictive analysis of image and gender, which prevents us from seeing all the meanings and contexts associated to it. The models represent not only a physical ideal but a social character as well, and the so-called top-models are nowadays a paradigm of autonomy, social success and economic power (values traditionally linked to masculinity) in a particular political and economic model (Soley, 1995). The fact that they are women and that their autonomy and success come from using their body does not matter. Thus, modelling is a basic reference when critically analysing the new work and social mobility patterns (23) for women.

I am against seeing women as victims in their experiences regarding image because they cannot be seen as social agents. And I think that we must deeply revise some issues, such as social contradiction between beauty and intelligence or the use of seduction in public or in the work place, which is maliciously and mistakenly referred to as “women’s weapons”. These issues I reject because they contribute to the social underrating of women. I am fully aware of the fact that my arguments are slippery and need to be thoroughly investigated. But I have never been so sure about what I am saying, because there is something in me that rebels against simplification, against victimisation and pushes me to go further.

I am particularly interested in the influence that social sciences have on ruling behaviours and homogenising culture. That is much more evident when talking about such scientific fields as Biomedicine, or anthropological periods as colonial expansion, but which dies out as we get closer to the present time. Even though the anthropology or the social sciences that deal with the body seem to be critical and aim to unmask, I am sure that they have an influence upon behaviours and discourses, an influence totally matching the ideological system they serve and which they are a part of. In this sense I am worried about the fact that from the anthropological field we keep on dividing humanity into two groups: the one made up by anthropologists, intellectuals, or feminists, and the others’. As if we were subjects, and the others were victims. I am worried because we all make up the group of the others, even if the starting point and the living conditions are rather different. And that is why I see the same need for a critical gaze, as for self-reflection. It would be interesting to analyse the importance of the appearance of the seen body, in academic and scientific life, to determine the physical profiles promoted, how image and body are ruled in our field, how "normal" and "abnormal" are constructed, and what all this has to do with other requirements such as group belonging or social self-legitimisation. A restrictive and narrow definition of otherness going beyond "good and evil" determines the anthropological task. Talking about oneself from one's experience, about one's contradictions, conflicts and pleasures, without giving up or censoring one's own body is a basic condition for this task.

As far as I am concerned, a minor and peripheral dimension of anthropology could be developed: self-anthropology or anthropology from oneself, that is, a radical form of anthropology at home (24). This has been controversial because some methodological principles key to the previously dominant positivism have been actively restated, such as the status given to objectivity or to the distance between researcher and research object. However, this practice is useful for evaluating other means of expression or other approaches to social reality, and it recognises the value of the personal, the subjective in scientific or academic fields, without breaking down the anthropological task (25). And for some people this implies a real epistemological menace (Hernández, 1999).

Self-ethnography and medical anthropology

Medical anthropology, the framework of this congress, is a suitable field, an emerging context, for self-ethnography, although there are only a few people who have spoken about their experiences of illness (26). In general, those who have done so have survived serious cancer processes, disabilities caused by accidents or various illnesses that have pushed them to make a break in their lives (27). At the same time or later on, they retrieve this experience and analyse it in an attempt to search for legitimisation, as a need to understand what has happened and inscribe it back on their biographies, sometimes facing arguments, perspectives and even colleagues from their own field.

In all these works the limits between researcher and object of study is blurred, and so are the boundaries between the subject who thinks and systematises and the subject patient, between perception, experience, emotion and elaboration. Their narratives are full of feelings and pain and become the thread to explain and understand multiple aspects that are related not only to health care and the relationship with professionals but also to the experience of illness and disability. But beyond their power to be touching, it is their power to convey and rebuild states, situations, roles and experiences in an absolutely committed, septic and intentionally non-neutral manner that is most striking. For what makes these ethnographies special is mostly their authors' skills at reflection, observation and self-observation, the details and thoroughness of interpretations, which do not contradict a balanced, self-critical and relativist analysis. These self-ethnographies are fed and re-fed by high doses of passion, rebelliousness and resentment: against the health system, against discipline, against society, against destiny. And this is an excellent starting point for scientific creation as I said before. They are works that captivate readers and place them in situations that force them to commit, to take a stance, even if they have not undergone them themselves.

One's own experience is a knowledge resource, but it is also a sharp shock and that is essential. Analysis of this experience is claimed to be an exceptional strategy to reach experience contents and interpretations otherwise unreachable and which risk being excessively intellectualised in other studies. But because they complain, this field does not always welcome studies like these. These issues are frequently criticised for being individual and personal, as well as for getting carried away by emotions or experience. Behind this patronising and apparently generous attitude there is an essential question for the discipline: what is the right and precise interpretation of the facts? This attitude is patronising about what can and cannot be done, which is nothing but an expression of fear about the possible lack of control which broadly characterises our culture and which has been an important axis for constructing social and anthropological thought.

Authors who apply self-ethnography to them do not accept limits to their professional fields, their research task or knowledge, which seem endless at first sight. I do not mean the logical conditioning of theoretical models, but self-control, a filter that the discipline sets up and legitimates it. Despite all the changes, since the 19th century the dominant scientific framework gave priority to what was quantifiable and had the social function of standardising and normalising behaviours. These methodological principles also affect anthropology, for it has adapted them to its specific features, clearly stating what is scientific and what is not. It is true that society's borders are accounted for in anthropological analysis and this grants it singularity against others, but it does not prevent it from building other borders, other abnormalities that are more difficult to incorporate and which are quickly confronted. In self-ethnography, informant and researcher as one claim their right to speak till the end. And this may bring unrest.

As Donna Haraway (1995) pointed out, all observation, all analysis is placed on it and is subjective, partial and incomplete, while at the same time real, privileged and necessary. Self-ethnographic tales have the same doses of partiality as the others, but are absolutely privileged and essential. Besides, they have an advantage typical of anthropology: as a result of the bad conditions in which observation occurs and develops, and because of the legitimisation difficulties from the start they are more aware of their own limitations than anthropology itself. However, I am not only claiming the need to tackle experience, but to use one's own experience as a way to attain the cultural, political and economic dimensions of the analysed phenomena, from local to global and from individual to collective.

Consequently, self-ethnography, self-anthropology, are a good way of resetting old scientific debates and of establishing new ones, a good way of fighting against chronic anthropological or feminist illnesses, of enriching theory and methodology, of making a deep revision of the discipline and social sciences in general. A scientifically necessary exercise because it allows the merging of positions and realms of the human that we still consider as being irreconcilable. But what make them essential are not only the precise results, its methodological and epistemological contributions or their right to be taken into account, but legitimisation of the anthropologist's self, his/her own existence and, therefore, the feasibility of anthropology itself.

Notes

(1) This paper has been translated into English by Eli Tolaretxipi.

(2) I think that this kind of articulation characterises scientific work in general, though connections between biography, research and social and historical context is not always linear.

(3) The concept of *embodiment* is central to the current study of the body, even though it is generally used in this area mostly in Anglo-Saxon backgrounds and not used exactly in the same sense by all authors. There are authors who prefer to use the term *bodilyness* (Csordas, 1994). The notion of *embodiment* aims to overcome the idea that what is social is inscribed in the body, to refer to the bodily as the real ground of culture as the "material process of social interaction" (ibidem) underlining its potential, intentional, intersubjective, active and relational dimension. The body as: «Agent in, and as locus of intersection of, both an individual psychological order and a social order, and as well as for seeing the body as both a biological being and a conscious, experiencing, acting, interpreting entity (...) The interactive dimension of agency acquires a broader basis when the social actor is understood as an embodied agent» (Lyon and Barbalet, 1994: 55,63).

A perspective searching for the break of the main dualities of Western thought: mind/body, subject/object, objective/subjective, objective/preobjective, passive/active, rational/emotional, language/experience; or, what is more important, a perspective that discusses them. I consider that within the notion *mindful body* first used by Nancy Scheper-Hughes and Margaret Lock (1987) for their proposal of body and health analysis, this conjunction between rational, emotional and bodily processes is well reflected.

(4) In Spanish there is no agreement as to how to translate this concept. Some authors are using "encarnación" (García Selgas, 1994; Del Valle 1999). Others prefer "*corporización*" (Capitan, 1999) trying to avoid the religious content of the former term. There are also those who use the term in English (Orobitg, 1999). I have chosen the adjective "*encarnado/a*" and the noun "*corporización*".

(5) In any case, present social theory derives from Michel Foucault's work, where, for instance, the concept biopower is underscored. See, for example, Foucault (1987,1992).

(6) The project was called "*La Construction des sexualités en Europe du Sud*" (1993-1996) and apart from me, there were representatives from Greece, France and Portugal. This project was coordinated by Marie-Elisabeth Handman (Laboratoire d'Anhropologie Sociale-E.H.E.S.S. de Paris) and consulted by Teresa del Valle (UPV-EHU). Subsidies were received from *the Ministère de la Recherche* and the A.N.R.S.- Agence Nationale de Recherches sur le SIDA from France and the Programa de Cooperación Franco-Española from Spain.

(7) The most important papers I have published so far are the following: *"El cuidado de la imagen en los procesos vitales. Creatividad y miedo al descontrol*" (1997/98) focused, among other things, on reflections upon diets and weight regulation; and "*Promoción social y exibición del cuerpo*" (2000) which analyses the exhibition of the body in careers such as catwalk modelling and advertising.

(8) In her book *The Chrysanthemum and the Sword*, Ruth Benedict (1974 [1946]) makes a distinction between guilt cultures (Western cultures) and shame cultures (like the Japanese culture) stating, among other things, the fact that in Western cultures confession is used as an expiation of guilt. However, I think that for some marginal body experiences shame and guilt are closely linked.

(9) In *Perder la* piel (1996) Marta Allué thoroughly explains and analyses the experience of being observed when one has a look that socially generates contradictory feelings.

(10) Some authors warn against continuous dieting, which is something that young women in particular start at an early age, because of its physical and psychological consequences. Besides, bulimia can often be related to dieting. See, Polivy and Thomsen (1992).

(11) These centres, mostly promoted by feminist women, were established during the post Franco era with tight boundaries with the public health movement and other left-wing movements, and were very significant in Catalonia, Madrid and the Basque Country.

(12) I use this expression to refer to the body image and everything that surrounds it, as opposed to "internal" body that has been related to women, especially with everything related to reproduction. See Esteban (2000) for the relationships between the two terms and the risks involved in this differentiation.

(13) I must thank Rosa Medina for making me aware of the notion of "seen" body, which is not exactly the same as "external" body, which is the term I have used most frequently. She has warned me about the risk involved in excessively reducing my analysis by not taking into account other dimensions of body identity and experiences other than the visible.

I must also thank Beatriz Moral, Carmen Díez, Edorta Arana, Iban Ayesta, Luisa Etxenike and Raquel Santiso for their comments and suggestions about the first draft.

(14) There are some qualitative changes from time to time, such as the discussion on sizes in the fashion and design industry in Spain two years ago after some models and ex-models reported weight and size restrictions and requirements in their job. Anorexia associations because of the influence of fashion designers, editors and advertisers also made complaints on social trends regarding the body. As a result, a commission was created in the Spanish Chamber and a report written, by means of which some agreements were reached with various textile firms and fashion designers about the different steps to be taken. The only news I have heard on the evaluation of this campaign was at the *Pasarela Cibeles* fashion show in Madrid (2001). An association called *Anorexicas* reported that the agreement on the standard size of the models had not been fulfilled, and that the standard size was 38 and not 40.

(15) Anyway, in some places in Spain such as Zaragoza there are compulsive eaters' associations modelled after the self-help groups in the United States.

(16) Juan José Millás, in an article published in *El País* in the second fortnight of August 2000, claimed that when young people come up to him for advice on requirements for writing short stories or novels he answers that writing needs passions and resentment, specifically directed or general. On reading this article I realized that resentment could be a good starting point for research and self-ethnography.

A "less passionate" more intellectual version of this resentment could be what Celia Amorós calls the "polemic referent" a concept that, she argues, we should all bear in mind when we read, posing the question as "against what is the author writing".

(17) From the same author, see: 1978, 1980.

(18) I have borrowed this expression from Manuel Puig. He used it in an interview with journalist and writer Rosa Montero in 1988. She asked him if he was scared of getting older and he answered that he began to be aware of the end of youth when his body started to change, he began to lose hair and become a bit curved, noticing the loss of his "physical power". See the article "*Pasión por entender*" by the same author, where she remembers the interviews and interviewees who struck her most.

(19) Ernesto de Martino, underlining the change carried out in *Tristes Tropiques* by C. Lévi-Srtauss in the preface to his book *La tierra del remordimiento* (1999), makes a very interesting point about the passions underlying ethnographical work. The following quote is very interesting. It shows the self-ethnographic process I am defending: «For the ethnographical journey we need not give up the world that we think rejects us to get it back through a mythical regeneration, but to be aware of certain humanistic limitations of our own civilization; it is an incentive to go 'further' not beyond humanity in general, but our own circumscribed humanity, 'put into question' by a certain historical moment» (*ibidem*: 19).

(20) The term *agency*, so difficult to translate into Spanish, came about by considering subjects as agents and holds an important place in current feminist anthropology, together with the so called "practice" theory of social action as follow up and confrontation and resistance against cultural ideals.

(21) An interesting approach is the one by Teresa del Valle in her article "*La memoria del cuerpo*" (1997) which focuses on the analysis of the lives of two women. Del Valle analyses the interrelations between experience dimensions such as illness and motherhood, where the body has a specific projection, and the reconstruction of their own memory by the two women.

(22) Of course I am referring to a certain way of showing the body, of using it in social interaction, which would not be exactly like the one occurring in nudism or sports. However, I consider that making a difference between fields and exhibiting forms of the body would not stand against joint analyses of "exposed" bodies and that distinction does not help much when trying to find new contents and clues.

(23) I am using Soley's expression (1995:22).

(24) Anthropology is not the only science that has included "self" in its theoretical elaboration, but it has affected all social sciences since postmodernism and feminism attracted attention to it during the last decades of the 20th century (Hernández, 1999). Self-awareness groups were basic for theoretical and practical activities of feminism (see Esteban, 1993 and 1996).

(25) Following this, Hernández (1999) underlines that self-ethnography has a double commitment: to culture itself and to the scientific and academic community, observing and analyzing implications derived from this simultaneous activity. However, there is something against this kind of anthropology. There have been more definite practices and ethnographies than elaborate theories, thus reducing its "scientific power".

(26) See, for example, the references included in Capitán (1999). Some cases mentioned by this author are: Robert Murphy's (1987), based upon his paraplegia-tetraplegia; Susan Di Giacomo's (1992) who has worked on her experience as a Hodgkin lymphoma patient; Oliver Sacks (1994), on paralysis of one of his legs; and Marta Allué's (1996), previously mentioned.

(27) There are other self-ethnographies that are not so specifically related to medical anthropology but close to it and based on intense discomfort experiences, such as the ones made by rape survivors who have later analysed their experience. See Winkler (1994).

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Stories the body can tell (1).
On bodily perceptions as a link between alternative medical technologies and illness narratives

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One day in March 1989, I was driving along the main street of a small town in Zealand, Denmark. With me in the car was Julie, an alternative therapist, a reflexologist, in whose clinic I was at that time doing participant observation. We were on our way to Julie's yoga class, which she had invited me to join as part of my enquiry into her life as an alternative practitioner. Suddenly Julie pointed to a man walking along the street with a baby carriage. "*There goes one of my babies*", Julie claimed, and then she told me about the man and his wife, whom she had both been giving treatment to cure their infertility. According to Julie the new father was convinced that the reflexology treatment had caused their happy conception.

Julie then went on to tell me about other cases of infertility she had been treating, and elaborated on a case in which she was involved at the time. This case concerned Rebecca, a woman in her late twenties. According to Julie, Rebecca had had very irregular or missing menstruation since the age of 14 and had been told by the medical gynaecologist that her ovaries were all "dried up" and her body like a female body in the menopause. Julie did not believe this was true, since Rebecca had not had any excessive sweating. Julie herself was a woman of 56 and she knew from her own experience what it was like to be in the change of life. She rather suspected Rebecca's long time use of "the pill" to be the cause of the damaged ovaries.

Two months later I met Rebecca in Julie's clinic, where I observed her treatment and interviewed her. Before Rebecca arrived, Julie told me that they had had good results from the treatment: Rebecca's ovaries had been pulsating during and after treatment sessions and Julie interpreted this as a sign that the treatment was effective.

When Rebecca entered the clinic, Julie asked how she felt, and as Rebecca had not experienced any symptoms since last time, they proceeded to the examination of whether needles should be set in acupuncture points of her ears. For this, Julie used an electrical apparatus, which looked like a pen and sometimes made a sound when put to the ear. The sound was interpreted as a sign, that a needle could be appropriate at that point. By itself, however, it was not valid; it had to be coupled with Rebecca's feeling of pain at the particular point before a needle was inserted. The apparatus thus made sounds when put to the points believed to correspond with the uterus, the pituitary gland and the ovaries, but as Rebecca only felt pain in the points corresponding to the pituitary gland and the ovaries these were the only points to which needles were applied.

After this, the reflexological treatment began, or rather, the combined examination and treatment by foot reflexology began (see below for a further introduction to the philosophy behind this practice). Julie started by rotating her fingers gently on Rebecca's ankle joints in order to "make contact". She continued until Rebecca reported that she could feel a buzz in her fingers. Then Julie started the reflexological massage of the feet, and while doing this, she jokingly told Rebecca to take care not to walk into a pole. Then they joined in telling me that they had discovered that a fierce blow to her head caused Rebecca's menstruation cycle trouble when she was 19 years old. Thereby, they believed that her pituitary gland was damaged so that it was no longer able to properly control the hormonal production in the body. During that day's treatment, they also agreed that Rebecca still had problems with this gland. Julie recognised that «*it feels like there are three grains of rice [in the reflex zones] in the right side while there is only one in the left*», and Rebecca experienced considerable pain in these zones. Likewise, Rebecca felt pain in the zones corresponding to the ovaries. Julie asked whether they were painful, and Rebecca answered: «*Yes, in the foot, but not in the abdomen. And my hands are sweating terribly*». – A little later Rebecca reported to be able to feel her ovaries in the abdomen, they were pulsating, and curiously enough mostly in the left side.

When the treatment was over and Rebecca had rested for 15 minutes, I interviewed her in the clinic while Julie was busy elsewhere in the house. Rebecca told me of the disappointment she felt when a gynaecologist told her that she was not able to have children. After that message «*I was rotten for a week, I cried all the time, because, all the time I hoped that I could have children. It has almost become an obsession to have children. ... That may be why I* *protect myself, by not having too great expectations* [to the reflexology treatment]».

We talked about Rebecca and Julie's idea of the blow on the head as the cause of her infertility, and I asked Rebecca if she believed that to be true. She answered: «*Yes, I do. We reached this conclusion by joint effort. She could feel that the pituitary gland was sore and damaged... Then we also talked about when my menstruation stopped, and all of a sudden I remembered that I had a minor concussion the summer my menstruation totally messed up. So I believe in that.*» I then asked Rebecca if she had any idea of what happened in her body at that time, and she answered: «*Yes. It so happened that my pituitary gland produces hormones, and that is what I do not produce. Nothing is wrong with my ovaries and uterus. They send out a lot of signals, and at the moment I walked into the pole, I pushed something in my hormonal system out of balance.*» When I enquired about what effects she has experienced from the reflexology treatments she said: «*In the beginning my ovaries gave a lot of reactions – they started to beat and pulsate, I felt sudden pains, and I felt a pressure. Those things are more rare now. But then I started to get acne, hormonal acne, in the chin area, and I have not had that since my teen years.*» She told me that she never felt any sensations in her ovaries prior to taking up reflexological treatments: «*I have not felt anything in my ovaries the last 10 years. And that is why it is something I notice when it comes.*» Rebecca believed the acne to be a good sign, partly because it is located in the chin area. Julie has told her that in traditional Chinese facial diagnosis, the chin area was believed to correspond with the abdomen and the reproductive organs. «*I have also started to be more hot-tempered*», Rebecca continued, «*which I never used to – normally I am very balanced. But all of a sudden, some reactions have come that I just cannot understand. That is why I believe that something must have happened.*»

Alternative patients

The above case stems from a study based on fieldwork in alternative healing clinics of reflexology, biopathy and kinesiology in Denmark. This study includes information elicited through participant-observation during healing sessions, workshops and educational classes, and qualitative interviews with patients and healers. The fieldwork was conducted from 1988 to 1991 and covered 12 clinics and 286 patients from these clinics. In some ways Rebecca's case is not very typical – infertility was not among the most common problems brought to the alternative clinics, though I did meet other persons with this problem as well. In other ways it is very typical and it serves as a good illuminating case for the questions to be explored below.

A prolonged illness implies a long-lasting disordering of the life worlds of the patients. Several scholars have demonstrated that suffering of any kind implies a disruption to the "normal" life and life worlds of the persons involved (i.e. Good 1994; Kleinman, Das & Lock 1997) and this is certainly also the case when the suffering is bound in the body in the form of sickness. In sickness the body plays, in Donna Harraway's terms, the role of a "witty agent" or "trickster" who in very concrete and often painful ways disturbs the normal pace and doings of a person's life (Harraway 1991 in Lykke 1999:158). Much effort is put into silencing the trickster and returning to normality, whatever that may mean to the individual. Consulting a medical practitioner and receiving treatment are important strategies in this striving for a return to a normal life, and in Denmark – as in most other Western countries – the biomedical doctor (the GP) is the first resort. For many, one or more visits with the biomedical doctor, or the hospital, solves the problem; the sickness is cured or the symptoms repressed, suffering ceases and normality is resumed. But for some, this strategy does not work, and they are the persons most likely to try out alternative treatment.

Most people who go to an alternative therapist have already consulted various practitioners within the established health care system in search of a cure for their ailment. A representative survey among Danes receiving reflexological treatment showed that 85% had consulted the established health care system prior to the alternative. This seems quite logical as the same study revealed that 45% of the reflexology patients had had the particular health problem for 5 years or more, and 28% had suffered from this problem for 10 years or longer (Geil 1989: 7-8). In my study, 45% of the patients reported that a biomedical doctor had previously treated them for the particular health problem they now sought to be relieved through alternative therapy. 18% reported to have been examined by a biomedical doctor but either did not follow a suggested treatment or were not offered any treatment; and 16% reported to be in biomedical treatment simultaneously with the alternative treatment (Johannessen 1994: 191).

Many reasons could probably be given to explain why the strategies of resort are expanded from biomedical to alternative treatments. A very pragmatic one is the fact that many of the patients in the above mentioned studies suffered from ailments for which a successful biomedical treatment does not exist. Among the 286 patients included in my study, 24% suffered from chronic pain in the muscular-skeleton system or the head, 19% had allergic reactions in the respiratory system or the skin, 8% had digestive problems, and 7% reported psychological problems or stress as the problems they tried to eliminate through treatment (Johannessen 1994:190). All of these diagnoses refer to health problems for which no effective biomedical cure exists. Closely related to the pragmatic explanation of unmanageable diseases are, however, existential and cultural explanations referring to the recurrent state of chaos and anomaly in the lives of persons suffering from sickness incurable within established medical settings.

Therapeutic technologies

Whatever problem a person brings to a clinic of reflexology, biopathy or kinesiology the treatment involves an exploration that touches on a wide range of elements including bodily function, behavioural, emotional and social aspects as well as life events. At a phenomenological level, three aspects are important in the examination and conclusions reached. The first aspect is the therapeutic technologies applied, the second aspect is the perceptions and senses involved in the diagnostic process, and the third aspect is the extended talk on life, self and action that are involved.

In the three alternative systems to which the clinics I studied were attached, three different technologies were used, each involving certain practices of examination and treatment and ways of reading the body. In reflexology, both of the patient's feet were examined closely at every clinical encounter, no matter where in the body the patient experienced symptoms. During this examination, colours, tonus and sensations of pain or tickling in the feet were interpreted as signs of dysfunction in other body parts as well as the lives of the patients. The feet were believed to hold a map of the whole body and were divided into zones – reflex zones – each supposed to correspond to specific parts of the body as a whole. As a consequence of this belief, abnormalities in a specific reflex zone were interpreted as signs of dysfunction in the body part corresponding to this zone and indirectly as signs of improper behaviour or maladjusted emotions. The treatment consisted of massage of the feet, and changes in colour, tonus or sensations in the feet appearing after treatment were interpreted as signs of change in other body parts, signifying the effectiveness of the treatment.

In biopathy every clinical encounter involved examining electrical resistance of acupuncture points on hands and feet by the use of an electrical device called a "biotron". Based originally on Chinese models of correlation between specific acupuncture points, meridians and specific organs of the body, the relative skin resistance in meridian points was interpreted as a reflection of the "energy level" in meridians and organs. By measuring the skin resistance at points on all of the twelve main meridians an individual pattern of energy level and functional ability in the major organs of he body was created. The electrical apparatus showed the level of electrical resistance in three different ways: by a tone increasing in volume analogous to an increase in resistance; by a pointer moving up and down a scale; and by a green and red light interchanging. Anomalies in skin resistance were interpreted similarly to anomalies in the feet within reflexology, as signs of dysfunction in body parts, emotions and behaviours corresponding to the particular acupuncture point showing an abnormal level of resistance. The treatment consisted of dietary advice, herbal medication and homeopathic remedies, the relevance of which were verified by the use of the same electrical machine.

In kinesiology the relative strength of various muscles was given the same signifying importance. There were two basic systems of muscle testing within kinesiology. One system (Touch for Health) involved testing the relative strength in 14-48 muscles, supposedly corresponding with specific meridians, organs, biochemical processes and emotions. During the test, an image of energy levels, functional ability in major organs and mental dispositions and conditions was created. In the other basic system (One Brain) the whole test was performed on one muscle and variations in the relative strength of this (arbitrarily chosen) muscle were interpreted as digital answers (yes/no, well functioning/malfunctioning, enhances/debilitates, and so on) to questions formulated by the kinesiologist. Prescriptions were determined by giving remedies to the patient and retesting the strength of formerly "weak" muscles. If the muscles became "stronger" it was interpreted as a sign that this remedy strengthened the patient. Remedies could be food items, herbal medicines, homeopathic remedies or mental affirmations and visualisations. For testing affirmations, visualisations and emotions, the patient was asked to hold certain mental pictures, or say certain statements, while the strength of the muscle was being tested.

All of these technologies are practised within specific alternative medical systems, each centred on specific techniques and explanatory models. In Denmark, these alternative medical systems are made up of associations of practitioners and schools where the techniques and philosophies behind them are taught. With this close relation between associations, schools and technologies I believe that it is appropriate to talk about communities of alternative healing practice when referring to therapists applying the same clinical technologies. Such communities of alternative healing practice can be considered as contexts for what Lave & Wenger have called "situated learning". A fundamental assumption behind the notion of situated learning is that learning is a way of being in the world, and that learning can be viewed as a feature that is potentially present in all social activity (Lave & Wenger 1997:18-24). This further implies that knowledge and learning are relational features – that learning takes place in relations between people, and in terms of learning potential whatever is demonstrated in practice is more important than what is verbally expressed (ibid: 22).

The people that consult alternative therapists engage in social relations in the clinic and the technologies applied demonstrate ways of reading the body that differ widely from the ways biomedical doctors observe and read the body. During alternative clinical encounters, patients thus learn new ways of understanding their bodies and relatedness in body and life. This learning process is facilitated by the participation in a community of practice involving experts with close relations to schools and associations as well as by clinical demonstrations. I would, however, like to add to this perspective that whatever is *perceived* in practice is most conducive for the learning process.

Perceptions and senses in the body

The joint effort of therapist and patient in perceiving bodily signs and interpreting these in a wider life perspective was central to all three forms of alternative therapy although the kind of perceptions involved differed. In reflexology, the perceptions of patient and practitioner are of quite different kinds but supplement each other. Reflexologists perceive colours and tonus of reflex zones of the feet. The patients perceive pain and tickling in the feet, as well as heat, beats and buzzing sensations in the body at large. In the introductory case, Rebecca reported several sensations in her body: buzzing in her fingers, pain in reflex zones and acupuncture points, sweating, pulsation in the ovaries, acne and hot-temperedness. These sensations were very convincing to her, making her believe that the treatment was setting processes in motion in her body and that the explanations for her infertility explored through reflexology were true and trustworthy.

In kinesiology the perceptions of the patient and the practitioner were closer to each other in that both perceived the relative strengths of the same muscles at the same time. The difference lay in their respective access to the phenomenon: the patient perceived that she could not hold her arm up (or that she could), while the practitioner perceived her own ability to either suppress the arm or not. In biopathy, the patients and therapists perceived the same: the change in sound, lamplight and pointer on the scale. All of the perceptions in the biopathic test were one step removed from the patient's body, they appeared on the electrical machine, but they were supposed to stem directly from the skin resistance of the acupuncture points measured on the body.

Patients readily learned what to perceive and how to interpret the signs of the feet, the muscles and the biotron, and eagerly engaged in negotiations with therapists on whether a particular sign was significant or not. For patients in all of these forms of therapy, the bodily sensations and the direct perceptions were most important, and gave them a feeling that this was a true communication with their body. As one woman, seeking biopathic treatment said: «*Of course I believe in it. One can hear when there is something wrong*». And another woman in kinesiological treatment responded to a question of what she found best about consulting a kinesiologist by saying: «*I feel secure in knowing that it is MY arm that is narrating.*» The trust in these bodily perceptions is reflected in that some patients brought medicines prescribed by biomedical doctors to have them tested by the biotron or kinesiological test in order to see whether this medicine was appropriate for their particular bodies.

Talks about life and behaviour

Common to all of the treatment sessions I have witnessed in alternative clinics is that the perceptions of bodily abnormality are linked to the lives and behaviours of the patients in a broad perspective. The examinations of reflex zones, acupuncture points or relative muscle strengths were never confined to conclusions only involving these particular points of examination. Each anomaly was interpreted first as a sign of an abnormal condition in a corresponding body part in the body at large. Secondly, it gave rise to a discussion of emotions, social relations and personal behaviours associated with the organ or body part in question.

In Rebecca's case, the pain in the reflex zone corresponding with the pituitary gland started a process of exploration in which she and the reflexologist tried to find out when and how some damage could have been done to this gland. Both agreed that this gland plays an important role in governing the hormones of the body and, thus, that it could be central to the fertility problems experienced by the patient. They engaged in a verbal search of other signs of trouble in the hormone system, and Rebecca recalled how her never regular menstruation totally "messed up" after she had been hit on the head by a pole at the age of 19. As the pituitary gland is situated in the head, they readily agreed that this gland was damaged when her head was hit, and that her infertility originally stemmed from this incident.

It is not always the case that such clear connections between events in the past and contemporary perceptions of the body are stated. But it is general to all cases of these forms of therapy that any perception of anomaly in the reflex zones, acupuncture points or relative muscle strength gives way to a conversation on events, habits and relations in the lives of the patients. Any abnormality corresponding to the stomach thus caused the therapist to ask about eating habits of the patients. Abnormalities believed to correspond to the kidneys or liver gave reason to talk about drinking habits and social aspects related to the use of alcohol. Abnormalities corresponding to hormonal glands gave rise to talks on psychological and social aspects, etc. As the examinations covered zones, points or muscles corresponding to all major parts of the body, a large number of habits, emotional and social patterns and events were included in the clinical conversation between therapist and patient. As in Rebecca's case, the conversations most often involved a search for causal relations in a narrative plot leading to the present condition.

All of the therapists I studied had forms of practice that gave way to perceptions in and of the body. The kinds of perception varied from one form of therapy to another. However, all were directly accessible to patient, practitioner or both, and all were connected to the functions of the body at large as well as to social, psychological and habitual aspects of the patient in a wider perspective including events of the present as well as the past. To the patients and therapists, the perceptions in and of specific body parts became a key to knowledge of the body at large and the body was readily read as a medium carrying messages of the selves and lives of the patients.

A different way of knowing

There are no scientifically or biomedically proven connections between colour and tonus of specific areas of the feet and functional ability of specific organs in the body; in particular there are no links to aspects of self such as memories or emotions. Likewise, neither the electrical resistance of specific points on hands and feet nor the relative strength of muscles can scientifically be explained to connect to organs, memories or emotions. And yet these ways of reading the body were highly meaningful and logical to the patients and therapists involved. At a hermeneutic level these phenomenological aspects can be understood as implying forms of knowing and knowledge that resemble what Lévi-Strauss (1969) calls "the science of the concrete".

In a classic paper from 1962 Lévi-Strauss discussed different ways of knowing in a comparison of what he called mythical and scientific ways of producing and constructing knowledge of the world. He argued that two different forms of science which represent different strategic levels of epistemology – and not different stages in the evolution of thinking – are concurrently practised. The one, mythical thinking, is somewhat adapted to interplay between perception and imagination and thus labelled the science of the concrete. The other, so called rational scientific thinking, is displaced from direct perception, trying to get beyond immediate sensations to underlying messages and processes, and thus labelled the science of the abstract (Lévi-Strauss 1969:26ff). Both strategies involve exploring nature, but in different ways, one based on direct perceptions of signs, the other on concepts one step removed from direct perception.

In this paper Lévi-Strauss drew on examples from ethnographic research that described indigenous ways of categorising plants and animals and related these to humans and different forms of suffering. He showed that in the science of the concrete, congruence in form and colour are interpreted as signs of connections and therapeutic relevance. Opposite to this Lévi-Strauss situated the categorisation and ideas of relevance of plants and animals within the natural sciences, where direct perceptions of form and colour are subordinate to more subtle similarities i.e. of chemical substances in plants (Lévi-Strauss 1969:20-23).

The similarities between Lévi-Strauss' concept of the *science of the concrete* and alternative therapeutic technologies are obvious. The alternative philosophies of congruence or correspondence between observable and perceivable abnormalities in specific visible body parts and inner body parts as well as life events, emotions and actions provide explanatory systems that connect concrete perceptions with ailments in the body and life of the patients. If attention is paid to concrete perceptions in and of the body, information is produced on the sickness, its causes and potential ways of alleviating it. Another similarity between the science of the concrete and alternative therapy is the way that information is construed into knowledge. According to Levi-Strauss the science of the concrete focuses on collecting and interpreting whatever signs there are into a bricolage. Like the handy-man who uses whatever is available to construct a device, a therapeutic science of the concrete collects whatever signs the body may give and constructs out of this – in combination with what is revealed in conversations between patient and therapist –, an explanation and a strategy for the healing problem. In Rebecca's case, the perception of abnormality in the reflex zone of the pituitary gland was combined with abnormalities in other reflex zones and her memory of a bump on her head and a concussion. This complex of perceptions and memories led to an understanding that her infertility was caused by a damaged pituitary gland that led to a malfunction of the reproductive organs. The treatment sessions focussed on restoring the functional ability of the pituitary gland and reproductive organs by restoring the corresponding reflex zones.

Contrary to this *bricoleur* approach to the construction of knowledge, the science of the abstract follows certain lines of investigation according to a conceptual plan or some abstract ideas of underlying connections. Lévi-Strauss compares this approach with the way an engineer plans a construction and purchases whatever is needed according to the plan of construction (Lévi-Strauss 1969: 30). In biomedicine, where explanatory models of disease are ideally based on principles from the science of the abstract, the practitioner explores the body according to a preconceived idea of what the cause of the symptoms experienced by the patient could be. Atkinson (1988) has convincingly pointed this out in a study demonstrating that whatever is perceived or told by the patient that does not fit into the conceptual framework of the medical doctor is discounted. The approach is engineer-like. Many of the patients whom I met at the alternative clinics had experienced that the biomedical doctors were not able to give them a clear diagnosis or explanation of why they suffered the symptoms they had, just as Rebecca had experienced with the gynaecologist. Apparently the particular configuration of symptoms and clinical findings (if any) did not fit into patterns connected with specific biomedical diagnoses or explanations.

Patients and alternative therapists do not seem to be as selective and engineer-like as biomedical doctors in their search for explanatory models and diagnoses. On the contrary, there are obvious analogies between the knowledge bricolage described by Levi-Strauss and contemporary forms of thinking among patients and alternative therapists. A study of the psycho-social aspects of having and treating cancer within the biomedical system in Denmark showed that while the medical staff had an engineer-like approach to cancer and its treatment, the patients' way of thinking was much more like that of a handy man. Patients collected sensations in and of their bodies, and combined these with information from the media, friends and medical staff and memories of their lives. All in an attempt to create meaningful answers to why they had such a disease as cancer and why it should happen to them at this particular point in time (Jensen *et al.* 1987). The ways patients and therapists of alternative clinics strive to create meaningful narratives out of health problems is similar. Perceptions of pain and other bodily sensations interplay with mental processes of recalling events, emotions and actions and all of these elements are combined into disease explanations and illness narratives in a *bricoleur* way. A significant difference between biomedicine and alternative medicine seems to be that alternative therapists are much more *bricoleur*-like in their approach to the sickness and suffering of patients than the biomedical staff. In fact, the various alternative practices of reading the body facilitates such body-self-life bricolage building based on whatever is perceived.

The Danish philosopher Søren Gosvig Olesen goes one step further along these lines of thinking. He states that in alternative therapy we find not only a different way of producing and construing knowledge, but a totally different kind of knowledge that can not be subsumed to the scientific, mathematical rationale, and thus not be judged within or by the scientific epistemology. He argues that while biomedicine, ideally based on the natural sciences, aims to dominate nature on the basis of a truth that depends on the accuracy of mathematical calculation, alternative therapy "constitutes an attempt to let man reach an encounter with himself or his nature" (Olesen, 1995:154). According to Olesen alternative therapy seeks to realise that moment of truth where "I Express Myself – expresses that which the whole conversation has led to but which was inexpressible until now" (citing the Danish psychologist Søren Willert Olesen, 1995:156). This kind of truth is in opposition to scientific epistemology but, nevertheless, Olesen argues that it is a kind of truth and he finds that it can very well be "determined by shifting facial expressions, a shrug of the shoulders or by a sudden grin. Or by a sudden pain, tension or tickle; or by a yielding arm, or an erecting torso" (Olesen, 1995). Along similar lines of thinking, the American anthropologist Meredith McGuire states that such aspects as bodily features, emotions, memories, relationships, imaginations and spirituality all interpenetrate each other. In recognising this, we should be aware that there may be bodily ways of knowing that challenge many assumptions implicit in the established science and research of the body, health and healing (McGuire, 1995: 28).

Body as meaning and narrator

Based on a study of ritual healing in suburban areas of Boston, Meredith McGuire, concludes that to the respondents of the study «health and wellness was not merely – indeed not mainly – a physical condition; real health required closely related mental, emotional, social, and spiritual aspects» (McGuire, 1995: 18). In continuation of this conception of health, the issue of meaning evoked by illness, pain, disability and suffering was central to the respondents of McGuire's study. While the issue of meaning is generally not addressed in biomedicine, the body and illnesses are assumed to be laden with meaning in many alternative forms of treatment. As McGuire states, «part of the healing process [in alternative practice] consists of 'discovering' the meaning for each person and each illness and addressing that meaning through healing practices» (ibid: 20). For those I met at alternative clinics in Denmark, the body itself became most central in the process of creating meaning and illness narratives.

To Rebecca, bodily infertility obstructed her self and the meaning of her life. She had consulted biomedical experts regarding this problem but they were neither able to help her find out why her reproductive organs had ceased to function normally nor to help her overcome the problem. With the reflexologist, she learned to pay attention to the sensations of her body and they both collaborated in interpreting these signs and combining them with life events in a narrative that made the infertility meaningful and understandable to her.

Like Rebecca, narratives were important in the process of creating meaning for most of the patients suffering from chronic ailments and seeking alternative treatment. This aspect of narratives is not peculiar to the patients I have met; on the contrary, anthropological literature abounds with examples of the meaning creating function of narratives for persons suffering from diseases or other life disrupting phenomena. As Cheryl Mattingly has pointed out, life itself is without plot. But in narratives, a plot with a beginning, a middle and an end incorporates selected experiences and events of life and imposes meaning on the seemingly chaotic flow of events (Mattingly 1998: 28-29). One of Mattingly's major points in her research on occupational therapists is that the clinical practice implies narrative structure and points to future end points, and she has coined the term "emplotment" to signify this process of creating narratives for and with the patients through practice (ibid: 20). In the alternative healing clinics I have studied, emplotment also takes place. And in this context the emplotment is aimed at creating narratives that give meaning and explanations to ailments that can not be defined, explained or cured within the biomedical system. The emplotment in alternative therapy is embedded in the clinical practice of linking perceptions of anomaly in specific body parts to events and experiences in the patient's life. This way a plot is created that determines physical, social or emotional patterns that are believed to cause the ailment as well as point to ways to overcome it. In this process, perceptions of pain and tickling on the feet, the strength of muscles and shifting lights, sound and pointer movements on the biotron become bridges that link alternative healing technologies to narratives of the sickness embedded in the patient's life.

In order to reach beyond a conception of the body merely as a tool for creating narratives and meaning the body itself can be conceptualised as meaning, and in this connection several philosophers of phenomenology provide useful ideas and assumptions. Maurice Merleau-Ponty explored the phenomenology of the body and its spatiality and concluded that perception, action and conscience was an inseparable whole. He argued that the body is not an object, and that the consciousness one has of the body is not a thought. The wholeness of body and consciousness is implicit and unclear, and no matter whether it concerns one's own body or another body, one can only get to know it by living it, by taking over the drama permeating the body and uniting with it (Merleau-Ponty 2000: 169). He thus distinguished sharply between the reflexive idea of the body, involving a separation between subject and object and the experience of the body in reality (Merleau-Ponty 2000: 170). Based on the philosophers Løgstrup and Heidegger, the Danish philosopher Sune Frølund argues similarly that the body is not an object or a thing, but rather it is meaning and that meaning is timely-dynamic, as meaningfulness is an activity, is something *happening* (Frølund, 1993: 99-100). Frølund distinguishes between the body (as meaning) and the corporeal (as an empirical object located in time and space) and says that we do not *have* a body, we *are* not a body, but rather we embody our existence. Our bodying forth existence aims at the future and is based on the past and present and thus unites past, present and future in an inseparable meaningful whole (Frølund, 1993: 103).

It seems to me, that the arguments about the truthfulness of a different kind of meaningful and existential knowledge are based on a different way of knowing that is tightly bound to experience and perception in and of the body. This knowledge provides a conceptual ground for an understanding of therapeutic processes in alternative therapy. It moves beyond an understanding of alternative ways of reading the body as superficial and "just" symbolic to an understanding of these technologies as means for bodying forth experience, self and life through perceptions transcending space and time in a meaningful whole. This conceptualisation of therapeutic processes is a serious challenge to dominating scientific and medical thinking. It thoroughly dismisses the traditional Cartesian dualism that separates body and mind and the scientific focus on accuracy in the mathematical sense. It also challenges the ideas of those who are "experts" on sickness, as this understanding gives prominence to the patients' lived experiences of bodying forth existence. The practitioner is thus relegated to the status of a technician who knows how to make the body narrate about existence, while the patient ultimately is the only one who knows exactly what incidents from her life should be related to particular bodily symptoms and perceptions (Johannessen 1994: 136).

Highly respectable people who are deeply involved with scholarly and scientific thinking, and practised by patients as well as therapists in alternative medical clinics formulate this challenging position in scholarly terms. But the patients and practitioners of alternative therapy do not necessarily explain alternative practice along these lines of thinking. Rebecca and Julie had never read Levi-Strauss, Merleau-Ponty, McGuire or the Danish philosophers. Neither had any of the other patients or therapists I met, I suspect. At least they never referred to these scholars' ideas of the inseparability of body, meaning, life and emotions when telling me about sickness and therapy. But they all believed in the close relation between apparently separate body parts, and between body, life and emotion, because they perceived and experienced such connections. Many said that they could not explain how these things were related, others had ideas of physiological body connections through the nerve system or blood vessels or in the form of meridians as "energy-channels". Connections between emotions, behaviour and body were either conceptualised in rather mechanistic ways, in spiritual ways stressing the interrelatedness of everything in the universe, or not explained at all. The idea that connections in the body are physical and supposedly objective mirrors the dominant positions of biomedicine and the epistemology of the natural sciences in Denmark as elsewhere. Many alternative therapists and patients thus subsume their practice and knowledge to the epistemology of the rational mathematical science of the abstract and this could very well be done in an effort to give credibility to the therapeutic practice. The more spiritual explanations transcend the boundaries of scientific and scholarly epistemology, and thus render the phenomena to the realm of the unscientific. The spiritual explanations do, however, tend to acquire credibility (to the patients and practitioners involved) by being based on what is believed to be an "ancient" truth from before the world went rational and disenchanted (Wackerhausen, 1994). A third way of explaining alternative medical technology could, however, be based on existential and phenomenological approaches and on the philosophy and anthropology of the body. This approach seems fruitful for understanding the relatedness of self, life and body and what is going on in the alternative clinics. Though it is as abstract as explanations aimed at a mathematical truth it permits the subjective, fluid and individual experiences of patients and therapists to be taken serious within a scholarly epistemology.

Wider perspectives

Sickness involves much more than objectively observable bodily processes and is imbued with social, psychological, cultural and spiritual meaning. This implies that research on sickness and healing must also address this wider perspective in listening to the sick persons' whole and contextualised narratives of their experiences of bodies, healing and what they find significant in their lives (McGuire 1995: 20). Anthropology has a strong tradition in research of this kind, and can thus complement traditional biomedical research in an understanding of the processes involved in sickness and healing by providing theoretical and methodological approaches to investigate such embodiment of the self and embeddedness of the body in the self.

In regard to biomedical treatments, such anthropological research can provide deeper understandings of the processes involved in sickness and treatment. This research reaches beyond the observable changes in the body by relating them to processes of the self. Much medical anthropological research has already worked along these lines (conf. Quaranta, this volume). But since many biomedical treatments are prone to traditional biomedical research in regard to their effects, anthropological research is often considered to provide interesting perspectives that are, nevertheless, without importance for understanding why the particular treatment brings about a therapeutic effect. When turning to alternative treatments the picture looks quite different.

A major problem in the evaluation of the efficacy of alternative medicines has been the discrepancy between subjective and objective evaluations. Most studies including patients' subjective evaluation of treatments reveal that 60-80% of patients suffering from non-life-threatening diseases report on positive effects of the treatment, bodily as well as emotional and social, while the objectively registered effect is either totally absent or much less significant than the effect experienced by the patients (Launsø, 1995: 54; Johannessen, 1998). In these cases, traditional biomedical methodology does not seem adequate for researching effects and processes of the treatment, and other kinds of research are needed to provide explanations of what is going on. Investigations of the processes of interrelatedness of practice, body and narratives in alternative therapeutic ways of reading the body, along the lines sketched out above, provide venues for a deeper understanding. Although such close-up perspectives are by no means the only ones relevant for the study of alternative therapy, I believe that they offer understandings of processes that are implicit in the patient's subjective experience of the positive effect in alternative therapy. As such these perspectives supplement biomedical exploration and research, which does not always seem to be able to show what is going on and therefore seriously lacks explanatory power.

Although an analysis like this is appropriate in the study of therapy it is by no means the only contribution medical anthropology has to offer in this field. In a review of papers presented at international seminars during a four-year network project for research on alternative therapies, the American anthropologist Mary Ryan-Thorup provides a list of perspectives and methodologies applied to the field. Besides perspectives that focus on measuring efficacy on the basis of purely physiological definitions, as can be done by traditional biomedical controlled clinical trials, the list covers:

- measuring efficacy with quality-of-life methodologies;
- physiotherapy measures, dealing with physical movement and ability in household tasks;
- inter-subjective measures of experience related to everyday life from the perspectives of patient-, family- and practitioner satisfaction;
- financial cost-benefit analysis;
- political-economic concerns;
- measures based on entities recognised in medical systems other than the biomedical (such as vital energy, yin-yang balance, chakras and auras); –
- ecological analysis focussed on effects on the environment;
- aesthetic evaluations focussed on issues such as the intrinsic, felt value that goes beyond measurement (Ryan-Thorup 1997: 168-9).

It seems obvious that medical anthropology can provide contributions to most of these perspectives, and can thus play a major role in future research on the efficacy and implications of alternative therapies in a wide sense. As far as I can see, such approaches are relevant in the evaluation of biomedical treatment and therapy as well. Some of these perspectives are presently involved in biomedical technology assessment but most often they are mathematised in the processing. A more phenomenological and existential approach could turn the discussion on biomedical therapy and effect upside down and thus provide space for the patients' perspective in a way that is not found today.

In regard to anthropology in general, this essay points to medical anthropology as a field where many current theories and perspectives in anthropology can be synthesised into a meaningful coherent pattern throwing light on i.e. interfaces between the individual and the group, learning, knowing and knowledge, narrative, body and life. A synthesising focus on human bodily suffering, and therapeutic efforts to overcome it, also provides a way in which anthropology can re-centre as a science of man (in the West as well as the Rest). By providing research that may actually help people in their concrete struggle to get a decent life, anthropology reaches beyond the post-modern position of telling stories about other peoples stories so far predominantly offered to (or taken by) the discipline when applied at home. Anthropological research in this field can thus make a difference to the research field as well as to the mother discipline – and by synthesising the many current stances in anthropology it may even be a difference that makes a difference.

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Notes

(1) A book on foot reflexology published in the USA in 1963 inspired the title of this paper. The American masseuse Eunice Ingham, who developed the first reflex zone map of the feet, published as *Stories the feet can tell*, wrote the book.

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Towards an Anthropology of contraception: on the pill, control and embodiment

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Introduction

Access to modern contraceptives has increased rapidly in the past 50 years and contraceptive prevalence (1) has increased in all regions of the world. While demographic anthropologists relate increased contraceptive use to socio-economic changes, including an increased autonomy of women, it is clear that the global donor support to the implementation of family planning programs as a cornerstone of population (reduction) policies has increased the contraceptive options for women, if not actively pushed them towards using contraceptives by means of incentives or governmental sanctions for families with more the one or two children. Extensive fieldwork on the supply of contraceptives suggests that contraceptive pills, and often also IUDs, are present in remote areas in government health centres or that clinics of planned parenthood affiliates provide at least a limited range of contraceptives, usually for nominal fees or for free (Hardon *et al.* 1996). In addition, the commercial pharmacy generally sells a range of contraceptive pills. It caters especially for unmarried women and men who generally cannot obtain contraceptives from government clinics.

Anthropological ethnographies and studies have in the past described indigenous forms of fertility regulation and contraception, revealing how postpartum abstinence and lactational amenorrhoea serve as natural birth-spacing methods and how various herbs and other traditional methods are used by women to induce menstruation when their periods are delayed. (see for example Newman 1985). Such studies tend to mention the use of modern contraceptives as a means of fertility control only in passing.

In the 1990s a few ethnographies were published which focus on the use of modern contraceptive technologies and relate these to governmental population policies and the quality of family planning programs as well as to societal changes, gender dynamics and culture. Gammeltopf (1999), for example, has described the way the provision of the IUD affects women's lives in Vietnam where families with more than two children are subject to economic sanctions. Saavala (1999) describes how women opt for sterilisation as the method of choice in India where for decades now sterilisation has been promoted as an effective population control technology. Morsy (1995) describes the way in which the Egyptian State uses newly developed hormonal implants to control the fertility of poor women. Russel and his colleagues published an edited volume (Russel *et al.* 2000) which resulted from a conference that aimed to examine contraception cross-culturally.

The contraceptive pill is the most widely used contraceptive method worldwide. It has been part of women's lives since the 1960s when the technology entered the market in Europe and the US, initially for 'menstrual regulation'. In the media, the introduction of the Pill is associated with the sexual revolution – it is represented as a 'liberating' technology – it allowed women to enjoy sex without worrying about the chances of becoming pregnant. In the 1980s, the Pill started generating controversies. Women's health activists voiced concern about possible adverse effects, and there was growing concern about the way in which these contraceptives were being provided to poor women in the developing world in population-control oriented family planning programs. Rather than being a 'liberating' technology the pill was represented as medicalising agent and a tool for population control. The women's health advocacy movement promoted the use of barrier methods, which have no 'medical' effects on women's bodies and are user-controlled. In particular, the movement opposed newer generations of longer-acting hormonal injections (like *Depo Provera*) and implants such as *Norplant* on the grounds that the safety of these technologies in terms of health risks had not been sufficiently studied. The reason of such opposition was because the technologies enhance the power of medical professionals who administer the injectables and insert and remove the hormonal implants, and because they were seen to be instruments of population planners who aim to reduce population growth and control women's wombs.

Despite these disempowering potentials of contraceptives, women in many settings experience the technologies as a means of control over their lives. It is the every-day experiences with hormonal contraceptives that we intend to focus on in this paper. We focus on the ambiguities involved in terms of women experiencing the technologies as more or less liberating, while at the same time submitting themselves to control by state-led family planning programs, the marketing practices of pharmaceutical manufacturers, and medical professionals. Focusing on the lived experiences of women using contraceptives leads us to questions on the boundaries between artificial objects and natural bodies. We aim to describe how contraceptives affect women's material – biological – bodies and how they are embodied (2). A focus on embodiment allows us to question constructs of 'natural' bodies and alien technologies. Comparative analysis, which we undertake in this article also, allows us to question the 'givenness' of culture-specific fertility regulation practices. What appears to be 'natural' reflects an inscription in women's bodies by means of technologies of a hegemonic social order. As Quaranta argues in this volume (2001), it is through the processes of embodiment that the political processes that sustain it become obscured.

We explore the above issues of control and embodiment by contrasting findings from anthropological fieldwork on the use of the pill among coloured women living in a coastal town in the Western Cape Province, South Africa, and young Dutch girls living in the province of Utrecht (3). Let us now turn to the two diverse settings in which we conducted fieldwork on women's experiences with contraceptive technologies.

Case Study I. Young Dutch girls, the pill, embodiment and control

In the last 20 years, young people in the Netherlands have started having sexual relations at an early age. In particular, the sexual experiences of young girls have increased (Marneth in Ravensloot, 1991). The average age of girls who have had sexual intercourse is 16 years old. Contraceptive pill use by young sexually active women in the Netherlands is the highest in the world. 95% of the women within the age range of 20-24 years and almost half of the girls aged 15 to 19, sexually and non-sexually active, are on the pill (Brandt, 1991). The use of the contraceptive pill has significantly decreased the number of teenage pregnancies, and the number of abortions within the teenage group is the lowest of the world. (Brandt *et al.*, 1996).

For our study, twenty girls of 13 to 21 years old were interviewed. They all used the contraceptive pill. Most of them had started to use the pill at the age of 15 or 16, though five started earlier. The youngest started at the age of 12. Eleven of the twenty girls lived in the city of Utrecht and surroundings, and nine of them lived in a small village near Utrecht. All of them still live at home. We found no difference in views between the girls living in the predominantly protestant village of Almeida and those living in the less religious oriented city of Utrecht.

The pill, sex and health

> I: *«Can you tell me why you are on the pill?»*
>
> M: *«Because I had an acne problem. That is why I asked for the pill. And because I uh.. just did not want to get pregnant.»*
>
> ...
>
> I: *«Did you have a boy friend?»*
>
> M: *«No, I did not have a boy friend, but I knew I was going to having one soon, when he is there you cannot start anymore.... I find it during the summer time. I swallowed the pill for three months continuously, two no, three strips, one after the other, without stopping, because I did not want to menstruate – and it protects against pregnancy too.»*

The above text shows that the contraceptive pill has many functions for the girls. They take it not only to avoid becoming pregnant, but also for various 'medical' reasons and to have menstruation-free holidays.

We were surprised that more than half of the girls interviewed say that they started using the pill for reasons other than what we expected to be the main reason, that is being able to enjoy sex without worrying about becoming pregnant. The advantage of using the pill for reasons other than prevention of pregnancy is that they do not need to ask their parents for 'it'. Asking for the contraceptive pill when you have a boy friend is seen to be embarrassing – as if you are asking if you can make love to him. A girl explains:

> *«My father wanted me to start using the pill because I was sick each time I had my menstruation, and he was fed up of having to collect me from school. I think that if I had gone to my father to say that I wanted to start using the pill and he asked me: "Why?"... Then I would probably have said, I do not feel well... Look, you will never say to your father, I have a boy friend, in particulary not when you are 15...»*

And another says:

> R: *«Yes, I started at the time I had my menstruation, and not for 'safety', for a boy friend or so... it was somewhat different. I started taking the pill because I eh, was menstruating heavily... They considered it normal to take the pill for that reason..., that was o.k.»*
>
> I: *«And if you had not had heavy menstruations?»*
>
> R: *«Yes I think that it would have been different. I would have said, eh yes, I have a boy friend, or eh, I want to start the pill because I want to make love safely or something like that. They would have reacted differently. Then eh, oh, they'd probably ask "do you have to (have sex)"?»*

Dutch society is known for its tolerance. Young people are nowadays expected to talk openly about sexuality with their parents (the generation that was young in the sixties). Studies have shown that it is young people who would rather avoid talking about it. Parents intend to talk about sexuality with their children but when they try, their children often do not respond. Their adolescents prefer to get information through other, anonymous channels: girls magazines or TV programs, for example through (Ravesloot, 1997).

The contraceptive pill makes it possible for adults and their children to accommodate sex without talking about sexuality. With the exception of one respondent, all the girls had discussed with their mother whether they would start using the contraceptive pill, and often the mother accompanied them to the physician. In this way the mother tacitly agrees to the start of a safe sexual life and many girls find their mother's approval important.

The confidence in the contraceptive pill is enormous. The girls mention that the pill is the best way to control their fertility. They rely on it 100% Aware of the need to take it regularly, the girls have their strategies for not forgetting to take it. For example:

> *«I have my pills next to my bed on my table and then I see them and then I know it again. ... I am totally used to it, it's a habit. When I go to bed I take a glass of water, then I first take the pill and then I undress myself and then I go to bed...»*

A recurrent theme in all the interviews is the convenience of being able to 'plan' their menstruation. A number of girls told us that they started using the strip of pills on Monday, so their menstruation would start on Monday (4 weeks later) and be over by Friday – ensuring a menstruation free weekend. They also planned menstruation free holidays:

> *«You know when your menstruation comes, you can plan your holidays, and you are just not bothered by it.»*
>
> *«I am on the pill because I was lying on the beach three to four times this year and because I got my period at that time. With the pill you can swim and so on but really if you menstruate heavily, it is not convenient... The end of July I started, then I swallowed two strips one after the other... And yesterday was my birthday and I had to work the days following my birthday and I did not want to have my menstruation. So I swallowed the pill for seven more days... I find it very easy because I know exactly when I get my period, because I am usually very irregular.»*

The potential to control your menstruation as well pain are important functions of the contraceptive pill for women – they are at least as important as the pill's capacity to protect against pregnancy. Indeed most girls said they would continue to use the pill even if they were not having a sexual relationship.

Side effects of the pill

Most of the respondents are aware of a number of negative side effects of the pill. The most mentioned side effect is an increase in weight. About half of the girls say that they did gain weight while using the pill, but they did not consider this a problem. You can always stop if it bothers you too much. A number of girls mention that the side effects disappear after a while. Two girls were advised to switch to another pill because of their complaints. When complaints are mentioned to a doctor, the advice is usually to continue using the pill for at least three months as the body has to adapt to the change. The side effect is not blamed on the pill but on the body that has to adjust. If the adverse effects continue then they doctor usually advises the girls to switch brands. The underlying idea is that there is a contraceptive pill for everyone; it is just a matter of finding the right "match".

Most of the girls have heard about the risks of the pill and long term effects, but only a few have asked their doctor for information on possible adverse effects. The majority do not pay attention to the negative messages. A number even got angry about the negative stories about the pill. The reasons they put forward for not bothering about the side effects of the pill are their trust in the doctor and technology. In their view the advantages of the pill outweigh the disadvantages, and they focus on the short-term benefits rather than worrying about possible future risks. The following quotes illustrate these trends:

> *«Yes, I heard a lot about the side effects, but when I started it was not discussed. You now hear that the pill is good and that the pill is not good... But yes, I have taken the pill for a long time and I don't have any problems. When I go to the doctor for a repeated prescription, then I ask him if the pills I am using are bad, but he says they are safe. I trust him, I believe what he says.»*
>
> *«I do not think about it. Maybe after a few years it is dangerous or who knows what, but not now, not yet. Because I think when it is really dangerous they would have banned... If you do not take the pill, what can you do?»*
>
> *«Yes, there are stories that you can get cancer, or eh, other things, you are more at risk but nothing more... If I had not taken the pill then I would have probably got pregnant. And now I have taken it and I may have some other problems... I prefer not being pregnant now. I will see later.»*

The trust in the physician is considerable and carries more weight than the negative messages in the newspapers. «*If he says it is good, it is good. Who else can you rely on?*» Physicians prescribe the contraceptive pill routinely to young girls and pill-consultations are short. Little is said about the use and possible adverse effects of the pill. The physicians often refer to the pill-package insert for additional information. They assume a high level of knowledge about the pill among their clients (van Delft en Ketting 1992).

The findings from the way young women in the Netherlands experience the pill suggest that for them the pill is a liberating technology. It provides them with an instrument to control their menstruation and plan their lives. The women have no problem in remembering to take the pills every day – they incorporate the pills in their day-to-day lives. They value the fact that the pill protects against pregnancy – but the technology is more than that. If they discontinue a sexual relationship they intend to continue using the pill.

Let's now move to the coloured women in Hout Bay, Western Cape Province, where the pill is experienced differently.

Case Study II. Coloured women in Hout bay; the Pill and loss of control

For this study, Harries interviewed women attending the family planning clinic at the Hout Bay Day Hospital. Hout Bay is off the Atlantic coast on the Southern Cape Peninsula approximately 20 kilometres from the centre of Cape Town. The Day Hospital is a government run out-patient clinic in the "coloured" section of the Hout Bay Harbour area. The harbour community, locally referred to as the 'fishing village', is a residential coloured area, an enclave situated within the greater Hout Bay area.

Interviews took place in the waiting area outside the family planning clinic and in some of the women's homes. Thirty women were interviewed, all coloured, and all interviews and discussions took place in English with some dialogue in Afrikaans. The age range of the women interviewed was 18-25 years. All were unmarried and the average number of children was two. Most lived with their parents, boyfriend's family or with an extended family member. The women in Hout Bay tend to start using contraception once they have proven their fertility, after their first child. Most of the women were not currently working though some had been previously employed on a part-time basis in local shops, as domestic workers and in the fishing factory. All were Christian with the exception of one woman who was a "Muslim through marriage".

The contraceptive methods currently available in government clinics in South Africa are: hormonal injectables;[4] IUDs, which are rarely inserted due to the high incidence of sexually transmitted diseases in South Africa;

condoms and spermicides, and finally sterilisation. Emergency contraception and abortion are also now currently available. Female condoms are available at certain government clinics. Despite the range of contraceptive methods, *Depo-Provera* remains the most pervasive form of contraception administered in the family planning clinic.

All the women interviewed were receiving the contraceptive injection, *Depo-Provera*. The responses to why women had not chosen the contraceptive pill were fairly consistent in linking forgetfulness to conception and hence pregnancy. The following comments illustrate their views:

> *«We hate the pill. We forget and then we are pregnant.»*
>
> *«I am too forgetful. I can't remember to take the pill everyday.»*
>
> *«I always forget the pills. No thank you, I do not want any more children.»*
>
> *«I just have to look at the pill and then the next day I am pregnant.»*
>
> *«If I take the pill today then tomorrow I am pregnant.»*

Another woman stated:

> *«I am on the three monthly, Depo. I like the injection. I don't like pills. I am not scared of the injection because I don't want any more children, 'maar ek wil ook nie dat hulle my laat toe maak nie'.»* (But I also do not want them to close me up, a reference to sterilisation).

For these coloured women, there is a causal relationship between pregnancy and the contraceptive pill, the polar opposite of its medical function. The women claimed that they were forgetful, which is the reason why they preferred the injection to the pill. The precision with which they observe their medical appointments for the injection contrasts with the forgetfulness, which they associate with the Pill.

The notions of safety and surety associated with the injection in contrast to the pill's unreliability is symbolised by the utterances of a young woman of twenty:

> *«I only have to look at the pill and then I am pregnant. Once I see that injection coming then I ask no questions. It is only every three months so I don't mind. That injection doesn't really hurt, it goes in fast. It's over quick. I'm used to injections I've been having it already so many times. My friend who was on the needle started growing all kinds of hair – but for me the needle is fine because ek will nie my laat doen nie – (i.e. to be done is the colloquial for sterilisation.) So, no thank you, I do not like the pill. You see this baby here that is what the story of the pill is about. I just can't remember to take the pill every day. How must I remember? There are so many other jobs in the house that one must do, like taking the children to school, cleaning, shopping and cooking.»*

The injection is a surety in an uncertain world. Furthermore, unlike the injection, the pill is constructed and symbolised by stereotypical gendered polarities of male and female. The pill embodies female attributes, it is unreliable, disordered and capricious whereas the injection is male, powerful and controlling. The contraceptive injection is seen as symbolising modernity, a new technological development. Its efficacy and reliability is viewed as an advancement on the pill and the condom which are both perceived as being unreliable and, hence, unsafe.

The notion of forgetfulness voiced by many of these women takes on multiple meanings and can be connected to the loss of female agency within the home environment (5). Forgetfulness in the home may be linked to the exhaustion and time demands of domestic labour typified as household duties (cooking, cleaning and shopping) and child-care. Thus forgetfulness, as in forgetting to take the pill everyday, leads to pregnancy which in turn produces further body labour in the form of pregnancy, giving birth and child-care. The experience of loss of control in the domestic space forges the assessment of both domestic and reproductive labour as the loss of personal agency.

The hidden practice of the injection

An informant voices the final proof of the pills' unreliability: *«you see this baby here, that is what the story of the pill is about»*. This reference to the baby is tangible proof of the pill's inefficiency. A young mother conveys the pill's stigmatising visibility in the following narrative.

> *«Often our husbands want us to have more children. I say no thank you, not me. You see, I had this friend she was on the pill, she had to hide it from her husband so she hid it in the kitchen and then her husband found it and he was angry and threw them away. Then I told her just tell him these pills are to make you, you know, your periods regular and such. Another friend she hid her pills but then she would forget where they were hidden, you see this system is no good. The injection it is better all round. You know these men they want us to have more children but it is very costly to bring up children, but these men don't think about that. The injection is safe. My time is too busy to remember to take a pill everyday.»*

The pill is kept in the home, visible and thus potentially subject to the male gaze. The injection is hidden from their husbands, it occurs in a clinic beyond local male control and beyond their gaze. In hiding the pill and hence concealing the action, resistance and defiance is directed towards male domination in the home (6).

In this context of hiding, the clinic embodies feminised space; it is beyond the male gaze, which is associated with the domestic sphere. The injection detaches them from male control in the domestic and community sphere.

The history of contraceptive choice

The history of *Depo-Provera* contains a specifically racial component. Since the 1970's it has been used extensively in South Africa, who has an effective family planning programme and services directed towards the black population.

It is now widely accepted by most observers both within and outside government circles that the primary motivation for both the *Family Planning Programme* in SA and the *Population Development Programme* was the fear within the white community in the 1960's and 1970's of being swamped by the larger numbers of the black population. *Depo-Provera* thus became associated with population control and coercion and by the government's attempts to control and limit African women's fertility. In 1974 the government introduced a national vertical *Family Planning programme*. A nationwide network of Family Planning clinics was established with free services provided to all racial groups but on a segregated basis. At the same time, positive incentives were offered to the white population to increase the number of children per family. Stories of coercion abound. *Depo-Provera* was reportedly given to women in labour wards immediately after giving birth, a practice that was allegedly so widespread that nurses in SA government hospitals for Africans had a saying that "*Depo* was the fourth stage of labour". This practice continues today and has been reported by many informants living in the Hout Bay area.

A young unmarried woman describes it.

> *«At the hospital they make you take the contraceptive injection so you won't forget. Mine was a normal birth. They gave me the injection straight after the birth of my baby. I didn't even have time to think and the birth was so painful that I didn't even realise that they gave me the injection. So now I am on the three monthly injection, Depo Provera.»*

The nurse in charge of the family planning clinic informed Harries that it is unethical to give *Depo-Provera* post-partum, it's not right but the nurses are concerned that the women won't return for their six week check up and will forget about contraception. Nurses in these maternity hospitals have thus assumed the role of moral custodians and guardians of the state and further reinforce notions of forgetfulness, as discussed above.

The following exchange which forms part of a wider discussion around the experience of giving birth further illustrates the coercive administration of post-partum *Depo-Provera* and the manner in which it becomes entrenched in women's early reproductive cycles. Cindy a recently married woman of 22 recounts the following:

> *«The nurses were quite nice at the hospital. But just the only thing I hated was the injection – the contraceptive, and they made you take the contraceptive when you*

> *leave. They say it is best for you and they don't have any tablets. Because you are going to be busy. You are taking care of your child, and you are just going to forget to take the pill and then they tell you, you can always change again but just for these first 2 to 3 months – its just in case you forget, just so that you don't fall pregnant. The nurses asked me whether I wanted the 2 months or the 3 months so I said the 2 months. It's not like... it's just that they don't want you to forget or whatever, it's just a safety procedure. They didn't actually give me another choice but OK everyone has to take it. They asked me what contraceptive I would like. When I said the pill then they decided for me. They said it's better to take the injection.*
>
> *Afterwards when I came to the day hospital I carried on the injection for six months. It's as if when you ask for pills they say: "Are you ready for another child, do you have money, do you have a job' and stuff like that. But when I went to the day hospital to go and change onto something else, they said: " you must stop swapping like this, you must stay on one thing". So I said "well the first one wasn't actually of my choice and I am deciding what I want to go on" and then I went onto Triphasil. I think that people feel more comfortable on the injection because maybe they are worried that they are forgetful. They (the nurses) always stress that if you miss it out you can fall pregnant immediately and stuff like that. But I decided to take the pill. I am actually going to change my mind again and go for the loop (the IUD). I think it is safer to be off from all contraception and if I decide to have a baby again then I can have it taken out again.»*

On a certain level this woman is ambivalent about the fact that she was given Depo Provera in the maternity hospital claiming that «everyone has to take it» and «its a safety procedure». However, at a later stage she decides to change to the pill and is assertive about this decision.

Conclusion

The case-studies explore the embodied experiences of Dutch adolescents and South African coloured women with hormonal contraceptives, focusing on the extent to which they experience the technologies as medicalising agents of control or rather as liberating technologies. The narratives of the young Dutch girls show how the contraceptive pill enables them to regulate their fertility without talking about sex. The main reason for using the pill is, contrary to what we expected, not the prevention of pregnancy, but the treatment of menstrual pain, other menstrual 'irregularities' and acne. The medical discourse surrounding the indications for pill use facilitates communication between the girls, their mothers and doctors on the use of the contraceptive pill. They do not need to talk about sex, which they find embarrassing (Ravesloot, 1997).

The pill not only helps in the treatment of menstrual disturbances, it also enables the girls to plan their menstruation in accordance with events in their lives such as weekend parties and holidays. It thus serves as an important means of controlling their bodies (Hardon and van Zorge 1998). When a relationship ends and they do not actively engage in sex, most young girls continue to take the pill. It is like brushing one's teeth, they say, a self-evident daily practice. As a result, their menstruation becomes so regular that they know exactly on which day, and usually also what time of day their menstruation will start. The advantages of taking the pill in terms of control over their bodies outweigh the risks that pills have in terms of long-term health effects. The girls consider these risks to be minimal, an assessment that is reinforced by doctors. Better to prevent pregnancy now.

The South African women, paradoxically, associate the pill with forgetfulness, becoming pregnant and loss of control over their bodies. They turn to the contraceptive injection for protection and empowerment. Women's appropriation of *Depo- Provera* in contrast to the pill is linked to socially situated human agency (Gammeltoft, 1999: 6). For the Hout-Bay women, it is the injection that affords a certain amount of freedom and self-autonomy, because it can be taken without their partners knowing. The women complain that the men want more children than they do. By choosing the injection as a form of birth control, these women have both introjected the medical/population-control gaze and re-framed it in terms of their own everyday-life worlds. They relinquish their bodies to medical technology, yet through these actions they are able to free themselves from forced reproduction. Absent in their narratives is the need to control their menstruation, which for the Dutch adolescent girls is such an important characteristic of the contraceptive pill. This is intriguing, as *Depo-Provera* is known to cause menstrual disturbances, which women are unlikely to be pleased with. Apparently, for the Hout-Bay women the benefits in terms of protection against unwanted pregnancy outweigh the disadvantage of menstrual disturbances caused by the injection.

The notion of individual agency is rendered problematic when the wider political and historical context of Depo-Provera as a form of birth control is considered. Despite the cultural patterns discussed the controversy and negative inferences surrounding Depo-Provera and its place in feminist discourse cannot be disregarded. As we have discussed, *Depo-Provera* is a contraceptive method that has been advocated, distributed and popularised in developing countries. It is associated with curtailing the rights of women over their own reproductive processes because it has been used within the framework of coercive family planning programmes (Sciortino and Hardon, 1994; Morsy, 1995; Olu Pearce, 1995; Kaler, 1997). The prior objectives of state family planning policies in South Africa emphasised demographic imperatives in curtailing the birth rate. The conceptual framework of state health policy has undergone major changes in the post apartheid years with current policy encompassing a broader vision of reproductive health care. Yet injectable contraceptives account for between 66% to 80 % of contraceptive use by African women (Beksinska, *et al.*, 1998). One important reason for this preference is its preventative efficacy, especially in the context of many women's social and economic realities. However, the South African data suggests that the contraceptive injection may be preferred in many communities because it is a "hidden practice" which takes place away from the male gaze in the domestic sphere as against "the pill" a regimen that is visible on a daily basis.

In this paper we have explored issues of embodiment and control in relation to the use of contraceptives. This has implications for the literature on fertility regulation, which frequently does not look at the contraception in its wider socio-cultural and political context. By looking at contraception in two diverse contexts we are able to access issues of female agency and how it can reveal local re-appropriations of contraceptives. Contraceptives not only act upon women's bodies but are also utilised by women themselves to alter and impact on their everyday social worlds.

Medicalization and population control are forces which cannot be denied, and they co-shape women's contraceptive practices, but we have also seen that power is not a possession of particular social groups, i.e. doctors, but that it is relational and more dispersed (Foucault 1980). Power, in fact shifts from one actor to another in the trajectory of contraceptive use. Doctors or nurses in clinics make initial provision, but women decide to visit the doctor and/or attend the clinic to start using. The options for women are limited by what the gatekeepers have to offer and advise. In the Netherlands doctors believe that the pill is the method of choice, and they construct adolescents as responsible users. In South Africa health workers in family planning clinics consider the women to be forgetful, and overburdened, and they prefer to give hormonal injections. Women's embodied experiences in both settings are influenced by these medical actions: Dutch girls rely always on the pill; Hout Bay women consider the injection to be the best option. Once they have initiated use, it is up to women to continue using the methods, or not. We have seen that they choose to come back for repeat prescriptions, because the methods give them control over their lives – in different ways. The contraceptives themselves also exert power, not only because they prove to be effective in preventing pregnancy but also because, in the case of the pill, it's administration allows women to plan their menstruations. Here the biological action of technology contributes to the embodied experience of control that the Dutch girls exert. Without the menstrual regulating potential the technologies would probably be valued much less by the girls. The pill for the Hout Bay women has negative powers, which have nothing to do with its biological action; rather it acts as a screen on which they project the lack of control over their lives.

Our case studies encourage us to rethink issues of control and medicalization. Women clearly are not docile bodies acted on by medical doctors, subjected to governmental population control initiatives or the pharmaceutical forces of industry. They exert agency, which in paraphrasing Giddens (1984: 9) means that at any phase in the contraceptive encounter they could have acted differently. Whatever happened would not have happened if that individual had not intervened. But the choices they have are not unlimited. The actions of our respondents are conditioned by a culture in which the use of the contraceptive pill in the Netherlands and the use of *Depo-Provera* in South Africa is considered self-evident. Medical structures and local cultural configurations constrain our choices and the range of thinkable ideas and conceivable behaviours (Singer and Baer 1995).

The women's health movement has been an important de-medicalising power in the area of contraception. It has shown how family planning programs and medical practices have reinforced state ideologies on the need to reduce population growth and gender ideologies that give women the responsibility for contraception. The movement has developed alternative ideas and contraceptive options, including the use of diaphragms and condoms as dual means of protection against pregnancy and sexually transmitted diseases (*Boston Women's Health Collective* 1998). The movement has contributed both to an increase in options for women, and to a change in medical practice in some countries, where medical students are given courses in how to enhance reproductive choices, fit diaphragms and use condoms. However, these alternative contraceptive options do not appear to have had much effect on the way women in Utrecht/Almeide and Hout Bay use and experience contraceptive technologies.

Notes

(1) Defined as the number of married women or of reproductive age using contraceptives

(2) Csordas (1994) defines embodiment as an indeterminate methodological field defined by perceptual experience and mode of presence and engagement in the world.

(3) We haven't used a common conceptual framework for comparative purposes in the ethnographic case studies. The case-studies were done independently

(4) Depo-Provera (DMPA) given three monthly, *Nur-isterate* (NET-EN) administered two monthly, oral contraceptives *Nordette* and *Triphasil*

(5) The nursing staff alludes to these utterances of forgetfulness as well. Lifestyle issues and poor compliance are cited as the main reasons for the high usage of injectable contraceptives.

(6) Many of the households are female headed, yet social practices around child – rearing and domestic labour within the home are connected to gendered expectations and norms.

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Body and knowledge. Kinship, new reproductive technologies (NRT) and public values

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Since February 1998 we have been conducting ethnographic research into the social and cultural implications of infertility treatments (specifically *in vitro fertilisation*, IFV) in the Reproduction units of two hospitals in Barcelona, one public and the other private. The aim of this paper is to present for discussion some of the topics that have emerged from our research.

Ideas on reproduction have become the concern of a vivid debate not only among clinicians, biologists and present and future users of NRT, but also among religious and feminist groups and citizens in general. Modes of reproduction are powerful narratives integrated in a cosmological and social order, so much so that biological facts do not necessarily have an ontological priority over representations and beliefs. The anthropological analysis of NRT enables us to see how the body becomes the centre of a set of experiences and social representations.

On the basis of the narratives of different communities and social agents involved in the experience of infertility and its treatment (specifically for the results that we present: clinicians, biologists and NRT users) we have identified different themes and we present some of them for discussion:

1) The tension between nature and culture.
2) Dynamics between tradition and modernity in the public representations of NRT.
3) Conceptions of life and personhood: the meaning of life.
4) Ideas about kinship: maternity, paternity and heredity (to have one's own child).

1. The tension between nature and culture

One possible discussion is how NRT can blur distinctions. Mothers are not mothers, fathers not fathers, etc. The plot of the narrative is sustained by the technological intervention of the biological facts of reproduction (gametes, embryos, etc.). Intervention is confronted to nature because it is artificial and technological. Nature is not yet uniform. It differentiates and becomes artificial (frozen life, etc.). When nature is artificial, it is not recognised by society. Or we can imagine a future with two kinds of human beings: one genetically modified and the other natural. If you like to imagine, you can think of them not only in terms of different classes, but different species. Nature shifts into culture; is nature "artificial" (technology) and does culture become "natural"? Can the facts of nature, remade as technologies of reproduction, be the symbols of kinship relations that are so taken for granted? If not, what is taken for granted? Life? Nature? Or such less abstract things as interaction and relations? Another related narrative is that of "helping nature". Infertility is a biological problem and technologies enable problems to be solved. The plot of the narrative could be "market centred": a relation between a demand (social, individual, etc.) and a service (clinical, scientific knowledge). Consumerism and choice could be the main issues. The narrative is in terms of "problem solving": there are demands, there are risks, etc. And there is the need to minimise costs (social, personal, economic, etc.). This is the narrative of the technician and the clinician. It can be a narrative of hope (and therefore of miracles). Technology helps families to overcome problems in nature. By so doing, it solves psychological and social problems. Infertility is a source of individual stress and of social exclusion (there is pressure to be a parent). NRT try to solve these problems.

2. Dynamics between tradition and modernity in the public representations of NRT

Another possible discussion is that of the "novelty" or "oldness" of these technologies. They are "old" and "new". In biology they are not absolutely new and in society they are completely old (patriarchal, male chauvinist). What makes them "new" or "old"? The question can be analysed in terms of the organisation of the narrative. From one point of view they can be "new", they represent "changes". From another point of view they are "old", "traditional". What are the narrative points of view? I think that, in this case, the narrative oscillates between an epic narrative (progress in sciences versus power in society) and a sceptical narrative (nothing under the sun is new). New technologies may be seen as a quiet revolution. Changes are neither visible nor dramatic; they are changes by analogy to the "old". We see changes at the end of the process. After the facts.

The standard narrative of human conception stories – sperm meets an egg in the woman's body – changes when NRT are involved. Uncertainties about fertilisation – sperms do not always meet eggs – are replicated in NRT – a successful in vitro fertilisation does not always mean an evolutive embryo in the uterus. Scientific progress is based on "trial and error". Truth always has to be falsified in order to be scientific. It is formulated in probabilistic terms. It is a statistical truth. Scientific progress is translated into uncertainties; risks must be run and new decisions taken (i.e. genetic screening of the embryo means that decisions have to be made – abort voluntarily, run the risk, etc.). Scientific knowledge is not complete and it is translated into uncertainties in the genetic make up of the embryo. We could do another test in the future we could do other tests, etc.

The standard narrative of normal conception follows the idea of sperm meeting an egg in the woman's body. Sperms are released into the vaginal cavity, they go into the uterus and in the fallopian tubes they meet a mature egg, which comes down from the ovary in order to be fertilised. When a fertilised egg begins to subdivide and develop, it implants itself onto the walls of the uterus and pregnancy is established. An interesting question is how culture shapes how the facts of procreation are seen. The old ideas of seed and soil depicted the woman's uterus as the mirror image of the male genitals. The more recent idea of sperms and ovocytes were merged in a narrative of an active role of the sperm and a passive role of the ovocytes and the more interaccionist relation in which both gametes play their part (a sperm-oocyte interaction) implies a narrative of autonomous elements merging together.

This standard narrative is becoming more complex because clinicians need to know the gaps that make conception difficult. Couples who follow treatment need to know more about this simple standard narrative. They need to know how the ovaries work, how sperm is made, how hormones work, what elements make it possible for the sperm and the oocyte to fuse, what role endocrine control has in procreation, the genetic make-up of the embryo, etc. The scientific gaze divides the sequence into smaller and smaller stages or the process is scrutinised in different elements: oocyte retrieval, semen analysis, insemination, embryo culture, the first stages of development, embryo transfer, implantation in the uterus, etc.

The standard narrative of IVF can also be simple: eggs are removed from the woman's body, they are fertilised in vitro in the laboratory with the male sperm, and they are returned to the womb so that they can follow the natural course. This way of seeing the story is in analogy with the standard narrative of conception. In vitro is equated to in vivo. Technology helps nature. However, these narratives do not stand if the failure rates are as high as statistics show and mainly if the clinic gaze tries to see the causes of the failure and the obstacles to conception. Human reproduction is not as efficient as it is supposed to be.

It is a narrative that confronts a desire – to have one's own child – to an experience in the body that prevents one from achieving it. Reasons range from a low production of sperms to obstacles in the physiology of the woman's body. Paradoxically stories of IVF merge two kinds of knowledge: accurate knowledge of the parts of the body involved in conception and uncertainty about how to achieve conception. Increasing amounts of information about the process of conception is related to greater uncertainty about conception. If the procedure fails, the causes have to be analysed and another procedure tried. If we know a lot of things, it means that a lot of things can be wrong. The clinical gaze has to isolate a cause sequence, and try a new procedure.

3. *Conceptions of life and personhood: the meaning of life*

In biology life means the capacity to reproduce itself, but in culture, life means moral concerns, values, etc. Not far from the "meaning of life" is the idea of "life as a cycle", which naturally aims at reproduction. Obstacles in the path of this life cycle can be overcome by NRT. "Destiny" is an important idea for conceptualising life. The desire to have offspring is embedded in nature. There is a conflation of language between evolutionary genetics and destiny when it is said that life organisms have a biological drive to reproduce themselves, to reproduce their genes. If it is natural to have offspring, infertility is a natural problem. If it is natural to have children in a biological family, infertility is a social problem. As in kinship we have both "natural" and "social" elements. But these questions of infertility and destiny are normally thought of in a very primordialistic way (before social convention: a question of emotions and nature) and kinship language is a powerful source of primordialistic appeal. We have, then, infertility as a "social" and "natural" fact. It is inside kinship: a hybrid artefact of modern thought. Faced with this hybrid, narratives suppress one of the following aspects:

1. The domain of reproduction is naturalised and the introduction of medicine in this domain is proof of it. It helps nature.
2. The domain of reproduction is a social convention and NRT, as a technique in culture, can help to enhance social convention – lesbians with children, single mothers, etc Biology helps social conventions.

One is based on the idea that family is natural (before the social contract) and, so, science gives nature a helping hand. The other is based on the idea of alternative ways of having a family – family comes after the social contract – and science helps nature to follow alternative social conventions.

Moral concerns about abortion can become embroiled in moral concerns about NRT. In the research and manipulation of human embryos, the meaning of the life of embryos (or pre-embryos) is related to moral concerns about the meaning of human life and to the idea of the formation of a human person. The problems related to IVF are the implantation of three embryos (and the possibility of voluntarily aborting if all of them evolve) and the crytopreservation of embryos. They can be donated to a bank. The question is about rights: the right to use technology, the right to use genetic material, the right to "own" children, parts of the body, etc. Property rights and limits of science and knowledge are the main concern. This is the main issue of ethical and legal discourses. Another question is that of "population" (birth rates, mortality, etc.). This narrative deals with class or global politics of reproduction and wealth distribution. Who has access to these technologies? The main concern is political or politico-economic.

4. *Kinship beliefs: maternity, paternity and heredity: to have one's own child*

Kinship

For the common Western understanding, kinship is a hybrid of two different elements: social and natural. Human kinship is regarded as a fact of society rooted in the facts of life. Variability depends on how the facts of life are socially recognised and immutability is rooted in nature. Kin are a combination of substance and code of conduct. They are related by blood and acknowledged by a form of conduct. The idea of blood ties symbolises the fact that relatives have social claims by virtue of their biological relation. It means that biological relations have significance for human relations. They are taken-for-granted reference points and they are seen prior to everything. For the Western common sense, society takes after nature and kinship relations are considered primordialistic ties.

The narrative about NRT can be seen in terms of the experience of kinship. The way to imagine NRT is through analogies to kinship. On the basis of their kinship expertise, people interpret the possibilities offered by reproductive medicine in a highly personal and ironic fashion. They "deconstruct" the "facts of NRT" in terms of kinship relations. If kinship means "roots" or "primordial ties", how can the future of gametes in a bank be envisaged (without roots)? Analogies can be drawn in terms of adoption, foster parenthood and wet-nursing available in the domain of kinship. The language of the gift is a mediator between the anonymous donor (without roots) and the thing donated (life), as well as between abstract bodies (a bank) and concrete people (a genealogy).

If kinship means a future project, how is "biotechnology" to be envisaged in reproduction? Analogies can be drawn in terms of management of life (social and biological engineering) and in terms of enterprising families (technology helps to overcome infertility). Related to the experience of kinship is the personal narrative of women who have been taking therapeutic treatment for infertility. (For us it is our main concern and the object of our research). NRT is a "choice", but it becomes an individual necessity. It "takes over" individual life. Following different cycles is personal proof that one has tried everything available to overcome infertility. The emplotment could be a subject who wants something and she has obstacles in nature and in technology. It is an obstacle course. The result is love or despair.

It can also be a rich experience which reveals the body, its limits and the limits of science. Trying to create a new relation recreates old relations. Kinship becomes reflexive. Our problem is not to solve the main dilemmas that every body has in these narratives. Our problem is to analyse (like the old anthropologists) the "cosmologies" of the "reproductive model" in Barcelona through some questions that arose because of the displacement of NRT. We try to "denaturalise" reproduction, i.e., not to think in terms of a taken for granted fact of nature and establish "biology" and "technology" as symbols for social relations.

Changes in the ideas about human reproduction (the facts of life) imply changes in the ideas about kinship (after the facts of life). As Schneider reminds us, and in reference to American culture, kinship is whatever the biogenetic relationship is: "If science discovers new facts about biogenetic relationships, then that is what kinship is and was all along, although it may not have been known in the past" (1968: 23). Kinship is a powerful model of knowledge: If we now know more (or differently) than before, we can see the knowledge of the past from a very privileged point of view. We need to place social agents in the context of their knowledge. So, we know more (or differently) than them (the famous omniscient narrator of the ethnographies), but we also know the limits of our knowledge – we know that in the future others can know more (or differently) that in the present – (the famous reflexivity of the ethnographic accounts). If we add knowledge to the fact of biogenetic relations (the facts of life), we need new categories of relatedness – i.e. "genetic" parents is a new distinction within the old category of "natural" parents. We refer to a "genetic parent", even if we don't know anything about him/her except his/her genetic make-up. In our culture a kinship relation is a relation based on procreation – blood is not only a symbol, it is also literally true when it refers to genetic ties. If we add knowledge to the facts of procreation we need to create new distinctions in kinship relations. This distinction may not be socially relevant. We need to make another distinction: procreation is the biological process of producing new children while reproduction is the perpetuation of personal identities over time. In Western kinship both aspects were blurred, but advances in knowledge about procreation may envisage conceptual distinctions that were not visible before.

Concepts of fatherhood and motherhood

There have been two main shifts in the Western categories of reproduction. The first one was the separation of intercourse from reproduction by birth control – in the West this aspect of voluntary infertility is a social good and it is related to sexual autonomy and liberty.

The second was the clinical treatment of involuntary infertility and it implies that conception becomes possible without preceding sexual intercourse. Technology supplies sexual intercourse. The main symbol of kinship (sexual intercourse) is displaced by biotechnology. It implies also that the identity between the foetus and the mother or between the embryo and the father can no longer be assumed. Technology disperses concepts of parenthood.

This separation brought about by technology is united again by a process of symbolic reconstruction:

1) "Sexual intercourse" is a symbol in kinship of a biologically related descent. Trying to have a "genetically related child" is one of the main motivations of the technologies. IVF with the parents' gametes supplies "sexual intercourse".

2) The idea of family is complete if we put children in the picture. In spite of different alternative choices, two adults with children is still the normative idea of family. Technology tries to complete this normative idea.

3) Kinship is a hybrid of two realities: genetic and social. These two elements are simultaneous; genetics does not come before the social. Genitor is father and genetrix is nurturant. Maternity means genetic identity with the child, giving birth and giving nurturance. Paternity means power to create and engender life and socialise new life. When technologies separate one aspect of this continuum, the other is stressed. In ID, the father stresses the social aspect of his role in relation to the natural aspect of the mother. Life means social life added to natural life. IVF transforms the wife into the genetrix and the husband into the genitor and provides a child that is biologically related to both of them, the symbol of their bond (a complete family). What technologies separate, "sexual intercourse" and the process of getting a child unite. The difficulty of nurturing the embryo and of giving birth will be stressed instead of the "artificial process of the conception" (not in the woman body and not after sexual intercourse)

Having one's own child

Having one's own child is one of the main motivations behind infertility treatments. "Own" means different things. The context defines the meaning of this relation: genetically related, giving birth, and having gestated it. But "own" means mainly a biological relation of some kind. Note that in our culture self-knowledge is considered fundamental to personal identity, and it includes knowledge about biological origins and biological parenthood. This knowledge is figured out by means of genealogical trees and continuity in the family chain. The "own" child implies continuity in the genealogical chain. Notice that genealogy is related to biology and that a kinship relation is a literal translation of biological relatedness. The other relations are (as old anthropologist used to say) "fictive". The basic relation is the biological one; the others are metaphors – God-parenthood, foster-children, adoptive parents, etc... Even "in-laws" are relations that become kin (my sister-in-law is the aunt of my children). For an ego in the present they are "in-laws", but for the future (ego's children) they are kin.

The Western modernist reproductive process is conceived in terms of temporal relations that were biological or that would become biological: "roots" and "primordial ties" come from the past and are conceived in biological terms. Nature is a basic element in the conceptualisation of identity and nature in modernist times is conceived mainly in terms of biology. The future is also conceived in terms of producing new relations. The continuity of these new relations is conceived in terms of genealogies. And genealogies in Western modernist times also mean biological ties. Some modernist primordialism and some utopias are conceived in terms of biology. Primordial ties of community come from a common nature of in-breeding and future utopias are the result of genetically modified in-breeding. Identity is the common sentiment of culture rooted in the past and, since culture comes after nature, identity is rooted in nature. In the process there is an appropriation of nature: culture owns nature. The reproductive process replicates this modernist cosmology of nature in the microcosm of the individual: parents "own" children.

Related to the idea of having a child of their own is a discourse related to personal will. In public discourse "personal will" can be attributed to causes. The autonomy of the volition is the attribute of a mature person able to chose between different options. Volition can be attributed to others – a perverted volition induced by the clinic in order to regulate women's sexuality, a cultural mandate to be a mother, a natural drive to reproduce, a self-mandate of reproductive technologies. The character of these discourses is the negation of an autonomous volition that sees motivations in different domains – culture, technology, society, nature, etc. These discourses induce an image of the middle class woman "obsessed" with suppressing her infertility through the technology of IVF. Notice that even if not all the questions related to infertility are solved by IVF, this clinical technique has become the icon by which infertility can be overcome.

In contrast to this discourse of external causes perverting the volition to overcome infertility, there is another discourse that focuses on personal responsibilities (low-fat diets, exercise, smoking habits, etc.). Personal choices can prevent or cause diseases. In the case of infertility, the personal choice of postponing the decision to have a child can be seen tempting the fate of infertility. Fertility rates go down with age and one becomes aware of infertility too late. NRT have come to an era of birth control and low fertility rates.

In one discourse, volition is the result of external causes and in the other volition is the cause. A person is the result of previous kinship relations and is the centre of present kinship relations.

MIGRATIONS

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Introduction

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Migrations is a subject that always involves a tension between two poles: social inequality and cultural difference. Between these poles, pressure from the labour market, political and economic manipulation, national political traditions of social integration and migration policies in the receiving countries – for practical reasons this is the most important factor – create a complex set of problematic constructs that conceal the real questions. In order to simplify such a complex landscape and provide the agents involved with easier explanations, cultural difference becomes an axial ideological tool that encapsulates in a single factor the causality of a situation perceived as a problem. In this way, the sense of identity in the receiving society is strengthened because it is in opposition to potentially dangerous others, hiding their own inner conflicts and fractures in relation to immigrants. Therefore, cultural differences are perceived as an obstacle to living together and to maintaining cultural identity in the receiving society. Social inequality and the place reserved in it for minorities may be hidden in this way, so that we do not have to deal with a facet of our societies that is both ugly and contradictory to the official ideology of human rights and equality of opportunity.

The first consequence of mistakes being made from a simple explanation of cultural difference is the confusion between *social integration*, which refers to equality in rights and social and economic opportunities, and *cultural assimilation*. In this confusion, and in some countries, migrant people are driven to lose their culture or to constitute separate communities that keep their cultural references but which are outside the main receiving society; that is to say, in an excluded position which is legitimated by the discourse on cultural rights.

Anthropologists are considered to be specialists in cultural diversity and sometimes we agree acritically with the narrowest version of this idea. In this case, the main danger is the temptation to reinforce our role and, perhaps in order to find work, cooperate in the problematisation of others in the name of the need to take into account cultural specificities. This involves the risk of falling into cultural determinism, symmetrical in its effects to what Taguieff calls 'differentialist neo-racism'. Immigration introduces more diversity in societies that already have a high degree of inner diversity. Health is a field where this kind of inner diversity is a permanent object in anthropological research. Therefore, in theory, we have good tools to respond to questions related to migrations and health.

Of course, cultural differences and specificity's are very important and they must not be neglected. An anthropologist has a big role to play in this field. But pointing out the interest of this field is not the same as reducing all aspects of illness and health in migrant populations to the cultural difference problem. Sometimes we are surprised to find beliefs and behaviours related to illness and health in people coming from outside Europe which are the same as those in people belonging to the poorest and least educated classes in the receiving society. Usually, health professionals do not consider these last kinds of cultural settings as «cultural problems» and, as anthropologists, we must point out that cultural competency in health services means being able to deal with culture in all cases.

Understanding beliefs and practices related to illness and health in all populations coming from a lot of different countries and ethnic groups are an almost impossible task. Moreover, individual migrants are not always representatives of a supposed original culture. The effects of medicalisation all over the world must also be taken into account. But it is possible to know something useful about specific conceptions of illness, or of practices related to preventing sickness, healing and caring in people from different cultural backgrounds. As medical anthropologists we have a large field ahead of us in which to work. To define only the involvement of a medical anthropologist in the most classical cultural aspects is again an over-reductive approach. It is necessary to look more deeply at the migration process itself, which includes needs, family and local experiences. All this supports a project with objectives, which are always subject to revision. All these items must be considered if we are to understand the value assigned to health at each moment in the migration process and in the adaptation and settling in the receiving society. And, last but not least, research into how autochthonous people, including health professionals, respond to migrations must be considered as important as the knowledge related to migrants themselves.

The four contributions presented here adopt approaches which consider migrants as a part of the societies in which they have settled and take into account the facts of social inequality and lack of rights. They avoid approaches with hard culturalist and differential biases. In this section all the papers deal with Southern Europe. This means that there are no contributions from countries in which specific communities of foreign origin have been constituted as part of immigration policy, as happens in the United Kingdom.

Alejandro Goldberg's paper is a research project that provides an outlook on current migration processes from a well-defined radical political position. He draws the frame within which topics related to health must be considered. The paper presented by César Zúniga and Paolo Bartoli focuses on the health-seeking behaviour of migrants in Umbria (Italy). This text links the process of adaptation of migrants with their practices related to illness and health, and with their use of the health services. This services underline the important role of limiting the effects of inequality and social exclusion. The contributions by Xavier Allué and Maya Pellicciari emphasise the cultural gap between health professionals and patients, both migrants and autochthonous. In this respect, Allué asks if cultural competency in hospitals is only related to others coming from abroad, while Pellicciari points out how prejudices and contradictions rooted in medical training rise up more dramatically when patients are migrants. As Maya Pellicciari shows, migrants are a good mirror to study us.

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Cultural competence in Medicine

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It is only recently that the biomedical universe has become concerned with cultural diversity as a factor in health and disease. The growing tide of immigration from Third World countries into the First World has brought the subject to the attention of medical institutions such as the American Medical Association and the American Academy of Pediatrics (1998, 1999).

Various factors play a role in this subject. Just as health care is understood as a right and, in European countries, is regulated as universal and paid for by taxes, the concern about the peculiarities of minorities, how they gain access to care and how these peculiarities affect the management of disease processes becomes important. Across the ocean, in the managed care system of the US, the proper use of resources calls for a continuous concern for efficiency. Curiously enough for a country built on successive waves of immigrations throughout the 20th century, the United States of America has only recently begun to consider cultural diversity. Even more, most references on the subject are related to the questions arising from Hispanic, Latin-American, immigrants (*Committee on Pediatric Workforce*, 1999, Fox, 2000). All the other immigrants in the past, mostly of European extraction, did not have distinctive cultural backgrounds of significant influence in their health, and health histories.

Recently, the *American Government Office for Minority Health* made an effort to assure cultural competence in health care through a well-researched set of recommendations and guidelines (OMH, 2000) known as the standards for *Culturally and Linguistically Appropriate Services* (CLAS). These standards deal with the following points, among others: providing care that is respectful and compatible with cultural beliefs and given in the preferred language; recruiting staff representative of the demographic characteristics of the area; educating and training staff in cultural diversity; employing bilingual staff and interpreters; using a preferred (secondary) language in communications and written statements and reports; creating easily understood health care materials and leaflets; implementing policies and operational plans to provide CLAS; incorporating CLAS into internal audits; including data about individual patient's race, ethnicity, and spoken and written language in the medical records (and keeping it up to date); facilitating consumer involvement in management, and identifying, preventing and solving cross-cultural conflicts.

Obviously the impact of Latin-American immigration, with its baggage of illegality, plus the probable common reluctance of the newcomers to adapt themselves rapidly to American culture, unlike their predecessors from central and eastern Europe in the 1940's and 50's, is noticeably different and the cultural diversity becomes more evident.

In Spain the immigration phenomenon is fairly new. Migration in Spain has had two distinct aspects. Up until the fourth quarter of the last century Spain had been a net emigrant country. Galicians and Asturians have traditionally emigrated to South America in such large numbers that Buenos Aires, Argentina, houses far more Galicians that any Galician city. During the 1950's and 60's up to 3 million Spaniards flooded the train stations of Germany, the Netherlands, France and Switzerland in search of better-paid jobs, while Spain lingered in the gloom of the last years of Franco's dictatorship. Most of these emigrants returned to Spain in the 70's and 80's. On the other hand throughout these years, more than 4 million Spaniards migrated from the rural areas into the industrial cities of Northern Spain.

These migration phenomena have had little repercussion on matters related to health, disease, and health management. They took place over a period of time when the gradual industrialisation and urbanisation of the country, along with the development of a state-regulated National Health Service, contributed to a homogenisation of health beliefs and health care demand in Spain.

It is the recently growing immigration from African and Central and South American countries that has been attracting the attention of doctors and health administrators, along with the public exposure of immigration as a problem when certain social events have hit the news media (1).

However, being a quite recent phenomenon, the pressure on the health system has not been felt or, shall we say the pressure is limited only to certain areas of the country, and concern about cultural diversity is yet to be considered.

Even though the theoretical aspects of the cultural significance of health and disease have been widely studied by anthropologists and some medical practitioners, (noticeably psychiatrists) in Europe, and in Spain, there is a lack of medical literature on the subject.

Cultural diversity in a district hospital

Since the summer of 2000, we have been collecting observations on behaviours, opinions and practices in relation to cultural diversity in a district hospital. This is part of an informal data collection for a larger project on the subject of the theory of hospitals.

Immigration being, as stated above, a relatively recent phenomenon, there is no evidence that the activities of the hospital reflect on the existence of cultural diversity in its midst. Signs, indicators, posters and the like are usually written in Catalan, the official local language. Occasionally some might be written in Spanish, also an official language as in the rest of Spain. I recall the signs and indicators in The Montreal Children's Hospital in the early seventies. They were trilingual – in English, French and modern Greek – as the hospital was located in a predominantly Greek community in downtown Montreal.

However the perception of the hospital personnel is that "there are many immigrants nowadays" (2).

The hospital does not list patients by race or ethnic origin. In the admitting procedure there is no place to register any such information. The only related data could be the place of birth and whatever interpretations can be made from the names.

The place of birth is not universally registered and since, as mentioned above, many Spaniards have themselves been immigrants in the past, the records could well be misleading.

Some administrative and managerial meetings in the recent past have considered including racial or ethnic origin on patients' records. It was decided not to on the grounds that it may be unconstitutional (*sic*!), that it may invade patients' privacy or that it may generate problems with other patients if they are informed that they have to share rooms or other facilities with people from ethnic minorities. Curiously enough there are no records of any incident related to either the presence of foreigners or immigrants in the hospital, or complaints of having to share rooms or other facilities. Occasionally the nursing personnel have made arrangements so that people of different ethnic origin do not have to share the same room but no more than when this type of arrangements have to be made for differences in age or the behaviour of patients or families.

When the nursing personnel are questioned on these matters they may make vague references to problems, always minor, related to the presence of gypsy families in the wards. They usually refer to the common custom of Spanish gypsy families of coming to visit hospitalised relatives in large crowds. It may be mentioned that *«... gypsies are camping on the wards ...»* or *«... well, gypsies tend to do that ...»*. The author's experience is that, even though gypsies do tend to "invade" the hospital whenever they have a relative admitted, particularly if he or she is going to undergo a surgical procedure, the only annoyance is the sheer presence of large numbers of people in often closed quarters. Mostly they are just there, quiet and respectful of the hospital norms and policies (3).

A question was put to the personnel involved in the maternity service. Supposedly a growing number of immigrant mothers are having babies. The public hospital is state owned and all health care is covered by the National Health System – in Spain universal, free and paid for by taxes – it should take a greater load of foreign mothers. When the professionals were asked how many immigrant mothers had their babies in the hospital most answers were "quite a few", "many", "more than a few years back", and the like. When asked to volunteer a percentage figure the answers varied considerably, the vast majority exaggerating the actual figures. Tables 1 and 2 show the answers and the real figures.

The professionals directly in charge of the care of the delivering mothers sensed that the actual presence of immigrant mothers was far larger than the reality.

Table 1. Supposed percentage of mothers of non-Spanish ethnic origin delivering babies in hospital Joan XXIII, year 2000, according to health personnel

Midwives	Staff obstetricians	Obstetric residents	Anaesthetists
5-10%	10-15%	10-15%	Less than 5%

Table 2. Ethnic origin of mothers delivering babies in the Joan XXIII hospital in 2000

TOTAL	Mahgrebi	Sub-Saharan	Other non-EU	EU non-Spanish
1411	50 (3.54%)	9 (0.63%)	13 (0.92%)	20 (1.41%)

Percentage of non-Spanish 6.52%

When confronted with the actual figures the comments vary. But most were ready to accept that immigrants were more “visible”. Some related the erroneous appreciation to language difficulties, as many African women speak no Spanish at all. Having to deliver a baby, they say, requires the co-operation of the mother in following certain instructions. Language barriers, right in the middle of a rather hectic situation such as a baby’s birth, are perceived as added difficulties and thus more easily remembered.

These difficulties are extended to having to explain to the father or the family the results of the situation: whether everything had gone all right, whether the newborn is a boy or a girl and the like. Even though most male immigrants have a better knowledge of Spanish (or Catalan, for that matter) the more or less dramatic circumstances of childbirth may increase language distances. An anxious father may misinterpret instructions and information given at the door of the delivery room by a harried midwife or obstetrician, particularly if he does not fully master the language.

In fact the midwives had the closest guess, according to the tables, not the anaesthetists explained by the others as «they do not have to talk to the patients» (4) and, thus, they are not influenced by the language difficulties.

A few members of the personnel, including the anaesthetists, commented on matters related to religious beliefs and Islamic integrationist exigencies for the mother to be treated only by female personnel. This situation has taken place in a few cases. There is no written hospital policy to deal with these matters. Occasionally the Obstetrics service has tried to comply with the patients’ requests as all midwifes the majority of the Obstetrics residents and half the anaesthetists are female. Otherwise the family has been informed that no female personnel was available, all the senior obstetricians typically being male, and the procedures have been eventually carried out without much of a problem.

In no case did anyone verbalise that there could be “cultural” barriers or differences as such. Foreign immigrants are viewed as “different”, actually “strangers”, mostly as the words for foreign and extraneous are very close in Spanish (*extranjero* and *extraño*) and in Catalan, the official language of Catalonia (*estranger* and *estrany*). At the same time (see Allué, 2000) cultural factors among our health personnel are more commonly referred to as differences in behaviours, habits, daily or weekly schedules, diet and, also, religion, but hardly ever as illness or disease explanatory models, health beliefs or creeds. “Culture” is equated, then, to “knowledge” or education. Thus the differences present in foreign immigrants are usually dismissed as caused by poor or little education, “*incultura*”, sheer ignorance, in the same line that many health problems of both immigrants and Spanish citizens are due to lack of health education ("*educación sanitaria*") (5).

This aspect of "lack of culture", or ignorance, is also commented on over the treatment of other foreign nationals as well. The hospital receives a considerable number of tourists, particularly during the summer months as several million holidaymakers stay in the tourist resorts of the *Costa Dorada* or just drive towards the Mediterranean coast further south.

The hospital administration provides interpreters during the summer season to help tourists and doctors to understand each other. In the recent past the interpreters spoke mostly English, French, German and Dutch. In the past three years a large contingent of Russian and Ukrainian tourists have flooded the hotels on the coast but Russian interpreters were only enlisted this past summer. No interpreters for African languages (Arabic, Chelja o Swahili) have been provided nor even considered. These differences in the consideration of foreigners have only one explanation: money talks.

However, as difficulties arise with hospitalised tourists, once the language barriers have been set aside, the hospital personnel often mention that the tourists that come to our area, as tourist travel keeps getting cheaper and cheaper, belong to the uneducated lower classes, ignorant and unable to understand what they are told and undisciplined. Once again, culture is equated to "education". Peculiarly enough and in relation to tourists coming from European countries, the hospital personnel may say: "... they do not *even* speak English ..." as the English language is becoming more and more the *lingua franca* in the tourist and travel world (6) and in medical environments as well.

Doctors' culture/patients' culture

Most physicians at the hospital would place cultural issues in a quantitative fashion: more culture-less culture, more knowledge-less knowledge. The reality of a qualitative distance is hardly considered. It is generally assumed that the patients belong to the same culture and, the specifics of medical knowledge aside, what is considered "common sense" should suffice to reach a common ground of discussion when interrogating the patients, taking the medical history, or giving information during the hospital stay or with the discharge summary.

This last element, the discharge summary, called in Spanish "*informe de alta*" or "*alta*" for short, has been compulsory in all patients' discharges since the late eighties, when the Spanish General Health Law was passed.

Even though the philosophy of the law was that every patient had the right to a written statement on whatever resulted from a hospital stay, the discharge summary had its origins in the documents issued by doctors to enable or disable a worker to carry on his duties when the Spanish Health system was dependent on the Department of Labour back in Franco's days (7). Therefore, the document style is rather medical and usually contains a lot of medical jargon, the laboratory results are given in numerals and units, the diagnoses are explained in the terms contemplated in the ICD-9 WHO code and the recommendations are limited to a short sentence or one line, usually including a return appointment date and hardly anything other than the dose and name of the medicines to be taken.

Most doctors admit that the vast majority of their patients hardly ever understand any of what is written in the discharge summary. Many would argue that the discharge summary is meant for the family physician and also to be a typewritten summary of the history and progress notes so they can be read easily, a task that is usually quite difficult because of the proverbial indecipherable handwriting of many doctors. Other considerations include the legal value of the document since it may be used in litigation cases as the basic proof of the care given. At any rate, it is given to the patient on discharge from the hospital but is not "meant" for the patient.

Thus, the final medical act, the discharge after a hospital stay, consolidates and very often increases the cultural distance between patients and doctors. To my knowledge nobody has ever considered including any of the patients' opinions or views regarding their ailment in the summary. Only occasionally may one find such information in psychiatric discharge summaries, but this is also meant for the family physician, particularly if there are discrepancies between what doctors feel is wrong with the patient and the patient's own view. The information is thus included as a warning.

Having defined the concept of explanatory models of disease, Arthur Kleinman (1980, 1997) expressed his frustration over the use of such a term by the residents at his hospital. After the idea had been extended amongst the junior physicians while in Medical School, and the concept had been clearly explained in all its meanings, he found that when students presented a patient's case on the rounds, they would thoroughly relate that the patient may have such and such symptoms; such and such complaints; such and such physical signs; such and such biological test results or X-rays AND such and such "explanatory model" of his/her disease, as if the explanatory model was one more clinical feature to be collected with the rest of the clinical data, to be considered and analysed and eventually weighed against all the others but, obviously, well within the understanding of biomedical culture. The explanatory model had no more status than another bodily peculiarity such as the blood pressure, a skin rash or an X-ray image which, in any case, would rate as more objective, the explanatory model merely being the patient's subjective opinion.

Culture is the result of a combination of such factors as the language, history, learned knowledge and experiences of any social group. In the physician/patient intercourse each factor carries its own load of cultural values and norms, uses the vocabulary, syntax and semantics learned and evaluates every new experience on the basis of previous lived or learned experiences. Their personal histories are inseparable from the concepts of something as intimate as their own bodies and their own sense of health and illness, once it is framed in the grid of their social relationships. No patient, particularly no conscious patient, can be separated from his/her culture and understanding. But even the poor victims of an emergency in cardio-respiratory arrest reaching the Trauma Room deserve their cultural background, beliefs, religious or personal feelings to be taken into account while their medical care, resuscitation included, is carried out. Otherwise these victims will eventually be victims of the imposition of cultural values that may not be theirs.

The professionals have their own cultural conditionings. The medical jargon, learned in Medical School, is eventually incorporated as a language and many doctors, especially the young, have difficulties translating the medical vocabulary to lay people's language. In their information interviews with patients, many residents state whatever they have written in the charts or discussed with their seniors and then spend some more time putting the information in common terms if they happen to know them. Occasionally they may borrow some vocabulary from their interlocutor but more often impose their own (medical terms) in the dialogue.[8] What is more, some doctors, easily identified as rather conservative, resent the patients' use of medical terminology as if patients were taking something away from them.

It is in this setting that the idea of the need for a certain cultural sensibility or cultural competence finds its space.

The idea is to foster physicians' interest in the cultural peculiarities of immigrant ethnic minorities in order to understand and eventually treat their health problems.

The proposals go about including ethnic minorities' cultural beliefs, vocabulary, myths and popular knowledge in educational programmes in medical schools, residency programs and postgraduate continuing education programmes.

All those laudable efforts, however, miss one major point: they fail to consider the cultural distance between doctors and patients as they are. It is not a matter of doctors and all health personnel learning how to deal with the cultural differences of immigrant minorities but, rather, how to deal with the cultural determinants in *all* patients. Cultural competency means bridging the cultural distance between the increasingly growing ensconcement of medical and health personnel in hyper-technified, complex biomedical knowledge and all lay people, not just some marginal minorities.

In this sense, all our patients can be considered to be "immigrants" in the biomedical culture. It would not make sense to offer the minorities what we are outrightly denying the prevailing majority.

Cultural competence has been defined by health care providers and health care organisations as the ability to understand and respond effectively to the cultural and linguistic needs brought by patients to the health care encounter.

Well, cultural competence is also a professional commitment to bridge the gap that advancing science is creating with the people who are to benefit from it.

Medical Anthropology has the responsibility to make cultural diversity feel at ease with biomedical progress, and vice versa. *Clinically Applied Anthropology* has yet to be introduced as a practice for anthropologists in Spain as they hardly get a chance of intervention in most biomedical settings, being limited to research projects or the occasional participation in programmes related to admittedly social subjects such as mental health or AIDS.

Perhaps the need to develop cultural competence will bring about a common ground of interrelations for anthropologists and physicians, and will lead to a better understanding of health, disease and improvements in care.

Notes

(1) During 2000 a new immigration law was passed by the Spanish Parliament. The Government party, the Popular Party, which won the new elections and proceeded to change the law, making it more restrictive, contested the law. This situation created trouble with the illegal immigrants and probably increased the illegal influx of North-African immigrants through the Gibraltar straits with the increasing incidence of the sinking of small boats ("*pateras*") and drowning victims. Immigration has become the single most important issue in the news in the past few months in Spain.

(2) The figures for immigration in Catalonia are readily available through the *Institut Català d'Estadística* webpage (www.idescat.es) in English. The latest figure on foreign residents is 1.9% of the population, a rather meagre quantity by the standards of any other European country.

(3) An entirely different matter is whenever the admitted gypsy patient is involved in illegal activities, mostly drug addiction. Unfortunately the Spanish gypsy community has acquired a heavy load of drug dealing and drug addiction and the related problems of crime and AIDS. Whatever problems may arise are more likely to be related to crime, marginality or mental derangement rather than racial or ethnic issues.

(4) Actually anaesthetists do talk to patients in the pre-op procedures, but in many emergency situations such as a caesarean section, they may deal with patients in a wakeful state for only a very few instants.

(5) However, no one ever dares to say who is responsible or how health education should be imparted.

(6) For instance, indications and signs in the metropolitan underground trains in Barcelona are bilingual: in Catalan and English.

(7) The document still exists as such: the "*baja*" paper is issued by the family doctor assigned to the worker and presented to his/her employer. When the patient recovers a new paper is issued, the "*alta*". This nomenclature originated in the 19th Century and is common to many registries in Spain. When someone is "active" in the registry he is "*alta*" and when he becomes inactive "*es dado de baja*". "*Alta*" and "*baja*" in Spanish have spatial connotations (up and down, or high and low). Also casualties at war in Spanish are called "*bajas*".

(8) To use the term "virus" to refer to common febrile illnesses of childhood is relatively new in Spanish. Commonly mothers would use medical diagnoses such as tonsillitis, pharyngitis, etc. due to the prestige of the medical jargon and what has been termed the "loving dictatorship" (de Miguel, 1984) acted by paediatricians upon Spanish mothers during many years of Franco's era. As a mother put it, «... my child has a pharyngitis, but these mad doctors call it a *virus* ...»

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Health-seeking behaviours of immigrants in Umbria.

Practices of domestic management of health and illness and recourse to health and social services

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1. Introduction

Migration toward Western industrialised countries is a characteristic aspect of the current processes of globalisation that has attracted the attention of researchers, stimulated discussion in the world of politics and caused alarm and preoccupation in vast areas of public opinion. It is thus a complex and multi-faceted object of study whose constituent elements do not lend themselves to isolated and fragmentary analysis and interpretation. Even if we try to focus on questions involving immigrant conditions and behaviours surrounding health and illness, we must take into account a whole set of factors and dynamics. The main ones are the causes for the decisions to emigrate (*push and pull factors*), the interrelationships between migratory movements, the levels of development in the countries of emigration and the conditions of integration and co-habitation in the receiving countries. The processes of geographical mobility and acculturation in which migrants are involved cannot be adequately understood if we limit ourselves to studying only those segments of the immigrant's experience within the receiving country. We need also to take into account that such processes normally begin in the country of origin, giving rise to precocious and diversified forms of cultural cross-breeding and hybridisation (Amselle, 1999).

From the end of the 19th century until at least the sixth decade of the 20th, Italy was a country with very strong emigration toward the more industrialised areas of Central and Northern Europe, North and South America, and Australia. More recently, in the 1980s, it began its current transformation into a country of immigration. The development of this totally new situation has rapidly and increasingly given rise to a series of research projects and social programmes directed at various aspects of the phenomenon of immigration. These have involved a growing number of social researchers, particularly cultural anthropologists. It may be useful to point out that Italian anthropology did not come to this challenge unprepared, insofar as a focus on the national context and a constant sense of social commitment have been recognised as two strong and original characteristics of the Italian anthropological tradition (1).

Moreover, on the more practical level of how best to train the health care professionals who are being consulted by a growing percentage of immigrants, recent years have seen a multiplication of training programs with the significant participation of medical anthropologists.

The legal regulation of the conditions of foreigners in Italy provoked a heated debate among the various political parties. The conclusion, at least provisionally, was the approval of *Law N° 40 of 6 March 1998* entitled, "*Regulation of Immigration and Laws on the Condition of Foreigners.*" This statute, which, according to its most critical interpreters, is characterised by its marked distinction between legal and illegal immigrants, nevertheless assures both groups the right to health care. Specifically, articles 32 and 33 provide that all foreigners shall have the right to urgent and necessary outpatient and emergency hospital care for illness and injury as well as preventive medical treatment to safeguard individual and public health. To carry out the law's implementation, which delegates to local government the authority to ensure effective enjoyment of these rights, in June 2000 the region of Umbria set up a new health code called *S.T.P.* (temporarily present foreigners), in parallel to the code applicable to Italian citizens and legal immigrants. In addition to basic and specialised health services, this code assures hospitalisation, social services in support of pregnancy and maternity, children's health care, vaccinations, "international prophylaxis," and prevention and diagnosis of infective diseases.

However, even before the approval and implementation of national and regional laws ensuring the right to health care for all foreigners in Italy, Umbria provided health care assistance to illegal immigrants. The agencies were religious and lay voluntary associations or special "windows" located in socio-health agency districts with a significant immigrant population. It should also be pointed out that a more episodic form of health care assistance was provided for illegal immigrants by way of what might be called initiatives of brokerage, undertaken by legal immigrants with the help of their regular doctors or by Italian friends and employers. Furthermore, in 1995, in order to respond to the need to ensure a less fragmented form of medical care for illegal immigrants, an Outpatient Clinic for Immigrants, still in operation, was established in the city of Perugia on the premises of a District Health Office in the city's historic centre. The experience of this Outpatient Clinic, made possible by a contractual agreement between a voluntary association and the Local Health Care Agency, has also been a rich source of information for the present study. The information concerns the vital statistics of its users, the modalities of their recourse to the clinic and the relative illnesses or disease, as well as general information about the progress of migratory movements in recent years. These data are useful and interesting since the numerous illegal immigrants who have used the Clinic's services are obviously not registered either with the local Vital Statistics Bureau or with the law enforcement authorities.

2. General Characteristics

Our study of the larger question of health care and immigration, in this local context, is still in progress, and we are now able to report only the first and partial results (2).

The focal point of the study is defined by the concept of *therapeutic itineraries*, specifically related to the socio-cultural dynamics of migratory processes. This concept refers to the individual and collective behavioural strategies adopted in dealing with conditions of illness and disease. It seems to be a particularly useful framework for analysing the complex of resources, knowledge and practices drawn upon from time to time by the various groups of immigrants in the context of overall strategies for protecting their health. Therefore, an exhaustive description of immigrants' health-seeking behaviours must involve:

1. First of all, the activation in the domestic sphere of knowledge and practices that may relate not only to the traditional and "official" medicine of their countries of origin but also to knowledge acquired in various ways during their migratory experience.
2. Secondly, it must also involve the recourse to medical care provided by the public health care service both in terms of basic outpatient services (family doctor, paediatrician, women's health centres), hospital services (emergency room, clinics) and, where applicable, specialised care, provided in some cases privately.

3. Thirdly, it must not forget the recourse to "non-conventional" health care providers and therapists (herbalists, acupuncturists, homeopaths) or traditional healers if they are present in the local area.

The health-seeking strategies implemented by individuals on the basis of the type of medical systems[3] accessible to them in their own personal contexts can predictably be categorised as follows:

1) Unilateral recourse to a single medical system for all illnesses;
2) Parallel recourse to different medical systems in dealing with the same illness;
3) Recourse to different medical systems at different times for the same illness, as determined, for example, by unsuccessful treatment;
4) Differentiated recourse to a variety of medical systems in relation to different types of illnesses.

Nevertheless, the analysis of migrant behaviours, illness prevention and treatment strategies must take account of the specificity of their living conditions, of the broader context of socio-cultural factors related to their objective situation and to the subjective experience of the migratory process and dynamics of integration into the host society.

3. Methodology

A) Sample Development

The first step was to collect and analyse the regional statistics concerning non-European Community foreigners in Umbria. The idea was to establish the location and the numerical consistency of single nationalities for the purpose of developing a sufficiently representative "sample," both with regard to their location within the region and to their country of origin.

Given the fragmentary nature of the presence of single nationalities of immigrants in the region, we decided to focus on only some of them. The choice of the nationalities to be included in the sample was based on the numerical consistency of the national groups and their geographical diffusion throughout Umbria. We wanted to include the two main cities (Perugia and Terni) and also several "minor" towns characterised, however, by a significant presence of immigrants belonging to the national groups selected for the study.

After identifying the geographical areas and the nationalities, we decided to construct non-probabilistic samples within the single national groups.

This choice was made for two reasons. First, the official data on the presence of foreigners are not very reliable in that they do not include illegal immigrants and so we would have found ourselves in the insuperable difficulty of constructing a probabilistic sample on the basis of an insufficiently defined universe. Second, the construction of a theoretically sound probabilistic sample – in addition to its being highly unrepresentative for the above-mentioned reasons – would certainly not have ensured the availability of its members for in-depth interviews on delicate subjects concerning their private lives.

Contacts were established, therefore, with various associations of non-European Community immigrants and with voluntary associations capable of acting as intermediaries with the various immigrant groups. Based on these initial contacts we proceeded to construct a so-called *snow ball* "sample" within each pre-selected national group. The complex of informants from the various selected nationalities constitutes the sample of the study.

B) Method of investigation

The method of investigation chosen for the study was the interview and, given the study's qualitative approach, we decided to use the technique of the semi-structured individual interview. The interviews were conducted on the basis of a specially developed thematic outline in order to engage interviewees in in-depth conversations, in the course of which it would be possible to bring out individual experiences and subjective perceptions and meanings regarding the central subject areas of the study.

C) The interview

The survey interview presented the following outline: 1) the health risks connected to the migratory experience; 2) prevention and practices of domestic management of health/illness; 3) knowledge of and resort to social/health services; 4) knowledge of and resort to "other" health care providers; 5) significant episodes of illness; 6) recent illnesses or health problems; 7) reasons for emigrating, and 8) integration into the Umbrian context. In addition, the interview includes a form containing information relative to the structure of the interview, its overall evaluation, observations concerning the environment in which it was conducted and the behaviour of the interviewee, how contact was made with the interviewee and another form containing social statistics about the interviewee. The survey interview was pre-tested through the conduct of several preliminary interviews.

D) Operational phase of the study

Fieldwork began two years ago. Up to now some 127 interviews have been conducted in various geographical and economic areas of the region, distributed among the following immigrant groups: Brazilians (15), Ecuadorians (11), Peruvians (10), Colombians (2), Tunisians (20), Moroccans (15), Nigerians (25), Cameroonians (5), Ivory Coasters (3), Albanians (21). In addition, three interviews have been conducted with key informants: two physicians, one Italian and one Congolese, who practice medicine at the Outpatient Clinic for Immigrants in Perugia, and a physician from Sierra Leone who works at the Welcoming Centre for Immigrants in the same city.

4. Some initial results

As mentioned earlier, the study is still in progress and therefore we are not able to report final results, especially regarding comparative analyses of the various nationalities under consideration. Some trends have emerged, however, from the numerous interviews conducted so far and, although they will be further elaborated and examined in later phases of the study, they are ready to be usefully presented and discussed.

It must be stated at the outset, as a general frame of reference, that the overall state of immigrants' health on their arrival in Italy was substantially good. This situation, confirmed by numerous similar studies, is essentially explained by the fact that most immigrants are young people who have shown that they possess the necessary physical and psychological resources to handle the risks and difficulties of a journey, often undertaken under precarious conditions, to a foreign country. It must also be emphasised that from this point of view the study rules out immediately and definitively the widespread racist stereotype that sees immigrants, especially Africans, as dangerous importers of unknown exotic diseases.

The perception of health risks connected specifically to the immigrant condition appears to be insignificant, at least in general terms. Nevertheless, many interviewees commented on often-severe hardships suffered during the first period of residence. The reasons are the uncertainty or complete lack of adequate housing, the difference in climate and the difficulty of getting used to cold winters, changes in diet, problems of communication and orientation connected to insufficient or total lack of language skills. All of these negative factors are accentuated, as the interviewees themselves observe, by their unfortunately quite frequent illegal status. Even though the statements of the interviewees do not, therefore, give rise to a clear perception of health risks connected with the migratory experience, from an *etic* perspective, the potential pathogenic effects of stress on immigrants' mental health are quite evident (4). It should be recalled that the initial period of residence corresponds to the period of so-called "transcultural stress," or the psychological pressure to which immigrants are subjected as they are forced to question their own cultural models and existential equilibrium (Mazzetti, 1996). The terms most frequently used by interviewees when they try to describe a situation of profound distress are irritability, anxiety, fear, uncertainty, depression, loneliness and home-sickness. They may not recognise these effects on their own state of health but they nonetheless associate them with a form of acute discomfort connected to the immigration experience, and particularly to the initial period of residence in Italy. For many of them it coincided with their illegal status. The expressions of distress that we have collected from the interviewees have met with a sort of "medicalised" confirmation in the data compiled by the Outpatient Clinic for Immigrants in five years of operation (1995-1999). These data demonstrate that among the most frequent pathologies reported (5), the first or second place is occupied by "Poorly Defined Signs and Symptoms" (Damiani *et al.* 1999).

Correlation of the data from the Outpatient Clinic and the data gathered up to now by our study also yields significant results lower down in the ranking of pathologies, invariably occupied by disorders of the digestive tract and respiratory system. Many interviewees, regardless of their country of origin, identify the changes they are forced to make to deal with diet (6), and with cold and wet housing as important factors of distress and worrying risk factors for their own health. Even if we take into account an inevitable myth of food «*we eat at home*» and the «*sun that shines in our country,*» which show anchor feelings of homesickness and the values of one's homeland, these results show objective factors of distress and risks to good health.

Health risks associated with working conditions, often characterised, as everyone knows, by low safety standards, long working days, heavy labour and lack of union protection, deserve to be discussed separately. We plan to carry out a specific in-depth analysis of this central and heavily-debated issue in immigration (7). However, the data already gathered allows us to highlight a type of distress and risk, which, because of the nature of the workers affected by it and the private dimension in which it develops, frequently remains unseen. It is above all South American women (in our case Peruvians and Ecuadorians) who, quietly and within the "secrecy of the interview," complain of the fatigue, stress and frustration often connected to housekeeping work in Italian houses and, perhaps even more so, to providing assistance to old people (8).

With regard to behaviours of illness prevention, an initial and superficial analysis reveals that the interviewees almost unanimously declare that they do not do anything "in particular" to maintain or improve their own health. It would seem, therefore, that the issue could be dismissed by the hypothesis that there prevails among immigrants what might be called a traditional concept of health, understood as the absence of illness or a lack of symptoms. In reality the situation is more subtle and complex. Some identify "loyalty" to their own traditions as an effective means of protecting their health. At times this translates into simple moderation in eating, which was learned at home or a preference for the "healthy and natural" food of one's own country, when it is possible to procure it. At times, however, as in the case of Islamic Tunisians, it is the observance of the practices of one's religion, which suggests the rules of healthy living. Others, on the contrary, seem to perceive the migratory process as an opportunity for cultural growth and to acquire new and positive life styles. They include specific and "modern" activities aimed at improving one's health, ranging from playing a sport and dieting to avoid gaining weight, to giving up smoking and arranging for periodic medical check-ups. Often this latter practice, as stated for example by many Albanian interviewees, coincides with routine medical check-ups (annual or semi-annual) at the workplace, at least for those regularly employed in factories or businesses. For women, on the other hand, medical check-ups are very frequent and most appreciated during pregnancy; it even happens that this experience becomes the starting point for habitual periodic check-ups at the public gynaecological health clinic.

In general, it seems that married adults with children are more attentive to diet and the adoption of preventive practices aimed at protecting the health of their children. In this regard, it should be noted that recourse to paediatricians is frequent and regular among all immigrants regardless of their country of origin.

With regard to illnesses definable as *culture bound syndromes*, the only one reported up to now, and rather frequently, is *susto*, on the part of South American interviewees originally from the Andean region, as a specific problem for children. They have also referred to the *limpias* and *limpiezas*; the ritual practices designed to treat the problem, and reported that these are applied even in the immigration context without having to call upon true specialists. It is a problem, which is generally resolved in the domestic sphere with intervention by people capable of performing the *limpia* identified within the group solidarity network.

Many of the interviewees, and especially the women, show that they have a relatively broad knowledge of the therapeutic resources of traditional medicine in their home countries, especially with regard to herbal remedies used in the home to treat a large number of conditions and illnesses. Our findings show, however, that only a minority resort to these remedies, even though in many cases they have had experience with them in their country of origin. The most obvious reason for this, and the one most cited by the interviewees, is the impossibility of getting the necessary substances in the Italian markets. They can overcome it partially by the very rare return trips to their homeland, either by interviewees themselves or by friends and relatives. In these cases they come back with small quantities of plants believed to be medicinally useful.

Moreover, as pointed out by several Nigerian interviewees, these modest attempts at obtaining supplies can be dangerous and the substances intercepted when, during the inevitable checks to which immigrants are subjected at the border, police officers suspect that they may be dealing with illegal substances. It should be said, however, that the rather broad knowledge of traditional medical practices is not always accompanied by attitudes of indiscriminate trust or radical scepticism regarding their real efficacy. For example, many of the Albanians interviewed state that their country's traditional medical practices "work" only for some non-serious pathologies and only if they are performed by competent practitioners. It seems to be the case that in their country of origin, in the wake of quite substantial processes of acculturation, it is quite common to engage in a double recourse to both traditional and "modern" medicine, albeit within a context of the substantial hegemony of biomedicine.

Nevertheless, this evident discrepancy between the knowledge acquired in the country of origin and practices effectively put in action in the host country may point to important aspects of the migratory experience. For example, this discrepancy may reflect the break up of the nuclear family, given that the effective therapeutic competence at the household level belongs to elderly women who usually do not follow the young on their migratory journey. Primarily, however, it can be hypothesised that this issue brings to light some results of the process of acculturation which for many young immigrants, for example those from countries such as Tunisia, Nigeria or Albania, had begun even before emigration. Homesickness may be fed by memories of care received as a child from mothers or grandmothers expert in the use of medicinal plants. On the other hand, these same treatments and traditional medical practices may be considered as expressions of cultural backwardness characteristic of a pre-modern society. Many immigrants have tried to distance (9) themselves from them, albeit with great difficulty and significant amounts of ambivalence. At the same time it is legitimate to hypothesise that attitudes of highlighting or concealing traditional medical practices of the country of origin may not correspond exclusively to the internal dynamics of immigrants caught up in the ambivalence of their difficult and precarious sense of cultural belonging. They also represent a strategy of responding to acculturating pressures applied or suspected on the part of their new social context (10).

Furthermore, in the geographical area studied we met no traditional healers from the immigrants' homeland. The only exceptions seem to be a young Nigerian whose countrymen describe as an expert in traditional techniques of manipulating limbs, in the treatment of arm and leg pain, and a Brazilian woman who does not deal with illnesses but rather with questions related to people's personal lives and relationships.

The immigrants do not use practitioners of non-conventional medicines (homeopaths, acupuncturists, etc.). The most common behaviour among all immigrant groups (11) is the recourse to biomedical resources offered by the health care services network (12).

Domestic self-care practices are characterised by a more significant recourse to traditional remedies and practices. Our findings show that a whole series of routine problems and illnesses (headaches, colds, flu, sore throats), when not totally neglected, are treated with medicines purchased autonomously in pharmacies or previously prescribed by physicians and adopted with positive results (13).

The most striking and generalised finding concerns the massive recourse by immigrants to the services provided by the various levels of the health care service network. It is also in this area that we find clear evidence of a substantial correspondence between the health-seeking behaviours of foreigners and Italians. All the interviewees, for example, state that they can count on their own family doctor and, when they have children, on a paediatric general practitioner. They go to the hospital emergency room for emergencies, ask, when necessary, for referrals to specialists, are hospitalised in the various departments of local hospitals, and the women give birth in the same clinics where Italian women give birth.

However, our findings show that, in comparison to the majority of Italians, they have a more moderate and circumscribed medical "consumerism". One trend is to avoid the use of medicines when they are not absolutely necessary and at least to avoid excessive use. Another is not to go to medical services except for health problems they perceive to be serious or in emergency situations. This reluctance is attenuated or disappears altogether in the case of health risks for children, for whom the recourse to the doctor is much more timely and much more frequently associated with prevention.

Immigrants are almost unanimous, regardless of their country of origin, in expressing very high levels of satisfaction with the health care available to them in Umbria. This attitude is in contrast to generalised critical attitude among Italians about the public health service (14). They report no particular problems with access to services, appreciate the professional quality of physicians and nurses, and report positive experiences of hospital stays (15). People of the Islamic religion, for example, seem to appreciate very much the fact that hospital meals always offer an alternative to pork. Nevertheless, we do not believe that the substantial unanimity of positive evaluations of local health services can justify excessive complacency on the part of the regional health care system. If one reads between the lines of the responses of some interviewees, for example, it becomes evident that the generous evaluations of practitioners and services are partly based on comparisons with situations of serious inefficiency, disorganisation and class discrimination which immigrants experienced in their home countries. At the same time, experiences of frustration and at times rather serious distress are reported by some immigrants, regarding the quality of human relations with some care providers who have shown themselves to be impatient and not very respectful of the cultural diversity of these patients (16). More often, complaints involve the poor functioning of the health care bureaucracy, such as long waits at administrative windows to obtain a certificate or make an appointment, or the impolite behaviour of employees. Italians also voice these criticisms against the inefficiency and slowness of public agencies in health care services. To combat this, Italians have developed over time, almost as if it were involved in some kind of ineluctable national destiny, more or less effective strategies of adaptation and containment. It is probably the case, however, that foreigners, at least to some degree, attribute episodes of carelessness, negligence or downright discourtesy to attitudes of hostility to them as immigrants. It is not always possible, however, from the accounts given in interviews, to decipher the interweaving of suspicion, poor knowledge of common corrupt behaviours in the host country, and truly painful experiences produced by such episodes. It is a fact, however, that some immigrants, especially Africans, allude in veiled and not-so-veiled ways to instances of discrimination or of out-and-out racism which they have been subjected to within the public health service. These issues undoubtedly highlight the significant heterogeneity of subjective experience, which interacts with the different objective living conditions and levels of integration achieved or accepted by immigrants from the various national groups. Unlike the Albanians and Latin Americans, our Nigerian respondents are almost all highly educated and employed in poorly paid and unsatisfying jobs, and generally appear as the most disillusioned, or they declare themselves most often to be victims of discrimination by health services. They are the most critical of their overall experience as immigrants.

5. *Conclusions*

This initial and partial reading of the results of our study highlights a finding as generalised, or even obvious, as is commonly unknown or distorted: the health conditions of the vast majority of immigrants are substantially good. In this regard, our study can at least contribute to the unmasking of the inconsistency of the risks for public health that are raised from time to time by those who view immigration as a threat to the physical and cultural integrity of the Italian people. Instead, as other studies have also shown, many of the ailments and illnesses from which immigrants suffer originate – or sometimes, as in the case of tuberculosis, become worse – in the course of the migration experience. They are the consequence of the radical or brutal changes to which immigrants are subjected and the precarious living and working conditions which some of them must endure for many years (17). It is in this framework that it will be necessary to conduct a more in-depth examination of the nexus, which has emerged at several points in our research, between conditions of psychological distress (homesickness, loneliness, marginality, absence of prospects for improvement) and the abuse of psychotropic substances and alcohol. Both originate in and are nurtured by the stressful living conditions of immigrants and by the lack of effective social integration in the host country.

The other finding of our study which seems to call for greater attention involves the high levels of satisfaction generally declared by immigrants with regard to the services with which they are provided by health and social service agencies. This finding should be considered together with the analogous expressions of appreciation which immigrants with children reserve for the public schools and then compared to the strongly negative evaluations and complaints which many immigrants express in relation to the quality of work, housing, and social relationships with native Italians. Such a comparative examination produces a scenario where two of the most important institutions of social control in contemporary society, the public health care system and the school system, are more advanced and prepared to welcome new citizens than other sectors of civil society, rigidly ensconced in positions of refusal, discrimination, maginalisation or even criminalisation of immigrants. In other words, the contradiction that seems to emerge is that immigrants must overcome thousands of obstacles to enter the country at a time when thousands of measures are adopted to delay or impede their obtaining legal status. On the other hand, immigrants receive free health care and education even when they are illegal. This is not the place to offer an exhaustive explanation for this, perhaps only apparent, contradiction, which in any case implicates the entire complex and articulation of relationships between institutions and the social system. It seems to us to be possible, nevertheless, to sketch out a brief reflection at least with regard to health care institutions. It is immediately evident that such a reflection cannot be circumscribed to the problems of immigrants insofar as it inevitably involves the overall question of the role and function of the public health care organisation in Italian society. Yet again, therefore, natives and immigrants are in the same boat, or better, in the same clinic. Both, the former and the latter (18), are subject to a number of risks to their physical and mental health determined by a social system that gives first priority on the scale of values to production and money at the expense of the people's well-being. Both, substantially defenceless with respect to the great pathogenic agents of "modernity," can rely, however, on the consolation of a place to sit in the waiting room of the doctor's office or a bed in a hospital room (certainly with significant differences). It could thus be hypothesised that the "generosity" of the health care organisation, its willingness to welcome those who are in need of care, represents one of the many faces of the politico-cultural centrality of the knowledge/power of bio-medicine. Knowledge and power which, as the presence of immigrants only makes more evident, are called upon to perform the irreplaceable function of repairing the damage constantly produced by the capitalistic organisation of the economy and the international division of labour (19).

In any event, a clear and significant finding that undoubtedly emerges from the study is the generalised and for the most part satisfying use in Umbria of free and public health services on the part of immigrants, whether legal or illegal. It must be added, however, that with the new centre-right national government there are strong probabilities that this situation is destined to change. On the one hand, the political parties within Italian government have chosen as one of their primary goals a more rigid control and a reduction of immigration. On the other, the government parties are moving to contain spending on health care and toward the partial privatisation of the National Health Care Service, which will drastically reduce the resources assigned to the health care agencies and thus the quantity and quality of the services that they deliver. It is easy to predict that the first victims of a policy aimed at a *de facto* denial of the centrality and universality of the right to health care will be the weakest strata of the population, of which immigrants are certainly a part.

Notes

(1) These are the peculiarities which according to Saunders (1984) allow one to speak of an “Italian national anthropology;” on this same question see also Bonacini-Seppilli, Liliana; Calisi, Romano; Cantalamessa Carboni, Guido; Seppilli, Tullio; Signorelli, Amalia; Tentori, Tullio (1958) and Falteri, Paola; Bartoli, Paolo (1994).

(2) The study is being conducted within the framework of the scientific activity of *the Dipartimento Uomo & Territorio* of the University of Perugia and has received financial contributions from the *Region of Umbria*, the *City of Perugia and Local Health Agency N° 2* in Perugia, as well as from the University.

(3) This is not the place to rehash the debate, still in process, over the concept of medical system. For the purposes of our study we believe the following definition of medical system is both persuasive and useful: «a socially-determined complex of representations, knowledge, practices and resources, concerning the interpretation of pathological conditions and actions aimed at identifying and responding to them,» cf. Zúniga Valle, César (2000: 289).

(4) As far as our study is concerned, the problem of arriving at a clear idea of the reasons why immigrants have such infrequent recourse to mental health services is still an open question.

(5) The classification of illnesses adopted by the Outpatient Clinic is organized according to the criteria of the International Disease Classification (ICD IX, 1975).

(6) Particularly the irregularity of meal times caused by different work schedules, harmfulness of many foods owing, according to the interviewees, to manipulative processing and conservation practices.

(7) For this additional and specific topic of study we have received financial contributions from the regional office of a large national union confederation (CGIL of Umbria) and from the Commune of Gualdo Tadino (Perugia), the locality in which the survey will be conducted.

(8) In Italy, assistance for old people, even the non-autonomous, is largely delegated to immigrant women, very often without residence permits, who perform at very low cost the irreplaceable role of making up for the serious shortcomings of families and the public health care service.

(9) A 58 year-old Ivory Coaster, for example, had this to say about traditional medicine in his country: «Before we were primitive, we used traditional medicine. Then the whites came.»

(10) We fully recognize that the type of relationship and dialogue that the interviewer manages to construct from time to time with the individual interviewees and the way in which the latter interpret the situation of the study may significantly influence the strategies of highlighting /concealment enacted by the interviewee.

(11) Obviously, account must be taken of the glaring exception of Chinese immigrants, who have regular and perhaps exclusive recourse to their own acupuncturist doctors, by now widely distributed throughout the region of Umbria. Our study has not yet examined this large segment of the immigrant population, owing to the strong aspects of closure and isolation from the Italian context characteristic of immigrant groups from the People's Republic of China. We have limited ourselves, for now, to a long interview with a key informant who is a Chinese woman who has lived in Perugia for almost thirty years and who works voluntarily as a cultural mediator.

(12) Readers are reminded of what was said at the beginning of the article regarding the generalised provision of health care for all foreigners present in the region regardless of legal status.

(13) The medicine cabinets of the vast majority of interviewees are regularly stocked with anti-inflammatory medicines and pain relievers.

(14) This criticism creates stereotyped representations of hospitals' inefficient operation, of incompetence and arrogance of doctors, and of interminable delays.

(15) Although we have well-founded reasons to believe that these evaluations are sincere, it cannot be ruled out in this case as well that some interviewees may have been influenced by the desire to flatter the native Italian interviewer.

(16) Some African women, for example, complained of having been rudely reproved during labor or at the moment of delivery by nurses who found their way of expressing pain excessive and inappropriate.

(17) In this regard, see also: Ministero della Sanità; Servizi Studi e documentazione (2000); Geraci, Salvatore (2000); Pauluzzi, Sergio; Marroni, Massimo; Loso, Kwelusukila (1995).

(18) Certainly with significant differences both within and between the two categories depending on the position they occupy in the social hierarchy.

(19) It would be totally out of place here to rattle off the list, which would in any case be incomplete, of the authors who have worked in this field. Nevertheless at the risk of appearing odd we feel ourselves obliged to cite Jean-Claude Polack's. *La médecine du capital*. Paris: Maspero, 1971, whose Italian translation (*La medicina del capitale.* Milano: Feltrinelli, 1972), with an unforgettable letter-preface by Giulio A. Maccacaro, inaugurated the collection "*Medicina e potere*". This collection made available in Italy several of the fundamental texts of the debate on the political and social non-neutrality of biomedicine.

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Ethnography in the consulting room.

General practitioners' attitudes towards Italian and Immigrant patients in Perugia (Umbria)

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The following paper is based on the data that emerged during my first six months of fieldwork within general practitioners' consulting rooms (1). The enquiry, which is still in progress, is set in the Umbrian region, more precisely in District n. 2 of the Local Health Unit of Perugia. The object of my research is to study the patient/physician relationship by observing medical examinations in act, with particular focus on the physicians' point of view, emotions and experiences in the daily proceedings of their professional practice. I have chosen general practitioners because the lower technical-sectorial competencies their role requests mean that they have more opportunities to relate to patients in a more constant and profound way than specialists (working in hospital or on their own). The importance of this choice becomes clear, however, if one considers that, also for the complex implications it involves (compulsory professional secrecy, privacy, physician's duty to respect the deontological code, and so on), medical examination as it happens is currently not being studied as it should. As well as participant observation of medical examinations (and of the relational, linguistic and proxemical aspects of doctor-patient relationship), further investigative elements are the analysis of the implicit messages conveyed by the organisation of waiting and consulting rooms, and several in-depth interviews carried out with some general practitioners.

1.

A few years ago Edward Shorter, a well-known medical historian, wrote *Bedside manners: The troubled history of doctors and patients* (Shorter, E. 1986 [1985]). With this title he defined very well the complexity of a still open question which only recently has been object of medical-scientific reconsideration, although for centuries it has been a field of reflection, research and analysis of various epistemological sources (2). Psychoneuroimmunological research, in fact (Bottaccioli F. 1995), strengthened once and for all, even inside the scientific community, hypothesis and theories spread in anthropology since the beginning of the century, when in 1926 Marcel Mauss, for instance, wrote his *Effet physique chez l'individu de l'idée de mort suggerée par la collectivité*. The intersection in the human being between the biological and social dimension was thus starting to receive the first decisive impulses toward a progressive expansion to spheres and spaces confined before in the "natural" field. This was the beginning of the definitive corrosion of a false boundary, that is to became aware of the reciprocal influence of two aspects which, as it is clear now, acquire an operative value as analytical-interpretative categories precisely when the risks of dogmatic separation and objectivation is rejected.

Therefore, it is possible today to establish a dialogue between anthropological and biomedical research by looking at the close link between the central nervous and immunity systems: the arena is the specific incidence exerted by the psycho-emotional mood on the immunity defence mechanisms and on the whole physical functioning (Seppilli, T. 1996). Freud, *mutatis mutandi*, had already considered the same idea, in 1890, when he affirmed that the relationship between the patient and the curer, as well as the way in which it is handled, has an evident therapeutic efficacy within the health/sickness dynamics.

> «Probably, the effect of any remedy that the doctor prescribes, of any action he undertakes, is composed of two parts. One of these, sometimes major sometimes minor, but never completely negligible, is due to the psychic behaviour of the patient. The trustful expectations with which he affronts the direct influence of the doctor's action, depends on the intensity of his will to heal, and from his faith in his having taken the opportune steps. Then from his esteem of medical art in general, moreover from the power he attributes to the person of his doctor and even from the purely humane liking that the doctor arouses in him. There are doctors who possess a particular capability to earn patients' trust; the patient then feels relieved just seeing the doctor come into the room. [...] Throughout history, and in ancient times in fuller manner than today, doctors practised psychic treatment. If, for psychic treatment, we understand the will to create in the patient psychic states and conditions in order to help the healing, then this kind of medical treatment is historically the most ancient one» (Freud S. 1967 [1890]: 100-101) (3).

2.

The patient-physician encounter is, as we know, the place in which cultural logic and discursive rhetoric about body, "health" and "sickness" intertwine, clash and transform each other in a negotiation process that medical anthropology contributed to revealing, although it still looks as nebulous and rich in contradictions as ever. It is widely acknowledged, however, that the increasing dissatisfaction with the kind of patient-physician relationship legitimated by the biomedical approach (felt as "cold" and depersonalising, especially by patients) is one of the disruptive elements in biomedicine's profound present crisis which, it seems, can only be solved by once again questioning some of its axioms (4).

In Saussure's words we could define the patient-physician encounter as the moment of "*parole*"; that is, one of the moments in which the biomedical code of "*langue*" expresses itself through its speakers, who at the same time contribute to continuously modifying its structure. It is precisely these "human" features that such a kind of relationship introduces, and it means an incessant production of new meanings and new sense assignments, often clashing with each other. This explains why the patient-physician relationship is one of the privileged sites in which the biomedical paradigm (as well as the ideology of neutrality it bears and through which it legitimates itself) seems not completely succeed in dissimulating the relativity and arbitrariness of its epistemological assumptions. This reveals biomedical system to be the result of specific historical-cultural determinants, as much as other medical systems (5). With the same interpretive key we can read some of the dynamics within patient-physician relationships, such as the way those dynamics are implicitly handed down to medical students, as containment devices for the risks of "breaking up" that these encounters constantly engender, particularly when the social actors do not share the same cultural patterns, as in the case of foreign patients. In other words, these devices seem to bring such centrifugal forces back to the biomedical paradigm, thus making it more refined, and "open", though still (even more) hegemonic (6).

A considerable amount of research carried out in this field – including the anthropological – has focused on the patient; many other researchers have shown how medical behavioural training must be measured in order to improve relationships with patients, considering the hermeneutic process and the communicative flow between both subjects as essentially one-way. In a certain sense, this seems to paradoxically consolidate and maintain a prejudice: the idea that physicians are bearers of psychological and "culture-free" neutrality, learnt through the long and hard initiatory path towards the "Truth" that biomedical apprenticeship assures to its "followers". As Canadian anthropologist Brenda Beagan states: «increasingly medical schools offer courses in cross-cultural medicine and instruction about how patients from divergent social backgrounds may differ in their approaches to health and illness. Though a promising start, such approaches retain the belief that differences reside in the Other, in the patient, leaving the supposedly-neutral norms embodied by physicians unexamined and unrelativized». (Beagan, B. L. 2000: 1263)

I think, then, that we have to focus our gaze on the figure of the physician, and try to grasp on a more profound level the way in which he incorporates the biomedical paradigm as a specific "cultural system", and also reveals – acquiring them "personally" – its limits and contradictions. Such an interpretation would be useful to show us that there are complex and structural mechanisms at the basis of physicians' difficulties in relating to patients. There is, for instance, the way in which a biomedical paradigm tries to work out those centrifugal forces I previously mentioned, taking possession of further instances of "opening", without seriously discussing some of its basic assumptions, thus arousing conflicts that produce, like a vicious circle, new breaches and new "crises". As an example of this, every physician holds in himself, like oxymora, both medical "souls": the objectifying, reductionistic one and the empathic, "humanising" one. Therefore, the reductionistic core of some scientific approaches transmits values leading to the concreteness and materialistic objectivity of physical phenomena, to the measurability and reification of what concerns the human organism, and then to the detachment required for its correct management and manipulation (one example is the practice of anatomical dissection, for instance) (7). Then, there are tendentiously excluded, or unfavourably featured, inclinations to emotional involvement, counter-transfer, and excessive "humanisation" of the relationship with patients (regarded as more suitable to the nurse's role, for instance). In another way, values such as altruism, devotion and in general a humanitarian essence of the medical profession are interiorised as well, both through a real training process and through a more widespread myth of the physician as "saver" of human lives. Both these medical patterns therefore co-exist, clashing with each other, in those who decide to become doctors through what we must actually consider a true initiatory path. We ought to remember how much medical schools drive medical students to embody – teaching them a highly skilled, technique and a somewhat ritual language (8), and also a wide range of other "dispositions" (9) – systems of values, representations and attitudes which mould their profession, their world and their *Weltanschauung* (10). Being collectively socialised, then, such rules, conceptions and values, which often contradict one other, constitute the cultural heritage with which doctors approach professional practice. The idea that it is possible to dissipate them with just a mere invitation of comprehension and "cultural sensibility" is to some extent unthinkable, naïve or "inauthentic" at least (11).

3.

As early mentioned, the current research, the results of which constitute the present paper, set out to investigate, through an ethnographical survey of the patient-physician encounter inside consulting rooms, what it means "to be a doctor". That is to say, I wanted to find out how the role is constructed and how it appears "in action", also through the narration of the physician's personal experiences and emotional moods, in the way he perceived them. The fundamental presupposition from which I started, in fact, was the idea that before their training doctors represent "human beings" embedded in specific social networks. They are therefore the bearers of cultural patterns and "common sense" values, which are more widely shared than the ones they acquire during medical school training, in respect of those, of course, the latter often introduce contradictory elements. As far as the specifically professional level is concerned, what we must bear in mind is that the position single doctors hold is actually of extreme structural asymmetry with respect to the patient's position, because of their competence to solve people's health problems (Lupo, in press). Nevertheless, they are also strongly bound by the contractual power the patient possesses today, even more than in the past, and which physicians must contend with every day in a constant negotiation of their own role.

However, thanks to the ethnography inside the consulting rooms the need also emerged to critically review some theoretical references, calibrating and reciprocally integrating them to better reflect reality, and to drop prejudices and preconceptions (12).

With this idea, I decided to use the relationship between local physicians and immigrant patients as a privileged observation field and a prompt for conversations. It seemed to be a very important revelatory instrument: such an encounter, in fact, assumes the form of a "limit" situation, in which the heterogeneity of the cultural patterns held by the two protagonists acquires evident and sometimes extreme features. This allows some of the prejudices and devices I discussed above to emerge, rendering them visible, whereas in the case of local patients they remain concealed under reciprocal expectations of behavioural response, standardised and interiorized by both parties. For example, if a somehow paternalistic attitude seems so subtle as to be, at times, almost imperceptible or at least appreciated by the patients, in the case of migrant patients it often assumes great and glaring proportions. During one of my stays in a young lady doctor waiting-room, I realised at once that the patient she was dealing with at that moment was not Italian, because she was talking to him with a particular voice tone articulated in an almost grotesque way and loud enough to be clearly audible even from where I was. Because she seemed to take for granted that what she was saying would be unintelligible to him. And because the communication register she adopted would have been fit for a conversation with a young child rather than with an adult, even though he was Ecuadorian (and the answers the man gave showed a perfect control of Italian!).

An analogous situation occurred while I was in another consulting room. It involved an Albanian man in his forties. The doctor received him with a very kind attitude at first but, suddenly, he became irritatingly paternalistic and sarcastic as soon as the patient ingenuously “confessed” that he preventively had recourse to self-help care with domestic remedies from the Albanian tradition. It is not difficult in these situations to recognise in physicians the co-presence of values and concepts imbued by medical academies that clash with a broad set of other patterns acquired, more generally, in the course of life (13). Also evident is the conflict that many physicians experience between the need to be detached, impassive, unaffected and uninvolved with patients’ problems, and the wish to participate, alleviate and understand sufferings. This is the case of most physicians who have undergone medical operations, and who thus find themselves in the hospitalised patient’s shoes. Two years ago, at the age of 47, one of the doctors I work with had a heart attack. He learned then, to his cost, the significance of the “cold” and detached attitudes of physicians, which caused him a great inner struggle between what he still considers the “right way” to practice medicine, learnt at school (he once said: «*You must be detached, you cannot be overwhelmed, or else you’re dead*!») and the uneasy feeling he experiences every time he identifies with his patients’ pain, being aware of what one feels in a similar position. He told me:

> «*I’m more careful now. The first impacts of people feeling sick, the first time they get in touch with the medical structure and so on, I’m aware about what it is to feel lost, bewildered, to feel, I mean, tossed up and down... Because I remember how I felt in those three or four days in the hospital, I mean. During the hospitalisation, the worst thing was my colleagues’ coldness. Even if you’re a doctor you can feel a very strong*

> *sensation of powerlessness. What I felt was the physicians' will to avoid any emotional contact with me, although I would have appreciated [the opposite]...all my friends and colleagues that came to visit me were reassured about what the physicians had done to me, they told them everything but I was told nothing! The paternalistic attitude is the most irritatingly to me. I can't stand it.»*

In its most extreme and disabling cases, the experience of being sick can have the power to damage, once and for all, the real foundations of the doctor's image as a superman, invincible and therefore powerful against "evil" dangers. This is the image that is responsible for the asymmetrical axis he establishes in the relation with patients. The sole strategy he can use to recover a role of "authority" and to preserve the "divine" features threatened by the "offending" illness, seems to be the assumption of a new identity, which we could define as the "survivor" identity: because he has come back from the "realms of death", he is now invested with a new power, the power of participating and sharing patients' experiences (GODEAU, E. 1993). In other words, this kind of investiture seems to legitimate the "fall" from a dominant position, which merely leads to another immediate position of power, even though it is dissimulated by a rhetorical closeness to the patient. It is, however, an inauthentic approach: physicians' gestures, attitudes and words, though often only undertones, express, to a level that goes beyond appearances, a total empathic incapability.

4.

A widely spread opinion is that the growing discontent with certain kinds of patient-physician relationships is basically due to a few, somehow still stereotyped, elements: brief and heedless consultations, the coldness and indifference of physicians, and so on. It is quite clear now that the question should be posed at a deeper level, even if the contradictions internal to the complex dynamics involved seem to make an exhaustive analysis of all the elements very difficult. However, by their very nature, contradictions possess the great implicit power of "revealing". They destroy, in fact, the schemes of what is given, through a mechanism which interrupts the circular and self-regenerating flux of the logic from which contradictions themselves originate: they introduce discontinuous elements which make the constitutive structures and functioning procedures of such logic visible.

Therefore, to look more thoroughly at the patient-physician relational dynamics, the way in which patients themselves often express needs and requests at times incoherent and ambiguous, for instance, should be pointed out. They are in fact hardly solvable with a mere increase in dialogue and a more profound "humanisation" of the relationship (14). Many difficulties are rather mostly connected to the ever-growing technological presence in sanitary needs – in its turn produced by the ceaseless technological development of diagnostic-therapeutic methods – and linked to the availability of immediate information that the recent advances in telecommunication systems can guarantee. All this, together with the spreading of a "scientific mass culture", actually responds to what is natural and partly auspicated for the development of a medical system rooted in a context of liberal-democratic tradition (15). Nevertheless, the process of democratisation that in recent years has been investing biomedicine as a medical system has also roused that wide set of distorting effects and complex troubles which any process of structural transformation inevitably carries.

The professional routine seems at times to suppress physicians' passions and motivations. They appear "cold" and indifferent to the human history of their patients. However, the role of Italian general practitioners within the welfare state has recently undergone changes and they have had to assume functions that are increasingly bureaucratic (16). This has increased their frustration levels and their awareness of being just little pawns in an enormous sanitary apparatus (17).

> «*When prescribing a drug the doctor is guided by his own scientific knowledge and therefore... that's that! Moreover, he is responsible for what he prescribes, obviously! [...] But in this way [with these bureaucratic complications] they take away from me the freedom to prescribe "in science and consciousness"! Because I have to follow bureaucratic norms that someone else has set for me! [...] One feels almost "castrated", because... just the problem of remembering the numbers is enormous! In daily practice you just have to remember the name of the drugs, their instructions, their side effects, how they interfere with other drugs... and these are rightful things, and they have to be remembered! But what about remembering the number of the prescription, having to sign it, having to sign the exemptions... there are exemptions classified per pathology… than you must remember the number of each exemption... it has become an obsession! [...] When you live a profession you must also accept your responsibility: eh, I'm aware of this and I'm happy about it! But when they make me assume responsibilities just for bureaucratic acts, that's the end! [...] And it has two clearly negative effects: it takes up a lot of time, time that should be spent on other things, particularly on conversation with patients; second, it causes friction with the patients!*» (Doctor P.G., 54 years old)

If we cannot but consider a certain portion of administrative-bureaucratic engagement as a constituent and unavoidable part of the same medical practice, the idealization to the limit of the physician as a figure almost external to the economy's dimensions, just working for pure vocation, with a nearly supernatural inspiration, plays a decisive role in the perception of his professional practice as alienating and in the consideration of some requests as illegitimate and deviant.

Another critical point – even if it is a fundamental democratic achievement – is that due to the efforts of patients' rights organisations and a more pervasive scientific mass-culture, patients have today greater contractual power. This patients' empowerment is often perceived by physicians as a kind of blackmail (and frequently it actually seems to be), which they try to avoid by entrenching themselves behind a rigorous face of impeccable professionalism, thus lacking in empathy.

> «*It is very fastidious to think that today general practice in medicine is perceived on a commercial base. Because all doctors constantly fish for patients! [...] The patient's attitude is one of blackmail! He demands certain things of you and if you don't satisfy him, he goes to one of your colleagues, who is much more easy-going and at his own risk and danger he finally concedes those things. So the patient says: "If you don't give me that, I will go to another doctor and sign myself on!". These are the realities of today, and that's the worst aspect of the general practitioner's profession, because it doesn't permit you to be really authentic, or at least it is very difficult to be so, it is very difficult not to be "polluted" in that sense!*» (Lady doctor, A.R., 37 years old).

Moreover, the increasing medicalisation of daily life spaces in recently industrialised countries (among other factors) drives patients to look to doctors for answers to all kinds of questions, such as solutions to existential matters that he is not always able to provide. In addition, most doctors can no longer count on the "support" of people who, until a short time ago, especially in a rural reality such as Umbria, were covering similar roles: priests, neighbours and other social circles.

> «*I think there should be other characters, you know, because today everything is referred to the doctor... whereas we need to have other figures! I mean, once there were those figures, there was the priest, the village, the neighbours, I don't know... anyway, there were other roles, now it is absurd but everything is demanded from the doctor!*» (Lady doctor P.B., 48 years old).

Neither do the patients themselves really appreciate deeper conversations and examinations, it doesn't matter if they are Italian or immigrant (although apparently for different reasons) (18). They both sometimes express "closed" attitudes towards a relationship that tends to go beyond mere "drug shopping": they often identify general practitioners as mere distributors of medicines, tests and specialist check ups, which, even when superfluous, physicians end up conceding only in order to satisfy patients. In one of the consulting rooms I attend, people often come in and say: «*I am out of bird seed, I am dry!*». They stand in front of the desk, showing that they are in a hurry, and they reluctantly answer the questions about their state of health, as if their answers could somehow negatively influence their right to benefit from what they are asking for.

Some physicians told me about people turning to them, even though they belonged to another doctor, because the high confidentiality level and the strong emotional involvement that links them with their doctors prevents them from speaking about problems that they prefer to share with someone who is an "outsider".

> «*Sometimes it turns out that patients tell you things and not their own doctor! [...] Or maybe the reason is that in the first-aid station [where I'm working too] they don't know you, understand? Therefore maybe they feel easier telling you their problems, you know? [...] Maybe they feel freer talking with you, an unknown person!*» (Lady doctor P.B., 48 years old)

5.

To balance out the questions discussed above, it would seem that the complex dynamics of the patient-physician relationship and the entangled contradictions that emerge can be traced back to the fact that the whole biomedical paradigm is being transformed and reshuffled. Medical knowledge is undergoing a process of democratisation and, far from being an exclusive and "initiated" knowledge, it is now turning out to be more and more comprehensible (at least in its less specialist fields) to a larger part of the population (19). As a consequence of this phenomenon, deep internal conflicts have been generated in those who have for centuries been the privileged bearers of this knowledge. What is more, these effects seem to have made themselves felt in general practitioners, whose cognitive store – by its very nature wide and "generalised" – is the first to have been drawn away not only by broader general social changes, but also by the partial "collectivisation" of medical knowledge. Therefore, even more noticeable are the "self-defence" mechanisms generated in such physicians, whose response pattern to the current critical phase seems to be summarised in their attempt to construct a new "identity", perceived as a guarantee of a revitalisation/demand of their role within the medical system.

> «*The effort we have been making these years has been to give a connotation and a worthy image, a role, tasks and functions (codified and acknowledged) to the general practitioners... [...] The battle that we're all fighting is the emancipation battle of general practitioners against all other doctors: it has been the battle of women against men!*» (Doctor P.G., 54 years old).

The reference points of the recent past have little by little been falling to pieces (the classic character of the local medical officer, for instance) and the perspectives and new values that a medicine which is still undergoing changes can provide to general practitioners are still not clear. They are currently hanging on in a marginal zone characterised by confusion and uncertainty, and therefore sometimes by frustration and dissatisfaction. Thus, on the one hand, physicians can no longer recognise themselves in the traditional clichés but, on the other, they are not clear how they must adapt to the new requirements. This lack of definition of the general practitioners' identity seems to be reflected in how they perceive the attitudes of their patients (20), in the discursive strategies that many of them use, and in the identity that they construct by means of "opposition". The recurring rhetorical games that they use to define their own role are based on the differences and contrasts with the so-called "traditional doctor" and with what they perceive as negative features of other medical identities, above all clinicians and specialists. Positive and negative aspects of what the old panel doctor was and of what contemporary medicine can offer seem to alternatively stand out from their words. A new pattern is thus going to be constructed by chaotically capturing elements from an idealised past, cleaned of perceived negative aspects, and enriching them with the perceived positive elements of a "modern" present. In this way they will be softened and somehow legitimated by rooted historic precedents.

It is interesting to note, to conclude, how the discursive elements that physicians used during the interviews often reused concepts and arguments produced by the social sciences in their criticism of biomedicine: de-personalisation of relationships, high specialisation of competencies, dehumanising hyper-technicality, and so on. In other words, doctors seem strategically escape from these criticisms becoming themselves the bearers of such criticisms. Thus, as often happens, the results produced by the research, if still with sometimes ambiguous and deforming effects, turn to the experiences and discourses to whom the research were been directed. They slip out of the direct control and the purposes of the research itself, to be called upon and used in other directions and for other objects.

Notes

(1) This fieldwork periode constitutes the first part of my PhD project in "Methodologies of Ethnoanthropological research" [*Metodologie della ricerca etnoantropologica*], University of Siena (administrative office) – University of Cagliari and Perugia (associated offices), 2000-2001 academic year.

(2) Already in 1880 Cesare Musatti, pediatrician, coeval colleague of Giuseppe Pitrè, wrote about the necessity to "keep in great consideration" concepts, expressions and practices of popular medicine, in order to guarantee the correct outcome of the treatment (see Musatti, C. 1998 [1880]:

243). From then there are a lot of disciplinary approaches working on this topic, each one emphasising different aspects of the question: the psychological dynamics generated by the patient/physician interaction; the ways and the purposes with which every social system fixes the "role" functions of them both; the linguistic-semiotic aspects of the relationship; the symbolic contents conveyed by places, objects and proxemical registers with which doctors "familiarise" since their first years of medical school training; and so on. Despite their undeniable scientific value, these contributions sketch out a very fragmented picture, in which interconnected and interdependent factors have been managed in separate way by quite separate fields, with scleroting effects, which hampered for a long time the effective and necessary overall view on the patient/physician relationship question.

(3) Translation is mine. About the same theme, see also Balint, M. (1961).

(4) See again Seppilli, T. (1996). He reminds us, how: «this "question", this problematic horizon that anchors us to the *here* and *now*, cannot be tackled with the simple terms of an operation of "applied anthropology", as the answers to the crisis from which we start cannot be found in mere "touch-ups" *internal* to the existent medical structure, but rather in a conscientious and organic rediscussion of its own paradigm and of its own operative results» (p. 19).

(5) Margaret Lock, in the introduction to *Biomedicine revisited* quotes: «what is being demonstrated in research of this kind is not that medicine is "unscientific" because it is permeated by social forces: but, in contrast, that both medicine and science are essentially social enterprises» (cfr. Lock, M.; Gordon, D.R. (eds.) 1988: 6).

(6) In a 1976 paper, *Crisis de un modelo en la medicina?*, Foucault wrote: «What is diabolic in the present situation is that when we want to refer to a field we believe external to medicine, we realize that it has been medicalized. And when one wants to question medicine and its weaknesses, snags and injurious effects, it is done in the name of a more complete, refined and widespread medical knowledge» (translation is mine). See Dal Lago (ed.) (1997).

(7) «In the realm of medicine, the body is transformed into an object. It is inspected, touched, poked, cut. The body changes from the home of an ego to an object to be examined» [translation is mine] (see Young, K. 1999 [1997]: XVII). With regards to the same theme, see also Godeau, E. (1993) and Bertolini, G.; Massa, R. (eds.) (1997).

(8) «In the context of medical training, the ritual language is important (as are other, more general, forms of communication) in the combined constituent dispositions of the medical *habitus* [...]. And a specialist language must form part of any professional cognitive identity, in medicine, all examinations that medial students must pass are written or spoken in specialized scientific language. Learning the knowledge to pass exams is dependent on learning the language in which that knowledge is expressed and, indeed, exams are just as much tests of the use of the language that medical knowledge is expressed in as of the knowledge itself». (See Sinclair, S. 1997: 22-23).

(9) «[Dispositions are] structured structures predisposed to function as structuring structures, […] without in any way being the product of obedience to rules, objectively adapted to their goals without presupposing a conscious aiming at ends or an express mastery of the operations necessary to attain them and, being all this, collectively orchestrated without being the product of the orchestrating action of a conductor» (see Bourdieu, P. 1977 [1972]: 72).

(10) See Kleinman, A. (1995) («Learning medicine is learning to reconstruct the world anew, medically», p. 243 / «Seeing, writing, and talking "medically", the student is authorized to be a participant in a Wittgensteinian "language game" that in turn creates a "way of life": an ontology of being medical», p. 245) and Good, B.J. (1999 [1994]) («[...] to learn medicine is not simply to incorporate new cognitive notions or new ways of solving problems and new skills for problems, but rather joining in a new world [...]. To learn medicine is to increase the knowledge about this distinct life world and it requires entering a separate reality system», p. 110 [translation is mine]).

(11) However, even though there have been a few recent openings in this direction, the same scholastic training of medicine students seems to be still poorly calibrated with regards to the importance of psychic and cultural aspects of the patient-physician relationship, and on the objective weight of subjectivity in health/sickness dynamics. More in general, what emerges is a difficulty to critically

assume the epistemological basis and the whole paradigm of contemporary biomedicine. One of the doctors I personally interviewed said: *«We are set in a particular way, that is to find just what we can measure! They taught us, I mean, to diagnose what we can measure: so we got into crisis! General practitioners are the ones who most frequently burn out in a crisis! Then a wide set of other psychological problems also plays a role...»* (doctor T.S., 49 years old).

(12) See note 2.

(13) Inclinations to tolerance and equality hit head on with prejudices about the value of other medical approaches and about the presumed inability of immigrants to understand complex technical-scientific truths.

(14) If we read the incommunicability between patient and physician exclusively in that key, the perfect *compliance* many traditional curers obtain with very short consultation, uttering a very few words or even being totally silent, closed in a solipsistic dialogue with the patron gods shouldn't be intelligible. In these cases, in fact, it is probably the intensity or the symbolic-emotional mood of the contact, which plays a fundamental role. These elements have little space in the relationship between patient and physician, such as it is set up at present in accordance with the biomedical paradigm.

(15) In that sense, the role of health training campaigns and, more in general, the educational policies of prevention has been fundamental, but above all a great impulse has come from the ever growing space dedicated to health topics by television programmes and, more generally, by the mass media.

(16) «Because of its long development under the powerful regimen of industrial capitalism, biomedicine is the most institutionalized of the forms of medicine. [...] Now, at the close of the century, biomedicine is practiced in bureaucracies, whose effect is profound [...]. The rule of efficiency governs the lived time of the patient-practitioner encounter, regulations control practice, transforming the doctor into the 'provider' of a 'product' that is advertised, marketed, and sold. [...] The physician is a bureaucrat; the patient is a user, a consumer of the institution's services. The very imagery of care constructs an industrial logic to its delivery and evaluation, reducing the moral space of the career of illness and of the work of doctoring to a minimum» (cfr. Kleinman, A. 1995: 37-38).

(17) «The physician as a man has an important role to play in the great system of the technology of health, but in general his position, the same as that of the patient, tends to be swallowed up by the monster of public sanitary organizations, as much as to create a relationship problem between the physician himself and the medical institution. [...] He has the power not only to influence health but also the same life of the patient, and nevertheless he lives the frustration to feel that he is only an infinitesimal part of an apparatus bigger than himself, that tends to inhibit his creativity and humanity, and complicates more and more the concrete difficulty to understand the patient and to make himself understood by him» (see Valdré, L. 1995: 94).

(18) One of the lady doctors I interviewed talked at length about the trouble to which the patient himself will go to request a "reductionist" approach to the illness, and therefore a kind of relationship that is not "holistic" at all: *«I mean, if you ask a patient, even if you're a specialist, which other illnesses have occurred to him, how he feels, he tends to not... he says: "But, what do you care about that?"»* (Lady doctor L.B. 43 years old).

(19) For further information, see Spinsanti, S. (2001).

(20) *«Because if you could just look at the [traditional doctor's] bag, what would you think to find?! He didn't have anything! All things considered, he only accompanied patients, he accompanied them in their death, in their illnesses... eh, today patients request this too, they would like it, but at the same time they would like something technical too! And it is so difficult to steer a middle course between the two things... [...] So, they always say: they don't want any more queues, so you need a secretary! They want you to answer to the phone 24 hours a day, but when they are sitting in front of you they hate to hear the phone ring! And if you take a secretary, they say it is no more the old patient-physician relationship! Sometimes you hear on TV: 'The doctors of the past were so...', it's just like if the old physicians were doing miracles! But it's not true... [...] And on the other hand they want the modern technologies, they want a context for the general practice in medicine worthy of the third millennium!»* (Doctor T. S., 49 years old).

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Medical Anthropology and Ethnography.

An approach to a case study on immigrant health conditions in Spanish society

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Introduction

The present study is part of a current investigation: "*From the Migratory Itinerary to the Therapeutic Itinerary: Health, Illness, and Health Care among Senegalese and Gambian Immigrants in Catalonia*." The account is divided into two parts. In the first, the phenomenon of immigration is presented, as well as the contextual variables, which make its explanation a problem.

In the second part, some of Medical Anthropology's methodological and conceptual starting points are presented and such aspects as health, illness, and health care processes are analysed in the specific social group discussed here, that is, the Senegalese and Gambian immigrants residing in Catalonia.

Part I

1. Ethnography as a qualitative perspective in approaching a specific reality and phenomenon

From a relational stance, it is important to compare the different points of view of the players ("emic" aspects) within a holistic framework that assumes the dialectic between micro- and macro-social levels (1). In this way, the "anthropological glance" will focus on recognising and explaining the cultural implications that exist in the distinct social groups and their practices, within the framework of the processes of broader socio-cultural interaction. It will also characterise and deepen the knowledge of little-known complex realities, which the dominant culture may attempt to eliminate (2).

Ethnography should begin from the acknowledgement of "not knowing" (3), and begin serving (and not self-serving), giving voice to those who have voices, but are not heard, acting in this way as a vehicle, bridge, or mechanism in the communication of knowledge from other, distinct realities. If we adopt as an axiom the fact that science as a social product is never free from values and prejudices, we will find that the very act of comprehending involves an interest in transformation. All of us assume a stance, an ethical, political, and/or human role, when faced with the reality being studied and the people with whom we interact. In ethnography, the researcher considers him/herself to be the instrument, par excellence, with all that this implies (ideology, subjectivity, etc., as conditioners for his/her interpretations regarding the reality or the phenomenon being studied). In addition, the flexibility of the qualitative investigation's design is a distinctive element. Because the researcher is often going to study an unfamiliar reality, the design should be open and circular, in this way allowing constant redefinition of objectives, hypotheses, and other components of the project, including intuitions.

As researchers, we carry out numerous journeys through time and space, from the field to academia and from academia to the field again (as well as other places). It is in this sense that "the field" is redefined. It ceases to be simply a place or a population, and it becomes confined and defined in terms of the power relationships, which are demonstrated within the distinct spheres of interaction. For this reason, the field is not limited to the mere activity of displacing oneself to a determined site in order to carry out a study; rather, it is to be found throughout the investigative processes. C. Katz (1994) proposes the concept of "intermediary space" to designate the varied spaces occupied simultaneously by the researcher. We are never totally inside or outside the research area, and power relationships exist in all areas. Moreover, it is important to analyse the different journeys that we make strategically throughout our investigations (4).

In the ethnographies based on alternative paradigms (5), the criticism of positivistic viewpoints, the quality of social actions and the demonstration of their heterogeneity and their relational logic, expressed in words, images, narration's and observations is extremely important. The information is obtained through such techniques and procedures as participant observation, in-depth and semi-structured interviews, focused group discussions and others. Moreover, the discourse and its significance is relevant to qualitative approximations. Finally, the reconstruction and the analysis of the life trajectories of the players (6) is effective at gathering information about the reality of the subjects and the group studied. Likewise, photographic and motion pictures materials and equipment can improve the investigation.

2. Several starting points for the analysis

A) It is important to approach knowledge about the subjects' way of life by starting from the contrast provided by the explanation (the *emic* point of view). This is essential, in itself, in any social research. It is even more essential if it deals with "labelled" human beings, "stereotyped" or "stigmatised" as a specific group by the State and its institutions (medical, police, political, etc.). In this case, they are "immigrants" or "foreigners," a label which marks their existence within their multiple dimensions and decisions.

B) The modern/urban/post-industrial society that is studied is culturally diverse and heterogeneous (different cultural concepts and meanings attributed to actions, things and/or phenomena). It is also dual in its socio-political aspects: formed by exclusion and yet integrated in the system. The importance of this last point lies in the complexity of analysing the problem within the conflictive context where inter-cultural relationships are developed. At the same time, it must be pointed out that the group of State institutions tends to retransmit and interject the hegemonic, cultural values that support them into the studied subjects. These, many times, are in conflict with those values that correspond to sub-alternate sectors, which belong to different socio-cultural realities (7). In this sense, as I shall attempt to discuss later, the phenomenon of immigration can become a "problem" and, as such, be subject to control and stigmatisation by the State and its institutions (including the mass media), along with the socio-political consequences that this causes. In the case of migrations, stigmatisation

> «is unleashed in those situations in which 'the other' is presented as a dangerous rival in the fight for the limited basic resources available to the group (at an economic level, public administration, etc.). It is also so in the fight for the preservation of their very identity. That is to say, it is like a smoke-screen (or a "Judas goat"), used to divert the responsibilities of many of society's evils towards the outside.» (Romaní, 1999: 120) (8).

C) The current migrations being analysed are understood to be consequences-manifestations of the unequal development of the world capitalist system, which in its contemporary stage is defined as neo-liberalism. Also involved are elements of another type, such as the possible expectations of the individual to better himself, the dynamics of social control, etc. Immigration will be approached in the studied context as a "total, socio-cultural phenomenon," which has originated and has continued to reproduce and historically transform itself, within the framework of material and symbolic processes, throughout the world (economic, political, cultural, social, etc.).

D) Research which has theory as its central issue tries to give a conceptual analysis of the dynamics of the migratory lines and networks (9), on the one hand, bettering the static, abstract, and simplified approaches, which only consider macro-structural variables. And, on the other hand, it tries to refute the neo-classical theory of immigration that regards migratory processes from an exclusively individual perspective (Malgesini, 1998).

E) In my case, as a migrant researcher – a Latin American resident in Europe – I approach the problem of a population's journey through its burden of everyday life, which on repeated occasions the European-centred discourse makes completely obvious. At the same time, it is essential to analyse the interaction among the issuing countries, as well as the strategies generated by the migrant workers themselves, within their distinct receiving contexts.

3. *Globalisation, the European Union, and the flux of workers*

Globalisation is the current stage of the world's capitalist development, which economically involves expansion of the market, the hegemony of finance capital, and a war among the two hundred most powerful transnational companies on the planet to conquer new markets and territories. The ideology that supports this process is neo-liberalism, which tries to infiltrate in a uniform and global manner all of the spheres of social, political and cultural life within today's societies.

On one hand, the unification of the entire world into one single market and neo-liberalism operates under a process of «destruction and depopulation» and on the other hand the "reconstruction and reordering" of regions and nations, in order to open new markets and modernise those markets which already exist (insurgent sub-commander Marcos, 1996).

Within the European Union, economic globalisation has managed to erase the borders between rival states (enemies for a long time) and has required them to meet and consider political union. Political "unification" produced by neo-liberalism is economic. It is the unification of markets in order to facilitate the circulation of money and goods. In the gigantic world hypermarkets, merchandise circulates freely, but people do not. They try to eliminate the first who try to circulate, if not controlled. The people who do not circulate "legally" or "with their papers" are pursued.

In each phase of the capitalist process, the "New World Order" organises a flux of workers, both specialised and non-specialised, to go where they are needed. Much of the international politics of different countries has adjusted to this analysis. (This includes, as part of those political wars and ethnic conflicts, regional hyperinflation, high indices of evacuation, the "dollarisation" of economies, etc.)

It can be said, then, that the migratory politics of neo-liberalism is more oriented towards destabilising the world's work market than towards stopping immigration. The work markets, as such, are more and more defined by migratory fluxes. Close to home, for example, we have a great flux of migrant workers arriving in Spain. They come from countries where the economic and social work situations are becoming more and more untenable as a consequence of the settlement plans of the FMI and the World Bank, within the relevant neo-liberal models.

4. *Current migrations as part and consequence of this process*

At the beginning of the nineties, it became clear that global migratory movement was increasing, fundamentally from peripheral countries towards central countries (10). The structural situation in many peripheral countries is characterised fundamentally by the inequality in the distribution of income, the majority of the young population (a good part of the active economic population) without work or under-employed, and a high percentage of the population with its basic necessities unsatisfied. From a strictly economic point of view, the phenomenon of immigration refers us to the process of re-accommodation of the work force into the new globalised market of world employment. So-called "rural modernisation," which international financial markets demand for those countries determined to be "Third World" (11), has a great impact on traditional, social and economic relationships (e.g., family, community, co-operative, etc.) As in wartime, this provokes a mass exodus into the cities from the country. Upon the disappearance of local and regional markets, small and medium-sized producers see that they are unprotected and cannot compete with the transnational companies. The companies go bankrupt, and the workers end up unemployed. Meanwhile, in the urban areas, the work market becomes over-loaded, and the unequal distribution of income is predominant. All of this establishes a critical situation, which offers a propitious framework for looking for better conditions of life in more developed countries.

"World War Four," with its process of destruction/depopulation and reconstruction/reordering, provokes the displacement of millions of people. Their destiny will be to wander, with their nightmares on their backs. They will threaten the job stability of the employed workers in different nations, and will be considered an enemy, to replace the image of the employer. They will be a pretext for giving sense to the unjust racist, who has been created by neo-liberalism (insurgent sub-commander Marcos, 1996: 24).

In the case of the European Union, the political factors, which interact in the control of migrations (through the Schengen Treaty), correspond to a perspective of repressed contention. It is «a coherent politics, with a complete line-up of orientations, regimentation and actions, that have been developing in the European democracies since the mid-seventies. They outlined the dilemma, 'Liberty-Security', and they have chosen the second «(Romaní, 1999: 126) in the world "without borders," in the "global village.» Millions of people suffer xenophobic persecution, job instability, and the loss of their cultural identity of origin, political repression, hunger, prison, and death. With different names and under legal differentiation, sharing a miserable equality, migrants or refugees or the displaced people from all over the worlds are "foreigners" who are either tolerated or rejected (12).

5. *Context for the rise in the "problem" of immigration in Spain*

The fact that immigration is a relatively recent phenomenon in this country is reflected in the progressive change in status from a "country of emigration" to a "country of transit" and then, later, to a "country of settlement." Also to be noted is the deficient administrative and institutional handling of the rise in immigration, treating it as a "problem." This is reflected in the few investigations, which have been carried out from a socio-cultural point of view, oriented towards knowledge of the migrant populations, their specific processes, and their perceptions as players. Information is given about the central elements of each collective, such as its lifestyles, the codes and cultural guidelines that sustain them and affect their migratory networks, as well as the ways in which they insert themselves into a receiving society. Also included is the way in which they carry out the process of reconstructing their identities. All of this is contained in the framework of a current socio-political context, unfavourable for the integration of extra-Community immigrants, into a Europe, that day by day continues to reinforce its legal and real fences.

The discussions about extra-Community migration began to deepen when Spain became a member of the European Union in 1986. This act assigned to the Peninsula the role of the "Southern Frontier", the intended "European Fortress," with its principal cities built up to be cities of global or Metropolis status. In this framework, Spain receives vast contingents of Latin American (principally Andean and Caribbean), African (mostly North African and sub-Saharan), and Asian immigrants (from Pakistan, China, and other countries). Nevertheless, we can find literature which has brought interesting lines of analysis to the subject of immigration in Spain (13).

As mentioned earlier, from the mid-eighties and above all, once the nineties began, the situation changed: Spain has become a country of immigration. Since entering the European Union, the process of making the economy international and encouraging its economic growth has turned Spain into the Spanish-speaking country with one of the highest consumer levels in the world (based on set, macro-structural indicators). At the same time, it experiences intense, international migration processes, although these occur on a smaller scale than in other more industrialised European countries (Pumares: 1998).

Like all other European governments, the Spanish government has actively intervened in order to preserve its national, as well as its private, interests. It has instituted a sort of protectionism that is far from the established metaphor set forth in the hegemonic discussion (such as "the laws of the free market"). The same thing is happening with the idea of "freedom of circulation," which is limited to capital and merchandise, and which excludes people. The powerful states have demonstrated direct action, among other measures, through legislation and regulations (expressed in laws regarding aliens), in an attempt to regulate the movement of the population, in direct function of the needs of its work markets.

In this sense, the politics of the European governments are eloquent. The political powers mean to orient the discussion towards a more open vision of Europe, with respect to the arrival of extra-Community migrants, and in this way try to change the image of the "European Fortress". However, in contrast, the recent tendencies continue to support the European-centred concept, in favour of preserving the "state of well-being" of the old continent. This "well-being" is accomplished through the provision of migratory flows, due to the ageing European population. But, from this point of view, neither the economic nor the political situations of the countries generating these population migrations is questioned.

Particularly among the North Africans, the sub-Saharans and the Latin Americans there are factors which favour these population movements to

Europe especially to Spain. Among these factors are proximity, previous colonial relationships or historical ties, frequent contact, and knowledge of the language and of the social networks, which have been functioning for many years in various Western European countries. However, these characteristics, which have always been obvious in population movements, have been encouraged within the context of globalisation, thanks to the constant spread of information, the lowering of transport prices, and the increasingly dynamic functioning of the Mafiosi, dealing in the illegal trafficking of immigrants.

As is occurring in the rest of the countries in the European Union, all of which are moving towards the Post-phase – “Fordist” and Industrial –, the demand for workers in Spain is beginning to be concentrated towards rather unstable work positions. This may be due, perhaps, to the fact that they have to do with traditional sectors, where drastic cost reductions may be required, in order to continue functioning. Or perhaps this is due to the fact that they are productive sectors, which have a large demand for workers. A certain irregularity in immigrants is tolerated, because in this way there will always be a group of cheap workers, willing to work, who do not make even the most minimal demands for good working conditions, legality, or work security.

In addition to seeing them as competitors for work positions («they don’t even pay taxes…») the rejection of immigrants is partly due to the fact that they are usually poor, and so they arouse greater fears (since they may eventually “cause complications”). The *chabolismo* (shantytowns) among the Moroccans, for example, negatively affects the stigmatised image which is held of the Moroccans. This image also affects their hygienic habits, their health, and the performance of their children in school, and no one has ever said anything about this. The communications media in Spain have been rather irresponsible in how they have dealt with information regarding immigrants, who little by little install themselves in the system and become a part of it.

5.1. The “problem” with the communications media

«The new Law on Immigration will come into effect on the 23rd of January» (*El País*, December 27, 2000)

After that date, informed the biggest-selling Spanish language newspaper on the planet, those immigrants whose requests for regularisation had been rejected could be expelled from Spain. These foreigners received letters in which they were advised, «... you must abandon Spanish territory, for which you will be given a total of 15 days, effective as of the day after the date of the notification of this decision.» With this law, those who did not leave Spain within the ordered time limit would be sanctioned with a fine. However, when the reform became effective, they could then be expelled. The text established that to find oneself in the country, with no papers, or a Visa that had expired more than three months before, or if you were working without permission were sufficient causes to be expelled (14).

To give an idea of the migratory situation in a city such as Barcelona, for example, this province had the highest number of immigrants presenting petitions for regularisation (and which were rejected for "various" reasons – in many cases, no reasons were given). During the year 2000, 34,982 people were denied residency (71% of the cases resolved (49,271)), 14,042 petitions were granted, and 247 were put on file (15).

From the time of the institution of these regulations, foreigners with no legal documentation only had access to the obligatory health assistance and education facilities. The rest of their rights (reunion, association, public participation, unionisation, or striking) were restricted only to those people whose situation was legal. On the other hand, in the "most important act of the year 2000," according to the Sunday magazine in *El País*, dated 12/31/2000, the problem also appears.

Referring to the "national sphere" that is to say, the Spanish state (which actually is not a "nation" but rather a State, which includes such other nations as Euskadi and Catalonia, to name only a couple), *El País* headlined one of its feature articles with "The Challenge of Immigration." This provides an idea of how complex and worrying this phenomenon is, and about which we are now permitted to speak of as, "the problem" (along with "terrorism"). For this newspaper, linked to the opposition PSOE party, Aznar's government, "showed itself to be incapable of assuming the consequences of the largest wave of immigrants of this century. (This is)... a problem, which has just begun, ... and which could turn into the principal problem of the 21st century".

Some complementary facts presented in *El País* are:

- The Pro-Human Rights Association affirms that «more than 200 people have died, drowned off the coast of Spain, trying to cross the straight (and the figures for the deaths caused by police violence, racism, xenophobia, etc., are not included).»
- 20,000 people were intercepted and imprisoned in "sports centres" (read into this term, "centres of detention" (16) or "concentration camps").

According to this newspaper, Spain is the country in Europe with the third largest number of illegal aliens ("illegal," "irregulars," "refugees," "displaced people," etc.).

6. *A new enemy to combat: the figure of the "illegal immigrant"*

«A general discussion began. The strange part is that the possibility that I was a Dinosaur was not taken into account. The blame which was heaped on me was that I was Different, a Foreigner, and therefore, suspicious. And, the point which was being debated was to what degree my presence increased the risk of an eventual return of the Dinosaurs.» (Italo Calvino. *Memoirs of the world and other Cosmicomics*. Madrid: Siruela, 1994, p. 76.)

Many of the analysed factors, summed up, damage the immediate integration of migrants into the general context of Spanish society and, here and there, favour the explosion of social conflicts. Some racially violent incidents are being noticed, such as the one that occurred at the start of 1999 in Premià de Mar, a town north of Barcelona. Close to 100 skinheads turned up to march against immigration. These skinheads came from various Spanish and German cities, brought together by the neo-nazi pages on the Internet. There is also a more worrying incident, which took place in February of the same year in El Ejido, in the province of Almeria. As a consequence of the alleged murder of a woman at the hands of a «Moroccan undergoing psychiatric treatment,» a wave of uncontrolled, xenophobic violence, that did not appear to be a completely spontaneous reaction, was unleashed against immigrants principally of Moroccan origin. The result was: 58 wounded, immigrant houses burnt, *Chabola* neighbourhoods completely destroyed, persecutions and the lynching of immigrants, as well as other racist-based actions. The police acted in a delayed and passive fashion. A good number of the Moroccan immigrants in the region fled, fearing the threats and attacks (in the style of the Ku Klux Klan), which were aimed at them.

«Some fled to the mountains, where they keep guard all night long, afraid that groups will arrive with shotguns and sticks,» explained Mohamed Beyuki, of the Association of Moroccan Workers and Immigrants in Spain (AMWIS), referring to the true witch hunt against the "Moors," which began that Sunday in February.

They say that discrimination and racism are the children of fear and ignorance. The rise in xenophobia against immigrants in Spain is also the result of the lack of historical memory of its people, in addition to causes of socio-economic, cultural and political nature. It is sufficient to recall that (not counting the invasion of the American continent and the Colonial period) between 1840 and 1924 alone, 4.5 million Spaniards arrived in America, fleeing the poverty and hunger that plagued a good part of the old continent. In addition, between the years 1950 and 1975, some 2 million Spaniards emigrated to more industrialised countries in Europe, above all, to escape Franco's dictatorship, and also due to the little chance they had of bettering the quality of life back then.

Once again Europe appears on the threshold of fascism. "Skinheads" attack immigrants in Germany, England, Holland, and Spain (17), but the renewed fascism does not always wear a shaven head, nor does it always cover its body with tattooed swastikas. And even so, this does not cease to be a sinister reality (18).

With a modern mask, the fascist right has taken on neo-liberal theology with amazing ease (resulting in "neo-liberal fascism"), insisting in its electoral campaigns on themes of public security and employment, and warning against the immigrant "threat" (19).

Immigration as a socio-historical phenomenon is intimately related to the processes and situations described above. In the various spheres of society an infinite number of incidents of exclusion, complaints, marginalisation, and censorship are put into practice (20) for individuals, who due to their "otherness," or being different, strangers, foreigners, etc., become "Judas goats," used to justify, reproduce, and reinforce a particular social order.

Part II

1. How to approach a study on health and immigration in the studied context through an investigation guided by a theoretical framework-the methodology of Medical Anthropology

One of the objectives I have pursued within this current investigation has been to contribute to the knowledge of a concrete process, that of health, illness, and health care within a specific group, the Senegalese and the Gambian immigrants in Catalonia.

In what manner are the notions of health and illness formed among the Senegalese and Gambian immigrants? What "values" do they assign to health, the situations of "getting ill" and their connotations? In what ways do they respond to the complaints, uneasiness, and suffering that they experience? How do the Senegalese and Gambian immigrants perceive health, illness, and their care (although, as in all societies, there are many answers in the self-care domestic and micro-group circles)? In what way do these latter representations and biomedical practices differ from essential health care, and what elements do they incorporate into it? Will we be able to find and differentiate between types of "suffering of origin" and types of "suffering founded in the context of the receiving society"? Which of them and how many of them can be codified, interpreted, diagnosed, and cared for (and in what manner) by Spanish doctors? And will they be accepted, perceived of as illnesses, incorporated into their own medical knowledge?

In spite of the fact that Gambia and Senegal are different countries, Sene-Gambia can be considered a single unit of analysis. Definition of the area of Sene-Gambia, as a geographic region (or "geographic unit"), can stand up to such factors as space, population, and environmental conditions, among other things. This natural region also coincides with an ethno-linguistic area, which shares historical origins, cultures and nomadic people: the *peul*, *fula*, and *tekrur* (*tucolor*). In addition, they have the old, Medieval empires in common: from Mali (the *Mandingas*) and from Ghana (the *Saraholes*). The *wolof*, *djolas*, *akus*, *manjakos*, *bambaras*, and the fishing villages of the *serer* also live together in the region (Kaplan, 1998).

This does not signify that the Sene-Gambians approach a static unity. On the contrary, I will try to analyse them from a similar point of departure in their migratory processes, which share a certain way of organising their networks and migratory lines. These reproduce, somehow, a certain community of origin "lifestyle," while the strategies for insertion into the receiving society change and both collectives adapt to the context in distinct manners (through different jobs, and as a function of their specifications). For example, most immigrant Senegalese reside in Barcelona, because there is work available in street sales, an activity which a good number of them were "already practising before their emigration". Those who dedicate themselves to street sales usually stay in Barcelona for a while and then go to the coast. They stay there, preferably, from summer to Christmas (when they sell the most); later, they go back to Senegal for no less than four months at a time, in order to be with their families, and then they return to Spain again.

The Gambians, on the other hand, look for wage-earning work, with more secure and permanent contracts, which will allow them and their families to settle in towns with diverse, productive activities (construction, agriculture, etc.). They settle principally in the Maresme and in the province of Girona, where they represent a high percentage of the immigrant population.

It is necessary to point out that Sene-Gambian migration abroad is mostly Muslim (as well as being asymmetric in terms of type), since the role of the emigrant within the society of origin has traditionally corresponded to the man (Kaplan, 1991). In this sense, the adult population of Kaplan's study (1998) is mostly male – almost 70%. This confirms for the author

> «a characteristic, migratory trajectory in sub-Saharan Western Africa. The men emigrate alone, and once they reach a certain work stability, both legal and residential, allowing them to send money back to their countries of origin (while still paying the expenses of moving, housing, and maintenance at their destination), the regrouping of the family can begin.» (p. 99).

Kaplan (1988) started off by

> «considering Girona to be a province which fulfils certain, positive and fundamental conditions that favour the establishment of a migrant population, along with its relationships with distinct institutions and with the same autochthonous population ... These economic and institutional variables are taken into account, as are others such as migratory tradition, civil society etc.» (p. 81).

In the first approach to the fieldwork, I will analyse this valuation, keeping in mind, as one of the relevant variables, the increase in racist and xenophobic incidents which have occurred in the last two years in some of the towns in the province. The change in location, by Kaplan, from the Maresme to Salt, with the objective of increasing the representation of the resident collective in this new site (121 people), is relevant to my research. Through the European programme, "Project ECOBAZ: Bazaar Economy in the Euro-Mediterranean Metropolis," in which I have been an investigator for two years, I began to work with Senegalese immigrants who earned their living from street sales in an informal underground economy within the city of Barcelona. After the first approaches in the field, and once I had begun to investigate the area of their processes of heath, illness, and health care practices, I was able to confirm the difficulty of analysing those aspects which were related to their mechanisms of self-care. Within their new context they did not group themselves in domestic family units as they did in their places of origin. For this reason, and with the intention of improving the analysis, I made the area of study broader, including the Gambian families which inhabited the province of Girona, especially those living in Salt.

The characteristics that support the representation in Salt for Kaplan (1998) are:

- «The presence of domestic units comprised of men only and of families;
- The diversity in the areas of origin of the Sene-Gambians: both rural and urban;

- The specific ethnic groups to which the majority belong (*Mandingas*, *fulas*, and *saraholes*);
- The different years of arrival in Spain; and,
- The variety of work activities which they perform (agriculture, services, construction, etc.)» (p. 82).

In addition to the characteristics listed above, the conditions in which the Sene-Gambian population access the local health services are of vital importance to this study. The technical and the human characteristics of the health care personnel (with respect to the construction of medical relationships between patients or users) are also extremely important. These conditions are vital in determining Salt to be an appropriate unit of observation.

2. Starting points or assumptions of the investigation

A) Logic, rationality, and the dynamic of health, illness and health care processes must be looked for within the system of relationships that shapes them (and not only in the players themselves and the information they may hold).

B) Any system of medical attention (no matter how magic it may seem) not only possesses techniques, but also efficient ways of dealing with health problems. Moreover, any system of medical attention contains a series of elements that carry within them a particular concept of the world (it could be said more simply: of socio-cultural values) which give it structure.

C) The micro-group or the studied subjects possess organised knowledge, either conscious or unconscious, regarding the processes of health, illness, and health care. At the same time, the social groups practice syntheses, perhaps a series of healing and preventative beliefs and knowledge, with respect to illnesses, suffering, and/or the unfortunate problems that tend to worry them. These practices are dynamic and are transformed and combined along with other practices which are modified and which then tend to disappear (Menéndez, 1987: 31). This is significant in all historical societies and human groups.

D) All societies, through the subjects that comprise them, create epidemiological schemes within the population for dealing with the principal health problems, which affect them. This product is necessary to face these ailments, which, along with death, are of great importance to any group. They are so important that representations and practices are constructed around them (these vary from group to group).

E) The appearance of an organic anomaly in one of the members of the family group is "objectified" (made symbolic, classified, and categorised) from an ethical and moral perspective in order to becomes a health matter. The symptoms of the problems which arise in the biological order are "interpreted" through a "descriptive order" (symbolic), which has been adopted as the representation of the family, community, and socio-cultural order. This explains why not every organic anomaly or complaint of a subject (e.g., an immigrant) is perceived to be so by the hegemonic culture, as well as the inverse. Why the culture perceives to be an organic anomaly (and categorised to be an "illness") is not necessarily what it appears to be.

3. Some theoretical and conceptual elements

In the first place, it is important to point out how important the existing connections between life conditions are in this investigation (social, economic, political, etc.). They characterise the immigrant subjects within the context of a receiving society as well as their situation regarding health, illness, and health care processes.

Various authors present the idea of a relationship between health, illness, life conditions, and social reproduction (Almeida Filho, 1989, Laurell, 1986, and others). E. Menéndez (1994) is the author who gives us a definition which best fits the proposed analysis. For this author, the health, illness, and health care processes constitute a given, which structurally operates throughout the society, as well as in all of the social groups that make it up. Illness, complaints, and suffering health problems are part of a social process within which subjectivity is collectively established. That is to say that the subject, from birth, makes up and sets up this framework, based on the process mentioned above.

The "social answer" to the incidence of illness, suffering, and health complaints constitutes an "everyday and recurring" matter, which represents a necessary structure for the reproduction of any society. That is to say that health complaints and their resolutions are structural processes in every system and every social group. These not only generate representations and practices, but also structure the specific knowledge necessary in order to treat these health problems.

For the final part of this project, and in keeping with Menéndez (1983), it is ideal to approach the problem of health, illness, and the health care processes of the studied subjects from one of the analytical models that this author proposes: *The Self-care Model*. The self-care model corresponds to the realm of first aid, the first level of real care given within the micro-groups (domestic, occupational, etc.). Its structure is based on healing and preventative functions and, above all, carries out its socio-economic functions. According to Menéndez, the basic characteristics that define the self-care model are always pragmatic efficiency, the idea of health as a user good, and the tendency to perceive the illness as a kind of merchandise. Also listed are the structure of symmetric and homogeneous participation, group and community legitimacy, understanding based on experience, the tendency towards the micro-group's appropriation of the medical practices, the tendency towards synthesis, and the tendency to assume subordination, induced with respect to the other models.

Self-care is always based on the frequency, recurrence, and continuity of illness, suffering, and health complaints or problems. These affect the members of the primary groups differently from the domestic units, and these groups need to take immediate action, providing a solution as soon as possible (Menéndez, 1983). In any case these episodes, whether acute or chronic, are a constituent part of everyday life.

Self-care permeates the structure of all society and it is the first real level of health care. This is based on diagnosis and preventative health care, which may be provided by the person himself, or by the people belonging to his immediate family group (and/or to different community groups). For this type of care, a professional healer does not directly intervene (among other reasons, this is why they say that they are dealing with non-professional health care). In Menéndez's words, "self-care assumes the 'conscious action' of not doing anything, while on the way to finding a cure. This can include the use of a system of a particular grade of complexity" (Menéndez, 1983). Therefore, it constitutes a social practice, structured and direct (and/or indirect), to assure biological and social reproduction at the level of the domestic, family units. If self-care is a structure that cannot really be eliminated, at least it can be limited (21). In this sense, it is necessary to recall that the Hegemonic Medical Model (22) needs to impose its dominance. It needs to be *the* scientific and ideological reference, and to be considered the legitimate model for actions to be taken against illness (even when it can only be used by a relatively small part of the population).

Health self-care and self-attention allude to the personal or domestic dimension, where the most elemental care is administered for the promotion and repair of health. They also serve to prevent illness, which makes them the nucleus of any system. According to the distinct evaluations made, more than three quarters of reported symptoms are resolved in the home (Zola, 1966). In any case, self-care and attention make up a number of irreducible instances which are always present, not only in any process of assistance, but also in everyday life, which is developed at the domestic family level.

Notes

(1) The relational stance makes explicit the recognition that every human act, such as the processes of health, illness, and heath care, operates within a framework of social relationships, though beyond the valuation of these. These relationships assume transactions and are always being modified. The processes of hegemony/sub-alternation among the models discover in the term, "transactions," the concept with which the group of relationships, which are potentially operating, can be described and explained.

(2) To demythologise and reveal non-evident or underlying social facts tends to question from the start the instituted order. Questioning a person or studying a specific socio-cultural group from its specific and subjective vision, instead of assuming it to be homogeneous and able to be generalised, contributes to its resistance in the face of the neo-liberal, dominant culture's desire to make it uniform.

(3) The researcher should make explicit what he/she knows (at the start of an investigation) regarding the knowledge that the subjects possess; this is necessary because the investigation always involves a relationship between the individual and the others.

(4) Qualitative research is comprised of a process which goes from abstract theory to concrete facts in order to later reformulate the theory (as the dialectic proposes). However, it does not hesitate to return to the field and then to academia, as often as necessary, in order to fuel this process.

(5) For these alternative paradigms, the social reality is a construct and not something natural or logically given. However, other forms of societal organisation are accepted (and also other ways of understanding the world and living life). Reality is holistic in nature and cannot be grasped in fragmented form, even when the sum of its parts may explain everything.

(6) The "trajectories or life stories" which are used in this investigation are a suitable resource for the information that they provide about the past and, above all, for the importance which this information plays in the analysis of the reality of the studied subjects. In this respect, Miles and Crush (1993) hold that personal narratives should be looked at and interpreted as interactive texts, since they make up a product from a complex series of interactions, among themselves (as researchers) and among the researchers and the population being studied. The interactive text is created through the dialogue between the interviewer and the person being interviewed. However, the researcher, in his task of ordering and making the narration coherent, constructs, in one way, his own interpretation of the interview. This is where the matter of "intermediary space" surfaces, the same as the researcher's stance, at the time of choosing which of his/her subjects interviewed brings most facts and valid information to the objectives of his/her project.

(7) Romaní sets apart, as one of the faces of the "process of modernization" (that has existed in Spain since the sixties) what is defined as processes for the "normalization" of the social life. «...Some of these basic elements will be, at an economic level, that of consumption, and at an ideological level, it will be to advocate the existence of a generalized consensus around certain basic societal values. All of this is accomplished through several mechanisms of social control, among which there stands out the importance, which is acquired through means of social communication, as elements of permanent socialization.» (Romaní, 1999: 93)

(8) In this way, a relatively new phenomenon and in Spain still a numerical a minority (such as that of a determined type of foreign migration) forms part of several processes. These processes, influenced by social visibility and the intervention of formal, social control agencies (police and legislation, principally), end up producing social, marginalisation dynamics.

(9) Here, "migratory lines" is understood to be the transference of information and material support offered by family, friends, or countrymen to the potential migrants, so that they can decide, or eventually solidify plans for their journey. The lines make the process of departure and arrival easier. They may, in part, finance the trip, arrange documentation, employment, and acquire housing. They are also a source of communication for economic, social, and political changes that are produced within the receiving society and which could affect the potential migrants. As generally the arrival into a receiving society is downplayed, the migratory lines structure themselves on the strong presence of the ethnic group. (This presence is cultural, in the arrival place, which sometimes can limit the process of upward social mobility, or simply offer fewer possibilities for employment to those who have recently arrived.) (Goldberg and Pedone, 2000.)

(10) Through historical analysis I consider this conceptual distinction to be valid and relevant, – the politics of the development of capitalism. In particular, I cite the conditions of the international division of labour, in which there is an established dichotomy between countries, which are "industrialized, developed, and central" and those which are "not industrialized, in development, and peripheral." On the other hand, I do not believe the classification, frequently made between "rich" and "poor" countries, to be valid or real. Let's take the cases of Argentina and Brazil, two countries rich in varied natural resources (much richer than Switzerland and Austria, for example). The use of these natural resources is carried out in function of foreign interests, as much as for other countries as for multinational companies, due to the dependent or neo-colonial character of their governments.

Opposing the new proclaimed metaphors from the hegemonic discourse, García Canclini (1999) revives analytical categories, such as First/Third World, central/peripheral, etc. He outlines the contradictions generated in the "global cities," which should articulate both the local and the national in the light of globalisation.

(11) I don't refer here to the term, "Third World," frequently used in central countries and associated with a large region, often presented as homogeneous, and characterized by structural poverty and economic, political, social, and cultural under-development. As for the term, "Third World," and the cultural heterogeneity of the continents, countries, and regions which shape it, see A. Appadurai (1988) and G. Spivak and R.Guha (1998).

(12) The number of people who would be within the jurisdiction of the High Commission for Refugees of the United Nations (ACNOR) has risen disproportionately from a little more than two million in 1975 to more than twenty-seven million in 1995. It is impossible, then, to imagine how many people would qualify at present.

At the State level in Spain, the facts are confirmed in the reports put out by the Permanent Observatory on Immigration in Spain, but they are far from the reality described by the immigrants themselves, and the daily reality that can be seen on the street.

(13) Collective IOE (1992); Stolcke, V. (1994); Malgesini, G. (1996); Ramírez Goicoechea (1996); Bergalli, V. (1997); and, Martínez, Veiga (1997), among others.

(14) Relating to the theme of expulsions, it is worth pointing out that some European countries have laws which are complementary to their laws on immigration, and which reinforce their restrictive character. For example, in France, in addition to the sanction of expulsion, the Interdiction of the French Territory (IFT) is frequently attached. This consists of prohibiting entrance into this country for at least 10 years, when not definitive. The IFT dates back to the law of 12/31/70, and was related to narcotics infractions. However, throughout successive legislative reforms, its field of application has gotten considerably broader. The "Easter Law" of 1993 opened the way for its more extended application, for which only " a grave threat to public order" would be sufficient for this interdiction to be put into practice. There exist numerous cases of IFT expulsions (known in France as the "double penalty"), where the citizen, of French origin, has been expulsed to a country, where his parents were born and where he/she has never been (Faure, 1999). Neverthe-

less, there are other problems, such as the case of the sub-Saharans, for example, whose expulsion is truly impossible, since their countries of origin do not recognize them as citizens.

(15) Source: the Delegation of the Government on Foreigners and Immigration. (However, the present figures are sure to be worse, at least from the immigrants' point of view they are.)

(16) The Detention Centres for Foreigners in Spain (DCFs) were created by the Organic Law (7/1985). Later, no concrete arrangement was approved to regulate this specific situation. Due to the failure to carry out the regulatory mandate, there are no homogeneous criteria about how these centres should function, and they are still under the sole direction of each individual director. Their geographic distribution is completely unpredictable. Today, there are six centres in Spain (actually, six is the official number which has been made available to the public). They are to be found in Madrid, Malaga, Barcelona, Valencia, Murcia, and Las Palmas in the Canary Islands. The inmates are assigned to a centre independently of where they were detained, and where they may have their network of relatives and friends. Attorneys visit clients during a timetable which is even more restricted than in a prison, and they are always conducted under the visual control of the police. Only visits limited to a few minutes are permitted, and *vis á vis* do not exist. The maximum time limit of 40 days, established under the Law, when expulsion papers are to be processed, frequently expires. Also, there are immigrants whose nationality has not been able to be determined and whose country of origin does not recognize him/her as a citizen (this is the case with many citizens from African and sub-Saharan countries). These immigrants have often suffered successive internment, a situation that is legally prohibited. For more information regarding the DCFs in Spain, consult the following reports: 1) S.O.S. Racism (1998) *The Annual Report 1999: Regarding Racism in the Spanish State*. Barcelona: Icaria; 2) Stoop, Chris (1999) *'The Others': Deportation of the 'Without Papers' in Europe*. Barcelona: Bellaterra, among others.

(17) The leaders of these groups of skin-headed neo-nazis and their most active members belong primarily to the middle and upper classes, that is to say, they come from perfectly integrated families in European society. However, in recruiting, they have extended to peripheral neighbourhoods and sectors, hard-hit by the economic crisis and the instability of job security (as is the case in Spain). On the other hand, while for the European Parliament there are close to 1,300 racist and neo-nazi groups throughout Europe, which commit more than 500 aggressions daily, for the Spanish police, the offenders are simply individuals, who do not belong to any organization. However, there do exist organised, neo-nazi groups in 37% of Spain's cities with more than 25,000 inhabitants, and they are concentrated primarily in Madrid, Barcelona, and Valencia (Source: Sánchez Soler, Mariano. *Decline in Fascism*. Madrid: Grupo Zeta, 1998).

(18) All of the European fascists, like their counterparts in the U.S. and Latin America, insist on classifying society at face value, with the respective migrations for different countries listed as a "social problem" and thus categorising the immigrants based on their differences ("Blacks," "Latinos," "Spics," "Moors," etc.). In their time, the Nazis, for example, only had to warn that the existence of the Jews in the Third Reich was a "social problem" and this act of identification and stigmatisation resulted in the beginning of the end. In the same way, the Israeli army and police fire upon Palestinian civilians, because they have been labelled a "problem" for the security of the terrorist Israeli State. These were exactly the same tactics used by the military (lamentably, for such examples are abundant and continue to flourish on the path of terror and death), which executed terrorism for the State, under the guise of dictatorships in Latin America during the seventies and eighties. In all cases, these actions were financed, directed and imposed by the United States of America (this period's successor to the Nazis). Here, the identification of the "social problem" was the "Red Communist Enemy," which brought about the disappearance, assassination, torture, baby robbery and countless other crimes against humanity, enacted against thousands of people all over that continent.

(19) Moral language is formed and developed through social practice. In ideological form, in conjunction with censorship, it is primarily expressed through the process of creating stereotypes. (This is occurring in the case of the immigrants without papers in Spain: they change, subvert, and question ideological, political, economic, religious, and cultural concepts, regarding the dominant neoliberal capitalism in today's neo-Franco Spain of the Euro.) It is important to note the concrete historical significance of censorship, for example, with regards to the illegal aliens in Spain.

(20) Censorship has a clearly moral and political character. Given that it symbolically represents "correction and merit" when faced with "error and danger," it is at the same time a justification for repressive actions against violators. It is also an attempt to educate people in "desirable" habits and ways of life (one could also say, a "determined lifestyle"). The fact that it is often linked to moral principles gives it political potential, with regards to the fight for hegemony. "Moors," "Blacks," "Spics," "Illegal Aliens," and "Terrorists" (in the Spanish context) represent social censorship, which has the potential to mobilise the forces of order (that is, order and morale) against determined sectors of the population. Order, morale, values, lifestyle, and the concept of the world made up of dominant groups, tend to turn into institutionalized censorship within the discussions and practices of the State and its ideological tools (the media, courts, schools, etc.). Censorship takes on the general character of being internalized by people (Sumner, C., 1999).

(21) This is one of the points I analyse with respect to the subjects of the study and their arrival in this country.

(22) For its definition and development, see Menéndez (1989).

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ETHNOGRAPHY
WITH A PURPOSE

AM
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Introduction

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Anthropologists working at home face a somewhat different and often greater responsibility than anthropologists working elsewhere. Sooner or later their work is going to be confronted with the reality of the entourage. Even though the legitimate purpose of a researcher's endeavour should be to enhance knowledge and one should aim for knowledge of universal value, the pressure of everyday life and the closeness to the subject of research will determine actions, reactions, questions and answers, responses sometimes intended but occasionally unexpected.

The following six contributions are very good examples of ethnographies carried out close to home, even if "home" turns out to be for a long while some Brazilian slums. They all aim to produce information about reality which may eventually lead to changes in that reality.

This is not an unrestricted call for "applied" research in Anthropology as the sole purpose our elders warned us against, when colonial governments attempted to gain anthropologists' complicity in carrying out their imperialistic intentions, but rather the verification that the closer to home researchers are, the more easily will the results of their work carry some weight in the reality of their milieu.

Even more, to investigate, to observe activities, behaviours, or decision making processes in an attempt to change reality for the better, is bound to bring about changes both in the processes and the reality themselves. Let us not forget the uncertainty principle described by Heisenberg for the quantum theory in Physics but which is, nonetheless, certainly true for Anthropology, at least from our viewpoint. This adds further uncertainty to the discourse.

Medical Anthropology at Home for the time being, and apparently in this Second Meeting, is becoming mainly European Medical Anthropology. The very much appreciated contributions from such faraway points in the world as Quebec, Chile and South Africa, in this particular conference are, in essence, “European” since the context of their biomedical practice is similar to ours. Besides, the contributions are fine examples of “medical anthropology at home”. It is therefore normal that the contributions include as a frame of reference the realities of the European health care system imbedded in the “Welfare State”.

Whether evaluating the changing patterns of distributing the burden of care for the sick, the emerging responsibilities of others besides the medical organisations, or the ritualisation of practices, the anthropologist is bound to face not only people as subjects, but the organisations themselves as subjects. This is where policies are implemented and politics are proposed. And all along the line the ethical implications of the endeavour are considered.

As has been pointed out, the task of the anthropologist in this environment is more that of an actuary, one notch higher than just a registrar since, when acting with a purpose, the emphasis is on efficiency. And in this situation efficiency is not just the cost-efficiency of the world of insurance, but real efficiency in terms of better care, better assistance for the sick.

It is then that the ethical commitment becomes real.

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Self-help, reciprocity and redistribution in a changing Welfare State

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Introduction

Self-help groups and especially new models of associations constituted by people suffering from various health problems, largely chronic diseases, have been growing in number and size during the last ten years in Spain. This phenomenon follows a similar path to other countries, but must be considered within the particular developments of Spanish social policy and the historical process of the changing relations between the state, health services and citizens. These are also related, beyond the health field, to a wider and deeper historical and cultural background. Though the subject of this paper is part and parcel of a more general stream, at least in Western societies, its specific use at the local level is the only one that can be observed and read as a real fact, closer than abstract definitions of reality which are perhaps more useful in explaining wider global developments.

In the Spanish case there is considerable confusion between genuine self-help groups and associations providing services or working to vindicate rights. Although both models are necessary for the affected people and are mainly created by the people themselves, they properly represent different forms of help relations with different meanings for their members. In order to analyse this phenomenon, I shall focus my argument on some theoretical key points, founded on classical concepts in Economic Anthropology. By analysing the roles and the workings of self-help groups and associations, we see how *reciprocity* and *redistribution* are very useful concepts to help us understand what these groups are, and the place that they occupy in these times when the welfare state paradigm is changing.

The various forms of reciprocity and redistribution are conceptual constructions proceeding from research on "primitive" or "traditional" societies. Although redistribution has become a core concept in social policy in our historical context, reciprocity is in danger of becoming an abstract ideal type and it is frequently neglected because it is considered to be marginal in urban-industrial societies. This marginal role is, to say the least, highly controversial, because reciprocity even exists between individuals and groups at the top of financial and political organisations. Anyway, it is necessary here to assert the cardinal role of reciprocity in relations involving help and care. Even if we help somebody who is unknown to us, perhaps somebody we will never meet again, we do so because we believe in a generic reciprocity which ideally would entail all human beings in an invisible web of real or potential mutual services. The awareness of our own fragility leads us to acknowledge that we need the help of others at some moments. In some sense, moral economy is more economic than moral, although ideology usually leads to confusion; therefore, we must always deal in applied work.

The main aim of this paper is to propose a model for analysing self-help groups and associations according to the prevailing role of reciprocity or redistribution in them. The prevailing drifts towards reciprocity or towards redistribution are two poles of reference, which define different practices in help and social support. The first one is more inclined towards self-help among peers, following the most accepted model of self-help groups. The second one is more involved in larger redistribution systems and is dealt with more by other kinds of associations and non-profit organisations. Their functions, organisational patterns, activities and, above all, meanings for members and their consequences in rebuilding the self-identity of affected people are very different in each case.

As well as its theoretical interest and the need to check the validity of these classic anthropological concepts in our context, the research has an underlying applied aim. After I had discovered self-help groups, I used a proposal by Menéndez (1984), which defined mutual help as a concrete form of reciprocity, in an attempt to provide an anthropological explanation for them. I'll come back to this theoretical approach later. With these still very rudimentary theoretical tools I became involved in courses, conferences and symposia about the subject, sometimes addressed to health professionals, sometimes to associative promoters and sometimes to both categories. Those situations were very satisfactory because people involved in practice rarely ask anthropologists about theory. By discussing the different ways in which reciprocity works and how new meanings about the experience of illness are symbolically rebuilt in self-help, the people involved can understand their practices better and perhaps improve them. Finding a promising field that linked theoretical developments and applied work, and also feeling useful in it, was like a dream. But the dream turned into a nightmare when recently the confusion noted above took root in self-help organisations in Spain. Strengthening the theoretical approach became a compelling objective not only for the researcher's theoretical aims, but also for the people who were experiences the practical consequences of this confusion. Thus, the nightmare became a powerful stimulus.

A history of confusion and discourses on dependency

Here it is impossible to avoid explaining how the confusion between self-help groups and other kinds of associations appeared and was detected. In the late eighties and early nineties, when I first became aware of self-help groups, they usually matched the standard definitions imported from the Anglo-Saxon world. They were small groups, many of which were very unstable, characterised by horizontality in their internal relationships. The words *self-help* and *mutual aid* were used as synonyms (1). But at the time when confusion openly appeared, in the middle nineties, the people involved in these organisations begin to use the terms *group* and *association* indiscriminately, but progressively employing the latter. When I asked why they preferred the word *association*, some people answered that they considered both terms to be synonymous, but others, especially leaders and promoters, said that *association* was more useful, because *association* means an organisation with a legal statute giving more trust to people. «*To be an association is more serious*», one of them told me. Meanwhile, *self-help* was progressively preferred to *mutual aid*. If this last label was mainly, but not always, restricted to the most classic small groups, *self-help* covered a wide spectrum of associations constituted by affected people. This situation persists even now, and is further complicated by the frequent use of *self-help* to refer to care which individuals or families give to themselves, especially with preventive aims, instead of the more precise *self-care* (2). The new fashion of the so-called *inspirational* literature (literally "self-help books" in Spain), added further imprecision to the usual meanings of *self-help*.

My first detection of an incipient confusion was therefore a semantic one. It would not have been so important if it should had remained in the field of semantics, but at the same time deeper changes took place in practice, though they were well hidden at first. Some self-help groups realised that they needed to diversify their activities if they were to face new aims that members felt to be very important because of their own practice. These aims consisted of extending the news of the group to new people, having permanent places for meetings, searching for funding, getting more medical, legal and social information, demanding rights or specific services from authorities, sensitising society about their problems and so on. All this involved at least two different levels of action, both of which were perceived as absolutely complementary and necessary alike: self-help itself, on the one hand, and work in organisations, on the other. In that almost underground process, the way these different tasks were done in the practical life of groups was very revealing. Improvisation and voluntarism were the common rules. Very often, times and tasks were mixed in their meetings. Mutual support and help shared the same session with accountancy tasks, writing letters and putting them in envelopes, for instance. Everybody did everything, all the time. Thus, in this mixture of times and tasks, group members did not realise that mutual aid had been dumped in favour of organisation and a greater capacity for social and political influence. The search for this latter benefit – which is, of course, very important in itself – took a lot of time and work away from the specific aims of self-help (facing a shared problem, giving and receiving material and emotional help, learning new skills together, reinforcing autonomy and redefining members' own identity through sharing experiences, knowledge, strength and hope in the group) (Katz, 1981; Borkman, 1991; Roca, Villalbí, 1991).

A wide range of organisations are defined under the label *self-help* more through what they are not than by what they really are. Self-help has become a term used to name all organisations created to group people affected by a particular health problem (sometimes one's own illness, sometimes sickness affecting close relatives). Concurrent with that process of change from the original self-help groups to more complex associations, there also appeared a lot of new organisations, which did not experience the first step as mutual aid groups. This is an important fact, and it reflects a loss of autonomy in the initiative of affected people. Professionals, especially doctors and psychologists, increasingly intervened in creating groups and associations or supporting them from inside, sometimes also managing and leading them although they were not affected people. Confusion between self-help groups and support or therapy groups became an element present in our landscape. Although self-help groups may be an attractive alternative to medicalization, and they became a new object for professional intervention. It is important to remember here that the lack of hierarchical structure and professional intervention, except when the group specifically asks for it, are basic elements in all accepted definitions of genuine self-help groups.

At the same time that the above changes happened, another decisive factor came into play. In health and social policies all official administrations agree more or less on the principle of devolving part of their responsibilities for care and assistance to the people. *Civil Society* became a holy concept for social policy makers swimming in the stream of neo-liberalism hegemonic postulates and demanding profound reform of the Welfare State. Promoting associations became an explicit and important objective for them in order to discharge state administration of some direct implications in assistance. NGOs and associations located in the so-called *third sector* were considered more efficient and cheaper because they had less bureaucratic burden and, perhaps, because they were more subjectively involved in solving problems. The phrase *«to be an association is more serious»* (than to be "only" a self-help group), takes on a new significance in this context. Public funding is more attainable for associations since the administrations are also interested in promoting health associations. Of course, a necessary condition for applying for funds is that the association must be officially registered and has a formally constituted executive board. This also means that the association leaders become necessary interlocutors for the state agencies looking to delegate the management of services.

In Spain, however, the welfare state is still incipient and weak and it still supplies few services compared to average European standards. Therefore, in seeking care and assistance, the expectations of the majority should be the same for public agencies and services as for civil associations or NGOs. Though health services are the most developed branch of the Spanish welfare system, they are quite deficient for people needing special attention. For many affected people, new associations are simply perceived as providing the same services as public institutions, and they perceive themselves as users or clients according to patterns learned in public health services. The fact is – and this is what makes the difference – that associations offer services not provided, or poorly provided, by the public health system. Their own empowerment and full autonomy are not considered as objectives to be fulfilled by this group of affected people. So, although people join new associations voluntarily, the experiences and expectations of these people are perhaps not the same as those stated by people joining self-help groups.

Growing professional intervention and the place reserved for associations in the adjustment of the Welfare State must both refer to the same historical and cultural background, although at first sight they are different things. And they must also relate to attitudes such as those of dependant users on the one hand, or of leading professionals on the other. It is very important to remember here that self-help groups are an imported alternative in our country. Health professionals mainly introduced them and social workers that had found out about this kind of experience in other countries, directly or through literature. Usually, they respected the rule about accompanying the group in their first steps and afterwards promoting its independent life. These professionals were generally critical towards dependency in professional-patient relationships or they were fully convinced of the usefulness of self-help groups for patients' empowerment or as tools for dealing with problems where Medicine usually failed. These experienced professionals also found that not everybody would agree to join a self-help group. In fact, the most successful experiences were based on spontaneous groups when people began to meet in hospital services, unaware of what a self-help group was. But all these cases involved only a small minority of the potential membership. This kind of process still happens now, but it is conditioned by the attraction of formal associations. Although some associations are based on foreign models, they are usually based on a particular development rooted in Spanish conditions, with some variations due to historical, cultural and social diversity in different parts of Spain.

I want to emphasise that importing a structure from abroad is very different from importing meanings and ways of working. *Self-help*, as well as mutual aid groups, is an imported concept. If the English meanings of *self* are not easy to translate in a full sense, their applications are also prone to confusion. Something similar happens with the concept *autonomy,* so closely related to self-help. In the way *autonomy* is used here in Medicine, Psychology or Social Work, it is also a concept imported from another cultural universe. It is closely related to ideas about self-responsibility that are closely linked to Protestant concepts of individual and social behaviour. However, autonomy does not have a place in major everyday thought in societies with a Catholic background, where constituted help relations and related institutions are based on strong ties of dependency(3). Probably the celebrated individualism of Latin and Mediterranean people is only a stereotype, or it is reserved for public life, as a form of distrust in institutions. In current times, only people involved in the most competitive fields in the labour market embody anything like the concept of autonomy in everyday life, but health professions have done it for many years (at least, with reference to their patients). Although at first autonomy referred to physical capabilities, it was soon extended to psychological, social and moral meanings. Of course, this was the result of professional discourses from the most influential countries. In spite of this, many health professionals, especially doctors, are very suspicious of all forms of self-care, including mutual aid groups or any sort of practices which they do not control. Intervention through formal associations, where a hierarchical relationship between professionals and patients is maintained, is more reassuring for these professionals.

We should point out that reinforcing the autonomy of patients and their relatives is an idea that is consistent with policies looking to "return responsibilities to society" in fields related to assistance and caring. Returning to the central issue, it is possible now to assert that associations providing services which ignore mutual help or back it only on a secondary level, are better rooted in our social and cultural background than genuine self-help groups, at least in the way they are defined by theory. As a member of an association confessed once, *«we prefer to depend on an association belonging to us, but in any case we want to be dependent»*.

At this point I want to underline that the anthropologist must not be involved in technical or militant vindication of a concrete model of "good practice". He/she must only try to understand and explain how and why things happen, and perhaps remark on the benefits and difficulties of each way of working. The right to choose what to do belongs only to the people affected. Perhaps the confusion noted here allows transactions between theory and practice when the former is not adaptable enough to the context in which the latter is working. Conceptual indefinition may also be useful in this sense.

Mutual aid and reciprocity

The first step on the way to confronting the different types of organisations consists of analysing how mutual aid is generated in some models of reciprocity. Afterwards, we'll compare it with structures in which we can find another pattern of reciprocity and where functions of redistribution play a prevalent role. It is also important to relate the quality of the involved reciprocity with the possibilities it can offer in order to redefine the experience of illness in seeking a new "normality".

Here I prefer to use the term *mutual aid*, not only because it is closer to the Spanish *ayuda mutua*, but also because it allows us to avoid the more polysemic *self-help*, which also refers to other ideas like self-care, for instance.

Silverman (1980) said that mutual aid only happens when the person giving help and the person taking it share a history of the same problem. According to Silverman the process lies in mutuality and reciprocity, two terms which are often synonyms, though the second has a more precise and restrictive sense, at least for anthropologists. Many authors agree with Silverman and it is commonly accepted that reciprocity is the kind of relationship which distinguishes mutual aid from other forms of help:

> «The word help is defined as the action of giving a service or collaboration to somebody, or to put the means in order to fulfil something: the term mutual defines the reciprocity between two or more persons.» (Roca, Llauger, 1994: 214)

According to Menéndez (1984: 85), mutual aid groups are a modern variation of self-attention in health (*autoatención en salud* in the Spanish original), which is a structural and universal fact produced in domestic life. This author underlines the cardinal role of reciprocity in self-attention, following theoretical conceptions used by Mauss, Malinowski, Lévi-Strauss and Gouldner, among others, which were first codified by everyday practice. The basic norm of reciprocity asserts that a person is obliged to help whoever has helped him/her before. Menéndez also remarks that symmetrical reciprocity is essential for keeping equal relations between people, but reciprocity can also exist between asymmetrical positions. In this case, mutual aid tends to disappear; making it easier to establish relations based on dependency. Therefore, reciprocity only means mutual aid when it works between equal or equivalent people. Therefore, reciprocity acting as mutual aid needs a horizontal level in relationships which is not necessarily involved in reciprocity by itself (Menéndez, 1984: 91-92).

Following Menéndez's proposal it is possible to define those conditions in reciprocity that allow mutual aid: horizontality between partners and symmetry in things or actions exchanged. But in order to maintain this kind of reciprocity over time, it is necessary take into account a third factor: there should be no time restrictions on returning the help received. To exchange help depends on concrete needs at concrete moments, which are not always foreseeable. In this sense, it is different to exchanging gifts throughout the year on such well-known dates as Christmas or birthdays. In mutual help it is necessary to be able to return the debt with no fixed time limits. This means applying the concept of generalised reciprocity defined by Sahlins (1974)(4). In conclusion, horizontal, symmetrical and generalised reciprocity are the necessary conditions for discriminating reciprocity in mutual aid groups from relations involving giving and receiving help which we can find in other more complex and hierarchically organised associations. In these latter organisations there are help relations too, but the lack of horizontality and symmetry makes them different from mutual aid and favours dependency (5).

The theoretical frame described above has proved to be useful when trying to identify mutual help in empirical research. But these theoretical concepts can sometimes appear in practice as ideal types, formalised in a narrow *etic* approach and in conflict with real facts, which are more complex, polymorphous and fluid than concepts produced by theory. In an *emic* approach we find that reciprocity is an undefined reference, almost always unconscious and stated in a moral way. As is usual in everyday life, reciprocity is mostly perceived when somebody does not conform to its rules. Then, the complaints adjust quite well to the contents of theoretical concepts. Anthropological theories on reciprocity, when used to analyse mutual aid groups, show some weakness when they deal with complex interactions working over time. Theorists in an overly bilateral scheme have conceived definitions of reciprocity, while real interactions are usually multilateral. If we observe how the giving, taking and returning of services unfolds in groups, we can verify that the implicit bookkeeping of these exchanges is not, in fact, a bilateral one. The group as a whole acts as a general receiver, allowing individual members to balance their accounts without necessarily returning services directly to the same people from whom they received help previously. In this sense, *generalised* reciprocity takes another meaning. It can refer not only to the possibility of returning without conditions in time, quantity or quality, as Sahlins defined it, but also to a diffusion of giving and receiving in the group, all the members of which are subject to a common book-keeping. Therefore, members can feel that their actions and relations are altruistic, when in fact they are really following rules of reciprocity, precisely because they do not act in a bilateral way. In a certain sense, the group is like an impersonal redistributor. And because it is impersonal it does not disturb the horizontality and symmetry in relations between the members, avoiding asymmetries which redistribution tends to produce and which will be discussed below in this paper.

Reciprocity in redefinition of illness and self-identity

Beyond the conditions related to the dynamics of exchanges, one of the important keys for understanding why the mentioned forms of reciprocity are necessary in mutual aid groups is the close relation between these forms of reciprocity and the redefinition of the experience of illness and self-identity. This redefinition is important for affected people to be able to adapt themselves to their social world and to overcome the handicaps they suffer. Of course, not everybody succeeds, and some people make use of the group as a shelter which protects them from an adverse external world. Anyway, in a mutual aid group what is abnormal outside is the common rule inside, shared by all members. This gives meaning to the shared history of the same problem, in Silverman's words (see above).

One of the premises for fulfilling the forms of reciprocity that produce mutual aid is to answer questions about the necessary equivalence and symmetry between members in a group. Equivalence is a better term than equality because the members of a group are reall not equal in many respects, but the shared problem and similar experiences can give them the feeling of being equivalent enough. Of course, equality, equivalence and symmetry are ideal concepts which only can be applied in practice through pragmatic transactions. Anyway, the symbolical efficacy of mutual aid lies in factors that depend on a strong perception of equivalence and symmetry. If this perception is to be strengthened, the common problem may need to be emphasised, perhaps more than is apparently necessary. It is more than a question of identity. In this respect, external observers often think that members of groups are too obsessed with their own problems and illness. The well known formula *«My name is John and I'm an alcoholic»*, takes all its ritual meaning from this symbolical context (6).

Maintaining the best equivalence possible involves, of course, a positive identification between the people. The case of associations devoted to degenerative diseases, such as multiple sclerosis for instance, shows how the search for equivalence must be very strict on some occasions. If mutual interactions between people that are at the same stage of this disease prove to be useful, contact with people at a more advanced stage is usually felt to be very negative, a warning of the worst face of their own possible future. The perception of equivalence is broken because the potentially equivalent experiences are not the same at different stages of multiple sclerosis. Symbolic efficacy is then threatened by future fears and doubts are raised about the validity of the efforts that affected people are making to overcome the consequences of their sickness.

Establishing a sufficient degree of equivalence between members is a powerful reason for keeping professionals out. Strong leadership within the group is generally avoided, which is one of its greatest difficulties, while people try to replace the leader figure by other kinds of roles which are assumed to make the group work better (7). But this reason is not enough to keep professionals out. Some professionals are not authoritarian, but in a context of self-help there is something which only the members of the group can do: they can define themselves by giving a shared sense to the group and to the relations within it. If the definer is a non-affected professional, he/she can retain the power, which the act of defining confers by itself. Moreover, defining without sharing the history of the same problem introduces considerable asymmetry into the group, beyond previous asymmetries between "who knows" and "who does not know", so beloved by many professionals. I should also point out that professional empathy is much more limited in practice than the kind of communication that we can observe among people affected by the same problem. For instance, experiences, feelings, perceptions or fears shared by women with mammary cancer can be understood but hardly felt by others. One of these women told me once:

> *«My doctor does not listen to me when I say that I need my husband to caress the scar in my operated breast. But in the group we are always talking about these kinds of wishes...»*

Another woman, before her operation, spoke about a very common question in very common terms:

> *«According to my doctor I must be optimistic and live as if my cancer did not exist, making projects for the future, but I do not feel like it. My sense of future has changed. I'm living as if the future did not exist, but I'm well aware that my cancer does exist. Of course, I can go to a psychologist, but in the worst moments I cannot avoid thinking: 'What are you saying? You do not have a cancer!' (....) My family does not know how to talk to me. They only say: 'Do not think about it'. It's not so easy... They are the ones who really do not want to think about it! You need to live something if you want to really understand it.»*

This subtle difference between professional understanding and sharing feelings also makes the difference between the best professional intervention and mutual aid. People with good experience of mutual aid are keen to remark on this difference and many of them are convinced that nobody can fully understand it from the outside (8).

The group is also a field of symbolical interaction, which produces its own meanings and specific codes. So, the group goes far beyond its instrumental usefulness. Of course, the problem, which leads people to the group, is the first object that needs to be symbolically rebuilt. Moreover specific services or practical learning in each case affected people's need to orientate themselves, when faced with a situation that changed their "normality" and their position in the world around them. All these subjects must be redefined in order to give a new sense to life. In this way, "normality" also needs new definitions, free from all kinds of stigma. The term "temporally valid", employed by some physically handicapped people as a label for 'non-handicapped' people, expresses very well what I am trying to explain here. In a similar sense, the relation between the affected person and her/ his illness can undergo interesting changes. For instance, an asthmatic woman sketches her new relation with the disease in terms of friendship, after she has been re-elaborating it in a mutual aid group:

> «*Asthma is for me like a friend* (in the feminine, the gender that asthma is in Spanish). *She is quite a strange friend and you must know how to treat her.*»

As a good example of this seeking for new meanings of "normality", it is interesting to mention a group of parents whose daughters are anorexic. Because of their experience, members of this group show a radical rejection of professional intervention. In fact, the group has its origin in casual encounters in psychologists' waiting rooms, and even now psychiatrists and psychologists are the main targets of their criticism. They explain how in their former visits to these professionals they felt more and more guilty, increasing the feeling they already had. These parents are very lucid in their denouncing of the diffuse psychological impregnation our society is undergoing. A mother in this group says that she thought, before going to visit a psychologist, that in society there is a very elementary and mistaken understanding of some psychological assertions, but after being treated for some time by a psychologist, she now thinks there is not a big difference between the tendency to blame in the psychologist's office and in everyday social life. It is also interesting to remark how that group, at the beginning, tried to help her daughters and gradually it was more interested in empowering the parents facing their stigma as parents who "failed" in their duties. This drift has been very useful in order to overcome frustration, becoming more relativist in the belief in their possibilities to influence their daughters' cure. In fact, now they are helping their daughters better because they are less anxious and have improved their domestic relations.

The cases mentioned can help us to understand how horizontal, symmetrical and generalised reciprocity is a necessary condition in order to redefine illness and normality in an adaptive sense for groups' members. Of course, analysing all these facts we must work in an *emic* approach, avoiding interferences from professional languages and statements. In the process of redefinition in mutual aid we can observe interesting developments in illness semantic networks (Good, 1977, 1994), illness narratives and representations (Rappaport, 1993; Good, 1994), coming from the different fields where all involved persons built their own experiences.

Associations providing services: towards an industry of help?

In the city of Barcelona alone, 168 associations were registered at the end of 2000 under the label *Health Associations and Mutual Aid Groups.* Some of these associations have a short life or remain for a long time in an initial degree of development. As I have stated above, the origins of some of them were in mutual aid groups, while others were created by a leading group or directly by health professionals "from the top". In the first case, most mutual aid groups get lost on the path to becoming a more complex association. But a few associations, as in the mentioned example of women affected by mammary cancer, present a very interesting combination of formal organisation, supply of services and mutual aid group. Perhaps the intimate feelings related to the body, which they experience and exchange, make it easier to maintain structures based on genuine self-help. In general, where social stigma associated to sickness is stronger, mutual aid works better in spite of the hierarchical structures of the associations. In contrast, we can see how big associations group people affected by diabetes – sometimes a very grave illness, but the beneficiary of a social imagery that is closer to "normality"– provide services, teach abilities and sell clinical tools below market prices. And by so doing, they generate a big majority of passive users amongst their associates. And it is possible to find small groups of people everywhere interacting among one another as mutual aid groups in an informal way, while making use of other services or activities in an association. For instance, the physiotherapy service belongs to a foundation for multiple sclerosis (9).

The strongest associations are characterised by taking professionals as salaried employees. For some young professionals, to begin as volunteers in an association is an efficient way of finding employment in the future when it is very difficult to do the same in public services. This point is highly relevant to the process through which associations are increasingly becoming delegate agencies in the national health and welfare systems. The most powerful associations have activities and results that allow them to get more public and private funding. The increase in their economic resources and their more complex organisation reinforce the drift to creating more specialised roles in managing the association and to hierarchical structures, which follow the same bureaucratic schemes as public agencies or private business. Finally, achieving political influence is an important aim when negotiating with governmental departments, private funding providers (perhaps "politically correct" enterprises) or the most influential media.

Two years ago, a social worker expert in mutual aid groups made some speeches in an important association where mutual aid groups had never existed. Some people amongst her audience became very interested in the subject and they proposed that a group of this kind should be created in their association. The executive board angrily rejected their proposal, understanding it as a contest or a challenge to the existing organisation and its leadership. Only after a long argument, with the intervention of the social worker who had involuntarily sparked off the conflict, did the board accept a limited space for mutual aid. This story highlights very well the distance existing between the genuine mutual aid groups and this kind of association.

It should be pointed out that, with few exceptions mainly related to addictions, most members of in-groups and associations are female. If in some cases this makes relations based on mutual help easier, on other occasions it simply tends to reproduce a professional-patients hegemonic pattern, where women work very usually as mediators between their families and health professionals.

If we analyse how those associations get their resources and how they provide services to associated people, we find a typical scheme of redistribution. Some people, in this case the association's managers, get resources, concentrating and re-distributing them in accordance with established norms. Redistribution, of course, is a key concept in our societies as a way of acquiring better equality of opportunities. But redistribution is always a decisive way of building and legitimising power (Godelier, 1984). As new *big men*, associations are creating structures which, although useful and necessary for many people, also set up new positions, which enjoy power within their own organisations and welfare systems.

A provisional conclusion: on the need to link help relations and political economy

Under the label *self-help* we can find different forms of help relations which could be contradictory in many aspects. If mutual aid is an alternative way of medicalisation, other organisations that have recently appeared in Spain and have also made use of the terms *self-help*, are in fact delegate entities that assume their part in managing governmental redistribution policies, and also maintain the established models in professional-patient relationship. The hegemonic, economic and political tendencies in Europe, and almost everywhere, lead us to think that these developments will be more visible in the near future. Taking into account the tradition of dependency on institutions devoted to giving health care and to helping people in distress, deeply rooted in our historical and cultural background, it becomes necessary to clarify the ideas and concepts related to help and care. These aims are increasingly relevant when an increasing number of patients, or potential patients, are criticising more and more the hegemonic bio-medical model. Not only through ideological assumptions but also, in a big majority, based on their own experiences. At the same time, health professionals feel more distressed every day. These facts are closely related to the growing prevalence of chronic diseases, which are a difficult challenge for a medical practice that is unable to produce miracles in these pathologies, and also for health systems which are full to overflowing because of the prevalence of chronicity. In this context it becomes necessary to gain a deep knowledge of help and care relations, which is an important responsibility for social scientists on two different levels: as a contribution to improving health policy and in advocacy for patients and their relatives needs and rights. Moreover, when appeals to holy duties in the domestic and familiar frame, that is to say to women's traditional duties, are not so successful as they were in the past.

In the topic treated in this paper, discriminating between actions based on reciprocity and others based on redistribution systems shows that classic concepts from Economic Anthropology can be useful when they are applied to new objects of research and are linked to the more specific contributions made by Medical Anthropology. I think that this bringing up-to-date of classic concepts, which are sometimes linked too much to the old objects of Anthropology in "primitive" and "traditional" societies, is one of most interesting contributions that Medical Anthropology can bring to general Anthropology. In the same sense, research on so-called "micro-social" facts, as help relations apparently are, reveals the need to establish relations between different levels of social reality: general and specific aspects of culture, local and global developments in history, institutions in the widest sense, health and welfare systems and a wide range of facts which can be included in political economy. Medical Anthropology must deal with complexity and is therefore an excellent ground for learning how to overcome constrictions imposed by traditional observing units. As the Catalan anthropologist Lluís Mallart (1992:13) wrote: «Anthropology it is nothing more than the art of tying strings.» (10)

Notes

(1) In Spanish, *autoayuda* and *ayuda mutua,* respectively.

(2) *Autocuidado* in Spanish. For a useful comparison of concepts referring to care in their different dimensions, see Haro (2000).

[3] Beyond the involvement of churches in activities related to help and care, we must take into account that religion has been the last complete cosmovision, keeping an important influence on attitudes and behaviour with a heavy moral burden.

[4] Specially in chapter 5.

[5] Of course, dependency between individuals, in a more psychological sense, can always exist in horizontal and symmetrical reciprocity.

[6] In its origin that saying was adapted from a religious way of redemption.

[7] Training for implement those roles is a common activity in agencies supporting groups from outside (*clearinghouses* in the Anglo-Saxon world). In Barcelona there is an agency depending from the city hall and in Madrid another linked to regional government. But their main offer in training refers to managing in associations.

[8] For a suggesting distinction between *perception* and *experience as a feeling* (*vivencia* in the original Spanish), see Valderrama (1995: 17).

[9] It is interesting to remark how the marginal place of mutual aid in associations reflects the same place of self attention in the domestic frame seen from the institutional health system.

[10] Literal translation. The equivalent English saying is *to put two and two together.*

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Health and sanitation.

Environmental health and socio-cultural conditions in two favelas in the city of Salvador, Bahia (Brazil)(1)

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Anthropology and Epidemiology: a Challenge to the Analysis of Health and Sanitation

Historically, health anthropology applied to public health studies to analyse behaviour (Bourdillon, 1990) has been a response to a demand from epidemiology. Health anthropology has focused on interpreting culturally constructed universal symbols which have made communication possible between "social subjects" (Rodrigues Brandão, 1983) and has been dedicated to the discovery of those social structures that relate representation systems and actions with sickness.

The incorporation of health and sanitation anthropology into this research project is justified by our commitment to a model of Collective Health which means that the social sciences become an integral part of research into health (Canesqui, 1995). The epistemological and methodological contributions of the social sciences to the interdisciplinary studies of Collective Health allow for a better understanding of the health-sickness-health care processes from the perspective of the social actors (Nunes 1985, 1995).

The fruits of interdisciplinary projects combining health anthropology and epidemiology generate, above all, profound epistemological debates that endeavour to propose solutions through converging theoretical proposals such as ethno-epidemiology (Almeida Filho, 1998; Gil and Castiel, 1998), or socio-cultural epidemiology (Menéndez, 1998). These two proposals start from an epistemological reflection. First, from within epidemiological research, which attempts to overcome the methodological limitations in the process of data collection and proposes the construction of new objects of knowledge. Second, which finds itself within the realms of anthropological research, and attempts to integrate the knowledges of the social groups, acknowledging the subjects as active participants in the epidemiological structuring. Consequently, anthropology, and more specifically ethnography, can provide new alternatives that integrate the role of the social subjects into the health process in a more relevant manner. As Almeida Filho (1998) proposes:

> «In synthesis, ethno-epidemiology can be put into practice from the fundamental premise the phenomena, health-sickness, constitute social processes, and, as such, have to be seen precisely for what they are: historical, complex, fragmented, conflictive, dependent, and ambiguous and uncertain. It goes without saying that by adding new types of socio-cultural variables and pre-existing explicative structures does not resolve this issue, since simply acknowledging the inherent complexity is not sufficient. One has to respond effectively to the ambiguities and lack of definitions peculiar to this order of phenomena in the majority of its manifestations, and in connection with the historical-cultural nature of its derivations, in search of the meaning of risk and its determinants in society. I believe that the complexities and uncertainties in ethno-epidemiology, currently being developed, represents an opening for exploring new lines of research employing a trans-disciplinary approach which will allow for the construction of new paradigms in the field of collective health.» (Almeida Filho, 1998: 14)

Menéndez (1998) proposes, through health anthropology, a socio-cultural epidemiology that:

> «(...) Could recover the meanings and practices that social groups give to their sufferings, problems, anguish, and pain, etc., related to the structural and procedural conditions that are in effect in a given historical situation. [...] Socio-cultural epidemiology lies in recognising the existence of an epidemiological structuring in the knowledge of the social groups which we have to reconstruct beginning with these people themselves.» (Menéndez, 1998: 80-81)

Publications from the perspective of epidemiology (2) discuss the issue of converging or diverging points in interdisciplinary approaches. The dialogue between these two disciplines points to a greater understanding of the phenomenon of infectious diseases. The contributions of anthropology to epidemiology are of a methodological nature (Dunn and Janes, 1986): about socio-cultural aspects linked to the causal groups identified by epidemiology, about epidemiological analysis results in order to construct anthropological theories and working hypotheses and around collaboration with epidemiology in research oriented towards prevention and participation in applied programmes.

In contrast, anthropologists now highlight, as the greatest epistemological problem of this approach by both disciplines, the loss of critical capacity resulting from an observation that identifies health problems as being medical. The relevant point here is to try and show how social groups fight for their health without reducing this to problems defined only by the hegemonic medical model. The main challenge is to move beyond the interests of such methodological approaches to construct a theory that would allow for elaborating models that would improve our understanding of the phenomenon of infectious diseases as experienced by the social actors.

Health and Sanitation Anthropology

This study focuses on observing the socio-cultural knowledge and practices as a whole regarding health developed in thirty households located in the outlying areas of the city of Salvador that do not have a sewage system. This knowledge is constituted by the relationship between representations and practices beginning with power relations in hegemonic and subordinate relationships (Menéndez 1998). These representations and practices cannot be conceived in terms of separate explanatory categories, but rather as analytical tools developed to interpret a construction of social reality (Berger and Luckman, 1983). In other words, they only have meaning in the context of research that studies knowledge in the actual dynamics of social experience based on relations produced in the social, cultural, political, economic, and biological domains. The construction of representations and social practices is dynamic and interdependent, being impossible to divide the social experience into a grouping of previous ideas as determining factors for the practices. In addition, it is not possible either to separate social practices from the representations that give them order and meaning.

Scientists who support this separation defend the relevance of these representations as determining factors for the practices to such a degree that this tends to alienate the subject from the process of signification. For Alves and Rabelo (1998) the concept of experience, based on the phenomenological theory of Schutz & Luckmann (1973), overcomes the classic dichotomy between objectivity and the construction of the object, as it is based on intersubjectivity and acknowledges the priority of the practical dimension of the actions of subjects. In the case of becoming sick, it is the body, which makes the subject exist in the world, and the affliction is the way to express the sickness through the body. The introduction of the body into the world is a process by which everyday life is the only referent for the praxis. Therefore, all human activity can only be understood through itself, through its practical itinerary, that is, through its praxis. Any division of social experiences into representations and practices, as if they were different activities and perfectly separable, is artificial and arbitrary, and, therefore, does not allow the researcher to understand the complex totality of the events.

Our main objective in this research project is to analyse the experience of becoming sick and health care in relation to basic sanitary conditions in the process of appropriating space. Becoming sick is a biological process that is very closely linked to social questions, as, from this perspective, one can understand how individuals interpret their health problems. In order to understand the process of becoming sick in the case of the city of Salvador, one has to take into account the variety of interpretations that exist concerning practices and public policies developed in a context of wide-ranging cultural diversity and marked social inequality. All societies have institutions, organisations, and professionals, whose task is to cure sickness and disease, and everyone uses, to one degree or another, these resources provided for them by their society. This is to say that the ordering of collective experience is closely linked to the therapy solutions constructed by the cultural system. These solutions are related to health care models offered by medical systems (traditional, popular, biomedical), and family networks (at the level of self-care and self-medication). The family is the sphere in which the first preventative and curative practices are developed, and it is precisely this sphere that has been least researched. Behaviour linked to these practices to prevent or cure sickness are socialised in the sphere of the family, and it is the woman who is the principal agent directly responsible for providing and applying this care process.

At the beginning of the 1980's, the increase in anthropological studies on popular therapies was directly related to research policies developed during the period 1981-1990, in turn influenced by the United Nations declaring this as "The International Decade of Providing Water and Sewers". These studies attempted to focus on the study of health problems in populations in general, caused by the absence of adequate sanitary conditions, in search of a greater understanding of the relationship between health and sanitation, and for the development of more efficient measures to reduce infant mortality rates. Within this context, primary health care programmes continued to be promoted as opposed to programmes for supplying water and sewage systems, from the middle of the 1970's, the principal reason given being economic considerations:

> «This conjecture was based on the fallacious argument that the cost of each infant dysfunction, anticipated via the programmes for supplying water and providing sewers, was far greater than the corresponding costs for other primary health care measures, such as oral rehydration therapy, vaccinations, treatments for malaria, and breast feeding.» (Heller, 1997: 7)

Research into hygiene practices (Cairncross & Kochar, 1994; Almedom; Blumenthal and Manderson, 1997) has become one of priorities for research into the analysis of mechanisms of disease transmission resulting from the absence of sanitary conditions, and in the search for preventative solutions through primary health care programmes and health education. In this area of research, anthropology found a predominant role, above all within epidemiological projects on diarrhoeic diseases, in studies of social representations and practices linked to hygiene habits and house cleaning.

Sociological and anthropological approaches to the problems of sanitation have been mainly developed in geography (Hardin 1998; Chertow, 1998), and history (Strasser, 1998, Rosen 1994). In anthropological publications the lack of studies into sanitation is a clear feature, with the exception of those focused on the production of refuse (Rathje & Murphy, 1993; Stebbins, 1995). The majority of these studies concentrate on the area of the anthropology of consumption and only Stebbins (1995) tackles directly the problem of the lack of refuse collection related to health. Anthropology explored the subject of sanitation through health studies, changes in consumption habits, and environmental concerns. In the case of epidemiology, Léo Heller (1997) carried out a bibliographical study to analyse, understand, and systematise the relationship between sanitation and health. This study reviewed 256 epidemiological studies concerning sanitation, and attempted to offer answers provided in research publications concerning this relationship through historical, conceptual, and theoretical analysis.

Environmental Description of the Slums

This research project is primarily based on the anthropological study (3) of the social experience of sickness and sanitary conditions in thirty households (4) in two outlying areas of the city of Salvador. Later on, a comparison will be made between the two communities Nova Constituinte (Periperí) and Baixa da Soronha (Itapuã), for the purpose of observing what socio-cultural differences and similarities exist in these two different outlying urban slums. These sanitary conditions are explored through the analysis of interviews (5) with the inhabitants of these two respective slums.

Nova Constituinte and *Baixa da Soronha* are located in the outskirts of the city of Salvador in the urban districts of Periperí and Itapuá. They are two urban districts, that we can consider as slum areas, that came about as a result of occupying these areas along the lines that squatters do. In both areas, the inhabitants have a common history characterised by political measures of socio-economic exclusion: the urban infrastructure conditions and environmental sanitation are inadequate, and the economic conditions are those of extreme poverty (6). The total population of Nova Constituinte is 9,748, whilst Baixa da Soronha has a population of 2,671 (FIBGE, 1996). In both areas, the basic sanitation problems are characterised by an erratic refuse collection service, the lack of a sewage system, and the inadequate supply of running water. As regards income levels, the data from the FIBGE for 1996, gave the family average in Nova Constituinte as a minimum wage of 1.39 (7), and 2.44 for Baixa da Soronha.

Basic Sanitation and the Bahia Azul Programme

Neither of these urban districts studied has a sewage system. There are two reasons why problems related to a lack of sewage system in Baixa da Soronha is a notorious fact for those living there. First, because it is an occupied area situated on a slope and therefore extremely vulnerable to floods during the rainy season; second, because it is a densely populated area with open sewers exposed in the middle of the narrow streets that represents a health risk to the children. In Nova Constituinte the open sewers and channels, or ditches, give off a similar stench, but they are less visible because there is a lower population density and the inhabited area is on a hill, which facilitates the draining of water. For the inhabitants, improvements to their district and housing conditions are directly associated with the building of a sewage system and a bathroom.

They consider the building of a sewage system as a public right, but in reality this is conditioned by political or electoral promises. Thus, the inhabitants recognise that they are the object of electoral campaigns, and this, in turn, makes them even more aware of the situation of exclusion in which they find themselves. On this subject, Iara (Nova Constituinte) believes that the issue of a sewage system is an electoral trap because as soon as the candidate wins the elections they forget their electoral commitment.

> *«Our mayor, Imbassahy, owes us living here because when he was running for mayor, he went up and down all this here, shaking hands with the people, looking at our*

> *problem... down here. He went as far as the part where the dirty water runs down, went down to see what could be done to so there'd be less contamination for the people. The thing is that now he's more interested in the city centre, improving the tourist centres, forgetting about the working people that helped him get elected mayor. Ah! Because we suffered through rains and more rains to get votes so that he'd be elected. The people of Nova Constituinte have to collect on this debt from him, Imbassahy.»* Iara, Nova Constituinte (3/06/98)

For the inhabitants of Baixa da Soronha the health problems are related to the lack of sanitary conditions, and, in the words of Lucia, the city council technical staff, after a number of visits to the area, reported what were the unhealthy conditions in the housing in this urban district. During one of these visits, she ironically remembers a question by one of these engineers: "Who said you could build your house over these sewers?" Ignorant accusations of this kind do not appear during the electoral periods:

> *«During election time, because they turn up here much more when it's time to vote [...], the streets are full. Once a bunch of people turned up here, folders in their hands making notes about who knows what, and one said: 'Who said you could build your house over these sewers?' They talked. A lot of people talked about this one: 'Who said you could build your house over these sewers?' So, these people that turned up in the street spend their time measuring streets one by one, they're from the city council. This is more a health problem because of that sewer.»* Lucia, Baixa da Soronha (24/10/98)

For the inhabitants, the solution to this sewage system problem is a public / political responsibility issue. In the face of a lack of public policies they try to resolve the problem of flooding individually by re-channelling the water from the sewers that pass in front of their houses. In the opinion of some of the women, the lack of political responsibility in no way exempts them (the people of the area) from taking steps to avoid accidents. Flooding in the houses can also be caused by water from the sewer mixed with rainwater filtering through, or broken pipes that channel the water from the toilets to the septic tank. The people from the area also believe that these floods from the sewers are also a result of a lack of responsibility within the neighbourhood because they have not built a ditch to redirect the water flow.

During the process of occupying a piece of land in Nova Constituinte, the building of a kind of septic tank, in the form of a deep hole construction, is an option taken up by only a few families to get rid of human excrement. Those few women who have this kind of septic tank complain about the maintenance and poor construction quality which can lead to water filtering through, or blockages that end up making the situation even worse, adding to the problem of keeping the house clean. In the case of Rosa the main problem is the construction because of the flow of subsoil water. She herself acknowledges the need for a sewage system:

> *«[...] My problem here is a sewer, a sewer system we don't have. I dug a kind of septic tank hole at the end of the yard (quintal), and water seeped out. I had to cover it up. I dug another one, and water seeped out of that one too. So, to improve things around here, I think (we need) a sewage system, not so much for water, there's water, even though you can go two or three days without, we've always got water. In other places they can go two weeks or a month without. For me the water isn't such a big thing. The big thing is the sewage system. This street is full of mud and when it rains we slip over a lot.»* Rosa, Nova Constituinte (5/08/98)

The dirty waters are waters from the sewers that run through the yards, streets and open channels. Dirty waters are defined as those resulting from washing, washing clothes and dishes, and the more contaminated waters where urine and excrement are mixed together. Most of the families from Baixa da Soronha have a toilet, but the waste pipe goes directly into the open channel. In the case of Nova Constituinte, the majority of the families use "balão", as a method for getting rid of excrement. It is deposited in newspapers or plastic bags and then put in the garbage close to the house or in the river known as a sewer for the houses in Vista Alegre. The only three households that have a toilet built their own septic tanks. Although they realise these require maintenance, none of them are in a position to provide the necessary and costly upkeep in order to maintain some kind of level of cleanliness in these tanks. Consequently, when the septic tank is full, the most common solution is to build another near the house. For others this is conditioned by the channelling of running water, usually located higher up from the septic tank.

> *«The little that I have learned has taught me that we must be careful with the septic tank. The water mustn't come into contact with the contaminated places because this means our health. We are already poor, we don't have money to spend on a good diet, so are we going to spend it on medication? We can't! So, we're going to lay down another pipe [...] and lay it so we can use the septic tank in front. We'll have a pipe that will let us breathe, so there isn't a bad smell inside the house.»* Iara, Nova Constituinte (3/06/98)

In some cases the people burn the excrement, however, others prefer to bury it in their own yards rather than take it to the garbage dump:

> *«You make a really deep hole in the yard near to the house and there it stays, and it gets thrown in there. When it's nearly full you cover it up and make another hole [...] They say it's better to throw it away, but even if it's in a closed bag inside another closed bag the smell still gets out. That's why I don't agree with this, because the bad smell stays in the yard. I prefer to bury it [...] They say it's better to bury it.»* Milena, Nova Constituinte (29/07/98)

Furthermore, the "*balão*" can even cause, on many occasions, fights between neighbours. For example, Marli decided not to throw away the excrement near to her neighbour's home to avoid complaints. It was as a result of arguments and threats from this neighbour to report her to the Public Health authorities that resulted in her changing her mind:

> *«We don't have toilet, if we need to go to the toilet, we have to go down there, in that stream down there, in those bushes down there, that's where we have to do everything. If I have to go, I have to go! We can do our business at night, at night, and go over there and dump it. Any way we can in those bushes, in that crazy river over there, whatever. A sewer! We have to do all our business there, dump it there, because before, I'm not going to deny it, I used to dump it over here. When there were bushes, those great big bushes at the foot of that 'araça' tree that's where we used to dump it. After so many arguments, when the people come from their hell they only look for an argument. I don't like to argue things out with nobody. I'm not one for arguing things out, if I have to argue with a person I smack them in the mouth, I'm for sitting down and smacking them in the face. It don't argue things out, I haven't got the patience for that [...] Dumped it time after time I did, I'm not going to deny it, because I'm not a liar. So, we used to gather it up and we dumped it there, him and the children the same as me, we all dumped it there, but to avoid arguments, because there was one who said he was going to call the Health authorities, I don't know, I don't know! Arguing and me listening over there at the door, he didn't see me. I said to him: 'What are you talking about?' And when he started on about us we'd already stopped dumping it there, when he started on about us we weren't doing the 'balão' any more, we were dumping it down there!!! At night we make use of it (the bushes), because you can get the call any time of the day or night. Midnight, any time. We head off for the bushes and there's no knowing who's down there. I stopped dumping things over here some three months back now.»* Marli, Nova Constituinte (16/03/98)

The women are of the opinion that the Bahía Azul project will improve the sanitary conditions. But, the construction delays, increase of mud in the streets, and the lack of safety during the construction work, have generated more difficulties for the people living there resulting in accidents, such as those involving a number of children and others during the period of this research. The risk of accidents occasioned by the building of the sewer covers is a constant worry:

> *«Those from Bahía Azul came in here, put the covers here. When Bahía Azul came back, or another company, and finished the work, everything will be dug up again, what I mean is, there's going to be more mud, more holes, and lot of people falling over. I fell over as well, because of the problems with Bahía Azul. They dug over here, it filled up with mud, and I came by and fell over right by my front door. If I'd banged my head against one of these sewer covers I'd be dead. Why didn't they finish the job at the same time? [...] Then, he fell over (meaning her youngest son), he slipped again and the sewer stopped him [...] They should have done the whole channel, but they only did this. So, are they going to come back and do it again? I reckon there's a lot of hard labour here, a lot a work badly done, is it that they don't see we haven't got it! I myself dug two septic tanks, I'm not in a position to put one here because it'd fill up with water.»* Rosa, Nova Constiuinte (15/05/98)

When the construction work was finished the sewer covers in the streets stuck out and were a danger to the children. Those who were in favour of the wastewater disposal programme quickly changed their minds when the people had to deal with the problems of the construction work (mud, holes, accidents, etc.). The lack of information about the increases in the rates bill for connecting the households to the system was a major concern for one person who acted as a go-between for the Bahía Azul programme in the area. Those inhabitants that took part in this research were given no information as to how much the rates would increase.

The degree of misinformation concerning how and when the households would be connected to the central sewage system, the fear of what fines would be in case of inevitable clandestine hook-ups to the sewage system, are only some of the main problems that the women associate with the Bahía Azul construction project. We would like to make the point that these women see the prospect of implementing basic wastewater disposal as a health benefit. Meanwhile, the waiting period involved for achieving this goal makes manifest the problems involved because, at the same time that people are obliged to change their daily habits, they have to face up to new difficulties. That is, mud, holes, enormous cement pipes scattered all over, that are the causes of accidents such as falls, and result in complaints against what, in fact, should be a right for the inhabitants. In the following narration, a woman is frightened of being fined for making a domestic connection to the sewage system before the sewage system is up and running. On this topic, Rosa gave an example of a neighbour who secretly connected his domestic pipe to the sewage system and was warned by the engineer that if he did not disconnect his pipe he would be fined:

> *«I found out when they were in Nova Constituinte, they came by here saying they were going to build a sewage system. I stayed; I wanted to find out about it. A sewage system? When they got here I asked them. They told me: 'It's the Bahía Azul that's going to build a sewage system and you aren't going to have any more problems connecting you house to the septic tank, and then from there to the street. You won't have to build a septic tank at the back of the yard, you'll be able to take a bath, hook up the water, everything'. He told me: 'We won't be digging up the entire street'. They put a sewer; they laid down the pipes. But, up until now, they've put the sewers and pipes but there's not place where we can make a connection and make use of the Bahía Azul programme, as they're blocked off. They built a sewage system but we can't use it. If we try and use it the fine is two minimum wages [...].»*
> Rosa, Nova Constituinte (5/08/98)

In the occupation of Baixa da Soronha, where the sewage system was built during the period of data collection for this research project, the women expressed different opinions and ones of suspicion and distrust regarding the city council's promises for entering into this wastewater disposal programme:

> *«The very ones who run the council know about this here. They know what it's about. They were here a number of times, politicians. We had.... A lot of talks with politicians, they came here a number of times, including the engineers from CODESAL, people from the council, the mayor, city councillors, county councillors. They all know about this. [...] Bahía Azul is a sewage system project for the city isn't it? But the Bahía Azul that's going to take care of the sewers isn't the only thing that interests me. This project... after four meetings, getting the people together and explaining that it had to be built between November and January. We had meetings in a company here [...] and this group went to the last meeting at the Music Hall, in Largo de Abaeté. [...] A politician, one with another, reckons it should be this way, another reckoned that something else should be done, another reckoned nothing should be one, but the promise was so big that there were people there from the URBIS, from Caixa Econômica... So... for those that understood there was no problem, there wasn't going to be a problem [...] the promise was that it was going to be done between November and January. We're now in May. [...] Bahía Azul aren't going to take part in the work.»* Jorge, Baixa da Soronha (08/05/98)

In Nova Constituinte, the women consider what they are going to do in the future when the Bahía Azul wastewater disposal programme comes into effect, as some of them are holding back on certain alterations to their houses and are planning the building of a toilet for when they are connected to the sewage system:

> *«I wanted to put a bathroom (points to the bathroom), and a toilet... The whole works because the installation is already there (she means the Bahía Azul sewer, and I'll build my toilet [...] when I've got the money [...].»* Ana Luiza, Nova Constituinte (31/03/98)

Health and Sanitation

Within the collective knowledge there is a direct association between basic sanitation and health. The relationship is qualitatively proportional; that is, a better quality of sanitation increases the level of health of a person. For the inhabitants to enjoy good health they need a healthy diet, and a sewage system and a refuse collection service are necessary. On this point, Deuzita highlights the sewage system as a principle element for the health of children:

- *«That sewer that runs along the back of the house is harmful and a lot at that.*
- *How do you think this problem of a sewer for the community can be resolved?*
- *By simply making a channel, which is what Bahía Azul is doing at the moment. They're making the channel, it's the only thing.»* Deuzita, Baixa da Soronha (4/08/98)

Among the representations concerning sewers, it is the presence of excrement that represents the greatest threat to health. The sewer indicates one of the excrement outlet strategies. In addition to the situation of accumulation of excrement in the sewers, there is the possibility of contamination in the refuse caused by rain which can result in being mixed with running water because of the precarious condition of the pipes. The lack of maintenance by the Water Company EMBASA only favours the proliferation of diseases, as Iara well observed, especially in relation to diarrhoea:

> *«There's a kind of diarrhoea that's caused by the accumulation of everything where the rubbish is dumped, there are a lot of flies, mosquitoes, and mud and they get into the sewage system itself. You should see the amount of pipes that have come apart! Over here there are a number of pipes built by EMBASA that have separated.»* Iara, Nova Constituinte (3/06/98)

The increase of sewers, the stench that they give off, and the mosquitoes, are the causes of sicknesses that the majority of the people here are familiar with, and which can only be avoided by building a sewage system that is the responsibility of the state. To reduce the risk of environmental contamination caused by the sewers, the inhabitants are of the opinion that urban policies developed in Brazil up until now have to change in order to work to the benefit of those inhabitants living in these precarious conditions. The relationship between the environment and politics / policies is fundamental for understanding the following narrative which concerns the transmission of diseases:

> *«[...] There were so many people making formal complaints about the sewers, that they were a hazard to the children, even causing intestine infection, so many things, causing tiredness, lack of air, everything was happening in Brazil. And so I complain about this, that because of the time these miserable sewers have been here, swarms of insects [...] I don't believe God is going to bring any disease to anyone [...] Here in Brazil there's a lot to be done that the presidents and councillors don't do. At the end of the day it's the person living here that suffers. These sewers need some serious work doing to them. Everything is rush, rush, rush in this land because of these sewers, and it's only going to stop when they fix this sewer. There are some days when that sewer stinks... you wouldn't believe the stench! That over there only brings bad things for the people because it's never going to bring anything good. The water running down over there is contaminated, it's like a bomb waiting to go off.»* Ivana, Nova Constituinte (1/04/98)

The increased presence of mosquitoes is directly related to the accumulation of water, be it from sewers, channels, ditches, or buckets where clean water is stored. The women believe that the risk of disease is greater from those mosquitoes that fly over the sewers than those that are close to the buckets of water. In a campaign by the city council to avoid dengue fever, the people were advised to cover their buckets to avoid the accumulated exposed water in the houses. This campaign was relatively successful in changing habits, but the system of representations concerning the origin of dengue fever for some people is based on the idea that only those mosquitoes originating from sewers are the most dangerous. In this sense, the gravity of disease symptoms is related to ideas of contamination:

> *«I keep it in tanks with lids, the bottles have got lids on. I don't leave any water open to the air. I'm frightened of the dengue fever mosquito. As bad luck would have it I caught dengue fever once; it wasn't in my house. When I came here from there I crossed that stream over there where the sewer runs. It was infested with mosquitoes. I crossed over one day, it was at night, I didn't feel right in my body and I thought I was going to pass out. My body was suffering, hot and cold at the same time. The next day I woke up with a fever, and I went to work like that, I felt giddy, nauseous and that pain and headache was so bad. I couldn't work all day long. I came home, I got there, I went to bed and my whole body was in pain. I went to see the doctor and he told me a dengue fever mosquito had bitten me. I was fifteen days in bed, the only thing I could have was orange juice, carrots, limes, and drinking salt solution so I didn't dehydrate.»* Iara, Nova Constituinte (26/07/98)

For her, the mosquitoes that live in the sewers are the cause of dengue fever. This is especially the case for the small stream sewer for the houses in Vista Alegre, whose stench attracts sickness and mosquitoes. In her house, the advice given by the Public Health authorities regarding water is of no use because the street brings the disease to her house and her body.

Another of the informants from Nova Constituinte, Ana Luiza, observes a strong association between the presence of filth, the increased presence of mosquitoes, and the origin of dengue fever. This sickness affects many of the population in this area, and because of the gravity of the symptoms they believe that a feeling of weakness in the body (fraqueza) is related to the danger which the sewers represent. This, and the question of refuse, are related to leptospirosis known as the "rat sickness" or "rat urine sickness":

> *«Dengue fever is caused by the mosquito that's because of the filth, because if the water is stagnant it gets dirty. The dengue fever mosquito bites a person and they can even die from it. A person gets sick, and a person also breathes in the stench from the sewer, and a person gets sick. You can't breathe. You've got to be able to breathe clean air, good air, and not a dirty air. You get home and you can smell urine in the air, you can smell the excrement in the air, rotting mud, you can smell, I can even get a headache if I come to a place where I'm breathing foul air. My head hurts, I begin to get a headache, and then this can give a person a problem ". Get sick, get dangerously sick, and die [...]. The filth only brings sickness, in the body, in the house, in the street. We have a lot of children that are running around all over the place, stepping on garbage. This is harmful, and the rat, the rat urine. With the rat urine you'll end up in hospital, it's dangerous.»* Ana Luiza, Nova Constituinte (4/03/98)

The foul smell represents one of the causes of infectious diseases. The system of representations concerning the foul smell of the sewer does not establish a separation of cause and effect. The system was developed as a result of great efforts during the period of hygienist medicine (Larrea, 1997), in the 18th and 19th centuries before the experimental discovery of the microbe, however, one can still see a deep-rooted association in the collective knowledge. For example, in Baixa da Soronha there are constant references to the foul smell from the sewer, which apart from producing discomfort has the ability to generate diseases such as parasitosis (verminoses), cholera, and leptospirosis. The foul stench inside the houses generates discomfort for the inhabitants who, in spite of being accustomed to living with these smells, complain about them and suffer as a result. In these sufferings they claim that the contaminated air is the origin of many sicknesses:

> *«There's a fair range of parasites, different parasites, sometimes vomiting problems.... There's a cholera one. There was a lot around here [...]. There's that problem with dengue fever as well. [...]. There's that dead rat sickness [...] sewer rat poison... A boy from around here said he had it. It rained and the street flooded. He went to the vegetable garden at his aunt's house. When he got there he started to run a temperature, fever and giddiness. He went to the hospital. When he got there the doctor said he had... What do you call that sickness? That rat urine sickness. They had to admit him into emergencies at Couto Maia [...]. It's not easy to cure... because after he stepped on it he got it; do you understand what I'm saying? He went to the vegetable garden and for sure he walked over there.»* Lúcia, Baixa da Soronha (24/04/98)

Simple covering one's nose cannot solve the problem of the foul smell from the sewer; that is, it is not simply a problem of the senses. It affects one's being in the world where life is organised around the pollution, contamination, decay, infestation, and decomposition. The smell of the rotting meat enters the house, the body and one's life. For some of the inhabitants, the smell of the sewer and the refuse are responsible for respiratory sicknesses known as asthma or tiredness that mainly affect the health of the children.

> *«They're alright, but after a little while they start to get tired, it's the tiredness. I call it tiredness but people call it asthma. I think it's called asthma, 'dispinéia'. The doctors reckon its that, but I call it tiredness [...]. The rain, it hits the ground with that stench, you see a child's lungs aren't like mine. I'm already thirty four years old and he's five, and his lungs are more sensitive than mine [...].»* Rosa, Nova Constituinte (5/08/98)

The dirt from the streets inevitably enters into the house. This informant describes the relationship between the ground and the body and how prejudicial it is to the health of the children:

> *«[...] The mud ground in this bit, it's the only ground they walk on. I reckon it's because of the ground from there where the parasites can get into your foot, the dust*

> *when you sweep. A lot of dust gets stirred up, then you get the flu, you start sneezing, your nose starts to run. All of this is harmful.»* Rosa, Nova Constituinte (5/08/98)

In both communities, in addition to the foul smell and the evident increased presence of insects around the sewer and filth, the custom of going barefoot is considered by the women to be a main cause of infectious diseases. The majority of the women allude to the relationship between walking barefoot and parasitosis, although they acknowledge their failure to change this habit among the children. This is a habit practised in the house that extends into the street, or rather, in area surrounding the house, the neighbourhood, and to those places where one feels like walking. For these women, the dangers of this habit are greater among children than among adults. It should be pointed out that many of these children and women are lucky to have one pair of shoes which they tend to keep for when they go into the city or on some kind of errand:

> *«Here we've got the sewage from below, from the house of one of the women here [...]. There's tin, a pile of rotting clothes, a pile of rubbish, and there's a lot of mosquitoes, a lot of things. Sometimes the children play barefoot [...] sometimes a marble falls in, they pick it up with their hands, then they put it in their mouth. That's what it is. The sewers running down there. All the time putting theirs hands in to get something [...].»* Elza, Baixa da Soronha (7/08/98)

In the group of social representations concerning the idea of contamination, the informants consider the presence of the sewer, refuse, mosquitoes, foul smell and filth to constitute the causal system of infectious diseases. Notwithstanding, the lack of public policies is a question that is very closely linked to this environment of sickness. As an example, the foul smell functions as a metaphor to allude to the lack of sanitation and the subsequent lack of health in the two communities under study. The housing conditions associated with overcrowding, particularly in Baixa da Soronha, constitute an increase in environmental contamination. In this quote from Deuzita, one can observe that the increase in urban overcrowding is prejudicial to health conditions:

> *«For me contamination is that sewer in front over there. The rubbish... for me that's contamination, the rubbish from the house... the rubbish that comes from the sewer, the excrement all together. It's all-open in the street [...] running down the sewer, everything runs down...dead animal, dead rat, a lot of excrement. Anything you can think of runs down that sewer. Us here with the house like this over it. More people started moving in here and so there's more running down the sewer.»* Deuzita, Baixa da Soronha (12/08/98)

In the theory of causality founded on the principle of contamination they include the presence of bacteria, germ, and microbes:

> *«Contamination must be like this, something smelling bad. Rubbish dumped anywhere, an animal dies and they dump it anywhere, a sewer with that excrement can*

> *cause contamination. Excrement runs down it, microbes, and germs. It's contamination.»* Marli, Baixa da Soronha (5/08/98)

The references to smells, as much when talking about sensory discomfort as the theory of infection, constitute cognitive tools for developing a system of representations that associates precarious housing conditions with health. The use of olfactory metaphors for the origin of sicknesses in the system of transmission also constitutes a political mechanism for denouncing the conditions of social exclusion which places the majority of this social group a long way from urban improvements.

Conclusions

In this study we have observed that the lack of basic sanitation represents a generating element for criticisms of public policies and the role of the State in the outlying urban slums. For the inhabitants of both areas the issue of sanitary conditions constitutes a "utopia", and because of this, projects such as the Bahía Azul programme, are viewed with mistrust and suspicion. The dream of living in an uncontaminated urban area does not exclude them from looking for solutions to the problems of sanitation, such as the building ditches, channels, and sewers that re-channel the water supply and the rain. Meanwhile, they demand as a first priority, sanitary conditions as an acknowledged right for citizens, which later becomes an issue of health.

An analysis of the daily experience concerning the association between sanitation and health, constitutes a fertile research area that allows one to observe how the way of life, linked to the environmental space, is related to health care. Following on, the concept of contamination is the social category that best relates problems deriving from filth, produced by the accumulation of garbage and the presence of sewers in the streets, to the origin of infectious diseases. Since the representations that derive from the category of contamination express the idea of social order, the repeated contacts between filth increase the negative symbolic meaning leading to thoughts of the dangers of disorder and the origin of disease or sickness. "Filth only brings sickness, as much to the body, as to the house and in the street", were the words of one of the women interviewed. This expresses the relationship of symmetry between the different elements that give shape to a same system of reference: sickness. What is applied to the person, the body, is also related to the society, the house, and the street. The social problems deriving from the built-up urban areas, associated with the social exclusion from public services of wastewater disposal, are placed here in terms of contamination. This reference is a precept of political denunciation of the precarious material conditions experienced by the communities living on the outskirts of the city of Salvador. In this sense, the social practises of elimination and avoiding contact with filth must be seen as creative activities by individuals to organise their surroundings, as much in the political and moral sense as in the sense of daily life.

The question of basic sanitary conditions is perceived as a political project associated with improvements to the district. The application of the Bahía Azul programme, in this study, generates a whole set of expectations in the inhabitants linked to these changes in the urban conditions of their districts. In other words, we can say that although the sewage system represents for many a social right, the most important aspect regarding a wastewater disposal system refers to the connection of pipes that goes from the street to the house. In this sense it is the bathroom that would guarantee the individual toilet, an indicator to be considered. From house to street and vice versa, are the spaces where the people locate the social and individual representations such as filth, contamination, foul smells, feeling unwell, and many others, to signify the need to live in healthy surroundings. Healthy means streets without mud and with a refuse collection service, houses with bathrooms and clean water, as well as better medical care and diet.

For the inhabitants of both urban districts, sickness comes from the street and penetrates the house and the body. Externality and internality confer a unique place to represent the body for those who live in these poor areas of the city. Meanwhile, there are marked differences between these slums that are the focus of this study. These differences are hardly physical in nature but rather related to the individual contexts of the state of progress of the Bahía Azul programme. That is, one of the urban districts (Nova Constituinte) is undergoing a process of implementing the wastewater disposal programme; and the other (Baixa da Soronha) is living through a waiting period with regard to the implementation of this project. These two situations confer different ways of thinking about the sewage problem:

– Where the work has begun, the inhabitants are not passive observers of the installation of sewers; rather they admit to the necessity of connecting them to their houses. So, the house would become part of the street and the district, and the collection of houses linked by the subsoil would give shape to a city district equally connected between streets and houses. In the meantime, they confidently await the beginning of the connection unaware of the future rates to be paid and they cannot always count on sufficient economic means to dig up the ground and lay the pipes.

- Where the sewage system construction work has not begun, the inhabitants give a meaning to the Bahía Azul project as an invisible programme, although at the same time they expect it to happen. The expectations generated are the time process that conditions individuals to reflect on the question of wastewater disposal. They are not well informed concerning the implementation process in their area and do not understand why they have not yet been able to benefit from the programme as in neighbouring urban districts.

While they wait for a basic wastewater disposal system, the inhabitants of both urban districts reflect in their words the social devaluation, the problem of sicknesses, the precarious conditions of their sewers at present, but above all, the waiting that has become a new element inevitably incorporated into their daily life. That is, the social actors narrate their perception of the importance of sanitary conditions for health. They live in hope of other improvements (asphalt, housing, etc.) after the sewage system has been built. It is for this reason that the problems associated with the construction work are seen in a negative light as they do not foresee future improvements to their own district. Because they see the process of the programme as being dependent on promises made by politicians during electoral campaigns, they are suspicious as to whether the work will be finished and functioning. In Nova Constituinte, where the building of the sewage system was finished during the field research for this study, various problems were observed which were associated with the lack of safety during the construction work and the misinformation that they received during the period of construction and its subsequent implementation. In the case of Baixa da Soronha, the Bahía Azul programme generated expectations of improvements in the district, but a utopia linked to political interests, this being the reason why it was considered with suspicion and lack of credibility in the majority of the interviews.

The narratives of the social actors are negative references to the conditions of open air wastewater disposal, associated with the origin of sicknesses such as dengue fever, the rat sickness (leptospirosis), parasitosis, diarrhoea, and tiredness... The issue of sicknesses of the body, suffered as a result of the lack of sewers, is very closely related to their “sick houses”, their “sick district”. In addition to the foul smell being responsible for sickness, it constitutes a stigma of the sick environmental space.

Finally, it should be pointed out that anthropology and epidemiology have collaborated in this analysis to rethink and offer solutions to problems of health beginning with the experience of the subjects, as proposed by them. One of the proposals put forward by this paper is to try to encourage the development of ethnographic studies in the area of health anthropology and sanitation focused on the analysis of the experience of subjects who live in areas with precarious sanitary conditions. In other words, this ethnographic study reveals the importance that the subjects give to the association between environmental political elements and health when referring to the absence of sanitation.

Notes

(1) This article is the result of 18 months of ethnographic field work in two favelas in the city of Salvador de Bahia (Brazil). This anthropological study was developed within the interdisciplinary project of the Collective Health Institute of Federal University of Bahia and financed by the "Departamento de Recursos Hídricos" of the Bahia State.

We have used the term "favela" (similar to the word "slum" in English) in the absence of a more appropriate term to describe the communities living in the outskirts of Brazilian cities. It should be pointed out that the word "favela" has a negative connotation and the inhabitants of these urban areas avoid using it. Therefore, with the exception of the title of this article we use the term "urban area / district" or "local community" which is more in keeping with the image these people have of the area where they live.

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(2) See Almeida Filho, 1998; Gil e Castiel, 1998; Dunn and Janes, 1986; Trostle, 1986; Trostle and Sommerfels, 1996; Caldwell, 1993, and on medical and health anthropology (Menéndez, 1998; Grinberg, 1998; Inhorn, 1990; Inhorn and Brown, 1995; Helman, 1994; Kendall *et al.*, 1991; Massé, 1986; Symposium, 1997; Nichter and Kendall, 1991; Nations 1986.

(3) The ethnographic data collection fieldwork was carried out between December 1997 and September 1998. Four research workers in anthropology took part: two in Nova Constitiuinte and two in Baixa da Soronha.

(4) A household is a term used in this study to refer to kinship and grouped affinity relationships that manage survival and social reproduction strategies.

(5) To make these narratives more intelligible those of the research workers have been suppressed when the meaning or sense of what is being said is not altered.

(6) Guimarães, I. Brandão toma de Santos (1979) his definition of "urban poverty", refers to a specific historical notion socially related to way of life and material privation. In this kind of poverty one finds two aspects linked to urbanisation: «(...) this implies observing the city through two subsystems: an upper circuit which emanates directly from technological modernisation, represented through monopolies; and a lower circuit, formed by small scale activities that mainly serve the poor population» (Guimarães, 1998: 93)

[7] In 1998, minimum wage in Brazil corresponded to the figure of 138 reales. A real was valued at this time at 1.18 dollars. Now, in the year 2000, the basic salary is 153 reales and a real corresponds to 1.89 dollars.

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Rhetorics of madness and practices of healing.

An ethnography in the field of mental health

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In this paper, based on fieldwork carried out in an urban community in Central Italy (Gubbio, Umbria), I will outline the network of discourses and practices involved and articulated in debates about community mental health problems (1).

For this purpose, once I have identified the local political issues about the planning of social-health services, I will then describe the psychiatric process of dealing with mental health problems (particularly in the case of psychotic disorders), with an intricate plot of social relations and symbolic constructions. In this perspective, I will use projects of re-inserting patients into the world of work as case studies.

I will discuss basically two processes: the first is the birth and development of the psychiatric field; the second is the social contextualisation of narratives about working-life, illness, and care experiences produced by patients, relatives and professionals. As we shall see, the intensive study of daily practices can highlight aspects that could otherwise go unperceived when looking at the public form of representation. In particular, I want to show how the symbolic construction of social boundaries and healing practices can be peculiarly combined by the agents in relation to the discursive status of the "subjects" involved. Political strategy and forms of action/resistance are in this way dialectically articulated between polarities (public/private, self/other, and visible/invisible) and situated in opposing perspectives concerning how to manage the elapsing of time. Social practices about madness can activate dimensions of embodied social experience, for the most part "inarticulable", representing a situated critique of the local cultural assumptions about society and psychiatry.

1. *The psychiatric field*

Recent contributions in medical anthropology (Gaines 1992, Bibeau 1997, Littlewood 1998, Nichter 1998) have stressed how health policies, medical practice, and contesting "rhetorics of self-making" (Foucault 1988, Battaglia 1995) – used by different social actors – can be appropriately located in the field of local professional and popular ethno-psychiatry. From such a perspective, the network of psychiatric services and popular resources[1] can be considered as the generative *locus* of social practices that affect the confrontation between "madness" and "psychiatry". Moreover, in public debates about mental health problems, the privileged objects of observation can be represented by the semantic cores around which therapeutic practices interact with hybrid objects continually renegotiated and open to different forms of definition. I think that such hybrid objects are particularly interesting in the case of the Italian community psychiatry that has developed in the years following the psychiatric reformation act (1978, *Law of psychiatric reform 180*), best known as *Legge Basaglia* (2).

Italian public psychiatry – more than other branches of contemporary medicine – is as a field of knowledge and power (3) where conflicting strategies concerning institutions of social production (the world of labour) and social reproduction (the family, the school) are acted out. In daily routines of psychiatric services, social workers are engaged in mediating social micro-conflicts and establishing different alliances.

The confrontations about local policies and the rhetorical strategies concerning mental health problems could be interpreted with particular attention devoted to the development of public psychiatry. The Italian psychiatric field has been characterised by meaningful and substantial changes in its policies – implemented by the de-institutionalisation processes of the '70s and '80s – concerning mental illness and, in a more general sense, public health. In recent years, new elements have been at stake. With fluctuating and heterogeneous levels of institutional intervention and of popular participation, debates concerning the real activation of the "fundamental rights" of patients have been promoted. "Fundamental rights" concerning the ways of co-operation and organisation of initiatives in the local communities, and aggregation involving patients, families and psychiatric workers.

In the 1970s in Umbria, lively political debates took place within the local communities, often in rural areas, to re-insert patients discharged from mental hospitals into community life. A process of social negotiation was promoted to develop public Mental Health Centres (*Centri di igiene menta-*

le, CIM) in the whole region. During the eighties, pressures connected to new economic policies of budget reduction and to the processes of economic management (*aziendalizzazione*) in the Local Health Units (*Unità sanitarie locali*) have substantially led to a polarisation of the positions regarding the request for application of the *Legge Basaglia,* particularly, the implementation of residential or partially-residential structures for ill people.

In particular, the public Psychiatric service (4), where I did my fieldwork, exhibits some of the contradictions that have been progressively revealed throughout the last three decades, in the differentiated renewal process of Italian psychiatry (5). Furthermore, the double nature of the interventions of public psychiatry – medical and social – is a source of paradoxes incorporated into the very structures of the local psychiatric network. I shall briefly outline some of their salient features.

The Mental Health Centre in Gubbio today appears to some inhabitants of the town as a container of secret encounters still burdened by the stigma of *madness*. The shame ("*la vergogna*") that people used to feel when passing the Mental Health Centre rooms seems today notably reduced. Nevertheless the patients and their relatives are still involved in persisting situations of discomfort derived from stigmatisation. Psychiatric nurses and doctors recognise that the problems encountered by patients and their relatives in addressing the CIM (6) (*Centro igiene mentale*) are, for the most part, a consequence of a peculiar history of the "Servizio" (the name used by psychiatric workers to refer to the psychiatric service). A psychologist outlines the historical transformations in the following way:

> *«Here we have, in a sense, a historical discourse. At first all the patients were old: either aged – that is to say, those who had been here for a long time and were rather elderly –, or old, in the sense that they had a lengthy psychiatric background. At one point, then, we had many retired people, many of whom received an old-age pension.* [...] *Therefore, roughly since 1985 – in 1985 our Centre was reduced to its lowest terms; at its historical minimum we had approximately, more or less, sixty people – we had a service with these features:* a service with a small staff, essentially with chronic patients, patients from the Psychiatric Hospital... who had been discharged into the community [territorio] when the Hospital closed [...] *There was a range of... we could say, a residue of improper patients, too. We had a lot of improper requests and even patients with acute crises – cases that must be followed by the Service –, and we had great difficulty in persuading the patients to accept treatment. Because* "the CIM is the place where madmen are treated", *because "people go there to..." This aspect must be considered, because if we have a Psychiatric Centre only with old, sick and easily recognisable psychiatric people, then...»* (Luisa C., psychologist / INT PS3) (7)

If the Psychiatric service, the "*CIM*", – up until the mid 1980s – was perceived by people as a consequence of a parthenogenesis of the Psychiatric Hospital of Perugia, the implementation of the Mental Health Centre could also be interpreted as a restitution to the local communities of that "madness" moved, for about a century, from the urban and rural centres into the Psychiatric Hospital. Therefore, for a long period, most of the local population identified the territorial psychiatry (viewed as pharmacological and substantially chronic) with serious, evident, and somehow "public" mental illness.

These lay interpretations of the psychiatric activity are now still partially maintained, even if the requests for psychiatric intervention – especially those concerning large areas of social suffering that previously didn't come to the Service's attention – have increased considerably. In medical transactions, for instance, a conspicuous number of patients' demands have an existential tone. Questions expressed in psychological terms, through language that intertwines an idiom of strong emotions and elaborate descriptions of the "inner self"; a peculiar investigation of individual vulnerability and social etiological factors – like *stress*, fatigue, and so on.

> «*Then we can see the entry of what we could call "minor psychiatry". It concerns discomfort, or more precisely, the area of uneasiness and discomfort which is not very important from a psychiatric point of view: panic-attacks, reactive depression, the trouble a teenager can have trying to untie family bonds. Everything happens. On one hand, that's a good thing, in the sense that the Service not only deals with many different issues but also becomes able to offer higher quality answers to various problems, because we haven't only a concentration of... On the other hand, now we are obliged to reduce just a bit the range of patients and services, and to devote ourselves more to specific matters* [lo specifico].» (Luisa C., psychologist / INT PS3)

The members of the Psychiatric Service have adopted specific strategies to bypass problematic forms of interaction and to respond to the new questions expressed by their patients and families. In the following interview excerpt, a psychiatrist compares an old patient's stigma to the new requests for optimising social performance in the Psychiatric Service.

> «*We have invested especially in the reception of all requests. We have also tried to make the Service known externally, working with the community, making the public aware of interventions of prevention, where possible. Years ago there was a huge... because in '86 and '87 there were really few serious patients, and everyone came from the Psychiatric Hospital. Because there was a lot of prejudice too. Now, the prejudice has changed a little bit and the attitude towards psychiatry is different. Therefore the person that comes to the Centre now wants either to improve himself, or a member of his family. Well, this all means a person goes to a psychiatrist because he wants to function at his best.*» (Laura M., psychiatrist / INT PSC1)

Despite the increasing diffusion of idioms of distress characterised by pronounced psychological tones, and the consequent recognition of a hegemonic social role ascribed to the psychiatrist, the "Service" occupies a marginal medical area, sometimes subordinated to other biomedical branches. In fact, community psychiatry still has a marginal role in the management of economic funds and in the process of defining parameters for the output-evaluation of different Health Care Services.

In this way, the interviews I had with the psychiatric staff emphasise a contrast between the excessive formalisation of the administrative procedures – that is quantitative evaluation of resources and outcomes mostly diffused with processes of new management (*processi di aziendalizzazione*) – and the daily routine in the Mental Health Centre. The growing number of interventions, the differentiation of the rehabilitative structures that require routine activity, and the reduction in the time spent on the staff assessment meetings make an evident structural distinction between various occupational figures and a hierarchical division of roles and competences. Whenever the psychiatric staff enters into this sort of spiral, the hybrid side of mental health practice – mainly referable to the social action of the rehabilitation projects – disconnects from psychiatric professional knowledge and joins the social workers' "lay practices". In this way the *social* side of psychiatric practices risks being separated from the *technical* side and practitioners must recognise that it becomes increasingly difficult to prevent wide areas of society from becoming medicalised. In fact, psychiatrists are continually solicited to clarify the boundaries of their activity just like technicians. They have to avoid generic attention to social suffering and social control; but as representatives of the more qualitative and hybrid part of medicine (Giacanelli 1978). They have to be inevitably engaged in activities that are "too social" to constitute the pivotal axis of medical care. In other words, the public psychiatric staff is forced to work between a broad social delegation concerning responsibility on "madness", or a substantial subalternity to the other biomedical disciplines in the local policies for promoting health and prevention.

Nowadays, the dialectical relationships between the structural articulation of psychiatric field and the processes of local management of mental health problems tend to be shaped by the opposition between the increasing bureaucratisation of Psychiatric services and the "non-regulated creativeness" attributed to social workers and lay social actors belonging to the local community. Furthermore, I should like to add that the process described here in very general terms is part of a historical structural reorganisation of the psychiatric field. From such a perspective, processes of institutionalisation and emerging cultural forms tend to be embodied in the social praxis in proximity to the oscillating boundaries between *society* and *medicine;* boundaries that are continually redefined in relation to historical changes in psychiatric knowledge and practice.

In this regard, it could be hypothesised that a cultural phenomenology of the habitus (Bourdieu 1977, Csordas 1990) of patients and operators as well as the local delimitation of boundaries of community and of acting bodies/selves (Kaufman 1988) – especially in public debates – could provide good access either to social practices in conflicting situations, or to agencies of different social actors possessing different symbolic capital. For this purpose, public debates about mental health policies seem particularly meaningful.

2. The local debates

During my fieldwork, I paid particular attention to the questions that patients and their families asked local administrators, physicians, and social planners in debates on residential psychiatric communities and problems about employment (8).

The most interesting aspect of these debates was the peculiar interplay between public issues and the daily experiences of patients and their relatives. Moreover, a prevailing strategy adopted by social actors, as we shall see, consists of acknowledging the symbolic boundaries of 'Self' and 'Community', and interrogating some tenacious oppositions – such as normal/abnormal, health/illness, reason/madness –, to promote new "opportunities of citizenship".

In the "public arena" – where sometimes a thick plot of "private" and "public" meanings emerges (9) – social actors emphasise personal and domestic experiences by making a linguistic shift that notably changes the emotional tone of political confrontation. Patients' biographical paths are characterised by specific configurations of meanings and strong emotions, produced either during doctor-patient encounters within the therapeutic setting or, more generally, whenever the patients find themselves working out the meaning of the tests they have to face in the working world.

My fieldnotes describe different ways of constructing social meanings, which are exposed in public debates, specifically those concerning plans for rehabilitation. For instance, I recently participated in a meeting which discussed initiatives to find employment for the psychiatric patients, where a number of contradictory aspects clearly emerged.

About 40 people gathered in a Gubbio Hotel to discuss employment: psychiatrists, psychologists, members of social co-operatives, the staff in charge of the *Servizio inserimento lavoro* (Sil) [Employment service for people in need], some local entrepreneurs, patients, citizens, and members of the Association for the implementation of the psychiatric reform (*Associazione per l'attuazione della riforma psichiatrica*, Ass. Arp). In his introductory intervention, an operator of the Sil gave a summary of the situation. He stressed that employment is an important goal for patients, and that work is the object of many expectations in our society. He added that anxiety and strong emotions are linked to problems of occupation, autonomy and productivity. In his words: «*our society is divided on the basis of division of labour. I mean, usually it accepts the equation that normal is equal to work: if someone doesn't work, then he is abnormal*». He argued finally that, in order to understand the analysis of the labour market, and the mediation activity of the Sil, it is necessary to clarify that «work is not therapy». This is the aspect which social workers are usually forced to remind the entrepreneurs, when they repeat that «therapy is done within the psychiatric office». In fact, «*the Sil, together with the psychiatric service, plans itineraries of* normalisation, *projects of* normality» (Fwn 1)

From this perspective, the Employment service (Sil) is engaged in planning "projects in order to give the patients a series of trials". In the projects, the policies that acknowledge the patients' fundamental rights have an explicit aim, which is to construct the patients' identity. In fact, according to social workers, work lets the patients overcome the identity acquired through psychiatric diagnosis. During the debate, the same operator outlined a sociological framework, perhaps rather rudimentary, in which he stated: «*society is divided into roles, around which we construct our identity*» (*ibidem*).

The "job" (like the rehabilitation activity in the Psychiatric centre) is thus presented as an intermediate locus where the patients' potentialities are tested. It is represented as a liminal place of apprenticeship, where patients state that they need more time to prove themselves, where the rhythms of work are suitable for learning and where they can also make errors. Therapists, especially, also define the "job" as a portion of reality outside the domain of therapy. When psychiatric operators – particularly psychiatrists – try to identify their possible interlocutors within the community, they generally prefer to second the relatively reassuring division between medicine and society, therapy and social work. This rhetorical strategy traces boundaries around the spaces of therapy and rehabilitation – the psychiatrist's office, and the Day Centre of Rehabilitation – which, because of their own hybrid nature, often go beyond the narrow domain of medical approaches. In fact, every project concerning cases of psychosis needs to interact with the family, the neighbourhood, and the social groups to which the patient could be affiliated.

On the occasion of the public meeting mentioned above, the employers asked for more information about mental illness so that they could understand better what really happens in employment plans. They raised the issue that it might be necessary and opportune to know the life history of the people with whom they are committed during the working day. This request prompted another social worker to ask some questions. She said: «*What is normality? Who is normal? Many things are unknown to me too... What is the personal experience and the story of a person? Should we seek knowledge about the life-history of the people we meet and, if so, how long for?*» (FWN2).

These questions seem to claim that there is an area of emotional negotiation which derives *obtuse meanings* from social experiences, not directly visible (Taussig, 1987: 366-367, 393-395). The peculiar object of this negotiation is what Michael Taussig calls *implicit social knowledge*, a point at which history and social memory interact, and where we can see «what makes ethical distinctions politically powerful» (Taussig, 1987: 366). In this case, ethical distinctions seem to refer to a crucial choice, which the actors of the political debates have to face: either considering social exchanges under the psychological profile of the involved subjects (10), or paying close attention to the social demarcation of bodily boundaries that fluctuate in social interactions (11). Really, the embodied experience of social interaction – which has a conclusive role in discussions about psychiatric patients and their behaviour – cannot be separated from the power-relationships working in the local psychiatric field and the labour market (12). A psychiatric patient's words, pronounced in the course of the meeting on employment, help us to clarify this point.

Stefano, C., intervening with certain enthusiasm, described his present situation: his work in a small grocer's shop was going nicely, but – he sustained – it is important to have good relationship with the social environment. In Stefano's specific case, for instance, it was important to patronise a pub owned by one of the CIM nurses and to take part in the religious activity of a Catholic community. «*Although social prejudices toward mental illness are still widespread*», Stefano argued, «*the main problem is* to introduce social workers *to different places in the town*». And addressing the social workers directly, he asked: «*Please, tell us what kind of relationship you have with the town*» (FWN3).

The patient, questioning the quality of the social workers' daily life, does not properly express a "psychiatric need". Instead he proposes a problem to all the inhabitants of the town by evoking their shared "implicit social knowledge". That is, his main question is not only how psychiatric workers, as embodied social actors, usually build social relationships for the patients, but how they live and build common places for themselves and others in the town. Stefano claims that a split between "productive time" and "non-productive time" cannot be passively acquired. He points out that people must have a wide perspective so that they can locate the time of labour within a larger economy of time: an economy of time – involving a plurality of social life aspects – in which the problem of finding a job is not separated from creative activities or from the material and symbolic construction of the whole community (13).

3. A case study: "job stories" and practices of healing

As we have seen, a project concerning «psychiatric patient inclusion» often forces the protagonists of the public confrontation to re-define the social environment in which the patient has to be inserted. These transactions involve the social workers themselves who try directly to appraise the possibilities of social exchange in the local community, sometimes considered closed and fragmented in various narrow social groups.

Public debates on mental health issues amplify and combine local representations of madness and, in a sense, represent a stage on which social dramas generated by structural tensions are performed. If this is so, the "public stage" allows us to appraise how the narratives produced during the disputes about mental health policies can feed back to the social processes, providing them with "rhetorical structure", modalities of use, and meaning (Turner, 1986 [1982]: 134). In this way, we can observe better the metaphoric polarisation between semantic oppositions, and how such oppositions are articulated in the patient's narratives to express illness experiences and social conflicts.

So from the patients' narratives about their working-life we will find it useful to extrapolate descriptions about the social status of the employment insertion, trying to avoid limited interpretations of the psychic dynamics of the people involved. In a broader sense, we have to deconstruct the complex collective processes corresponding to psychiatric modes of production of biographical paths: what characteristics does a patient need to be inserted into the working world?; how are conditions of disadvantage appraised?; and how are material and symbolic "needs" considered.

3.1. The "Servizio Integrazione Lavoro" (SIL)

The *Servizio Integrazione Lavoro* (SIL) is a social service consisting of a social assistant, and employees of various social structures that deal with handicaps, substance abuse and mental health. Within the SIL, there is a group of specialists who draw up agreements with public administrations and private firms to promote employment for patients.

In its first phase of activity, the SIL analysed the labour market in the local area and made a survey of the firms available to employ patients. The procedure usually adopted by the SIL is the following: the name of a patient is put forward by one of the social services, the SIL-workers meet this person and, after interviews with the patient and her/his relatives, the case is evaluated. Finally, a plan with priorities and objectives is formulated. In the following excerpt from an interview, a psychiatrist describes the characteristics that are requested during the case-evaluation of the patient.

> *«Often, a project can simply try to verify if the person is able to tolerate the frustrations, even small ones, deriving from the specific type of work environment. Usually, the environments chosen are the least frustrating possible, with more tolerant dynamics than other working areas, and so on. Therefore, we try to point out which kind of* tolerance *the patient has, and his capability of* self-responsibility *as well. That is to say, the extent to which the person is able to carry out an assignment. Not only from the executive point of view, but chiefly from the point of view of* the burden of responsibility, *because this is what creates tension.»* (Giovanna E., psychiatrist / INT PSC2).

In the SIL projects, we can see a particular semantic integration of aspects of the local economy and of traits of subjectivity (responsibility, tolerance, etc.). So, in many circumstances, the possible psychiatric accesses to the biographical history of the patient need to be evaluated, and the procedures that produce the psychiatric history of the patient outlined. Within the psychiatric network, the negotiations between various social actors have to be appropriately situated in the modes of production of social relationships – not only with reference to the patients but, in general, to all the social subjects involved in mental health policies.

We must, therefore, consider the features of the wider context if we are to understand the idioms the patients use in order to speak about themselves and their own relationship with labour and society. We can outline at least four salient traits:

1) Firstly, the *inserimento lavorativo* in the investigated area is mainly promoted in small and middle-sized manufacturing firms, handicraft workshops and commercial activities. Such firms make it possible for patients to have a job with a variety of functions. These jobs frequently allow the patients to discuss the work with their employers and therefore to negotiate mutual expectations.

2) Secondly, patients' employment is promoted in an urban area where innovative ways of co-operation, involving either psychiatric patients or social workers, are still not adequately developed.
3) Thirdly, the objective possibility of finding a job must be put in a social context in which many people looking for a job are forced by the labour market to move to nearby areas. The patients can also be considered social subjects who are planning their own future in the milieu of an advanced industrial society, where ideologies of *flexibility* and *precariousness* connected to the working world are strongly rooted. This happens even if many working experiences are promoted in environments where the organisation of labour is less rigid and working rhythms less urgent (trade, tertiary sector, artistic craftsmanship).
4) Finally, many patients (between the age of 25 and 45), who are involved in employment projects, although they had never been inmates of the old mental hospital, have been treated for short periods of time in the Psychiatric service of diagnosis and care (*Servizio psichiatrico di diagnosi e cura*). The everyday life of these patients is nevertheless organised and strongly tied to the rhythms of their current psychiatric treatment.

3.2. Planning an uncertain future

A salient trait of the patients' narratives (14) about illness, rehabilitation, and working-life, is their attempt to produce – with peculiar narrative choices – complex plots through the combination of individual or collective events and personal experiences of uncertainty, crisis, and bewilderment. In these narratives, we can find a double social memory: one concerning the history of the community (the city and the villages in the surrounding territory), the other concerning the psychiatric service and its social roots. This is a history of deep structural transformations of the local economy linked to the emigration experience, the crisis of agriculture and the urbanisation process. They marked the family life-stories since the first half of the 20th century, the institutional landscapes, the regional welfare policies and the role of psychiatry in public health since the '60s .

The cultural configuration that best depicts this plurality of interpretative levels consists of interpretations about the elapsing of time, delays, and pressing working rhythms (often in factories). In fact, descriptions about the beginning of the illness trace an existential route within situations of hard conflict toward established stages marking sexual maturity, the access to a gender identity, and the crucial passages to acquiring "citizenship": school, military service, first working experiences, etc. The life histories are often marked by conflicts in the factory, particularly during the first phases of the psychiatric illness. Conflicts where sometimes the people risk losing themselves.

Edoardo M. (32 years old), a political science graduate, works now as a clerk on an employment plan in an industrial firm. After a period of hospitalisation, he has been under the care of the psychiatric service for the last two years. He remembers his experiences as a factory worker in the first part of his working life. His criticism of the factory and the assembly line is quite severe.

> EDOARDO – «*I had working experiences immediately after I graduated from high school. I went to work in a factory – in a small factory. I had to thread iron rods. It was ridiculous, I didn't like it at all. I didn't like the environment.* You produced nothing. You didn't create objects that could…»
>
> MM – «*What did you do there every day?*»
>
> EDOARDO – «*I was working at a machine, I had to put the rods inside, these were threaded, I pulled them out, and then I put some more inside. It was a workshop, not even an assembly line factory. Later, the owner wanted to make me work on Labour Day too. I said: "Yeah, bye bye!" Then I had another awful experience in a ceramic workshop. The fact is that the factory doesn't suit me. I don't know who...* [he laughs] *I don't know.* Because the factory – in my opinion – kills people. It kills people physically, but it also kills people mentally, because working on the assembly line means exploiting the body and armouring the mind.» (Edoardo M. / INT PT 4).

The fast rhythm of de-personalised work is frightening. The factory is frightening, too. The anxiousness to follow the rhythms of the other workers forces some patients to quit. Giuseppe E., for instance, after several failed attempts, now aspires to find more "human rhythms" and different labour relationships in a working environment.

> GIUSEPPE – «*I worked at the M.* [a furniture factory] *for ten months, but it was a bad experience. Because… even if I earned a million, a million and a half* [of Italian lire] *a month, you had to do... you were in charge of a part of production, it was an assembly-line-job and you were obliged to make so many pieces in an established time. So if you were in a place where you could work well, everything was OK, but if you were in a place where you were obliged to do an extra piece, and you could not make it on time, then you became anxious. Sometimes you fell behind with your job and it was difficult to catch up, and then your boss often told you off. Even because there was… At the end you were working for seven or even eight hours, with a lunch-break. It was a fairly fatiguing job.*»
>
> MM – «*And then you quit.*»
>
> GIUSEPPE – «*I left... after discussing it with my parents. They told me 'if you really can't make it, just quit.'*» (Giuseppe E. / INT PT 18).

In many of the patients' narratives, in contrast with the pressing elapse of time in the factory, we often find descriptions of peculiar "situated practices" in current employment projects. In an ordinary working day, the patients have to arrange things meticulously and on time. Their tasks consist mainly of placing goods on shelves, putting various products in order, and labelling merchandise with prices. To "put in order", "to clean", "to organise", these are all aspects of production/consumption which are often not even considered in a rigid organisation of labour. They are activities inserted in the gaps of the work procedures.

> MM – *«You said that your job consists essentially of positioning the goods…»*
>
> BRUNO – *«Yes, from the stock to the shop. A wide range of goods: from toiletries to various wines, dairy products and meat to various groceries.»*
>
> MM – *«And vegetables?»*
>
> BRUNO – *«No vegetables, no milk, no fish. I was assigned to the aisle where there were dog and cat products, and I help the man in charge of the bottles of water.* [...] *I also help whoever calls me, whoever needs something. The boss sees whoever needs help and calls me. I help the man in charge of the pasta, and then the one in charge of the oil, the tomatoes, the desserts, even the one in charge of toiletries.»* (Bruno N. / INT PT 12).

Sometimes, as in the case of Giorgio L., an assistant-gardener, the activity of arranging objects is directly related to the construction of the landscape. Giorgio's work is mainly to protect the garden from weeds and harmful insects.

Mauro, a 35-year-old sales clerk in a shop, uses a specific foreign word to speak about his present strange work.

> *«I have been working in this shop for the last three years. Everything is going fairly well. Mmm, I am practically… My work consists of moving the products to the front of the shelves so that people can read the price easily.* This is called "merchandising" in English. *Sometimes, but not often, I put the stuff on the shelves. This is a job that is similar to a sales clerk.»* (Mauro F. / INT PT 7).

Actually, the organisation of space-time seems to balance the uncertainties in the emerging social interaction. Uncertainties which seem to be related to ways of questioning the inarticulable dimensions of "normal" daily life: silence, the inner world of the emotions, doubts concerning "reasons and causes" (15) of obscure behaviour, and the inaccessibility of the pain of other people. An uncertainty that social actors sometimes use to discuss the boundaries and the margins of the Self (16).

As in the case of Tommaso T., a 44-year-old car-park attendant, who belongs to a co-operative that manages a public parking lot. He works six hours a day, six days a week. He is frightened by the reactions of nervous motorists, who are "the victims of rush". In his story, exchanging glances with unknown people are a motive for reflecting on his closed and shy character.

> Tommaso – «*Yes, I stamp the ticket, I lift up the bar and I let them go through. Then if they find a place they park, if they don't find one, they don't pay. There are others... Instead, with the ticket, I ask them to pay and I elevate the bar. They pay according to the hours they have parked. That is, they pay a thousand lire per hour: one hour a thousand, two hours two thousand.*»
>
> MM – «*You told me that there are good people and others...*»
>
> Tommaso – «*Like everywhere, everywhere… But you know, overall, you don't known how to behave, because it's really hard. Aside from the fact that I am not a big talker, I am even closed, and shy, and so on… Anyway now everything is going well. This is a good period, I wish that everything would continue like this.*» (Tommaso T. / Int pt 20).

The risk of being entrapped in a scheme of a "non-chosen life" is what many patients try to avoid. There are moments when they withdraw or escape. When they feel that something is not going well, they are tempted to leave, and to separate themselves from the shreds of normality (often built around the fulcrum of their job). At this point different forms of therapist-patient relationships come into play.

3.3. Looking for a job: crisis, struggle, and imagination

The precariousness of conflicting relations with the outer world is a distinctive trait of the biographical stories. The daily actions linked to the working-life are part of a larger consideration concerning an uncertain future.

Patients discuss their expectations and desires. That's why a «phenomenological approach based on the construction of personal meaning/being» (Frankenberg, 1988: 330) becomes particularly deep, whenever they delineate the features of the working world (17).

In Stefano's narrative – the 35-year-old patient mentioned above – the stories of his parents' and grandparents' working experiences are linked to vicissitudes of his illness and of social rehabilitation. His narrative is important because it gives us a deep perspective of the transformations that have occurred in the psychiatric field within which he traced his life history. During one of our encounters, he told me with a smile on his face that he was «a historical patient», in that he has been a part of the history of the psychiatric service for many years. So, his narrative strategy (in describing his interests, reading, projects) is twofold: on the one hand, he tells a story about his movements, with his family, in the network of private and public psychiatry; on the other hand, he marks the semantic boundary between material and intellectual labour.

Stefano, born in Luxembourg to Italian migrant workers, during the first years of his life followed his parents who had to travel around to look for a better job. In fact, a few years after Stefano's birth, his father, who had been working as a truck-driver for a wine merchant in Luxembourg, was hired as a mechanical worker in a big factory in Northern Italy. Stefano remembers the heavy work his father had to do, his father's descriptions of life in the factory, and his attempts to leave the assembly line, to return back home to his native Umbrian village where he could finally retire.

> «*When he* [Stefano's father] *was a welder he couldn't go on anymore... perhaps he could, I don't know. Then his only escape was to begin to study. For a certain period he attended a specialisation course, and so he avoided being fired during an initiative of dismissal promoted by the factory.* And he liked that job quite a lot, because it was a "brain job" [un lavoro di testa]." (Stefano C. / INT PT 10).

Stefano began feeling ill when he was a 19-year-old undergraduate student. At the beginning, he felt a sense of bewilderment, an increasing fear, until finally what he calls "the voices" arrived. Then, the period in which he heard voices was followed by what Stefano calls the "mystical moment" and the fear that people around him could be subjected to an inevitable genetic mutation. His family then decided to move back home to Umbria, in order to find possible answers to Stefano's affliction – which had manifested itself in a large industrial area, a context where it was more difficult to find adequate help and assistance.

> STEFANO – «*At a certain point, the most terrible thing that happened was when the voices arrived. I mean, with voices one begins... I began to believe that my parents were not my true parents, but the doubles* [sosia] *of my true parents, and so on. That's why I have suffered so much, because you suffer terribly for such a thing.* [...] *But I think that then I was already ill. In the sense that when it was spoken about... – what's the correct name? not nervous breakdown, but depression – I was probably already depressed. However, for instance, when I used to read about depression in the newspaper, I said, "Come on, I feel tired, but it must be because of all the studying I do".*»
>
> MM – «*And had you begun to feel like that before? When you were at University…*»
>
> STEFANO – «*No, it happened later, thinking about it again, when I saw… When I realised that I was ill. For example, I don't know, another thing was that I often got drunk and it was a sad drunkenness. It wasn't that I was drinking so much. But then, when it was summer, I really drank a lot. This later made me reflect about my situation. And now I do miss the University. The truth is that my friends often told me to stop drinking, and to begin studying again, but there was little to do.*»
>
> MM – «*So you weren't able to stop.*»
>
> STEFANO – «*The alcohol? Yes, it was basically because I had nightmares.*»
>
> MM – «*They were connected…*»
>
> STEFANO – «*It was like a huge narcotic. Well, because it becomes funny, for instance, when you fear you could be a part of a genetic mutation, or, you yourself, a genetic mutant. You are terribly frightened.*» (Stefano C. / INT PT 10).

About three years ago, the psychiatrist told Stefano that he was on the road to recovery. Therefore, it was time to reduce the intake of psychotropic drugs. Everything seemed as if it were going well, when suddenly Stefano stopped eating, he withdrew, and avoided all communication with others. He was admitted to the General Hospital of Gubbio and was fed intravenously. Then from there, he was taken to the Psychiatric service for diagnosis and care in Perugia.

The sickness was a process of continuous change that alternated between ups and downs. The initial *debacle*, which deeply marks a biographical history, can be contextualised in narratives where periods of well-being and suffering oscillate. In Stefano's case, the inevitable conflict with the psychiatric service was produced and reconstructed after long conversations with his therapist.

During my fieldwork, I frequently spent time walking and talking with Stefano in town – sometimes even along the road that led from his house to his job. At the time he was engaged in a downtown office, where he worked two hours a day three days a week. He often repeated that his wasn't a real job, but only a trial period. «*I would like a true job*» he often added, but then he too realised that he wouldn't have been able to carry out "an-eight-hour-day-job". Perhaps a part-time job could have been the solution. But he complained that when he was experiencing periods of despondency, and radical crisis, paradoxically he felt that he had a higher productive functionality. Now that things seem to have sensibly improved, and that he no longer feels the weight of his illness, Stefano says that he needs a «*real job*».

> STEFANO – «I hope they find a real job for me. *Even though I like the work that I do now. My daily tasks are going to the post-office to deposit checks, sending insured or registered letters, and so on… I operate the personal computer to issue the firm's invoices. Above all it is a word-processing job… I fill out deposit forms… You know, nothing in particular. In fact, there are days that I have nothing to do. For instance, last Wednesday, I worked only twenty minutes.*» (Stefano C. / INT PT 10).

A "true job", a "real job", are recurrent expressions in psychiatric patients' narratives. During his long illness, Stefano has had various temporary jobs: such as a librarian or a clerk in a bureau, etc.; and there have also been proposals of manual work. Some of them were accepted, as in the case of the recent employment as assistant in a grocer's shop, others refused. Regarding the proposal of manual jobs, Stefano recalls:

> «*Then they made me a proposal to enter into a community where reaping-machines and bulldozer are used, but my father… I didn't feel up to working with a bulldozer. Then I changed my mind, but my father said, 'No, you shouldn't do that kind of work, because I can't imagine my son working with a bulldozer'*»(Stefano C. / INT PT 10).

Today Stefano is again planning to enrol at University, in the faculty of Political Science. He hopes to begin writing and to take an interest once again in politics. He does mention that now his health is better than it was a year ago, although he still feels insecure.

> STEFANO – *«I still have the same dream, that is to have enough money to buy a tobacconist's shop and to make it my livelihood.»*
>
> MM – *«That's your dream.»*
>
> STEFANO – *«No, my real dream would be to have a bookshop…* [a long silence] *My greatest dream would be to attend the University again… and to write something.»* (Stefano C. / INT PT 10).

Politics, one of Stefano's passions at the time he attended University, is described as collective spaces where personal and social imagination seems to convene. A locus where the uncertainty connected to the embodied experience of social need is projected in a collective future:

> *«Politics must be the realisation of a social project. I think that politics should be more related to social needs. For instance, I would like to see the trade unions not as the transmission belt of a political party, but instead the political party as the transmission belt of the trade unions* [then he smiles]. *However many things have changed in my life, so I am not able to express political opinions objectively.»* (Stefano C. / INT PT 10).

Stefano expressed the idea that politics should be strictly related to social needs with an enthusiasm that was immediately dampened by his ironic smile. He has to consider the difficulty that he lives in an ever-changing reality, and his fear that he could lose himself once again. His imagination of the future, his dreams that could become concrete possibilities of life, here show a peculiar combination of collective projects and personal desires: political ideals, social projects, a love of books (he is fond of detective and spy stories), a passion for smoking. In Stefano's narrative it is therefore possible to perceive the delicate texture of personal agency through a changing historical reality, and the possibility that imagined social shared experiences could be suddenly invested with uncertainty and affliction of the incarnate self.

3.4. Questioning processes of insertion

The plans of the SIL are continually monitored with the purpose of testing how patients cope with the difficulties they encounter. Operators try to appraise parameters, which define working environments, causes of social pressure and the personality of the patient. That is, they try to analyse either the organisation of labour or the psychological processes of the subjects.

Many patients ironically observe the implementation and follow-up evaluation of the projects by the SIL. In Stefano's narrative, for instance, questionnaires and psychometric tests administered at the SIL are considered as ineffective tools that cannot grasp experiences and concrete daily problems. Moreover, the double nature of such questionnaires doesn't escape Stefano's attention. On the one hand, the tests are described as tools chosen to delineate the personality and the attitudes of the applicant (for a job, a house, a rehabilitating activity, etc.). On the other hand, they are considered as techniques to classify and diagnose personality disorders, psychiatric illness, and problematic behaviours.[18]

Stefano recalls that before being admitted to the "residence group" – the house that he now shares with three other patients – he had taken the *Minnesota* test (Minnesota multiphasic personality inventory, MMPI). The psychologist administering the test suggested to him that he had to jot down some considerations about the questions included in the list. There were too many questions – Stefano remembers – and he didn't feel like writing.

> STEFANO – *«Yes, you know those test they give us… they mean nothing. What do they mean? They asked me "do you feel well or unwell?" "Well". And then?»*
>
> MM – *«They are the SIL tests.»*
>
> STEFANO – *«Yes, they are the SIL tests. There is also "the Minnesota". The Minnesota test. I can't see the point of that. I did it before entering the residence-group. I did it at the Psychiatric Service, with the doctor. She gave me the test and asked me to fill it out.»*
>
> MM – *«What do you think about the idea of the test?»*
>
> STEFANO – «[With a whisper] *I don't know what to say. Because, when I took the test, my fears were more rooted than now. I mean, there are times you feel like a monster, in the sense you are formally deferential to other people, but you are substantially scared to death. And you wonder what kind of formal deference to have. Anyway I took the test, but now I don't know if it is useful or not.»* (Stefano C. / INT PT 10).

In this passage, the attitudinal tests for employment do not seem to be dissimilar to those diagnostic tools that are used to define and manage a psychiatric patient's life-course. In a sense, idioms of tests and trials seem to recall the same paradoxes emerging during working trials and continuing apprenticeship.

In fact the patients, like therapists and psychiatric operators, perceive work as a trial, but they do not seem to accept the idea that this trial does not lead necessarily to a steady job. To force a therapeutic relationship some patients can use such ambiguity. This is precisely what happened to Pietro, a 30-year-old patient working in a handicraft workshop. After two years of psychiatric treatment, he decided to interrupt his pharmacological treatment and to break off the therapeutic relationship but still try to keep up his job (which he had got from the SIL). But when Pietro realised that his job was threatened because of his dismissal from the Psychiatric service, he called the Labour Union to find out what exactly his situation was and what it really meant to be a psychiatric patient on an employment plan.

In these circumstances, the relationship between psychiatric care and work is radically questioned, and contradictions, emerging in the intermediary locus between society and medicine, can be activated in local forms of resistance. The following excerpt of a conversation I had with the SIL's psychiatrist concerns the ambiguous bond between psychiatric care and work:

> MM – *«It's a situation, I would say, which is not so ambiguous at the beginning, but which becomes so contradictory. It tends to be…»*
>
> Psychiatrist – *«Every time. Because it would not have been so ambiguous if the work was directly part of the therapeutic intervention. If SIL* [Employment service] *had been a part of the CIM* [Psychiatric service] *this ambiguity would probably not exist.»*
>
> MM – *«But perhaps there would be others.»*
>
> Psychiatrist – *«Of course.* [she smiles] *We are favourable to ambiguities.»*
>
> MM – *«Even if these contradictions emerge and then seem to be somehow resolved, they highlight objectively more complicated situations. In this manner, psychiatry can never resolve them because it is, itself, part of a range of conflicts and relationships…»*
>
> Psychiatrist – *«Exactly, but even…* even because the person, the citizen, the real one, lives within contradictions. Therefore, if the patient is "outside contradictions", it means that he is "outside citizenship". And it is true that these ambiguities come out more clearly if the person is progressively liberated from psychiatry. Because when he is under "Psychiatry's wing" things are fairly clear.» (Giovanna E., psychiatrist / INT PSC2).

The link between "acquiring citizenship" and "living within contradictions" proposed by the psychiatrist is quite interesting. In her model, the patients' actions can contribute to unmasking some taken for granted assumptions of social life. The resulting impact of such actions could be very problematic for psychiatric devices too.

In this regard, it may be useful to consider ambivalent linguistic uses of the word *tirocinio* [apprenticeship], in the descriptions of the plans of the *Servizio inserimento lavorativo*. The semantic network where the *tirocinio*-apprenticeship is situated progressively loses its core meaning, from the moment that the acquisition of professional ability does not seem to maintain any strong link with the perspective of steady employment. So the "*Tirocinio*" does not necessarily seem to be a real "apprenticeship", but a training that

– because of the crisis of the labour market – does not result in direct access to a steady job. Edoardo's critical perspective about his expectation of an improbable steady job, after a training period, is very meaningful.

> *«OK, then, at that point, you* [the employer] *say "I accept or I don't accept the tirocinio". Because, at that point, you say "I have here a guy who can operate alone, after explaining some specific things to him." Then, at that point, what are you going to do? You ask: "Is my firm at his disposal for an apprenticeship?" Yes or no? If you say no, other possibilities are looked for. But not in a year! Because if I wait for a year, it's because, in the meantime, you evidently told me that you have had organisational problems, but you have also thought of giving me another possible job. And this is what they made me believe.»* (Edoardo M. / INT PT 4)

Those aspects of psychiatric rehabilitation, which Benedetto Saraceno ironically calls the peculiar psychiatric vocation of *entertainment* (Saraceno, 1995), are here subjected to strong tensions deriving from the patient's expectations of a stable job. It seems that around the crucial issue of the division and the management of Time not only are there healing practices, but also psychiatric disputes about job and rehabilitation activities.

The interaction between work, time and transformation of the Self in therapeutic settings is particularly interesting whenever we observe that the acquisition of ability in the Day Centre of Rehabilitation (*Centro di accoglienza diurno* CAD) is described with terms recalling those which are used to speak about the patients' working life. In the interviews with patients and psychiatric workers, the two contexts – work and rehabilitation – show points of contact and seem to interact around the crucial matter of "a situated economy of time".

According to the psychiatric staff's rehabilitation model, the Day Centre of Rehabilitation is the frame of social and cultural activities that runs parallel to effective therapeutic itineraries. In fact, psychiatric workers tend to consider the *Centro di accoglienza diurno* as a place where the practices activated are only supports to facilitate the therapy ("*facilitatori*"), and they do not directly affect it. In their model, psychiatrists have the role of sponsoring the activities and supplying means and opportunities, while maintaining a certain distance from the actual problems directly concerning illness and care giving.

In fact the activity of "meta-reflection on processes activated in therapeutic relationship", considered by psychiatrists as a peculiar trait of the therapeutic task, seems to be very difficult in the case of rehabilitation. This is particularly evident in the discussions that psychiatric operators have about the possible assessment of "concrete", "material", hands-on activities carried out in the Day Centre of Rehabilitation – that is, workshops about painting, writing, video-making, cooking, and so on. The central question of assessment, then, is how such a hybrid space should be evaluated?

In the following excerpt of an assessment meeting, a psychiatrist outlines the volatile features of the moral world where patients' agency is tested.

> *«We have some parameters. They are parameters of subjectivity. The patient becomes responsible for his subjectivity before us and before the world. The more he becomes aware of his expressions and requests, the more this thing* [the activity of rehabilitation] *is good for him. For instance, this is a very general element, which is also a strong criterion for judging … His requests, the way in which he expresses himself as a person who is asking questions, or doing something… The fact that he is not passive, but more aware* […] *They are very long processes, and it is highly complicated to define the parameters that really… and sometimes they are subjective parameters. Perhaps videotapes could be used, even those videos that we made together with the patients three years ago… and we can see them today: posture, mimicry. That could be done. Because it becomes so complicated to define the efficacy… It is just as if we try to compare ourselves today to how we were three years ago. We are different.»* (a psychiatrist during an Assessment meeting / Ass 4).

The passage above makes it possible for us to grasp aspects, substantially opaque, of those transformations – occurring in a setting of rehabilitation – which seem to be closely related to processes of embodiment (Csordas, 1990, 1994; Connerton, 1989). Since it is not possible to constantly monitor rehabilitating activities, the quality of transformations occurring over long periods of time could be referred to the "embodied presence" of the patient within psychiatric devices.

Finally, considering the ways in which psychiatric devices are produced, we can see how, in the "domain of the mind" circumscribed by psychiatric practices, indices concerning patients' bodies are a crucial issue in understanding transformations that can occur over long periods of time. The moulded *habitus* (Bourdieu, 1977) symbolises, therefore, the patient's changed capability of negotiation, his "presence" (de Martino, 1977; Pandolfi, 1993) empowered through activities in workshops and other rehabilitation environments.

As we have seen, in assessment dialogues, psychiatric patients are depicted as embodying devices of rehabilitation. But the efficacy of healing practices and the opportunity of recovery are projected in a blurred and distant future. Ironically the practices of rehabilitation reveal that they have the same inner paradox – as Arthur Kleinman suggests – which is at the heart of health care and medicine: «Psychotherapy, the major form of symbolic healing in contemporary health care and biomedicine, illuminates a postmodern paradox. Healing has become increasingly marginal to the West's dominant healing system.» (Kleinman, 1988:139).

4. Conclusion

In this paper, I have analysed some of the problems of the knowledge and practices of community psychiatry, paying attention to the contradictory experiences that emerge from local confrontation and the daily activities of the psychiatric field.

From the chosen perspective, rhetorics of madness and practices of healing have been considered not as opposed to each other, but in a dynamic mutual relationship, within the policies of mental health. Rhetorics, far from having a merely instrumental value, represent attempts to force the existent order into a conflict of interpretations. For this reason, they have to be considered in their deep cultural roots, either as authoritarian and hegemonic exercising techniques, or as tactics working from the bottom at the corrosion of structured power relations (Comaroff; Comaroff, 1991; Herzfeld, 1997). On the other hand, practices can be considered as attempts, continuously renewed, to naturalise existent social reality, through innovations and experimental forms which have, in turn, a historical problematic nature.

As we have seen, an analysis of public psychiatric practices shows the "obtuse" and "inarticulable" meaning (Taussig, 1986) of oppositions (mind/body, public/private, visible/invisible, self/other) emerging either in local debates, or in situated descriptions of the paradoxes of illness, labour and embodiment. Moreover, a discontinuity between patients' narratives and psychiatric projects of rehabilitation suggests that when psychiatry withdraws into the "technical locus of therapy" – avoiding the fruitful exchange at the margins with society, labour and creative activities – it tends to be reabsorbed in forms of psychiatric management of risk (Basaglia, 2000; Castel, 1973).

Finally, in the mental health field, the confrontation between visible/public elements and rhetorics of self-making can illuminate features of local processes of producing what is natural and hegemonic. The fact that these processes are so important in understanding some of the naturalised dimensions of the social world evidently does not mean that practices of healing can be effectively and consciously performed by social actors in the "political arena". Such practices, however, appear in their ambivalence either as possible ways of confirming social boundaries, or as potential criticisms of cultural stereotypes. In any case, questions concerning bodily experiences and paradoxes emerging from local debates – rather than being neglected – can be used in the local community to produce experimental forms of coping with illness, care and madness.

Notes

(1) The research was carried out between November 1998 and June 2000, in a Mental Health Centre in a community in Umbria – the territory of Gubbio in the *Comprensorio Eugubino-Gualdese* (province of Perugia, Umbria). The area chosen seemed particularly interesting because of the coexistence of different community resources and (popular and professional) help-seeking behaviours concerning mental health problems.

(2) In the context I will refer to the plurality of the resources which denote the co-presence of different and conflicting *systems of reasoning* (Young 1995a, 1997) about social suffering, madness and death. The research was essentially based on a set of case studies through which is explored local networks sustaining a plurality of social practices and knowledge about health, sickness and the body. Most of the ethnography was centred on a small number of people who have used different forms of treatment and support. The cases have been considered as an index of social conflict areas between providers of care-competence and subjects with different levels of power.

(3) According to Franco Basaglia, the importance of the "Italian experience" resides in an attempt to recognise social contradictions and to declare the role ascribed to the psychiatrist as "intellectual", involved in processes that reproduce fundamental power divisions and current systems of social control. In most of his theoretical writings (Basaglia 1981, 1982, 1987, 2000), Basaglia considers the bodily experience of patients (subjected to "hospitalisation") as a primary argument in the analysis of psychiatric institutions. He argued the importance of promoting a social process of legitimisation of individual, social and political bodies (see Scheper-Hughes; Lock 1987), in order to increase the chances of social interaction and exchange. In this way, he sustained a necessary and enduring praxis in the permanent social confrontation and conflict. As Bendetto Saraceno (Saraceno 1995) has recently suggested, this approach implies peculiar sensibility for different sources of "otherness" in the social space.

(4) I use the term "field" in the meaning outlined by Pierre Bourdieu (Bourdieu 1977, 1989, 1994).

(5) The Mental Health Centre in Gubbio is committed to protecting and to promoting mental health prevention and care, and programmes and co-ordinates the existing network of intermediary structures in North-East Umbria.

(6) An interesting description of the recent transformation of Italian psychiatry is in Scheper-Hughes – Lovell 1987. In the English language, there are the works of Lovell (Lovell 1985), Ramon (Ramon 1983, 1985; Ramon; Giannichedda 1988), and the polemic reading of Jones (Jones 1988). A general history of the "Umbrian psychiatric experience" is not available at the moment. An accurate review of the writings produced in the last thirty years has been edited by Patrizia Guarnieri (Guarnieri 1998). A framework could be outlined looking at some interesting works: Micheli 1982, the interview of Carlo Manuali in Venturini 1979, Scotti - Brutti 1980, 1981, Guaitini 1974, Scotti 1995. An anthropological analysis of attitudes toward psychiatric transformation of the 70s is proposed in Guaitini; Seppilli 1979. The authors have outlined a tripartite model of fractured modernisation of Italian society to describe layered and contradictory cultural interpretations of madness and psychiatry.

(7) "The CIM" (Center of Mental Hygiene) is the name still used today by inhabitants to refer to the current Mental Health Centre (CSM). The whole history of the de-institutionalisation processes and the social construction of psychiatric territorial networks is focused on this outdated terminology. The Centres of Mental Hygiene were in fact, in the 70s, the first psychiatric structures, exclusively territorial, in Umbria. Within a political movement to promote health care and prevention, CIM was the main advocate of reinserting ex-hospitalised patients into their own native communities. Concerning this subject, one can see the transcriptions of the public meetings (*assemblee*) in Guaitini 1974.

(8) The following conventions are used in reporting my fieldwork material: Fdw: fieldwork diary notes; Int: audio recorded interview; Ass.: audio recorded assessment meeting. All names used in the text are fictitious. In the audio recorded tape transcript I have emphasised some meaningful passages.

(9) I have gathered together and studied the documentation on local public debates held in the last 30 years. Among the documents are the minutes of the *assemblee* that were held to discuss the organisation of the new territorial psychiatric services in the first half of the 70s (see Guatini 1974); public interventions and debates in local media about some cases of suicide in Gubbio (in the middle of the 80s) which involved psychiatrists and local administrators; video-recorded public meetings, called *conferenze permanenti* (in 1990, 1991, 1992); public interventions – in newspapers and on a local TV network – by politicians, psychiatric workers and members of the Association for implementing the psychiatric reform. More recently I attended some *assemblee* about the new Pact for community mental health, an initiative activated by public administrations and psychiatric services at the beginning of the year 2000.

(10) A thick plot of meanings, which the protagonists of debates try frequently to unravel by resorting to stereotypes. As Michael Herzfeld has shown (Herzfeld, 1997: 156-164), the study of stereotypes in social poetics and rhetorics, may represent a fruitful access not only to hegemonic cultural constructions, but even to forms of resistance to established powers.

(11) This is generally done in some public and private discussions about psychiatric cases, which consider the "structured structures" crossed by patient's biographical pilgrimages of individualisation (Bourdieu, 1994). For a particular case of psychiatric rehabilitation, see Estroff (1993).

(12) "Language games" seem to prevail in social interactions which are connected to the social production of the "private experience" (Wittgenstein, 1953, 1978; Das, 1996, 1998) – not only the patients' experience, but even the experiences of all the social actors involved as well. On demarcation of bodily boudaries see Devereux (1967).

(13) I consider the insightful suggestions of Veena Das (Das, 1998) about the relationships among "language games", "private experience" and "embodiment". The interest in the body, the role of scepticism in social relations and how "public secrets" (Taussig, 1993) are played in hegemonic processes, can also be discussed in a critical framework, which includes anthropological works that are rather different from each other: De Martino reading Heidegger and Gramsci (de Martino, 1977), Taussig reading Benjnamin (Taussig, 1987, 1993, 1999), Das reading Wittgenstein (Das, 1998).

(14) Time in medical and psychiatric settings is a crucial matter when we try to observe the intercourse of meanings within precise power relationships. For time and medicine, see Frankenberg 1992. As far as psychiatry is concerned, an original critical perspective – with a psychoanalytical approach – has been adopted by Fachinelli 1979, 1983. In the case examined here, local conceptions of time can not be separated from the experiences and power relations of labour (Thompson, E.P. 1967) and consumption (Appadurai, 1996).

(15) In this study, I only consider male patients, for the following reasons: *a*) firstly, because there are more male patients in rehabilitation projects: most of the patients attending initiatives held in the Day Centre of Rehabilitation are males, between the age of 25 and 45. *b*) Moreover, gender differences seem to recall a sort of division of psychiatric labour; in fact, the prevailing male presence in rehabilitating groups is the counterpart of the prevailing female composition of the psychiatric staff. *c*) Finally, in the acquisition of citizenship through employment insertion, some biographical paths of the patients are marked by established steps, which seem to be particularly well defined in the case of the social construction of the male gender.

(16) For the distinction between "reasons" and "causes", see Bouveresse (1991), Young (1995b), Wittgenstein (1978).

(17) In psychiatric settings, dynamics directly involving the dialectics between visible and invisible (DEVEREUX 1967) are sometime consciously used by doctors and nurses. This happens in working groups, where the communication of patients' symptoms is discouraged, and some aspects of group interaction are collectively questioned.

(18) See Kaufman (1988) and Corin (1990). Interesting suggestions by Lock and Scheper-Hughes (Scheper-Hughes; Lock, 1987) regard the opportunity of interpreting idioms of emotions in correspondence of the overlapping three bodies: individual body, social body, and body politic.

We have anyway to remember the criticism that de Martino (de Martino, 1977) moved to those phenomenological approaches which seem to forget the fundamental role played by social history in embodiment processes.

(19) Kurt Danziger (Danziger 1990), in a penetrating study of how psychology produces his subjects of inquiry, has shown the pivotal role played by psychometrical tests in the paradigmatic configuration of the psychological science.

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Medicine and change: making agency count

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The aim of this paper is twofold. First, I will reflect on the theoretical approach of agency. Second, I will problematise it from my field position. Medical anthropology has a well-developed tradition of using the agency approach in the field. In the 1980s, with the reflexive approach, social scientists themselves came into the text (1). Actually, anthropologists have always been in the text, even though they initially thought they were not. The fashions had changed and it had become unnecessary to try to blend into the wallpaper (2). 'It is an academic convention that authors are present to a greater or lesser extent in their texts. These 'conventions' caused me considerable pain when I was struggling to expose my agency in my texts. I gave up any hope of writing the right 'style' and made it part of my argument: it is an essentially Western tradition to see social reality in terms of agency. I stated in the foreword to my dissertation that the thoughts, which were not otherwise annotated in the text, belonged solely to me. That was my agency in me, which I was failing to show.

Turning now to the main theme of the conference, medical anthropology, depends heavily on the agency that we, medical anthropologists, have in academic, medical and political fields. I want to go further than Bourdieu (1990) by saying that anthropology should not only be a critical discipline, but also be responsible for the critique it produces.

What does 'agency' mean and how useful is it for interpretation? In a recent international meeting, which tried to establish an interdisciplinary micro-approach network of social scientists between Nordic, Baltic, and Russian scholars, a discussion of micro vs. macro approaches arose. Macrosociologists appeared to have acquired a great deal of the power in the current everyday practice of their discipline, leaving too small a space for other perspectives. Anthropologists could proudly withdraw from the dispute, claiming a complete absence of the problem from their discipline. Even more – we all used either discourse or agency (or networks as agents did) as tools to interpret our texts.

I will stress a few basic premises of the debate, which are central to my later argument. First, the agency vs. structure approach is one of the central questions and debates in social theory. However, relationships between agency and structure have always been more important than agency itself. Second, agency can be seen to be located either in structures or individuals. Regardless of the initial position of interpretation, actions can always be analytically traced back to agency (3). Third, agency is a product of a particular historicity and space. It is at once a theoretical term that bridges the tension between the individual and structural perception of one's own person in the Western world (4). Agency as such has been problematic, further questioning the centrality of human agency. This problem seemed to have been solved by actor-network theorists that allowed relationships, foetuses, scallops, machines and others to join the club without involving structures. Agency itself was still taken for granted.

I believe that by developing a theoretical perspective on agency anthropologists can contribute to solving many practical problems in the field. This would also mean that anthropologists move from a passive to an active research position. It would allow us to avoid the uncomfortable position of detached observers.

I started as a critical anthropologist, examining doctor-patient relationships and the medicalisation of human life, which I considered rather evil. I found that critical medical anthropology has been a driving force behind the change in doctor-patient relationships. Methodologically, I tried to blend in with the wallpaper during my fieldwork, knowing at the same time that it is impossible. In my dissertation, I described the ways in which doctors and patients communicate and how childbirth practices change over time. I criticised the field I studied and withdrew from it.

None of our works (even if made for the enjoyment of our own scientific community) is politically neutral. Wilfully or not, we become participants in the process. The divide between the 'academic' and 'politics' is curtailing our agency. Anthropologists had had implicit or explicit intentions to influence the policy process. I can mention Margaret Mead as an example of setting 'natural' childbirth movement in the USA and inspiring a theory of child development.

Traditionally anthropologists work as experts on behalf on academic or other funding institutions. In the 1990s the approach began to change.

Reacting to the failure of the health care reforms in the developing states, the World Bank began to advocate a bottom-up approach (5). This approach is based on the belief of human agency. Democratisation of the developing countries became the issue for insuring the success of different policies, including health policy. Participatory democracy is also one of the key slogans of the European Union. Social scientists are taking part in this process, becoming moderators between the science, government and society.

I came back to the field I could traditionally call mine as an expert on behalf of the European Commission and the UN Development Programme. I noticed a dramatic change. The emerging Western type of agency I saw in the mid 1990s began to fail since 'agents' could not see a space to exercise it. It appeared that there could be no participatory democracy in the society, which basically believes that only structures can possess agency.

Working in a group of experts for the European Union I participated in the drawing up of the Latvian National Development plan. It was a plan for the state's future activities in definite areas, including health care. It was important to the medical field since the pre-structural funds of the EU would be distributed according to the priorities of the plan. At the same time the plan defines the broader relationship of the medical field to state politics. The previous version of the plan failed to obtain EC approval because it was designed as a shopping list for various ministries and lacked societal perspective. The mistake was corrected, putting societal interest as a strategic goal in the preamble of the plan. Backstage experts were encouraged to provide this 'societal imitation' throughout the body of the plan. In large, the effect was thought to be reached by two means. First putting something 'social' in the plan like health care and unemployment. Second, the plan had to imitate the participatory democracy and 'sound' social enough. Under these two covers there was still the same shopping list since the distribution of the means between the different fields depended on their political capability to negotiate. The non-governmental sector was not allowed in even though there is the practice of delegation of the state functions to NGOs.

The image of participatory democracy combined with the absence of corresponding agency resources pays back double. As is commonly known, Latvia is a democratic country moving towards the European Union. According to the principle of new democracy, agents should express their views in a forum. In the previous Soviet system of rigid structures the basic principle was 'you do not count as a person without a paper'. In the participatory democracy papers have become less important, the person became unimaginable without the voice.

The grassroots of agency I fixed in the mid-1990s had disappeared. Previously active participants 'fell' back into the system approach, merging with the structure and giving up the voice. It appeared too difficult to achieve goals partly because members of the medical staff were badly organised, partly because they came to distrust the state. Their skills were not sophisticated enough to count as agencies. This drawback allowed the state officials legitimacy to ignore their potential voice, making the situation more dramatic.

The first apparent example of losing voice occurred on a slightly different scale when I was still writing up my fieldwork data into my doctoral dissertation. A woman who had longed for home birth and conducted it at home despite the opinion of her midwife suddenly began to interpret the event as the irresponsibility of the midwife. In a year the birth event ceased to be a 'wonderful miracle truly born out activity of both – father and mother'. Now their midwife and health care in general were responsible for putting the life of the patient and the baby at risk.

Several similar transformations happened amongst the doctors. Previously active and reflexive agency seemed to implode. The new meanings and activity had collapsed within themselves. A depressive mood and helplessness dominated in interviews. In the mid-nineties these doctors were in the middle of events. They initiated and enacted the change in their wards and health care programmes. Wards became open and patient-oriented. The practice itself changed. Medical technology masked under 'human help' replaced wooden stethoscopes in obstetrics. A new knowledge became a requirement for practice.

Reasons for the imploding agency can be found in the status of the health care system within the broader political context. Firstly, the medical profession is one of the least valued, along with that of schoolteachers. Doctors' salaries are well below the average salary and nurses receive slightly more than the minimum wage of the country. The historical roots of this tradition can be found in the Soviet period. At that time the medical profession became female dominated and therefore lower paid. However, in comparison to the Soviet period, doctors' wages have fallen twofold.

Secondly, health care appeared to be a rather costly policy. Latvia underwent a rather complicated health care reform. The rationale of the reforms themselves is poorly understood not only by patients but also by medical staff. Channels of financing are tricky, combining the state budget, local government resources and obligatory and voluntary health insurance. Local governments are put in an especially difficult situation, being forced to sell and buy their own health care products. Financing is always insufficient to implement the health-care programme. At the end of the budget year or even in the middle of it a sudden hole in the budget opens up. In 2000 it appeared that the budget did not have enough means to cover the medicine compensation programme. The first solution offered by the large service providers was to draw the sum from the doctors' salaries. In 2001, the largest maternity hospital announced that it had fallen into debt because more women are giving birth than expected. When the state insurance company refused to lift the quota, the hospital threatened to send the birth-giving women to the company's offices. Finally, the Ministry of Welfare reminded them that deliveries are the state's priority and should be covered by all means. No additional means from the budget were allocated to solve the problem given that the quotas for planned operations in several central hospitals were also exceeded 5-6 months earlier.

Additionally, the financing of the medical care changed from one principle to another. Currently a mixed system of points (given for certain operations) and capitation (a certain amount per registered patient) applies. Doctors have named the new principle 'decapitation (of doctors)'.

The femaleness of the profession is a poor explanation for the status of the profession. Another argument (which I will unfold later) is the absence of appropriate tools and skills to voice and advocate the professional interest. To explain the argument of implosion of agency, I will illustrate it with a real case.

A director of a hospital refused to accept any new patients on the grounds that the state evaluated quota (and financing) for the patients had already been reached. This problem arose in October 2000 in many hospitals when their quotas for the year were reached two or three months early.

Clearly, a refusal to accept patients at the hospitals' own risk could be called a political protest action aiming at influencing policymaking. This is what the director of the hospital *could* mean when one is looking with the eyes of a Westerner. What his colleagues in this action saw is the following:

> *«Look at A, he is a director in one hospital and holds a post of a state representative in another. He commands his hospital and tries to put that other hospital on its knees (to join the initiated protest action). Well, medicine really needs resources and I support this. But A is doing this to gain popularity before elections [A is on the candidate list for local government elections]. So it is done – the same people moving from one post to another, mixing between themselves like in a dark pocket. Others are not welcomed in. This is why one cannot understand the system of health care now. Why is the institution X established? B didn't have an important post, so others establish one for him to preserve the solidarity. All this system is made to ensure posts for its members but not for developing a coherent health care system.»* (Dr. B)

Dr. B was a previously politically active doctor. Some 10 years ago she pioneered the change in maternity services all over Latvia. She was proud that her opinion and experience were highly regarded in Moscow. She managed fund-rising abroad and ran programmes of developing maternity and neonatal services in Latvia in the first years of independence.

Moreover, she was not the only doctor ceasing to see her agency under new circumstances. 'The structures' became a serious obstacle to exercising one's agency. For example, Dr. C actively started a new private exemplary practice some six years ago. At that time his initiative was in line with health care reform. He had managed to use resources to establish his practice at the right time and place. Now the process was interpreted differently:

> *«That process of certification (post-diploma education) costs my month's salary. I would die from hunger if my wife did not support the family and me. Look, where does this money go? OK, lecturers should be paid, but they do not take that amount of money. The rest goes to private account of the president of our association D.»*

When I inquired why nobody objects, given that money for the certification is considerable amount for a doctor, C replied:

> *«I have not passed the certification yet. It is too risky to start the protest before I go through. Besides exclusively D does all this education. I think it must be taken by the university.»*

'Inaction' to a great extent is conditioned by the perception of the field. What helped in adopting this perspective? First, there is strong competition between the doctors in the field. Any collective action is still in doubt since hospitals and doctors are competing for scarce resources. Latvia still has a rather high number of specialised doctors and not so long patient queues for treatment. This model ensures more jobs for the medical staff. However this system is rather costly. The situation is especially difficult for specialised providers of maternity care. This sector mostly depends on the state budget since assistance at delivery is within the state granted health-service minimum. With the drop in birth-rate the competition between the hospitals and doctors became fiercer. Now a reverse effect can be observed. The birth rate rises slowly. However, hospitals do not receive more money that was planned in the budget. Hospitals and local government do participate in the planning process but nonetheless they see the whole planning process in a rather dim light.

The agency implosion is also due to the fact that the state policy is not explained to the doctors. I heard various beliefs about the way the health system works and I could not find any single person at the executive level of the hospital who would volunteer to be an expert in the current health care system. The knowledge of practitioners helps in perceiving the events in the field without giving control of the process.

Another reason for passivity is the already mentioned financial shape of the medical staff. Most of them take extra-hours at work to survive. Female medical staff have their double burden at home – taking care of their parents, husbands and children. Some doctors and nurses are single heads of their families. Some of them work additionally. I met a gynaecologist who worked as a cleaner in the evenings. She was a single mother and had to take care of her ill mother. An extra job was an absolute must to feed the family. Comparing the input in the work, the second job was much more rewarding. The doctor herself felt shy telling me this; that was a low prestige job and incompatible with the doctor's position in society.

As a justification for one's passivity a strong and closed power hierarchy is mentioned. This power is attributed to the posts and structures, rather than to the participants themselves. This helps the agency to transcend. With agency transcending, the individual responsibility dissolves. One does not participate in the policy process because one does not count as a participant and one is not responsible for the process. The only strategy for reflecting on the situation is talking to friends and relatives. Being (or rather feeling) outside the process allows one to criticise it implicitly without being responsible neither for the critique nor the (in) action.

There are still doctors who carry a different interpretation of the field. These had chosen a different strategy already in the early 1990s, starting to work through an NGO structure. I must explain that professional associations, which include virtually all doctors and nurses also, are non-governmental organisations. However, these organisations deal with exclusively professional and regulatory matters. In fact associations are structures, not a collectivity of individual agents. For this reason, medical professional associations are not very suitable for dealing with advocacy matters. On the one hand, professional medical organisations work as the state partner regulating the discipline. On the other hand, they lack sufficient authority beyond professional competence.

There are examples of spontaneous protest actions in medicine. One of the most recent ones concerns so called middle-level medical staff – nurses and midwives. British and Norwegian governments have expressed a wish to contract Latvian nurses for work in their countries. The Norwegian government has even agreed to support nursing education in general and Norwegian language courses for the selected nurses in exchange for work contract of Latvian nurses in Norway. Latvian hospitals already lack nurses since the salary is rather low. In this respect the situation is similar to that in Britain and Norway. Latvian clinics are expected to lose much of their qualified and experienced staff. The event was widely discussed in media and many nurses have already applied.

However, it did not turn out to put pressure on Latvian government concerning nurses' wages. Nurses organised a protest action at the Cabinet of Ministers asking for a rise in salary. Even though the protest meeting was well attended by nurses, and some doctors and patients joined them, the protest action did not achieve the expected result. Government officials explained that the budget structure should be changed to satisfy the demands of the nurses. This, of course, could not be done in a day. It is not done even in a month's time. As an answer, the Latvian Association of Nurses plan to strike.

When compared to other member benefit professional organisations, the scope for the action of medical associations is rather limited. For example, the Latvian Association of Fishermen and Fish industry works exclusively as a lobby for members' interests. Acknowledging that their interest would not be taken into account when they were absent from the policy process, the group had delegated a representative who actively searched for the right time and place to interfere in the decision-making process. The representative expressed the interest of his association, mentioning that this is the view of 80% of Latvian fishermen. He was proud to present the fact that the Ministry respect and fear their opinion to a great deal. At the same time the state officials rarely informed the representative about the course of events. It was solely his responsibility to present the opinion.

Protest actions like strikes, demonstrations and meetings are the most popular form of public involvement in politics in Latvia (6). They are believed to be most influential ones after voting in elections. Even though protest actions take a significant place in the political landscape of Latvia, compared to France, Latvians use these means rarely. An average 13% of Latvian population had participated at least once in such an action.

Many more strategies are used by non-governmental organisations. Around 280 of them deal to some degree with the issues of reproductive health. Around 20 deal exclusively with the matters of reproductive health.

Non-governmental organisations in the medical field unite members of different professions. When I started my fieldwork in 1996, there was one major organisation for family planning and reproductive health "Papardes Zieds (7)" (PZ). Its major aim was education in reproductive health and contraception. By 2000 they had established their local network all over Latvia.

They prepared volunteers for lecturing at schools and organised interest education for youth. However, when the network was stabilised, another need occurred. The organisation managed to deal successfully with the lack of information by providing it itself. The failure was in not influencing education policy at large.

It did not succeed in establishing education as a part of school programmes. To affect the education in reproductive health, the subject syllabus was prepared and handed on to the Ministry of Education and Science. Teaching courses for teachers were initiated. The result was a small number of enthusiastic teachers actively working with children. Health lessons were not obligatory. The rest of the system remained intact. As a 16 year old girl recounted:

> *«Our teacher of biology took over the health classes. She is old. With all her views what is proper and what not. She lectured about hygiene in these classes. That was only one class when she shortly and generally told us about process of reproduction. I doubt she had ever heard of contraception and like. That was not what we expected to learn.»*

At the beginning of the education campaign PZ turned its main attention to youth. In fact the older generation felt repelled by their actions, considering talk about the intimate part of human life indecent.

Broadly speaking, the problem was not in the generating of new kinds of ideas. It was in their implementation. Looking back at the establishment of the health NGOs, it happened mostly due to the fact that those individual gynaecologists became aware of the abortion problem in Latvia already in the 1980s. Then, abortion procedures were seen as a personal pain when conducting an unacceptable operation and personal inability to prevent the high rate of abortions. Almost 9 % of women of reproductive age had undergone an abortion (8) in the 1980s. Abortions were a part of the state reproductive policy and certainly not a medical or ethical problem since the 1950s. These individual anxieties of doctors became collectivised by establishing a non-governmental organisation for family planning and reproductive health. The initiative came from a foreign Latvian. This is typical of Latvian NGOs in general. At that time not only new ideas but also skills and attitudes to affect these ideas were learnt. NGOs took a different path from that used in hospitals or professional associations.

> *«This started with the right attitude. We came together and realised that we think similarly, that real things can be done to cut down the abortion rate. I personally learnt the argumentation and presentation skills. How to present my ideas effectively. I work with a female collective. I know how difficult it is to make the Department meetings, how difficult it is to discuss matters here. People are not used to positive communication.»* (Dr. L, member of PZ)

The strategies selected by NGO members looked beyond the traditional medical field, choosing a flexible approach. They also opened a space for open discussion and collective action.

Firstly, PZ co-operated with its international counterparts in attracting the financing. Their first projects were financed by foreign aid organisations. The state ministries were not ready to participate in the international Cupertino projects and potential donors preferred to invest in NGOs. Secondly, a PZ member represented the whole Latvian State in the Cairo conference. Due to her professional and NGO experience, she simply appeared to be the most suitable candidate to address questions of population growth and reproductive health. The doctor L recounts on her experience:

> *«It was an incredible feeling. A doctor from Latvia raises the card with state name and says: In the name of Republic of Latvia. I learnt all that language and the way people talk and advocate their interest. Feeling that you can do the same. In the late conference I heard the representatives of the Holy See? speaking. I almost forgot for a moment what my own position concerning abortions was.»* (Dr. L)

Acknowledging the limits of their educational strategies, the attention of the PZ members was turned towards advocacy of their interest. It was done by all possible means, from educating politicians during ordinary trips to conferences and meetings to influencing them as patients. Besides, PZ participates as an official and unofficial partner in developing the state health policy. Although civil servants consult the NGOs in preparing projects of the normative acts, NGOs are not participating as partners. PZ also represents the NGO health sectors in all Summits, presenting an alternative report on developments. PZ co-operates with other health sectors NGOs influencing health-care legislation. Different means are used to gain influence. This year the Baltic Congress of Gynaecologists and Obstetricians has the Prime Minister as its Patron. At the time of the invitation he was the Mayor of the capital of Latvia – Riga. His political advancement helped to raise the prestige of the whole Congress.

In the long run, non-governmental organisations have appeared the most effective space for exercising one's agency. This appeared to be a suitable environment offering not only knowledge but also developing skills for exercising that knowledge. Speaking about change and improvement in the health sector, NGOs were the most suitable agents for it.

Medical anthropology has a strong agency approach. This is good base for further development of the theory of action, which could be utilised not only for the academic but also for empowering our informants. Of course, this need is born out of specific time and space. Where is the place for anthropologists in present-day Europe? Anthropological theory has been in line with politics, going together with funding from the colonial to the post-colonial era. No opinion can be politically neutral, even that expressed according to academic standards. Science students are taking an open position of mediators between the society, science and the state.

With anthropologists becoming mediators and responsible participants of the social processes, medical anthropology as a discipline will be strengthened. Medical anthropology has always been a critical discipline in relation to biomedicine. Its critique has helped develop the medical field itself (9). However, the critique should become constructive by providing ways to solve the problems diagnosed.

The proposal goes well beyond the scope of applied anthropology. I call for developing theoretical and methodological means for participatory research. It is certainly possible to continue the analysis, for example using Kleinman's model. One can improve the model and adopt it to specific cultural backgrounds. However, the core of the problem might not be in the models of transactions or education of doctors. It might be in the respective agencies of the participants. The same educational background due to agency skills may result in different modes of translation.

In a conversion with a polyclinic doctor I discovered that the polyclinics have gynaecologists for the 'rich' and the 'poor'. The doctors worked next door to each other and used the same equipment. Reflexivity and ability to use their reflexivity drew the borderline between the two kinds of doctors. The educational background of these doctors was similar. The difference in the doctor-patient relationship was enormous. The doctors of the 'rich' attracted the most affluent patients and received higher fees.

The solution of the poor doctor-patient relationship can be hardly found in the models of mutual understanding or education. Using the concept of agency allows us a broader approach, relating all factors curtailing or strengthening one or another expression of agency.

Looking at the events in the field of health care in Latvia, a critical approach will hardly provide solutions. It is not enough to conclude that the health care system is chaotic. Health politicians do not read academic reports in social sciences. Doing research simultaneously becomes the responsibility of an anthropologist to the field he or she criticises. Otherwise, an anthropologist becomes an echo, reproducing the same problems he or she brings out.

Pointing out the hegemonic nature of biomedicine and believing that the expression of the critique in academic texts is the limit of our activity, I rather propose going beyond the critical function of medical anthropology towards designing the strategies to go beyond the critique – detecting potential agents for change and proposing strategies for solutions.

In my case it was evaluating the change in the field; reaching the conclusion that change was linked to the change in perception of agency and evaluating strategies to develop agency and skills for sustaining that agency. The doctor-patient relationship goes well beyond the medical field; it is as much about the welfare state and international politics.

Empowering the subjects of research, we, as developers of empowerment strategies, will gain a strong agency of our own. Therefore my suggestion is rather to develop a stronger agency for medical anthropology itself rather than trying to reach influence by contributing to the field of general anthropology. Developing strategies for exercising agency may become an important advantage especially doing anthropology at home where social scientists from different disciplines respond to the same problems. This allows for the growth of the discipline and the finding of common goals with anthropologists working in fields other than medicine.

Notes

(1) e.g., Woolgar, Ashmore, Krumeich.

(2) See Tonkin, E. (1984), p. 216-217.

(3) See Ashmore (1994), p. 734-735.

(4) Foucault (1972).

(5) See also Krumeich (1994), p. 5.

(6) Human Development Report 2000, UNDP, 2001.

(7) This is the name of a mythical flower which blossoms only on midsummer night in the forest. One can find happiness just by seeing the flower. However, both happiness and the searching process are strongly linked to sexuality.

(8) *Demographic Yearbook of Latvia* 1997, Riga, 1998: 82.

(9) See Putnina (1999).

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Liturgical categories and ritual process(1).

The Nordic welfare states encounter with workplace health problems

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An anthropological approach to health in the Norwegian welfare state

This study starts out from a problem area of growing importance in the Nordic welfare states; people who do not function adequately when fitting into the system of their workplace due to what is defined as health problems. I have chosen two very different groups to illustrate my point. The first group is pupils in elementary school who have behaviour disturbances and therefore can not follow their class in the ordinary educational programme. The other group is employees with chronic, diffuse musculoskeletal pain that prevents them from functioning in their job.

My aim with the study is to see how the system deals with these problems and how the individuals themselves can be empowered to take alternative strategies to the system approach. My presupposition of the Norwegian system is that solving health problems is seen as the responsibility of the state. The state is a bureaucratic organisation that needs a set structure and routine to deal with each case. Individuals are put into categories so as to fit into the structure. These categories derive from a medical system of diagnoses. What happens when the system does not function any more because the individuals do not fit in the categories?

The two cases are chosen because they represent two very different approaches both from the welfare system and from the individuals involved, in a situation where the established concept of how the state should take on and solve people's health problems do not work. The psychologists and pedagogues working with 'difficult' pupils find more and more complex sets of problems that are not so easily solved within the established system. The employees with chronic, diffuse musculoskeletal pain have more or less been abandoned by the ordinary medical system.

I do not intend to find a solution to these problems through my study. I don't think there is just one, but many, as will be evident in the description of the rehabilitation programme for the employees with musculoskeletal pain. I only want to look at the system from an anthropological standpoint, and view the medical system and the welfare organisations as cultural systems constantly facing new complex problems and making continuous adaptations. In these adaptations there is also a power aspect that needs to be detected to make the people involved able to act according to their interests. Motivating the study lies a concern for people losing not only control over their own lives but also important life quality by being defined as 'outside' of standard normality. Empowering them requires a demasking of discursive power in the Foucaultian sense.

The Nordic (2) welfare state overflowing

The Nordic welfare systems are considered to be some of the most successful in the world. Practically all groups in society not able to support themselves are covered, in one way or another. Poverty is less frequent and class differences smaller than in most societies. After WW II the notion of the state as a home for everyone was actively used by the politicians, connotating that the state would take care of everyone's needs. This was first and foremost the programme of the social democratic parties, but gained massive support from the majority also in most of the other political parties. In spite of the changing colours of the governments in the last 30 years, the welfare state has been maintained and developed.

The 'home' as a metaphor for the state has, as I see it, had very important implications for welfare policy. From the start it connotated safety and security for the weak and support for major taxation of income from those who had work and could support themselves and their families in a notion of national solidarity. But especially over the last 20 years the aspect of the solidarity with the weak has given place to a notion of 'home for all' meaning rights for all. The state has become the 'allfather' that is obliged to solve everyone's problems. To twist the old slogan 'Do not ask what your country can do for you but what you can do for your country' – it is rather; 'Do not ask how you can help yourself, but; isn't the state going to do anything about it?'

I not aiming a critique of the Nordic welfare states here. Doing anthropology at home, I am also a member of this society, and in that capacity a strong supporter. But as an anthropological observer I see a system that has taken on too much for itself. The welfare state has become a container for problems, and it is about to overflow.

The watershed was with the massive unemployment that hit the western world towards the end of the 1980's. The number of people that could no longer support themselves grew enormously and had to be dealt with politically. The state had to take on new and costly responsibilities. To compensate – to some extent – costs were cut and services rationalised in other fields. For our purpose here, two aspects are important. The state tried to save costs in the school system by having bigger classes, effecting the possibilities for the teachers to give 'difficult' pupils extra attention. On the labour market the possibility for early retirement for those with health problems were made easy to free jobs for others. These are only two small pieces of a big picture. But they represent two important trends; the professionals producing the welfare services, like education and health are continuously being stretched to produce more. The slack that gave them time and resources to deal with the extras, like the difficult pupils, was cut. The second is the extra expenses the state has taken on through pensions. This is a major problem in Germany and France, but also an important factor in Nordic public finance.

The cultural logic of liturgical categories

As a political system with a need for legitimisation the welfare state has to be organised in a way that is seen as just by the overall majority of the population. So just treatment is an important issue. Dealing with thousands of people in a just way can only be done within a firm structure. So the welfare state has developed structures and routines that secure at least a notion of equality for people approaching with their problems. In matters of health this question also has to relate to the scientific categories of medicine.

When the MAAH-meeting sets 'liturgies and rituals in health and illness' as a main subject, new and metaphorically rich associations are given to this material. Liturgy is to me one of the main inventions by which the church maintains its continuity and legitimacy. Liturgy is a system of acts with a predefined meaning that the individual goes into and takes part in. By taking part, the individual is absorbed into the collective, the church. The liturgy is not subject to negotiation. By taking part, the individual accepts the rules, but expects salvation. Seeing the Welfare State as an organisation with a liturgy for dealing with health problems creates interesting perspectives.

When the parents or the teacher of a ‘difficult’ child reports problems, the ‘priests’ – the psychologists or pedagogues – take action. The child is interviewed and tested according to set routines, evaluated, and then sent on to medical experts to be diagnosed. If the child is found to be ‘outside’ normality, that ‘outside’ needs a categorical description accepted by the system; a diagnosis. The diagnosis will then trigger rights to special treatment both in the health and the school system.

What is striking for me as an outside observer is the variation both in concept and description of the condition of the child by the psychologists. My prior mapping of the field left a picture of a strict and well-defined system of categorisation based on ICD-10. Interviewing the leaders for the unit (3) they described a system in which the pupils were tested scientifically and followed up accordingly. When I then interviewed some of the psychologists their description varied, and they were less scientific in their language. They seemed to avoid ICD-10 terminology, and talked about ‘overactive’, ‘reduced concentration’, ‘learning difficulties’, ‘psycho-social problems’ and the like. They worked actively with parents, teachers and others around the child, and the child, to work out solutions and were not particularly quick to go for diagnoses. If they found this necessary, the child was sent on to a medical institution with the psychiatric authorisation to diagnose.

I have yet to collect significant material on the actual practice of diagnosing, but according to the professional personnel the parents often pushed for an evaluation and possible diagnoses. That would strengthen their demands for resources on behalf of the child.

The diagnostic system can well be seen as a cultural system in the Geertzian sense (Geertz, 1973) but with important modifications in practical use. Obviously knowledge of the system differs, which influences the work of the culture as Keesing pointed out (1994). But it is still a fairly complete system that can be described. Its function seems to be important for regulating the justness and thereby giving legitimisation to the whole welfare system.

The room for agency

What I see at stake here, besides a liturgy for justness, is normality. It is normal for children to be a little active and wild and lacking in concentration sometimes. And the normal must be accepted within the ordinary limits of the system. But where is the border between normality and abnormality? As far as I can see, this is negotiable. If the child can function in a way that is acceptable to the teacher and the other children, and the parents don't demand more resources, the liturgy is not carried on. But if one of the parties presses for a category that gives more resources, then the liturgy has the necessary parts for that as well.

The process that defines the child as normal or abnormal can be seen as a discursive process in the Foucaultian sense. The school system enforces a rather strong form of discipline on the children by demanding that they respect strict rules in the classroom. But the system also gives them some slack because it tolerates some degree of 'wild', 'overactive' or 'unconcentrated' behaviour as part of the normal. The teachers and the front line of psychologists work to maintain the child within the frame. But if children are seen to be too troublesome they are sent to be diagnosed and thereby labelled as abnormal. Psychologists and psychiatrists take care of that in the second line, institutionalised within the medical system. To be diagnosed is clearly stigmatised, but in a social democratic way. The welfare system takes care of the abnormal as well as the normal. The pupils get a strengthened school situation with more resources.

Following Foucault and Austin, Judith Butler points to the space for agency that is left between the illocutionary and perlocutionary aspect of a speech act in her theory of performativity (Butler, 1997). To me, a diagnosis is a very typical speech act. When the medical expert points to the child and says 'ADHD' (the most common diagnosis), he or she makes the child the diagnosis. The whole system around the child is programmed to act on this new characterisation. The diagnosis is not negotiable as it is 'scientific' and out of the hands of the child and the parents. It follows a 'divine' logic beyond the people involved. But it implies a great deal of power. This is not the power of one person over the other, in the Weberian sense, but can best be seen as a discursive power in a Foucaultian sense. It is a liturgical power. The performers only carry out the needs of the system. And not only that, they are seen as helpers. They help to find a category for the children so that they can still have a place in the system. That is the intention of the diagnosis, the illocutionary aspect of the diagnosis as a speech act.

But, as Butler points out in accordance with Austin (Austin, 1962), the speech act has an effect that is not causal to the illocutionary aspect. The object, the one addressed, can react in ways taht were not intended by the addresser. In the case of diagnoses of pupils, this happens when the parents react as activists for the pupils' right to resources. The diagnosis could illocutionarily be seen as a way of categorising the child to legitimise that the school can not educate the child adequately and has to take measures to put the child outside the rest of the class. The parents in some cases counteract this by organising themselves in national interest groups and demand far more resources. They accept the diagnosis, but turn it into a fight for more resources for the child. This was not the intention of the diagnostic liturgy, but the perlocutionary effect of the diagnosis, worked out by the addressed (or the parent on behalf of the addressed). This opening for reactions that are not intended by the speaker, and therefore can oppose the power of the speaker, or the system the speaker acts on behalf of, is what Butler would call *the room for agency.*

The need for agency

The other case history differs from the first in the sense that the welfare system *has* already overflowed. While the school system still manages to coopt the children and their demands in a – to the system – normal way, the employees with chronic, diffuse musculoskeletal pain are causing a big problem in working life and society, now also recognised by the system.

A considerable group of employees experience pain in their musculoskeletal system that causes them to take long sick leaves, and later leave their work permanently. Without going into statistical details this is the largest group for early retirement in Norway today.

The parallel to the first case is that neither group can function adequately within a work organisation and therefore needs to be categorised in a way that gives them a place in the system outside the normal. But while the school/medical system manages to do this with the pupils, the work organisation/medical system has faced greater difficulties with the chronic, diffuse musculoskeletal sufferers. The main strategy for the medical system has been to look for objective, physical causes so as to categorise the pain within the framework of well-known somatic medicine. To some extent this has been successful for problems like lower back pain, but the majority of these people cannot show these objective indications.

In the late 1980's and early 1990's substantial unemployment made it less of a problem to exclude these people from the labour market. The welfare state was made responsible for their income by giving them an early pension. In the late 1990's this was shown to be a great burden on the pension system, and resulting fiscal practice. From the mid-1990's, programmes for developing rehabilitation programmes were initiated. I have followed one such programme since 1995 to see what kind of social and cultural properties can be detected from this complex problem.

The typical trajectory for a process ending in pre-pension is people, mostly women, experiencing severe pain to the extent that they have problems in functioning in their daily activities both privately and at work. They seek medical help from a GP, are referred to physiotherapy and granted short-term sick leave. This helps and they go back to work for a short period, only to find the pains coming back and continuing. If these are persistent enough, they get the GP to refer them for more thorough medical evaluation. After some months in this process, and nothing has been found, they are back for more physiotherapy. Many of them now also start seeking help within alternative medicine. Not being able to continue working, after one year of sick leave they have to find a more permanent solution. With the help of their GP, who has now given up trying to cure them, they get the necessary medical statement to enter the pension system. They either go straight on a pension or go through a three-year programme of retraining paid by the welfare system to see if there are other job opportunities they can live with. They always have to accept reduced income and, therefore, a reduced standard of living. After years of dissatisfaction with their job situation, many can be relieved by early retirement, but many will also find that their quality of life decreases.

The rehabilitation programme I have followed[4] focuses on group therapeutic methods taken from Gestalt therapy, psychodrama and similar pedagogical ideas. But the programme is rather self-therapeutic and resembles self-help groups more than professional psychological therapy as practised within the medical system.

A group of 10-12 people come together for 4 hours every two weeks for 6 months. Two group leaders, trained health workers but not therapists, lead the sessions and direct the participants in different exercises. But most of the work is reflexive dialogues within the group.

The aim of the programme is not to cure the pain but to empower the participants to cope better with the pain. In the terms of performativity I would describe it as *activating agency*. The participant has been found unfit to function in the work organisation. But the medical system has not been able to re-categorise the person by producing an adequate diagnosis for the suffering, failing to transform the pain into a recognised disease. The work organisation/welfare system has produced a ritual in the Turnerian sense (Turner, 1967) without a structure (the workplace), or an anti-structure (the sick leave), and the new structure (the early retirement) is satisfactory neither to the system nor to the person. It is too costly for the welfare system, it does not take away the pain and it reduces the standard of living of the person involved.

What work organisation does though is to privatise or individualise the problem. The problem owner is the person, not the system. The ritual process is, therefore, not satisfactory to the person's self-image either. It places the blame on the individual.. In the medical cultural system it is usually possible to avoid this blame by getting a diagnosis, which places the blame on something outside the self, something external and objective. By not being able to produce such a diagnosis the medical system fails to establish a new structure that satisfies the self-image. Psychologically the person is left in constant liminality.

The rehabilitation programme addresses this problem by helping the participant to perform a self-reflexive process, deconstructing and reconstructing a new self-image. Analysing the possible causes for the pain and in this way identifying plausible causes outside the self does this. But, unlike the ordinary medical system, the programme does not provide any solutions to the problem outside the participant itself. He or she has to make choices, act in response to the new situation, and learn to cope in a more conscious way. In the programme this is called 'training for strengthening the self', and seems parallel to empowerment.

Liturgy and ritual

In the conceptualisation of this workshop I have described one example of diagnostic praxis as liturgical and one praxis where adequate diagnoses are absent as ritualistic. The main difference which the use of these two metaphors emphasises is that the liturgy of diagnosing is non-reflexive while the rehabilitation programme turns the failed liturgy of medical treatment of people with chronic musculoskeletal pain into a (self-) reflexive ritual.

The lack of reflexivity in the first process can be analysed as a discursive performance of power. But, as mentioned in this example, and following Foucault, there is always room for agency that can be acted on and made reflexive.

Notes

(1) This short paper is a presentation of work in progress. I am still doing fieldwork on the case concerning schoolchildren with behaviour disturbances. I would like to thank my employer, Vestfold University College for financing my project.

(2) The ethnography is from Norway and the Norwegian Welfare State. In the literature on welfare systems the Nordic countries are usually grouped as one, and especially the three Scandinavian countries. Denmark, Sweden and Norway have so many cultural, social and organisational similarities that it is reasonable to group them in one category.

(3) The unit is called 'psychological-pedagogical service' and serves one municipality. My study was done in a middle-sized Norwegian town with 15 primary schools.

(4) The programme is called 'an educational programme for people with generalised chronic musculoskeletal pain', and is described in Steen and Haugli (2000).

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Ethical review of qualitative studies and health services research in Medicine

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Introduction

The 1964 *Declaration of Helsinki* (World Medical Association 2000) has recently been described as «the ethical cornerstone of biomedical research» (Woodman 1999). Since 1964, ethics committees have become so well established that an editorial in the *British Medical Journal* felt able to state that «it should be obvious to all participating in human research that ethical principles should be followed and that approval of a study by an ethics committee should always be sought» (Alberti 1995). This sweeping statement was not followed by a consideration of the different types of human research, although sociological studies were recognised to be a difficult area. In fact, although human research may be conducted using a wide variety of different methodologies, the constitution of ethics committees does not take account of this variation. Most ethics committees are primarily oriented towards the assessment of randomised controlled clinical trials (RCTs), and they normally use the same review procedures and criteria for all types of human research.

The academic discipline of medical ethics is dominated by what Guillon calls «the four *prima facie* principles of health care ethics»; namely, respect for autonomy; beneficence; non-maleficence; and justice (Guillon 1994), (Armstrong and Humphrey 1994), (Beauchamp and Childress 1994). These are universal principles and therefore may be supposed to underlie the work of all ethics committees in medical research. However problems of variability have been reported (Garfield 1995) (While 1995).

In this paper we draw upon our experiences of a qualitative research project about children with asthma and their parents (ASPRO2). The project was designed by a multidisciplinary group of scientists from several European countries who gave particular attention to the inclusion of ethical guidelines in the protocol. The co-ordination of the project was funded by BIOMED, through the European Commission Directorate General XII. Co-ordinators of studies from six European research sites (UK, Spain-Tenerife, Spain-Madrid, Germany, Greece and Finland) sought the approval and participation of clinics. The proposed methodology of using focus groups with children (and separately with their parents) is a non-invasive technique of data collection. Adult facilitators who moderate the focus group discussions collect the data. Although focus group methodology does not constitute an intervention, it has its own ethical issues.

Gaining ethical approval for the identical protocol presented in different locations was so varied that all project co-ordinators discussed this process at several ASPRO co-ordination meetings. This has led us to reflect on the remit and constitution of ethics committees for human research. In particular, we consider the appropriateness of current arrangements for evaluating health services research, the application of the four principles to different types of methodology, and we make some suggestions for improvement.

Some of the variations we identified in relation to ethics committees appear to characterise the workings of ethics committees generally, and have been discussed in the medical press. Questions have been raised about the criteria that should be used, the functions of ethics committees, their composition, and the difference between audit and research. The issues raised in this paper are part of this general uncertainty, but our experiences of interdisciplinary multinational research have given us some particular insights into these problems.

Given the possibilities of terminological confusion in this paper, we will clarify our usage at this point. The term “medical research” will be used as a generic term to include clinical and health services research. The term “respondent” will be used to refer to people participating in research who are not the researchers or clinicians. For the purposes of this paper, the term “ethical principles” will be used to include health care ethics and principles of bioethics.

A. Differences in ethical evaluation in different countries

The international committee of ASPRO and the EU approved the ASPRO study. Guidelines about ethical issues were included in the original protocol. These guidelines covered informed consent and confidentiality. They confirmed that pharmaceutical products would be neither tested nor promoted, that researchers would not provide information about treating asthma, and that children found to be in need of medical care that was not being provided would be assisted in obtaining appropriate care.

Researchers in each site had to seek local funding and ethical approval, on the basis of the same research protocol. It might be expected that, in countries which had all endorsed the Helsinki Declaration and which have similar legal requirements for medical research, ethics committees might behave in similar ways. However, we experienced a wide variation in ethics committee requirements.

In the *UK*, the study has to be submitted to two ethics committees. On various occasions, concerns were raised about the "seriousness" of the study according with RCTs methodology. Several copies of the protocol and supporting documentation had to be provided, and approval was only given after a period of several months. Before it could be granted, the UK researchers had to provide information about how the participating GP practices would select children; about the facilitators; about the indemnity arrangements for the facilitators; and about the letters to parents and consent forms.

In *Greece*, the approval by the head physician of the department of paediatrics where the study was carried out was the only requisite, without any formal application to any ethics committee. Similarly, in *Finland*, the study took place in a health centre and in a hospital, and the head nurse and the head doctor gave permission. No formal application was made. However, the ethics committee for an earlier study had given ethical approval to the same team with a similar methodology (open interviews but not focus group discussions with children).

In *Spain*, the heads of the departments involved (including the hospital paediatric board) approved the protocol after careful evaluation. The researchers wanted to submit the study to the local ethics committee for clinical research, but were not allowed to, as the regulations governing ethics committees only deal with drug trials (according to the "*Real Decreto*" 561, April 1993).

It seems that the question of whether a study is considered by an ethics committee or not depends on local and subjective factors. This variation raises a number of questions.

Do these differences reflect different standards of research and ethical assessment? Do they reflect cultural differences? Should ethics committees be entirely concerned with local issues or should they reflect universal values? Are the current systems appropriate for health services research? Alberti (Alberti 1995) noted that what he termed “social” protocols seemed to create the biggest uncertainty for ethics committees. It is possible that some of the variation we experienced was due to the fact that the study used a focus group methodology to explore parents’ and children’s experiences of asthma.

B. Should medical ethics committees evaluate health services research and qualitative studies?

The origin of contemporary ethics committees lies in the Nuremberg code of 1947. This code was a response to the medical crimes committed by Nazis during the holocaust. The enormity of these crimes was a product of the particular characteristics of clinical research; namely, the great potential for harm combined with the powerlessness of the patient. This situation thus represents the violation of at least two of the four ethical principles: non-maleficence and respect for autonomy. The power imbalance in most doctor-patient relationships may compromise the patient’s autonomy even in situations where the doctor has the patient’s best interests at heart. In clinical research, the uncertainty of the outcome may also compromise the principles of beneficence and justice. Thus, clinical research has the potential to violate all four ethical principles. However, this raises the question of whether health services research (HSR) and qualitative research (QR) in general fall into the same category. We believe not, for the following reasons.

The potential for harm in HSR and QR is much lower than in clinical research because the nature of the intervention is very different. HSR and QR do not usually involve direct physical intervention. Instead, the potential harm of these approaches includes the taking up of people’s time, the invasion of privacy, and the asking of questions which may be upsetting or conflict-evoking. The imbalance of power is not the same as in clinical research, as most people would probably find it easier to ask an interviewer to leave their house than to refuse medical treatment. Respondents are not likely to have any previous relationship with the researcher and have nothing to lose if the relationship is terminated. Clinical and health services research are probably less divergent in relation to beneficence and justice, as all medical research must have the potential to benefit at least some sections of society if it is to be considered in the first place.

The particular characteristics of clinical research, and especially the randomised clinical trials (RCT) referred to above, mean that it is usually underpinned by legal requirements. Other kinds of medical and health services research are free of such well-defined legal requirements, but subject to general regulations regarding privacy and confidentiality as well as to procedural requirements from funding bodies or research agencies. Although this is standard practice, it also means that this kind of research is susceptible to more subjective assessments from researchers.

In social science research, ethical issues such as confidentiality, privacy, respect for autonomy and consent is dealt with through the use of professional guidelines (6).They are all concerned with articulating guidelines, responsibilities or obligations for their members, who are exhorted to conduct their research in an ethical manner and not bring their discipline into disrepute. Thus, for example, the British Sociological Association's Statement of Ethical Practice (British Sociological Association 1994) includes a detailed specification of informed consent. It states that research participants should be made aware of their right to refuse participation whenever and for whatever reason they wish; research participants should understand how far they will be afforded anonymity and confidentiality, and should be able to reject the use of data-gathering devices such as tape recorders and video cameras; where there is a likelihood that data may be shared with other researchers, the potential uses to which the data might be put may need to be discussed with research participants. It goes on to state that when making notes, filming or recording for research purposes, sociologists should make clear to research participants the purpose of the notes, filming or recording, and, as precisely as possible, to whom it will be communicated. They should also point out that it may be necessary for the obtaining of consent to be regarded, not as a once-and-for-all prior event, but as a process, subject to renegotiation over time. Finally, guidance is given for those situations in which access to a research setting is gained via a "gatekeeper". There is a similarly detailed explanation of sociologists' obligations in relation to anonymity, privacy and confidentiality.

Thus the question remains: should non-RCT medical research be evaluated by the same ethics committees as RCTs, or is it sufficient that researchers follow the guidelines produced by their own professional organisations, which do not necessarily refer to respondents who are also patients? This raises the question of how HSR and QR differ from other forms of social science research. In many cases, perhaps the only difference is that health services researchers may access respondents' medical details either directly or indirectly.

C. *How the four principles relate to different methodologies in medical research*

Medical research embraces a range of methodologies from invasive and experimental clinical trials to observational studies. Each one has its own theoretical background, its own scope and objectives, and its own technical procedures. Each one addresses a different type of question. Some want to test well-defined accountable hypotheses in an experimental design, some want to explore different organisational procedures, some describe different approaches in health care delivery, and others try to elicit, discover and generate hypotheses. These different approaches can be divided into three main categories:

1) Experimental studies, including randomised controlled trials and meta-analyses, are very powerful but usually answer very limited questions; the same applies to HSR which adopts the same type of experimental and randomised approach.
2) A second category is quantitative population based studies. These include epidemiological research seeking to establish the distribution of a risk factor or disease in the population, through analysis and observations of a limited number of previously defined variables. It also includes quantitative non-experimental studies, which are the only way to get sufficient information about health settings that cannot be exposed to experimental designs, as well as survey research. In some cases, medical research is based on the formation of large banks of biological specimens or data (for example DNA samples) that could be further linked with other medical data from patients.
3) Finally qualitative studies aim to elicit the perceptions, attitudes, knowledge or approaches to health and health care delivery of patients and users. This type of research is based on individuals. Qualitative studies are based on methods and theoretical approaches deriving from sociology and anthropology, which are often very different from those of biological medical research. Health service research's includes both quantitative and qualitative approaches.

These various research methodologies, if they are assessed at all, are normally assessed by ethical committees with expertise in one particular type of research; mainly the experimental design of the RCT. Although knowledgeable about trial design, members of ethical committees may lack the necessary expertise in all other fields and types of research. The scientific merit and the ethical issues concerning such a variety of designs can only be adequately assessed by a multidisciplinary and open approach.

The methodological requisites of qualitative studies are different from those of RCTs in a number of ways. Firstly, qualitative research is more likely to generate and discover new hypotheses or lines of work than to test pre-established and well-defined hypotheses. For these reasons qualitative research relies on a more intensive analysis of a relatively small number of respondents. The methods of data collection are also different and often use open questionnaires or interviews in which no predetermined answers are given. Statistical analysis is often inappropriate, and new interpretations of behaviour and its causes and effects, or new views of reality are more important than quantifying numbers of occurrences or similar variables. It must also be taken into account that analysis is often performed at the same time as the collection of data, and may modify the same data collection. In a qualitative study it is not usual or advisable to wait until the whole data collection is finished before the analysis is undertaken. These differences have nothing to do with the quality of research but with different methodologies. It would be as inadvisable to carry out a RCT with qualitative methodologies, as it would be to use the RCT methodology to perform a qualitative analysis.

Are there common grounds for the evaluation of such different types of approach? Which ethical requirements do they have in common, and which ethical requirements are different for RCTs and qualitative studies, to take two extreme examples? Are the four principles equally applicable to all these types of research?

We argue that even if theoretical backgrounds, goals and purposes and methodologies are different, the four ethical principles can be applied to both RCTs and qualitative research.

Non-maleficence

Non-maleficence is the injunction to do no harm. One of the main reasons for ethical assessment of clinical research is to ensure that the risk of causing patients harm with new treatments is minimised and correctly balanced with their expected benefits. Much of the design of clinical trials goes to ensuring the protection of respondents.

In qualitative research, interventions are much less intrusive. Possible harm is mostly related to issues like the invasion of privacy; upsetting or inappropriate (according to the respondent) questions; conflict evoking or reappraisals of personal difficulties; even the use of the “patient’s” personal time for research. Ethical assessment of qualitative research must ensure that the researchers have no hidden agendas which they impose on respondents, especially if this is done in a subtle or manipulative manner, and that no “brain-washing” methods are used. The ideal, not only for ethical reasons, but also for methodological purity, is to minimise interference with respondents’ private lives. Nevertheless, ethics committees and especially their lay members must be clearly aware that respondents’ views and expectations do not always correspond with doctors’ biomedical views.

Social scientists are not supposed to "impose" the "correct" knowledge, as they are not trying to be health educators but are trying to learn the points of view of the "other side".

Autonomy

The other main rationale for the ethical assessment of medical research is to protect the autonomy of respondents who are patients. This is especially important because patients, as sick people, are disadvantaged in terms of the balance of power with health professionals. An important part of the job of an ethics committee is to protect people from doctors. They have to ensure that the weaker partners in the relationship are supported in their right to refuse a treatment, a research protocol or a new intervention, without jeopardising their clinical care. The most visible part of this is informed consent. Ethics committees dedicate a considerable amount of time to ensuring that patients are given correct and sufficient information about the trial, and that they are free to accept or refuse the intervention. Lay members of the committees have a special role in this issue.

The same considerations apply to social science research. Social research usually requires the active participation and continuous consent of the "informant" for any data to be collected. It may sometimes be easier for a respondent to opt out of an RCT, by just "forgetting" to take a drug, or calling up to say that he or she does not want to continue in the trial. In qualitative research it may be harder for the respondent to say directly to the researcher that she/he doesn't want to continue. On the other hand, patients' dependence on the health system, and sometimes on the same doctor, may prevent them from opting out of a particular study, whereas it may be easier to refuse participation in a study that has nothing to do directly with their lives and health care. In the ASPRO study, high non-attendance rates for focus groups in all the participating countries indicated that no coercion was involved and that potential respondents indeed felt free to refuse.

In an RCT, the main concern is likely to be about causing (physical) harm. In social sciences the main concern is often protecting the privacy and confidentiality of the individual, and the very private and personal information that may be gathered through interviews, observations, and so on. For this reason a primary concern in the ethical assessment of social science research must be patients' anonymity and the security of data collection and analysis.

Beneficence

An RCT should only be undertaken if there is a potential benefit of the new treatment or procedure to be tested, which is not clearly known or quantified. All participating respondents should have a potential benefit from the intervention and the knowledge should be made available to the scientific community. In social science research applied to health, the benefits for the individual respondent may be minimal (even if sometimes talking and discussing the research questions may benefit and relieve the respondent). The knowledge gathered may be used, later on, to identify and test new hypotheses and to develop educational or intervention programmes for the benefit of future patients.

Justice

Justice has been regarded as one of the main ethical principles. In the particular field of health research it is mainly related to the adequate allocation of health care (and research) resources, and the extent to which the results of the research can be generally applied to society. It is mainly a societal concern. In this regard, RCTs may give a very precise and concrete benefit, in terms of knowledge and subsequent behaviour (dosage forms, drugs, and so on) but very often they offer a marginal benefit to society. On many occasions the applications of the trial go beyond its original scope, which can be misleading and even dangerous.

Social science research has little potential benefit for the individual respondent, but the information obtained may be used in a broader context for the improvement of health care. In this sense, even if the knowledge provided is less precise and immediately applicable it may make a big change in health care procedures or educational strategies.

D. Possible strategies for ethical assessment of health services research and qualitative research.

How should HSR and QR be ethically evaluated? We wish to outline four different approaches to this question, without making any final recommendations at this point.

Some scientists support the idea that social studies do not fall within the framework of medical ethics committees, even if they study patients, because the subjects of the studies are individuals or citizens who just happen to be sick. They also maintain that their studies have nothing to do with clinical interventions and could not possibly cause "health harms" to the "informants". In those cases, the ethical "gold standards" must be the research guidelines drawn by the different professional bodies, such as the British Sociological Association guidelines. The studies must follow these ethical guidelines, but ethics committees should not be involved in this evaluation because they lack both the right and the knowledge. This is a model of professional accountability within the different disciplines involved. While this may seem extreme, it is what actually happened in most of the countries involved in the ASPRO study.

At the other extreme, research funding agencies, university bodies and even editorial boards of health journals now require approval by an ethics committee of any research done with anybody labelled as a "patient" or in any way related to health. This model is clearly reinforced by strict laws for a particular type of medical research, namely RCTs. The rest of health research, including HSR and qualitative studies, are not encompassed by legal regulations, but are assessed by the same ethics committees. If these committees do not have the necessary expertise to evaluate the scientific merit and the ethical requirements of other types of research, the results of their evaluations can be misleading or, even worse, random. This model does not work for any kind of research that does not fit the narrow description and the requirements of RCT, and should be improved in one way or another.

One way of improving this situation could be to create separate multidisciplinary and more broadly-defined ethics committees for non-experimental research. These new committees should take into account the methodological particularities and the ethical characteristics of qualitative project designs, as well as those of the population-based type of studies (epidemiological, quantitative non-experimental, sampling studies, and so on). In order to do this, the composition of the committees should reflect the types of study being evaluated, and health professionals should be represented but not be the majority. These committees may cover wide geographical areas (7). This kind of Ethics Committees should be an alternative to, and not in addition to, the existing committees. They should also aim to diminish bureaucracy instead of increasing it.

If this suggestion cannot be put into practice, in the meantime, ethics committees evaluating other types of health research (HSR, qualitative studies and the like) have the duty to look for internal or external expertise in the appropriate methodologies. Instead of the "Good Clinical Trial practices" they should use the BSA and existing professional guidelines for social science research before coming to any judgement. A good start could be the HSR evaluation published by the HTA (Murphy *et al.* 1998).

This whole issue requires further discussion. Health services research is improving, as is the quality and level of clinical research. All of them are necessary and must be promoted. The rights of the patients and doctors (in fact, individual citizens) should be protected by safe and independent assessment but each methodology should be evaluated with the appropriate instrument.

Notes

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(6) For example, the *British Sociological Association* (British Sociological Association 1994), the American Sociological Association (American Sociological Association 1997), the British Psychological Society (British Psychological Society 2000), the American Anthropological Association (American Anthropological Society 1998) or the National Association for the Practice of Anthropology (National Association for the practice of Anthropology 1988) all have their own sets of guidelines, none of which recommend evaluation by external ethics committees. The American Anthropological Association has even published a handbook on this field, which is available online (Cassell & Jacobs 2001).

(7) For example, the recently constituted "Ethics Committee" of the University of La Laguna, in Tenerife, Spain, is composed of five members with different backgrounds (a Professor of Ethics in the Philosophy school, a Professor in Penal Law, a Professor in Psychology, a Professor in Biochemistry and Molecular Biology, and, finally, a Professor in Medicine, clinical Pharmacologist and president of one of the "RCTs Ethics Committees" of the region).

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CLOSING NOTES

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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 medical 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.

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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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