

## An outsider's fascination for Dutch medical anthropology, and more

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Fascinated by The Netherlands, Nicoletta Diasio, came to this country around 1993-1994 as an Italian anthropologist to study 'Dutch medical anthropology'. What fascinated her about The Netherlands was its art and peculiar sense of beauty, its specific construction of otherness and tolerance of various kinds of diversity within defined boundaries, its social construction of 'the normal' and 'the pathological' within its pluri-religious context, its specific forms of resistance against Nazi-fascism during the Second World War (for instance, the wearing of a yellow star even when not Jewish), its strong feeling about civil rights and its 'soft battle' for those rights that contrasted so much with the angry and conflicted battle in Italy, its strong attachment to *het heilige* (the holy) while at the same time putting it in question (as described by Mulisch), its deep religious nature while simultaneously outstripping others in laicisation and libertarianism, and much more. When Nicoletta approached me as a potential informant, I was infected by her enthusiasm for her study but also a bit anxious. Wouldn't she become disappointed finding out that not much was going on at the time that could be labelled as 'medical anthropology', and wouldn't it be impossible to get a good grip on 'the history of medical anthropology' – a by no means defined field in The Netherlands – for a non-Dutch-speaking person? I soon learned that I didn't need to worry. Nicoletta found her way, meeting a great variety of people who were more than willing to help her reach her goal, consulting dictionaries with a great persistence and interest, and learning to understand at least some Dutch. Having lived during her youth in various countries, it apparently had become her second nature to emerge herself quickly in another culture, trying to understand it from within. Furthermore, I realised later, were anthropologists not trained to study what is supposed to be 'underdeveloped' and to discover in the process that a fascinating world can lie behind the so-called 'underdevelopment'?

Something of Nicoletta's fascination for what is Dutch and for what lies behind the 'underdevelopment' of Dutch medical anthropology at the time, I find back in her article. The reason for her fascination for the trajectory of medical anthropology in The Netherlands as described by Diasio, can only be understood fully if one reads her book, in which she contrasts the Dutch trajectory with the trajectories of medical anthropology in France, Great Britain and Italy (Diasio 1999). That book is based on her Ph.D.,

which she defended in 1996 at *l'Ecole des Hautes Etudes en Sciences Sociales de Paris*, and which got the laudation “très honorable avec félicitations du jury”.

The four trajectories as described by Diasio (1999) are very different. This raises the question to what extent the outcomes of these trajectories in the present time have retained those differences and whether one can indeed speak of a ‘genuine Dutch medical anthropology’ as Diasio states in the abstract of her article.

What Diasio describes in her book and her article is the long and problematic road of cooperation between traditional biomedicine and more holistic approaches to health, disease and healing and of integration of the subject matters of the various approaches. The latter is a question of ontology and not epistemology as Diasio presents it. The two should be distinguished and not conflated as she has done. The approaches Diasio focuses on most in her description of the process of cooperation, integration and (mutual) expulsion are those of medicine, tropical medicine, philosophical anthropology and cultural anthropology: medicine in general relating to philosophical anthropology and tropical medicine to cultural anthropology. What I am seriously questioning is whether Diasio doesn’t give a too flattering image of what happened in The Netherlands in terms of cooperation and integration. Had she interviewed (more) medical doctors and medical specialists instead of mainly social scientists during her fieldwork, she might have come up with a different picture.

Diasio’s opinion that, compared to France, Great Britain and Italy, the process of cooperation between medicine, philosophy and social science was less problematic, is partly based on the inaugural address by Hofstede on the Dutch as people. In this address Hofstede in his turn bases his argument on writings of foreigners produced during the past five centuries in which he identifies a number of clear points of agreement. Diasio has selected three of the eight social roles which Hofstede distinguishes as characteristic for Dutch culture. Underlying our ‘trading, missionary and charity culture’ was what I would call our ‘polder model’ culture, a culture of compromise. But was there always so much compromise as Diasio describes? I can imagine that there are also sources to be found that point in the direction of conflict or benign neglect.

Diasio’s position concerning Italy is based on literature about regional differences, about folk medicine and important developments within biomedicine. For France she could use the *Annals de Médecine et Pharmacie Coloniale*, and literature about mainly West Africa. Her social science approach to her subject matter is preponderantly based on French authors. Some of the material used about Great Britain refers to health problems in the colonies, from Asia to Africa, and theoretical developments concerning the relation between biomedicine and the social sciences. Because The Netherlands has no strong tradition in theoretical developments – before World War II it followed German and French developments, and after World War II Anglo-American developments, to the extent that, for instance phenomenological approaches developed in Germany and France reached The Netherlands via the United States – The Netherlands has no tradition in ‘theory wars’. In line with our polder model tradition our theoretical life world was not very exciting. A negative consequence of this was that – despite important incitements in the Dutch past – no real battle was ever fought for the integration of (medical) anthropology and medicine. Did we ever have a big conference where the

fundamental differences in the ontological subject matter between medicine and (medical) anthropology and fundamental differences in approaching the subject matter at stake (particularly the differences between the quantitative approach of biomedicine and the qualitative approach of anthropology) were confronted with each other? One would expect that with the recent health care policies on interculturalisation, medical anthropology would have a prominent role to play. On the contrary, it is very much marginalised. The semantic gap between biomedicine and medical anthropology pointed at by Diasio seems greater than ever in a period where a sharp turn is taken 'back to the body' again; back to biological health due the fast progress made in the discoveries about the genetic base of more and more diseases. Paradoxically, this did not mean that medical anthropology has not made a great leap forwards in its development.

Not using medical people as her informants, which Dutch natives did Diasio use? At the time of her study there was not anyone who had had an official training in medical anthropology as is possible today. The few 'medical anthropologists' she could interview were positioned differently at the various intersections between (tropical) medicine, cultural anthropology and non-western sociology. Their multi- or interdisciplinarity was all self-made. Nevertheless for Diasio there is a history to be written about the development of medical anthropology that has its origin in the first part of the nineteenth century. She traces the historical strands that in their intertwinement over the years have created a thread, which is so strong that it promises a great future. Apparently we need an outsider to remind us that our discipline is rooted in a great past and has a bright future. Therefore, no need to hold on to the 'Tom Thumb complex' is one of the gists in Diasio's article. Today, more than three decades after the year (1970) in which Diasio ends her historical investigation, no one in Dutch medical anthropology, I believe, does suffer from this complex. But does a 'genuine Dutch medical anthropology' exist? Diasio herself stresses that 'no rigorously coherent body of knowledge exists by virtue of belonging to a particular place'. She envies the fact that no unifying mark is present in Dutch (medical) anthropology and that, on the contrary, there is so much plurality to be found. A plurality that appears to be cherished nowadays by what could be called 'the Amsterdam school of medical anthropology'. A school in which, due to all sorts of globalisation processes, one cannot only find a plurality of subjects of research, research methods applied, and theoretical concepts and frameworks used, but also a plurality of people coming from around the globe. What do all these people know of the history of 'Dutch medical anthropology'? Is medical anthropology as it is practiced today by medical anthropologists from The Netherlands and their associates really rooted in that great past as described by Diasio? Whatever the answer to this question, I tend to agree with Diasio that 'we' have a great history. About the future I am less optimistic than she is. Let me explain why.

In the Leiden University Medical Centre (LUMC) where I work, there are no chairs anymore in social medicine, tropical medicine, and the history of medicine. Simply without much protest, they disappeared. With them the great history of tropical medicine in Leiden tends to be forgotten. It must be noticed, however, that tropical medicine (mainly approached from a biomedical perspective) is immensely popular among medical students and that a minority among them have a great interest in 'the world beyond

hospital walls'. But is that interest enough to guarantee a great future as far as an integration of medicine and anthropology is concerned. I myself work towards that integration and have been very much welcomed in the LUMC by its board. The question is what I as a single person can accomplish in the field of medical anthropology in an institution that is almost exclusively focusing on biomedical issues in its research. The board of the LUMC, however, does promote some linkages with non-biomedical fields. During the time that my chair 'culture, health and illness' came into being it asked the department of anthropology of the Faculty of Social Sciences of Leiden University whether I, as a professor of culture, health and illness, could have a non-paid affiliation with that department in order to bridge the gap between medicine and anthropology. The reaction was negative. The department did not see any common ground between its work and mine. Does this indicate that the famous Leiden anthropology tradition of addressing health issues as described by Niehof (2003) will follow the fate of the famous Leiden tradition of tropical medicine and come at a standstill? It is obvious that the thread described by Diasio has since 1970 slowly been moved away from Leiden and picked up by Amsterdam.

Recently, I was told, there is a kind of struggle going on within the Dutch Association of Tropical Medicine. Among its members, predominantly medical doctors, opinions differ whether to acknowledge the importance of the social sciences and institutionalise cooperation with medical anthropologists within the Association or simply keep them out and ignore them. But, even if they will be formally accepted, will they be able to turn the tide towards biological health?

Is it medical anthropology's fate to remain 'at the margin' as argued by Kleinman (1995), that is to say at the margin of medicine as well as at the margin of anthropology? Speaking for myself, I experience that marginality continuously when faced by the representatives of the 'real' anthropology, the 'real' medicine and the 'real' humanities. Not being surrounded much by medical anthropology colleagues but often functioning and working among academics specialised in one particular traditionally recognised discipline, I indeed feel the 'impurity' of medical anthropology as described by Diasio. That does not mean that I see no merits in working at the margin and at times being part of the small tribe of medical anthropologists. Being small does not per definition mean that one cannot stand up to the giant in one way or the other, as little Thumb proved.

To me the article by Diasio raises many more questions than I can address in this short reaction. Let me end with the first question that came to mind when reading the article and learning about the Dutch tropical doctor Eijkman who demonstrated that there was no metabolic or physiological difference between Europeans and 'natives'. I would like to add at this point that Eijkman got the Nobel prize for his work. I read Diasio's reference to Eijkman in the period that the Eijkman medal was awarded by the Dutch Association for Tropical Medicine to someone who made an exceptional contribution to tropical medicine. This raised the question for me which of the persons who played a prominent role in the Dutch history as described by Diasio would we like to see remembered by naming a medal after him, which at intervals would be given to someone who contributed to the making of a great history for medical anthropology?

Pruys van der Hoeven, Van Ossenbruggen, Kleiweg de Zwaan? Or do we as medical anthropologists feel no affiliation with any of these and the other men featuring in Nicoletta's story (anymore)? Apart from that, where are the women in that story? There must have been at least nurses of flesh and blood, who contributed in one way or the other to the creation and strengthening of the medicine-anthropology thread that should lead us to a great future.

### Note

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### References

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