Discussie

"Traders, missionaries and nurses", and much more

Early trajectories towards medical anthropology in The Netherlands

Nicoletta Diasio

Dit artikel biedt een buitenstaanders blik op de voorgeschiedenis van de medische antropologie in Nederland. Het betoog loopt van de Hygiënisten in de Negentiende Eeuw en koloniale ambtenaren aan het begin van de Twintigste Eeuw tot de invloed van de Amerikaanse medische antropologie in de zestiger jaren van de afgelopen eeuw. Een grote variatie aan auteurs en doelstellingen, veldwerk en denkkaders typeert de Nederlandse medische antropologie. Dit overzicht van locale intellectuele tradities schudt aan de conventionele afscheidingen tussen disciplines en laat hun historische en culturele contingentie zien.

[medische antropologie, antropologische geneeskunde, ongeluk, Nederland, Europese vergelijking]

Just as Molière's Monsieur Jourdain wrote prose unaware so anthropologists, doctors, administrators, missionaries and travellers all contributed to the development of medical anthropology, long before the term was actually coined by Scotch in 1963. What contribution have Dutch intellectuals made to thinking on the normal, the pathological and their variations? This is the question I raise in this article. While I offer no definitive answer, what I do propose is to draw attention to the semantic complexity of the term anthropology and to its many intersections with the fields of medicine and health. An epistemological study in the social sciences must examine how the two sciences came together, how concepts were transferred from one field of study to the other, and what meanings and practices gradually derived from the merging of 'anthropology' and 'medicine'.[1] The terms themselves are significant in that they are at the origin of widely different types of contemporary medical anthropology. In this article, I shall first show the heuristic importance of the history of medical anthropology, then examine those theories and approaches to knowledge which, in the Dutch tradition, have made an original contribution to the field as a whole.[2]

Medical anthropology: An indiscreet mirror

At the intersection of medicine and anthropology, medical anthropology is an excellent observatory of both fields. Partly within and partly outside at one and the same time, it is well placed to question not only certain fundamental notions of general anthropology but, notwithstanding its current success among the sciences, truths in biomedicine. Medical anthropology is now well-charted territory, but there is still a disturbing proliferation of sub-fields which cannot be placed under the signpost of ignorance: 'Miscellaneous' mentioned by Mauss in his essay on techniques and the body (1934), or do not lend themselves to rigorous attempts at systematisation. Social, cultural, physical anthropology, ethnology, ethnography, biomedicine, alternative medicine, human genetics, Hippocratic medicine... the list is long. Medical anthropology, deriving from two different sources, is perforce segmented, and still searching for the point of balance between the different scientific sensibilities from which it is composed. The story of the struggles and conflicts in its development is fascinating from an epistemological point of view: it tells of the birth of an area of knowledge, of its heterogeneity, and of the negotiation processes that took place within each field on the subject of perspectives – sometimes complementary, frequently contradictory. A science is not only defined by what it accepts within its confines, but also by those other areas of knowledge it touches upon, what it rejects and what it relegates to the margin. Medical anthropology throws light on the many meanings of the term 'anthropology', on the strategies of inclusion and exclusion of closely related scientific fields, and on the dialectics of the pure and impure in the construction of an area of knowledge. 'Dangerous and in danger' like all the social sciences (Foucault 1988: 359), medical anthropology occupies an epistemological field at the intersection of other scientific domains which explains the wide range of questions it addresses and the difficulty in defining its limits as an area of study. It is an 'impure' science that makes the link between other areas of knowledge, but also bears the marks of its interdisciplinary status. Pronouncements on the 'essence' of medical anthropology, attempts at clarification, do less than justice, and are reductionist. It is however a discipline in the accepted sense of the word, in that it stands up to rigorous scientific research and study.

A comparative history of medicine and anthropology as a single study area allows local knowledge – traditions – to be brought to light and put into perspective.[3] While anthropology has brought us popular wisdom from other worlds – wisdom, which at some time or another is in phase with our own concerns – it has difficulty drawing meaning from the body of knowledge it has built up over time. On the other hand, there is an intellectual tradition which draws on what Ludwig Wittgenstein has called 'family resemblances', that is, common characteristics such as a way of walking, the colour of the eyes, temperament and height – but none of these characteristics belongs to all members of the family, or is particular to any individual. These resemblances can be mixed or layered and, as they interweave, create a thread whose strength "does not come from the fact that any particular strand runs the whole length of the thread, but rather from the fact that several strands become entwined" (Wittgenstein 1990: 148).

These local intellectual constructions, which sometimes have the status of absolute truths, illuminate each other through their historical contingency: the French, British, Italian and Dutch anthropologists I have studied do not identify with one and the same Anthropology. Similarly, experiments today have elements of both continuity and radical change with regard to the questions addressed by Dutch practitioners in the Nineteenth Century which were similar to those that North American medical anthropologists have been working on since 1977, for example. An indiscreet mirror reveals the relativity of fundamental notions – be it professional, intellectual or 'national' – but also jargon, factors of identification and constraints to which another may not be subjected. I am aware that reference to national traditions in research lends itself to both criticism and controversy. No rigorously coherent body of knowledge exists by virtue of belonging to a particular place; again, my background and profession are clear reminders of how vague the concept of 'national identity' is. Any area of study develops within a system of scientific rules and procedures, which reply to a social demand for knowledge. This demand may be a request for truth in the Foucauldian sense of the term (1971, 1976), and the request for truth itself may be of a political or economic order that coincides with national interests. The genealogy of knowledge gives substance to the past, makes it understandable and, in doing so, calls into question the purist principle at the basis of any search for origins. If "history alone can free us from history" (Bourdieu 1982: 9), taking into account intellectual traditions seeks to bring out those variations that lie behind seemingly monolithic blocks of knowledge. Just as looking towards the centre from the periphery allows both anthropology and medicine to be examined with the hybrid products their merging produced, so the study of areas of knowledge classed as peripheral, less accessible because they are less well known, and sometimes even as the fallow land of academic production, weakens pretensions to intellectual hegemony and gives thickness to what lies behind fashionable labels.

Medical anthropology is all too often said to be a North American import, a modern Trojan horse, which allows medics to rule over the field of ethnology, and anthropologists to build up profitable joint ventures (Diasio 1999). It has, however, a long tradition behind it. For two hundred years or more, the linking of medicine and anthropology has produced much speculation on the connection between the biological and the social, on the relationship between sameness and otherness, and on the articulation between collective and individual experience. Today, this alliance still has a strong influence on thinking and practice in medical anthropology.

The Netherlands make an ideal observatory from which to view this rich, multifaceted field and, paradoxically, the smoothing effect that time, ideology and conventions have had on a tradition which is sometimes underrated and, in spite of the international reputation of its members, all too rarely identified with a specifically Dutch model. When I was preparing my thesis on medical anthropology, I had the opportunity to meet Dutch anthropologists. Their pronouncements, which were not always encouraging – "This is a small country", "You will find nothing new in The Netherlands", "We are not the creative kind" – aroused both curiosity and a sense of frustration. Such ingenuousness seemed suspect, in the manner of the façades of their suburban houses, unshuttered and open to all eyes, which so surprises the Italian visitor, who is used to

stone buildings and Venetian blinds, a tight separation of private and public worlds. We wanted to discover other scenes of intimacy: gardens, where neighbours meet and Sunday fêtes are held. We needed to look beyond medical anthropology and venture into territory which belonged neither 100% to ethnology nor 100% to medicine: in other words, we needed to search on the garden side and, above all, break down the parallel 'small country' – "anthropology with a small 'a'."

In fact, this "small country" holds the highest density of anthropologists in the world (Kloos 1991: 25), and has a long, rather neglected past. The 'Tom Thumb complex' has meant that the work of Dutch anthropologists has sometimes been underrated and that the nature of their research has been simplified into the formula "a pragmatic approach compensates for theoretical weakness" (Blok & Boissevain 1984). On the other hand, to the outsider, the absence of any unifying mark in the very different work produced is an element of enviable freedom. Here there is no trace of feeling permanently under threat, which has led French anthropologists, for example, to entrench themselves behind a wall of distrust of knowledge from other related fields. Here we have anthropology in its plurality. Plurality through the variety of subjects of investigation, the worldwide spread of the fields of study – the constraint of working in the former colonies was removed early on – and the heterogeneous nature of the theoretical references which come together in this crossroads of the diverse.[4]

Balancing the universal and the particular: From Pruys van der Hoeven to *antropologische geneeskunde*

"Not only the rules, but also the exceptions, not only the universal principles of our art, but particular observations, too" (Pruys van der Hoeven 1824: xvi). With these words praising Hippocratic teaching and a medical art turned towards recognising individual characteristics beyond the general rules, Pruys van der Hoeven begins his work on the relationship between medicine and anthropology.[5] These principles were soon brought into question by the revolution in experimental medicine, which gave precedence to the rule over the particular and to the science of the universal over knowledge of the individual. Pruys' thinking is not a relic of another age. Rather, its theoretical focus is at the heart of considerations in medical anthropology today – the relationship between the theoretical and the clinical, between science and context – and launched a line of thinking which was to last for thirty years and, in 1851, led to his writing *Anthropologisch Onderzoek*, which can be considered the founding text of Dutch medical anthropology.

Pruys van der Hoeven is the most important representative of the *hygiënisten* group, that is, those practitioners who, in the mid-Nineteenth Century, from a reformulation of the theory of miasma, developed a view of medicine as a social science. This approach saw in sickness the culmination of a complexity of natural and social circumstances affecting health. Two models link the Dutch hygienists, the French ideologists (Hallé, Villermé), the English sanitarians (Chadwick) and the German liberal practitioners (Virchow, Neuman): first, the principal factors of morbidity are social conditions

and individual behaviour which then fall within the compass of medicine as objects of scientific study; secondly, the vocation of the medical profession is essentially political and pedagogical. According to Virchow, who influenced Pruys and was an eminent anthropologist, the social sciences are a branch of medicine, the most complete of all the sciences. Politics, in this view, is simply medicine practiced in a wider context (Richters 1987).

While Virchow, as a physiologist and cell pathology specialist, sees in the natural sciences approach the most appropriate method for understanding human society, its forces and internal laws, Pruys criticised the natural human species concept for being reductionist – he even said that he was an anti-Darwinist for religious reasons – and saw in medicine a point of convergence between biology, sociology and morals. In a speech given in 1826 at the beginning of his career, he outlined the characteristics of the ideal practitioner and called for medical practice where knowledge from the social sciences and theory-based knowledge, such as history and philosophy (Pruys van der Hoeven 1826-27), could be combined. Where Virchow sought to define the universal laws governing cells and society, Pruys, whose approach was more clinical, was primarily concerned with understanding how and why individuals react differently to disease.

His constant interest in how universal rules can vary among sick subjects gives the term 'anthropology' a strange ambivalence: if the commonly accepted definition – the scientific study of man as a natural species – is in his view too restrictive, from the description he gives of it, the field seems virtually limitless. His anthropology includes the study of racial differences, medical geography, comparative anatomy, the history of the classification of diseases, the understanding of the social causes of morbidity, reflections on "what constitutes the specifically human" and, from there, the Christian doctrine of redemption (Pruys van der Hoeven 1866: 187-196). His approach is multifocused: it can centre on individual consciousness (e.g. the role of hope in the experience of suffering), or on the historical and political context (cf. the analysis of *sudor anglicus*, 1846), but it is also full of contradictions. He is a polygenist when he studies the human races,[6] and yet he emphasises the influence of the environment and circumstances on the distribution of diseases in individuals a priori unsusceptible to contracting them: thus tuberculosis affects Africans in Europe more than in Africa (idem, p. 330). The case of diseases makes the line between self and others difficult to draw. The *descriptiones etnographicae*, which closely follow Von Humbolt's example, blur the line even more, in raising questions frequently posed at the time: Are there different diseases or different populations? How can the distribution of pathologies and the specific nature of epidemics in particular places be explained?

The debate did not end with Pruys and the practitioners of his time. Indeed, it continued during the emergence of tropical medicine in The Netherlands and its institutionalisation (Peypers 1902): what is the aim of creating a distinct area of knowledge? Where does the difference between 'them' and 'us' lie? Through their study of pathological anatomy, Willem Bosch, the director of the military medical service, and Pieter Bleeker, the head of the first medical school (*Dokter* Djawaschool), showed the similarities between certain tropical and European diseases. Similarly, in the period 1887 to 1896, Eijkman demonstrated that there was no metabolic or physiological dif-

ference between Europeans and 'natives'. Research at the Weltevreden bacteriological laboratory confirmed this from the point of view of susceptibility to so-called 'tropical' diseases (Flu 1923; de Knecht-van Eekelen 1989). But, if infectious diseases are the same in the tropics as in Europe, what is the point of 'tropical medicine'? How is it different from western medicine?[7] These developments show that, beyond a concern for efficient cures, the debate on diseases was the theatre of a wider debate on social construction. At a time when cholera, typhus, diphtheria and malaria were sweeping across Europe, the problem was not only individual differences and disease, but also strategies for controlling differences within different political, economic, social and religious contexts.

This complexity of which Pruys van der Hoeven was the forerunner finds its most complete expression in *Anthropologisch Onderzoek*. This study consists of four parts focusing on: pathological anthropology, which proposes a sort of comparative pathology through the ages and in different social conditions; historical anthropology, which takes into account the differences brought about by changes in customs and lifestyles (the importation of tea, coffee and tobacco, for example); clinical anthropology, which places these differential elements within the moment of consultation and Christian anthropology, which centres on the theological and moral aspects of man.

The ambivalence of this anthropology comes from its moving to and from an organicist view of man in society – which makes it a truly social science – and psychological and moral considerations. The plural anthropology of Pruys van der Hoeven and the swing between naturalism and idealism in the work of the *hygiënisten* are, in many respects, close to the preoccupations of contemporary North American medical anthropology, as can be seen in the definition of disease, illness and sickness.[8] The work of Pruys van der Hoeven seems to prefigure the then unresolved conflict between the social dimension of illness and personal experience of ill health that medical anthropology later brought into the open. According to the anthropologist Richters (1987), the swing from one to the other affected the social engineering role of doctors in the Nineteenth Century – a role welcomed by some, refused by others. Van der Hoeven's wish to establish a powerful model to explain medical facts is echoed in the work of A. Kleinman who deplores the weakness of the theoretical model of medical anthropology and its inability to counter, if not replace, the dominant biomedical ideology.

The originality of Pruys van der Hoeven's thinking is even clearer when compared with the anthropological work of many Dutch practitioners of his time. In his analysis of anthropology as practiced by doctors in the Nineteenth Century, Nyessen (1929) simply gives an account of studies in the field of physical anthropology, but makes no mention of Pruys van der Hoeven. Van Bork-Felkamp (1938), whose emphasis is on the contribution of clinicians to the study of racial differences within different Dutch population groups, and on the importance of the notions of heredity and eugenics, treats Pruys van der Hoeven as a heretic. The considerations put forward by Harting and the Sasse's, father and son, on the origin and characteristics of the Dutch people, and Bolk's research into the causes of their differences, are typical of this 'anthropography'.[9] While Dutch cultural anthropology and ethnography developed more par-

ticularly in the East Indies (Indonesia and Java), the branch concerned with morphological and biological differences found a fertile field of study on home territory. The importance of understanding and managing difference within the country led the Society for the Advancement of Medicine (*Maatschappij tot bevordering der Geneeskunst*) to create in 1865 an Ethnology Committee, a sort of permanent observatory of the Dutch people. Indeed, we should remember that, like their Italian, French and British colleagues, these medical anthropologists had to explain difference and provide tools for managing differences which were often seen as a potential source of conflict.

In the 1920's and 1930's interest in anthropological medicine (*antropologische geneeskunde*) was renewed by the psychologist Buytendijk, under the influence of the neurologists and philosophers Von Weizsäcker and Plessner.[10] In his anthropological project, Buytendijk proposes to re-introduce the subject in physiology through the 'revelation' of what constitutes the uniqueness of a human being: the spiritual. Drawing first on Christian neo-Platonism, then on phenomenology and existentialism (Husserl, Scheler, Heidegger, Merleau-Ponty and Binswanger), he sees the determinants of the social being in the ever-renewed tension between corporal and spiritual subjectivity. This dualism is reflected on the methodological level when he proposes to complete the explanatory approach of the natural sciences with an understanding of individual experience. His anthropological medicine – *antropologische geneeskunde* – is, first and foremost, a practice which emphasises the meaning given to illness and what is specifically human about it: as the pathological condition is an existential condition that reveals man to himself, it is not surprising that Buytendijk concentrates on aspects such as pain or the doctor-patient relationship (Buytendijk 1957, 1963).

This line of thought was taken up again in the 1980's in an unsparing critique of biomedicine by a group of Dutch doctors and philosophers. In his work produced in 1983 on the relationship between the medical theories of contagion and miasma, the philosopher Ten Have re-proposes a conception of anthropology derived from the Kantian formulation of the 'specifically human'. At the same time, his analysis of the influence of Bentham on medical thinking shows the role of miasma theory in the formulation of the idea of context. His hypothesis is that two models of thinking dominate medical theory in turn: the biological (focusing on the individual) and the sociological (focusing on the human environment). According to Ten Have this dichotomy is found in all the sciences: philosophy, with the opposition between rationalism and empiricism, linguistics (the Chomsky school versus the Bloomfield school), biology (neo-Darwinism versus neo-Lamarckism), etc. Anthropology is then seen as that view of man, which determines the dominance of one or the other of these patterns (Ten Have 1983: 251-278).

This oscillation between universalism, which is in keeping with a philosophical view of the human, and the recognition of the social and cultural – and therefore relative – character of the concept of disease needs to be interpreted in the light of the difficulties inherent in clinical activity. On this subject, the practitioners of *antropologische geneeskunde* underline in particular the dichotomy between practice focusing on a subject considered as a psycho-physical whole, and theory based on biological reductionism: if patients are all different, explanatory theories of pathological phenomena

must be based on generalisations. The term 'anthropology' touches on the territory of the psychosomatic and makes up for the inadequacies of the natural sciences in consultation practices; 'anthropology' serves to promote more efficient clinical work that is not in contradiction with the theory from which it derives. This tension between the relative and the universal, between psycho-physical integration and somatological reduction, recalls one of the main concerns of Pruys van der Hoeven's *klinische antropologie*.

In the work of Ten Have and other proponents of anthropological medicine, however, the specific characteristics of the practice/theory dialectics and the individual/society relationship are unclear. For example, one never really knows what conception of the subject is under discussion. One only needs to think of the different notions of the person coming from ethnographic research to see that anthropological medicine lies outside the compass of the methodological approach of *culturele antropologie*, but completely within the search for alternatives to the pre-eminence of biomedical, theoretical frames in clinical activity. But the questions it raises are most significant: indeed, the importance given to reworking the contradiction between theory and practice (evidenced also in the two terms *medische antropologie* and *antropologische geneeskunde*) and the interest in understanding the individual/group relationship are present, in differing degrees, in any anthropology concerned with suffering.

An anthropology of misfortune: Van Ossenbruggen and the contribution of the *Indologen*

The first Dutch ethnological studies came from the observations and curiosity of those civil servants in the colonies who were asked to get to know the people they were to administrate and understand the many social problems with which they would have to deal. This was in Indonesia, which came under Dutch rule again in 1812. Skills training was given in courses at the colonial administration offices in Delft in 1842 and in Leiden from 1891 onwards. These courses indicate a deep, widespread interest in the subject, very different from the stereotype of the Dutchman: the navigator par excellence, little interested in exploring the vast territories he occupied. But what was surprising to foreigners at the time was that these courses were for administrators, a mix of the brainworker and the practical man.[11] There were courses on learning language, law, geography, ethnology, folktales – a wide range of Indonesian studies, which turned public administrators into *Indologen*, that is specialists in a geographical rather than a scientific field. The notion of *Indoloog* is important for understanding the line taken by Dutch anthropology: its openness to developments in other areas of knowledge – the explanatory frames of politics and economics, in particular – and the emphasis given to careful, detailed description. The link between meticulous representation of small details of everyday life and immediate action is even today a characteristic of studies on development aid (Blok & Boissevain 1984: 335).

The work of the *Indologen* did not give immediate recognition to anthropology and ethnology as distinct areas of knowledge – their early productions were accounts of

journeys in which they simply mentioned the peoples they met on their way, or recorded curious, silly facts, with occasional excessive generalisations or strong bias towards the attitudes and behaviour they described.[12] It was Veth who defined the field of *Taal-, Land- en Volkenkunde van Nederlandsch Indië* – literally, the science of the language, the land and the people of the Dutch East Indies – a discipline which he introduced into the Colonial Administrators Training Academy in 1864, and which he taught in Leiden from 1877 to 1885.[13] However, it was Wilken in particular who developed the two branches of research which were to characterise Indology: one, the study of *adat*, that is, Indonesian law and the social organisation it implies; two, religion and ritual (cf. Koentjaraningrat 1975).[14] Thus his studies of corporal mutilation (1888) were not submitted to explanations of a hygienist order, but came rather within the field of sacrifice (the offering of *pars pro toto* to a divinity) or rites of passage; similarly, the discussion on the social character of circumcision, which put him in opposition with practitioners of the time.

It is precisely within the studies on *adat* and animism that other studies developed. These can be considered forerunners of 'anthropology of ill fortune' in that they link the phenomenon of disease – which, in this view, cannot be identified with psychophysical changes alone – with a cosmic disorder. The expression 'anthropology of ill fortune' evokes a current of French ethnology in the 1980's. Its proponents, who were highly critical of medical anthropology of North American inspiration, considered disease as one of the 'elementary forms of the event', an object, among others, that anthropology designates as the centre of a sub-discipline (Augé 1983, 1986). The most significant representative of this anthropology of misfortune is, without doubt, Van Ossenbruggen. He was born in Indonesia where he spent most of his life, first as a lawyer, then as head of the *weeskamer*, the colonial affiliation office, and finally as a teacher at the Training School for Indigenous Administrative Officers in Magelang in Central Java. In his professional capacity, he gained a deep knowledge of the laws of *adat*, the structure of the Indonesian family, the rules of descendancy and parentage, the role of women and paternal laws. He was to draw on this knowledge to write his fundamental work: a comparison of rituals carried out for protection against smallpox among the different peoples of Indonesia (Van Ossenbruggen 1911, 1916).

The key notion, which gives coherence to the practices considered, is the notion of magic power (*magische kracht*). According to Van Ossenbruggen, the belief in this force came before the belief in spirits and the soul, and characterises primitive thinking. Primitive thinking has four distinctive features: it observes concrete phenomena but cannot formulate abstract notions; it cannot see the connection between cause and effect; it does not therefore link natural phenomena together through the associative process; it attributes a magical power to all beings and objects which, if excessive, can produce a dangerous situation through the imbalance this brings to the cosmic order. These assumptions on primitive thinking echo Robertson Smith's mana theories, Tylor's hypotheses on animism, and Lévy-Bruhl's law of mystic participation. What is new is the way in which, with this all-embracing notion of magical power, Van Ossenbruggen's study on smallpox interlinks social, ritual and biological occurrences, thereby removing from any one of them a single explanatory role. This is one of the

first times that, in the history of medical anthropology, disease was not only conceived as distinct from its biological reality, but served as an important backdrop for observing social organisation and collective attitudes. *Magische kracht* was believed to inhabit the whole environment and had to be maintained in a state of equilibrium: calamities and disease were the consequences of cosmic disorder due to an excess of dangerous powers. Prevention practices work by re-establishing order: either through a ritual which transfers surplus magical power onto an object or an animal, which must then be banished or killed, or by the liberation of an even stronger power, which counterbalances the surplus energy and restores the initial balance. It is in this context that Van Ossenbruggen explains the notion of taboo, certain *adat* measures concerning the prohibition of incest and adultery (these were thought to be a source of additional magical powers). The punishment of breaking taboos was death and banishment, both of which were seen as a form of social purification through the expulsion of the scapegoat (Van Ossenbruggen 1916: 111-210).

The shift from naturalist-type signifiers to culture and social organisation stems, I think, from Van Ossenbruggen's knowledge of the local languages and from the importance he gave to forms of designation. Van Ossenbruggen questions the validity of the parallel made between indigenous and European linguistic signifiers (smallpox), similarly, the parallel between medical nosology and local classifications of diseases. The vagueness of the very concept of smallpox (when considering childhood diseases, for example) brings out the importance of the socio-cultural explanatory frame and the conceptual identity between the notions of disease and ill fortune. This concern for forms of classification is at the heart of his last work on Monco Pat, an ancient form of a village-type confederation. His analysis is based on the symbolic value of the figure five in Javanese culture and on the importance of division by five in indigenous categorisations: here, in following the lead given by Durkheim and Mauss, Van Ossenbruggen also provides a starting point for Dutch structuralism founded by Josselin de Jong.

Van Ossenbruggen's work is also interesting through the hybridisation of its conceptual frames. It integrates formulations around the notion of power and the ambiguous nature of the sacred which were later to become specific to Otto and Van der Leeuw's phenomenology of religions and to the work on sacrifice and gift produced by the French school of sociology. It establishes a sort of distant dialogue between the German *Völkerkunde* and French and English colonial ethnology – for example, between the concept of popular thinking (*Völkergedanke*), formulated by Max Bartels in his *Die Medizin der Naturvölker* (1893), and Lévy-Bruhl's contributions to the study of the mental functions of primitive peoples (1910). In the final note of his work published in 1911, Van Ossenbruggen goes beyond the 'them' and 'us' divide to underline the existence of a pre-, or even a logical mentality characterising popular attitudes towards disease. By focusing attention on magical thinking in Europe – for example on reactions towards the plague or cholera – Van Ossenbruggen again suggests a distinction between popular and scientific thinking, a distinction which can be found in Europe in research on popular traditions and among Italian practitioner-folklorists (Diasio 1999: 64-67).

The innovative character of Van Ossenbruggen's approach is lost in the work of other ethnographers and practitioners of his time: Nieuwenhuis, Kleiweg de Zwaan and Elshout. Nieuwenhuis, a contemporary of Van Ossenbruggen, is known for his participation in the 1893 expedition to Central Borneo sponsored by the *Maatschappij tot Bevordering van het Natuurkundig Onderzoek der Nederlandsche Koloniën* (The Society for the Advancement of Research on the Natural Environment in the Dutch Colonies). The report of this expedition, *Quer durch Borneo*, devotes much space to an analysis of indigenous medicine, phytotherapy and healing magic. In his introductory address as a professor of anthropology at Leiden in 1904, Nieuwenhuis indicated his interest in ecology and the relationship between cultural progress (i.e. creativity and artistic crafts) and the favourable or inhibiting features of the environment. His ideas of the importance of the relationship between nature, environment and culture, especially in the early stage of the development of cultures, was also formulated in his theories on the origin and early development of religion which he discussed in his book *Die Wurzeln des Animismus'* (Koentjaraningrat 1975: 47).[15]

The notion of *dynamic order* is re-introduced in Elshout's analysis of the medical practices of the Kenja Dajak in Borneo (Elshout 1923). This doctoral thesis in medicine suffers from the ambivalence of its stated aims. If the first two parts are given to a description of village organisation and to the religious beliefs of the Kenja, along with a classification of the world of the spirits and their function in the divinatory system, Elshout then organises his observations in the field from a nosological point of view: the origin, prevention and treatment of infectious diseases, psychoses, pregnancy and childbirth and pharmacology. His interest in animism and magical powers comes from the need to understand healthcare practice and the native systems of classifying diseases. If, for Van Ossenbruggen the colonial administrator, smallpox is simply a pretext for getting to the heart of how society functions, in the work of Elshout the doctor, the relationship is reversed, and the theory on the primitive mentality is secondary to medical considerations. The very structure of his work, which makes a difference between natural and magico-religious-based diseases, abandons Van Ossenbruggen's all-embracing approach and leaves us with a form of sector-based specialisation which is foreign to the training, even the ideology, of the *Indoloog*.[16]

We should also remember that at the beginning of the Twentieth Century the divorce between medicine and anthropology had become final. The spread of Bernard's experimental revolution, the general application of Pasteur's findings, the emergence of distinct branches in medicine, and the development and recognition of social anthropology as a separate area of knowledge, all led to a gradual epistemological divide between the explanatory frames of these disciplines. For those involved in scientific expeditions, ethnographic observation then became a sort of mental holiday, an amusing quest for the queer and exotic from which anything too closely linked with clinical practice was eliminated; or, again, those in the field were to reinforce the traditional enthusiasm for medical objectification and categorisation which reduced natives to simple samples of the human race.[17] If, early on, the colonial experience produced a conceptual field in between medicine and anthropology (for example, an epistemology of ways of seeing based on observation, description and objectification, the heuristic

value given to the field as a living laboratory), little by little it was to differentiate between, and separate out educated interest and scholarly practice, the commitment of practical men and the speculations of brain workers.

Translating cultures, changing societies

> The Frenchmen who returned from Algeria were treated like heroes. Here in Holland, the colonisation was never something people were proud of. I have several uncles who settled in Indonesia. Most of them were killed by the Japanese. Others got out in time. So, they worked, did a job like anyone else. They were concerned about the health of their workers. All the large plantations had their own doctors. One of my uncles was a doctor on a plantation in Sumatra. The workers worked nine months on the plantations then went home for three. One of my uncle's problems was the battle against venereal disease. For nine months he took care of these people; they all had venereal disease. After nine months everything was fine, they were clean. But then they went home. As the journey home was long – they had no cars or anything like that – they stopped overnight in the brothels, and when they arrived home they had contracted the disease again and passed it on to their womenfolk...[18]

The plantations, the fight against venereal disease, the trains and brothels: this reads like the setting of a colonial epic. Yet the feeling that comes through this account is a mixture of detachment from and participation in the scene: those who escaped from the Japanese are not heroes, but rather members of the middle class who became rich and went back home in time; taking care of the natives is simply part of the normal procedure for preserving material – tools, peasants, shops. The colonial was just doing a job. This is of course a recent account: time, hindsight and conscience have all taken the gloss off the myths, but the ambivalent attitude towards colonisation is, as far as I may speak, one key feature of the Dutch way of constructing the other.

The ambiguity towards the colonial government, which is neither criticised nor officially glorified, can be understood only if one takes into account the (near) absence of a land-owning aristocracy in Holland and the essentially commercial character of Dutch imperialism. For these anti-heroes, the colonies were reservoirs of commodities more than virgin lands over which they were to rule: they did business, worked to maintain productivity levels on the plantations, and looked after the natives, their principal work force.[19] In this way, the liberal spirit of the ruling classes, the repulsion for any dogmatism aimed at limiting their activities, the concern for settling conflicts potentially harmful to trade, the activities of the administrators – accused of liking *their* natives too much to want to change them – led to a profound mistrust of measures promoting the cultural integration of the natives.

Active interest in the colonial question reached a peak in the 1920's and 1930's with the ethical movement which fought against any form of colonial domination whose sole purpose was exploitation and the destruction of other cultures, and forced political powers and public opinion to address the question of 'humanitarian colonial-

ism'. This concern for the protection of exploited cultures did not question colonial policy itself, but sought rather to bring to the native populations the benefits of the social and humanitarian ideas that were spreading across post-war Europe. A long parliamentary debate brought changes in colonial policies, among others, the creation of a multi-functional social services system for supervising usury, debts and loans, schools, healthcare services, and agricultural training.

The ambivalent character of the reform movement is apparent in the work of De Kat Angelino. In his work *The Colonial Problem* (1931), he assigns the western powers the function of preparing the ground so as to spread national sentiment; and of quelling religious and ethnic conflicts which, because of their increasing violence, were an obstacle to the development of the colonies. It is interesting that the final point in the development of these native societies should have been the – very European – nation-state, bringing a multitude of differences under one and the same authority.[20] There is similar ambiguity in De Kat Angelino's examination of the cultural question. Here, he advocates a policy of synthesis, which can be identified with neither a mix nor an acceptance of other cultures. Noting that climatological and "*raciques*" theories cannot explain the differences between societies, he stresses the importance of national character and culture. His ideal is one of cohabitation, where the western model would have a mediatorial role.

The health education campaigns of the time reveal the limits of this tempered relativism. We should remember that, whether it was seen as part of a civilising mission, or as a subtle form of conquest, medicine was not only an efficient means for penetrating colonial territory, but also a conceptual model for understanding the native mind and dominating it (Diasio 1999: 40-57). Western imagination has fed on the image of the white doctor operating on black patients, sometimes even chalking the treatment given on their bodies (Vaughan 1981). Between humanitarianism and intervention, assistance and reification, the discourse on and about medicine acts as an indiscreet mirror in which the contradictions and inconsistencies of society at large are reflected. Thus, De Kat Angelino praises the public health campaigns against prejudices, campaigns from which the native population benefits in spite of itself. The figures he gives are impressive. Between 1925 and 1927, in nine residences in the Dutch East Indies, there were about 255,000 home demonstrations, 9,000 public talks, 800 talks in schools, 1,000 demonstrations with microscopes, 400 special talks, and 200 live demonstrations (De Kat Angelino 1932: 390). And yet these activities were themselves a stumbling block for strategies for change and cultural integration. Quoting a doctor in the public health services, De Kat Angelino notes how difficult it was to bring together two mentalities – the western (scientific) and the native mentality: "teaching people to create for themselves new habits for hygienic living is, in many cases, tantamount to asking them to radically change their way of life" (De Kat Angelino 1932: 389). This disenchantment with what was thought to be the easy conversion of natives to western medicine was later expressed by Verdoorn, who, in an analysis of the limits and mistakes of policies for introducing obstetrics into Indonesia, recognised that the success of sanitary work in the tropics was not a problem of medical knowledge, finance or management, but of culture (Verdoorn 1941).

The ancient tradition of acceptance of differences, the awareness of their negotiability, and the spread of American anthropology in the post-war period, were to lead, in 1964, to the publication of the first formal work in *medical anthropology*: a case study on the introduction of health care services in a rural context among the *Asmat* in New Guinea by Van Amelsvoort.[21]

Taking his inspiration from Verdoorn and North American work from the 1950's on medical systems in developing countries, Van Amelsvoort sees medical anthropology as a new "inter-discipline between medicine and cultural anthropology" (Van Amelsvoort 1964a: 1), whose task is to identify and explain those elements that have a direct impact on a doctor's work. He does not consider himself an anthropologist and so pays only superficial attention to the Asmat way of life. The ethnologist identifies 'operational indicators' and translates these descriptive elements into "intelligible terms from a medical point of view (...) this 'translation' will allow the practitioner concerned *to decline it in terms of the six basic sub-divisions of clinical medicine: anamnesis, examination, diagnosis, prognosis, treatment, and epicrisis*" (ibidem 1964b: 152-153, Van Amelsvoort's emphasis). Diluted in the epistemological frame of biomedicine, ethnological knowledge loses its analytical impact. More a translator than interpreter, a negotiator than critic, the medical anthropologist, as he is represented here, is the product of a mentality which, while refusing the forced cultural integration of others, seems also to refuse to look critically at his own culture.

These persuasions also explain the ready welcome given to the notion of *medical system*, where the idea of a self-contained system makes it easier to define cultural limits and to establish areas of compatibility or total opposition.[22] Here again we find the attitude of the merchant doing his *job*: the tropical anthropologist does not seek to integrate the Asmat or change their conditions of existence; rather, he wants to know what practical means there are for helping him achieve his task. Furthermore, his perspective is that of the practitioner who, in a far-away country, experiments in a situation where he cannot treat patients with the conventional professional tools he was trained to use.

A very different tone marks the works from the mid-1960's to the late 1970's, which while not constituting a true sub-discipline in the sociology of non-European countries, do nevertheless have their place in studies on disease: for example, the work of Schenk-Sandbergen on the life of refuse collectors and cleaners in China and India (1975). "Although we had not carried out specific studies in these areas (illness, death, therapeutics), my husband and I became deeply involved in these during our work. It was impossible for us to simply observe the suffering of these people. Once in the field, we realised that ethics are as important as the academic rule, which says that there must be no involvement with the group under observation. And so we tried to intervene in a number of cases of serious illness we met" (Schenk-Sandbergen 1979: 131). In Van Amelsvoort's work, the few notes on the social life of the Asmat are secondary to the smooth running of the rural health services; with Loes Schenk, illness exposes a form of social organisation which brings into question not only a socio-economic system that generates poverty and exclusion, but the very rules of the scientific method: the principle of non-interference and mutual exclusion that sometimes stands between ethics and academic norms. If the *medische antropologie* of the tropical ethnologist can be

seen as a form of mediatory anthropology, the incursions of sociology into the field of diseases point the way to an anthropology of subversion.

Neither of these approaches, however, questions the importance of doing something, but they differ over aims and what to change. Should work focus on the native mentality, or on the structural conditions of development? Does concentration on cultural differences divert attention from the conditions of inequality and exploitation? Who are the beneficiaries of anthropological work? There is clear evidence here of two different views on the involvement of the social sciences in transformation processes.

The ethical movement often seems unable to formulate answers to the questions it addresses: for example, focusing on obstacles to action, Stone-Age beliefs, the capitalist system, the will to dominate etc., sometimes paralyses reflection, and weakens the movement's internal dynamics. Changes in perspective of an ethnological type, bringing out other realities, lines of thought and interpretations, are rare. The notions of well-being and anguish do not easily lend themselves to intellectual searching of no practical necessity. Unlike the champions of *antropologische geneeskunde*, the aim is not to understand the particular and what eludes analytical frames, but to explain doubtful choices. Practicing one's art while constantly calling it into question is a less than comfortable exercise: Pruys van der Hoeven's search for knowledge – knowledge deeply aware of its fallibility – is of another age, the age of uncertainty.

Conclusions: Back to a great future

Medical anthropology is a fully recognised discipline in The Netherlands today. It developed from scholarly traditions characterised by their great heterogeneity, the main lines of which include:

- *anthropological medicine (antropologische geneeskunde*) which, consistent with the German medico-philosophical tradition, centred on the notion of the sick subject and advocated linking the phenomenological and existential approach with the explanatory methods of the natural sciences;
- *anthropology of disease and misfortune* – before its time – which made disease the point from which to observe native cosmogony, magical thinking and the links between disease, transgression and social exclusion. This current was closely linked with the French school of sociology (Durkheim, Mauss, etc).;
- *medical anthropology*, which developed in the 1960's-1970's under the influence of North American anthropology, with the importing of the medical system concept. It focused on mediation and subversion, and was run through by a determination to act and bring change, either by 'translating cultures', or by transforming existing economic and power relationships.

The differences between these fields are an indication of how far variations within medical anthropology are related to aims – curing, understanding, managing, standardising practice, effecting social change – the scale of observation – infra-individual, individual, micro-social, macro-social – the conceptual frames for constructing and

interpreting subjects of research; social demand legitimising and prompting studies on the sick as a subject of research, social grouping assessment models, justifications of or critiques on imperialist policies; the places and institutions where knowledge is produced, with the different ways of looking at the centre from the periphery: healthcare centres versus academia, tropical medicine versus mother country medicine, intellectuals versus civil servants, theoretical thinking versus applied anthropology. Medical anthropology thus gives scope for exposing and deconstructing the high purpose behind tracing clear subject area limits, defining classes and aims, even if these operations are conducted during the construction of body of knowledge. If anthropology and medicine are, in their way, simply socio-historical means for separating out the real from the contingent and the absurd, they will be that much closer to achieving this if they can divest themselves of the sacred aura in which they are swathed. This will be impossible unless historical and epistemological depth is re-introduced into the field of medical anthropology – a field which has occasional doubts about its identity, and is frequently forgetful of its past.

This article would not be complete if I did not indicate the lines of continuity which, in my view, are the particular characteristics of what the Dutch medical anthropology tradition has brought to other local knowledges.

There is first a certain reticence with regard to positivism and its acolytes, a constant appeal to the Kantian moral imperative and its integrated view of man. This call to order over what is specific to humanity, in an age when anthropology was seen more as a natural science, takes on a near-sacred aura and finds expression in the concern for the moral implications of all knowledge in medical anthropology, this is echoed by Held's appeal not to ignore the ethical consequences of the social sciences (1953: 875). This direction, which is present today as the variety of emancipatory social sciences (feminist, Marxist, ethic studies, etc.) shows, found favourable ground in the field of disease and cure. To a foreign ear the word *welzijn* (health) – literally *well-being* – has a religious flavour, and the moral justifications put forward during the debate on the reform of *welfare* policies (*welzijnsbeleid*) are, in my view, important signs of this trend. Neither "the close relations Dutch anthropology has with organisations for development", nor the fact that "applied anthropology has never been a distinct discipline" (Kloos 1991: 569) should give surprise, for the tendency towards involvement is so strong that the creation of a separate field of a specifically applied type, would be a pleonasm.

This propensity for involvement seems to me more characteristic of medical anthropology through the importance given to clinical concerns. Except for Van Ossenbruggen, it was not until the mid-1970's that researchers in the humanities entered the territory of medicine and, even then, attention focused more on applied than intellectual outcomes, and the virtues of mediation with the medical *establishment* took precedence over the vices of critical analysis. In the history of this discipline, negotiatory knowledge seems to me to have developed from the point at which the idealist and humanitarian movements met – from the ethical movements during the colonial period to the support given to Third World development projects – and from disenchantment, a

return to the pragmatism of lesser aims: hence, a form of anthropology which seems to doubt its intellectual strengths, and yet occupies more and more space within the medical sciences. This does not mean giving up its capacity for cultural critical analysis: the complexity of the development of Dutch medical anthropology is an invitation not to confuse a concern for avoiding sterile conflict with servile obedience, and not to take discretion for passivity. This complexity in which idealism and disenchantment, pragmatism and the exercise of doubt are entangled, undermines the gross social representations of Dutch spirit incarnate in the three characters of the merchant, the missionary and the nurse (Hofstede 1987). Each of these figures seems to wink to each other, question and reveal, in a subdued mode, its inconsequence.

Finally, the foreigner is struck by a paradox: Dutch medical anthropology – which has welcomed and brought together intellectual traditions where dialogue has frequently been difficult (French sociology, German philosophy, *Völkergedanke*, British social anthropology, American medical anthropology), and is open to other disciplines (linguistics, politics, economics) – has, throughout its history, been developed from quite distinct areas of study. These have co-existed, and still do, rather like couples who, fearing divorce, move into separate homes. This pluralism, without miscegenation as Rivet would have said, explains why there is a lesser degree of conflict here than in France or Britain. I have often asked myself if the history of this discipline does not reflect the importance given to lines of demarcation within Dutch society – a heterogeneous society where the low level of conflict comes from the acceptance of, and space accorded to differences, and where the simple establishment of well-defined lines between different social groups (cf. the notion of *verzuiling*)[23] has enabled the Dutch to experience a taste both for the norm and for irreverence, both for deferring to social conformity and for respecting differences: a propensity for multiplying 'separate equals' (Shetter 1987: 256) even in the construction of knowledge. It is as if the authors I have studied have only too well observed the cautions of Ockerse (quoted by Nyessen 1927: 14), an analyst of the psychology of the Dutch in the Eighteenth Century who wrote: "overdreven zucht tot orde is in dit land de bron van eindeloze wanordes en verwarringen geweest", (exaggerated love of order in this country has been the source of endless disorder and confusion).

Notes

Nicoletta Diasio is an anthropologist currently teaching at the University Marc Bloch in Strasbourg. Her major areas of interest include the anthropology of the body, European comparatism, the construction of multi-level identity in Rome (*Patrie provisorie. Roma, anni '90: corpo, città, frontiera*, Milano, Franco Angeli, 2001) and Warsaw. (Address: Université Marc Bloch, Strasbourg, UMR 7043-CNRS Cultures et Sociétés en Europe; E-mail: etnos@hotmail.com / diasio@umb.u-strasbg.fr).

This article is based on a chapter in my study *La science impure* (1999). I have long hoped for this occasion to thank Eduard Bonsel and Annemiek Richters for their advice, guidance and support during all these years of research.

1 These terms appear between inverted commas because of their many shifts in meaning and links with others: for example 'klinische antropologie' (1857), 'anthropologie morbide' (1864), 'anthropologie pathologique' (1896), 'clinici antropologi' (1891), 'medici folkloristi' (1880-1890), 'medical ethnology' (1916), 'etnoiatria' (1941), 'anthropotherapy' (1965), 'clinical anthropologist' (1976) etc. (Diasio 1999). My thesis research analyses the relationship between anthropology and medicine in four European countries (France, Great Britain, The Netherlands, and Italy), taking an historical angle as well as analysing the discourse and practices of today's anthropologists and doctors.

2 This article presents a reflection on the origins of Dutch medical anthropology until the '70s and the beginning of what I consider contemporary medical anthropology. It is the moment some of my informers were coming to light. For this reason, I chose to omit the works of the protagonists of today's Dutch medical anthropology such as Van der Geest, Van der Veen, Richters and others. A methodological problem in my research was my ignorance of Dutch. Fortunately that didn't stop me. Many texts, up to mid-Nineteenth Century are in Latin, then many communications are delivered in French and German, finally after the last world war English became the international scientific language. Of course, I encountered some difficulties a few times and used a dictionary. Some chapters of Pruys van der Hoeven and Kleiweg de Zwaan were explained to me by Annemiek Richters and Eduard Bonsel.

3 The recourse to history is one of the methodological approaches favoured by researchers in the 1960's. The focus then was on the study of anthropological knowledge as an aspect of western culture. Hallowell in particular stated that research into links between anthropology and other disciplines (ethnoscience, for example) could be useful in understanding the differences and similarities between anthropological models both in their historical development within the 'western tradition', and when comparing different cultural traditions (Hallowell quoted by Pandian 1985: 98). Other research on similar lines has developed over the last thirty years: the work of Stocking Jr., where observers become the observed (1983), Kuklick's social history of anthropology (1993) and the work on ethnographic writing by the American post-moderns (Clifford & Marcus 1986). As Jamin says (1988) the history of anthropology is now ready to serve as an assessment and validation grid, whereby the work of individual anthropologists will be integrated into a series, into a model, where past models will give validity to present work.

4 It is not possible within the confines of this article to analyse all those movements between 1650 (publication of Kyper's *Anthropologia corporis humani*) and the early 1970's, which led to the linking of anthropology and medicine in The Netherlands. I shall mention here only those authors who in my view are most representative of preparing the ground for the Dutch approach to medical anthropology.

5 The full quotation well illustrates the Hippocratic tradition of Pruys van der Hoeven's thinking: "Atque hoc quoque interpretandi genus adhibuit Hippocrates. Is enim, quam animo sibi informavit Naturae humanae Historiam, ita persecutus est, ut non tantum quid a morbo distaret sanitas, observando, comparando, atque analogiae ratione adhibenda indagaverit; verum etiam, quae esset homini valetudo sive secunda, sive adversa, qua aetate, quo sexu, qua corporis temperie, quo vitae genere, quo loco, quo anni tempore quaesiverit, omnesque et sanitatis et morborum investigaverit diversitates. Quippe alia est puerorum, alia senum sanitas; alia virorum, alia feminarum; alia sunt pueritia morbi, alii senectutis; alii hyemales, alii aestivi; alia Europaeorum, Asiaticorum alii (...) non tantum regulas, verum regularum quoque exceptiones; non tantum universalia artis principia, verum singulas etiam observationes" (Pruys van der Hoeven 1824:xiv-xvi).

6 The debate opposing the monogenists and the polygenists revolved around the question: do all men have one and the same origin, with differentiation coming later through a process of transformation or degenerescence (monogenism), or do they have different origins which give rise to radically different species (polygenism)?

7 Worboys' highly sophisticated analysis of the relationship between science and imperialism in the establishment of tropical medicine in Britain shows, through the hostility of the Royal College of Physicians, the difficulty in defining the limits of this new discipline, and the strong links with business interests which demanded results. They financed research but imposed the conditions under which it was to be conducted. A similar line of discussion was taking place there (Worboys 1979).

8 Medical anthropology in the U.S. became more structured in the late 1970's with definitions of what constitutes ill health: disease refers to a biophysical change as defined within the conceptual frame of biomedicine; illness refers to the personal experience of ill health; sickness refers to the social and cultural construction of ill health (Young 1982).

9 It is interesting to note here the problem that the Jews posed for racial theories. Given the similarity of the data derived from the measurements of Jews and non-Jews, Sasse Sr. (1883) and Bolk were forced to recognise that the differences between peoples are national rather than racial (Van Bork-Felkamp 1938: 71). The question of purity and origins was of ideological importance in that it helped produce a kind of standard for constructing collective identity and national legitimisation – hence the appeal of a medical model in the definition of the healthy, the moral, and the normal.

10 For the contribution of Viktor von Weizsäcker to the introduction of the phenomenological concept of the subject into medicine and the development of psychosomatics (through the fusion of psychoanalysis and neurological physiopathology from the Heidelberg school) see Verwey 1990.

11 For example: "It is both regrettable and remarkable that The Netherlands, a country of navigators par excellence, and a major colonial power, should prove so unproductive when it comes to studying charted areas, and exploring their vast new territories by themselves. It is not that they lack perseverance or scientific curiosity – from Valentyn, whose work of 200 years ago is still valuable today, to the great Veth, whose name will be for ever linked with the pearl of Indonesia, the Dutch have always shown great interest in getting to know their colonies – but rather that the work is a pastime for civil servants, educated men using material supplied by others" (Dozy 1890: 130-131).

12 In the tradition of accounts of such journeys, Bontius' *Medicina Indorum* published in 1620 (1931) is exceptional. The emphasis on local treatment and the meticulous ethnobotanical and phytotherapeutic descriptions set this work apart from other accounts of tropical diseases of the time. We should also mention the significance of Dutch-Japanese relations, which produced a number of important studies on Japanese medicine and ethnography, cf. Beukers et al. 1991.

13 Veth, a theologian, orientalist and linguist by profession, introduced, parallel to the systematic analysis of the Indonesian milieu (the archipelago, flora, fauna, and the 'natural' study of the customs and beliefs – in other words, the *Land* and the *Volk*), the study of written and spoken language. The comprehensive nature of his learning is exemplified by the expedition he organised in 1877-1879 to Sumatra, with 23 specialists in different fields ranging from geography to history, botany, the arts, law, and medicine, for example. He was a professor at Leiden University from 1877 to 1885.

14 The son of a missionary, a civil servant in the colonies in 1869 and professor at Leiden from 1895, Wilken produced the first ethnological handbook on the East Indies which structured

material using cultural rather than geographical criteria (the social system, art, religion, material aspects of culture) (*Handleiding voor Vergelijkende Volkenkunde van Nederlandsch-Indië*, 1893).

15 Nieuwenhuis was also influenced by Tylor's theories on animism, but he disagreed with his views on the origin of the notion of the soul. A doctor by training, Nieuwenhuis thought that the soul did not come from the experience of dreaming but from the observation of a difference between dead and living bodies. Among other contributions, he postulated a sex-based totemism which, at differing degrees, structured Borneo societies on the principle of sexual differentiation.

16 On the other hand, the remarkable number of explanatory levels and the care he took in describing vernacular terminology reveal the same interest that the colonial administrators had in the social systems of the Indonesian people.

17 This polarity can be seen in colonial visual imagery. Group photographs, where the doctor, ethnographer or civil servant, stand out in their white clothes, contrasting with the nakedness and dark colour of the natives. The whiteness of their clothing is further accentuated by stance, which, by opposition, implies a dominator-dominated relationship: standing when the natives are crouching, seated, when they stand. Similarly, the symbolic importance of details of the body – hands, feet, teeth, skulls, shoulder blades – or of portraits – close-ups, frontal or side views – identified simply by sex, age, sometimes by region of origin, in a few very rare cases by first name, as Van der Sande's tables show (1907).

18 A personal account told by the sociologist Eduard Bonsel.

19 This pragmatism and absence of any real conservative ideology sustained by the symbolic importance of colonial domination also explain the failure, in the Dutch colonies, of all those initiatives designed to support the White ascendancy in the tropics: *jingoism* or the creation of a National-Socialist Party of Indonesia, for example. Dutch legislation delegated the planning and management of the colonial territories to the private sector after prolonged discussions opposing conservatives, advocates of the national administration, and the liberals, who wanted greater freedom for business. Similarly, it was the entrepreneurial classes which financed the Koninklijk Instituut voor de Tropen (The Royal Institute for the Tropics), the most important research institute in this particular field. At the same time this almost shameful colonisation did not keep the promise to "protect indigenous populations from oppression and exploitation" (Multatuli 1991: 126), of which the novel *Max Havelaar*, as much as the ostracism of its author Eduard Douwes Dekker alias Multatuli, bears witness.

20 What is to be thought of these ethnic conflicts? De Kat Angelino does not even postulate the responsibility of the colonial governments in these.

21 The welcome that Van Amelsvoort gave to other intellectual traditions is striking here, given that the impact of the formulation 'medical anthropology' came only one year before: with the publication of Scotch's article (1963).

22 The concept of the medical system goes back to the public health studies of the 1950's. Of particular note is Paul who, in 1955, developed a 'conceptual and strategic' model for adapting the North American health care system in developing countries. In line with Parsons, he saw medical institutions as sub-systems within the cultural system. Hence the idea that a coherent medical system could not only be clearly defined, but could also support comparison and manipulation within its individual parts. This model – totally directed towards clinical efficiency – was more likely to generate social mathematics than a search for understanding the radically different (Paul 1955, Hunter 1985).

23 A classic example of the production and cohabitation of differences in Dutch society is in the pillar-type organisation (*verzuiling*: "vertical segmentation", pillars, on an ideological basis),

where religious affiliation plays a dominant role in the development of social services – schools, political parties, unions, professional groups – in other words, almost all the social forms of structuration and representation (thus, there are: reformed, catholic, protestant, moslem and lay schools, all subsidised by the state). Today, other pillars, based on ethnic or sexual identification, have been added to the traditional forms of membership based on religion. This segmented system channels opposition into a global process directed towards mediation and consensus, and asserts differences through acceptance, separation and surveillance.

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