

The Fear of (One's Own) History. On the Relations Between Medical Anthropology, Medicine and History (*)

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SUMMARY

Clinical and Ethnographic Writing. The Role of Ethnographic Writing in 20th Century's Medicine and Anthropology. Medical Heterodoxies. Anthropological Heterodoxies. Orthodoxies. The Reinvention of Anthropological Medicine?

ABSTRACT

Even though for most of medical anthropologists, history of medicine is far from their professional interest, that is not the case in South European and specially in Latin American medical anthropology. For us, history of medicine is a seminal point of academic discussion in the last two decades particularly in those anthropologists who work on the processes of health/disease/care linked to medicalization. Among others interesting consequences, common areas of interest develop. This article aims to explore a main obstacle to the full conquest of interdisciplinarity, namely the persistence of subaltern discourses and practices related to medical history and to social sciences among the medical professions, which at the same time becomes also an artifact that led social scientists to misunderstand the image of medical history in medical practice.

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A Enrique Perdiguero

«Tout ce qui est ferme est par le temps détruit»
(Du Bellay, *circa* 1525).

The recent publication of *Writing at the Margin* by Arthur Kleinman (1) and *Sickness and Healing* by Robert Hahn (2), both of whom are physicians and anthropologists (3), represents a point of inflection in North American medical anthropology (4). Kleinman includes an interesting discussion about the liminality of the physician-anthropologist, a self-criticism of his intellectual and professional career and a declaration of principles about the role played by history and political economy in the development of medical systems and in health professional cultures. Hahn suggests that anthropology should formulate an *anthropological medicine* as an alternative to the crisis of biomedicine. He renounces at term to a medical anthropology done by anthropologists. Although they are well-established anthropologists, both texts reflect their medical identity and their commitment with medicine. They are reluctant to abandon medicine and are looking for a new mixed medical and anthropological identity.

The orientation of the Harvard group, known as *Clinically Applied Anthropology* (5), to whom both belong is a pragmatic school of anthropology within medicine that has opened a space for anthropologists with or

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- (1) KLEINMAN, ARTHUR. *Writing at the margin*, Berkeley, University of California Press, 1996.
 - (2) HAHN, ROBERT. *Sickness and healing*, Cambridge, Mass., Yale University Press, 1995.
 - (3) This professional background is quite common between medical anthropologists. Some of them do not abandon the profession of medicine even if they are considered professional anthropologists. This ambiguity is useful in the relationship with health professionals.
 - (4) See JOHNSON, THOMAS; SARGENT, CAROLYN. *Medical Anthropology. Theory and Method*, Westport CON, Praeger, 1996; COMELLES, JOSEP M.; MARTÍNEZ, ÁNGEL. *Enfermedad, Sociedad y Cultura.*, Madrid, Eudema, 1993; MARTÍNEZ, A.; COMELLES, J. M. La medicina popular. ¿Los límites culturales del Modelo Médico? *Revista de Dialectología y Tradiciones Populares*, 1994, 39 (2), 109-136.
 - (5) See CHRISMAN, NOEL; MARETZKI, THOMAS. *Clinically Applied Anthropology*. Dordrecht, D. Reidel Publ. Co., 1985.

without previous training in health sciences. The research acted by this group during the seventies and the first eighties was empirical, clinically-related, framed within classical anthropological model (6). Their aim was to convince health professions that their practice could be improved if they were to consider other dimensions of disease that the biomedical model does not consider (7). The pragmatism of clinically applied anthropology was also expressed in its hesitation to incorporate into its agenda the historic, economic-political, dialectic or critical perspectives about the role of medicine in Western society. Even when their aim is to explore it, they take Western medicine as a particular case of medical system. However the research developments about it are ethnographically and actually based (8).

The intellectual position of clinically applied anthropology, were harshly criticized by authors like Michael Taussig or Allan Young (9). They pointed out the relevance of the social, economical and political context of the medicalization process, or the way in which the hegemony of the biomedical model is constructed over other medical systems. The nature of criticism rooted in the Marxism and in Foucault, and more recently in the ideas of Gramsci, Bourdieu and even Basaglia (10) led

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- (6) I take the notion of classical anthropological model from MENÉNDEZ, EDUARDO. Definiciones, indefiniciones y pequeños saberes. *Alteridades* (México), 1, 21-32. The discussion of relationships between this model of anthropological practice and the theory and practice of American medical anthropology, has been explored in COMELLES; MARTÍNEZ (1993), and in MARTÍNEZ; COMELLES (1994), note 4.
- (7) This aim was formulated by the seminal book of FABREGA, HORACIO JR. *Disease and social Behavior*, Cambridge, M.I.T. Press, 1974; EISENBERG, LEON; KLEINMAN, ARTHUR. *The Relevance of Social Science in Medicine*, Dordrecht, D. Reidel Pub. Co., 1980; KLEINMAN, note 1; HAHN, note 2.
- (8) Probably the best example of it is the excellent reader edited by ROBERT HAHN and ATTWOOD GAINES. *Physicians of Western Medicine*, Dordrecht, D. Reidel Publishing Co., 1985.
- (9) YOUNG, ALLAN. The anthropologies of illness and sickness. *Annual review of Anthropology*, 1982, 11, 257-285. TAUSSIG, MICHAEL. Reification and the consciousness of the patient. *Social Science & Medicine*, 1980, 14 B, 3-13.
- (10) I had to remark than this influence must be seen with some critical distance. Americans, until recent years have read the Europeans authors in English, sometimes partial translations: this has been the case of Gramsci and Foucault. The use they

to a re-consideration by anthropologists of the role of history in an anthropology largely dominated by empiricism and synchronism. Debate is between history and anthropology, not between medical anthropology and history of medicine. For most of the medical anthropologists, history of medicine is far from their professional interest because they do applied work in non-Western societies and for them the specificities of Western-medical history are a general framework reference (11). We can find in this kind of literature references taken from George Rosen, Henry Sigerist, Foucault or Freidson (12) whose object is to take from him notions like *medicalization*, *renferment*, *exclusion* and others.

The case of South European and Latin American medical anthropology is quite different. History of medicine is not an anecdotal reference, is a seminal point of academic discussion in the last two decades particularly in those anthropologists who are working, from micro-social perspectives around the processes of health/ disease/care linked to the so-called process of medicalization. This is a fact in Italian medical anthropology since the fifties, in some groups in France, in Spain and specially in Latin America (13). From Europe two problems raise: the discussion about the meaning of the expression *popular medicine*, featured around

do is sometimes dubious. Most often the information they have about history of European medicine is very poor and for that reason they follow the partial documentation employed by Foucault as a fact. Remark that the medicalization process in Europe is very different that those of the USA. The most of American medical anthropologists think about history of medicine in terms of its own country. They largely ignore European medical history.

- (11) An excellent presentation of the terms of this debate in PERDIGUERO, ENRIQUE. *Historia de la Medicina y la Antropología. Quaderns d'Antropologies*, 1992, número especial, 7-15; and PERDIGUERO GIL, ENRIQUE. *Historia de la medicina y antropología de la medicina. In: Romani, Oriol; Josep M. Comelles (comps.) Antropología de la salud y la medicina, La Laguna, Asociación Canaria de Antropología, 1993, pp. 35-56.*
- (12) For a good example of this limitations see FREIDSON, ELIOT. *La Profesión médica*, Barcelona, Península, 1978, that refers to the American medical profession.
- (13) The development of a debate between history of medicine and medical anthropology is more evident in Italy, Spain and in some sectors of French medical anthropology than in the British, German or Scandinavian. In South Europe there is a critical discussion about the idea of popular culture, and to the influence of Gramsci and De Martino, and of the *histoire des mentalités*. See COMELLES; MARTÍNEZ (1993), note 4, pp.

the notion of survival developed by 19th Century's evolutionism, and the problem of popular knowledge in countries that have developed complex systems of public welfare.

In a European and in some Latin American contexts, the process health/disease/care cannot be understood without reference to history of medicine, medical institutions, and health policies (14). This was sometimes difficult to explain to anthropologists anchored in a model of practice hegemonically centered in ethnographic work, to historians centered in a conception of history related to the Great Tradition, or to doctors whose image of ethnographic work was *medical folklore*.

The consequence of the incorporation of history by the anthropologists, and in this case of history of medicine has three effects: The fading of limits between medical anthropology and medical history in European contexts, the development of common areas of interest centered around the process of health/disease/care in popular classes or marginal groups and the development of the health professions and institutions. This panorama has, in Europe some idiosyncratic features: An irregular professionalization of medical history, the weakness of medical anthropology, the presence of overlapping interests with social historians and historical sociologists, the development of amateur research in social sciences and humanities done by doctors cut from the theoretical and methodological issues of history or social sciences (15).

The field of «social and cultural» studies about medicine in Europe are not placed in the same position that Kleinman or Hahn reports in

(14) In vice royal Mexico the development of Western social care institutions began in the 16th Century in a level comparable to the European development: Presence of galenic medicine, dozens of hospitals.

(15) This kind of amateurism exists also in the USA. An example can be find in Internet listservs as CADUCEUS. So in the USA the professionalization of medical sociology and anthropology are a fact and the role of amateurs is diminished. In Europe, and in Spain, the situation is quite different. Part of this amateurs have academic or institutional position not related with their hobby. They are reluctant to accept the presence of professionalized social scientists because this professionalization evidence the limits of amateurism. The case of schools of medicine are a good example of the difficulty of a non M.D. to hold an academic position in it.

the United States because the professional academic segmentation and the absence of social scientists in medical and nursing education and training. This absence is related to an idiosyncratic process derived from the specific conditions of deployment of health institutions and professional training (16). Its consequence is the absence of health applied empirical research done by social scientists. Also the appropriation of health social research and of the teaching on medical sociology or anthropology by doctors or medical historians. This appropriation has been done in two ways: Sometimes assuming the development and evolution of this field (17), or reinventing the field placing it in the framework of a diffuse idea of «medical humanities», or taking an obsolete idea of medical anthropology linked to medical folklore.

My aim in this text is to discuss the sense of the persistence in medical profession of subaltern discourses and practices related to medical history and to social sciences. My hypothesis is that this presence, even in this marginality, is being a main obstacle to develop interdisciplinarity, and also it becomes, sometimes an artifact who led to misunderstood the image of medical history or medical practice by the side of social scientists.

1. CLINICAL AND ETHNOGRAPHIC WRITING

My starting point is going to be that ethnographic practice, ethnography and anthropology have been, are still and can be genres that are characteristic of medicine, independently of their also central role in shaping the professional anthropological practices and some orientations of sociology and history. The narrative production of these medical

(16) Look at the different situation of medical history in France and in Spain. In France, as JEAN-PIERRE PETER pointed out, is essentially an amateur field (per. comm.).

(17) See, for example, in Spain the case of the course *Cultura, salut i malaltia* in the Faculty of Medicine at the University of Alicante (now, University *Miguel Hernández*). It is not common to find in Spain an entire course devoted to medical anthropology in a school of medicine as it is the case. More generally, there are few contents of this field distributed along other courses or in incidental seminars.

genres should not be interpreted in terms of anthropology, sociology or history *avant la lettre*, but in terms of their meaning within the practice and the theory of medicine in the social and historical context in which they develop. The presence of this genres remains, as an autonomous issue, even after the academic professionalization of sociology, history and anthropology (18).

Hippocratic texts, and particularly *Airs, Waters and Places* and *Epidemics*, developed two models of technical medical writing: A narrative one that uses the local knowledge as an instrument to shape medical practice and insert it into society (19), and another that described individual episodes of sickness in environmental contexts based on the intellectual matrices of the former that would be at the origin of current clinical writing. Both genres consider clinical narrative and *ethnographic practice* as the pillars on which rest the comprehension of the context of sickness, its aetiological interpretations and the therapeutic implications that make it possible for itinerant physicians to become a part of the community in which they work. So the Hippocratic texts also contain an ethical and juridic narrative that describes the relation between the professional and the patient which takes also the form of a specific medical genre (20).

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- (18) I have largely developed this arguments in COMELLES, JOSEP M. Medical Practice and Local Knowledge. The Role of Ethnography in the Construction of Medical Hegemony. In: S. Sakai; H. Kuriyama (eds.) *Environment and Sickness*. Osaka, Tanigushi Foundation, 1998 (under press). A part of medical history would be analyzed in this terms: Not as an academic historical discourse, but as a «medical» discourse whose meaning might be related to corporative expectations. Another part of medical history is simply a part of History and related to the meaning of history in society.
- (19) In this paper, *local knowledge* refers to the field experience of the practitioner. Remark that this field experience is based in a technical knowledge of the milieu, a long time of presence in the community, a series of intersubjective experiences with their patients and their related social networks. The actual term who refers to this kind of practice is *participant observation*.
- (20) The Hippocratic ethic bore in a specific cultural, social and political context in classical Greece. It was not a universal proposal, but a specific development from a particular development of medical practice in a cultural context. LAÍN ENTRALGO, PEDRO. *La relación médico-enfermo*. *Historia y Teoría*, Madrid, Revista de Occidente, 1964, show how the generalization of it by its articulation with Christian theology allowed them a more universal deployment, because of the embeddment of Christianity in Western cultures.

There is continuity in the writings that follow on from the model of *Epidemics* or from the ethical or theoretical Hippocratic texts. There is not between *Airs, Waters and Places* and the modern texts that adopt its guidelines (21). It seems as if this matrix of local observations had been written for physicians to organize their experiences in the field but not to set them down in writing (22). Medical practice proposed to intervene in suffering interpreting causality from rule-based observation of the natural environment. This style of observation find a value if *local knowledge* is fundamental. It shows the difference between the doctors and the other healers. The efforts of modern author to establish criteria for classifying field observations and to record them orderly are related with the need to develop a medical narrative genre in which practitioner is the broker between public authorities and popular classes.

Doctors' *local knowledge* was constructed on what is known today as participatory observation, which is to say, on an attitude that assumed the sickness as an intersubjective experience in which there is not an unidirectional flow of technical knowledge but complex transactions that lead to a constant reworking of the scenarios of practice. Recovering these experiences is fundamental in forming an ethic that in turn structures the cultural image of physicians and reinforces their social and cultural legitimacy. If these dimensions of experience can be present in medical texts that deal with what the good *doctor's practice should be like* (23). The duties of the good doctor showed to the student or the neophyte that the role of the intersubjectivity of the experience and personal commitment to the community implied a personal local experience unrepeatable, unique and non-comparable (24).

(21) RILEY, JAMES C. *The Eighteenth Century Campaign To Avoid Disease*, Londres, MacMillan Press, 1987.

(22) In this training arena, teacher and student live both the same field experience, side by side, nearby the patient and his social network. The teaching incorpore also to live an intersubjective situation. The case of modern medical training is structurally different.

(23) See COMELLES, JOSEP M. Parole de médecin. Le récit sur la pratique dans la médecine contemporaine. In: A. Nouss; J. Lévy; J. B. Martin; F. Laplantine (eds.), *Récit et Connaissance*, Lyon, Presses Universitaires de Lyon, 1998 (under press).

(24) In recent medical records or medical writings there is no place for subjectivity. We find it in the literature write by doctors: autobiographies, lectures in that they

Epidemics' narrative style describes the clinical course of individual sickness, removes the essence of the accident, although its literary skill enables the reader to evoke the context. The first part of *Airs, Water and Places* establishes what is fundamental for understanding the environment ell; however, the style of the second part is interpretive and favors the subjectivity of the observer through the notion of temperament. The Hippocratic author, or the subsequent compiler of the text is sensitive to the limits in the description and interpretation of local context but in turn, in more modern days, matrices of codification establish whose object is to enable compare data and refrain authors' subjectivity.

The importance of lengthy, participatory observation in this model of medical practice accounts for the hegemony of empiricism in the narrative style of the holistic monographs' o local communities. Physicians' participation is fundamental for structuring their personal and professional commitment with helping and caring for their patients. Both ethical texts and those that describe the duties of the physician agree on this. However, in technical text *such as Epidemics* or *Airs, Water and Places*, and their sequels, what is seen dominates what is listening. Descriptions follow guides that externalize observation and prevent subjectivity from contaminating the product.

The hegemony of observation over listening implies that physicians and modern anthropologists, are trapped by the temporal limits of their observations, and by the notion of time derived from this: the description of current sicknesses is *a tranche de vie* as in the naturalist novels; description of the environment is a cyclical reality governed by the rhythm of the seasons. Time is done away with in favour of space. Realism and naturalism are narrative procedures opposed to the narrative models of historicism but also to those of the writing of legends, tales or myths. They look for a distant regard in relation to the expression of the patient subjectivity that masks the symptoms by using *cultural idioms of distress* in a way that is different from how the physician understands and assesses them.

explain «their experience» interviews and so on. I need to distinguish between this kind of works and the literary work —in fiction or other genres— of doctors as Céline, Conan Doyle or Michael Crichton.

Medical narrative is connected with the narratives of natural history developed by modern science and is an alternative to the narrative of the old natural histories that were open to fantasy. Even when the model to be followed is *Epidemics*—a *medical record* constructed from the biographical account of the patient—the text imposed by Hippocrates concentrate the narrative so much and disregard so many of its attributes that the product impresses for its atemporality, and leads to a cyclic idea of time that I feel, even today, prevails in the institutional routine (25).

Medical training focuses now in hospital clinics. The students receive little information about the limits of clinical epistemology. By this way clinical training becomes a dogmatic routine, which combines observation, listening and documentation (26). In the last thirty years the role of observation and listening in diagnosis has decreased in favour of technology. The consultation between colleagues has lost its role because of the easy access to medical information. Medical routines became an idiosyncratic model of thinking and describing reality, a professional culture (27).

This professional culture does not involve physicians being isolated from society, nor their being citizens and co-participants of a cultural system, especially in modern times in which physicians strive to impose

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- (25) In the reports of rural or urban doctors, the time schedule follows their way from home patient to home patient. The description begins with descriptions of the slum or the household. Anecdotes are frequent. See as examples of the reconstruction of the practice of a rural doctor GARCÍA GARRETA, FERNANDO. *Autobiografía de un médico rural*, Tarragona, Arxiu d' Etnografia de Catalunya, 1989 mimeographed. The description of the time schedule in institutions is very different. The time in institution is perceived as a cyclical and regular routine in which the patient's career is placed: see ALLUE, MARTA. *Perder la piel*, Barcelona, Seix-Barral-Planeta, 1996.
- (26) Here the word documentation is taken in a wide sense: All the technologies of diagnosis are written.
- (27) My own clinical medical and psychiatric training influence the way I do fieldwork as an anthropologist. I always prefer to combine direct observation with documentation, and I am reluctant to the massive use of biographical techniques or in relation to cultural hermeneutics. My interest for symbolic interactionism might be related to this point. The medical training of professional historians of medicine in Spain might explain also the hegemony of neopositivism, in front of other historiographical methodologies.

their condition of organic intellectual. It is consequently that there is a subtle barrier full of ambivalence between the medical genres in the strict sense and the purely literary texts that some doctors write quite separately from their practice. The former are medical, professional texts that help them to consolidate their prestige in the profession while the latter have a different value, and provide the physician with an identity an intellectual or as a humanist that transcends their dimension as men of art. This change from medical to literary writing is a characteristic of the medical profession in the 19th and 20th Centuries. This double facet has the obvious consequence in contemporary medicine of the split, often quite radical, between the «medical» text, represented today by the regulations of the most important journals, and the «literary» text, which does not comply with these requirements. The freedom of composition of the latter belongs to a space that lies beyond biomedicine that it shares with a historical narrative on hagiography and professional legitimation that contributes to the emergence of the cultural image of the «physician as a writer and artist.» There is no conflict while this barrier is clear out. It arises when both overlap and apparently dilute the identity of the physician in a context in which local knowledge no longer plays a fundamental role in the shaping of his practice and his professional and corporative reproduction.

2. *THE ROLE OF ETHNOGRAPHIC WRITING IN 20TH CENTURY'S MEDICINE AND ANTHROPOLOGY*

Biomedicine abandoned ethnography as a main technique in its practice at the time that anthropology abandoned history and historicism (28). The hegemonic biomedical model turns around the clinical and experimental anatomic method and the medicalization of the hospital placed as the core of medical training. The constitution of the classical anthropological model is based in ethnography, participant

(28) Not only anthropology, in general the entire social sciences with some exceptions like Weber, the authors influenced by Croce, and the Marxists. Authors as Caro Baroja in Spain, De Martino in Italy or Pearce and Rosen in the United States are not the rule. They have been taken as basic references in the last twenty years.

observation, a-historicism and is aboriginally centered. Changes in the arenas of observation of doctors and armchair anthropologists affected medical writing, in favour of clinical and epidemiological genres, and anthropological writing, in favour of the so called *ethnographic realism*.

As long-term observation in hospital became the setting in which to do diagnoses, the relative importance of the anamnesis was reduced in favour of physical semiology or instrumental diagnosis. Its hegemony meant that ethnographic writing, linked to the local knowledge, was relegated to a marginal position because field observations was less important in the shape of medical knowledge. Even so, the environmentalist theories that provided a complete framework of interpretation for these observations were in crisis. The 20th century, medical topographies have not been written by the greatest physicians, but by humble local practitioners at the margin of academic networks (29). Ethnographic writing is restricted to those *practitioners* whose professional task is still heavily committed to local knowledge in rural areas or in the slums of the big cities. Some of them use ethnographic texts to denounce the blights in society. It expresses the loss of influence of local knowledge on medical practice. Also, the subordination of primary health care to the hegemony of the hospital practice and education. Ethnographic practice had counterbalanced clinical practice in a context in which the cultural image of the physician and his presence in the community was constructed from his local knowledge. «Literary writing» of contemporary doctors offers a «humanist» explanation for a biomedicine which reifies' sickness and reduces suffering to a sign as a strategy for intellectualizing what until then had been an essentially practical and applied profession.

The ethnographic practice of enlightened physicians mediated between the local health situation and the general policies of public health. They operate as corporative policies who intended to place doctors as organic intellectuals of the new society. As Peter pointed out, this intention failed very soon (30). Doctors did so by abandoning their

(29) See PRATS, LLORENC. *La Catalunya Rància*, Barcelona, Alta-fully, 1996. He does a good sociological description of the writers of medical topographies.

(30) See PETER, JEAN-PIERRE. Le grand rêve de l'ordre médical, en 1770 et aujourd'hui. *Autrement*, 1975-1976, 4, 183-192, and PETER, J.-P. Reparar el desorden del

condition of social scientists that had up to that time characterized their theories on public health. They assumed a highly individualized study area that they observed on the margin of society and culture and they developed a series of theories that focused on their corporative legitimation: sometimes by expressing the duties of the «good» professional, sometimes by constructing a genealogy of their own practice looking for their roots in the Classical Greek Medicine (31). The evolutionist theory, and the idea of survival that it coined, provided an intellectual excuse explaining the persistence of archaic reminiscences of Galenic or Hippocratic features in the health practices of popular classes. These features could be interpreted as the fruit of the immobilism, ignorance and superstition of the ignorant masses, and legitimate an academic medicine rooted in modern science, progress and civilization. History of medicine, and the description of popular medical practices are fundamental to place academic medicine in culture and society. Both genres must be seen as «medical genres», not as anthropological, folkloric or historiographic genres. The former legitimates the medical model as the pinnacle of an evolutionary process of intellectual and technical advances while ethnography establishes its cultural limits.

In spite of their technical defects and methodological shortcomings, the topographies reflected the vague idea of a total and dense ethnography of a community in which nothing should be ignored or forgotten by the observer. The reports of medical folklore, whose ruler was Giuseppe

mundo. La medicina ilustrada ante la enfermedad epidémica (Bas-Poitou, 1784-1785). In: José Luis Peset (ed.), *Enfermedad y Castigo*, CSIC, 1984, pp. 3-26. In Spain we have the same failure in psychiatry. See COMELLES, JOSEP M. *La Razón y la Sinrazón. Asistencia psiquiátrica y desarrollo del Estado en la España contemporánea*, Barcelona, PPU, 1988.

- (31) The foundations of the modern medical practice in the classical Greece were in the former works in history of medicine, like in LECLERCQ, DANIEL. *Histoire de la médecine*, 1696 and in FREIND, JOHN. *History of Physick from the time of Galen*, 1725-26. (Rodríguez Ocaña, pers. comm. 1997). This subject was a matter of fact in the lectures of old doctors who spoke about the ethics of medical practices to the young medical students or to young doctors in 19th Century. The ethics of ancient medicine was the basis for the definition of the duties of the good practitioners (COMELLES, note 18). LAÍN ENTRALGO, note 20, does a highly scholar development of it in his entire work.

Pitrè (32) whose aim was to build a regional or local pattern of the features of popular medicine, ignores consciously the integration of popular medicine in the local world. Its aim is not to discover the sense and the place of popular medicine in culture or in a specific community, but to define the practices that from the *medical viewpoint*, do not belong to it. The notions of popular or folk medicine are medical concepts.

The acceptance of cultural or social evolutionism by doctors in the 19th Century might be seen as a form of historicism. This is an illusion. Medicine assumes vulgar evolutionism precisely because it is essentially anti-historicist, the product of a stratigraphic concept of life and society constructed by means of empirical patterns that are to be used to characterize every historical period without taking into account conflict and social transformations, or by reducing them to almost mechanical, random processes of cultural diffusion. It is an archaeology. This attitude is coherent with the dominant thought in the biomedical model and often acquires a dogmatic value, insofar as it vaguely refers to two fundamental sources: common sense reveals marginality, archaism and the superstitious origin of certain popular practices that are beyond medical practices: the belief that some healers are in league with divinities, or the numerous popular practices that refer to the language of humoral theory and are of a syncretic nature. This double aim, pragmatic in the first case and strategic in the second is guaranteed by the reliability of the observer. A doctor might be objective, because

(32) The epistemological and methodological *breakdown* of medical folklore was the work of Giuseppe PITRÈ. *Medicina Popolare Siciliana*, Torino-Palermo, Carlo Clausen, 1896. He establishes a cultural *pattern*, based on popular medical practices thirty years before North American culturalism was to produce the notion of *pattern*. He constructs it making a systematic use of anatomic-clinical medicine as the observation and classification matrix, so that it could only be constructed by a physician, in his own words. Pitrè's conception of medical history and folklore, as genres at the service of a medical project is to a large extent on the margin of his other condition of prestigious international folklorist. This dissociation in his triple role as rural physician, medical ethnographer and «classical» folklorist is not free of tensions and his methodological attempt to define a concept of popular medicine by the way of medical theory reveal some overlaps with the conceptual framework of folklore.

his legitimacy as a clinician is based on this fact. As ethnographer, the practitioner becomes the teller of a reality whose aim is the complicity with his readers, generally other physicians. They find in this ethnographic accounts, a portrait or a mirror of their practice. Nevertheless, as Paola Falteri (33) has pointed out, clinical ethnographers never do detailed descriptions of their own practice as rural or urban physician (34). To do so would mean questioning the dialectics that exists between medical and popular practices, and the complex processes of mediation between the intellectual and the popular classes and to explore the local conditions of medicalization. It was impossible for clinical ethnographers to place them in a more critical position. They are committed in the process of medicalization as apostles of science and modernity. To introduce in their writing a critical methodological approach would mean to introduce a conception of dialectic and not stratigraphic history and also to discuss the cultural or social limits of their practice. They did not. Their goal are already not social medicine, only the survivals of popular medicine that remained at a side of their own practice.

In Pitre's epistemology, popular medicine might be placed in the framework of clinical methodology and epistemology. The consequence is the projection above popular knowledge of the fragmentation of cases and parts of the body that characterizes modern medicine. This idea is, in Pitre's clinical ethnography, an alternative to the narrative about collective health that was featured by neo-Hippocratism and by social medicine. Disease etiologies ceased to be related to the context, environmental, social or cultural. History or ethnography would be written in positivistic terms. Medicine forgets history as an instrument to explain its practice and the medicalization process. Medicine retains history only as an instrument to describe it.

(33) FALTERI, PAOLA. La medicina popolare. Umbria. In: Tullio Seppilli (ed.), *Le tradizioni popolari in Italia. Medicina e Magia.*, Electa, Milano, 1989, pp. 160-165.

(34) Sometimes the practice emerges as a need of narrativity. This is the case of colitis in the well-known book of MUNTHE, AXEL. *La Historia de San Michele*, Barcelona, Editorial Juventud, 1957.

3. *MEDICAL HETERODOXIES*

«The abandonment of a child many take many different forms. First of all there is the state of being an orphan. The working man's home, whose only economic base is the father's job, often breaks up when he dies. The lower class woman is hardly ever capable of coping with her more pressing needs of supporting a family. She valiantly attempts to fight against the circumstances. She is compelled to work in the dreadful conditions that, despite protecting law, modern industry imposes to women workers. A woman is almost obliged to make extreme efforts, her organic weakness represents an insurmountable limit and she becomes a victim of one of those diseases that are patrimony of organic impoverishment. Then the children, without the help of public charity that never have been based on rights but on the most outrageous of favouritisms, find themselves at the mercy of all sorts of adversities in the social environment. In an attempt to satisfy their hunger they almost always use licit means, but when these are ineffectual, the immense field of crime appears to them. The best that can be expected is, if their impulses are socially harmless they stroll around the city in their rags, rebellious and independent, because life has taught them that they can only expect to satisfy their needs through their personal effort (35).

This text is an example of a large amount of social medical writings related to social reform during the 19th and the 20th Centuries (36). I like it because in two hundred words the text evokes a series of problems that had been largely described by the naturalist novelists and because he tries to understand the complexity of the problem, not uniquely its empirical or clinical description. Sanchís Banús adds an

(35) SANCHÍS BANÚS, JOSÉ. Estudio médico social del niño golfo, [1916]. In: Antonio Rey (ed.), *Estudios médico-sociales sobre marginados en la España del Siglo XIX*, Madrid, Ministerio de Sanidad y Consumo, 1990, pp. 173-195 (quoted from p. 182).

(36) About this kind of medical writings see the classical work of ROSEN, GEORGE. *De la policía médica a la medicina social*. Mexico, Siglo XXI, 1985, and about Spain RODRÍGUEZ OCAÑA, ESTEBAN (ed.), *La constitución de la Medicina Social en España*, Madrid, Ministerio de Sanidad y Consumo, 1987; REY, note 35, and HUERTAS, RAFAEL; CAMPOS, RICARDO. *Medicina Social y clase obrera en España (siglos XIX y XX)*, Madrid, Fundación de Investigaciones Marxistas, 2 vols., 1992.

analysis of causality that does not attempt to describe the facts but concatenate a large number of the existing variables. The text belongs to social medicine as an instrument of social change (37). Unless thousands of texts like this one can be easily found in libraries and archives, it was not the hegemonic narrative style in European medicine in the 20th century. Even so, there is not, in Europe a development of multidisciplinary research between health professionals and social scientists in the way these relationship developed in the United States. It seems that, in Europe, doctors do-by-themselves what beyond the sea is done in collaboration with social scientists or exclusively by the latest.

A few years later Sanchis Banús' paper the rural doctor Jose Villalaín (38) won a prize awarded by the *Real Academia Nacional de Medicina* for his medical topography of the municipality of Corvera de Asturias. This book is a very good ethnography (39). We recognize the influence of evolutionary anthropology and neo Hippocratism. Nevertheless his ethnographic quality appears when he analyze the relations between economic strategies of country folk and emigration, the effects of the lack of industry, the local social organization and its consequences on local culture or he links the prevalence of tuberculosis to of women's work conditions in a context of enormous male emigration. He attempt to understand the economic background of migrations, its role in the strategies of the country folk, and its influence on their customs daily life and rituals. One of his main arguments was emphasizing the high average level of literacy of the common people he does not resort to arguments about the omnipresence of ignorance to account for certain practices.

(37) About the Spanish doctors' attitudes in this context see HUERTAS GARCÍA-ALEJO, RAFAEL. *Organización sanitaria y crisis social en España.*, Madrid, Fundación de Investigaciones Marxistas, 1995.

(38) VILLALAIN, JOSÉ. *Topografía Médica del Concejo de Corvera de Asturias, premiada por la Real Academia de Medicina 1924, Premio García Roel*, Madrid, Imprenta de la Ciudad Lineal, 1925.

(39) For a global state of art of medical topographies see LLORENÇ PRATS, note 29; LARREA, CRISTINA. *Los miasmas, antropología histórica de un concepto médico*. Doctoral Dissertation. Barcelona, Universitat de Barcelona, 1994, published as: *La cultura de los olores*, Quito, Abya-Yala, 1997; and CARRILLO, JUAN LUIS (ed.), *Entre Sevilla y Madrid. Estudios sobre Hauser y su entorno*, Sevilla, Imp. Pinelo, 1996.

Although it is a medical topography, its «medical» content accounts for hardly one-third of the book. The rest of it is a thorough, and at times extremely dense, attempt to reconstruct local life in a very similar way to that of the functionalist or structural functionalist monographs are doing at that time. Its author had not read nor Malinowski nor Robert Redfield but, like them, he attempts to project onto the reader the enormous amount of knowledge that was the result of a long period of participatory observation in the community.

These sociological or anthropological approaches done by doctors are not an exception. They never have been recognized as anthropology or sociology. Sometimes they have been recognized by the social scientists as a quite good sources of ethnographic data written by enlightened amateurs, with some degree of personal commitment with their communities. In general they are considered as anecdotal issues by biomedicine.

If European ethnographic medical texts does not appear, in our century, as a compulsory kind of writing, this is not the case of the reports of *pasantía* written by the mexican *pasantes* at the end of their period of national service (40). There are thousands of texts in hundreds of unordered files dating from 1937 to the present day. I randomly and sequentially examined a dozen and a half texts written between 1940 and 1980. The quality decreased in the more modern texts but the older monographs revealed very interesting material and transmitted the personal commitment of some of their authors to a task associated with their contract with their country and with the group in which they were to practice their profession. They are not simple accounts of personal experiences, although if they are the answer to a bureaucratic formal requirement. In a lot of cases they are also a way of sorting out their ideas and expressing their reaction to a set of experiences that

(40) Since the late thirties, all the young mexican doctors do a one year stage in a rural community. They are obliged to write a final report. This program begun with financial support of the Rockefeller Foundation under the presidency of Lázaro Cárdenas. The guidelines of the reports are inspired by the classical guidelines of medical topographies. About the Rockefeller Foundation in Mexico see SOLÓRZANO, ARMANDO. *¿Fiebre dorada o Fiebre amarilla?* Guadalajara, Universidad de Guadalajara, 1997.

had a good deal of influence on their professional, and personal training and in their political commitment (41).

This enormous amount of information has never been evaluated. Recently, historians of medicine and anthropologists had paid attention to them, not as public health reports, but as geographical, anthropological or historical sources of data. Why the health sector forgot this materials, and why this somewhat literary genre is so largely cultivated in spite of its less public health importance are problems to resolve (42).

Manuel Cabaleiro Goas, a psychiatrist from Orense, turned up at the University of Madrid with a doctoral thesis under his arm that had been supervised by Pedro Laín Entralgo. He was awarded only an average grade despite the fact that he was one of the outstanding psychiatrists in the Spain of his time. Faced with his academic failure and the lack of response of his colleagues, Cabaleiro refused to speak about his thesis and did not have it published (43).

The basis of his doctoral dissertation was his clinical experience of some two thousand cases of private and hospital patients which constantly reflected the popular conceptions and expression of mental illness (44). He carried out a personal ethnographic investigation associated to

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- (41) The recent texts are short and dull. They show the bureaucratization of *pasantía*. See SÁNCHEZ PÉREZ, HÉCTOR. *La situación de Salud en Chiapas, Mexico: ¿mayor medicalización en la resolución de problemas de salud?* Mimeografiado, Departamento de Sociología, Universidad de Barcelona, 1996.
- (42) PETER suggested that it could be in the compulsion of writing certain reports the need for the isolated doctors in critical situation to put order in the experiences they are living, to rationalize them.
- (43) I have been able to obtain a copy of the Doctoral Dissertation of CABALEIRO GOAS, MANOEL. *La Psiquiatría en la Medicina popular Gallega*. Tesis de Doctorado. Universidad de Madrid, 1953, by the deference of David Simón Lorda and Emilio González. They have published recently one of the chapters: CABALEIRO, M. A psiquiatría na medicina popular galega: etiopatoxénia. In: Marcial Gondar; Emílio González (eds.), *Espiritados. Ensaíos de Etnopsiquiatría galega*, Santiago, Liovento, 1992, pp. 123-140.
- (44) MARINO FERRO, XOSÉ RAMÓN. A etnomedizina na Galiza, and GONZÁLEZ, EMILIO; SIMÓN LORDA, DAVID. Pensamento antropoloxico dos medicos galegos. Apunte histórico. In: M. Gondar; E. González (eds.), note 43, pp. 91-120.

documentary work on Galician folklorists who had written about the evil eye, witchcraft and other psychosomatic disorders in an attempt to understand their meaning and investigate their cultural logic. With no other ethnological training than the texts that were available in his private library in Orense, he structures his work in three parts; in the first he makes a nosological classification of the popular Galician sufferings according to the criteria of country folk; in the second he attempts to explore the emergence of these nosologies using three types of guidelines, one psychological, one ethnological and the other historical, in which he reviews the great theoreticians from Frazer to Mauss, passing through Durkheim and Havelock Ellis. He agrees with Jung's notion of unconscious and he assumes the functionalist theory of Malinowski's necessities. He discusses and rejects Levy-Bruhl's attitudes about primitive mentality, because he believes that the thought of Galician country folk is anything but primitive (45). Cabaleiro criticizes the systematic use of the notion of survival by folklorists and provides a comprehensive vision of the popular conceptions of pathology that shows the influence of his phenomenological training and a highly functional matrix of ethnographic observation that is very close to the attitudes of American culturalism. Despite its defects and its technical shortcomings, the conclusions are interesting since it rationalizes the logic and the sense of popular therapeutics by assessing the collective meaning of the ritual act in an attempt to verify ethnographically some hypothesis about the efficacy of therapeutics that he said were irrational.

It is surprising to find this intellectual curiosity and this travel from kraepelinism to functionalism in a psychiatrist living in the Deep Spain during the postwar period. His approach to functionalism does not represent a break because he approaches to them by the way of psychoanalysis and phenomenology well represented both in his personal library. This attitudes led him from an initially clinical attitude (*etic*), to a more comprehensive position of the popular discourse on illness and ailment (*emic*). His limit are his own position as a psychiatrist

(45) Giovanni JERVIS. Considerations neuropsychiatriques sur le tarantisme. In: MARTINO, ERNESTO DE. *La Terre du Remords*, Paris, Gallimard, 1966, pp. 327-328, who works as psychiatrist with De Martino and later with Basaglia does a similar criticism about the notions of survival and primitive mentality.

trained in orthodoxy. Even so, in front of this last one position, he takes distances from the notion of survival in that it attempts to look for a culturally embedded sense of popular beliefs and practices. His intuition moves him from the odd ideas about popular beliefs as archaeological artifacts to a relativist position of the ailments as culture-bounded syndromes. Cabaleiro was growing apart from Pitrè and getting closer to the comprehensive attitude of Malinowski. His work shows that medicine can be approached in a comprehensive ethnographic way using a phenomenological approach. The interest of his work lies in the background tensions between medicine, history and anthropology which account for the imperfection and shortcomings of the final project. Its originality emerges from its experimental condition, from its desperate search for theoretical and methodological resources and its intellectual do-it-yourself.

The thesis is an exceptional document that allows us to understand the epistemological break that occurred in European medicine between medical practice and theory and the Social Sciences. Cabaleiro verges on a literature that provides him with answers to his questions and the key elements for developing a project in Galicia that could have led not only to the development of something similar to ethnopsychiatric studies but also, is more important a different deployment of the welfare policies. However, in his context, he had no interlocutors either in medicine or in anthropology. In terms of Lain Entralgo's medical anthropology, his proposal was too empirical and his study of country folk culture too distant from high culture. For the Spanish folklore of this period, who used the notion of survival as their only interpretive matrix, it was a break too radical. For physicians, it was an insult to equate the efficacy of ritual care with the psychiatric therapeutics of that time. Cabaleiro, who was interned for life in Orense, was not able or did not know how to connect with medicine or with an anthropology that he had discovered intuitively but which did not exist in his country.

I have taken these examples at random. The first is an impeccable socio-anthropological analysis written by a neuropsychiatrist and contained in a report. The second is a local monograph by a village physician. The third is a compulsory exercise for almost militarized physicians. The fourth is the empirical doctoral dissertation of an intellectual isolated.

They are not exceptions, just examples of the difficulties to develop in Europe such a dialog between medical and social sciences. None of these reports are clinical ethnographies about «popular medicine» or local physician' historical studies. Despite his crudeness, their self-didacticism and their shortcomings they compare favourably with professional anthropological ethnographers. Like them, they are based on long experience in the field, on the hegemony of participatory observation. The difference with them are their methodological and technical resources and the absence of readers who could understand and place their work in a context of intellectual and academic debate.

Their aim is not to abandon medicine and became anthropologists and sociologists. Their aim is always to contribute to medical knowledge and to improve the health conditions of the population. They spoke in a medical language and with medical concepts. They sometimes suspect that health conditions can no longer be explained simply in terms of the relations between climates, smells and the environment, that history and political economy are not an entelechy in public health.

I do not intend to give the impression that there are a biunivocal identification between the physician's commitment and the militant political commitment. The social militancy of Sanchís Banús and the Marxist militancy of many young Mexican physicians is well known, but this is not the case of Villalaín or Cabaleiro. They handle their commitment differently, sometimes in a very personal terms, in a way I suspect they are speaking about themselves. This is also present in the clinical ethnographers as Pitrè. Unless their efforts to be the neutral memorialists of popular practices their attitude inevitably emerges from empathy with and understanding of their subjects. They respect them. Even if their theoretical framework is the theory of popular culture made of survivals held by ignorant and uneducated people, there are simultaneous references to common sense, good logic and to what the people do well. There is ambivalence between their position as physicians who write for their colleagues, and their position as ethnographers, folklorists and more recently anthropologists from whom they take theoretical references or textual models. The main effect of this ambiguity springs from their commitment with the people they observe. This is why it is important to ask ourselves about the personal and professional meaning

of these medical narratives in a medical context that disdains it and that do not consider them among its priorities, and in an anthropological one who regards them as examples of the hotch potch of narratives written by idle amateurs.

4. ANTHROPOLOGICAL HETERODOXIES

Between 1947 and 1949, an as yet little-known young man named Claude Lévi-Strauss published two articles in *Les temps modernes* and in *Archives d'histoire des religions* that, in Europe, raised the question of the role of the efficacy of social and symbolic factors in therapeutics using various ethnological examples. His *primum movens* was Cannon's paper on *voodoo death* and the relations between culture and biology (46). His aim seems to be to discuss the efficacy of psychotherapeutic techniques and the limits of the efficacy associated to ritual and religious practices. It was written with physicians and psychoanalysts in mind. Looked at in this way, *L'efficacité symbolique* and *Le sorcier et sa magie* are an important contribution to the anthropology of the practice not only of the healers or shamans but also of the physicians and psychoanalysts. He does so in a more complex way than Parsons who at the same time wrote about the role of the patient, based on his own ethnographic experiences. Unlike Parsons, his analysis and his deconstruction of the healing practice received no response. The psychiatrist and psychoanalyst readers do not seem to echo this text perhaps because Lévi-Strauss's psychoanalytical theory was rather crude and his vision of psychoanalytical healing might be seen as profane and disrespectful. In a context of corporative fratricidal struggles between psychiatrists, psychoanalysts and their different sects, it is easy to understand the reluctance to start a debate on the cultural, therapeutic and symbolic limits of practices that were sacred and heavily involved in French culture and society (47). Just in case, Lévi-Strauss, who was a good friend of Lacan, did not return to the subject.

(46) LÉVI-STRAUSS, CLAUDE. *Anthropologie Structurale*, Paris, Plon, 1958.

(47) Lévi-Strauss did not develop the implicit applied orientation of both articles. Differently of the enormous impact in the fifties of Parsons' notion of *sick role* in American social scientists, there was not a debate since the sixties in French ethnology.

In 1959, Ernesto de Martino, an anthropologist and an historian of the religion, began a research on tarantism, a cultural syndrome that was very well known in the Italian and Iberian peninsula (48). Due to the weight of literature that considered those suffering from tarantism to be sick, he decided to set up an equipe, consisting of a psychiatrist a psychologist, an ethnomusicologist, an ethnographer and a social worker. Even though hi project was an academic investigation in anthropology and religious history, the inclusion of such professionals was necessary to respond to a syndrome that have been described as a sickness by medicine that wanted to see the cultural expression of the toxic syndrome resulting from the arachnid's bite.

Read today, at the height of anthropological post-modernity, *La Terra del Rimorso* is a fascinating example of ethnographic radicalness *avant la lettre*, which is thirty years ahead of its time. It is an unequalled model of the possibilities that it could have open to an European medical anthropology. The text develops a methodological proposal based on the repercussions in the shaping of the syndrome of the interdisciplinary dialectic on two different planes: on the one hand there was the work of the team on the other the brilliant historic interpretation of the multidisciplinary debate that since the 17th century had been feeding the controversy between folklorists, physicians and the religious orders and which responded to different corporative strategies in each of them (49). These strategies were not only to end by subverting the original logic of tarantism in society but were to help explain the perceptible degradation in the ethnographic observations of the present. As well his extremely sophisticated game, served up with an admirable prose that changes register in each chapter, the work is structured like a dialogue between abundant ethnographic observation carried in single month and the analysis of descriptions from tarantism done by

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- (48) MARTINO, ERNESTO DE. *La terra del rimorso. Contributo a una storia religiosa del Sud*, Milano, Il Saggiatore, 1961 (French translation: *La Terre du Remords*, Paris, Gallimard, 1966).
- (49) Which although present in previous ethnographies by the same author, MARTINO, ERNESTO DE. *Morte e Pianto rituale. Dal lamento funebre antico al pianto di Maria*, Torino, Editore Boringhieri, [1958] 1975, and *Sud e Magia*, Milano, Giangiacomo Feltrinelli [1959] 1983 (12th. ed. 1994).

doctors, priests and writers. This was not very common in the anthropologies and the folklore of the time in which the ethnographic account is correlated to the professional status of the author. On a second level, this comparison between two forms of ethnographic writing is based on a meticulous historic-cultural investigation based on a methodology that combines phenomenology, structuralism and Gramscian Marxism.

The text is impressive if we consider the idea of the reconstruction of the total social reality that Mauss proposed. De Martino links the present and the past, ethnography and history, the diachronic and the synchronic, the material and the ideal. He reconstructs the boom and the decadence of the popular meaning of tarantism in the context of its social formation and of the role of physicians and priests in the characterization of evil according to its special corporative strategies and in its management. Tarantism levels the complex set of links between the political, the economic, the ideological and the cultural and the influence that the Church and physicians had on the construction of popular wisdom. Tarantism is just one more product, quite apart from its real existence as a psychopathological disorder, of this struggle and it is this that causes it to be written about.

De Martino does not consider his work to be only an intellectual or academic exercise. He believes it has an applied target that goes beyond the purpose of creating an awareness in the reader. In contrast to those who, in Europe, anathematized the applied work of anthropology as a venal and contemptible concession, de Martino made it quite clear that there is no ethnography without commitment.

It is quite easy to understand the silence around Martino's work, the lack of a sincere relationship between psychiatrists and social scientists (50), the resounding silence of the european anthropologies

(50) Even in Italy, in spite of the collaboration between Jervis and the Martino, and Jervis and Basaglia, there was not a relationship between psychiatrists and anthropologists. In France the situation was similar. See PANDOLFI, MARIELLA. Beyond Gramsci and De Martino: Medical Anthropology in contemporary Italy. *Medical Anthropology Quarterly*, 1992, 6 (2), 162-165. PANDOLFI, M. Le self, le corps, la crise de la «presence». *Anthropologie et Sociétés*, 1993, 17 (1-2), 57-77.

in reaction to his work, the ignorance of American anthropology of everything European that was not French. The classical anthropological model could not agree to such a radical break in the organization of investigation: The role of the team rather than the alone investigator, the ethnographer's commitment, the handling of historical documents as ethnographic accounts, the vindication of history. It could not accept a demarche that involved the destruction of the corporative boundaries between medicine, psychiatry, history, social science and even literature, music and poetry. De Martino undermined the model of clinical ethnography that had dominated studies on European popular medicine throughout almost the whole of the 20th century and he also tore to shreds the empirical assumption of anthropological structural functionalism and culturalism.

The empirical and relativism radicalness of hegemonic anthropology could not understand this dimension of the problem because it fear history. In order to be able to understand it, it would have had to deny its own historicity and put it in the epistemological context in which it wanted to place the problem.

5. *ORTHODOXIES*

De Martino related sickness and suffering using the notion of crisis of *presencia*, linked to Heideggerian phenomenology and the Gramscian Marxism. Phenomenology was also the starting point for Pedro Lain Entralgo's reflections on the relations between sickness and suffering (51), on the relationships between the physician and the patient as well as the idea of a medical anthropology connected essentially to philosophy and which is somewhat distant from social or cultural anthropology.

Although there may be a certain parallelism between De Martino and Lain Entralgo, they are different in that the Italian is an ethnographer and the Spaniard a physician and because their attitudes and political commitment. De Martino is interested in establishing connections between the subordinate classes and hegemony theories and practices, Laín

(51) LAÍN ENTRALGO, note 20. Also in *Antropología Médica para clínicos*, Barcelona, Salvat, 1984.

Entralgo in the relations between the physician and the patient as an individual meeting between two people. De Martino deconstructs medical practice, Laín Entralgo attempts to rationally build its foundations to propose an epistemology and to develop professional ethics.

Laín's discourse connects clinical practice to a relational ethic whose roots are to be found in the notion of *phylia* in classical medicine but he leaves it to the individual will of the subjects whether they comply with the programma. He does not use empirical and systematic investigation of what is done, but proposes an ethic and some values which are compatible with the biomedical model accepted as the pinnacle of a secular evolutive process. The individualization of the relation between the physician and the patient makes social and cultural variables of secondary importance and reduces its weight in medical epistemology. While De Martino's proposal, is a tripartite dialogue between medicine, cultural history philosophy and ethnography. This dialogue led him to explore the historical role of doctors as organic intellectuals (52), and at another level as in part creators of tarantism as a culture-bound syndrome.

Laín Entralgo even if his intellectual background is overlapped with those of De Martino, disregards ethnography as a tool of research. He is skeptical about cultural anthropology or empirical sociology. That is to say that medicine does not debate so and cultural factors but deals with them using a philosophical dissertation that belongs to an enlightened academic and intellectual tradition but which does not aim to empirically explore what medical practice is or where it comes from.

Nevertheless, Lain Entralgo's is the witness of a transitional stage of medicine in which, in the fifties and the sixties to a relational ethic the sixties, the medical practice in Europe was moving from the patient's home to the hospital, and from a largely private owned health system to a public one. In some way, his work expresses the *desenchantment* about the important changes that medical profession are suffering.

The different attitude of both authors could be also explained by their position in relation to medicine. De Martino observes as an

(52) Note that it does it at the same time of George Rosen's work.

ethnographer the practice of medicine and its role in building knowledge. However the major interest for him is to explore, comparatively, the organic role of doctors and priests by looking at their controversies about the aetiology of tarantism. The object of his work is not medicine, but modern society. The object of Laín's work is essentially medicine. The meaning of history for them are distant. De Martino wants to place medicine in society. Laín accepts this fact but is interested propiously in medicine.

De Martino and Laín Entralgo show two scholar attitudes who characterize the academic discourses between medicine, history and the social sciences in Europe. So, to a large extent, although in a context structured by other controversies, Horacio Fabrega's attitude is not very different from the attitude of Laín (53). In his seminal book *Disease and Social Behavior*, he begins with an emphatic statement:

«As physicians we are concerned with medical problems of individual persons. The patient's aches and physiological constraints become our concern; and our efforts are directed to helping him. The emotional and social consequences of disease to the individual and his family invariably enters in the picture also, and in varying degrees our efforts in treatment are affected by these factors.»
(Fabrega 1974:XIII)

As a psychiatrist although he is also an anthropologist he uses a highly reified conception of sickness. Although in the quotation he does make a concession to other dimensions of sickness, he does not formulate them very differently from how the 19th century clinicians did so. Medical practice is a mix between diagnosis, treatment and support that necessarily involves a lack of discussion about the cultural roots of disease. This is Fabrega, the physician. But on the following page he says:

«Social scientists, who note and describe the regularities in the

(53) FABREGA, HORACIO, JR. *Disease and Social Behavior*, M.I.T. Press, 1974. Fabrega is the first real theoretician of North American empirical medical anthropology and the one who attempted to establish an operative study area for it.

way the people behave and conduct life and who then study factors that may explain these regularities, have increasingly been drawn to problems associated with disease.» (Fabrega 1974:XIV)

Note the change in the narrative style. The champion of modern medical anthropology identifies himself as a physician and looks on social scientists as others. It should be asked, then, whether his purpose is social science, or a form of reintegrating social science into medicine within a project which is essentially medical. And it is for this reason that the concept of disease in its medical conception, and with the medical connotations which have been passed on to the whole of the population does little for him. The rest of the book reveals that Fabrega's problem is not medicine, but the limited conception of medicine which leads to the current model of practice. When faced with the critical attitude of questioning all of this, Fabrega adopts, like Lain an ambivalent position. He wants to explain to doctors the fact that their does not allow them to understand the non biological dimensions of sickness. But this is not an obstacle to dividing sickness into two sub concepts and attributing one of them to medicine and the other to the social sciences, because in his book he attempts to show precisely the opposite. Here, Fabrega is trapped by his double status of physician and anthropologist, by his commitment with both disciplines largely academicized and professionalized. Pitrè tried to distinguish his folklorist practice from those of clinical ethnographer. He incorporated historicism to his folkloric work, and he reserved a radical medical positivism in his work about popular medicine. Fabrega assumes that disease/illness is a common object of study for medicine and anthropology. For him historicism is not a problem because he is trapped in the American anthropological empiricism. So, by this way, developing a medical anthropology based on disease/illness as its main object of study, and neglecting history, what is the difference between the physician and the anthropologist?

6. *THE REINVENTION OF ANTHROPOLOGICAL MEDICINE?*

Roger Bastide said that without a strong selfcriticism of each member of an interdisciplinary relation, interdisciplinarity was not

possible (54). He said so in full knowledge of the facts for he was one of the few European social scientists who was sincerely committed to such a project. I do not find nor in anthropology, nor in medicine such a self-criticism. I ask myself to what extent we have not correctly described the history of our own professions. We thought of the biomedical model as a monolithic structure but when we delve into the ethnography of the medical profession we find contradictory and disparate settings, texts which we have referred to practice in primary health care or in psychiatry or in the prevention of drug addictions. These qualitatively separate settings in reality represent the most frequent space for medical or nursing practice. The same facts are presents in history of anthropology (55).

While health workers nowadays have lost their awareness of the meaning of *local knowledge* within their practice, and the instruments with which this knowledge had been historically handled have been forgotten, doctors and nurses have slowly but inexorably drawn nearer to the social sciences. They search for answers to questions caused by the ups and downs of their practice, and which are born from their concern about uncertainty, the limits of their knowledge and their capacity to understand the reality that surrounds them. These questions mostly refer to their existential problems rather than to their technical problems. When faced with the social scientist, the health worker sits on an imaginary couch but is very often only prepared to listen to encouragement or comfort and not enter into questioning the limits of his practice that are giving him an identity. We could find this also in the particular history of medical historians and medical anthropologists. Are we historians or anthropologists who discuss medicine to explain culture or society, or our role is to answer internal questions of medicine?

Those of us who come from medicine and who have changed side

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- (54) BASTIDE, ROGER. Prólogo. In: DEVEREUX, GEORGE. *Ensayos de Etnopsiquiatría General*. Barcelona, Barral (1973).
- (55) See STOLCKE, VERENA. De padres, filiaciones y malas memorias. ¿Qué historias de qué antropologías?. In: Joan Bestard (ed.), *Después de Malinowski*, Tenerife, Asociación Canaria de Antropólogos, 1993, pp. 147-198. COMELLES, JOSEP M.; PRAT, JOAN. El estado de las antropologías. *Antropología, folclores y nacionalismos en el Estado Español. Antropología* (Madrid), 1992, 3, 35-62.

to history or anthropology we are placed in a particular position. I suspect the most we have never stopped being physicians and we retain and use referents which show this —and maybe this very article is a form of being so again—. Our original professional culture launched us into our occupation with the subjective confidence of our mission in the world, although with very few technical resources for carrying it out. But this confidence involved a certain rationalist skepticism, an inveterate tendency for intellectual do-it yourself, and a pragmatism derived from the overwhelming need to have to respond without hesitating to the anguished demands of the patients and their social networks. The commitment of the physician to the local context of his practice, in his facet as participatory observer, made him have to respond to crises immediately and write them down not from distance but while they were occurring. This is also the professional culture of scholar medical anthropology working in actual problems of aboriginal or peasant societies around the world. But it is not the same case in medical anthropologists or medical historians that are working in Europe in an academic context.

This is why I can understand the pragmatic attitude of North-American medical anthropologists. Kleinman, Fabrega and Hahn, physicians and anthropologists, proposing an agenda that embeds largely medical practice, and trying to reinvent a sort of anthropological medicine, not far from the ideas of Pedro Laín Entralgo of other doctors committed with the humanization of modern medicine. The success of *Clinically Applied Anthropology* in medicine can be easily understood. It is a discourse which can be placed in the margins of medicine, because even the most radical biomedical model cannot cover all the situations in which biomedicine must give answers. In fact the place of clinically applied anthropology in to-day medicine is not different from the position of clinical ethnography fifty years ago. Its main objects of study we find the culture-bound syndromes or the ethnic disorders, the problems of care delivery in less-medicalized areas and so on. Even from a methodological point of view the hermeneutic approach largely developed by the main authors can be linked to the role that phenomenology had in medical and psychiatric discourse along the 20th Century from Husserl, Heidegger and Jaspers to Merleau-Ponty or Ricoeur.

If I consider the reluctancy of *Clinically Applied Anthropology* to look at history as a central theoretical issue it seems that the reason is the fear of the own history. It derived from the ambivalence of authors as doctors and anthropologists. Both histories are so contradictories that it became difficult to assume their implications in the development of an ambivalent professional culture. The suggestions held in the works of Ernesto de Martino, or even in the medical anthropologists who are not physicians or who have abandoned their medical identity, seek to establish an arena of research centered around the medicalization process as a fact embedded in the development of society and culture. This is a sociological, or historical, or anthropological problem, not necessarily a «medical» problem. Their object is society or culture, not medicine. Their identity became those of sociologist, historian or anthropologist even if they mainly work on medical subjects. The question is if changing our identity we shall maintain our position in medicine in the same terms without changing also the identity of biomedical physicians to those, so well represented in the past, of social scientists.