Making Medical Anthropology in Japan:

A memoir of the ten years of Osaka in 1980s

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1. Historical metaphors and Actual Realities

The story that I would like to tell is not a historiographical fact but a kind of fable about making an academic discipline, medical anthropology in Japan around the 1980s. Even though the story depends on my historical realities, I would like to narrate in detail. My story can be an allegory for making originally “a kind of academic discipline” in Japan where the native habitants were/are good at faking as “imported scholarship”(YU-NYŪ GAKUMON) [Suzuki 2007]. Why is the allegory important? I would like to explain how young Japanese students imagined what is called “medical anthropology” when this was not in presence in the 1980s university curriculum. For me it is not important if this is an “imported scholarship” or not, because any kind of scholarship should be contextualized to its specific locality[1]. It’s origin does not matter for me.

[1] This reminds us the episode of the Sugita Genpaku’s book, “RANGAKU-KOTOHAJIME” (1815). Genpaku and his collages had laboured to translate Duch edition of German anatomist, Johann Adam Kulmus’ “*Anatomische Tabellen*”(1722), without translators and dictionaries in Edo period (ancient Tokyo). Their own struggle work like a cryptanalysis were reflected in his memoir by Genpaku forty one years later after

In 1980 I graduated as a Bachelor of Science at Kagoshima University. I studied field ecology of wild Japanese monkeys in Miyazaki Prefecture, southern Japan. ‘Unfortunately’ I began studying in a master course at the Graduate School of Medical Sciences at Osaka University, because I failed my entrance examination for a primatology and ecological anthropology master course at the Graduate School of Science in Kyoto University. After the first half of my year at Osaka University, I applied to enter a biochemical laboratory to prepare my master thesis. The biochemical lab is incorporated with one of world’s most famous research institutes for biochemistry, physical chemistry, and molecular biology. I participated in a small research unit studying rat brain metabolism relating to bio-circadian rhythm under the effects of various psychotropic medical substances (Ishikawa et al. 1984). But eventually I could not handle a series of animal experiments with “sacrificing objects painless,” as it made me, the ‘subject,’ painful (Ikeda in preparation). I had enjoyed my time before with monkeys in a wild forest environment for more than one year. Anyway I dropped out of the natural science lab after only within a few months.

I just start from the anecdote in which I met with Prof. Yonezō Nakagawa in early 1981. Do you remember the name of Yonezō Nakagawa in the Prof. Margaret Lock’s book? His name is appeared in the dedication of her book, “Twice Dead: Organ transplants and reinvention of death,” published in 2002.

In early 1981, I visited the office of Prof. Yonezō Nakagawa (1926-1997), who taught medical history, medical ethics (later bioethics), and history of ideas in environmental medicine. I told him that I wanted to study something “like a cultural anthropology” in a master course in the medical sciences. He said that actually there had been a new emerging area, with the name “Medical Anthropology.” I was fascinated by its sound of “anthropology” because I dedicated myself to the task of my first fieldwork with wild Japanese monkeys in undergraduate days, 1978-1980. Anyway in Nakagawa-sensei’s office, I borrowed the textbook, “Medical Anthropology” written by George Foster and

their finishing.

Barbara Anderson published in 1978 by John Willy & Sons, from him. Prof. Margaret Lock's first medical ethnography, "East Asian Medicine in Urban Japan," based on her fieldwork in Kyoto from 1973 to 74, had just been published in 1980. Two years later her book was translated into Japanese under Prof. Nakagawa's name with his introductory note.

At the same time he introduced me to his laboratory members. They were some graduate students, and his followers, 'Nakagawa-philes,' or enthusiasts for the professor's books and his thought – however I doubt whether "his thought" can be understood easily. They held a spontaneous study group and seminar once a week where they read not only his books but also books written by Iago Galdston (1895-1989), Pedro Laín Entralgo (1908-2001), George Rosen (1910-1977), Thomas McKeown (1912-1988), George Libman Engel (1913-1999), Ivan Illich (1926-2002), Michael Foucault (1926-1984), and so on. Soon after we organized a new sub-group which tended more toward the medical anthropology discipline. As we denominated our group, the Medical Anthropologists in Osaka, its acronym was M-A-O. So we were members of this group, the MAOists. The MAOists is a homonym for the communists who embraced the political doctrine of militaristic and peasant-populist Mao Zedong thought. One Chinese visiting scholar explained us that "mao" has four different meanings according to four different pinyin; cat (māo), contradiction (máo), rivet (mǎo), and flourish (mào). As such, we enjoyed it because it represented our own diverted images of medical anthropology. Needless to say our spiritual leader or "great guru" was Nakagawa-sensei. Under the liberal and anarchistic atmosphere of his and our laboratory, we were reaching toward some kind of "critically thought," HIHANTEKI-SHIKŌ/SHISŌ. We wanted to criticize the present medicine reforming towards a utopian medicine. According our vision the present medicine would reflect on its negative instances, e.g. misuse, malpractice, and structural corruptions, all things come from the structural problems of the capitalist society.

We denominated this perspective of our idealistic medicine, HIHANTEKI-IRYŌ (critical medicine). We expected that medical anthropology gave a hint to construct and reconstruct

idealistic medicine through critical methodology. We were not megalomaniac utopians on a sudden inspiration. We shared in a part the history of the liberalist social-hygiene academics (*Gesellschaft für Hygiene*) of the Osaka Imperial University from 1930, in the difficult years before 1945 (Maruyama 1969) .

2. HIHANTEKI-IRYŌ: A Critical Medicine

I began to study medical history, including its history of ideas, sociology, economics, ethics, and anthropology. On collecting these sub-disciplines Prof. Nakagawa invented a neologism, “medical humanities”, for which he contrasted with biomedicine. In his sense there were two cultures in the studies of medicine, *medical humanities* and *biomedicine.* He used biological medicine to refer to the “narrow” scientific medicine. These terms were like C.P. Snow’s book, *The Two Cultures* (1959), he used to divide two categories, the sciences and the humanities. I think Nakagawa-sensei’s idea of the dichotomy between medical humanities and biomedicine seems to be *sui generis* because the Japanese medical authorities used the completely different dichotomies between basic and clinical medicine, and/or between clinical and social medicine. All these dichotomies, though, belonged among just one side of scientific medicine; *biomedicine* or natural sciences (SEIBUTSU-IGAKU or SHIZEN-KAGAKU). We never had medical humanities as an integrated discipline. The only exception was medical historiography, e.g. the works of Yū Fijikawa (1865-1940), but I think that this academic work, budded from amateur science, was not an integrated discipline to university curriculum.

(Now I will back to Nakagawa-sensei’s personal history relating with ethos that we have shared).

Dr. Nakagawa and his disciples share a similar “ethos” (the distinctive spirit of a “culture”) against “social control by medical establishment.” We thought that all the social institutions could be erroneous in their treatment of patients. We remembered that Nakagawa sensei used to say, “<u>All types of medical treatments have attributes of</u>

experiment, e.g. *having a trial & error aspect*, while the object of medicine is a human being, therefore we can say that all medical treatments are human experiments."

Dr. Nakagawa was born in Seoul of Korean peninsula, the colonial town of the Japanese Empire in 1926. He was fostered as a pro-militarism boy, he said after 60 years later. But he was shocked when that undefeated imperial army was finally defeated. After 1945, during his medical student period in Kyoto Imperial University, until 1947, then in Kyoto University he had drastically converted into something liberalist. After his graduation, he participated in a voluntary party, called "SEINEN-KAGAKUSHIKA-SHŪDAN" (Young Group of Historians of Science) in the 1960s. This was after the political movement against "NICHIBEI-ANPO" (the US-Japan military alliance)[2] conflict of 1960. In the period of "young radicals in campuses" during the conflicts at the end of 1960s and the beginning of 1970s, our elder colleagues among the MAOists had radical experiences as university undergraduate students. But I was one of parts of later generations fallen behind the time. So to say it simply, I was in part of the *post fēstum* (after the feast) generation, because I was born in 1956. As a four years old boy, I was too young to understand the politics in 1960 of the first renovation of NICHIBEI AMPO. Even 10 years later, I was still too young, as a fourteen years old kid, to participate in the "struggle" of university students in 1970. In this sense the *fēstum* means political disturbance. So I was in an in-between generation of two big political *fēsta*.

Why did a dozen of students, sharing the same ethos against "social control by establishment", gather around prof. Nakagawa who was part of an older generation? Because there were no other social spaces where young students could talk freely about of this topic. This was true not only in Kansai (western Japan) but also throughout Japan.

There were two major academic currents for studying medical history at the beginning of 1970s: one was Thomas Kuhn's, and the other was orthodox Marxism. His old friend, Dr.

[2] The NICHIBEI-AMPO is a Japanese second level acronym of "NICHIBEI ANZEN HOSHO JYŌYAKU," that is also first level acronym expression of the original redundant title. The official name of this agreement is translated as "the governmental Treaty of Mutual Cooperation and Security between the United States and Japan."

Shigeru Nakayama translated Thomas Kuhn's book, "*The Structure of Scientific Revolutions*" into Japanese in 1971, nine years after of original edition published in 1962. We could not accept fundamentally the Marxist theories, especially one of the Japanese Communist Party's localized version, because they were too dogmatic in their analysis of medical practice, which always used the framework of labor processes. But at the same time, we had a tolerance for the framework of Marxist theory, especially in the case of Western Marxism, which could be used to analyze how patients were alienated. The Kuhnian model of "revolution[3]", conversely, was attractive to us because we pursued a kind of paradigm change by inventing the medical humanities as opposed to the biology-dominant medicine, "biomedicine".

Until 1980, Dr. Nakagawa was an associate professor that had no chance of being promoted above this position. When he was finally promoted to the professorship, he was 54 years old – I am now three years older than him. He had the charisma to be our spiritual guru and best theorist for medical humanities, like our western heroes that I mentioned before. His personal character was that of a good egalitarian, unlike any other professor in the faculty of medicine. He had great tolerance and never to directed in a magisterial style when he would comment on our research presentations.

A senior student, who was a medical doctor, proposed to us his creative concept of "HIHANTEKI-IRYŌ," the Critical Medicine[4]. We welcomed this conception of him. It helps us develop our position that would take us away from social control by medical establishments and towards the liberation of oppressed people. We were charmed easily by this dogma of critical medicine. At that time, there were a dozen of key concepts for constructing a medical "theology for liberation" in the western medicine e.g., anti-psychiatry, illness labeling theory, a series of negative aspects of modern medicine; total institution, involuntary hospitalization, professional dominance, medicalization,

[3] At least for me, the wording of "revolution" is more like to "brand-new renovation" than "political uprising." I have been used to using this wording as "Matrix Revolutions" more than as "Sandinista Revolution."

[4] The concept of "critical/critique" was borrowed from Marxist Critical Theory. Later we have confronted with the same wording of the "Critical Medical Anthropology, CMA" and "Political Economy of Health" in Merrill Singer and Hans Bear's textbook with same title in 1995.

iatrogenesis, victim blaming, and also, Foucauldian concepts of *panopticon*, *anatomopolitique*, and *biopower*, et cetera. But today I regret that we had very naïve political thinking, and believed that all medical institution would be simply oppressive. Anyway we were too idealistic to make a concrete plan to reform the "conservative" medical system.

At that time we encountered prof. Margaret Lock's paper in Japanese, entitled "RYŌSAI-KENBO NO TEIKŌ" (Resisting against becoming good wife and wise mother) published in "KIKAN-JINRUIGAKU" (Anthropology Quarterly), Vol.15, No.1, Pp.36-60, 1984. At least for me, it was amazing article because she wrote a sophisticated argument that took a critical approach to both the grand theory of Japanese women's somatization and the newly emerging neologism of pseudo-disease, e.g. "BOGEN-BYŌ" and "DAIDOKORO-SHŌKŌGUN." "BOGEN-BYŌ" can be translated into "Child illness induced by deficiency of mother's social responsibility" on one side, and "DAIDOKORO-SHŌKŌGUN" can be translated into "House wife "kitchen" syndrome," both were very curious pseudo-disease terminologies even for Japanese. Her argument is very clear that the concept of somatization could not only be necessary to know one of universal types of psychopathology but also should be understood as a certain cultural representation of personal distress. I had just apprehended that her style of writing could be needed to create "our" medical anthropology, as HIHANTEKI-IRYŌ (critical medicine).

Unfortunately I had no time to do so because I should leave from Japan to Honduras, Central America, for volunteer work in a rural public health program, from 1984 to 87. In Honduras, during the first year I worked in a malaria prevention program, and for the final two years in a rural health program in western Honduras. After arriving in Central America under the political atmosphere of Cold War, I wanted seriously to preach the importance of medical anthropology for Honduran health workers. Needles to say that was a losing battle. Although I was serious, they felt that my ideas were bizarre because they thought that it was useless to introduce my cultural sensitive approach to a rural public health program. They were satisfied with their own work. They did not have a comparative perspective to

need a better good life for rural people. They did not even care if rural people achieved good health; the public health work was only work for minimum wage (Ikeda 2001). So I abandoned my preaching and my plan to introduce medical anthropology to them. And then I started myself to do fieldwork on traditional folk medicine, commoditization of rural health, and medicalization processes, for the purpose writing academic papers. After returning to Japan, I began publishing a series of papers on medical anthropology based on my rural fieldwork experience. But it took more than 14 years before published my first book of ethnography, "JISSEN NO IRYŌ JINRUIGAKU" (Medical Anthropology of Health Practice in Rural Honduras) in 2001.

3. Visiting Foreign Medical Anthropologists

In George Foster and Barbara Anderson's text (1978), there were major four historical roots of medical anthropology: Physical Anthropology, Ethnomedicine, the Culture and Personality School, and International Public Health. Three of the four are theories oriented in schools or the sciences, and the other is applied science. Psychiatrist George Engel's paper "The Need for a New Medical Model"(1977) insists that it is very important to rush into making "bio-pycho-social" medicine instead of the problematic "biomedicine." We can observe a lot of his critiques of biomedicine, but he could not succeed in suggesting a concrete image of "bio-pycho-social" medicine, in proposing an alternative medicine.

Anyway back to Nakagawa's lab again. I had not been educated into becoming an ethnographer. And I did not receive systematic education in cultural anthropology. We were more familiar with medical sociology, for example sociological works by Irving Zola, Ivan Illich and Eliot Freidson, than with medical anthropology. The only exception was Arthur Kleinman' first ethnography, "Patients and Healers in the Context of Culture: An Exploration of the Borderland Between Anthropology, Medicine, and Psychiatry"(1980). Even though we knew of his celebrity as a young and smart psychiatrist *cum* anthropologist, we were slightly frustrated by his phenomenological approach, which seemed "scholastic", far from the critical medicine approach. But we loved very much his ethnography in the

later parts of his book. On the one hand, we were impressed by his vivid description of Taiwanese Tâng-kis' shamanistic trance and their interaction with their clients' family members. On the other hand we complained a bit about his style of dispassionate description, which we felt was like E-P's (Edward E. Evans-Pritchard's) ethnography (Geertz 1988:61-62).

By the way before leaving from Japan, I had more than two years fieldwork experience on the healing processes of the Tantric Buddhists-Shintoists, SHUGEN-DŌ, in various esoteric Temples around the IKOMA Mountains in eastern Osaka, 1982-84. We have happy memories with Joan and Arthur Kleinman, when they visited Japan to participate in international conferences in the 1980s. Nakagawa Sensei asked us to invite them sightseeing in Osaka. We, young graduate students, had just read Arthur's ethnography and conceived of the idea of taking them to an exotic temple in Osaka, similar to the Taiwanese one. That place was the ISHIKIRI-JINJYA (Ishikiri-Shrine of Sintoism) in eastern Osaka near the IKOMA Mountains.

We enjoyed a half-day excursion to the shrine and observed the "exotic" petition of patients and their families for curing disease, healing paraphernalia, and "traditional" therapeutic workshop offices in these areas. After leaving the shrine, ISHIKIRI-san -- we are used to this anthropomorphic terminology even for shrines or gods -- I remembered that it was around January 10th, because we visited the other famous shrine for commercial and fishery god, EBETTSU-san, at the IMAMIYA-EBISU shrine, in the south of Osaka City. Joan and Arthur were a young mid forties couple when we met each other, Arthur, who was famous as one of the founders of the "Culture, Medicine, and Psychiatry" journal in 1976, seemed a very quiet guy on the one hand. For us Joan – later we knew she was a Sinologue who helped Arthur's fieldwork in Taiwan -- was friendlier than Arthur, on the other.

4. Japanese Medical Anthropologists in a teacup

We, MAOists, sometimes have been criticized that we are NOT medical anthropologists, by "mainstream" cultural anthropologists in Japan. Mainstream means that they were educated at and graduated from an official anthropological course. In one academic meeting that we organized in 1980s, I remember one big name medical anthropologist used to say that, "You are social medicine oriented, not by cultural and social anthropology." We were not hurt but we never forgot it. The big-name might think that Japanese medical anthropologists should be educated in an "orthodox" anthropology course. We did not worry about this slight accusation because we ourselves, even ethnocentrically, thought that medical anthropology ought be a part of critical medicine. But we dislike this type of labeling on us because the criticizer cannot take a cultural relativist position. They neglected the fact that we also had learned from textbooks in not only medical but also cultural anthropology. This is the common sense that even an undergraduate anthropology student knows. This anecdote always reminds me of a typical Japanese intolerance ethos towards the stranger outside of closed corporate community; in Japanese, "TATE-SHAKAI" (vertical society) (Nakane 1970), "BURAKU" (local hamlet) (Kida 1967), or "TAKO-TSUBO" (small cell pot of octopus trap by using their own habit) (Maruyama 1961).

In the 1980s Japan, when becoming a medical anthropologist, their identity politics were very important but now it seems to be trivial, I think. Once the identity was a concrete reality for each subject, but now it is a source of power for creating a concrete subject. When Michel Foucault mentioned what is identity he said, "I think identity is one of the first products of power, this kind of power that we have is in our society. ... It should be remembered that the power is not a set of mechanisms of denial, refusal, and exclusion [means *oppressive power* – the author]. But the power actually produces [*productive power* – by author]."[5] This teaches us, if one wants to self-nominate as Medical Anthropologist, he or she just uses the creative force [*productive power* in Foucaudian sense] of making who wants to be; Remember, *Yōda*, the master of Jedi said, "*May the force be with you*."

[5] Je crois que l'identité est un des produits premiers du pouvoir, de ce type de pouvoir que nous connaissons dans notre société. ... Il faut rappeler que le pouvoir n'est pas un ensemble de mécanismes de négation, de refus, d'exclusion. Mais il produit effectivement.

This is not only my personal lesson but also historical fact that I will mention below. Thus one day we, the graduate students, were invited to a closed business meeting whose agenda was not made clear to us. One assistant professor of Tokyo University who had met before in our organized academic meeting said; "We should have an academic association of medical anthropology in Japan. We need your help for supporting this gentleman, who will be the president of our society that will be established." The gentleman who met us this first time was chief of the Department of Biological Drugs in the Ministry of Welfare, "KŌSEISHO" (1938-2001, present name is KŌSEI-RŌDŌSHŌ, Ministry of Health, Labour and Welfare, 2001-). He would later become well known publicly in the HIV-tainted blood scandal. At that time he had just become professor of Tokyo University. We were naïvely surprised at this authoritarian way of thinking of both the KASUMIGASEKI[6] bureaucrat and the Japanese most famous university. Then we decided to cut off our relationship with these kinds of people. We went back to Osaka and rushed to establish our own society of medical anthropology. We respected the founders of the Society of Medical Anthropology in North America. We entitled our newsletter, "Newsletter, Medical Anthropology." We did not want to make our group a "GATTSUKAI" (authorized academic society) but to give name "KENKYU-KAI" (voluntary research group) with our anti-bureaucratic feeling. Our first newsletter, Vol. Zero was issued on July 1st, 1988 with prof. Nakagawa's preface essay entitled "The beginning of Medical Anthropology." Prof. Margaret Lock's headline review article entitled "Changing Medical Anthropology: From Ethnomedicine to Critical-Interpretive Approaches," appeared in Vol. 2, No.5, November 1989.

5. Recombination of "DNA of Japanese" Medical Anthropology

The story that I have mentioned above is not a value-free (*Wertfeiheit*) nor real, but deviated or decentered (Weber 1946). You may read or listen to the fictional (*fictiō*) like a *roman picaresque*. It seems very difficult to explain the early period of making Japanese

[6] KASUMIGASEKI is the locality in Tokyo where are the governmental ministries are headquartered.

Medical Anthropology. So I recommend that you suspect if I have fabricated this story. And also you may use your own imagination to read any kind of fabulous story[7] including medical ethnography. This is a reason why I use historical anecdote.

Now I summarize two major limitations of our critical medicine project mentioned below.

(1) *A priori* critique against biomedicine

We borrowed the relativistic concepts from medical humanities as tools of critique against biomedicine. Because we focused on only negative aspects of biomedicine, we could automatically made the "begging the question error" (*petito principii*) in evaluating neutrally biomedicine. We could not consider the alternative. Our image of "bio-psycho-social" medicine can be still poor (Engel 1977). We loved critiques of critiques but did not to look at the realities of biomedicine as it had transformed during over thirty years. Biomedicine has the potential to become an oppressive institution on the one hand, but in some aspects patients are possible to tame biomedicine to guarantee their own survival probabilities even as they have their own limitations. Needless to say today we should treat our analysis of biomedicine more dynamically (Lock 2013).

(2) Need for ethnographies of various types of ethnomedicine-s

We always insisted on the importance of holism when we taught in the classroom. But our holism images diverge in detail. Our image of biomedicine is monolithic on the one hand, while the image of ethnomedicine-s relatively is broad on the other hand. Both are stereotyped images. We needed more ethnographic conceptual enrichment in ethnomedicine.

We have to inquire again what medical anthropology is. We sometimes define that medical anthropology is anthropological study of health and illness. But in our society, biomedicine and the medicalization process are very influential today (e.g. Lock 2013). We cannot ignore or neglect the biomedical presence in our modern life. Our problem is which aspect

[7] In this sense I love reading Kary Mullis' fabulous "*Dancing Naked in the Mind Field*" (Pantheon, 1998) more than Paul Rabinow's plain "*Making PCR: A story of biotechnology*" (Univ. Chicago Press, 1996).

of biomedicine-s evokes universality on the one hand, and which aspects of biomedicine diversifies locality on the other. We can use biomedical knowledge when we analyze biomedicine itself. I wonder how our relativistic sense fosters when we analyze biomedicine by using biomedical epistemic tools.

Another aspect I question is which kind of radicalism is medical anthropology. For discussing profoundly I borrow his concept of Clifford Geertz' article, "Blurred [blə'ːrd] Genres: The Refiguration of Social Thought" in his book "*Local Knowledge*," 1983. Needless to say, medical anthropology seems to be taking a position of the interdisciplinary genre between anthropology and medicine. According to the inspiration of Kenneth Burke's "*A Grammar of Motives*" (1945)[8], the problem should be understood how both *agents*, so to say, anthropologists and medical scientists, inter-*act*, what is the context of the *scene*, which *agency* is mediated between them, and what *purpose* they expect. This is a reason why I would like to say that medical anthropology is a blurred genre. At least modern medical anthropologists share epistemologically the belief that this challenging field can be a transgressive area between anthropology and medical sciences with their creativities. Students of each side can also share ontologically the other partner's methodologies for analyzing their own topics. These situations can be understood using the metaphor of "dialogue" between anthropology and medical sciences. But the problem is what kind of dialogue can be possible in this case? Even though both inhabitants look like neighbors, they use a different language and live in a different culture.

How many years do we have medical anthropology? "Our" field has actually accumulated huge studies for more than thirty years. Somebody says etymologically that we have more than fifty years of tradition. In North America, and even in Japan and other East Asian countries, medical anthropology is one of the most popular disciplines. So we cannot say this area is a "*sunset industry*." But I think that the true crisis is to be satisfied by our own mind not to challenge to participate controversies with other disciplines.

[8] "What is involved, when we say what people are doing and why thy are doing it?" Burke (1962[1945]:xvii) says, we shall use five terms, *Act, Scene, Agent, Act, Agency* and *Purpose*, for generating principle of his investigation.

Our critical medicine studies group, the MAOists, respect North American colleges who published in the *Medical Anthropology Newsletter* from 1970 to Nov. 1982. So we decided to publish our newsletter, entitled "*Newsletter, Medical Anthropology*" in 1988 in Osaka. Unfortunately we confronted problems ourselves with mannerism more than financial problem. We experienced the newly emerging similar academic areas of medical anthropology, e.g. medical sociology, bioethics, and so on. We had to stop publishing the *Newsletter;* the final volume was No.21 (Vol.4, No.6) in 1996. That was the final stage for the academic voluntary group of medical anthropology, the MAOists.

Medical anthropology is popular among Japanese as well as between North Americans and Europeans, but today there is not academic voluntary group in Japan. What are the differences between them? We cannot explain it by population. Last year I advised one young medical anthropologist to organize a studying group within the Japanese Society of Cultural Anthropology, JASCA[9]. I have a new dream that medical anthropologists in the world are able to disseminate "anthropological knowledge and its use to solve human problems[10]." What should medical scientists and anthropologists do now?

The popular image of medical anthropology in 1980s had still been a "blurred genre." The blurred genre is ambivalent, potentially provocative, and critical. I remind that we should re-read prof. Lock's article on "Resisting against becoming good wife and wise mother," including a re-consideration of the Japanese social and political atmosphere[11]. I can assert some agendas that this article made important for us;

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[9] In February we have good news that the JASCA has decided to support our studying group having plan to develop standardized under- and post graduated curriculum of medical anthropology in Japan.

[10] These are borrowed from the phrase of the *Statement on Ethics, AAA*, 2012.

[11] Lock's Japanese article (1984) published in "KIKAN-JINRUIGAKU" has two Japanese big-names comment; One is Hayao Kawai (1928-2007), a Jungian psychoanalyst also ex-Commissioner for Cultural Affairs, MEXT, 2002-2007, and our Master Nakagawa-sensei. I think both comments were not impressive nor appropriate because Kawai-sensei attacked the disharmony between her methodology and representation of the data and Nakagawa-sensei complained that she should not take "minor" health problem of women but treat "major" health issue, e.g. cancer and heart disease. Both sensei-s complained that her descriptive style is too westernized to fascinate the Japanese intellectual. Today I have more sympathy her article than their comments. My brain has been westernized already, hasn't it ?

(1) The article can be interpreted as a message to Japanese unaccomplished "medical anthropologists" on how to make an "anthropological critique" according to concrete ethnological issues.
(2) Some stereotyped pseudo-disease labels for Japanese women can be understood not as a psychosomatic biomedical disorder but as a cultural representation that indicates the positionality of Japanese women in the medicalization process.
(3) The article made the strong traditional gender ideology visible; this ideology could be maintained not only by traditionalist conservatives but also by women themselves. And,
(4) The article does not depend on a cultural determinist approach, but presents the potential possibilities that can empower to women by representing them as subjects of resistance.

Needless to say, the Japanese women's good wife and wise mother ideology has been criticized as statecraft by many feminists scholars. Through Prof. Lock representation of Japanese women as partaking in a performative practice which has adapted to the medicalization of women, she can propose that women have the potential to dislocate and self-fashioning (Greenblatt 1980) a new identity as autonomous subjects, apart from the state ideology of "good wife and wise mother", even if they are still maintaining this stereotype.

When I re-read Lock-sensei's old paper at this time, I am encouraged myself by her productive power, the *force*, of maintaining the blurred genre. It is important to imagine historically the critical aspect of this blurred genre, Medical Anthropology, because the etymology of "revolution" means, "rolling back to ideal past."

Remember, as the Jadi master's phrase, "*May the Medical Anthropology be with you*!!"

[**Thank you for your attention**]

Tables and Images

Table 1. My Classification of Sub-disciplines of Medical Anthropology (Ikeda 1997)

1. Physical anthropology
Paleopathology
Epidemiological geography and Historiography
Nutritional Ecology
Human Ecology
2. Ethnomedicine
Sorcery and Witchcraft Studies
Shamanism Studies
Ethnobotany and Ethnozoology
Folk Etiology Studies
Folk Pathology Studies
Anthropology of Body
3. Culture and Personality School (Studies)
Psychoanalysis
Psychological Anthropology
Transcultural Psychiatry
Comparative Psychiatry
Ethnopsychiatry
4. International Public Health
Behavioral Sciences in Public Health
Acculturation Studies under Introducing Modern Medicine
Development Anthropology

Table 2. Topics of Medical Anthropology (SMA online)

What is Medical Anthropology?
- Health ramifications of ecological “adaptation and maladaptation”
- Popular health culture and domestic health care practices
- Local interpretations of bodily processes

- Changing body projects and valued bodily attributes
- Perceptions of risk, vulnerability and responsibility for illness and health care
- Risk and protective dimensions of human behavior, cultural norms and social institutions
- Preventative health and harm reduction practices
- The experience of illness and the social relations of sickness
- The range of factors driving health, nutrition and health care transitions
- Ethnomedicine, pluralistic healing modalities, and healing processes
- The social organization of clinical interactions
- The cultural and historical conditions shaping medical practices and policies
- Medical practices in the context of modernity, colonial, and post-colonial social formations
- The use and interpretation of pharmaceuticals and forms of biotechnology
- The commercialization and commodification of health and medicine
- Disease distribution and health disparity
- Differential use and availability of government and private health care resources
- The political economy of health care provision.
- The political ecology of infectious and vector borne diseases, chronic diseases and states of malnutrition, and violence
- The possibilities for a critically engaged yet clinically relevant application of anthropology

Source: http://www.medanthro.net/feature/what-is-medical-anthropology/

Photograph 1.

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医療人類学ことおこし

中川米造

　昨年の暮れに知り合いの仲間とかたらって東京で医療人類学の国際シンポジウムを開催した。日本にも医療人類学という言葉を定着させ、それについての関心を拡大し深めようというもくろみによるものであった。資金の方はなんとか協力してくれる財団があり、外国から招待する学者についても快く出席の返事はいただいたのだが、心配したのは国内からの参加者がどれほどみこめるかということであった。

　身近に医療人類学に興味をもってくれそうな人の数をかぞえてみるが、ときに五〇〇人くらいは見込めるという強気の意見がでたりときには一〇〇人位ではないかと弱気になったり、そのたびに会場の手配を変えなければならないので右往左往させられた。最終的にはその中間をとって二〇〇人規模と推測して会場を決めたのだが、いざ蓋をあけてみるとそれは弱気の推算であることを思いしらされた。

　開会数日前に参加希望者が定員を越えた。当日は別会場を設けてテレビ中継で勘弁していただかなければならない参加者もでた。

　おどろいたのは、懇親会の参加者も予想外に多かったことである。この種の懇親会は別に会費を払うことでもあり、顔みしり同士が半ばは義理で出席することがおおいものだが若手の新顔が多数まじって、しきりにおたがいに自己紹介をくりかえしていた。

　聞いてみると、北は北海道から南は沖縄までほとんど全国から集まっていることがうかがわれた。しかもそうした若手のなかには、医療人類学がおもしろそうだから勉強したいという人々のほかに、すでにアメリカやフランスなどの大学で医療人類学を勉強したり、あちこちのフィールドで調査をしている方々も相当あった。これらのひとびとが、いずれもこのわが国はじめての医療人類学の旗揚げシンポジウムの開催をよろこんでくれ、さらに組織的な取り組みにむけて結集すべきであると口々に語り合っていた。そこでとりあえず、まずはお互いの存在確認をかねて日本における医療人類学研究の広さと深さを量り、それをさらに拡げ深めるために、ニュースレターのようなものをだしてみようという声が私の周辺からおこった。編集に伴う事務的な仕事もひきうけてくれるというのでここにその第0号ができあがった次第である。これを起動力として日本にも医療人類学が根づくことを切に期待する。

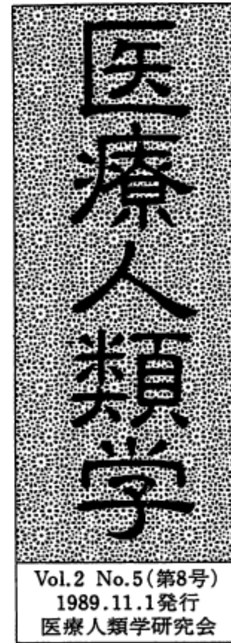
　わたくしの考えでは医療人類学は医療を人間的な営みであることを承認した上で、それを記載し構成的に理解することで、ともすれば独自の世界にこもりやすい医療を人間の行為一般の枠によって見ることである。それによって、いま閉塞状況にあって展望をもとめている現代医療や健康問題にも新しい地平を提供できそうな事と信じている。

（なかがわよねぞう・医療人類学）

(Cover article by Prof. Yonezō NAKAGAWA, July 1988)

Photograph 2-1.

医療人類学　Vol.2 No.5（通算8号）　1989.11.1



変貌しつつある医療人類学

—民族医学から批判的・解釈的アプローチへ

マーガレット・ロック

　医療人類学は、三十年以上この方、公式的には人類学の下位領域の一つとみなされてきた。健康であれ病気であれ人間の体が、このフィールドにおける研究の出発点である。その研究には、身体に関する表出や説明解釈についての歴史的かつ通文化的な研究、さらに病いや、老化の影響を説明し分類しそこから救い出す普遍的な試みに対する分析が含まれている。

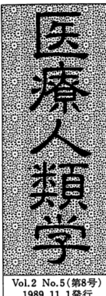
　健康や病気を考察した初期のモノグラフ（研究論文）の多くは、医療人類学を念頭において書かれてはいなかった。その研究者たちは、明らかに宗教・儀礼・呪術・思考様式の比較などを研究していた。しかし、身体は〔それを通して様々なことを〕「考えるのに適しており」、どの社会においても象徴的な紐帯を生みだすための第一の対象である。そのため、これらの著作が医療人類学の古典になっていったことは正に必然的であった。その最もよく知られたものは、もちろん、エヴァンス・プリチャードの『アザンデ族における妖術、託宣および呪術〔1937〕』、ヴィクター・ターナーの『象徴の森〔1967〕』と『不幸のドラム〔1968〕』および、メアリー・ダグラスの『清潔と危険〔1966〕』（邦訳『汚穢と禁忌』）である。

　振り返って見れば、人類学を含む社会科学の分野内で、過去二十年以上にわたって行なわれてきた理論的検討の大部分が、具体的には、次のような論点に関するものであったことは明らかである。つまり、それは〈世界に関する「事実」は発見されうるという立場〉と、もう一つは〈「事実」とは研究者と研究テーマとの相互作用の産物であるという立場〉との間の

(Cover article [partial] by Prof. Margaret LOCK, November 1989)

Photograph 2-2.

医療人類学　Vol.2 No.5（通算8号）　1989.11.1



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論争なのであった。先に述べた古典的なモノグラフに共通するように、医療人類学の作業の大部分がこのうちの最初の立場、すなわち〈厳格で経験的な研究が対象や出来事について「もっともらしい」叙述や結論を導いてくれる〉という一連の考え方に陥ってしまっている。このタイプの研究は、もちろん、その大部分が文化的に感受性が強かったため、文化的コンテクストの中で分析がおこなわれた時、健康や病気に結びついた信念や行為がいかに「意味を持っているか」を示すことに重点がおかれた。また、しばしば、それに加えて、「未開人」、移民、及び、難民たちも理性的存在であることを示そうとした。しかしながら、その一方で、このタイプの医療人類学は、次の点に関して驚くほど感性を欠如していた。つまり、それは、科学もまた「文化」であり、その文化が、人々が問う問題の性質を規定するということである。ヤングが指摘しているように、「西洋の社会科学や西洋医学に関する認識論的な検討は、棚上げになっている（1982:260）」のである。「伝統的な」医療体系の文化的分析は様々に試みられるのだが、生物医学（「科学」医学）は、正にその生れながらの性質によって特権化されているものと見なされ、そのような分析からは免れている。

　そのようなアプローチがとられる時には、通常以下のような前提が伴っている。すなわち、科学を適用すれば、自然の世界を論理的合理的に充分に理解することが理論的には可能であること、さらには、テクノロジーの手段によって結局は人体を含めた自然を支配することができるであろうという前提である。健康や病気について言えば、邪視についての関心から寺院での読経にいたるまでの行動やその説明のための全体的な装置は一方では、心理的な防衛機転で了解可能であろう。しかし、いったん、西洋生物学の普遍的な教育が常識的になってくると、そのような説明装置は必要ではなくなるとおおかた考えられている。そうなると、人体内の測定可能な物理的変化が「実体real」でありその他の現象は無関係だ、という考え方が一般に受け入れられてしまう。その時、私たちは「最も真剣に病気を〔あるがままに〕理解する方法、そして、つまり、最も健全に〔隠喩的な先入見にとらわれずに〕病気になることこそが、〔ガンや結核といった〕隠喩がらみの思考から最も純粋にのがれることであり、その思考に最も抵抗することなのだ（1978:3）」と言う時のスーザン・ソンタグに自分自身が一致していることに気づくだろう。

〈医療人類学における批判的—解釈的展望〉

　社会科学における最近のもう一つの理論的方向は、秩序だった合理的な説明を求めるのではなく、かわりに、社会生活は「基本的には〈様々な意味の取決め、取り引き〉として認知されなければならない（マーカスとフィッシャー、1986:26）」という方法に焦点を当てる。社会科学における実証主義者たちのヘゲモニーは、このような批判的—解釈的立場においては明白に拒絶されたのだが、これには、現象学、文化構成主義およびネオ・マルクス主義の貢献があった。この方向というのは、還元主義的な科学を全体的に再検討しようとする、もっとずっと広い運動の一部なのだ。そして、この運動には、西洋医学の営為を、西洋独特な歴史的文化的なコンテクストの産物であるとして再検討しようとする視点も含まれている（ロックとゴードン、1988; マルケイ、1979; トゥールミン、1982）。

　この認識は医療人類学にとって大変重要である。というのは、生物医学の世界自体が、このような視点から、医療人類学的分析を受ける必要があるからである。

　批判的—解釈的アプローチをとるならば、医療人類学はもはや「代替的な」医療体系、医療信条及び

〈二面最上段へ続く〉

(Cover article [front page] by Prof. Margaret LOCK, November 1989)

Glossaries

- BOGEN-BYŌ - Child illness induced by deficiency of mother’s social responsibility, a pseudo-disease invented by a Japanese medical doctor.
- BURAKU - local hamlet in Japanese.
- DAIDOKORO-SHŌKŌGUN - House wife “kitchen” syndrome, a pseudo-disease invented by a Japanese medical doctor.
- GATTSUKAI - authorized academic society or association.
- HIHANTEKI-IRYŌ - critical medicine.
- JISSEN NO IRYŌ JINRUIGAKU - "Medical anthropology of practice": The author's book on Medical Anthropology of Health Practice in Rural Honduras, an ethnography published in 2001.
- KENKYU-KAI - voluntary research group.
- KIKAN-JINRUIGAKU - Anthropology Quarterly, a Japanese Journal of Anthropology published Kyoto Association of Anthropology, Kyoto University, 1969-1989.
- KŌSEISHO - Ministry of Health,1938-2001, now Ministry of Health, Labour and Welfare, 2001- .
- KŌSEI-RŌDŌSHŌ - Ministry of Health, Labour and Welfare, 2001- .
- MAOists, M-A-O - acronym of the Medical Anthropologists group in Osaka.
- NICHIBEI-AMPO, NICHIBEI ANZEN HOSHO JYŌYAKU - the US-Japan military alliance, “the governmental Treaty of Mutual Cooperation and Security between the United States and Japan.”
- RANGAKU-KOTOHAJIME - "Beginning of Duch Scholarship,"(1815) The book name of SUGITA Genpaku, 1733-1817, Medical doctor of the Edo period.
- RYŌSAI-KENBO NO TEIKŌ - Resisting against becoming good wife and wise mother.A title of the Margaret Lock's paper.
- SEIBUTSU-IGAKU - biomedicine.
- SEINEN-KAGAKUSHIKA-SHŪDAN - Young Group of Historians of Science.

- SHIZEN-KAGAKU - natural sciences.
- SHUGEN-DŌ - a syncretic Japanese Mountain Religion influenced by the esoteric-tantric Buddism, MITTKYŌ.
- TATE-SHAKAI - vertical society. A typical character of Japanese society, by Chie NAKANE, 1970.
- YU-NYŪ GAKUMON - “imported scholarship”of western academics to Japan.

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