My Testament to Students Studying Critical Medical Anthropology

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Dear friends,

As the time has come to say good-bye to my students in medical anthropology, I feel this is a good time to make my testament. This document can be divided two parts; the first part describe my own experience in rural Honduras in the mid-1980s, and the second part describes the heroes that I looked up to when I was a graduate student of public health and social medicine. I will also add some citations.

In the mid-1980s, I joined the Japan Overseas Cooperation Volunteers, JOCVs, in Honduras, Central America. My work was involved assistance for public health education in rural areas in the western mountainous part of Honduras. I researched how people think and act about "health" through specific practices. The local people who received our public health program understand "health" simply as the absence from disease. They do not give the word "*salud*" (in Spanish, that means "health") the positive meaning that westerners sometime refer to as "positive health". I think the concept of "health" was newly introduced from outside the community. There existed two concepts of "health." one was the traditional concept of the conditions of a body "without disease." The other was "positive health" in the modern western sense that we would try to introduce from outside the community.

Nonetheless, we tried to introduce new "positive health" into communities, the people did not accept this and maintained the old concept. We confronted an epistemological barrier of the local people. One Honduran Ministry of Health officials used to say they were "ignorant." He said that because of local people's ignorance, our public health program would fail. He thought that the villagers were ignorant in public health knowledge. However, this official had completely forgotten that his own concept of positive health also had once been educated.

On the other hands, the villagers, of course, did not consider themselves ignorant. Nor were they aware that they were "resisting" against the official public health program. The village people expressed that the new public health program was simply too difficult to use and understand. Consequently, they were ironically labeled as "resisters" by the officials.

Of course, the programs had attractive points for the villagers. If they could attend a free seminar of our programs, they were offered basic drugs, a notebook, a meal, or some snacks as rewards by registering their names. Also, there were advantages such as being able to mak friends by attending the workshops. Once the project started, villagers benefited from being able to borrow free-loan money for the installation of latrines. A small but new latrine can be a strong symbol of introducing a new concept of positive health. Those who accepted the project recognize themselves as "progressive," while those who did not accept it were "still ignorant." But the ones who did not accept it were criticized by "progressives" as having "sold their souls" to the outsiders, such as government people. The public health program had introduced the seeds of discord into the village. The officials never express people who did not accept the program "ignorant" in front of them. Unfortunately, this kind of insult was also introduced into the village through the public health program. At the same time, in villages where various social dynamics were functioning, *informed consent* did not always proceed rationally.

In so far, not all villagers would accept a new public health program. Program supervisors were evaluating the program by yield rates and performance in communities. Officials there participated with explicit competition according to their yield rates and performance among their own different community's programs. *For whom was the public health program?* Naturally *for the common people*, but also *for the working officials* who were ordered by their project to provide supervisors.

Here, I would to explain this case using the Foucauldian theory. For instance, a person who had studied these theories would interpret it this way. Michel Foucault said that power, especially political power, does not only oppress people but makes them into *new subjects* that practice under social effects. In my case, to be a recipient of public health program is to be a *subjec*t through being acted on. However, then

a person who rejects the public health program coming into the village must also "becomes *another new subject*." These "resisters" oppose the program, and this is why the stereotypical adjectives, "ignorant," "conservative," and "not progressive," were attached by the proponents of the program. When I participated in the health care program in Honduras was in the world-wide Primary Health Care, the Alma Ata movement Declaration started 1978. As stated above, I assume that the Foucauldian theory can be applied to the primary health care approach.

Here there are two images of "good health", the Honduran on the left and of the Nicaraguan on the right. These two images of good health were different depending on their governmental political ideology; Honduras was an anti-communist country supported by former President Ronald Regan of the United States, Nicaragua had the Sandinista Revolutionary Government which promoted the anti-capitalist good health policy under the support by Cuba. The mid-1980s' figures demonstrate the national differences between them.

図13－2 「健康的な状態」(1)
出典：Ministerio de Salud Pública (MSP), 1985. *Manual técnico para la utilización del rotafolio de patricipación comunitaria.* p. 25. Tegucigalpa, Honduras: Ministerio de Salud Pública, República de Honduras.

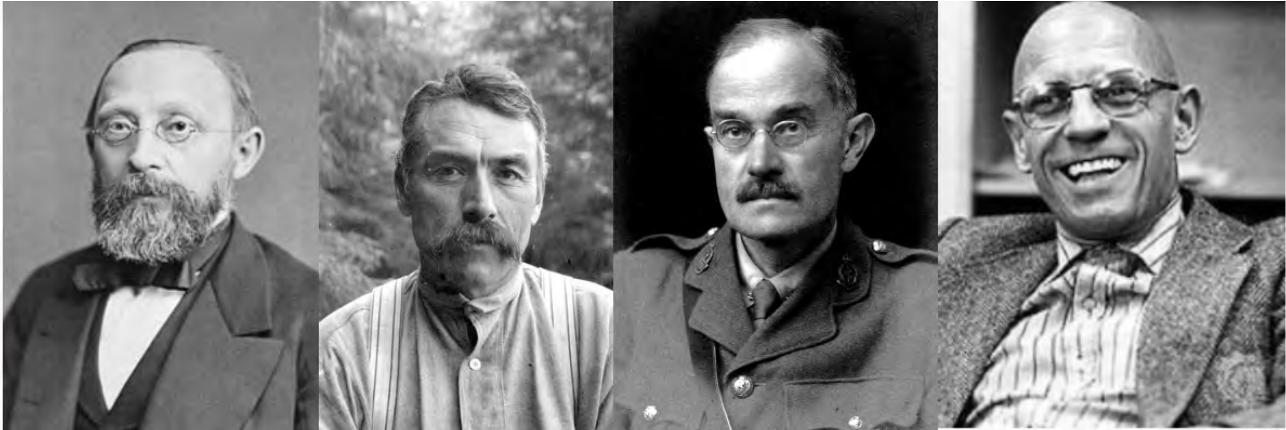
図13－6 「我々の革命的プロセスでは……」
出典：En nuestro proceso revolutionario (Donahue, John. M., 1986. *The Nicaraguan revolution in Health : From Somoza to the Sandinistas.*, p. 80, Massachusetts : Bergin and Garvey.)

Two figures demonstrate the national difference of "good health or healthy lives" between Honduras and Nicaragua in the mid-1980s.

Then, even if “community-based” and “community’s participation” based on informed consent are central, the self-determination of “resistance” to the introduction of external programs might also be respected. I was not very aware of this during my stay in Honduras. After leaving the country, I learned about the Rural Appraisal by Dr. Robert Chambers, the principle of the action research by Sol Tax, which has a long history in anthropology, and the subsequent Community-Based Participatory Research (CBPR), in which the option of “rejection” from the peoples' point of view, rather than “resistance” from the side of the power holder, I found that it should be respect for accepting the option of “refusal” as being equal “accordance and/ or acceptance.” Just as I have learned the peoples' autonomous spirits in public health programs.

When medical anthropologists have the “will” to change the conservative or traditional things in a village, this is always considered problematic as it violates the dogma or doctrine of “cultural relativism” that anthropology has long accepted as discipline to its work. On the other hand, in applied anthropology, it is commonplace to identify malfunctions within a community and, through discussions with the residents, to confirm the “will” of the community to promote projects. Today, when the former term “applied anthropology” has faded and become public anthropology and/ or engaged anthropology, egalitarian dialogue within the community's autonomy is very important. The cold-hearted word of “cultural relativism” has now receded in medical anthropology, and the emphasis is now on “cultural egalitarianism,” “dialogue under equal conditions,” and “community-based autonomy.”

Over there, in the 1980s, a project of communities’ total conversion for modern public health based on paternalism, is not different from the “medical missionary work/medical mission” of the colonial era. When I was writing the paper about the story mentioned above, later entitled “Health Promotion and Health Ideology,” I guess I had not yet arrived at this perception of medical anthropology as “medical missionary work.” There, I was probably stuck in the *doxa* that it is the residents who change their ideas and actions through health and medical treatment projects, not the medical anthropologists themselves who change their own ideas and attitudes.



Pictures present from left to right; Rudolf Ludwig Carl Virchow (1821-1902), George Hunt (1854-1933), W.H.R. Rivers (1864-1922), and Michel Foucault (1926-1984)

I began studying medical anthropology in 1981, and there were four heroes for me at that time. In order of their birth dates, they are Rudolf Ludwig Carl Virchow (1821-1902), George Hunt (1854-1933), William Halse Rivers Rivers (1864-1922), and Paul-Michel Foucault (1926-1984). Foucault was born in the same year as my mentor, Yonezo Nakagawa (1926-1997). Virchow and Rivers are well known as the founders of medical anthropology in the Anglo-American world. Each of them is a unique and brilliant individual who has influenced my books and articles in various ways.

Yonezo Nakagawa (1926-1997)

Virchow brought us a practical challenge at the roots of medical anthropology with his dictum,

“**medicine is a social science to the bone**.” W.H.R. Rivers was the psychiatrist who, along with Sigmund Freud, described war neuroses or shell shock (a kind of combat fatigue), considered to be a related syndrome of Post Traumatic Stress Disorder, PTSD. He also established the genealogical method, a significant advance in kinship research. On the other hand, he participated in the Cambridge University Torres Strait Expedition, organized by Alfred Cort Haddon, and argued that, apart from their capacity for acuity, the “savages” had no physiological differences in their repertoire of sensibilities, and that language and metaphor provided diversity in illness expression and classification. In particular, he suggested that the classification of sickness was as systematic in “uncivilized societies” as to be comparable to the Western taxonomy of diseases or nosology. Foucault not only developed the concept of bio-power, but also considered the concept of governing, the term, governmentality, how to govern people and society through biomedicine and demography. Today, the concept of governmentality has become an essential analytical tool for many researchers analyzing the public health and medical ethics.

Many of you may not know George Hunt. However, he is called as "*Quesalid*," a sorcerer or shaman who appears pseudonymously in Franz Boas' “*Ethnography of the Kwakiutl*,” today as the Kwakwaka'wakw. In the chapter of “The Sorcerer and His Magic” in Lévi-Strauss' monumental book, entitled as “*Structural Anthropology*,” published in 1963 translated from French to English. Among many anthropologists it is known the name of Quesalid but never known his real name George Hunt. I learned that Quesalid was George Hunt from James Clifford's book, “*The Predicament of Culture*” (1988). Hunt's genealogical origins were both Tlingit and British, not Kwakwaka'wakw, and he grew up in Kwakwaka'wakw territory with his parents and through intermarriage and adoption became himself a native anthropologist familiar with Kwakwaka'wakw language and culture. Franz Boas became friends with Gorge Hunt to exhibit the Kwakwaka'wakw at the World’s Columbian Exposition in Chicago in 1893. Boas taught Hunt linguistic anthropology and phonetic notation, especially Kwakwaka'wakw orthograph. Hunt is said to have written more than 10,000 pages of ethnographic notes of Kwakwaka'wakw including his autobiographical experience for Franz Boas.

When I still reread the chapter, “The Sorcerer and His Magic” by Lévi-Strauss, through his storytelling, I am still impressed by the auto-ethnography of George Hunt, that is the things about Quesalid. It seems to me that native anthropologists can reach the inner recesses of cultural understanding without going through the dogma of “cultural relativism.” It also seems to me that the technique for reading across cultures is not to immerse oneself in the culture of the others, but to always be “conscious” of the fact that one's own culture dissolves in the culture of the others e.g., forgetting what one has learned. In other words, as an anthropologist himself, George Hunt dissolved his role as a sorcerer and proved himself that the existence experienced by the healer in the culture in question is tied to the practice of cross-cultural reading as reflexive process. The important thing is not that he took epistemological relativism but that he did understand what is to be powerful healer among the Kwakwaka'wakw through his devious and an-ethical performance among Indians.

Japanese social medicine from the 1920s onward, as described in the proceedings of this meeting, tried to live up to Virchow's dictum that “**medicine is a social science to the bone**.” Medical doctors, like applied medical anthropologists today, tried to practice their social medicine by spending time in rural villages and urban squatters. However, in Japan from the 1930s to 1945, they were grabbed by thought control policy, recruited by military soldiers (and even some of them defected to the Soviet Union and were purged by dictator Joseph Stalin). Young idealist medical doctor survivors were disappointed by Japan's defeat in the war. It can also fall into another pitfall of reproducing unreflective criticism, criticism for criticism's sake, and falling into “mere condemnation.” Criticism is an act like walking a tightrope. But it worth trying again.

I quote my favorite passage from Heraclitus’ “All things change” by Quincy Jones and Ray Brown,

Everything must change
Nothing stays the same
Everyone will change
No one stays the same

The young become the old
And mysteries do unfold
'Cause that's the way of time
Nothing and no one goes unchanged
-- *Everything must change*

My last words, my testament, are as follows: We must not only hope that through criticism, the future of the subject will change in a favorable and appropriate manner, but we must also have the courage to change ourselves as critics.

Yours Sincerely,

Mitzub'ixi Qu'q Ch'ij
Your good friend.

P.S.
If you will permit, I will also annoy you with Samuel Beckett's poem…

First the body. No. First the place. No. First both. Now either. Now the other. Sick of the either try the other. Sick of it back sick of the either. So on. Somehow on. Till sick of both. Throw up and go. Where neither. Till sick of there. Throw up and back. The body again. Where none. The place again. Where none. Try again. Fail again. Better again. Or better worse. Fail worse again. Still worse again. Till sick for good. Throw up for good. Go for good. Where neither for good. Good and all. – from "Worstward Ho "

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