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ON BIOLOGY AND CULTURE: INAUGURAL ADDRESS AT THE NATIONAL SEMINAR ON THE ANTHROPOLOGY OF CARDIO-METABOLIC ADVERSITIES ON 25 SEPTEMBER 2015 (ORGANIZED BY THE DEPARTMENT OF ANTHROPOLOGY, UNIVERSITY OF DELHI)

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I welcome you all to this seminar on the anthropology of cardio-metabolic adversities, being ably organized by my colleagues, Drs. K.N. Saraswathie and R.P. Mitra, the first a physical anthropologist, renowned for her research works on molecular genetics, and the second, a social anthropologist, well known for his writings and researches on ethnicity, migration, and marginalization. In this ideal combination of the conveners of this seminar – one a physical anthropologist and the other, a social anthropologist, both 'hard core' and 'unflinchingly committed' to their respective specializations – that the meaning, strength, scope, and aesthetics of anthropology lies. Whilst anthropology, libertine as it is, provides every opportunity to its pursuers to choose an area for investigation, howsoever minuscule or vast, they are most interested in, because of which it is often called a 'discipline without frontiers', it unfailingly reminds its practitioners that human life is rooted in a dialectics of biology (and bio-genetic substances) and culture. Each of these has its own nuances, dynamics, constraints and limitations, laws and thoughts, but they act on each other, as they have always done, ceaselessly, unrelaxingly. With this perspective, emerging out of the interaction between biological and cultural aspects, anthropology also approaches the relations human beings have with animate and inanimate forms of existence in the universe. However, so different biology and culture appear exteriorly that the possibility of ignoring one at the expense of the other is quite high.

Not only that, it has also been observed that the departments of anthropology, which have both the specializations in physical and social anthropology, are often fraught with a never-ending conflict between physical and social anthropologists, each one claiming oneupmanship over the other, sometimes treating the other undignifiedly, vociferously exercising their respective rights and controls over the scarce resources, funding, and positions, and this is one of the reasons why one specialization closes its eyes to the other. In an unfortunate scenario like this, the possibility of undertaking a study where both biological and cultural variants may be studied in a relationship of dialectical interconnectedness, is ruled out,

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notwithstanding the urgency and importance of such a study. Although, as said previously, this situation may not exist in those departments of anthropology where only one specialization reigns, my submission is that interpersonal squabbles between specialists of different branches should not mar the advantages of carrying out bio-cultural and bio-behavioural studies. Well known is the fact that anthropology is perhaps the only academic discipline that provides an exceptional opportunity to look at several phenomena from the perspectives of biology and culture and this merit of anthropology should not be glossed over.

Secondly, it is important that the university administration keeps in mind that whenever new departments of anthropology are opened up, all its branches should be introduced both at the level of teaching and research, and those departments that are truncated now, or just have the benefit of one branch or the other, should be given the representation of the other branches, so that the skewedness continuing from generations is corrected. In case, because of one reason or the other, if this condition is not likely to be met, it is better not to start anthropology departments that give a partial and eclipsed picture of the discipline. I am not inclined to favour the argument that may be held by some that let the department be started even with a partial specialization, and in course of time, the lopsidedness would be corrected, because it just does not happen, and the departments once opened cannot be closed down as the students have already been admitted. Against this backdrop, it is imperative that we critically look into the social organization of the departments of anthropology, and address the lacunae, interpersonal differences, and the problems pertaining to an equitable distribution of funding and positions positively and amicably.

Having argued favourably for bio-cultural and bio-behavioural studies, we should not forget the areas in anthropological researches which may require keeping either biology or culture constant. For instance, a peasant movement is studied without any reference to the biological variables; similarly, one may study the genetics of sole prints independently of the characteristics of the families or the religion from where our samples of study come. The first study will come closer to the ones that are carried out in disciplines of history and sociology, whereas the second will share similarities with those in genetics, medicine, or zoology.

This, however, is not the case with those domains of study in which both biology and culture hold equal partnership. Known to us is the list of what may be called the 'special anthropologies', the pursuance of which assumes an equal, and democratic, understanding of both biological and cultural factors. One such branch is medical anthropology; the others are demographic (or population) anthropology, ecological (or environmental) anthropology. Even the study of the primate behaviour will want us to have an understanding of the biological and cultural systems.

Medical anthropology purports to study the evolutionary and functional aspects of diseases in human populations and societies, for it submits that although a disease

initiates biological changes in the body of the sick, it is *managed* socially, *interpreted* culturally, and *treated* by a 'complex system' in which medical, psychological, social, and cultural aspects act collectively, and to a large extent, cooperatively. And, not to forget, the ailment is stationed in an ecological system, which is itself undergoing evolutionary changes.

Although it is easier to convey this idea theoretically, it is difficult, requiring a lot of imagination, to put it into practice, assessing the role of each of these factors that impinge upon the body, and their cumulative consequences. Needless to say, such studies necessitate not only an interdisciplinary approach, but also a triangulation of investigators from different disciplines who brainstorm and moot the modalities of research. In course of time, the outcome of the interdisciplinary researches is the emergence of new disciplines, with fresh approaches, that besides serving new needs, transcend the old interests, themselves becoming 'primary disciplines' over time. Examples of this may be sought in new departments and courses in gender studies, development studies, ecological studies; and soon, medical anthropology will join this rank in many universities, as it has already done in some of them. For instance, the Institute of Human Behaviour and Allied Sciences (IHBAS) in Delhi has a department of medical anthropology. The departments of anthropology which earlier did not have the teaching of medical anthropology have now started teaching as well as research in this branch.

The two-days' seminar on the metabolic adversities that cause, trigger, or intensify cardiopathies will bring to the fore the holistic approach to their study: the genetic aspects will be examined along with the life style factors that have bearings on the problems. However, the anthropological approach – or when one speaks of the 'anthropology of' (as in the present one, 'the anthropology of cardio-metabolic adversities') – is more than that. Cardinal to anthropology is the comparative approach – the comparison of different societies, at different levels of acculturation and transculturation, to reach a set of conclusions about their common and dissimilar features. That there are diverse forms of society and that cultural and social diversities will never be transcended, notwithstanding the impetuousness of globalization, are the basic premises of anthropology. In all times to come, thus, there will be different types of societies, with differing values and ways of living; and the challenge before us will be to refine our comparative method so that our conclusions are not incorrect. Since most of the disciplines, including that of medicine, have an urban-industrial origin, it is obvious they largely address the people from these societies. The tribespersons and the peasantry often remain the excluded lot. These disciplines, it is unfortunate, did not ever think for a long time that there might be ways of living qualitatively different from that of the western world. With respect to tribal and peasant societies, their opinion was that sooner or later, sooner than later, they would all become west-like. It was believed that their cultural ways were unstable before those of the west, and were destined to be

discarded once they came in contact with the outside developed world; there was no need, hence, to give any attention to an understanding of their ways of living.

Anthropologists, however, thought differently. They never believed, in spite of what some historians and apocalyptic theorists argued passionately, that there would ever be homogeneity in human societies, even when the forces of change acted in a manner to bring this about. Each culture has its own power, its attachment to the core, and therefore, it would withstand changes, keeping itself intact. Similarity at the external level, say at the level of the material culture, did not imply that the thought patterns would also be the same. The subtleties of culture will create differences; and each culture will have its own characteristics, which will affect the way it would handle different situations. For anthropologists, thus, the so-called 'primitive' and 'traditional' societies were of great value, for they were different from the west, at the same time, they were fast changing. Their systems of knowledge, though mutilated under the impact of the west, were still distinct, and before they were further dilapidated, they needed to be studied, understood, and documented; and who could do this job better than the anthropologists. Anthropology told the other disciplines that they nurtured short-sightedness by ignoring the existence, and the viability, of tribal and peasant societies.

Notwithstanding the criticism, which did impress upon these disciplines, they have continued to be Eurocentric and urban-oriented. With the lenses they have been wearing for years, they look at all societies, not realizing the qualitative and phenomenal differences between people because of their habitat, history, heritage, and habits. In other words, the experiences of cardiopathology, of patients and their curers, will vary across communities. Differential indices of hypertension or cholesterol levels have been noted across communities. Obesity is far less among tribespersons and peasants, not only because of the strenuous physical work in which they wholetimely engage, but also because of the food they eat. The nutritionists point out that they consume seasonal vegetables and fruits, unlike us who consume frozen foods, out of the season, not realizing that such foods may indeed have deleterious consequences, for they do not harmonize with the ecological cycle. There is a lot of diversity in the foods of tribes and peasants, since their habitats are rich in bio-diversity and they make all possible attempts to keep the diversity intact. Compare this with the urban situation where diversity in food is gradually disappearing. Our food habits are becoming more and more monolithic. All this will have its impact on the health standards.

Against this backdrop is needed an ethnography of cardiac ailments, which would take care of the local expressions, narratives, etiology and classification of illnesses, and the accumulated knowledge of the treatment module. That these variations are real may be substantiated with the example of the ongoing revision of the international list of psychiatric conditions and behavioural disorders. The

list has included – and is including – the culture-linked syndromes. In fact, as said previously, anthropologists are severe critics of the idea of the homogenization of societies, and monolithic and universalistic explanations. Time and again, anthropologists, armed with intensive field studies, have emerged with results that have opened up the clogged mental faculties of the other disciplines. Wasn't it illuminating when Kirin Narayan, in her study of the family systems, told us that whilst the Western scholars think of the marriage of a male as the starting point of a household, in South India, people always speak of the marriage of the female; the ego is a female rather than a male, as has been the convention in kinship studies? Isn't it a great lesson to learn the myopia of the androcentric studies and correct it accordingly? Wasn't illuminating to western psychiatry that the shaman, who entered into trance, with distinct changes in his psychic state, was not 'insane', with behavioural disorders, but was performing a culturally-prescribed role, in accordance with the local theory of disease causation? Wasn't it an alternative to the western political theory which gave primacy to the struggle for power and competition that there were societies giving an overwhelming importance to cooperation, where power was shared, where people wanted each one of them to be a winner?

That the perception, cognition, narration, diagnosis, and treatment of illnesses is culture-bound is an important lesson that anthropology has taught us. When societies were collective, with individual consciousness disappearing in collective consciousness, as Émile Durkheim said, the cause of illness lay in the stresses of interpersonal relations, the overpowering cosmology wherein dwelt nefarious spirits acting punitively, the infringement of roles almost amounting to defying the ominous djinn. Now with the rise of individualism, gradually encompassing all of us, the causative agents of illnesses are in the deviations the individual indulges, for instance, smoking and alcohol-consumption, savouring greasy foods, long hours of sitting, consumption by work, strains of everyday life, overambitiousness, and sundry others. Contemporary illness etiology is what I would call 'I-broke-my-leg' syndrome: in a nutshell, "I'm solely responsible for my state, and thus, for this, I've to change myself, my life-ways."

From this, however, it should not be inferred that anthropologists are cultural reductionists. They consider full well the universality of medical conditions and their biomedical cures. What they submit is that both the disease symptoms and the scientific regime of its treatment is sieved through culture, and it needs to be the bottom line. Cultural responses to illnesses vary; if Americans descend to depression after having learnt that they suffer from heart ailments, in another culture, news of this type provides an opportunity for the family members to come closer, take care of the sick, and the latter, instead of sinking into depression, feels happy enough to brave surgery with a positive mindset. He finds the warmth of his family, which takes away the quantum of his worry; in fact, in many cases the 'family itself becomes the medicine'. The sick feels significantly cured amidst his family.

The response to post-operation situation also varies. In one situation, chest cuts and cheloids embarrass a person; in another context, they are the marks (or rather, 'trophies') of one's victory over the heart ailment. The faith patients have in their doctors also makes tremendous difference; there are cultures where the doctor's words are taken as sacrosanct. I vividly remember my father's jubilation after his valve-replacement surgery in 2000 when his doctor told him that his chances of having heart ailment for the next two decades were almost ruled out. Not only did he feel confidant, but also, with renewed energy, he started attending to his work. Surely these are individual differences, but they need to located in the cultural milieu. The ethnography of illnesses will document these differences. Medicine is rooted in culture. The body-curers are 'culture-beings'.

This seminar is a humble attempt to reinforce the idea of diversity of societies, each having its own resilient micro-culture. It is an effort to render a holistic picture, based on first-hand field studies, of the cardiac illnesses, their evolutionary and functional aspects, in an ultimate attempt to make this world a good and sustainable place to live.