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Interview with Sjaak van der Geest

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Introduction

In 2015, when he delivered a special lecture to mark the 40th anniversary of his career at the University of Amsterdam (VAN DER GEEST, 2015), the Professor Emeritus of Medical Anthropology Sjaak van der Geest, our guest interviewee for the Drug Trajectories project (ZORZANELLI, 2020), stressed how experiences of everydayness marked his fieldwork, contrasting this with the assumed preference anthropology gives to the exotic or the dramatic. Interest in the mundane and everyday means making the things we take for granted, the things that are sources of security, which may be seemingly unquestionable or constitute tacit dimensions of our everyday lives, worthy of investigation. And it is precisely for this reason that everyday life – in its commonplace acts, gestures, and beliefs – deserves the perceptive gaze of the anthropologist, who may discover the unusual, the odd, the bizarre or the incomprehensible enmeshed in the fabric of the quotidian.

The core of his work on the everyday is based on field research conducted in Cameroon and Ghana on topics like sexual relationships and birth control, hygiene and defecation, popular song texts, meanings of growing old, concepts of dirt and perspectives on privacy. But there is one everyday subject he addresses that is of particular interest here, and that is the use and distribution of medicines. And it is important to pay attention to what Prof. van der Geest wants us to understand from this: the use and distribution of medicines is ordinary, part of people's everyday lives, so much so that their meanings and uses can sometimes become invisible, tacit. Throughout the 1980s and in his extensive fieldwork on the topic in the subsequent decades, van der Geest studied the distribution and use of pharmaceuticals in Cameroon, considering this an important mode of de-exoticization, "because the focus was on 'our own' pharmaceuticals and not on herbal medicines, amulets, or spiritual healing. I was particularly interested in the hidden use and the informal – often illegal – sale of these medicines in small shops and at the market" (VAN DER GEEST, 2015, p. 84-85). This then led to the first steps in his fundamental contributions to the anthropology of medicines. In 1988, van der Geest and

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Susan Reynolds Whyte (also an interviewee for the Drug Trajectories project) published *The Context of Medicines in Developing Countries: Studies in Pharmaceutical Anthropology* (VAN DER GEEST; WHYTE, 1988), and then went on to join forces with Anita Hardon to publish another important book, *Social Lives of Medicines* (WHYTE; VAN DER GEEST; HARDON, 2002), which brings together a number of studies and concepts to form a field in which therapeutic substances are understood as having materiality, which itself is understood as having a role in social life. For the anthropology of pharmaceuticals, the social uses of substances are of more interest than their chemical properties.

This interview, conducted in March 2019 in Amsterdam, gives us a chance to hear the author reflecting on his early years developing a new field of study. As the interviewer, I feel compelled to express what a great opportunity this was to ask him directly the many questions I had scribbled in the margins of his and his colleagues' work. I hope other researchers find it just as fascinating to accompany this journey into the living history of the anthropology of pharmaceuticals.

Finally, I wish to thank my dear colleague Soraya Fleischer (Professor at the Department of Anthropology, University of Brasília) for having put me in contact with Prof. Sjaak van der Geest.

RZ: Would you like to compare or to think about the similarities and the differences concerning the issues that first inspired your work on the field of the anthropology of pharmaceuticals in the 1980s with the current issues in the making?

SG: A lot has changed since then. When I started I was interested in pharmaceuticals, our own biomedical substances. There was then hardly any interest in or attention for pharmaceuticals in anthropology, and that had to do with what I call exoticism. At that time, you know, the 1960s, 1970s, even the 1980s, anthropology was still very much associated with faraway countries, far away from our European perspective. So if you are an anthropologist, you go somewhere else and when you are in a faraway place you would not have an interest in things that come from your own country, let's say, schools, hospitals, modern forms of governments, churches. You would be interested in "traditional" religion ("traditional" between inverted commas), traditional medicines, etc, etc. So, that is a huge difference with today. If I look at my younger colleagues in Medical Anthropology, for example, here in Amsterdam, a lot of them, I think the majority, are working in their own culture, doing research among scientists and modern developments in biomedicine, so that's a huge difference.

I'm not saying, of course, that early anthropologists were not interested in medicines, in a more general sense. They would even have called them medicines, but they looked at those substances from a religious point of view, as magical materials. The famous book by Evans-Pritchard (1976), *Witchcraft, Oracles, and Magic Among the Azande*, is a beautiful example. The word "medical anthropology" does not appear in that book. It's about religion, it's about fortune-telling, and

oracles, etc. Even though Evans-Pritchard brought with him medicines and was using medicines for himself and for his close friends and assistants, he never thought of looking at these Western medicines as a possible topic for research. It was all religion. Rivers, one of the first *avant la lettre* medical anthropologists, was writing about religion; he did not look at medicines from the point of view of health and curing. It was about fortune and misfortune. He looked at them from the point of view of the people and interpreted them first of all as religious things. These are two big differences between when I started to look at pharmaceuticals in the 1970s and the beginning of the 1980s and now.

I don't know if I should add this... but the reason that I became interested in this topic is interesting. It's very specific. I remember exactly when I suddenly thought: "Yes, this is something we should look at". It was during my own PhD. research. Most of my research was in Ghana. During that research, I was looking at sexual relationships and birth control methods as we called them at that time. Both young people in the town where I did my research and students at the university were talking about a certain medicine, a contraceptive which they used and found quite effective. The contraceptive could also be used to cause an abortion. If it failed to prevent pregnancy, it could still be taken in a higher dose to terminate the pregnancy. The medicine was called Alophen. I had never heard of it, so I went to see a doctor in a hospital nearby and asked him, "What is Alophen?" He said, "No idea." "It's a medicine," I said, "it's part of your business." "I never heard of it," he repeated. I asked another doctor; the same answer. I went to a drugstore and bought Alophen. I discovered it was a laxative produced in Birmingham [city in the UK]. That was the moment when I got a strike, a sudden blow. How is it possible, I thought, that first of all, a laxative is everywhere among young people considered to be a contraceptive and abortifacient, and secondly, how is it possible that a medical doctor is not aware of a medicine that is used widely around him? That was actually a question. I didn't know what my future would be but I thought "if I ever get a chance to stay in anthropology and do more research, I'll focus on pharmaceuticals". Apart from the contraceptive experience, I noticed that medicines like antibiotics, pain killers, antimalaria tablets, anti-worm medicines for children and a few others were the first things people were looking for if they had a medical problem, not the traditional doctor or the herbalist. Anthropologists kept saying, quoting from quotes from other quotes, that for 75% of the people, the first step when they had a medical problem was going to a traditional doctor. But that was no longer true! They would go to a drug store. I realised this was a new development and we needed to know more about it. It's a huge health issue. That's how it started. So apart from the contraceptives, if we want to understand normal daily life and health concerns and health behaviours, we should look at medicines, pharmaceuticals. That's my history of many years ago. Very different from today, 30, 40 years later.

RZ: I would like to go back to your lecture in July 2015, at the occasion of your retirement from the University of Amsterdam. You said that "Everydayness has had my interest throughout my academic life" (VAN DER GEEST, 2015, p. 79). Could you talk a little bit about the anthropology of pharmaceuticals in the context of anthropology of everyday life?

SG: I already mentioned it somehow in the end of the previous question. Let me go back to a famous book by John Janzen (1978), *The Quest for Therapy in Lower Zaire*. He did research in Zaire, Congo now; it was published in 1978. I read the book and reviewed it also. Janzen makes an important observation. He says we anthropologists have always been interested in dramatic illness stories when we first try this, then something else, and again something else. There are family conflicts and there is a lot of drama and noise around them. But that is not normal life. In normal life, people just feel unwell, feel pain, a headache, and they do nothing or take a medicine. Medicines are part of daily life. But it is a difficult topic to do research about, because if you ask people "when did you take your last medicine?" they forget. Three days ago they took an aspirin but they have forgotten. But they remember a dramatic illness of ten years ago. They start talking about the big events but not about the little everyday things. Some medical anthropologists have said that maybe 90% of medical health actions are very minor actions and only 10% are the dramatic type, that should go to a hospital. In Congo, also in Ghana and Cameroon, where I did my research, you sometimes have to travel 30 or more kilometres to find a doctor. But in their home they have medicines which they bought at the market in their own community, like antibiotics, painkillers and the ones I mentioned before. In Cameroon, I noticed that in little medicine boxes in the house were also injection vials and needles to self-medicate their own family. What I mean to say is that taking pills or ointments is a part of everyday life and even the place where you keep your medicine becomes part of your house. It's a piece of furniture. Like a table in the kitchen, you have a little cabinet for medicines. So I think it's a splendid example of everyday practices involving medicines. In the morning, you brush your teeth and you make up your face, perhaps, you apply some ointments, etc.; they are all little medical actions in everyday life. They fit very well together.

RZ: Still in this same conference, you said: "In 1980, I studied the distribution and use of pharmaceuticals in Cameroon. It was an important step towards de-exoticization because the focus was on 'our own' pharmaceuticals and not on herbal medicines, amulets or spiritual healing" (VAN DER GEEST, 2015, p. 84). This de-exoticization of investigating our own pharmaceuticals had perhaps its heyday with the anthropological studies of performance drugs, tranquilizers, opioids and other prescription drugs. Does investigating the chronic use of western medicines in western scenarios (capitalism, urban

areas, liberal values) not put us back to the anthropology of magic? Are we – with our stimulants, tranquilizers and pain killers – so far away from rituals and amulets?

SG: That is an excellent observation. I wouldn't say they take us back to magic; it rather shows that magic has never been away. It's not for me *either* magic *or* chemical reactions. The two go together. We are not substances that automatically react to another substance; no, we are human beings. We can reflect on what we are doing and this has a tremendous impact on what medicine does to us. Think of the placebo effect. The whole literature and the discussions about the placebo effect show that if the context is reassuring, and you trust and you're optimistic and you believe in it, the effect is likely to be much better than if you don't believe and you're suspicious and afraid or pessimistic. Magic, as Evans-Pritchard and other anthropologists have written, is a psychological part of the medical experience. I wrote an article for a conference in Tarragona, Spain with the title "Sacraments in the hospital: Exploring the magic and religion of recovery" (van der Geest, 2005). I wrote that taking medicines, but also other actions, such as the behaviour of doctors, nurses, etc., can give you hope or the opposite, make you desperate. This has a tremendous effect on the process of recovery or getting sicker. I used the word "sacrament" because in the Catholic religion, that's what sacraments are supposed to do: give hope. Yes, it is a metaphor but it's close to reality. I think people experience the medicines and treatments as blessings. They improve your condition because you believe in them.

The difference between biomedicine, biomedical actions in the context of hospitals in our own society, and the so-called magical effects of witch-doctors or prayer healers is not so big as we tend to believe. The ritual and the magic of a lot of medical practices, their paraphernalia – brushing your hands, the white clothes, the stethoscope around the doctor's neck – it all works as traditional medicine that makes you trust what is going to happen to you. I don't see it as going back; it confirms that it has always been there. But when we say this, biomedical doctors may feel offended. They think you take something away from their expertise and their professionalism. But my point is: no, we don't take anything from them, but we add something. Doctors who reflect on what they're doing acknowledge this. I have been attending consultations of a doctor with his patients. I was allowed to sit in. Every conversation was supposed to take only 7.5 minutes, because that was how the doctor organised his day: every 15 minutes, two patients. I was most impressed by the psychological and social skills of the doctor to make a patient happy and yet get rid of him in 7.5 minutes. It was more a psychological skill than a medical skill. All this is "magic". Does that answer your question?

RZ: Yes. I was thinking of the research I'm conducting in Brazil. A lot of the subjects say something really similar. They say: "well, even if I'm not using the tranquilizer" – whose name is Rivotril®, the brand in Brazil, sold by Roche – "I want to have it in my bag, then I feel safe".

So, "I'm not using it, but this feeling of safeness that the medicine gives me, this is the most important thing".

SG: It's a good example. In our book *Social Lives of Medicines* (2002), one chapter is about doctors' prescribing habits, I wrote that chapter. I said that just having the prescription with you or the medicine is a metonymic representation of the doctor. You have the doctor in your pocket, as it were. He is with you; you are safe because he gave it to you. "He is a good man, he is a professional, he is a clever man, he gave me that medicine, so it's with me, I'm ok." That's exactly what you're saying now too. The symbolic dimension of medicine taking should not be underestimated.

RZ: I think it was in the first paper you wrote [on this topic], in 1982, "The illegal distribution of western medicines in developing countries: Pharmacists, drug pedlars, injection doctors, and others. A bibliographic exploration.") that you wrote: "The fact that people rely on illegal medicines in the absence of qualified doctors does not need to occupy us here; it is the use of illegal medicines in the presence of qualified doctors which looks puzzling" (VAN DER GEEST, 1982, p. 211). Your first text anticipates a current issue in the field: the overconsumption of over-the-counter and prescription drugs, even in high-income countries with reliable health systems. How can we think about this phenomenon in a multilevel perspective?

SG: Maybe we should first briefly look at what we mean by a multilevel perspective. We use different terms. Our syncretic way of addressing this topic of pharmaceuticals is that at different levels of medicine use and production, different people are involved with different interests and different ideas. The top level is perhaps the pharmaceutical laboratory, the factories that produce the medicines. From there it enters the circuit of doctors, hospitals and pharmacies. It goes down from the top level to the next level with people who distribute them. There are sellers, going for money; the medicines become commodities. Then there are families and patients, and again the medicines become something else: life-saving or pain-killing substances, very important to them, etc. The word "social life" is almost the same, or the idea of a biography of medicines. We tend to look at medicines as having a life cycle. The medicine is born in the factory, then it starts its journey, and at the end it dies when I take it with me. That is the completion of its life, the fulfilment of its original purpose in life. The whole process ends with using them, taking them for some reason.

In 1982, I became interested in pharmaceuticals, and I think I started writing about them even before my fieldwork on medicines in Cameron. I had been searching for literature on pharmaceuticals. It was very scant but I thought it would be useful, at least when I started drawing conclusions to see what we already knew. And one thing that struck me – and that I also found out in my

own research in Ghana before – was that people have enormous confidence in pharmaceuticals, *our* medicines. They think, "if I have the medicines, I am ok". The doctors are less important, certainly, if you are not too sick. If it's very acute and serious, you may have to go to a doctor. But for a lot of health complaints, we know what to do. If I only have the medicines, it's ok, I can manage. Why should I travel 30, 40 kilometres to see a doctor to get a medicine if I can buy it on the market in my own community? So although pharmaceuticals are there, or perhaps in the official pharmacy, why should I go to a pharmacy where I have to buy a whole strip of medicines, which I cannot pay? If I go to the market, I can buy just three tablets. That's what I need now and what I can pay. Doctors and nurses who prescribe or provide medicines are therefore skipped and people go straight to the medicines. Moreover, when you travel perhaps 20, 30 kilometres to see the doctor or nurse, he may not be there. A very common thing. Or you have to wait for two or three hours before he has time to see you and then you have to find transport back home. The whole day is wasted. "I could have bought the same medicine at home, around the corner."

The same goes for official licensed pharmacies that exist usually only in big towns. "When I get sick in the night, I can't go to the pharmacy, even if I live in town, because the pharmacy closes at 6 o'clock. But at a little chemical store or at the market I may still manage to get medicines from the woman who sells them. I can just knock on the door and ask, 'please, give me the medicine'." The informal, often "illicit", sale of medicines is in such cases closer to their style of living and more efficient. These are a few examples why even when there is a somehow functioning medical system, people may still prefer to find their own way to get the medicines they need. And don't underestimate lay people's pharmaceutical knowledge! Since they have to look after themselves, they have learned the use and the effects of the most common medicines very well. I can give you examples later on. These people are not using medicines wrongly. They know what medicines there are, and how they work, even if they may be wrong according to biomedical rules. I realised at the time [when conducting research in Ghana] that my old mother, who was taking several medicines, had no idea what she took. She knew them as white pills and blue ones and yellow ones, and that she had to take them at such and such time of the day. She just followed the instructions of the doctor. The doctor knows, she doesn't know. But in Cameroon, where doctors are not close to their patients and have no time to explain things, people have learned how to help themselves. These are a few examples that emerged from the – very scanty – literature, and also from my own research.

RZ: I think the next question has something to do with the last one. Concerning the issue of self-medication: When people are struggling to access basic health needs, as can be the case in low-income countries, people tend to take up whatever medical biotechnology has to offer – diagnoses, drugs, medical procedures – and pay little attention to the

associated risks. They assume that whatever is biomedical is good *per se*. How can we think about self-medication and agency in the context of low- and middle-income countries?

SG: I think I must disagree with you saying that they will take any medicine because it is a western product and therefore good. I just emphasised that people do have quite some knowledge on the medicines that they need in their daily life. I'll give you one example from my research in Cameroon. I was most of all interested in self-medication and the informal sector of medicine distribution. But let me first say this: when I asked for permission to do research in Cameroon, I realised they might not allow me since I was focussing on informal and illicit practices. I therefore wrote in my proposal that I wanted to study the use of medicines. I referred to hospitals, medical doctors, official pharmacists and finally, almost in small letters, to the popular sector, to self-use, "illegal" medicines, antibiotics on the market next to bananas and sardines.

When I had settled in Cameron, in a small provincial town of about twenty thousand people, I spent many hours at the bus station, where people were waiting for public transport. There were three little kiosks or tables where medicines were sold. I was hanging around and talked with the sellers. Some of them were young boys who had more knowledge about medicines than I had expected. I also spoke to customers. I remember one case. On the table were antibiotic capsules with an expiration date on them. The date had expired. A man was looking at them and bought the expired capsules. I asked him, "Did you see that they have expired?" He replied, "Yes, of course I saw that." "But you still use them?" "Yes, I use them because even if they are expired, if you open them and you sprinkle the powder on an open wound, it helps, it works." I went to see a doctor at the local hospital and asked for his opinion. The doctor replied that it was a very clever way of using the antibiotic. So, here we have a striking example of lay people's practical knowledge of medicines, how in difficult contexts, where they are expired, they can still use them in a useful way. I must therefore disagree with you to so some extent that they are naive and use anything they want. Of course, misuse also takes place, over there and here in my own society. Sometimes they use it wrongly, but in their rationality, it is right. There is a famous article about epileptic patients using medicines, not in Cameroon but in the US. Some patients use them in a way which is quite different from what the doctor told them, but they are not ignorant; they do it for a reason. The doctor never took those medicines, but *they* have taken them because they have the problem. They found a way which was more convenient and worked better for them. An intelligent doctor realises when he writes a prescription that patients are not machines; they are human beings living in a social context and they have to handle and manoeuvre in the most optimal way, which sometimes means that they disagree with the doctor. I think that we should have more respect and more attention for so-called non-compliance or the wrong use of medicines, and not only here in our own society, but also in other countries, such as Ghana and Cameroon.

RZ: In this sense, concepts like misuse or rational use are more useful for biomedical research than for anthropological work.

SG: The irony is that perfect medicines, when they are used for a wrong purpose, can become bad medicines. A few minutes ago, I talked about the end of life of a medicine. The different stages of its life may be successful, but in the end it is used for the wrong purpose, and as a consequence its entire life changes into failure. Wrong according to the doctor, but not to the patient. For example, using an overdose of sleeping pills. They are meant to help you sleep, but you take an overdose because you want to finish your life. You are tired or whatever, you don't want to live on your own. In Ghana, too. Self-help abortion is another example. An overdose of malaria tablets, for example. In this country, the Netherlands, you can't get those without a prescription. In Ghana, you can buy them on the market, like the antibiotics. When I go to Ghana, I never buy my malaria tablets here because it's too much fuss. You have to visit a doctor, etc. As soon as I arrive in Ghana, I go to town and I just buy the pills at any store. I know what I am doing. I don't need a doctor, I don't need a prescription. These are a few examples of using medicines in a rational way, but according to the doctor or the provider or the pharmacist, it may be the wrong way.

RZ: Concerning the idea of efficacy: if one thinks that pharmaceutical efficacy embraces the set and setting that are part of drug consumption, how can we avoid the stigma of being radical constructivists or naive idealists? Also, how can we avoid the dichotomization between the chemical properties of pharmaceuticals and their sociocultural embeddedness?

SG: First of all, I think the word stigma is too strong. It's not a stigma, but they may criticise you for being careless or ignorant. A while ago, we talked about magical versus biomedical efficacy. It's almost the same thing. By emphasising the context-related ideas and practices in the use of medicines, we don't deny their chemical and biomedical attributes; we only emphasize that the work of medicines cannot be fully understood if we isolate them from the context. In anthropology we say that everything depends on its context. Historians and anthropologists are probably the only disciplines that emphasise context as determining the meaning of things, words and practices. Limiting our focus to the scientific product from the laboratory without considering its context is insufficient and naive.

I remember a famous quote, "we are never out of context, even when we say 'this is out of context'". Now, I contradict myself perhaps, but there is still the context of not having a context. In the case of pharmaceuticals, it would be more correct to say that we are missing the most relevant context. Being in an empty room is also being in a context: an empty room. By emphasising the context, we are not "constructing" medicines; we are enlarging and nuancing their meaning; we observe them in the context where they are being used.

In that sense, pharmaceutical anthropology, if I may use that term, is not different from any other type of anthropology. Seeing things in their context is what we do in participant observation. I want to be there. I want to see with my own eyes what's happening. I don't want to send my students with questionnaires to the field while I remain sitting in my office waiting for the results and drawing conclusions. I wasn't there. I haven't seen the context. I haven't seen the context of the interview, leave alone the context of the medicine that they were talking about in that interview. It's only in the context, if you are there, in participant observation, that you can say with a reasonable amount of certainty that you have understood what the other one has in mind. It's not perfect but it's the best possible that we can do.

RZ: In one of your most recent publications, you said: "The multilevel perspective demonstrates how the 'same thing' becomes a 'different thing' when it moves to another level" (VAN DER GEEST, 2018, p. 3). This multilevel perspective on pharmaceuticals – "biography of pharmaceuticals" or "social lives" – has always been present in your work. Would the fluid trajectory of entheogenic substances being used for treating mental disorders and of psychotropics being used for recreational and performance goals be a good example of the way the "same thing" becomes a "different thing"? Could you talk a bit more about it?

SG: First of all, I must confess that in all my interest and study of pharmaceuticals I've almost completely ignored or overlooked the recreational part of drugs, as we know them. Amsterdam is a very active place in this field. I was very close to it geographically, I could see it happening from my window at the university. It doesn't mean that I can say anything about it. It is not different from the other examples that I've already given: medicines taken from one context, used in another context for a different purpose. We talked about sleeping pills used for ending life, about antimalaria pills for abortion, etc. It's the same thing. The medicine was produced for one purpose, but people discovered it also worked very well for another purpose. The recreational use of morphine is an example. It's the same story. And no one can control its use after the medicine has been sold or stolen. Once it has arrived at the market of commodities, the buyer can do whatever he likes. He can also use it to kill his partner or do stupid things. Some years ago, one of my students, a wonderful person, died from GHB [gamma hydroxybutyrate]. She had no experience with the drug, but a friend gave it to her and she died. These are tragic examples in the biography of medicines.

When I say, they become another thing, this is not of course in the literal sense. It is the same thing and yet it changes into something with a different meaning and effect. Life-giving substances can become life-ending ones. The knife that you use to cut your bread can become the weapon that kills. That's why I think it's an important topic for research. Policymakers have a hell of a job to take the

right decisions in this field of use and misuse. You cannot forbid the selling of certain medicines, but you can try to organise it in such a way that it becomes difficult to get them. But today we have a new problem, because we can buy everything on the internet. So all the laws and rules we have in this country about getting or not getting medicines without a prescription is completely overruled by the internet. A few days ago, oxycodone was on television, a strong opioid painkiller that is frequently prescribed by doctors. But oxycodone is now the most popular recreational opioid in the United States. It is estimated that about 11 million people in the US use oxycodone in a non-medical way. Doctors, lawmakers or police can't control this development.

RZ: Could you share with us some of your thoughts about how useful polarisations such as licit/illicit, ritual/non-ritual, natural/artificial, treatment/enhancement are in the context of the ongoing themes that the field of anthropology of pharmaceuticals is facing nowadays?

SG: Legal/illegal, all these dichotomies, these opposite pairs are of course a simplification of reality. These contrasts may be useful for methodological or heuristic reasons, but we know that it is a fluid field. Let's take the example of ritual and non-ritual. If I start my day every morning with a vitamin pill and end every day with a sleeping tablet, these activities become rituals. Or if during lunch I always take a particular drug that the doctor has prescribed, this also becomes a kind of ritual to me. I am using a wide definition of ritual, not "ritual" in the specific meaning that theologians and students of religion attach to it. Ritual and non-ritual merge within the same act. The same goes for legal/illegal. There are doctors who overprescribe medicines because they want to be popular or they want to make the patient happy or to make more money. The doctor has the legal right to do so but I think it's illegal. He is trespassing the law because he should be a good doctor and not overprescribe. He is far too generous in the prescription of antibiotics. In this country, doctors are comparatively reluctant to prescribe antibiotics because of the problem of resistance. In other, even neighbouring countries, antibiotics are prescribed on a much larger scale. The contrasts that you've mentioned in your question are somewhat problematic because reality is far more nuanced. There is a lot of illegality in legal practices and vice-versa. There is much non-ritual in the ritual. What were the other contrasts you mentioned?

RZ: Natural/artificial, for example, treatment/enhancement.

SG: Okay, it may be useful to make such contrasting distinctions for the sake of analysis, but in the end you have to cancel their opposition. I use such distinctions to organise my research like an agenda for my work. But after I finish studying a particular issue from a contrasting perspective, I have to bring the two sides together again. Or, let me say it differently: looking from the perspective of difference is the most effective way of seeing the absence of difference. By studying illegal and legal medicines in their natural day-

to-day context you may end up with the conclusion that legal and illegal are intertwined. When I was doing research in Cameroon, I also did research in the hospital, a legal place *par excellence* one would think. But a lot of practices are not legally correct. Doctors, nurses and their relatives are allowed to take home medicines which are meant to be used for patients in the hospital. When a nurse goes home for holidays, she can't arrive in the village without medicines. She would be regarded a bad daughter. Parents expect their daughter who is a nurse to bring medicines along. Different moral worlds are clashing. The situation on the ground is far more complex than the neat distinction of legal/illegal, ritual/non-ritual, etc.

RZ: This was our last official question, but is there anything else you would like to add?

SG: Something that we didn't talk about? We talked about quite a lot of anthropological aspects of pharmaceuticals. It's good that we mentioned the internet because it's a recent development that is getting more attention now. Anthropologists, also in our department, are writing about the digital world in connection with privacy and marketing.

RZ: How can you get there? Is it like a black market on the internet? It seems a bit tough to find informants.

SG: No, I didn't have this experience. The internet is easy because it's anonymous, so there's no risk for you. When I was doing my research in Cameroon, about 10-11 months, I felt very much at ease in the so-called illegal market because people didn't see it as illegal. The policeman was buying his "illegal medicines" in the market. That's everyday life. Officially it is illegal but if the law would be really applied and police would chase all the women and men selling medicines at the market away or arrest them, it would be a disaster because people need the medicines. So it is a normal thing. We call it illegal from one perspective but for them it is a normal thing. Only once I got stopped by the police. They picked me up and they took me to the police station, but not because I was doing research in that sort of illegal market, but they thought: "what is this guy doing in town?" They found my presence suspicious. Was I a CIA man?. I was interrogated and they let me free again after I had presented my research permit. I agree that certain fields are difficult and risky. You know what difficult is? To get entry to a pharmaceutical factory laboratory. They are not happy with an anthropologist coming in. The few anthropologists or sociologists studying their laboratories did not write very favourable reports. But the informal/illegal market in Cameroon was not a problem. I felt very much at ease.

RZ: Great. It was really a pleasure. Thank you a lot.

SG: Thank you for your attention and for being inspired by my work. Anthropologists write and write but it seems no one is reading what they write except for some colleagues. It makes my day happy to meet someone who is taking inspiration from our work. Thank you.

References

EVANS-PRITCHARD, Edward Evan. **Witchcraft, Oracles, and Magic among the Azande**. Oxford: Clarendon Press, 1976.

JANZEN, John M.; Arkinstall, William. **The quest for therapy**: medical pluralism in Lower Zaire. Berkeley: University of California Press, 1978.

VAN DER GEEST, Sjaak. Pharmaceuticals. **The International Encyclopedia of Anthropology** , Wiley Online Library, 2018. DOI: https://doi.org/10.1002/9781118924396.wbiea1757.

VAN DER GEEST, Sjaak. How can it be!? Ethnography as magical realism and the discovery of the ordinary. **Medicine Anthropology Theory**, [*s.l.*], v. 2, n. 2, p. 79-94, 2015.

VAN DER GEEST, Sjaak. 'Sacraments' in the Hospital: Exploring the Magic and Religion of Recovery. **Anthropology & medicine**, [*s.l.*], v. 12, n. 2, p. 135-50, 2005.

VAN DER GEEST, Sjaak; WHYTE, Susan Reynolds (ed.). **The Context of Medicines in Developing Countries:** Studies in Pharmaceutical Anthropology. Dordrecht: Kluwer, 1988.

WHYTE, Susan R.; VAN DER GEEST, Sjaak; HARDON, Anita. **Social Lives of Medicines**. Cambridge, UK: Cambridge University Press, 2002.

ZORZANELLI, Rafaela. Drug Trajectories: Interviews with Researchers. **Pharmacy in History,** [*s.l.*], v. 62, n. 1-2, p. 47-48, 2020.

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