Plural Medicine, Tradition and Modernity, 1800–2000

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Research into 'colonial' or 'imperial' medicine has made considerable progress in recent years, while the study of 'indigenous' or 'folk' medicine in colonised societies has received much less attention. This book redresses the balance by bringing together current critical research into medical pluralism over the last two centuries. It includes a rich international selection of historical, anthropological and sociological case studies ranging from New Zealand to Africa, China, South Asia, Europe and the USA.

Contributions focus on the exchanges and overlaps between various strands of different medical theories. Chapters tackle different aspects of current debates on medical pluralism, including nationalism, globalisation and spirituality. Topics include:

- the underlying dynamics that lead to the perceived marginalisation of 'indigenous' medicine in non-Western countries, and of 'heterodox' or 'alternative' medicine in the West
- the problematic nature of dichotomous categorisations, such as 'traditional' and 'modern' medicine
- the scope and limitations of medical pluralism within different geographical and cultural settings and historical periods
- the ideological and economic factors that contribute to the ways in which different medical systems are imagined as 'rational and scientific' or 'irrational and unscientific'.

Essential reading for scholars of the history of medicine, this work will also interest historians, social anthropologists, sociologists, and scholars of colonial and post-colonial studies.

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1 Plural medicine, tradition and modernity

Historical and contemporary perspectives: views from below and from above

Waltraud Ernst

In current writing on the history and development of medicine 'pluralism' figures prominently. Cant and Sharma, for example, entitled their recent book *A New Medical Pluralism?* and asked whether the perceived increase in the popularity of alternative medicines meant that we were witnessing a new form of medical pluralism.[1] The idea of pluralism seems to capture particularly well medical developments at a time when the world is supposed to be in its 'post-modern' and 'post-colonial' stage, and when references to cultural diversity and the variety of local practices abound.[2] Even the similarly ubiquitous term, 'globalisation', which implies, in the view of some, the undermining of variety and pluralism, has come to be seen by many instead as the apotheosis of a plurality of local practices, as encapsulated in the slogan 'think globally and act locally'.[3] Emphasis is on the wide range of medical approaches patients turn to and the multitude of existing and newly emerging professional interest groups and formal as well as informal medical institutions – from high-tech cardiac wards staffed by specialist nurses and doctors, to health clubs, traditional Chinese medicine centres, internet discussion groups and chat rooms filled by occasional as well as habitual web surfers, and spiritual or psychotherapeutic healing sessions attended by what Sharma called 'earnest seekers', 'stable' and 'eclectic users'.[4]

However, pluralism is new neither as a favoured concept within the history and philosophy of science (or within philosophy in general), nor as a phenomenon characteristic of medicine. In regard to the latter, we have learned from historical analyses such as Porter's *The Popularization of Medicine, 1650–1850* that 'the terrain of healing has always been characterized by great diversity', with learned or scientific medicine existing alongside popular or folk traditions, irregular or alternative medicine, as well as 'quackery'.[5] The variety of medical practices has also for long been a major focus within social anthropology. Arthur Kleinman and Charles Leslie, founding figures of medical anthropology in the USA, highlighted the existence of different strands of folk medicine alongside 'learned' Asian medicine as well as the varied, culturally specific medical traditions that co-exist alongside (or compete with) 'Western' medicine.[6]

One of the early classics of medical anthropology published in 1976, *Asian Medical Systems*, is based on the contention that 'Asian medical systems are

intrinsically dynamic, and, like the cultures and societies in which they are embedded, are continually evolving'.[7] In a number of essays the 'culture of plural medical systems' is very much at the centre of analysis.[8] Patients' perspectives and what have become known among social historians of medicine as 'views from below' were not neglected either, as practices such as 'healer hopping' – namely patients' strategies of consulting a number of healers in their pursuit of cure and better health care – were investigated in as much detail as other cultures' medical literature and their practitioners' variedly applied treatment regimes. Unlike in much of the medical historical and sociological writing of the same period, within the context of medical anthropology patients were perceived as active subjects rather than merely passive objects, subjugated by the prevalent medical discourse and suffering the treatments imposed on them by domineering medical experts.

Perhaps most importantly though, from the perspective of medical anthropology, Western medicine's claim to epistemological and therapeutic superiority was being challenged by contrasting it with the successful treatment outcomes and the high levels of patient satisfaction of a variety of non-Western medical systems. It was shown that Western medicine was not always the universally preferred (or easily accessible) treatment option in all areas of the globe, and that a number of profoundly effective and highly sophisticated 'traditional' systems of healing not only predated the arrival of modern Western medicine in non-Western cultures, but also adapted successfully to the changing circumstances of a modern world.

Medical historians have only slowly come to avail themselves of the conceptual and empirical insights of anthropological scholarship in non-European cultures. Up until the 1990s or so a strand of 'social historians' of medicine, newly formed during the 1970s and 1980s, had been too busy throwing off what they perceived as the shackles of 'Whig' history, breaking away from the traditional, narrow historiographic focus on the medical profession, on medical institutions, and medical ideas. With social history of medicine came a focus on medical alternatives or 'heterodoxies', folk medicines, 'quackery', as well as on 'the patient's view'.[9] On the whole, however, this new historiographic approach remained, much like its Whig predecessor, for a time essentially Euro- and Americo-centric in scope and in outlook. Critical publications on the history of colonial medicine, and the persistent vigour and challenge of fashionable subaltern and post-colonial theories eventually caused social historians of medicine, too, to draw on anthropological perspectives and to consider the development of non-Western medical paradigms and indigenous medicine worthy subjects of historical analysis.[10]

Despite the current trend towards anthropologically informed histories and inter-disciplinarity, typically only lip-service is paid to the recognition of non-Western perspectives as valid medical systems epistemologically, if not therapeutically, on a par with Western medicines. But at least recently published textbooks and encyclopaedias of medical history now contain (albeit short) chapters on 'Eastern' or 'non-Western' traditions alongside 'the Western tradition', and university courses on history of medicine in Britain include modules on non-Western medical perspectives.[11] The cross-fertilisation between medical anthropology and medical history certainly constitutes a welcome development.

At least potentially it enables previously marginalised non-Western ideas and practices to be valued, if not yet always on their own terms, then at least alongside Western medicine, as part of a plurality of traditions – within both Western and non-Western cultures. This book is a contribution to the growing field of studies that cut across academic methodologies and theoretical concerns and, most importantly, aim at breaking away from an exclusively Western and biomedically centred perspective. The essays on medical ideas and practices in India and Africa reveal the extent to which different medical traditions, including Western medicine, have prevailed and continue to exist alongside and, at times, in competition with, each other. In other chapters a similar situation is shown to have been prevalent also in nineteenth-century England, and modern-day China, Britain, Northern America, and New Zealand.

Despite the fecundity of inter-disciplinary and pluralist perspectives a number of conceptual (and perceptual) problems still persist. First of all, the conundrum of dichotomously arranged categories that tend to unduly restrict phenomena to criteria relevant to their binary opposites remains as yet unresolved. Debates about dichotomies and the move towards pluralism are, of course, not characteristic only of medical history and anthropology. Medical sociologists, cultural theorists, philosophers and literary studies scholars, too, are variously engaged in breaking away from the restrictions of deterministic monisms or dualisms and simplistic concepts and perceptions based on seemingly clear-cut binary constellations.[12] They all attempt to fathom the extent to which pluralist perspectives allow more sophisticated analyses.

Despite critical awareness, terms like 'indigenous medicine', 'folk medicine' and 'healer', for example, even if used in their plural forms, are still redolent of those features that they have for long been thought of as lacking in comparison to their binary opposites (namely 'Western medicine', 'learned medicine' and 'medical expert'). So much have they become seen as synonymous with 'unscientific', 'superstition' and 'quack' that even when they are not explicitly denigrated, their scientific status, the validity of their knowledge base and the integrity of their practitioners is almost automatically impugned. 'Western medicine', in contrast, is not usually required to justify its status as a 'scientific' procedure – it is implicitly thought of as such, even if, as explored in Bradley's essay on hydropathy and orthodoxy, the basis on which the claim to scientificity is established may not be as solidly 'objective' and 'scientific' as it appears to Western imagination.[13]

We may well have come to see pure, perfect and pristinely delineated medical 'systems' and categories as inherently 'ideological constructs' that need to be used with caution.[14] Their legacy, however, still lingers on even as we turn attention to medical 'encounters' or 'exchanges' or 'interactions' between ... – well, one medical 'system' or category and another. The language of pluralism still tends to reflect the very same static and discrete meanings and perceptions that many writers, including the contributors to this book, aim to challenge and expose as products of restricted and restrictive imaginations and ideologies. Even terms such as 'hybridity' and 'syncrecy', 'the global' and 'the local', fashioned and put forward as solutions, tend instead to further highlight and illustrate the very problem of

dichotomising a reality that is multi-faceted, forever in flux and never purely delineated, as these terms, too, are built on the assumption of pre-existing discrete (however vaguely defined) entities.

An emphasis on medical pluralism alone thus can, of course, not offer a straightforward solution to dichotomous polarisation. Its apparent capacity to challenge Euro-centrism, cultural myopia and prejudice may, however, make it conceptually preferable to the earlier focus on 'Western medical superiority', 'power' and 'domination' that did as much to reify these as to expose them. The current weariness with the 1960s and 1970s focus on issues of power, domination and hegemony and the wish to embrace a – seemingly – less deterministic perspective make pluralism appear as a more positive term that is congruent with and supportive of what is widely perceived as desirable social and political developments, such as the emergence of modern multi-cultural societies in former colonies and in Western countries with significant immigrant populations. As is shown in the essays on the options offered to and chosen by 'consumers' of healthcare in Britain, India and New Zealand, medical pluralism is indeed an important feature of multi-cultural societies all over the globe.

However, the emphasis on pluralism also harbours certain dangers. To begin with, it may well give further credence to one of the persistent ideological ploys of Western biomedicine: that medicine is located outside the realms of power, domination and hegemonic strife. An exclusive focus on medical pluralism in the domains of medical ideas and professional institutions, and in regard to patients' freedom of choice colludes with the image of the medical market place and the sphere of healing as a 'liberal heaven', in which patients of all social and cultural backgrounds are supposed to have free choice and easy access to their favoured medical treatment; where medical professionals and itinerant healers of all stripes are said to ply their trade alongside, and in mutual respect for, each other; and where biomedicine could not only be simply one of a number of different modes of healing but also abstains from undue claims of epistemological superiority and greater efficacy and efficiency.

It is important here to differentiate carefully between the desirability of medical pluralism and the extent to which it has been realised in a 'globalised' medical world that is still powerfully dominated by American and European pharmaceutical firms, and by the promulgation of Western images of a healthy life-style and of biomedicine as the ultimate point of reference for the assessment of health problems and treatment outcomes. Analyses that focus on pluralism therefore still need to be situated squarely within the wider social and political context, being also sensitive to issues of power and medical hegemony. The essays in this book are written with this contention in mind. As shown in the chapters by Arnold and Sarkar, Scheid, Liebeskind, and Reis, patients' and practitioners' choices of and preferences for particular approaches are not simply individual decisions, but are also closely related to the struggle and search for national(ist) identity and the assertion of, and resistance to, cultural and political hegemony. An analytic focus on medical discourses in addition to reflections on patients' views from below and practitioners' virtuosity are therefore called for. As pointed out by Cant and Sharma, 'The biomedical power which social scientists have wished to critique is no illusion. Historically

speaking it has grown from ... biomedicine's political alliance with the state and ... its espousal of scientific method as the basis for its authoritative claims to knowledge and expertise'.[15]

Another potential flaw of pluralist perspectives has been discussed particularly well by philosophers of science who argue that although pluralism is rightly envisaged to encapsulate tolerance towards different cultural and scientific frameworks and practices, it still requires to be constrained in some way on moral grounds (and, for some, on ontological grounds as well). Acceptance of differing views may on the whole be desirable, but on occasion particular approaches ought not to be tolerated (as in the case of Nazi medical experiments). This need to impose restrictions on medical practices and procedures on morally justified grounds posits again the very problem that medical pluralism may have been hoped to have dispensed with, namely the question of who is to assume the authority to decide on restrictions of pluralism and, therefore, issues of power, hegemony and domination.

The resulting problem is illustrated well by discussions in the United Kingdom and the United States about government intervention and professional regulation of the pluralist, alternative medicine market and the policing of health-related internet sites. Vankevich explores this issue further in his essay on the limits of pluralism. When the ethics, efficiency and effectiveness of alternative approaches are to be assessed, authorities steer precariously between the Scylla of imposing the well-tried and supposedly superior, scientific criteria of biomedicine on a whole range of healing practices, and the Charybdis of leaving the public exposed to potentially unprofessional, unethical and fraudulent, or simply ineffective, practices. In a similar vein patients' and alternative practitioners' interest groups, too, make at times incompatible demands when canvassing consumers' rights to free choice and access to a range of treatments, while simultaneously reasserting government's and scientific experts' obligation to protect the public from potentially harmful practices.

Far from constituting a *counter*-paradigm to those much favoured up until recently (such as power discourses, medical systems and hegemony), a critical and informed pluralist perspective could therefore be conceived of as bringing both diversity *and* power issues into view. Importantly, power needs to be looked at not only in regard to Western biomedicine, the usual 'bad guy' in revisionist histories of the Foucaultian as well as the post-colonial genre. Traditional and non-Western systems of healing that have more commonly been seen mainly as victims of Western domination and arrogance are on their part not immune or averse to professional power play, shrewd global marketing and personal networking either. This point is explored in the chapters on Chinese medicine (Scheid), homoeopathy (Arnold and Sarkar), Unani (Liebeskind), and Ayurveda (Bode), in which the romanticised vision of non-Western systems of healing, as aloof from the profane domains of politics and profiteering, and true only to their ancient origins, spiritual values and holistic philosophy, is challenged.

It also is important to keep in mind that supposedly never-changing medical traditions such as Ayurveda (Hindu medicine), Unani (Islamic medicine), and Chinese medicine are not only made up of a number of different schools and diverse strands, but that they have also, over time, adapted in a variety of ways to

changing local circumstances and global trends, and even shown themselves more recently as particularly adept in becoming active players in the medical market place – in their country of origin as much as in the West. Ayurvedic medical centres, for example, flourish not only in their expected strongholds (such as Varanasi in India), but also in cosmopolitan conurbations such as Mumbai, New Delhi and Calcutta, as well as in New York and London where Ayurvedic doctors can now be consulted and 'traditional Ayurvedic' remedies easily purchased in any 'Body Shop'.

This phenomenon could well be lamented and construed as crass Western-style commercialisation of traditional medicine, as some sort of McDonaldization[16] of traditional medicine that ought to be differentiated from the 'real' thing, the pure and original Ayurveda based on an age-old tradition that has been clearly codified in the ancient Vedic texts and practised the same way ever since. A significant number of traditionalist Ayurvedic practitioners as well as some New Age Western protagonists of the 'real' Traditional Ayurveda do indeed perceive these recent developments in such terms. However, they could also be seen as testimony to the fact that any one 'tradition' or 'medical system' is inherently heterogeneous (i.e. 'plural') and represented by different groups of people with diverse views on how practice ought to be adapted (or not) to changing circumstances – a potential for profiteering and commercialisation notwithstanding.

Moreover, just because a medical corpus can trace its origins back to some ancient text does not mean that it has to be inherently static and homogeneous. In the case of Ayurveda, for example, it has been shown that scriptural injunctions such as 'the wise must ... adhere to tradition, without arguing' (in *Susruta Samhita*[17]), do not necessarily imply homogeneity of approaches and consensus on diagnostics and treatment.[18] Not only have a number of different interpretations of Ayurvedic doctrine prevailed in any one period, but they have adapted variously to changing social and environmental realities, at times even running counter to particular, simultaneously held prohibitions (such as the consumption of meat alongside vegetarianism in India).[19] 'Medical traditions' are intrinsically 'plural' – both in terms of the variety of ways in which any one tradition has been interpreted and codified by different learned authorities, and in terms of the great variety of their practical applications.

The further point that different paradigms, even if based on seemingly contradictory positions, can be successfully held together by one individual is illustrated by an anecdote about the Mysore-born and Western-trained poet A.K. Ramanujan who succeeded in combining realms that appeared to some of his contemporaries as irreconcilable. Pondering on whether there was such a thing as 'an Indian way of thinking', he recollected memories about his father:

> He was a mathematician, an astronomer. But he was also a Sanskrit scholar, an expert astrologer ... [who] had just been converted by Russell to the 'scientific attitude'. I (and my generation) was troubled by his holding together in one brain both astronomy and astrology; I looked for consistency in him, a constituency he didn't seem to care about, or even think about. When I asked him what the discovery of Pluto and Neptune did to his archaic nine-planet astrology, he said, 'You make the necessary corrections, that's all'. Or, in answer to how he could read the *Gita* religiously, having bathed and painted on his forehead the red and white feet of Vishnu, and later talk appreciatively about Bertrand Russell and even Ingersoll, he said, 'The *Gita* is part of one's hygiene. Besides, don't you know, the brain has two lobes?'.[20]

The question then arises of how a seemingly clearly bounded 'tradition' or 'medical system', whether of the 'Western' or the 'traditional' variety, comes into existence. In a broad and straightforward sense a plausible answer would be that 'traditions' are the result of negotiation among the main protagonists at any one time, namely authors of medical treatises, promulgators of medical lore, practitioners, state authorities, cultural communities, patients, and the public. An important, yet more elusive, dimension in this process of negotiation, and at times contestation, is the way in which traditions are 'envisioned', 'imagined', if not 'invented'.[21] Examples of this process are discussed in Bradley's chapter on the emergence of medical 'orthodoxy' in mid nineteenth-century Britain and in Reis' essay on 'traditional healing' in Swaziland.

Another example of how cultural representations have a bearing on the ways in which a particular medical system is perceived and defined is the current inversion of the meaning of 'traditional medicine'. At least since the period of the Enlightenment, Asian and African 'traditions' and 'customs', for example, had by many Europeans (and, increasingly, by Western-educated Asians and Africans, too) been associated with a variety of negative terms, such 'inferior', 'backward', 'uncivilised', 'barbaric', 'crude' and 'primitive'.[22] Yet more recently the term 'traditional medicine' has acquired further, largely positive, connotations by virtue of commercial marketing strategies that present Ayurvedic or traditional Chinese medicine, for example, as wholesome, spiritual, holistic, authentic, humane, and as something people in the West as well as in the East would be well advised to make use of in order to live in harmony with the modern world. Bode and Reis explore this further in regard to Ayurvedic and Swazi medicine.

It is, however, not merely the ways in which traditional medicine has come to be represented and envisioned that have changed to conveying the opposite of what it was imagined to be during earlier periods. The very stuff of which Ayurveda, for example, is supposed to be made has changed, too. The particular procedures and specific remedies that are selected from the wide-ranging repertoire of traditional Indian medicine and offered for wholesome consumption by modern man and woman have only a tenuous link with the whole package and complex sequence of medical and health-related practices from which they are isolated. Ayurvedic treatments, for example, have in the West been adapted to pander to, and to elicit, Western images of relaxation and gentleness by purging them of those components (such as purgatives, emetics and errhines) that had a central place in their practice in India, yet would be considered as too 'interventionist', 'violent' and off-putting to sensitive Western consumers. Zimmermann described the modern emphasis on the gentle elements in Ayurveda, arguing that it 'changes

the tradition significantly'.[23] Modern Ayurvedic medicine has been truly re-invented. It is now imagined as based on ancient tradition and as offering 'an alternative to the harshness of biomedicine'.[24] In 'contemporary practice in South Asia, as well as in Ayurvedic therapies exported to the West, practitioners avoid using emetics or drastic purgatives. All violence has disappeared from medications aiming to cleanse the patient's humoral system. Neither red (the red of bloodletting), nor black (the black of chemical oxides), but green – the green of herbs freshly gathered, a symbol of nonviolence: this is the new motto of Ayurveda's flower children.'[25]

It would be plausible but naïve to conclude that 'traditional medicine', in this case Ayurveda, is simply being misconstrued by profiteering business people or ignorant Westerners. First of all, as shown in the chapter by Bode, in India itself 'traditional' has become for some largely a designer product, with positive connotations that conjure up relief from the stresses and strains of life, and with pills available straight off the shelf, in a truly 'modern', nicely packaged and easily swallowed shape. Secondly, how would we decide *which* Ayurveda was more 'authentic', more 'original', more 'traditional'? Would it be appropriate to assume that rather than the practices and procedures focused on in modern-day Ayurveda, those mentioned in the ancient Vedic texts, for example, were the truly authentic and traditional ones? And, if so, which one of these, out of an array of different textual traditions, would we choose as the definite source? Even if there was such a thing as an original blueprint of *the* Ayurvedic doctrine, would it make sense to elevate the written tradition above Ayurvedic doctors' real-life, and usually more 'messy' and idiosyncratic, practical adaptations and modifications of the theoretical corpus? And what about patients' active role in the pursuit of better health and consumers' decision in favour of medical approaches that appeal to them on account of their perceived authenticity and anticipated benefit? Does it matter that current representations of 'traditional medicine' are at times but faintly linked with any one of the various brands of Ayurveda practised in India centuries ago? Ultimately, we are faced with the questions of what is supposed to count as authentically 'traditional', and what, if anything, is 'traditional' about 'traditional medicine'.

Scheid has recently tackled these questions in regard to the case of Chinese medicine.[26] He suggests that traditional Chinese medicine (TCM) is thought of in the West as well as in China as the continuation of an ancient, original and authentic tradition practised widely and successfully over the centuries. Yet what has been referred to as TCM in recent times is merely the revived medicine of the former elite of pre-revolutionary China. This medicine has been promoted in the People's Republic since the late 1950s by the Communist government and undergone modernisation along Western principles of standardisation and scientificity. Like modern Ayurveda and Swazi indigenous healing, TCM, too, can therefore be conceived of as an 'invented tradition',[27] largely grown out of nationalistic endeavour and the pressing need for health services for the masses.

In this collection of essays as well as in the wider literature, the term 'plural medicine' is used in basically two different ways. In its long familiar version it denotes 'plurality' in the sense of a variety of medical approaches existing alongside each other, at times in competition and at times in collaboration with or complementary to each other. In its second, more complex, version the term refers to the plural or multi-dimensional qualities inherent in medical practices and experiences, as these draw on and are open to different approaches, are 'bastardised' or hybridised, syncretic, and versatile. Analyses of plural medicine in the wider sense of the term, focus on what could be described as practitioners' 'virtuosity' in moving between different doctrines or medical approaches and patients' 'versatility' as they draw on a number of different strands of medical practices – in India as much as in Leicester, Swaziland and in cyberspace.

As some of the essays in this volume show, plural medicine is not new, nor, arguably, is it on the rise – even if the extension of pharmaceutical marketing and the fast-and-easy internet have accelerated the pace with which medical practices – 'modern' and 'traditional' – have become globalised. What needs explaining therefore is the increased focus on it. It is suggested here that recent debates on 'national identity' and the meaning of 'tradition' in the (post-)modern and post-colonial age have led to an increased interest in pluralism, as questions about the nature of modern multi-cultural or 'syncretic' societies in the west and of former colonial countries, that aim at becoming part of 'modern' world society without losing track of their 'traditional', cultural roots, have moved centre-stage. Any exploration of plural medicine, therefore, needs to be aware of issues of tradition and modernity, of national identity and globalisation.

The essays in this book assess the many interpretations and practical applications of any one medical system as well as the variety, or plurality, of medical approaches that co-exist or compete with each other at any one time and place. Some explore the phenomenon of plural medicine and medical pluralism through the eyes of the patients (Laing, Reed, Hardey, Reis). Others assume the practitioners' (or students') perspectives (Scheid, Bradley, Reis, Digby and Sweet) or investigate the processes by which particular medical approaches become imagined and represented as 'scientific', 'alternative', 'orthodox', or 'traditional' (Bradley, Bruchhausen and Roelcke, Liebeskind, Arnold and Sarkar, Vankevich). Although the analysis of medicine(s) as systems of knowledge and discourses of power is not lost sight of, it is the pliability of a medical corpus and the virtuosity of its practitioners in adapting to changing social and cultural conditions, that are very much to the fore.

Of course, a collection of essays on plural medicine could not possibly explore all and every aspect in an encyclopaedic way. Instead detailed examples from diverse settings are presented, intended to reveal some of the issues involved in discussions on the nature and the manifestations of plural medicine. It is hoped that specific case studies will enable readers to recognise and relate particular phenomena to what they may have come across and be aware of from other cultural or historical settings.

The individual chapters have been arranged in chronological order, with the first five, historical, essays focusing on the tensions and the cross-fertilisation between 'orthodox' Western biomedicine and 'other' medical approaches within the context of different cultural settings during the course of the nineteenth and early twentieth centuries. Here the geographic perspective is wide-ranging (from India, to Britain, and to Africa) and the major conceptual focus is on medicine(s) as knowledge and

discourse. Although clearly located within the discipline of history, some of the issues raised in these essays resonate and link up with modern concerns. The chapters by Bruchhausen and Roelcke (on German East Africa) and Digby and Sweet (on South Africa), for example, highlight the continuity of the past in the present on the level of academic discourse as well as in regard to professional tactics, and Arnold and Sarkar observe that an '[e]levation of immunity from modern/Western discourses into the sole criterion for valorisation might at times be seriously anachronistic' (p. 54).

The remaining chapters assess present-day issues in locations as far afield as Swaziland, China, India, Britain, New Zealand, and the virtual world of the internet. Despite a diversity of disciplinary backgrounds (ranging from anthropology, to science studies, medical sociology and media studies), the focus is here on how ideas about seemingly polarised entities, such as 'tradition' and 'modernity', 'heterodoxy' and 'orthodoxy', influence medical practice, medical marketing and patients' health-related behaviour within diverse cultural, economic and political contexts as well as on the world wide web.

The first essay focuses on the interactions between 'hydropathy' and 'orthodoxy' in mid-nineteenth-century Victorian Britain. Bradley shows how hydropathy emerged as a newly consolidated 'heterodoxy' out of the water cure procedures that were very much part of the Hippocratic corpus, the repertoire of 'folk' medicine, as well as mid-nineteenth-century 'mainstream' medical practice. More importantly though he argues that 'heterodoxy' was as much defined and delimited by 'orthodoxy' as 'orthodoxy' took shape and defined itself in contrast to 'heterodoxy'. Bradley's aim is to 'resist the urge to divide the world into centres and peripheries' (p. 19), and to 'decentre' an assumedly monolithic orthodoxy that was, just like its heterodox counterpart, 'evolving, mutating and ever so slightly amorphous' (p. 21). He inverts the contention of many medical historians that 'medical heresies', such as hydropathy, were the shadow of orthodoxy, by suggesting that 'orthodoxy was constructed as a shadow of heterodoxy' (p. 32).

Arnold and Sarkar focus on homoeopathy, another 'heterodoxy' that was popular in nineteenth-century Britain, and which spread to India as well. Homoeopathy was readily accepted on the Indian subcontinent on account of the cheapness of its remedies and its self-help appeal. It enabled educated Indians who were excluded from pursuing successful careers in the almost entirely British-dominated Indian Medical Service to engage in what was thought of by many as a modern, rational medical system. Homoeopathy transcended not only 'the conventional boundaries between "Western" and "indigenous" medicine' (p. 49), but also 'India's seemingly entrenched ethnic and cultural boundaries' (p. 42). Rather than necessarily defining its practitioners as 'Indian', Ayurvedic or Unani, and long before the supposedly unique age of 'globalisation', it enabled them to see themselves as part of a wider international community – a community, that was imagined as 'Western' and 'modern', without being colonial.

In their conceptually wide-ranging essay, Arnold and Sarkar critique also some of the assumptions that underpin both conventional histories and 'subaltern' and 'post-colonial' writing on Western and indigenous medicine in (post)-colonial

countries. They show that the usual story of homoeopathy as a Western heterodoxy that was appropriated by the colonised and accepted as 'an almost indigenous form of medicine close to the people' (p. 43) is anchored in a series of problematic polarities in which 'the apparently opposing elements are implicitly assumed to be homologous and inseparable' (p. 41). The history of homoeopathy in Bengal, they argue, 'cannot be made to fit a sharp Western/indigenous divide' nor should its 'popular' or 'subaltern' dimension (p. 53–4) be over-emphasised and construed as a kind of 'indigenous cultural nationalist reaction to the domination of Western colonial discourse' (p. 51). The Western/indigenous divide is shown to be particularly problematic as it continues a prominent nineteenth-century pre-occupation: it tends to 'excessively prioritise the question of origins' and to focus on nationalist strife (p. 54). By so doing it makes, 'in effect, the rejection of ideas of Western origin the sole criterion for authentic autonomy' (p. 54).

In her essay on Islamic (Unani) medical practitioners in India, Liebeskind too touches on nationalist ambitions and anti-colonial strife insofar as these constituted the context within which claims to the scientificity of indigenous medicine in the five decades leading up to India's Independence in 1947 were put forward. Her specific focus is on a detailed study of the defence of Unani as rational and scientific knowledge by three eminent practitioners. In spite (or rather because) of the commonalities of Unani and pre-modern Western medicine – in terms of their shared Greek philosophical origins and humoral frameworks – Islamic medicine was considered by the majority of Western-educated doctors in India as unscientific, irrational, and as an outdated relic of the sort of practices the West strove to distance itself from in the wake of the Enlightenment and the rise of modern science.

In their response Unani practitioners pursued revivalist strategies that ranged from the attempt to synthesise the best features of indigenous and modern Western medicine to the fundamentalist approach of reviving and accentuating features then considered to be 'pure' and 'traditional'. Representatives of both camps agreed however on two major issues: first, that Unani was essentially scientific and rational, and, second, that biomedicine itself failed to live up to the scientific criteria of its own rhetoric. By basing both their defence and attack on criteria favoured by Western bioscience, they implicitly accepted biomedicine as the benchmark. Much of the discussion about Unani's claim to scientificity and biomedicine's failure to live up to its own standards drew on the classic Aristotelian framework of natural philosophy and realism (which Islamic medicine shared with pre-modern Western medicine). It consequently mirrored the wider philosophical debates during much of the twentieth century in Europe that critically engaged with and still continue to challenge logical empiricism and positivism.

The three hakims or practitioners of Islamic medicine discussed by Liebeskind may well have used the very same criteria that were part of the hegemonic discourse of Western scientific knowledge. However, as Liebeskind concludes, 'looking at biomedicine from the outside from an inferior position in the power-game but one grounded in a strong sense of the history and achievements of their medicine, [the

hakims] unpicked its rhetoric and positivism, value-neutrality and universality and highlighted its construction in Europe by Europeans' (p. 71).

The construction of scientific knowledge and of its imagined counterpart, 'indigenous medicine', is also at the centre of the chapter on 'African medicine' by Bruchhausen and Roelcke. The authors investigate how modern images of 'traditional' or 'indigenous' African medicine are redolent with earlier formative discourses of the colonial period. In regard to German discourses on East African healing practices they show that what is nowadays conceived of as authentically and intrinsically 'African', may in fact have been the creation if not invention of Europe. Traditional African medicine, Bruchhausen and Roelcke argue, is 'the result of political and scientific developments, ethnographic and psychological approaches, administrative activities and, last but not least, controversies about orthodox and heterodox medicine in Europe' (p. 76). The translation of a complex array of heterogeneous medical ideas and practices extant in the territories of German East Africa into one single, allegedly homogeneous and authentically 'African medical tradition' occurred between 1884 and 1918, when German doctors, missionaries and ethnographers busied themselves with the collection and categorisation of cultural artefacts and customs. Although originally construed as a unifying label, 'traditional African medicine' provides indigenous populations with a wide range of easily accessible treatment options available to them alongside Western biomedicine.

In her essay on traditional healing in modern-day Swaziland, Reis explores how patients suffering from epilepsy as well as healers make use of a number of different strands of both Western and traditional Swazi medicine. As patients are engaged in 'healer hopping', picking the treatment of their choice, and practitioners are shown to draw on a wide range of traditional, biomedical, as well as Western alternative, even 'new age', methods, the intrinsically plural character of both 'Western medicine' and 'traditional Swazi-medicine' is revealed and their supposedly clearly bounded nature is called into question. At the same time, however, Reis discerns a process of perceptual re-dichotomisation that finds its expression in public representations of Western medicine and herbalism as mainly 'technical procedures', in contrast to a traditional Swazi medicine that is grounded in respect for the sanctity of the ancestors and the Swazi King. According to Reis, these contrasting representations are based on the different degrees of moral legitimacy, spiritual propriety and national authenticity attributed to the various approaches. Even if easily embraced by both patients and practitioners, Western biomedicine is seen to be devoid of one particular aspect that is vital to Swazi people's self-identity, both on an individual level and in terms of national identity. Unlike divinatory healing, biomedicine is not inspired by respect for ancestral authority and loyalty to the King, and therefore is not by itself nor in combination with other, traditional medical techniques (such as herbalism) imbued with spiritual and political legitimacy.

Consequently, the 'biomedical *vs.* traditional medicine' dichotomy that is usually taken to be the unquestioned analytical starting point for both its apologists and for its critics does not adequately capture the situation in Swaziland – neither in

regard to patients' treatment choices and practitioners' preferred approaches nor in regard to public and politically endorsed perceptions of what is to count as authentic Swazi medical practice. First, both patients and healers move easily between and across the divide between Western and traditional medicine. Second, rather than traditional healing being simply subject to incorporation into a Western, biomedically dominated national health system, 'Swazi healing easily incorporates biomedicine into the traditional idiom of illness and healing' (p. 107). Third, the one dichotomisation that is most clearly manifest in public representations of medicine in Swaziland derives its impetus from the perceived centrality of ancestral (and royal) legitimacy, and thus of divinatory healing. The latter is thought to be superior by far to both Western biomedicine and traditional herbal medicine.

Digby and Sweet's study shows how biomedically trained nurses in South Africa moved easily across the allegedly strict boundaries between Western missionary medicine and traditional modes of healing. Since the early days of the mission hospital in South Africa biomedically trained African nurses successfully managed to reconcile their role as 'standard bearers of Western medicine' with their allegiance and sympathy for indigenous practices. Western-trained doctors in mission hospitals depended on nurses' skills in translating indigenous symptoms into the categories of Western medicine and making Western medical intervention and treatment methods culturally acceptable to patients. Western missionary societies therefore expected African nurses to facilitate the replacement of indigenous beliefs and healing practices with Christianity and Western medicine. This they did, reliably, within the confines of Western institutions and a biomedically dominated atmosphere. However, the further nurses' workplaces were removed from the centres of institutionalised Western medicine, the more versatile and plural their approaches became. Digby and Sweet suggest that in remote areas community nurses acted as mediators or 'culture brokers', advising patients of the whole range of medical options available to them – both Western and indigenous. In order to fulfil this role successfully, it was vital for nurses to be accepted by, and willing to co-operate with, leading traditional community representatives and indigenous healers in the different localities.

Scheid's chapter critiques the continued reliance on the discourse of modernisation which proceeds from a juxtaposition of 'tradition' and 'modernity'. Like Arnold and Sarkar, Bruchhausen and Roelcke, and Reis, he highlights the restrictiveness of this perspective and the ideological, Europe-centred bias that goes along with the application of this set of oppositional terms and prevents a more sophisticated understanding of medical practices. In a formal sense and at the level of medical discourses, the case of Chinese medicine shows a plurality of different practices co-existing at any one time: modern traditional Chinese medicine and modern biomedicine in China, and modern traditional Chinese medicine in the United Kingdom or the United States. The disjunction between the modern and the traditional may therefore serve well as a useful heuristic device, even if narrowly conceived. However, it would be misleading to assume that individual practitioners would fit easily into one of these seemingly discrete heuristic categories.

Scheid illustrates this point in his case study of Professor Rong who is at the centre of a variety of intersecting networks of practices, and moves easily between them. His work would not be adequately characterised by labels such as 'modern' or 'traditional'. Being part of a number of medical, social, and political networks, Rong makes, for example, use of inherited cultural tools in the pursuit of contemporary goals. As Rong's case shows, medical practice is multiply determined and locally emergent – this holds true in the case of Chinese medicine as much as, arguably, in regard to other practices as well. Scheid suggests that rather than merely focusing on the variety and plurality of medical practices, it may be more appropriate to conceive of medical practice as intrinsically plural and, on account of medical practitioners' virtuosity, as infinitely more complex than reference to the dichotomising discourse of tradition/modernity suggests.

The conceptual boundaries around different healing discourses are crossed, too, in Laing's chapter on constructions of Maori healing. Laing's reflections draw on both her expertise as a medical anthropologist and health researcher, and on her personal health beliefs and healing strategies in response to a medical diagnosis of breast cancer. She provides an engaging and self-reflective account of the various medical and spiritual approaches she drew on. Laing's illness narrative shows her reluctance to let herself be constrained by biomedical notions and role prescriptions of how cancer 'patients' ought to behave, on the one hand, and by ideas about Europeans' alleged 'materialist', non-spiritual nature, on the other.

Laing traces what she perceives to be the misleading and politically motivated juxtaposition of Maori people as 'spiritual' and 'superstitious' with Europeans as 'rational' and 'materialistic' to nineteenth- and twentieth-century anthropological characterisations of Maori people by Europeans. She shows how these fuelled the ideologically and politically fraught debates preceding and following the passing of the *tohunga* (Maori healers) Suppression Act of 1907. Laing argues that what had originally been intended by European and Westernised Maori as an essentially negative attribution (spiritual = superstitious = inferior Maori healing) has more recently been inverted by some Maori groups to convey positive connotations (spiritual = non-materialist = superior Maori healing).

In her own quest for spiritual and bodily health Laing cuts across such simplistic and restrictive equations, making use instead of a plurality of approaches that range from new age goddess cults to Maori ideas of *mana wahine* (women's authority), Christian-based anthroposophy to Eastern philosophy. All of these become fused in what Laing conceives of as a feminist perspective on women's health.

In her chapter on British South Asian mothers, Reed argues that while the categorisation of medical approaches into 'Western', 'Indian' and 'alternative' may be appropriate and revealingly indicative of ideological strategies at the level of medical discourses, the conceptually strict boundaries around these collapse once people's health beliefs and behaviours are the focus of research. On the basis of in-depth interviews with British-born South Asian women in Leicester, Reed examines the ways in which her respondents drew on a variety of different medical approaches that were available to them in both Leicester and India. The women were members of a number of social networks, both in Leicester and other locations

in Britain as well as in their parents' countries of origin. They made use of the different medical systems connected with all of these in a syncretic way, 'mixing and matching them and creating something new in the process' (p. 173). Rather than interpreting 'diasporic' women's use of Indian health products and health services in India as an indication of the search for authenticity, she suggests that a more pragmatic reading may be more appropriate.

While Reed shows us that British-born Indian women make syncretic use of a range of medical approaches and medicines from both Britain and India, Bode looks at the equally syncretic ways in which Ayurvedic and Unani pharmaceuticals are marketed in India. Both Ayurveda and Unani medicine are usually characterised as representative of 'tradition' and as inextricably linked with 'nature'. Yet, as Bode shows, in the marketing of its products, tradition is being linked up with the 'modern' and the 'scientific'. This is most poignantly expressed in the advertising image of a Hindu *rishi* (seer) meditating in a test-tube. As one of the representatives of the three pharmaceutical firms studied by Bode put it: science has been added to culture. Indian consumers easily recognise particular images of Indian culture, traditional values and nature used in advertisements. These are promoted alongside those of Western culture, science and efficiency, creating not merely something 'modern', but something new and contemporary. Bode concludes that as 'traditional and modern medical forms are creatively rearranged in the Indian context', medical pluralism exists *within*, rather than between medical systems.

Hardey explores the new space of the internet, where health-related advice is freely available, the sale and purchase of medicines and potions flourishes, and medical pluralism is all too evident. Rather than investigating cyberspace marketing techniques, Hardey focuses on the consumers' perspective, exploring the health-related behaviour and motivation of a number of chat-room participants in the UK and of personal web-site owners in the UK and USA. He finds that patients in search of medicine and health information value the internet on account of the free and easy access it offers to members of the public. It also plays an enabling role. Although internet access itself is not available to people of all social classes, those who are connected to it can turn from passive patients to active consumers. They do not have to rely exclusively on their doctor as the sole and only source of medical expertise.

Yet, patients are at the same time aware of the need to be wary and selective in regard to the usefulness, efficacy and quality of the products and information offered. Despite its status as a paragon of 'modernity', the internet is subject to the very same issues that exercised members of the public and orthodox and heterodox practitioners long before the advent of modernity. Hardey's chapter title, 'Health for sale', which is borrowed from Roy Porter's historical account of quackery in England, gives an indication of the contentious issues modern patients and practitioners are still struggling with. The internet constitutes yet another marketplace where tricksters as well as experts, genuine practitioners and any member of the public can spread information or ply their trade. As such it is also subject to discussions about the need to impose controls and restrictions on pluralism.

Whilst Hardey's study focuses on the freedom of choice enjoyed by internet-literate patients in the UK, Vankevich explores how medical practitioners in the United States attempt to goad them back to the narrow confines of the biomedically defined 'sick-role'. Taking the internet-based campaigns of Dr Stephen Barrett and his *Quackwatch* web-site as a starting point, Vankevich shows that the age-old idea of 'quackery' still has currency in the modern world and in cyberspace. In fact, the use of an antiquarian term such as 'quack' within the very modern space of the internet further highlights the prevalent dichotomising discourse that aims to discredit the 'old-fashioned', 'traditional', 'folksy' and heterodox by contrasting it with the 'modern', 'scientific' and orthodox.

Drawing on the familiar juxtaposition of 'science' and 'quackery', Barrett warns web-surfers of the inefficacy and dangers of alternative medicines and of the ulterior motives and uninformed/unscientific methods of alternative practitioners. From Barrett's perspective, the lay public ought to confine itself to seeking advice and treatment from biomedically-trained practitioners, rather than making use of what the plural health and medicine market has on offer. As Vankevich points out, the regulation of the medical cyber-market with a view to preventing fraudulent and potentially harmful practices may be well justified. However, Barrett's approach is to reject and label as 'quackery' each and every approach that is not part of science-based medicine. Quite apart from minimising or even ignoring the patient's involvement in any healing process, Barrett's equation of good medicine with science reasserts the latter as the one and only criterion for how medicine is to be practised and therefore eschews medical pluralism.

As Hardey's and Vankevich's studies show, today's internet-based discussion groups and alternative practitioners are both strong protagonists in the plural medicine field and victims of the hegemonic discourse of Western science-based medicine – just like the hydropaths in nineteenth-century England, the homoeopaths and Unani practitioners in nineteenth- and early twentieth-century India, and the indigenous healers in German East Africa.

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Notes

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