Medical Pluralism
Past – Present – Future

Edited by Robert Jütte

MedGG-Beiheft 46

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Preface

Robert Jütte

The recent widespread interest in alternative medicine points, in the words of Ted Kaptchuk and David Eisenberg, to a "dramatic reconfiguration of medical pluralism – from historical antagonism to what might arguably be described as a topical acknowledgment of postmodern medical diversity".[1] The question is, how the late 20th century birth of complementary and alternative medicine (CAM) resulted in yet another transformation in medical pluralism, locating quackery no longer in adhering to an unconventional treatment. The line of demarcation can now be found in a more ethical field, e.g. competency, qualifications, conduct, responsibility and personal professional development of a practitioner, almost regardless of the form of therapy in question. But does it really make sense to use the label "new pluralism"[2] coined by Cant and Sharma for this phenomenon?

These and other questions were addressed by a conference entitled "Medical Pluralism – Past and Present" which took place in the Villa Vigoni in Loveno di Menaggio (Italy) in May 2011. It was organized by the Institute for the History of Medicine of the Robert Bosch Foundation and the Centro Italo-Tedesco per l'Eccellenza Europea, in collaboration with the Dialogforum Pluralismus in der Medizin. Unlike previous conferences discussing medical pluralism in past and present[3], this symposium did not only focus on the tensions between orthodox medicine and other medical approaches within the cultural settings during the course of the 19th and 20th century. Any exploration of plural medicine including the historical perspective needs to be aware of the conflict between regular and irregular healers which existed already in the premodern era, although distinctive features such as "scientific", "alternative" or "traditional" which are so familiar to us today did not yet play a role. In the early modern period we observe a complex array of heterogeneous medical ideas and practices which has not much in common with the kind of pluralism or plurality which we can find in modern health care systems in Europe and non-western countries (e.g. India, Japan).

Comparing the medical market place in pre-modern, 19th, and early 20th-century Western Europe with the present situation in health care, the papers presented at this conference dealt with the historical development as well as with the present state of medical pluralism in and outside Europe. The papers selected for publication come up with data and evidence from a variety of sources, suggesting that unconventional medicine has been a persistent pres-

1 Kaptchuk/Eisenberg (2001), p. 189.
2 Cant/Sharma (1999), p. 194.
3 Cant/Sharma (1996); Gijswijt-Hofstra/Marland/Waardt (1997); Ernst (2002); Michl/Potthast/Wiesing (2008).

ence in health care over the past two to four hundred years. The contributors were drawn from different academic disciplines such as medical history, medicine, sociology, and anthropology. The chapters fall into two categories: those focused on forms of medical plurality in the age before the rise of biomedicine and those focused on medical pluralism today, bringing examples from Western European countries such as Italy, Germany, France, and Great Britain, but also from a country which has an outstanding reputation for practicing medical pluralism, India.

The contributors to this volume vary in the extent to which they engage with the theoretical perspective of the term medical pluralism, but each of them points out the underlying dynamics that had led to medical pluralism within different geographical and cultural settings and historical periods. Those chapters which deal with the medical plurality in pre-modern societies show that it was a long way before the tradition of healing became orthodox in the sense that a specific expert knowledge gained the logic and status to discredit other approaches as "quackery". They also explore the ideological and economic factors that contributed to the ways in which different medical systems were imagined as rational or irrational. If one fell ill in early modern times one had access to a considerable array of healers even if one was not well off. There were non-official or half-official specialists for all the more or less clearly defined afflictions: cutters of hernias, tooth pullers for toothaches, bone-setters (who usually also served as executioners) for dislocations, enchanters and wise women for lumbago. The case studies included in this volume (Gentilcore, Jütte, Ramsey) show that patients chose their healers horizontally or vertically, guided by aspects of reciprocity or the search for protection or, in other words, according to a social logic that they themselves determined. The term "medical pluralism" only applies with restrictions here. Prior to 1800, the healing system was neither homogeneous nor harmonious but riddled with conflict. We must nonetheless not base our description of these competing systems on the differentiations we make today between rational and irrational, natural and supernatural, religious and superstitious, especially when referring to the period prior to 1850 when this kind of dichotomy was still largely incomprehensible.

Those papers which focus on the 19th century (Marland, Nicholls, Baubérot, Stollberg) demonstrate that the process of professionalization that has penetrated the health care system since the 18th century had a lasting impact on the medical health care systems in England, France and Germany. The lay system – at least in theory – was no longer permitted to provide any medical services apart from nursing and care. Since the middle of the 19th century an increasing part of the population consulted medical experts when they were ill, even if they were not always university trained physicians but often semi-professional healers (e.g. non-academic surgeons and dentists). The social reasons for their behaviour are obvious. The degree of medicalization, or – more precisely – the density of physicians also played an important part in this. This change occurred as part of the overall modernization of society.

Today we have a clear dividing line between professional and other healers that is strictly monitored by the legislator, for the "benefit" of the patient. Non-medical practitioners nowadays have to undergo training and pass examinations before the relevant authorities to obtain a licence. Traditional healing rituals, reaching from faith healing to the charming of warts, although they survived, have been marginalised. The "new" pluralism requires that complementary therapists operate from a position of needing to establish their status as "experts". This means that the gap between CAM and conventional medicine may be much less than the general public believes, as the pressure exists that CAM should be judged by exactly the same standards used for conventional medicine (i.e. the rules established for an evidenced-based medicine).

The contributions collected in this volume tell us much about the ways in which diversity in medical health care has been achieved and practiced in different cultural and historical settings. They also tell us a lot about continuity and discontinuity, substantiating the findings by Cant and Sharma who stated: "The history of complementary medicine is discontinuous in that the emergence of a dominant medical orthodoxy pushed it into a particular position […]."[4]

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4 Cant/Sharma (1996), p. 20.

Medical Plurality, Medical Pluralism and Plural Medicine. A critical reappraisal of recent scholarship

Waltraud Ernst

Introduction

Since the 1980s and 1990s in the wake of debates on the role of Complementary and Alternative Medicine (CAM) within western societies, the term medical pluralism has flourished among historians and health policy makers in countries across the world. An appraisal of the continued currency of this concept and the insights garnered seems appropriate following nearly three decades of historical, anthropological and sociological studies of different historical and contemporary contexts. This will here be undertaken from the perspective of a social historian who has worked across disciplines, including cultural psychology, medical sociology and social history, with a particular focus on the social, political and cultural context of varied medical paradigms during the age of empire in Asia and the Pacific.

Existing work clearly attests to the fact that the field of healing in all periods and localities has been persistently characterised by a plurality of approaches, presenting a multitude of treatment options for patients in their pursuit of health. The extent to which developments in the late twentieth-century health care market in western countries have in fact been characterised by a "new" kind or a "dramatic reconfiguration" of medical pluralism has been widely debated.[1] Continuities between earlier and more recent periods are emphasised by some, and more current shifts in institutional authority in modern health care environments accentuated by others. Arguably, earlier concerns about the demarcation of "orthodox" versus "heterodox" approaches have been replaced more recently by a focus on the ethics and efficacy of practice regardless of the perceived conventionality of approach.

Two questions emerge. First, have the emergence of a "new pluralism" and the postulated shift from historical antagonism towards acceptance of medical diversity been substantiated? Second, has historical scholarship on medical plurality provided any new conceptual insights since its emergence a couple of decades ago; have there been new developments in the historiography of medical plurality? The first issue was to be investigated at the conference from which this essay results.[2] Here I will focus on the second set of issues, namely an assessment of the historiographic changes, if any, in the field

1 Cant/Sharma (1999); Kaptchuk/Eisenberg (2001).

2 Medical Pluralism – Past and Present. Organized by the Institute for the History of Medicine of the Robert Bosch Foundation, Stuttgart; Centro Italo-Tedesco Villa Vigoni, Loveno di Menaggio; in collaboration with the Dialogforum Pluralismus in der Medizin, Berlin (2011).

of the history of medical plurality. My reflections will mainly be based on the contributions presented at the conference to highlight some of the achievements in scholarship, the continued vibrancy of research and persisting gaps in the field.

"Viewing the Patient" versus "The Patient's View"

In his elegant contribution to "Patientenorientierung und Professionalität", Peter F. Matthiessen illustrated the plurality of medical paradigms and the varied cosmologies and ways of seeing and thinking going along with them by reference to Henry Moore's sculpture "Locking Piece".[3] Depending on the observer's perspectivity or angle of observation, the aesthetic appearance of the very same object varies considerably. Matthiessen is a medical practitioner and his aim was to highlight the scope for building bridges between followers of different medical paradigms, from the mainstream and the complementary medicine fields, by identifying their shared object of interest: the patient. It is in fact among the medical fraternity that the focus on the patient has been most significantly to the fore. "Patient-centred medicine" has during the last decade become a rallying call even for orthodox practitioners who had previously been criticised by patients and CAM healers alike for having lost touch with their main constituency since the heyday of modern, science-based medicine.

Intriguingly, among historians of medicine, patients and their families tend to figure less prominently in Anglo-American scholarship. This is despite the fact that earlier historical work on medical plurality was inspired by the paradigm of social history, which mooted a focus on the "view from below", namely the patients, rather than the traditional emphasis on medical policies and "big men, big ideas, and big institutions".[4] Admittedly, the continued, favoured choice of historical research perspective, which looks at medicine and sees varied medical concepts, a plurality of medical practitioners and a multitude of medical institutions and professional networks in the medical market place, has produced some path-breaking work. For example, heterodox and orthodox medical thought systems and practices and the roles, status and professional inclinations of their varied practitioners have been investigated in relation to different state policies in particular national and cultural settings – in western as well as non-western and post/colonial countries.

A recent example is the volume on "Medicine and the Market in England and its Colonies, c. 1450–1850", edited by Mark Jenner and Patrick Wallis.[5] It provides both geographically wide-ranging, in-depth case-studies of varied medical approaches and a cogent critique of the suitability of the concept of

3 Henry Moore, "Locking Piece". Bronze, 1963–64, Millbank, London. In: Matthiessen (2010), p. 99.

4 See, for the foundational statement on medical histories from below: Porter (1985).

5 Jenner/Wallis (2007).

the "medical marketplace" for pre-modern societies. Another example, in relation to non-western medical approaches, is Guy Attewell's path-breaking "Refiguring Unani *tibb*. Plural Healing in Late-colonial India".[6] It focuses on the varied ways in which a particular medical corpus was practised in late nineteenth and early twentieth-century South Asia. Within the European context, historians working on the pre-modern period, such as Jütte, have deftly employed anthropological methodology to explore healers' networks of practice and the complexity and fluidity of guilds.[7] However, in contrast to these nuanced accounts of how the medical field is characterised by a plurality of approaches and the recognition that practitioners are adaptable and versatile in their approach to and vernacularization of codified and informal ways of healing, patients and their families have remained neglected in historical research in the English-speaking world. Notable exceptions within the German historiography include Dinges's work on patients in homoeopathy.[8]

A further problematical issue concerns the age-old challenge of "structure and agency", which has plagued modern theorists from Durkheim to Bourdieu. This is relevant in regard to historical as well as contemporary policy debates. Even within frameworks that consider patients as active agents, as ever, the structures within which this agency has been socialised and exerts its preferences still require attention. There is an ample literature in the field of the history of (post-)colonial medicine that explores this nexus particularly well. Any investigation into medical plurality worth its salt is bound to investigate both the legacy of structural constraints imposed by legal, religious and professional authorities and particular interest groups and issues of resistance, subaltern agency, continued pluralities, and emerging "multiple modernities" – in addition to an acknowledgment that patients and their families may have other concerns than just the narrowly medical.[9]

In a similar vein, the best and most comprehensive medical anthropological research investigates the full spectrum of political, socio-economic and personal parameters within which medical plurality manifests itself. Etsuko and Eguchi for example explore patients' multiple realities and journeys through varied treatment options available in modern Japan, ranging from conventional medicine and hospital treatment to religious and shamanistic practices.[10] Scheper-Hughes, perhaps more controversially, has highlighted the role of the pharmaceutical industry in the medicalization of hunger and starvation, exploring the social production of illness and patients' responses within the constraints of the exploitative socio-political structures of north-east Brazil and its flourishing medical market in her patient/structure-focused analysis of "The madness of hunger: Sickness, delirium, and human needs".[11] Such

6 Attewell (2007).
7 Jütte (1991).
8 Dinges (2002).
9 Ernst (2007).
10 Etsuko (1991); Eguchi (1991).
11 Scheper-Hughes (1988).

attempts by medical anthropologists to deal with medical plurality within more or less hegemonic and unabashedly exploitative socio-political and medical structures – while clearly putting the life-worlds and needs of patients, their families and communities at the centre of analysis – are still scarce in historical writing on medical plurality and medical pluralism in Europe.

A distinctive attribute of anthropological work has been its focus on patients to a far greater extent than historical research: on patients' and their families' varied perceptions of health and illness; on their diverse illness behaviours; and on their active role in seeking out particular practitioners and medical paradigms aligned with different medical systems (what has been called "healer hopping"). Arthur Kleinman has spearheaded this work and established a school of thought and research methodology that focuses on "illness narratives", namely sick people's narratives about their illnesses and the effect on their lives.[12] In contrast, the way in which the historians participating at the meeting at the Villa Vigoni interpreted their task of providing résumés of medical plurality in a number of western countries remained almost exclusively focused on particular groups of heterodox medical practitioners, their un/official treatments and professional networks, on the one hand, and state policies, professional regulations and, somewhat more testing, the role of self-help movements, on the other. Just one contribution foregrounded the agency of patients rather than the structures within which patients and their families are situated. But even here the investigation accentuated the media (domestic medicine books) to which patients referred for self-medication. For historians, so it seems, the term "medical pluralism" is still mainly perceived from and circumscribed by the perspective of medical discourse and treatments, the structures of professional organisation, state regulation and the networks of healers. The perspective by which the agency of patients and their families could be gleaned still remains largely unexplored. In contrast, for practitioners from complementary and, increasingly, orthodox medicine backgrounds, the patient has moved to the centre of analysis.

Framing the Patient

Practitioners of all stripes in Europe and North America have become acutely aware of the fact that there ain't no medicine and no doctor – qualified in conventional medicine, CAM or as a quack – if there is no potential patient. And as medical anthropologists keep demonstrating, patients and their families are indeed active in their pursuit of better health. As consumers or "stakeholders" in the pluralistic medical market place they may vote with their feet, seeking out particular healers and demanding specific service provisions. Following from this, a currently prominent theme in western countries is "integrative medicine", which is concerned with how the patients' needs can be satisfied in

12 Kleinman (1998).

a professional and ethically sound manner and health services devised that cater for patients' tendency to "healer hop" or consult treatment providers from a variety of different healing paradigms. There is an ambition to move beyond the internecine warfare between mainstream and CAMs that characterised earlier decades such as the 1960s and 1970s – in some countries notably more so than in others. How does the patient figure in the flow charts of clinical research groups and modern health service providers?

The chart below is from Sweden and focuses on the "Key Processes" or research group activities (P) and the "Structures" or organisational elements (S) created by a research group working on the adaptation of the model of "integrative medicine" to the Swedish primary care context. One question to be asked is how easily we can spot the patient in this diagram.

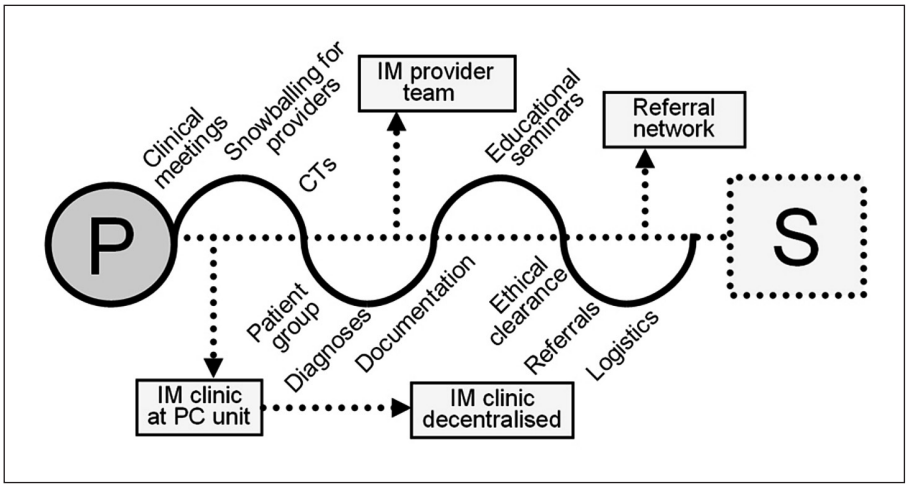

Figure 1: Processes and Structures. Source: Sundberg et al. (2007), p. 3.

The figure refers to the "patient group", lined up alongside other factors such as diagnoses, documentation, ethical clearance, referrals and logistics. The patient is clearly allocated a subordinate role within the processes and structures that characterise this model. Luckily, the Swedish research group developed another chart, which purports to clarify how the patient is supposed to figure in the wider scheme of "integrative medicine" or, as the researchers put it, in a "clinical case management flowchart" (see Figure 2, below).

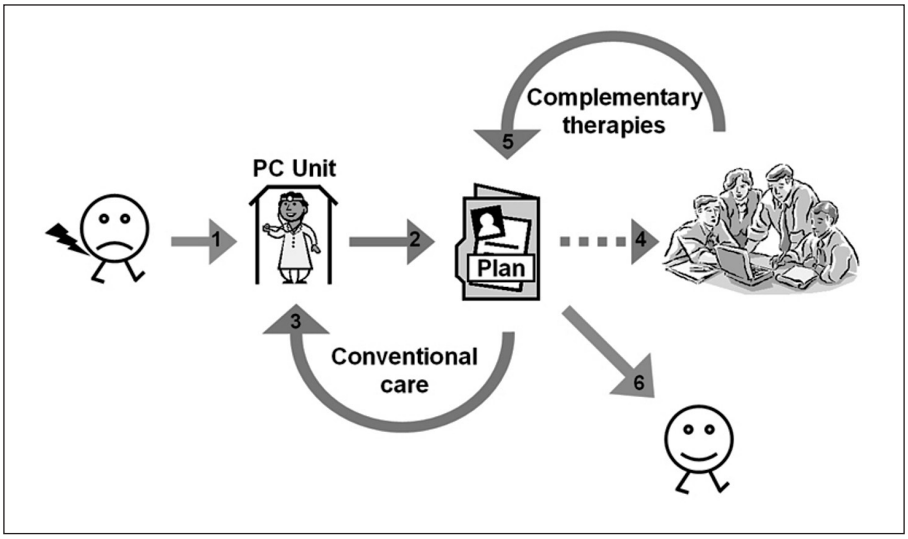

Figure 2: Outcome, the integrative medicine model. Source: Sundberg et al. (2007), p. 6.

Whether the chart indeed clarifies particularly well what is being done to the patient is up for debate. The general idea seems to be: unhappy patient in – happy patient out. What is happening to the patient in between is less clear. Let us see if the further explanations that are provided by the research group help us understand the main processes captured in the model [emphases below are added; WE]:

The integrative medicine model adapted to Swedish primary care illustrated as a clinical case management flowchart:

1) The patient with sub-acute to chronic low back pain or neck pain consults the general practitioner **gatekeeper** at the primary care unit;
2) The patient **and** the general practitioner develop a treatment plan;
3) The patient is **offered** conventional care, i.e. treatment **as usual**;
4) Should complementary therapies **be considered appropriate**, these are integrated into the treatment plan by way of a **consensus case conference** with the integrative medicine provider team;
5) The patient is **offered** complementary therapies as part of the treatment plan, i.e. integrative care;
6) When the treatment plan is completed the case management is finished. **Please note that integrative care was only delivered for up to 12 weeks**.[13]

This Swedish model of integrative medicine in primary care and many others like it are not altogether unproblematic. Where exactly could an active agent be located on the map of pluralistic service provision? We can see the patient at the beginning and at the end, but not anywhere in between. Is the patient being "processed"? How can a self-willed, dynamic factor be fitted in, allo-

13 Sundberg et al. (2007), p. 6.

cated a place, and "framed" – perhaps in the double sense of the term – within the wider context of state regulations and the bureaucratic machineries of professionally vetted and ethically and clinically sound user services? Who drives these kinds of through flows of patients? The conventional doctor? The "IMMPT", which is short for "integrative medicine model provider team"? The health service accountant or research administrator who decides on the length of treatment? The patient? In terms of the language employed in the Swedish model, the conventional practitioner clearly remains the "gatekeeper" – in relation to both patient and IMMPT: the patient is being "offered" conventional treatment first and CAM second, and CAM approaches and their practitioners are being integrated into the treatment plan only if judged "appropriate" by the general practitioner.

It seems that despite the recent attempts to shift attention from "medicine" and "practitioner" to "the patient" as the main subject at the heart of medical pluralism, the patient still emerges – usually as an individual rather than within his or her family or other relevant community contexts – as no less elusive in most of the newly designed clinical service settings than patients and families have continued to be in most historical accounts. Paradoxically, the recognition that patients are active agents whose health behaviours tend to cut across disciplinary boundaries and institutional networks has not prevented the reincarnation of Parson's passive "patient role" within the administrative schedules of integrative and supposedly patient-centred medicine.

In regard to the role of CAM practitioners within the integrative medicine model, their integration may well be considered a step forward from earlier opposition and hostility on the part of conventional practitioners some 20 years or so ago. As Kaptchuk and Miller put it: "Opposition, the traditional ethical position that the medical profession must eradicate unconventional medicine for the good of the patient, has withered away."[14] However, they rightly highlight also the major pitfall of integration, which is that it is being achieved on the terms set by conventional medicine. Like many other practitioners, Kaptchuk and Miller therefore champion the principles of patient autonomy and cooperation between and the integrity of conventional as well as CAM approaches. How these principles can be fitted into flow charts and service provision remains an open question.

Plurality and Pluralism

There is the danger of re-objectifying and "passive-ying" patients by the very means intended to chart the channels of patients' shifting preferences and multiple treatment choices from a pluralistic field of health care provisions. The "patient's view" is clearly not the same as viewing the patient. Arguably, CAM practitioners do not fare much better as they still figure as the poorer

14 Kaptchuk/Miller (2005), p. 286.

cousin of state-sponsored orthodoxy or adjuncts and accessories to the default setting of conventional care or "treatment as usual". Health policies continue *de facto* to favour the vantage point and methodologies of particular professional interest groups, despite acknowledgement of medical pluralism, which, misteadingly, enunciates for many the idea of equitable coexistence of ideas and practices alongside and complementing each other. The ways in which the maps of medical plurality are drawn in various European countries, the United States, and to a certain extent also in Asia, remain indebted to the predominance of the conventional medicine paradigm, which continues to define the conceptual grid and methodological parameters within which other approaches and the patient are to be located.

Paradoxically, an emphasis on medical plurality and on patients' tendency to healer and paradigm "hop" constitutes both an important corrective to and a reminder of how relevant Foucaultian issues of biopolitics and its *Körpertechniken* continue to be. In the former sense the talk of medical plurality constitutes, as Walach has noted, a thorn in the side of orthodoxy.[15] Rallying around the bandwagon of medical plurality enables CAM practitioners to remind conventional medicine of the popularity of heterodox approaches and the need to reserve a space for the latter lest patients vote with their feet. Therefore, to those faced with the continued biomedical domination via the integration of CAM into the conventional structures of healing on the terms set by medical orthodoxy, mulish insistence by CAMs practitioners on plurality constitutes a means by which to shirk such domination.

At this point the clarification of the terms of reference is called for. How can we conceptually grasp the kind of understanding of medical plurality mooted by CAM practitioners in contrast to the one employed by conventional doctors? Here it may be useful to differentiate the notion of medical plurality from the concept of medical pluralism. The tenets of pluralism enunciate the ideology of a kind of modern liberal heaven where all are equal – but some remain more equal than others. Plurality, in contrast, circumscribes a variety or multitude. It may be argued that issues of definition are trivial farfetched wordplay. However, as Heidegger has stressed, "the word is the house or home of being". Terms such as plurality and pluralism – or nation and nationalism – enunciate related though vitally different phenomena. The "isms" enunciate ideologies. This does not mean that plurality and nation are necessarily devoid of imbalances of power. Rather they may not always be adequately grasped in reference to one particular, period-specific mechanism of legitimating power imbalances, such as pluralism.

"Pluralism" indeed has a chequered history, linked, as it is, to the rise of liberalism in the west – a history of contradictions and controversy in the wake of the European Enlightenment and the unfolding of capitalist society. Although aspired to by liberals intent on doing away with dogma, inequality, patronage and "preferentialism", pluralism has a more sinister side as it is also

15 See Walach's essay in this volume.

referred to in contexts characterised by structural inequity. In the latter case, the appeal to pluralism in society has been instrumental in the cover up if not reification of power imbalances, even the sidelining, subordination or subjugation of particular strands of thought, practices and communities' expression of their individual identities. Pluralist societies are not aloof from power politics and hegemonies; they can be a hotbed of them.

To a certain extent, the insistence on differentiating medical plurality and pluralism has its counterpart in more recent concerns about the use of the language of "the medical market" in historical writing. As in the case of medical pluralism, reference to terms such as "supply and demand", "free markets", "commercialisation" and "consumer society" are appropriate only in regard to a particular period, i.e. when the phenomena enshrined in them emerged during the modern period. Gentilcore and Jütte, in their work on healers in pre-modern Italy and Germany respectively, focused on "healing communities" and the openness of and fluidity between specific medical approaches in order to accommodate period-specific concerns and dimensions.[16] They emphasise that the language and notions of the market and pluralism sit uneasily and inappropriately alongside notions of religion, magic, guilds, charity and corporatist structures.

Despite such concerns, the terms medical pluralism and medical market have been used by historians in a merely descriptive way in relation to a variety of historical and geographic contexts to capture the pluralistic and economic aspects of medical practices respectively. Therefore, as pointed out by Jenner and Wallis in relation to market terminology, "its meaning has become vague to the point of confusion".[17] More importantly, its rise during the 1980s characterises late twentieth-century political preoccupations with the ideologies of free markets and the rollback of the state in particular European countries and in North America. The use of market and, arguably, pluralism terminology in historical analyses may therefore be woefully "presentist". Greater precision in the application of enduringly fashionable terms and awareness of their historical and ideological legacies is required lest medical historians mistake historiographic for historical phenomena.

Plural Medicine

In the 1990s, the renowned German philosopher of hermeneutics, Hans-Georg Gadamer, published "The Enigma of Health".[18] He argued that healing is akin not to science but to art, whereby the practitioner is a facilitator who merely helps the patient to "find their own, independent way" on the path to

16 Gentilcore (1998); Jütte (1991).

17 Jenner/Wallis (2007), p. 2. See also Pelling (2009), p. 343.

18 The work was not widely received in English-speaking countries, although a translation was made available in 1996. Gadamer (1996).

recovery from illness.[19] According to Gadamer even modern biomedicine consequently finds itself in "an exceptional and problematic position" *vis-à-vis* other forms of knowledge, with practitioners being pulled in the two different directions of growing scientific rationalization on the one hand and the patient-focused delivery of prudential, personalised treatment on the other.[20] In Gadamer's understanding medicine is practised in a multitude of ways, as successful practitioners will not only interpret and implement medical theories and learned dogma in varied ways but also adapt them to suit different kinds of patients. Within this framework, health and, by implication, medicine are necessarily what I would call "plural".[21] There is a difference between "plural medicine" and both "medical plurality" and "pluralism". Plural medicine signifies that medicine *per se* is always 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.

Seeing any medical approach as plural in itself is particularly relevant in relation to the conference "Medical Pluralism – Past and Present". Here the focus was on medical traditions with a strong literary heritage or grounded in a historical canon of medical texts and therapeutic practices, which despite many changes and transformations retain their value as formative elements of socio-cultural identity. This is particularly relevant in relation to what is often referred to as "indigenous" healing practices common in specific regions, such as Ayurveda, Unani and Siddha in South Asia, for example. Such "traditional" Asian practices have become part of the CAM field of healing in western countries in a multitude of modified and re-imagined versions that better suit the needs of European and American patients. In the history of medicine the focus has usually been on the transfer and dissemination of the western medical model from the west to the east. While this may have been the case in relation to developments during the age of western imperialism, from at least the late twentieth century onwards the globalisation of medical practices has not been a mere one-way traffic. Ayurveda, for example, has been "exported" to the west from India and subsequently re-imported, as its newly westernized and various New Age forms appeal to a largely urban, cosmopolitan elite. Westernized New Age Ayurveda has also been modified further and re-imagined to better resonate with local needs and perceptions in India. These processes of re-invention and re-imaginings have received much attention recently, with earlier concepts such as "hybridization" being replaced with those of the "vernacularization" of, and circulation, crossover and entanglement between, varied medical approaches.

Neither the currently fashionable conceptualization of "indigenous" healing practices as dynamic and subject to globalisation, localisation and re-localisation, nor the phenomenon itself are new in the sense of being a specifically

19 Gadamer (1996), p. 109. "Treatment always also involves a certain granting of freedom."
20 Gadamer (1996), pp. 32–33, 39; see also Dallmayr (2000).
21 Ernst (2002).

modern or recent phenomenon. The phenomenon of "vernacularization" of approaches originating in Europe has been traced for both heterodox and orthodox medicine. For example, in my work on mesmerism in British India during the early nineteenth century, I have shown how an approach considered as heterodox (even fraudulent) in Britain was introduced by a Scottish Presbyterian doctor to hospitals and lunatic asylums in Bengal. Here it was adapted with great success to local requirements by his Indian subordinate staff.[22] And Mukharji has shown that even conventional western medicine underwent reconfiguration and was being "vernacularized" or adapted to the socio-cultural needs of patients and practitioners in late nineteenth and early twentieth-century India in the shape of "Daktari" medicine.[23] Clearly, earlier historians' focus on East-West and North-South divides and on one-way transfer and the globalisation of the western medicine paradigm has been superseded by increased emphasis on local modifications and adaptations and on the links and exchanges between nations and localities across the globe.[24]

One persistently contentious issue concerns the point that there may be disagreements among and between scholars and practitioners about which one of the many kinds of Ayurveda, for example, might be closest to any supposedly "original" blueprint. Would it be appropriate to assume that those practices mentioned in the ancient Indian Vedic texts, for example, are the truly authentic ones, preferable to the practices and procedures focused on in modern-day Ayurveda? 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 and practices of particular approaches are relatively recent re-inventions of tradition (as in the case of Traditional Chinese Medicine[25]) or akin to modern re-imaginings on the basis of current needs (as in modern Yoga, for example[26]), and therefore at times but faintly linked with any one of the various brands of medicine practised in South Asia or China centuries ago? Ultimately, the question arises of how we could define, delimit and "frame" any one particular medical approach if we think of them as intrinsically plural and therefore as perceived and practised in a dynamic, versatile and pluralistic way in different locations and points in time – in South Asia and China as much as in Europe and North America.

22 Ernst (2004).
23 Mukharji (2009).
24 See, for example: Ernst/Mueller (2010); Digby/Ernst/Mukharji (2010).
25 Scheid (2002).
26 Ernst (2003).