# Health care, hierarchy and the intracultural politics of recognition: Medical pluralism and its narratives as ethnographic objects

*Helen Lambert*
*University of Bristol*

Medical pluralism has been a major topic of interest among anthropologists working on health, illness, medicine and treatment in diverse regional settings for the past half-century. Studies explicitly focused on explaining the "co-existence of medical traditions" were particularly common in the latter decades of the twentieth century since when interest in the topic, so defined, appears to have declined[1]. This paper briefly summarises some trends in anthropological scholarship associated with the rise and fall of interest in this topic and discusses ways in which "medical pluralism" has frequently been misconceived, before introducing a case study of India in order to demonstrate the possibilities of an alternative conceptualisation[2].

Prior to the formulation of "medical anthropology" as a named and distinctive subfield of the discipline, anthropological attention to (then almost exclusively) non-Western understandings of ill health and modes of treatment was primarily centred on religious and ritual responses and – as in the famous examples provided by the work of Rivers (1924) and Evans-Pritchard (1937) – sought principally to demonstrate the situated rationality of indigenous understandings in the context of local cosmologies. In the post-World War II era when anthropology first came to be associated with development initiatives in these former colonies, anthropologists began to be recruited into international health promotion and disease prevention efforts to help shed light on the superficially puzzling phenomenon of majority-world peoples either being reluctant to utilise western medicine, or continuing to use other non-biomedical forms alongside it (see for example Paul 1955). Thus the study of "medical pluralism" was born, and anthropological interest in documenting the diversity of modes for dealing with ill health within particular settings continued to grow through the 1970s and 1980s. This arose in part from a preoccupation with cultural

change and a desire to capture indigenous modes of knowledge that were seen to be changing irrevocably as biomedicine became globally established (see for example Frankel & Lewis 1989). Ethnographic studies of medical pluralism have helped to contest normative assumptions associated with modernization theory about the inherent superiority of biomedicine and the provision of care in official health policy that posited the eventual disappearance of all other modes of treatment (Lambert 1996; Leslie 1980; Leslie & Young 1992: 3; see also Lock & Nichter 2002: 3-4).

The identification of "medical pluralism" as a phenomenon worthy of interest can thus itself be seen as anthropology's key response to observations of the increasing pervasiveness of biomedicine across the globe in the last half of the twentieth century. The deployment of this term deliberately sought to give a place to the whole variety of medically-related ideas and practices within a given setting whereby «Western "cosmopolitan medicine" or "biomedicine" […] was shown to be one system among many» (Roseman 2002: 111). Unfortunately, the diverse components to be found in any medically plural setting have frequently been misrepresented as notionally equivalent health care options and efforts to conceptually level out an uneven playing field have had the effect of obscuring power differentials between different medical "systems" (Khan 2006). This is exemplified in a still-influential model of health-seeking that portrays the entire gamut of health care practices and responses to illness as a single (national or regional) "health care system" (Kleinman 1980), among which patients move at will among different sectors and (sub)systems of health care. Although effective in bringing to light the continuing importance of non-biomedical therapeutic modalities, such a rendering of medical diversity obscures the structural distinctions that affect political legitimation and practical access through regulatory mechanisms, and elide historical processes that have shaped the contemporary structure and form of medical plurality itself (cfr. Leslie & Young 1992). In this way many studies ostensibly of medical *pluralism* ("the character of being plural", Oxford English Dictionary) have been more simply studies of medical *plurality* ("the state of being plural; the fact or condition of denoting, comprising, or consisting of more than one", OED).

Emphasis on the interplay between "global" biomedicine and "local" traditions and on the effects on local medical cultures of the arrival of biomedical institutions and technologies, as well as a general tendency to focus on more esoteric, elite and putatively autochthonous components of medical diversity rather than on mundane or subaltern elements of medical practice (Frankel & Lewis 1989; Lambert 2012a) have also often obscured attention to the internal socio-political structuring of medical diversity. Portrayals of medical pluralism frequently oppose indigenous

institutions to biomedical ones, highlighting the ways in which biomedical technologies and practitioners come to be valorised over local ones or examining differences in their knowledge systems, but ignore "internal" hierarchical stratification among the various medical traditions, practices and practitioners as they are arranged within particular geographical settings. This stratification – seen for example in terms of differential access to official recognition and government resources or gradations in the social prestige afforded to different therapeutic modalities, often underpinned by structural characteristics of gender, class, caste, ethnicity and religious identity among practitioners and their clientele – is particularly obvious in country contexts where codified (textually based) medical traditions are to be found, but is likely to be universal. Accounts of pluralism that emphasise the nature of medical diversity frequently conceal the existence of embedded social inequalities in the preferment of different therapeutic modalities or differentials in access to these modalities among different sections of the population (Broom, Assa & Tovey 2009). Issues of governance and the role of the state in shaping medical pluralism per se – the latter a strong focus among medical historians and recently among anthropologists working on global public health issues – have also been less well examined[3].

A full exploration of these issues and a corresponding shift in focus to intracultural translations (Burghart 1996) among medical forms and social actors within particular social settings and on the uneven ground upon which we impose the construct would require us to abandon "medical pluralism" as an organising framework and reconceive it more clearly and consistently as an ethnographic object. The case for such an approach is unpacked in the following case study, with particular reference to India as an ethnographic example.

## Medical pluralism in South Asia – a potted history

In South Asia a great variety of medical traditions and therapeutic practices co-exist and India has repeatedly been described as an exemplar of "thriving" medical pluralism (Sujatha & Abraham 2012). As in other Asian settings, therapeutic diversity includes not only a variety of non-institutionalised and orally transmitted traditions that show regional variation, but also a number of textually sanctioned or "codified" and accredited systems of medicine. These codified systems are contributing to an expansion in the range of therapeutic forms available elsewhere in the world (see for instance Banerjee 2009; Bode 2006, 2008 describes the commodification of Ayurvedic preparations and Zimmerman 1992 discusses changes in Ayurvedic theory and practice consequent on its uptake among Westerners). Meanwhile, introduced forms of non-biomedical therapy (such as homeopathy,

introduced in the early 20th century and more recently, acupuncture and acupressure) have expanded the range of medical diversity within the subcontinent (Bhardwaj 2010). In the past decade, the Government of India has accorded an unprecedented degree of recognition to certain non-biomedical traditions in its national health policy, as discussed further below (GOI 2003, 2010; Chandra 2011). Thus while accounts of medical pluralism elsewhere in the world have tended to posit a binary division between biomedicine and "other" forms, in India the latter are split into codified and officially sponsored medical forms on the one hand and informal traditions on the other, producing a tripartite hierarchy of biomedicine; state-legitimated medical traditions; and what is usually described as folk medicine, which until recently was «either tolerated as harmless superstition or directly opposed as mendacious and potentially harmful "quackery"» (Hardiman & Mukherjee 2012: 8). While anthropologists have studied individual "folk traditions" in detail, anthropological research and official representations of India's medical pluralism alike have paid relatively little attention to the official and unofficial hierarchies between traditions and how these shape access to and utilisation of these diverse forms of therapy for different sections of the public, as well as historical shifts in these hierarchies (cf. Attewell, Hardiman, Lambert & Mukherje 2012). Moreover, the ways in which analytical frames for understanding temporal changes in the configuration of medical diversity both replicate and are translated into vernacular explanatory narratives have been largely overlooked. In what follows, I attempt to characterise some historical broad trends in approaches to "medical pluralism" with particular reference to the Indian context, before offering some empirical examples from recent research to illustrate this alternative conceptualisation.

With the exception of WHR Rivers (1924), whose posthumously published seminal contribution to the comparative study of medicine was based on his work among tribal peoples in the Nilgiri Hills of south India, little early anthropological work focused on medical or health-related phenomena. Early medical anthropological studies in India took their lead from the more general post-second World War trends described above when anthropologists started to take an interest in modernization and development. An initial assumption here as elsewhere was that the primary explanation for the continuing use of other non-biomedical forms was to be found in cultural "barriers" to the use of biomedicine – the domain of anthropology. Early studies (Gould 1965; Marriott 1955; Opler 1963) offered explanations of observed preferences in terms of "cultural resistance" (Sujatha & Abraham 2012: 14), although some authors offered more nuanced accounts variously of hierarchies of preferment, the interplay of faith and treatment, or the political economy of health at work in medically plural situations (Beals

1976; Carstairs 1955; Djurfeldt & Lindberg 1975). Questions of interpretation aside, research into medical plurality during this period mainly focused on lay people's perceptions and actions in regard to the treatment of illness and on forms of ritual healing rooted in local cosmologies. Thus studies of the medical domain in this phase were concerned in one way or another with the "folk". Towards the end of the twentieth century, however, two key shifts occurred in social science approaches to the study of the medical sphere. First, it became apparent that what in India is termed "allopathic" medicine was widely accepted and indeed, was actually in great demand (although, in reality, preferment of "English medicine" – as biomedicine is termed in Hindi – for the treatment of certain complaints had been evident from at least the late nineteenth century (Lambert 1995, 1997). In India, sociological and public health commentators argued that biomedicine was readily accepted and that the continuing use of other therapies was a response to the relative inaccessibility and poor quality of biomedical care in rural areas (Banerji 1973). Other sociologists began to study biomedicine and aspects of the formation of modern health services directly (Minocha 1980; Madan 1969, 1972; Jeffery 1988). In contrast, most anthropological scholarship paid relatively little attention to the economic, structural and institutional dimensions of health care provision or to differentials in access to the range of medical forms.

There was an additional, regionally specific impetus to the move away from studying "folk" aspects of health care (people and practitioners). In the wake of Louis Dumont's (1970) seminal work on caste and influential call to establish a comparative sociology of India that would give due weight to the civilizational character of Indian culture, anthropologists largely turned away from village-based ethnography to focus on particular social and cultural institutions. In the medical sphere, the existence of textually-based or "codified" medical traditions gives a different configuration to the form and character of medical pluralism than in other parts of the globe where therapeutic forms other than biomedicine are rooted exclusively in oral tradition. The need to give adequate weight to textual authority as manifest in these codified forms was given significant impetus by the work of Charles Leslie (1976) and most anthropological research on medical traditions in the Indian subcontinent since the 1980s has focused largely on one or other of the textually-sanctioned medical traditions of Ayurveda, Unani and Siddha (see e.g. Langford 2002; contributions to Leslie 1976, Leslie & Young 1992, Sujatha & Abraham 2012; Zimmerman 1982). Although Leslie (1976: 6) himself argued that «[A]ccess to medical knowledge and to consultation with specialists is another critical variable for comparing medical systems», emphasis on studying the formation and character of single codified traditions has been sustained to date, in spite

of the fact that these forms of medicine have, at least until recently, only ever served an elite minority of the population.

One consequence of this selectivity of scholarly attention is that anthropological work has failed to challenge official representations of "medical pluralism" (the character of medical diversity). Most of what has been written about both South Asian health care and more specifically about medicine in India, whether in academic scholarship or in health policy circles, has treated Indian medicine as essentially comprising the institutionalised textually-based medical traditions, both indigenous (Ayurveda, Unani and Siddha) and introduced (biomedicine or allopathy and homeopathy). Between Independence in 1947 and the first decade of the 21st century, government policy recognised only the "Indian Systems of Medicine" (ISM), originally defined as Ayurveda, Unani and Siddha, to the exclusion of non textually-based traditions. The latter – ranging from travelling mendicants, bonesetters and village midwives to exorcists, herbalists, shrine priests and snake-bite curers, many of whom practice part-time and without direct remuneration – were either disregarded by the state or lumped together with unqualified doctors who use biomedical techniques and technologies as 'quacks' (e.g. Rao *et al.* 2011: 3; Sheehan 2009).

## Narratives of decline: Medical pluralism goes global

In the past two decades, in India as elsewhere a preoccupation with "pluralism" and the co-existence of diverse traditions has been replaced by an increasing emphasis in the social science literature on the globalisation of biomedicine, particularly in relation to pharmaceuticalisation, reproduction and the influence of biomedicine on local constructions of health and the body (see for example van Hollen 2003; Cohen 1998; Ecks 2005). The insistence, however flawed, on the diversity of therapeutic options inherent in the construct of "medical pluralism" and the consequential neglect of political and moral economies shaping health has, it seems, led to its timely abandonment in favour of a focus on the geopolitical economies of bioscience and bioethics. The continuing importance of what is termed in policy circles the "informal sector" in providing health care in India is well known (Rao *et al.* 2011), but study of the numerous semi-qualified and unqualified providers of biomedical care (often referred to as Registered Medical Practitioners or RMPs) has largely been left to applied work commissioned by international development agencies, while anthropological studies of indigenous therapy are increasingly rare and have continued to concentrate either on the practice of codified traditions or on religiously based therapeutic modalities (e.g. Barrett 2008; Sax 2009).

While the pervasive and expanding influence of biomedicine, the pharmaceutical industry and global markets for bioscience, donor organs and surrogates undoubtedly constitute eminently worthy objects of anthropological study, this scholarly shift in focus can also be viewed as implicitly endorsing the dominant modernist narrative of decline with respect to indigenous medical forms whereby, as described above, a gradual displacement and then elimination of "traditional healers" was assumed to be inevitable. Although the above-described shifts first to the study of major codified systems of medicine from an earlier "village-based" approach and secondly to the influence of global bioscience was both desirable and significant, in ceasing to attend to non-codified aspects of indigenous therapeutics, anthropological scholarship has implicitly assented to the reality of this narrative of decline rather than treating the narrative itself as worthy of ethnographic investigation. Pharmaceuticals may be readily available in local medicine shops and the urban poor and lower middle classes in particular may be increasingly dependent upon variably competent biomedical practitioners and their pharmaceutical representatives, but medical plurality has by no means disappeared. During intermittent fieldwork in Rajasthan over several decades, local informants have frequently expressed the view that the 'old' traditions were nowadays of little significance, while further probing has invariably revealed instances where they or their family members had utilised traditional modes of treatment; and casual observation readily throws up, for instance, a popular new shrine reputed to treat cases of stroke, the continuing use of subaltern therapies such as the ritual of *jhara* ("sweeping" out of certain conditions), or resort to local bonesetters for musculo-skeletal problems. Such observations suggest that narratives of decline are not merely objective characterisations of changing conditions that anthropologists should document but also an intracultural discourse about medical pluralism expressive of an exclusive vision of modernity.

## Selective systematisation and knowledge extrusion

In the twenty-first century, Governmental recognition of "traditional medicine" has expanded from a delimitation of the traditions designated as "ISM" (Indian Systems of Medicine – Unani, Ayurveda and Siddha), to encompass a more eclectic range denoted by the acronym AYUSH (Ayurveda, Yoga and Naturopathy, Unani, Siddha, Homeopathy and, since 2011, Sowa Rigpa). This expansion could be read as offering an expanded definition of medical diversity and an increasing willingness to accept different varieties of medical tradition as legitimate modes of health care. However, the content of what is deemed "traditional medicine" by the Department of AYUSH within the Ministry of Health and Family Welfare only includes discrete

"systems" that have been selectively reframed as exclusively naturalistic, compatible with scientific principles (even if not – as yet – "evidence-based") and institutionalised through the provision of formal avenues of college training leading to state-accredited qualifications. Modelled on the template of medical education established for the biomedical health professions, these other medical traditions are thereby rendered amenable to State governance and incorporation within state health care systems (Lambert 2012a).

Many historical and sociological studies (e.g. Attewell 2005; Hardiman 2009; Langford 2002; Leslie 1976) have shown how the textually-based Indian medical traditions have undergone significant transformations in the revivalist process of being systematised and professionalised. Ayurveda as taught and practised for the purpose of an accredited college degree is not the same as Ayurveda taught and practised by "traditional" vaidya whose experience-based knowledge and understanding of particular Sanskrit or vernacular texts is passed on through apprenticeship modes of learning. Lang has described how one branch of classical Ayurveda, *bhūtvidyā*, that attributes what is now rendered "mental illness" to spirit possession and sorcery, has largely been excluded from the syndicated version of Ayurvedic psychiatry that is taught in accredited college syllabi (Lang & Jansen 2013), an observation that concords with my own conversations with Ayurvedic teachers about *bhūtvidyā* at a government Ayurvedic college in Rajasthan 25 years ago. These "irrational" aspects, excluded from formal Ayurveda in its pursuit of legitimacy on the grounds of scientific rationality, continue to influence vernacular understandings of mental illness and interpretations of Ayurvedic treatment.

Processes of legitimation entailing state recognition and the incorporation of particular systematised medical forms into governmental health systems thus always also entail the exclusion of other forms. As with the example of Ayurvedic psychiatry above, elements of codified knowledge that have been extruded from systematised versions of the traditional corpus continue to be found in vernacular versions. The case of vessel manipulation for dealing with abdominal disorders provides an analogous example in the non-codified sphere. In rural Rajasthan, a technique of massage provided by lay experts in this technique is ubiquitous for the treatment of abdominal disorders. Based on generalised ethnophysiological understanding of such disorders as associated with a system of internal vessels that can be inadvertently displaced, it has no contemporary place in formal Ayurvedic education or practice, although Ayurvedic Sanskrit texts clearly describe the system of vessels to which these techniques of manipulation are directed (see Lambert 2012a for a fuller account). In other cases, one consequence of such extrusion has been a splitting of what earlier constituted a continuum across elite and vernacular domains into two streams, where dual "versions" of a particular tradition can be found. In the case of Siddha, the south Indian traditional

medical system that shares many features with Ayurveda but draws on yogic and alchemic philosophies, Sebastien describes the continuation of a tradition of medicine among unqualified practitioners whose expertise is transmitted through familial or voluntary apprenticeship, as distinct from the Siddha medicine that is taught in government and private medical colleges. The former type of practitioner, being unqualified, is not legally permitted to practice medicine and thus is formally inferior to his/her qualified counterpart but is commonly seen as acquiring superior training and greater expertise than college training provides (Sebastian 2012).

Similarly Jansen (2016) describes the trajectory of Naturopathy, a modern medical tradition which originated in Europe as "nature cure" and was refined and popularised in India by Mahatma Gandhi. Jansen describes how, since the opening of the first Naturopathy college in 1970, this tradition has split into two strands: those trained in state-recognised colleges to degree-level (where they are awarded a BNYS – Bachelor of Naturopathy and Yogic Science) as professional naturopaths; and unqualified practitioners, termed "psycho-nutritionals", who are mainly concentrated in parts of Kerala state. Since 2010 professional practitioners in Kerala state have been able to register themselves under the Department of AYUSH so that while this institutional version of naturopathy is government recognised, those without accredited college qualifications are technically practising illegally. The particular irony here is that both types of naturopath promote a form of health care based on Gandhi's notion of "self-rule" that holds ill health to be result of inappropriate lifestyle and particularly, diet, with illness seen as potentially remediable by self-regulation and dietary modification. Psycho-nutritionals, in rejecting the requirement to professionalise, uphold the tenets of this therapeutic modality and its emphasis on self-reliance and avoidance of "medical" intervention, while professional naturopaths regard unqualified practitioners as lacking the basic training in aspects of physiology and biochemistry that enable them, by contrast, to treat patients safely and effectively.

These illustrations not only demonstrate the need to move beyond the official tripartite portrayal of medical forms in describing medical pluralism and accounting for its contemporary configuration, but also to begin to examine how these processes influence perceptions of authenticity, the selective retention and transmission of technical content, and access to particular modes of treatment.

## Legitimation and marginalisation as constitutive processes

Despite the portrayal of Indian "traditional medicine" both in international health and in national rhetoric as the main source of treatment for the majority of the population, given continuing limited access to biomedical

care for the poor and rural populations, the codified medical traditions have in most parts of India been a ready source of health care mainly for the elite. Traditional Ayurveda and Unani in the pre-colonial era was not widely available to the rural masses, although in the princely states some royal patrons and wealthy merchants sponsored free dispensaries for the poor as an act of charity (Lambert 1997). Similarly, biomedical care has been readily available only to those with the economic means to ensure access to high quality biomedical institutions while, due to rampant corruption and chronic underfunding of the governmental health system, rural populations and the urban poor are frequently reliant on a simulacrum of biomedical care provided by inadequately trained private practitioners (Hardiman & Mukherji 2012: 14).

From the colonial period onwards representatives of the various codified forms of Indian medicine have lamented its decline as a consequence of governmental neglect and under-resourcing following the withdrawal of more traditional sources of patronage. Subsequent processes of systematisation and professionalization may have unforseen effects that have yet to be examined. In some respects these processes have, as described in the previous section, resulted in a narrowing of certain elements of the knowledge corpus and a reframing of legitimated traditions along the lines of western science, probably contributing (despite the existence of reserved seats for particular marginalised caste communities under affirmative action schemes) to the maintenance of a relatively restricted social and economic profile among indigenous practitioners of these codified traditions. However, over the past two decades, in consequence of state liberalisation policies the number of private as well as government training colleges has substantially increased, leading to significant growth in the total number of qualified practitioners of AYUSH (the accredited forms of medicine). Together with the launching of a government strategy to improve health care provision in part by posting a qualified AYUSH doctor in every Primary Health Centre covered by the National Rural Health Mission (NRHM)[4], this expansion in the availability of non-biomedical education is likely to facilitate an unprecedented degree of access to AYUSH medicine. However, policy statements that qualified AYUSH doctors are being incorporated into primary care facilities on the grounds of increasing patient choice are coherent only if one accepts the official representation of AYUSH as a unitary category, analogous to the manner in which in Euro-American settings the various diverse forms of Complementary and Alternative Medicine have come to be treated, in contradistinction to biomedicine, as a single category known as "CAM". In reality, it is implausible that patients' choice will necessarily be met by the provision of a single AYUSH doctor at an outpatient facility if, for

example, that doctor happens to be a qualified homeopath and a patient wishes to obtain, say, Unani treatment.

The appeal to patient choice as grounds for the establishment of AYUSH practitioners in government primary care facilities is generally seen as a figleaf intended to justify a policy instituted for an entirely different purpose. The main reason for initiating the incorporation of non-allopathic therapies into the public health system is, from the perspective of the state, that it offers a cheap way of plugging the longstanding gaps in public health care provision to the rural poor in "underserved" areas where biomedically qualified practitioners refuse to work[5]. This uneven distribution of medical forms has major implications for issues of equity regarding access and for local and national configurations of medical plurality, as well as speaking volumes about the gradient in prestige afforded to biomedical and AYUSH practitioners respectively. Yet qualified *vaidya*, *hakim* and other AYUSH practitioners, who have significantly lower social and professional status than allopathic doctors, are in turn superior to practitioners of uncodified medical traditions, as an example from my own research into non-professional therapeutics will illustrate.

## The marginalisation and continuation of a local tradition

There has been a tendency to assume that, with the exception of the traditional midwife (*dai*), non-codified therapeutic traditions in South Asia are exclusively religious in nature (Lambert 1997, 2012a: 111-112) and I have suggested above that studies of medical pluralism in India have largely ignored other therapeutic practices that continue to exist beyond the purview of the state. The effects of historical shifts in the preferment of different medical forms by local populations and of changes in governance of these therapeutic forms have consequently remained largely invisible. Earlier work however showed that in the colonial period, certain secular therapeutic specialisations – primarily those dealing with complaints requiring surgical intervention – disappeared in the first half of the twentieth century following the introduction of European medicine (Lambert 1997). More recent (2009-10) fieldwork and archival research on vernacular therapeutic forms has suggested that, conversely, at least one therapeutic modality has maintained its standing in the years since Independence, despite progressive marginalisation by the Indian state.

Bonesetters or more accurately, "bone doctors" (*haad vaidya*) are a particular kind of unqualified but often hereditary urban practitioners who specialise in the treatment of musculo-skeletal problems using both manual manipulation and herbal ointments. My research documented the presence of around 30 such practitioners in the state capital of Jaipur,

many of whom practiced their occupation full-time, and analogous traditions are found widely throughout south India (Unnikrishnan, Lokesh & Shankar 2010). In Rajasthan, they provide a well-known source of therapy for fractures, sprains and other musculo-skeletal problems beyond state-sanctioned forms of medical care. These practitioners were, in the decades following independence, entitled to seek state registration under the Rajasthan state Board of Indigenous Medicines, as were other types of practitioner who had not obtained a formal degree through a State-recognised college (Lambert 2012b). Since apprenticeship was still at that time still the predominant mode of medical training in all forms of indigenous medicine, "mode B" registration was established to allow "experience-based practitioners" who lacked an accredited college qualification in Ayurveda or Unani to obtain registration by passing an oral examination (Board of Indian Medicine 1953).

The regulatory Board which conducted vivas to examine the experiential knowledge of bonesetters and other uncredentialled practitioners seeking registration under the "experience-based" mode consisted in representatives from allopathy (a MBBS-qualified doctor and a registered nurse) as well as practitioners possessing accredited degrees in Ayurveda and Unani respectively. This clearly illustrates both an established hierarchy among indigenous therapeutic forms and the way in which, while "Indian medicine" and its practitioners are regarded (and regard themselves) as inferior to biomedicine, at lower levels of the therapeutic hierarchy the systematised medical traditions that offer standardised training are structurally superior to non-codified medical traditions and are officially authorised to appraise them.

After the passing of the Central Council for Indian Medicine Act in 1971 establishing an apex body for registration and accreditation of Indian medicine degrees nationwide, the "mode B" avenue of state-level legitimation for non-qualified practitioners was withdrawn. It was the presence of Board registration certificates from the 1950s and 1960s hanging on the walls of a number of bonesetters' clinics that first alerted me to this subaltern history of legitimation and marginalisation (see Lambert 2012b for a more detailed discussion).

This brief sketch demonstrates that state regulation may have important and unexpected effects on the content and form of medical pluralism; in the case of the north Indian class of "bone doctors" who were the focus of my recent fieldwork in 2009-2010, delegitimation did not lead to the disappearance of this medical tradition. Indeed the positioning of this therapeutic modality at the margins of the State and its relative invisibility to statutory authorities may in part be responsible in part for its continuing existence. This contrasts with other modalities

such as the vernacular tradition of barber-surgery, which in Jaipur appears to be in terminal decline following practitioners' moves to professionalise by seeking accredited degrees in other, codified forms of indigenous medicine. In 2009-2010 I identified three *jarraha* or barber-surgeons (including two generations of one family) who were still practicing medicine and minor surgery in Jaipur under this title (see Lambert 1995 for an earlier account of a rural *jarraha*), and who all had college degrees in either Unani medicine or (in one case) homeopathy. Other local informants opined that barber-surgery as a hereditary occupation has all but disappeared and noted that the sons of families formerly practising this occupation had turned to other lines of work. They explained that the traditional role of *jarraha* as circumcisors to the Muslim community – a specific ritual procedure clearly linked to the broader surgical expertise associated with barber-surgery – had been displaced by the provision of circumcision services provided by biomedically qualified practitioners through charitable organisations associated with the local mosques. Nevertheless, two of the *jarraha* I met stated that they do still perform circumcisions as well as continuing to specialise in treatment and minor surgery for skin complaints in line with their hereditary occupation.

The temporal dimension in this comparative example illustrates the need to determine empirically how "medical pluralism" is configured historically and structurally. It further shows how important hierarchies among indigenous therapeutic forms, changes in their relative status and differing pressures to professionalise or transform practice are rendered invisible when these forms are aggregated into the unitary categories of "traditional (codified) medicine" and "folk medicine" (by anthropologists), or "AYUSH" and "local health traditions" (in official terminology); even more so when these forms are represented as structurally equivalent components of a "thriving" medical pluralism with the latter treated as a conceptual framework rather than as an empirical object of enquiry.

## Discussion: From conceptual category to ethnographic object

While the process of professionalization of indigenous practitioners has been widely documented, it is often seen as a straightforward manifestation of competition with or mimicry of biomedical arrangements (but see Last 1990 for a programmatic statement that analyses professionalization in relation to types of state governance). The role of the state and attention to forms of governance as constitutive of medical pluralism (the character of medical plurality) is particularly crucial, not simply as a means to understand

the effects of political formations in shaping both the character of and access to elite and subaltern therapies, but also for conceptual reasons, as illustrated by the above example. The official designation and naming of a category tends to transform its object and this is especially clear in processes whereby non-biomedical therapeutic forms are institutionally classified and recognised. In Europe, for instance, as mentioned above "CAM" is increasingly referred to and analysed in policy initiatives and academic research alike as a unitary category, although many complementary and alternative medical forms have nothing in common epistemologically or therapeutically beyond the singular fact that – like "traditional medicine" elsewhere – they are not biomedical. This designation does not merely name a class of therapies but, like all forms of translation, creates of itself a new ethnographic object. Anthropologists have often confused these objects with analytic categories.

The recent move in India to valorise non-codified medical traditions provides an apposite illustration. In 2005, as part of the establishment of the National Rural Health Mission, the Government of India not only proposed the integration of qualified AYUSH practitioners into primary health care as described above, but also advocated for the first time the "revitalisation" of "local health traditions" (MOHFW n.d.). On the one hand, the terminology of "revitalisation" demonstrates continuity with prevailing modernist assumptions that such traditions are always-already disappearing. On the other, the recognition of a role for non-codified therapeutic modalities that would once have been designated as "folk medicine" signals an important shift in Statist views from a position of neglect to a revivalist advocacy. While few details are provided in policy documents as to the nature and content of these "local health traditions" (LHTs), the only specified activities refer to the utilisation by local communities and primary health workers of medicinal plants and to the "validation" and testing of these natural resources, indicating that the "LHTs" envisaged as having potential for providing state-sanctioned care are those that entail the use of medicinal substances. Initiatives have been started by non-governmental organisations to promote local medicinal plant use and to "validate" and offer accreditation to particular kinds of indigenous practitioner. The substantialisation of medicine to "medicines" clearly reflects broader processes of commodisation (Bode 2006) and an eagerness on the part of the Indian government to profit from the country's bioresources. Social scientists have begun to study these processes of "pharmaceuticalisation" but their consequences with regard to the nature and configuration of therapeutic practices, the social distribution of therapy and patterns of access to treatment have been largely overlooked.

In accreditation initiatives, individual certification and/or membership of healers' organisations is made available exclusively to those practitioners who only use herbal medicinal products for treatment (Banerjee 2010; Dabhai 2012; Roy 2012; Venkat 2012). The wide variety of practitioners who combine *mantra* (sacred words) and medicinal therapies, use exclusively ritual modes of treatment, or offer other treatment technologies such as massage, manual manipulation, fracture reduction, treatment for poison bites, dietary therapy and so forth are excluded by omission, as of course are collective rituals and community spaces for healing such as shrines. Thus within the space of a decade, a new category – the now-capitalised Local Health Traditions ("LHTs") – has been established, with a restricted referent of herbal medicinal treatment that nonetheless reaches back historically to retrospectively reconstitute of existing vernacular forms an entirely new medical object. While it might seem inappropriate to deny approbation to initiatives that offer some scope for (re) valorising subaltern therapeutics through some measure of official recognition, anthropologists are uniquely positioned to provide critical reflection on the nature of these moves as simultaneously constituting intracultural narratives that shape medical pluralism (the character of medical plurality), to point up distinctions between, for example, local health traditions and "LHTs" and to highlight the displacements and exclusions that the creation of such new designations inevitably entail.

## Notes

1. Medical pluralism is perhaps most used in a purely descriptive sense as "the co-existence of diverse medical traditions". Some authors have taken "medical pluralism" either implicitly or explicitly to refer to a normative position analogous, for example, to "multiculturalism", where "medical pluralism" as the co-existence of diverse medical traditions is advocated in policy terms, rather than, for example, "integration" between them. In what follows I argue for a reconceptualisation of medical pluralism as referring to the character of medical plurality, which requires empirical investigation.

2. It is beyond the scope of this paper to review, let alone summarise, the vast range of ethnographic literatures on medical pluralism and component traditions that have developed in reference to different regional settings. I wish simply to highlight some broad tendencies in the way that "medical pluralism" itself has been understood and analysed, while acknowledging that there are doubtless many contributions to this literature that do not conform to these tendencies and indeed, already incorporate the kind of approach that I set out below.

3. This is not to say that issues of political economy, the internal structuring of medical diversity or the role of the state have never been dealt with in studies of medical pluralism; Crandon-Malamoud (1993) offers one well-known example. This influential ethnography analyses medical dialogue as providing an idiom for the expression of values and identities indicative of changing ethnic and social divisions, whereas my contention is rather that therapeutic modalities, their forms and availability are themselves materially structured by socioeconomic influences and political formations.

4. The National Rural Health Mission, launched in 2005, has provided a substantial injection of state funding for certain "focal" States with the aim of improving health care provision particularly in areas that have lacked properly staffed and maintained primary care facilities. See MoHFW (n.d.)

5. Bibeau (1985) makes a similar point regarding the establishment of "barefoot doctors" in China in an article that considers the central role of the state along the lines that I am proposing, by discussing how various models of health care delivery adopted by different African states may selectively transform "traditional" medicine.

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## Abstract

*Medical pluralism has been a major topic of interest among anthropologists working on health, illness, medicine and treatment in diverse regional settings for the past half-century. Studies explicitly focused on explaining the "co-existence of medical traditions" were particularly common in the latter decades of the twentieth century, since when interest in the topic, so defined, appears to have declined. This paper summarises some trends in anthropological scholarship associated with the rise and fall of interest in this topic and discusses ways in which 'medical pluralism' has frequently been misconceived. It then introduces a case study of India through which to demonstrate the possibilities of an alternative conceptualisation of medical pluralism as referring to the character of medical plurality, which requires empirical investigation.*

*Key words*: medical pluralism, India, governance, traditional medicine, ethnography.

## Riassunto

*Il pluralismo medico è stato uno dei campi di maggior interesse per gli antropologi che hanno lavorato su salute, malattia, medicina e cura in diversi contesti regionali negli ultimi cinquant'anni. Studi che si sono esplicitamente concentrati sulla spiegazione della "coesistenza di tradizioni mediche" erano comuni negli ultimi decenni dello scorso secolo, quando l'interesse per questo tema, così definito, sembrò declinare. Questo contributo riassume alcune tendenze nel dibattito antropologico associate con l'ascesa e il declino di interesse per questo tema, e discute i modi in cui esso è stato di frequente mal compreso. L'autore quindi introduce un caso indiano che mette in luce le possibilità di una concettualizzazione alternativa di pluralismo medico che si rifà al carattere plurale della medicina, che richiede maggiori indagini empiriche.*

*Parole chiave*: pluralismo medico, India, *governance*, medicina tradizionale, etnografia.