

2.4 *Other medicines.* *Which wisdom do they challenge?*

Elisabeth Hsu

University of Oxford
[elisabeth.hsu@anthro.ox.ac.uk]

Introduction

Some students of medical anthropology make generalising statements that any discussion of disease implicitly involves the issue of causality, as though this principle of biomedical ideology would apply to any form of healing. Students of this persuasion also tend to consider medicine and healing as prominently explicable in terms of belief and knowledge, thereby overlooking the importance of bodily dispositions and embodied skills, regardless of whether they are referring to biomedical forms of practice or other ones. Furthermore, they investigate medical knowledge, in particular that of other medicines, with methods that liken it to biomedicine, methods that differ from those for investigating the knowledge of patients and thereby the preconception that practitioners' knowledge is qualitatively different from that of lay persons is reinforced and reproduced. This article critically examines such issues that are grounded in principles of biomedical and, by extension, medical anthropological wisdom, and it shows that an attentive study of other medicines challenges those very principles⁽¹⁾.

The article suggests, first, that narrative analysis, which is now generally used to research on patients' knowledge, could also be applied to the investigation of medical knowledge. Second, awareness that the mood in which medical knowledge is expressed need not always be the descriptive indicative mood that alienates the speaker from his or her object of speech, may open new avenues for understanding the interrelation between text, word, and bodily practice. Third, contrary to the general assumption that knowledge of the illness cause (a cause that temporally precedes the effect) explains treatment choices, there are medical ideologies that emphasize the importance of synchronous signs, and there are thinkers who have long pointed out the importance of the issue of 'risk and redemption' of 'pres-

ence' for understanding how healing 'works'. Developments in the history of medical anthropology show that biomedical ideology has had a profound impact on medical anthropologists because we frame our questions in ways that are often guided by preconceptions derived from our own (bio-) medical ideologies. The way other people think and act, and the other forms of medicine they practise, challenge the very foundations of medical anthropological questions and, implicitly, biomedical ideology.

The term 'other medicines', in this article, refers to a wide range of medical knowledge and practice. Anthropologists have long been interested in the medical practice and knowledge of other peoples and investigated 'folk', 'popular', or 'indigenous'⁽²⁾ forms of medicine and 'traditional medical systems'⁽³⁾. Some of these medicines are now practised outside their home countries, side by side with biomedicine, and in the process of translocation have been transformed. Together with other non-biomedical forms of therapeutics, they are referred to as 'alternative'⁽⁴⁾ and 'complementary'⁽⁵⁾ medicines or 'non-conventional therapies'⁽⁶⁾. Needless to say, mutual appropriation of practice and knowledge among these forms of medicines is common, and various forms of biomedicine, to various degrees, have modified them and been modified by their continued presence in health care.

The term 'other medicines' furthermore is meant to refer to patients' knowledge of medicine. Regardless of whether the practitioner is a biomedical doctor, a CAM (complementary and alternative medicine) practitioner or a traditional healer, patients' knowledge of medicine is usually regarded as inferior or even as non-existent. However, it would be an oversight for the anthropologist to adopt the ideology of health care providers, and not take seriously the knowledge of patients with regard to medical matters, even if this knowledge is not always as verbalised as that of the practitioners.

By setting the scene in this way, and asking which aspects of medical anthropological 'wisdom' are challenged by the investigation of 'other medicines', the study may appear flawed in two ways. First, the term 'other medicines' lumps a whole range of practices other than biomedical ones together for comparison and contrast. This reiterates a stance that is today questioned for its ethnocentricity. Second, the article uses the term 'biomedicine'⁽⁷⁾. This choice is deliberate, since it is precisely some basic features of the ideology of the bio-sciences, rather than the daily practice of the general practitioner, that has had a profound impact on medical anthropological 'wisdom', and will therefore be discussed in this article.

To be sure, the establishment of illness taxonomies, the investigation into illness causation and the exploration of belief for understanding practice

represent some of the most valued studies medical anthropologists have undertaken, and this is not questioned here. Nevertheless, the assumptions which guided these endeavours are grounded in insights of biomedicine that more recently have been challenged and should direct the anthropologist's attention towards further aspects of medical practice.

Syntagmatic and paradigmatic temporality: from classifications of disorders to narrative analysis in medical anthropology

Scholarly articles on illness classifications appeared before medical anthropology had become consolidated as a discipline. Frake's (FRAKE C.O. 1961) article on Subanun skin diseases is one of these ethnoscientific undertakings. Although Byron Good criticised Frake's endeavour already in 1977, medical anthropologists continue to publish work that builds on it, not least Christopher Davis in 2000, in his book *Death in Abeyance* (that begins with nosological taxonomies but goes beyond those, and ends with illness narratives set in local history). Inspired by componential analysis that works with minimal pairs, Frake set up neat hierarchies of skin diseases that obtained their structure from the anthropologists' judicious questioning. Whether a sore was distal or proximate, deep or shallow, were features the astute anthropologist had identified⁽⁸⁾. Good emphasized that we need to identify the subjects' own associations, i.e. the connotations of a term like *narahatiye qalb* (heart distress), and instead of invoking a hierarchy of taxonomic knowledge, he established semantic networks. Semantic networks typically reflected the terms people themselves used, and they highlighted interrelations between these terms. These interrelations were not necessarily causal but associative, and they were often ill-defined and vague, and have therefore remained a useful fieldwork method to the present day⁽⁹⁾.

The study of 'other medicines' in the 1970s and 1980s was that of so-called 'folk' and 'traditional' medicines, and their taxonomies. It was emphasized that indigenous medical practice was not merely a hodge-podge of superstitious practices but grounded in knowledge systems that were internally coherent; anthropologists explained that standards and concepts that applied to the biomedical sciences should also be used for accounting for so-called traditional sciences and medicines. Not only biomedicine had disease taxonomies but also other medicines; it was a very timely and worthwhile undertaking, and many medical anthropologists continue to explore those aspects of other medicines, and there still remains much to do.

The preferred topic of studying 'other medicines' has since shifted, however; one speaks of the narrative turn. The last fifteen years have seen a

series of studies that centre on patients' narratives, on disabilities, chronic conditions and terminal diseases. However, as Shimazono (SHIMAZONO Y. 2003) emphasizes, narrative analysis in medical anthropology has so far centred on patients' narratives in biomedical settings; it has barely been applied to the study of narrative in the construction of a 'diagnosis of disease', neither in biomedicine nor in so-called traditional medical settings. The medical knowledge of patients is thus analysed within a different paradigm than that of doctors and healers, a paradigm that resides in a different 'temporality'.

Following Paul Ricoeur and Jerome Bruner, Shimazono (SHIMAZONO Y. 2003) stresses that the generation of knowledge through narrative is different from the paradigmatic mode of setting up taxonomies. The narrative mode of knowing takes account of intention and desire, and is interested in context-bound connections. The knowledge of medicine that emerges from narrative analysis is thus contextual and situation-bound as is typical of 'syntagmatic temporality'. This is fundamentally different from the decontextualised paradigmatic knowledge that the natural sciences strive for, and that has been valued in the study of traditional and indigenous, complementary and alternative medicines (by setting up nosological taxonomies, for instance).

If we define the 'other' medicine as the patient's knowledge of medicine, take the method of narrative analysis used for eliciting the patient's knowledge, and apply it to the study of biomedicine and traditional and indigenous, complementary and alternative medicines, we challenge the wisdom on which biomedical, and by extension medical anthropological knowledge, is based: namely, that medical knowledge is primarily based on the paradigmatic mode of knowledge production that leads to the establishment of classificatory schemes of disease.

Needless to say that several medical anthropologists have challenged this wisdom already. Various authors have pointed out the need to take account of a temporality that differs from the one that produces nosological taxonomies. Bibeau (BIBEAU G. 1981) in the early eighties already pointed out that people refer to different morbid stages with different words and that it is problematic to speak in those cases of a single disease entity that progresses through different stages. Farquhar (FARQUHAR J. 1991) emphasized that the category, which in Chinese medicine accounts for a morbid condition, the differentiation pattern (*bianzheng*), is based on a different notion of temporality to that of the biomedical disease concept. Both authors recognised the intrinsically different notions of time that the terminology im-

plied of the disorders they studied, and contrasted those with the paradigmatic mode of knowledge in biomedicine.

One can go a step further and, rather than contrasting the knowledge of patients and practitioners, non-biomedical and biomedical practitioners, highlight how contextual and situation-bound the production of all practitioners' medical knowledge is. Hunter (HUNTER K.M. 1991), for instance, by focusing on biomedical doctors' narrative, and Berg and Mol (BERG M. - MOL A. eds. 1998), by highlighting differences in biomedical domains, have done so with respect to biomedicine. However, while there are studies of medical narrative in historical times (DUDEN B. 1991 [1987], FURTH C. 1999), narrative analysis, apart from being applied to rather formulaic case histories (e.g. FARQUHAR J. 1991, 1994, SCHEID V. 2002), has rarely been applied to the study of contemporary traditional and indigenous medical knowledge; Shimazono (SHIMAZONO Y. 2003) stresses this⁽¹⁰⁾.

Elegant Theory and Messy Practice, and the Relevance of Embodied Skills

At about the same time as there was a turn towards narrative analysis, with its emphasis on interview culture and the spoken word, medical anthropologists have started to stress non-verbal aspects in the medical encounter. Particularly authors who come from the phenomenological perspective that builds on M. Merleau-Ponty's writings have set out to investigate the aesthetics of healing and have emphasized how music, rhythm, odours, and bodily movement can become important for the therapeutic process (e.g. CSORDAS T.J. 2002, DESJARLAIS R. 1992, 1996, LADERMAN C. 1991, ROSEMAN M. 1991; LADERMAN C. - ROSEMAN M. eds. 1996, and also JACKSON M. 1996, DEVISH R. 1990, and HONKASALO M. this volume, among others). They have explored emotionality and aesthetic sensibilities rather than engaging in a detailed study of the meanings of the texts that are sung. Their study of other medicines thus draws attention away from the intellectually grasped contents of the texts used in medical practice towards the importance of bodily dispositions during the medical encounter.

These authors can be understood implicitly to have challenged the aspect of biomedical ideology, and also much medical anthropological investigation, which derives from the belief that 'theory' describes the processes in question accurately, and that inaccuracies between theory and practice arise from medical practice being messy. The interrelation between medical theory and medical practice, as known from biomedicine, is often taken as a

prototype for how text and practice are thought to interrelate. This is so particularly in the analysis of so-called 'traditional' medicines and CAM. Those often comprise an important body of texts, considered to capture the workings of the universe and of medical knowledge, and they tend to be treated as medical 'theories'. The question that arises then is whether by treating them as 'theories', one distorts their intrinsic relatedness to medical practice⁽¹¹⁾.

As pointed out elsewhere (Hsu E. 1999: 233), texts in biomedical theory are descriptive and their formulation requires the author to be distanced and alienated from his or her subject. Accuracy and un-ambiguity of the meanings of the terms are highly valued qualities of a scientific text. There is, however, always a 'gap' between biomedical theory and biomedical practice. Texts in knowledge traditions other than biomedicine need not always be descriptive, and consequently the interrelation between the author and his or her subject of investigation need not be as alienated from each other as in biomedicine. To be sure, these texts are insightful and contain knowledge about the body and the world, as any 'theory' does, but the relation the practitioner has to text and practice, need not necessarily be the same as that of an alienated bio-scientist to the world (pp. 105-127). The canonical texts in Chinese medicine may well have a proscriptive aspect, and they may well have been written in another mood than the indicative, perhaps in an optative or conjunctive mood (pp. 210-217). If a text is proscriptive, the relation between medical text and medical practice differs from that between a descriptive medical theory and medical practice. The notorious 'gap' between theory and practice disappears.

Some practitioners may claim that in Chinese medicine a differentiation pattern (*bianzheng*) provides a description of reality. They are right but only to a certain extent: differentiation patterns do not only pertain to describe reality, they also contain proscriptive information for adequate treatment selection⁽¹²⁾. Moreover, the flowery language that one finds in these texts may have a different effect on those who recite them than merely providing a detached description of 'reality'. The study of the texts of other medicines thus inspires the medical anthropologist to think about the significance of texts for medical practice, and to rethink the relationship between medical text and medical practice. There is always a 'gap' between descriptive biomedical theory and practice, the epistemology being that medical theory is elegant and the real world messy, but such an epistemology has a very specific purpose in the biosciences, does it do justice to the relation between word and deed in other medicines?⁽¹³⁾

Needless to say the above authors, particularly in the context of spiritualist and shamanic healing performances, have proposed that emphasis on somatic modes of attention and embodied skills. Investigation of medicines with textual traditions would suggest that it might be fruitful to transfer their insights to a wider range of medical 'theory' and practice. In this way, familiarity with other medicines challenges this particular biomedical, and medical anthropological, wisdom.

Notions of Causality, and the Choice of Adequate Therapeutic Intervention

The third biomedical, and also medical anthropological, 'wisdom' that illness causation explains adequate choice of treatment would seem more difficult to challenge since many 'other medicines' do refer to illness 'causes', and some refer to notions of illness causation that predate biomedicine⁽¹⁴⁾. One has to think carefully about what is meant by 'cause', and also how thinking about illness 'causes' has coloured medical anthropological writing. The ideas presented below suggest that it is the biomedical ideology of illness causation that influenced anthropologists, and it is the usefulness of that ideology for understanding other medicines that is questioned here.

Illness causation was a theme already dealt with by W.H.R. Rivers and E. E. Evans-Pritchard. Rivers (RIVERS W.H.R. 1924: 48) stressed that the medical practices of other peoples were a 'logical consequence' of their beliefs about the causation of disease. He was convinced that these beliefs were wrong but was empathetic when he said:

«The practices of these peoples in relation to disease are not a medley of disconnected and meaningless customs, but are inspired by definite ideas concerning the causation of disease. Their modes of treatment follow directly from their ideas concerning aetiology and pathology».

Beliefs about illness causation, Rivers maintained, explained unfamiliar therapeutic interventions. He was interested in invariant relations between belief and therapeutic practice. Evans-Pritchard (EVANS-PRITCHARD E. E. 1937: 69-70), by contrast, in his explanation of witchcraft among the Azande, deals with causal reasoning in another way. In the context of discussing causality, he addresses the questions "why me? Why now?", which ask for answers that do not point to invariant relations of causation but to particular personal intentions:

«Now why should these particular people have been sitting under the particular granary at the particular moment when it collapsed? That it should

collapse is easily intelligible, but why should it collapse at the particular moment when these people were sitting beneath it? ... We say that the granary collapsed because its supports were eaten by the termites. That is the cause that explains the collapse of the granary. We also say that people were sitting under it at the time when it collapsed. To our minds the only relationship between these two independently caused facts is their coincidence in time and space. We have no explanation of why the two chains of causation intersected at a certain time and in a certain place».

Thus, Rivers suggested transposing the notion of illness causation as relevant in biomedicine into other cultural contexts, and he emphasized that there was an invariant relation between belief and medical practice that was 'logical', 'causal', and 'rational'. Evans-Pritchard, by contrast, was interested in sequences of events for which the biosciences provide no causal explanation, and his discussion of causality elaborated on 'coincidence'. The two invoked 'causality' for explaining rather different aspects of other medicines. Yet both had an understanding of causation as given in the modern natural sciences.

Causal reasoning in medicine is closely related to the question: what counts as evidence in diagnosis? Practitioners are confronted with everyday life problems; yet in their explanation often allude to variables outside everyday life experience and perception (LEWIS G. 1975: 223). What goes beyond immediate perception is considered a cause, and to a certain extent, one can say that medical anthropologists have been quick to link evidence in diagnosis to 'causal explanation' in much the same way as biomedical practitioners conceive of biological processes as the result of cause-effect relations. In biomedicine, a pathological condition has a pathogenesis, and treatment that goes beyond the alleviation of the momentarily perceived symptom, is meant to deal with the cause of the disease. Biomedical treatment differentiates between symptom alleviation (towards which it considers T/CAM to be oriented) and treatment of a causative agent. T/CAM by contrast, often accuses biomedical treatment to be body – and symptom – oriented, and also claims to treat the cause of the illness (e.g. UNSCHULD P. U. 1992).

To reconcile these viewpoints, medical anthropologists have pointed out at least two problems that surround talk of causality. First, there are different levels of causation. One may speak of proximate and ultimate causes (SINDZINGRE N. - ZEMPLÉNI A. 1981) and, in addition, discern further levels and qualities of causation. An effect may be produced by multiple causes, which are not mutually exclusive. Whereas causative agents in biomedicine are often micro-organisms or degenerative biological processes, T/CAM may find causative agents in variables like hot and cold, spirit loss or indulgent

behaviour, which are often directly linked to the social, religious, moral, political and ecological environment. In other words, the level of causation invoked and the quality of causative agents may differ (which is not to exclude the possibility that both invoke the same variable, just in a different vocabulary). Many medical anthropologists have emphasized this.

Secondly, causal reasoning is considered an aspect of rationality, and it is treatment that is grounded in rational thought or 'logical thinking' that acquires legitimacy. Causality, rationality, and legitimation of treatment are thus inextricably linked to each other. This makes any kind of detached study into questions of illness causation difficult because treatment directed at the cause of the illness is considered the only legitimate one. If T/CAM practitioners were to deny that their medical practice is directed at treating the cause of the illness and deny that they are interested in questions of causation, they would deny themselves their claim to the legitimacy of their treatment, its coherence and internal consistency.

In the light of Rivers' understanding that beliefs of causation explained treatment procedures, that causal reasoning was evidence of other peoples' rationality and their treatment's legitimacy, one can understand why an empathetic anthropologist would wish to use the notion of cause in a wide sense. There are, however, reasons to challenge the biomedical as well as the general medical anthropological wisdom that investigation of illness causation is as important as generally assumed. In other words, the study of other medicines would suggest that, rather than widening the notions of 'cause' and 'causation', it might be useful to narrow its sense down, and demonstrate that issues other than the illness cause are important in peoples' management of illness and disability. Pool (POOL R. 1994) has long questioned the ethnographer's preoccupation with illness causation. From a pragmatic sociological viewpoint, maintaining social relations, for instance, may be just as important (NICTER M. 1996, 2002, WHYTE S. R. – HARDING A. – VAN DER GEEST S. 2003). This article, however, sets out to show that there are medical ideologies which do not consider illness causes the most relevant aspect of the illness event for determining adequate treatment.

Evidence in diagnosis need not, by definition, be linked to causal explanation, and what counts as evidence in diagnosis need not always stand in a Humean cause-effect relation to the problems presented, where causes temporally precede the effect. Evidence may be found in signs that are synchronous to the complaint. Naturally, one may say these signs are indicative of causes. However, there are signs that people do not consider indicative of causes, and they cannot be viewed as causes that precede effects

because they are synchronous. These 'synchronous signs', rather than ideas about the illness cause, may be the most relevant factors for determining adequate treatment. I will demonstrate this by taking recourse to a study of an ancient text, rather than interviewing respondents today (who certainly would not be eager to find that their medical reasoning was not causal).

In a formulary Chinese text of the second century BC, diagnosis was not dependent primarily on establishing the illness cause. In my understanding of that text, the doctor differentiated between the following three aspects of the illness: the name of the illness, the cause of the illness, and the quality of the illness. He himself did not speak of name, cause, and quality of illness, however. These are words of my choice. What I call the name of the illness was introduced by the recurrent phrase: "I said" (which followed an introductory phrase of saying that he had examined the ill person); what I call the cause of the illness, is perhaps better paraphrased as that form of behaviour for which the patient is to blame, and it was introduced by the standard phrase: "The illness was contracted by"... (e.g. alcoholic beverages); and what I call the quality of the disease was introduced by the standard phrase: "the reason I recognised it was that..." (e.g. the pulse was slippery). My analysis demonstrated that while the names of the illness varied in each of the twenty-five cases that were recorded in this text, in almost half of the cases the cause of the illness was attributed to indulgence in sex and wine. In other words, the cause of the illness could not have been the determining factor for establishing the twenty-five different diagnoses (Hsu E. 2001a). Instead, I found that the quality of the illness regularly correlated with the name of the illness (Hsu E. 2001b).

The analysis of this ancient text of a traditional medicine is relevant to the question of what wisdom other medicines challenge in that it points out that the cause of the illness need not always be known to choose an adequate treatment strategy. In this ancient text, it was not the cause of the illness but its quality that was relevant for determining the name of the condition, and to a certain extent also the treatment strategy⁽¹⁵⁾. The quality of the illness was not claimed to be established by means of investigating the pathogenesis of the patient, and identifying a cause for the illness in the past history of the patient. Rather, it was claimed necessary to feel the pulse and observe the complexion, to search for signs that were synchronous. To be sure, this was only an ideology. One may object that in reality, while the doctor takes the pulse, he or she also speaks to the patient, and the patient reveals her illness history and that, ultimately, even

the doctor who claims to know the condition from the feeling of the pulse, actually knows it from listening to the patient's narrative. The point I wish to make is that there are medical ideologies that challenge the biomedical ideology that knowing the illness cause is the most important factor for determining adequate treatment. This challenges the biomedical, and medical anthropological, wisdom that knowing the cause of the illness is essential for delivering treatment.

One need not go into the analysis of an ancient text to emphasize that according to some medical teachings the cause of the illness is unimportant for the selection of adequate treatment. As already mentioned, in modern TCM it is not the diagnosis of a disease but pattern differentiation (*bianzheng*) that is essential for establishing adequate treatment (FARQUHAR J. 1994: 154-169). This process of pattern differentiation ideally involves four different diagnostic methods: looking, listening, smelling and feeling (the pulse); the patterns that a doctor diagnoses are not disease entities but patterns of the patient's condition in the moment when he or she is diagnosed; they are expected to be different according to constitution, age, gender, etc. of the patient, and differ from one moment in time to another. The point about pattern differentiation that I wish to stress is that it takes account of the condition of the patient at the very moment of diagnosis; doctors are not preoccupied with finding the cause of the illness, this is not a matter of interest, but rather qualities of colour in the face, pulse, and many others that the patient can communicate to the doctor, the frequency of urinating, the quality of the stools, and the like, are matters of concern.

I have spoken to TCM doctors who claimed that the cause of the illness is intrinsically given through these qualities of the illness condition, and they emphasized that the cause of the illness is contained in these signs. Eager to present their medicine as scientific, they were quick to attribute this to causal reasoning. One teacher who taught me was, however, very explicit to the contrary. He said that if a woman was diagnosed with a wind-cold-common-cold (*fenghan ganmao*), it was not because she had exposed herself to a draft or heavy winds the day before, but that signs on her tongue and her pulse at the time he made the diagnosis were relevant. The woman may have thought it was the cold and wind she had experienced the day before that caused her to have a wind-cold-common-cold, but a TCM doctor made his diagnosis on the basis of synchronous signs (fieldwork notes 1988-89). In this way, Chinese medical pattern differentiation challenges our wisdom that for treatment to be effective one has to know the cause of the illness.

As Lewis (LEWIS G. 1995: 559-560) puts it: «The anthropologist's dilemma is the choice between being too active or too passive. How does one encourage people to express thoughts, which are silent or implicit, without distorting them with a foreign style of questioning?» An anthropologist's «method of question and answer might give unwonted clarity and direction to the representation of causal understanding in another culture» (*ibidem*: 559) ⁽¹⁶⁾. It is precisely this aspect surrounding the investigation of illness causation that leads anthropologists and their respondents into directions that are given by biomedical ideology but may not be important in the cultures in question.

It may be that spirits are invisible, but are they really only known through the perceived 'effects' anthropologists consider them to effect? Is it not the framework of causal reasoning that makes spirits 'invisible agents' that produce 'effects' that can be perceived? This framework suggests that the visible world, contingent as it appears, can be explained by principles ruling the invisible world. It is a credo of the natural scientist, formulated in an ocular metaphor, which has been adopted by many medical anthropologists in their study of other medicines. However, if someone says of an illness, it 'is' a spirit, does the person mean that it is 'caused' by the spirit or that it 'is' the spirit? The latter would presuppose an ontology different to our own.

Once we admit that other medicines are challenging the 'wisdom' intrinsic to our own ontology, which is grounded in the same ontology as the biosciences, new avenues for studying illness and healing open up. This is a point Ernesto de Martino has long made. The three aspects of medical anthropological wisdom discussed above – the preoccupation with illness taxonomies, the emphasis on medical theory, and the focus on illness causation – all have been guided by the assumption that biomedicine and other medicines are primarily concerned with 'knowing'. In de Martino's words, however,

«Magic is not primarily concerned with 'knowing' the world, nor with changing it, but aspires to guarantee the world to which the being may make itself present». (DE MARTINO E. 1988 [1948]: 107)

It is likely that the centrality of illness causation in biomedical reasoning led to its centrality in medical anthropological research, and anthropologists, who granted their subjects rationality, widened the concept of cause to include aspects of medical reasoning that are perhaps not always best described as 'causal'. To be sure, it would be simplistic to state that other medicines and magic are not concerned with 'knowing'. However, as de Martino points out, the aspect of other medicines that most interested him, so-called 'primitive magic', was importantly concerned with the «risk

and redemption of presence» (*ibidem*: 92). In this way, illness and its treatment become an issue of an existential drama concerned with the mastery and consolidation of «the elementary being-in-the-world or presence of the individual» (*ibidem*: 150). It is the ‘reality of presence’ that is a problem, presence being «something to be aimed for, a task, a drama, a problem» (*ibidem*: 147).

Rather than likening medicine to the sciences, as biomedical ideology does, and as medical anthropologists have done with regard to other medicines by emphasizing their paradigmatic taxonomies, theories, and ideas about causation, treatment of illness can be concerned primarily with the self, its being-in-the-world, and its ‘presence’ in this world. De Martino stresses:

«Here we find ourselves faced with a limitation that is characteristic of the historic consciousness of our own civilization [...] so our guaranteed and fixed presence is considered (still within the limitations of our historical consciousness) as the model for every possible historical presence: it is felt that the presence, in every historical and cultural world, must follow this model, and that, in no civilization, can the reality of presence become a problem or a self-established reality». (DE MARTINO E. 1988 [1948]: 147)

De Martino opposed ‘the historic consciousness of our civilisation’ to ‘the cultural world of magic’, our taken for granted of the self, on the one hand, and the drama surrounding the struggle of the presence of the self, on the other. This opposition allowed him to flesh out the peculiarities of what he called ‘primitive magic’. However, in the meantime, medical anthropologists have repeatedly stressed that such oppositions between modern and magical, between us and them, tend to mystify rather than clarify the issues at stake.

With this in mind, let us return to the question: other medicines – which wisdom do they challenge? Not only does the attentive study of other medicines highlight the bias intrinsic to the investigation of patients’ narratives (rather than practitioners’ narratives), theories (rather than bodily dispositions and embodied skills), and illness causation (rather than questions surrounding the issue of ‘presence’), but it also shows up that this bias of medical anthropological inquiry reproduces and reinforces biomedical ideology. Furthermore, the observation that the establishment of ‘presence’ is central to some forms of healing and that there are other medicines, like Chinese medicine, that stress the importance of ‘synchronous signs’ for diagnostic purposes, may alert the medical anthropologist to the possibility that these dimensions of wisdom in other medicines may also be constitutive to the various forms of biomedical practice, in spite of ideological claims to the contrary.

Notes

⁽¹⁾ I would like to thank the editorial committee of this volume for their valuable comments on the draft presented in the panel 'Spreading medical ideas', at the MAAH conference in Perugia, Italy, 24-28th Sept 2003. An early version of this article was presented in the panel 'Challenging medical wisdom', at the BAAS in Salford, UK, 8-12th Sept 2003.

⁽²⁾ The terms 'folk' and 'popular' medicine were common particularly in early writings, though they continue to be used often for local forms of medical knowledge and practice. More recently, researchers refer to 'indigenous' medical practice particularly in the context of intellectual property rights and ethnopharmacology, where the indigenous knowledge of flora, fauna, and minerals is researched. The term 'indigenous' medicine thus often alludes to the medical knowledge of small-scale societies.

⁽³⁾ Paradoxically, the term 'traditional' as in 'traditional medicines' is often used to designate those forms of medicine that recently have been revived, and in the process of revival have been transformed and 'modernised', such as Traditional Chinese Medicine (TCM) in China or the medicine of 'traditional' herbalists in Africa.

⁽⁴⁾ Adherents of 'alternative' medicine in the seventies and eighties stressed the need for refashioning life in another way than late capitalism demanded, and they were often motivated by ideas of decentralisation, ecological and environmentally thoughtful living.

⁽⁵⁾ From the eighties and nineties on, adherents of 'complementary' medicine often came from within the medical profession, as the belief waned that biomedicine can solve all health problems. It was recognised that non-biomedical treatment can effect changes that biomedicine validates. The discourse that dominates CAM today is motivated by the endeavour to validate non-biomedical treatment as 'complementary' to biomedicine.

⁽⁶⁾ The term 'non-conventional therapies' is now increasingly used to refer to CAM, and also to practices that could be described as 'folk' or 'popular'. The term singles biomedicine out as the medicine that has become the conventional form of medicine, and thus alludes to the differential institutional setting of conventional and non-conventional forms of medicine. The term is mainly used in Europe and North America, and some but not all of these non-conventional therapies may have existed historically before biomedicine became firmly established.

⁽⁷⁾ Frankenberg (FRANKENBERG R. 1993) has criticised the use of the term 'biomedicine' because bio- alludes to the ideology of general practitioners rather than to their daily practice. It is the ideology that is discussed in this article.

⁽⁸⁾ Davis (DAVIS C.O. 2000) is careful to provide taxonomies based on the criteria of her subjects.

⁽⁹⁾ Kleinman's (KLEINMAN A. 1980) explanatory models (EM) built on Good's (GOOD B. 1977) semantic network approach, though Kleinman structured EMs into four distinctive knowledge domains – illness causes and treatment, symptoms and social problems (see diagram p. 108) – which were modelled on biomedical wisdom that patients and practitioners of other medicines do not necessarily share.

⁽¹⁰⁾ Indeed, advocates of traditional and indigenous medicines emphasize scientific aspects, i.e. the paradigmatic mode of knowledge production; narrative analysis does not fit their programme.

⁽¹¹⁾ Farquhar (FARQUHAR J. 1994), by calling her book *Knowing Practice*, points in this direction, although the book investigates texts. As has been variously remarked, Pierre Bourdieu's definition of *habitus* is singularly disembodied.

⁽¹²⁾ To a certain extent, differentiation patterns (*bianzheng*) can be regarded as 'illness taxonomies' in the sense of Nichter (NICHTER M. 1996: 120).

⁽¹³⁾ A dynamic tension between word and deed is also given, for instance, by ironic situations and statements (LAMBEK M. 2003). Statements made in an 'ironic mood' would contrast with proscriptive ones in that they defy intentionality.

⁽¹⁴⁾ In the Middle Ages, Aristotle's four causes were central to causal explanation, and also applicable to medicine: the material, formal, final, and efficient cause. Lloyd (LLOYD G. E. R. 1995: 538) explains: «The matter corresponds to what a thing is made of, the form to the characteristic fea-

tures that make it the thing it is, the final cause is its function or the good it serves, and the efficient selects what brings it about», and points out: «Of these four, only the efficient cause looks like a cause in any ordinary English sense».

⁽¹⁵⁾ The study in question only demonstrates that the quality of the disorder determined its name. Since the treatments the doctor applied were more varied than the repeatedly named cause of wine and sex, it is reasonable to assume that the quality of the disorder played a larger role for determining the treatment than did the cause of the disorder.

⁽¹⁶⁾ Lewis (LEWIS G. 1995) points out arbitrary distinctions between what an anthropologist calls 'description' and 'interpretation' (the anthropologist writes about burning a leg with scalding water in terms of a 'description', while strange connections between coincidences are mentioned in the rubric of 'illness causation'). It comes as no surprise then that the investigation of 'illness causation' is often related to public health efforts at overcoming 'mistaken' beliefs and attempts at changing peoples' behaviour.

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