ASIAN MEDICINE: TRADITION AND MODERNITY

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As President and General Secretary of the International Association for the Study of Traditional Asian Medicine (IASTAM) we are proud to have edited the first issue of *Asian Medicine—Tradition and Modernity*, the Society's new journal. IASTAM was established in 1979 and is an international organisation working in the field of Asian medicine which has made a serious attempt to embrace the work of both academics and practitioners. IASTAM has always sought to give each of these communities a platform for the expression of their views, respecting the integrity of each group while nevertheless privileging the free exchange of knowledge over involvement in any particular commercial interest or therapeutic regime. The collection of essays we offer here represents the Society's latest initiative in nearly 30 years of dedication to the field.

The journal has grown out of the meeting of many minds in the course of producing 21 IASTAM newsletters, five meetings of the associated International Congress on Traditional Asian Medicine (ICTAM), which have been held in Germany, Indonesia, Japan, and India, and the general business of the Society. It aims to preserve and extend the spirit of IASTAM's charter by publishing articles and reports that approach every aspect of the dynamic and evolving nature of Asian medical practice in the modern world. The journal will make available in one publication contributions from a range of disciplines, and the wide range of expertise of our editorial board reflects this ambition. In our first issue, the authors interrogate closely the nature of early traditions, modern practice, and some of the many relationships that lie between.

That the breadth of our remit will produce a bricolage of different academic and professional approaches, their subjects, geographical areas, and methodologies, will be our trademark and virtue. The result will inevitably challenge the intended readership, but there are distinct advantages to facilitating a more widely informed engagement with Asian medicine. On the one hand we hope to bring a little

'colour' to the world of academic journals. And on the other, in the interests of developing more rounded and comprehensive perspectives in the study of medical traditions and their modern applications, we intend to make specialist studies, such as those based in medical anthropology or philology, accessible and interesting to a general audience. As editors of a multidisciplinary journal, aimed at contributors and readers with expertise in the practice and use of Asian medicine, its histories, medical anthropology, medical sociology and in Asian languages (such as Chinese, Tibetan, Sanskrit, Persian, Arabic, Japanese and Korean) we refuse to define rigid geographic or disciplinary boundaries to the field of Asian medicine to which we aspire.

The journal title demands further probing. If we accept that there are a variety of epistemologies and traditions that bristle together under the rubric of 'biomedicine', then can we really isolate a contrasting field of 'traditional medicine' or even 'Asian Medicine'? Where would all the myriad Asians that have contributed to bio-medical innovation and research fit? No doubt these and other questions about the boundaries of Asian medicine will remain an interesting source of perplexity for us. For now our answer as editors is that there are many journals dedicated to the kinds of medicines that style themselves 'scientific' and few concerned explicitly with the virtues of their tradition.

There has also been an increasing reversal of the meanings attached to 'traditional medicine'. At least since the period of the Enlightenment, Asian and African traditions, beliefs, and customs, were associated by Europeans (and by Western educated indigenous elites) with a variety of negative terms, such as 'inferior', 'backward', 'uncivilised', 'barbaric', 'crude' and 'primitive'. But more recently the term 'traditional medicine' has acquired further, largely positive, connotations in the packaging of āyurvedic (traditional Indian medicine) or traditional Chinese medicine, for example, as wholesome, spiritual, holistic, authentic, humane, and as something people in the West as well as in the East would be well advised to make use of in order to live in harmony with the modern world.

Yet it is naive for us to imagine that just because parts of a medical corpus can trace its origins back to some ancient text, the practice related to it is inherently static and homogeneous. In the case of āyurveda, for example, it has been shown that scriptural injunctions such as 'the wise must . . . adhere to tradition, without arguing'

(*Susruta Samhita*), do not necessarily imply homogeneity of approaches and consensus on diagnostics and treatment. Indeed the same text has passages that promote empiricism and the spirit of free debate. Not only have a number of different interpretations of āyurvedic doctrine prevailed in any one period, but they have adapted variously to changing social and environmental realities, at times even running counter to particular, simultaneously held prohibitions (such as the consumption of meat alongside vegetarianism in India). 'Medical traditions' are intrinsically 'plural'—both in terms of the variety of ways in which any one tradition has been interpreted and codified by different learned authorities, and in terms of the great variety of their practical applications.

Asian medical systems and traditions provide us with a fascinating set of subjects to research as they become an intellectual, economic and social force in health care worldwide. Taking the rapid globalisation of Chinese medicine in recent years as an obvious example, there is clearly an urgent need for educators to engage with the general public in debate about the nature and application of traditional medicines. Investment in informed patient choices should surely be of primary importance in the matter of mass health care. The 40 per cent of Chinese in China that use traditional medical clinics as their first health care strategy alone constitute nearly a quarter of the world's population. Moreover, their spending power is enormous. And that is before we even begin to consider the impact of a modern, standardised, professionalised 'tradition' on the globe as a whole since they embrace regimen made up of all manner of dietary, exercise, reproductive, hygienic, and cosmetic health care practices. This multitude of products and practices is increasingly in evidence on European and American high streets. Certainly traditional medicines continue to thrive by default where the provision of biomedicine is not easily accessible. But the rapid growth of traditional medicines demonstrates also that biomedicine is not always the universally preferred treatment option.

What then is a modern form of traditional medicine? Is the prophylactic and curative use of 'artemesinin' *qing hao* 青蒿 for malaria, an example of a traditional medicine meeting global demand? Or does the fact that it passed muster with clinical trials in America and Britain, has been standardised, commodified and subjected to mass distribution, mean that it is no longer traditional? At what point do we deem there has been a disjunction between science and

tradition? Is a traditional medicine traditional by virtue of its relationship to ancient theories and styles of practice, and to the context and quality of the clinical encounter? All these are valid questions for this journal and ones that we are lucky to be able to ask, not least because of the current emphasis on the value of interdisciplinary cooperation.

Social historians of medicine, newly formed during the 1970s and 80s, began to throw off the shackles of 'Whig' history, breaking away from the traditional, narrow historiographic focus on the medical profession, its ideas, institutions, and obsession with the idea of 'progress'. This led to a focus on medical alternatives or 'heterodoxies', folk medicines, 'quackery', as well as on 'the patient's view'. Critical publications on the history of colonial medicine and the persistent vigour and challenge of fashionable subaltern and post-colonial theories eventually drew attention to the value of anthropological perspectives and took indigenous medicine as a worthy subject of historical analysis. Three decades on, as Asian Medicine becomes a tangible economic and intellectual force in global perspective, departments of the history of medicine are now making substantial commitments to serious research in the 'field'. Recently published textbooks and encyclopedias of medical history now contain (albeit short) chapters on 'Eastern' or 'Non-Western' traditions alongside 'The Western Tradition', and university courses on history of medicine in Britain include modules on non-Western medical perspectives. The cross-fertilisation between medical anthropology and medical history certainly constitutes a welcome development. It enables previously marginalised non-Western ideas and practices to be valued, if not yet always on their own terms, then at least alongside Western medicine, as part of a plurality of traditions—within both Western and non-Western cultures.

However, the emphasis on pluralism also harbours certain dangers. To begin with, it may well give further credence to one of the persistent ideological ploys of those who defend Western biomedical supremacy: that medicine is located outside the realms of power and hegemonic strife. Acknowledging the existence of medical pluralism both in biomedical and traditional Asian medical ideas and professional institutions, and supporting the right of patients from all social and cultural backgrounds to have free choice and easy access to their favoured medical treatment might lead one to imagine the sphere of healing as a 'liberal heaven' untouched by moral concerns. The

question of imposing restrictions on the traditional medical market place on moral grounds posits again the very problem that supporters of medical pluralism may have hoped to have dispensed with, namely who is to assume the authority to decide on restrictions of pluralism and, therefore, issues of power, hegemony and domination.

Even if medical pluralism is fashionable in academic circles we must call to question the extent to which it has been realised in a globalised medical world. American and European pharmaceutical firms still dominate the 'First World' where biomedicine remains the ultimate point of reference for the assessment of health problems and treatment outcomes. Not only biomedicine, but also traditional Chinese medicine (TCM) owes much of its success to a successful alliance with the state. TCM has been government sponsored in the People's Republic since the late 1950s and has undergone modernisation along Western principles of standardisation and scientificity. TCM is therefore very much an invented tradition, grown out of nationalistic endeavour and the pressing need for health services for the masses. 'Traditions' are the result of negotiation among the main protagonists at any one time, namely authors of medical treatises, promulgators of medical lore, practitioners, state authorities, cultural communities, and individual patients. We therefore encourage studies that situate Asian medicine squarely within the wider socio-economic and political context.

Traditional medicines are hardly immune to professional power play, shrewd global marketing and personal networking either. The apparently never-changing medical traditions such as āyurveda, unani (Islamic medicine), and Chinese medicine are not only made up of the thoughts and practices of myriad schools and individual voices, but they have also, over time, adapted in a variety of ways to changing local circumstances and global trends. More recently some have become particularly active players in the medical market place—in their country of origin as much as in the West. Āyurvedic medical centres, for example, flourish not only in their expected strongholds (such as Varanasi in India), but also in cosmopolitan conurbations such as Mumbai, New Delhi and Calcutta, as well as in New York and London where āyurvedic doctors can now be consulted and 'yoga' remedies easily purchased in any branch of the 'Body Shop'. You can even have online consultation with authentic āyurveda families who claim to be descendants of generations of practitioners.

This phenomenon is often contrasted to the 'real' thing by those

who profess to practise a pure and original āyurveda or Chinese medicine based on an age-old tradition codified in and legitimised by ancient texts and practised the same way ever since. However, they themselves are perhaps testimony to the fact that any one 'tradition' or 'medical system' is inherently heterogeneous (i.e. 'plural') and represented by different groups of people with diverse views on how practice ought to be adapted (or not) to changing circumstances—a potential for profiteering and commercialisation notwithstanding.

In deference to the plurality of traditions, times and places that constitute traditional Asian medicine, articles on any topic referred to in this editorial are suitable for submission. The thematic scope will not be limited by geographic boundaries. We will cover the application of Asian systems and traditions of healing in the West, within both biomedical institutional settings and alternative medicine and 'New Age' practices. Similarly we welcome contributions on the arrival of biomedicine and biomedical innovation in Asia that are concerned with the encounter with 'tradition'. The idea is to enable readers to engage with Asian medicine as 'traditions' as well as with their various historical and modern-day modifications and adaptations to changing circumstances. However, the editors will ensure that material will be accessible to readers from a wide range of disciplines and backgrounds and not only to expert readers in one particular field. The use of jargon will therefore be discouraged and technical terms will need to be explained. This requirement is set out in the 'guidelines for contributors'.

The journal is meant to provide a forum not only for scholars engaged in the study of Asian medicine, but also for practitioners of the various strands of medicine currently in use in Asian and Western countries. In this first issue of the journal we have contributions from at least four practitioners and we hope to increase the ratio of practitioners to purely academic scholars. While acknowledging the increasing number of scholar-physicians that are crossing disciplinary boundaries, the journal will include both scholarly articles, and practitioners' reports in two separate sections according to their subjects. What perhaps characterises the second section of *Asian Medicine* is a recognition that new medical cultures emerge in the process of practice. We therefore wish to take Asian medical 'practice' in its broadest sense as a guiding principle in the selection of articles and reports. All those influences that have and might come

to bear on practitioners of Asian medicine, past and present, are fertile territory for potential authors: the full range of practitioner skills and social relations, medical technology, beliefs and knowledge that align in practice at a given time or place. While early medical treatises are mostly theory driven, historical studies of recipes manuals, medical literature, case histories, official documents, and local gazetteers begin to bring us closer to understanding practice in the past and in the present.

Patients' preferences for particular approaches are not simply individual decisions, but are also closely related to the struggle and search for national(ist) identity and the assertion of, and resistance to, cultural and political bullying. Studies in medical anthropology show that patients are active subjects rather than merely passive objects, subjugated by the prevalent medical discourse and suffering the treatments imposed on them by domineering medical experts. 'Healer hopping'—namely patients' strategies of consulting a number of healers in their pursuit of cure and better health care—is common behaviour in many societies. We would like to hear from the medical anthropologists, medical sociologists and practitioners, but also from the patients themselves about their health care strategies and experiences. Submissions can be in the form of letters, short reports or longer articles.

Our ultimate ambition is to facilitate information exchange and better understanding between clinicians and academic scholars, thus encouraging research that is relevant to academics on the one hand and clinical practice that is historically and conceptually aware on the other. The journal will be a written embodiment of IASTAM's charter. It is therefore appropriate that at least three of the authors and both editors in this first issue have been intimately involved in the evolution of the Society. In future issues we are keen to attract more Asian writers and members of the editorial board. We will make every attempt to fund good quality translations of the best and most original articles.

Both scholarly articles and practitioner reports need to be based on original research and the material should not yet be published elsewhere. Practice reports and reflections on practice-related matters need to be focused on issues that concern practitioners in their practice, rather than material that aims at promoting a commercial enterprise or one particular practitioner's business. Reports promoting 'miracle cures' are not appropriate for the journal *per se*, but we

are particularly interested in descriptions of the circumstances in which such treatments emerged historically or in recent times, their application, and details about the process of evaluation. Practitioners' accounts of historical developments of clinical practice will not be encouraged if these are based on impressionistic and anecdotal evidence. They might be included under the rubric 'discussion point' if the peer review panel considers such reflections to merit exposure to the wider scholarly and practitioners' community.

In general submissions need to show an awareness of current issues, be up-to-date with relevant literature and have the potential to stimulate further fruitful debate. Narratives of practitioners' clinical experiences and learning processes, case studies of patients, and clinical research data are ideal, especially those that reveal the diversity of interpretations we know to exist in the world of traditional medicines. Contributors will make deliberate or intuitive choices about the degree to which a case narrative might be better told using a patient's original language or demands interpretation and explanation. We would like to encourage attention to the difference between medical anecdote and an account that applies critical analyses. The former of course is perfectly appropriate when explicitly presented. It is likely that each submission will evolve in communication with the editors and the editorial board. Ethical requirements will need to be met in regard to the anonymity of patients and their families.

The *Practice Reports* section is also the place for recording patients' views, profiles both of practitioners and patients, as well as news, forthcoming events and letters. In the next issue we will develop a section on remedies ancient and modern, giving translations and explanations of how they are used. In this issue we cover the work of Dr Volker Scheid, a long-term practitioner of Chinese medicine in the UK. We would like to encourage authors to provide descriptive profiles of Asian medical practitioners and non-Asian practitioners of Asian medicine working worldwide.

In this first issue we have an article on innovation in Song dynasty medicine by Asaf Goldschmidt, a pair of articles on ancient Asian aphrodisiacs, by Donald Harper and Kenneth Zysk, complemented by a study of the issues that arise between sexuality, magic and yoga by Joe Alter. Among the practice reports you will find an article about traditional medicine in Bhutan; Dominik Wujastyk's assessment of the very topical House of Lords Select Committee on complementary and alternative medicine in the UK, as well as an

exploration by Dagmar Benner of medical ethics in professionalised āyurveda.

But perhaps the most immediate impact of this first issue will be its scientific and technical illustrations. With Catherine Despeux's article and Akio Morishima's designs you will find a wide range of images from medieval alchemy, to the dissemination of biomedical ideas in China, and the transmission of Indian medicine to Europe. Our theme of globalisation is therefore addressed through a variety of visual media. While the articles de-code the social and cultural contexts of Asian medicine, the illustrations allow the viewer to transcend boundaries of language and region, easing dialogue across cultures and across time. Together we hope that they provide an account of Asian medicine that is at once both authoritative and easily accessible.