

# Introduction

*Charles Leslie*  
*Allan Young*

Western interest in Asian medicine has a long history, extending back to classical times. Until relatively recently, however, this interest has been predominantly practical, reflecting a venerable Western tradition of seeing all forms of non-Western medicine as a potentially exploitable source of efficacious substances and procedures that might be added to the Western medical armamentarium. Even Western scholars who were students of Asian society, and who were ordinarily interested in understanding people's behavior in the context of their cultural meanings, tended to look at Asian medical beliefs and practices from an essentially pragmatic point of view, seeing them as technologies for managing illnesses and to be understood mainly in terms of efficacy. Indologists and sinologists, Western scholars who might be expected to have a more global perspective on Asian medicine, showed little interest in this subject, and were content to let Asian medicine languish in the shadow of Asian religion, art, and philosophy, the *locus classicus* of Western interest in Asian conceptions of the self, the body, and the world.

A similar situation recently prevailed in other areas of academia. Among anthropologists, for example, relatively few scholars were familiar enough with Asian languages to have studied Asian medicine, and those few who had the knowledge tended to concentrate on the traditional interests of their discipline—kinship, caste, and ritual. But now things are different. We take for granted that Asian medical systems are worth studying in their own right, no matter how unsatisfactory their beliefs or how useless their practices appear to biomedical ways of thinking. Yet three decades ago most Westerners would have found this proposition simultaneously dubious and indulgent.

One should not press this point too far. Not all Asian medical traditions were ignored in the past, at least not to the same degree. Because of the

Greco-Roman origins of both Arabic and European medical traditions, Western historians have been less negligent of Islamic medicine. The medical traditions of India, China, and Japan, however, are another matter. A glance along a library shelf shows that, with some notable exceptions, Asian medicine has attracted the attention of indigenous scholars rather than Westerners. And where Westerners did turn their interest to Asian medicine, the scholarly convention was to concentrate on written texts abstracted from the stream of contemporary history and the context of everyday clinical practice.

Western pragmatism—in its tendency to view medical systems as technologies—does not necessarily prevent a Western observer from being curious about the ideas and theories that inform Asian therapies and procedures. If one starts off with the assumption that the ability to discover efficacious treatments is somehow connected to the discoverer's ideas about the etiology of disease, pathophysiology, and pharmacology, then pragmatic interests might lead one deeper into these ideas, and into the theories and epistemologies that support them. Therein lies the rub: it is precisely this assumption that Western observers of Asian medicine have tended to reject. Given the history of Western medicine that has shaped Western attitudes, these observers have had good reasons for this attitude. We all know this triumphalist history: it begins in the sixteenth century, with the rapid and progressive accumulation of knowledge of anatomy and physiology; then it moves on to the nineteenth century, in which one great discovery follows another—germ theory, antiseptis, and anaesthesia; and it arrives in our time to record the discovery of antibiotics and the development of diagnostic imaging technologies and microsurgery, to name a few. The history of Western medicine moves relentlessly from triumph to triumph, leaving far behind every other medical system.

Insofar as Western attitudes toward Asian medical beliefs are concerned, it is this history's subtext rather than its details that makes it interesting. Briefly, its message is that biomedicine's extraordinary progress is a consequence of its scientific epistemology, that distinctive set of rules by which biomedicine knows what it knows. In this account, the fact that Asian medicine had so little to give to the West in the way of superior cures is evidence of both the uniqueness of biomedicine and the irrelevance of the theories and explanations with which Asians have embroidered their few authentic discoveries. To Western pragmatists, the ideas of Asian medicine were entirely ignorable. It made more sense to believe that the few successes that Asian medicine could claim, such as the drug *rauwolfia*, a hypotensive that originated in *Āyurvedic* medicine and was later incorporated into the Western pharmacopoeia, were products of Asian empiricists—indigenous protoscientists who stumbled on their remedies through trial and error—rather than the work of savants reasoning from indigenous systems of medical knowledge.

The derogation of Asian medical theories and epistemologies was not an isolated event. Rather, it was an expression of a more general cultural phenomenon—that collection of attitudes, interpretations, and theories that we bundle together under the labels “modernization” and “westernization.”

Modernization, according to writers and researchers on this topic, is irresistible, both as an interpretation of culture and history and as a force for change, because it embodies an ontologically privileged understanding of the world and because it represents the victory of reason and pragmatism over culture and tradition. In retrospect, it is clear that many of the putatively culture-free ideas that these universalizing thinkers found in biomedicine—the idea that mind-body dualism is a self-evident fact of nature, for instance—reiterate notions that are particular to Western culture. What interests us here, though, is not so much the modernizers’ particular mistakes but, rather, the source of their remarkable presumption. How could they claim to know the point where culturally configured knowledge leaves off and reality takes over, the point at which the knowledge claims of biomedicine separate from those of, say, Āyurveda?

The modernizers based their claims on what was then the dominant philosophy of science—logical empiricism. According to this philosophy, reality—in our case, the objects, events, and processes that constitute the domains of health, sickness, and healing—is something that exists prior to and independent of people’s attempts to understand and control it, and what science (biomedicine) says about reality closely corresponds with reality. This correspondence between reality and the way science represents reality, a match guaranteed by science’s epistemology, makes scientific representations not merely useful, but also true. Yet, non-Western epistemologies and systems of belief, Āyurvedic and Chinese medicine, for example, inevitably culturalize reality and deserve our attention only to the extent that they create obstacles to instructing people in the lessons of biomedicine. Within this frame of reference, the theories and ideas that surround Asian medicine are simultaneously untrue and impermanent because human nature is intrinsically pragmatic (freed from tradition, people are rational maximizers and satisficers). Since biomedicine is patently superior to traditional Asian medicine, resistance to it will decline over time and Asian medicine can be expected to gradually fade away.

Ironically, the theory of modernization, a conception of cultural change that seemed compelling to Western social science only a short time ago, has been undermined by historical processes it failed to grasp, and by social and political developments it failed to predict, while Asian medicine continues on.

Like the theory of modernization, the correspondence theory of scientific knowledge has also been left behind. Beginning in the 1960s with the publication of T. S. Kuhn’s *The Structure of Scientific Revolutions*, philosophers and

sociologists of science persuasively challenged two previously accepted claims of logical empiricism: that scientific knowledge is ontologically privileged (it corresponds to external reality) and that scientific knowledge is the product of scientists following distinctive rules (either rules that can verify its facts or, following Karl Popper, rules that can show that the facts are not yet falsified).

In place of the philosophy of logical empiricism, students of culture and society now largely follow what they consider to be a more edifying account of scientific knowledge. This is naturalism, and it says that in its origins, scientific knowledge is essentially no different from other kinds of knowledge. All knowledge is the product of a natural process, social and cognitive in character rather than logical and axiomatic, through which human beings and groups of human beings struggle to make sense of the world. By socializing and historicizing scientific knowledge, by calling attention to the role played by individual and social interests in overriding epistemological principles, for instance, naturalism uncoupled the link that heretofore joined biomedicine's ability to predict, control, and manipulate objects and events with biomedicine's particular knowledge-claims about these objects and events—the point being that the superior technologies of biomedicine do not logically entail privileged ontologies.

The ascendancy of naturalist and relativist epistemologies of science, like the decline of the concept of modernization, are symptoms of a transformation that is now taking place in Western intellectual sensibilities. As a consequence, this transformation has opened a space for cultural studies of Asian medical systems.

The opening up of this space was signaled by the Introduction to *Asian Medical Systems* (Leslie 1976), a collection of articles that originated, like the present volume, in a conference sponsored by the Wenner-Gren Foundation for Anthropological Research. The introduction made four points which, taken together, map a field for cultural studies of Asian medical systems.

The first point starts from a very general observation that the medical systems of contemporary Asia—Āyurveda, Unani, Chinese medicine—are intellectually coherent. Each system consists of beliefs and practices connected by an underlying logic and each is underpinned by a coherent network of assumptions about pathophysiology, therapeutics, and so forth. The systems are connected to one another conceptually and historically by ideas about bodily humors and their relation to sickness and healing. Prior to the rise to dominance of allopathic medicine in Europe, similar humoral ideas and practices, commonly traced to Galen, also dominated medicine in the West and linked it to the Asian systems. Homeopathic medicine, whose professional rivalry with allopathic medicine continued into the twentieth century in the United States, and which is now enjoying a renaissance in West-

ern Europe and francophone Canada, represents such a link among Asian, European, and North American humoral traditions. The cultivation of T'ai Chi Chuan and Yoga exercises, along with Āyurvedic and Chinese medicine, by students and consumers of "alternative medicines" further perpetuates this connection.

The second point is that, like medical systems elsewhere, these Asian systems are each embedded in distinctive cultural premises and symbols. Thus, while it is reasonable to talk about *Asian* medical systems in the same way that we reason about *humoral* or *allopathic* systems, it is important to identify the cultural features that distinguish between the classic, literate medical system of a given Asian society and its local appearances, for example, the distinction between an urban pundit's and a village vaidya's versions of Āyurveda.

The third point is that Asian medical systems cannot be fully understood outside the stream of history. Because history is a process running through the present into the future, and because a people's or a culture's history is the product of both endogenous and exogenous forces, it is unsatisfactory to see Asian medicine as something frozen in time or insulated from the influences that have connected Asia with the rest of the world over the ages.

All societies are permeable to exogenous influences. Technical systems—whether they are military, industrial, or medical—seem to be particularly permeable. The permeability of Asian medicine—the fact that over the centuries, Asians have "discovered" and adopted European practices and notions, for instance—has been consistently misinterpreted by both Western modernizers and Western celebrants of Asian traditions. Among modernizers, the tendency has been to see the permeability of Asian systems as evidence of the irresistible encroachment of Western medicine, presaging either the disappearance of Asian medicine or its marginalization as "superstition." Among celebrants of Asian medicine, the tendency has been to identify permeability with the transformation of hitherto unchanging medical traditions. Given the continuing vitality of Asian pharmaceutical and other health care traditions, the modernizers' conclusion is, at best, very premature. The second view often sees permeability as contamination, and is a view shared by a number of Asian keepers of the literate, high tradition. It is difficult to dismiss, since this issue is largely philosophical or conceptual and not empirical. The argument is analogous to the familiar debate over the identity and continuity of particular languages, that is, the dispute between essentialists who see their language as a fixed system whose constituent elements must be defended against exogenous influences and corruptions, and advocates of the idea that every language is an evolving system, constantly borrowing from the outside while ceaselessly transforming itself on the inside.

The position adopted in the introduction to *Asian Medical Systems*, and the

view now shared by a majority of scholars in this field, is that Asian medical systems are intrinsically dynamic, and, like the cultures and societies in which they are embedded, are continually evolving.

The final point was the introduction's most controversial, and returns us full circle to the challenge of reconciling our understanding of "science" with our interest in cultural studies of Asian medicine. The introduction suggested that henceforth writers should reject using terms such as "Western," "scientific," and "modern" as ways of identifying the dominant medical tradition of the industrial societies. In their place, it proposed "cosmopolitan medicine." The term "biomedicine" serves the same purpose and is now widely used by writers in this field, but perhaps "cosmopolitan medicine" can be retained as a synonym for biomedicine when an author wants the connotation that the ideology and institutional forms of biomedicine are part of the capitalist world-system. The introduction rejected the term "Western" because biomedicine is clearly international. To take an obvious example, public and private research institutions are the main source of new biomedical knowledge and technologies. Fifty years ago, almost all of these research institutions were located in either Europe or the Americas or in the colonial possessions of Western powers, operating under imperial auspices. Today, well-established medical research institutions operate in Japan and in other Asian countries. The term "scientific medicine" was rejected on two grounds: clinical work necessarily includes much by way of inference, intuition, and judgment that is clearly medical but cannot reasonably be labeled science; "science," like the term "Western," implies a greater degree of homogeneity than this medical system can justifiably claim. "Modern" was rejected for reasons we have already given. Among other faults, it implies a spurious inevitability.

Unfortunately, some readers of *Asian Medical Systems* concluded that the argument over the appropriateness of terms such as "modernization" and "scientific" was a celebration of Asian medicine as a curative system, a rediscovery of an Oriental efficacy lost, and an advocacy of "alternative medicines." Far from making a case for the specifically medical power of Asian medicine, however, the introduction was an appeal to scholars to study Asian medicine as a civilizational process, to approach it in the same way that one might approach other sets of historically and culturally constituted beliefs and practices.

Nearly two decades later, these points are no longer remarkable. What needed arguing in the 1970s is common sense for most medical anthropologists and students of Asian medicine today. The original problem, resistance to the idea that Asian medical systems are aspects of civilizational processes, had at least two sources. The first of these was a tendency to cite medical anthropology, as an academic specialty, within a discrete division of labor—

more specifically, a tendency to see anthropologists as collectors of local knowledge in the service of physicians and public health specialists who needed help recognizing cultural and social obstacles to the programs they wished to introduce into traditional and non-Western communities. This once-pervasive attitude (which today remains embedded in methodologies such as the “rapid ethnographic survey”) is a narrowly empiricist view of medical anthropology. It is ahistorical, blind to its own apriority, and preoccupied with bits and pieces of belief rather than systems of knowledge.

Even those early researchers who were prepared to adopt a less empiricist view of their subject were at a distinct disadvantage. In Asian societies, they confronted long-established pluralistic and syncretic humoral traditions, along with the world system of biomedicine modified in numerous ways to accommodate local conditions. In trying to understand these complex medical systems and humoral traditions, medical anthropologists were blinkered by a paucity of comparative research. Up to this point, relatively little research had been conducted on the historical development of Asian medicine. The role played by humoral medicine in cultural revivalism, the creation of Asian medical institutions paralleling the schools and clinics of cosmopolitan medicine, the growth of an enormous pharmaceutical industry based on humoral preparations, the professionalization of humoral practitioners—each of these remarkable developments lay outside the gaze of medical anthropologists and sociologists.

Theoretically inclined ethnologists had long been interested in the symbolic aspects of ritual curing, but they did not think of themselves as medical anthropologists. Nor did they generally concern themselves with learning how instances of ritual curing fit into indigenous systems of diagnosis and treatment. Further, their most influential studies were written in the ethnographic present to describe “peoples without histories.” And this ahistorical work was preoccupied with shamanism, witchcraft, and sorcery to the neglect of humoral concepts and treatments of ordinary illnesses. The 1971 conference on which *Asian Medical Systems* was based eschewed ritual curing and, instead, emphasized the history and ethnology of Islamic, Indian, and Chinese humoralism. Its theoretical interests were in the historical processes of conflict and accommodation between these traditions and the world system of cosmopolitan medicine.

The conference concluded by discussing ways to draw like-minded scholars into an invisible college that would promote new historically informed work. This resolution took form in 1979, when Professor A. L. Basham organized an international conference on traditional Asian medicine at the Australian National University and used the occasion to found the International Association for the Study of Traditional Asian Medicine (IASTAM). The Wenner-Gren Foundation awarded IASTAM a small start-up grant, and the three hundred scholars who attended the Canberra conference were enrolled.

Five years later, IASTAM sponsored a second major conference hosted by Airlangga University in Surabaya, Indonesia, and in 1990 IASTAM organized a third conference in Bombay, cosponsored by three Indian universities, and attended by over six hundred participants. Today, the Association publishes a newsletter and its chapters in Europe, North America, and India sponsor various scholarly activities in their respective regions.

Public interest in Asian medicine was stimulated in the early 1970s when the People's Republic of China, having opened its doors to foreign journalists, scholars, and tourists, promoted its "integrated system of Chinese and Western medicine" as an exemplar of Maoist enterprise. Widely published photographs showed alert patients undergoing major surgery while anesthetized solely by acupuncture, schoolchildren were shown gathering medicinal herbs, and stories were told and retold about the impressive achievements of barefoot doctors exploiting traditional medical resources. In the wake of these images and developments, numerous conferences on Chinese medicine were organized in Europe and North America. The most important of these for the ethnology of Chinese medicine was organized by Arthur Kleinman, Peter Kundstadter, Russell Alexander, and James Gale. (The proceedings are published in Kleinman et al. 1975, 1978.) Since social science research was not yet tolerated in the People's Republic of China, the papers reported research undertaken in Taiwan, Hong Kong, and overseas Chinese communities. The conference's focus was anthropological; for comparative purposes, it included a few papers on other Asian cultures.

Arthur Kleinman was the most influential medical anthropologist in North America during the 1980s. Besides editing a journal and a book series, he wrote four books, numerous articles, and conference papers, and helped to edit several large volumes of essays. His books on Chinese culture and medicine are *Patients and Healers in the Context of Culture* (1980), which centered on his ethnographic work in Taiwan, and *Social Origins of Distress and Disease* (1986), based on his research in a psychiatric unit in the People's Republic of China. Kleinman's enduring interest has been in the social construction of illness experiences, and in the ways that different popular, folk, and biomedical interpretations of illnesses are mediated in clinical settings. The main criticism directed at *Patients and Healers in the Context of Culture* was that his concepts and clinical observations neglected the large-scale political and economic forces that affect people's illness experiences, their access to therapy, and the epidemiology of the diseases that afflict them. *Social Origins of Distress and Disease* was an answer to this criticism in that Kleinman analyzed the Chinese disposition to somatize social and psychological distress, and the political and social reasons that the concept of neurasthenia, a somatizing conception of distress, has been maintained in China long after it became obsolete in Western psychiatry. His analysis attended to a historical context



by showing how the persecution that occurred during the Cultural Revolution was a source of later disorders revealed in patient narratives and clinical histories. In this book, Kleinman was particularly concerned with what he called "the sociosomatic recticulum," the symbolic bridge between social and bodily distress. These ideas were further discussed in *The Illness Narratives* (Kleinman 1988), a book written in an intimate voice that drew largely on clinical experience in the United States.

Although Kleinman's books describe beliefs and practices associated with Chinese humoral medicine, they are not his main subject. Rather, they are treated as part of the cultural background needed for understanding clinical interactions in biomedical settings. Anthropological research has been severely restricted in the People's Republic of China and, so far, the best ethnographic work by Western scholars on the professional culture and the institutional practice of Chinese humoral medicine is based on research in Japan. Margaret Lock's book, *East Asian Medicine in Urban Japan* (1980), is a major study in this field. Lock centers her work on Kanpo (humoral) clinics and pharmacies in Kyoto. The book also includes descriptions of acupuncture, moxibustion, and massage, and briefly analyzes the practice of cosmopolitan medicine. Thus, her study takes full measure of the pluralistic context within which Kanpo is practiced in contemporary Japan. Lock has subsequently addressed the changing cultural role of biomedicine in Japan as part of an ambitious program of comparative research. (See Lock and Gordon 1988, Lock's essay in the present volume, and her contribution to Norbeck and Lock 1987.) The subject of medical pluralism in Japan is also treated by Emiko Ohnuki-Tierney in *Illness and Culture in Contemporary Japan* (1984), a book that provides detailed accounts of traditional conceptions of physiology and pollution, magical thinking in religious curing, and patterns of sociality connected with sickness. Ohnuki-Tierney's examination of Japanese medical culture is strongly influenced by the perspective of symbolic anthropology.

Despite the impressive contributions of Kleinman, Lock, Ohnuki-Tierney, and other social scientists during the past twenty years, philologists and historians can claim to have made greater progress in research on East Asian medicine than have anthropologists and sociologists. We will mention only four of these writers. The most reknown figure among Western historians of Chinese science is undeniably Joseph Needham. For an example of his work on Chinese medicine, see *Celestial Lancets: A History and Rationale of Acupuncture and Moxa* (1980), written together with Lu Gwei-djen. The German Sinologist, Manfred Porkert, has written an authoritative exposition of humoral theory in *The Theoretical Foundations of Chinese Medicine: Systems of Correspondence* (1974). Nathan Sivin, the leading specialist in the United States, translated part of a 1972 handbook published in Beijing. This is published in *Traditional Medicine in Contemporary China* (1987), together with a valuable two-hundred-page introduction that focuses on problems of under-

standing this system of knowledge and provides an analysis of the ways in which it is changing. Finally, Paul Unschuld, who contributes an essay to the present volume, has been enormously productive over the last two decades, having published, in German and in English, *Medical Ethics in Imperial China* (1979) and a three-volume work, *Medicine in China* (1985, 1986a, 1986b). The first volume, *A History of Ideas* (1985), emphasizes the development of medical pluralism from the earliest period to the present. The second volume is *A History of Pharmaceutics* (1986a). The concluding volume is a translation of *Nan-Ching: The Classic of Difficult Issues* (1986b) and includes commentaries by Chinese and Japanese scholars from the third through the twentieth century.

These authors have made the history of Chinese medicine (and, more particularly, Chinese medical texts) accessible to laypersons and scholars in other disciplines. Anthropologists interested in Asian medicine will find these texts essential reading. Readers who want to examine the Chinese texts directly should consult Unschuld's *Introductory Readings in Classical Chinese Medicine* (1988). This book contains sixty selections in Chinese, a list of all the characters in each selection, together with their meanings, a transliteration of each text in Western script, and an English translation.

Translation inevitably involves many issues of interpretation, and each of these scholars of Chinese medicine finds points of disagreement with the others. The proceedings of a conference that addressed these kinds of problems is published in *Approaches to Traditional Chinese Medical Literature* (Unschuld 1989), which includes three essays on problems of translating ancient and medieval Sanskrit, Arabic, and Latin texts.

Moving from East Asia to South Asia, G. Jan Meulenbeld was awarded the Basham Medal in 1990, during the Bombay meeting of IASTAM, for his English language translation and annotation of the *Mādhavanidāna*, a key Āyurvedic text (1974). Meulenbeld's *History of Sanskrit Medical Literature* (forthcoming) will be the first volume (or volumes, since it is a monumental work) in a new series to be published by the Royal Asiatic Society and the Wellcome Institute for the History of Medicine. The series is jointly edited by Lawrence Conrad, an Arabic specialist, Dominik Wujastyk, a Sanskritist, and Paul Unschuld. In addition, Meulenbeld has recently edited the proceedings of a conference that aimed at identifying priorities for historical and philological research on Āyurveda (Meulenbeld 1984). Also notable in this connection is the work of Kenneth Zysk, who has published two essential studies of the Hindu-Buddhist tradition in the period before the composition of classic medical texts. Zysk's work appears in *Religious Healing in the Veda* (1985), which includes translations and annotations of curing hymns from the Rigveda, and *Asceticism and Healing in Ancient India: Medicine in the Buddhist Monastery* (1991).

The most original historical analysis of Āyurveda to date is *The Jungle and the Aroma of Meats* (1987), by the French Indologist and anthropologist, Fran-

cis Zimmermann. In scope, a comparable work on humoral thinking in Chinese medicine is Manfred Porkert's *Theoretical Foundations* (1974). But Zimmermann's study is strongly grounded in an anthropological conception of science and culture and, in this respect, it is quite different from Porkert's. Influenced by the ideas of Louis Dumont, Claude Lévi-Strauss, and Gaston Bachelard, Zimmermann argues that the ecological contrasts between dry and wet regions of South Asia structured the Āyurvedic classification of therapeutic substances and the cosmic physiological processes that sustain life. Like Porkert, though, in this book he is primarily interested in describing a system of thought apart from particular historical circumstances that affected its development.

Students of Chinese and Sanskrit texts, writers like Nathan Sivin, Paul Unschuld, Kenneth Zysk, and Francis Zimmermann, have a sophisticated understanding of the social sciences, but anthropological and sociological perspectives are not conspicuous among students of Arabic texts. The only book we know of that deals in a sociologically informed way with the transition from learned humoral traditions to cosmopolitan medicine in a Muslim country is Nancy Elizabeth Gallagher's *Medicine and Power in Tunisia, 1780–1900* (1983). Gallagher argues that this transition was facilitated by the inability of the humoral traditionalists to deal with epidemics of plague, cholera, and typhus, in contrast with the abilities of nineteenth-century European physicians. We should also mention the work of LaVerne Kuhnke, who has written a sophisticated study of the introduction of cosmopolitan medicine into Egypt in the nineteenth century (Kuhnke 1990). Like Gallagher, Kuhnke emphasizes the political significance of nineteenth-century epidemics in the context of capitalist development and imperialism. However, Kuhnke focuses on conflicts within biomedicine—between advocates and critics of contagion theory, and between social and curative models of practice—and largely ignores indigenous medical traditions.

During this same period from 1970 to 1990, Asian scholars have also published significant works on the classic texts and their history. For example, Priya Vrata Sharma has published a new edition and English translation of the *Charaka Samhita*, the most important text in Āyurveda (1981, 1983). In 1990 IASTAM awarded Yamada Keiji of Kyoto University the Basham Medal for his research on ancient Chinese medicine. In Japan, an annual International Symposium on the Comparative History of Medicine, East and West, has been sponsored for many years by the Taniguchi Foundation, and its papers are published in English. However, fewer critically trained Asian scholars work in medical anthropology and sociology than in history and philology. The exception may be India. Here, the most notable writer is the psychoanalyst, Sudhir Kakar, author of *Shamans, Mystics and Doctors: A Psychological Inquiry into India and Its Healing Traditions* (1982). But the prevail-

ing tendency among Indian ethnologists and sociologists has been to neglect research on Āyurveda, Unani, and other forms of indigenous medicine, in favor of biomedical institutions (Banerji 1986, 1988; Madan 1980).

Medical anthropology as a special field of research has been very largely a creation of North American scholars, and the majority of Asianists among them have worked in South and Southeast Asia. For various reasons—political, economic, linguistic, and professional—anthropologists have had easier access to these regions. Several symposia on Asian medicine have been published during the 1980s in *Social Science and Medicine* and *Culture, Medicine and Psychiatry*, and they reflect the range of topical and regional interests represented in this anthropological literature. (See Crandon 1987; Dutt 1980; Elling 1981; Good, Good, and Fischer 1988; Laderman and Van Esterik 1988; Manderson 1987; Pfeleiderer 1988; Rifkin 1983; Weisberg and Long 1984.)

One of the most original works in medical anthropology in the last twenty years is *Jero Tapakan: Balinese Healer* (1986), by the ethnologist Linda Connor, and the anthropological filmmakers, Patsy and Timothy Asch. The book is accompanied by four films on the life and work of Jero Tapakan. The book has chapters on the process of making the films and on their ethnographic content, and one film shows the shaman watching herself and commenting on her performance as a spirit medium in another film. This unique combination of film and text gives the viewer/reader access to the working relations between the ethnologist and filmmakers and their subject, Jero Tapakan, but it maintains a spare style, in contrast to the self-indulgence that mars much of the current discourse on anthropological reflexivity.

Although numerous medical anthropologists have worked in Thailand, the most accomplished and ambitious book on the indigenous medical system to date is *Traditional Herbal Medicine in Northern Thailand* (1987) by Viggo Brun, a linguist, and Trond Schumacher, a physician-botanist. Brun and Schumacher are Scandinavian scholars and their book is a source of detailed information that sets a standard of excellence for ethnobotany. However, it is a book that readers are likely to consult topically, rather than read through from start to finish. In contrast, Carol Laderman, working in an adjacent region, has written two monographs in the best tradition of literary ethnology. Her *Wives and Midwives: Childbirth and Nutrition in Rural Malaysia* (1983) began as a doctoral dissertation at Columbia University, where there was a strong tradition of biocultural studies. In this book, Laderman employs ethnographic, ecological, and biomedical data (including dietary analyses) to criticize the assumption, common among biomedical planners, that village cultures are intrinsically obstacles to improving health care in developing countries. Her main point is a familiar one to anthropologists: villagers are flexible and pragmatic in acting on and interpreting their cultural ideologies,

even though these systems of belief appear rigid and self-limiting to outsiders. Laderman's second book, *Taming the Wind of Desire: Psychology, Medicine, and Aesthetics in Malay Shamanistic Performance* (1991), includes a comprehensive ethnographic description of Malay curing rites. Other recent books describe comparable rituals in other Asian cultures, for example, Laurel Kendall has published on Korean shamanism (1985, 1988) and Bruce Kapferer on the ritual dramas of the famous Singalese devil dancers (1983). However, Laderman's monograph is distinctive in the scope of her ethnography. After analyzing the elaborate poetic performances of the Malay shaman in the context of village medicine and cosmology, she goes on to describe the historical relationship of these performances to medieval Islamic medicine and indigenous traditions of theater.

For Āyurveda, we have already mentioned Francis Zimmermann's historical work. Zimmermann is presently translating into English an ethnological study that he published in French (1989), *The Discourse on Remedies in the Land of Spices*, based on study with Astavaidyān Vayaskara N. S. Mooss, an Āyurvedic physician of the Malabar Coast. This new book reports the most thorough and elegant ethnographic research so far published on any system of humoral medicine.

Among American ethnologists, Mark Nichter's work in South India and Sri Lanka stands out. Nichter's book, *Anthropology and International Health: South Asian Case Studies* (1989), has the descriptive fullness and complexity that distinguish first-rate ethnography. *Labour Pains and Labour Power* (1989) by Patricia Jeffery, Roger Jeffery, and Andrew Lyon—a study of women and childbearing in neighboring villages, one Muslim and the other Hindu, in North India—is likewise a combination of first-rate ethnography and critical analysis.

We close this inventory by mentioning two other studies on South Asia, although they deal with governmental agencies rather than with indigenous health cultures. Roger Jeffery's *The Politics of Health in India* (1988) is a sociological analysis of the historical development of cosmopolitan medicine in India. Judith Justice's *Policies, Plans and People: Culture and Health Development in Nepal* (1986) analyzes the ways in which international agencies operate in developing countries. Her research breaks new ground for anthropologists, who usually study villagers and townspeople, by focusing on international bureaucrats and showing that major problems of development lie with the developers themselves.

This brief review of literature which has appeared since the publication of *Asian Medical Systems* indicates the great variety of current work. The Wenner-Gren conference on which the present volume is based brought together scholars whose research spans a wide range of topics and regional cultures, but these essays have been selected to focus on a particular set of

interests: the sources and modalities of medical knowledge. A more diverse collection of essays drawn from the same conference and edited by Beatrix Pfeiderer has been published as “Permanence and Change in Asian Health Care Traditions” (Pfeiderer 1988).

The chapters in *Paths to Asian Medical Knowledge* are about the ongoing evolution of Āyurveda as a professionalized system of knowledge in a modern state (Leslie); the persistence of meanings of death and nurturance in Indian medicine (Trawick); the cultural assimilation of knowledge of epidemic disease in south India (Nichter); the place of experimentation and ideas about proofs in Āyurvedic clinical practice (Obeyesekere); the epistemology of the case study in Chinese medicine (Farquhar); the role of epistemology in relation to changing notions of legitimacy in Chinese medicine (Unschuld); continuities in folk concepts of physiology and etiology in Chinese geomancy (Seaman); the medicalization of the lifeworld in a rapidly changing Japan (Lock); and the role of Islamic humoralism in Malay medicine (Laderman). One chapter splits the arena of inquiry between Asian and Western societies: an account of the “discovery” and reinterpretation of Āyurveda by Westerners who have rejected Western therapeutics (Zimmermann). While other essays concern particular twentieth-century settings, one chapter (Kuriyama) examines eighteenth-century Japan’s extraordinary encounter with Western medicine via Dutch anatomical engravings, and another chapter (Good and DelVecchio-Good) is an account of Islamic medicine as a symbol system encompassing the breadth of Asia.

The shared perspective throughout the book is epistemological. Authors ask: How do patients and practitioners know what they know? What are their various rules of evidence, what kinds and categories of information do they find persuasive, and under what circumstances? How do they know when a medical judgment is wrong or correct? What do “wrong” and “correct” mean to patients, to village practitioners, and to experts trained in the great tradition? What sorts of inductive logic and analogy are at work here? Under what circumstances are these people inclined to accept or ignore novel medical ideas and practices?

## REFERENCES

- Banerji, Debabar  
 1982 *Poverty, Class and Health Culture in India*. New Delhi: Prachi Prakashan.  
 1986 *Social Sciences and Health Service Development in India: Sociology of Formation of an Alternative Paradigm*. New Delhi: Lok Paksh.
- Brun, Viggo, and Trond Schumacher  
 1987 *Traditional Herbal Medicine in Northern Thailand*. Berkeley, Los Angeles, London: University of California Press.