

# Don't Tell the Doctor:

Case Studies of Traditional Medicine Sustainability Efforts  
in Indonesia, Ireland and New England (USA)



*Inside the Dunboyne clinic, allopathic scientific implements alongside traditional tools,  
both utilized to produce medicine.*

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# **Introduction**

## **Voices of Healing**

Early in life, my father named me ‘Nurse Caitlin’, referring to my inclination towards taking care of others whenever illness, injury or the weight of life took its toll on those around me. With seriousness more mature than my age, I would instinctively and unflinchingly rush to grab medicine or a bandage from the cabinet, clean up a wound or stomach sickness. Today, I’ve found that my friends and family have come to rely on me as a healer, whether it is for headaches, stress, or increased pain from a woman’s cycle - this has only increased as I continue my herbal training and medical research. Over time I waffled back and forth about pursuing an education in healing, but my passion for it has continually pushed the topic to the forefront of my research interests. Even when studying anthropology in my undergraduate program at Georgia State University, my interest was in biomedical and forensic Egyptology, learning about mummy bones to help scientists track the evolution of diseases over time in hopes of creating medicines for future strains. In many communities, healers are called to the practice by something similar to whatever would not leave me alone. I decided to give in to the pursuit finally after speaking with one of my professors, Rory Turner, who asked me why I was so hesitant to call myself a healer? I began to think about this in depth over the next few months, researching different cultural concepts of healing methodologies. What does it mean to be a healer and what did it mean to heal?

I owe the beginning to Dr. John Hoopes'<sup>1</sup> lecture on "*Emic and Etic Models for Sorcery as Medicine in Pre-Hispanic Central and South America*". During my undergraduate education at Georgia State University, I was lucky enough to sit in on his presentation during the Society for American Archaeology conference in 2012. For me, it introduced the vital role of local healers and their political standing in many communities and inspired me to research how we might sustain and respect local hierarchy when offering outside medical aid.

There is a common understanding in the power that comes along with healing in that if you can heal, you also have the knowledge of what can cause harm. This carries a hefty weight and power and encourages communities to respect the wishes and laws enforced by the healer, lest they either incur the healer's wrath or lose access to healing. This community role is vital to maintain social order. Hoopes used the example of one Therianthrope, or sorcery-based shapeshifter, the Kanaima - a jaguar-like shaman in Brazil who uses terror and the threat of violence in his animal form to control the social behavior of the community, acting as a last resort when other local methods of policing fail to work.

This social and political balance is often based on the power held by the healer as the ultimate control of death and the spirit realm. Any healers presenting a more powerful and successful form of healing could easily displace the original healer in the hierarchy. So, what might happen if an outside allopathic medical professional provides aid for an issue that the local healer has not been able to cure and these allopathic healers are successful? I began to question the deeper issues that may have been presented by colonial and postcolonial introductions of allopathic biomedicine and the Western mentalities that come along with it. I have since been

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<sup>1</sup> Director of the Global Indigenous Nations Studies center at the University of Kansas

examining different healing communities and the interactions between different healthcare methodologies in culturally diverse regions.

“*Don’t tell the doctor*” can mean so many things. In this work I discuss what it means to be a healer, as well as to specifically shoulder the title of “*Doctor*” – something that varies from country to country based on cultural understandings of the word, as well as regulations determining what a person with such a title may do. These regulations can lead to issues of certification for practitioners of other healing methodologies, which further hinders any respect and collaboration between doctors and other healers. Further, patients may fear telling an officially credentialed doctor – a position placed on a pedestal due to the dominant allopathic hierarchy – that they are practicing other healing methods for fear of being looked down upon. There is the additional issue of who has access to a doctor to tell them anything in the first place, as well as the problems leading to the necessity for research such as this – who and how can we speak up about this to see change? How do we prevent marginalization of non-allopathic healers and help patients not feel shame for seeking out these other practitioners?

Initially, I intended for this research to present case studies on the Indonesian islands of Sumatra, Sulawesi and Alor, with accompanying narratives of local scholars, scientists, and practitioners of various healing methodologies. I settled on Indonesia due to its “wealth of biological resources and cultures, many of which have developed their own, distinct health care systems. Moreover, it is believed that the situation of traditional medicine in Indonesia is more or less characteristic for that in several other countries in the region” (Trips, 2.2). I undertook intense cultural, historical and legislative based research for each of these locations and then sought the help of Dr. Gerard Bodeker, Chairman of the Oxford-based Global Initiative for Traditional Systems of Health (Project Southeast Asia, 2014). He connected me with an

Indonesian scientist at Gadjah Mada University by the name of Dr. Mustofa Mustofa, a professor in the faculty of medicine, specializing in biomedical research and extraction of Indonesian medicinal plant constituents. He has shown a great interest in preserving the plants and sustaining the traditions behind them, and recently has begun to work with the anthropologists at his own university to further this interest.

Dr. Mustofa graciously agreed to serve as my local representative for the very complicated government protocol necessary to attain a Foreign Research Visa via the RISTEK, or Ministry of State for Research and Technology. After six months of paperwork, difficult phone calls due to language barriers, and waiting, the time came to fly to Yogyakarta to meet with Dr. Mustofa. RISTEK had scheduled a conference call with him to discuss our collaborative research and we wanted to sit down and discuss the details in person before he met with them. I expressed my interest in also connecting with the anthropologists he was partnering with and shared with him some of the locations where I was planning to pursue my research. After emphasizing my awareness of biopiracy, cultural sustainability and intentions to stay within the comfort zone of the practitioners, he recommended some additional places to consider and promised to do his best to get my paperwork finalized. The next week he was to have a conference call with the RISTEK committee, but sadly they had connection issues and the meeting never happened. Dr. Mustofa and I repeatedly tried to contact the office via phone and email, and finally heard back a month later. They rescheduled the meeting and at its conclusion, suggested I partner with a different faculty and resubmit my paperwork to begin the process again. They also emphasized that they would not be able to begin processing it until after the Indonesian presidential elections were finalized, an announcement that I anticipated would push my timeframe back further than I could work around. I redirected my research to incorporate

case studies in three different countries, each unique in their views and approach to medical methodologies and sustainability of traditional medicine culture.

The first, of course, was Indonesia – an incredibly culturally diverse country that cannot and should not be summed up as either a singular whole, or even by individual islands. According to a survey by the National Institute of Aeronautics and Space Indonesia includes 18,307 islands, 900 of which are currently inhabited, and the archipelago is home to over 300 recognized cultures (CIA, 2014). During my stay here, I primarily worked with the aforementioned Dr. Mustofa, as well as with Daud Manggalatung. Daud is a retired anthropologist and former village leader, now running the Rianna Homestay (named after his lovely wife) with his family, who practices and grows traditional medicine in Rantepao, on the island of Sulawesi. He was quite interested in my work and, along with Dr. Mustofa, has also expressed interest in future collaboration when I continue my research in Indonesia. After I completed my field research, both Mustofa and Daud agreed to answer questions via email and Skype to allow me to continue working with them without violating RISTEK or IRB protocol. To further ensure I followed protocols, any additional information concerning Indonesia was acquired through non-sensitive, personal experiences or secondary resources.

Next, I journeyed to Ireland where I interviewed Rosari Kingston and her colleague Anna-Maria Keaveney, both of whom lecture at the Cork Institute of Technology in the Herbal Medicine program and are professionally qualified Medical Herbalists. During my first few years in the Goucher Masters of Cultural Sustainability program I had undertaken detailed research on Irish history and traditional medicine practices, having been inspired by my own family's Irish ancestry and the discovery that numerous clan members had been, or are currently, involved in the healing profession. Ireland proved to have a very long-standing, though complicated,

tradition of healing that is made apparent through their battle to leap from the margins of the healthcare system.

Finally, I returned to my home in Rhode Island, USA, to interview Dr. Bonnie O'Connor, a recently retired cultural mediator and folklorist who still serves as an advisor and member of the ethics committee at Rhode Island Hospital. She served, and continues to graciously do so, as an excellent mentor on the intricacies of healing traditions in the culturally diverse United States of America, and on the importance of pluralism in medicine to sustain healing traditions, cultural context and holistic health.

It has been fascinating to find that despite the unique aspects of each country and culture, each narrative discussed similar issues, hopes, and community interest in sustaining traditional methodologies of healing. Each expressed concern over the negative aspects of globalization, consumption of medicine, and the unsustainable demand for herbal products, should interest in herbal medicine continue to grow alongside our population. Additionally, the core aspects of each healing methodology utilized and preferred in the different countries varied only slightly, with most preferring a touch-based therapy, an herbal-based therapy, spiritual aspects, and some allopathic medicine. However, the cultural context and application of each was vital to their continued interest in it, and the importance of these unique details of each tradition must be emphasized.

These voices of healing speak to the necessity for culturally-sensitive healthcare and a culturally-specific approach to both sustainability and strategies for improved global health. They provide case studies of the particular histories, current statuses, and future goals for these three countries and serve as arguments against the complete integration and white-washing of the healthcare field. In the following chapters, I will utilize these narratives to discuss the role of



medicine in the holistic health of communities, as well as the legislation governing - and often hindering - medical practitioners and how it contributes to the often volatile relationship between allopathic and non-allopathic medicine. Through sharing the stories of the training passed down through family lineages and formal education in traditional medicine, I will highlight the ways in which these communities are making efforts to promote the sustainability of traditional medicine practitioners and their plants, and the implications of the lack of a sense of community among practitioners. Analysis of the ways in which the hegemonic and colonialist domination of conventional medicine has influenced healing communities will be considered, with an in depth focus on two primary approaches to including non-allopathic medicine in community healthcare: integrative and pluralistic models. Finally, I will apply all of this to highlight the necessity for a change in the way we approach community health through proposed strategies and current work towards pluralism and sustainability of healing communities.

### **Defining Healing**

In each culture there is a wide variety of concepts of health and an even wider assortment of methodologies utilized to achieve healing: chants and hymns, herbalism, sacred spaces, food and nutrition, dance and movement therapy, and a variety of associated rituals, spiritual practices and beliefs. Some might argue that many of these are a placebo type effect, though this only serves to support the important healing power of the immaterial mind over the material body. Countless healing traditions espouse the necessity of listening to our mind and bodies when it comes to assessing what we need in order to heal. There is a ritual to our rhythmic cycles of sleep, eating, and recharging. Anthropologist Sienna Craig, working on the efficacy of traditional Tibetan medicine, suggests that “Medical anthropology teaches us that illness and healing can never be reduced to biology. Culture matters. But the specters of biomedicine – the possibilities

of its miracles and its more mundane public health benefits – are ever present, driving health policy and defining what we mean by ‘disease’ or ‘risk’.” And so, as Craig and many others question, how do we work within local concepts of healing, honoring and respecting them, while also helping more community members survive? (“With One Heart”, 29).

“Why did you want to learn about Tibetan medicine, after you’d already begun studying and practicing Western medicine?” As Dr. Craig, in her work entitled *With One Heart*, presented this question to a Tibetan healer, the implications of the details of language stirred for me. “In Tibetan, one can either refer to biomedicine as ‘medicine from the West’ or ‘foreign medicine’, though the latter can also mean medicine from *gya nag*, China.” In line with this, telling of a European doctor who worked in Tibet for a decade, she recalls that “the most difficult thing about doing healthcare work here is that most people are convinced Western medicine was invented in China, in 1950, and that nothing has changed since! In this context, it was worth asking if ‘Western medicine’ and ‘biomedicine’ necessarily meant the same thing” (Craig, 31). Craig presents an example of how healing terms may take on different meanings in different contexts, supporting the need for insider voices to illustrate the ways in which culture constructs concepts of health.

Many cultures utilize herbal medicines as a part of their healthcare systems, and it seems to be the one methodology that everyone can agree has genuine effects - even allopathic medicine, which often labels methodologies lacking quantitative research as quackery. Could this be because even allopathic medicine has its roots in medicinal herbs and natural products? For non-allopathic practitioners, however, herbal medicine is not considered an alternative medicine but rather is a primary part of healthcare. The way that each book, discipline or community labels and defines methods of healing creates a confusing, culturally-diverse

approach to how we discuss health. This array of definitions for healing terminology often hinders communication and respectful partnership, and can create a sort of false dichotomy within academia and the healthcare system: an ‘us’ versus ‘them’ mentality. We have the interchangeable terms of “allopathic”, “Western” and “conventional” medicine, which have already somewhat shown to vary in their definitions for some cultures, the varying concepts of how one might define “traditional” and “folk” medicine, the academic terms of “TCAM”<sup>2</sup> and “integrative medicine”, the term “holistic” – which seeks to include all methodologies, and the all-encompassing terms for ‘them’: “non-allopathic”, “non-medical” and “non-scientific medicine”.

When analyzing the difference found in the use of medical terms in popular media, “folk medicine” would appear to cause people to discredit a form of medicine as snake oil, ridiculous or even dangerous. But labeling something as “traditional medicine” seems to have developed a form of romanticism – rare, old world, raw; or else in that its efficacy has been newly reconsidered as if it was only recently discovered – either way, its legitimacy is actually being considered. As folklorists so often witness, the use of the word “folk” has negative connotations that seem to steal the importance of a cultural aspect. Even the term “traditional” still receives this bad rap, as Jamison argues in *Globalization and the Revival of Traditional Knowledge*. “The diverse array of ‘non-scientific’ human knowledges have come to be labeled as ‘traditional’ with all the negative and derogatory connotations that the term has come to imply” (82). I have chosen, within this work, to primarily refer to what is commonly referred to as ‘modern, Western conventional’ medicine as allopathic and each of these methodologies either utilizing its individual, culturally-accurate term or a general term based on its material use – such as herbal medicine. When referring to medicines that do not fall under the category of allopathic, I will use

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<sup>2</sup> Traditional, complementary and alternative medicine.

the term non-allopathic. I am hesitant to propagate the concept of what I view as a false dichotomy within healing systems, however for ease of discussion I have settled on the general term: non-allopathic.

“Medicine is traditionally considered a healing profession, but it has neither an operational definition of healing nor an explanation of its mechanisms beyond the physiological processes related to curing; Science values operational definitions” (Egnew, 255; 257). In Egnew’s work on the *Meaning of Healing*, he defines healing as “the process of bringing together aspects of one’s self, body-mind- spirit, at deeper levels of inner knowing, leading toward integration and balance with each aspect having equal importance and value; Healing is the personal experience of the transcendence of suffering” (256; 258).

Could we ever have a solid operational definition of healing that is applicable to such a widely diverse world of cultures? Personally, I’m not so sure. One of the main arguments and internal disputes I’ve encountered by those discussing this topic is related to the idea of a global definition or set of regulations for concepts that are exceedingly culturally diverse. The necessity of these solid lines to increase expectations for good health practices, but also the implications of damage when ostracizing those who don’t or can’t meet these expectations. So often medicine or healing is defined as valid by its scientific backing, but even the definition of science in Western terms has culturally-biased implications. Words translate linguistically with slightly different meanings, and we use different words based on the code we choose to communicate in at a specific moment. Science, to most in the West, means laboratories, microscopes, chemicals, white jackets, computers and pristine environments. However, the definition of science is more widely-encompassing. For a more detailed explanation of many of the terms used both within

this work and in the wider literature discussing healing systems, please refer to the glossary I have included towards the end of this work.

## Literature Review

As mentioned in the introduction to this work, my primary inspiration came from Dr. John Hoopes' lecture on "*Emic and Etic Models for Sorcery as Medicine in Pre-Hispanic Central and South America*" (2012). In this presentation he discussed the role of local healers in their communities as a sort of political and spiritual-based social control through the example of the *kanaima*, or jaguar shaman. His work highlighted some of the intricate ways healers work within their society which might not be immediately apparent to non-members of the group, and showcases the necessity of local healers for a holistically healthy community.

Thomas Egnew's *Meaning of Healing* further investigates the role of a healer, utilizing crowdsourcing to investigate a more general perspective healers have of their job requirements and the expectations patients have of them. It discusses the changes that have happened within the healthcare system as allopathic medicine becomes a dominant hegemony for many communities. "In the process, cure, not care, became the primary purpose of medicine, and the physician's role became 'curer of disease' rather than healer of the sick" (Egnew, 255). The practitioners interviewed in the article analyze the meaning of "wholeness" and what it might mean when practitioners seek to return people to this state through healing.

One physician suggested that "the concept of wholeness as a definition of healing lacks only one thing. What anybody means by the word 'whole' and what it means to 'make' whole ... much less the word 'again,' which implies that the person was whole prior to the healing ... [i]f you mind that, then it's a terrible definition" (Egnew, 257). So then are we born whole? How do we lose this wholeness and when we do, what are we then? Is there harm in considering oneself not-whole, i.e. *broken*? "We find we are not enough," Hammerschlag noted. "It's too isolating.

It's too disconnecting. The nature of the human experience is not solitary. Ill patients experience a transformation in their sense of wholeness characterized by loss and isolation. Not being the persons they have known themselves to be, they suffer" (Egnew, 257). Through a discussion of the role of practitioners in the healing process, it settles on the idea that "healing is independent of illness, impairment, cure of disease, or death" (Egnew, 257), but rather utilizes their tools to bring peace and wellness to the patient through re-instating the sense that they are whole and themselves, whether the patient feels they lost that wholeness or not.

Egnew's discussion of the narrative as part of the healing process intimately ties his piece to the work done in cultural sustainability and to my research efforts within the field. "Healing is an intensely personal, subjective experience involving a reconciliation of the meaning an individual ascribes to distressing events with his or her perception of wholeness as a person. Healing may be operationally defined as the personal experience of the transcendence of suffering. Physicians can enhance their abilities as healers by recognizing, diagnosing, minimizing, and relieving suffering, as well as helping patients transcend suffering" (Egnew, 255). Medical narratives are a way to help voices be heard and connect them to other voices echoing the same fears, pain and hopes to create a sense of community that not only fosters healing for the individuals involved, but also for their communities as they seek to sustain their healing needs.

One important, under-researched topic is the concept of a culture-bound syndrome, something I was introduced to in Amber Haque's work, *Culture Bound Syndromes and Healing Practices in Malaysia*. "Often termed culture-specific syndrome, culture-bound syndromes (CBS) represent a combination of psychiatric and somatic symptoms that are acknowledged only in a specific culture. Many of these patterns are indigenously considered to be 'illnesses' or at

least, afflictions, and most have local names. Anthropologists emphasize the cultural aspects of the syndrome, while physicians stress the biological dimensions of the disorder” (Haque, 685). Her research gives ample evidence of the necessity for culturally-sensitive, unique approaches to healthcare for each culture and individual. It expresses the necessity of understanding these "ways of knowing" and concepts of illness in order to cure them, because the patient will not accept that they have been healed if the proper methods haven't been used. Her work states that the lack of understanding of these mental illnesses can cause issues from communities being forced to rely on western concepts of healing and a loss of access to their own, though research is lacking on this within immigrant communities. The term “‘Culture Bound Reactive Syndrome’ was first documented in 1969 by Pow Meng Yap, a psychiatrist in the Hong Kong Government. Before Yap’s introduction of this term, such conditions were thought to exist only in the non-western world and were thus labeled ‘exotic psychotic syndromes’” (Haque, 685). It wasn’t until his published work that many of the CBSs were acknowledged by the academic and professional community. Could publishing reports on traditional medicine encourage traditional medical beliefs and methodologies to be accepted, or at least acknowledged, by the allopathic and academic community? “One is reminded that reality is, in fact, a creation of one’s own culture. What we believe in is often what we have been taught and what we have learned or experienced over the years” (Haque, 694). Research into cultural-bound syndromes can teach clinicians to consider other ways of perceiving healing, as many cultures still have their own methods of approaching illnesses. An important problem discussed here has been in approaching these syndromes within their own cultural context; however in reality it is more likely that outsiders are comparing them to illness concepts within allopathic or Western ways of knowing.



*Cultural Democracy: The Arts, Community and the Public Purpose*, by James Bau

Graves, discusses the issues of ruling paradigms applying hegemonic ideals to a broad spectrum of cultural ideas. While it does not directly discuss traditional healing, the concepts it introduces can be applied to all types of intangible heritage and intellectual knowledge – traditional medicine, included. In the beginning, the author states that the work is a “report card on American culture. My focus is on the choices that individuals make about how to shape the fabric of their lives, and about the mechanisms that make those choices available” (Bau Graves, 3). While this work specifically discusses the issues facing culturally diverse America, it actively applies to my interest in the New England area, as well as the varied communities in Indonesia and the increasing number of cultures present in Ireland. As globalization continues, we must prevent the “inevitable cultural grey-out from the destruction of traditional societies and the homogenizing influence of mass communications” that Alan Lomax warns of (Bau Graves, 7). Yes, cultural sharing is inevitable and has historically always been a factor in community growth and change. But the rapid spread of culture through modern technology has changed the game dramatically.

In his work, Bau Graves points to UNESCO’s emphasis that cultural resources are non-renewable, and that the primary protection has gone towards physical sites, such as monuments, while intangible heritage has suffered. It is understandable that it is difficult to create laws and protections for items that we cannot see or hold, but the worth of knowledge is indisputable as we see it stolen, appropriated and patented. As with many who seek to sustain traditional knowledge with its cultural context, Bau Graves also fears that global exchange of this knowledge will lead to a smoothing out of the ‘ethnic edges’. He blames our short attention span for the concept of time, and the future – something that many sustainability workers would agree

with. In his work, he seeks to lay out strategies to bring traditional knowledge and cultural practices out from behind closed doors - driven by indigenous practitioners, of course – to prevent them from diminishing. Expressions of culture to formulate and present personal identity and access to traditional healing practices are necessary when patients seek to maintain that identity.

As I considered the difficulties of creating infrastructure and legislation to protect intangible medical heritage, I referred back to Weintraub and Yung's *Music and Cultural Rights*, which presented me with the groundwork understanding of laws and legislation concerning intangible cultural heritage and intellectual property rights, as well as the difficulty in defining cultural heritage and the potential negative implications of outsiders creating these laws. This volume brings together a variety of case studies in music-based cultural rights issues to present the importance of these cultural aspects to their communities. It shows how cultural rights issues have surfaced and how the laws and institutions interacting with them have evolved. It presents a wonderful example of approaching an oftentimes difficult to grasp concept of culture, which can be learned from and applied to examinations of other intangible cultural heritage domains, such as traditional medicine. The editors emphasize the importance of further detailing the laws and approaches to dealing with issues threatening indigenous music traditions, while also considering the negative implications of outsiders creating new laws for communities of which they have a limited understanding.

Within communities that do not exercise the dominant hegemony, or which have suffered from colonialism, practicing traditional medicine can act as a form of cultural representation that, like musical performances, “provide unique ways to assert and negotiate power among groups with competing ideological interests” (Weintraub and Yung, 2009). The Universal Declaration of

Human Rights illustrates this assertion against Western-centric ideals implemented through mass, blanket-statement legislation. However, the Declaration does vouch for role of culture in “maintenance of dignity and development of one’s personality” (Weintraub and Yung, 2009). Through Weintraub and Yung’s work on cultural music rights, I was able to understand how traditional medicine regulations might also be governed by the United Nations, the United Nations Educational, Scientific, and Cultural Organization (UNESCO), the World Intellectual Property Organization (WIPO), and the World Trade Organization (WTO). The references within this work helped point me in the right direction for further research into the legislation, and gaps within it, governing my field work locations and acting as an excellent reference for ways in which appeals are being made within the musical world which might be utilized for efforts within traditional medicine communities.

Richard Kurin’s *Safeguarding Intangible Cultural Heritage: Key Factors in Implementing the 2003 Convention* discusses the definition of Intangible Cultural Heritage (ICH) and the Convention to safeguard it, as well as the issues that arise when attempting to define living ICHs that are constantly flowing and changing in a natural way. It also addresses the issues regarding a government program being the “protector” of ICH when so often it has been the cause of conflict with the practices, themselves; communities may not want to work with the government to sustain and protect their heritage due to lack of trust and concerns over power play. Kurin goes on to propose alternative ‘protectors’ and their pros and cons – such as museums and universities. The importance of a working, continually updated inventory of ICH practices, along with other strategies for safeguarding, is expressed, though he questions if safeguarding is enough.

The World Health Organization's *Traditional Medicine Strategy for 2014-2023* is referenced numerous times in my work, as it lays out instances of problems within current legislation and strategies to work towards solutions for these issues. "As T&CM<sup>3</sup> becomes more popular, it is important to balance the need to protect the intellectual property rights of indigenous peoples and local communities and their health care heritage while ensuring access to T&CM and fostering research, development and innovation. Any actions should follow the global strategy and plan of action on public health, innovation and intellectual property" ("Traditional Medicine Strategy", 17). However, while research of traditional medicine can aid in further validating it for legislative purposes, it can also be used to misappropriate *medica materia*. Patenting the use of these plants is not only appropriation, but also monopolization of a medicine that typically ends up costing such obscene amounts that it is no longer accessible by the originators of the knowledge. The work acknowledges the growth of global trade in these products, and how this increases the need for protection of biodiversity and prevention of biopiracy. As I stated with reference to my utilization of *Music and Cultural Rights*, the *Traditional Medicine Strategy* calls for use of "current intellectual property frameworks (to) be used to protect innovations based on T&CM and be extended to include appropriate safeguards to prevent the misappropriation of T&CM" (47).

Other legislative sources that proved useful in my initial research were the highly detailed protocols of the Convention on Biological Diversity. The Convention is "an international treaty for the conservation and sustainable use of biodiversity and the equitable sharing of the benefits from the utilization of genetic resources. The Convention seeks to address all threats to biodiversity and ecosystem services, including threats from climate change, through scientific

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<sup>3</sup> Traditional and complementary medicine

assessments, the development of tools, incentives and processes, the transfer of technologies and good practices and the full and active involvement of relevant stakeholders including indigenous and local communities, youth, NGOs, women and the business community” (“Secretariat of the Convention on Biological Diversity”, 2009). The protocols include requirements for “parties to respect, preserve, and promote traditional knowledge relevant to conservation and sustainable use of genetic resources” (Convention on Biological Diversity, 2014) which facilitates channels of communication between indigenous knowledge keepers and those seeking to acquire this knowledge and also ensures that indigenous communities play a role in the ways it is used.

A new protocol has been presented by the Convention on Biological Diversity, known as the Nagoya protocol, which would require that the “pharmaceutical industries would need the written consent of local people before exploring their region’s genetic resources or making use of their traditional know-how” (Hall, 2013). This protocol not only seeks to protect the intellectual property of the people, but also to aid in the sustainability of their natural and genetic resources. It has become widely acknowledged by members attending the Convention on Biological Diversity that we must partner with indigenous people to safeguard these resources by using their traditional knowledge to maintain the health of the ecosystems providing us with them.

Executive Secretary of the Convention, Ahmed Djoghla, opened up the most recent meeting to discuss the implementation and necessity of these practices, stating “We must also take the time to consider a forward-looking programme of work on how traditional knowledge may be better used to address the grave problems currently facing humanity, including our unsustainable practices and the ever-rising tide of extinctions. I firmly believe that the survival of species and the survival of traditional knowledge and of the holders of this knowledge are inextricably linked” (“Secretariat of the Convention on Biological Diversity”; 2009). The

protective laws that are necessary due to Western people's insistence in utilizing non-allopathic methodologies of healing has required acknowledgment of their potential validity and ushered forth a wave of research to prove this validity. This is also forcing allopathic health practitioners to consider the potentials of these other methodologies and to be open--minded concerning their effectiveness.

A piece that highly contributed to my understanding of how and why communities choose healing methodologies was *Biomedicine and Alternative Healing Systems in America*, by Hans A. Baer (2001). He discusses the role of past medical experience, previous or current socio-economic status, and immigrant status in the determination of healing methodology choices for immigrant or non-European-American individuals. There is a lot to be said for finances determining healthcare choices, and I would argue that Europeans and European-Americans are just as often influenced by these histories and statuses. He presents examples for how the various folk medicine traditions he discusses have emerged as responses to the wisdom gained from the history of a people and which focus primarily on the problems of everyday life. Additionally, there is discussion on the reasoning behind visiting a traditional healer as opposed to an allopathic physician – the latter lacks knowledge of culturally-unique ailments and how to treat them, some of which are newly suffered from the pressures of a changing experience in daily community life due to a rapidly globalizing world. To quote from Baer's work, "A traditional healer's ability to evolve as the world and their community's needs do is vital to a sense of stability and continuity in the face of disrupting urban-technological change" (2001). In fact, many community healers do more than just medically heal their clients – they act as advocates, mediators and go-betweens for them, something that they often consider an extension of their

role in the community. These additional roles have all too often been ignored by outsiders, and the marginalization of a traditional healer does more than just isolate patients from their herbs.

The works compiled by Erika Brady in *Healing Logics*, and especially the work therein and elsewhere of Bonnie O'Connor, helped continue my understanding of traditional medicine and cultural concepts of healing through a variety of community lenses. Additionally, Dr. O'Connor's work and our conversations, making up a chapter of this capstone, helped me move beyond simply analyzing the false dichotomy of healthcare methodologies towards a deeper appreciation of the need for pluralism in healing. In her *Introduction*, Brady discusses the almost universal concept in traditional medicine methodologies of the soul and body as being inextricably linked regarding health and wholeness. She mentions that few people entirely stick to biomedical protocols when healing themselves and others and points to examples of this body-soul link even in hospitals. In fact, when my father was passing in the hospitals, they would play recordings of Catholic prayer over the loud speaker every day. However, she goes on to express the issues that lend to the problematic dichotomy in the healthcare world, referring to allopathic medicine as an "almost Olympian extra-cultural inevitability, existing outside the social, cultural and historic contingencies that shape other aspects of custom and practice – a kind of secular religion" (Brady, 4).

Allopathic medicine is placed on a pedestal of privilege, often overreaching its own credibility, and placing all other medicine, regardless of intent, firmly in the category of quackery, "no matter how amply supported by generations of informal empirical observation" (Brady, 5). She goes into the details of the Flexner report, developed in the 1900's, which created the current allopathic medicine paradigm that has placed them at the top of the imposed medical hierarchy. Brady dubs this medical superiority an "organizational commodification of healing in

the West” (Brady, 6). This relates back to Baer’s work and discussion of finances. It is unfortunate, and dangerous, that the only reason allopathic practitioners and their medicine providers are considering “alternative medicines” is because they have seen proof that patients are utilizing, and spending money on, these other healing methodologies. It creates the potential for unsustainable environmental stewardship, loss of cultural context and traditional practitioner agency, and haphazard training.

For me, one of her most important discussions is concerning the authority of the community and its determination of the credibility of healing methodologies and practitioners. It seems that this has changed and become disconnected, somewhat, from the community when it comes to allopathic practitioners, their credibility coming from a piece of paper in a frame on the wall rather community support. I cannot remember the last time I was able to gain a quality referral from a friend. None of them are able to give reasons why a particular doctor or dentist is superior to others, and few people try out multiple practitioners. Now we have created a new type of relational authority, something that “everyone does and has always done” – unquestioning settling for a practitioner who will write us a prescription every time.

Additionally, she addresses the implications of the “new age” medical fads and its appropriation of traditional practices. This is an entirely other subject tied up with medical tourism, loss of cultural context, and other issues of cultural sustainability and I could go on about it for hours, but that’s for another day. The same hope for miracles has been imprinted on traditional medicine in the form of traditional medicine tourism.

Another piece within *Healing Logics* is the work by Bonnie Glass-Coffin: *Reflections on the Experience of Healing: Whose Logic? Whose Experience?* (2001). It begins with a tale she tells her classes and uses it to bring up various responses her students, and others, have to



concepts of healing that are culturally foreign to us. One response is the often utilized comparison of sorcery and intent to placebo and nocebo effects – the ways in which culture and traditions can effect perceptions of reality. She goes on to explain interpretive drift, a kind of change in consciousness, and its role in exploring the efficacy of difficult to explain spiritual and symbolic healing practices. She gives thought provoking examples of the problem of reasoning and concepts of normalcy that create bias and a sort of blindness towards different ways of knowing, seeing and experiencing.

Another response to these other ways of knowing is to claim that they are another way to explain things that a community cannot otherwise justify with what is considered rational by dominant hegemonic mindsets. The third response is an encouragement of experiential research for personal assessment and diagnosis. This can at least encourage the respectful perspective towards ‘I may not feel this way, but I believe you and understand that you do.’ It presents alternative reality possibilities and facilitates understanding. Experience adds context, and as the author points out, experience and observation are a large part of the scientific method – this further lends itself to my discussion of the definitions at the beginning of this presentation, and the more widely-encompassing, literal definition of the term ‘science’ versus what is taken to be the common meaning of the word.

The author is here giving an example of the importance of educating students in a bottom up approach. Advocating for culturally sensitive health care in hospitals, clinics and with many other healthcare facilities or personnel can often come across as “just another person trying to tell me how to do my job, when they aren’t a doctor themselves”. This can often become lost in their already too-busy work schedule, or come across in a way that is flat out unwelcome. While we cannot remove the cultural lenses we have on, we can be aware of them.

As referenced earlier, Dr. Bonnie O'Connor also has a work within *Healing Logics*, co-authored by David J. Hufford and titled *Understanding Folk Medicine* (2001). This work focuses on the flawed concept of a static, or linear, theory of folk medicine, often still utilized to label traditional medical practices as outdated and uninformed (O'Connor and Hufford, 2001). They touch back on Brady's mention of the issues of romanticizing traditional medicine, leading to further perception and image issues, and the argument that self-care is a mixture of 'official' and cultural concepts of healing. They go on to further express the issues of a lack of funding and research for folk medicine practices, despite their generations of usage and reputations of efficacy. Their research expresses that part of this stems from many methodologies' seeming lack of systemization and reliance on orality – regardless of the changes these methodologies are undergoing.

The work continues with deeper insight into the definition of folk medicine as a concept. It discusses the multiple aspects and tools of healing approaches, as well as how their moral elements are vital for the interconnectedness of the community and its health. The authors touch on the different types of illnesses treatable by folk medicine and why these non-allopathic modalities cannot be ignored by allopathic practitioners.

Finally, the work by Sienna Craig guided me as a model for investigating traditional medicine communities and discussing the changes that are affecting them, amplifying their voice as they seek sustainability of their cultural heritage through efficacy of their practices. Her background is in Tibetan medicine, as she illustrates in her works *Healing Elements: Efficacy and the Social Ecologies of Tibetan Medicine* (2012); *Portrait of a Himalayan Healer: Traditional Medicine in Mustang, Nepal* (1998); and *With One Heart* (2004). She documents the difficulties Tibetan medicine has faced as it seeks to retain its cultural authenticity while also

providing efficacy according to the standards of biomedicine. She asks the question, “what does it mean to say traditional medicine ‘works’?”, examining how expectations of efficacy are developed, by whom and to what ends, stating that it is “inextricably tied to global regimes of governance, from conservation-development agendas to techno-science and the business of global pharma” (Craig, 2012). As the world globalizes, it becomes increasingly interconnected and aware of alternative concepts of healing. Despite this, allopathic medicine’s reductionist nature still focuses on the question ‘but does it work?’

Craig’s studies analyze the role efficacy plays in how people fall sick, understand their sickness, take medicines, experience their outcomes, and make sense of these events within their cultural context (2012). She expresses that efficacy, rather, refers to the capacity to produce desired outcomes in ways that factor into cultural context, as well as environmental, political, economic and historical factors at play. Traditional medicine “and the manifold domains of its efficacy can be fruitfully analyzed,” the author argues, “as social ecologies, a concept borrowed and expanded from public health, epidemiology and parts of medical anthropology” (Craig, 2012). This demands a holistic approach, not only to medicine itself, but also to the study of health and healing.

She further expresses the difficulties in actually proving efficacy, as it is often culturally determined by success in a particular context. In an interview with Ann Armbrecht, of *Numen: Conversations about the Healing Powers of Plants*, Craig argues that “there is also the ritual act of doing something to feel better to alter your state of being. It is hard to separate out what occurs on a cellular level and how you experience what occurs” (Armbrecht, 2014). She suggests that our understandings of how medicines work on the body and mind are still not fully understand, primarily from a lack of consideration for how we experience their effects. “We lose

something when we draw a stark line and say a medicine has an effect or does not have an effect” (Armbrecht, 2014).

She also suggests the idea that bodies and plants change over time, causing issues to the inflexibility of standards set by regulatory bodies ignorant of this medical phenomenon. Craig argues that we should instead focus on the individuality of practices, similar to a patient-focused medical model, so that practitioners can focus on the individual needs of their patients, considering different ways of knowing and placing them on an equal level with biomedical standards and understandings. Her works, more than any other, acted as a model and guidance for my own research and efforts within this capstone.

## **Methodology**

As I stated in my introduction, I encountered some issues when dealing with the regulations overseeing acquisition of a research visa in Indonesia. I was later informed that most researchers tend to apply for a different visa when working there – a sort of trade secret for those in the know about the country’s extensive bureaucracy and the in-process updating of their paperwork systems. While it came a bit too late for my current research, it will come in very useful for any future work I do in the country. In order to follow the laws expressing the necessity of a research visa in order to undergo formal field research, I drew from my participant observation in Indonesia, focusing on personal experiences of health, casual conversations with community members and examinations of available healthcare facilities while in the field. I was unable to record any formal interviews or conversations with community members while in Indonesia, to maintain IRB and RISTEK protocols, but followed up with secondary research and long-distance Skype and email formal interviews with two individuals – Daud and Dr. Mustofa.

Over my several weeks of waiting to hear back from RISTEK, I waited in Singapore so that I might be nearby the office where I was to pick up my research visa. During this time, I spent many of my days researching in their large public library, where I gained access to a large amount of Southeast Asian resources that I might not otherwise have discovered or had access to. In between my study sessions, I explored the city and began observing and learning about the various healing cultures that made up the very diverse country. There were neighborhoods which provided a close knit community for each culture – Chinese, Malay, Singaporean, and Indian, which all had aspects of Buddhist, Muslim and Hindu spiritual and healing beliefs. The clinics

reflected these communities as well, and I documented many of them for future research potential.

I continued to meet individuals involved with the healthcare system while here: surgeons and doctors visiting to pass their exams, biotech sales representatives, Buddhist monks, and one American woman who worked for a company in California that developed pacemakers, even though she utilized and preferred traditional Chinese medicine. On one day when I was especially frustrated from waiting to hear back from RISTEK, the woman and I visited the Buddha's Tooth Shrine and walked around, observing the chanting devotees. One female devotee spotted us watching respectfully and not taking any pictures. She slipped out from behind the ropes and handed us several small cards depicting various sacred individuals, before taking our hands and leading us around the temple – showing my friend how to bow and pray at each altar. She was so overwhelmed with honor at this caring act and as I watched her, glowing with joy at this easy connection, I realized I had been trying to force myself to continue research in Indonesia because it was what I had planned to do – it was not allowing the flow that might come from an easier connection. I had clearly underestimated the complications of a research visa, RISTEK and missed the implications a controversial presidential election might have on my paperwork. I resolved to give myself a deadline before moving forward and upon return to our hostel in Little India, I immediately emailed Rosari Kingston in Ireland to ask if she might be able to work with me on such short notice. The next morning I had a response from her that she would be more than happy to help me out!

Rosari Kingston and her colleague Anna-Maria Keaveney provided me with insider perspectives of herbalists from traditional and institutional training perspectives, as well as tours of facilities where training, processing and practicing occur. Anna-Maria gained permissions for

me to use information and photographs acquired at Dunboyne Herbal Farm and Clinic, although she expressed that Sean Boylan, the owner, was not at all secretive and hoped that other successful models like his own might grow. I informally interviewed both herbalist women while in Ireland and later held formal Skype interviews with them to discuss overarching themes I had encountered in my research and further details I had interest in concerning Irish traditional medicine. One such was introduced to me by my friend Fionuala, who I had visited on one of my last days in Ireland and after explaining my research, she told me her own experience with The Cure in her youth. This provided me with more directions for research when I returned to the United States and I included these findings in my interviews with the herbalists.

With the Ireland research, I was exceedingly curious about the differences between herbalism there and in the United States. I had spent the summer before my field research working and training on an herbal farm to increase my knowledge and understanding of an herbal tradition, with the idea that my efforts at Farmacy Herbs could help me connect with healers who utilized herbal medicine abroad. This, of course, in addition to my own interest in training as a healer and developing a concept for what my culture of healing might be, as the descendant of Irish immigrants who moved to the Appalachian Mountains in the 1700's. America's Appalachians are widely-known for their Irish-American and Chinese-American herbal medicine communities, both of which have a strong tradition that has continued in the region with numerous class offerings. Recently, a report on NPR dealt with the efforts to grow traditional Chinese medicine in the Appalachian mountains that could better adhere to GMP<sup>4</sup> as often the resources imported from China do not meet the regulations imposed in the UK and United States (Harris, 2014).

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<sup>4</sup> Good manufacturing practices.

After contacting my advisory team to ensure that the changes to my research direction would be accepted, I contacted Dr. Bonnie O'Connor to ask if she could also work with me, providing the American portion of my multi-location narrative which presents various regions of the world and their interest and efforts in sustaining traditional medicine. She was also happy to continue working with me and was excited to hear about my research upon my return. Bonnie provided me with stories of her firsthand experience working in the intersection between healing beliefs and further strengthened my concept and argument for pluralism in medicine. We conducted our interview in person over lunch at Rhode Island Hospital, and despite being my first formal interview of the series I would conduct, she acted as a sort of glue for the entirety of my research.

Leading up to my work in the field, I took the time to research, in detail, the various international regulations governing traditional medicine sustainability. My aim was to have an understanding of what overarching forces were currently at work, or in process, regarding the current approaches to sustainability of traditional medicine and its practitioners. I identified gaps and potential problem spots in the legislation, making note of them for observations in the field, before moving on to local laws and regulations to develop an understanding of how they might interact with the overarching international infrastructure. One particular bit of legislation I was interested in investigating is proposed by the World Health Organization's recently updated Traditional Medicine Strategy. "The knowledge and qualification of practitioners have a direct bearing on patient safety. The ways in which T&CM practitioners obtain their knowledge and skills vary between countries. However, in many developing countries, TM knowledge and skills have been transferred from generation to generation orally, making it difficult to identify qualified practitioners. Member States should consider their own situation, and identify their



specific needs. These may include upgrading their knowledge base and skills, supporting collaboration between TM practitioners and conventional health care providers and, where necessary, considering regulation or registration of practices. 56 (43.5%, number of member states) with regulations on T&CM practitioners, 56 (43.5%) with no regulations, 17 (13%) unanswered” (WHO, 2013). How might each country I was investigating approach this proposal?

“The World Health Organization (WHO) estimates that 4 billion people, 80% of the world population, use herbal medicine in primary health care” (Hall, 2013). This large majority number, along with the efforts of WHO, were driving forces and inspirations for the questions I am seeking to answer with my work. I’ve presented my research here in an ethnographic format to encompass and give contextual detail to the narratives. These narratives address questions regarding locally-driven efforts to sustain traditional medicine and healing beliefs, concepts and responses to globalization, technology and changing ideas of health, and the implications of local and international legislation on these issues for each country.

The overall questions at the beginning of this research were largely qualitative and I knew going in that these would change drastically once I entered the field and began talking to healers, patients and other community members. Indonesia was my initial focus, so the questions I formed beforehand and those brought up during my time there ended up creating many of the overarching topics I would have going forward as I continued my research in other communities. I was curious about how socioeconomic status and geographical location affected the decision for which type of healthcare individuals might choose, as well as what would be available to them. I also wanted to know what the relationship was for non-allopathic practitioners and patients with the medicinal industry – both pharmaceutical and non-allopathic product-wise. As I read more of Bonnie’s work, I started to assess evidence of pluralism versus integrative models

in communities and how this interplayed with the impact of globalization on the people. In regards to direct connections to cultural sustainability, I was hoping to learn about efforts of traditional medicine sustainability through regulations, lineages of practice and knowledge, and community driven efforts to continue healing heritage that had value for them.

# **Chapter 1: Indonesia**

## Modernization of Tradition

From the very beginnings of my research and travel journey, I have encountered an impossible number of interactions with an assortment of individuals involved in various medical fields or sustainability. This served to not only continue to strengthen my arguments, but also acted as a sort of regular affirmation that I was on the right path. The flight from the USA to Japan saw me seated next to a professor of bioethics and soil conservation on his way to Jakarta to make appeals for Indonesian environmental sustainability. He served as an excellent sounding board, helping me refine the explanation of my interests and goals for future conversations with RISTEK. During my short layover in Japan, a large group of young missionaries were behind me. As I watched a few of the girls pull American herbal medicine tinctures from their bag, offering them around to their friends, we engaged in a productive conversation about the importance of traditional medicine for individuals, its occasional relation to spirituality, and how many traditions have been discouraged by the church. They seemed open and interested to this discussion and I hope it took some seed, as, when I questioned them about their own work over there, they replied that they just knew they were going to ‘repaint buildings and stuff’. Indonesia has a long history of religious change as various countries and cultures invaded and colonized the people. Toraja, on Sulawesi – a central location for my research - has particularly seen a complicated history with Christianity. Their funeral practices are among the only traditions to overtly show a clear connection to their pre-Christian spiritual heritage, though the extent of this syncretism varies from village to village.



*Over 150 years ago, infants who passed away before their first tooth appeared were buried within this tree.*

*The sap is a milky white substance which they believed continued to feed the babies a form of mother's milk.*

*The practice was mostly wiped out as the Toraja were converted to Christianity, though they still believe that on a full moon, white orbs float above the trees all over the hillside, accompanied by the sounds of babies crying. The two bundles pictured here are infants whose remains fell from the tree. Their descendants were unsure what to do with them, since they no longer believed in the practice, but did not want to disrespect their ancestors by burying them in the Christian belief, so they remain here, cradled by the roots of the old mother tree.*

My final flight into Indonesia included an overnight layover in Jakarta before I continued on to meet my travelling companions Matt and Patrick for our final flight to Sulawesi. A day later, with the help of locals who continually asked my name and where I might be going – something at first jarring, but intended to be genuinely kind and helpful - I arrived in Denpasar, Bali, where my companions and I would spend the night before our flight to Sulawesi. As my journey continued, I would find that this comfort in approaching *bule*, foreigners, was fairly

common wherever tourists were found and it proved truly helpful when it came to asking for help and feedback on my research. I question, however, if this openness to foreigners could prove counterproductive, opening the door to biopiracy and the appropriation of traditional intellectual property.

We spent the evening in a gorgeous hotel, heavily adorned in *canang sari*, a daily offering made by Balinese Hindus to the gods.



*Canang Sari are trays made of palm leaves, filled with an assortment of betel leaf and nuts, lime, tobacco, and gambier. Flowers are placed in specific directions within the tray to represent a specific Hindu god, each with a coordinating color. Finally, a money offering is placed on top as the essence, or sari, of sacrifice in thanks for peace.*

The evening of our arrival was a full moon, or *Purnama* – a special day of ceremonies in Bali, during which the Gods descend to the earth to offer their blessing. There are hundreds of ceremonies all over the island, and the vast number of *canang sari* echoed this. Sadly, we were unprepared to seek permission to attend or observe one of the ceremonies, so we spent the evening at a seafood restaurant filled with celebrating families, preparing to attend one of the events. The next morning we awoke early, before the sun had risen, to the sound of roosters

crowding during the dawn Islamic call to prayer. Bali is primarily Hindu, but nearly every island in Indonesia is culturally and spiritually diverse, with the Western islands having a long history of being predominately Islamic.

Our arrival in Makassar connected us with our guide, Yusuf, a member of the indigenous Toraja who would be travelling with us over the next several days. We boarded a bus full of locals heading home for a nine hour journey north to Rantepao, the main town in the land of the indigenous ethnic group known as *Toraja*, ‘people of the uplands’. The regency of Tana Toraja (“Land of Toraja”) is located on the Eastern coast of Southwest Sulawesi and is home to around half of the over one million members of the community. Currently, most of the population has been converted to Christianity by the Dutch colonizers and missionaries who arrived in the early 1900’s, when Indonesia was known as the Dutch East Indies. Originally the people followed an animistic belief known as *Aluk To Dolo* (“The Way of the Ancestors”), and many of their practices still reflect this today (Adams, 2006). Although this religion is rapidly dwindling – according to the most recent statistics, only 11% still practice *Aluk*. These numbers, however, are hard to verify as government-sanctioned identification cards, which require a note of the holder’s religion, often state the dominant religion in the area – Christianity (Adams, 1993).<sup>5</sup>

At one point, we were stopped outside of a Christian church by curious children who wanted to know why we were visiting. I explained that I wanted to study *dukun*, and the children laughed, making hand gestures and noises that appeared to be a mocking way of referring to the practitioner type – it reminded me of how I had seen American children pretend to be wizards casting a spell. I pulled my translation book out and held up a leaf, clarifying with the term *dukun tradisional*. They nodded and one girl pointed to a large scratch on her elbow – I realized I

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<sup>5</sup> It is important to note here that the Indonesian president newly elected in 2014 campaigned against the identification of religion on the ID cards and stated he would have it removed.

would have to be more specific in the future, though I was pleased to see that even the children attending church utilized *dukun*.

During our time in Tana Toraja, Yusuf introduced us to many of the traditional practices and spoke with passion of the meaning and history behind each. I truly wish I had been able to record Yusuf's stories to share here, but without permission from RISTEK I would be violating IRB protocol. Though it was helpful for me in light of this barrier, the wealth of knowledge produced by early anthropologists is connected to a complicated history of colonialism in the region. This led to some vast cultural changes for the Toraja as tourism peaked and they became a sort of celebrity group for Indonesia. I utilized these, and more modern, secondary anthropological resources to further clarify the quickly jotted notes I took as Yusuf painted us gorgeous pictures of his heritage (Yusuf, 2014).

Over the next few weeks, my experiences, observations and interviews in Indonesia directly touched on many of the overarching issues I was interested in exploring in my research. Both Daud and Dr. Mustofa discussed the interconnectedness of the systems of indigenous and allopathic medicine, though they often existed as parallel but separate when patients in some communities choose one exclusively over another. Mustofa provided ideas concerning how these relationships came to be by highlighting some of the ways in which the government has supported traditional medicine through passing regulations, but how the common difficulty in gaining funding had slowed the efforts at proving efficacy. My own observations, as well as the conversations with these two Indonesians, introduced me to the various types of medicine available in Indonesia and how problematic it could be to attempt to label any practice as either allopathic or traditional.



### **Homegrown Healing: An Interview with Daud Manggalatung**

In Rantepao we set up shop at Riana Homestay, owned by Daud Manggalatung and his wife, after whom the homestay was named. Here we were greeted by a rich array of trees, bushes and other foliage, completely surrounding the small courtyard of his home. It was a space that was both welcoming and calm-inducing. After a short apology to Daud for our late arrival, his helpful daughter and son helped us settle in to our room, which was complete with an incredibly large bathroom and Disney Princess bed sheets. Once we set up shop, we introduced ourselves to the collection of down-to-earth Canadian, German and Japanese backpackers and headed through the dark market streets to find our delicious dinner of *satay*, peanut sauce, rice and avocado ‘juice’ (smoothie). Patrick informed me that he had specifically arranged for us to stay with Daud due to his previous position as village chief and experience as both an anthropologist and local guide, with a doctorate specializing in Toraja culture – what a wonderful surprise!



*Our home in Rantepao: Riana Homestay. (Tripadvisor, 2013-2014).*

The next few days we backpacked through the villages south of Rantepao with our guide, Yusuf. We were invited to witness one of the famous Toraja funeral ceremonies, highly regarded by anthropologists and cultural tourists alike, which had been the inspiration for the trip for Matt and Patrick. This was one of the remaining aspects of the indigenous animist religion and its role in dealing and healing after death appealed to my research interests. We sat under one of the houses, decorated with fabric banners in bright orange and black colors, echoing the beautiful carvings on the *tongkonan*. Yusuf informed us that the attic of this house had held the deceased while the family saved up for the elaborate funeral. After the family member passes away they are considered 'sick' until the funeral, so they are preserved, bedded in the attic, fed, and visited by family members until the funeral. During our observation of the ceremony, the wife of the deceased came to thank us for honoring the family with our visit and informed us that her husband had passed away at the age of 127.



*Toraja funeral ceremony. Gifts of wild pigs and water buffalo, donated by attending family members, wait to be sacrificed and fed to the attendees. The orange and black of Toraja surrounds the ceremonial area, and the elders sitting across from this, pictured here.*

Later in our journey, we stopped to talk with a woman coming in from the rice fields and our guide informed us that she was his friend's mother and was 110 years old. I asked Yusuf if the Toraja operated on a different calendar system, as it was rare for people to live this long. He said that in Tana Toraja people do not retire when they grow old, but rather continue to live productive and busy lives, harvesting rice, and that this keeps them healthy.



*Matt and I hike through the rice fields where the elderly woman we met harvests her family's grain.*





*The 650 year old historical village, Ke'te Kesu. As we journeyed around Tana Toraja, we were greeted everywhere by tongkonan – the traditional houses of the Toraja. On the right are smaller houses used to store rice, whereas the larger ones on the left are now used as guest houses for visiting relatives and for the storage of the “sick”. Now, larger modern homes are built, though still decorated with the traditional colors and carvings, to allow for the changes introduced by modern consumerism: televisions, fans, and indoor plumbing. This village is now used for local student and tourist educational purposes, only.*

While travelling in the North Tana Toraja mountains both Matt and I came down with something – sun poisoning, food poisoning, water-based bacterial infection, who knows. We had spent the last few days on planes, air conditioned night buses and in low altitude, air-conditioned hotels before hiking 9-hours uphill through difficult rice terrace terrain. To combat the illness,

one of my other travelling companions pushed me to take Ciprofloxacin (Cipro for short), as did the nurse who was bunking in the room above ours and who was also ill. The two other ill individuals took Cipro and continued their symptoms for nearly a week. With my past research into the tendency for the general public to feel overly casual regarding antibiotics, I was hesitant to take them, myself.

Studies have shown a growing problem of antibacterial resistance, often for very major conditions such as Tuberculosis and MRSA<sup>6</sup>, the latter of which led to my father's passing. In an interview with Dr. Arjun Srinivasan, an infectious disease specialist and associate director of the CDC, he explained the current situation. "There are patients for whom we have no therapy, and we are literally in a position of having a patient in a bed who has an infection, something that five years ago even we could have treated, but now we can't" (Farberov, 2013). We have been utilizing antibiotics since Professor Alexander Fleming discovered penicillin in the 1940's (American Chemical Society, 2014) and they have been massively helpful in preventing infections during organ transplants, stem cell and bone marrow transplants and chemotherapy. However, "people have fueled the fire of bacterial resistance through rampant overuse and misuse of antibiotics" and "pharmaceutical companies are at least partially to blame for this problem – they have neglected the development of new and more sophisticated antibiotics that could keep up with bacterial resistance because 'there's not much money to be made' in this field," says the CDC director (Farberov, 2013). If there is no money to be spared in developing new biomedical antibiotics, how could there be research funds for non-allopathic possibilities?

But isn't that a vicious circle, when we could instead put money towards preventative measures and immune boosters applied over time and which could prove to be less costly – in

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<sup>6</sup> *Methicillin-resistant Staphylococcus aureus*, a highly antibiotic-resistant infection in humans

more than one way? Additionally, over-prescribing of antibiotics and casual use by uneducated patients can further increase risk of antibiotic-resistant bacteria taking hold. About a month ago, a friend of mine told me that she had taken some leftover antibiotics because she had been feeling under the weather and wanted to “kick it before it stuck.” In a study specifically discussing Indonesian medicinal plants, Kardono states “Even nowadays, there is no shortage of physicians who prescribe piles of medications without first making sure that they do not interact among themselves, or whether a change in lifestyle, such as eating less and walking more, might suffice. In short, we are going through a hyper-medication epidemic” (Kardono, 2003). This idea of increased health through an active lifestyle is suggested by the extended lifespan of the two women we encountered, who both continue their daily labors despite their age. In addition to the casual over-prescribing of drugs, this lack of knowledge of negative drug interactions extends to interactions with traditional medicines and may contribute to the reasons many patients are hesitant to visit allopathic practitioners.

To return to discussing the antibiotic I had been recommended, Cipro is the fifth most commonly prescribed antibiotic, often handed out to people for travelling abroad along with some very non-specific instructions to take it when there is suspicion of having contracted the local equivalent of “Bali or Delhi Belly”, over an unspecified number of days. “Cipro has been used to treat minor infections readily treatable with older, less broad spectrum antibiotics, and as a result many bacteria have developed resistance to this drug in recent years, leaving it significantly less effective than it would have been otherwise. Resistance to Cipro may evolve rapidly, even during a course of treatment. Many factors, including antibiotic policies, over-the-counter use (which often leads to over-use) and lack of information on the prudent use of

antibiotics may contribute to the emergence of quinolone-resistant organisms” (Vatopoulos, 1999).

Needless to say I refrained from taking the pills, instead opting to ask our host Daud to recommend some of the traditional medicine he would give to his family. I was worried that I would not be able to replenish my body’s good supply of bacteria after taking the pills, due to the town’s lack of probiotic yogurt and the like, and Daud had studied traditional medicine since he was a child, having learned from his grandparents and parents, and has been passing it on to each of his children. He expressed concern over our illness and recommended hot tea to help it pass out of our systems faster, continued rest in a moderate temperature – too much movement between air conditioning and outdoor humidity/heat can cause illness, he explained - and traditional medicine. He offered to harvest some fresh local root for me to chew on. Given the chance to experience local medicine for myself, I accepted his kindness. He walked the fifteen kilometers, hand in hand with his four-year-old son and student, in order to dig up the root.

Upon return he began shaving the bark off the root while teaching me about it and its uses. It was a bitter! The concept of a ‘bitter’ for stomach upset was one I was very familiar with from my own herbalism training at Farmacy Herbs in Rhode Island. I initially pursued this training to ensure I had a base understanding of herbal medicine concepts when conducting my research, though I was also seeking methods for increased personal preventative care and training for my own interest in becoming a healer. During this time, I found that several of the chronic health issues I’d had, such as joint pain and circulatory issues, were alleviated, and the bronchitis, tendonitis and menstrual issues I had acquired from stress and conditions in my workplace disappeared entirely. Since then, I’ve often preferred herbal medicine over allopathic approaches to any health issues that I may encounter.

Daud instructed me to chew small, one-inch-long bits of it while he made me a hot tea from the fresh root – it was very bitter, indeed. I chewed away at the pulpy root, swallowing the juices that formed as my saliva broke it down. Soon Daud returned with a pot of the tea, the bitter smell of the medicine rising in the steam as he poured me a cup. I replaced the chewed up root with the liquid form, slowly slurping at it which allowed it to cool a bit and my tongue to adjust to the strong taste. As I drank, Daud produced a bottle of locally made lemongrass oil and demonstrated how to massage it into my hands and feet to heat them up, increase circulation and get the sickness out of our systems faster.

Sinking into my chair, listening to the roosters begin to crow as the sun set, I was already beginning to feel better –less weak and shaky. Daud’s overjoyed smile stretched across his face as we began discussing herbal medicine with renewed vigor. I showed him a plant I had picked during our hike that I wanted to ask him about – *Plantago major*, which I continue to find in every place I have ever visited. By the time the other healthy guests were ready to leave for dinner, I was able to go with them to reintroduce my stomach to food in the gentle form of toast and rice. I continued to slowly recover, while the nurse and my friend both remained very ill for several more days.





*Plantago major*, often considered a common weed to those trying to perfect their lawns. During my time at Farmacy Herbs, in the USA, we learned that when stung by a bee, wasp or other bug, you can chew a leaf to a pulp and place it on the sting to pull the pain out. It works like a charm.

As we waited for Matt to recover so that we could move to the next leg of our journey, I sat with Daud and spoke with him about the lineage of knowledge represented by the overflowing vegetation in his small yard. The flora here was intentionally planted, not just for culturally valued aesthetics, – for almost every home we encountered in Indonesia was filled and surrounded by flora and fauna – but also for medicine and education. As we sat and drank *kopi* (coffee), the retired village leader, anthropologist and traditional healer gestured to one of the smaller potted plants near our room. It looked as though a lot of bugs and children have been at it. “This one does not grow large. It is for smaller stomach problems,” he informed me. The children *had* been at it, as well as the guests and the rest of the family, any time someone had minor upset stomach. A full tree of the same plant also resides in the yard, near the fence and

bearing fruit used for cancer prevention. In fact, many of the trees in the yard were for this. A few years back, Daud's mother was diagnosed with the beginning signs of cancer. He utilized these trees to treat her and since then, he contends, her cancer has disappeared. This medicinal garden is apparently quite common all over Indonesia. "Some years ago, the Ministry of Health launched a campaign to promote the development of community and family medicinal gardens in order to stimulate both the use of traditional medicine for common ailments and the cultivation of medicine plants." This was also done to aid in securing the supply of raw materials for research institutions, NGOs and commercial *jamu* (medicinal tea) companies (Trips, 2.2).

As I listened to Daud's story, I reflected on Sienna Craig's *Portrait of a Himalayan Healer*, wherein the elder healer of the lineage she was working with grew ill and began rushing to complete the traditional medicine training with his son. The traditional doctor examining him determined it was cancer, even stating that the elder healer's room "smelled like cancer". The author reflected on this statement – "*What does cancer smell like?*" She expressed that it was difficult to watch the struggle between traditional medicine and allopathic, as the son considered placing his dying father on a helicopter to a larger city. "Much more discerning than a clash, these medical traditions are twisted up in a precarious dance of mind and body, or, the need to operate versus the need to cure sickness through ceremony. I am firmly convinced that one is not better than the other" (Craig, 29). Later, the elder healer was, in fact, transported to an allopathic practitioner and the diagnosis of cancer was confirmed – an illness on the rise in that area as changes to the environment, diets and other cultural habits are forced by changing times.

Daud's family rarely visits allopathic practitioners, nor do many of the other villagers. "It is too expensive. We have traditional medicine from plants all around our village and it works well. Especially people from villages distrust [hospitals], but sometimes people use both

depending on their sickness” (Daud, 2014). According to a report by the Association of South-East Asian Nations’ (ASEAN) workshop on the (Agreement on) Trade-Related Aspects of Intellectual Property Rights (TRIPS), in the past decade traditional medicine use has increased dramatically, “partly because formal health care became less accessible and less affordable due to the economic crisis” (Trips, 2.2). Traditional and allopathic health care are rarely integrated, instead aiming to co-exist for patients who switch between different methodologies. Most villagers know at least some traditional medicine, and for what they do not know there are more extensively trained practitioners, *dukun*, throughout the village. He has friends who are *dukun*, or traditional Indonesian healers, who teach him how to “kill bad bacterias in the body,” visiting “different types of *dukun* according to certain sicknesses” (Daud, 2014). He utilizes what he learned from his grandparents on a weekly basis to provide preventative and strengthening care for his family. According to Daud, there are no Toraja laws governing traditional medicine practice, however there are village councils. If I get a chance to return for another visit, since the incident with RISTEK prevented that this past summer, Daud has promised to take me to a council meeting of the local practitioners so that I can meet them, though he recommends I brush up on my Sulawesi dialect of *Bahasa*.<sup>7</sup>

Daud’s lineage of knowledge represents the organic way in which communities exert agency to maintain their personal concept of health. The daily choice to heal in the way he and the other villagers define healthcare is a grassroots effort to sustain his community’s cultural way of healing, and this evidence of the continuation of a healing tradition from father to son presents hope for cultural sustainability in light of globalization. The way any community defines health is unique, not only to the group, but also to individuals who often differ in concepts of health

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<sup>7</sup> The official Indonesian language.

based on their “interactions among physical environments, social engagements, and individual bodies. Ignoring biological variation blinds us to... forms of health inequalities not always captured in surveys” (Lock, 2).

This all ties into themes of environmental injustice, unsustainable and toxic methods of rainforest harvesting, and the Toraja habit of snacking to maintain energy for labor - now fed with tinfoil-wrapped sugary snacks, which rapidly produces litter in mountain villages with no waste disposal infrastructure. While much more detail is owed these topics, they are not central to the discussion within this research and much information can be found pertaining to these issues in academic and scientific research publications.

### **Sustaining Tradition Through Modern Policies: An Interview with Dr. Mustofa**

While on Sulawesi it would seem that no strict regulations are imposed on the practices of dukun and traditional medicine use, the more globalized and industrialized islands to the West are home to organizations working within the law to further the efficacy of their traditional healing systems. “As plants have been used for medicinal purposes for many centuries, presently, Indonesian herbal products are being used in Indonesia in its health care system, as well as home remedies. The national working group on Indonesian traditional medicines (*Pokjanas Tumbuhan Obat Indonesia*) routinely holds a national seminar twice a year on this area” (Kardono, 2003). They discuss concerns on their cultivation and conservation for sustainable development and continuous supply, standardization, safety and efficacy with regards to Indonesian traditional medicine development. Another group conducting this research is the Center for Research and Development of Medicinal Plants and Traditional Medicine (B2P2TOOT), an institution that offers programs in pharmacology of indigenous medicinal plants. It is also home to a large

garden collection of local medicinal plants, established in the early years after the country's independence, which serves as a Technical Implementation Unit at the Agency for Health Research and Development, part of the Department of Health's efforts to research the potential of these plants for prevention, maintenance and improvement of public health (B2P2TOOT, 2014).

Another scientist involved in this research is Dr. Mustofa Mustofa, a phytomedicine researcher in the faculty of medicine at Gadjah Mada University. After my companions and I departed Sulawesi, we ventured to Yogyakarta on eastern Java so that I could meet with him to discuss my future research. After navigating the giant campus, I finally made it to his office for our first in-person meeting. We discussed my research interest and hopes at length and he promised to try to accurately convey them to RISTEK to help me gain approval for a research visa. As previously mentioned, this did not end up working out as I had hoped. However, upon my return home, he agreed to a Skype interview with me. This proved to be profoundly useful, as it allowed us to not only discuss our previous conversations, but also the rest of my experiences in the field in Indonesia, Ireland and the USA.

He started off by going into detail about his own work at Gadjah Mada. "I do research about traditional medicinal plants from Indonesia, especially research about anti-cancer or anti-diabetic. Also, we create extracts of herbal medicines. To turn herbal medicines into phytomedicine, you have to use extracts of herbal medicines. My specialty is to try to isolate active components of the herbal medicine" (Mustofa, 2014). I prompted him to discuss his interest in the cultural aspects of traditional medicine, which he had previously excitedly expressed in our in-person meeting. "It is not my domain – normally its social science, not faculty of medicine. So we do not interact with *dukun* or traditional healers. I am very interested

to work together with other faculty, but until now we don't have enough time to work together. To work together with you like this as an anthropologist to continue documentation of traditional medicine. We must make collaborations with our colleagues from social sciences" (Mustofa, 2014).

When I was first connected with Dr. Mustofa, I noticed that his department was a part of the pharmacology faculty, which immediately prompted concerns over pharmaceutically-driven biopiracy. "Bioprospecting is the removal or use of biological and genetic resources of any organism, mineral or other organic substance for scientific research or commercial development. When bioprospecting is pursued without the knowledge and free prior consent of the owners of the resources and without benefit sharing – it is called biopiracy" (Trask, 2014). Patenting the use of these plants is not only appropriation, but also monopolization of a medicine that typically ends up costing such obscene amounts that it is no longer accessible by the originators of the knowledge. Through interviews and research I was pleased to put my concerns at ease: Mustofa's department, and many others they partner with, are making great strides to promote the efficacy of local healing techniques not to profit, but to aid in sustaining their traditions.

Many Indonesians, it would seem, have a different way of thinking regarding pharmaceuticals, preservation and implementation of traditional medicine, and the role it has in their society. Despite my earlier discussion of the cultural changes that have occurred in Tana Toraja due to tourism, Indonesia's government is very interested and invested in sustaining culture and implementing education and legislation to this effect. Mustofa described it as a "strong cultural concept of back to nature." "They want to maintain dukun," he said. The goal is

to legitimize their traditional medicine within their own evolving systems, documenting and researching their *medica material*<sup>8</sup> before others steal and patent it.

Most of the biodiversity in Eastern Indonesia have yet to be registered and identified and until the Nagoya Protocol<sup>9</sup> is ratified by the local government, biopiracy will continue at its rapid pace. According to data from RISTEK, over 80% of the 500 foreign research proposals in Indonesia aim to study biodiversity in that region (Kamis, 2013).<sup>10</sup>

I brought these concerns up with Mustofa in our interview.

CF<sup>11</sup>: *When I came to visit, I think we talked a little about the idea that some traditional healers don't want to give other people their knowledge because they worry that it might be stolen or unsustainably used. Have you found that to be true at all? Because sometimes pharmaceutical companies will put patents on the medicine and then claim it as their own, stealing traditional knowledge. Have you heard of this?*

MM<sup>12</sup>: This is our problem with medicinal plants – they may be stolen, or lost due to the plantations of palm oil like in Sumatra. But a lot of people are trying to conserve the medical plants in Indonesia.

CF: *Is this related to why your team is working to create synthetic versions of the plants so people will still have it even if it becomes hard to find?)*

MM: Yeah, I try to learn about traditional medicine and how to preserve the knowledge. That is my mission. We have more than 300 ethnicities in Indonesia, and each one has its own traditional knowledge about herbal medicine and their own health system. But there isn't very much documentation of the traditional knowledge of the ethnicities here, especially traditional medicine. It's my problem with my work. In Borneo, one plant is now difficult to find. Because I find this plant only in the mountains, and the plant, we call it – the local name is – *sankupa*. In the past the plant is planted, and used medicinally. Now a lot of people don't use this plant, so the plant you only find in the mountain.<sup>13</sup>

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<sup>8</sup> The Latin term internationally used in the scientific community to refers to medical substances.

<sup>9</sup> Refer to page 21, paragraph 2 for discussion of the Nagoya Protocol.

<sup>10</sup> In the past decade, there has been an increase in 'high-profile' biological resource and traditional knowledge based misappropriations around the world, which has highlighted the importance of addressing biopiracy. The Convention on Biological Diversity has created principles for how to implement protection of these resources, so that we can ensure they are not used without informed consent of their knowledge holders.

<sup>11</sup> Caitlin Farley - interviewer

<sup>12</sup> Dr. Mustofa Mustofa

<sup>13</sup> Traditional medicine awareness has also aided in preservation of forests.

As we returned to the subject of *dukun* and the concepts of traditional medicine, he explained to me the various general categories in Indonesia. There are 3 classification types of Indonesian medicine: *Jamu* (a sort of tea/juice), the production and sales of which are restricted by the government to certain individuals; herbal medicine; and phytomedicine, somewhat expensive and the only one used by allopathic doctors – though only the ones which have had clinical trials. Phytomedicine is created through extractions from herbal medicines proved in their effectiveness, *Jamu* and herbal are both used preventatively and at home, though *Jamu* is also a commercially sold traditional medicine. I told Mustofa about an encounter I had in Bali, where *Jamu* was sold in the food court of a large mall. He explained that there are strict laws about who can sell it and mass produce it to encourage safety and adhere to efficacy standards, though some people do make it at home in the villages. These three classifications of medicine demonstrate how many indigenous healing methodologies are far too complex to split into an overly-simple dichotomy of either modern or traditional medicine. Cultural context would label phytomedicine as modern, though it derives its knowledge and materials from traditional knowledge. And where, then does *Jamu* stand?

We spoke of the issues non-allopathic methodologies have in acquiring funding, and he shared that they had the same problem. “Funding is not easy to obtain, from government and also from industries, and especially for facilities to isolate active compounds. Our facilities are very limited so it is very difficult. It takes a long time to isolate the active compound from an herbal medicine. And although a lot of people use traditional medicine in Indonesia ... however ... traditional medicine hasn’t been used in the formal healthcare system. Medical doctor cannot use officially in the practice. So it makes things difficult” (Mustofa, 2014).



Curious about the differing perspectives between Daud, in the villages of Tana Toraja, and Dr. Mustofa in the city known for universities on the capital island of Java, I brought up many of the questions I had asked Daud.

CF: *Is it very expensive to use medical doctors?*

MM: No. Since 2014 we have implemented insurance to all people in Indonesia. So I think that it's not expensive to go to a medical doctor. Everyone is able to have it, since this year. Our government is giving insurance to all the Indonesian people.

CF: *Do people learn traditional medicine from a special teacher, or from parents? Is it a tradition that is passed down?*

MM: *(he laughs, and I get the feeling this is a relevant question for him)* There is no special education for traditional medicine in Indonesia. So I think *dukun*, they learn about traditional medicine from their parent. But now, we try to introduce traditional medicine in our curriculum in the faculty of medicine and pharmacy and maybe in the faculty of nutrition. In our country there is also a special program for traditional medicine. I think there is a Masters in Traditional Medicine at a university in Jakarta. But it is not a lot.

*Dukun* is a broad term used to describe traditional Indonesian medical practitioners, whether they inherit a lineage focusing in herbal, massage therapy, spiritual matters, or even hypnotherapy. Mustofa explained that there are still very many kinds, and many practitioners in Indonesia. I was curious if he thought this would remain true with the recent push for doctors to learn traditional medicine. Might traditional *dukun* begin to disappear?

MM: I'm not sure. Because our government has a program to maintain, to conserve the *dukun*. Culture preservation. It is important to conserve traditional knowledge, including the traditional medicine.

CF: *It is not always the case that a government feels that way!*

MM: Our government is very interested. We have laws to preserve traditional knowledge, like with *jamu* – how to make it, how to prepare it, what plants can be used, the knowledge of the

biological analytics of medicine. There is a National Food and Drug Administration in Indonesia who limits the traditional medicine.

CF: *Someone I stayed with while I was there said he and his family never go to the doctor; they only use the plants in their yard. Is that very common?*

MM: I think it is not very common. Yes, a lot of people go to the medical doctor in Indonesia, but a lot of people *also* go to the *dukun*. But the medical doctor is an important role in our health system. Some people, yes, only go to the *dukun*. But not a lot – mostly in villages.

CF: *So the people that you mentioned have a degree in traditional medicine, can they work in a hospital?*

MM: Hmmm, this is the problem! Until now, there are no people with the degree in traditional medicine working in hospital. But normally, authentically to get herbal medicine you have to go to the industry (*I think he means the shop, here*). But there is a rule from government how someone can practice traditional medicine. They have their own shop, their own office. There are clinics of traditional medicine.

CF: *Is it common for a doctor to send someone to a traditional healer? Do they ever work together?*

MM: No. Maybe not officially. But I think maybe the patient wants to go to the medical doctor and another week he may want to go to the *dukun*. I think it will change. Our government supports, in the hospital, to have clinics of traditional medicine. Just some, certain hospitals. Not all hospitals. Because there is a rule to make clinics of traditional medicine in the hospitals. For example, the government wants medical doctors to use traditional medicine. But the medical doctor has to get training how to use traditional medicine, knowledge of it. So it's possible for medical doctors to practice traditional medicine and now a lot of medical doctors are interested in practicing herbal medicine. The doctors train in the community, the concept of back to nature - it's important for the doctor to know about traditional medicine.

Ten percent of the worlds' plants are found in Indonesia and only around 900, of the total thousands, have had their medicinal properties researched. To echo Mustofa's frustration over the lack of interdepartmental and interdisciplinary collaboration, while "a number of efforts have been undertaken to study and/or make an inventory of the medicinal plants used in certain parts of the country, the resulting databases and inventories of biological resources and traditional medicinal knowledge are scattered among different sectors, research institutions and organizations" (Trips, 2.2).

It would seem that the Indonesian Ministry of Health is aware of this issue and has expressed a desire to collect this data into a single database, which would be “accessible to all parties concerned, notable health care providers, researchers and communities. The idea is to develop a comprehensive traditional medicine database, covering methods of treatment and traditional drugs, in order to strengthen the development and use of traditional medicine” (Trips, 2.2). The World Health Organization made a note on this publication, expressing the implications of intellectual property rights issues and the need for protection of knowledge holders and the database. Connecting to the issues behind Mustofa’s, and other researchers’, frustrations over a lack of collaboration, the report of an ASEAN Workshop on the TRIPS Agreement and Traditional Medicine goes into further details about *The Choice to Disclose*<sup>14</sup>, the debate between protection for traditional medicinal knowledge and the importance of the intellectual commons:

- some holders of traditional knowledge reject the idea of anyone having ownership rights over (traditional) knowledge and/or over the related biological resources;
- other stakeholders are mainly concerned with avoiding biopiracy and -especially- with avoiding the misappropriation of (traditional) knowledge;
- there are those who consider that the capacity for further development of traditional medicine is generally insufficient in the (developing) countries where most of this knowledge originates; therefore, they feel, its protection would mainly benefit foreigners (and may thus indirectly encourage biopiracy);

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<sup>14</sup> Article 6.3 of Trips, CBD and Traditional Medicines: Concepts and Questions. Report of an ASEAN Workshop on the TRIPS Agreement and Traditional Medicine, Jakarta, February 2001.

- publication of traditional medicinal knowledge is a high priority for projects aimed at promoting traditional medicine and making it more widely available as a source of health care;
- last, but certainly not least, protection of traditional medicine is likely to lead to an increase of its costs and/or to restrictions on its use or diffusion, which would reduce access, notably of those who are most dependent on traditional medicine: the poor.

(Trips, 2001)

### **Application on a Global Scale:**

This chapter, discussing Indonesian narratives, presents a unique example of how traditional medicine methodologies are neither static nor linear in their application even within a single country. The practices and beliefs of Indonesians are a complex reflection of their history of colonialism, international trade and tourism that can be observed in the individual concepts of healing held by each individual. This diversity is an excellent demonstration of the necessity for patient-centered approaches in any healing methodology, and the importance of the respect towards cultural ways of knowing with relation to culturally diverse communities receiving medical aid.

In this regard, it would seem that the considerations and methods for consideration of traditional medicine in the hospital and allopathic setting are different than what we see in Ireland or the United States. Firstly, within *The Choice to Disclose*, mentioned above, Indonesia's government explicitly details that individuals with financial difficulties are more likely to seek access to traditional medicine – this is something that I found to not necessarily be true in my case studies of Ireland and New England. Secondly, allopathically-trained Indonesian physicians are the ones returning to their own communities to learn traditional practices and find

a way to sustain their culture of medicine – in Europe and America, it is often foreigners appropriating traditional knowledge from other communities and discarding the cultural context.

With future research in Indonesia, I would like to gain more insight regarding the interplay between global convention protocols and national laws governing Indonesian traditional medicine and the actual ways in which they affect practice. My intention here is to broadcast the voice of a community struggling with their post-colonial identity, to provide a better understanding of the lasting damages caused by culturally-insensitive interactions between healing methodologies and beliefs. This knowledge can be taken into consideration by cultural mediators and foreign medical aid organizations to diminish damage they might do to health culture sustainability efforts of local community members. Additionally, Indonesia offers a unique example of the interplay between technical legislation and actual application of medical laws, within a decentralized country of great cultural and geographical diversity. This is something I felt I had a better grasp on from my research, observation and conversations in Ireland and the US, as these countries are more geographically condensed and connected, and seem to be more closely regulated by their governing bodies. However, Indonesia's diversity is an excellent demonstration of the necessity for patient-centered approaches in any healing methodology, and the importance of respect towards culturally specific ways of knowing with regard to culturally diverse communities receiving foreign medical aid.

To explore another voice of traditional medicine sustainability, I ventured onwards to Dunboyne, Ireland.

## **Chapter 2: Ireland**

A Tale of Two Herbalists

After discovering that my research visa would not be clearing in time, I reconnected with Rosari Kingston – an Irish medical herbalist, co-founder of the Irish Institute of Medical Herbalists and Director of the Irish College of Traditional and Integrative Medicine. About a year prior, I had connected with Rosari to learn more about her program and research, as it pertained to my interest in the loss of the Irish herbal tradition in Irish-American immigrant communities. I explained the new direction for my research and she agreed to meet with me, introduce me to other Irish herbalists, show me some of the centers and answer any questions I might have.

My journey to Dublin was marked by more chance meetings with healthcare-involved individuals; I was seated next to a student from Saudi Arabia who was attending the Royal College of Surgeons in Ireland who kindly helped me find my hostel for the evening while we chatted about the history of Arabic medicine traditions. While I waited for classes to break for the weekend, giving Rosari time to meet with me, I headed west to Galway where I caught a ferry to *Inis Mór*, the largest of the Aran Islands. My interest here stemmed from the image painted by the tourist industry of these islands as the “last outpost of traditional Irish culture”, “unspoilt”, where all natives speak Irish and the rocky terrain is covered in ancient forts and stone structures (Aran Islands Visitor Information, 2014). I wondered about their concepts of healthcare in relation to this emphasis of tradition – how much had tourism effected this image?

The ferry ride over was filled with island inhabitants returning from the market, visiting family members, a school group on a field trip, and several tourists. I was greeted by pouring rain, but managed to grab a cab to head halfway across the island to my gorgeous home for the evening - the Man of Aran cottage, a historically accurate set of cottages built for a film of the same name and with a garden that, according to the reviews, produced legendary salads. As I

placed my bags down to look around my room and out at the garden, I noticed a book on the shelf – Nature Guide to the Aran Islands by Con O'Rourke. With some time to spare before dinner, I immediately settled in to the small window nook to read through the book while eyeing the plants in the garden outside. Several of the plant profiles in the book made reference to their use in traditional herbal medicine, though most only stated that they were utilized traditionally, with no further detail. I made note of the plants in a journal so that the next day, while biking around the island, I could attempt to spot them.



*A view of the garden at the Man of Aran Cottage. The flora it produced absolutely held up to the legendary reputation of the salads grown by the owner of the cottage, Joe Wolfe.*

Around dinnertime I pulled myself away from the book to wander into the kitchen area, hoping to ask Joe or Maura Wolfe, the owners, some questions. Husband and wife were busily working away side by side in the small kitchen, putting the finishing touches on our meal. After they presented us with the most amazing salad I have ever had the pleasure of eating, Joe



returned to the kitchen to clean while Maura sat and picked up her knitting. She, along with many of the other families on the island, knit handmade sweaters that are renowned for their patterns. After getting the cue from other guests that it was alright for us all to chat over dinner, I asked Maura about the book that I had found in my room. She warmly assured me I was welcome to read any of the books I found in the cottages. When I questioned her about the current use of the traditional medicine plants, however, her tone grew short and harsh – no one uses traditional medicine on the island anymore.

My impression was that she had been offended by my question and I felt that it might have been due to the image portrayed by the tourism industry of the Aran Islands as incredibly old-fashioned. She had perhaps not wanted to seem out of date, simple, poor or backwards-minded – following the tendency for outsiders to look at others' pasts with nostalgia and to ignore the organic changes that have occurred. I attempted to smooth ruffled tail feathers by explaining that I was only interested because I, myself, utilized herbal medicine and had noticed that some of the plants in their beautiful garden could doubly serve in that purpose, on top of producing the best salad I had ever eaten. At this moment, her husband Joe saved me by emerging from the kitchen, hot apple pie in hand, and piping up a 'thank you' for my compliments to the chef and gardener. The guests passed the rest of the evening exchanging travel experiences, and I was left considering Maura's reaction to my question.

The next morning I explored their garden and backyard a bit more before borrowing a bicycle and riding off to *Dun Aonghus* – one of the most well-known stone circle forts in Europe. Along the way I spotted some medicinal herbs I was familiar with, as well as some I had seen in the book. At the fort itself, I found even more, as the land was kept fairly *au naturel* to preserve the heritage site; only the occasional grazing cow wandered through the stone-walled fields.

Finished exploring, I rode the long distance to the docks to catch the ferry back to the mainland. From Galway I headed south to Dingle, in the westernmost portion of County Kerry, to visit the home of my ancestors and ride a portion of the Ring of Kerry in search of holy wells and other sacred spaces. During my bike ride I came upon the statuary at *Slea Head*, though no one was able to tell me much about its potential continued use – perhaps it was just a tourist point of interest now?

The Díseart Institute of Education and Celtic Culture, located on Green Street in Dingle, is attached to a convent that is the site of a historic, nearly-forgotten, holy well. According to a sign next to the well, the grounds had been neglected and which saint the well had been dedicated to had been forgotten. Little of the original structure had survived, but the well was very deep and this helped it to be re-discovered, restored, and re-dedicated to the founder of the convent's sisterhood – Nano Nagle. Unfortunately, despite the excellent restoration, the water is unreachable and the top of the well has been sealed off with a clear plastic covering.

Traditionally, holy wells have been visited on pilgrimages or during *patterns*, feast days to celebrate the patron saint to whom the well is dedicated. The wells are as commonly found on church grounds, where they could be used to swear in kings, as they are near the sea, or on hills underneath one of the sacred Druidic trees, such as oak, willow, or holly (Lucas, 1963). Many *patterns* occur around harvest time, originally connected to the seasonal pagan holiday *Lúnasa*, dedicated to the Celtic god *Lugh* – though now many saints' days have been placed during this time in an effort to replace the pagan celebration. “Many of the wells are known for their curative reputation” with names such as *Tobar na Súil* (“of the eyes”) and *Tobar an Ailt* (“of the joint”) (O Giollain, 15). Depending on their location in nature, the wells were associated with various forms of healing – rocky and mountainous areas being for bones or teeth, and places

where fresh and salt water met designated for cures for barrenness (O Giollain, 2005). Rosari Kingston has also researched the use of holy wells by traditional Irish healers, who often placed the wounded within these wells and utilized herbal washes and incantations to cure (Kingston, 2009). The Irish tradition of pilgrimages to sacred sites was ancient, so as the wave of Catholic change washed over the country, “as long as superstitious practices were not a part of them and...the water’s potency was attributed to the intercession of the saint” the Catholic hierarchy allowed *patterns* to continue (O Giollain, 36).



*Tobar nano, a holy well located on the property of a convent in Dingle.*



*Slea Head's iconic crucifixion monument,  
overlooking the bay and the historic, abandoned Great Blasket Island.*

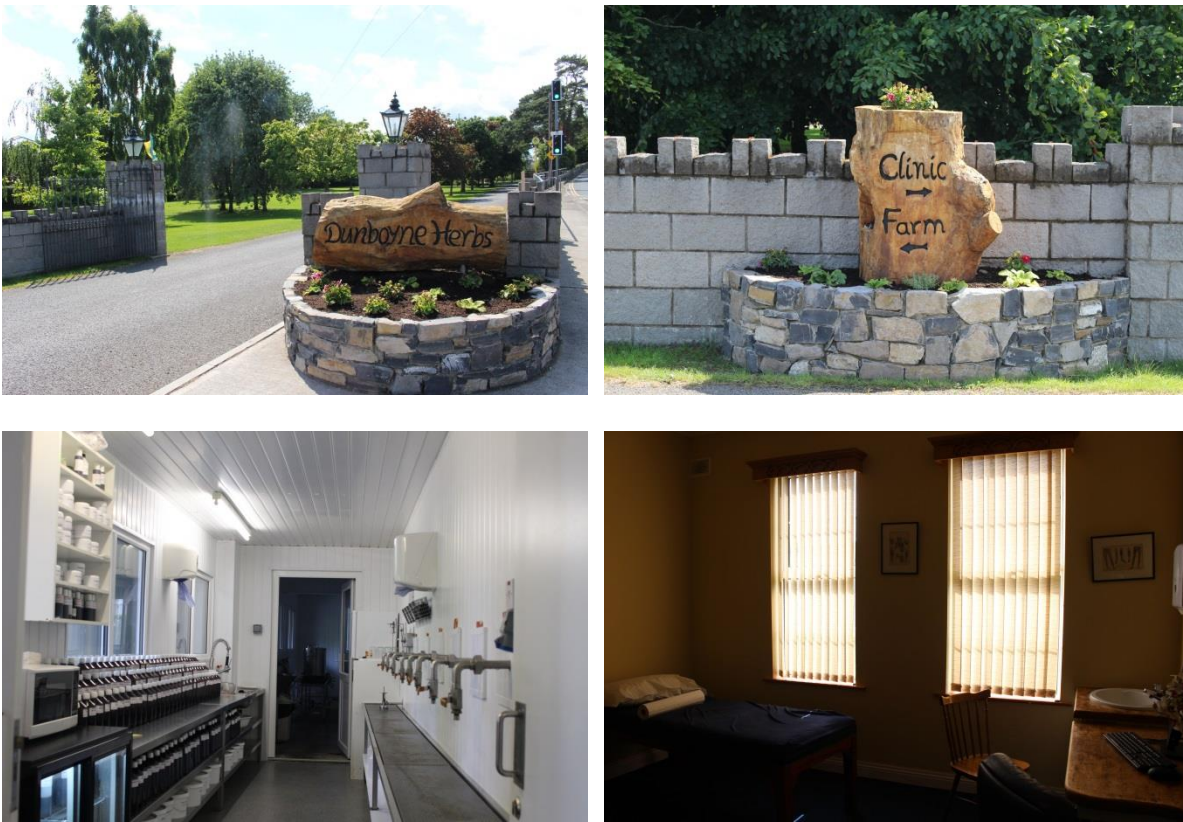
My investigations in Ireland and the narratives shared here illustrate the country's unique interrelationship and conflict between past and present as its lineage of healers navigate the complexities of proving the efficacy of their healing methodologies. Models that integrate biomedicine and traditional healing are examined, as well as the arguments surrounding these new models of training. As well as the historic healing sites previously mentioned, I visited more structured healing centers where stories of the efforts towards legitimacy and fears of marginalization and a fractured community were shared.

### **CIT and Dunboyne Herbal Farm: Two Models of Irish Herbal Education**

Finally it was time to head to the Cork Institute of Technology (CIT) to meet with Rosari and her colleague, another medical herbalist by the name of Anna-Maria Keaveney. We met up for lunch in one of the campus restaurants where we had a lengthy conversation that began with discussion of my studies and extended to every related herbal medicine and medical tradition topic under the sun.

After lunch, Rosari headed off to see to family business, while Anna-Maria gave me a tour of the facilities where she taught her courses at CIT. Her training is somewhat unique, in that she began with a degree in genetics at Trinity College before moving on to counseling, herbal medicine and even a Masters in primary health care from the Royal College of Surgeons. Currently she is a lecturer for the Bachelors of Science program in Herbal Medicine, which has been offered since December of 2005. The course focuses in “plant science and production, human biology, food and nutrition, and herb and natural product applications” utilizing lectures, lab and fieldwork, projects and self-directed research to provide “the educational foundation necessary for a career as a Medical Herbalist” (CIT, 2014). After the students complete their training at CIT, the Irish College of Traditional and Integrative Medicine, where Rosari lectures, offers a two-year master’s program. Rosari’s Irish Institute of Medical Herbalists sponsors these programs and leads the pursuit for support of herbal medicine by the Irish government. In an interview with Irish-America magazine, Kingston argues that: “Herbal medicine is proven, natural and environmentally friendly. Unlike conventional drugs, it is relatively inexpensive and has few side effects. It frequently offers solutions where conventional medicine has failed” (2009).

The next day, I hopped a train north past Dublin to meet Anna-Maria in Dunboyne. Here she practices medical herbalism alongside a multidisciplinary team at Sean Boylan's Dunboyne Herbal Farm. In addition to herbal practitioners, there are practitioners in sports rehabilitation, sports massage therapy, yoga, Amatsu and Reiki. As the former manager of the senior football team in County Meath, Sean Boylan has always had a lot of involvement with the health of athletes. His pluralistic center aims to "provide a wide range of treatments" to allow them "to provide a holistic approach to health and well-being," and has expanded well beyond just keeping the county's top athletes in peak physical form (Dunboyne Herbs, 2014). Rosari had mentioned the farm to me in our first conversation, and during my travels around the country I had several people refer me to it once they learned of my research interests. The center's website expresses the "knowledge, empathy and professionalism" of their experts, which was supported by the many positive reviews associated with the referrals. The specific mention of "empathy" here echoes the often expressed contrast in the discussion of differences between allopathic and non-allopathic practitioners, wherein it is argued that allopathic practitioners must remain emotionally distant to avoid compassion fatigue. Charles R. Figley, co-author of *Compassion Fatigue: Coping with Secondary Traumatic Stress Disorder in Those Who Treat the Traumatized* defines compassion fatigue as "the emotional residue or strain of exposure due to working with those suffering from the consequences of traumatic events" (1995). There are a number of studies concerning this topic, with most referring to its effect on nurses and therapists.



*A view inside Dunboyne Herbal Farms and clinic.*

*“To Cure Sometimes, To Relieve Often, To Comfort Always”*

During my tour of the Dunboyne clinic, one of the first things I realized was how much stronger their herbal medicine was compared to what I had learned in the USA at Farmacy Herbs. The ratio of active constituents in each product is such that the high quality requires laboratory-grade storage, constant refrigeration for the teas and an official prescription from an herbalist approved by Sean. If the patient is unable to immediately take their medicine home to refrigerate it or return within a month to assess the effects of the medicine, the clinic will not dispense the product. According to Anna-Maria, herbal product manufacturers in the UK and Ireland create two grades: a clinical quality that requires a formal herbalist prescription, and a

weaker variety that was safe for store shelves and self-care. Due to FDA<sup>15</sup> law, this latter quality is roughly equivalent to most of the herbal medicine made and sold in the United States.

In addition to being a football manager, Sean is a fifth generation traditional healer, not certified by one of the colleges, but rather trained from a lineage. As he was out of the clinic during my visit, Rosari told me of his education:

RK<sup>16</sup>: He inherited Cures<sup>17</sup> for five conditions from his parents and they include the use of seven herbs, they're permutations of seven herbs. He inherited them from his parents and they're actually unique to him. Because I have traced the herbs he uses from 14-15<sup>th</sup> century to the present day. He would know how to use those seven herbs in various combinations and what he sees in a person.

CF: *Those seven herbs - are they or did they used to be local to Ireland?*

RK: They're local to Ireland. They're common weeds in Ireland.

CF: *Where did Sean learn his medicine?*

RK: He comes from a lineage. He can trace back his lineage as a healer to about the 17<sup>th</sup> century. He's unique in that he has this well established clinic and he brings outside people into it and he isn't very secretive about it.

CF: *From conversations you've had with him and from what you know, from your understanding, why do you think he feel less secretive?*

RK: It isn't that he feels differently, it's just what he is. He's proud of it, extremely proud of it. He inherited Cures for five conditions from his parents and they include the use of seven herbs. He inherited them from his parents and they're actually unique to him. Because I have traced the herbs he uses from fourteenth to fifteenth century to the present day. Two or three of them are totally unique to him, particularly what he uses the herbs for, are totally unique to him and in the others he's more or less almost unique. So the knowledge that has been handed down – and he started learning at the age of three, he started working at the age of three with his father. And that's the thing we might need to look at is orality. What happens when you lose the oral tradition?

CF: *Absolutely! Did he have any training other than his family lineage? Does he teach classes?*

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<sup>15</sup> Food and Drug Administration

<sup>16</sup> Rosari Kingston

<sup>17</sup> I have capitalized the word "Cure" in each instance wherein it is used to refer to "The Cure".



RK: No, just from his parents. And he doesn't so much teach classes and I don't think he could. He takes apprentices, rather. This is back to the oral tradition. Sean diagnoses very much by touch and observation; by the feel of the skin, the observation of the hand, of the face. You can't teach a class on that. It's very much observation. I know an apprentice who's been with him three to four years and she says it's only now she's beginning to get the hang of it. His children are also doing it, they're still young. There is a boy about seventeen and a boy, twenty-two, who is at university but works in the clinic at every opportunity.

She went on to explain how Sean's lineage, steeped in tradition, has evolved over time to ensure that it reflects the needs of the community in which its inheritors practice. This is no different than "scientific 'tradition' born and bred in Western Europe which, over the past 200 years, has become the globally hegemonic form of knowledge production. Philosophically, modern science has its own characteristic procedures of experimentation and 'falsification,' its own specific theories of justification and verification, which are by no means the only way to achieve an understanding of reality" (Jamison, 83). Traditional ways of knowing have continued to go through trial and error, tests and changes to evolve over time, just as the "Western scientific tradition" has and I feel this is ignored all too often. Rosari was inclined to agree.

RK: "That's a very important thing, medicine always evolves. Whether it be traditional or modern. There is this notion that traditional medicine is stagnant or static and it's not. Sean Boylan's tradition has evolved enormously. He has even added new herbs. I would say 'Sean have you tried this?' For example, he has come to love my herb, carrageen moss, he would use that now. He uses Rose, which I introduced him to. Medicine must never be static because illness is never static. I suppose, to put it one way, the healer has to become an antidote to consumerism. You know, how much of modern illness is caused by it."

In my research I came across numerous culturally-unique examples of traditional medicine practitioners learning to heal 'new illnesses':

In *China Witness: Voices from a Silent Generation*, a medicine woman in Xingyi spoke of the difficulty for some healers to adapt to the new illnesses. "I see more and more new illnesses: sore eyes and back from sitting in front of the computer, or in an office, acne from

eating too much McDonald's, stomach upsets from too much travelling, earache from too much karaoke, exhaustion from too much driving..." (Xinran, 22).

In Mexico and South America, traditional concepts of illness help heal problems that have become more common due to globalization. "The indigenous peoples share this ancient concept of a soul trauma or spirit wound, called *susto* in Spanish. And many have rituals and ceremonies to call back the spirit from the place where the trauma happened that disturbed the person's life force. Traditional indigenous medicine can help us understand this trauma across generations and across time that we often carry as a people. That's what's important about revitalizing and preserving indigenous traditional medicine. We have healing ways that can help us understand and undo the very serious issues we have in the indigenous Americas" (Koepeke, 2012).

As with new cures created by traditional methodologies, old cures and concepts of illness are just as vital for the continued health of communities. Rosari presented another example of a healing methodology that operates through a different way of knowing:

RK: I would also say I'm a great believer in having a scientific understanding. I'm a great believer in the endocrine system. I believe that if we don't understand the endocrine system, we'll get nowhere. Because it's a system that will appear anywhere in the body and it will affect almost everything. But I would argue that there are things we do not yet understand and to put everything down to chemistry or biology is a mistake. For example, homeopathy works. We don't fully understand how it works.

CF: *While I consider myself very open minded to healing methodologies, I admit I've always been a bit skeptical of homeopathy...*

RK: Well, we don't know how it works! I have a friend here that is a vet, actually, and we had a pony that was very ill. Tom (the vet) came out and gave 2 tablets to the pony and you could not believe the difference in that pony in 24 hours. This was homeopathy. It was a very sick pony and the steroids weren't working.

CF: *That's something where you can't say its placebo effect because you can't tell the pony how it works!*

RK: No, you can't! Exactly. Precisely. And this is why I really like it because as a vet, he knows it's not placebo. He got into it years ago because he was a standard vet and the veterinary college asked him to disprove homeopathy and he said that was easy. 'I have 6 dogs at the moment that are going to die, I know they're going to die.' So he treated the 6 dogs with homeopathy and 5 of them got better! It converted him totally to it! I don't think we have the science yet to understand it. I think it actually might work on physics. There is something I read in today's paper, something about neurosensory, there is this new thing that they're wondering how relics work. They're working on this theory that the energy of a person can recreate or something. Can realign the molecules. Why can't it apply to medicine or healing?



*Two homeopathic clinics I stumbled across while exploring Dublin, Ireland.*

Returning to the tradition at Dunboyne, Anna-Maria spoke further on the ways in which Sean has worked to reflect his community with his practice.

AM:<sup>18</sup> There are traditional healers like Sean Boylan and they definitely stick to their tradition. But I've worked with Sean and I find him very scientific. He does read up, he's aware of clinical trials, he's aware of the latest research. He doesn't sit the tradition in isolation. From what I've seen of him, the tradition sits very much in this century but it's still very much *his* tradition. For instance, he would be aware of drug interaction, he would be aware of clinical research, he would be very strong on pathology and medicine and that. His diagnosis would be very different. I wouldn't even start to fathom it but it's amazing. I think he epitomizes the difference. You can be completely immersed in your own tradition and yet be very aware and have your medicine functioning within the century you're in.

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<sup>18</sup> Anna-Maria Keaveney

As Jamison, a specialist in science theory, expresses: sometimes it is less an effort to create a different science than it is to “provide a different cultural framework for the development of science” (85). This is similar to the concept of appropriate technology.<sup>19</sup>



*Inside the production facilities of the Dunboyne clinic, where tradition and innovation exist side by side. The wood and green machinery is a traditional method for extraction of herbal constituents.*

The expanding Dunboyne clinic isn't the only pluralistic center in Ireland. While they are not yet hugely common, there is also a community center in Claregalway, and one or two in Dublin and Cork – though they do not yet have a medical herbalist on staff. One of the things that make Sean's so unique is that it is run by a traditional herbalist. Anna-Maria explained how this model works quite well because it reinforces their practice when they work together. She stated that most traditional herbalists still work on their own and wouldn't have a very formalized clinic, though many of the practitioners trained with Sean, or he trained them. “Sean

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<sup>19</sup> People-centered, energy-efficient, economically viable technology suitable for the locale and community.

was probably one of the first, if he's still not the only, traditional herbalist to develop his clinic to such an extent. So it's quite unique in that sense. It's very much family, and that's been Sean's approach for years so everyone kind of just follows along with that. It'd be lovely to see a lot more clinics like that, to develop around that model. It's very lonely being a practitioner on your own and it's an awful lot of work and you're really, really having to carry a huge burden which reduces the amount of time you can see patients. And that's what actually pays for everything. This really just frees you up so your main function is just seeing patients." This team model, with its growing number of patients, could potentially even provide a model for prevention of compassion fatigue in busy practices.

### **Different Backgrounds, Different Ways of Knowing**

Despite Anna-Maria and Rosari both training in the same Irish Medical Herbalist tradition, their ways of viewing the evolving practice are somewhat different. Rosari's research has focused intently on the culture of the traditions of healing in Ireland, whereas Anna-Maria comes from a background that has prompted her to think greatly on the role of Western medical science in training healers. This, in some ways, provided an example of the contrasting backgrounds that form the views on the future steps of the Irish herbal medicine tradition. I spoke with them about their own perspectives on what it meant to be a healer and an herbalist within their community, and what the future of this community might look like: split from the growing pains of necessary change.

RK: The worldview of the healer, be it doctor or herbalist, is important. I think one of the things that the herbalist has to do, the formally trained herbalist, is to be careful that they don't impose a different perspective on herbal medicine when they use it, as opposed to someone with the lineage. I'm conscious that we (referring to medical herbalists) are trained in the medical subjects, whereas the traditional person would be trained differently. I would say that in the Irish Institute we are making a huge effort to blend the two. I would see them very much as traditional

physicians. As in the hereditary medical families in Ireland where you have huge knowledge but you also have the realization that that knowledge includes what people believe, it includes emotional, physical and spiritual. It's not reductionist. It's not someone coming in with a headache and giving them something for it. It's someone coming in with a headache and you saying, 'okay, have you taken a walk today? What do you do for your spiritual and emotional wellbeing?' It's the realization of what is out there in the community that can actually help that. What traditionally did they do?

Here, Rosari expresses an acknowledgement of the changed in the expectations of patients, law-makers and definitions of "good healing". Simultaneously, she speaks of the importance of tradition and a pluralistic perspective, as well as how expansion to the repertoire of knowledge for a healer is also a tradition – it prevents reductionism. She argues that this widening of knowledge is not an allopathic white-washing of the herbal tradition, but rather a growth in the abilities of the healer community.

Anna-Maria speaks even more passionately for the expansion of knowledge, however still maintaining the tools and mental approach that makes each practice unique.

AM: For me, I would call it my three hats – conventional medicine, herbalist and my other styles – nutrition, therapy and such. To train herbalists, I suppose, is practicing medicine. And medical training is expensive. And this is the difficulty, how do you provide an accessible training program, but one that is also enabling the practitioner to be fit for purpose. And it's delicate even speaking it, because there is a presumption that, you know sure everyone's okay - I don't know what it's like in the US - but I know some organizations were saying that you know you shouldn't be doing that, you aren't qualified for that. And...yeah...I find this very difficult. I suppose the question I ask of herbalists is: what is it about herbal medicine that appears to require you *not* to be trained? Where you have to actually step back from your training and let someone else evaluate it? And it's done, not just as an evaluation or accreditation from a university or college, but it can be done by your own structures, it can be done by your own systems, and it doesn't have to be a university or college.

CF: *But do you think the homogenization of training and potential loss of pluralism could be done in ways that aren't harmful?*

AM: I think that goes back to some of the points I was making earlier in that, I suppose medical herbalists right from the start have quite strong medical training as a part of our training. We cover all of the standard conventional - probably the weakness is that we don't have this exposure to a patient base. So you don't get the honing of the skills as a conventional doctor who goes out and does the hours and hours at a hospital. But, the other traditions here in Ireland might not have as strong a base of that, or wouldn't have had originally. That's very much changed

over the last 20-30 years. Most of the practitioners would at least make a reasonable effort to learn anatomy, physiology, pathology, medicine, diagnostics. That's what I mean, I suppose, by there's not that much difference already. And that's the difference from where I'm coming from and what you're reflecting. It's that there's been a push to sort of medicalize herbalist training. So I think maybe that's where there's not that much difference between all the different strains, there's more similarities than differences because there's been such a homogenization of training. There has been a core training right across, developed from the European Herbal Practitioners Association to Chinese, to Tibetan, to Western, to Ayurvedic. There's been a very strong coalescing of the training already in that way.

*CF: What about the necessity of different ways of approaching a medical condition? A lot of patients will go find a different kind of practitioner, they'll go to an herbalist; they'll go to an acupuncturist, as well as a doctor, because they want someone who thinks a different way. I wonder if that is lost, changes a lot, when you incorporate the medical training into the other methodologies. Do you think that you can have medical training in these other fields but still be able to approach healing differently than allopathic practitioners?*

AM: I agree with you there. There are very different ways of thinking. You have to swallow and learn it and understand it, that's conventional learning, but then you have to unlearn it so you can look at it from a distance and say 'how do the two link?' 'When do I need to concentrate on one rather than the other?' And I would switch between the two and sometimes they fit easily together and sometimes they don't. But the conventional is very important, I suppose, for a number of reasons. One, to understand drug herbs and what their possibilities are; for example what a drug could be doing, how it's working, what's happening with it in the body. And so to assess what the herb together with the drug could do, good or bad. But also I suppose in the Western, is to actually understand the pathology and the physiology of what is going on in the body and then you kind of superimpose, you put that aside, and then you say from an herbal point of view what is happening and then you put the two together. So I suppose the other aspect for conventional pathology is to make sure you're not missing something more serious. But I know there are traditional ways of assessing that, as well. So yes - you do, you flip between the two and assess how things are. But I think, as far as my understanding in things like China, where you have schools of Traditional Chinese Medicine (TCM) practitioners, they also have an understanding of conventional and the two would come together. It is possible, but it is difficult. It's not to be underestimated. It's a difficult training and I suppose that's what I meant by... I suppose it's getting to an understanding between knowing what you should do, knowing what herbs to give or identifying conditions or addressing situations and then being able to say why things are happening and the deeper questions – that takes longer. Rosario was saying that to train as an herbalist in Ireland in the 12-14<sup>th</sup> century was 17 years in total, including the equivalent of spending time in a university. I know the length of time in Ayurvedic is 7-10 years. But now there seems to be a big push for very short training, and a very quick turn-around which I question.

Drawing back on the concept of compassion fatigue and the argument that many doctors seem to withhold their emotions, and by association their show of empathy, many nurses have

expressed to me that they have heard the same thing time and time again: “Doctors treat the disease and nurses treat the patient.” Literature reflects a growing argument against the loss of patient-centered medicine, with patients complaining that doctors don’t take the time to figure out the cause of their symptoms, rather focusing on them as a sort of direct cause and effect equation that they can approach chemically, without consideration of environmental factors which could be addressed with preventative care discussions.

Despite her argument for ‘medical’ training for traditional healers, Anna-Maria drew a line in the way this was taught and the tools utilized in practices.

AM: I’ve definitely heard that before. I think it’s their training. I think they’re quite capable of thinking differently, but I think they’re very much ‘find it and fix it’. I don’t think about that at all because that’s what they are paid and trained to do. That’s come out of their history, and their tools. Someone asked me why they don’t have things to treat an irritable bowel and I went ‘they don’t have the tools to do it’. They have antimicrobials and antibiotics – that’s it. And they’re very powerful tools. Their tools are blunt in this way. Like a hammer – WHAM – it either works or it doesn’t. And the banging damage – that can be worse than we started with. So I suppose I see that they have their tools and I have my tools – I *like* my tools! But there are times where their tools can be quite nice.

I shared with her my experience in Indonesia with traditional medicine as opposed to Cipro, and my research concerning the problems of its overuse. I preferred her style of tools for that situation, as well! The nurse we had met in Indonesia had, after all, recommended her learned tools and they hadn’t worked for us. Neither she nor the medication she recommended properly addressed our environmental conditions and recent histories when considering our symptoms.

AM: Again I put that back – that’s their training. That’s what they are trained to do. And I think one of the problems may be that the initial research was just so successful that they didn’t have to do any different. So it never got to ‘what is the underlying cause’ but if you look at the ‘find it fix it’ idea - up to quite recently it worked very well, maybe not necessarily for the patient, but it worked for everyone else in the industry. It ostensibly worked for the patient if they didn’t dig too deep. As herbalists you have to dig below, because your medicine is more diffuse, on the whole. An antibiotic would barge through and it can be highly toxic, but it will be generally,



except for resistance, very good at what it did, very successful. But herbal and microbial is a much more delicate creature and you have to make sure you can get it to where you want it, you have to make sure it stays concentrated, you have a lot more work to do. I think it's a circular argument – your tools reinforce your training.

CF: *Down the line I'll be interested to see if this education in conventional medicine fosters communication in Ireland, because they have a greater understanding of what each other do.*

AM: Hah! No, it doesn't.

### **Tradition isn't Static: The Changing Face of the Irish Herbal Tradition**

One of the major issues that blocks cooperation and mutual respect between different types of medical practitioners is the tendency for extremism when considering what is viewed as their opposite – something that creates a false dichotomy that is harmful to the growth of medical understanding and the holistic health of communities. The science-based medicine school of thought tends to label all non-allopathic practices as pure quackery, whereas, as Anna-Maria points out, “If I saw somebody studying herbal medicine and heard they had a science background, I always knew they'd come to herbal medicine from a rejection of that science. They're both very influential groups, very vocal” (Keaveney, 2014). Additionally, as expressed in the previous chapter on Indonesia, many individuals distrust, or even fear, allopathic medicine for a variety of community or individually-specific reasons. In contrast to this, Anna-Maria is quite the rare exception. There are many individuals trained in allopathic medicine that go on to learn from Complementary and Alternative Medicine (CAM) programs, and several medical anthropologists who are also trained as physicians. However, very few traditional medicine practitioners go on to formally learn Western science, and even fewer Western scientists (trained in fields other than healthcare) go on to learn traditional, or even other non-allopathic, medicines.

AM: I always felt that's where I was quite different. I love the way herbs are meant to act as medicines. We need more exceptions. I mean, there are definitely some, but herbal medicine needs exceptions because it's fabulous and has nothing to fear from science. Its only going to grow with science, but its people who fear science that would stifle it. I love the tradition, how

things are done and why they're done. I don't think science has all the answers in the sense that our ability to find out the answers from science is limited. Science, at the moment, doesn't have the techniques to give us what traditional knowledge can give us. It doesn't need to be either or, there's so much that can blend together and work together, if people can just put the effort into it.

I suppose I could also identify as one of these exceptions. I come from a background in biomedical and forensic anthropology and find myself equally interested in training in allopathic medicine - for the understanding - and the herbal medicine tradition.

For me, a large part of applied cultural sustainability is emphasizing the importance of the bank of traditional knowledge that represents a type of science that has been running tests for thousands of years. This is knowledge that has been passed down as successful, through trial and error, where reputations are at stake for roles like a traditional healer. When we just disregard traditional knowledge, which is a sort of scientific study that has been going on for a very long time, there are results that we could be utilizing; tests running much longer than any test has been running in a modern-day lab. It's a whole other branch of knowledge that many scientists have trouble accepting as science. But by the Oxford Dictionary definition of science, that is exactly what traditional knowledge is: "The intellectual and practical activity encompassing the systematic study of the structure and behavior of the physical and natural world through observation and experiment" (2014). The importance of this knowledge ranges from concepts of healing to methods of environmental sustainability through responsible land stewardship, the latter of which is something that can actually be encouraged through recognition of *materia medica* available in nature. In fact, in Sienna Craig's work, she points out that the Tibetan name for their traditional medicine, *Sowa Rigpa*, translates to the "science of healing" ("Healing Elements", 2).

Anna-Maria echoed my own interest in a movement towards collaboration between the ways of understanding, though I admit I am more hesitant to blend too thoroughly. After hearing

Dr. Mustofa, in Indonesia, express interest in working with others to sustain the herbal medicine tradition, I questioned Anna-Maria on the collaboration efforts in Ireland. We all seemed to agree that conversations needed to happen between and within communities.

AM: (In Ireland) We're afraid to. Even, being honest, I'm talking to you and I'm afraid – could it be perceived as hurtful. And that's a million miles from where I want to be. It's the difficulty just speaking – you stop speaking, because people, they're very hurt by your comments. It separates people back out again because you just can't communicate, you're afraid to communicate. There is a big risk in being open and honest about situations. Or at least that's my feeling. The positive is I think we're getting more open and I think things are improving, but very slowly. So I think that maybe what needs to change is an acknowledgement that some people don't want to change and that those who do are going to – there has to be a letting go and a freedom, so that those who don't want to change have to let those who do want to change go. Because we all want to stick together but you can't have both.

*CF: What do you mean? Has there been a large split with the move to medicalize herbalism?*

AM: One of the things I find within herbalists is an inability to separate business from personal. The whole concept of professionalism within, let's say, conventional medicine, and how they view the business of maintaining their status, their influence, whether it's camaraderie or protecting each other's backs. There is a sense of cohesiveness in their way of thinking and functioning that I find is lacking in herbal medicine, and I don't think it's just within herbal medicine in Ireland and the UK. I don't know if it's the people who are attracted to it, or just the structure, or lack of one. If I say 'I think we should have x,y,zed' in our training, people who don't have it might say 'oh, so you don't think I'm qualified to practice?' They can't see the larger picture – everything is very personal. The picture of arguing fit for purpose, or your practitioner base or patient base – those kinds of issues become very personal and everything goes downhill to become personal. You can't do that. It's too big. If we shared it, we'd be more likely to progress.

AM: We ask our members, where do you want to be, where do you want to practice, where do you see yourself? And the answer is always at the heart of the community. Or at least part of the community. And yet you can't be part of the community if you don't reflect that community. And I think that is the whole thing, you talk about the concept of different traditions because they're embedded in their own communities. And yet we have herbalists in this country and in the UK which don't reflect their communities. The journey of their training is part of the journey of that lifestyle and that lifestyle takes them to the wilderness. It's a theme that keeps coming up – are the herbalists part of society or outside society. There has been thought that traditionally they are outside society but I would challenge that – the healers are central. We keep going back to insider, outsider. I've always felt an outsider within herbal medicine because I don't fit within that nice little defined role – I'm always challenging the role of the herbalists. I remember in college – I wanted to look at the entire aspect of treatment of diabetes and the lecturer said 'oh, you can't do that. You never know what you might come up with. Be careful of putting your

head above the parapet because you might get shot at.’ I know the history of all that, but that whole concept really just angers me.

### **Limited Good: The Changing Face of Ireland**

During our lunchtime conversation, the herbalists expressed a frustration presented by the history of colonization of Ireland by the British. In one of her articles, Rosari expressed that the “Botanical based medicine is the traditional medicine of the Irish. It is a knotted, tangled, almost broken thread of a system that cared well for Irish society until its displacement and dislodgement in the political turmoil of our history” (Kingston, 2009). In the seventeenth century, Flemish chemist Jan Baptist van Helmont recorded the effects of this on the Irish medical tradition: “By the early part of the seventeenth century the profession of *liaig* (Irish herbal physician) had been destroyed by English colonization. Under new penal laws, no Irish person could practice their profession or receive an education. Some Irish doctors went abroad, and those who stayed behind were forced to find other occupations. The hospitals and medical schools closed. The huge body of knowledge that had been built up over many hundreds of years largely disappeared” (Self, 2013). Initially, there had been many long lineages of hereditary physicians. Rosari presented some examples from her extensive research: “the Donleaveys/Mac (or O) Duinshleibhes and the O’Shields/O Siadhails were very famous medical families and Ó hÍceadha (Hickey) and Ó Leighin (Lane) mean literally healer and leech respectively” (Kingston, 2014).

Due to colonialism, there has been a bit of loss of context over time concerning the use of herbalism for healing. For many countries, the dangers to sustainable harvesting of local flora and subsequent efforts to create more synthetic and semi-synthetic herbal medicine has presenting an even greater threat to the cultural context of herbalism. Irish herbalism has been somewhat inextricably entwined with the British tradition, leading to the frustration of my two

Irish herbalist friends. “The Irish medicine if you like, was defeated. After 1640, after the last Irish Medical School closed, you had to train at Trinity according to the British model. So any of the physicians, our own nation’s physicians, became poor to some extent and were only able to pass on a certain amount of their knowledge. Our training schools disappeared, in other words. We had great hereditary medical families and they are no longer as common” (Kingston, 2014). Rosari went on to share a story of colonialism that is unfortunately all too common – the only reason they could justify taking over another’s land was the inferiority of the indigenous people, and this inferiority extended to their traditional medicine. Physicians lasted a bit longer in Ireland however, as the British did not adapt well to the damp and relied on local cures to heal them. After a time they were forced to adapt to the English way, which was taught at Oxford, Cambridge and Trinity. A methodology that involved five years of classics, then theology, before a mere two years of medical theory; ironically they didn’t quite understand all of the knowledge coming out of the Arab world that had been implemented in the British medical tradition.

Anna-Maria expressed an interest in the basis, background and context in which the traditions were used. “I suppose I very much try to put what I do in context. But I think we use herbs terribly out of context now. We really should go back to how were they used, how were they processed. It’s just so important and everything is a tincture or a tea - it’s just so homogenized. And it was much more diverse in the past” (Keaveney, 2014). She explained that one of the reasons she loved the Dunboyne clinic was its traditional ways of herbal use and processing. I asked her why she thought the clinic, and herbalism in general, had made such a comeback since their Independence from Britain.

AM: It’s so approachable for us because... We’re quite a spiritual people and we’re in flux as regards the conventional, which was imposed by the Catholic church. So I think again a lot of this is seen as part of the spirituality and lifestyle. It feeds a need in the practitioners. You have the ones who don’t want to go to the doctor so they’ll go to some sort of alternative practitioner.

You have the others who've tried everything but they want to be cured 'like yesterday'. And really anything in between. I can't think when the last survey like that was done. Very similar to what you'd find in any other survey of who goes to see an alternative practitioner, anywhere else.

Further illustrating the re-strengthening of the tradition, Rosari regaled me with examples of patients who had expressed general herbal knowledge. I was pleased to hear her mention a cousin to the common herb, *Plantago major*, I referenced in the last chapter that I had been encountering all over the world.

RK: I had interest in a patient I had yesterday. I was treating a leg ulcer - I used ribleaf, *Plantago lanceolata* (\*lesser/narrow leaf cousin to *Plantago major*) - and she told me when she went home that she sent her husband out looking for it and he said that he remembered that as a boy if somebody cut themselves. He remembered one incident where somebody cut themselves very badly on the farm. And first the bleeding was stopped with a cobweb, which would be correct and very common, then placed a leaf of *Plantago* and then they bound the whole lot with the lining of the pocket of the coat where tobacco had been kept. In Ireland *Plantago* is known as *Slanlus* – it means the herb of health.

As our conversations progressed, we began to discuss legislation, cultural sensitivity and diversity in traditions of healing. During the interviews, I realized I had made an assumption of Ireland after growing up in the United States – a very culturally diverse country, and researching in the ethnically and religiously diverse Indonesia. Thomas Sowell, cited in *Cultural Democracy*, discusses the “sheer magnitude of American ethnic communities” which “makes them autonomous cultures with lives of their own – neither copies of some mainstream model, nor mere overseas branches of some other country’s culture” (Bau Graves, 29). Indeed, in Ireland I was told that some Irish-Americans often come across as more Irish than those still living in Ireland – family crest tattoos on their shoulders, “Oh, you’re Irish are you? Which clan are ya from?” However, in contrast to this within the same work, Bau Graves argues that America’s dominant ideology has demanded the “surrender of ethnicity as a part of the passage to American citizenship. Many immigrants to this country have viewed the trappings of ethnicity as barriers to full participation in the bounties of the golden land” (Bau Graves, 29). This no doubt adds to the

difficulty not only sustaining traditions, but also wearing them with pride. It also unquestionably creates complications in clinics, as it further encourages the concept of “don’t tell the doctor”, when it comes to using other, culturally traditional, medications and healing products. This likely leads to further accounts of negative drug interactions, though there is a lack of available research concerning this – perhaps due to inaccessible medical files, published research for non-doctors, or a lack of interest.

I recalled some of the articles and bits of news I had read over the years concerning Ireland and the impression they gave, which I had forgotten about in my travels, of a country that resisted cultural diversity and change. Anna Maria called out this assumption, reminding me that Ireland had a long history of “just being Irish.” The United States has embraced and even celebrated its diversity, for the most part, which has led to our complicated issues of defining good practice in traditional health methodologies – blanket-statement laws cannot work as well when meant to apply to such a diverse country. She explained that this was part of her frustration with their own hurdles towards passing herbalist-supported legislation: Ireland focuses on cultural unity and yet there really is a refusal to take the last step.

According to the 2014 World Health Organization’s Traditional Medicine Strategy, “to ensure the safety and quality of T&CM, national health authorities must develop policies and strategies that reflect their specific needs in dealing with the most popular forms of T&CM practiced in their country” (WHO, 32). However, Ireland has been changing, culturally, for quite some time and there seems to be a denial of this. There is no discussion concerning these changes, and therefore especially no discussion of the new healing traditions that may be brought in by these new cultures. The Traditional Medicine Strategy acknowledges how global

traditional medicine is, and encourages local lawmakers to “be prepared to deal with new forms of T&CM being introduced from other countries” (WHO, 32).

I acknowledged my previous assumption, but also realized that without it we may not have discussed this Irish denial of cultural change. Tying this line of thought with Anna-Maria’s earlier discussion of herbalists no longer reflecting their own community, I suggest the need for healers, while training, to consider what community they are intending to work within. Concepts of good practice and health needs must reflect the standards and expectations of their patient community. As globalization continues, traditional practitioners are going to find that many of their patients have been exposed to allopathic standards and expectations, and refusing to meet them – in their own way – will further endanger the continuation of their tradition. While I certainly don’t suggest we require university training for all healers, I would agree with Anna-Maria that healer-friendly legislation concerning good practice will aid in sustaining healing traditions. Diversity and undeniable discrimination, however, complicates these laws. Legislation concerning the certification of healers in Ireland has been on hold for years. Anna-Maria explained the current lack of collaboration within the Irish healer community, and how this has hindered the passing of this legislation

AM: ‘Are you saying that since you have a degree that you’re better than us? You know, we don’t have a degree.’ And I can assure you that the degree is not the be all and end all. I’ve seen people get degrees and I’ve seen people do the old style and they’d be a million times better trained. And I suppose what I would say is that... *(she pauses a long time, trying to carefully phrase her next words)*... we spend so much time as herbalists trying not to stand on anyone else’s toes that actually, we’re tiptoeing ourselves out of existence. It’s like you’re spending so much time, you can’t define yourself because if you do you seem to insult somebody else. And so you cease to exist because if you split yourself so many ways, you can’t exist, you can’t be seen. If you can’t find your terms of expertise or your breadth of practice because somebody else is different and you might insult them, then you have no breadth of practice or expertise. And that’s not negating those delicate issues – I still think there is a way around it. There is a way of defining competence as an end product. But it’s just been split so many ways, and you can’t keep splitting. You can’t and survive. Just sometimes you have to draw a line and say okay, this is what we do and this is what we need to do it. There’s still loads of flexibility. There’s loads of



movement for maneuvering and I think that a lot of people would actually find that if they stood up and put themselves to the test that they probably would meet it, but I also think there is a fear of ‘I didn’t have this so I’m going to fail’. I see that with some of the traditional herbalists, they might feel that they are weak – well I don’t actually think that they are.

Her words resonated deeply with me. The concept of being a healer can, and should, place a weight on the practitioner. The idea that so many are relying on you to provide them with relief from pain should be taken seriously. At times, that weight can seem even more daunting when having to adhere to a new set of standards than one might have previously been accustomed. However, here Anna-Maria suggests that if a practitioner has held themselves to high standards, these regulated expectations can be met by many of the individuals fearing change while also helping to weed out those unwilling to put in the work to respect the faith their patients have in them.

Within my original assumption, I had been concerned about the difficulties of creating legislation when dealing with a culturally diverse country. Anna-Maria’s continual replies to my line of questions concerning this community diversity suggested that there had been a misunderstanding due to my assumptions – this did not quite apply to Ireland in the same way. I re-directed my line of approach, explaining the idea of a Cultural Mediator<sup>20</sup> in healthcare and asking if she had encountered any similar concepts.

AM: I had never heard of the role of cultural mediator until you mentioned it! There is no concept in Ireland of that, at all. And the very fact that you have that in the (United) States speaks volumes of why you steadfastly kind of nurture the different traditions. There is no concept because you aren’t allowed to discuss culture. If you do, then you might be a racist – so people don’t.

After explaining my initial accidental assumptions, due to my own experience and focus on the diverse immigrant culture of the United States, I carefully expressed to her the new general perception of Ireland that I had been forming, fearing that it might be offensive. Was

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<sup>20</sup> See Chapter 3 for a more in-depth look at the role of Cultural Mediator.

there a sort of push against any non-Irish immigrant cultures having an influence, or a large community in Ireland? Several years ago I recalled hearing of Nigerian immigrants in Ireland that were faced with the situation of not being able to acquire work and having no place to go. Many years prior to that, while researching the difficulty faced in attaining Irish citizenship, I faintly remembered reading that there was a push to make it very difficult to live in Ireland, to “keep Ireland Irish”.

Anna-Maria sighed deeply before replying.

AM: It’s a very difficult question and it’s a question that’s really being pushed under the ground. There is a real taboo to even discuss it – and I think that’s a dangerous thing. We’ve moved from a country that would be 98-99% predominately Irish, if they weren’t Irish they were definitely European/UK. To a community that is hugely diverse. You walk down our streets and there are whole communities that you would hardly see an Irish person. There are schools where there might be 3 Irish people out of a thousand students and that’s in less than 20 odd years. There is no discussion as regards of what the impact of that is on our country. We have a situation over the last 7-8 years of the downturn in which we’ve had a quarter of a million of predominately Irish young people leave, at the same time as we’ve had around a hundred thousand people come into the ground. Now – that’s huge complex issues and the figures are a bit frayed – deep issues. But that’s an exchange of nationalities. I would have thought in some sense that we were incredibly tolerant...

I’ll give you an example that really sums it up. I remember, several years ago, there was a woman from Poland and she said ‘I came here and the Irish were friendly and they were lovely – but they’re not THAT friendly.’ And I just looked at her and I went...’ I remember when I was a child and we moved down from Dublin and I always felt an outsider. I stopped worrying about feeling an outsider the day I was maybe 13-14 and I was chatting away to my friends. And one of them started talking about her mother, and we must have been talking about me moving from Dublin because obviously it moved on to that, and the girl said her mother had always felt “blown-in”, basically an old phrase that means you didn’t belong, you’re from somewhere else. And she was only in the last maybe couple of years, settled in, and the kids were all grown up and this was the youngest, and the youngest was 12-13. And I went, ‘oh where’s your mom from?’ and she said ‘oh from a mile up the road.’ We are an incredibly conservative, clan-ish people.

Rosari was familiar with the concept of a cultural mediator, but acknowledge that it was elusive in Ireland.

RK: The concept of cultural mediator is foreign to us. I think there is an effort being made to be sensitive, and if anybody is doing it it’s the church. I would say there is sometimes a resentment

of different cultures here. There is a concept, if you go through Irish folklore, of ‘Limited World Good’. It’s quite prevalent. Have you ever heard of the ‘Irish Begrudgery’? Where people begrudge someone getting off and people say sort of ‘Well who does he think he is?’ That sort of thing. Completely different from America where people are admired for getting off. People have said it’s because of jealousy, or it might come from us being an island, but there is a concept that there is only a *certain amount* of good - be it luck, water, air. So if there is the concept of Limited Good in a community, then if someone takes too much, then somebody else suffers. It’s protecting what you have. Because somebody might steal your luck, so it fits in with the concept of luck in Ireland which is very important, as well. And good health is seen as good luck. So you protect it, you walk the bounds to protect your land on May Day. So everything was about protecting the milk, protecting the butter, protecting the produce of the land. If you have that concept of Limited Good, then a lot of immigrants coming in are diluting the good that’s available to you.

Literature supports this concept of “Limited Good” historically in Ireland. In Foster’s work on the peasant society in Ireland he states that “The rivalry expressed in fighting at key points in the agricultural year seems to have been based on a notion of “limited good”; that the abundance assured by the saint’s protection of the crops of one district was made possible only by scarcity in another district (Foster, 293).

### **The Cure: Irish Medical Tradition**

My last day in Ireland, I returned to Dublin to meet up with an Irish friend who had recently moved home after living in America for a few years. Over tea and fancy sandwiches at Fionuala’s favorite little quirky café, we discussed her experience with Irish medical traditions through what she called “The Cure.” As a child, she had developed a horrible case of warts covering the fingers of her left hand and her mother had sought help from a neighbor who had overcome the same issue. The neighbor suggested going up the road to speak with a man who had ‘the knowing’, or “The Cure”. Fio’s mother took her to the man who gently took her hand and looked it over, then went outside and shortly after returned with a grass in his hands. He rubbed it roughly all over her hand and then said a short prayer, drawing a cross above her hand

with his own. Within the week the warts had all but disappeared, and Fio said they never returned. She explained that it was the only time she had ever met someone with The Cure and still wasn't entirely sure what had happened, nor was her mother. Having discussed the loss of a large body of traditional Irish medical knowledge in our previous meetings, I contacted Rosari and Anna-Maria for a Skype interview to discuss The Cure and other ways the Irish tradition had survived.

AM: There are different points of view of The Cure. It's quite Irish. They could be herbal meds, but they could also be hands on or laying of hands, or saying a prayer or tying a string on you. It could be vast, bury something in the bog. It was hugely varied. There were some that were lighthearted or didn't have a lot of substance to them while others would be much more in depth and there would be a strong credence to them. To one extent they came out of our more structured herbal training in the past. I don't know how extensive it is to have that kind of concept of what we call The Cure in other countries. They would absolutely consider themselves healers - they're commonly considered traditional healers. Some of them are finding it impossible to pass 'the knowing' down. Their children and other people don't want it. It's strongly dying out. Again Sean Boylan, as a traditional healer, would be quite unique in coming forward and bringing outside people into his clinic and letting you sit in where he's working. Traditionally things would be very secretive and they would only pass it on to the right person. It tends to die off then. I have never worked with that sort of traditional healer. And they're usually not trained at all. It's kind of like a gift rather than learned.

Rosari's research has covered The Cure extensively. "The Cure is a generic term. I always thought it meant one Cure, but I've discovered it means someone with healing ability. It's not A Cure. It's rather somebody who CAN Cure. Sean Boylan would be known to have The Cure, but he has the Cure for about 20 different diseases" (Kingston, 2014). Some families have only one, or a few, specific Cures – for shingles, colic, sprains, etc. It is passed down through the generations within the family, and referrals come by way of "someone who knew someone, and it was the only thing that worked." All too often, the knowledge is lost with the death of the member who had 'the knowing' – either they felt that a chosen inheritor hadn't presented him or herself, or they might not have felt the family member ready for the knowledge. When an

individual has only one Cure, we are seeing a diminishment of the tradition being handed down.

Rosari explained that, “the best way I can describe it is, if you have political turmoil and you’re a physician in the seventeenth century and you have five children, you could be shot today.

You’ve started training your children with what you know. You start them with one Cure. You try to get them to learn the most important things; you hardly have time, because life is very volatile, unsure. And then you get killed. So your children are cut off from the knowledge”

(Kingston, 2014). Some losses have been recorded, as a sort of marker for blank spots representing the loss of knowledge:

RK: In one instance, I have read that with Victor Lane, who is a bonesetter. He’s from a very old medical family in Ireland. The only gift handed on was the bonesetting. What’s interesting is that his father used to also use herbs, so he used to have a lot of Cures. He had herbs for swollen tonsils, he had herbs for different Cures for different things. It was quite wide ranging. He would never tell Victor, he would say ‘there’s time enough for that, there’s time enough for that.’ And then one night he told Victor to get a pen and paper because he had to tell him about those Cures and by the time Victor got the pen and paper he was in a coma and he died the next day. That’s how you got the diminishment of the skill. Part of the problem is that, whatever the instruction was that was handed down, it’s as if they are waiting for a sign or waiting until they feel their children are ready to get the knowledge.

Another one - 2 or 3 of the local vets told me this. There was a woman in Wicklow, you know *brucellosis* is a disease that effects vets, right? There’s really no cure for it conventionally. But there was a woman in Wicklow who had a Cure for it and every vet in the country who was infected was treated by her and she was to leave her Cure to her son. And she was a relatively young woman, only in her sixties and her son was in America for the holidays and the Cure died with her. I’ve seen this time and time again and I can’t understand it. Victor kept asking his father for the Cures and then it was too late. And I think this is what actually happens. With the instance of Sean Boylan, they started him at the age of 3 and they never formally told him (that he was starting). The apprenticeship started and he absorbed it all through his teens and all of that. Probably without even realizing it.

I was reminded of Daud, in Toraja, teaching his son in a similar manner and told Rosari this story. She smiled, replying that her own daughter had actually learned from her without her realizing it. They had been visiting the botanic gardens in Washington and sat down for a rest while her daughter continued ahead. Rosari watched her explain the medicinal use of some of the

plants to other visitors and was amused. She said, “You know an awful lot about herbs – where did you learn it?” and her daughter replied, “Mom! I grew up with ya!” She had never been taught formally, but she has the knowing and she knows quite a lot.

With globalization and urbanization, this lineage of traditional medicine is becoming rare in many places, with their children often preferring allopathic treatment instead. Rosari suggested that “this shift to urbanization may also mean that the guardians and holders of such ‘cures’ do not see their significance in the Irish herbal tradition” (Kingston, 2009). However she went on to say, “It’s common enough. I know somebody who has a Cure for heart fever, someone with a Cure for shingles, someone with a Cure for skin cancer, someone with a Cure for liver conditions. So those alone, that would all be passed on orally. The practitioners wouldn’t have the repertoire that Sean Boylan has and they seem to have lost some of the skills of diagnosis. The person with the Cure for skin cancer - he could diagnose and say whether or not its skin cancer; he’s quite clear when something is skin cancer or isn’t. But Sean’s ability to diagnose is superb. He would know how to use his seven herbs in various combinations based on what he sees in a person” (Kingston, 2014).

But there are other threats to the sustainability of the Irish healer tradition. I was reminded of the encounter with Maura at the Man of Aran cottage and recounted the experience to Anna-Maria in our follow up interview.

AM: There is a whole, I think I’ve mentioned it and Rosari has mentioned it, there is a whole concept that herbal medicine is associated with the poor. It’s beginning to go away. I think what would make a huge change to it is if they see herbalists making a good living. I suppose, giving our history, we are desperate to show we are longer poor. We are very hip and with it. And that means pharmaceuticals and that’s a big issue here in Ireland. Yes, herbalists do quite well and there is a very strong herbal tradition. But I think that’s part of the not telling the doctor, the secrecy. It’s more they don’t want to show they’re – like that poorness – that they could be on the margins of society. So they hide herbalists.

CF: *In the United States and in many countries there is the argument that traditional medicine, especially herbalism, is a more affordable option for healthcare. The World Health Organization goes into extensive detail concerning this. It is especially more affordable than pharmaceuticals.*

AM: So this is the opposite, this is the funny thing about it. Herbal medicine is not an affordable medicine in Ireland. It's a very expensive medicine. Now, I don't know if it's *as* expensive as going to the doctor. Our consultations would be very similar. It might be as expensive to go to the herbalist as to go to the doctor.

CF: *So that is a big difference between Ireland and the US then!*

AM: Yeah, it's not the cheap option. Some herbalists very much espouse that cheap option. And it was very clear that they espoused the whole kind of wouldn't it work to just have the money box, where people paid what they found was reasonable for their consultation and herbs. And I suppose that to me is quite alien at this point. I put a lot of time and years and money into training. I've lost a lot of earning power by going back to college for 4 years. Now I'm lucky that I got a job at a college so I'm protected. But I have no qualms about asking consultation fees because I think I've worked to earn it.

CF: *I've never really looked at the expense difference between American and Irish hospitals. I wonder if it's less of a difference in that...herbalists do charge more because yours have certification and ours is sort of informal. Or if it's the fact that our hospital bills are widely considered to be absurdly high.*

AM: To go to a GP (general practitioner) it would be somewhere between fifty to seventy euro on the whole, which is very consistent with going to an herbal practitioner. Some are less; some are thirty to forty euro. But then again that's ten minutes with a GP and an hour with an herbalist, for the same price. So in that sense, it isn't as expensive. And people do acknowledge the time spent. We don't have free health care. We do have medical cards and 45% of the country has medical cards, which gives them a minimum of free GP treatment, so they don't have to pay for consultation. Hospitals are a different story. Most of the country would have some kind of private health insurance that would still cover them. Now, you still pay – but if we were to compare it to America, it's miniscule in comparison.

CF: *So returning to the concept you mentioned of 'not telling the doctor' – What do you do when that happens? What does "don't tell the doctor" mean, exactly?*

AM: I suppose a part of our training is to sort of trust a patient's autonomy and to encourage them to tell their doctor. The perspective was once a focus on patient autonomy, and that's their decision and you can't break that trust, just encourage them. Or make sure it's clear that they need to impart that information. But there is, I suppose, a small change now whereby to be seen to not allow the patient to push you into the margins, to actually claim your space. To instead say, 'actually that's fine, but I actually do need to let your doctor know.' Sometimes patients out of their own fear, push you into the margins.

CF: *They're afraid their doctor will be mad at them? Is this because you aren't yet put on an even ground with allopathic practitioners?*

AM: Yeah, and some are! I think that's part of it. You're not the same status, you're pushing the margins. We are there because patients are kind of pushing us into that because they won't confront the doctor. How much of that is on us to say, 'no this is our space, we aren't going to be pushed out of it?' But again, these are difficult because we can't push them into things they don't want to do, but we're trying to make a living as well. There are GPs and doctors that are open, but if they get so open they just get the training and do it themselves. But because it's not always formalized, they aren't sure. If they refer to herbalists or other practitioners...the liability and should something go wrong, the book stops with them (the doctor) because they sent them on. Reputation for herbalists is building so referrals do happen. You just have to get out there and practice well – change is happening...

Going back to our earlier conversation on legislation...one of the biggest problems is that of the legality, the fact that there is no legislation underpinning us at the moment. It doesn't bother because we are outside the law, we operate from tradition. But if you are a young man wanting to go into a career and you realize you're up against big pharmaceutical? And it's not even so much that as European law, because in the rest of Europe you have to be a Doctor to use complimentary medicine. And then you can use herbs, reiki or kinesiology, but not otherwise. Only in Ireland are you outside the law on that. It's Common Law, which comes from the old British law as a colony. It basically says that you can do anything you want to do unless you're told you can't do it. Where European and Napoleonic law says you can't do anything unless you're given permission to do it. So there is no law that says you cannot practice medicine – you don't have to be a doctor to practice medicine. You can't say you're a doctor, you can't imply. But you can practice medicine. The only thing I can't say is that I'm a doctor. Even if I have a Ph.D. I can't say Doctor Anna Maria...because people would assume I was practicing medicine, that I was a medical doctor. But on the whole I can do all the examinations, anything. I can take blood, though biomedical scientists have refused to process blood in the labs unless you are a doctor. And so it's not a free for all. It's not an ideal world, you aren't seen as equal – but by God we have a huge freedom.

### **Application on a Global Scale:**

While certification of traditional practitioners seems to be creeping forward, the efforts of the Irish people to sustain their medical traditions seems to have aided in working towards a more positive reputation for herbalists and even the occasional referrals for them by allopathic practitioners. The many members of the International Institute of Traditional Medicine collaborate to prove the efficacy of Irish traditional medicine by teaming up with the program at CIT, while retaining their agency and individual methodological approaches. The work being



done by Sean Boylan and many medical herbalists in Ireland illustrates the continued creative growth of traditional medicine and the necessity of agency when interacting with standardized sciences, especially in their increasing collaboration and usage of these sciences as tools to provide accessible validation of their knowledge. There appears to be a need for increased conversation and bridge building between traditional healers with different thought processes, without which many of the local legislation processes have ground to a halt. An Irish definition for ‘good practice’ within traditional medicine is still in the works in order to work towards the legislation that will aid herbalists in stepping out of the margins and gaining a more even footing with allopathic practitioners.

Unfortunately, the idea presented of ‘official’ and practitioner, or patient-defined, legitimacy does not always overlap. In her work *Healing Elements*, anthropologist Sienna Craig discusses efficacy and the need for individual countries to implement GMP towards their own traditional medicine, due to the globalized product sales. The World Health Organization, along with many other global health organizations, proposes strategies and legislation concerning these regulations.

As discussed in this chapter, this is difficult for many countries whose culture diversity often complicates the implementation of laws that cannot easily apply to all medical methodologies. In her work, Craig suggests that “GMP rarely conflicts directly with traditional medicine standards,” however it can present issues when applied to mass-production businesses that sever the connection with the communities of traditional medicine practitioners (Craig, 2012). In the UK, the company Herbs in a Bottle has allied itself with certified herbalists and has made leaps forward thanks to this collaboration. Models such as Herbs in a Bottle not only utilize local labor force, but also present hope for retention of cultural context as herbal products

become more synthesized to accommodate increasing demands for herbal medicine products. I would argue, however, that efforts to apply GMP to traditional medicine, especially when considering the Irish tradition, may ignore individualized practitioner recipes and methodologies and create a standardization that would accelerate loss of the Irish herbal tradition.

The efforts being made in Ireland to increase licensure for traditional medicine practitioners present a model of hope for other countries, as we will see in the next chapter on the USA, where non-allopathic practitioners still struggle to gain solid footing. Despite a history of colonialism, Ireland has fought to sustain their traditional practices and beliefs and to adapt them to a changing world. They have fought to involve themselves in the globalization of medicine, including its product consumption, with the ferocity and passion often attributed to the Irish people. While they have made these large steps, they still have quite a ways to go as they consider the ways in which Ireland is changing culturally, as countries diversify with waves of immigration, as well as technologically – something that so far has split their once strong community of healers in half.

Both Irish narratives provided a look at yet another community seeking to stabilize their identity in terms of healing and health after a history of colonial rule and the imposing of foreign concepts of medical training. While at times the two women disagreed with each other, this only further illustrated the difficulties the Irish traditional healer community is having as they fight to keep out of the margins and sustain their practices. In fact, while in Indonesia the narratives seemed to focus on a regularly seen dispute between allopathic medicine and communities preferring traditional medicine; in Ireland the narratives instead presented the disagreements between different non-allopathic healers who came from the same core of training and all identified as herbalists. As I stated at the beginning, this deeply expresses the lack of partnership

and communication issues in communities of healers which further fractures the ability for communities to attain holistic health and culturally-sensitive healthcare. Overall, my work in Ireland demonstrated the need for a community-defined concept of ‘good practice’ for traditional practitioners, which will further increase sustainability of traditional cultures of healing and culturally-sensitive healthcare. However, this can only come about through further collaboration between traditional practitioners of different mindsets and solidarity of their communities to gain a more even footing with other healing methodologies.

## **Chapter 3: New England, USA**

Narrative of a Cultural Mediator

The United States, and especially the New England area, has historically been a haven for a diversity of immigrants from all over the world. Each individual left their home for a different reason – be it to flee a harsh life, forced displacement, hope for sanctuary from oppression, or any number of other purposes. One of the most difficult challenges individuals and entire communities face when they move is health. Whole health of the self and of the community: physical, mental and spiritual. Many immigrants bring their own varieties of complementary healing practices with them when they arrive on American shores and they prove to be essential resources for those seeking to maintain their identity and stave off the feelings of being homesick. Often, when healers of different communities find themselves in close contact with each other, they are provided with the unique opportunity to influence and learn from each other. Unfortunately, allopathic medicine often clashes with new traditions of medical practice when they interact, either through inter-community aggression or negative drug interactions<sup>21</sup> within one patient. Non-allopathic medicine practitioners typically use a more holistic variety of entire-self healing that could benefit the practices of allopathic medicine, if only the communities could respectfully collaborate. Healers of all traditions (ideally) seek to provide optimal healing for both the immigrant community and for humans in general.

In my conversations with Dr. Bonnie O'Connor, and my deeper analysis of the healthcare issues facing the culturally diverse United States of America, I sought to gain a deeper understanding and appreciation for the role of cultural mediator in a clinical setting. Bonnie shared with me her passion for sustaining pluralistic voices in healing communities, the issues and limitations presented by integrative systems, and her strenuous efforts to educate and advocate for culturally-sensitive healthcare in medical schools. We also examined the

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<sup>21</sup> When two or more medicines interact chemically in the body to create negative side effects for the patient.

complexities of the terms used when discussing healing systems and the difficulties presented by the current legislation governing non-allopathic healing practitioners.

### **The Role of a Cultural Mediator**

Well over a year ago, my advisor Dr. Robert Baron helped put me in contact with Dr. Bonnie Blair O'Connor, recently retired cultural mediator for the Rhode Island Hospital in Providence. There are a meager few playing the role of Cultural Mediator in the medical setting: Dr. Bonnie O'Connor at Rhode Island Hospital and her mentor Dr. David J. Hufford, recently retired Director of Humanistic Medicine at the Penn State College of Medicine, are currently working to bridge the gap between cultural and medical studies to provide more culturally sensitive healthcare for diverse communities. Dr. O'Connor acquired her training through a combined focus in folklore and a fellowship in medical humanities at University of Pennsylvania, where she worked in the faculty of community and preventative medicine. The Rhode Island Hospital (RIH) caters to a wide diversity of cultures, many of which still utilize traditional healing and ritualistic preventative concepts. On one occurrence, O'Connor acted as a mediator between pediatricians and a family to discuss the importance of preventative medicine, using the family's own show of concern through use of a protective charm on a necklace on their child. This opened the door for discussion of an additional and complementary form of preventative care for their child while simultaneously respecting the family's healing and spiritual beliefs.



*Inside a botanica. (Goodfriend, 2013).*

In our most recent meeting, I asked Bonnie to explain the role of a cultural mediator and why she feels it is a necessary role in clinical settings.

BO: Everyone is comfortable with the healing traditions they grew up with. Most people are using what they heard about through word of mouth. . I've had a Portuguese social worker come to me and be concerned about her son hanging with the wrong crowd, afraid he'd start doing drugs, not acting right. 'I need stuff from the Botanica but if anyone from my church sees me coming out of there it would be a bad thing.' And I said 'what do you need' and she gave me a list and I got it for her. So I've been a go-between. So yes, I introduce people sometimes, but mostly I can tell them where good services are. People also ask me in the hospitals, just sort of hallway consultation. . Also people ask me all sorts of medical questions because they figure if you work in a hospital you must know all that kind of stuff.

*CF: Have you trained in any healing?*

BO: I have not.

*CF: But do you find that people consider you a healer?*

BO: Yes, in some ways. Some people say so really directly. It's a responsibility. And actually, when you know stuff from the inside of the medical system which is very arcane for some people. We don't know what to expect when we come to a big place like this. Whatever I can help people know about that, assuages their concerns. Because I feel like if you have good knowledge that you've learned from being on the inside, you're sort of obligated to share it with

people who need it. And I think that's a healing service in a way. I think it's a gift you can give to other people if it's something they want, if it's something they can accept from you. You don't need to throw your weight around about it. I keep a little folder called 'I'm Remembering Why I Do This' because sometimes it's very frustrating to be the black sheep in this environment and you have to be a failure of socialization in medicine and remain a failure of socialization to a degree to do your job properly. All groups want to assimilate you, talk like this, think like this, and then you wouldn't be doing your job.

I recalled my conversation with Anna-Maria, in Ireland, and how she, too, expressed feeling like an outsider in her environment. Bonnie's emphasis on learning the medical system, but refusal to be socialized within it, is also in line with Anna-Maria's discussion on how a medical herbalist can train to adhere to good practice without losing the individual mindset of their tradition. I asked Bonnie about her interactions with doctors and her efforts to introduce the role of a cultural mediator in clinical settings.

BO: In the beginning it didn't work at all, mostly because pediatric practices in the community are too busy. They don't have time to stop and talk to you about even what they might need to have from you and they certainly don't have time built into their schedule for you to come make them a little presentation...

You want it to be a ripple effect. What you don't want...Medicine is so territorial. And everyone's stuff is 'so important'. So getting one hour in a med school curriculum is as much as your life is worth because that means that hour – someone else has to give it up and nobody wants to give it up and their stuff is more important than your stuff, you can just ask them and they'll tell you. That kind of stuff is very difficult to nose in so what you don't ever want to do is have 'oh I'll do the special course on cross-cultural blah blah blah' and it'll be an elective course - which it turns out they don't pay you for and only those who're really interested will take it - but that's the only way I can do it because its outside the regular curriculum. Then as soon as they don't have time or money for the students to sit around an hour a week in that, it's easy pickins. Because you know what? You only get 'X' amount of students anyway and that course is no longer sexy. So that's how it went.

Bonnie shared with me a story from her experience teaching at Brown University, in Rhode Island. It was an elective course, which she offered on her 'own time and own dime',



though she did receive a small grant of around \$2000 to develop the curriculum. She was given the slot for an hour long, eight-week course – far less time to present material than she was used to having. During the course, she brought in practitioners and clinicians as guest speakers for two years, paying each a meager \$50 from her small grant to compensate them for their time.

However, on the third year the money ran out. She appealed to the Brown medical committee for another grant to compensate her guests in some way, ‘a little tip of the hat’. The school responded that the practitioners could ‘put it on their resume’, which was a bold response and assumption – many of these practitioners did not work on a paper resume system. “For instance, I had a vodou practitioner who came to talk to us, and well...he didn’t have a ‘resume’ as it turned out. Resume is not a thing – that isn’t how that works. He didn’t need a resume. It’s a *big* cultural misunderstanding. And I said I’m not going to ask clinicians who are giving social services to the patients in Providence to come and teach the fairly well off university for nothing. *‘You come teach our students for free because it’s supposed to be such a big honor’*. I will not do that” (O’Connor, 2014). I was shocked by this story. Not only was it ignorant to the cultural differences of the practitioners she was bringing in, it was also a slight towards the allopathic practitioners with which they were familiar. On multiple occasions Bonnie had regaled me with the lack of public know-how concerning how hospitals work financially. Physicians and researchers both bring in their own funding through patients and grants, which means any sacrifice of their work time cuts into their ability to make a living. Is cultural competence an afterthought, despite the importance of understanding your patients? There seems to be some convenience associated with the ease of appealing to White, culturally white-washed patients who have no qualms with paying out of pocket, no culturally-sensitive complications and no dispute with the practitioners’ decisions.

At RIH, Bonnie's position did not fall into a clearly defined category for the payroll of the hospital. As such, her job was under constant threat of the budget cuts from higher-ups' lack of understanding of her work.

BO: And the weird thing is, not very many people in the hospital actually knew what I did. But some did. They knew to associate my name with culture. They knew they could call me if they had a question that involved some product, ethnic group, patient curiosity, something like that. They knew that I mostly did arcane things in my office. And you know I could do you a little program on folk remedies in the local environment. I'd lay out a table full of stuff and say 'this all came from around here. And this is what your patients are using so here's what you should know about it.' That kind of thing. And so from time to time somebody would say 'oh, cultural competence person? Understanding complementary and alternative medicine? Why yes there is a person on our faculty.' They'd trot me out for a little dog and pony show and then maybe two years later it would happen again. But mostly you are below the radar.

However, RIH is innovative in their establishment of an in-house ethics committee. According to the American Medical Association, 'the function of an ethics committee should be to consider and assist in resolving unusually, complicated ethical problems involving issues that affect the care and treatment of patients within the health care institution' (American Medical Association, 1994). It further states that the recommendations of the committee impose no obligation for acceptance by the institution, staff or physicians, but rather that the committee's recommendations should receive serious consideration.

BO: I'm on the Ethics Committee, and my spot is to represent all of these different cultural perspectives, because someone would say something like 'who could possibly mind blah blah blah' and I would say 'Wellll...I'm met these different kinds of people who would mind it, and here's why'. And it's really important to widen that perspective and that has been a really wonderful forum. And the people who join an ethics committee – nobody gets paid for being on it – it carries some prestige. It's a medical staff and executive committee. But they are people who want to think and enjoy abstract thinking. And that's not always the profile of many physicians you meet. They (many physicians) enjoy the detective work in diagnosing and treatment planning and stuff like that, but they don't just enjoy necessarily tossing an idea around and going 'but what if this, and what if that'. So folks on the ethics committee are predisposed to be very interested in these kinds of issues.

CF: *Do you often have moral qualms while discussing cases presented to the ethics committee?*

BO: I don't think I've had moral qualms with what the patient wants, but I've had moral qualms with what the treatment team wanted. Those are things that come up in the ethics committee and I just say what I think because that's a forum where we speak our minds. So I'll explain why it's bothering me, or I'll say 'for this particular patient, given this or that fact about their biography, I'm wondering if we shouldn't consider a, b or c. Which hasn't been brought into the conversation yet.'

CF: *Do you feel like that changes things often?*

BO: Sometimes. I'm not known as an 'ah-hem' *wallflower* in ethics meetings, that's for sure.

The implementation of an ethics committee in a hospital - and its inclusion of cultural mediators - is a large step in the right direction, as it appeals for cultural sensitivity to those who are already open-minded. However, more should be done to begin to expand the number of people who are open to the necessity of cultural sensitivity in health care.

Referring back to Thomas Egnew's work, I would suggest that there is a gap in his work in that he exclusively interviews allopathic physicians who have shown an interest in the definition of healing and concepts of holistic medicine. I would be more interested to interview doctors who haven't ever spoken about this, to understand where the real gaps in concepts of healing might be. This is similar to the issue faced with these ethics committees. However, Egnew's work, along with these committees, provide me with hope, as they highlight allopathic physicians who encourage the connection between healers and their patients, following the argument that "healing is more apt to occur under those circumstances" where the patient feels familiar and safe when "you come not merely in a professional role, but in a role of one human being meeting another" (Egnew, 258).

Bonnie's recollections of the difficulties she faced when working to educate health-focused students demonstrates the places of tension where barriers need to be broken down.

One of the major factors that hinder this is the lack of a sense of community between not only regional traditional practitioners, but even within the field of cultural mediators. With each narrative I have discussed there has been reference to the difficulties in creating a cohesive community for collaboration between healers within their own and other disciplines, as well as a lack of partnership with other disciplines that have similar interests in sustainability of the practices. Bonnie agreed that this has been a problem for her that also hindered her goal of establishing the role of cultural mediator through jobs in clinical establishments.

BO: It's not so easy for us to find each other, not to mention where the places will be for us in the healthcare system. Anywhere in primary care is a likely spot, because that's an open portal of entry through the medical students. That's always a likely spot where you can say 'okay, tell me about your patient population and I can tell you what I can do to help you understand them.' Public health venues are always good, too; any kind of program that's trying to be community-based healthcare. How well do they know their community? You can help them know their community.

CF: *Is the role, or cultural-sensitivity, becoming more common?*

BO: Well, this is actually very interesting. We might have to look at a longer view of this to see, but you don't hear as much about cultural competence stuff anymore. See, when I graduated from Penn in 1990, this had become a very big deal, you know? Cultural competence and also we were just rediscovering what came to be known as complementary and alternative medicine. And so now we're talking about integrative, I just wrote a chapter on it - fascinating subject. They have a ten to fifteen year period as the hot idea. And then everyone seems to think it's either already been taken care of or the next new thing is around anyway. However, people are now looking at social determinants of health in a very big way. Which has been around for a long time, but it's sort of been on the ascendant of late. So great! Let's talk about social determinants of health, let's talk about why we tolerate a society where these kinds of people, but not those kinds of people, are allowed to live in an inferior standard of life that is perfectly well known exposes them to many more health risks across their lifespan. There are a lot of places where we can slide it in...

And why are people doing other things to take care of their health? This is getting to be a pretty big deal now in conventional medicine circles because people are noticing at the hospital management levels and stuff. And a lot of the conventional medical programs, there is some skepticism about 'well, this is a marketing ploy.' Well, why is it a marketing ploy? Because enough people were going elsewhere for stuff that they really needed for their healthcare that you had to sit up and take notice.

Bonnie introduced me to an article published by David Eisenberg and his colleagues in a 1993 issue of the *New England Journal of Medicine*, which is credited as being the 'wake up

moment' that caught everyone's attention concerning the utilization of non-allopathic medicine. In the past, most surveys concerning non-allopathic medicine use simply asked how many people were utilizing it and which ones they were using. His work, however, discussed the number of office visits made to these practitioners (Eisenberg, 1993). This drew attention, Bonnie explained. "There were xx million, 25 hundred million visits to alternative practitioners for the first year of their survey, which I think was 1990. And that exceeded the total number of visits to all primary care providers by 37 million. OH! That got some people's attention. And, p.s., there were xx billion dollars spent on that. 10 million of it or something like that, out of pocket. No insurance" (O'Connor, 2014). None of this took into account the additional implications of self-care, but this was a large statement from the public that they weren't getting what they wanted just from allopathic medicine. With newly opened eyes, healthcare practitioners began to look anew at concepts of integrative medicine.

### **Integrative medicine**

Bonnie and I began to discuss the various terms used when discussing medical systems that utilized non-allopathic methodologies. She helped me to take a deeper look at the way the various terms referenced in the glossary<sup>22</sup> are applied realistically. Many of the works I had read introduced me to the dangers posed by integrative medical training for individual practitioners: loss of cultural context, cultural appropriation, and malpractice by sparsely trained practitioners.

Referring back to Dr. Sienna Craig's work on the changes to traditional medicine in Tibet, she illustrates how these dangers are made real. "In the West, we have come to scorn the 'primitive' medicine of strange lands, and to most of us the remedies and practices of these medicine men appear foolish and inefficient. But this is not really fair, for these doctors have a

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<sup>22</sup> Refer to the glossary within this work.

knowledge of medicinal herbs which is often staggering, and even borders on scientific exactitude. Today, the ‘scorn’ has changed into an increasing – sometimes blind – reverence for ‘alternative’ medicine in the West. Yet there is a continuing decline in the number of ‘traditional’ doctors practicing in ‘traditional’ settings” (Craig, 2012). Some have to travel to India or America to get the same quality of training their forefathers did. The First International Congress on Tibetan Medicine was held in Washington, D.C. The irony! On the upside, the globalization of this practice increases awareness and many traditionally trained practitioners are travelling to international conferences on indigenous knowledge and healing, teaching at clinics in countries where large numbers of Tibetan refugees live, and acting as consultants for international programs focused on sustainability. However, spiritual elements of the Tibetan medical practice have been stripped in these international, and many other, instances (Craig, 1998).

BO: Let’s talk about integrative. It was reconfigured in 1998 as the National Center for Complementary and Alternative Medicine and just this year they provide comment on another proposed name change to National Center on Research of Alternative and Integrate Health, not healthcare. From 1980-89, I find one article that uses the term integrative healthcare. It refers to the integration of services within conventional disciplines. The next decade, ’98-’99 there are 30 index papers, 27 of them are clearly about this. And then it’s just been exponential since then, so that’s about when it popped onto the scene. It was very early. Right about the time that the whole discovery of complementary medicine was, too, because the office of alternative medicine, their deal, their agenda, was they’ll research therapies and find out what works and then incorporate it into conventional medicine, right? Oops. It’s what I call the ‘traditional colonialistic philosophy’ which is ‘Hi! I like your stuff, I think I’ll take it.’ ...

Let’s look at some definitions of integrative medicine. The only thing they all have in common is that they all mean some conventional stuff and some TCAM stuff. *‘It shifts the orientation of medicine to one of healing rather than disease...’*, *‘partnership’*, and *‘stimulate the bodies innate healing potential’*. Ok... *‘therapies outside its boundaries work together in non-hierarchical ways’*, *‘a collaborative team approach between a variety of western medicine, traditional and CAM licensed health providers’*- Now that would be great, that is what we want, right? However, here *‘the care, while multidisciplinary, is physician directed’*, *‘conventionally degreed physicians oversee the care and personally deliver conventional medical services, mind body*

*interventions, nutritional counseling and in some cases acupuncture*'. Well, well. So then my next argument is, well with all of these stipulations somebody is going to disagree with every single one of them. And everybody who is making those stipulations is trying to put a stake in the ground because this is hot territory, it's new, it looks important, we're all going to be jockeying for position here. And the CAM providers would like to come in on an even footing – we're colleagues here, it's non-hierarchical. Obviously, others believe it should be physician directed and we're not on an even footing. So anything you introduce like that into the definition, you're making a statement about what the ground is and who is holding the reins. I only picked a few, but there are a million definitions.

These integrative medical programs, offered at schools across the country, allow you to do post-doctoral work, but rarely do we see practitioners in non-allopathic fields pursue later training in allopathic medicine. The previous chapter on Ireland introduces one of the rare situations wherein allopathic and non-allopathic medicine can collaborate on a semi-even footing, though it too had its share of complications. It is not often that we find opportunities for traditional medical practitioners to learn more about allopathic medicine in a formal setting catering to them. Bonnie had also observed this gap in educational opportunities. “Want to go do a fellowship in integrative medicine? Supposing I'm a chiropractor, or a massage therapist - I would love to do a fellowship in integrative medicine. Is that open to me? Oh I see it's only open to M.D.s and D.O.s” (O'Connor, 2014). These programs offer education in non-allopathic medicine, but they do not give back of their own knowledge – clear appropriation of this knowledge. Additionally, allopathic practitioners seem to be trained with such a narrow focus on the system of healing they initially learned, that it does not even occur to them that they do not fully believe in the traditional forms of other ones they may be learning in these programs. They just see that some aspect of it works and so begins the reductionism. When I questioned her on how this education system could be used in a more positive way, she presented the example of the difference between allopathic and non-allopathic office visits.

BO: Learning about alternative medicine is absolutely important, knowing how to make an informed referral. Practice in them if they are so inclined and they find it's really good. If a primary care practitioner finds that for the patient population that they see, knowing some really fundamental massage therapy techniques is very helpful then great. What if there are pediatric rheumatologists and they have little kids with juvenile rheumatoid arthritis and they can really relieve pain in an office visit. There's a thing that's also pretty astonishing in a difference. In the practitioner-based systems, I go to my physician's office and I feel like shit. I go in and we talk and think and get a prescription, I go out and I still feel like shit. And then I can go get my prescription filled and in a few days maybe I'll feel better. I feel like shit, I go to my massage therapist's office, I go get a massage therapy treatment, I go out and feel better. What a difference – so much to be said. You go to the place to get the treatment. It's an important difference. Obviously people like it.

CF: *What about Traditional Chinese Medicine? It is standardized and utilizes some Western allopathic medicine methodologies. Is this a model of successful integration?*

BO: But it's not to be confused with, it's still not the same as. So there are many advocates of the idea that 'one day we won't need these rules anymore, it'll all just be good medicine'. I'm not sure I'm a proponent of that position because whose identity and whose territory is going to get subsumed under that. It's like Columbus saying 'one day we won't have this distinction between Indigenous people and Europeans, we'll all just be Americans only guess which ones will be on top'.

This presents the decidedly negative side of integration and globalization of healthcare. I wondered, then, what might be preferable to the model of integrative medicine. The end game is to offer a culturally-sensitive approach to healthcare in healing institutions in such a way that context is considered and practices can be sustained. How might we do this?

BO: There is some suggestion that you might want to separate integrative medicine from integrative healthcare models which I kind of like.

CF: *So one practitioner with multiple types of training as opposed to a team based approach?*

BO: Right, a pluralistic model. It includes self-care, it includes patient perspectives, it's much more representative of what people are actually doing on the ground. So that's kind of an interesting thought. But it depends on who gets to call the shots where. This is coming from the concern that if I'm in an institution that's called an integrative medicine center, the doctor calls the shots. Maybe I want to set up a place where we are interested in all of the healing models, working in an informed way where we all refer back and forth to each other, under the same roof or located over a distance – we can form other kinds of networks.



An example of this seen in popular media, though from a slightly more allopathic-focus, is the television show *Private Practice*. It focuses on a center in California where practitioners trained in a variety of practices work under one roof, sharing files and referring patients to each other as necessary to achieve holistic health. For example, it allows them to allopathically treat an assault victim, then to ease their trauma with mental health care and Chinese medical approaches to stress-relief. Bonnie works in a similar model in the Osher medical center's Boston branch which provides an excellent case study for successful pluralism.

BO: Everyone has equal access to the medical record. The people who created it at the Brigham Women's Hospital sat down when we first opened and each practitioner provided their needs for a template within their own field as part of the whole record. Everyone shares it across the whole practice, so you open up the patient's record and everything is displayed there. It's all in one. Every clinician is credentialed and paid by the hospital and they all have proven access to the medical record. It's very non-hierarchical and everyone has access to the medical record equally, Cultural notes are considered important, so I can make notes, as well. I'm a documentarian and I've been working with them since Eisenberg first started the idea of making this a clinic. So how do we create a thing like this, what do we think it ought to look like, what kind of clinicians ought to be involved, how do we hire them, how do we credential them, how do we find out if they're any good? I have 11 years' worth of field notes on an example of how to do this. However, people largely self-refer into that clinical and its mostly middle class, white, well-educated population. But I have suggested it to other people and taken them there, and it has proven largely successful for everyone that I have referred.

So how do we move towards implementing models of pluralistic healthcare that appeal to individuals that aren't a part of the white, upper-middle class population and who have more of an interest in sustaining their own healing beliefs? One of the successful models presented in *An Anthropology of Biomedicine*, takes place in the central Arctic region of Rankin Inlet, Nunavut. In 1993, a birthing center was opened that staffed non-Inuit midwives, Inuit maternity care workers and interpreters. It was developed to address the high infant birth mortality rate, and in an audit performed in 2004 to assess the changes since it opened, no maternal or pre-natal deaths were

recorded. This center has been ‘recognized as exemplary by the Society of Obstetricians and Gynecologists of Canada’ and it has been praised by WHO (Lock, 2010).

### **Pluralism**

Jamison discusses the tension between the traditionalist and allopathic approaches in his piece *Globalization and the Revival of Traditional Knowledge*. “Contemporary western views of nature are fraught with the dichotomy or duality between person and nature... In Indian cosmology, by contrast, person and nature (*Purusha-Pakriti*) are a duality in unity. There is a noticeable ‘pro-science’ backlash, a visible mobilization against those who challenge the global hegemony of modern science, which is likely to weaken even more the role that traditional knowledge can play” (Jamison, 96). As with code switching, the confusions and clashes between ways of understanding and explaining healing come primarily from using different languages, or codes. Often, scholars studying various healing methodologies attempt to de-code these concepts to explain them in their own cultural context in an attempt to aid in validating them. However, this eliminates the important pluralism offered by multiple voices sitting on a sort of council to provide various approaches to a problem.

When someone approaches multiple types of practitioners, what they want to add is someone who is an excellent thinker in a completely different frame of reference. How you define a problem has a lot to do with what suggests itself to you as a solution. I asked Bonnie to further explain her opinion on pluralism as a superior model to integrative training.

BO: I’m not sure I think it’s [integrative medicine] a good idea. I think I would rather see an openly pluralist healthcare system. It’s de facto pluralist the way people use it now – people just use whatever works for them - but I would like to see it openly so. In which people are knowledgeable enough about various modalities and practitioners that they can say, ‘you know this particular kind of pain from this particular kind of origin, I think probably you should see a

massage therapist or acupuncturist for it because they happen to be particularly good at this, and we aren't as good. If you want a different way of thinking of the whole condition, go to a practitioner of traditional Chinese medicine. Get a completely different, new perspective. Look at it from multiple points of view. Instead of saying its holistic I think of it as holographic – multi-dimensional. You see it from all the different ways that can be seen, and I think that's probably better.

CF: *Are you referring here to traditionally trained practitioners, operating within their own cultural context?*

BO: I would, myself, rather have a traditional Chinese trained acupuncturist than an MD acupuncturist. And that's a real distinction and it's an important one. I would rather have a traditionally trained massage therapist, rather than a physical therapist that approaches it in a more mechanistic way. I don't think it's so simple as a false dichotomy. We do have biomedical stuff and its very reductionist and there is a particular way of looking at things where you pick things into little pieces so you can understand them one piece at a time – and that's very good for some things. But I want other stuff that's very good for other things and I don't want them to become confused or fused in such a way that I can't tell one from the other anymore.

CF: *So do you think the concept of a dichotomy exists currently?*

BO: That's the current viewpoint. What I'd like to see is where we have a biomedical perspective, we have a traditional Chinese medicine perspective, we have a chiropractic perspective, we have the perspective of trained therapeutic massage and body work. These are all professions in their own right. They have their own subdivisions, as well. We have a pluralistic system in which we have a range of healthcare options open to us and we cross-refer and interconnect based on what's best for the patient at this time.

CF: *So why do you think people tend to refer to healing methodologies as “Western medicine” and “everything else”?*

BO: Most people are because the allopathic medical profession began, as soon as they could, to try to define it as official, as opposed to other stuff that's not taught in the medical school or not in the usual medical system or in the hospital. Josephine Biggs, the current head of the NCCIH<sup>23</sup> makes a wonderful distinction and I don't know why other people haven't thought of it before. And she says what does CAM study? These are a very wide range of therapeutic disciplines and modalities, which have their origins outside of the history of mainstream medicine. And that's a good statement. They have their origins and very different perspectives and that continues to be part of the legacy and I would hate to see them get medicalized to the point of thinking allopathically. Should the hospitals have acupuncturists, and massage therapists, and hypnotherapists, and body workers on staff to help deal with post-surgical pain? Hell yes!

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<sup>23</sup> National Center for Complementary and Integrative Health

In *An Anthropology of Biomedicine*, Charles Leslie writes concerning the idea that allopathic practitioners assumed that over time, indigenous medical practices would die out. However, “aside from some notable exceptions where, due to major political upheavals or social disruptions, medical assistance of all kinds is virtually absent, nowhere has indigenous medicine simply faded away” (Lock, 2010). The authors of the text go on to argue that considering the extent to which people all over the world consult with multiple practitioners, many of which are not biomedicine, allopathic approaches alone cannot meet the needs of the people. Biomedicine is often associated with colonial oppression, and the choice to utilize one’s own medical tradition is a way to sustain a sense of culture and agency (Lock, 2010). Pluralistic approaches to healthcare, be it under one roof of a center, or through culturally-sensitive changes to legislation, seek to undo the damages caused by colonial oppression.

### **Legislations and Regulations**

One of the main ways legislation can make positive change towards culturally-sensitive, pluralistic medical systems is through licensure of practitioners – as discussed in the previous chapter concerning Ireland. In the United States, however, we have the added complication of individual state law, which changes frequently. Bonnie remembers “when only 5 states licensed naturopaths and now it’s more like 17 states license naturopaths. There are places where you might have a perfectly good naturopathic physician who knows the botanical medicines inside and out, but they aren’t licensed to medicine, or they have to practice under the nominal supervision of a physician or other healthcare provider of some kind.”

This regulation applies to all healing practitioners who cannot attain licensure of their practice, including herbalists such as Mary Blue at Rhode Island’s Farmacy Herbs.



*Classes take place at the teaching farm located behind the shop and classroom of Farmacy Herbs (left), and Farmacy Herb's booth at the local Rhode Island Farmers Market (right).*

*(Blue, 2014)*

Mary has been taking on herbalist apprentices and students for over ten years, manages an herbal farm, store and production kitchen, and has been teaching classes at hospitals, colleges, conferences and non-profit groups for years. Additionally, she has been awarded numerous honors, directed documentaries and supported the partnership amongst the New England community of herbalists (Blue, 2014). And yet, she is not a licensed practitioner of herbalism as per United States and Rhode Island law. However, if a chiropractor, untrained in her healing art, oversees her work she would be able to practice in a more clinical way. Currently, she is forced to emphasize that her practice focuses on preventative supplements. This varies from what I learned was the case in Ireland, so I asked Bonnie to explain this further.

BO: There is a big debate for if chiropractors are regular medicine or alternative. Chiropractors are called doctor – that’s their official title. They are physicians. Using those terms, as we learned from our two chiropractors at the Osher center in Boston, doesn’t mean M.D. or medic, but the term still holds weight. You can have a very skilled practitioner of ‘X’ in a state that doesn’t license ‘X’, but they can’t be solo and practice that profession in that state. Just because someone doesn’t have a license doesn’t mean they aren’t capable, but it does mean either they didn’t pass or their state doesn’t have licensure. Most of the integrative health programs in academic health centers or mostly physician-dominated environments will only hire licensed practitioners. So if your state doesn’t license a certain practice, you won’t have one in your integrative health centers. *Unless you have them under some other title.* So you can have a *Curandera* listed as a community mental health worker.

CF: *do they need a license in something else?*

BO: Not necessarily because as long as you say ‘this is our community mental health worker and one of the things that she does is she sees clients and talks to them and speaks to them in their own language regarding their cultural views of why they are sick and that sort of thing and she can work with them as a community therapist but under the supervision of’...whatever, nurse practitioner, physician, or whatever level of supervision is required. Also, there are a lot of health promoters who are just regular folks from the community and they are outreach workers, mostly in public health positions. And they work under the nominal supervision of someone who is licensed so that they can do that. And they’re a lot of good!

CF: *The herbalist I was studying under was telling me that many herbalists don’t seem to want licensure.*

BO: And why is that? It’s a big debate. Licensure implies this sort of standardization model that comes with conventional medicine. We may have a person with the flu, so you do this particular thing, and then you give medicine depending on the symptoms and that’s how you treat everyone across the board. So this is a state, where I’m not allowed to dispense medical advice in a professional capacity unless I fall under the rubric of some of these licensed professions that are allowed to give professional healthcare advice. So to do it as an herbalist or naturopath, I have to first have a degree in clinical nutrition and a certification, or whatever is required.

The interesting thing is that once you have that certification as an M.D., there seems to be an almost unlimited scope of practice. “They can prescribe herbal medicine, they can try their hand at acupuncture, whether they have training or not. Their scope of practice is massive and most of the scope of practice laws in this country allow everything unless it is specifically forbidden,” elaborated Bonnie. Earlier Anna-Maria had recounted how this law was similar to what they have in Ireland, yet it seems to be applied in such a way that it allows for herbalists to

practice so long as they do not refer to themselves as ‘doctors’. A fascinating contrast in how a law can be applied based on history, culture and wording.

BO: This is one of the reasons that it was so ridiculous when acupuncture came to the United States in the mid 70’s mostly. And Chinese acupuncturists began to be invited to come here so people could learn stuff from them and they could not practice under their own training and licensure. There was a license that allowed them to practice without being supervised by an M.D. who didn’t know anything about it. Isn’t that a riot? Even in my work on the ethics committee, where

So perhaps a primary difference between Ireland and the USA here is the utilization of the title of ‘doctor’ – something only used for the medical profession in Ireland, but used to denote a doctoral degree in the USA. Anna-Maria, trained in a healing profession, is unable to use the title, yet Bonnie is, despite no training in any healing practices. Dr. O’Connor explained that she uses the title doctor in her work with the ethics committee, so when she needs to access a patient’s records to assess how she can give advice, she simply introduces herself as Doctor O’Connor. “Sometimes it freaks me out because they don’t look at my ID or anything – I could be some lady off the street, acting like I am supposed to be there” (Bonnie, 2014).

### **Application on a Global Scale:**

The various terms used to discuss the systems, issues and changes occurring in healthcare approaches still lack agreed upon official definitions. This problem is illustrated within this narrative to point to the positive change and cooperation that could occur if systems instead worked towards the idea of pluralism. Pluralism works to sustain cultures of healing from all traditions, including allopathic medicine – a loss which is feared by the evidence-based science community in their continual labeling of many non-allopathic medicines as pure quackery (Science-Based Medicine, 2014). Globalization will only continue to spread, as will the growth in consumption of medicine as our population grows. Knowledge of local cultural beliefs and

understandings concerning healing will ease the strain of this growth and prevent the perpetuation of colonialist ideals, for many people represented by allopathic biomedicine. The important role of healthcare in the holistic health of communities is inarguable, as the main goals of good practice, in any tradition, are to attain good health and wellbeing in the patients of every community. Through re-examining regulations concerning licensure of practitioners and encouraging utilization of cultural mediators in clinical settings, we can promote sustainability of traditional medicine, prevent cultural appropriation, and improve the overall health of communities.



## **Conclusion**

### **An Appeal for Pluralism; or Return to the Round Table**

*“The chasm between two worldviews not only could be bridged, but must be bridged, if we really want to make an impact on survival” (Craig, 2004).*

Throughout this work there are overlying themes of common challenges and hopes expressed within each story as communities interested in the sustainability of traditional medicine exert their agency. Each narrative or chapter takes place in a culturally, economically and politically distinct area of the world and each region has walked the path towards cultural sustainability of their traditional healing systems in a unique way. The regulations in place which guide these paths are influenced by the diversity of both globalization and histories of immigration and colonization. As traditional medicine communities work to provide efficacy of their practices, allopathic medicine seeks to acquire the knowledge of these methodologies to further their scope of practice, number of patients, and income. Global dialogue concerning best strategies for approaching these exchanges of knowledge and power are growing, but many steps are necessary to aid non-allopathic communities in gaining an even footing with the wealthy allopathic medical systems.

How do we measure community health? The standards used to think about this issue need to include the “four pillars of sustainability” as laid out by Hawkes: “the sustainability and wellbeing of a community requires a holistic approach that takes into account environmental responsibility, social justice, economic viability, and cultural vitality” (Hawkes, 2001). All of these tie up into community-centered concepts of health – the preservation and health of the

surrounding ecosystem which supplies food, water and *medica materia*; the ability for locals to express their agency through the ability to approach health in their own way; the affordability and accessibility of healthcare; culturally sensitive medicine and the sustainability of traditional ways of healing. Social scientists and workers spend so much time breaking down what a sustainable healthy community might mean that often we forget to refocus on actual local healing methods. Medicine, healing and healers are all at the heart of and act as a major determinant for the health of a community.

### **Community**

The Convention for the Safeguarding of the Intangible Cultural Heritage (ICH) covers only “those forms of cultural expression consistent with human rights”. How are these determined? How would one prove and defend a folk medicine practice if it were actually partially harmful, but still must be protected because of the freedom to practice one’s beliefs, and who decides which cultural expressions are necessary for a community? Additionally, it is never as easy as declaring that a tradition will be protected – communities following through with educating the new generations can be met with multiple barriers and complications, including but not limited to, an uninterested younger generation. “ICH is not preserved in states’ archives or national museums. It is preserved in communities whose members practice and manifest its forms. If the tradition is still alive, vital and sustainable in the community, it is safeguarded. If it exists just as a documentary record of a song, a videotape of a celebration, a multi-volume monographic treatment of folk knowledge, or as ritual artifacts in the finest museums in the country, it is not safeguarded” (Kurin, 12). To work towards this goal, one of the strongest

underlying messages within these narratives is the expressed desire for a greater sense of community for healers, both locally and abroad.

Many non-allopathic healers practice in communities that have marginalized them as globalization and colonization spread through their regions. As indigenous people seek to regain their foothold through cultural sustainability, they work to find their place in shifting political and economic landscapes. In many regions, traditional medical knowledge and practices have been passed on orally among practitioners for many generations. In recent years, some countries have strengthened training programs to develop the knowledge of traditional health practitioners. The research institutes in Indonesia and the training centers in Ireland reflect these developments. Associations meetings, workshops and educational/apprenticeship programs, such as those discussed in each of the narratives presented here, are invaluable methods for fostering partnership between healing practitioners of all methodologies. This will encourage the formation of a healer community that can work towards culturally-sensitive, locally-relevant systems of holistic health for their region. It will also create a forum to help healers preserve and transmit what they know to a new generation, as well as share personal advice on how to determine quality, accessibility, sustainability and affordability.

The World Health Organization recommends in their Traditional Medicine Strategy that “partners and stakeholders foster a culture of communication, documentation, evaluation and innovation among practitioner communities, both nationally and internationally” (48). But all of this seems simpler said than done, as many of the narratives in this work have suggested. Throughout the Strategy, there are countless references to this need, each re-wording the expected steps for each country and region, however, there are so few successful and easily accessible models for these communities to learn from and adapt for their own cultural needs. It

expresses the need for a movement towards mutual respect and destruction of the dominant hierarchy systems at work in healthcare, but without the collaboration between communities globally working towards these efforts it would seem to be “all talk”. In each narrative presented here, the individuals speak towards the need for greater communication and partnership between marginalized healer communities – necessary to further these strategies.

### **Training and Regulations**

Traditional medicine practitioners often have a lack of knowledge of allopathic medicines, how they work and how effective they are, and this can cause issues regarding efforts towards mutual respect and preventing negative drug interactions. While some individuals, such as Dr. Mustofa and Anna-Maria, argue that medicalization of these practices are necessary for them to meet efficacy expectations and survive, others argue that this process would lose the cultural context and aspects of the practices that make them valuable and unique. However, knowledge of potential negative drug interactions is something that I would think both sides could benefit from. The hierarchical and dominant hegemonic training systems prevent ease of access to this knowledge for non-allopathic practitioners, furthering the divide between communities of healers. Traditional medical practitioners are rarely respected or treated equally when a community also has practitioners of allopathic medicine. Often there is no way for them to gain licensure or permission to officially practice and work towards gaining the necessary legitimacy to facilitate this equality and respect. This also hinders regulations on safety, agency of the indigenous people, and ease in sustaining the training and practice of traditional medicine – a valuable resource in affordable, accessible and holistic healthcare.

Regulations governing safety and quality are something that most practitioners should agree with to protect their patients. However, these regulations must be made with the involvement and voices of indigenous healers, otherwise the intricacies that are a part of various lineages, and the intimate ways in which they influence the political, economic and social structures of practicing communities will be lost or harmed in unforeseeable ways. For instance, culturally-constructed ideas of mental disorders that are treated by traditional practitioners may be less shameful than the stigmas attached to Western concepts of psychological illness. The loss of these culturally sensitive concepts and approaches could not only prevent full treatment of the disorder, but also prevent access to mental healthcare for entire communities.

### **Integration and pluralism**

The fear of many non-allopathic practitioners and researchers is that the value of these healing methodologies will increasingly become defined by their ability to make a profit, rather than their use value in healing patients. This is something already visible as allopathic practitioners' increased interest seems to have been triggered by surveys – such as Eisenberg's research<sup>24</sup> - acknowledging the number of patients utilizing non-allopathic methods of healing and the monetary value of these methods. This further endangers chances of sustainably harvesting herbal medicine and other *medica materia* utilized in these healing practices.

Corporate and government bias in financial backing is what so often defines legitimacy and superiority, both in medicine and beyond. This is something we are starting to see vocalized as a problem, though the struggle to attain financial backing for non-allopathic medicine varies in intensity based on the public demand for focus on what seems more immediately important –

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<sup>24</sup> Eisenberg, David M. et al., “Unconventional Medicine in the United States – Prevalence, Costs, and Patterns of Use.” *New England Journal of Medicine* (1993): 328, pp. 246-252.

continual and never-ending ‘wars’, monopolization, security, etc. It would seem that with the most recent outbreak of Ebola, thanks to media attention – the largest influence over aforementioned public focus – there has been a slight increase in funding for creative new directions in how to fight the disease. I’ve seen numerous articles during my research, one of which stated that a *medica materia* from a country in Africa is actually being assessed for Ebola prevention or healing. Wouldn’t it be horribly ironic if a regionally local *medica materia* was then processed into a pharmaceutical product and sold for an inaccessible price so that those suffering (and aiding those suffering) couldn’t afford it?

Dr. O’Connor and Rosari both expressed a fear of the implications of too much integration of various healing methodologies. A better approach and apt term for the systems of collaboration that would remove hierarchy and implement superior holistic health for communities is encouraged in much of Dr. O’Connor’s work – *pluralism*. It not only encourages a round table of voices to discuss the future of sustainable and improved healthcare, but also encourages culturally sensitive education for practitioners from all backgrounds. “Safeguarding forms of knowledge that have been developed in different ways and different places, promotes a multicultural, multidisciplinary and multimodal approach. Such a policy makes health systems more comprehensive and preserves cultural diversity, thus contributing to human development” (Roberti di Sarsina, 1-2).

The primary benefit of a pluralistic system, as expressed in Bonnie O’Connor’s example of the Osher Center, or as displayed in the television show *Private Practice*, is the shared weight of patient number. For healers seeking to spend more time connecting with their patients, there is a risk of compassion fatigue from emotional exhaustion, which could lead to poor bedside manner and hinder the healing process for the patient. As I worked as a coffee barista during school for a time, I’ve found that lately I’ve been comparing this to the difference between a

good cup of coffee and a quick cup of coffee. Coffee shops and their baristas who crank out fast coffee for endless lines in a drive-thru or similarly busy setting tend to produce sub-par coffee with little effort and only a minimal connection with their customers. Those that take their time to create thoughtful, hand-crafted coffee tend to connect with their customers better and produce a more delicious (and often eco and grower-friendly) coffee. However, if you take the methods used in the hand-crafted coffee shop and try to increase the speed and amount of customers, you end up with baristas who lose their enchantment with the product, lack care in the creation of it, and ultimately acquire tendonitis – a barista’s compassion fatigue. In a pluralistic healthcare system, where healers share patients and collaborate to encourage holistic healing, greater care can be given to patients without sacrificing patient-centered approaches or the large risk for compassion fatigue.

A regularly suggested flaw of allopathic medicine is the practitioners’ lack of time to connect with patients and therefore a lack of experience in guiding sufferers through their stories and towards healing. Storytelling is limited in order to maintain an efficient schedule and simplify diagnostic processes – often the opposite of what is looked for in patient-centered care models. By partnering with non-allopathic healers, the patient’s need to be heard can be more deeply met and allopathic practitioners can learn more patient-centered models of diagnostics to increase the success of their practice and diagnosis. “Member states should encourage cooperation and information sharing between conventional health care professionals and T&CM practitioners. Information which is easy to understand is the key to the safe and appropriate use of T&CM self-health care. This includes encouraging patients to inform their usual health care professionals about their use of T&CM products” (“Traditional Medicine Strategy”, 53). The encouragement to share information with all health care providers will help prevent

marginalization of non-allopathic practitioners and decrease negative drug interactions – it directly combats the “don’t tell the doctor” issue that many of the individuals I interviewed suggested to be a problem.

### **Strategy for Cultural Sustainability of Traditional Medicine**

What does this look like for communities whose healing approaches are a vital part of their health and identity? There is great importance in community-driven sustainability and utilization of traditional medicine. Promoting patient-centered healthcare that is culturally-sensitive and a pluralistic model allows for multiple perspectives when approaching holistic patient care.

There would seem to be a lack of research discussing efforts towards understanding between allopathic practitioners and patients who come from a culture differing from their own. In fact, that is part of the reason for the research in this work – to reach a broader understanding of how we can encourage communication between patient and practitioner, as well as practitioners from different healing traditions, to increase practitioners’ abilities to help their patients - especially as the world becomes increasingly globalized and the threat of homogenization looms.

As Bonnie O’Connor suggests, an excellent way to bridge the gap of misunderstandings is through placement of cultural mediators in clinical settings with diverse communities. Cultural mediators help health practitioners maintain cultural-sensitivity to understand how their patients might be approaching their healthcare methodology. They also encourage and foster agency for their patients, and act as translators for both language barriers and questions about how the health system functions. This would also be invaluable in mediating between practitioners in pluralistic



systems or when patients are utilizing multiple systems of healing. By acting as this bridge initially, partnerships can begin between practitioners, and as trust builds, the cultural mediator can remove themselves from the equation and move on to help build another new partnership. Building these bridges will also create partnerships and resources for the long term, and a stronger community that understands and can network to protect and preserve the traditions and environments supporting these traditions. This role is one all too familiar and fitting for cultural sustainability workers.

In addition to the actual sustainment of marginalized healing practices, the role of cultural mediator will aid the field of cultural sustainability in a better understanding of the impact of displacement on cultural practices that are important to an immigrant community's identity, but which might be considered inferior by the indigenous community. It will help cultural workers understand how this encouraged acculturation can affect the health of immigrant communities. Also, further research into concepts of healing will bring attention to the importance of respect and sensitivity towards alternative perspectives on what defines a healing practice: dance, spirituality, food, music, herbal products, rituals, etc. By building these bridges, cultural sustainability workers familiar with healing communities can work to encourage alliances between healing practitioners to better provide long lasting holistic health for communities. With any luck, "as the marketplace for T&CM becomes more global, harmonization and cooperation will increase in value" ("Traditional Medicine Strategy", 45).

Ideally, I hope that this research will work towards requirements for advisory roles on existing medical aid organizations, as they already reach out to so many communities in need of healing and establish their infrastructure and reputation. Cultural mediators would work with and appoint advisors - local healers/leaders who are chosen by the community to represent them

and partner with the medical aid organization. Additionally, including staff made up of non-allopathic healers, cultural mediators and anthropologists, folklorists, ecologists and sustainability-trained individuals (environmental, cultural, etc.) would ensure the larger organizations are educated on awareness and cultural considerations for working with a community that does not operate under the assumptions of the outside organizations. Education is the best way to bring attention to the potential negative impacts that can ripple out from providing healthcare without respect to the current cultural ecosystem in these communities. A good model of pluralistic healthcare would provide comfort in ritual and feelings of normalcy, community-focused, culturally-sensitive healing, and play a part in restoring identities in the face of cultural upheaval brought about by globalization, immigration and disasters.

I entitled this work *Don't Tell The Doctor* to highlight my main interest in the implications expressed by these narratives of the lack of community and partnership between healers and healing methodologies. As the tendrils of globalization spread wider into communities all over the world, there is bound to be an increasing number of interactions between these healing methodologies and there will unquestionably be a hierarchy produced after much clashing of heads. However, in many countries we have seen the beginnings of integration of different healing traditions. This is something which I, along with several of the individuals I interviewed, voice my concern with here, as this poses a threat by loss of cultural context and a watering down of the aspects of many practices which make them valuable – both to the communities which discovered the knowledge initially and the new communities of patients hoping to find increased health from them. Integration has led to further marginalization of traditional practitioners of non-allopathic medicine, which is illustrated by many of the narratives expressed within this work.

In conclusion, I argue for the introduction of this type of role in more culturally-diverse clinical settings, especially for foreign medical aid organizations, as well as for a shift from

integrative medicine to pluralistic systems that utilize multiple practitioners, each trained in the whole of the practice. This will prevent loss of the intricacies that make each practice important for health, as well as preventing cultural appropriation and increasing sustainability of traditional medicine communities. I have here discussed some of the strategies and regulations in place to sustain traditional medicine which are in line with many of the strategies presented within the field of cultural sustainability, as efforts are made to increase community health. However, I argue that these strategies are merely presented as recommendations and that without further dialogue and collaboration between communities of healers, as well as implementation of culturally-specific efficacy standards for healthcare systems and settings, no improvements will occur. One of the strongest underlying messages within these narratives is the expressed desire for a greater sense of community for healers, both locally and abroad. Sienna Craig's work, referenced often within this work, as well as Dr. O'Connor's endeavors as a mediator, Rosari and Anna-Maria's outreach efforts through the Irish Institute of Traditional and Integrative Medicine, and the progress in Indonesia towards sustaining traditional medical practices through increased efficacy are all achievements towards this goal. Their accomplishments are fantastic examples of cultural sustainability efforts, driven by their own communities and each following their own path as they navigate obstacles encountered within their unique histories. They illustrate the necessity for community-specific approaches to sustainability and the importance of traditional healing methodologies for overall, holistic health of the community – truly the heart of the field of cultural sustainability.

## Glossary:

*“Unconventional says who? I mean all this language has the same problem. It’s all fraught. So alternative, says who? Complementary to what?” – Dr. Bonnie O’Connor, interview (2014).*

To give context to the concepts presented within this research, I present here a glossary comprised of definitions for many of the terms referring to healing methodologies. The sources represented those most easily available to the general public, rather than those necessarily most authoritative, in order to illustrate the common understandings of the terms below:

*(some terms have multiple definitions displayed to illustrate the wide variance)*

### **Acupuncture**

Acupuncture involves the insertion of extremely thin needles through your skin at strategic points on your body. A key component of Traditional Chinese medicine, acupuncture is most commonly used to treat pain. Traditional Chinese medicine explains acupuncture as a technique for balancing the flow of energy or life force — known as qi or chi (CHEE) — believed to flow through pathways (meridians) in your body. By inserting needles into specific points along these meridians, acupuncture practitioners believe that your energy flow will re-balance. In contrast, many Western practitioners view the acupuncture points as places to stimulate nerves, muscles and connective tissue. This stimulation appears to boost the activity of your body's natural painkillers and increase blood flow. *(Mayo Clinic, 2014)*

Western medical acupuncture is a therapeutic modality involving the insertion of fine needles; it is an adaptation of Chinese acupuncture using current knowledge of anatomy, physiology and pathology, and the principles of evidence based medicine. *(White, 2009)*

### **Allopathic medicine**

"The system of medical practice which treats disease by the use of remedies which produce effects different from those produced by the disease under treatment. M.D.s practice allopathic medicine. The term "allopathy" was coined in 1842 by C.F.S. Hahnemann to designate the usual practice of medicine (allopathy) as opposed to homeopathy, the system of therapy that he founded based on the concept that disease can be treated with drugs (in minute doses) thought capable of producing the same symptoms in healthy people as the disease itself." *(John Hopkins University, 2014)*

### **Bonesetter**

A person who sets broken or dislocated bones usually without being a licensed physician. *(Merriam-Webster Dictionary, 2014)*

**Complementary/alternative medicine (CAM)**

The terms "complementary medicine" or "alternative medicine" are used interchangeably with traditional medicine in some countries. They refer to a broad set of health care practices that are not part of that country's own tradition and are not integrated into the dominant health care system. (*World Health Organization, 2014*)

“Complementary” generally refers to using a non-mainstream approach together with conventional medicine.

“Alternative” refers to using a non-mainstream approach in place of conventional medicine. (*National Center for Complementary and Alternative Medicine, 2014*)

**Conventional medicine**

A system in which medical doctors and other healthcare professionals (such as nurses, pharmacists, and therapists) treat symptoms and diseases using drugs, radiation, or surgery. Also called allopathic medicine, biomedicine, mainstream medicine, orthodox medicine, and Western medicine. (*National Cancer Institute, 2014*)

**Folk medicine**

Traditional medicine as practiced nonprofessionally especially by people isolated from modern medical services and usually involving the use of plant-derived remedies on an empirical basis. (*Merriam-Webster Dictionary, 2014*)

The traditional art of medicine as practised among rustic communities and primitive peoples, consisting typically of the use of herbal remedies, fruits and vegetables thought to have healing power, etc. (*FreeDictionary.com, 2014*)

**Heal**

- 1: to make sound or whole; to restore to health
- 2: to cause (an undesirable condition) to be overcome; to mend or patch up (a breach or division)
- 3: to restore to original purity or integrity (*Merriam-Webster Dictionary, 2014*)

**Healer**

One that heals; a Christian Science practitioner (*Merriam-Webster Dictionary, 2014*)

**Health**

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. (*World Health Organization; not amended since 1948*)

## Herbal medicine

Herbal medicines include herbs, herbal materials, herbal preparations and finished herbal products, which contain as active ingredients parts of plants, or other plant materials, or combinations.

- *Herbs*: crude plant material such as leaves, flowers, fruit, seed, stems, wood, bark, roots, rhizomes or other plant parts, which may be entire, fragmented or powdered.
- *Herbal materials*: in addition to herbs, fresh juices, gums, fixed oils, essential oils, resins and dry powders of herbs. In some countries, these materials may be processed by various local procedures, such as steaming, roasting, or stir-baking with honey, alcoholic beverages or other materials.
- *Herbal preparations*: the basis for finished herbal products and may include comminuted or powdered herbal materials, or extracts, tinctures and fatty oils of herbal materials. They are produced by extraction, fractionation, purification, concentration, or other physical or biological processes. They also include preparations made by steeping or heating herbal materials in alcoholic beverages and/or honey, or in other materials.
- *Finished herbal products*: herbal preparations made from one or more herbs. If more than one herb is used, the term mixture herbal product can also be used. Finished herbal products and mixture herbal products may contain excipients in addition to the active ingredients. However, finished products or mixture products to which chemically defined active substances have been added, including synthetic compounds and/or isolated constituents from herbal materials, are not considered to be herbal.

(*World Health Organization, 2014*)

Herbal medicine -- also called botanical medicine or phytomedicine -- refers to using a plant's seeds, berries, roots, leaves, bark, or flowers for medicinal purposes. Herbalism has a long tradition of use outside of conventional medicine. It is becoming more mainstream as improvements in analysis and quality control along with advances in clinical research show the value of herbal medicine in the treating and preventing disease. (*University of Maryland Medical Center, 2014*)

## Holistic medicine

Holistic medicine is defined in different ways. In general, it focuses on how the physical, mental, emotional, and spiritual elements of a person are interconnected to maintain health. When one part is not working well, it is believed to affect the whole person. Holistic approaches focus on the whole person rather than just on the illness or part of the body that is not healthy. (*American Cancer Society, 2014*)

## Homeopathy

Homeopathy is a medical philosophy and practice based on the idea that the body has the ability to heal itself. Homeopathic medicine views symptoms of illness as normal responses of the body as it attempts to regain health. Homeopathy is based on the idea that "like cures like." That is, if a substance causes a symptom in a healthy person, giving the person a very small amount of the same substance may cure the illness. In theory, a homeopathic dose enhances the body's normal healing and self-regulatory processes. A homeopathic health practitioner (homeopath) uses pills or liquid mixtures (solutions) containing only a little of an active ingredient (usually a plant or mineral) for treatment of disease. These are known as highly diluted or "potentiated" substances. There is some evidence to show that homeopathic medicines may have helpful effects. (*WebMD, 2014*)

## Integrative medicine

The Consortium of Academic Health Centers for Integrative Medicine defines it as "the practice of medicine that reaffirms the importance of the relationship between practitioner and patient, focuses on the whole person, is informed by evidence, and makes use of all appropriate therapeutic approaches, healthcare professionals and disciplines to achieve optimal health and healing". Proponents say integrative medicine is not the same as complementary and alternative medicine nor is it simply the combination of conventional medicine with complementary and alternative medicine. They say instead that it "emphasizes wellness and healing of the entire person (bio-psycho-socio-spiritual dimensions) as primary goals, drawing on both conventional and CAM approaches in the context of a supportive and effective physician-patient relationship". Critics of integrative medicine see it as being synonymous with complementary medicine, or as "woo". (*Wikipedia, 2014*)

## Medicine

- 1: a substance or preparation used in treating disease; something that affects well-being
- 2: the science and art dealing with the maintenance of health and the prevention, alleviation, or cure of disease; the branch of medicine concerned with the nonsurgical treatment of disease
- 3: a substance (as a drug or potion) used to treat something other than disease
- 4: an object held in traditional American Indian belief to give control over natural or magical forces; *also* : magical power or a magical rite (*Merriam-Webster Dictionary, 2014*)

## Naturopathy

Naturopathic medicine is a distinct primary health care profession, emphasizing prevention, treatment, and optimal health through the use of therapeutic methods and substances that encourage individuals' inherent self-healing process. The practice of naturopathic medicine includes modern and traditional, scientific, and empirical methods. (*American Association of Naturopathic Physicians, 2014*)

**Osteopathy**

A system of therapy founded in the 19th century that is based on the concept that the body can formulate its own remedies against diseases when its parts are in a normal structural relationship, it has a normal environment, and it enjoys good nutrition. Although osteopathy takes a holistic approach to medical care, it also embraces modern medical knowledge, including use of medication, surgery, radiation, and chemotherapy when warranted. Osteopathy is particularly concerned with maintaining correct relationships between bones, muscles, and connective tissues. The practice of osteopathy often includes chiropractic-like adjustments of skeletal structures. Craniosacral therapy, a practice in which the bones and tissues of the head and neck are manipulated, also arose in osteopathy. (*Medicinenet.com, 2014*)

**Phytotherapy**

The use of plant-derived medications in the treatment and prevention of disease. Phytotherapy is a science-based medical practice and thus is distinguished from other, more traditional approaches, such as medical herbalism, which relies on an empirical appreciation of medicinal herbs and which is often linked to traditional knowledge. An herbalist's approach generally has not been evaluated in controlled clinical trials or in rigorous biomedical studies, whereas numerous trials and pharmacological studies of specific phytotherapeutic preparations exist. The interpretation and acceptance of such evidence for phytotherapeutic practices varies. In some countries, it is considered sufficient to license phytotherapeutic products as medicines, whereas in other countries, phytotherapy is viewed as a form of traditional medicine. (*Encyclopaedia Britannica, 2014*)

**Physiotherapy**

Physiotherapists help people affected by injury, illness or disability through movement and exercise, manual therapy, education and advice. They maintain health for people of all ages, helping patients to manage pain and prevent disease. The profession helps to encourage development and facilitate recovery, enabling people to stay in work while helping them to remain independent for as long as possible. (It is the British term for physical therapy.) (*Chartered Society of Physiotherapy, 2014*)

**Quackery**

A "quack" is a fraudulent or ignorant pretender to medical skill or a person who pretends, professionally or publicly, to have skill, knowledge, or qualifications he or she does not possess; a charlatan. (*Random House Dictionary, 2014*)



**Evidence-based/science-based medicine**

Science-Based Medicine is dedicated to evaluating medical treatments and products of interest to the public in a scientific light, and promoting the highest standards and traditions of science in health care. That idea is already formalized in a movement known as evidence-based medicine (EBM). EBM is a vital and positive influence on the practice of medicine, but it has limitations and problems in practice: it often overemphasizes the value of evidence from clinical trials alone, with some unintended consequences, such as taxpayer dollars spent on “more research” of questionable value. (*Science-Based Medicine, 2014*)

Evidence-based medicine (EBM) aims to apply the best available evidence gained from the scientific method to medical decision making. It seeks to assess the strength of evidence of the risks and benefits of treatments (including lack of treatment) and diagnostic tests. (*painmedicine.com, 2014*)

**Traditional medicine**

Traditional medicine is the sum total of the knowledge, skills, and practices based on the theories, beliefs, and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness. (*World Health Organization, 2014*)

**Western medicine**

‘Western medicine’ labels the medicine it denotes by its origin. It is commonly used particularly in contexts in which non-Western medicines such Chinese, Arabic and Ayurvedic medicine are discussed. Some consider ‘Western medicine’ inappropriate because this medicine is now used across the globe and because it has major contributors outside the West. (*Wiseman, 2004*)

**Woo**

n.(or adj), the way a person is when they uncritically believe unsubstantiated or unfounded ideas. Short for "woo woo". (*urbandictionary.com, 2014*)

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