Revisiting medical pluralism

Viola Hörbst
Ludwig-Maximilians-Universität, Munich

Rene Gerrets
Universiteit van Amsterdam

Pino Schirripa
Sapienza – Università di Roma

Medical pluralism is not a new issue in medical anthropology. Over four decades medical anthropologists have studied and reflected on medical pluralism, emphasizing different perspectives of professionals, patients, users and institutions. They have tried to understand the multiplicity of realities within and across contexts, and have studied the ways in which different therapeutic practices occur side by side, sometimes competing with each other, while also mutually influencing (pre)suppositions, understandings and practices. With growing recognition that plurality figures prominently in peoples' therapeutic practices across the world, medical pluralism has become a more or less taken-for-granted concept in medical anthropology. Meanwhile, cutting-edge debates in contemporary scholarship have moved on to notions such as "diversity"[1], raising the question if and how these developments could inspire new horizons for the concept medical pluralism (Krause *et al.* 2012).

Talking about medical pluralism today involves – in some way – looking back. Since the notion was first coined in a discussion group around Charles Leslie during the 1970s, medical pluralism was framed as a scientific endeavour with an embedded political agenda that sought to defend the right of non-biomedical healing practices to exist in a world where biomedicine was seen as becoming increasingly dominant. Initial worries that biomedicine might supplant other traditions proved unfounded as evidence mounted that pluralism remained a prominent feature in healing practices around the world. This observed prevalence of medical pluralism in, for instance, investigations of healing practices, stands in contrast with the relative paucity of critical (theoretical) debate about the concept, which has shaped and coloured theorizing.

Inspired by this gap, this special issue aims to reassess the salience of the concept of medical pluralism for current debates in anthropology by exploring new theoretical horizons opened up by contemporary scholarship on plurality that focuses, for instance, on issues such as globalisation and the transnational and national mobility of people, knowledge and technologies. To move beyond recurrent criticism that scholarship on medical pluralism often approaches phenomena as relatively one-dimensional, singular and static, we use the notion "pluralisation" as the overarching analytic term to emphasise the multi-level, multiplex and fluid aspects of the phenomena examined. Although one could argue that "plurality" also evinces these aspects, since this term also connotes a state whereas pluralisation suggests a process, we considered the latter term analytically more fruitful. Explicitly or implicitly engaging various aspects of pluralisation, the contributions in this special issue explore the ways in which the analytical depth and theoretical grounding of the concept of medical pluralism can be enhanced. How can the notion medical pluralism be mobilized and modified to examine current and emergent phenomena? Which novel theoretical approaches can the notion inspire?

Collectively, the articles in this special issue examine different manifestations of medical pluralism in order to shed light on the processes of pluralisation embedded in this concept. Such processual aspects of pluralisation can be seen as multi-faceted and changeable, involving for example, the increased mobility of people, ideas and things – a key feature of the present era (see Hsu, Raffaetà *et al.*, this special issue). Another manifestation of this plurality involves scalar differences, as can be observed in the political and economic forces that pervade and shape medical pluralism in domestic and public spheres, at national, international and transnational level, through various organisations, institutions and individuals (see Vega, Lambert, LaPlante this special issue). Increased diversification constitutes a final example, not only with regard to biomedical knowledge and its applications on so-called traditional healing practices, but also of recombinations such as those resulting from bricolage, hybridization and creolization (see Pool *et al.*, Russo, Vega this special issue).

Given the principal aim of this special issue, the introduction will not dwell on the history, development and use of the concept of medical pluralism which have been discussed in several excellent treatises[2]. Rather, it charts recurring themes in debates that are useful for appraising the theoretical and analytical operability of the concept and, conversely, its usefulness for exploring contemporary issues in medical and general anthropology. For example, tracing different uses of the concept, medical pluralism helps to identify intersections with other concepts central to medical anthropological debates in the last four decades, such as medical

systems, professionalization or biosociality (see Raffaetà *et al.*, Lambert, Hsu this special issue).

Debates on these concepts took different forms while topics that gained traction in the English-language literature often acquired wider circulation than those foregrounded in other languages. Of course, anthropologists based in different localities and scholarly traditions interact with each other and bibliographies regularly quote works in different languages. Nevertheless, in particular settings certain issues attract more interest than others. For the purpose of this appraisal it is helpful to summarize some less well-known engagements with medical pluralism. By contrasting these trajectories, this introductory paper aims to open up a window for the contributions presented in this special issue and for future analysis of pluralisation in medical anthropology.

Medical pluralism: a concept evolving across time and space

Since its beginnings, medical pluralism was used as a tripartite concept that blended experiential, political and theoretical aspects. First, as a scientific endeavour, medical pluralism described people's diverse treatment realities around the globe, and the highly variable logics and practices informing these realities. Second, medical pluralism was also mobilised for political purposes in order to emphasize the right of non-biomedical healing practices to exist. Third, medical pluralism was presented as an analytical concept for understanding both the variability and context specificity of healing.

Whether separately or blending into each other, these three aspects can be observed in a huge body of literature, which shows that medical pluralism provides both a window for understanding healing practices and for exploring wider social and cultural phenomena. Thus medical pluralism has served as a lens for investigating specific issues such as primary health care, health seeking behaviour, professionalization, and medical systems but also for exploring broader topics such as power and agency, social political change and gender dynamics[3].

The breadth of this literature is reflected in several excellent comprehensive genealogical works that offer bibliographical and historical summaries, overviews and evaluations of medical pluralism. In contrast, theoretical discussions on the concept medical pluralism are rare, especially in recent decades. This paucity of contemporary theoretical reflection sits uncomfortably with the proliferation of studies that draw on medical pluralism. Attesting to its appeal, the concept has spread beyond anthropology into domains such as history, sociology or public health, where it acquired different understandings and uses[4]. The appropriation of the concept of medical pluralism in domains beyond

(medical) anthropology can be seen as another manifestation of its analytical capacity to deal with such a plurality; also in these domains, the analyses intersect with the three aspects delineated above.

This introduction seeks to contribute to the literature by appraising how debates involving the concept of medical pluralism have inspired new lines of thinking in the past in order to examine its analytical usefulness/ potential. In the next paragraphs, we discuss several main themes in these debates, focusing mainly on those engaged by contributions in this special issue. In so doing, we also try to pay a particular attention to some of the contributions written in languages other than English that have been not widely discussed in the reviews on medical pluralism quoted above.

From system(s) to practice(s)

The use of medical pluralism as an analytical tool began four decades ago in a discussion group around Charles Leslie, when the term referred exclusively to medical pluralism in Asian settings (Leslie 1976). Early writings on medical pluralism tended to invoke Leslie's definition, though perceived shortcomings spurred modifications of the notion (see also Lock & Nichter 2002; Johannesen 2006; Baer 2011; van Eeuwijk 2010; Penkala-Gawęcka & Rajtar 2016; and Lambert, this special issue). In one way or another, scholars criticized early work on medical pluralism for propagating embedded tacit assumptions, particularly with regard to a certain taken-for-granted "systemness" and "boundedness" that did not always fit well with the ethnographic complexities encountered on the ground (Last 1981, 1992; Parker 1988; Pool 1994).

Mounting criticism of analyses that approached medical pluralism as more-or-less co-existing, bounded systems spurred a shift toward practice-based and actor-oriented perspectives. This reorientation brought into focus issues such as power dynamics, financial and political interests, and micro-to macro-level differences. Inspired by ethnographic research in a range of settings, these modifications aimed to hone the concept of medical pluralism so that it can better account for the complex interactions between therapeutic practices and the context in which they occur. Such approaches can draw inspiration from scholarship in Science and Technologies Studies which showed that biomedicine is multiple rather than a coherent body of knowledge (Mol 2002).

With some notable exceptions (Janzen 1978; Frankenberg 1980), most early work engaging medical pluralism focused primarily on issues such as classification and coherence of knowledge within specific healing traditions, expertise and professionalization (Last & Chavunduka 1986). Studies on medical pluralism furthermore often invoked concepts such

as medical systems, health seeking behaviour, "healer shopping" and hierarchy of resort[5]. Typically, these studies adopted a «bird's eye view» (Hsu 2008: 318), foregrounding perspectives of biomedical institutions and highlighting causal explanations of patients' therapeutic behaviour. Moreover, assumptions about systemness and boundedness informing the notion of medical pluralism illustrated both a residual functionalism and a tendency to emphasize coherence that permeated anthropological thinking at the time.

Reflecting this zeitgeist, much of research and work through the 1980s centred on analysing medical systems. For example, the interpretive model proposed by Arthur Kleinman (1980) neatly differentiated discrete medical systems in order to capture interplaying sectors of medical practices. Elaborating on Kleinman's ideas, Allan Young approached a medical system as a set of medical traditions and medical sectors – understood as both the cognitive and the experiential background of the disease, as operational areas of diagnosis and therapy – that are used by specific social or community groups (Young 1990).

Steadily gaining momentum in the wake of this shift, critics called into question the presumed systemic and coherent nature of medical practices and the supposedly clear-cut linkages to whole, neatly bounded cultures (Feierman & Janzen 1992; Pool 1994). Inspired by these debates, scholars became increasingly interested in exploring the messiness of social life, its underlying logics and contestations. In a seminal article, Murray Last (1981) emphasized the lack of coherence and unity within medical systems, and insisted on recognizing both the systemic and the non-systemic character of medical knowledge. Extending Last's argument, Pool (1994) claimed that medical systems exist more clearly in the head of analysts than in peoples' practices, and he proposes to abandon the notion all together. Making a similar point, Massé (1997) emphasized the indeterminacy of knowledge and practices and called to abandon the "mirage of rationality" in the analysis of healing traditions.

An early study that sought to move away from presumed coherence and boundedness in medical pluralism was the work of Eric de Rosny (1981, 1992). A Jesuit missionary based in Cameroon, de Rosny proposed a more expansive definition of medical pluralism that included the wide array of social actors who use medicines in various ways, such as actors associated with Pentecostal and charismatic churches that often play prominent roles in therapeutic processes (Lado 2011). Thus de Rosny moved away from earlier ethnographies that typically focused on the dichotomy biomedical/traditional medicines but paid little attention to the involvement of religious actors, institutions involved in healing, and new religious movements that were spreading across the continent.

Likewise imagining new possibilities for medical pluralism, Didier Fassin (1992) used the notion as a lens for studying politics and power relations in his monograph set in Pikine, a suburb of Dakar. Drawing on insights by Foucault and other French scholars, Fassin analysed unequal access to health care facilities – both modern and traditional – to challenge the prevailing tendency of classifying medical practices based on the axis traditional /modern and, instead, highlighted areas of convergence and syncretism. By starting from the perspectives of differently positioned social actors, especially therapists, Fassin emphasized that medical pluralism – which in Pikine involved attempts to legitimize traditional medicine – is characterised by continuous renegotiation of the social role of therapists who seek to reposition themselves on different levels within their therapeutic and social fields (see also Hsu, this special issue). In a second analytical move, Fassin reinterpreted the concept of "medical system" as

A health market – a site of exchange wherein individual operators compete with each other within the overarching (capitalist) economy for patients who can choose among healers. In such health markets relations between healers and patients typically are temporary and transactional, functioning according to rules similar to those in the labour market or the housing market (Fassin 1992: 340).

Similarly, French scholar Jean Benoist (1993, 1996) extended the notion medical pluralism in a different way by conceptualising it as a "field" (French: champ)[6] wherein new synthesis and contradictions arise through meetings, communication and confrontation. To illustrate the workings of this field, Benoist deployed the metaphor of a "crossroads", understood as a place where different therapeutic practices – including biomedical ones – meet and interact, in the process generating further interesting "crossings". Benoist's conception of medical pluralism focuses less on individual actors as becomes clear in his discussion on health seeking behaviours:

the challenge of the multiplicity of choice, behaviours, treatments adopted simultaneously or in series by the same individual cannot be identified by a subject-centered, strictly individual, interactionist approach, which retains only the strategy of choices to understand the inner logic. A hermeneutic of the health seeking behaviours leads to a cognitive interpretation that neglects to incorporate those behaviours into the social. Yet, medical pluralism is largely the result of social relations that transcend individual behaviour (Benoist 1996: 19).

The ways in which scholars such as Benoist and Fassin redefined the meaning of the notion medical system - as dynamic, multi-layered, riddled with different tensions, involving diversely positioned actors and groups pursuing varied, at times conflicting, agendas – illustrates efforts to

identify, address and understand pluralisation across divergent therapeutic realities. This shifting thinking profoundly influenced scholarship on medical pluralism, a transition further stimulated by developments in anthropology at large as scholarly interest turned from structures and systems to actors and practices.

Approached from this perspective, social actors are seen as negotiating their societal positions and as navigating, mobilising and competing for resources, processes which illuminate tensions and conflicts that run through society in general. This negotiation of positions and the associated social conflicts impinge on relations that are structured by hierarchical configurations shaping these dynamics. Developing this idea further, Schirripa (2005) drew on Pierre Bourdieu's concept of "field" to advance the notion "therapeutic arena" which foregrounds that social interactions and therapeutic trajectories depend on and are affected by shifting power dynamics.

A consequence of this shift in favour of actors and practices is that notions such as medical system and medical pluralism were gradually side-lined in scholarly debates, particularly in the Anglophone medical anthropological literature.

Looking from social actors' points of view

At the end of the 1970s, authors critiquing systemic and structural approaches to medical pluralism such as John Janzen (1978), Mark Nichter (1980) or Murray Last (1981) emphasized the need for contextually sensitive analyses that explored the relationships between cultural assumptions and values, individual healing practices and socio-economic structures. Research under this banner challenged what was often derided as non-rational treatment-seeking behaviour by patients – such as "healer- or doctor-shopping" – by shedding light on the pragmatic aspects of decision-making. When therapy management groups or individuals choose between one therapeutic resource or another, this usually involves multiple considerations, balancing for instance result-driven evaluations with the need to navigate between political and economic constraints (Janzen 1978; Whyte 1997; Lock & Kaufert 1998). This focus on patient-level treatment practices foreshadowed the spread of actor-oriented perspectives in anthropology during the 1990s (Obrist & van Eeuwijk 2006: 8).

Such efforts to integrate users' views and practices as well as social interactions into research and analysis has led to a more sophisticated understanding of the ways in which actors, patients and professionals mediate and understand pluralistic therapeutic choices, and how they resort to and combine diverse approaches. This shift reinforced the insight that therapeutic choices by patients within pluralistic settings are always informed by concrete

social contexts while also contributing to an undertheorised issue in medical anthropology, the relation between choice and behaviour. Since patients navigate specific therapeutic resources by weighing economic, cultural, ideological, and structural considerations, these dynamic engagements cannot be reduced to reductionist models. As Benoist states:

All this could be summarized by saying that patients do not proceed solely based on an underlying logic that predetermines strategies or a simplistic bricolage that profits of all the available therapeutic options. Primarily concerned with results, they behave in such a way which, in their eyes, is a practical, pragmatic conduct which does not result in abashment, objections or interdiction (Benoist 1996: 447).

The issue of power with regard to medical pluralism featured centrally in the work of Eduardo Menendez (1981), whose ideas strongly influenced anthropology and medical anthropology in Latin countries such as Mexico, Spain and Italy. Menendez insisted that power differences shape social actors' options. The various practices and regimes of knowledge to which social actors refer are, according to Menendez, primary expressions of social groups, the power struggles between them, and hierarchical differences within society. Drawing on the concept of hegemony as put forward by Gramsci[7], Menendez emphasized that one medical practice and its attending knowledge regime imposes itself as dominant. In the Mexican context he studied, biomedicine became hegemonic – not only pervading society but also orienting the leeway available to other medical traditions.

To better understand how care practices and knowledge are transmitted among different groups in pluralistic medical settings, Menendez proposed the term *autoatención* (which can be translated into English as 'self-care,' noting that the term *autoatención* has a broader semantic meaning). *Autoatención* refers to what social actors do in order to improve their health, or that of their relatives, before or instead of referring to a therapeutic specialist. Actors develop such *autoatención* in a field wherein techniques, practices, devices and aetiologies anchored in particular medical traditions meet. Following Menendez, ideas and practices encountered in a pluralistic medical field shape actors' knowledge and modes of knowing though not necessarily in any predetermined manner. The concept of *autoatención* is useful to understanding how variously positioned social actors mediate, combine and transmit different medical traditions by taking into account power relations, the dynamic of hegemony and resistance present in a specific social context.

Biomedicine and its "others"

While much early scholarship investigating medical pluralism tacitly or explicitly contrasted the logics and practices of traditional healing with

those of biomedicine, the latter initially received less critical attention. Although medical anthropological scholarship on biomedicine started blossoming in the 1980s and 1990s, these studies were seldom done under the rubric of medical pluralism. Barring some exceptions (Frankenberg 1980), inquiries into medical pluralism were largely confined to a handful aspects of biomedicine such as doctor-patient relationships or relations between biomedicine and other bodies of medical knowledge and practice (Hörbst & Wolf 2003: 21). As a consequence, a rather "static and dichotomised" picture of "modern" versus "traditional" bodies of medical practices persisted in research and the literature for a lengthy period (Foster 1976; Hörbst & Wolf 2003: 21f; van Eeuwijk 2010: 142).

This (false) dichotomy between traditional practices and biomedicine assumed in many early studies on medical pluralism also travelled into domains beyond medical anthropology and attracted considerable interest in powerful international organisations such as the World Health Organization (WHO). Within WHO, this static dichotomy was deployed instrumentally to fix problems in health systems, particularly following the 1978 Alma Ata Declaration on Primary Health Care, which recognized the value of traditional medicines and healing (WHO 1978; Unschuld 1976: 548; Bichmann 1987: 70 ff). Since in many post-colonial countries available resources – e.g., human, technological, financial – often were insufficient to build up an extensive biomedical health care system, drawing on traditional medicines and healing was also seen as a matter of efficiency (Bichman 1995: 50). However, even though recognition of non-biomedical therapies was growing, WHO as well as national governments usually tried to render them compatible with and subordinate to biomedical national health systems. Such policies and argumentations were analysed and heavily criticised by a range of medical anthropologists (van der Geest 1985: 9; Pfleiderer & Bichmann 1985). Murray Last pointed to the heterogeneous interests and coalitions pushing such processes of institutionalizing traditional medicine forward:

Governments (whether parties, bureaucracies, military men) who need both to cut costs and maintain popular support; WHO (or a section within it) urging these governments on with ideas and international pressure; psychiatrists puzzled by solutions to patients' problems in other cultures and pharmacologists on the look-out for new compounds; idealists seeking to develop a truly national medicine and sceptics weary of medical profession, its claims and its drug companies; radical of varying persuasion, backing for example the countryside against the town or the folk" against the bourgeoisie; or realists who simply remark that "primary health care" is already, *de facto*, the province of traditional medicine (Last 1986: 1).

Such dichotomous thinking contrasting traditional medicine and biomedicine as rather monolithic forms and practices was criticized by

scholars such as Janzen (1978) and Feierman (1981). They pointed out that patients as well as experts regularly drew from different medical traditions whose coherence, as discussed in the previous section, often was overemphasized by anthropologists foregrounding patterns (Last 1981; Pool 1994; Pool & Geissler 2005: 43-45). As Hsu (2008; see also Hörbst & Krause 2004) reminds us, other lines of research in and beyond medical anthropology focused on deconstructing biomedicine (e.g., Rhodes 1990) further critiqued false dichotomous assumptions and helped to re-direct research and analysis. For example, drawing on science and technology studies, scholars such as Annemarie Mol (2002) showed empirically and analytically the multiple realities within biomedical practices. Thus supposedly monolithic and uniform biomedical knowledge and practice came to be understood as being multiple, fragmented and fluid, with frictions arising in between experts as much as between experts and patients. Incoherence in knowledge and practices, once claimed particularly for non-scientific healing traditions, thus also entered investigations and analyses of biomedical practices in medical anthropology. This approach paralleled and simultaneously supported research on medical pluralism and globalisation discussed next, and both reflected growing contemporary scholarly interest in actors, scales, plurality and flows.

Pluralisation beyond single sites

During the past decade, a critical understanding of socio-political and economic powers influencing health related issues and relations became prominent in research and literature involving medical pluralism (van Eeuwijk 2010: 141). Critical medical anthropologists analysed hierarchies of power and conflict (Baer *et al.* 2003; Singer & Baer 2007), noting that «medical pluralism flourishes in all state or complex or state societies, whether pre-industrial, industrial, or post-industrial, and tends to mirror the wider sphere of class and social relationships» (Baer 2011: 413). Marxist scholars in particular critiqued biomedicine for adopting rhetorical stance wherein medical pluralism disguises socio-economic constraints and structures as "choice".

This move toward more expansive interpretive frames gained further momentum as studies of globalisation proliferated in medical anthropology. The question as to how magnified scales of intensification in contacts and movements by people, things and ideas originating from various places and bodies of knowledge influence health-related practices became a central analytical focus. Recent scholarship exploring this issue stresses that social economic and political forces active on various scales stimulate variability and plurality in medical phenomena, underscoring a

need to investigate these forms and practices (Lock & Nichter 2002; Hsu 2008; Hsu & Stollenberg 2009).

For instance, Lock & Nichter (2008: 18) emphasize the importance of paying close attention to wider political and economic frames, arguments and actors as well as to international interdependencies, competition and partnerships responding to national and global interests. They suggested taking into account commercialisation and rising powerful global players such as NGOs, pharmaceutical enterprises or the food industry. Similarly, Hsu notes the importance of attending to macro-level social, economic and political dynamics, as these always entangle and influence illness events, decisions and care management (Hsu 2008: 319).

With globalisation, most importantly, the frame of interpretation and reference for medical pluralism extended beyond single localities and nation states to explicitly include transnational and international social, economic and political dynamics. Reflecting this shifting orientation, medical anthropologists have developed methodological approaches that facilitate multi-level analyses of phenomena at the micro-, meso- and macro-level by incorporating a variety of social spaces and localities as well as trying to cover historical changes and political moves (see for example Hsu, Raffaeta *et al.*, Lambert, Russo, and LaPlante in this special issue).

From medical pluralism to medicoscapes?

Through the shifts sketched above, scholars have pointed toward new horizons that may enrich scholarship on medical pluralism. For example, inspired by Appadurai (1990), Hörbst, Wolf & Krause brought together scholarship on globalisation and power to coin the concept of medicoscapes (Hörbst & Wolf 2003; Hörbst & Krause 2004; Hörbst & Wolf 2014), which aims to grasp analytically the embedding of medical pluralism within worldwide distinct and asymmetrical dynamics in the (re)-formation of topographies of power through new configurations of actors interacting across the globe. The notion medicoscapes challenges simplistic notions of culture – as neatly bounded to places and bodies of knowledge – that accompany prevalent understandings of medical pluralism (Hsu 2008). Thus medicoscapes can counter a key weakness in medical pluralism: a descriptive term, drawn from empirical research but not providing a «theoretical founded conceptual framework» that attends to the processes that generate and maintain difference (Hsu 2008:319). Combining analytical thoughts on perspectives and positions in landscapes by Hirsch (1995), Hsu suggests the term medical landscapes as a theoretically enhanced concept that attends to situational and global heterogeneity in medical knowledge and practices (Hsu 2008: 320, Hsu this

special issue). By stressing «social processes, relatedness and movements between foregrounds and backgrounds and across boundaries» (Hsu 2008: 320), Hsu claims medical landscapes to provide an innovative theoretical framing for studying phenomena of medical pluralism. Similarly to Hörbst & Wolf (2003, 2014), Clarke brought forward the term healthscapes (Clarke 2010), combining an Appaduraian understanding with Colliers and Ong's heterogeneous assemblages of things, powers, actors and knowledge regimes (Collier & Ong 2005).

Building on Hsu's critique that medical pluralism lacks sufficient theoretical grounding, Krause, Alex & Parkin (2012) suggest to focus on how processes of diversification and permanent reconfiguration of boundaries as markers of difference unfold (*ivi*: 8). They also put centre stage processes through which medical knowledge produces variance in social categories through classifying people (*ivi*: 2012: 12, 15). While according to these authors diversification emerges «through linkages, connections and encounters between bioscience (including biomedicine and biotechnologies) and socio-cultural phenomena» (*ivi*: 21), by «dis-embedding and re-embedding of models, rituals and forms of knowledge».

Having succinctly charted key theoretically-oriented discussions involving medical pluralism, with special attention to theoretical and conceptual weaknesses, we now turn to the seven articles that draw on contemporary ethnographic investigations to rethink the concept. Inspired in one way or another by various manifestations of pluralisation, the thread that cuts across these disparate cases, each of these ethnographic contributions aims to probe the analytical and theoretical possibilities and potentialities of medical pluralism. As part of imagining such new possibilities and potentialities, each article dabbles in its own way with the semantic and conceptual weight associated with the term medical pluralism, a weight which at times is so burdensome that for several authors terminological innovation is integral. Building on this history, we proposed the notion "medical pluralisation" as the overarching analytical term for examining the dynamism, fluidity and creativity inherent to the phenomena studied in this special issue. Regardless of the route taken, collectively and individually these papers suggests that the concept medical pluralism elicits analytical and theoretical inspiration that can be profitably used for analysing peoples' lived realities in settings marked by globalisation and pluralisation.

The articles in this special issue:
innovatively engaging medical pluralism

To different degrees the contributions explore how medical plurality comes about, unfolding through interactions along unpredictable improvisations

and new intersections: around the travelling of therapeutic things, ideas and practices within and across national contexts. They highlight the ways in which medical pluralisation is connected to travelling social actors and their specific contexts and status, the (re-)production of inequalities and the roles of state activities in these processes. Jointly the papers show the fresh analytical potential of the concept medical pluralism. Explicitly or implicitly, they follow distinct approaches to comprehend categories deeply entangled with medical pluralism (like system, behaviour, and choice but also things and state activities) in a new light. In doing so they open up the meaning of such categories that are all too often understood as overly bounded or coherent.

Elizabeth Hsu opens this special issue by charting novel manifestations of medical pluralisation. Drawing on her ethnographic fieldwork in Chinese medical clinics in East Africa, she proposes to approach therapeutic encounters in order to better account for their materiality as well as their goal oriented, exploratory character. Hsu traces interactions of diverse and pluri-potent entities – such us actors, rituals and therapeutic paraphernalia – during various therapeutic encounters. In so doing, she challenges an often encountered tacit assumption in the medical pluralism literature: that "culture" – taken as a bounded phenomenon – provides social actors with a routine set of behaviours and practices. Breaking with this perspective, Hsu approaches medical pluralism as a mode of dealing with change when new configurations of people, objects and entity arise in specific place.

In the second article, Concetta Russo explores the transformative journey of scorpion poison as it travels between Cuba and Italy. Whereas for Cubans, scorpion poison became a state-endorsed homeopathic palliative, Italians who encountered and started using it during visits to the island gradually endowed the drug with new meaning and purposes when taking it to Italy. To analyse the shifting social meanings, use and circulation of the poison, Russo tracks the "social life" (Whyte *et al.* 2002) of this drug, is so doing she emphasize how not only a drug travels, it can be also associated with different meanings and functions in relation to the different and plural contexts in which it operates.

In the third paper Arantza Meñaca, Robert Pool and Christopher Pell with Nana A. Afrah, Samuel Chatio, Abraham Hodgson, Harry Tragbor and Marije de Groot also examine how therapeutic ideas and practices change as they travel. However, while Russo focuses on transnational mobility, this article concentrates on processes within national boundaries. By tracking the disease concept of asram across Northern and Southern Ghana, the authors show how patients' and practitioners' therapeutic ideas and practices are negotiated, reconstructed, and transformed. This context-bound fluidity of asram, echoing Hsu, suggests that the medical

pluralism observed here is far more complex than co-existing different therapeutic traditions by underscoring how complicated negotiations pluralise both the meanings and practices associated with asram.

Mobility also features centrally in the fourth article by Roberta Raffaetà, Kristine Krause, Giulia Zanini and Gabi Alex. They combine a critical reading of transnationalism and spatial theorizing to bear on the concept of medical pluralism. Distilling cross-cutting issues from their different research topics (on reproductive travellers' itineraries, transnational NGOs advocating local healing traditions, and migrants navigating various national health systems in Europe), the authors rethink such classical concepts as therapeutic itineraries, health seeking behaviour, hierarchies of resort and therapy management group by taking into account that the spaces in which these activities take place stretch across borders (Janzen 1978). Following de Certeau, they lay out different ways in which people organize their health seeking tactics and movements across Europe to gain access to certain treatments.

While Raffaetà *et al.* focus on interactions of local and global power hierarchies, in the fifth paper Rosalynn A. Vega concentrates on one national context – Mexico. Examining the tacit socio-political forces structuring the layered medical diversity around childbirth, Vega traces the institutionalisation of medical pluralism in the Mexican health system. In her multi-site study, Vega contrasts the birthing models and methods used by different groups of birth attendants – "traditional" and "professional" midwives, gynaecologists, obstetric and perinatal nurses – in response to the reproductive health care needs and preferences of Mexican women across ethnic groups, socioeconomic classes, and geopolitical divisions. Vega shows how different "groups" of people, stratified according to professional hierarchies and strategic professional/political agenda, rework the meanings and practices of medical pluralism.

The complexities of national policies and political levels are at play in the analytical focus of Helen Lambert. She uses a case study on Indian "bone doctors" to address major conceptual weaknesses underlying numerous studies on medical pluralism. Lambert insists on the fact that the role of the state and forms of governance as constitutive of medical pluralism have been insufficiently examined, obscuring structural distinctions that affect political legitimation and practical access to different therapeutic modalities through regulatory mechanisms and eliding historical processes that shape the contemporary structure and form of medical plurality. This would require us to abandon "medical pluralism" as an organising framework and reconceive it, and narratives about it, more clearly as ethnographic objects.

In the last paper Julie LaPlante draws on long-term ethnographic research of a pre-clinical trial involving muti – a South African traditional

medicine – to propose the notion of medicine multiple. By following people and medicine through various stages of this randomized control trial, LaPlante opens up the materiality of muti, its practices and its organization in order to show how the medicine is continuously being made, often times more through improvisation than through pre-determined procedures or programs. Resonating with ideas formulated by Mol (2002), medicine multiple aims to move beyond limitations inherent to the concept of medical pluralism, in particular residual thinking in terms of medical systems and the corresponding agenda of describing, comparing and reifying such "entities".

Acknowledgements

Notes

1. In recent years, diversity has become a focal topic in the social sciences, especially in fields such as sociology, migration studies and economics. The meaning of the term, however, is far from clear-cut or uniform (Krause *et al*. 2012), yet generally speaking in the social sciences it refers to the increased complexity in (Western) societies. This growing complexity is resulting from processes such as advancing individualisation and fragmentation of traditional milieus, families, political parties, etc. These long-term processes are accompanied by a simultaneous increase of instability in private and professional lives while these processes also decrease adhesive forces in societies to different extents (Nieswand 2010). As a result, analytical categories and characteristics are becoming blurred, overlap or merge. Examining diversity in terms of ethnicity, gender, religion, age, legal status, education, access to resources etc., Steve Vertovec (2007) uses the term "super-diversity" to describe the increase in complexity by overlapping forms of differences. Thus he points to diversification that encompasses several dimensions of existing social and cultural plurality. Yet, diversity as a theoretical concept has not been extensively used in the analysis of medical plurality. A reflection on diversity and medical plurality can be found in Krause, Alex & Parkin 2012, and Parkin 2013.

2. See e.g. Lock & Nichter 2002; Han 2002; Hsu 2008; Baer 2011; Johannessen 2014.

3. See for example Ademuwagun *et al.* 1979; Kleinman 1980; Press 1980; Lee 1982; Heggenhougen 1987; Last & Chavunduka 1986; Baer 1989; Crandon-Malamud 1991; Cant & Sharma 1999; Ernst 2002; Hörbst & Wolf 2003; Hsu & Stollenberg 2009; Parkin 2011. Additional references on specific issues will be cited in subsequent sections.

4. To discuss all those meanings is beyond the scope of this introductory paper which aims to chart the discussion about medical pluralism in anthropology and, more precisely, in medical anthropology.

5. Kleinman 1980; Bibeau 1991; Fassin 1992; Schirripa & Vulpiani 2000; Baer 2001; Johannesen & Lázár 2006; Dekker & van Dijk 2010; Solomon 2011; see also note 2.

6. Benoist uses the word "champ" (field) as does Bourdieu (whose formulation is better known), yet with a different emphasis. For both authors, the term is conceived as a social arena where a multiplicity of actors act. Bourdieu defines a field as a system of relations that is shaped by the power forces lying within it. The field and its power forces are both formed by individuals' agency and social relations, and inscribed by hierarchical structures. All of these aspects reflect dominant and dominated positions, and shifting distribution of capital (symbolic, social, etc.). Consisting of more fluid and more stable elements, a field is an arena where the actors struggle to keep and transform social relations and their status within it. Unlike Bourdieu, Benoist pays less attention to power struggles but focuses on cultural and social plurality, yet insisting on the idea of the field as an articulated social arena.

7. Of course, Menendez is not the only medical anthropologist who has used Gramsci, See for example Frankenberg 1988; Crehan 2002; Pizza 2004, 2012.

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