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Résumé

During the four last decades, Asian medical and religious systems have poured into and become rooted in Western societies. The visibility of “Asian” or Asian-inspired practices and beliefs – whether therapeutic or not – epitomizes a wide-scale phenomenon, one that some authors, like Campbell (1999) have called an “easternization” of the West. However, the spread and rooting of Asian medical systems in the West parallels to another global process: the spread of Western medicine in Asian countries. Drawing on fieldwork, conducted on the Buddhist milieu in France and in Sherpa villages of

Northern Nepal, this article attempts to highlight, in a comparative way, three different issues: the social determinants of “health” and uses of medical systems in these two different contexts, the conditions and modes of adaptation of foreign medical systems in new settlings, and the acculturative processes that are observable for the same medical systems, in two dissimilar environments. The discussion aims for a reconsideration of Campbell’s theory, after Dawson, and offers a critical examination of a similar and parallel process: the “westernization” of Asian medicines.

Texte intégral

- 1 In the three last decades, the so-called “alternative medicines” have witnessed a rapid growth (in numbers and in popularity) in Western countries, and especially in Western Europe. One interesting aspect of this phenomenon – among many others actually – is the fact many of these “medicines” are labelled “Asian” or at least contain a more or less explicit reference to “Asia” (as an encompassing cultural category). The most widespread of these are probably acupuncture, (different kinds of) meditation, and bodily-based healing practices like Reiki or Shiatsu, but one can also encounter many complete systems such as Chinese medicine, Indian Ayurveda, or Buddhist medicine (Tibetan, in particular). These few examples, although neither similar in importance, nor equal in their impact in the West, are all located in the very heart of a wider galaxy of “soft” therapeutic techniques that have recently flourished in industrial societies¹. All of them are indeed among the new fashionable techniques of “well-being”, or “complementary therapies” in the West – two much discussed but empirically significant semantic categories.
- 2 The increase in visibility of such therapeutic methods, and their success among “Westerners” (urban and privileged people in particular) have led the governments and academics milieu in different areas (in Western Europe, Australia, and North America) to question their meaning and role in the transformations of Western therapeutic and religious landscapes, and to evaluate the relevance of their claims to provide a “complementary” (though “spiritual”) set of therapies to existing biomedical models and institutions. That is, scholars and academic institutions have carefully investigated this process in English-speaking countries², but in other countries, such as France, the institutional conditions surrounding these medicines look surprisingly similar – a point that justifies the use of the broad (and highly controversial) category of “The West”.
- 3 The “success” that these “Asian” medicines have had in such social settings and cultural landscapes have hence already received much attention in academic fields. Issues such as therapeutic efficiency, psychological and organic effects, or their contribution to a better understanding and treatment of chronic diseases range among the preferred subjects of scientific investigation in the field³.
- 4 Otherwise, the apparent social and historical reasons for the progress of Asian-oriented or Asian-inspired new therapeutic techniques in the West have been under consideration in the Western mass-media for decades: the failures of modern therapies, the rise of new

“spiritual” conceptions of health and sickness, their “traditional” ability to cure modern ailments, etc. Academically speaking, these arguments can be discussed. Yet, little attention has been paid to the description and analysis of the ideological conditions of reception of such systems, the diffusion processes underlying their expansion, and their adjustment in new social and cultural settings abroad. These Asian or Asian-oriented therapies nowadays spread in many ideological and practical spheres: management and coaching, techniques of well-being, or ordinary diet or mental preparation for professional sportsmen, for example. As with many people raised and educated in France, I have been sporadically in contact with Asian therapies in different contexts: my (western) doctor has a diploma in acupuncture, friends and relatives practice meditation for “feeling better”, members of social networks use herbal “native-American” or other traditional remedies, people encountered during my travels have been initiated in various techniques of “natural” therapies and praise the effectiveness and softness of such medicines. But despite the apparent social dispersion of “Asian” medicines, they concentrate in different geographic and social sectors of French (and Western) societies, and are particularly visible in what Colin Campbell has called the “cultic milieu”⁴.

- 5 The first aim of this paper is to highlight the conditions and modes of settlement of “Asian medicines” in the West. But to focus solely upon the presence of Asian medicines in the West may overlook the counter-process of diffusion and settlement of Western medicine in Asia. The second aim of this paper is to combine these two processes in a unified theoretical scope: one cannot fully understand the issues of cultural acceptance and social appropriation of Asian medical systems in new environmental settings without a comparison with the parallel process: the diffusion of Western medicine in Asian countries – Nepal, in this case. First, I will briefly outline some of the consequences of such processes, with a special emphasis upon the issue of “easternization” or “orientalisation” of the Western therapeutic landscape.

Asian Medicines in the West

The path of Asian medicines in the West

- 6 Historical reconstitutions of Asian medicines’ path⁵ to Western countries are nowadays not has numerous as one might expect, despite the interest of social and biological sciences. Accordingly, the research lacks a general history of Asian medicines in the West. National-wide reconstitutions, such as Sita Reddy’s study of Ayurveda in the United States nevertheless demonstrate that each medical tradition has followed its own path but they generally surfaced in the West in the 1970s and 1980s. But the process has deeper

historical roots.

- 7 The cultural acceptance of Asian medical traditions – which can be Asian *religious* traditions converted into *therapeutic* ones – is also linked with the issue of Orientalism, at large. Edward Said's views of *orientalism*, while accurately pointing at the Western “fabric” of the East as a reverse mirror on which the Western fantasy is projected on an imagined East, was mainly (and stereotypically) limited to the context of colonial relationships between Europe and the Middle-East. This is not really a surprise: Said's influence extended far beyond his disciplinary region and area of study – in Asian studies his reflections have been at least as crucial as they were in (middle) Oriental studies⁶. But the ideological layers of “Asian” orientalism are quite different from those of “middle-East” orientalism. If, on the one hand, the Near Orient was initially seen as the site of sophisticated civilisations, it later came to represent the figuration of the horrifying Other. Far-East orientalism, however, stands at the opposite side of the Western imagination of the non-Western Other. Whilst the Middle-Eastern Other, initially constructed as the “Persian” (a enlightened intellectual) has turned into the “Arab”, (synonymous with “uncivilized”), the Far-Eastern Other, formerly shrouded in the mystery and strangeness of the remote and exotic, has transformed into a highly appealing and fashionable item. This appeal, which also applies to Asian cultural and religious “products”, dates from the late 19th century and is still growing today – although not *all* products from *all* Asian countries have become particularly popular. Some have been subjects of these Western appropriations. However, practical and symbolic therapeutic and spiritual traditions have become particularly popular and have been heavily imported since this time. “Asia” is indeed a powerful brand image for the importation or exportation of beliefs, practices, and goods in the West or to the West.
- 8 In his 1995 opus, *Généalogies des médecines douces*, Francis Zimmermann harshly criticized what he called the “ethnicist poison”: with this highly critical expression, the anthropologist, a specialist on Indian Ayurveda in its national context, was pointing to the misconceptions and misuses of traditional South-Asian medicines and spiritual beliefs in the West⁷. But in the introduction to their coedited volume *Paths to Asian Medical Knowledge*⁸, Charles Leslie and Allan Young adopt a very different attitude. They note that these ideological frames (on both sides, “Asian” and “Western”) played a key role in the mutual reception (or rejection) of these culturally rooted systems. As it was the case for Asian *religions* in the West, Asian *medicines* have been considered and “repackaged” in the different frames of the Western imagination. This is not the place for a detailed description of these complex and diversified processes but one is worth mentioning nevertheless: the reframing of Asian religious traditions into therapeutic ones, namely, a process of “therapization” of Asian religions.
- 9 As early as the late 19th century – in a germinal phase – and the 20th century – in an expansive phase – Asian traditions (especially Hinduism and Buddhism) have indeed

settled deeply in the West and were reinterpreted, partially or fully, as “therapeutic” systems. In other words, they were not entirely “therapeutic” (in the Western meaning of the term) *before* taking root in the West. Despite a common emphasis upon suffering (sanskrit: *Dhukka*) Buddhism and Hinduism are not exactly “therapeutic” *per se*, since Ayurveda, the ancient Indian medicine, and Buddhist medical systems are both embedded in religious traditions, yet they have a distinct identity – one that allowed them to circulated more or less independently from their religious backgrounds.

10 After the Second World War, the rise and growth of the New Age movement played a crucial role in the shaping of new conceptions of the body, the mind, and the health balance, and concomitantly in the reception of Asian traditions. The ideological layers of the “Aquarius” movement were indeed new “paradigms” centred upon the inner experience of health, an emphasis on mind-body relationships, and holistic forms of curing⁹. Asian traditions, especially those of Indian origin (Hinduism and Buddhism) were considered at the time as perfectly “fitting” these views since they were *also* inner-centred, emphasizing bodily experiences, and offering holistic methods – and they still are. Simultaneously, a large part of new Western “healing methods” and “new religions” were directly inspired by Asian traditions¹⁰. The intermingling between medicine and religion, East and West, Orientalism and the New Age movement, wound up appearing in two different adjustments of Asian religious traditions in the West: the “therapization” of Asian religious traditions (a process remarkably obvious in the case of Buddhism¹¹) on the one hand, the location of Asian or Asian-based therapeutic movements (whether “genuine” or newly invented “medicines”) among the category of “complementary” medicines, on the other.

11 Since the early 1990s, the World Health Organization (WHO) has been instrumental in the recognition of the importance of “traditional medicine”, and its acceptance (by means of “promotion” and “development”) in established medical practices worldwide. The recent legitimacy granted to previously disqualified therapeutic non-western systems has led to the development of new research programs and guidelines¹². One of the major shifts in the global policy of the WHO is the recognition of the *spiritual* dimension of traditional medicines, validated by the cultural embeddedness of such beliefs and practice systems¹³. However, the WHO concern with traditional medicines also blurs the distinction between “traditional” and other “complementary” or “alternative” medicines, all of which the WHO places under the same generic category¹⁴, at the risk of causing confusion over the differences between “traditional” and “non-traditional” medicines, and between “medicines” and “religions”. For instance, in 2002, the WHO for instance launched an international program for the promotion of “traditional medicines” – especially those relating to ethnopharmacology. But even if herbal medicines are popular in all Western and non-Western countries, they fall far short of epitomizing all the “traditional” medicines that have flourished in the West, and especially those Asian traditions that have been converted into “complementary” medicines. Moreover, the diversity of Asian (or

Asian-oriented) medicines suppose an exploration of their paths, audiences and symbolic functions.

Asian medicines for Asian migrants: “traditional medicines” in motion

¹² Academic research on Asian medicines has in recent years focused on the ways in which therapeutic beliefs and practices have become rooted in Western societies. Migration fluxes - or “transport” - is one of the main processes¹⁵. Asian medical beliefs and practices consequently, and above all, generally the most relied-upon responses to disease among Asian migrants, or populations from Asian origin, and to a significant extent they remain their first therapeutic choice, in spite of the prominence of a Western biomedical system¹⁶. In multicultural English-speaking societies, “ethnic-specific” health services have thus been established for the use of “minorities”, including those of Asian origin¹⁷. Accordingly, psychiatric services for “Asian” (newcomers or not) patients in the United Kingdom incorporate traditional forms of healing to which certain populations are attached to¹⁸, whilst *Home Health Services* are provided by “culturally competent” (i.e. ethnically focused) professionals for Asian Americans in the United States¹⁹. All in all, Western medical institutions and services for Asian minorities in Western multicultural countries are slowly but significantly transforming into *integrative medical systems*, encompassing both “traditional” and western medicines²⁰. In this global trend, France is a curious case since no particular ethnically-oriented system exist for Asian migrants or (to the notable but isolated exception of “ethnopsychiatric” consultations of the Centre Georges Devereux in Paris, where the psychiatrist and anthropologist Tobie Nathan attempts to adapt the healing techniques of Western psychotherapy to the cultural references of migrants). But there is one important point to mention here: Asian medical traditions are obviously not only appealing to populations experiencing much psychological and/or social suffering, and neither do they attract displaced people only. Quite the contrary, “Westerners” (at large), and French people in particular (but for rather different reasons), are regular consumers of “Asian” therapies, but few of them actually suffer from the same ailments – if they ever truly “suffer”, given the fact that Asian “medicines” are much more sources of *well-being* rather than cures for *illness*.

¹³ Academic focus today is mainly on the fascination that “Westerners” have for Asian medicines. In Western countries, sociological studies have demonstrated that the spread of alternative medicines is obviously related to high levels of economic and industrial development in host countries: For instance, most of diseases are caused by behaviour rather than by biological sources, and chronic diseases – the pathological category in which alternative medicines flourish – largely originate from demographic patterns, such as the

growing number of people reaching old age²¹. Asian medical systems (Tibetan medicine, Reiki and so on) target a population of urban, educated, middle-class individuals, more interested in “feeling better” than in searching for a cure for an identified disease. But it is not just because Asian medical systems have become “fashionable” that they are easily accepted in their Western host countries. The case of France illustrates a great paradox of Asian medicines, that they are torn between strong public appeal and official limited acceptance.

Tolerance, rationality and illegitimacy: the paradoxical situation of Asian medicines in France

¹⁴ In the late 1970s, around 34% of French people had used some form of complementary medicine at least once. In the mid-1980, this rate rested at 49%²², and was about the same in the late 1980s²³. According to the WHO’s Worldwide review, Legal Status of Traditional and Complementary Medicine (2001), a 1987 survey mentions that 36% of allopathic doctors used – occasionally, for most of them – complementary forms of therapies. The same survey estimates the number of non-allopathic therapists as topping 50,000 ²⁴, which is a very large figure. The most popular complementary or alternative medicines however remain those that share technical and ideological proximities with “official” medicines: homeopathy, osteopathy, chiropractic, and thalassotherapy²⁵. Nevertheless, and despite the rapid growth of “alternative” or “soft” medicines, non-allopathic medical practices are illegal in France (a situation that is slowly changing). The limited tolerance of French administrations and therapeutic institutions is related to the standard of scientificity of medical practice, which represents a frame for the cultural acceptance of foreign health practices.

¹⁵ In March 2007, an article entitled “France opens the door to Chinese traditional medicine” appeared in the French weekly journal *L’Expansion*. Following a visit of the French minister of Foreign Affairs to China, and the signature of cooperation contracts between France and China, the French government decided to experiment with the introduction of certain techniques derived from Chinese traditional medicine, in both research on and cures of chronic or rare diseases. This news is challenging the status quo of medicine in France. But in the country of Descartes, the history of medicine has gone through a long process of extreme positivistic rationalization and the expulsion of “folk” beliefs and practices from the medical domain. From Laurent Joubert’s *Erreurs populaires au fait de la médecine* (1578) to Anthelme Richerand’s *Des erreurs relatives à la médecine* (1812), France has witnessed a long stigmatisation of the “mistakes” of non-professional physicians and therapists, and the domination of biomedicine over second-rate “popular medicine”²⁶. One of the main reasons for French government resistance to “unofficial”

medicines lies in the spiritual emphasis most of the healers place in their practice. Consequently, many groups, movements or independent healers were suspected of “illegal” medical exercises and many were consequently prosecuted. These trials cut at the very heart of “sect controversy” in France: the French response to the expanding “healing religions” was to reaffirm the unconditional division between religion and medicine, and to sanction the therapeutic “shift” toward New Religious Movements, labelled as “sects”, from the first parliamentary report on sects (*Rapport Parlementaire sur les Sectes*) in 1995 to the last one published in 2008.

- 16 On the other hand, in the margins of “official” medicines, spiritually-oriented therapies are slowly growing. In France, purported “alternative” medicines (*médecines parallèles*) indeed embrace a wide range of beliefs and practices, ranging from “scientific-inspired” techniques (psycho-corporal, “energetic”, dietetic, homoeopathic) to more “spiritually-oriented” ones (meditative, faith-based). This opposition highlights the two opposite poles at the ends of the range of “alternative” medicines: the “scientific” one, and the “religious” one. In France, the two poles remain clearly separated and to a certain extent, hermetic to each other. In other contexts, (the United States, for example) healers dealing with “complementary medicines” attempt on the contrary to sort the two “paradigms” within one all-encompassing medical landscape²⁷. Yet, New Age ideas are still infusing the practice of medicine, but the influence of these “unorthodox” conceptions still remains located at the margins of official medical institutions. In France, for instance, the biomedical system maintains hitherto its monopoly upon the institutional field of therapeutic practices. On the other side, Asian historical traditions or Asian-inspired New Religious Movements continue to absorb the New Age milieu, and especially the spiritual-healing movements²⁸.

Western medicine in Asia

- 17 Western medicine – also called “allopathic” or “modern” medicine – penetrated Asian countries as early as the 16th century (despite the beginnings of the exploration of Asian societies in the 13th century), when travellers and missionaries began to settle and found themselves in greater contact with local populations. Medical conceptions and practices thus range among the many cultural influences Asia has received from the West. Asia is another anthropological site where Asian medicines and Western medicine encounter one another. In the Himalayan highlands, the therapeutic landscape is as diversified as it is in the West. Whilst the actors are quite the same (Western doctors and traditional healers), their relationships within the medical system, are, in such a context, similar: they are, again, characterized by competition and conflict. The case of Nepal will briefly offer an illustration of the similarities and differences between the two contexts – Western and an

Asian ones.

Western medicine in Nepal

- 18 For geopolitical reasons (the political isolation of Nepal for a century), allopathic medicine entered the Hindu Kingdom slowly since the late XIXth century, when the first hospital was built in Kathmandu, in a time when the Indian Ayurveda was still the official (royal) medicine, but it catch on much before the 1950s²⁹. In 1951, with the fall of the Rana dynasty, Nepal opened its frontiers to foreign influences, and aligned its economic, social, and sanitary politics alongside the Western ideologies of “development”. Since the mid-20th century, the Nepalese governments have systematized a series of five-years development plans, in order to remodel their productive, educative and medical institutions. The need to decrease the high rates of child mortality, to restrain the epidemiological extension of “poor countries’ illnesses” (tuberculosis, diarrhoea, etc.), and to increase the life expectancy ranged among the unequivocal goals of the medical section of these five-year plans, from their start in the early 1950s to the latest programs. Between 1999 and 2003, I conducted fieldwork over several periodes (in average, three months long each) in the highlands of Northern Nepal. In the early 1990s, a French NGO had established hospitals and dispensaries in the rural and remote areas at the foot of the mount Everest. In this region, the centralized state of Nepal has not succeeded in setting up a medical system as developed as it is in the valley of Kathmandu. Small primary health posts are scattered throughout the region, and there provide basic healt services. International NGOs, such as Himalayan Trust (founded by the New-Zelander mountaineer and first man to climb the summit of mount Everest, Edmund Hillary), CARE or Tashi Delek (based in France) supply all the facilities and services which the governmental health post cannot (surgery, gynecology or traumatology). In the villages of the Solukhumbu district, located at the foot of the mountain, Western medicine was introduced by “foreigners”: the government and the international non-governmental organisations. Both governmental health programs and NGO medical services are available to the underprivileged of the area. But Western medicine is considered by the Nepalese to be “medicine for the rich”, while the traditional therapies (shamanism, Buddhist medicine and Ayurveda) are seen as “medicine for the poor”. Western doctors working in Nepalese rural zones now openly question the nation’s choices relating to public health issues. After more than 35 years of practising medicine in Nepal, Stephen Bezruchka found the alignment of Nepalese health programs with Western ones objectionable³⁰: in his view, the issue of health is not a medical one, but a sociological and economic one. The high rates of morbidity and mortality – although declining in recent years – are the indirect results of social pressure, poverty and low education in a highly-differentiated society. The most common ailments in Nepal are indeed those of most any disadvantaged country –

tuberculosis, diarrhoea, pulmonary diseases, etc. – which can be prevented by simple everyday prophylactic behavior. health is not a *medical* issue but a *social* and *economic* one. The profound causes are not located in epidemiology, but in lifestyle. But nevertheless, the Nepalese medical system is currently aligning itself with the international standards of health and medicine – i.e. the standards of the World Health Organization.

Impacts: a cross-cultural comparison

An Orientalization of Western Medicine?

- 19 Colin Campbell's famous thesis of the "orientalisation of the West" suggest that the cultural and religious spheres are, in the West, literally "irrigated" by cultural flows from the East. Campbell concludes that both religion and medicines have been deeply reshaped by eastern models³¹. But A. Dawson³² refutes this thesis and maintains that eastern traditions have been "Westernized" during their expansion in the West.
- 20 On an empirical level, the proof of a "Westernization" of Asian traditions and therapies upon being absorbed in Western landscapes are ample and significant. This is, for instance, the case with Buddhism (as a religion) which has been repackaged as a "non-religion" or a "philosophy", according to the leading modernist ideological views on religion³³. Correspondingly, since Western societies pay more attention to the issue of health, many of the expanding Asian traditions, like the neo-Hinduist movement³⁴ or the new Japanese religions such as the Soka Gakkai³⁵, are now switching toward becoming spiritual *therapies*. Buddhism, in its Tibetan form, has also transmuted into a "soft medicine" by a process of "therapization": collective rites, individual mediation and prayers, even if they are *religious* (i.e. soteriological) in purpose, are considered as *therapeutic* (i.e. "recovering" or "balancing") in practice³⁶.
- 21 Along the same lines, certain sectors of "official" Western medicine, (especially nursing and psychological) are now more open to the incorporation of the religious dimension of health and illness, and aim for a reconciliation between medicine and religion. Medical innovations, such as "spiritually oriented health interventions", borrowing techniques – such as meditation – from Asian traditions are increasingly launched³⁷. But this inflection towards a "spiritual medicine", even if the latter sometimes resembles Asian traditions, is not exactly the result of Asian influences. Consider one of the major features of contemporary alternative medicines, Asian-inspired or not: holism. Many herbal remedies, acupuncture techniques, and relaxing or meditative practices are included in the category of "holistic" medicines. Asian traditions – especially Tibetan, Japanese, Hindu or Chinese –

have developed these features, but they are not *unique* to Asia. The New Age movement, though generally considered to have been “fertilized” by Asian influences, has also evolved in its own way, and the trajectory towards holistic religious and medical practices is not *entirely* influenced by Asian therapeutic and spiritual models³⁸.

A “Westernization” of Asian Medicine?

22 In parallel, the establishment, promotion and improvement of the Western biomedical system in Asia, and especially in Nepal, can also lead to the conclusion that the Asian therapeutic landscapes are gradually being altered by the influence of Western medicine. Considering the world-wide spread of biomedicine, Marxian-inspired authors such as Bernard Hours, were prompt to lament the “imperialist” forced adoption of Western medicine by non-Western countries, and the concurrent destructive effects on traditional health systems³⁹. This opinion, though controversial, is partially true in the context of Asian societies. In the “modern” urban context of South Korea, for example, traditional medicines have “suffered marginalization” following the introduction of Western medicine⁴⁰. But the wide majority of ethnographic reports throughout Asia – and elsewhere – illustrates an opposite process surfacing: the resistance and even the renewal of “traditional” medicines, within the context of an expanding Western biomedical system. In the case of Nepal, the very syncretic nature of local medical systems could explain such abilities to resist the settlement of Western medicine⁴¹. But other (political and ideological) forces must be taken into account.

23 In the South Asian subcontinent, the promotion of Western medicine has undergone a complex process of officialization, state promotion, national-wide quantification of morbidity and epidemiological studies, and the medical activism of health professionals. The activism of newly-trained doctors, nurses and other health professionals, in particular, has had a significant impact on the diffusion of Western *ideas* on health and illness. The most visible of them is the strong-minded claim of the superiority of allopathic medicine over local, traditional ones. In Nepal, countless articles in national newspapers express these views, and the doctors explicitly charge local shamans (*dhami-jhankris*) with worsening their patients’ illnesses. The expansion of Western medicine is therefore associated with the expansion of scientific and positivistic ideologies, that are, to a certain extent, contesting the legitimacy of local and culturally-embedded traditions. When I was conducting my own fieldwork in the Himalayan highlands, I was struck by doctors and nurses’ chronic indifference toward, and even criticism of, “traditional” medicines: it was actually quite difficult to enter the world of traditional medicines.

Ethnographer : “I’d like to work with the shamans (*dhami*). I visited one today”

Doctor (smiling): “What are you doing there? There is nothing to learn from them,

except superstitions”.
(extract from my fieldwork notes)

- 24 This “colonial” conquest by Western medicine of Asian countries⁴² is nevertheless largely limited to certain geographical areas and sociological segments of society (the urban *milieu*), and their impact is constrained by the resistance of “traditional” medicines. It is also worth mentioning an odd paradox: French or otherwise Western doctors are much more tolerant than their Nepalese counterparts. For instance, the aim of an NGO I have been working with, Tashi Delek-Himalayan Health, centers on the improvement of health by means of Western medicine, but also the conservation of local traditions. But traditional beliefs about health and illness, and the existing cultural institutions, have not needed this help to survive: Western medicine still has to adapt to local beliefs and practices. In this mountain region of Nepal, the failures of allopathic medicine are benefiting local medical systems in exactly the same way that Western medicine’s successes are related to the failures of “traditional” medicines. In the northern highlands of Nepal, as I observed, the establishment of Western medicine hence did not weaken local therapeutic traditions. Quite the reverse, Tibetan *amchi* medicine, the *dhamis*’ shamanic faith-healing and traditional *vaidyas*’ divination are on the contrary more visible and more active than ever. In this context, they have faced a challenge, and given the penetration of a new actor in the therapeutic landscape, they have responded with a increased promotion of their techniques and efficiency against the presence of a foreign and competitive therapeutic system⁴³.
- 25 On the other, the metamorphosis of Asian medicines, while settling in Western societies, are not grounded solely on the level of beliefs and practices, but on the level of social *organization* and *institutional shaping* of medical training and curative practices. In many Western countries, Asian (or Asian-inspired) physicians, like other “alternative physicians” can adopt two different strategies. The first one is a process of professionalization, i.e., aligning their practice with the model of Western medicine, at least on the organizational level (standardization of knowledge, training in practice, official certification...) ⁴⁴ since the theories of health and illness, the scope of practice, and the issue of efficacy remain in stark contrast with “orthodox” forms of medicine⁴⁵. For instance, the Indian Ayurveda now adopt a “professional” form in the United States⁴⁶, and Chinese medicine has espoused an official “registration” for practice and training⁴⁷.

Conclusion

- 26 The cases of the settlement and implementation of the Western biomedical system in Nepal and the diffusion of “Asian medicines” in the West are two remarkable illustrations of the contemporary internationalisation (or “globalization”) of medicines. They highlight

both the complex movements (from the West to the East and from the East to the West), and the modes of cultural and social acceptance of the *same* medical systems in different cultural settings. Issues surrounding the legitimacy of “alternative” and “complementary” medicines or the problem of the “acculturation” of these medical systems, therefore, open new lines of thought. From a comparative point of view, (almost) the same actors are indeed rooting in a two pluralistic fields (but “plural” in a different way) in Asia (Nepal) and the West (France): Western allopathic medicine is, there, confronting Asian “holistic” and traditional therapeutic traditions. To a certain extent, the same lines of tension are observable. Yet, some clear convergences are brought to light by comparative study. In short, in the West Asian medicines resemble “psychiatric and social” responses, insofar as they concern both mental troubles (for migrants in despair) or well-being (for Westerners in search of blissfulness), and are based upon a *relational* conception of health (in social and symbolic relationships). Therefore, they turn out to be *psychomedical* and *sociomedical* systems⁴⁸, but are only indirectly concerned with organic troubles. In Asia (at least in this ethnographic context), the same distinction seems to exist: local traditions favour the sphere of moral and social troubles (by means of magical and religious communication with non-human agents), while organic pathologies fall within the sphere of allopathic western medicine.

27 As noted by many authors, Western medicine seems to be in a state of “transition”, and this metamorphosis appears, to a certain extent, inspired by Asian cultural and religious traditions. Western “integrative” therapies (especially in psychiatry and nursing) today attempt to join Western and non-Western, “traditional” and “modern” forms of medicines in a same global system⁴⁹. This trend could disclose a process of “hybridization” of medicines on the Western side – similar to the culturally adaptive “hybridising” strategies observable on the Asian side⁵⁰, or the intermedical “mix” complementary which healers attempt to establish⁵¹. But are these medicines *really* and *deeply* hybridising?

28 The growth of Holistic-based practices (in consultations, preventive and curative nutrition) is surprisingly much more a *Western* development than an *Asian* influence: it is related to changes in the medical field, and the rediscovery of the “spiritual” roots of Western therapeutic systems as a “response” to modernity. Likewise, and in addition, the formulation of a concept of “spirituality” similar to those prevalent in Asian traditions (holistic and inherent to human nature) in the context of nursing⁵², has – apparently – little to do with Asian influences. Asian “medicines” also engage in metamorphosis: they adopt a double posture – a posture of “ubiquity” – *in* and *out* of the Western medical sphere, located in *both* the (positivistic) hard medical and (spiritual) soft healing sides of the cultural landscapes of their new host countries. The transcultural comparison of Asian and Western medicines’s adjustments suggests that, despite the WHO’s aspirations for reconciliation and mutual support between “traditional” and western medicine (since “all medicine is modern in so far as it is satisfactorily directed towards the common goal of

providing health care”⁵³), their integration in a single system is a utopian dream. Local social conditions, ideological frames in contact, and issues in power and economic development shape the modes and the depth of the mutual tolerance and influences of these traditions in each others' presence.

Notes

- 1 Actually these new spiritual and therapeutic resources are now spreading and settling worldwide, far beyond just 'Western' countries, but I will limit my scope here to « The West ».
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