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Medical knowledge, therapeutic practice and processes of diversification

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Abstract

This paper[1] outlines the research interests of the Medical Diversity Working Group within the Department of Socio-Cultural Diversity at the Max Planck Institute for the Study of Religious and Ethnic Diversity, Göttingen. The working group brings together scholars working on medical knowledge, therapeutic practices and diversification. While the group is in its early stages of development, we have identified three fields of inquiry that we outline in this paper.

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Keywords

Diversity and health, medical anthropology medical pluralism, health and migration, health and syncretism

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Contents

Diversity has become a buzzword. The meaning of the term is, however, far from clear and differs from context to context: In some countries it has replaced notions of multiculturalism, thereby facilitating a shift from thinking about communities to thinking about intersecting markers of differentiation (Parekh 2006). Another terrain in which the term has made a career is that of management.[2] The notion is used here to specify the individual differences of staff members in order to tailor the performance of a business and/or its services (Pincus 2006: 3)[3]. With regard to public services, it is employed to reflect the insight that the diversity within a society should be represented in its civil servants. Neologisms such as 'differently abled' mirror this trend to value the different experiences, world views and competences of people as an asset.[4]

Critics, in particular feminist theorists, argue that diversity discourses have become so widely spread, because they suit not only companies but also the transformation of most states towards neoliberal forms of governance, which tend to address individuals rather than groups (Sauer 2007: 38-43). Along a similar line, other authors have pointed to the tendency, of diversity approaches to replace questions of distributive inequality with questions of identity (Fraser 2000, see also Schönwälder 2007: 174). Some feminist theorists, however, regard diversity politics – meaning here the consideration of multiple inequalities and their intersections – as the most promising way for creating political equality (Squires 2007a: 45f).[5]

With this concept paper we do not attempt to provide an exhaustive treatment of the discussions around the term diversity, nor can we solve the contradicting views of what the term stands for. We do, however, think that it might be promising to engage critically with the talk about diversity from the different perspectives ensembled in Medical Anthropology, Science and Technology Studies and the Sociology and History of Medicine.

In the following we will outline the research interests of the Medical Diversity Working Group within the Department of Socio-cultural Diversity at the Max Planck Institute for the Study of Religious and Ethnic Diversity. This group brings together

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2 On the question of how affirmative action programs became diversity management see Kelly and Dobbin (1998).

3 This also includes 'value diversity' or 'informational diversity', the latter referring to differences in knowledge and work experience, and the former to differences in goals and views of the mission of the work group (Knudsen and Holbek 2007: 239f).

4 In some cases this neologism is even used for people, who are physically challenged such as with hearing or visual impairments.

5 This discussion is very relevant to the realm of health, but has to be the subject of another Working Paper.

scholars working on medical knowledge, therapeutic practices and diversification. While the group is in its early stages of development, we have identified three fields of inquiry in which we hope to develop research projects:

First, on the *level of publicly organised* health care the question is, how health institutions react to an increased cultural and ethnic diversification of its clientele and staff. Here we refer to diversity as encompassing ethnicity, gender, religion, language, and legal status, values and norms, etc.

Secondly, on an *epistemological level*, it can be asked how medical knowledge does not only react to socio-cultural diversity within a population, but itself produces diversity by describing and classifying bodily differences, for example by labelling what is perceived as an illness through categories such as alcoholic, schizophrenic, dyslexic etc. Furthermore, new diagnostic technologies generate differences in individuals, as in the case of genetic testing, which are mediated through new social forms and institutions.

Thirdly, the exploration of therapeutic practices (including different biomedical disciplines and various forms of non-biomedical healing traditions) in medical anthropology, sociology and the history of medicine can be seen as examples in which issues of diversity have been discussed on a *conceptual level*. The inherent multiplicity within biomedicine for instance, has been a topic challenging the general idea of coherence in medicine and pointing to the unstable and situated nature of therapeutic knowledge. Similarly, the subject of medical pluralism – the co-existence of different medical practices and forms of knowledge – has been a classical field of research. Debates have moved from an understanding of pluralism as consisting of separate systems to thinking about mixture and intersections of different therapeutic practices. Drawing on these two research traditions and departing from a view of medical systems or disciplines as notions with sharp boundaries, our working group seeks to enhance a perspective that foregrounds how boundaries are constantly reconfigured through intersecting markers of difference.

These three fields are not our invention; on the contrary, all of them are well established and grounded in substantial bodies of literature. In each of these three fields the term diversity plays a different role. We will offer a selective reading on what the notion of diversity means in each respective field, beginning with the question of health institutions.[6]

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6 Since our background is in Social Anthropology, the views expressed in this concept paper are very much influenced by the debates within this discipline. The paper presents a work in progress and has to be seen as part of an ongoing conversation.

1. Health institutions and socio-cultural diversity

For health institutions, diversity mainly means cultural and ethnic differences among clientele and staff.[7] Research in Europe and North has therefore mainly concentrated on ethnic diversity and inequality in health status. From the perspective of feminist theories, however, diversity and health care would comprise other issues as well, such as gender and health (Annandale 2010 and the health needs of lesbian, gay, bisexual and transgender people (LGBT) (Mayer et al. 2008, Wolitski et al. 2008), as well as other vulnerable groups such as the homeless and individuals with specific bodily challenges.

Although the health state of migrant workers has always been a concern with regard to the maintenance of their ability to work,[8] it was only in the 1980s that ethnic diversity and health disparities became a key issue in questions of equality in Europe and the US. This might have been the result of the emergence of multicultural discourses and policies in the 1980s, and the increased attention given to the health of newly-arrived migrants and established ethnic minorities (Nazroo 1997: 1f, Ahmad 1993a).[9] A population's state of health can be used as a measurement of a society's achievements in regard to equality and the fair distribution of resources (Bradby and Nazroo 2010: 123). The access and experience of health care can be seen as an important area for understanding when and how being a member of a minority group produces disadvantages (Jayaweera 2010). The late 1990s saw for instance the emergence of a number of professional journals in the Anglophone academic context, dedicated to this field of study like *Journal of Immigrant Health*[10], *Ethnicity and Health*[11], *Journal of Transcultural Nursing*[12] and

7 Leaving management studies aside, diversity within health staff appears to be quite understudied, although many national health systems rely substantially on health professionals who have left their home countries.

8 See for instance Yano (2001) on the compulsory health screening of guest-workers from Turkey before they entered Germany.

9 For critical overviews, see Ahmad (1993b), Stubbs (1993).

10 The first issue was published in 1999; the journal covers public health, epidemiology, medicine and nursing, population research, immigration law, and ethics. The Editorial Board consists solely of medical scientists based in the US. It was renamed as 'Journal of Immigrant Health' in 2006.

11 The first issue was published in 1996, mainly epidemiologic and public health, but with a critical angle. The Editorial Board is mainly based in UK.

12 The first issue was published in 1989; published in association with the Transcultural Nursing Society (founded 1974).

the *IOM Newsletter on Migration and Health*, and *Cultural Diversity and Mental Health*.[13]

The accommodation of needs related to religious or cultural identities, such as being vegetarian, the provision of halal or kosher food in hospital settings, as well as space dedicated to religious practices such as prayer rooms, have become standard in many democratic countries that recognize religious freedom and adhere to one or the other form of multiculturalism.[14] A pertinent issue for encounters between biomedical professionals and their clientele, apart from the challenges of cross-cultural communication (Fuller 2003), are the practical problems related to linguistic diversity (Jones and Gill 2003, Greenhalgh et al. 2008). It has simply become impossible to cater to all of the language groups present in global cities such as London, Singapore, or New York (Greenhalgh et al. 2008: 132). Since communication lies at the core of health care, difficulties of expression or comprehension of what is being explained by health professionals, is a widely recognised problem (Jones and Gill 2003).

Access to meeting a biomedical professional in the first place might, however, be hindered by many other factors. Barriers to access of public health services have therefore been a central topic. Next to linguistic and cultural barriers, access is seen to differ from country to country, depending on national policy frameworks. Most of the literature makes a point of distinguishing the different migration pathways and legal categories of migrants, because to a marked extent, the legal status of a migrant influences health needs and access to health care; the status ascribed to them restricts or enables their access to care and their ability to establish candidacy. Causes of ill-health, cited by a wide range of authors in regard to refugees (Watters 1998, 2001a, 2001b, 2003, Silvoe 1999, Silvoe & Watters 2000, Nygren-Krug 2003), could apply to all migrants in general: dangerous migration routes, difficulties to obtain legal status, poor housing, inaccessible information about health services, acculturation stresses, the loss of a familiar environment and support systems, discrimination, and the lack of health and safety in the workplace (Chavez 2003).

It is beyond the scope of this paper to provide a full review of the literature on ethnic diversity and health.[15] In the Anglophone context in particular, the discussion

13 First issue was published in 1998, now *Cultural Diversity and Ethnic minority Psychology*. The Journal is an organ of the Society for the Psychological Study of Ethnic Minority Issues of the American Psychological Association.

14 See, for instance, the EU-project *Migrant friendly hospitals*, and in particular the literature review by the Swiss Forum for Migration and Population Studies (sfm) available on the webpage **http://www.mfh-eu.net/public/home.htm** [accessed 15 January 2012].

15 For an overview see Bradby and Nazroo (2010).

about the reasons for health inequalities has shifted from emphasising cultural difference[16] to examining the effects of racism[17] or socio-economic inequality.[18] Research on the intersection of different categories, including increasing diversification with respect to education, religious affiliation, legal status and ethnicity has, however, rarely been conducted (Jayaweera 2010, Phillimore 2011).[19]

1.1 Intersectionality, super-diversity and health care

The term diversity is relevant for health institutions, in that it describes the co-existence of various aspects of socio-cultural heterogeneity caused by migration, with social transformations in the majority population, leading to more complexity within social situations.[20] For instance, developments which have been termed individualisation, (Beck 1983, 2008) or the shrinking significance of traditional values and forms of societal organization,[21] make it is no longer possible to pre-assume a shared understanding of social institutions across the population in one local context: what constitutes marriage and family, a good or a bad death, or the trustworthy relationship to a doctor is differently understood by a catholic heterosexual father, or by a lesbian couple, by an unemployed, disabled single man, or a Hindu business woman. The point of a diversity perspective is then to consider the dynamics of cultural and ethnic diversification and individualization together and to highlight, how they increase the complexity of social situations in their combination, , and not to just look at migration or changes in values and biographies among the majority population. If understood in this way, research on how health institutions react to processes of socio-cultural diversification can contribute to moving away from an ethnic and

16 See for this position, but mainly related to the UK context, the work of Qureshi (1989, 1992) and Bhugra (2004a, 2004b).

17 See for this position, but mainly related to the UK context, the contributions in Ahmad (1993d), Pearson (1986), Stubbs (1993).

18 See for this position, but mainly related to the UK context, the work of Nazroo (1998, 2002).

19 But see the journal *Diversity in Health and Social Care* (first issue 2004) which embraces a broad notion of diversity beyond ethnicity. Concerning a call for research into super-diversity and health see Phillimore (2011).

20 We draw here on a work in progress of our colleague Boris Nieswand.

21 The question, of whether the term individualization adequately describes the transformations that have occurred within the last century, and whether class background is not still the main hindrance for social mobility, cannot be covered here. See Beck 1994 for a summary.

cultural lens, towards an exploration of intersecting markers of difference. Theories of intersectionality and the recently developed concept of 'super-diversity' can be useful here (Dören 2007).

Theories of intersectionality reflect the critique by Black feminists that existing approaches to gender and class neglect issues of race (Crenshaw 1989, Davis 2008: 19, Squires 2007b: 158). They argue that in order to describe social stratification, it is no longer satisfying to simply add different social categories, but instead, it is necessary to analyse how social positions of people emerge through the intersection of different, mutually constituent categories, such as age, bodily condition, gender class and race (Anthias 2005).The relevance of specific categories is thereby specific to different historical locations and situations (Yuval-Davis 2011a: 4, 2011b: 6-10).

The concept super-diversity (Vertovec 2007) ties into this understanding of social stratification by providing a new lens for looking at migration related ethnic diversity. It transcends previous theories of multiculturalism, in that it recognizes a level of socio-cultural-economic-legal complexity distinguished by the dynamic interplay of overlapping variables including country of origin (comprising a variety of possible variations such as ethnicity, language, religious tradition, regional and local identities etc.), migration experience (often strongly related to gender, age, education, specific social networks, particular economic niches) and legal status (implying a wide variety of entitlements and restrictions)[22] (see also Phillimore 2011 and Faist 2010).

2. Medical knowledge produces and establishes diversity

The second research field, surrounding the question of how medical knowledge produces and establishes diversity, concerns a different level of analysis: how is medical knowledge used to describe and classify difference on an epistemological level is.

Biomedical classifications are linked in numerous ways to the stabilisation and legitimation of differences between individuals and groups. This is particularly evident when it comes to bodily conditions grouped under a particular diagnosis, which lead to entitlements such as pensions, disability rights or the rare case of access to legal status for in illegalised migrants. Medical knowledge has also been used to control and to pathologise people. These correlations have been theorised under the label 'medicalisation', meaning the translation of socio-political issues into medical ones.

22 This summary is based on a concept paper by the working group member Charlie Davisen.

Although initially coined by Irving Zola (1972), medicalisation has mainly been analysed in drawing on the work of the French philosopher Michel Foucault on the intrinsic relation between knowledge and power, as displayed in institutions such as the medical clinic.

As several authors have argued, to understand medicalisation as pure surveillance, is neglects the interest of patients and consumers in labels of bodily conditions, strategic categorisations (Watters 2001a) and the inclusion of 'emergent illnesses' in catalogues of disease categories (Dumit 2005). It furthermore does not pay attention to the resistance against the medical gaze and medical categorisation (Lock and Nguyen 2010: 78).

The appropriation of medical categorisation by people beyond the strategic use of specific diagnosis can be explained by what Ian Hacking calls the 'looping effect' (Hacking 1986). In his works on the history of medical conditions, mainly in the realm of mental health, he shows how people are not merely labelled by medical experts, but embody and reproduce these labels. Allan Young (1995) has demonstrated this effect in his work on Post- traumatic Stress Disorder and Vietnam Veterans in US clinics.

As one of the most powerful globally recognised epistemologies, biomedical classifications can be translated into rights. Recent work concerned with how medical subjectivity can be translated into political subject positions, speaks of citizenship projects when analysing the tactic of gaining legal recognition through a bodily condition. The terms used in this discussion range from biological (Petryna 2002, Rose & Novas 2005), or therapeutic (Nguyen 2005) to medical or biosocial citizenship (Fassin 2001, Fassin and D'Halluin 2005, Ticktin 2006). The authors argue that what is expressed in this constellation is a shift in the discourse on rights, recognition, and citizenship: a person becomes recognised through his/her pathology and is not regarded as having rights on the basis of being a human being as such.[23] The sick body is assigned more rights and recognition than the 'bare body' of a human (Arendt 1975 [1951]: 260). Adryana Petryna writes with regard to people affected by the aftermath of Chernobyl that 'the damaged biology of a population has become the grounds for social membership and the basis for staking citizenship claims' (2002: 5). Vinh-Kim Nguyen defines therapeutic citizenship with regard to HIV as a 'form of stateless citizenship whereby claims are made on a global order on the

23 Rose and Novas (2005) diverge partly from this position by viewing the biosocial as a potential avenue for political activism.

basis of one's biomedical condition, and responsibilities worked out in the context of local moral economies' (2005: 142).[24] Nicholas Rose and Novas use the term 'biological citizenship' to 'encompass all those citizenship projects that have linked their conceptions of citizens to beliefs about the biological existence of human beings, as individuals, as families and lineages, as communities, as population and races, and as a species' (2005: 440).

This last conceptualisation of biological citizenship resonates with the usage of the term diversity within the field of life sciences, where the notion is used to describe the multiplicity of different bodies, which is only insufficiently represented in conventional 'one-drug-fits-all' approaches. 'Personalized medicine' in contrast, attempts to develop individually tailored pharmaceutical and medical procedures that match specific genetic markers (Gibbon et al.-2008: 6ff; Jain 2009: 1f). A related development can be seen in the change of legislation in the US during the 1980s in response to political pressure to include minority and marginalized groups in health research. Groups that have to be included in clinical trials were defined along the lines of gender, age and race (Epstein 2008). Underlying both developments is a logic that conceptualises differences between humans as being based on biology (Lock and Nguyen 2010: 351f).

As can be noted from this short summary, bodily disparities often come to matter in the life of people through their medicalization or translation in terms of medical knowledge. Non-biomedical practices can also play a role in producing differences between people. As frames of references, which often overlap with religion, they provide subject positions that allow people to make sense of their suffering and to review their life course through a different episteme. Lock and Nguyen therefore argue that medicalization commenced much earlier than the historical emergence of biomedicine as a highly legitimated profession, when other non-biomedical, but literate medical traditions of Europe and Asia 'made themselves available to deal with physical malfunctions and disease of all kinds, as well as with the exigencies of everyday life, including difficulties relating to the life course' (Lock and Nguyen

24 Fassin calls this 'the biopolitics of otherness' – the extreme reduction of the social to the biological, in which the body appears to be the ultimate refuge of a common humanity (Fassin 2001: 4). Taking up this thought, Ticktin points to the problem that, in this way, rights have been replaced by humanitarianism, and moralisation has taken on the role of political action (Ticktin 2006: 34). Fassin and Ticktin also point to the fact that in case of illegalized migrants, their living conditions will often already entail hazardous health conditions. Thus the health consequences of their precarious status can become grounds for justifying their stay (Fassin 2001: 5, Ticktin 2006: 39).

2010: 67). However, today, due to the fact that biomedical knowledge represents one of the most powerful and globally recognised epistemologies, it is mainly biomedical classifications that can be translated into rights affecting the social status of people, for instance in forms of entitlements, such as eligibility for pension schemes.[25]

3. Medical Pluralism and diversity within biomedicine

The coexistence of different therapeutic practices, as well as the fragmentation of biomedicine in its different disciplines has stimulated a lot of research that is, in our view, very relevant for the question how to conceptualise diversity beyond the description of ethnic or religious plurality among people. The study of biomedical practice, as mentioned in the previous section, has not only shown how medical knowledge provides terms for classifying difference, but also how the perceived unity of medicine is disaggregated in its enactment as practice. Similarly, the debate on medical pluralism – the coexistence of different therapeutic practices in one local context – has struggled with the tension of how to describe systemic elements of different therapeutic traditions without losing sight of the phenomena of mixture and intertwinement.

In our view, these discussions have a lot to offer in terms of how to think about situations of mixture, overlap and increased complexities. Terms such as situated knowledge, plurality/pluralism, multiplicity, heterogeneity complexity, hybridity, syncretism and creolisation share a semantic field with 'diversity' and can be plundered for imbuing the concept with meaning. In the following we present our reading of these two fields by concentrating on the shift from thinking in systems or units to thinking about latticed practices and multiple bodies.

3.1 Medical pluralism

The fact that a plurality of therapies can be found in almost all societies, past and present, has been widely acknowledged in anthropological writing, but only in the 1970s did the concept of medical pluralism enter medical anthropology. The concept

25 Dumit writes on conditions that have a name, but are not yet codified, such as Chronic Fatigue Syndrome: 'one must have laboratory signs in order to be suffering; one must suffer in code in order to be suffering in fact, or one does not suffer at all' (Dumit 2006: 580).

is strongly linked to the idea of 'medical systems', which underlies much of the literature on medical pluralism. The volume, Asian Medical Systems, edited by Charles Leslie (1976) is an attempt to develop this concept theoretically and, in contrast to later critiques, Leslie and his colleagues pay close attention to processes of syncretism and homogenisation (Hsu 2008: 317), as well as of professionalization and institutionalisation by comparing different regions in Asia.

The first volume edited by Leslie and the subsequent literature on medical systems in South Asia had an impact on the debate on medical pluralism, because the term 'system' helped evoke notions of gravity and significance, in contrast to earlier studies, which 'just talked about religion' (Reynolds Whyte 1989: 289). It was seen as upgrading non-biomedical practices to something systematic, informed by an inner logic and effectiveness, as was biomedicine itself perceived (cf. Johannessen 2006: 2f). In the definition used by Press, medical systems are understood as a 'patterned, interrelated body of values and deliberate practices, governed by a single paradigm of the meaning, identification, prevention and treatment of sickness' (Press 1989: 3).

Whereas early studies focused mostly on pluralism from the perspective of the patient and the choices that arise with the plurality of medical provisions (Janzen 1978, 1987, Feierman 1985), other studies have looked at how medical pluralism is dealt with from an institutional and state based perspective. Cant and Sharma (1999), for instance, investigated medical pluralism in Western health care, which they categorised into 'orthodox'[26] and 'alternative' or 'complementary' medicine.

In the late 1990s the debate turned towards globalisation and transnationalism (Hsu 2008: 320). Traditional medicine from the East such as Ayurveda and TCM suddenly gained popularity in the West, and the use of alternative and complementary as opposed to orthodox medicine was becoming a field of study in the anthropology of Europe (cf. Cant and Sharma 1999, Hog and Hsu 2002).

In this concept paper, we are interested in the persistence of the concept of systems during the 1970s and 1980s and the on-going discussion it initiated. Similar to debates on the notion of 'culture' employed in conceptualisations of multiculturalism (cf. Baumann 1999), the literature on medical pluralism has engaged with the problem of how processes of mixture and entanglement can be conceptualised.

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26 The term 'orthodox' meaning biomedicine in its various forms.

3.2 From thinking in systems to thinking about latticed practices and multiple bodies

Although a focus on the systemic character of codified medical knowledge in written sources, other than biomedical textbooks, has been an important contribution to the debate, the concept of systems reproduces a specific epistemology within biomedicine, and perpetuates a tendency to construct single, bounded entities, similar to the closed notion of culture in conceptualisations of multiculturalism. The constant interchange and mutual influence of medical traditions, across both geographical and cultural 'space', the overlapping character of different medical practices, the 'latticed knowledge' of medical experts, the interwoven appropriations of patients in the process of undergoing sickness and seeking cure – such phenomena are inherently resistant to representation through the concept of systems (Pool and Geissler 2005: 43-45).

This aspect was highlighted particularly by anthropologists working in Africa, where most therapeutic traditions are passed on orally. Murray Last (1981), Robert Pool (1994a, 1994b), and David Parkin (1995) stress the point that in order to understand fluent appropriations of different medical traditions, it is not helpful to talk about systems. In their view, the concept is unable to express the simultaneous disjuncture and interweaving of Western technology, biomedical knowledge, Islamic medicine and varieties of other healing methods in the health practices of people.

The underlying epistemology of 'medical systems' is that medical practices are perceived as being held together by a single logic (Parkin 1995: 150). However, in the enactment of knowledge and within attempts to solve a problem practically, patients and practitioners often engage with more than one paradigm of meaning.

This point is supported by Murray Last in his often quoted and reprinted article, 'The Importance of Knowing about Not Knowing'. In it he makes a general criticism of medical anthropology's efforts to seek out illness taxonomies (Last 1981: 387). Instead, he places emphasis on the exchanges between different traditions of medical and religious knowledge, and on the power interests involved in processes of diagnosis. He argues that what might in theory appear to be a system, might in fact be a bundle of very scattered and de-systematised practices. In his case study of Hausaland, Malumfashi (Nigeria), he shows how medical practices are positioned in a hierarchically structured spectrum of various medical traditions that are used by patients, their therapy networks and practitioners when 'appropriate'. Last thus concludes: 'there are no "alternative" treatments, only appropriate ones – appropriate, that is, to the place where one happens to be' (Last 2007: 7). Writing along similar lines, David

Parkin argues that medical practices are always directed towards solving a problem and have to be understood in relation to the needs they address. He aims to capture the blending of different therapeutic practices by coining the terms 'latticed interaction' and 'latticed knowledge' (Parkin 1995: 148). In particular, he questions how the concept of systems assumes boundaries. He speaks of 'overlapping areas of competence' (ibid.: 149) that allow for practices based on the shared grounds of Islamic medicine and biomedicine.

Another intervention has been made by Robert Pool, who criticises the tendency among medical anthropologists to search for local equivalents of biomedically defined diseases (Pool 1994a). Based on his work on sickness related to the malnutrition of children in Cameroon, he shows that in the search for systems, certain elements are selected from what in practice is a continuous whole. In deconstructing the search for systems, he writes: 'the result of all this is perhaps not so much that the "medical system" is wider and more inclusive than some authors suggest, but that there is no system at all' (Pool 1994a: 264, 1994b). Pool does, however, admit that there might be practical reasons for differentiating distinct bodies of medical practices through systematisation. Similarly, Parkin and Last remind us that although the anthropologist might state that there are no separate systems, and only overlappings, interpenetration, and syncretism (Pool and Geissler 2005: 39-45), people might still perceive healing traditions as exactly such systems.

Similar aspects of pragmatism have been highlighted in the context of studies on religious 'syncretism',[27] cultural 'creolisation',[28] or 'hybri-

27 The term describes religious synthesis evolving from the 'amalgamation' of two or more traditions (Lindstrom 1996: 539, Parkin 1970, Stewart and Shaw 1994: 2, Palmié 1995: 74f, Stewart 1999). Due to the underlying assumption that some religious forms are pure and not mixed, and the derogatory meaning of the term in the context of Christian mission, the term has been avoided by many anthropologists (Stewart and Shaw 1994: 1, 14-15, Peel 1968: 133-134). However, Rosalind Shaw and Charles Stewart argue for a recasting of syncretism by focusing 'upon processes of religious synthesis and upon discourses of syncretism' (Stewart and Shaw 1994: 7) when borrowing and transfer are denied and the purity of a system is claimed. They also call attention to the phenomenon of claiming authenticity based on the mixture of different traditions, as for instance in the case of voudouon.

28 Creolisation, originally a linguistic term, describing the languages that evolved as a result of the transatlantic slave trade in plantation economies, has been transferred to processes of globalization (Hannerz 1987), in particular to capture, how in situations of cultural interaction, new varieties of cultural forms and expressions emerge, that supersede the prior forms (Cohen 2007). For a comprehensive review of the usage of the term in anthropology, see, Palmié (2006).

dity'.[29] What these studies share with the thinking about medical pluralism is the challenge of how to describe processes of mixture without reproducing the idea of clear, separable units, which represent the 'pure' original state. One solution to this problem has been to instead look at when and how boundaries are claimed, and then to decide how they can be neatly drawn. This so called 'boundary drawing perspective' (Wimmer 2009) has proved particularly fruitful in anthropological research on ethnicity. Furthermore, as theories on syncretism have highlighted, boundaries are often held up to increase legitimation. The same can be observed in situations of medical pluralism: for instance, practitioners of religious healing insist on doing something different than biomedical treatment, in order to be able to draw authority from this differentiation (cf. Krause 2008).

3.3 Multiple enactments of biomedical knowledge

There have been other fields of approaches that touch upon the problem of how to understand when and how experts of specific therapeutic traditions conceive of their tradition as a closed system, despite the fact that their practice is characterized by fuzzy boundaries. The study of biomedicine and biotechnologies within Science and Technology Studies, as well as studies of transnational health and the globalisation of medicine and healing, portray biomedicine and other medical and healing traditions as assemblages (Collier and Ong 2005: 4) of heterogeneous forms of techniques, knowledge, *materia medica*, experiences, and bodily material (Hsu 2008: 319f, Berg and Mol 1998). Here diversity is seen as an inherent factor of the complexity of medicine and healing; therapeutic practices are thus viewed as emergent and multiple, as fragmented, unstable and situated. As Elisabeth Hsu writes:

> Medical pluralism implies there are many systems other than 'Western medicine'. However, 'Western medicine' does not exist as a monolithic discipline. The biomedical worlds are hugely diverse, fragmented and fluid in themselves, changing in orientation, organisation, research and care delivery in a changing world. (Hsu 2008: 320)

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29 Hybridity is a term from biology, denoting the cross-breeding of two different species. In reference to the writings of Homi Bhaba (1994), the term hybridity denotes the third space which opens up through translations of hegemonic discourses in the language of the marginalized other, who is never met by the description available in the dominant discourse. This mismatch configures what Bhaba calls the 'third space'. Hybridity, as it is used in relation to multiculturalism, however, is characterized by the fallacy that it always refers to something which is not hybrid (cf. Cağlar 1997). It thereby becomes just another way of how the dominant culture incorporates minorities on its terms, without granting equal rights (Ha 2006).

Science and Technology studies on biomedicine point to the fragmentation and differentiation within the enactments of disease, including the fragmentation within different sub-disciplines of biomedicine as well as that within the patient (Mol 2003: 152-154). Thus the perceived coherence of medical or religious systems, which has been weakened by critical thinking that views medical pluralism as latticed knowledge, is further deconstructed here. This is achieved by not seeing different therapeutic traditions as expressing different representations of disease, but by questioning the existence of disease as an entity before it is handled in diagnoses and treatment.

Annemarie Mol and Marc Berg outline how the unity of medicine is disaggregated at different levels through this conceptual move (1998: 3-7). Classic writings on medical pluralism needed biomedicine as a counterpoint (ibid.: 5), and often portray scientific medicine as 'an overrationalised, technocratic and closed system of beliefs' (ibid.). Through the ethnographic exploration of biomedicine, the perception of a closed system was first challenged by contrasting the view of doctors and patients through the distinction between disease and illness (Kleinman 1975, Frankenberg 1980, Young 1982). However, 'conceptions' are not only beliefs, attributed to certain groups of people, 'but also elements of practice' (Mol and Berg 1998: 5). Disease as an object does not precede knowledge about it: '(K)nowing is about partaking in a reality' (Mol 2003 154), thus there is no psychosocial perception of disease that can be isolated as illness. 'Western' medicine, according to Berg and Mol, can thus be analysed as 'the juxtaposition of countless procedures' (Mol and Berg 1998: 5), and, we would like to add, this applies to religious healing as well. Differentiations can then be found embedded in techniques, buildings, gestures, regulations, and standards.

Along this line of thinking, another unity that now proves to be of 'failing coherence' is the patient. By constructing biomedicine as a system against a variety of other systems, the patient was erected 'as a whole' and as a 'normative standard' in the classic paradigm of medical pluralism (Mol and Berg 1998: 6). Scientific concepts of disease were confronted with the perspective of illness, perceived as stemming from the experience of one coherent subject. Yet, as Mol and Berg explain (1998: 6-7):

> the idea that there is a single body preceding knowledge and treatment is no longer self-evident. Instead, many bodies shaped in medical practices are displayed [in the form of] a composite picture involving many measurements, numbers, intuitions, habits, humans – not to mention dead ends and (often unresolvable) contradictions.'

This view on therapeutic practices and the 'body multiple' (Mol 2003) emerging from it, requires that the general idea of coherence in medicine and healing be recon-

sidered in view of the cross-cutting diversity of medical techniques and knowledge configurations. The study of global transfers of medical knowledge and the transnational travel of therapeutic practices has furthermore shown how diversification occurs through the dis-embedding and re-embedding of models, rituals and forms of knowledge. Thus diversification as a process can occur through linkages, connections and encounters between bioscience, (including biomedicine and biotechnologies), and socio-cultural phenomena.

Conclusion

Therapeutic knowledge, broadly conceived as encompassing various disciplines of biomedicine but also traditions of non-biomedical treatment, provides on the one hand, categories to describe differences in individuals, but also conceptual frames to understand bodily conditions and their treatment. Medical knowledge and therapeutic practices are therefore contributing and responding to processes of sociocultural diversification. We have thus suggested that there are three fields of inquiry in which the relation between medical knowledge and therapeutic practices and processes of socio-cultural diversification can be studied: how health institutions respond to differences among its staff and clientele, how medical knowledge produces categories to describe diversity and how therapeutic practices represent a case in itself for theorising complexity and the intersection and mixture of different ways of thinking.

Based on the discussions in the working group, we have drawn attention to an empirical and conceptual shift, which in our view is relevant for all three fields: from the implications of boundedness and internal coherence of the different parts, to a recognition of their porous and flexible nature, against which, despite their liability, they retain some emic distinctiveness in relation to each other. Of particular significance, is the turn away from the idea of multicultural/multiethnic societies that lay stress on the importance of groups as being internally united by culture and ethnicity and as being distinct from others on the basis of these markers.

Early theories of medical pluralism referred to a notion of distinct but parallel systems, which patients could use sequentially or at the same time. This approach to medical pluralism stresses the cross-referential and interpenetrating use of different medical traditions that, while still regarded as internally coherent and systematic, are also clearly subject to processes of syncretism and adaptation. The use of the

term syncretism suggests some analogy with the domain of religion and is indeed instructive, given religion's often claimed healing powers and the fact that Christian missionary conversion was often made possible through the promise and apparent efficacy of biomedical clinics and hospitals; in a similar way Islam has spread for centuries in many parts of the world, especially where major mosques were connected to schools and large hospitals. Thus, later approaches paid more attention to the interrelations between different medical traditions, their overlaps and their positioning within hierarchies of knowledge.

The ambassadors of diversity approaches relevant for the first field, how health institutions react to diversity, have argued that diversity brings into focus the multiplicity and intersection of factors that are perceived as salient in a given context and supports inclusion of intersecting markers of differences, including race, class, gender, age, religion, sexual identity and social inequality. The promise of inclusion inherent in diversity discourses can however eventually lead to a re-affirmation and re-essentialisation of inequality, rendering their political and social origin invisible, by not paying enough attention to the socio-political conditions and power relations through which disparities in society are (re)produced.

We therefore see the emergent emphasis on diversity as both promising and dangerous. On one hand, by supporting an individualistic view of social processes, it can mask existing wider disparities and so lead to their reinforcement. On the other hand, by bringing into focus the multiplicity and partial overlap of factors perceived as salient in a given context, it can help to show the situational character of diversity, which may encompass the intersectionality of race, class, gender, age, religion, sexual identity and social inequality. The term diversity can however become inflated and self referential: with everybody regarded as different, and everything as diverse. Such reductionism can lead to the idea of diversity as representing diverse individuals; it then develops an affinity with an atomized view of society, and neoliberal ideologies of governance. Hence, some balance is needed between the wish to capture the situational and intersectional nature of diversity as a concept and the danger of a neoliberal, atomised individualism which disregards the collective influence and movement of society as a whole and the socio-political conditions through which disparities in society are (re)produced.

While keeping these dangers in mind, we hope to generate new impulses for the critical study of processes of diversification with this working group by drawing on the wide range of works from Medical Anthropology, Medical History and Sociology.

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