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The Efficacy of Traditional Medicine: Current Theoretical and Methodological Issues

The efficacy of traditional medicine is an issue that continues to vex medical anthropology. This article critically examines how the efficacy of traditional medicine has been conceived, operationalized, and studied and argues that a consensus remains elusive. Efficacy must be seen as fluid and shifting, the product of a negotiated, but not necessarily shared, understanding by those involved in the sickness episode, including physicians/healers, patients, and members of the community. Medical anthropology needs to return to the field to gather more data on indigenous understandings of efficacy to counteract the biases inherent in the utilization of biomedical understandings and methods characteristic of much previous work. [traditional medicine, efficacy, indigenous peoples, Native Americans]

Medical anthropology continues to be vexed by the issue of the efficacy of traditional medical systems and practices. On the one hand, ethnographic narratives describing healing practices among peoples throughout the world often implicitly suggest that such practices "work" without detailing just what that means. On the other hand, studies of certain aspects of traditional medicine are often mired in Western scientific thought and employ a biomedical understanding of efficacy without comprehending the biases this engenders. The result has been a lack of consensus within medical anthropology about how best to understand efficacy.

The intent of this article is to critically examine how *efficacy* has been conceived and operationalized in the study of what is often referred to as *traditional medicine*. Related questions to be addressed include: (1) how has the conceptualization of efficacy been different for traditional medicine than for biomedicine? and (2) after many years of studying traditional medicine, what key issues remain unresolved?

The definition of *traditional* medicine remains problematic. Such medical systems are often described under the banner of "ethnomedicine," and while characteristically they include what has become known as "religious" or "ritual" healing (e.g., Csordas and Lewton 1998), they also include various techniques of manipulation

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as well as the use of herbs and other plant medicines. The transmission of medical knowledge is primarily through oral means. In this article, I am less concerned with studies of indigenous pharmacology and surgical practice than with other aspects of traditional medicine. Although I draw on literature pertaining to contemporary healing movements, such as Christian healing, I am particularly interested in those medical systems that have found themselves especially vulnerable to the colonizing influences of biomedicine. More specifically, I have in mind the medical systems of indigenous peoples such as Native Americans. The key point here is that these medical systems are often seen as culturally constructed, subjective, and primarily symbolic. They are counterposed against a universal, acultural, and empirical biomedicine, shrouded in a scientific "aura of factuality" (Rhodes 1996), especially when the issue of efficacy is debated. Many of the issues I raise in this article could easily contextualize our ongoing discussion of alternative or complementary medicine today.

I begin by revisiting the conceptualization of the disease/illness and curing/healing dichotomies, which, despite some operational and intellectual ambiguities, remains an essential ingredient in comprehending efficacy. I also examine some broader epistemological differences between biomedicine and traditional medicine. Some core questions are addressed along the way, such as (1) how do we define the "patient" in any treatment encounter? and (2) who has the authority to define efficacy and render judgment? I argue that there remains no singular way to look at efficacy and that restrictive definitions and the blind application of biomedical standards damage our ability to comprehend both traditional medicine and the healing aspects of biomedicine. The evaluation of efficacy can only be properly undertaken by combining all the perspectives of the actors in the sickness episode.

Curing, Healing, and Efficacy

The epistemological distinction between *curing* and *healing,* while reminiscent of elementary medical anthropology, is still at the center of controversies over the efficacy of traditional medicine. The terms are awkward and inadequate to explain the phenomena they seek to describe, and they are often used interchangeably and indiscriminately. Following the early lead of Eisenberg (1977), Foster and Anderson (1978), Harwood (1977), and Kleinman (1980) (see also Young 1979, 1983), it has become de rigueur to accept that *curing* refers to a primarily biological process that emphasizes the removal of pathology or the repairing of physiological malfunctions, that is, disease, while *healing* refers to a broader psychosocial process of repairing the affective, social, and spiritual dimensions of ill health or illness. Together they describe *sickness.* Singer and Baer have offered a critique of the disease/illness distinction, emphasizing it as "nothing other than a replication of the biomedical separation of 'signs' and 'symptoms' " (1995:22–23) that allows medical anthropology to eschew studies of disease as outside its parameters. This is an ill-informed view of medical systems that may stem as much from the ambiguity inherent in the terms *disease* and *illness* as from a deeper epistemological and ideological opposition to their construction.

While the distinction between disease/illness and curing/healing remains useful, it is erroneous to assume that biomedicine only "cures disease" or that traditional

medicine only "heals illness," or that they are completely distinct phenomena. It is also erroneous to assume that only illness, and not disease, is culturally constructed. Every medical system is a cultural system (Rhodes 1996) and is engaged in both healing and curing. While biomedicine appears to be more focused on curing and traditional medicine on healing, this may be either the result of differing epistemological approaches to the universality of human sickness and suffering or the result of a priori assumptions guiding research into the two different medical systems. In the case of the latter, for instance, much anthropological inquiry has focused on the ritual aspects of healing in traditional medicine. While it is not unusual for a "cure" to be pronounced immediately after treatment, this seems to be of less anthropological interest than the ceremonial and symbolic aspects of the treatment itself. In terms of understandings of efficacy, it behooves us to comprehend the intent of any medical intervention and to be clear whether we are discussing the effectiveness of curing, healing, or both, whatever the medical tradition.

McGuire's study of contemporary Christian healing in the United States is insightful. She notes that "to be healed is not necessarily the same as to be cured. It is common to have received a healing and still have symptoms or recurrences of illness" (1991:42–43). As she suggests, a crippled patient may be "healed" and remain crippled. Similarly, it is not necessary to have a biomedically recognized or diagnosed condition to be healed. The elimination of disease is not always the ultimate goal of traditional medicine. This is also true, of course, of biomedicine, but critics of traditional medicine often ignore this fact, leading to hypocritical allegations of charlatanism (e.g., Hines 1988; Randi 1989). The line between what might be termed "legitimate" and "nonlegitimate" healers becomes blurred; even a healer who uses outright deceit may nevertheless effect a healing if the patient is unaware of the deception and harbors a belief in the healing abilities of the doctor.[1] The key to this process is the manipulation of healing symbols, what medical anthropologists refer to as "symbolic healing" (Dow 1986; Moerman 1979, 1983). One of the most important symbols, following McGuire, is the naming of the patient's problem. Deceptively simple at first glance, identifying and naming the scourge is an essential step in healing and identifies the healer as one with the "power to establish order" (McGuire 1991:235) within the disordered context of sickness.

Another important aspect of this process of establishing order is the need to place the sickness and, therefore, the healing within a proper context. The idea of healing comprehends the social, economic, historical, and cultural context of sickness, perhaps more so than with curing (Crandon-Malamud 1991; Finkler 1994). Understandings of efficacy, for both the patient and healer, are likely to be imbedded within these broader parameters and may extend well beyond the locus of the sickness itself—that is, the patient. This explains why traditional medicine often involves other members of the community and why, sometimes, the patient may seem almost irrelevant (that is, in the eyes of the biomedical observer accustomed to the physician-patient model). Community healing, as among the !Kung, where the entire community joins during healing episodes, blurs the boundaries of the patient-healer relationship (Katz 1982). So, too, does the broader socioeconomic-historic context. Crandon-Malamud, in a study of Bolivian Aymara, argues that the patient in such a context is not a "Rational Man looking for medical efficacy; rather, he is a social and political animal who at times may be looking for meaning through efficacy which becomes a validation of some sociopolitical or economic

proposition, but more often is looking for efficacy through meaning in a sociopolitical and economic context" (1991:33). This, she adds, "also explains how the patient, and even the healer, can maintain contradictory ideologies at the same time" (1991:33).

Healing, therefore, appears at odds with the primary goals of biomedicine. It can be directed toward alleviating physical pain and suffering but often also concerns itself with repairing the emotional state, possibly even leaving the pathology itself unaltered. Healing can occur while the disease remains; healing can also help the patient deal with the medical problem, even prepare for death.[2] In this sense, healing becomes a means of coping with disease, distress, disability, and recovery. Much of the consternation that flows from efficacy studies is related to the confusion between healing and curing, which mirrors the confusion between disease and illness. Biomedical inquiry, erroneously accepting the universality of its model of disease and curing, simply assumes that the model is, or should be, appropriate to all other medical systems.

In this environment, then, understanding what is meant by *efficacy* is problematic. Young, conceptualizing *efficacy* in terms of goals, has defined it broadly as "the ability to purposively affect the real world in some observable way, to bring about the kinds of results that the actors anticipate will be brought about" (1976:7). This definition includes both hopes for what should happen and expectations of what will happen "regardless of whether or not the sick person's situation has been improved by the healer's activities" (1976:7). More specifically, Young has defined "medical efficacy" as "the perceived capacity of a given practice to affect sickness in some desirable way" (1983:1208), which he defines broadly as either "curing disease, or . . . healing illness." This latter distinction is characteristic of much of the efficacy literature, erroneously implying that the *healing* of illness and *curing* of disease are separate, unrelated aspects of the treatment of sickness.[3]

Young (1979) argues that efficacy should be determined according to at least three kinds of standards. "Empirical" proofs are anchored in the "material world" and confirmed by events that are explainable; "scientific" proofs are those confirmed through the application of scientific methods; and "symbolic" proofs, the most ambiguously defined of the three, pertain to the "ordering" of "events and objects" that give meaning to, and allow people to manage, sickness episodes. In their totality, what these standards tell us is that efficacy can be viewed from many different perspectives. Even within these types of proofs we must accept that definitions and determinations of efficacy are shifting within specific sickness episodes and more generally within the different medical traditions themselves. Furthermore, while Young's formulation implicitly suggests that his three types of proof are mutually exclusive, they are, in fact, often interrelated.

Nichter has probably come the closest to understanding efficacy from the differing perspectives of curing and healing. He suggests that "curative efficacy is generally defined as the extent to which a specific treatment measurably reduces, reverses, or prevents a set of physiological parameters in a specified context" (1992:226). This inherently quantitative understanding leaves little room for the role of the patient in assessing efficacy. But while it sounds very biomedical, a critical reading reveals nothing unique to biomedicine; that is, other medical traditions, including traditional medicine, may well be engaged in curative efficacy as so defined. These other medical systems may not, however, measure in the same

way that biomedicine does, and they may not share an understanding of physiological processes. But it would be folly to assume that they are unconcerned with physiological disorders and their elimination.

Nichter states that "healing . . . may or may not entail curing" and "involves the perception of positive qualitative change in the condition of the afflicted and/or concerned others" (1992:226). Healing efficacy, then, is defined in terms of the "symbolic aspects of a treatment . . . inclusive of placebo responses." Nichter rightly questions the extent to which curing and healing efficacy can be distinguished. Within the biomedical clinical encounter, the patient's assessment of the continued existence or elimination of symptoms is important information used by the physician when determining if a cure has been achieved. Similarly, healing is, in part, related to the assessments made by the physician regarding the patient's condition, based on, for example, elimination of external or objective signs of physiological disorder. Indeed, critical examination reveals that the boundaries between curing and healing are really quite unclear.

The view of the patient is not necessarily distinct or neatly separable from the view of the practitioner in any treatment encounter. These views often interact and affect each other. The physician/healer may ask how the patient is doing, and the response may help form the practitioner's determination of the success of the treatment. Similarly, the physician/healer may inform the patient about the success of any particular procedure or ceremony or the results of a test, which will factor into the patient's assessment of his or her condition. Practitioner and patient may or may not agree on the issue of the efficacy of the specific action taken. Efficacy, then, must be viewed as something that is essentially negotiated, in part, in each encounter of a patient and a practitioner in both biomedical and traditional medical systems.

Epistemological Issues

Biomedicine and traditional medicine represent somewhat different epistemological approaches to the problem of sickness for individuals and societies; this confounds studies of efficacy. Superficially, from a biomedical point of view, they may appear to share the same goals, that is, the "cure" of the patient. This apparent similarity renders it justifiable for biomedical standards to be used to assess traditional medicine, standards that are believed to be universal for defining and measuring "cure." An important and confounding fact in this assessment is the application of the supposedly culture-free language of science to what is clearly a cultural phenomenon. The use of biomedical concepts and the English language in examining traditional medicine tends to obscure the form and function of the latter. Even the basic concepts of *traditional* and *medicine* are fraught with Eurocentrism and English-language biases, and they may be little more than very crude approximations, at best, of complex indigenous thought. For example, within contemporary Native American societies, *medicine* has several possible interpretations. The word is a poor gloss for a complex comprehension of powerful, somewhat mysterious forces that guide the universe; but the word is also used by Native Americans today to describe both traditional and biomedical services. Furthermore, where it is possible to conclude with some confidence that "the intent and outcomes of ethno- and biomedical behaviors may be identical," as Etkin warns in a discussion

of indigenous pharmacopoeias, "the former cannot be explained with reference to 'alkaloids' and comparable language of biomedicine" (1998:307).

The continued use of concepts such as *health, illness, disease,* and *cure* may be artifacts of scientific inquiry into traditional medical systems. Adelson, for instance, in her study of the Cree of James Bay, Canada, noted that there is no Cree word that translates into the English word *health,* and she presents the Cree expression, *miyupimaatisiiun,* meaning roughly "being alive well" (1998:10). Adelson explains this as follows:

> "Being alive well," more specifically, is distinguished from "health" in that it draws upon cultural categories that are not intrinsically related to the biomedical or dualistic sense of individual health or illness. That is, the articulation of wellness is made in relation to factors that may be distinct from the degree of one's biological morbidity and are constituted from within as well as outside the boundaries of the individual body. Thus one might speak simultaneously of being both unwell yet feeling *miyupimaatisiiu.* [1998:10]

One can easily sense the frustration of the researcher trying to describe a Cree perspective using the English language and biomedical concepts. Yet, the uncritical use of supposed English language equivalents often leads to the erroneous belief that traditional medicine is inherently similar to, and therefore testable by, biomedicine (cf. Good 1994:23). This belief has parallels with, and ultimately derives from, the biomedical view that "diseases are universal biological or psychophysiological entities, resulting from somatic lesions or dysfunctions" (Good 1994:8). The cultural and individual expression of disease and illness becomes clinical noise that the biomedical practitioner must tune out in order to find the "real" problem. And, as Etkin notes, where biomedical criteria and testing actually result in the judgment that a traditional practice is efficacious, it is concluded that this is because "the indigenous model is not only functionally, but also conceptually, like that of biomedicine" (1988:309) (cf. Claus 1984:69).

The search for scientific or biomedical approximations in traditional cultures has a long history within anthropology; early investigations into such topics as "primitive surgery" and "primitive psychiatry" by influential ethnographers such as Erwin Ackerknecht and George Devereux long influenced thought on traditional medicine and how it should be investigated (Ackerknecht 1971; Devereux 1940; see also Kleinman 1980; Singer and Baer 1995). An example of this is found in Browner et al.'s investigation of *susto* (soul loss caused by fright, found among hispanic populations), wherein the researchers deliberately sought out features "amenable to bioscientific assessment" (1988:685), in part to identify areas of convergence and divergence between the two medical systems. Their conclusion, based on the use of bioscientific diagnostic criteria and methodologies, was that susto was "not a discrete illness within the bioscientific taxonomy of disease" (1988:686). This is a dangerous conclusion, for it not only reinforces the privileged position of biomedicine as the arbiter of efficacy, but it also precludes the possibility that a specific, biomedically measured outcome may be spurious.

The study of traditional medicine is further compounded by the fact that contemporary practitioners have often absorbed both lay Western and biomedical understandings of illness, disease, and treatment, and may even use the English language (or another national language) to convey these understandings

(Jones 1984; Landy 1977; Leslie 1976).[4] They may state, for instance, that they can "cure" a particular disorder. This phenomenon has been recorded among such disparate groups as Taiwanese shamans (Kleinman and Sung 1979) and northern Canadian Cree healers (Morse et al. 1987; Young et al. 1989). But rarely do researchers fully explore how the healers understand the concept of *cure* and the particular disorders they are treating to determine if their knowledge is indigenous, biomedically based, simple mimicry, or a combination. Csordas's (1989) examination of Navajo understandings of traditional "cures" for cancers suggests that Navajo understanding of these diseases is very different from that of biomedicine. In suggesting that cancers have a "mythic origin" often caused by lightning, the Navajo are articulating a perspective that clearly is outside the parameters of biomedical knowledge. Are Navajo and biomedical understandings similar enough to assume that when each speaks of a "cure" for "cancer" they understand both of these concepts in the same way? This is not likely, and therefore we must also question if it makes any sense to assess Navajo treatments using biomedical criteria and standards.

The biomedicalization of traditional medicine,[5] involving the incorporation and use of biomedical language and technology by traditional medical practitioners, is not a surprise in a postcolonial era of globalization.[6] Many clients of traditional medicine have come to expect this, and healers no doubt have implicitly, if not explicitly, acknowledged the power and reach of biomedicine in their own practices. Therefore, they may speak of "diseases" and "cures" in biomedical terms without comparable biomedical understanding. This appropriation of biomedical language leaves traditional healers open to scrutiny by biomedicine; if a healer says he or she can "cure psoriasis," as in the Cree project cited previously, it makes sense that biomedical standards of efficacy might be appropriate, but only if the healer understands both *cure* and *psoriasis* in biomedical terms. In the Cree case, the healer selected psoriasis from photos of skin disorders in a medical text, applied a Cree name to the condition, and noted that the Cree grouped the condition with other skin disorders, such as excema. There is little here to suggest that he understood the condition as biomedicine does, despite his use of the language.

Inefficacious Practice and Failure

This brings us to the issue of inefficacious practices. By this I do not necessarily mean practices that cause harm, but, rather, the existence and conceptualization of failure within traditional medical systems. Early theorists such as James Frazier and Emile Durkheim often argued that ritual, an essential ingredient in many aspects of traditional medicine, always achieved desired outcomes (Ahern 1979). More recently, Kleinman once boldly asserted that traditional healers "must heal" because "they provide culturally legitimated treatment of illness" (1980:362) and not the treatment of disease; he subsequently recanted (Kleinman and Gale 1982). Nevertheless, Kleinman's initial assertion was tied to a broader view within the field that efficacy was always culturally defined to ensure "success." "Failure," to the extent that it existed at all, was believed to be typically explained in a way that left the underlying epistemology of the medical system unchallenged. This is false insofar as it implies a lack of empiricism; certainly, individual failures might be

rationalized, but such failures are essential to the empirical nature of all medical systems.

The related view—that the perpetuation of traditional healing practices through time was a priori evidence of their adaptive function (e.g., Alland 1970)—has also been challenged (e.g., Edgerton 1992). According to Young, "The point that traditional practices persist because people believe they are efficacious should not be pushed too far, however. Even in traditional communities there are occasions when people are not wholly convinced by empirical evidence, and the persistence of certain medical practices owes more to the absence of alternatives than to people's strong beliefs in their efficacy" (1979:71). Indeed, Young (1977) notes that medical practices are not always expected to achieve a cure or prevent sickness and that skepticism is very much a part of traditional medicine.

This observation leads naturally to two possibilities. First, specific practices within medical traditions may be designed to do something other than cure or heal a specific individual (the "patient"). Second, failure is an essential component of the empiricism inherent in all medical systems: it can be rationalized in a way that deflects a challenge to the legitimacy of the system itself, and it can also lead to a refinement of understandings of disease and illness, as well as specific medical practices. Failure in treatment can be readily pinned on the practices employed (Young 1979). Failure also exists as a test of physician/healer skill, allowing for the emergence of specializations and a hierarchy of practitioners in which some are known to be more successful for specific problems than others, and in which notions of incompetence and malpractice can be developed. The key point here pertains to the definition, function, and significance of *failure*. Traditional medicine, like biomedicine, must have failures, especially if new knowledge is to be developed, and in this sense the two systems are more similar than not.

Only a few studies have looked at conceptions of failure within traditional medicine (e.g., Finkler 1985; Waldram 1997), and fewer still theorize the possibility of incongruities between intended and actual effects of healing activities (e.g., Ahern 1979).[7] This may be a reflection of what some critics have argued is the overly romantic relativist tendency within medical anthropology to avoid seemingly negative studies of traditional medicine (e.g., Eisenberg and Kleinman 1981; van der Geest 1988). However, in order to properly understand efficacy, it is essential to both comprehend what constitutes a lack of efficacy and examine specific instances of failure alongside those of success. Furthermore, success in achieving a desired or predicted outcome in any specific case is only a small part of the explanation for the perpetuation of the practice itself. As with biomedicine, single cases within traditional medical systems are viewed not as isolates but, rather, within the context of many other similar cases over time. It is essential that we comprehend the empirical nature of these medical systems and escape the lingering bonds of the antiquated view that traditional medicine can only be understood in terms of religion, superstition, and magic (Foster and Anderson 1978:5–6).

The Time Frame for Determinations of Efficacy

What is the appropriate time frame in which the determination of success or failure (or judgments of other types) is made? At what point can a determination be

made that a patient is free of disease (i.e., has been cured) or has reachieved personal and social balance and harmony (i.e., has been healed)?

Etkin correctly argues that "one of the most formidable obstacles to full comprehension of efficacy and other characteristics of indigenous medical systems is the failure to understand healing as *process*" (1988:301). Her distinction between proximate and ultimate effects is particularly useful. Proximate effects refer to some physical sign that the "curing/healing" process is under way, such as a reduction in fever. The ultimate effect may be the restoration of health, perhaps the complete remission of the disease. Efficacy could be assessed at either stage. But healing may also be a lifelong process in which total recovery, however understood, is never achieved. Religious or spiritual healing, in particular, often promotes the need to continue a certain lifestyle until death as part of one's healing (McGuire 1991; Waldram 1997). Healing, therefore, is best understood as involving a possible myriad of phases or stages through which varying determinations of efficacy may be made, perhaps with ever changing criteria and definitions of efficacy. In describing symbolic healing, Kirmayer articulates a form of therapeutic process not usually resulting in "the grand sweep of healing transformation" (1993:176) that we might think of as a graphic, unequivocal display that a person is better. Instead, we witness "the small turns of thought and feeling" that accompany the process. These small turns may not be visible to the clinical eye. Similarly, Csordas suggests the existence of "incremental efficacy" (1996:106), the view that assessments of efficacy are shifting, often building on one another over time.

The dilemma, then, is to identify the precise stage at which efficacy can logically be assessed. This is hardly self-evident in traditional medicine. Biomedicine has developed precise technology to determine the presence and absence of many pathologies and is prepared to pronounce a cure; in contrast, traditional medical systems are often more circumspect (and perhaps humbler) in their pronouncements. While success may be pronounced immediately after an intervention (for instance, after an object has been removed from the body by sucking), healing is often seen as a longer process, even lifelong, without a logical end point. Whereas biomedicine can confidently declare a patient cured after a period of time in which no disease pathology is evident (for example, the five-year benchmark used for some cancers), traditional medicine often views linear time as irrelevant. In many ways, the pronouncement of a cure within biomedicine is arbitrary and is done to precipitate a redefinition in the relationship between the physician or medical system and the patient, including the termination of the relationship completely. The cured individual need not continue his or her relationship with the physician. The need to pronounce a cure may be partly a consequence of the modern biomedical business, as it becomes important to the management of health resources, for example, the freeing of hospital beds, as well as for the medical economy (the paying of physicians, insurance claims, and research grants). Perhaps the European model that most closely approximates the approach of much traditional medicine would be the 12-step philosophy of addictions treatment, such as that promoted by Alcoholics Anonymous. An individual in these programs is never "cured" and is encouraged to admit to the need for a lifelong process of healing.

Studies of traditional medicine that have focused on the views of patients or healers immediately following treatment (i.e., proximate effects) have been criticized because of a biomedical belief that certain emotional or biochemical reactions

to the healing experience (which is often very dramatic) are short-term and do not indicate a permanent reversal or recovery in the patient's condition (i.e., ultimate effects) (Finkler 1980; Kleinman 1980; Kleinman and Sung 1979). It has been argued that follow-up studies are necessary to determine if healing "really" took place. There are two problems with this position. First, any short-term improvement in the patient's condition should not be dismissed as insignificant or unimportant. Second, implicit in these critiques is the view that there is, indeed, a logical point in time after treatment at which efficacy can be determined, at least by biomedical standards. Just how that point is established never seems to be addressed, but this sometimes appears rather opportunistic on the part of researchers.

Determining the "Patient"

Who is being treated in any medical encounter? Are medical systems designed to treat individuals, collectivities, or both? These are considerably more complex questions than they first appear (Laderman and Roseman 1996). Efficacy studies tend to focus on the singular human patient as the locus of healing, the "individual body" within the schema presented by Lock and Scheper-Hughes (1996). But the patient-physician/healer model, as the core of therapeutic treatment, is not universal.[8]

Even within biomedicine, the clinical treatment of patients often includes several related individuals. Obvious examples are the preventive treatment of family members exposed to a tubercular individual, relieving the anxieties of individuals who have a family member suffering from a serious disease, and group psychotherapy.

But what of the "social body?" Many traditional medical systems contain etiological explanations that situate the genesis of sickness within the social realm, in the relations among people, animals, animated objects, and the cosmos. It is common for sickness to be differentiated into two distinct (though often related) treatable realms, etiology and symptomatology; understandings of etiology in particular often require treatment that extends beyond the individual and into the "social body." Atkinson has suggested with respect to Indonesian shamanism that "the relation between a ritual's symbolic action and its therapeutic benefits may be neither obvious nor direct. . . . The ritual under question simultaneously addresses patients and a wider audience as well" (1987:353). The author's own experiences with Native American healing ceremonies involving the sweat lodge suggest that, while one individual might be conceived of as the "patient," the lodge often fills with other individuals who experience a kind of residual or collateral healing by virtue of their exposure and participation. In this sense, the healing itself may only be tangentially directed toward a designated individual.

Perhaps this situation is simply too complex for those who study efficacy. The site of curing/healing is normally thought of as the individual body, a designated "patient." Collateral healing, or the healing of individuals other than a designated patient, and the simultaneous treatment of many individuals are characteristically omitted from efficacy studies. Where healing, or even a biomedical clinical encounter, involves individuals other than the physician/healer and patient, then the potential for collateral healing exists.

The Authority to Determine Efficacy

Precisely who is authorized to undertake the assessment of efficacy? Whose view of efficacy should be given primacy, if anyone's? With few exceptions (e.g., Lewis 1993), medical anthropologists often privilege the external, objective perspective supposedly offered by the researcher/scientist. But the clinical/healing encounter involves several actors, typically a patient and a healer/physician. There is no reason to believe that these two would have congruent views on the efficacy of specific treatments for specific problems, since the personal experience of suffering from an illness or disorder is distinctly different from the experience of good health, and the patient is a distinct individual from the physician/healer. Other individuals may also participate in the determination of efficacy; these may be members of the patient's family, friends, other members of the treatment team, or even the whole community. The views of these individuals, grounded in the quotidian experience of the sickness, can be contrasted with that of the scientist, detached from both the patient and healer, who undertakes deliberate outcome studies of specific treatments. Here, Young's distinction among scientific, empirical, and symbolic efficacy is useful, for he notes that "while the form in which scientifically and empirically efficacious practices persist ultimately depends on how they are believed to affect the sick or those threatened by sickness, the persistence of symbolically efficacious practices depends on how they affect *all* the people who participate in sickness episodes" (1979:70).

Determinations of efficacy, then, are made in different ways by different actors in the sickness episode. Each actor occupies a unique position, with unique and often very personal perceptions, experiences, and motives from which he or she draws as efficacy is negotiated. Very different views of the anticipated and actual outcomes of treatment, or the state of the patient, will emerge from this complexity.

The ethnographic approach has led to the development of rich data on the cultural context of traditional medicine, etiological understandings, and treatment techniques. Perhaps surprisingly, little attention has been paid to healers' views of efficacy, both generally and in case-specific instances. The role of significant others in assessing efficacy is even less evident, likely subsumed within more general ethnographic descriptions of healing offered by cultural informants and without reference to specific cases or sickness episodes. The research focus has been on subjective assessments by patients or external assessments by research scientists.

Finkler's (1980, 1985) pioneering study of Mexican spiritualist healers is representative of the "patient-perceived" approach to assessing efficacy and remains one of the most comprehensive studies to date. Her effort was "not to ascertain therapeutic results by employing scientific standards of evidence" but, rather, to deal "only with illness, impaired functioning as perceived by the patient within a cultural context" (1980:274–275). Patient perceptions of outcomes were gathered using two primary methods. The first was the Cornell Medical Index (CMI), which, at the time of the study, was a tool widely used in cross-cultural research to assess health status. Finkler was aware of the potential problems in using the CMI and presented a detailed explanation of its advantages and disadvantages in the research. Patients seeking healing were interviewed at a healing temple using this instrument and then again several days later in their homes. During the second session, a

"directed interview and open-ended discussion" was also used (Finkler 1985:276). The results revealed strong congruity between the CMI and interview data on the question of success or failure of treatment. However, it is possible that this congruity is explainable by the fact that both the CMI and the process of "directed" interviewing of patients were themselves congruous techniques with a strong biomedical underpinning; the directed interviews simply may have been another way of administering the CMI. Insofar as patient perceptions are mediated by a biomedically based instrument or interview approach, we may be no further ahead in understanding the efficacy of traditional medicine.

McGuire's (1991) view of Christian healing is also appropriate to this discussion of traditional medicine. Like Finkler, McGuire defines success in terms of the perceptions and interpretations of the patients themselves; this is perhaps the most common means of assessing efficacy. Similar to the point made earlier by Young, McGuire notes, "Participants have a sense that their healing system 'works' when a sickness episode is consistent with their expectations. . . . Insofar as these alternative healing systems adequately match adherents' expectations with their experiences, they 'work' " (1991:189). Expectations, of course, are developed by the individual patient based on prior knowledge of both healing specifics and broader cultural understandings. But this personal understanding of efficacy does not distinguish traditional or alternative medicine from biomedicine. In the latter, patients enter the clinical context with an array of expectations, and the extent to which these are met will possibly influence compliance with the physician's instructions, judgments of efficacy, and whether another physician, or alternative, will be consulted.

Studies by Kleinman (1980), Kleinman and Gale (1982), and Kleinman and Sung (1976) represent the perspective and problems inherent in the scientific investigation of traditional medicine. These studies argued for the rejection of "subjective" or patient-centered assessments of efficacy. As discussed earlier, it is argued that patients often say they feel better after traditional treatments, only to relapse, and that some patients who subjectively reported no symptom change, or even a deterioration, sometimes still report that the treatment was successful. For these researchers, there seems to be very little variability with respect to efficacy when seen through the lens of traditional healers and their patients: in other words, everybody heals.

In an effort to eliminate this type of self-serving subjectivity, research scientists often suggest that it is essential that studies of efficacy emanate from a point of reference external to the patient/healer relationship; this point is characterized as the objective research scientist. Kleinman and Gale (1982) attempted this in a Taiwanese study. Not surprisingly, however, their study was inherently biomedical. Patients were assigned to "sickness classes. . . . [b]ased upon biomedical assessment by the public health nurse utilizing history of present illness, clinical evaluation of symptoms and signs, and medical records when available" (Kleinman and Gale 1982:407). The efficacy of both traditional and biomedical treatments was then assessed through subjective patient assessments and through assessment by biomedical staff. The biomedical bias that pervaded the study was partially acknowledged by the authors, including the existence of antitraditional medicine sentiment among some research staff. But this does not excuse the existence of the bias: traditional treatments were categorized using biomedical criteria and assessed

by biomedical staff. The inclusion of patient views in assessing efficacy does not free the study from biomedical biases: as noted earlier, patient assessments, when offered in response to inquiries from scientific researchers, are partially artifacts of the interviewing process and may be significantly different from patient assessments made for purposes of selecting and evaluating treatments for the restoration of health.

The conundrum becomes clear: both the biomedical assessment of traditional medicine outcomes and the scientific study of patient and healer assessments of efficacy are problematic. The focus on symptom removal in patient-centered approaches represents a biomedical concern with symptoms and somatic expressions of *dis*-ease. This ignores the apparent fact that traditional medicine may pay little attention to symptom removal and still be considered successful by patients. As Csordas has suggested, religious or symbolic healing systems "[do] not necessarily include removal of symptoms, but change in the meaning the patient attributes to the illness, or an alteration of the patient's lifestyle" (1983:334). The concern with both signs and symptoms in efficacy studies provides convenient tools for measurement, but do biomedically recognized signs and symptoms have the same or any meaning within the cultural context of the medical tradition under study?

It is essential that we conceive of efficacy not as a fixed concept anchored to a singular perspective of health, illness, and disease, but, rather, as something that is constantly shifting and being negotiated between the various role players in the sickness episode. The existence of medical pluralism, where individuals have access to many different types of medical practitioners and systems, often leads to serial and simultaneous utilization (Garrison 1977; Press 1969; Romanucci-Ross 1969; Waldram 1990; Woods 1977); this implicitly supports the notion of a fluid conceptualization of efficacy. In this sense, neither the patient nor the physician/scientist/healer has the sole voice in how efficacy is defined and when it has been achieved in specific circumstances. The same sickness episode may be simultaneously characterized by different interpretations of both the meaning and current status of efficacy. Young asserts that "people do not know all of their medical facts in the same way" (1981:326), and I would add that this holds for both patients and physicians/healers. Community and cultural knowledge of these "medical facts" is similarly ambiguous. This would include even the affirmation of healers by the community. As Garro (1990) has described for a Canadian Anishinaabe (Ojibwa) community, there is often a lack of community consensus on the identity of traditional healers, their skills and specialties, and their adherence to community/cultural standards. Similarly, Etkin and colleagues (1990) have described the existence of broadly based knowledge of diagnostics and treatment among the Hausa and a lack of consensus concerning indigenous plant medicine nomenclature. The notion of efficacy, then, is hardly based on any fixed and shared understanding of the various components and principles of specific medical systems. Efficacy is inherently ambiguous, perhaps purposefully so.

Issues of Power and Hegemony

The power and authority of science and biomedicine are beyond doubt, having been recognized by such disparate authors as Foucault (1973) and Kleinman

(1995). What is significant here is how biomedical hegemony has affected our understanding of the efficacy of traditional medicine.

The argument that the controlled clinical trial is the only bona fide mechanism through which to determine efficacy seriously affects our ability to understand traditional medicine. This "gold standard" asserts that efficacy should be assessed through clinical experiment, involving the random assignment of subjects to therapeutic and control groups, the "double-blinding" of both patients and researchers, and the use of sufficient numbers to allow for statistical analysis (Anderson 1992). Statistics, rather than human experience, become the only acceptable means through which efficacy can be established. Studies of traditional medicine that do not employ the gold standard or that assess efficacy in culturally meaningful terms tend to be quickly dismissed as unscientific romanticism (Edgerton 1992; Eisenberg and Kleinman 1981; Hahn 1995). When there is an attempt to use the controlled clinical trial, as in the northern Canadian Cree study discussed earlier, the result is invariably ambiguous or, more likely, negative. This is not surprising for a variety of reasons. It is easy to argue that the practice of traditional medicine is altered when removed from its own cultural and situational context. However, the more significant issue is the possibility that research studies are often looking for indicators of efficacy that are different from those being sought by the patient and healer. Furthermore, in arguing that the clinical trial is the only means to assess efficacy, biomedicine is insisting on a standard that it itself fails to meet in contexts parallel to the practice of traditional medicine.

Most studies of traditional medicine have actually been studies of grounded clinical treatment and not clinical trials. That is, the healer and patients have usually been studied in situ. This, however, does not immediately avoid the broader methodological issues identified in the previous paragraph. Here, the healer diagnoses and treats patients who come to him or her in an unsystematic way, with a variety of complaints and a variety of intentions to accept and comply with the healer's understandings and instructions. The biomedical parallel to this is not the controlled clinical trial, but the actual clinical encounter between physician and patient, in which a whole host of factors come into play in the diagnosis and successful treatment of patients (such as compliance, ability to afford medical care, and even individual physician competence). It is essential that we distinguish medical *science* from *practice,* as Young (1979) reminds us. Since medical science is "produced for and evaluated by the community of medical professionals and researchers," it is clearly different from the actual practice of clinical medicine, in which "clinical exigencies and other circumstances often make scientific standards of proof impracticable and unnecessary" (Young 1979:78). Similarly, Good cautions that "questions of the efficacy of clinical medicine, especially as practiced in much of the world, are often quite distinct from the truth claims of biomedical science, and the same is even more true for other forms of healing" (1994:28). In fact, as Gordon explains, there is a profound lack of science in both medical research and clinical practice (1988:260–261).

The dilemma is clear: to employ a controlled clinical trial necessitates the removal of traditional medicine from its proper cultural context, but to assess it in situ using the criteria of the controlled clinical trial applies a standard that biomedicine does not normally apply to itself. The existence of a double standard in the assessment of traditional medicine, as well as within biomedicine itself, is apparent

(Lewis 1993). Furthermore, as Good has argued, "grounding cross-cultural analysis on practices current in contemporary biomedicine may produce findings more apparent than real" (1994:23).

A consequence of biomedical hegemony has been the dismissal of what may be the most significant aspect of traditional medicine: the placebo effect, "one of the most powerful tools in any healer's armamentarium" (Laderman and Roseman 1996:7). Rather than accepting the placebo as evidence of a therapeutic "general medical effect" (Moerman 1983), a profound example of the ability of the body and mind to work together to achieve healing, the placebo is rendered "illegitimate" and is expelled from the controlled clinical trial. "Placebo effects," writes Sullivan 1993:229; "are marginalized as unexplainable and therefore always somewhat unreal healing phenomena" (1993:229; see also Hahn 1995:96). One of the main pieces of evidence for the efficacy of traditional medicine is therefore ruled inadmissible. Without conceptualizing (and, I would argue, reconceptualizing) the placebo as central to our understanding of healing (cf. Dow 1986; Kirmayer 1993; Moerman 1979; Waldram 1997), it becomes impossible to understand the efficacy of traditional medicine.[9] But it is naive to assume, as Kleinman suggests, that biomedicine simply chooses "not to elaborate nonspecific therapeutic sources of efficacy that are associated with the rhetorical mobilization of the charismatic powers of the healer-patient relationship that persuade patients and families to believe in successful outcomes and thereby enact scenarios of efficacy" (1995:33). The dismissal of the placebo is an intentional act and part of biomedicine's quest to identify those aspects of human experience over which it can claim authority and therefore assert control.

Traditional medicine in many countries remains outside the direct control of the state and biomedicine, but not unaffected by it. Traditional medicine becomes one element of "rejected knowledge," as Laguerre describes it, "to be ridiculed by the larger society, downgraded by the school system, attacked in the religious propaganda of established churches, and sometimes outlawed by the state" (1987:11). Native American medicine in both Canada and the United States has experienced such rejection, from the banning of the Plains Indian Sun Dance and the Northwest Coast healing ceremony known as Spirit Dancing *(tamanawas)*, (Bracken 1997; Pettipas 1994; Waldram et al. 1995), to prohibitions on the use of peyote by the Native American Church (Aberle 1982; Anderson 1996), to broader government- and church-sponsored programs of assimilation. Laguerre argues that the continued existence of Afro-Caribbean folk medicine "must be seen within the political context of western science, where political power is a key to legitimacy" (1987:11). "The status of rejected knowledge," Laguerre also suggests, "relies more on questions of power than on standards of truth and effectiveness" (1987:11).

The power and hegemony of biomedicine can be seen in still another way. In Western countries it is typical for the state and biomedicine to be intimately supportive of one another. Biomedicine has been able to claim the role of official supplier of health services to the populace, a role it protects with diligence. Strong professional organizations representing biomedicine and acting through the publication of scientific journals maintain the hegemony, in part by actively investigating the claims of alternative medical traditions.[10] In return for handling the medical matters of the state, the state offers legal protection. What constitutes the lawful practice of medicine is defined, and the state provides sanctions (by way of legal codes, courts,

and prisons) against those who violate biomedical codes of appropriate practice, codes that are applied to individuals regardless of the medical tradition within which they operate.

The "body politic" as "mindful body" (cf. Lock and Scheper-Hughes 1996), consisting of both biomedicine and the state, provides the framework that allows biomedicine to define efficacy and the procedures through which it will be determined. Here, Kleinman accurately states, "Thus, in the postmodern state, biomedicine has come to serve a major political mission. . . . [It] has outstripped its own professional autonomy and become inseparable from the state" (1995:39). The logic becomes teleological: lawful, and therefore real, medical practice largely becomes practice provable by biomedicine to be effective in ways that biomedicine understands. The current dance between biomedicine and the "complementary" therapies in North America should be seen primarily as evidence of the still incomplete hegemony of biomedicine in its efforts to eliminate or control the competition.[11] If anything, biomedicine's concern with these therapies has diverted attention away from traditional Native American medical systems, providing something of a respite from the law, but not from the scientist. Nevertheless, a traditional healing ceremony occasionally finds itself under assault from the Western legal system.

A revealing example of this occurred several years ago in British Columbia. In a civil action, the plaintiff, a member of the Coast Salish people but by his own admission not a follower of their ways, sued several Salish healers who forcibly initiated him into the Spirit Dance. Suffering from problems associated with alcoholism, the plaintiff had become estranged from his wife who, following Salish custom, requested that the healing take place. The healing ceremony was undertaken without the plaintiff's consent, but in accordance with Salish tradition. The court report described a rite that could only appear primitive to outsiders and devoid of any therapeutic efficacy, if not actually harmful: the plaintiff was "lifted up horizontally by eight men, who then took turns digging their fingers into his stomach area and biting him on his sides;" he was forced to fast for four days, was made to bathe in cold stream water, and was "whipped or beaten with cedar branches, hard enough to raise welts on his skin" (cited in Waldram et al. 1995:223; see also Denis 1997). The judge agreed with the plaintiff that he had not experienced healing under Salish custom but, rather, "assault, battery, and false imprisonment" under Canadian law and awarded him damages. In his ruling, the judge asserted that the rights of the individual are inviolable and that no one can be "coerced or forced" to believe in or practice any religion or tradition. The collective right of the Salish people to heal one of their own was subservient to the right of the Canadian state to define lawful medical practice and to impose its view that the individual, not the collective, is the basic unit of legal citizenship.

If biomedicine has become inseparable from the state, as Kleinman asserts above, then are medical anthropologists who examine the efficacy of traditional medical treatments through the use of biomedical concepts and measurements inadvertently serving the interests of the state and the biomedical system? If we accept that all medical systems, including biomedicine, are culturally constructed, then the answer is yes. We must be aware of the potential implications of negative studies of efficacy derived from the use of inappropriate methods. It becomes necessary to reject Gilbert Lewis's assertion that, in studying traditional healing,

"the anthropologist has staked a claim in a field [science] where people look for facts and want to use objective criteria" (1993:194–195) and that therefore efficacy studies should be judged according to scientific standards. We need to reconceptualize the field so that traditional medicine can be evaluated on its own terms. A broader view of efficacy is essential to this task.

Conclusion

There is no singular view of efficacy. It is a complex concept, and there is a tendency to speak too glibly about it without excavating the biases and intricacies that inform it. The efficacy of traditional medicine is still a contentious issue among medical anthropologists, many of whom seem unable to escape the influences of biomedical science and many of whom lament the relativist, some say postmodern, influence on ethnographic research and writing.

Determining the efficacy of specific treatments in any medical system is problematic both conceptually and methodologically. The conclusion that emanates from this analysis is that the absence of a consensus on the nature of efficacy is a logical outcome of the many divergent views that have been brought to bear on the issue. I have tried to emphasize that an examination of key issues, such as how efficacy is defined, who makes the determination, who is the subject of the healing, and at what point in time a determination can be properly made reinforces the view that efficacy is shifting and fluid, shared among many role players who do not necessarily exhibit the same views, and whose views may develop or change through time. Perhaps the greatest problem in efficacy studies to date has been that they often measure very different things in very different ways and for very different purposes. Who the researcher is trying to convince (e.g., anthropologists or medical scientists) clearly influences the methods used.

The search for a universal comprehension of efficacy appropriate to all medical systems has not been fruitful. Rarely have indigenous understandings and methods compatible with those understandings been included in studies of traditional medicine, and this represents both a significant gap in our research as well as perhaps the most promising avenue to explore as we continue to grapple with the riddle of efficacy. Medical anthropological inquiry needs to return to the field, to explore and comprehend how efficacy is understood within traditional medical systems themselves. The current propensity to employ biomedical concepts and methods, to search for apparent biomedical parallels within traditional medical systems, or to fixate on biomedical terminology that might have intruded into these systems often leads to a false sense of our ability to assess traditional medicine's efficacy. Scientific inquiry often leads to the creation of biomedical artifacts masquerading as universal truths.

It would be folly to advocate at this time that there is a "perfect" study of efficacy. Young's delineation of empirical, scientific, and symbolic proofs remains the best starting point. However, as argued in this article, we need to better conceptualize how these various measures of efficacy relate to and affect each other within both cultural and temporal contexts. We need also to come to grips with the fact that the definition of efficacy itself is not fixed and will shift throughout a sickness episode. Efficacy is a moving target, and it behooves medical anthropologists

to restrain themselves from the temptation to make efficacy studies easier by arbitrarily anchoring them in a specific culture, time, place, or situational context.

NOTES

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1. The legitimation of physicians/healers often involves some process of certification or validation. There have always been cases of individuals lacking such legitimation who nevertheless have developed effective clinical or healing skills.

2. There are some interesting similarities between traditional medicine's approach to death and biomedicine's emerging understanding of the needs of palliative care patients. This comparison has not yet been fully developed in the literature to my knowledge.

3. Young (1983:1208) does note that a medical intervention can combine both curing and healing components, but it is unclear if these are separate and distinct components or aspects of a single intervention.

4. Press (1978), in a publication that is still valuable for its insights, characterizes traditional medical systems as relatively "open," that is, more accepting of new, alternative, or foreign ideas, in comparison to the relatively "closed" nature of biomedicine.

5. Compare this notion of biomedicalization of traditional medicine with Kleinman's (1995:24) and Etkin et al.'s (1990) description of the indigenization of biomedicine. According to Kleinman, biomedical practitioners are often influenced by local cultural norms, beliefs, and practices. Etkin et al. demonstrate how the use of biomedicine can be influenced by indigenous understandings of disease and treatment. These views are in obvious contrast to those of Press (see note 4).

6. Much of my discussion here could also be applied to the "alternative" or "complementary" treatment modalities common in North America, which employ biomedical language and concepts while espousing very different philosophies and principles regarding health, illness, and healing. It is possible that the employment of biomedical language by traditional healers is a step toward the eventual transformation of traditional medical systems into systems that look more like these alternative therapies.

7. Etkin (1992, 1994) has examined the cultural construction of "side effects," therapeutic effects unrelated to the objective of treatment. Side effects are often, though not always, seen as undesirable. Although the concept of *side effects* is different from my notion of the failure of therapeutic techniques to produce anticipated outcomes, it is clear that the study of side effects adds much to our understanding of all medical systems. There has been very little research done on the construction of side effects within traditional medical systems, aside from the work of Etkin cited above.

8. A related question, of course, would be "who is the 'healer?' " In both biomedicine and traditional medicine, clinical teams and multiple practitioners are often involved in treatment. Community and family members usually also have a role to play, as do religious practitioners. This is an important issue but beyond the scope of this article.

9. Given the dissatisfaction of patients generally with biomedicine, and the use of "alternative" or "complementary" therapies, perhaps the placebo could be characterized as a remnant of an earlier, "traditional" medical system, unconsciously labeled by biomedicine as primitive and in need of elimination.

10. McGuire (1991:8), for instance, notes that the American Medical Association funds an agency that investigates "quacks" and aids in their legal prosecution.

11. In an editorial accompanying Eisenberg et al.'s report "Unconventional Medicine in the United States" (1993), Campion warns that "the public's expensive romance with unconventional medicine is cause for our profession to worry" (1993:283). A companion editorial to a similar Canadian study (Millar 1997) argued that "alternative practices should continue to be carefully combed for those that can pass scientific scrutiny. . . . The burden of proof remains on the proponents" (Beyerstein 1997:150).

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