

1 Policy Formation and Debate Concerning
2 the Government Regulation of Ayurveda in
3 Great Britain in the 21st Century

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5 [Draft of 2 Oct 2004]

6 **Abstract**

7 Since 2000, the British House of Lords and the Government have
8 been working towards a regulatory scheme for Complementary and
9 Alternative medicine in Britain, a scheme that will include ayurveda.
10 The present paper discusses these regulatory moves by the Govern-
11 ment, and suggests that shortcomings in the range and type of evi-
12 dence taken into account by the various Government agencies will leave
13 a legacy of difficulties for CAM practitioners and their patients.

14 **The House of Lords Select Committees**

15 The House of Lords, the upper house of the British Government, has the
16 power to appoint ‘Select Committees’ which return reports on particular
17 topics on which the Government requires specialized information and judge-
18 ments.¹ Past committees have reported on such topics as the use of animals
19 in scientific experimentation, the monetary policy of the Bank of England,
20 and religious offences in England and Wales.² The House of Lords Se-
21 lect Committee on Science and Technology was established in 1979 with
22 a broad remit ‘to consider science and technology,’ and it works in the fol-
23 lowing fields:³

- 24 • Public policy areas which are, or ought to be, informed by scientific

¹See ‘General Information about House of Lords’ Select Committees’ at <http://www.parliament.the-stationery-office.co.uk/pa/ld199697/ldselect/ldscgen.htm>.

²For a list of topics, see <http://www.parliament.the-stationery-office.co.uk/pa/ld/ldselect.htm>.

³See <http://www.parliament.the-stationery-office.co.uk/pa/ld200102/ldinfo/infonote.htm>.

25 research: e.g. health effects of air travel, complementary and altern-
26 ative medicine, legal status of cannabis.

27 • Technological challenges and opportunities - existing and future -
28 which government faces or ought to face: e.g. resistance to antibi-
29 otics, management of nuclear waste, human genetic databases, in-
30 novations in microprocessing, and the implications of digital imaging
31 for the law of evidence.

32 • Public policy towards science itself, e.g. as it affects Research Coun-
33 cils, schools and universities, public sector research establishments
34 and industrial research and development.

35 Its work is principally carried out through Inquiries. Each Inquiry is conduc-
36 ted by a subcommittee of specialists and prominent establishment figures,
37 and leads to a report, published together with the evidence on which it is
38 based, setting out the subcommittee's findings and making recommenda-
39 tions to the Government and others. Some of the reports appear in print,
40 and an increasing number also appear on the internet.

41 The Government does not always accept the main recommendations
42 of a subcommittee's reports. This happened, for example, with the report
43 'Cannabis, The Scientific and Medical Evidence.' This report recommended
44 that cannabis should be legalised for medical use, and although this was re-
45 jected by the Government at the time, the Lords felt, rightly, that report had
46 raised the profile of a difficult issue and given encouragement to research,
47 which is now well under way.

48 *The House of Lords Select Sub-Committee on CAM: 1999–2000*

49 In the 1999–2000 session, the The House of Lords Select Committee on Sci-
50 ence and Technology produced six reports, the last of which was entitled
51 'Complementary and Alternative Medicine' (henceforth the 'Report').⁴ In
52 this report, a Lords sub-committee set themselves the immense task of char-
53 acterising all aspects of Complementary and Alternative Medicine (hence-
54 forth 'CAM'). In their report they attempted to survey the use of CAM in
55 Britain and and the USA, they examined the topics of patient satisfaction,
56 the role of the therapist, the placebo effect, the evidence for efficacy and
57 safety, statutory- and self-regulation, professional training and education
58 of practitioners, research and development in CAM (including methodo-
59 logy and funding), public information dissemination, and CAM health-care

⁴House of Lords Select Committee on Science and Technology 2000.

60 delivery. The report included appendices on randomised controlled test-
61 ing, and accounts of visits to particular CAM centres. The Committee was
62 chaired by Lord Walton of Detchant, and consisted of a number of peers.⁵
63 The documentation accompanying the report states that only seven of the
64 eleven members of the sub-committee had special ‘declared interests’ re-
65 lated to CAM issues: two were on the Parliamentary Group on Alternative
66 and Complementary Medicine, the Natural Medicines Society and the Na-
67 tional Federation of Spiritual Healers; the other five were academics or
68 practitioners of modern establishment medicine (henceforth MEM) men
69 with only tangential involvement with CAM. However, the sub-committee
70 took special advice from Professor Stephen Holgate, Clinical Professor of
71 Immunopharmacology, University of Southampton, and Mr Simon Mills,
72 Director of the Centre for Complementary Health Studies, University of Ex-
73 eter. It appears that there was no representation on the sub-committee
74 from medical anthropology, medical sociology, or medical history, fields
75 which would appear prima-facie to be essential to an understanding of the
76 issues the committee was grappling with.

77 The central achievement of the report was to divide CAM therapies into
78 three large groups and to support practices falling into Group 1, and de-
79 precate those in Group 3 (See Table 1). Therapies in Group 2, that ‘mainly [x-ref]
80 make claims in the area of relaxation and stress management’, were ap-
81 proved when used as adjuncts to conventional medicine. As may have
82 been predicted, this finding caused a great deal of consternation amongst
83 CAM practitioners of almost all traditions. In the aftermath of the public-
84 ation, for example, the Indian Government went as far as to send a deleg-
85 ation of senior ayurvedic practitioners to the House of Lords to meet Lord
86 Walton and discuss the Group 3 classification given to their practice.⁶ Many
87 commentators noted that the presence of ‘Acupuncture’ in Group 1 was at
88 odds with the appearance of essentially the same practice as ‘Traditional
89 Chinese Medicine’ (TCM) in Group 3.⁷ This distinction appeared to re-
90 flect little more than the greater lobbying powers of the Society of Medical
91 Acupuncturists (qualified MDs) over those of the community of TCM prac-

⁵Earl Baldwin of Bewdley, Lord Colwyn, Lord Haskel, Lord Howie of Troon, Lord Perry of Walton, Lord Quirk, Lord Rea, Lord Smith of Clifton, Lord Soulsby of Swaffham Prior, and Lord Tombs. See <http://www.parliament.the-stationery-office.co.uk/pa/ld199900/ldselect/ldsctech/123/12329.htm>.

⁶Personal communication from Dr Shailaja Chandra, then Secretary of the Indian Ministry of Health & Family Welfare, Department of Indian Systems of Medicine & Homoeopathy. The delegation included Dr Narendra Bhatt, currently a member of the IASTAM Council.

⁷Personal communications from Dr Vivienne Lo and other colleagues.

Group 1 The first group embraces what may be called the principal disciplines, two of which, osteopathy and chiropractic, are already regulated in their professional activity and education by Acts of Parliament. The others are acupuncture, herbal medicine and homeopathy. Each of these therapies claims to have an individual diagnostic approach and are seen as the 'Big 5' by most of the CAM world.

Group 2 The second group contains therapies which are most often used to complement conventional medicine and do not purport to embrace diagnostic skills. It includes aromatherapy; the Alexander Technique; body work therapies, including massage; counselling, stress therapy; hypnotherapy; reflexology and probably shiatsu, meditation and healing.

Group 3 The third group embraces those other disciplines which purport to offer diagnostic information as well as treatment and which, in general, favour a philosophical approach and are indifferent to the scientific principles of conventional medicine, and through which various and disparate frameworks of disease causation and its management are proposed. These therapies can be split into two sub-groups:

Group 3a includes long-established and traditional systems of healthcare such as Ayurvedic medicine and Traditional Chinese medicine.

Group 3b covers other alternative disciplines which lack any credible evidence base such as crystal therapy, iridology, radionics, dowsing and kinesiology.

Table 1: The CAM groups identified by the House of Lords Select Committee. Cited from the Committee's *Report*, 'Summary of Recommendations'.

92 titioners (professionally fragmented and sometimes embedded in a Chinese
93 language milieu).

[x-ref
target]

94 **The Submission of the Secretary-General of IASTAM:** 95 **1999**

96 In the year before publication, 1999, the House of Lords sub-committee
97 invited interested parties to submit statements for their consideration.⁸ I
98 submitted the following statement, which has been lightly edited for the
99 present publication. Footnotes added at the time of present writing are
100 enclosed in square brackets.

101 *Scope*

102 My remarks are directed to ayurveda, the traditional medical system of India. In
103 India the government supports this medical system financially and administrat-
104 ively as part of the national policy of supporting plural medicine (Unāni, Yoga,
105 and Siddha medicine are also supported).⁹ Outside India, ayurveda has in recent
106 years been gaining a following in Europe and America as part of the CAM scene.

107 *Credentials*

108 My published works on the history of Indian medicine include the volume in
109 the Penguin Classics series entitled *The Roots of Āyurveda* (Wujastyk 1998)
110 which presents my own translations of ayurvedic medical texts from the original
111 Sanskrit, together with a historical introduction to the subject. I have also
112 published research and survey articles on ayurveda and Indian medical history in
113 refereed journals and in such volumes as *The Companion Encyclopedia of the*
114 *History of Medicine* (Wujastyk 1993), *Oriental Medicine: an Illustrated Guide to*
115 *the Asian Arts of Healing* (Wujastyk 1995), and *Religion, Health and Suffering*
116 (Wujastyk 1999). I teach an MA unit on the history of ayurveda at the School
117 of Oriental and African Studies, where I am a Research Associate. I am not a
118 medical practitioner (my doctorate is a DPhil.). I am currently Secretary-General
119 of the International Association for the Study of Traditional Asian Medicine.¹⁰

120 *Terminology*

121 I should like to make a preliminary remark regarding the appropriateness or oth-
122 erwise of the term 'Complementary and Alternative Medicine' (CAM) used to

⁸These were said to have been published in the printed form of the final report, but do not appear on the report's website.

⁹[See now the Indian Government website, <http://indianmedicine.nic.in/>.]

¹⁰IASTAM; <http://www.iastam.org>. [The present Secretary-General is Dr Vivienne Lo.]

123 refer to the medical systems listed in the Committee's 'Call for Evidence' letter,
124 and in the name of the Committee. The medical systems listed in that letter
125 (Acupuncture – Yoga) are widely divergent in their presuppositions, their histor-
126 ies, their techniques, their stands vis-à-vis contemporary European establishment
127 medicine, and so forth. Whatever name is chosen to refer to them collectively
128 will inevitably betray certain presuppositions on our behalf. All such names are
129 contested. The name CAM attempts to avoid certain types of controversy by
130 including two ideas, complementarity and alternativeness, which each suggest
131 something rather different about the nature of these therapies. This attempt
132 is only partially successful, and there are several underlying assumptions in the
133 name CAM which are undesirable from some points of view. This difficult issue
134 has been discussed in a valuable paper by Matthew Ramsey published recently in
135 the special issue of the journal *Medical History* dedicated to 'Alternative Medi-
136 cine in Europe since 1800'.¹¹ Ramsey gives serious arguments for the use of
137 the terms 'medical outsiders', 'nonstandard medicine(s)' and 'counterhegemonic
138 medicine' in various contexts. I would draw the Committee's attention to this
139 brief but lucid discussion, which can serve to raise awareness of several critical
140 issues which are implicit in the Committee's name and documentation.

141 *Evidence*

142 Controlled clinical trials are an inevitable component of any attempt to bring
143 the practice of CAMs under the same funding, institutional, and managerial
144 structures as contemporary biomedicine, whether in Europe or in India or other
145 Asian countries. India, for example, has a long history of modern scientific
146 research in evaluating traditional medical herbs through laboratory testing. There
147 are numerous centres which undertake such work, amongst which the Central
148 Drug Research Institute in Lucknow takes a leading role.¹²

149 However, the Committee should be aware that in some circles this a contro-
150 versial matter. For example, papers by Darshan Shankar, Director of the FRLHT
151 (see below, p.9, ¶14), and his colleagues, have argued passionately that the [x-ref]
152 traditional knowledge systems which developed in India over many centuries and
153 whose theories justify the application of particular herbs, are an integral compon-
154 ent of a treatment situation. To take a herb, for instance, that has a history of
155 traditional use in India, to remove it from its traditional epistemological setting
156 and to appropriate it for international use through ethnopharmacological analysis
157 and synthesis is to lose an essential component of the medical situation.¹³

¹¹Ramsey 1999.

¹²Cf. <http://www.cdriindia.org>.

¹³See, e.g., Shankar and Manohar 1995, and Shankar 1995. [To which could be added Shiva 1988].

158 It is also important in this context to be sensitive to the patenting issues
159 which have caused so much public outcry in India in recent years. The case of
160 the American patent on a particular Neem tree oil compound is just the best-
161 known of several such cases in which medicinal plants with long histories of
162 traditional use have been crudely appropriated by foreign companies for profit
163 under exclusive terms which have profound economic and social repercussions in
164 India.

165 *Public Information*

166 This is a critical issue for ayurveda. It is difficult for either doctors or patients
167 to lay hands on reliable information on ayurveda. Two things are needed: first,
168 sound guides to the small number of important and reliable information sources
169 that do exist; second, the production of more informational works which are
170 based on scholarly research.

171 The last decade has seen an explosion in the publication of popular works
172 promoting ayurveda as a new therapy for the West, as well as for the westernized
173 middle classes in India. All these books are written by authors who are primarily
174 interested in promoting ayurvedic therapy in practice. But these authors may not
175 have either an awareness of historical issues bearing on ayurveda, or any linguistic
176 abilities in Sanskrit. They may have a strong vested interest in increasing their
177 client base. The dominance of this kind of literature is not useful when trying to
178 come to a balanced and properly-informed opinion about ayurvedic medicine. But
179 it often seems to be the only literature easily available through normal channels.

180 Sanskrit remains vitally important in this respect because it is the language in
181 which the bulk of ayurvedic literature is written. Only a relatively small amount
182 of this literature is available in English translation, and most of this is produced
183 for a reading public in India which is fluent in Hindi and therefore conversant with
184 the many technical terms in Sanskrit which are not translated. More translated
185 texts are available in Hindi and other regional languages of India. But as recently
186 as 1920s, the great ayurvedic scholar Gananath Sen chose to write his works in
187 Sanskrit on the grounds that it was the only lingua franca amongst ayurvedic
188 practitioners in all parts of India. His books were still being reprinted, in Sanskrit,
189 in the 1960s. Not only is Sanskrit important for access to many primary works;
190 it is also important because the epistemological basis of ayurveda makes use
191 of many concepts and categories which are embedded in Sanskrit culture. The
192 philosopher wishing to work professionally on the opus of Plato or Aristotle must
193 acquire Greek; a serious researcher into Chinese medicine would be expected to
194 have some knowledge of the Chinese language. Similarly, serious scholars and
195 interpreters of ayurveda must have a good command of the Sanskrit language.

196 There is another reason why a knowledge of Sanskrit is vital to the proper

197 understanding and interpretation of ayurveda. Āyurvedic therapy is very largely a
198 herbal medicine. Thousands of herbs are mentioned in the literature. While many
199 of these are clearly identified, there remains an important body of medicinal herbs
200 whose identity is not certain. Research using botanical, historical, and literary
201 sources can often clarify these matters, but this research depends essentially on
202 a knowledge of Sanskrit.

203 Therefore, the production of reliable information on ayurveda will be a task
204 to be shared by Sanskritists, historians, and doctors.

205 Promoters of ayurvedic medicine normally make a strong appeal to the long
206 history of this type of medicine. This is an integral feature of the appeal and
207 popular validation of this therapy. However, the strength and ubiquity of these
208 appeals is normally matched by a dismal absence of any substantial historical
209 understanding. Training courses in ayurveda do not normally include modules
210 on the history of the science, and the lack of general historical knowledge about
211 Indian medicine amongst practitioners is shocking. Platitudes about ayurveda
212 originating thousands of years BC are distressingly common. The many changes
213 and developments in ayurveda which have taken place historically over the cen-
214 turies are commonly elided in preference for an image of ayurveda as a timeless
215 incarnation of medical truth. This lack of general historical knowledge is dam-
216 aging because false information circulates in the public sphere, and this is likely
217 to mislead potential patients. Because ayurvedic practitioners normally stress the
218 importance of the long history of ayurveda as a principal virtue of the system,
219 it is vital for correct information on the history of ayurveda to be prominently
220 available.

221 I would therefore encourage the Committee to consider most seriously the
222 question of the provision of reliable, historically-informed information about ayur-
223 veda. This subject is intimately linked to that of the education and regulation of
224 ayurvedic practitioners.

225 *Research*

226 Double-blind placebo clinical trials are today necessary to create confidence
227 amongst doctors and patients. But it is important to be aware that ayurvedic
228 herbal medicine is normally delivered in compounds consisting of dozens, some-
229 times scores of individual substances. Clearly there is a need to conduct trials
230 which use not just simples, but these complex herbal compounds. The inter-
231 actions between the constituents in a compound may be crucial to its modus
232 operandi. This may greatly complicate the testing of ayurvedic medicines.

233 I would also note that it is critical that research into ayurveda should also
234 include the participation of sociologists, anthropologists, ethnopharmacologists,
235 and scholars of ethnomedicine, bioethics, biodiversity, and ecology. These are all

236 fields which have a vitally important contribution to make to the understanding
237 and practice of ayurveda, and Asian medicine in general. Funding from bodies
238 with a strong primary focus on biomedical science, such as the Wellcome Trust
239 and the MRC, does not always cater for the broad spectrum of scholarly fields
240 which are critically important to understanding certain CAM therapies, especially
241 those of Asian origin where cultural, historical, and tropical medicine issues all
242 converge.

243 To take one example: ayurvedic medicines are chiefly herbal, and there is a
244 large and growing ayurvedic pharmaceutical industry in India which consumes a
245 huge quantity of raw herbal substances. The majority of these plant resources
246 are collected through informal traditional channels, commonly through hillside
247 and forest picking in uncultivated areas. Few large companies in India are yet
248 cultivating their own herbal crops on any scale. These ecological issues are press-
249 ing, and need to be understood and addressed. The same is true of other types
250 of understanding mentioned in the previous paragraph. Issues of biodiversity are
251 indeed already being addressed vigorously by such organizations as the Found-
252 ation for the Revitalization of Local Health Traditions in Bangalore,¹⁴ with the
253 support of Danish aid funding, but more needs to be done in all these areas of
254 study.

[x-ref
target]

255 High quality research input from experts in the above-mentioned fields is
256 also critical for an appropriate understanding of the issues which surround the
257 introduction of a non-European medicine into a European setting. There are
258 numerous historical and cultural issues here which bear strongly on decisions
259 concerning medical practice and the regulation of therapies.

260 *Training*

261 Modules on CAM should certainly be integrated into contemporary medical edu-
262 cation. The Medical School of University College London has for many years
263 enabled its students to take an Intercolated BSc in the History of Medicine at
264 the Wellcome Institute.¹⁵ This intensive one-year course is taken between the
265 second and third years of the medical degree. This scheme has been very success-
266 ful, and it would seem to offer a model that could be used to offer CAM courses
267 to interested students. UCL has also recently introduced another module system
268 whereby medical students can take short courses in a selection of extra-curricular
269 subjects. These new modules are, in my opinion, too short to be used for more
270 than a very superficial introduction to CAM.

¹⁴FRLHT; <http://ece.iisc.ernet.in/ernet-members/frlht.html>.

¹⁵[The Wellcome Institute was closed in 2002, and the research and teaching staff moved to the new Wellcome Trust Centre for the History of Medicine at University College London, where this BSc continues to be taught.]

271 The Centre for Complementary Health Studies at University of Exeter is one
272 of the few centres of higher education in Britain where postgraduate degrees in
273 CAM can be taken. The Exeter CCHS has an excellent reputation (I have been
274 an external examiner for their MPhil program), and hope that the Committee
275 has an opportunity to benefit from the informed opinion of the teachers and
276 managers of the Exeter program.¹⁶

277 The Government of India regulates the teaching and practice of ayurveda in
278 India. There are hundreds of colleges nationwide which teach the Bachelor of
279 Ayurvedic Medical Science (BAMS) and higher degrees. This system of college-
280 based ayurvedic education is mainly a post-independence development, modelled
281 on Western medical education. Its establishment was highly controversial, and
282 for good reasons. In pre-colonial times, education in ayurveda was principally
283 conducted in traditional Sanskrit schools in which students started very young
284 (10 or less), and were grounded for over 12 years in the Sanskrit language and in
285 the medical literature. Apprenticeship to a practising physician was also essential.
286 Unlike China, pre-modern Indian did not develop a system of medical licensing,
287 and the right to practice, as well as professional success, were a function of good
288 reputation, training by a famous teacher, and sometimes court patronage.

289 Many people, especially biomedically-trained practitioners in India, view ayur-
290 veda and biomedicine as being fundamentally different in their presuppositions,
291 methods, and understandings of the human body and its functions. Critics of
292 the college-based ayurvedic education, which aims to teach a mixture of ayur-
293 veda and basic medical science, argue that these colleges produce students who
294 are neither fish nor fowl: they are not trained thoroughly in either ayurveda or
295 biomedical science. Standards in Sanskrit language are very poor; teaching is in
296 English or the local state language. The educational situation in India is com-
297 plicated by the fact that a training in ayurvedic medicine is sometimes seen as
298 an option for students who fail entry requirements for biomedical medical school
299 but who still want a profession in medicine.

300 In my opinion there is no easy answer to the question of ayurvedic education
301 for practitioners. Clearly a return to a pre-modern full-immersion/apprenticeship
302 system is impossible, although some experiments in this direction at the ayurvedic
303 college in Coimbatore have been strikingly successful. The problem of quality,
304 both of students and of teaching, is critical.

305 If ayurveda is to form part of the health care portfolio in modern Britain,
306 some planning and regulation of ayurvedic education will be essential. For the
307 time being, the BAMS degree is probably a minimum qualification level below
308 which practice in Britain should not be permitted. But the BAMS by itself may

¹⁶[Most regrettably, this centre was closed in mid-2004.]

309 not be enough to provide adequate or appropriate training for a physician working
310 in a modern environment in Britain.

311 *Regulation and Risk*

312 A criticism sometimes levelled at ayurveda is that its medicines contain danger-
313 ous heavy metals. I should like to note for the Committee that the classical
314 foundational reference encyclopedias of ayurveda make almost no use of metals
315 whatever. It is certainly valid to argue that a 'pure' form of ayurvedic therapy
316 does not use metals or metallic compounds, but relies exclusively on herbal com-
317 pounds, oils, and a selection of animal products. Metals came into medical use
318 only at a relatively late time in India, broadly coinciding with the advent of Islam
319 and the Moghul period. (There are unanswered historical questions here.)

320 Clearly the public must be protected from dangerous medication. This is
321 valid for all forms of medicine, biomedical or CAM.

322 In his submission to the Committee, Ivan Corea, Fellow at the King's Fund,
323 has recommended the establishment of a Complementary Medicine Commission
324 with associated Regulatory Bodies. I am in full agreement with the his views on
325 this matter.

326 *National Health Service Provision in the UK*

327 Britain today has a large minority population of people of South Asian ethnic
328 background. Āyurvedic ideas and therapies are deeply embedded in Indian cul-
329 ture, and have an immediate appeal and meaning for even second and third
330 generation Asians. This has obvious implications for both patients and doctors.

331 In the clinical encounter, a patient of Indian ethnic background presenting to
332 a doctor may use unfamiliar language and symbolism to describe symptoms. For
333 example, a simple statement such as 'I am hot' (or 'I have been eating hearty
334 food') can have a humoral connotation for a person whose foods are traditionally
335 classified into hot and cold categories which have nothing to do with temperature.
336 It would be advantageous to NHS doctors to have at least a basic understanding
337 of the medical concepts and presuppositions that are likely to be present in
338 patients from these communities and with cultural backgrounds that include
339 many ayurvedic traditions.

340 I also believe that a move to make ayurvedic treatments available through
341 the NHS would meet an extremely positive response from the Indian ethnic
342 communities in Britain.

343 The appeal of ayurveda to the wider population in Britain as part of CAM is
344 certain to continue growing, and with it will grow the demand for its therapies
345 through the NHS.

346 Certain ayurvedic oil massage therapies do seem to be non-threatening, ex-
347 ternal, and of proven value in a range of rheumatic and related ailments. This
348 would seem to be a reasonable and non-controversial starting point for experi-
349 ments in offering selected ayurvedic therapies through the NHS. Standards for
350 evaluating this type of therapy are comparable with those already in use for
351 physiotherapy and osteopathy.

352 **The Government Response to the *Report*: 2001**

353 As mentioned above, the House of Lords *Report* produced strong reactions
354 in the CAM community of practitioners and organisations, reactions which
355 continue to reverberate. Less publicised was the fact that the *Report* was fol-
356 lowed by a formal response published by the Department of Health (hence-
357 forth the '*Response*').¹⁷

358 *Discussion*

359 The *Response* is interesting for several reasons. It traversed the original
360 *Report* paragraph-by-paragraph, offering comments, qualifications and fur-
361 ther information. The most common phrase at the start of each paragraph
362 is 'The Government agrees. . .'. The *Response* was indeed in general agree-
363 ment with the original *Report* in wishing to see an increase in regulation
364 and control of the CAM profession, coupled of course with increased stand-
365 ardization of education and practice. And yet, the *Response* projected a
366 rather different overall atmosphere. Where the *Report* may appear some-
367 what strident and overbearing, the *Response* appears more emollient and
368 reasonable. For example, on the key issue of the *Report*'s notorious 'three
369 groups,' the *Response* did not reject the categorisation, but did accept that
370 it is 'necessarily broad in nature, and it need not imply that all therapies in
371 each category have identical features.' The *Report* continued,

372 In some circumstances there may also be scope for some ther-
373 apies to be allied for a specific purpose across the boundaries of
374 the proposed groupings. For example the Government considers
375 that, for the purposes of professional self-regulation, those as-
376 pects of the traditional therapies listed in Group 3a which in-
377 clude the use of herbal remedies could come together within
378 a federal grouping of therapies in Group 1 under the general
379 heading of herbal medicine, while still retaining their individual
380 identities and traditions. It may also be possible to bring within
381 Group 1 those aspects of traditional therapies which practise

¹⁷The Secretary of State for Health 2001.

382 acupuncture. Under the general headings of herbal medicine
383 and acupuncture, there would therefore be scope to protect the
384 public by affording statutory recognition to large parts of these
385 more traditional therapies...¹⁸

386 This is a far more trenchant criticism of the *Report's* central classification
387 than the mild language would suggest. The Government was in fact re-
388 cognising the point made above (5) that the *Report* had separated some [x-ref]
389 practitioners of identical practices, such as herbal medicine and acupunc-
390 ture, into separate groups apparently as a result of effective lobbying by
391 practitioners, or a rejection of underlying medical models, rather than on
392 the basis of the actual medical methods involved.

393 The *Response* stated that the Department of Health had taken three
394 practical steps. First, it had commissioned the Foundation for Integrated
395 Medicine to conduct an assessment of existing reports on consumer pref-
396 erences in CAM. Second, as part of its annual survey of NHS patients, the
397 Department had also asked NHS cancer patients to identify their use of
398 complementary therapies. Finally, the Department had commissioned the
399 Office of National Statistics to include questions on the use of complement-
400 ary medicine in its National Statistics Omnibus Survey in March 2001.

401 The *Response* mentions the Prince of Wales's Foundation for Integrated
402 Health at several points, tacitly accepting this organisation as a key refer-
403 ence resource in developing information and policy for CAM regulation.
404 This Foundation is an independent consultancy closely linked with the
405 Prince Charles, the Prince of Wales. The current board of Trustees includes
406 senior figures from the medical establishment, representative practitioners
407 of osteopathy, homoeopathy, herbal medicine and establishment medicine,
408 lawyers, educators and journalists. Its mission is to promote patient choice,
409 especially in the area of CAM therapies, to encourage CAM professions to
410 develop and maintain statutory or voluntary systems of self-regulation as
411 well as nationally recognised standards of education and training, and to
412 increase the capacity for research into CAM.¹⁹ The Foundation is commit-
413 ted to promoting 'an holistic and integrated approach to healthcare which
414 engages with all aspects of a patient's being including mind, body and spirit
415 and which takes into consideration environmental, psychosocial and nutri-
416 tional aspects of health'.²⁰

¹⁸The Secretary of State for Health 2001, 4.

¹⁹The Foundation's website is <http://www.fihealth.org.uk/>.

²⁰Cited from the Foundation's website, http://www.fihealth.org.uk/fs_what_we_do.html, October 2004.

417 In spite of the influence of the Foundation for Integrated Health, the
418 *Response* shared with the *Report* a basic attitude that CAM was something
419 to be tolerated, controlled, regulated, and made safe not because of its
420 potential health benefits, but solely because patients want it.²¹ Examples
421 include the following:

422 ‘CAM can also play a part in treating NHS patients. But if it
423 aspires to be an equal player with other forms of NHS treatment,
424 it must meet the same standards required of them.’ (*Response*,
425 p. 1)

426 ‘We recommend that familiarisation should prepare medical stu-
427 dents for dealing with patients who are either accessing CAM or
428 have an interest in doing so. This familiarisation should cover
429 the potential uses of CAM, the procedures involved, their po-
430 tential benefits and their main weaknesses and dangers (para
431 6.77).’ (*Response*, p. 12)

432 ‘We recommend that every medical school ensures that all their
433 medical undergraduates are exposed to a level of CAM famil-
434 iarisation that makes them aware of the choices their patients
435 might make (para 6.79).’ (*Response*, p. 12)

436 ‘... and CAM therapists should encourage patients with condi-
437 tions that have not been previously discussed with a medical
438 practitioner to see their GP’ (*Response*, p. 17)

439 The subtext in such passages is that patients who make unorthodox choices
440 of therapy must be protected from their own folly and from the predations
441 of quacks. This is quite a different premise to that of the Foundation for
442 Integrated Health, which is interested in,

443 Emphasising the key importance of individuals taking more re-
444 sponsibility for their own healthcare, which requires teamwork
445 amongst patients and healthcare practitioners. (Foundation web-
446 site, *ibid.*)

447 The *Report* and the *Response* were interesting on the topic of the so-
448 called placebo effect. The *Report* put its opinion in the following terms:

449 In our opinion any therapy that makes specific claims for being
450 able to treat specific conditions should have evidence of being

²¹The paragraphs referred to in these quotations are references to the original House of Lords *Report*.

451 able to do this above and beyond the placebo effect. This is
452 especially true for therapies which aim to be available on the
453 NHS and aim to operate as an alternative to conventional medi-
454 cine, specifically therapies in Group 1. The therapies in our
455 Groups 3a and b also aim to operate as an alternative to con-
456 ventional medicine, and have sparse, or non-existent, evidence
457 bases. Those therapies in our Group 2 which aim to operate as
458 an adjunct to conventional medicine, and mainly make claims
459 in the area of relaxation and stress management, are in lesser
460 need of proof of treatment-specific effects but should control
461 their claims according to the evidence available to them. . . .²²

462 And the Government responded,

463 The Government agrees with the need for strong evidence bey-
464 ond the placebo effect to support the use of any complementary
465 therapy in Groups 1 and 3 on the NHS. The test proposed – i.e.
466 that any treatment that makes specific claims should have evi-
467 dence of benefit above and beyond the placebo effect – is a tough
468 one. However this is the right standard to set for therapies in
469 Groups 1 and 3, especially as the report goes on to accept that
470 therapies which are mainly about relaxation and stress man-
471 agement and make only limited claims, need not satisfy this
472 particular test.²³

473 These statement exemplify well some of the topics discussed by the med-
474 ical anthropologist Moerman 2002. Moerman has developed the concept of
475 the ‘meaning-response’ to replace the term ‘placebo’. By doing this, Moer-
476 man refocusses the debate about medication and treatment to privilege *the*
477 *recovery of patients* over the application of therapy. He provides much care-
478 fully evaluated statistical evidence that shows how patients become sick
479 and well in response to the meanings of their experiences, which include
480 actual chemical drug effects, but also a wide range of responses to the cul-
481 tural, social and ultimately semiotic content of their experience. The fact
482 is, patients get well for many reasons, only some of them connected with
483 the drugs administered by doctors.

²²House of Lords Select Committee on Science and Technology 2000, ¶4.

²³The Secretary of State for Health 2001, 5–6.

484 **Medical Error, Medical Truth**

485 And patients often become ill as a result of Modern Establishment Medicine
486 (MEM) therapies. It is now almost thirty years since Illich delivered his
487 famous thundering critique of MEM, with its ringing opening sentence:

488 The medical establishment has become a major threat to health.
489 The disabling impact of professional control over medicine has
490 reached the proportions of an epidemic.²⁴

491 Illich claimed that at the time he wrote iatrogenic illnesses were causing
492 between 60,000 to 140,000 deaths in America each year, and leaving 2
493 to 5 million others more or less seriously ill. Moreover, the situation was
494 worst at the heart of the medical establishment, i.e, university hospitals
495 where one in five patients contracted an iatrogenic disease which usually
496 required special treatment and led to death in one case out of thirty. Iatro-
497 genic disease has continued to be a major problem. The drug scandal sur-
498 rounding Ciba-Geigy's Clioquinol, for example, reveals processes at work
499 within MEM which run counter to the vision of MEM as a purely rational
500 and science-based process. It took eight years from the clinical demonstra-
501 tion that Clioquinol caused subacute mylo-optic neuropathy for Ciba-Geigy
502 to withdraw the drug. Even then, the company was not acting on the sci-
503 entific evidence, but because of an international campaign against the drug
504 by its victims and their doctors.²⁵ The editor of the *British Medical Journal*
505 noted in 1995 that only 15% of biomedical interventions are supported
506 by solid scientific evidence.²⁶ In August 2004, the *British Medical Journal*
507 published an analysis of the first results to come from the recently-formed
508 National Patient Safety Agency.²⁷ This agency draws together reports of er-
509 rors regarding the safety of patients and systems-failures that are provided
510 by health professionals across England and Wales. The report found, in-
511 credibly, that, 'About 850,000 medical errors occur in NHS hospitals every
512 year, resulting in 40,000 deaths.' And yet only 4000 misadventures are
513 reported per annum, and only 2.2% of all hospital episodes contain any
514 mention of an adverse event. The conclusion is stark: the medical profes-
515 sion is not being honest with itself or with the public about the nature and
516 extent of lethal error in its own practice.

517 The processes at work within MEM are complex, and highly influenced
518 by issues of finance, corporate culture and, above all, politics. In the

²⁴Illich 1976, 1.

²⁵Shiva 1988, 251-53.

²⁶The Editor 1995. For further informed discussion see Horton 2003.

²⁷Aylin *et al.* 2004.

519 present context, where a government is attempting to use one set of med-
520 ical professionals to regulate another, we may recall another of Illich's
521 trenchant passages:

522 ... the insistence of the medical guild on its unique qualifica-
523 tions to cure medicine itself is based on an illusion. Professional
524 power is the result of a political delegation of autonomous au-
525 thority to the health occupations which was enacted during our
526 century by other sectors of the university-trained bourgeoisie: it
527 cannot now be revoked by those who conceded it; it can only
528 be de-legitimized by popular agreement about the malignancy
529 of this power.²⁸

530 The work of Britain's National Patient Safety Agency shows that there is an
531 incontestible case for practitioners of MEM to put their own house in order,
532 to admit and integrate the now-public fact that one in ten people entering
533 hospital will experience a medical error, and that half of these errors are
534 preventable. It is only once the dangers and failures of MEM are honestly
535 faced that improvement in safety can begin.

536 All this does not, of course, automatically mean that CAM practice is
537 good. But it does mean that naive arguments against the safety and effect-
538 iveness of CAM based on an assumed contrast with MEM can no longer be
539 taken seriously.

540 Arguments concerning the pervasiveness of iatrogenic disease in MEM and
541 the primacy of guild politics in the control of public medicine have been
542 with us for a long time. If these are given due consideration, then
543 medical authorities and practitioners might be expected to show greater
544 interest in evaluating a wider range of safe therapies, including meaning-
545 responses (placebos). The meaning-response, or placebo, demonstrably
546 produces wellness in many patients, both in MEM as well as in CAM. If the
547 aim of medicine is to cure patients, then it is hard to see why the meaning-
548 response is cast as the epitome of poor medicine in the documents under
549 discussion. This is a large and subtle subject, raising many difficulties, and
550 it cannot be explored here. But it has to be said that the *Government Re-*
551 *sponse*, like the *Report* before it, is strikingly unsophisticated concerning
552 matters that have been the staple of medical anthropologists and medical

²⁸Illich 1976, 14.

553 sociologists since the 1960s, not only matters concerning the placebo ef-
554 fect, but meta-issues concerning the whole process of medical profession-
555 alisation and modernization.²⁹ Modern work towards an anthropologically-
556 informed view of healing processes in the context of contemporary medi-
557 cine may be traced back at least as far as the work of Rivers during the
558 First World War;³⁰ just one example of excellent work in this area that is
559 relevant to the Asian medical traditions is that of Bannerman and his col-
560 leagues,³¹ but of course it is the medical anthropologist Charles Leslie who
561 has perhaps done most to develop a modern understanding of Asian medi-
562 cine as it enters and interacts with the modern world.³² The absence of any
563 reference to the considerable body of work achieved in the last fifty year
564 by medical anthropology and related fields lends a curious and unexpect-
565 edly archaic feeling to the present Government documents, which share
566 several features of style and unreflective hegemonic discourse with some
567 early twentieth-century reports on medical regulation in India.³³

568 Neither the *Report* nor the *Response* make any reference to the consid-
569 erable body of work on Traditional Medicine published in recent years by
570 the World Health Organisation. This is a striking omission. The WHO has
571 a department devoted to Traditional Medicine, and has in recent years de-
572 veloped an active program for the appropriate describing, evaluating and
573 promoting the traditional medical systems of many countries.³⁴ It has also
574 published important documentation on them, including meta-studies on
575 appropriate methods for evaluating herbal therapeutics.³⁵ Its publication
576 *WHO Traditional Medicine Strategy 2002–2005*,³⁶ for example, presents
577 the core of the WHO Strategy for Traditional Medicine for 2002–2005. It
578 provides brief information on the growing needs and challenges faced by
579 traditional medicine worldwide. It also gives key messages and a check-
580 list for the safety, efficacy and quality to policy-makers. Finally, it sets
581 out WHO's role and how the WHO Strategy could meet the challenges to
582 support WHO Member States in the proper use of traditional and comple-
583 mentary/alternative medicine. The Government's *Response* showed some
584 evidence of a wider awareness of work in this field when it made reference

²⁹I am grateful to Dr. Madhulika Banerjee for several illuminating conversations on the above topics; see also Banerjee 1995, 2002, 2004.

³⁰See, e.g., Rivers 1924.

³¹Bannerman *et al.* 1983.

³²See, e.g., Leslie 1975, 1983, 1992, 1998; Leslie and Young 1992.

³³See Wujastyk in preparation.

³⁴The WHO programme on Traditional Medicine is described at <http://www.who.int/inf/en/pr-2002-38.html>.

³⁵World Health Organisation 2002a.

³⁶World Health Organisation 2002b.

585 to a preliminary draft of a directive on traditional medicinal products cir-
586 culated to member states of the European Commission.³⁷ Nevertheless, the
587 omission of any reference to WHO documentation or policy is a matter for
588 serious concern when coming to a judgement about the trustworthiness of
589 the UK government's *Report and Response* or the breadth of consultation
590 that went into them.

591 *Proposals for Statutory Self-Regulation: 2003*

592 The most recent Governmental development at the time of writing is the
593 Department of Health's publication of a document entitled *Regulation of*
594 *Herbal Medicine and Acupuncture. Proposals for Statutory Regulation* (hence-
595 forth *Proposals*).³⁸ This document locates itself as a direct successor of the
596 *Report* and the *Response* (p. 5). It is based on the reports of two working
597 groups established in 2002. The first was the Herbal Medicine Regulatory
598 Working Group (HMRWG), consisting of representatives from the Depart-
599 ment of Health, the Prince of Wales's Foundation for Integrated Health and
600 the European Herbal Practitioners Association. The second was the The
601 Acupuncture Regulatory Working Group, which was jointly established by
602 the Department of Health and the Prince of Wales's Foundation for Integ-
603 rated Health.³⁹

604 The *Proposals* conclude that a statutory regulatory system is considered
605 necessary in order to ensure patient and public protection. A period of
606 further public consultation, to end in June 2004, will lead to an amended
607 partial regulatory impact assessment, which will reflect the outcome of the
608 consultation process, and this will also be subject to further consultation.
609 The final goal is to prepare a draft Order under section 60 of the Health Act
610 1999 in order to establish the new statutory system.

611 Initial public reaction to this new Proposal has been nervous. It has been
612 argued on the basis of the previous introduction of statutory self-regulation
613 in medical practices such as osteopathy, that participation in the regulatory
614 system is likely be prohibitively expensive for even highly qualified and
615 successful practitioners.⁴⁰

616 It appears that the British Government's movement towards the estab-
617 lishment of statutory self-regulation bodies for the governance of the vari-
618 ous types of CAM has achieved a momentum that will not be deflected. It

³⁷The Secretary of State for Health 2001, 9.

³⁸Department of Health 2004.

³⁹The reports of these two working groups, published in 2003, are separately avail-
able as <http://www.advisorybodies.doh.gov.uk/herbalmedicinerwg/> and <http://www.advisorybodies.doh.gov.uk/acupuncturerwg/>.

⁴⁰See, for example, the report in *The Economist* (Anonymous 2004, 30).

619 is regrettable that the preparation of the various policy documents which
620 define the present situation did not make use of the full spectrum of know-
621 ledge and information that could have thrown more light their delibera-
622 tions. It is also regrettable that such a bluntly hegemonic approach to CAM
623 has been the informing principle behind these documents, in stark contrast,
624 for example, to the approaches taken by the WHO. The regulating bodies
625 that result from the present initiatives will have to struggle with the legacy
626 of these shortcoming.

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