

# Complementary Medicine: Cosmopolitan and Popular Knowledge, and Transcultural Translations – Cases from Urban Mexico

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*Muchos aquí practican la forma de masaje externa, pero no la interna. Utilizan el masaje para relajar no para curar [como se puede a través del masaje Shiatsu]. Es como querer comer comida Italiana aquí en México, ya no es lo mismo. [Many here practise the form of external massage, but not the internal one. They use the massage to relax, but not to cure [as is possible through Shiatsu]. It is like wanting Italian cuisine in Mexico, it is not the same.] (Shiatsu therapist in Cuernavaca, Mexico)*

**T**HIS QUOTE illustrates how the boundaries between healing, and the commodification of medicine reflect claims over mastery. I refer to a mastery over an 'original', 'deep' knowledge regarded too often as contaminated by its relocation as a new object of consumption. In this article I want to discuss some issues related to the 'travel' of some aspects of oriental medicine and its transformation into cosmopolitan and popular medical forms in Mexico. I am addressing, through a particular ethnographic case, ways in which a form of medicine 'travels' and is 'relocated' in particular sectors of Mexican society. In my view a 'travelling' theory is

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an angle through which to make sense of re-formulations of medical knowledge(s).

Second, in this article I focus on the transculturation of medical knowledge insofar as this focus can help us to understand the development of complementary and alternative medicine in Mexico. If transculturation is a phenomenon of the 'contact zone', so a 'travelling' medical knowledge gives us insights into how 'disparate cultures meet, clash and grapple with each other' (Pratt, 1992: 4). A relevant question that Pratt addresses is about the appropriation of dominant representations in the periphery. The case of oriental medicine in Mexico, discussed here, highlights how peripheral representations are projected and appropriated by different social groups – still being the other of a dominant, even if heterogeneous, bio-medical knowledge and practice.

As I have argued elsewhere (Napolitano, 2002) the development of complementary medicine in Mexico suggests important aspects in the expression of an alternative modernity. With alternative modernity I refer to the open-endedness and the possibility of reversal of a project of modernity. To capture some of these dynamics we can focus on the imageries and forms of empowerment and disempowerment that are imbued in 'new' and emerging types of medical and healing practices that themselves manifest continuities and reversals of a project of modernity. Through some aspects of the particular phenomenon of a 'travelling' oriental medicine in Mexico we see that alternative modernity is not an other outside modernity 'but "what-has-been-formed" in conjunction with and in differentiation from modernity over time' (Lowe and Lloyd, 1999: 16). As such it shapes popular and cosmopolitan expressions of citizenship.

Finally, I argue that some expressions of the development of complementary and alternative medicine in Mexico indicate not only ways in which the 'global gets inside us' (Franklin et al., 2000: 141), but also ways in which a globalized and 'travelled' medical knowledge is reshaping particular expressions of the popular and the cosmopolitan. In fact while the development of complementary and alternative medicine (from now on referred to as CAM) in Western societies has often been associated with the privatization of medicine and a model of personal management of risks, through some Mexican cases I argue that its development cannot be fully understood without considering the ramifications it has for the politics of grass-roots health movements. However, before I try to weave these threads together, I need to introduce my understanding of transculturation and its relation to medical knowledge(s) and their commodification.

### **Transculturation, Acculturation and Medical Knowledge(s)**

Néstor García Canclini (1989) has reminded us that hybridization in Latin America has been happening through a reconversion of the traditional and the popular via capitalist and late capitalist market conditions. The popular is not annihilated, but transformed by modernity, nor has a political economy of globalization prevented hybridity and transculturation from

taking place; on the contrary it has helped the creative multiplications of its different forms. As Román de la Campa rightly notes Canclini's interest has been on the cultural production of the market and its different forms of intertextuality. Cultural reconversion in the light of transculturation theory becomes 'a new nexus between the subjectivity of popular culture producers and the hegemony of market economies' (de la Campa, 1999: 69). This transculturation perspective emerges out of, but also contests, an earlier notion of acculturation. Acculturation referred to a functionalist expression of homogenizing, dominant (often nation-state-related) projects, such as for instance the ideology of *mestizaje* in Mexico, which other subordinated cultural forms had to comply or merge with.<sup>1</sup> Instead transculturation distances itself from a linear acculturation model and becomes a lens which magnifies the tensions and the mutual reproductions between the popular and a market economy.

Fernando Ortiz in his study of tobacco and sugar on the Cuban island (1947/1995; see Coronil, 1995) subtly set off this shift from acculturation to transculturation. He considers the relation between tobacco and sugar as a dyadic, rhythmic relation (between, e.g., masculine/feminine, nation/colonial power), which can be reversed and poetically transgressed. He is interested in the rhythm of contra-punctuation of these forces and symbols, and their mutual definition through the historically changing conditions of production that they represent in Cuban history (Coronil, 1995: xxiii). Transculturation becomes an historical unfolding of a creative transmission and interface which occurs between distinct cultures, mainly in different positions of power. Interestingly enough, his work has not been widely acknowledged by anthropologists who came after him,<sup>2</sup> but it has had more influence in literary studies (Benítez Rojo, 1992; Coronil, 1995).

The aspect of transculturation that I am interested in discussing in this article is a central aspect of Ortiz's work, namely the fact that things and commodities become social actors in a transculturation process. The agency of changes rests not only in humans, but also in the life and 'travelling' of things and, I would add, in the life and travel of knowledge(s). Through the life and travel of knowledge(s), transculturation captures ways in which peripheral knowledge(s) interface with the dominant one and, as a result, the ways in which the popular and the cosmopolitan interact. It also focuses our attention on the shifting nature of a travelling knowledge, which shapes a 'local commodity path' (Appadurai, 1986: 56), part of a wider-world consumption of medicine.

The ethnographic, transculturation angle which I develop in this article is the analysis of some aspects of oriental medicine – part of the development of CAM in Mexican urban society. To be precise, the analysis draws from two different fieldwork periods in the cities of Guadalajara and Cuernavaca.<sup>3</sup> The development of CAM in developing countries is a very interesting phenomenon, because it brings to the forefront postcolonial tensions and paradoxes of alternative modernity. In fact, if we look at some of its dynamics, we can observe projects of the recuperation and recasting

of medical knowledge(s) – both postcolonial processes. Moreover, while CAM in developed societies has been associated with a postmodern turn of the ‘privatization’ of health, a turn to the ‘natural’ and to an individualization of healing (especially in the most extreme forms of the New Age movement, see Heelas, 1996), in cases from Mexico we can see how the wider phenomenon of CAM development cannot be understood separately from community health movements and therefore from a process of transformation of the popular. This is also due to the fact that ‘traditional’ Mexican herbal medicine has always been strongly linked to popular medicine as it is practised in low-income neighbourhoods. Moreover, in more recent times, the development of CAM in Mexico has paralleled and intertwined with a ‘rediscovery’ and commodification of traditional Mexican herbal medicine.

### **Complementary and Alternative Medicine: Developments and Tensions**

CAM has a very fluid and debatable definition, which is not the subject of this article, but it is important to mention some general points about this emerging market. First, out-of-pocket expenditure for CAM medicine is rapidly increasing, not only in developed countries but also in developing ones. However, most studies published in medical journals cover issues and aspects related to clinical trials and the empirical validation of CAM via a bio-medical gaze (e.g. Cushman et al., 1999; Joos et al., 2000).

Second, most sociocultural analyses have focused either on historical reconstruction of ancient manuals and philosophical ideas about a meta-narrative of ancient, traditional medicines (for instance, the Ayurvedic medical system; see Cohen, 1995) or on sociological accounts of the culture of practitioners and patients in developed society – with a primary focus on Western Europe and North America (e.g. Adler, 1999; Boon, 1998; Easthope et al., 2000; Schepers and Hermans, 1999). Within this latter field, attention has begun to be paid to the nature of the changing consumer market and the changing attitude of the bio-medical professions (Sharma, 1999).

The existing socio-anthropological literature on UK and American case studies has mainly focused on the boundaries of alternative medicines, the struggle for their professionalization, their theoretical underpinnings and narratives of healing sessions between patients and practitioners (Baer et al., 1998; Fuller, 1989; Saks, 1992; Sharma, 1992). Thus, it is commonly understood that a central focus of the phenomenon is the development of different medicines, and the borders and boundaries between them, and medical and therapeutic practices. Nonetheless, alternative and ‘traditional’ forms of medical knowledge cannot be disentangled from those who practise them: knowledge cannot be disembodied, nor de-contextualized from its strategic applications. It is always a form of situated knowledge. This is even more important where there is a long ‘tradition’ of herbal and ‘local’ medicine that interfaces with an under-regulated and rapidly changing health market. This can result in an idealization and a nostalgia for an

indigenous healing knowledge that, precisely for this reason, is increasingly commodified in particular and selective forms for a non-indigenous public (Ayora-Diaz, 2000).

Whole areas in Latin America, such as Mexico, are mainly left to the paradigm of 'indigenous', 'folk' medicine, rather than exploring the complex interaction between bio-medical knowledge, 'traditional' medical systems (such as Chinese medicine, Ayurveda and Mexican herbal medicine) and complementary and alternative medicine (such as homeopathy, for instance).<sup>4</sup> Moreover, this also occurs in some studies of health practices among Mexican migrants to the US.

Much socio-medically oriented research on Mexican migrants' health in the US holds a view that folk/native medicine is in widespread use in the home country, and therefore that the recourse to this type of care must still be a central concern of research (Baer and Bustillo, 1998; Burk et al., 1995; Engebretson, 1994). What emerges from these studies is a partial representation of migrants relying either on folk medicine, 'traditional' forms of faith and beliefs (such as notions of *susto*, *nervios*, *empacho*) and expressing a particular 'cultural behaviour' or rejecting these 'traditional' forms of health care for bio-medical care.<sup>5</sup> However, Mexican migrants to the US, especially those coming from metropolitan and urban areas, may well have been exposed to a range of CAM as well as bio-medical options (Napolitano, 2001). A divided and, I suggest, somehow reductive representation is still present in non-bio-medical health care studies regarding Mexicans and the Latin American migrant population abroad more widely (Dawson et al., 2000).

Beyond the potential pitfalls of stereotypical representations of health consumers, what happens when 'oriental' medicine is translated and practised in a Mexican milieu? Or when for instance Tibetan medicine reaches the USA's Californian shores? There are two major responses that occur when medical forms of transculturation take place. On the one hand there is an impulse towards both the legalization and the criminalization of these medicines, promoted by institutional bodies and governmental legal forces, while on the other there is an impulse towards professionalization of the practices, often championed by the practitioners themselves.

The legalization of specific alternative medicines is a politico-cultural process where bio-medical bodies, private practitioners and training schools play an important role, often in an unequal balance of power. However, legalization impulses emerge together with criminalization ones. In the US, the latter are promoted by institutions such as the FDA (Federal Drug Agency) and the recently formed NCCAM (National Centre for Complementary and Alternative Medicine).<sup>6</sup> This phenomenon is intriguingly described by Vincanne Adams in an analysis of the recent development of Tibetan medicine in the US (Adams, 2002).

Tibetan medicine is scrutinized under bio-medical paradigms for scientific validity, but there is a disturbing split taking place among the – US-based – Asian practitioners of such medicine. Moreover, Tibetan

medicine itself is becoming alluring to bio-chemical companies. The work of Tibetan medical doctors coming to give training courses or practise in the US is heavily scrutinized and often impeded. The legalization of their knowledge and practice currently rests on double-blind tests that select only one part of Tibetan knowledge – basically some of the herbal remedies – while no real interest has been shown in diagnostic practices (such as the observation of the urine, skin, pulse and so on). A restricted set of Tibetan herbal remedies becomes an area that is somehow ‘easy’ to grasp through a bio-medical ‘Western-trained’ reading. The testing and validation of Tibetan medicine by the US medical system are also promoted by pharmaceutical companies (e.g. Johnson & Johnson), which are already well set on a commodification hunt by directly sponsoring some of these double-blind tests and research projects.

These forms of bio-medical and pharmaceutical company interventions generate a split between a Tibetan knowledge (to be converted into a commodity) and a Tibetan medical practice (practised by native/migrant doctors, which needs to be kept at bay, regularized and criminalized). This split reminds us of Roger Rouse’s discussion of Mexican transnational labourers in Redwood City, California (1992): under the conditions of late capitalism and transnational migration there is a split between the unwanted migrants (seen as illegals and a threat to the civil and legal order) and the wanted labour (the product of their labour which is the necessary and founding basis of the growing capitalist pyramid). A similar, disturbing phenomenon is happening in the ‘transculturation’ of a medical field: there is a criminalization of the Asian practitioners of Tibetan medicine and a welcoming of their knowledge which is then ‘taken away’ by being controlled, purged and commodified.

A first reflection on the transculturation of medical knowledge(s) therefore is that the commodification of medical knowledge may engender a potential split and tension between knowledge and knower, between the embodied knowledge which is practised and a knowledge which is reproduced within an arena of legalized, commodified reproduction. Moreover, the paradox is that a ‘transcultural’ medical knowledge may become more widely available only if it has undergone a process of commodification and reproduction that undermines the content of its own practice. This Tibetan example shows one mode of insertion of CAM and traditional medicine into a ‘transcultural’ field, but it is not the only one. Hence there are multiple forms of insertion of travelling medicine(s) into a nation-state field associated with their commodification, legalization and professionalization, and their relation to dominant medical systems.

The Tibetan medicine example becomes interesting when we transpose some of these paradoxes to the analysis of CAM in urban Mexico and we unveil other forms of insertion. The field of alternative medicine in Mexico is under-regulated in comparison with the US. There is a gap between the legalization (or the lack of it) and the practice of CAM in Mexico. A national law proposal was under discussion in 2001, about the

recognition of acupuncturists and practitioners of Chinese medicine. The only training college that is officially recognized (for Chinese Medicine and Acupuncture) is the Polytechnic of Mexico City and the proposal is to require a minimum 1500 hours of practical experience with patients, before being accredited as a Chinese medicine doctor. This requirement is so high that even the best and most experienced Chinese medicine doctors will fall outside these requirements. However, the reality on the ground, as far as standards of practice are concerned, is much looser, and many who have limited training can practise: they can do so either if they have a medical degree or if they have a medical doctor who will act as a guarantor for their work vis-a-vis the *Consejo de Salubridad General*<sup>7</sup> (as is the case of those who have a degree in clinical psychology, for instance, who only need a guarantor to practise).

### **The Transculturation of Oriental Medicine in Mexico: Popular and Cosmopolitan Medicine**

The Mexican national health system has been in need of major reforms. Health care reform has been politically discussed for the last 15 years and through three different presidencies, but the reality is that there is a divergent pull between a need to strengthen the health provision for the poor sectors of the population as well as amelioration of the existing services and the tightening of national spending. The current Vicente Fox government sees health care reform strictly linked to a more equitable and redistributive financial and fiscal reform, and to an operational health system which should become more decentralized while cutting costs (Julio Frenk Mora, Minister of Health in *La Jornada*, 2001).

The reality on the ground is that more than 50 percent of the population has to resort to non-national health system forms of health care: these range from private bio-medical doctors, to CAM doctors and practitioners, to 'traditional' healers<sup>8</sup> (Nigenda et al., 2001). Many practitioners have multiple formations and, because the open and private medical market is becoming more and more competitive, some bio-medically trained doctors are beginning to acquire knowledge and specialization in complementary medicine fields. However, in some cases, their training is short and very pragmatically oriented. It is oriented to solve particular pathologies, rather than engaging fully with a different approach to illness, the restoration of health and energy balance.

Nonetheless, this is not always the case. Dr Carlos<sup>9</sup> was originally trained in bio-medicine, but for the last 20 years has been training in and practising Chinese medicine. He is one of the founding figures of the AMASA association (Asociación Mexicana de Asociaciones y Sociedades de Acupuntura). The ways in which he has shifted his interest and focus on Chinese medicine reveal changing forms of consumption of and demand for Chinese and oriental medicine in Mexico. His clientele is basically middle and upper middle class, but he has also given seminars for groups of *medicina popular* (see below). The demand and 'desire' for Chinese

medicine have been changing through 'fashionable' trends. In the first period, from the 1970s until the late 1980s, he realized that people were demanding acupuncture and Chinese herbs above everything else. The first trend was highly influenced by the Confucian school of thought, which privileges a more 'scientific' view of Chinese medicine and the use of acupuncture and Chinese herbs; somehow a pragmatic aspect of Chinese medicine was pushed to the forefront.

Yet some patients are now beginning to ask for healing that resonates more with a Taoist thinking. Taoist thinking is geared toward the maintenance of health and balance primarily through diet, meditation, Qi Gong/Tai-Chi, and only when the health balance is lost are people encouraged to turn to Chinese herbs and acupuncture (considered as 'heavier' forms of medicine). This is not a predominant shift, but a shift which is beginning to take place. Dr Carlos, and other practitioners of Chinese medicine in Cuernavaca, realizes that he has to be able to provide for this type of demand, rather than continuing to work strictly on the acupuncturist/Confucian medicine line: '*La gente pide una medicina más sutil*' (People ask for a subtler medicine).

This shift has also been noticed by Shiatsu practitioners. This is the case of Mauricio, who practises both in Cuernavaca and Mexico City and who is aware in his own practice that there is a pull from patients towards a Taoist practice which embraces nutrition and meditation, as well as Shiatsu massage. He has observed in his practice that the 'effectiveness' of the healing is directly proportional to subtlety of the cure. Like Dr Carlos, he recognizes that the majority of patients do not know much about Chinese and even less about Japanese medicine, philosophy and principles, but they come with specific requests for one particular treatment rather than another.

But what does an increasing interest in Chinese and oriental medicine mean? And why is there beginning to be a subtle orientation toward Taoist-inspired Chinese medicine in Cuernavaca? One explanation is of course the increasing competition between private bio-medical consultancies and complementary medicine options available in the market (such as homoeopathy, Reike, bioenergetics, Temascal – a ritual sauna, Bach flower remedies and others). This is happening while the government is pushing toward an increasing privatization of the national health system and patients are progressively realizing the drawbacks of bio-medicine, especially when private and often under-skilled doctors practise it.

Another interesting line of thinking is the issue of exoticism and the impact that a 'foreign' medical knowledge has in an urban and complex Mexican setting, as well as tensions between 'popular' and 'cosmopolitan' medicines. Let me explain some of these tensions. While Dr Carlos treats mainly middle-class patients, there is another area called *medicina popular*, where a similar but also different implementation of Chinese/oriental medicine is taking place. Groups and practitioners who are part of this broad movement operate in popular and working-class neighbourhoods. Either organized around the activities of the Catholic Church or around some forms

of women's organizations, this form of medicine is mainly preventive and targets chronic illnesses. Patients may have tried different routes beforehand, but because of the inefficacy and the high cost of the cures they turn to this 'community service' form of health care.

This is the case of Vanessa, a practitioner in the neighbourhood of 'La Lagunilla' in Cuernavaca – a neighbourhood well known for having a large part of its male population migrating to the US, as well as being a part of town where taxi drivers are reluctant to drive you after dark. Social, family and economic problems are common in this neighbourhood. Vanessa sees many patients each day and has also been trained in Chinese/Japanese medicine. She has been given courses by a Japanese doctor who resettled in Nicaragua and who has spread knowledge of oriental medicine throughout Central America and Mexico via the existing network of *medicina popular* groups.<sup>10</sup>

Vanessa knows about the diagnostic pulse, the meridians and therapeutic massage, as well as some basic points of acupuncture and Japanese diagnosis. However, she has integrated this knowledge into a fluid system of her own diagnostic and healing practice, which combines flower remedies (both Bach and Argentinian) with oriental medicine and homeopathy. What she has retained of her Chinese and Japanese medicine training is the diagnostic practice that she pursues through the reading of the tongue and the colour of the skin, as well as the kinaesthetic use of a copper bar which allows her to discover which treatments/herbs or flower remedies are indicated for the specific patient.

Needless to say, her practice resembles Dr Carlos's practice only remotely, but it is still as effective with patients in her neighbourhood as his is for his more middle-class patients. Vanessa has now established a practice which is also connected to the local Catholic church: she has a group of women in the church who she is training in natural remedies, Chinese and Japanese diagnosis, flower remedies, Shiatsu and massage. Part of Vanessa's formation has been in the activity of the Catholic Church and in different forms of consciousness-raising. Like other women involved in this grassroots health group, she believes that their work is geared towards ameliorating the life-conditions of the people living in their neighbourhood and in other poverty-stricken areas. Moreover, their health work is also connected to a strengthening of their gender position: self-help and self-education are primary tools in this form of grassroots, community-oriented health practice, and this gives women a strength and a possibility for self-improvement (*superación personal*), as well as an improvement in their families' and children's conditions.

Vanessa and other health promoters of *medicina popular* in Guadalajara low-income neighbourhoods believe that their work connects with and is part of a Mexican 'tradition' (Napolitano, 2002) and they refer to the danger of the '*Malinchismo*' of Mexican people. This is the belief that whatever is foreign is to be valued more highly than the local,<sup>11</sup> and, in this specific field, whatever medicine comes from abroad may attract more

attention than local ones. Because of a belief in valuing the 'Mexican' through a form of popular medicine, many promoters of *medicina popular* see that it is possible to practise Chinese medicine with 'Mexican' herbs.

In the *medicina popular* movement, but not exclusively so, there is an interest in handling Chinese remedies through 'traditional' Mexican medical practices. There are over 500 Chinese herbs that are currently used in Chinese medicine and a little over 40 that are currently used in Mexican herbal medicine. Moreover, the import of Chinese herbs to Mexico is very expensive (they have to be imported through the US) as well as very risky, since the herbs may never pass through Mexican customs, where they are considered suspicious and are often delayed. So Dr Carlos and some practitioners of *medicina popular* both in Cuernavaca and in Guadalajara have learned to treat Chinese herbs in a Mexican way. Chinese herbs are left in an alcoholic solution to obtain a tincture – called *microdosis* – that is used directly under the tongue. This form of herbal preparation is very well known and commonly used in the *medicina popular*. If the Chinese herbs are not available within the oriental diagnosis, the patients will be offered a Mexican herbal remedy that is thought, or has been observed to have a similar effect as the missing Chinese remedy. This practice is an ongoing attempt to translate some of the benefits of Chinese medicine into what I would call an 'orientalized' Mexican medical practice.

It is clear that the knowledge and the experience of the practitioner/doctor are fundamental, rather than the 'purity', borders and validation of a disciplinary alternative/traditional medical knowledge. In the presence of a loose system of 'quality' control and low-level of 'criminalization' of CAM and traditional medicine – which is nonetheless showing some signs of changing toward a North American model<sup>12</sup> – practitioners are taking a central role in the development of a medical practice that is translated and continuously modified in relation to a local and heterogeneous knowledge. Oriental medical knowledge is recast through 'local' experience.

Hence the 'localization' of oriental medical knowledge expresses a 'contact zone' (Pratt, 1992), which does not refer strictly to a relation between a dominant/colonizer knowledge and a subordinate/colonized one, but suggests ways in which knowledge is negotiated, recast and shaped through multiple contacts between central and peripheral knowledge(s). Moreover, it suggests processes through which a peripheral medical knowledge acquires status, and how it appeals through its commodification, consumption and appropriation by different social groups.

This leads our discussion to a third level at which Chinese medicine and Japanese therapeutic massage have been commodified in urban Mexico. This is the level of exclusive health spas that are increasingly offering oriental medicine and other alternative medicine services.<sup>13</sup> The type of clientele they address ranges from middle-upper to upper class and their market stresses notions of exclusivity, 'natural beauty' and stress relief. The way in which this market operates is to create a 'need' and a desire for what

I call a 'cosmopolitan' medicine. In my view, this cosmopolitan medicine transforms an elite medical product into a commodity fetishism by singling out the product over and apart from any similar one, therefore concealing the hierarchical mirroring between different classes of consumers (Žižek, 1989).

In other words Chinese medicine (as acupuncture) and oriental body massage (as Shiatsu), when part of cosmopolitan medicine, are not presented as 'alternative medicine' but as part of a weekend, particularly branded form of health care which is tailored to the needs of the individual patient/consumer. These health spas could not sell the 'same' medicine in the high street, but have to package it with a hint of glamour and exclusivity. What is sold is a particular 'remaking' of oriental medicine that is either branded with the name of the health spa or the name of the therapist who practises it. It is also a form of medical 'eclecticism' in which therapists may combine different trainings in a particular 'branded' method. This phenomenon of exclusivity is not confined to the Mexican case, but is possibly a common trait of a global 'exclusive' health market. 'Cosmopolitan' medicine is both a demand for a certain medical product, as well as the consumption of a plural medical style that differentiates people. This rhetoric is often filtered through a nostalgia for authenticity, which fixes 'traditional', healing and medical knowledge into a non-hybridized form that can be better consumed (Ayora-Diaz, 2000).

Jackie Stacey has studied the reinvention of nature through the translation of Third World medicine and exotic products into consumable commodified forms (see the case of the Body Shop) and she argues that global access to different types of medicines and remedies is shaping a 'new universalism' where the consumers are 'offered a sense of participating' in an endless possibility and desire for 'distant' and exotic forms of healing and body beauty care (see Franklin et al., 2000: 141). Her point is to stress that a process of globalization of nature goes hand in hand with a new practice of 'global self-health' where 'the self becomes the ultimate arbiter of appropriation'.

Cosmopolitan medicine is definitely driven from a desire for 'global self-health', and an aspiration to global citizenship through the consumption of local as well as 'exotic' medical and healing practices. In fact, cosmopolitan medicine is composed of 'traditional' medicines (clients in health spas such as La Misión del Sol are given a choice which includes Mexican herbal medicine, and indigenous Temascalas as well as oriental-inspired massage), but is not geared to the reproduction of a local or a national identity. It is geared instead to make people feel that they are part of a global market, the products of which may be available in Houston and Colorado as they are in Cuernavaca. Cosmopolitan medicine is aimed at differentiating consumers and at delivering a product of medical transculturation in a global market. It fosters an individual tailored consumption of a desire for difference.

My discussion of the appropriation of oriental medicine by other

consumer groups of Mexican society partly challenges Stacey's view (see Franklin et al., 2000) of the hyper-individual focus of alternative medicine consumption. The cases that I have discussed suggest rethinking broadly the phenomenon of CAM and the commodification of 'nature': they are still processes that are part of particular histories of national and popular medicine. Oriental medicine is transformed by travelling through low-income Mexican barrios, and the end result may be rather different from the medicine practised for a middle-class public, but what it suggests are important ways in which the Mexican-national and the popular can be reinforced via the travelling of this medicine. Hyper-individualized consumerism shapes only one side of the Mexican picture.

### **Conclusion**

I have argued that popular medicine introduces a 'Mexicanization' of Chinese/oriental medicine that is congruent with a discourse on raising consciousness about difficult living conditions. Some forms of oriental medical diagnosis and cure are creatively translated into a grassroots form of medicine which, in its everyday form of practice, can partly challenge gender position and reformulate a power of a 'national' culture, even if, in practice, some of the efficacy of oriental medical forms may be diluted.

Cosmopolitan medicine instead works against a notion of the popular and is not part of a discursive practice that reinstates the popular and the local as part of the national. It is instead part of a national where the popular is purged and the 'traditional' becomes one of the multiple components of the cosmopolitan. Cosmopolitanism is a special knowledge that can travel and be recontextualized without being devalued, and which 'stimulates' a local knowledge rather than becoming one (Hannerz, 1996: 110–11). The aim of this type of knowledge, Hannerz suggests, is to acquire a new form of mastery which is not threatened by the encounter with a 'local' Other and the exotic foreigner.

I opened this article on an ambiguous note on the mastery over medical knowledge(s). I have only sketched here modes of cosmopolitan and popular forms of mastery and appropriation of oriental medicine in Mexico. There is still much to explore about the relationship between these cosmopolitan and popular forms of knowledge(s): ways in which they are perceived by a heterogeneous and changing Mexican bio-medical body of professionals; the modes in which oriental medicine could eventually be integrated and 'institutionalized' within a Mexican health care reform; or the tensions perceived between cosmopolitan and popular modes of medical delivery by practitioners who cater for different publics.

It has been argued that the increase of CAM use in Latin America is connected to the forging of civil society and a citizenship mode (Madel, 1999). Whether the modalities of consumption bypass the national or actually reconstruct both the national and the popular, these cases suggest ways in which a transculturation of medical knowledge reveals aspects of citizenship formation. This citizenship formation develops in a sphere of

consumption and is revealed through – as Ortiz reminded us – the agency of knowledge and the social relations that produce it. When oriental medicine ‘transculturates’ into urban Mexico, it also becomes part of a cosmopolitan medicine which reveals a desire for singularity, as well as a popular medicine which is much more about a re-discovery and a re-empowerment of the ‘Mexican’. Since transculturation is an ongoing historical process, this Mexican case shows that a ‘transcultural’ medicine has to be understood both as part of a global consumption of the ‘traditional’ and the ‘natural’ as well as part of particular aspects of national history.

Finally, the cosmopolitan consumption of oriental medicine in Mexico, the gradually increasing demand for a Taoist medicine, the ‘Mexicanization’ and popularization of oriental medicine diagnosis, as well as the criminalization of Tibetan medicine in the US are different but still interconnected expressions of what Jean and John Comaroff call Millennium Capitalism – ‘the shifting provenance of the nation-state and its fetishes, the rise of new forms of enchantment, and the explosion of neoliberal discourses of civil society’ (Comaroff and Comaroff, 2000: 293). They are angles of analysis through which to further understand quests for healing as forms of enchantment that drive the formation of the popular and the national during this time of global capitalism.

#### Notes

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1. See the importance that an ideology of *mestizaje* and its counterpart – the *indigenismo* movement – had in shaping a new Mexican state via educational reforms after the 1920s revolution (Brading, 1988).
2. Malinowski wrote the introduction to Ortiz’s book in 1947, but never used his work later.
3. This research draws on fieldwork in two major Mexican cities: Guadalajara, in the state of Jalisco (especially during 1990–2 and 1997) and Cuernavaca, in Morelos (during spring 2001). While the state of Morelos has a long history of indigenous presence and native healing practices, the metropolis of Guadalajara in particular shows a more fragmented and weaker influence of indigenous cultures. The two urban cases present differences and convergences, but it is around the convergences that the ideas of this article are developed. The fieldwork was carried out through interviews with CAM practitioners (mainly homeopaths, acupuncturists and Shiatsu practitioners) as well as patients, and through direct participant observation of the healing/curative process, especially in the grassroots forms of *medicina popular* (see below). This study is connected to an ongoing collaborative project between myself at the Centre of Latin American Studies, University of Cambridge and Gerardo Mora at the Mexican Institute of Public Health over patients’ use of CAM in Cuernavaca.

4. There are obviously some exceptions; see, for instance, Madel (1999) for a general and insightful discussion on CAM in Brazil and Latin America, or Ayora-Diaz (2000), Nigenda et al. (2001) and Whiteford (1999) on Mexico.

5. I may appear heavy-handed in affirming that the stereotypical Hollywood representation of Mexicans as sombrero-wearers, drug-traffickers and tequila-drinkers extends to the medical domain of 'traditional' *curanderos* and folk medicine. Needless to say these forms of healing do exist in renewed forms in the Mexican urban areas. The point, though, is the balance of cultural representations of 'homogenized' Mexicans, both in their homeland and as a migrant population in the US, which are often too one-sided and unproblematized.

6. The NCCAM is part of the NIH (National Institute of Health). It was founded in 1992 and was first called OAM (Office of Alternative Medicine); in the beginning of 2000 it had quadrupled its budget, to over US\$20 million. The range of research that has been sponsored by the NCCAM is within a particular bio-medical paradigm of clinical trials. This means that the validity and the acceptability of CAM are tested via paradigms which on the one hand rightly try to protect the well-being of the patients/consumers against possible misconduct, but on the other test the validity of those systems through a system of validation that is alien to the CAM systems and philosophies.

7. This is a juridical body, part of the Department of Health, which has the power to promote proposals for public health legislative reforms to directly control health research and programmes, as well as to control and regulate the national guidelines for the establishment of new professional and specialist health services in the country.

8. In Cuernavaca there has been a particularly long history of traditional healers as well as, for a combination of reasons, a complex history of traditional and complementary medical influences from different parts of the world (see the proximity to both the metropolis of Mexico City and the town of Tepoztlan, which has been a very important centre for Mexican and international holistic thinking and practice since the early 1970s, as well as a 'sacred' place in pre-colonial history; Echeverría, 1994). This is not specifically the case with Guadalajara, which had been a colonial centre of power since the 16th century with a relatively subdued, but nevertheless discernible indigenous presence. However, the present reality is that in both urban cases there is a growing and diversified presence of, and demand for, CAM, which cuts across class and gender.

9. All names have been changed for confidentiality.

10. *Medicina popular* in Mexico has developed through two channels. During the mid-1970s, the WHO ran a programme to develop traditional medicine in Mexico, which aimed to develop practical methods of self-help on the model of the 'barefoot doctors' in China. At that time, Illich's work on iatrogenic diseases was an important stimulus to the promotion of 'traditional' medicine at grassroots level in Mexico, as an alternative to the use of allopathic remedies (Beltrán, 1986). Second, *medicina popular* spread through networks which overlapped with Liberation Theology. Another of its roots was in primary self-help revolutionary groups during the contras repression in Nicaragua. It is important to mention that Paulo Freire's work on education and consciousness-raising among the poor became an important ideological basis on which *medicina popular* has developed as a structured grassroots movement composed of different networks, in both urban and rural areas, focusing

mainly on *herbolaria* (herbal medicine) as well as different forms of complementary medicine for primary health care.

11. *Malinchismo* derives from La Malinche, the woman who became the partner of Cortez at the time of the conquest of Mexico in 1519. She became a symbol of the link between the natives and the colonizers, but also a symbol of the betrayal of Mexican roots: she was seen as the first to engender 'race'-mixing, through 'giving in' to the colonizers' world. This stereotypical gender representation connects to a particular interpretation of Mexican history and imagery, which associates women with a weaker and subjugated aspect of the 'Mexican character'. Stereotypes fix reality in an a-historical way; nonetheless there are more than a few examples in Mexican popular culture and literature of this 'syndrome' of inferiority and subordination of 'the Mexicans' toward whatever is foreign (Paz, 1950).

12. The *Ley General de Salud* (article 79) only recognizes medical activity conducted by bio-medically trained doctors, not by native healers. For instance, since 1976 midwifery has been recognized only if bio-medical staff train midwives. However, since 1998 there has been a discussion about a new legislative framework for the practice of traditional medicine in Mexico. The debate is over whether, and how, traditional healers should be recognized as patented, and which government bodies would be entitled to issue these patents. In 2001 there are only two regional government initiatives – in Morelos and in Chiapas – that have tried to begin to regulate this field.

13. This is the case, among others, with the health centres La Misión del Sol and Guinot Spa in Cuernavaca.

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