



The International Association
for the Study of Traditional
Asian Medicine
Newsletter September 2003

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Welcome to the IASTAM Newsletter, the first since the ICTAM V held in Halle, Saale, Germany in August 2002 Congress. I am keenly aware of how important editorial responsibility of this Newsletter is, as it needs to be a joint effort. I would therefore solicit the help and cooperation of all members world wide in continuing this newsletter as an active shared mode of communication which, even in this day of e-mail and e-groups, finds a place and significance.

The Halle conference was a stimulating and exciting one. Most of you must have seen the conference report already available on the ICTAM website for quite some time now. The members' meeting held during the time was exciting and long and the renewal of faith in this group and endeavour was hearteningly evident. Equally, a sense of expectation about some new path for IASTAM was palpable. In the last issue that Dr. Ernst edited, she suggested that ICTAM V was perhaps a good time to assess IASTAM's mission statement. In keeping with the mood of the conference and the new pointers it indicated, I would like to suggest that these pages might be a good place to discuss and debate them. I expect this in the spirit of exploring the possibilities for extending the reach of the study of Traditional Asian Medicine.

The broad realm of public activity in TAM, whether through markets or government, has grown enormously in the last twenty years. This is not only in volume, but also in terms of parameters and directions of these systems; not just practice, but pedagogy; and most importantly, not just domestic laws but international trade agreements in the commodities that are produced under the rubric of these systems. Because for our little community, the significance of the 'study' of TAM is naturally of ever increasing importance, our studies have kept track with these developments, but this is not obvious in the wider world where we could have a greater impact. We feel our contribution can be significant and should indeed be taken cognisance of, but this is unlikely to happen in the natural course of things. And we are likely to find partners in this quest. Our friends in public health, reviewing and renewing their energies this 25th year of the Alma Ata declaration, are a good example. If we begin the search, we are sure to find others.

I would like to suggest that some part of our energies be channelled in this direction, while maintaining the basic orientation of IASTAM. Even if we have not needed to focus on these wider fields so far, there is perhaps a need to explore the role of IASTAM in this changing world. I invite responses from members and others, with ideas and suggestions, for the next issue that we hope to follow up with quite soon. We could begin with a freewheeling discussion and then gather the strands as we move on. By the time of the next ICTAM at Austin then, we might have a great set of new ideas we could discuss face to face!

In the meantime this newsletter will continue to be a source of news, reviews and information, as before. Looking forward to making it a forum for dialogue and exchange as well, we bring you this new issue.

Madhulika Banerjee

Editor

madhulikab@iastam.org

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**CLOSING LECTURE OF ICTAM V
JOSEF N. NEUMANN**

Respected Ladies and Gentlemen,

We are at the end of an international congress that has shown us the manifoldness of medicine. Indian and Tibetan medicine were highlighted, but aspects of Arabic, Chinese and Japanese medicine too were discussed in lectures and discussions. In this, the respective particular therapeutic concepts, the image of the human being and the understanding of disease presupposed in medical actions, the relationship of the medical systems to religion, and their role in the formation and development of state health systems, were of interest. At the same time, the whole congress was, in all discussions, accompanied by two questions, even when these were not always articulated: the question of the relationship of the medical systems addressed here to their historical past, as well as that of the relationship of the traditional medicines of South and East Asia to European and North American medicine.

Both questions are closely related. It is a characteristic of the medicine of Europe and North America that one believes that their history prior to the 19th century is without practical relevance, and can be neglected in the light of today's technical means of action. There are many reasons for this ahistorical selfestimation, a major one of which is a positivism, mostly unreflected, through which our (Wissenschaftstheorie)

of modern scientific and technical medicine (naturwissenschaftlich-technische Medizin) is characterised; another reason is the negation of death as the unavoidable reality of human life, expressed through the goal of endeavour being the prolongation of life. Fundamentally different is, as we have seen, the situation in the South and East Asian medical systems. Here there is, from the historical past until today, a continuous tradition that has proved itself to be a stable and integrative force in the processes of change induced from outside since colonial times.

The introduction of scientific and technical medicine in the countries of the so-called Third World before and after their independence has inevitably led to a confrontation of indigenous forms of therapy with those of European and North American medicine. Because of this, the question of the possibilities of intercultural encounter, and understanding on aims and the means of proceeding, have become unavoidable in the state health systems in the countries of Asia, but also of Africa and Latin America. In this we have a predominantly practical problem, namely the question of how an understanding on different interpretations of the significance of disease and healing between people belonging to different cultures is possible, and of how these differences can be accommodated within the concrete situation of medical action. We are thus called upon to address ourselves again and again to the question of how persons belonging to different cultures perceive the health behaviour and the forms of therapy of the respective other, and what repercussions this experience has for one's own understanding of disease and



health. In other words, we are here faced with nothing less than the problem of inculturation.

Inculturation applied to the sphere of medicine presupposes that scientific and technical medicine, including its image of man, and understanding of disease, as oriented in accordance with the concept of function, is not only exported with its claim of exclusive effectiveness, for in this way one ignores that traditional societies have their own concepts of health, disease and healing, and are in a position to satisfy the needs felt and articulated in the context of their culture through forms of therapy handed down and adjusted. One has today to accept it as a given that European medicine in non-European cultures does not in any way operate in a medical care vacuum, but rather, as has been made clear again by this congress, in a space filled with established, traditional systems of medical care.

Faced with this global situation, medicine today is inevitably challenged by the task of addressing itself to the question of how understanding in medical action and interaction between people of different cultures is possible. But this presupposes that we, by which I mean we in Europe, learn again how to learn from others, that there is no claim to sole authority on the part of scientific and technical medicine.

The orientation along the principles of scientific endeavour of the technical experiment has led to important successes in modern medicine since the middle of the 19th century. This does not, however, justify the claim to be the only possible and legitimate medicine. Our perception is limited, and due to this we tend to identify the human being with those aspects of its reality to which a certain methodical instrumentarium of cognition and action leads us, whereas we neglect other things when our methods are inadequate, or else forget them again in the course of history. That, ultimately, is what the differences between cultures are about, in which only certain manners of interpretation of the significance of human existence and social cohabitation become reality. Each culture creates its own medicine for itself, and thus realises a certain manner in which disease can be understood, and the sick individual can be helped.

The variety of cultures and their medical systems is, thus, no contradiction, but complementation, and if we wish to know mankind, in the fullness of its possibilities of living, better, then we will have to learn from each other. Because of this congresses such as the one now ending have their special import in a time in which the meeting between people of different cultures in every place on earth is part of daily life. Thus my sincere thanks too go out to all in this city and university who have contributed towards the success of this congress.

**REPORT OF THE 5TH INTERNATIONAL CONGRESS
ON
TRADITIONAL ASIAN MEDICINE (ICTAM)
HALLE (SAALE), 18.-24. AUGUST 2002
RAHUL PETER DAS**

This ICTAM was an important event from the perspective of both scientific merit and representation - not the least

also for the City of Halle and the Martin Luther University Halle-Wittenberg -, and was taken notice of by important public media too. The positive impression that it has left can easily be perceived from the fact that, while a long time span of eight years lay between the fourth and the fifth ICTAMs, and while it was relatively easy to gain acceptance for Halle as the venue, after this fifth ICTAM there was the unprecedented number of six serious candidates for the sixth ICTAM, all of them promising to hold the conference within two to three years. These were locations in Bangladesh, India, Indonesia, Russia (Buryatia), Turkey and the United States of America; some of these applications were supported by important instances of the state. The University of Texas at Austin was chosen as the next venue.

A significant factor leading to this positive development is certainly the fact that there were several very prominent participants. Among these were a member of the Indian Cabinet (the Minister for Health and Family Welfare), a Secretary of State from his ministry, the Deputy Premier of the Republic (Buryatia) of the Russian Federation, a personal physician of the Dalai Lama, and the President and Vice-President of the German Physicians' Society for Acupuncture, with approx. 11.000 members the largest society of its kind in Europe.

Based on the comments of many participants it can, however, also be inferred that a significant positive factor was the influence of the conference on the awakening or reawakening of interest in a forum bringing together for an intensive exchange of views not only persons from various disciplines, but also from various professions and countries. In this connexion the particularly stimulating role of the many plenary sessions in furthering this exchange was highlighted; this corroborates the effectivity of the novel conception of this conference.

Various initiatives, particularly on Asian medical systems in a Western environment, were intensively discussed during this ICTAM, and it may be presumed that some of these will lead to visible results, since several of those taking part in relevant discussions are also active and prominent actors on the national or EU stage. Moreover, the first intensive exchange of views on Tibetan medicine in the context of modern health care systems took place during this conference; this will surely have consequences particularly in the medical and pharmaceutical spheres.

The participation of a largish number of persons from Asia and Eastern Europe was subsidised. All in all, 374 persons were registered as legitimate participants; amongst these, 18 were students. Establishing the legitimacy of the registration turned out to be problematic inasmuch as not only individuals, but also professionally organised trafficking gangs from some Asian and African countries attempted to obtain entry permits for the EU through the ICTAM. It was also necessary to register many participants without prior payment of the registration fee, as this registration was the precondition for obtaining funds for participation in their home countries. However, it turned out that the major portion of this group of participants did actually participate. Nevertheless, the preparations, connected with considerable costs, for the number of participants mentioned constituted a great risk for the organisers. But for the generous support of the City of Halle, the Martin Luther University Halle-Wittenberg, the

German Research Association (Deutsche Forschungsgemeinschaft) and several private sponsors, it would not have been possible to minimise this risk, or to financially support the participation of selected individuals.

Ultimately, however, in spite of all efforts not all registered persons could participate. There were various reasons for this, the most important being, apart from financial problems, probably caused by the international political situation and natural events that frustrated the organisers' plans. Among these were the general fear of travelling, and particularly flying, after the events of 11.9.2001, the tightened security and entry regulations and, last but not least, the flood calamity that afflicted Halle and its environs at the very point of time of the ICTAM. As an example for the influence of these events, it may be mentioned that not a single one among the registered participants from Pakistan or Africa could obtain an entry permit; this pertained to 48 persons, approx. 13% of all registered participants.

Nevertheless, about 270 persons (not counting students) actually participated in the ICTAM. One did, however, often gain the impression that during the meeting times the number of participants in the city and its surroundings could have been less, and, conversely, more at the actual conference venue.

It should also not be overlooked that this was the first time that the ICTAM did not take place on the "home turf" of one of the Asian medical systems; due to this, the hitherto usual large number of participants from the organising country could not be reached. In fact, only about 23% of all participants came from Germany itself; in Surabaya, Bombay and Tokyo the locals had numbered over 40% in the most unfavourable case. By contrast, in Halle the number of participants from India was higher than the number of participants from Germany. On the other hand, it must be emphasised that these numbers represent a degree of internationalisation that does not appear to be common for a conference in Germany, and especially in an internationally little known region like that of Halle.

Attention should also be drawn to the relatively meagre number of participants from Halle and its surroundings. Even though the activities in connection with the floods certainly played a role in this connexion, it was striking that the five evening lectures in German for the general public were visited by only about 130 persons, and that at the conference itself there was hardly anyone from the medical or pharmaceutical departments of the University present. This makes it clear that, in contrast to large parts of the general public, in the academic sphere the acceptancy of Asian medical systems cannot simply be presupposed. This must have been an incisive experience for many participants from the Asian countries who were, maybe for the first time, confronted with the reality in the countries of the West also highlighted by various plenary sessions. This problem of the acceptancy of Asian medical systems outside Asia, particularly by public health systems, necessitates a serious scrutiny of the matter that can be furthered especially by a forum such as the ICTAM, probably most effectively, however, if it does not convene in surroundings in which Asian medical systems do not have problems in being accepted anyway.

The 374 registered participants came for a total of 36 countries (place of residence, not country of origin).

Their breakdown is as follows:

Australia	3	Austria	5
Bangladesh	7	Bosnia & Herzegovina	1
Belgium	1	Canada	2
China	12	Czech Republic	1
France	1	Germany	102
Ghana	5	Greece	1
Guinea	11	India	108
Indonesia	1	Iran	16
Israel	3	Italy	1
Japan	6	Lithuania	2
Malaysia	1	Mongolia	1
Nepal	3	Netherlands	5
Nigeria	9	Pakistan	23
Philippines	1	Poland	2
Sweden	2	Russian Federation	9
Sri Lanka	1	Switzerland	2
Thailand	1	Turkey	2
UK	11	USA	12

The practical realisation of the congress organization was entrusted to the company konzept+form of Halle. They have done a good job, as is also documented by the comments received subsequently.

IASTAM MEMBERS MEETING 22ND AUGUST 2002 HALLE (SAALE) GERMANY

Council Members Present:
Narendra Bhatt
Aysegül Demirhan Erdemir
Vivienne Lo (Chair)
Dominik Wujastyk.
ICTAM Delegates
Secretary: Emma Ford
Apologies: Waltraud Ernst
Charles Leslie
Joe Alter

1. Confirmation of Council Elections: All members were in agreement of the appointment of Vivienne Lo as Secretary General
2. Financial Report and Appointment of Auditors: As Joe Alter was absent for the meeting it was agreed by the members that a financial report would be circulated to members via the newsletter and website. No auditor had been appointed. It was agreed by council members that the auditor should be local to Joe Alter and that confirmation of the appointment would be circulated to members with the financial report. Rahul Peter Das (m) suggested that it may be wise to change the UK sterling bank account to Euros as well as keeping the USA Dollar account. This would be easier considering how many European members would be paying dues and for back issues etc. Members agreed. ACTION V.L.
3. Outgoing Secretary General's Report: Dominik reported that the 2000 office ended in a postal vote to all members, with nominees forthcoming and a ballot had been held. Dominik reported that the newsletter was still a very successful tool and was at the core of IASTAM. He reported that the database (ACT) Had been put in place and was working very successfully. He acknowledged the sad deaths of: BASHAM, SAID AND PARIKH during his term.

Dominik also reported that he and the council members were in regular contact in between ICTAM's and that all emails were archived. There were still council places to be filled and he suggested a call for nominations later in the meeting. He also suggested that as it is quite labour intensive to remind each member about dues, we charge everyone annually in April. All members agreed. Dominik concluded that he had enjoyed his time as Secretary General and wished Vivienne well. Dr Bhatt thanked Dominik on behalf of all the IASTAM members for his work and all agreed that it would have discontinued without him. **Please see Dominks report on Page 11..**

4. Incoming Secretary General's Report: Vivienne Lo was happy to report that IASTAM now has over 500 members and that through the success of ICTAM there was a 10% increase in membership. She also acknowledged Dominik for his report and the Wellcome Trust Centre For The History Of Medicine at UCL for their support. In her short time as Secretary General 2 newsletters had been produced and distributed and a volume of back issues from 1982 till 2000 had also been collated for sale to members. Vivienne also reported that the website had been revamped at no cost to IASTAM and that there were now online facilities for registration as well as donations. There is also a contents list online so members can search for topics of interest. Plans are afoot to construct a networking environment online so members will be able to get in touch with each other to help with research and share ideas, this should raise IASTAM's global profile and help to establish a more effective community.

5. Nominations for the next location and date of ICTAM: Several bids were put forward by members and all will be explored by the council. A decision will be made in the near future, the bids were as follows:

Martha Ann Selby - Texas: Prof. Selby expressed that The University of Texas at Austin is the largest in the US and has marvellous conference facilities. She suggested that it could be well subsidised as the university has a large colleague base in Asian Medicine. It would be advantageous for IASTAM to target new members in the states and bolster US interest in Asian Medicine. *PROPOSED DATE: 2005/2006*

R K Mutakar - India: Prof. Mutakar suggested that a conference in India would advance the development of the disciplines and academic issues. The conference would be guaranteed Government support and it would be easy to obtain visas. This relationship would aid the conference admin should any political situation arise. IASTAM India could also be used as a serious forum for Indian scholars, which would be expanded internationally. ALL disciplines would be represented. *PROPOSED DATE: 2004*

Aysegul Dermirhan Erdemir - Turkey: Prof. Erdemir stated that there is no Asian Traditional Society in Turkey, but there is a local Turkish Society of Medicine. They are happy to already promote an International Congress on Ayurvedic subjects. She stressed that she could organize a very comfortable conference on a low budget. *PROPOSED DATE: 2006*

Prof. Sutarjadri - Bali: Prof. Sutarjadri was the convenor of the 2nd ICTAM in Surabaya in 1990 and the proceedings are available as an example. He proposes 2 conferences, one in the next 2 years to promote local Indonesian interest in IASTAM and then the next ICTAM to be after that in 2007. Not only would it be an ICTAM, but

it would allow members to see Bali. *PROPOSED DATE: 2007*

Dr Bair G Balzhurov - Deputy Prime Minister of Buryatia (previously Minister of Health), and Envoy in Moscow: Rahul Peter Das relayed information in the absence of Dr Balzhurov. This venue has high level government support as well as the support of IASTAM India and would be a very interesting venue for the ICTAM. It has potential to recruit new members in that part of the world. *PROPOSED DATE: 2004/2005*

Prof. Nurul Islam - Bangladesh: Prof. Islam stated that there are 200 International students who would find the ICTAM of interest. It would be held at University of Science and Technology Chittagong. There would also be support from the government. *PROPOSED DATE: 2004/2005*

The council responds.

Dominik was very pleased with the number of bids and the enthusiasm from the members. Comments from the members were sought. Vivienne Lo said that response demonstrated a widespread recognition of the potential for IASTAM.

6. Nominations for Assistant Secretary General: Vivienne nominated Madhulika Banerjee as she is dynamic and as Secretary General thought that a personal relationship would be very beneficial. Madhulika accepted.

7. Constitutional Reform: Dominik made a number of suggested changes to the constitution to be explored by Vivienne. Details are in the Outgoing Secretary's Report. Prof. Mutakar suggested that we use the by-line 'Founded by Basham' on correspondence. All agreed. Bhatt said that as it is already in the constitution that the Council is in control of all changes to the constitution and members have a right to protest the changes, therefore all amendments should be circulated as soon as they have been suggested. All agreed. Dominik also brought to the table an addition to the constitution about the Basham medal; what it is for, why it is given. There were mixed reactions to this, but it was decided that the council will need to discuss this further. It was noted that the matter of the country of origin of the constitution has first to be investigated, before action can be taken. **ACTION V.L**

8. New Editor: Appointment of the New Editor of the Newsletter: The council welcomed the offer by Madhulika Banerjee to take up editorship of the newsletter. All agreed. Barbara Gerke will also continue to format the newsletter.

9. New Journal: Vivienne reported that Waltraud Ernst has formulated a proposal for establishing an IASTAM journal. She noted the need for an Asian Medicine Journal, independent from academic institutions and practitioners. All members of the council felt that it would inject new life into IASTAM and raise subscriptions of members. Further details will be given in the next newsletter. Prof. Das felt that financing could be a problem, and suggested that if it was yearly or less then it would be of a higher quality. **ACTION W.E**

10. Relationships with other chapters: It was noted that India did not have an international conference and memberships stood at the 490 mark. It was agreed that as members of the Indian chapter join for life, they were not able to join the International IASTAM for free. All agreed that the International body could be of assistance to the

Indian Chapter and that we must concentrate to develop good communication between the chapters. There is no need for amalgamation. Dominik responded that the finer details should be discussed amongst the council members. Bhatt reported that a solution was very close and agreed that it will need further discussion between council members after the ICTAM. ACTION N.B

11. Registrations: Participants for the meeting were told that they were entitled to 2 years free membership as a delegate at ICTAM 2002.

12. A.O.B: Vivienne thanked members and participants for attending the meeting and also Prof. Das for organising the 2002 ICTAM.

CONSTITUTIONAL EMENDMENTS

DOMINIK WUJASTYK

1. Throughout

Emend male pronouns to be non-gender-specific.

2. 18.2

Nominations of candidates for election as Officers of the Association, except the Founder, Prof. A. L.

Basham, who remains in that position, and Associate Secretary, who is appointed according Section 16 (2),

18. Nominations of candidates for election as Officers of the Association, and Associate Secretary, who is appointed according Section 16 (2),

3. 20.1

The normal business of the Council shall be conducted by post, and the normal business of the Council shall be conducted by post and email.

4. 27.3

'An amendment to the objects and purposes of the Association shall not be effective until approved by the Registrar of Companies in the Australian Capital Territory'. Delete.

5. 27.4

'An alteration of the objects, purposes or rules is of no effect until a copy of the alteration is lodged with the Registrar of Companies in the Australian Capital Territory.'

Delete

6. Appendix: Basham Medal

An award in the name of Professor Arthur Llewellyn Basham is to be awarded on the occasion of the ICTAM meetings. The award was instituted by Prof. Paul U. Unschuld during his period as president of IASTAM. The principle of the award is to preserve the memory of Prof. Basham, co-founder of IASTAM with Prof. Charles Leslie, and to recognise special contributions by IASTAM members to promoting the goals of IASTAM. Two medals.

CONFERENCE REPORT

ASIAN MEDICINE: NATIONALISM, TRANSNATIONALISM AND THE POLITICS OF CULTURE

JOE ALTER

14 -16 November 2002, University of Pittsburgh, Asian Studies Center.

This conference was borne out of a sense that contemporary research on various medical systems in Asia required a new direction. While it was recognized work done from a range of disciplines yielded a great deal more information and understanding than before, that tended to become more and more specific to the uniqueness of each particular case. In an effort to complement these studies, an interdisciplinary conference focussed on national identities with those dealing explicitly with the way in which nationalism, transnationalism and the politics of culture inform medical practice and the production of medical knowledge throughout Asia, was organized at the University of Pittsburgh. A number of leading young scholars in the field participated, including Susan Brownell, Nancy Chen, Christopher Cullen, Waltraud Ernst, S. Irfan Habib, Sean Hsiang-lin Lei, Vivienne Lo, Deepak Kumar, Sylvia Shroer, Ruth Rogaski, Martha Selby, Michele Thompson, and Cecilia van Hollen.

The theme and questions were as follows:

Theme: There is no denying the fact that the local, regional, national appropriation of medical traditions is a common and important framework within which theoretical and practical innovation has occurred. In the scheme of historical time, however, the bounded nature of these regions is a relatively recent development, and tends to obscure the way in which Asia -- however that entity might be defined -- is characterized by an integrated history of practice and theoretical innovation as concerns the development of medicine.

Stretching from the periods of "classical civilization" up to the advent of European colonialism in West, South, Southeast and South Asia, history suggests extensive inter-regional contact and communication by way of trade, political conquest and religious proselytization. However, it is important to understand that more contemporary forms of medical practice in the colonial and post-colonial periods also cross-cut regional and state boundaries.

What this suggests is that there is a critical tension, both in terms of theory and practice, in the different ways in which "traditional" Asian medicine is conceptualized as either "nationalistic" or inherently transnational. The conference explored the nature of this tension.

Given the tension between nationalism and transnationalism, a key question is when, why and how medicine is linked to the social, political, religious and economic culture of a state, and when, why and how does it extend beyond these delimited, bounded frameworks of legitimation? In many ways this is a question framed by institutionalized state politics. However, reflecting current developments in social theory and cross-cultural comparative analysis, the conference reflected a perspective on the nationalistic politics of culture within states rather than the politics of governments as such. It focused on transnationalism as a cultural process rather than on the formal structure of economic trade or international rela-

tions.

Questions: The conference was designed to examine the relationship between medicine and the national and transnational politics of culture in the context of three broadly defined time periods.

1. The first "time period" is defined less by chronology than by the production of canonical texts. The question posed is: How do canonical texts reflect the political culture of their production, and does this political culture reflect a concern for containment and control or dissemination, teaching and "popularization?" When medical knowledge moved "across borders" -- South Asia to East Asia, Middle-East to Southeast Asia, East Asia to Southeast Asia, or within regions in any one of these areas -- did it retain its character as the medicine of a particular region or state? If so, how and why?

2. The second time period engages with the politics of expansionist modernization, broadly defined. The question posed is: How and why was medicine and medical knowledge appropriated by various groups in the context of colonialism, nationalism and the construction of "imagined communities" in Asia? In this period why, where and how did medicine reflect the interests of particular groups within newly defined states?

3. The third time period extends from the midtwentieth century to the present era of rapid globalization and the transnational flow of knowledge, capital and people. The questions posed are: Within Asia how do states concern themselves with the modernization of "traditional" medicine? How does the transnational hegemony of science enable the nationalist articulation of alternative medicine in the context of specific states? How do discourses of science and "new age" spirituality facilitate the transnationalization of "Asian" medicine?

Overview of Panels and Papers:

In most general terms Christopher Cullen, Michele Thompson, Vivienne Lo and Sylvia Shroer, and Joseph Alter were concerned with the questions in the first time period. Irfan Habib, Deepak Kumar, Waltraud Ernst, Ruth Rogaski and Sean Lei engaged with the questions in the second period. Nancy Chen, Cecilia van Hollen, Susan Brownell and Martha Selby were concerned with the third. As was quite evident, however, the framing device of chronology rudely intrudes into the space of medical culture, and both nationalism and transnationalism cut through these time frames and pervert the logic of historical classification.

Another over arching point is the relationship between formal politics manifest in the state, and what is often referred to as the politics of culture. Unlike institutionalized law and policy, the politics of culture can be manifest almost anywhere in any form -- and this might be regarded as problematic.

When is the culture of medicine political and when and under what circumstances is it not? What analytical tools are available for making sense of this question?

What a number of the papers presented at the conference clearly show is that there can be a very direct correspondence between institutionalized state interests in the bodies of its citizens, but that precisely because it is the bodies of citizens that are implicated in medicine, one is dealing with forms of power that are not simply institutionalized, but that are also not simply ideological. An interesting angle to take on this is to "read backwards" as it were

from the bodies of citizens -- the qigong masters effecting miraculous cures (Chen); Vietnamese who choose to write about coconuts and other medical things in a specific language with a specific script (Thompson); T. A. Majeed's Ayurvedic cure for AIDS (van Hollen), for example -- to look at the way in which the state seeks to control bodies that it cannot quite control either by institutionalizing laws -- such as described so clearly by Sean Lei in the case of National Medicine in China -- or by developing ideologies. It is at least in part precisely because the bodies of citizens are the ultimate objects of medical treatment, that the state is unable to control medical knowledge and the production of knowledge by individuals. What was very interesting about Vivienne Lo and Sylvia Shroer's paper is the way in which the meaning of medical knowledge and the practice of acupuncture therapy in England is linked to a long history of the Chinese state's concern with controlling the health and behavior of its people. Although clearly not this simple, states are very uncomfortable with superstition in general, but in particular superstition that is believed to have very material consequences -- that is, consequences that are embodied. Consider here, also, the state's anxiety over claims made by T. A. Majeed to have cured AIDS, and the states -- or in this case an anticolonial nationalist elite's -- much more comfortable and

self-assured support for projects that are scientific and rational, as in the case of Hakim Ajmal Khan and Verrier in India (Habib). In many respects both the similarities and differences between India and Indonesia throw into sharp relief the way in which colonial regimes struggle with the fact that regardless of their efforts to "discipline through science" it is the bodies on the margins -- so to speak -- that reveal a history of medicine that has not itself succumbed to that discipline..... or at least not completely.

One issue with which almost all papers engaged was the advent of modernity and the specific transformations in the relationship between medicine and politics that can be linked to modernity. Into this question one must factor transnationalism, for it can be argued that transnationalism -- properly speaking -- is a function of modernity. Following Benedict Anderson there is a tendency to implicitly if not explicitly think about the relationship between nationalism and transnationalism as a purely modern phenomenon. There is something unique about transnationalism in an era where it is the nation -- rather than some other entity such as an empire or a clan community -- that must be transcended. And yet when you look at the case of a cosmetic surgeon in China who trained in the United States but practices in China (Brownell), when you consider the popularization of Ayurvedic gynecology (Selby), when you look at the case of Dr. Soetomo who came to India from Indonesia and left disappointed (Kumar), when you look at the case of Dr. Ray who used his medical training in England to construct Hindu chemistry (Habib), and when you think of Frank Ros in Australia inventing a theory of Ayurvedic acupuncture (Alter), the question is, is all of this categorically and structurally different from what was going on when scholars from various parts of what is now China engaged with scholars at Nalanda in the 8th century. Is it that different from what was going on in Vietnam in the early 19th century (Thompson)? Clearly "Science" -- with a capital S -- must factor into this, but the question is how and to what

degree. With regard to the 8th century the question is, at least in part, how and to what degree did Buddhism -- with a capital B to match the capital S in science -- link Asia together, and to what extent did it not?

Many of the papers -- even those dealing with the specific time period to which it would be relevant -- engage directly or indirectly with colonialism and the legacy of colonialism. Waltraud Ernst, Deepak Kumar, Irfan Habib, and Ruth Rogaski showed how the dynamics of power in contexts of colonial encounter are not simply characterized by control and resistance. There was a sense of doubt about the seamless hegemony manifest in colonialism's totalizing pretensions, drawing attention instead to the ambiguities, ambivalences and contradictions not just on the margins of colonial power, but at its very heart. This drew attention to the general question about a kind of hegemony built into transnationalism in general and the transnational dynamics of post-colonial academic scholarship.

The question is this: Can we better engage with the forms of knowledge that are impacted in colonialism and the legacy of colonialism by suggesting that, at least on some level, one of the problems of colonialism is that it has imposed the whole category of medicine as such on Asia? The very idea of medicine -- the category itself -- might count as one of those "invisible standards" that Donna Haraway refers to in her critique of academic discourse in the history and philosophy of science. The body and concepts of embodiment can serve as a way to think about medicine outside the strictures of medical logic. But in many cases things that relate directly to medicine extend beyond the body -- zoology, botany, cosmology, alchemy and, of course, religion and philosophy come to mind. Common sense would dictate that medicine is the logical framework for a history of medicine. But what is it that produces this sense of common sense? It is most certainly convenient to talk in terms of medicine, but convenience reflects a high degree of homogenization. Perhaps medicine is a derivative category of thought, and the problem with using the body as an alternative frame of reference is that it, too, poses the question of value in narrowly utilitarian and practical terms, or even in terms where priority is placed on the phenomenology of experience -- being cured, for example -- rather than on something which seeks to go beyond experience with regard to the problem of ordering and reordering the world.

For those who are interested, more specific information on individual presentations is available on the conference web page www.ucis.pitt.edu/asianmedicine.

THE 'MODERNIZATION OF EAST ASIAN MEDICAL CULTURES' WORKSHOP AT HARVARD UNIVERSITY, 20-21 DECEMBER, 2002.

KIM TAYLOR,

The 'Modernization of East Asian Medical Cultures' workshop was organised by Dr. Bridie J. Andrews of the Science Center, Harvard University and generously funded by the Harvard University Asia Center. Altogether there were twelve speakers, seven of whom had been invited from abroad. The aim of the conference was to compare and contrast the pattern of 'medical modernization' across

East Asia. The conference opened with a debate led by Bridie Andrews about just what 'medical modernization' was, the different stages involved, and the particular characteristics of 'medical modernization' in the 19th and 20th centuries. With these questions in mind, the conference began.

Addressing various aspects of medical development over the last one hundred and fifty years in different Asian societies, the papers at the conference turned out to be extremely well-balanced. Speakers representing the modern history of medicine in Japan were Togo Toshihiro and Mieko Mace, representing Korea were Shin Dongwon and his wife Yi Ggodeme, representing late imperial China was Ruth Rogaski, representing mainland China were Bridie Andrews, Caroline Reeves and Sean Lei (Nationalist period), as well as Kim Taylor and Volker Scheid (Communist period), representing the reception and subsequent appropriation of Chinese medicine within the United States were Linda Barnes and Ted Kaptchuk. There was also an active and involved audience which ensured much lively discussion.

In all, a number of interesting issues were raised. It appeared that modernisation did not occur 'naturally', it required impetus, and this impetus usually came in the form of brute force. In Taiwan, Korea, and parts of China, this propulsion into modernity happened at the hands of the Japanese. In Japan and most of China it came through direct confrontation with the West. In either case, the general suppression of indigenous know-how by a ruling elite, and the consequent imposition of Western standards of knowledge led to what we now regard as the 'modernisation of medicine', in this case largely synonymous with a 'Westernisation of medicine'. The main stages of modernisation in medicine across East Asia have been remarkably similar, and often took place along a comparable time-frame. Once in a position of weakness, solidarity ensued; indigenous medical practitioners formed cohesive groups which would publish a journal, set up schools, organise teaching programs, perhaps run a clinic or two. In other words, the groups would attempt to present themselves in the same external format as Western medicine in order to gain ground in the medical terrain of their time. The different paths that each group took to attain these aims were highlighted in the various presentations, and it is expected that an edited volume will develop the rich findings of this conference more fully.

MATERIALS FOR THE EDITOR

PLEASE FEEL FREE TO SEND ADVERTISING, BOOKS FOR REVIEW AND CONFERENCE REPORTS TO THE EDITOR C/O THE ADDRESS BELOW.

Emma Ford
IASTAM
Wellcome Trust Centre for the
History of Medicine at UCL
Euston House
24 Eversholt Street
London
NW1 1AD
UK



IASTAM continues to have two bank accounts, one in the United States and one in England. The reason for holding two accounts is to enable members from around the world to submit membership dues more easily. As accounts of a non-profit organization, both accounts are held free of taxes.

The financial health of the association is good with a balance of \$ 7806.23 in the US account and £255.33 in the UK account.

For the US (\$) account the monthly transaction were as follows:

Month	Beginning balance	Deposits	Deductions	Ending balance	
July 01	7645.17	0	0	7645.17	
August 01	7645.17	0	25	7645.17	
September 01	7645.17	140.06	0	7766.23	
October 01	7766.23	0	0	7766.23	All deposits were membership dues. Deductions reflect the charge for issuing new checks.
November 01	7766.23	0	0	7766.23	
December 01	7766.23	40.00	0	7806.23	
January 02	7806.23	0	0	7806.23	
February 02	7806.23	0	0	7806.23	
March 02	7806.23	0	0	7806.23	
April 02	7806.23	0	0	7806.23	
May 02	7806.23	0	0	7806.23	
June 02	7806.23	0	0	7806.23	
July 02	7806.23	0	0	7806.23	

For the (£ sterling) account in UK the monthly transactions were as follows:

September 01	533.23	0.04	0.00	533.27	All deposits reflect membership dues. Deductions reflect the charge for establishing an online website based payment system and for increasing website capacity.
October 01	533.27	16.29	0.00	549.56	
November 01	549.56	32.54	0.00	582.10	
December 01	582.10	0.04	0.00	582.14	
January 02	582.14	0.04	317.67	264.51	
February 02	264.51	45.52	90.00	220.03	
March 02	220.03	71.38	0.00	291.41	
April 02	291.41	0.02	0.00	291.43	
May 02	291.43	0.02	0.00	291.45	
June 02	291.45	44.29	0.00	335.74	
July 02	335.74	44.59	125.00	255.33	

PROPOSAL: NEW JOURNAL
ASIAN MEDICINE - TRADITION AND MODERNITY
BRIEF DESCRIPTION FOR PROMOTIONAL
PURPOSES
WALTRAUD ERNST AND VIVIENNE LO

Asian Medicine is a multidisciplinary journal aimed at researchers and practitioners of Asian medicine in Asia as well as in Western countries. It makes available in one single publication academic essays that explore the historical, anthropological, sociological and philological dimensions of Asian medicine as well as practice reports from clinicians based in Asia and in Western countries.

With the recent upsurge of interest in non-Western alternative approaches, Asian Medicine will be of relevance to those studying the modifications and adaptations of traditional medical systems on their journey to non-Asian settings. It will also be relevant to those who wish to learn more about the traditional background and practice of Asian medicine within its countries of origin.

On account of its appeal to scholars from a range of academic backgrounds (such as history, anthropology, philology, sociology, archaeology) as well as to practitioners based in Asia and in Western medical institutions and alternative health care settings, the journal constitutes a

unique resource for both scholarly and clinically focused institutions.

AIMS AND SCOPE

a) Asian Medicine is a multidisciplinary journal, aimed at contributors and readers with expertise in the history of medicine, medical anthropology, medical sociology and at philologists specialising in Asian languages (such as Chinese, Tibetan, Sanskrit, Persian, Arabic, Japanese and Korean). The journal's ambition is to make available in one publication contributions from a range of disciplines in order to facilitate a more widely informed engagement with Asian medicine and the development of more rounded and comprehensive perspectives in the study of medical traditions and their modern applications in the West as well as in Asia.

b) The thematic scope will not be limited by geographic boundaries, as the application of Asian systems of healing in the West, within both biomedical institutional settings and alternative medicine and 'New Age' practices, will also be covered. The idea is to enable readers to engage with Asian medicine as 'traditions' as well as with their various historical and modern-day modifications and adaptations to changing circumstances.

c) The journal is meant to provide a forum not only for scholars engaged in the study of Asian medicine, but

also for practitioners of the various strands of medicine currently in use in Asian and Western countries. The ambition is to facilitate information exchange and better understanding between clinicians and academic scholars, thus encouraging practice-relevant research on the one hand and historically and conceptually aware clinical practice on the other.

Topics covered

The ambition is to publish research that focuses on a range of different disciplinary perspectives. It will include both scholarly articles as well as practitioners' reports (in two separate sections). The scholarly articles need to be based on original research and the material should not yet be published elsewhere. The practitioners' reports will need to be clinically driven rather than marketing/commercially motivated. Practice reports need to be narratives of practitioners' clinical experiences and learning processes; case-studies of patients; or clinical research data. Ethical requirements will need to be met in regard to the anonymity of patients and their families.

Topics not to be included

No topic in the field of Asian medicine will be excluded. However, the editors will ensure that material will be accessible to readers from a wide range of disciplines and backgrounds and not only to expert readers in one particular field. The use of jargon will be discouraged and technical terms will need to be explained. This requirement will be set out in the 'guidelines for contributors', alongside the caveat about the originality of the material.

As far as practitioners' reports are concerned, it will be made clear in the 'guidelines for contributors' that material that aims at promoting a commercial enterprise or one particular practitioner's business will not be acceptable for publication. Practitioners' accounts of historical developments of clinical practice will not be encouraged if these are based on impressionistic and anecdotal evidence. They might be included under the rubric 'discussion point' if the peer review panel considers such reflections to merit exposure to the wider scholarly and practitioners' community. In that case, such submissions need to be expected to stimulate further fruitful debate.

A. L. BASHAM AWARD: ACCEPTANCE SPEECH DOMINIK WUJASTYK

Saturday, August 17, 2002

1. A L Basham

It is a great honour to receive this award, and for several reasons. First, the award is named after one of the co-founders of IASTAM, Arthur Llewellyn Basham. I met Bash only once, at an earlier ICTAM conference held in Surabaya, Indonesia, in 1984. He was a model of courtesy and consideration, a true gentleman. I told him a true story about my undergraduate days. When I was approaching the final examinations in Sanskrit language; I discovered to my horror that there was a history and culture paper. I had spent three years reading Sanskrit texts, but felt wholly unprepared for a general paper of this kind. I ran to my professor, Richard Gombrich, who calmly said: "just read Basham's *The Wonder that Was India*. Everything you need for a first class degree is in that book." As I had intended, Bash was pleased by this story,

but he was quick to reply that although he had helped the field of Indian Studies to grow through his writings, the contribution he cared about most was the academic support and guidance he had given to a generation of research students throughout his long career.

2. Excitement of contemporary research

There are still many unexpected and unexplored areas in Classical Indian medicine. The public orthodoxy amongst many practitioners and publicists for ayurveda does not do justice to the richness and diversity of the historical record. I shall address some of these issues in my oration today.

3. Jan's History of Indian Medical Literature

Jan Meulenbeld's History of Indian Medical Literature is a milestone in Indian medical studies, and will revolutionise all future writing on the subject. (Jan is a past Medal recipient).

In 1901, Julius Jolly wrote a small but extremely scholarly book on Indian medicine, which has been the standard work for students and scholars since that time, especially since it reached a wider readership in India through its 1956 translation by Prof. Kashikar. For 100 years, we have relied on Jolly's excellent little book for an overview of the history of Indian medical literature and theory. Excellent works were published in Hindi by PV Sharma and by Atrideva Vidyalankara. But these were not widely available outside India.

Jan Meulenbeld's new History will, I believe, form the foundation for the study of Indian medical history the next hundred years, and perhaps longer. And it will inevitably create a revolution in scholarship, raising the standard of the work that all of us can do.

4. My current work

A very few words about my own current research, which is unusual in that I am looking at developments in a relatively late, but deeply interesting period, 1550-1750.

This project is a study of the Indian medical knowledge systems – principally as expressed in the Sanskrit language – which were current between approximately 1550 and 1750. The proposal is to research the indigenous modes of medical thought and expression on the eve of European colonialism, at a time when the Indian scholarly establishment of brahmanical learning – including medicine – was at a peak of creativity and innovation, but was about to disappear forever.

4.1 The research problem

European colonialism established itself decisively in the Indian subcontinent in the period from 1770 to 1830. This period, and the century following it, have in recent years become the subject of much creative and insightful work in medical history by scholars such as Arnold, D Kumar, Harrison, A. Kumar, Ernst and others. A number of historical cruxes have been uncovered, and genuinely innovative historical discoveries and interpretations have been presented. A new and exciting focus on colonial medicine in India has thus emerged. This work has depended on the systematic exploitation of English-language resources such as the rich archival holdings of the India Office library collections at the British Library. Other scholars, including notably Pearson and Grove, have looked more closely at

the engagement between early European medical practitioners in India and the Indian physicians they encountered, chiefly through the study of Western-language sources in English and Portuguese.

The intellectual life of indigenous India up to this time, however, was conducted principally in Sanskrit and Persian. There is thus a historiographical gap concerning the period preceding that studied in these impressive works. Little attention has thus far been paid to what was taking place in Indian scholarly – including medical – circles immediately before the colonial period. Clearly one cannot legitimately criticize scholarship for not doing what it does not set out to do, particularly as there is an almost total absence of secondary sources about early modern Indian intellectual life in this period. The lacuna is nevertheless a particularly striking one because the two centuries from 1550 to 1750, just preceding the European colonial establishment, constitute one of the most creative eras in Sanskrit intellectual history.

A central aim of this research project will be to study the medical scholarship produced in this period with a view to discovering the extent to which medical thinking participated in the changes which were happening in the other fields of intellectual endeavour. For original Sanskrit medical works were composed in great abundance during these two centuries.

5. Thanks

I should like to end by expressing my deep gratitude to IASTAM and the members of the Council for the singular honour they have bestowed on me today, and for opening up the opportunity for us all to remember the founder of our Association, Professor A. L. Basham.

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OUTGOING SECRETARY GENERAL'S REPORT DOMINIK WUJASTYK HALLE AUGUST 2002

1. From 1995

In 1995, I joined the Council of IASTAM as Secretary. At that time the other board members being Dr L. I. Conrad (President), Dr Shigehisa Kuriyama (Vice President), Dr K. G. Zysk (Secretary General and acting Treasurer), and Lawrence Cohen (Newsletter Editor).

In December 1995, IASTAM held a very successful conference in London, on the topic "Traditional Asian Medicine in the Modern World". Nearly 150 people enjoyed two days of discussions, during which fourteen invited speakers addressed the symposium theme as it applied to the Middle East, South Asian, and East Asia. Some of the IASTAM members from India and elsewhere that I see here today made important and valuable contributions to that meeting.

Between 1995 and 2000, several developments took place on the Council. Dr Zysk, who had been generously acting as Treasurer until someone else could be found, was replaced by Prof. Vincanne Adams as Treasurer. Dr Waltraud Ernst joined the Council as Editor of the Newsletter. I myself assumed the duties of Secretary General.

2. The Newsletter: Asian Medicine

Dr Waltraud Ernst went to work on the Newsletter with a will, and produced a strong series of new issues that brought a new sense of life, purpose, and identity to IASTAM. The importance of these Newsletter issues in reviving the energy and life of IASTAM cannot be overestimated.

3. Controlling the membership information

I assumed responsibility for distributing the Newsletter, supported by the resources of the Wellcome Trust, where I used to work. Initially, I worked with a membership and distribution list that I inherited from Dr Vincanne Adams, via Ken Zysk. After posting out the first of the new Newsletters to several hundred people, I received many returns, marked with various error and non-delivery messages. Thus began a lengthy and time-consuming process of updating and modernizing the IASTAM mailing list. My secretary and I worked through all the addresses, adding, deleting and updating them. Most importantly, we computerized the whole operation for the first time. I count it one of my most important contributions to IASTAM as Secretary General to have introduced a powerful and flexible contacts database to manage the membership and mailing list details of IASTAM, and to have – as the expression has it – laundered the data. The next two or three IASTAM mail-shots conducted in the later 1990s were each more successful than the last, with fewer returns. And new memberships began to flow in as a result of promotion in the Newsletter. Today, our membership data is secure and dependable, and our mail-shots are properly targeted and accurate. (Potential advertisers please note! Contact the new Editor!)

4. Relations with the Indian Chapter of IASTAM

During 1994 and 1995 a strong attempt was made to resolve certain differences that had unfortunately arisen

between the Indian chapter of IASTAM, and the International mother organization. The difficulties revolved around the details of reciprocal membership and the payment of international membership dues.

Dr Bhatt, Ken Zysk and I had a meeting in Trivandrum in late 1994 to go over the issues, and try to resolve matters. Although we felt we had arrived at a satisfactory set of solutions to all the problems, set out in an agreed document exchanged on 30 November 1994, matters remained unresolved through 1995.

I should like to make it particularly clear that at no time during our discussions was there any ill-will or hostility. On the contrary, we have all been the best of friends throughout, and the International Council has nothing but admiration for the dynamism of the IASTAM Chapter and its success in organising a series of important activities. I am delighted today to see Dr Bhatt on the International Council, where we are all hoping that he will be able bring these matters to a satisfactory conclusions by addressing them in the IASTAM Constitution. But I will leave him to say more about this.

5. Website

During my period in office as Secretary General, the world wide web became increasingly important. I designed and mounted a website for IASTAM, so that it would have a proper internet presence. Until recently, I maintained this website, and I feel that it has played an important role, complementary to the Newsletter, in projecting IASTAM's identity to the world.

6. Elections

In the year 2000, the terms of office of the Council came to an end, and as laid down in the IASTAM constitution, a postal vote was held by all members in good standing. First, all members were mailed with requests for nominations to the Council. Once the nominations were received, details of the nominees were sent to all members, along with a postal ballot. Since the number of nominees was less than the maximum permitted Council positions, all the nominees were de-facto elected to the Council. I personally announced my wish to stand down from the Council at that time, but other incoming Council members asked me (with threats) to remain on the Council, in order to provide a link and continuity with past traditions and activities of IASTAM. This I did to the best of my ability, although I stood down from the position of Secretary General. Since none of the other Council members was in a position to take up the post of Secretary General, the Council held a discussion and ballot, in accordance with the Constitution, and appointed Dr Vivienne Lo to that position. Vivienne has done a marvellous job in shouldering all the difficult tasks that are the responsibility of the Secretary General. She has taken over the IASTAM website, and arranged a complete overhaul of the design (which she managed to get done by a noted expert at no cost to IASTAM!). One of the jobs of today's meeting is to vote to confirm the Council's decision to appoint Dr Lo to the post of Secretary General.

7. Sadnesses

The two greatest blows of the past few years, as far as

IASTAM was concerned, was the death of Prof. Basham, and also of Hakim Muhammad Said, whose sudden death was a terrible shock to us all. More recently, we are sad to note the passing of Dr Parikh, whose hard work was so important in creating and maintaining the Indian chapter of IASTAM, and in organising the ICTAM in Bombay.

8. Points for the future

8.1 The Council

The IASTAM Council still isn't big enough. I hope the existing members will give careful thought to choosing appropriate hard-working and committed people who can be invited to join in the Council's work. We are especially in need of a new Newsletter Editor. But in fact, the Council just needs to be expanded with dynamic members.

Furthermore, the positions of Vice President have lapsed, and need to be reinstated. IASTAM has a very nice opportunity here to offer support and recognition to selected members who share in IASTAM's goals and activities.

8.2 Financial year

The Constitution of IASTAM states that the financial year of the Association is the period beginning on 1st January in each year and ending on the 31st December of the same year. However, somehow our practice has been to make memberships active for a calendar period from their payment. Someone who paid in June would be a member until the next June.

Now that the membership records are in good order, and we are in a position to administer memberships more effectively, the Council has decided to return to the practice enshrined in our Constitution, and memberships will run from January to December.

8.3 Valediction

I have enjoyed working to promote IASTAM and I still believe firmly in its goals and activities. I am very glad indeed to see the new Council moving with energy to take the Association forward into the third millennium.

BOOK REVIEW

**VOLKER SCHEID, 2002, CHINESE MEDICINE IN CONTEMPORARY CHINA. PLURALITY AND SYNTHESIS. LONDON AND DURHAM: DUKE UNIVERSITY PRESS
ANNA LORA-WAINWRIGHT**

Chinese medicine in contemporary China is a compelling book, well written and meticulously annotated and referenced. Based on Volker Scheid's anthropological fieldwork in China as well as on his own experience as a Chinese medicinal practitioner, this work presents an original contribution to the study of Chinese medicine in contemporary China. It offers a comprehensive account of the recent history of Chinese medicine, of the political manipulation of its claims as a science and as a foundational element in the Chinese cultural heritage and of the multiplicity of factors at work in the moulding of Chinese med-

ical doctrines and practices.

In the course of his analysis, Scheid unravels the misleading picture of coherence conveyed by the term 'Chinese medicine', and shows it to be a discursive device through which Chinese medicine asserts its authority within the global setting, while it constantly changes to adapt to local milieus. By undermining its pretensions to being static and unitary, Scheid portrays Chinese medicine in its plurality and adaptability, as it emerges "at the intersection of ideological, clinical, institutional, historical, and personal struggles" (2002: 2).

Initial attempts at professional unification in the face of the threat by Western science during the 1920s reached a climax with the integration of medical practice into a nationwide healthcare system post-1949. This is intertwined with the creation of a 'new China' and shaped by contradictory political imperatives including nationalism, Maoism, the valorisation of science and technology, market economics, the desire to project an image of China as having an unbroken cultural heritage while also emulating Western models of rationality.

Since Deng Xiaoping's efforts to build 'socialism with Chinese characteristics', which entail a valorisation of Chinese culture combined with the transition to Western market economy, private enterprises have exerted an ever increasing influence on the health care sector. The Maoist emphasis on a medicine for the masses has been replaced by one on hospital-based services, a focus on cities, on technological advances and on the generation of revenue, while healthcare is still officially subservient to the state. Such privatisation and commodification of medicine have ensued the re-emergence of unofficial healing practices, as the state is forced to give up some of its ideological control in exchange for economic gain.

Contemporary China, Scheid explains, is characterised by an enduring attempt to affirm its genius at home and abroad and by an economic effort to expand the international market for Chinese medicine. In China, this entails asserting itself as a continuous tradition which nonetheless constantly develops under the guidance of biomedicine and the Communist Party. The social construction of *bianzheng lunzhi*, 'pattern differentiation and treatment determination, as a defining practice in contemporary Chinese medicine vis-à-vis Western medicine is an example of such endeavours. By contrast, Chinese medicine exported to the West is constructed as traditional, as the use of the expression 'traditional Chinese medicine' implies, reinforcing Western assumptions about the unchanging, holistic East.

The strength of Scheid's analysis lies in the due consideration given to the plurality of agencies, processes and social interactions involved in the continuous reconstitution of medicinal doctrines and practices. Although Chinese medicine has been able to survive because it has been co-opted by the state, Scheid contends that the latter is not an all powerful agent. Despite its attempts to control and standardise medical practice, it never managed to discipline practitioners at large and is constantly changed in its engagement with Chinese medicine. Equally, medical practitioners and patients engage in relentless negotiations of medical theory and practice, as their agency emerges tactically and performatively in concrete local contexts.

Being a Chinese medical practitioner places

Scheid in a special epistemological position, from which he is able to offer an insider's view about Chinese medical theory and practice. At the same time, his interdisciplinary position compels Scheid to speak to a variety of audiences, and he is only too aware that his sometimes heavily theoretical language may pose an obstacle to readers without a background in social sciences. His endeavour is all the more to be praised in light of this. It offers a crucial contribution to medical anthropology and Chinese studies, and offers great potential for much needed communication, collaboration, and mutual understanding between disciplines.



ICTAM VI

Announcement

The International Congress on
Traditional Asian Medicine VI

will be held on

April 27th through 30th 2006

at the Texas Union on the campus of the
University of Texas at Austin, USA.

The theme for the 6th Congress will be

***"Sense and Substance in
Traditional Asian Medicine."***

An initial Call for Papers and Panel
Proposals will be announced in the spring of
2005

BOOK REVIEW: BAKHTIAR, LALEH, O. CAMERON GRUNER, AND MAZAR H. SHAH (EDS.), 1999. *THE CANON OF MEDICINE (AL QĀNŪN FI'L-ṬIBB)*, AVICENNA (ABŪ 'ALĪ AL-HUSAYN IBN 'ABD ALLĀH IBN SĪNĀ), VOL. 1 OF GREAT BOOKS OF THE ISLAMIC WORLD. CHICAGO: KAZI PUBLICATIONS, INC.

DOMINIK WUJASTYK

Abū 'Alī Al-'Husain Ibn 'Abd Allah Ibn Sīnā, known to the Latin West as Avicenna, was born in Bukhara in AD 980 and died at Hamadan in AD 1037. A child genius and polymath, he was one of the greatest scholars ever to work within Islamic culture. Avicenna wrote works on astronomy, physics, chemistry, medicine, mathematics, natural sciences, logic, poetry, philosophy, and Qur'anic exegesis.

In or shortly after AD 1012, in Jurjān (on the south-east shore of the Caspian Sea), Avicenna began work on a new synthesis in Arabic of the medical knowledge of his age (Gohlman 1974: 45, 55, 93–5). This was to grow in succeeding years to become the famous "Canon of Medicine" (Arabic *Al-Qānūn fī' l-ṭibb*), cast in five large volumes: 1. General theory and practice of medicine, 2. Simple drugs, 3. Diseases of individual body parts, 4. Systemic diseases, 5. Pharmacopoeia.

Avicenna's *Canon* dominated medical thought and practice for a thousand years in the Middle East, Europe, and parts of Asia. It was translated into Latin in the twelfth century by Gerard of Cremona (1114–1187), and this version was printed in Milan in 1473. The Arabic text was first printed in Rome in 1593. The *Canon* was taught in the universities of the Middle East and of Europe until the 17th century. It continues to function as the foundation text of Islamic Unānī medicine in South Asia up to the present day. An important printing of the Arabic text appeared in Bulaq/Cairo in 1877. A Russian translation of the *Canon* was published in Tashkent between 1954 and 1960, and parts of the text have appeared in French, German, Hebrew, Greek, Persian, and Urdu (at least). But Gerard's Latin version of the text remained until very recently the only European language version of the whole work based directly on the original Arabic.

The background to the English text presented in the edition under review is complicated and is not clarified in the prefatory matter of the book. To save readers the trouble of working the details out again, I present them here.

First, in spite of its title, the present book offers an English translation of only the first volume of the *Canon*, 'General theory and practice of medicine'. Volumes 2–5 of Avicenna's medical opus are not included in the present translation.

Second, this work is not a new translation. It is mainly a light revision of the well-known translation of O. Cameron Gruner. Gruner first published his book with Luzac & Co., London, in 1930. Gruner's translation was "based on the Latin translations produced in Venice in

1595 and 1608, supported by a study of the Arabic edition printed at Rome in 1593 and the Bulaq edition" (Gruner 1930: cxvi). Another English translation of book I of the *Canon* was published in Pakistan by M. H. Shah in 1964. This translation was based on the Urdu translation of the *Canon*. The chapter on Anatomy from Shah's translation has been inserted into the present translation, since it was omitted by Gruner from his original 1930 publication. This final composite translation has been compared by Jay R. Crook with a critical edition of part of the Arabic text of the *Canon* that began publication in Delhi in 1982 (Institute of the History of Medicine and Medical Research, New Delhi 1982–).

For much of the twentieth century, scholars without Arabic learned most of what they knew of Avicenna's medicine from Gruner's 1930 translation and essay. It was a learned and valuable work, and as Norman (1991: #45) noted, it was "accompanied by a large number of valuable notes and comments on the text, which bring out the close connection between Arabic and Chinese medicine, and the influence which Avicenna had upon many medieval scholars." In spite of its strengths, however, Gruner's text presented only one fifth of the work, and it was principally based on the Venetian Latin translations of the turn of the seventeenth century.

Clearly there was a need for two developments in *Canon* studies. A new critical edition of the Arabic text based on sound principles and sources, and a new European-language translation based on that new text.

Both these desiderata have been addressed by scholars working at the Jamia Hamdard University in New Delhi (Hamdard Nagar, New Delhi 110 062, India; <http://www.jamiahamdard.edu/>). That renowned institution of higher Islamic learning began publishing a new edition of the fundamental Arabic text of the *Canon* in 1989. It was completed in five volumes, seven years later. It is based principally on a manuscript from the Aya Sofia, Istanbul, which is dated to 618 AH and which claims to have been compared with the author's own copy. Earlier printed editions of the Arabic text were consulted for readings, including the famous 1593 edition of Rome, as well as more recent editions from Tehran, Bulaq/Cairo, Lucknow, and Delhi. (The quality of this edition must be reviewed elsewhere, by scholars of Arabic (cf. Siddiqi 1977).)

And based on this new edition, the scholars of Jamia Hamdard began publishing an English translation in 1993, made directly from the newly established critical Arabic text. These volumes are not as widely distributed in libraries as they should be, and can be difficult to acquire from outside India. This has hindered scholars from incorporating this important new work into general studies of the *Canon* or of the history of Islamic medicine more generally.

Nevertheless, it seems inexcusable that the volume under review, published six years after the appearance of the first English volume from Jamia Hamdard, should on the one hand make no reference whatsoever to any of the work undertaken at Jamia Hamdard, while on the

other hand present only a repackaging of scholarship from 1930.

Gruner's 1930 annotated translation of book I of the *Canon* was sterling work for its day, and this new edition makes it available again in an updated, if confusing, form for anyone who wants to own a copy. But even here the publication frustrates, since the volume is priced beyond all but the longest pockets.

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