

Medicine and Multiculturalism

Who should the power of healing belong to: the patient or the doctor?

by Ziauddin Sardar

It is frequently said that the National Health Service is the glory of Britain. The model of a publicly funded health service free for all citizens is claimed as Britain's gift to the modern civilized world. There is only one problem with this statement in 21st century multicultural Britain. The problem has nothing to do with under-funding, the crumbling infrastructure, the inroads of privatisation by overt or covert policy, or the ethical dilemmas and increasing costs of high tech medicine. The problem is the universality of values invoked in support of our National Health Service. Muslim Britons should be quick and insistent in pointing out that the first public hospital dispensing treatment freely to all opened its doors in Baghdad in 809 AD. In short order no Muslim city was without such hospitals. The hospitals were organised as teaching institutions where medical and pharmacological qualifications were standardised. They were centres for advancing clinical understanding, where medical and surgical practice was pioneered. The hospitals were supported by state funds, and by waqfs or private, individual charitable foundations and endowments. How Baghdad came to have free public hospitals is neither a mystery nor a quirk of history. It was the logical outcome of basic Islamic values, which were being crystallised and institutionalised in Muslim consciousness and social practice. Britain's health service is an expression of core Western values, but also draws support from the values of many other cultures and civilizations. To narrow cast our view inevitably leads to ignoring the wider, more universalist foundations on which we must build to secure the practical fulfillment and delivery of shared values in a multicultural society. How we enjoy life, what we think of our bodies and how we treat them, how we shape our environment—all this is governed by our worldview. While worldviews shape lifestyle, lifestyles determine our states of health. In his highly regarded *Diseases of Civilization*, Brian Inglis lists heart diseases, cancer, mental illness, infectious diseases and iatrogenic disorders (illnesses induced by doctors and their treatments) as the main illnesses of Western civilization. All except iatrogenic disorders relate to lifestyle. For example, heart diseases are a consequence of affluence: they are the result of overeating, rich food, refined foods, stress, chemicals in the environment and lack of physical exercise. But lifestyles can also radically transform old diseases. For example, in early 19th century USA, polio was a mild childhood illness. It started to disappear in the 1920s as American cities began to clean and purify their water supplies. Later it came back: this time, it could kill and cripple. It had now become a disease of affluence.

There is thus a direct relationship between worldview and health. By promoting certain life-styles and producing an environment within which these life-styles can flourish, worldviews determine the state of health of individuals and societies. But worldviews also form the matrix of health care systems. Thus, modern medicine is a product of the worldview of the Western civilization. And non-Western medical systems—Islamic, Chinese, Ayurvedic—are products of their respective civilisations and worldview. To identify the common principles and shared values of different worldviews is a necessary step in uncovering the creative strength of a genuine multicultural society. Without incorporating certain values and approaches to medicine from other worldviews we cannot speak of any meaningful multiculturalism.

Unfortunately, non-Western worldviews are not seen as equal or full partners within multicultural society. This inequality is often expressed in terms of a language of inferiority. Thus non-Western medicines are described as 'alternative', 'complementary' and 'traditional' systems. Such a terminology not only equates a sophisticated system of medicine such as the Chinese with New Age upstarts, it also defines them as substandard. The first step towards accommodating non-Western worldviews in modern Britain is to look at medicine itself in a radically different way. It is already acknowledged that multiculturalism is changing medicine in a practical way. For example, we now see the epidemiology of a multicultural society as a new challenge: the incidence of heart disease and diabetes are much higher among Pakistani and Bangladeshi populations, sickle cell anemia is a particular affliction among Afro Caribbean and African Britons. Gradually, it has been recognised that respect must be accorded to non-Western ideas and attitudes, both as a matter of basic principle and civil right as well as a pragmatic means of insuring the effective delivery of rights and services to minority groups. Health workers with appropriate language skills and conversant with different cultural practices, access to more female doctors, working with the broad range of community groups to encourage use of available health services are all part of the landscape. However, this is a long way from engaging with the other worldviews as equal partners. We understand 'medicine' as modern Western medicine, which assumes there was nothing before the arrival of modern, scientific medicine; diseases, sickness, ill health and premature death were the norm before the emergence of the modern scientific miracle. It is therefore necessary to make a special effort to remind ourselves that what we call modern medicine is as old and venerable as 60 years, beginning with the development of penicillin. Until 120 years ago, when Pasteur pioneered the germ theory of disease, Western medicine was in large measure derived from other civilizations. Only penicillin and antibiotics transformed medicine from a healing art into a true science in the mechanistic mould. The rewriting of history eradicating how much the present competence and expertise of modern medicine owes to non-Western civilizations. For example, the medical encyclopaedia of Abu al-Qasim al-Zahrawi (c. 936-1013) illustrated the basic set of surgical instruments that

would be recognisable to modern surgeons. What we now denigrate as ‘alternative’ or ‘complementary’ medicine was the foundation of modern medicine. Such bad history makes it difficult to acknowledge that until the arrival of penicillin, Western medicine was essentially the same as Islamic medicine. In both cultures, ibn Sina’s (980-1037) *Canons of Medicine* was a standard text for centuries. It obliterates the fact that in 1716 Lady Mary Wortley Montagu, wife of the British Ambassador to the Ottoman court in Istanbul, became fascinated by the widely practiced technique of infecting healthy people with a weakened strain of smallpox to confer immunity. Lady Wortley Montagu took a keen interest because she herself was badly scarred by smallpox, a common occurrence in Europe at that time. Before that, al-Razi (854-935), the renowned Muslim doctor and scientist, had described the disease in such detail that his observations are considered a scientific marvel even today. Yet, Western medicine confers the pioneering breakthrough, the invention of a smallpox vaccine, to Edward Jenner (1749-1823) and the victory over smallpox to 20th century medical delivery systems. My argument is that Western medicine should be seen not as something apart from history, but as the youngest of a number of great traditions of medicine. When scientific medicine commenced it appeared to have miraculous powers, death defying capacity. It is little wonder that ordinary people were filled with awe at the potential, the rapid and ever expanding capabilities of modern medicine. Viewing Western medicine as a tradition, we can see other traditions of medicine as equally valid, and highlight the correspondence and similarities between traditions as well as critically evaluate their differences. From the non-Western perspective, two values in particular are important. The first is context. In non-western traditions of medicine the patient’s family, social and financial circumstances, as well as the general situation of society and environment are important factors in diagnosis. Modern medicine sees the human body as a machine made up of a number of different parts, the organs. Diseases are well-defined entities and tend to have singular causes. Recently it has been accepted - only in the face of mounting evidence - that environment too is a causative agent. If these external factors are isolated and crushed, by chemical or surgical intervention, the body can be repaired and the patient cured. In contrast, non-Western medical systems look at the body in holistic terms; illness can be caused as much by personal, social, and environmental circumstances as by the discrete outside invaders, the disease agents. The point is that context should be integrated into the way we think about sickness and health. The Western, reductive model, despite much propaganda, has been successful in only a few special cases, such as acute infectious processes. It cannot explain the overwhelming majority of illnesses. The decline of the mortality rate over the past century owes almost nothing to modern medicine, but, as recent research shows, to pure or treated drinking water, pasteurised milk, indoor plumbing, closed sewers, improved nutrition, clean and safe work places and shorter working hours. In other words, improvements in health came through improvements in society. The second non-Western value relates to power. In non-Western traditions of medicine the power of healing belongs to patients, not doctors. Doctors can offer remedies but they work with the power of the whole person, the patient. In the Western system, the power of the medical establishment, the consultants, and the doctors is absolute. No wonder patients arriving in a hospital perceive themselves as helpless victims whose only function is to bring diseases for the doctors to fight and defeat. Thus an expectant mother, as I discovered during the birth of my own children, becomes a helpless patient who is ‘ill’. Pregnancy is not seen as a natural phenomenon but as a form of sickness that can only be cured in hospital. In Britain, it is against the law to practise childbirth at home, unattended by qualified medical practitioners. Nature cannot be trusted to produce a normal birth; it has to be actively managed by technology. Once inside the hospital, the pregnant woman lies there helpless while obstetric technology takes over. However, the most common danger to women in labour is haemorrhaging. The remedy requires plasma and sterile water but midwives are not allowed these supplies because handing even this limited amount of technology to the midwife means that the medical establishment undermines its own control and power. In such circumstance, systems of medicine based on other world-views are naturally seen as a threat to the power and domination of modern medicine. Medicine is about income; and advances in modern medicines are not made with health but financial rewards, as well as prestige and fame, in mind. Witness the history of heart transplants. But beyond economics, they present a real threat to the very notion of modernity itself. That is why, under colonialism, non-Western medical systems were ruthlessly suppressed and banned, their research centres were closed, and their practitioners threatened, outlawed and in some cases killed. In India, Islamic and Ayurvedic medicine was declared inferior, irrelevant and outlawed. We need to break this power structure not just to bring non-Western values and medical systems into the National Health Service but also because such authoritarianism is no longer viable. The recent cases of Dr Shipman, who mass murdered his patients unsuspected and undetected for decades, and the consulting gynaecologist, Rodney Ledward, whose botched operations over 16 years have left a trail of more than 400 maimed women, well illustrate the malaise within the system. It is the emphasis on the whole person and the power of the patient to heal her/himself that has made non-Western medical systems so popular in Britain. Overwhelmingly, patients are discovering that non-Western medicine can deliver. It delivers cures, it delivers relief of symptomatic problems and it delivers a quality of caring for the patient as a whole person that has slipped out of the practise of modern medicine. Its cures, therapies, and medications have developed and evolved over very long periods of time. What most British users of non-Western medical systems know is that they deliver cures in less potent and less invasive ways. In the end, genuine multiculturalism in medicine, as much as in society as a whole, is not a question of different values. It is much more the knotty questions of what medicine should do and how it should do it. It may also be that non-Western traditions have retained more of the ideals of healing and health promotion, because they have been on the outside lacking access to modern medicine. These attitudes could provide the ballast modern medicine needs to develop as a more humane tradition. There is more at stake here than bowing to public demand and market forces, whose place in any medicine I would vigorously question. The recent resurgence of non-Western medicine and traditional therapies point to philosophical lacunae in our whole concept and practice of modern medicine—its failure to grasp and grapple with itself as a tradition and therefore to mature beyond the arrogance of adolescence into the humility and wisdom of age. As traditions, the diversity of systems of medicine can

learn from each other, interact with each other, and cooperate with each other. Medicine then becomes a model of how a multicultural society operates as an ongoing dialogue of values among citizens sharing equal responsibility for improving the well-being of society.

(An unabridged version of this article, including endnotes, is available from New Renaissance upon request.) A fuller version of this article is included in Sohail Inayatullah and Gail Boxwell, eds. *Islam, Postmodernism and Other Futures: The Zia Sardar Reader*. London, Pluto Press, 2002.

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