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Faculty of Humanities and Social Sciences

The practice of Ayurveda in the UK and the role of spirituality. A practitioner perspective.

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Doctor of Philosophy

May 2013

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ABSTRACT FOR THESIS

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This thesis examined the changes that occur when a system of healing is transplanted from the East to the West. Ayurveda is both a system of healing and a way of life; though its origins are in India, it has moved across boundaries into many Western environments. The literature on global Ayurveda suggests that it has been promoted as a spiritualised system of healing as it addresses the mind, body and spirit. Currently, there is little research on the practice of Ayurveda in the UK.

This research analysed how the practice of Ayurveda is changing and adapting to the UK environment, and analysed the role of religion and spirituality in the consultation. A qualitative approach was adopted. In-depth interviews were undertaken with a range of practitioners. In addition, participant observation data of Ayurveda events were included in the analysis.

Analysis of the data showed that the lack of traditional remedies, together with regulatory restrictions impacts on the nature of the consultation and therapeutic recommendations in the UK. Practitioners are adapting their practice through the processes of simplification and modification as well as creatively mixing healing techniques to produce 'hyphenated' approaches. The treatments have changed from standardised recommendations to individualised ones and practice has changed from drawing on learnt knowledge to applying principles.

The results further suggest that religion and spirituality manifest in various forms in different Ayurvedic educational, social, political and professional environments, illustrating their 'religious-cum-secular' nature across the Ayurvedic contexts. Spirituality emerged as an important component of the practitioners' definition of UK Ayurveda; however, it did not appear to be the key influence in shaping the consultation which tends to be aligned with the biomedical paradigm as it seeks to be perceived as a credible science.

The findings suggest that a contemporary model of global Ayurveda needs to take into account and recognise its fluid nature as it changes and adapts to a new environment and culture. I interpret this fluidity as a necessary strategy for the survival of a system of healing that sits on the margins of mainstream healthcare in the UK.

This research has significant implications for Ayurveda as a holistic system of healing. It suggests that education and training for UK Ayurveda needs to be in line with the changes taking place in consultations, rather than based solely on the Indian curriculum or classical texts. An adapted approach is required for research as UK practice is no longer standardised compared to that in India.

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List of Abbreviations – Acronyms

APA	Ayurvedic Practitioners Association
AYUSH	Ayurveda, Yoga, Unani, Siddha, Homeopathy
BAAAP	British Association of Accredited Ayurvedic Practitioners
BAMS	Bachelor of Ayurvedic Medicine and Surgery
CAM	Complementary and Alternative Medicine
EBM	Evidence Based Medicine
GP	General Practitioner of biomedicine
MAV	Maharishi Ayurveda
PBM	Practice Based Medicine
RCT	Randomised Controlled Trial
TCM	Traditional Chinese Medicine
TM	Transcendental Medicine

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"And, when you want something, all the universe conspires in helping you to achieve it."
(The Alchemist, Paul Coelho)

The universe did indeed conspire in bringing all the people and opportunities to enable me to complete this research.

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This thesis is dedicated to my mother who understands the value of education for a woman. I will always be grateful for her unwavering support and encouragement throughout this journey. I also thank my brother for his sweet words of support throughout.

Chapter one Introduction

> [.....] The divine sages accompanied by the Gods residing in the heaven heard the sacred word of great sages and were extremely delighted to hear this. "Oh Excellent" this deep and melodious sound produced in the heaven by the delighted Gods resounded the three worlds. The auspicious winds blew and all the directions were illuminated by lights. Divine showers by flowers and water dropped down and then the Gods of wisdom viz. Intellect, accomplishment, memory, understanding, patience, fame, forbearance and pity entered *Agnivesa* and other disciples and these works (Ayurveda), accepted by the great sages were established on this earth for the good of all creatures.
> Ca/su/v32-40. (Sharma and Dash, 2001, vol 1: 24)

1.1 Aims of this research

Ayurveda, a system of healing from India,[1] has gained popularity in recent years as a holistic approach to health and well-being as it claims to address the body, mind and soul. Deepak Chopra, [2] David Frawley, [3] Vasant Lad[4] and Robert Svoboda[5] are prominent among authors who have written books describing the basic principles of Ayurveda for a non-medical western audience and presented it in a spiritualised form to the West (Wujastyk and Smith, 2008: 18). According to Warrier (2009: 1-2) Ayurveda in the UK has become part of the holistic health milieu, where practitioners trained in a range of complementary and alternative medical (CAM) [6,7] traditions offer healing and treatments that are deemed to be holistic i.e. address the mind, body and spirit of their clients.

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[1] According to Alter (2005: 1) the idea that Ayurveda originated in India needs to be considered cautiously as current India is a political entity and the notion of a country and its borders is questionable in terms of meaning and significance. Alter argues that: *The structure of scholarship in terms of funding for research is linked to government interests. This produces the illusion that there is a "tradition" of medicine linked to each particular political entity, even when part of the illusion is that the "tradition" has undergone change with other traditions.* This is appropriately illustrated with the example of Ayurveda, which is currently accepted as a medical system of India, though the history of its development took place in parts of what is now India, Pakistan, Afghanistan, Nepal and Bangladesh through an exchange of ideas across all these borders.

[2] Chopra, D. (2012) The Chopra Center[online]. [Accessed 10.4.13]. Available from World Wide Web: <http://www.chopra.com/aboutdeepak>

[3] Frawley, D. (2013) American Institute of Vedic Studies [online].[Accessed 10.4.13]. Available from World Wide Web: http://www.vedanet.com/about/about-acharya-david-frawley-pandit-vamadeva-shastri/

[4]Lad, V. (2011). The Ayurvedic Institute [online]. [Accessed 10.4.13]. Available from World Wide Web: http://www.ayurveda.com/

[5]Svoboda, R. (no date). drsvoboda.com [online]. [Accessed 10.4.13]. Available from World Wide Web: http://www.drsvoboda.com/index.html

[6] See The Road Map for CAM European Research (no date) [online]. [Accessed 10.4.13]. Available from the World Wide Web: http://www.cambrella.eu/home.php? **Terms for CAM in Science:** AM Alternative Medicine, CM Complementary Medicine, CAM Complementary and Alternative Medicine, UCM Unconventional Medicine, TM Traditional Medicine, IM Integrative Medicine. **Terms for CAM in other fields:** Experience-based Medicine (Erfahrungsheilkunde, Germany), Soft medicine ('Sanfte Medizin', Ger), Médicine douce (France), Holistic Medicine, Biological Medicine,

I trained as an Ayurveda practitioner and became fascinated by how a spiritualised holistic approach to health might manifest in an Ayurveda consultation. As there is little research on Ayurveda in the UK, I undertook a qualitative approach to explore the following two research questions: first, how is Ayurveda practice changing in the new UK environment? Second, what is the role of spirituality in the practice of Ayurveda during the consultation in terms of how it is defined, the way practitioners perceive its link with health, and the way in which practitioners make decisions to include it in their treatment prescription? Other research questions are outlined in detail at the end of this chapter.

This chapter begins with a brief introduction to my background and training in Ayurveda. This is followed by some examples to support the need for a practitioner perspective on research in this field. I then discuss the rise of biomedicine as the dominant system in the UK and the increased popularity of CAM with a parallel rise of different spiritualities, [8] and holistic systems of healing. This is followed by a description of Ayurveda as a holistic system and the political and social factors that influence it. The chapter ends by establishing the research questions and an outline of the thesis.

1.2 My journey to studying Ayurveda

While growing up in the UK, I remember my mother using home remedies for common ailments, or warning us about foods that aggravate certain health conditions, and alerting us to incompatible food combinations. I had no idea at the time that my mother's knowledge was actually based on the principles of Ayurveda which I studied formally many years later, as part of a degree course at the University of Middlesex. For my mother, knowing the qualities and preparation of food, following daily health routines such as oil massage, was part of everyday wisdom that had been passed down from one generation to the next. As Newcombe, (2008b: 252-275) and Langford (2002: 2) have suggested, this passing on of information demonstrates that Ayurveda is a way of life that is part of Indian culture.

Naturheilkunde ('Natural' Healing), Folk medicine, Ethnomedicine, Traditional medicine, Second (deuxième) médicine (France). **Existing Terms for 'Non CAM'**: Conventional Medicine, Mainstream Medicine, Orthodox Medicine, Regular Medicine, Scientific Medicine, Evidence based Medicine, Allopathic Medicine, Biomedical Medicine (Biomedicine), Western Medicine, Modern Medicine, Academic Medicine, Scholarly Medicine (Germany: Schulmedizin), University Medicine, Established Medicine, Conservative Medicine.

[7] Cant and Sharma (1999: 9), and Sharma (1995:4) discuss the problem with terminology used to label CAM traditions.

[8] See Woodhead and Heelas (2000: 110) on what Heelas calls the spiritualities of life.

My mother's reminiscences about her own childhood visits to the local family *Hakim*[9] or *Vaidya*[10] in North India coloured my perception of healing, with the effect that I developed a broad and holistic approach to health. Through describing her visits, my mother yearned for treatments that would get to the root of the illness using natural herbs, as compared to the practice of biomedical doctors who, she believed, only treat the superficial symptoms using synthetic drugs.

After a series of academic research and local government projects, a variety of factors guided me to study the relationship between buildings, space and health. I attended various short courses and talks at the college of Psychic Studies in London[11] (for example, on dowsing, spirit release, space clearing), and other mind-body-spirit events. [12] I undertook a course in *Vastu* and also trained in spiritual healing. These courses provided pathways to acquiring knowledge which fitted my holistic worldview.

In 1998, by chance I picked up a book by Deepak Chopra (Chopra, 1990) which rekindled my interest in Ayurveda. I sought out two local Ayurvedic practitioners, however felt disappointed after consultations with them as my expectations of a holistic encounter were not met. These two practitioners were first generation practitioners from India, who had studied the *'mishra'* or integrated Ayurvedic BAMS degree course which is heavily influenced by biomedicine (Welch, 2008: 130).

A few years later I was introduced to Dr Chawla, a *vaidya* visiting from India. On this occasion I was anticipating herbal remedies; instead, this practitioner 'read' my pulse and recommended that I should read the *Bhagavad Gita*. He said the cause of my health issues was on a spiritual level and was affecting my physical functioning, so I required a spiritual solution. He indicated that I needed to reconsider my career path, as there was also frustration with my career which was contributing to my poor health. I felt he had addressed the issues at the time, unlike the previous practitioners. Inspired by the consultation which I felt was holistic as it did address my health concerns at all levels of mind, body and soul, I attended his lectures during his stay in London.

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[9] In the Arabic language the word Hakim means doctor and the term can refer to an Arabic or Muslim physician and practitioner of Unani medicine.
[10] The title given to a practitioner of Ayurvedic medicine.
[11] The College of Psychic Studies founded in 1884 (2013) [online]. [Accessed 10.4.13]. Available from World Wide: http://www.collegeofpsychicstudies.co.uk/index.html
[12] Mind Body Spirit (2013) [online]. [Accessed 10.4.13]. Available from World Wide: http://www.mindbodyspirit.co.uk/

My route to Ayurveda is similar to that documented by Warrier (2009: 8) who describes the pathways that people take to come into studying Ayurveda in the UK, including inspiration through a 'guru'. Soon after, I heard about a diploma course in Ayurveda and enrolled as it was my childhood dream to find out about Ayurveda and a natural step on from studying *Vastu* and spiritual healing. I had most of the characteristics that Warrier (2009: 5) describes of students who study Ayurveda in the UK: I was a mature student, with an interest in holistic approaches to health and spirituality.

My childhood expectation and my consultation with Dr Chawla led me to think that I would be studying something 'magical', but I was disappointed to find that the course had been 'biomedicalised' (Warrier, 2009: 10) and the Indian syllabus suitable for India was being taught without a thoughtful interpretation of how the knowledge should be applied to a starkly different environment in the UK. The Ayurvedic classical texts emphasise that the principles[13] should be applied according to time, place and circumstance. It appeared that the course leader was keen to establish the course in the UK, but failed to make it relevant to the UK environment (Chopra, 2008: 246). Nonetheless, I found the Ayurvedic modules interesting. The diploma became an undergraduate degree course validated by Middlesex University.[14]

The Master's degree course in Ayurvedic medicine provided me with the opportunity to visit hospitals and clinics in India for the internship. Initially it was interesting to observe the application of the theory in a clinical setting, but then I questioned the relevance of that experience, and how I could usefully translate it for a practice in the UK. For example, many of the complex remedies that are commonly prescribed in India are unavailable abroad and the onus was on the students to try to interpret the information (Svoboda, 2008: 122).

The undergraduate and postgraduate courses provided little clinical experience that was relevant for a practice in the UK and this was the greatest shortcoming in training to be an Ayurvedic practitioner in the UK (Warrier, 2009: 11). A clinic had not been set up and

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[13] The diagnosis based on *doshas* and *gunas* and prescription should be according to the diet, lifestyle, climate and social/ cultural environment of a client.

[14]Middlesex University London (no date) [online]. [Accessed 1.1.13]. Available from the World Wide Web: http://www.mdx.ac.uk/courses/undergraduate/complementary_health/integrated_masters_Ayurveda_mcm.aspx

students had to seek out clinical experience, which was by and large observational rather than 'hands on'. The outcome was that students had some theoretical understanding of the principles in the Indian context, but not the in-depth experience of how to apply them in the UK environment. Another difficulty was that the course tutors, qualified practitioners from India and Sri Lanka, seem to be challenged in becoming university academics and fitting into British Higher Education system. It seemed that a vocational course was being made to fit into an academic mould for the sake of official recognition, but in that process the experience needed for clinical practice was lost.

I had a desire to undertake doctoral research from the beginning of my Ayurvedic studies, as its practice in the UK is largely unexplored, and it would be intellectually stimulating. In terms of my personal growth, it would be an opportunity to develop skills and gain a qualification to pursue an academic career (Maxwell, 2005: 14). In addition, I felt that I had not gained sufficient clinical skills to start practising. As a result of these factors I made a decision to undertake this research project.

As a practitioner researcher with a broad interest in healing and health I was amenable and open to holistic systems of healing, with a particular interest in aspects that may be considered metaphysical or spiritual. I adopted a reflexive approach to this study and endeavoured to be aware of any underlying prejudices I may have had against practitioners who did not share the same approach to health.

Other challenges of this research were that I was undertaking qualitative research though all my previous education has been in the sciences. In addition, I was based in the Department of Theology and Religious Studies, an academic discipline that was at first unfamiliar to me. I was qualified to practise Ayurveda and take a practitioner's perspective, though the qualitative research literature on global Ayurveda had mainly been written by academics in disciplines such as Social Anthropology, Sociology, History and Indology. Therefore, I was dealing with the vocabulary and perspectives of different disciplines as this was an interdisciplinary research study crossing Complementary and Alternative health and Religious Studies, as well as the challenges faced by practitioner researchers undertaking research (Eyles, 2009: 28).[15]

[15] Eyles writes that the researcher's own experience and contexts inform the process and outcomes of enquiry. The researcher is part of the final report and should acknowledge how they may have affected data collection, analysis and interpretation. I discuss these issues further in Chapter three.

1.3 The practitioner perspective

My intention to undertake research in Ayurveda from a practitioner perspective was accompanied by the desire to introduce a pragmatic interpretation of Ayurveda practice, and to balance the somewhat 'romantic' view presented by some academic scholars from other disciplines. The differences in interpretation between one academic scholar and my own practitioner perspective are illustrated with the following example: Zimmerman (1992: 209) argues that Ayurveda in the West is associated with non-violence which is an attractive value of modern times. This is because it excludes the violence of emetics and purgatives of classical Ayurvedic *panchakarma* procedures. The modern emphasis is on the gentle aspects, thus transforming classical Ayurveda into a gentle 'flower power' version for the West.

Zimmermann identified an interesting transformation resulting in a different version of Ayurveda; however he fails to consider a number of reasons that may have contributed to the transformation of classical 'violent' Ayurveda into the modern 'gentle' practice in the West. Legal, cultural and practical factors need to be considered in addition to changes in ideology. Legal restrictions imposed on practitioners in the UK only permit biomedical practitioners to induce emesis. In practical terms, in order to carry out emesis and purgation, patients need to follow treatment procedures (*panchakarma*) that take several days. Few people can afford the required time from their busy modern schedules or the high cost of these long treatments, which can run into thousands of pounds per week.[16] A team of people are required to enable *panchakarma* treatments; therefore the resources are a restricting factor.

In cultural terms, the status of Ayurveda practitioners both in contemporary India, and more so in the West, is quite different from that in ancient India. In modern society it is easier to challenge and even take litigation against practitioners, thus the 'gentle' treatments are a safer option.

Zimmerman also describes another distortion of Ayurveda by giving an example of how the basic practice of Ayurvedic pharmacy has changed. He refers to decoctions, a common form of medicine which is made from fresh plants crushed and dissolved in water.

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[16] For example see Essential Ayurveda (2004) [online] [accessed 28.12.12] Available from the World Wide Web: http://www.essentialayurveda.co.uk/store/home.php

Zimmerman argues that medicines in tablet form have taken over the use of decoctions, eliminating the ideas of fluidity and solubility, and as a consequence the spirit of Ayurvedic pharmacy is lost. The following factors should be considered to understand the immense complexity around the changes leading to the 'loss of fluidity' from global Ayurveda.

Firstly, Ayurvedic pharmacy textbooks such as *Bhaisajya Kalpana Vijnana*[17] (a textbook on the science of Ayurvedic pharmacy) describe a number of different forms of medicine: fresh decoctions, tablets, pastes and medicinal wines. Therefore, it is inaccurate to assign decoctions to traditional practice and tablets to modern practice. Tablets have been described and made in the past, though I argue that in modern terms they are a convenient form of medicine. They are easier to export and easier to stock and sell as 'over the counter' medicines as they have a long shelf life compared to liquid decoctions which must be consumed quickly in order to gain the medicinal benefits.[18]

Secondly, in the West it is not easy or practical for practitioners to keep and maintain their own personal herbariums and medicinal gardens from where they can pick fresh plants and make up decoctions for their patients. Again, it is an issue of resources in terms of having land, and the time to grow all the required plants, but also importantly, an issue of a climate which is not suitable for many Indian plants.

With these examples, I have illustrated that the practitioner-researcher perspective needs to be considered to balance the somewhat 'romantic' interpretations of Ayurveda practice by some academic scholars. This will be discussed further in the next chapter. As a result of my practitioner training I am attuned to the detailed changes to practice that may or may not reflect underlying changes in ideology. As a consequence, I have presented this research through my voice and compared my findings with those of scholars and discussed how the different perspectives may be understood to present different parts of the whole picture which depict Ayurveda in the West and in particular the UK.

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[17] For example see *Bhaisajya Kalpana Vijnana* (Ayurvedic Pharmacy) translated by Dr K Rama Chandra Reddy. Published by Chaukhamba Sanskrit Bhawan. 2001.

[18] I suggested that remedies in tablet form are in line with the 'self-help' trend in health care whereby people can make their own decisions about many ailments and purchase what they require without seeking professional advice.

1.4 Background to CAM in the UK

I begin by making some key historical points pertaining to the medical system that existed in the UK before the rise of science, biomedical[19] hegemony and CAM[20] which are significant to this thesis. According to Bivins (2010: 6-10) humoural medicine had holistic links between mind, body, society and environment, in which health depended on one's own action and inactions, what was eaten and drunk, sleep, sexual activity, exposure to different environments, the seasons and social interactions, as well as the influence of the heavens at the time of birth. Thus the practitioner also had knowledge of astronomy. The physical interventions included bleeding, purging and vomiting. Changes in lifestyle and remedies would have been administered to maintain the balance of the humours (blood, phlegm, black bile and yellow bile) which exist in dynamic equilibrium with each other, the climate, celestial spheres and emotions. Though this sounds very much like Ayurveda and Traditional Chinese medicine (TCM), it is however a description of the medical system that existed in Western Europe from the classical period through to the end of the eighteenth century.

According to Bivins (2010: 13), Chinese, Indian and European practitioners believed in the impact of the macrocosm (the world) on the microcosm (individual) as they were made of the same basic materials. The parallels between the Chinese, classical and medieval European and Indian systems were remarkable (though local differences made them distinct). Across the three systems practitioners viewed disease in terms of imbalance caused by disharmony between the individual and the environment.

Religion also played a role in each of the three systems, underpinning the cosmological[21] beliefs. Supernatural and natural entities and actions could cause illness. In Ayurveda, effects of accumulated karma could impact on health, providing explanations for illnesses without a known cause. In the European system, prayer, repentance and religious cleansing were ways of dealing with medical issues. However, since the period of the Enlightenment,

[19] Reed (2003: 4) defines medicine as including the following elements: claims to be curative, some body of knowledge or theory which includes ideas and causes of illness and health, some kind of technical intervention by a practitioner.
[20] Reed (2003: 11) cites various definitions for 'non-Western' medicine: alternative, indigenous, non-orthodox, unorthodox, non-conventional. All these suggest that Western medicine is 'normal'.
[21] Cosmology refers to theories of the universe.

[22] there has been a tendency to separate science and religion and push religion into the private arena (Carrette and King, 2005: 13):

> It is often recognised that, since the Enlightenment, 'religion' has been subjected to an erosion of its social authority with the rise of scientific rationalism, humanism and modern liberal democratic models of the nation-state (a process often called secularisation). In modern western societies, to varying degrees, this has usually manifested itself as the regulation of 'the religious' to the private sphere.
> (Carrette and King, 2005: 13)

Ayurveda and Chinese medicine continued to be practised both in their countries of origin, and also in Europe (Bivins, 2010: 28), whereas Western humoural medicine began to decline after the Scientific Revolution (1543 – 1700) as empirical and experimental knowledge started to be privileged. Western humoural medicine persisted until the mid-nineteenth century so until the eighteenth century there were broad similarities between Western and non-Western medicine (page 31). It was during the eighteenth century that changes in European medicine began to create a boundary between European and non-European medical practices as a result of the development of a new system of medicine based on science and experiment, as opposed to scholarship and experience. With the new boundary, the exchange of medical knowledge which was initially based on curiosity (Alter, 2005: 8) came to an end with the beginnings of imperialism (Bivins, 2010: 32).

Medicine as a significant representative of culture indicated the 'measure of men' and the European model of knowledge and medicine became the standard by which other cultures were to be measured (Bivins, 2010: 32). Langford (2002) in her detailed study of Ayurveda in India gives an excellent and insightful account of the effects of colonial rule on the transformation of traditional Ayurveda to one that mimicked the European scientific system (discussed below).The assumption that medicine should be based solely on science solidified by the late nineteenth century. The twentieth century saw the industrialisation of medicine (Bivins, 2010: 36). The stronghold of scientific medicine or biomedicine grew as it positioned itself as holding absolute knowledge, and practitioners who held different knowledge must position themselves as either complementary or alternative to biomedicine. 'Complementary' meant accepting a subordinate place within the scientific

[22] Also referred to as 'The Age of Reason' was a cultural movement of intellectuals, during the 17th and 18th centuries and started in Europe. The purpose was to reform society using reason and advance knowledge using scientific methods.

hierarchy and 'alternative' expressed an oppositional relationship with biomedicine and suggested a resistance to assimilation with biomedicine.

Empirical science favouring experiment gained support over professional experience to the extent that the 1858 Medical Act granted biomedical doctors state registration and laid the foundation for the alliance between the state and biomedicine,[23] giving it a position of privilege (Cant and Sharma, 1999: 84). Until that point medical pluralism had existed in the UK with a wide range of practices including western humoural medicine (Bivins, 2010: 9), western herbal medicine, homeopathy, mesmerism and naturopathy (page 12), as well as Chinese medicine, including acupuncture, which had come to England in the eighteenth century (Bivins, 2010: 109). The 1858 Medical Act defined the boundary between biomedicine and all the other various healing practices.

Tovey et al (2005) write that many CAM practices have emerged from traditional health practices, but over time, they have been shaped by Western models of care, for example, Herbalism, Reiki or Naturopathy. Some CAM have emerged from traditional belief systems and have moved away from their philosophical roots e.g. Chinese acupuncture, resulting in different, but not entirely distinct, healthcare modalities e.g. Western forms of acupuncture. Other CAM, such as homeopathy, have emerged within Western contexts, but are distinct from biomedicine in terms of their underlying paradigms. They consider CAM as encompassing a disparate range of modalities, but what characterises CAM is a lack of integration into biomedicine, and some CAM incorporate physical and metaphysical elements in treatment processes.

I have used CAM in very broad terms to refer to all the historical, traditional approaches to healing in the UK (and Europe) that had been practised for centuries, as well as the more contemporary systems that have appeared in recent decades. I also use CAM to refer to the traditional systems such as Ayurveda and Chinese Medicine which are from the East and embedded within other cultures. Some scholars refer to these as TCAM (traditional, complementary and alternative medicine).

In Britain, biomedicine secured a position of social, economic and ideological hegemony in the health care market through its alignment with science and State support, and remained

[23] Sharma (1995: 5) reports a variety of terms: biomedicine, orthodox medicine, cosmopolitan medicine and modern medicine.

dominant for at least a century (Cant and Sharma, 1999: 1). CAM practitioners continued to practise in the shadows of biomedicine until cultural, social and political factors starting in the 1960s allowed CAM to attract attention and gain popularity, so it is more accurate to say that CAM re-emerged rather than appeared in recent decades (Bakx, 1991: 22). Cant and Sharma (1999: 55) further suggest that it was inaccurate to refer to the 'revival' of CAM as many therapies had maintained a constant place in the overall medical provision in most societies.

A variety of reasons were given for the re-emergence of CAM, including dissatisfaction with biomedical treatments and the side effects of biomedical drugs. Some people were also seeking a more holistic approach (Newcombe, 2012: 207). The question arises: what is CAM and how is it defined?

1.5 What is CAM?

Cant and Sharma (1999: 5) suggest that CAM[24] refers to forms of healing that depend on knowledge bases that were distinct from that of biomedicine, and did not share the special legitimation that the state had awarded biomedicine. More recent discussions by CAMbrella[25] suggest the following 'pragmatic European definition':

> Complementary and Alternative Medicine (CAM) utilised by European citizens represents a variety of different medical systems and therapies based on the knowledge, skills and practices derived from theories, philosophies and experiences used to maintain and improve health, as well as to prevent, diagnose, relieve or treat physical and mental illnesses. CAM has been mainly used outside conventional health care, but in some countries certain treatments are being adopted or adapted by conventional health care.

CAM includes a highly diverse range of systems and is not a single, homogenous entity. For example, Pietroni (1992) developed a typology of CAM based on knowledge base: complete systems of medicine (homeopathy, herbal medicine, and acupuncture), diagnostic therapies (iridology), therapeutic therapies (reflexology), and self-help approaches

[24] Cant and Sharma (1999) use the term 'alternative medicine' rather than CAM. However, I used CAM to include all the range of non-biomedical healing systems, both complementary and alternative as suggested by CAMbrella.

[25] CAMbrella is a European research network for complementary and alternative medicine (CAM). The group consists of 16 partner institutions from 12 European countries and is focused on academic research into CAM. The group was established under the Seventh Framework Program. Between January 2010 and December 2012 the CAMbrella consortium examined the current status of CAM in Europe from various perspectives.
See - The Road Map for CAM European Research (no date) [online]. [Accessed 10.4.13]. Available from the World Wide Web: http://www.cambrella.eu/home.php?

(meditation, relaxation). There were other ways to categorise CAM, including varying levels of alignment with biomedicine.

The re-emergence of CAM led to an increase in medical pluralism. As a result, Cant and Sharma (1999: 49) suggest that the definition of health using biomedical and physical terms is no longer useful. Instead, 'good health' should be seen as a product of spiritual, emotional and physical wellbeing. This led to a blurring of the boundaries between the medical, recreational and aesthetic techniques of the body, therefore 'what lies 'inside' or 'outside' biomedicine at any one time is not always easy to decide' (page 6). The increased interest in CAM was evident from the numbers of books in the health section of bookshops, the array of remedies in chemist and health stores, and the regular articles in newspapers and magazines (Cant and Sharma, 1999: 20; Reed, 2003: 124).[26] An increase was noted in the numbers of people using CAM both in US and UK (Partridge, 2004: 52).

The recent report by Arthritis UK (2013: 5)[27] suggests that approximately one quarter of the UK population use CAM in one form or another, and around one in eight will consult a CAM practitioner in any year.[28] Previous research findings have also indicated that substantial numbers of people in the UK use CAM (UK Market Synopsis, 2006: 1; Bishop et al, 2005: 144), with estimates of up to 40% of General Practice Partnerships providing some form of complementary health at any given time (Owen et al 2001: 154).

Surveys in other countries (Australia, USA Canada, Finland and Israel) show similar trends (Harris and Rees, 2000: 92). One survey estimates between 30% and 90% of the adult

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[26] Rosemary Taylor (cited in Sharma, 1995: 85) suggested the popularity of CAM is a product of the Participation Revolution of the 1960s which challenged many forms of authority, including the medical profession, but it did not change the doctor-patient relationship. The Market Orientation of the 1980s gave patients more choice about their healthcare. Rosalind Coward writes that the popularity of CAM is due to even broader cultural changes which embraces 'New Age' therapies, holistic health and wholefood movement and the quest for the 'natural' in various areas of life. These shifts go beyond the critique of biomedicine, and show a result in well-being and the spiritual side of people.

[27] Arthritis UK report estimates that Britons spend over £450 million per year on complementary or alternative medicines and treatments, and The Health Survey for England 2005 found the following information:

- 44% of respondents reported using complementary or alternative medicines at some time.
- 26% had used them in the past 12 months.
- 12% had consulted a practitioner in the last 12 months.
- 51% of respondents with pain and 17% of those with various forms of arthritis reported using complementary or alternative medicine in the past 12 months.

[28] According to Arthritis UK (2013) research the use of CAM is higher among people with pain or musculoskeletal conditions such as arthritis.

population in industrialised nations use some form of CAM to prevent or treat a variety of health problems (Hyland et al, 2003: 33). The popularity of different CAM modalities varies across Europe, reflecting the differences in medical culture and the historical, political and legal position of CAM[29] (Zollman and Vickers, 1999: 837). A recent review undertaken by CAMbrella suggests that one out of two European citizens use complementary and alternative medicine.[30] Thus, CAM cannot be regarded as a fringe activity (Cant and Sharma, 1999: 49). Different therapies are popular in different countries (Cant and Sharma, 1999: 55). Recent research by CAMbrella on the use and prevalence of CAM in Europe[31] found that it is widespread but variable (0.3 – 86%). CAM users were mainly women and a key reason for turning to CAM was dissatisfaction with conventional care. However, Posadzki et al's (2013: 126) recent systematic review, which aimed to estimate the prevalence of the use of CAM in the UK, indicates that many of the surveys are flawed, with poor reporting of data and lack of a universally agreed definition of CAM, which means that information on the prevalence of CAM in the UK is less than reliable.

Given the reported increased interest in CAM, I considered the relationship between CAM and spirituality and whether people are attracted to CAM because they perceive a link between CAM and spirituality? Roof (1999: 107) writes that 'health' is an idealisation of a kind of self and healing is part of the process by which growth towards the ideal is achieved. According to this, the idealisation of the self increasingly includes the spiritual. Because the embodied self is understood to be the site of spiritual transformation, central

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[29] Last (cited in Cant and Sharma, 1999) developed a typology of 'national medical cultures' with 3 models:

A) Exclusive systems
- The French model
- The (former) Soviet model
- The American model

B) Tolerant systems
- The British model
- The German model

C) Integrative systems
- The Indian and Chinese models
- The 'Third world model'

National medical cultures are complex, have contradictions and can vary over time.

[30] CAMbrella newsletter (Jan 2013) - http://www.cambrella.eu/home.php

[31] 'CAM Use and Prevalence' presentation by Professor George Lewith, at the CAMbrella final conference 28.12.12. Issues include poor data quality, and poor reporting as data was only available from half the EU states and no single agreed definition of CAM, identifying the need for coherent, comprehensive and rigorous prospective data collection. See - The Road Map for CAM European Research (no date) [online]. [Accessed 10.4.13]. Available from the World Wide Web: http://www.cambrella.eu/home.php?

to the notions of wellbeing is a growing emphasis on spiritual health. This approach opened the doors to holistic systems that claim to treat the mind, body and soul.

Partridge (2005: 16) also suggests that the focus throughout the holistic milieu is on the development of an individual's potential and the removal of any hindrances to that development. The aim is well-being[32] – the health of mind-body-spirit: health and spirituality are part of the same well-being package in the holistic milieu. Partridge quotes the Kendal Project, [33] 'The holistic milieu activities facilitate the convergence of the spiritual path and the *personal* [author's emphasis] path'. Physical, personal and spiritual well-being are not only interrelated, but also person-specific as 'health and well-being is a personal *bricolage*[34] project, tailored to the individual's needs' (page 16). These are discussed further in relation to the Ayurvedic encounter in Chapters six and seven.

Adams et al (2012: 13) have summarised succinctly findings from the literature on why people use CAM treatments. They group the reasons as push factors (push away from biomedicine) and pull factors (pull towards CAM). The push factors suggest that CAM users are pushed towards using CAM because they are dissatisfied with biomedicine. This may occur for a number of reasons: they have lost confidence in biomedicine's ability to treat a range of prevalent chronic conditions effectively; they perceive negative side effects of the drugs and consider they are over-prescribed; and they see its failure to meet the emotional needs of patients.

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[32] Partridge (2005: 17) provides his insights into the meaning of 'Wellbeing culture' and suggests there is a spiritual element within well-being culture. This includes a wide range of products, therapies, centres and events, self-help books, yoga. Wellbeing is almost always a holistic term, suggesting integration of mind, body and soul. Advertisers, practitioners use this term without mentioning 'the spiritual', but know it is implied. Partridge (2005: 19) says that holism sells because a large number of people think it matters. Products need to fit the changing social and cultural climate. Partridge (2005: 20), says there has been a recent phenomenal increase of organic products which is also related to well-being.

[33] Heelas and Woodhead undertook field research to quantify the interest in spirituality in Kendal, a town in the north of England. The findings are published in '*The spiritual revolution*' (2005).

[34] French anthropologist Claude Lévi-Strauss (1974) used the concept of bricolage to describe the characteristic patterns of mythological thought. A bricoleur is one who performs bricolage. In the context here, bricoleurs perform a wide variety of tasks and sometimes use means for achieving goals which are in some respect circuitous or indirect. Bricoleurs have a characteristic approach to their tasks. They review their existing resources to see what is useful. According to Lévi-Strauss, the bricoleur makes do with whatever is at hand to achieve their goal (Hatton, 1989: 74-75).

The pull factors suggest that users are pulled towards CAM for a variety of reasons, including: the holistic and personalised approach of many treatments, the longer consultation times, and the spiritual dimension to care. Further underlying reasons maybe that the holistic CAM approach is more consistent with many people's personal values and philosophical orientations towards health. It forms part of a wider identification with an alternative ideology or subculture and it is perceived to work where biomedicine does not. These push and pull factors are likely to be related.

Adams et al (2012: 14) also suggest that wider societal changes may influence increased use of CAM: for example there are a greater number of smart consumers, and more people are better informed about health-related issues and use their own personal judgement about their health. Further, the media has promoted a consumerist health culture, providing information in popular magazines and newspapers. However, they also emphasise the need for more sophisticated research into CAM users, which is sensitive to variations in the type of modality used, the nature of use (prolonged or intermittent) and the type of user. There is a need for a better understanding of CAM users' journeys through time and space and the motivations of the increasing number of CAM users.

Newcombe (2012: 204) explored the use of Eastern CAM traditions (TCAM). She describes factors that have enabled the increased interest in and uptake of CAM treatments from the East such as Ayurveda. She writes that the cultural authority of biomedicine was challenged in the 1960s and 1970s, due to the way in which patients were dehumanised, the failure of germ theory to cure many illnesses and the continued prevalence of major illnesses. From the 1970s, women were also challenging the biomedical profession for being patriarchal and disempowering e.g. the medicalization of childbirth (page 205). In addition, the 1960s gave rise to an influential anti-psychiatric movement associated with R.D. Laing, and people interested in this were also interested in Eastern spirituality. These people were disillusioned with traditional forms of religious, medical and political authority. Newcombe suggests that there is a demographic overlap between people who participate in Eastern spiritual or fitness activities and those using Eastern healing systems: many people who practise yoga also use Ayurvedic treatments.

Newcombe also suggests that since the 1970s the increased opportunities to travel to exotic locations has had a popularising influence on exotic and Eastern forms of health and well-being (page 204), but the extent of this hypothesis would need to be verified.

Newcombe (2012: 206) describes multiple ways in which Westerners may engage with CAM. 'Pragmatics' are people who use CAM to find relief from chronic or acute problems: their primary concern is whether the therapy works. The 'True Believers' have completely rejected the biomedical approach in favour of a theologically based world view, e.g. sectarian Christians who solely rely on faith and prayer for healing, and the 'Holistics' who have a significant amount of metaphysical beliefs and use CAM not only for treating illness but also for promoting health and well-being.

Newcombe (2012: 206) writes that up to fifty per cent of CAM users may be turning to CAM because it addresses the spiritual aspects of a person. Nonetheless, not all CAM is explicitly 'spiritual' and some people use CAM[35] as they perceive it to be more effective, less invasive and an alternative to biomedicine for physical or psycho-physical conditions (Sharma, 1995: 24-25). People make rational decisions when choosing between biomedicine and CAM and consider the physiological and social costs and benefits, as well as the short and long term benefits (Sharma, 1995: 81). Other factors influencing decisions to use CAM include recommendations from people they know and who live near them and have used CAM (Sharma, 1995: 13). A number of other reasons underlie the popularity of CAM including: pressures on the NHS, the over- technical nature of modern medicine, the demand for a more person centred therapy and the rise of informed consumer consciousness (page 88).

In summary, CAM carries a number of meanings which include the addressing of spiritual needs, being natural, or simply an alternative to biomedicine. Along with the growing interest in CAM, there has been an increased interest in spirituality (King, 2009: 1) and the emergence of the New Age spiritualities (Heelas and Woodhead, 2005: 1). Reddy (2002: 104) argues that there has been a marked ideological shift towards spiritualisation in relation to CAM in the last two decades. The relevance of these new spiritualities, their link with health and their impact on Ayurveda in the West are discussed next.

[35] Sharma (1995: 24) writes that people use CAM mainly for chronic conditions that are not cured by biomedicine e.g. pain, allergies, psychological problems. People decide which kind of medicine can best treat a particular complaint

1.6 Religion and Spirituality

Connolly (2004: 4) reports that conflicts about the definitions of religion usually revolve around what can and cannot be included and no definition of religion is above criticism. Nevertheless, scholars have begun to favour multi-category definitions of religion (Connolly, 2004: 6). Scholars like Harvey (2012) advocate that religion and spirituality need to be considered in a new way, not as traditional religion, but as a 'lived experience'.

Woodhead and Heelas (2000: 3) suggest there are three points on a spectrum of understandings of the relationship between the divine, the human and the natural order. They differentiate between three types of religion: religions of difference, religions of humanity and spiritualities of life. They argue that religion in modern times co-exists in different forms. The co-existence takes place on a global, national, local and personal level. Woodhead and Heelas (2000: 5) claim that religion in modern times is a product of the complex interaction and interplay of different types of religion with different contexts. The interaction takes place in different ways, at different speeds, and in different parts of the globe. [36]

Bellah (cited by Woodhead and Heelas, 2000) writes that '*one aspect of the great modern transformation of religion involves the internalisation of authority'* [author's italics] … and this has profound consequences for religion. The process of detraditionalisation[37] lies precisely with this internalisation of authority from 'without' to 'within'. The change is from an authoritative realm which exists over and above the individual, to the authority of the first hand spirituality- informed experience of the self. Woodhead and Heelas (2000: 112) also report a widespread trend towards the 'inner' and the 'valorisation of life'.

Partridge (2004: 57 - 58) writes that whilst disenchantment has shaped Western society, there has also been a gradual emergence of alternative spiritualities. He argues that religion is being reshaped, relocated and redefined as spirituality, and what is emerging as a trend is that people tend to say they are spiritual but not religious (Partridge, 2004: 46). Surveys show growing numbers of people becoming interested in 'spirituality'. The

[36] Woodhead and Heelas, (2000: 5) report four important trends in religion in modern times, which co-exist: secularisation and sacralisation relate to the 'quantity of religion'. Detraditionalisation and universalisation relate to the transformation of religion.

[37] Detraditionalisation is a turn from authority of the past and external institutions and authority figures to the authority of the self (Woodhead and Heelas, 2000: 5)

situation is nevertheless complex, and Partridge (2004: 38) also says that there is a global trend of a gradual upsurge of religion, e.g. in Japan, it is flourishing. There is a growth of both spirituality and religion.

Carrette and King (2005: 1) argue that there is a lack of clarity in the use of the concept of spirituality. This may be one reason why it has been so popular; it is an umbrella term which can carry multiple meanings. Its ambiguity allows it to operate across different social and interest groups. According to Carrette and King 'religion' is an even more complex and vague word (page 31). Religion and spirituality are increasingly understood as distinct concepts (King, 2009: 2) and discussed further in Chapter seven.

Partridge (2004: 2) reports that scholars have used the term 'New Age'[38] to define a particular network of ideas and beliefs, but he also suggests that the New Age is a slippery word (page 71), encompassing a broad range of spiritualities and therapies, that are broadly mystical and directly influenced by Eastern and Western esotericism. According to Bruce (2002), the New Age resonates with the culture in the contemporary West. [39] He outlines six key themes of the New Age: The self is divine; epistemological individualism (there is no higher authority than the self); epistemological individualism leads to eclecticism; New Age spirituality emphasises holism, rejecting the reductionism of modern scientific worldviews; epistemological individualism and eclecticism lead to relativism (no path is better than another); the goal of New Age spirituality is health and happiness, (rather than health and happiness being a by-product of the religious life).

Many of these themes overlap with the philosophies of the CAM traditions. For example, Warrier (2011b: 11) from her study of Ayurveda in the UK, described the focus on *prakriti* (the individual's constitution) which feeds the desire for individualism and even divine self.[40] Partridge (2004: 34) suggests that the New Age has encouraged individuals to become consumers, a behaviour which mirrors the trend of CAM seekers as consumers (Cant and Sharma, 1999: 21-24), thus giving the potential for the two to overlap. Some people seeking meaning in their lives also look for holistic systems of healing which bring

[38] Woodhead and Heelas (2000: 112) write that the term New Age has been used since 19th century, but more commonly used since the 1960s. It overlaps with the spiritualities of life.
[39] Bruce (cited by Partridge, 2004: 32-33) calls this 'diffuse religion' as it does not have a central authority.
[40] Woodhead and Heelas (2000: 5) define detraditionalisation as a turn from authority of the past and external institutions and authority figures to the authority of the self.

together spirituality and health, and turn to Eastern systems of healing including Ayurveda. This raises the question: what is the position of spirituality in traditional Ayurveda?

1.7 Ayurveda: sacred or secular?

Scholars with an interest in the history of Ayurveda suggest that the origins and early development of Ayurveda are unclear (Zysk, 1990: 23; Das 1993: 62; Meulenbeld, 1995: 1). The *Atharvaveda*[41] contains the earliest hymns, which Zysk (1990: 11) describes as magico-religious healing practices. He suggests that there is a gradual shift to empirico-rational healing practices which is captured in the classical Ayurvedic texts such as the *Charaka Samhita*.[42]

The scholars of Ayurveda have mixed views on the nature of the classical texts. Proponents of Maharishi Ayurveda (MAV) argue that Ayurveda is inherently a spiritual science and their version is a restoration of the original spiritual tradition (Jeannotat, 2008: 285). Meulenbeld (1995: 3) suggests that the role of religion in the Indian medical literature varies. According to him both religion and philosophy are 'conspicuously present' in the *Charaka Samhita*. He cites a number of other medical texts that do deal with religious aspects and concludes that recent literature indicates a secularisation of Ayurveda. Welch (2008: 134) agrees that the Ayurvedic classical texts do refer to spiritual topics, though in her opinion the bulk of the text focuses on the clinical practice. She suggests that the traditional role of the *vaidya* involved practising various spiritual arts and being a guru and it may be for this reason that it is difficult to separate Ayurveda from its religious and spiritual contexts.

According to Leslie (1976: 360), the classical medical texts were mainly secular and rational, however through a process of sacralisation over a long period of time, the actual 'traditional –culture practice'[43] became saturated with religion and magic. Therefore the process of professionalization driven by revivalism re-secularised Ayurveda (page 360) and

[41] The *Atharvaveda* is one of the four *Vedas*, described as the books of knowledge, containing information on different subjects. The other three Vedas are: the *Rg Veda*, *Yajur Veda* and *Sama Veda*.

[42] The following are considered as the three ancient classical texts in Ayurvedic literature: *The Charaka Samhita, Sushruta Samhita, Ashtanga Hridayam*. These are referred to as *brhad* meaning heavy but in this case interpreted as meaning old. A later set of three texts include: the *Madhava Nidana, Sharangdhara Samhita,* and *Bhava Prakasha*. These are referred to as *laghu,* meaning light, but interpreted in this context as new, in comparison to the ancient three texts. For example, see: The Ayurvedic Institute (2011) [online]. [Accessed 23.1.2013]. Available from the World Wide Web: http://www.ayurveda.com/online_resource/ancient_writings.htm

[43] For example, Leslie describes the syncretic traditions of Ayurvedic and Unani medicine as Traditional-Culture medicine (Leslie, 1976: 358).

transformed it into a blend of popular culture (Leslie, 1976: 359) and scientific medicine (Leslie, 1976: 364). For practitioner Dr Ananda Chopra (2008: 244) in Germany, Ayurveda is not a spiritual science, but rather a medical tradition.

Clearly opinions about Ayurveda being a spiritual tradition or a secular medical practice are mixed. The problem is that these authors do not clarify what they mean by 'spiritual' or how it may be defined in an Ayurvedic context. I suggest that the religious and spiritual elements have always been an integral part of the Ayurvedic approach. It incorporates various aspects of the six systems of Indian philosophies. *Sankhya*, *Vaisesikha* and *Nyaya* philosophies provide paradigms for understanding the physical world, while *Yoga*, *Mimamsa* and *Vedanta* deal with inner reality and spiritual development (Lad, 2002: 1-10). In this way, Ayurveda integrates both the physical and spiritual realms.

To give further support for my argument, I turn to the *Charaka Samhita,* [44] one of the classical texts of Ayurveda compiled around 500CE (Wujastyk, 2001: 2). Although scholars like Das (2003: 207) have argued that the *Charaka Samhita* is not entirely representative of all the versions of healing practice in India, it is nevertheless considered a seminal text and course reference on the curriculum of the BAMS degree course as well as the degree course in the UK. I present a selection of verses from an English translation to highlight some of the basic principles. The *Charaka Samhita* explains that a human being, *purusha*, is made up of mind, body and soul.

> Mind body and soul – these three are like a tripod; the world is sustained by their combinations; they constitute the substratum for everything. This (combination of the above three) is *purusha*; this is sentient and this is the subject matter of this *Veda* (Ayurveda); it is for this that this Ayurveda is brought to light.
> Ca/su/1/v46-47 (Sharma and Dash, 2001, vol 1: 32)

This verse indicates that in addition to the body and mind there is another more subtle aspect of a person which is not recognised in the biomedical model. The Ayurvedic text explains that the soul enters the foetus after conception and brings information with it from its past life.

> Being guided by the associated past actions, the soul who travels with the help of the mind, transmigrates from one body to another ..... the soul enter the foetus are the products of the past actions. Ca/sa/2/31-36 (Sharma and Dash, 2001, vol 2: 360)

[44] The verses are taken from: *Caraka Samhita*. Text with English translation and critical exposition based on Cakrapani datta's Ayurveda Dipika. by R. K. Sharma and Bhagwan Das. Published by Chowkhamba Sanskrit Series Office, Varanasi. This was the recommended translation on the BSc Ayurveda course curriculum of Middlesex University.

This information from the past can also be interpreted now as the inherited information from the parents' genes. Regardless of the interpretation, this idea provides the sense of continuity beyond the physical body. The next verse gives details of the *atman* or soul, describing it to be consciousness and as giving life to matter.

> The six *dhatus*, that is the five basic elements and atman possess specific qualities.. [thus, the five elements are incapable of imbibing consciousness of their own even if combined together. Consciousness is the distinctive feature of atman alone]... Their combination and separation are conditioned by the past action of atman.
> Ca/su/11/v12. (Sharma and Dash, 2001, vol 1: 207)

This verse describes the connection between the material elements that make up the physical body and the soul which imparts consciousness to it. The *Sushruta Samhita*, describes the features of good health in the following verse:

> The *doshas* are in equilibrium and the digestive fire is in a balanced state,
> The tissues and the waste products are in optimum functioning,
> The soul, senses and mind are in a pleasant state. This is a healthy person.
> Sushruta/su/15/v44. (Athique, 2003: 179)

Therefore, good health is not only a balanced functioning of the body, but the mind, sense and soul must also be in a positive state. This definition of health makes Ayurveda a holistic system and indicates a relationship between the mind-body systems.

In addition, Ayurveda has a distinct religious and spiritual component as the *Charaka Samhita* describes religious and spiritual treatments (*daivavipashraya*), psychological (*satvavijaya*) and physical (*yuktivipashraya*) treatments depending on the needs of the patient:

> Therapies are of 3 kinds; spiritual therapy, therapy based on reasoning, and psychic therapy. **Spiritual therapies are incantation of mantras, talisman, wearing of gems, auspicious offerings, gifts, oblations, observance of scriptural rules, atonement, fasts, chanting of auspicious hymns, obeisance to the gods, going on pilgrimage etc.** Administration of proper diet and medicinal drugs comes under the second category. Withdrawal of mind from harmful objects constitutes psychic therapy.
> Ca/su/11/v54. (Sharma and Dash, 2001: vol 1, 230)

Although the *Charaka Samhita* makes reference to topics such as the soul and consciousness which fall within the remit of religion and spirituality, the syllabus of modern Ayurveda training in India has been stripped of these elements. Factors leading to the emergence of a biomedicalised version of modern Ayurveda in India are briefly outlined to illustrate how political and social factors influence a traditional system of healing to change.

1.8 Modern Ayurveda in India

Ayurveda has been shaped through history by various foreign influences, including Unani medicine from the Middle East from the thirteenth century, and the first encounters with Western medicine from the sixteenth century onwards.[45] Major changes began in terms of the revival of Ayurveda from the nineteenth century (Meulenbeld, 1995: 9, Leslie 1976: 356; Das 1993: 68,) which resulted in 'Modern Ayurveda', one of the versions in India (Leslie 1976: 359).

Wujastyk and Smith (2008: 2) coined the term 'Modern Ayurveda' which refers to Ayurveda which is contained within the geographical boundaries of the Indian sub-continent and developed due to colonial pressures which forced professionalisation and institutionalisation during nineteenth century.[46] Warrier (2011a) gives a good overview of the changes to Ayurveda. These changes were driven externally by the colonial rulers imposing their foreign medicine (Langford, 2002: 5)[47] and internally by the practitioners themselves wanting to professionalise in order to compete with biomedicine and revive their practice.[48] The changes were characterised by the secularisation of the practice as Indian practitioners sought to legitimise Ayurveda by establishing its basis in 'rationality' and cleansing it of all ritual and magic (Warrier, 2011b: 5). The impact of colonial rule and

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[45] A detailed account of the changes in Ayurveda is beyond the remit of this thesis.

[46] Early foreign interest had been one of curiosity (Alter, 2005: 8) as the initial encounter between Western and Indian practitioners began as an informal dialogue in the seventeenth and eighteenth centuries. This changed to the scientific scepticism by the nineteenth century. One consequence of the divergence was that the colonial state withdrew patronage from indigenous systems of medicine of which Ayurveda was one (Pati and Harrison, 2001: 9-10).

[47] Langford (2002: 7) argues that significant transformation was triggered by T.B. Macaulay's *Minute on Indian Education* in 1835, which declared that all Indian higher education would be conducted in English and modelled on the British educational system. Ayurveda was compelled to transform from an '*eclectic set of healing practices'* to an institutionalised system of Indian medicine. Now there was a need to impose and displace the indigenous practices with European systems. It was a shift from non-coercive to coercive methods of imposition. Langford (2002: 109) writes that the 1938 Medical Practitioners Act was passed to regulate the registration and education of *vaidyas*. On the one hand it gave the *vaidyas* medical rights similar to those of biomedical practitioners, but on the other hand it abolished the study of Ayurveda through the *guru-shishya parampara*. Only Ayurveda courses that incorporated European medical subjects would be officially recognised. This led to a split in ideology among *vaidyas*; some wanted *suddha* (pure) Ayurveda, a version which is taught and practised without any influence of biomedicine. Others practitioners wanted *mishra* (integrated) Ayurveda, a version which is influenced by biomedicine. In terms of education, both traditional subjects are taught along with modern science modules, and in terms of practice, diagnostic procedures from both systems are taken. Recommendations may include both Ayurvedic and biomedical remedies.

[48] The *vaidyas* were compelled to professionalise, establish institutions, associations, colleges and pharmaceutical companies in order to compete with biomedicine or face extinction (Banerjee 2008: 201, Kumar, 2001: 29).

dominance of European medicine resulted in the institutionalisation of Ayurvedic education, and the pharmaceuticalisation of its manufacturing processes (Banerjee, 2008: 201-214).[49]

Langford (2002: 99) argues that the biomedicalisation and institutionalisation of Ayurveda created deep and serious problems. The Ayurvedic Institutes were seen as 'empty formality without meaningful function'. The very structure of the standardised Ayurveda courses did not enable students to become skilled practitioners, hence putting them at a disadvantage. [50] According to Svoboda (2008: 118) contemporary Ayurvedic education in institutions developed to compete with biomedicine imposed by the colonial government. Presenting Ayurveda as a unified system at the political level, despite the sectarian and regional differences was an enormous challenge (Wujastyk and Smith 2008: 7). According to Payyappallimana (2008: 141) although education was institutionalised and the university programmes were designed to standardise and improve the quality of medical Ayurvedic education, the quality of learning actually deteriorated. Payyappallimana gives the example of pulse diagnosis, a method of diagnosis. Traditionally this would have been taught over a long period of time, allowing the student to learn through experience, whereas now it may be covered in a week or completely omitted from the training.

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[49]Banerjee (2008) examined the changes in terms of the pharmaceuticalisation of Ayurveda. The manufacturing processes of Ayurvedic remedies were also influenced through the competition from the availability of mass produced biomedical medicines, and the continuous output of biomedical research information particularly in relation to the efficacy of new medicines. She gives an excellent account of the practical challenges that Ayurveda practitioners and manufacturers faced in order to compete with biomedicine. They had to transform its production, marketing and research, a radical change from the traditional practice to fit modern frameworks. Banerjee details many difficulties and uncertainties in translating the processes described in the classical texts for large scale production.

[50] The nature of these institutions is problematic on a number of levels centring on the lack of the traditional guru. Firstly, Payyappallinana (2008: 140) points out that until the late nineteenth century the education of Ayurveda was through gurus, through whom students gained experiential learning, hands on practice and specific, localised knowledge of the local area and diseases. Berger (2008: 106) also highlights this shift from traditional Indian system of rural 'home' learning to 'public' learning in the urban setting. This move meant the loss of knowledge about local specific illnesses, plants and remedies which led to a new type of practitioner fit only for urban practice. Secondly, and closely related, is the concern that 'trade secrets' of Ayurveda are not passed down in these organisations as the traditional deep *guru-shishya* relationship cannot be formed. For example, the art of pulse reading is not taught adequately in the institutions, though it is seen as very much a part of the traditional diagnostic set of tools (Svoboda, 2008: 119). Few students find *gurus* for in-depth experience outside of their BAMS course, thus the majority of students turn to practise biomedicine which they are qualified to do, after they graduate (Svoboda, 2008: 119).

In parallel to the influence of the colonial pressures, Langford (2002: 10) argues that social forces were also influencing Ayurveda. The Independence movement in India, in the early part of the twentieth century defined and promoted Ayurveda as Indian culture. In addition, Berger (2008: 101) suggests that the emerging middle class in north India influenced the theory and practice of Ayurveda at the beginning of the twentieth century. She attributes this to the increase in the Hindi printed material which was used as a medium to disseminate knowledge about Ayurveda.[51] Therefore, Berger (2008: 112) concludes that it was public discussion that determined Ayurveda's social and cultural relevance. Printing press technology made a significant difference to making Ayurveda texts available (Das, 1993: 68; Leslie, 1976: 362) though it is not clear how much influence such social factors had in promoting Ayurveda as national medicine.

Berger (2008: 104) argues that Ayurveda became relevant to politics in the mid nineteenth century when the colonial government was forced to regulate and institutionalise Ayurveda to address the health needs of the Indian population. In the 1920s it transferred the responsibility of medicine to provincial control. She reports that after World War One there was a growing realisation that indigenous medical practitioners played a culturally and financially vital role in the basic health of Indians. Pragmatism outweighed colonial ideology and Ayurveda could not be ignored. Therefore it was the social and cultural context that shaped health services. On the one hand, the colonial rulers dismissed Ayurveda as unscientific by categorising the traditional practitioners (*Hakims and Vaidyas*) as businessmen in order to lessen their significance as medical practitioners, while on the other hand they were forced to accept it.

Though the social and cultural forces described by Berger seem to have been a positive factor in maintaining Ayurveda, these were not sufficient to counteract the effects of institutionalisation and professionalisation. These changes were set in motion during the colonial period and, despite India gaining Independence in 1947, the legacy of colonial rule appears to have lingered on. This is exemplified by Wujastyk's survey of policy (Wujastyk,

[51]Hindi printed material played a significant role through published articles and affordable user friendly books about *chikitsa* and other health topics which took Ayurveda into the middle class household. The articles not only presented information about various medical conditions but also linked Ayurveda to Hindu identity, and Indian nationalism.

2008)[52] and Benner's exploration of the code of ethics for Ayurvedic practitioners (Benner 2005).[53,54]

Ayurveda has therefore faced a number of challenges in its attempt to fit into the modern world, trying to meet expectations and fit into frameworks which were not designed for it. It is no wonder that Payyappallimana (2008: 140) describes Ayurveda in India as being in a 'sorry state'. This makes clear that modernisation has not had a positive impact on its development. Despite the promotion of Ayurveda during pre-Independence, the Indian Government's help since that time has been more symbolic than practical. For example, in terms of assigning economic resources, a minimal fraction (3%) of the health budget is given to Ayurveda and according to Svoboda (2008: 123) the image of Ayurveda in India is often one of shame rather than pride. This may be exemplified by current Ayurveda in India as a mix of traditional Ayurveda and biomedicine (Das, 2001: 157; Pati and Harrison, 2001: 9) or a hybrid of traditional Ayurveda and biomedicine (Warrier, 2011b: 6).[55]

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[52] Wujastyk's (2008: 43-76) brief survey of the evolution of the Indian Government's policy on Ayurveda gives some insight into the influences on the thinking behind the health care provisions and the status accorded to biomedicine and indigenous systems including Ayurveda. It appears that there was an alternating 'pull and push' both pre- and post-Independence, whereby one report was favourable to indigenous medicine, while others blatantly condemned and marginalised it. The question of why the post-independence Government did not accept the favourable reports remains unanswered. One hypothesis might be that the scientific biomedical model was so strongly embedded and part of an international language that it had to be supported so that India could be on a par with the West.

[53] Benner (2005: 185-203) presents a very interesting example which illustrates the 'low self-esteem of Ayurveda' in post-Independence India. The Central Council for Indian Medicine (CCIM) issued a code of ethics for practitioners of Indian medicine (Ayurveda, Unani, Siddha) in 1982. The ethical guidelines were based on standards set by the World Medical Association in the Declaration of Geneva of 1948 and the International Code of Ethics of 1949. This indicates the continuing influence of foreign medicine on the early professionalisation of Ayurveda. It also shows how the ethical standards expressed in the Ayurveda classics such as the *Charaka Samhita* were undermined. For example, the values and morals underpinning the conduct of the physician were not included and the relationship between the individual and the environment were not considered. Hence, the CCIM code of Ethics is not an expression of the indigenous medical traditions and their values. An alternative interpretation could be that the CCIM code of ethics aligned itself with international standards, therefore ideologically placing Indian medicines on a par with biomedicine.

[54] For example see Benner's new book 'Well Mannered Ayurveda'. Oxford University Press (2013) [online]. [Accessed 10.4.13]. Available from the World Wide Web: http://www.oup.com/us/catalog/general/subject/Medicine/Ethics/?view=usa&ci=9780199856268

[55] Robinson et al (2012: 605) describe a similar situation in China, between the integration of Chinese medicine and biomedicine. The roots are in the early People's Republic of China, when traditional medicine was 'scientised', through standardising and adapting the traditional theoretical basis of acupuncture. This was followed by further pushes towards integration in the 'Great Leap Forward'. Western medicine was also a priority for China in the new Republic. Since the 1990s, the Chinese government has continued to emphasise the importance of including high quality services integrating TCM and western medicine.

Despite the grim and perhaps frustrating picture painted so far, Tirodkar (2008: 227-241) found in her research that Ayurveda in India caters for all classes of clients who seek out its practitioners. This is likely because, as she suggests, there are different tiers of practice catering for the lower middle up to the wealthy classes (Tirodkar, 2008: 230). She describes four practice models that she found thriving in an urban city in India, which is a helpful analysis of the various versions of Ayurveda practice. First is the traditional practice: the practitioner has trained through *guru-shishya* lineage system and uses the traditional eightfold techniques of diagnosis and prepares and recommends traditional formulae; second, the modern practice: the practitioner has trained in an Ayurveda college and gained a BAMS degree and incorporates both biomedical and Ayurvedic diagnostic techniques, and tends to emphasise the treatment of specific symptoms; third, the commercial practice: these include health spas and rejuvenation centres which offer health promoting services without diagnosis of the condition, focussing instead on well-being services; fourth, the self-help model: here the patient uses an array of sources of information to self-diagnosis and treat using books and the internet, and may purchase 'over the counter' Ayurveda medicines.[56]

Leslie (1976: 358) describes a number of types of medicines showing the plural nature of medical practice in India, and according to Leslie, biomedicine depends on indigenous medicine to meet the exceeding demands for medical services, and abolishing Ayurveda would result in a 'medical catastrophe'. Therefore, Ayurveda may be in a 'sorry state', but it is an essential part of the medical services in India, and continues to serve the masses.
To summarise, I have described the various factors which have resulted in mainstream Ayurveda taking the form of Modern Ayurveda, a biomedicalised version. I now contrast this with the perception of Ayurveda outside India. Under a different set of social and political circumstances, Ayurveda has been adapted and some scholars suggest that Ayurveda has been intentionally 'spiritualised' for the Western audience. Reed (2003: 125) notes the impact of globalisation as a period of intense spatial upheaval, instantaneous worldwide communications, the breakup of local coherence, and a new phase of time and space compression. Culture is being globalised through the appearance of global products

[56] Tirodkar (2008: 238) suggests that Indians when they seek Ayurveda treatments undergo a process of remembering cultural information (page 240). This occurs either through re-establishing oneself in the local cultural paradigm or through extracting oneself from the global paradigms. Her argument is interesting, and raises questions for further research about how Non Resident Indians (NRIs) experience Ayurveda.

and global trends e.g. world music. The link between culture and place is breaking down, which are explored further in Chapter five in relation to the UK definition of Ayurveda.

1.9 Global Ayurveda in the West

Though Ayurveda has its origins in ancient India[57] it has crossed national boundaries and been 'transplanted' outside South Asia (Reddy, 2002: 98). It has been changing and adapting through the ages in India (Leslie, 1976: 356, Meulenbeld, 1995: 6-9) and undergone further changes in its new environments abroad (Zysk, 2001: 10, Zimmerman, 1992: 209; Warrier, 2009: 1). Wujastyk and Smith (2008: 2)[58] use the term Global Ayurveda to refer to Ayurvedic knowledge that has been transmitted to geographically widespread areas outside India. Warrier (2011a: 88) rightly suggests that global Ayurveda should not simply be considered in different national contexts but understood as a transnational phenomenon:

> 'where personnel, ideas, meanings, symbols, products and practices are constantly crossing boundaries, and where developments in any one section of the globe have almost immediate and highly significant implications for this tradition in other areas as well.'

According to Leslie and Young (1992: 3) it was the cultural circumstances that opened the way for Ayurveda in the West. These included the rise of naturalism/relativism and decline of modernism. Leslie argues that the dominating medical model was shaken up by the counterculture of the 1960s (Reddy, 2002: 105) when young people attacked materialistic values and the notion of scientific progress and began to explore alternative lifestyles and Eastern philosophies. Holism[59] was central to this counterculture and continued as a theme through the New Age milieu. These social changes led to interest in CAM and alternate spiritualities, holism and a search for other ways of healing beyond the reductionist

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[57]Alter (2005: 1) states that the analysis of Asian medical systems has been focused within the framework of contemporary nation-states. However, from 'classical civilisation' up to European colonisation in Asia there has been extensive inter-regional contact and communication through trade, political conquest and religious proselytisation. As a result there is historical, theoretical, applied and practical overlap between key concepts of Asian medical systems e.g. yin/yang and *prakriti/purusha*, *qi* and *prana*, three *dosas* and four humours. Western forms of medicine have also been integrated into Asian medicines.

[58] Wujastyk and Smith (2008: 11) describe four paradigms of global Ayurveda, New Age Ayurveda, Ayurveda as mind-body medicine, Maharishi Ayurveda and Traditional Ayurveda in an urban world. These are useful at looking at different practices.

[59] Paterson and Britten (2008) write that holism can be defined on a number of levels. An abstract view of reality sees the whole as a greater than the sum of its parts. By the 1970s the concept of holism entered healthcare, to counteract the limitations of the reductionist nature of biomedicine, and described as 'the deep interdependence of body, mind, emotion and spirit and looking toward the good health of all those simultaneously rather than separately'.

paradigm of biomedicine. The New Age, the subjective turn,[60] and postmodern[61, 62] thinking were some of the influences. Ayurveda was able to fit into this holistic health arena. Reddy (2002: 100) emphasises the commonalities between it and other healing traditions, and suggests that this enabled Ayurveda to find a niche in the West. The various healing systems and therapies that claim to address the mind, body and soul are also referred to as the holistic milieu. This network welcomed Ayurveda and its spiritualised version. Popular authors like Deepak Chopra gained fame with their best-selling books that appealed to seekers of holistic health who seek alternative views to health.

Zysk (2001: 10) argues that Ayurveda transformed into a spiritualised form when it came to the US to meet the needs of the people who were spiritually hungry. In popular writing by authors such as Deepak Chopra, Ayurveda has been presented as a spiritual system of medicine. These authors promote Ayurveda as a science that is embedded within spiritual framework as it addresses both physical and spiritual matters. In contrast, academics such as Zysk (2001: 12) and Warrier (2009: 1) argue that Ayurveda has been intentionally spiritualised in order to make it appealing to a western audience.[63]

I have selected and summarised some of the academic literature on global Ayurveda (Appendices 1a and 1b) to illustrate the way in which scholars have described Ayurveda in the West. Although the summary may suggest these are ideal categories, the practitioners may not see these distinctions in their clinical practice; for example, a practitioner may emphasise a spiritual approach to healing, and have simplified the consultation and be operating in a commercialised setting.

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[60] See Heelas and Woodhead (2005; 2-5)

[61] Heelas et al (1998: 1) report that the term postmodern carries a number of views: refers to the disintegration of the certainties of modernity; it has created a gap for postmodern religions (e.g. Gnostic or New Age spiritualities); the distress of modernity has resulted in the valorisation of a pre-modern past (see partridge 'romancing the pre-modern'); the postmodern religion is associated with changes taking place within mainstream capitalist society. Dedifferentiation is a characteristic of postmodern.

[62] Heelas et al (1998: 13):

• Premodernity – Christendom, Tradition

• Modernity – the dialectic of Enlightenment, communism, instrumental reason, European Integration

• Postmodernity – Progressive triumph of the market, fluidity of identities, collapse of communism, 'the end of history'.

[63] Warrier (2011a) has written a helpful overview to Ayurveda in the West.

The first category 'Spiritualised Ayurveda' includes Maharishi Ayurveda (MAV) and versions of New Age Ayurveda[64] as described by Zysk (2001), Reddy (2002) and Warrier (2009). Spiritualised global Ayurveda may be deemed spiritual for different reasons: for MAV the cause of disease is at the spiritual level and treatment requires spiritual practice; New Age Ayurveda has features that are in common with the New Age and practitioners who are spiritual seekers reflect their personal inclination in their practice.

The second category is 'Simplified Ayurveda' where the simplification can be at a conceptual or practice level. This includes 'Flower Power' Ayurveda as described by Zimmerman (1992). Thus, global Ayurveda appears to be undergoing simplification at both the conceptual and clinical levels and new forms may be emerging due to hybridisation. What is clear is that global Ayurveda is being influenced by a variety of processes which include spiritualisation and simplification resulting in various versions. Stollberg (2001) mentions 'Hybrid Ayurveda' which is a hybrid of traditional Ayurveda and biomedicine. Alter (2005) describes 'Self Help Ayurveda' as a commodified form whereby people as consumers read popular books and purchase remedies that they think they require. The changes occurring to Ayurvedic practice are discussed in greater detail in Chapter six.

The proposition that Chopra, Lad and Svoboda intentionally spiritualised Ayurveda in order to market it to a consumer group hungry for spirituality may be partly true, though other factors must also be considered. I argue that these author-practitioners all had spiritual gurus and therefore they may have been spiritually inclined and their personal inclination would have flavoured their presentation of Ayurveda (Wujastyk and Smith, 2008: 18-20). This is illustrated by Svoboda's (2008: 124) personal knowledge of Vasant Lad. He says that Dr Lad had been nurtured by spiritual gurus and that his Ayurveda work is his 'spiritual calling'. Deepak Chopra was influenced by the TM movement and the Maharishi, and Robert Svoboda also had a spiritual guru. The effect of personal inclination is illustrated by

[64] Warrier says that some scholars describe 'New Age Ayurveda' as inauthentic and faddish (Warrier, 2011b: 9). Carrette and King (2005: 87) suggest that New Age interpretations of Asian traditions are aspects of ancient traditions which have been translated into a modern Western context. The wisdom of ancient traditions becomes commodified for eclectic interests of spiritual consumers in the New Age marketplace of religions. Contemporary prosperity-oriented spiritualities claim the authority of ancient wisdom, while promoting a philosophy of individual self-expression and social conformism. The general 'pick and mix' approach characterises the New Age orientalist approaches to Asian traditions. People appeal to the authenticity of ancient traditions to promote their virtues.

a quotation from Dr Jani who is a biomedical GP, but integrates Ayurveda in his practice in the UK:

> Need to nourish mind, body soul. Need to start with spirit. People need to become aware of spiritual side through meditation, *pranayama*, yoga. (BAAAP conference, 2009).

Research so far illustrates that Ayurveda is a fluid system which adapts according to the social context. Tirodkar's (2008: 227-241) study of Ayurvedic practice in an urban city in India describes a range of practices which support the idea that a practitioner can draw upon various elements from Ayurveda, including those that maybe described as spiritual. Langford's (2002: 25 - 62) detailed and vivid account of three Ayurvedic practitioners: Dr Sharma, Dr Karnik and Dr Upadhyay, illustrates their differing relationship with modern modes of knowledge. Langford argues that their interpretations of Ayurveda are not determined by a cultural domain of ethnomedical beliefs, but by political viewpoints as they are influenced by their relationship with Indian nationalism and biomedical hegemony. Broom et al (2012: 116) suggest that Ayurveda in India is 'deeply embedded in local cultural sensibilities and religious ideologies, producing a complex interplay of medicine, culture and identity'. This study examines the complex interplay of politics and culture on Ayurveda practice in the UK.

From my experience of many consultations with a variety of practitioners both in India and the UK as well as in attending conferences in the USA and Germany, Ayurveda is a system which allows for various holistic approaches to healing which are described next.

1.10 My personal experience of Ayurveda

Over time, I have met a number of different practitioners, had consultations and realised that each individual has his/her own style and approach to clinical practice in terms of level of medical and spiritual intervention. This personal experience is significant as I am critical of the literature which has focused only on certain versions or models of global Ayurveda which do not represent the range of practices I have witnessed.

I have had personal Ayurvedic consultations with ten practitioners over a period of ten years (1998 – 2008), and have summarised key information about the practitioners and consultations in table 1.1. In the top five rows are practitioners who graduated with a BAMs degree in India. The remaining five practitioners, in addition to the university training, received guidance from personal mentors or gurus. All the practitioners used questioning as a way of collecting information; some asked detailed questions about diet

and daily routine, whilst others depended much more on getting information through pulse, tongue and other traditional methods.

Table 1.1 My experience of Ayurvedic consultations

Practitioner	Training / Practice	Style of consultation	Diagnosis	Outcomes
Dr Chel	BAMS – 1st generation in UK	*modern	Not given	Prescribed herbal tablets, diet.
Dr Esha	BAMS – 1st generation in UK	*modern	Not given	Prescribed herbal medicine and exercise.
Dr Paresh K	BAMS – now in UK	*modern	Not given	Herbal remedies.
Dr Prakash R	BAMS - India	*modern/ ***spiritual	Stress – caused imbalance and disharmony	Meditation. Herbal remedies.
Dr Mohan	BAMS – India but travels abroad	**Traditional (tongue, pulse)	Emotional	Herbal remedies, diet, emotional counselling.
Dr Vishnu	Guru - India	**Traditional (tongue and pulse)	Ayurvedic physiology disturbed.	Prescribed herbal medicine.
Dr Chawla	BAMS/Guru – India but travels abroad	**Traditional/ ***Spiritual	Wrong career. Spiritual issue.	Read *Bhagavad Gita*, mantra
Rosalind	BSc / Guru - UK	**Traditional/ ***Spiritual	Ayurvedic physiology disturbed.	Herbal remedies, diet, fasting, Emotional /Psychology.
Dr Sangeeta	BAMS / Guru – India but travels abroad	**Traditional (pulse)	Ayurvedic physiology disturbed.	Herbal remedies and fasting, diet.
Dr Vasudev	BAMS (Guru) – USA and travels abroad.	**Traditional/***Spiritual/ Astrology/*Vastu*	Emotional	Herbal remedies, *pranayama*, emotional counselling, mantra

*modern – only considered physical issues and prescribed accordingly.
**traditional – Guru training - used all traditional Ayurvedic diagnostic techniques and traditional remedies. Explained the pathology in Ayurvedic terms.
***spiritual – holistic, includes spiritual aspects particularly in recommendations. May be using intuition or other subtle methods to diagnose the problem.

The table indicates that the practitioners who only have the BAMS training tended to use a modern style consultation, considering physical issues and prescribing herbal remedies, similar to a medical GP. The two exceptions were Dr Prakash R, who suggested the underlying cause was stress causing imbalance in the physical body and prescribed daily meditation as part of the treatment package. Dr Mohan incorporated traditional diagnostic techniques such as checking the pulse and tongue and suggested the underlying issue was caused by an emotional imbalance. The remaining five practitioners who have received training from a personal mentor or guru all based their consultations on traditional techniques, described the problem in terms of Ayurvedic physiology and gave a very holistic prescription which included diet, lifestyle and herbal remedies, but also spiritual advice.

This data from my personal experience indicates a pattern linking the type of training practitioners receive and the type of consultation they give, or the level at which they diagnose the problem and type of recommendations they make. Hence, I argue that Tirodkar's (2008: 227) categories of 'traditional' and 'modern' are not rigid, rather they are fluid. All the practitioners who studied with a guru tended to take a holistic approach, regardless of their institutional training. This indicates that personal inclination and a spiritual worldview is significant in the way a practitioner offers his/her services. It also suggests that research must include a range of different practitioners in order to get a full understanding of the practice.

In parallel, Ward's (2011) findings serve as an example of the variety of practices that can appear in traditional systems. She examined what is meant by Chinese medicine and discovered six styles of Chinese medical practice which she refers to as enactments. This indicates the diversity of practices that come under one single label at a single point of time, as well as the varying levels of engagement with biomedicine.[65] Next is a brief overview of Ayurveda as part of the holistic milieu in the UK and the relationship with British Government.

1.11 UK Ayurveda[66]

Newcombe (2008b: 252-275) gives a helpful historical overview of Ayurveda in Britain showing that Ayurveda is part of the South Asian culture in terms of the use of traditional home remedies, diet and lifestyle and these practical aspects of Ayurveda came with Indian migrants to the UK.[67] While 'Indian medicine' has been practised within Asian communities, Newcombe suggests that some of the development can also be attributed to

[65] Ward describes the following six enactments that describe Chinese medicine:
1) Modern, Independent and Equal,
2) Classical Wisdom,
3) Biomedicine – the facts
4) Chinese medicine the Grand Narrative
5) Chinese Medicine – a way of being
6) Pragmatic Combiners

[66] I refer to Ayurveda in the UK as 'UK Ayurveda'.

[67] Stollberg (2001: 7-8) points out that difference in migration patterns between Germany and the UK. The UK has attracted immigrants from South Asia as a consequence of its historical links, whereas Germany has not had the same pattern of immigration. He suggests this may have resulted in Ayurveda being practised by ethnically Indian practitioners in their ethic subcultures and ethnically British practitioners in medical subcultures.

the activities of the School of Economic Science[68] as well as those of yoga practitioners who have a specific interest in Ayurveda.[69]

In the UK, there are currently two associations for Ayurvedic professionals. The Ayurveda Practitioners Association[70] (APA) has eighty practitioners (qualified to diagnose conditions and prescribe medicine). Over a quarter have a BAMS degree (Bachelor of Ayurvedic Medicine and Surgery) from India. One quarter of the practitioners qualified in the UK with an MSc or Postgraduate diploma from Middlesex University which enables them to diagnose illness and prescribe treatments. Graduates with a BA degree from Thames Valley University (TVU) or Mayur University also have practitioner status. The British Association of Accredited Ayurveda Practitioners[71] (BAAAP) website has thirteen practitioner members, mainly with BA degrees from TVU or Mayur University. A few practitioners including biomedical practitioners have other qualifications. It is possible that the number of practitioners is higher than that reflected on the websites of the two associations, as some may not be members of either of these professional organisations.

The House of Lords Select Sub-Committee on CAM, 2000 produced a report entitled Complementary and Alternative Medicine (HMSO, 2000) the purpose of which was to characterise all aspects of CAM in the UK (Wujastyk, 2005: 163). The report stated that CAM included a large range of therapies, some with well-developed regulatory structures, and others were fragmented with no consensus about regulation. It classified CAM into three groups. Therapies placed in Group 1 included the most organised CAM professions where NHS provision is increasing and where research into their effectiveness had either already commenced or was likely to be beneficial. The therapies assigned to Group 2 also have support from the NHS, but are used in a complementary way alongside conventional medicine. They require further research and need to develop their regulatory structures. The therapies placed in Group 3 were considered to have no evidence base for clinical

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[68] School of Economic Science [online]. [Accessed 28.12.12]. Available from the World Wide Web: http://www.schooleconomicscience.org/. The School of Economic Science is a centre for spiritual and practical knowledge enquiry.

[69] Newcombe (2008a) focuses on a particular legal case involving the Maharishi Ayurveda group (MAV) in the UK. Newcombe makes the key distinction between the fate of yoga in the UK which was accepted by the medical establishment as it took a complementary role to biomedicine. MAV on the contrary suffered disrepute because it challenged the medical establishment.

[70] Ayurveda Practitioners Association (2012) [online]. [Accessed 28.12.12]. Available from the World Wide Web: http://apa.uk.com/

[71] BAAAP (2013) [online]. [Accessed 28.12.12]. Available from the World Wide Web: http://www.britayurpractitioners.com/

effectiveness. Initially, Ayurveda was included in the third group, but the Ayurvedic community raised objections as it considered this an inappropriate classification. The Government of India sent an expert delegation and presented on the scientific evidence base of Ayurveda. Subsequently it was agreed to place Ayurveda in Group 1. However, rather than understanding Ayurveda is a traditional system of medicine, it was grouped as a sub-branch of herbal medicine, which the Ayurvedic community consider to be an error. The UK Department of Health has so far ignored the demands from various Ayurvedic stakeholder groups and not made any further amendments. [72]

Ayurveda to date is not regulated by the Government, therefore Ayurveda practitioners together with other herbal practitioners have been lobbying the British Government for statutory regulation in order to be accepted as authorised health professionals. The regulation would permit them to continue to access third-party supply of herbal medicines. The Traditional Herbal Medicines Directive implemented in April 2011 and its impact is discussed further in Chapter five (see page 47).[73] Therefore, this research began at a time that was both frustrating and uncertain for practitioners.

The Ayurveda community is still very small compared to other CAM communities such as those of Traditional Chinese Medicine (TCM) and Acupuncture. Ayurvedic practitioners work on the margins of health care, similar to their counterparts in the US and in Germany. Being on the edges and relatively unknown, Ayurveda lacks widespread recognition as a serious science. Pole (2008: 223) writes that the initial image of Ayurveda in the UK was of a disorganised system of medicine. This started changing as the Ayurveda community began to unite as a result of the establishment of the APA in 2005 (Pole, 2008: 223; Newcombe, 2008: 278). This concern was echoed by the practitioners in Murthy's (2010: 58) study in New Zealand 'Ayurvedic professionals not being taken seriously within the health profession' and further 'there is an idea that it [Ayurveda] is not a serious modality, pharmaceutical medicine is a serious modality'.

[72] Ayurvedic Practitioners Association (2012) [online]. [Accessed 12.5.13] Available from the World Wide Web: http://apa.uk.com/about/ayurveda-in-the-uk
[73] MHRA (2013) [online]. [Accessed 29.12.12]. Available from the World Wide Web: http://www.mhra.gov.uk/#page=DynamicListMedicines

1.12 Conclusion

The literature on Ayurveda outlines a dynamic history of changes to the practice which have been occurring as a result of contact with other healing traditions in India. The postcolonial influences appear to have brought about the most dramatic changes to the identity of the Ayurvedic profession leading to the biomedicalisation of the practice which continues to date in education, research and production of Ayurvedic products. Globalisation is producing further new appearances of Ayurveda in the new social and political environments of the West. The impact of social trends such as New Age and postmodernism are resulting in changes to Ayurveda and producing holistic and spiritualised versions. These changes indicate Ayurveda to be a fluid system which I argue is particularly important for the Ayurveda practitioners who seek credibility as health practitioners.

The aim of my doctoral research was to capture a snapshot of the current practice in the UK. It was an empirical study which involved collecting data from a variety of sources, primarily from practitioners, and some key people in the field. The aim was to explore the following research questions:

1. How is Ayurveda practice changing in the new UK environment?
2. What is the role of religion and spirituality in the practice of Ayurveda during the clinical consultation?

I referred to the concepts of religion and spirituality as a multifarious network of ideas which are immensely complex (Francis et al, 2008b: 609). I endeavoured to understand the role, relationship and meaning of religion and spirituality in the Ayurvedic context as described by Ayurveda practitioners in the UK. I was aware that these are contentious and much debated terms (for example, scholars such as Taylor (1998) have analysed the terminology).

I investigated a number of other questions that arise out of the suggested polarity between modern Ayurveda, which has embraced a secularised version of Ayurvedic knowledge and biomedicine, and some versions of global Ayurveda which have emphasised the philosophical and spiritual aspects (Wujastyk and Smith, 2008: 2). These questions are in relation to my research in the UK and included:

Q How do UK Ayurvedic practitioners perceive global Ayurveda in the UK? I discuss this in Chapter five, through an analysis of how practitioners define and perceive Ayurveda.

Q From a practitioner's perspective, is spiritualisation as suggested by Warrier (2009) central to shaping Ayurveda practice in the UK? I describe the processes which appear to be most influential in shaping the practice of Ayurveda in greater detail in Chapter six.

Q Do Ayurvedic practitioners perceive themselves as medical practitioners or religious healers? Reddy (2002) suggested that Ayurveda practitioners in the US experience a professionalising dilemma with regards to identifying themselves as medical practitioners or as religious healers, depending on circumstances. I examine this dilemma in relation to the findings of this study of UK practitioners further in Chapter six.

Q What is the relationship between religion and spirituality in different Ayurvedic contexts? The literature on the Ayurvedic community in the UK appears only to have explored the social context to suggest that Ayurveda is a New Age version. Therefore, I analyse data from other contexts (education, political and clinical) to understand the relationship of religion and spirituality and how it changes due to social factors in these various contexts.

Q How do UK practitioners define spirituality in the Ayurvedic context?
Ayurveda has been popularised as a spiritual system of healing that addresses the mind, body and spirit. I examine the practitioners' understandings of how they address spiritual matters in Chapter seven.

Q What are the changes from classical to contemporary *daivavipashraya* (spiritual treatments)? The Ayurveda classical text *Charaka Samhita* describes spiritual /religious treatments (see page 34). I compare these to the spiritual recommendations that contemporary practitioners make in Chapter seven.

Q When do practitioners prescribe spiritual treatments (*daivavipashraya)*?
This question explores the circumstances in which practitioners recommend spiritual treatments, and I discuss these in Chapter eight.

Q According to UK practitioners, what are the mechanisms of spiritual treatments (*daivavipashraya)*? I examine Ayurveda practitioners' understandings of how spiritual practices impact on health in Chapter eight.

Q What is the role of the practitioner during the Ayurvedic consultation in the UK? A variety of different relationship models are described in the literature. I discuss the complexity of the role of the Ayurveda practitioner in Chapter nine.

Q What do UK practitioners define as authentic Ayurveda? I explore various meanings assigned to authentic Ayurveda in Chapter nine.

1.13 Outline of the thesis

Chapter two describes different theoretical approaches. Issues around different ways of knowing are also discussed in relation to considering Eastern traditions of healing. Reasons for adopting a qualitative methodology and reflexive approach are outlined.

Chapter three describes the research strategies and data collection. The qualitative research methods used to collect and analyse the data are explained in detail. These include interviews with practitioners, as well as participant observation of events such as conferences and meetings.

Chapter four gives a detailed account of each stage of the data analysis. It outlines the process followed to develop the initial and focused codes. From these codes, key themes were identified for discussion in the remaining chapters. I also revise and discuss the practitioner categories.

Chapter five sets the background as it examines how practitioners define Ayurveda and negotiate between different paradigms. It describes practitioners' perceptions of biomedicine, modern research and the State regulations as well as the status of the classical Ayurvedic texts in the Ayurvedic practice in the UK.

Chapter six examines how Ayurveda practitioners in the UK are adopting a number of strategies to practise in an environment in which their access to a full range of remedies

and treatments is restricted. The role of spirituality is examined and various factors are identified that influence the key changes to the clinical consultation.

Chapter seven examines the relationship between religion and spirituality in the educational, social, political and professional (clinical) contexts. The factors that influence the changing relationship are discussed. The distinction between religion and spirituality and what is secular and what is sacred is discussed. The definition of spirituality in the Ayurvedic context is described and the changes from classical *daivavipashraya* to contemporary spiritual prescriptions are examined.

Chapter eight analyses the way practitioners define spirituality in the context of Ayurveda practice and their understanding of the link between spirituality and health. The practitioners' decision making process to recommend spiritual treatments is examined.

Chapter nine describes the changing role of the practitioner in the UK. The practitioner is no longer a prescriber of remedies, diet and lifestyle, but is also involved in a process of negotiation and in some situations may facilitate the patient's journey to discover a suitable spiritual practice. The practitioners' understanding of authenticity in relation to UK Ayurveda is also discussed.

Chapter ten presents the conclusion. The key themes of fluidity and credibility are discussed. The role of spirituality is summarised to show the way it takes on different meanings as it crosses from the private sphere into the public sphere. The challenges of crossing different paradigms are described and suggestions are given for further research.

In the next chapter I discuss the ontology and epistemology from an Ayurvedic perspective and in relation to methodology for this study.

Chapter two Methodology

In the first part of this chapter I briefly outline three key epistemological approaches and relate these to Ayurvedic approaches to knowledge. I then discuss the assumptions in relation to hierarchies of knowledge that underlie the Ayurveda and biomedicine paradigms. This is followed by a discussion of the qualitative approach which is employed for the data collection and analysis of the data and my role as a practitioner researcher.

2.1 Introduction

The literature on social research strategies is complex because of the inconsistency in terminology as one term can be used in different ways (Crotty, 1998: 1). For example, Crotty (1998: 5) describes three different epistemologies: objectivism, constructionism and subjectivism, whereas Bryman categorises objectivism and constructionism as ontological approaches. Bryman (2008: 13) describes positivism and interpretivism as epistemological approaches, whereas Crotty calls these theoretical perspectives (which incorporate ontology).

I have summarised Crotty's (1998) discussion of the three theoretical approaches (see appendix 2) and related these to an Ayurvedic approach to the understanding of knowledge. Modern biomedical science is based on a positivist approach and continues to claim that scientific knowledge is objective and valid. This is illustrated by the following questions by Cant and Sharma (1999: 20) which suggest that some ways of knowing are superior whilst others are subjugated ways of knowing in the understanding of health and healthcare:

> Does increased use of CAM represent a destabilisation of biomedicine and science as forms of knowledge? Is the resurgence of non-biomedical forms of healing an example of postmodern rejection of universalism, and a breakdown of the authority of the medical meta-narrative?
> (Cant and Sharma, 1999: 20)

There is a need to consider that there may be many ways of knowing, without a hierarchical structure. Subjugated ways of knowing include practical and spiritual ways of knowing of women, or of groups who are oppressed (Clarke, 2005: 5). Boyce-Tillman (2005: 10) writes that the Enlightenment period led to a shift to a different value system in which the intuitive visionary experience was at best marginalised and at worst pathologised. Reason became paramount and influenced the way all creative expression was regarded.

To illustrate the difference in the ways of knowing and how reality is understood in the context of this study, I refer to Scheid and Macpherson (2012: vii) who write that illness is surrounded by uncertainty and CAM and biomedical professions deal with the uncertainty in different ways. CAM traditions address this uncertainty by consulting with canonical texts or thousands of years of experience which is now termed as practice based medicine (Murthy, 2010: 61). In contrast, the biomedical profession traverses the uncertainty with laboratory science, statistics and randomised controlled trials (RCT).

The uncertainty stimulates a constant search for new knowledge, treatments and theoretical constructs. According to Scheid and Macpherson (2012: xi), Asian medical traditions' way for determining 'what works' depends on: the critical reading of revered classical texts, historical interpretations of the literature and their modern synthesis, compiled historical and contemporary clinical cases and close observation of teachers, mentors and colleagues. These are in addition to careful observation of the patient, clinical experience and feedback from the patient. Scheid and Macpherson point out that even up to World War Two, Western biomedicine continued to value evidence based on single patient responses. The basic unit of evidence was observation of the patient (Scheid and MacPherson. 2012: xi). However, after World War Two, with the development of the RCT, the concept of evidence underwent a radical shift. A treatment was only considered effective if the change in the experimental group was more than the control group. This way of researching effectiveness through minimising subjective bias led to the development of evidence based medicine (EBM).

According to Loughlin (2009: 936), EBM has gained popularity as a way of increasing scientific rigour and is considered a way of generating the 'best evidence', rendering expert opinion, intuition, clinical experience and tacit knowledge to be labelled as poor evidence or not really evidence. EBM has a neo-positivist ideology, and is different to that of the Eastern traditions which are quite often guided by insight. The EBM approach assumes that complex problems can be reduced to simple ones because the world is made up of simple cause and effect chains between agents (Scheid, 2012: 29). According to Scheid and MacPherson (2012: 16), the underlying motive for employing EBM methods is to reduce healthcare inequalities arising from subjective biases and is more appropriate for research on populations, rather than individuals. This suggests that EBM is not an appropriate

research approach for person centred medical practices, such as Ayurveda, though research trials employ scientific methods.

Scheid (2012: 18) draws attention to further difficulties in understanding traditional systems like Ayurveda because they can be understood as 'notional systems' e.g. based on the notion of humours (or bio-psychosocial energies, the *doshas*). But these 'notions' have been reconceptualised as 'basic theories' of Ayurvedic medicine and this causes the problem in trying to understand its underlying paradigm. Practitioners draw on notional systems in different ways depending on the characteristics of the illness and person, and practitioners are not expected to describe the reality in minute detail. These notions are not fully captured by scientific research, as they are vague concepts and science requires precise definitions.

Another matter that Loughlin (2009: 938) explores is that people who support the EBM approach have an inherent belief that it provides better evidence, which is required for clinical decision making, as it is rational, objective and has a rational basis and is assumed to be opposite to subjective and personal ways of thinking. Loughlin suggests that this idea of a conceptual division between objective and subjective is not philosophically sustainable. If the subjective element of reasoning is stripped out of the decision making 'you have not rational, evidence-based decisions but rather no rational basis for distinguishing good from bad'. Having referred very briefly to the differences in how reality is constructed by different paradigms, the practical matters of undertaking this research are described next.

2.2 Methodological approach

As discussed above, an Ayurvedic approach to knowledge is complex, incorporating elements from the range of social science epistemologies. For the purpose of this research, the aim of which is to understand the practitioner's subjective perspectives and experiences, I took a subjectivist / interpretivist approach and adopted a qualitative methodology in order to keep the practitioner's view as the focus of my research; this included elements from the Grounded theory for the data analysis which I discuss in Chapter four. This is in line with the Ayurvedic view that people are individuals and their

perception of social reality is according to their individual *prakriti,* psychological *gunas, samskaras,* as well as cosmic influences acting upon them.[74]

Qualitative research methods were chosen as appropriate to gain insight into the influences that shape the practice of Ayurveda and the role that spirituality plays, which is a largely unexplored terrain. This would be achieved through listening to practitioners and their viewpoints either as individuals or collectively at practitioner events. A qualitative approach allowed for an in-depth exploration of the thoughts and experiences of Ayurvedic practitioners and others in the field.

2.3 My position in relation to this research and reflexivity

Ely et al (1991) argue that undertaking qualitative research is by nature a reflexive process. The concept of reflexivity may be a way of bringing qualitative methods to account for them. It involves questioning how the processes of research and analysis have an effect on research outcomes and is usually perceived as a way of ensuring rigour. A reflexive researcher is one who is able to step back and take a critical look at her own role in the research process. The goal of being reflexive in this sense has to do with improving the quality of the research and recognizing the limitations of the knowledge that is produced, thus leading to more rigorous research.

Reflexivity is the researcher's capacity to acknowledge how their own experiences and contexts, which may be fluid and changing, inform the process and outcomes of enquiry. The researcher is at the centre of the analysis of the knowledge produced through social research (Richards, 2005: 42). It draws on a variety of biographical aspects such as values, motives, politics, employment and personal status as well as on issues related to the key social divisions of age, gender, sexuality, ethnicity and ability as they specifically apply to the researcher.

Taking a reflexive approach was crucial in enabling me to be aware of the preconceptions and assumptions brought about by my thoughts, feelings, dual cultural upbringing, environment, training, experience and dual identity and in particular my personal views on spirituality on all aspects of my research. I am a British-born female of Indian origin and grew up in a multicultural suburb of London. I have always felt a part of mainstream

[74] In terms of research questions and matching appropriate research methods, I take a pragmatic view to research and am of the opinion that methods should match the questions. Therefore quantitative methods serve a purpose when the research questions require a quantitative answer.

society, but at the same time I have been a part of a BME community with a different culture that applies worldviews that differ from the mainstream. This experience has given me insights into what it is like to be part of a minority community, holding a different understanding of the world and this has helped facilitate my role as an insider in this research study. Being an insider meant that I came with experiential knowledge.[75] Being of Indian origin enabled me to relate to the Asian practitioners for whom English is a second language and to understand the difficulties they face in settling into a new environment. Growing up in London enabled me to relate to the European practitioners.

2.3.1 My role as the insider and practitioner researcher

The role of the researcher in the group or area being studied is relevant to all approaches of qualitative methodology as the researcher plays a direct and intimate role in both data collection and analysis. The researcher may be an insider sharing particular understanding or experiences with the participants, or an outsider to the commonality shared by participants. Corbin-Dwyer and Buckle, (2009: 55) say that 'the personhood of the researcher, including her or his membership status in relation to those participating in the research is an essential and ever-present aspect of the investigation.'

For the researcher, being an insider enhances the depth and breadth of understanding a population; however, questions about the objectivity, reflexivity, and authenticity of a research project are raised because the insider knows too much or is too close to the project and may be too similar to those being studied (Corbin-Dwyer and Buckle, 2009: 57)

Corbin- Dwyer (Corbin-Dwyer and Buckle, 2009: 56) describes her experience as an insider:

> … when I was conducting my data analysis, I found myself writing both "we" and "us," and "they" and "them." Sometimes I wrote myself into my research, and other times I did not. On further reflection, I realized I sometimes shared experiences, opinions, and perspectives with my participants, and at other times I did not. It is not that I sometimes saw myself as an outsider instead of an insider. Rather, not all populations are homogeneous, so differences are to be expected.
>
> … As a qualitative researcher I do not think being an insider makes me a better or worse researcher; it just makes me a different type of researcher.

The terms emic and etic are also used to denote different perspectives used by anthropologists and by others in the social and behavioural sciences to refer to two kinds of data or viewpoints concerning human behaviour. The emic approach investigates how

[75] Experiential knowledge is: 'knowing an entity – person, place, and thing, process – in face to face encounter and interaction. It is knowing a person or thing through sustained acquaintance.

local people think, perceive and categorize the world, their rules for behaviour, what has meaning for them, and how they imagine and explain things. The etic approach shifts the focus from local observations, categories, explanations, and interpretations to those of the researcher. According to this approach, members of a group or culture may be too involved in what they are doing to interpret their cultures impartially. When using the etic approach, the ethnographer emphasizes what he or she considers important. Both approaches can be complementary to each other, and a practitioner research juggles both viewpoints.

2.3.2 Advantages of being an insider

Insider research refers to when researchers conduct research with populations of which they are also members so that the researcher shares an identity, language, and experiential base with the study participants. The complete membership role gives researchers a certain amount of legitimacy. This insider status frequently allows researchers greater acceptance by their participants. Therefore, participants are typically more open with researchers so that there may be a greater depth to the data gathered.

The benefit to being a member of the group one is studying is acceptance. This provides a level of trust and openness in the participants that may not have been present otherwise. One has a starting point (the commonality) that affords access into groups that might otherwise be closed to outsiders. Participants might be more willing to share their experiences because there is an assumption of understanding and an assumption of shared distinctiveness.

2.3.3 Disadvantage of being an insider

The disadvantages of being an insider include a heightened level of researcher subjectivity that might be detrimental to data collection and analysis. Researchers might struggle with their conflicting roles and issues around loyalty. The dual role can also result in role confusion when the researcher responds to the participants or analyses the data from a perspective other than that of researcher. Role confusion can occur in any research study but there is a higher risk when the researcher is familiar with the research setting or participants through a role other than that of researcher.

The insider status has the potential to impede the research process as it progresses. Participants may make assumptions of similarity and therefore fail to explain their individual experience fully. It is also possible that the researcher's perceptions might be

clouded by his or her personal experiences and that as a member of the group he or she will have difficulty separating it from that of the participants. This may result in the interview being shaped and guided by the researcher's experience rather than the participant's experience. This might affect the analysis, leading to an emphasis on shared factors between the researcher and the participants.

Further, individuals are often so enmeshed in their own experience that the adequate distance required to know their experience is not available; therefore, someone from the outside might more adequately conceptualize the experience. People are full of overlapping, confusing, ambivalent, mixed, and sometimes contradictory goals, motives, desires, thoughts, and feelings. Because of these features of the human experience, another might sometimes be able to see through the complexity in ways the individual cannot. Others external to the experience might be able to appreciate the wider perspective, with its connections, causal patterns, and influences, than someone internal to the experience.

In summary, there are costs and benefits to be weighed regarding the insider versus outsider status of the researcher. Being an insider might raise issues of undue influence of the researcher's perspective, but being an outsider does not create immunity to the influence of personal perspective. Furthermore, although there might be caveats to being a member of the group studied, for many access to the group would not be possible if the researcher was not a member of that group.

The practitioner researcher has to deeply reflect on the subjective research process, with a close awareness of his / her own personal biases and perspectives. This reflexive approach may reduce the potential concerns associated with insider membership. Furthermore, one does not have to be a member of the group being studied to appreciate and adequately represent the experience of the participants. Taking this stance, being an insider or outsider is not as important as having the ability to be open, authentic, honest, deeply interested in the experience of the research participants, and committed to accurately and adequately representing their experience.

2.4 Practitioner Researcher

Practitioner Researcher falls within a smaller category of the insider/outsider circle, or the emic / etic approaches. Practitioner research refers to academic research or research in the workplace performed by individuals who also work in a professional field as opposed to

being full-time academic researchers. Practitioner research has two categories: research in the workplace, such as a service evaluation or needs assessment, and academic research related to the practitioner's role, such as a master's degree or PhD in a relevant subject.

McLeod defines practitioner research as 'research carried out by practitioners for the purpose of advancing their own practice' (McLeod, 1999: 8). Practitioner involvement in research is carried out by professionals who directly deliver services. This is embraced across a wide range of professions as an essential ingredient of good practice and therefore desirable (Shaw 2002: 1).

Most practitioner research is employer-led, 'applied', and based on an expectation that it should lead to results that are directly useful.

2.4.1 Advantages of practitioner research

Practitioners are familiar with their working environment and know how to carry out various processes that contribute to professional action (Fox et al, 2007: 33). It is also held to improve the quality of the practitioner-researcher's practice.

Carmichael and Miller (unpublished paper) say that the use of practitioner researchers is an appropriate and powerful method of plunging deep into the culture and environment of the research setting in ways that would be very difficult and time consuming to achieve otherwise.

Fox et al (2007: 25) identify different types of knowledge that practitioners hold, which are essential for their work, making their knowledge base both dynamic and complex. They have different components of professional knowledge: propositional knowledge which concerns the underlying theoretical basis of practice, process knowledge which correlates to knowing the processes in which professional engage whilst practising, personal knowledge about the self and value-based knowledge relating to moral and ethical values. Professional judgement is based on all four types of knowledge, with an understanding of practice which has been gained through experience (page 27). All this is also brought to the research project.

2.4.2 Disadvantages of practitioner research

Shaw (2002: 1) cites a number of disadvantages of practitioner research. Practitioners have a tendency to treat the nature and application of evidence in simple terms; there is an absence of cross-professional dialogue and development; too little attention is given to

identifying methodology and appropriate research strategies for research, simple deductive assumptions about the relationship between theory and practice are made; and the service user's perspective is excluded. Shaw says that practitioners are not critical of their insider standpoint. In addition, they may find it difficult to think about new ways of working and may come to research with preconceptions about issues and solutions (Fox et al, 2007: 33).

Carmichael and Miller (unpublished paper) found that in the sub-text of discussions with potential recruits was the concern whether they were they being required to take on additional work for which they would probably not be properly paid, and which would represent an additional work-load for which they would not be given adequate time to cope. Aside from this worry, some were intimidated by the view that it would involve them in 'academic' activities that they had left far behind in the days of their training. Therefore, practitioner-research can be difficult as it challenges the world-view of the practitioner-researchers, making them re-examine the nature of their practice. It also focuses upon the assumptions and the implicit value-judgements that often affect and direct the ways in which practice operates. For all these reasons, this kind of research is of great value to those who participate in it.

Research work carried out this way is slow as each step of the process presents difficulties. Negotiations around arriving at working practices, shared understanding of language, and on the very manner in which the research is conducted are not resolved quickly and carry on throughout the project. The participants find that their own practice is challenged in various ways, and as they meet certain institutional barriers and problems. Although a research project could be carried out more efficiently and effectively by employing professional researchers that would be a different exercise. In this study, I have undertaken research funded by a University studentship rather than an employer. The timescales were different as I had three years whereas practitioner research tends to be short term and small scale.

In addition, having graduated as an Ayurveda practitioner and as a member of the professional community in the UK, I have good insight into the challenges that my participants face as Ayurveda practitioners in the UK. I would describe my standpoint as primarily a postgraduate researcher with a practitioner background, rather than a practitioner in an academic setting, as the pressures to meet academic standards and the

requirements of a doctoral programme far outweighed the tendency to act and think like a practitioner. Therefore, the notion of 'the space between' suggested by Corbin- Dwyer and Buckle (2009: 60) fitted my experience. They say the notion of the space between the insider and outsider challenges the dichotomy, and to present these concepts in a dualistic manner is overly simplistic. It is restrictive to lock into a notion that emphasises either/or, one or the other, you are in or you are out. Rather, a dialectical approach allows the preservation of the complexity of similarities and differences. In reality, there is fluidity and multi-layered complexity of human experience. Holding membership in a group does not denote complete sameness within that group. Likewise, not being a member of a group does not denote complete difference. Therefore, it is necessary to consider the space between these two positions.

There are complexities inherent in occupying the space between, and in reality it may be that researchers can only ever occupy the space between. Some may be closer to the insider position or closer to the outsider position, but because the researcher's perspective is shaped by his or her position as a researcher, neither one nor the other of those positions can be fully occupied.

The downside of occupying this third space is a heightened sense of vulnerability. The process of qualitative research is very different from that of quantitative research. Qualitative researchers are not separate from the study, with limited contact with the participants. Instead, the researcher is in all aspects of the research process and essential to it. The stories of participants are immediate and real, individual voices are not lost in a pool of numbers. The words in the transcripts, representing experiences, are clear and lasting. The researcher's personhood affects the analysis and the analysis affects the researcher. The intimacy of qualitative research does not allow the researcher to remain a true outsider to the experience under study, and at the same time the researcher is not completely an insider (Corbin-Dwyer and Buckle, 2009: 61).

The space in which I am both the researcher and a practitioner meant that I could not claim to be totally detached from my participants or the field of study. As an insider, some practitioners thought I was undertaking this research in order 'to do something for Ayurveda'. This indicates that participants had an underlying trust that this research would in some way help the Ayurveda community. Other practitioners commented that we 'need more research,' implying that my research might somehow show the effectiveness of Ayurvedic treatments. The general feeling was that the participants trusted me and felt

there would be some benefit. I endeavoured at every point to clarify the purpose of the research.

The main disadvantage of being a practitioner-researcher was that I did not question everything as I am familiar with Ayurvedic concepts activities and events, whereas someone without an Ayurvedic background may have taken a different approach and explored new topics. The advantage was that I was able to tune in to the issues being discussed and understood terminology and concepts without the practitioners having to explain them.

A reflexive approach enabled me to examine my role and relationships in this study. Although, as described in Chapter five, the practitioners perceive themselves to be a marginalised group, my insider status meant that there were no obvious issues around power relationships. A hierarchical relationship between the participants and myself was avoided as the practitioners knew me as a fellow colleague or acquaintance.

There are a number of ways that reflexivity can be woven into research practice (Bryman: 2008: 683; Charmaz, 2006: 188-89). Techniques include keeping a research diary and getting feedback on the research process. I have taken several opportunities to present my research to audiences both at research events at the University of Winchester as well as external conferences, in order to get feedback on my process and interpretation of findings. This included giving presentations to a variety of audiences including a CAM postgraduate research group in Southampton University and events for postgraduate students at Winchester University, as well as other conferences.

2.5 Quality of qualitative research – criteria and standards in qualitative research.

The quality or rigour of research that is undertaken needs to be of a good standard; however, the concept of quality has been contested in recent years and several lists of criteria have been proposed as alternatives to the quantitative research criteria (Bryman, 2008: 380), with some researchers questioning whether qualitative research should be evaluated at all.

In social research, quality is evaluated by the parameters of validity, reliability and generalisability which are generally applied to quantitative research. Scholars differ in

opinion about how useful these are for judging the excellence of qualitative research and the complexities of social research. Mason (cited by Bryman 2008: 376) accepts these criteria of quantitative research, whereas Ely et al (1991) say that the language of positivist research is not congruent with or adequate to evaluate qualitative work. Alternative criteria to establish the trustworthiness of a study include the following four criteria: credibility, transferability, dependability and confirmability as suggested by Lincoln and Guba (cited by Robson 1993: 403).[76]

Researchers in some other disciplines, for example phenomenology, view the analysis of qualitative data as an art and prefer an intuitive approach and even have concerns about concepts like reliability and validity (Robson, 1993: 373); others take less extreme views, remaining mid-way on the scale between adopting quantitative criteria and developing alternative qualitative criteria (Bryman, 2008: 381). This is the position that most qualitative researchers take, i.e. their accounts are one of a number of possible representations rather than a definite version of social reality, e.g. Hammersley (1992a). For Wolcott (1990a: 136), validity neither guides nor informs his work. His goal is to identify the critical elements in his research and write plausible interpretations. According to him, the concept of validity is a distraction from understanding what is going on and it does not capture the essence of what he seeks, which is 'understanding'.

In summary, some researchers such as postmodernists or interpretivists reconceptualise the traditional concepts of quality criteria, whilst others adhere to the positivist tradition, and some researchers altogether dismiss these criteria.

From an Ayurvedic point of view, for example according to *Nyaya* philosophy, perception can be *laukika* (ordinary) and *alaukika* (extraordinary) and in this category *yogaja* perception (intuitive perception) is described as:

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[76] Credibility relates to internal validity. This can be improved in a number of ways which include: prolonged involvement, persistent observation, triangulation, and peer debriefing, negative case analysis and member checks. Transferability relates to external validity (generalisability) and is judged by the thick description of everything so the findings are understood (Geertz, 1973). Dependability relates to reliability and requires the research process to be clear, systematic and well documented. Safeguards against bias are employed and triangulation is used. Confirmability relates to objectivity for which an audit trail of the method links it to the purpose of the study (Lincoln and Guba cited by in Robson 1993: 403).

> ‘Perception of all objects –past and future, hidden and infinitesimal- by one who possesses some supernatural power generated in the mind by devout meditation (*yogabhyasa)* (Athique, 2001: 4-6).

Therefore a person who has attained ‘spiritual perception’, or an enlightened or *satvic* person, would be regarded as a trustworthy source, and information from such a person would be accepted as he or she has the ability to perceive the truth. In epistemological terms, information through intuition is acceptable, so quality criteria would be quite different from this perspective.

Creswell and Miller (cited by Creswell 1998: 201) undertook a review and as a result offer a classification of eight verification procedures that are often discussed in the literature: prolonged engagement, triangulation, peer review / debriefing, negative case analysis, clarifying researcher bias, member checks, rich thick description and external audits. Creswell (1998: 201) suggests that at least two of these verification procedures are included in any study.

With regards to this study, a reflexive approach was most important for assuring quality. In addition, I considered my experience of being part of the Ayurveda community and tacit knowledge as prolonged engagement in the field. I incorporated a triangulation of methods by undertaking both interviews and participant observation to collect data (described in the next chapter). I took many opportunities to present my findings to get feedback from different academic audiences both in the CAM research community and Religious Studies.

Member checking which involves going back to participants with a summary of their interviews and observations to get their perspective on whether the developing theoretical model represents their experiences (Creswell, 1998: 202) was not included. This was because it has been criticised as respondents’ responses generate further data, which should simply be considered as additional data, not as validation (Silverman, 2001: 235). Respondents may have further knowledge about their context, but there is no reason to assume that participants have privileged status as commentators on their actions, therefore member checking only produces more data (Silverman, 2001: 235). I did not consider any of the data as examples of negative case analysis; however, I ensured a wide range of Ayurveda practitioners (described in the next chapter) were included, some of them being exceptional cases.

The next chapter describes in detail the data collection strategies employed for this research study.

Chapter three Research Strategies

3.1 Introduction

In the previous chapter I discussed the epistemology and methodology for this study. In this chapter I describe the research strategies that I employed to collect data which included unstructured interviews with practitioners and experts, as well as participant observation of a number of events including practitioners' continuous professional development (CPD) workshops, campaign meetings and CAM seminars.

The original aim of this study was to interview both practitioners and patients and compare their expectations of an Ayurvedic encounter. I conducted a pilot study to test the feasibility and included four practitioner and five patient interviews. I reviewed the aims of the study and after a discussion with my supervisors, I decided that the study would focus on the practitioner perspective and the changes in Ayurveda practice in the UK and the role of spirituality. I stored the patient interviews for future analysis (see Chapter ten, suggestions for further research).

3.2 Participant inclusion criteria of Ayurvedic Practitioners

The inclusion criteria that I employed to select participants for the study included practitioners who are qualified to diagnose and treat illness and are eligible for APA or BAAAP membership in the UK. This included practitioners with a BAMS (Bachelor of Ayurvedic Medicine and Surgery) qualification from India (or DAMs from Sri Lanka), Ayurveda BSc degree from Thames Valley University, PG Diploma or MSc degree in Ayurvedic medicine from Middlesex University or equivalent.

I did not apply any other criteria as the number of Ayurveda practitioners in the UK is relatively small compared to other CAM practitioners. Adding other criteria such as number of years of experience or the availability of support for the practitioners after their participation in the interview as a way of debriefing (Eyles, 2009: 35), would have seriously reduced the number of possible interviewees.

All the practitioners were practising in the private sector; some were working on a fulltime basis, others part time while maintaining a main career or along with another CAM approach. Some worked from home, others were based in either their own or rented clinic.

Some practitioners focused only on Ayurveda, while others combined it with other CAM approaches. Some were based in London, whilst others lived in smaller cities or towns in different parts of the UK. The geographical diversity was important as a practice in multicultural London may differ from a practice in a town catering to predominantly white British residents, e.g. advice on diet and availability of herbs as well as treatments. I used a demographic form to collect basic demographic data to monitor the heterogeneity of the sample (gender, age, current and previous profession, ethnicity, levels of education, religious affiliation see appendix 3).

3.3 Access, Recruitment and Sampling

Snowball sampling is commonly employed by researchers taking a qualitative approach which means being introduced to more interviewees by the previous ones. This technique was not required; rather I employed a convenience sampling strategy as it was easy to approach prospective interviewees either via the professional association websites or in person at the Ayurveda events. I used the social events as an opportunity to introduce myself personally to prospective interviewees at events and explained my research and invited people to participate if they were interested. All the practitioners I spoke to were positive about the research and agreed to participate.

Purposive sampling is a non-probability form of sampling to sample participants in a strategic way so they are relevant for the research questions and there is a variety of participants who differ from each other in terms of key characteristics (Bryman, 2008: 415). The purpose of this research was to include a range of practitioners, hence four different sub groups of practitioners were identified: practitioners who had qualified with a BAMS degree from India and were now settled and practising in the UK, practitioners with a non-medical background who had graduated in the UK, practitioners with a medical background who had subsequently studied Ayurveda (medical converts) and practitioners from India who were visiting the UK and offering consultations during their visit. The subgroups of 'visiting practitioners' and 'medical converts' were included to give a broad range of practitioners and fall into the 'exceptional' cases.

I also included people who had an expertise or interest in Ayurveda, but were not practitioners. This included two tutors on the Ayurveda degree courses, including one tutor who had taught Sanskrit and philosophy modules.

Theoretical sampling is a process of data collection for generating theory used in the grounded theory approach to refine the emerging ideas and collect further data that enables the development of a theory (Bryman, 2008: 415).This method was employed for four interviews in order to specifically collect data to define in greater detail the concept of spirituality.

In order to recruit visiting practitioners, I contacted the people who organised their trips to the UK in order to arrange interviews. The organisers acted as gatekeepers. The gatekeeper is the person who controls research access. For example, in an organisation it may be a manager or senior officer, or in a group or community the person who makes the final decision as to whether to allow the researcher access to undertake the research. Unless permission has been granted by a gatekeeper from within the group, community or organisation in which it is planned to undertake the research, it is possible that access is denied. Gatekeepers can have a helpful role in facilitating communication as well as providing suggestions to adapt the research. [77]

The gatekeepers in this research tended to act as barriers, as they inquired about the actual purpose of the research in greater detail than the practitioners that I approached directly. Therefore recruiting the visiting practitioners took up more time than the other types of practitioner.

3.4 Data collection methods

Interpretive qualitative methods enable the researcher to enter the participants' worlds and learn about their views and actions and understand their lives (Charmaz, 2006: 19). I employed two data collection methods simultaneously: qualitative interviews and participant observation.

The aim of the qualitative interviews is to explore a particular topic or experience in-depth and is used for interpretive inquiry. The researcher seeks to understand a topic and the participant shares his or her experiences of it. The in-depth nature of interviews elicits the participant's individual interpretation of his or her experience (Charmaz: 2006: 25).

[77] www.nursingtimes.net (no date) [online]. [Accessed 1.10.13]. Available from the Worldwide Web: http://www.nursingtimes.net/nursing-practice/clinical-zones/management/the-process-of-gatekeeping-in-health-care-research/203728.article.

Interviews enable the researcher to probe into the experiences, thoughts, experiences, feelings and actions of the participant.

Interview data can help to reconstruct events, as the past cannot be directly observed. Interviews tend to be less intensive as they are less time consuming than participant observation, though they can be included in a longitudinal design and repeated on many occasions to investigate changes over a period of time. They are good for focusing on specific issues. I used qualitative interviewing to elicit practitioners' experience of practising Ayurveda in the UK.

Participant observation is inherently a qualitative and interactive experience and relatively unstructured. It is generally associated with exploratory and explanatory research objectives, i.e. why questions, causal explanations, uncovering the cognitive elements, rules, and norms that underlie the observable behaviours. The data generated is often free flowing and the analysis is of an interpretive nature.

Observation methods provide researchers with ways to check for nonverbal expression of feelings, determine who interacts with whom, grasp how participants communicate with each other, and check for how much time is spent on various activities as well as develop a holistic understanding of the phenomena under study that is as objective and accurate as possible given the limitations of the method.

Reasons for using participant observation in research is to identify and guide relationships with informants, and to gain an insight into how things are organised and prioritised, how people interrelate, and what the cultural parameters are. What the participants deem to be important helps the researcher to develop questions that make sense and are relevant to the participants.

In addition, being on site over a period of time gives the researcher opportunity to become familiar with the community, thereby facilitating involvement in sensitive activities to which he/she generally would not be invited. It gives the researcher a better understanding of what is happening in the culture and lends credence to one's interpretations of the observation. Participant observation also enables the researcher to collect both quantitative and qualitative data through surveys and interviews.

I used participant observation to observe the Ayurveda practitioners as a community and gain insight into their collective issues and observe the environments that they create

when they come together. I used participant observation to record individual and collective actions, and to understand the significant processes occurring in the setting and what the participants define as interesting or problematic.

3.5 Interviews

I collected data from nineteen formal interviews and one informal interview (appendix 4). The aim of the one to one in-depth interviews was to explore aspects of Ayurveda practice and spirituality in relation to Ayurveda practice. The interview was not deemed to be of a sensitive nature as questions about the participant's personal religious or spiritual beliefs were not directly probed. The pilot study had highlighted that practitioners describe Ayurveda as a system that addresses the mind, body and spirit. Therefore I included questions to probe their understanding about spirituality and Ayurveda in the interview guide as prompts. I only asked the questions about religion and spirituality if the interviewee made reference to the topic, for example if they described Ayurveda as a system that addresses mind, body and spirit. I gave a project information sheet and consent form to participants to ensure they were clear about the research and their involvement and gain their signed consent (appendix 5).

Winchester University's Research Degrees Quality Committee (RDQC) granted ethical approval for this study in October 2009. I applied confidentiality and anonymity by excluding any identifiable information on the recorded material or in the quotations. Real names were replaced by pseudonyms. My approach involved being respectful of all participants, providing detailed information to enable them to make informed decisions about participating in the research.

I developed an interview schedule as a result of a brief literature review on modern and global Ayurveda, the pilot study, as well as personal experience of training as a practitioner. I collated the questions into an interview schedule to act as prompts during the interview rather than a strict framework (appendix 6). I used an unstructured approach to interviewing in order to avoid imposing a predetermined agenda on the interviewees. This allowed for perspectives that are important to participants to be revealed of which the researcher may be unaware (Charmaz, 2006: 26). An unstructured approach offers flexibility and also allows the researcher to change direction if required (Creswell, 1998: 99). However, open interviews have been criticised as having an element of social control

which shapes what people say, i.e. if the researcher maintains minimal presence and asks few questions, the interviewee may struggle to know what is relevant and therefore what he/she should say. Further, the interviewer's passivity can put the interviewee under great pressure to talk (Hammersley and Atkinson cited by Silverman 2001: 90).

I used the first four interviews with practitioners as the pilot study to test the schedule. I transcribed the pilot interviews and examined the data for themes. This enabled me to develop theoretical sensitivity which refers to the researcher's insight and understanding of the data. I completed a further seven interviews and several common themes began to emerge through the data analysis. I decided to focus more specifically on the topic of spirituality so added extra questions to the schedule in order to elicit some nuanced information (appendix 7). I developed a short interview schedule relevant for experts (appendix 8) and employed this for the two academic interviewees. I interviewed a biomedical practitioner with an interest in Ayurveda, as an exceptional case. Finally, I met Dr Murli and although I did not get the opportunity to interview him on a formal basis I had a long and useful conversation and made notes and have included him in the list of interviewees.

3.5.1 Conducting the interviews

When I met the interviewees I reiterated the background and aim of the research project. I gave the interviewees the opportunity to ask any questions and told them that they could stop at any point. I asked them to read the project information letter and sign the consent form. I confirmed how much time they had so as not to cause inconvenience by running over time as all the practitioners were self-employed and some met me during their clinical hours, thus potentially forsaking a consultation fee. Most participants were happy to be interviewed for up to an hour. In a few circumstances where extra time was required, I checked with the interviewees their time commitments, and all interviewees agreed to continue being interviewed.

I was familiar with most of the practitioner interviewees and found during the pilot interviews I tended to give signals of agreement. As I became aware of this I made a conscious effort to 'step back' and adopt a neutral stance during the open interviews of the main phase, as the way an interviewer conducts an interview can influence the results obtained (Charmaz, 2006: 27). I modified my own behaviour, to control my own responses,

as I have a tendency to express my feelings, particularly of agreement. Maintaining a neutral stance initially caused discomfort as I wondered if the interviewees were feeling uncomfortable by my lack of response. I felt my behaviour was out of character by trying to maintain a neutral stance during the interviews. For example, I had a desire to show approving responses when participants were talking about issues they face as practitioners.

Through being reflexive, I realised I have a tendency to establish rapport and empathy with participants in order to establish a relationship so that they could feel comfortable and express their views. From a feminist perspective, Oakley (1981) provides what has become a classic critique of the objectivity of the research interview. Her analysis highlights how traditional approaches to research interviewing, where the interviewer maintains detachment and distance, is not only bad practice but is also antithetical to a feminist research philosophy that seeks to validate the subjective experiences of women. This perspective enabled me to find a balance in my approach to interviewing.
Whilst interviewing I jotted down words as prompts to explore any areas of interest in greater depth. Therefore I was simultaneously listening to the interviewee and formulating the next question and trying to remember to follow up topics of interest. This was cognitively very demanding as it required 'mental multitasking' while keeping the flow of the conversation, and ensuring the interviewee had my full attention. On looking back at the transcripts, I realised that in almost all cases I had explored all the avenues and not missed any topics I considered important for this study.

I completed three interviews by telephone and audio recorded them. I emailed the project information sheet and consent form to the interviewees in advance, and gained verbal consent before starting the telephone interview. I also confirmed how much time the participants had for the interview before commencing the interview. The telephone interviews worked well as I was familiar with two of the participants, therefore many of the issues such as not being able to observe body language or facial expressions were not missed. It also worked well with the participant I had not met previously as she appeared to be comfortable. Research indicates that there is little difference between face to face and telephone interviews (Bryman, 2008: 457). The telephone interviews provided rich data and comparable with the data collected through the face to face interviews.

3.5.2 Evaluation of my interview skills

To evaluate my skills as an interviewer I used ten criteria outlined by Kvale (cited by Bryman, 2008: 445 - see appendix 9 for a list of the ten criteria). As I was familiar with the subject I was able to stay focused during the interviews. I kept the interviews open but used an interview schedule as a guiding principle around ascertaining information about the practice. I initiated all the interviews with a question about the definition of Ayurveda and finished by asking interviewees about their thoughts for the future. The questions were kept simple and straightforward, and kept open so I could explore strands important to the interviewee. I maintained a flexible approach, but at the same time the interviews were steered in a way to get the information required. I maintained a critical stance and where appropriate clarified inconsistencies in the interviewees' responses. I made short notes as a technique to help me remember points to explore further. I occasionally repeated or re-phrased what was said in order to ensure correct interpretation. I remained sensitive to what was said, though I did not initially meet the criteria of being 'gentle' which requires allowing participants to finish and is tolerant of pauses. As I became aware of this I developed a gentler manner. Overall, I met nine out of the ten criteria, and through being reflexive about my style I was able to work on the area of being gentle to ensure I was a successful interviewer.

3.5.3 Recording and transcribing interviews

All the interviews were audio-taped. There were several reasons for audio taping the interviews. Firstly, to increase the accuracy of data that was being captured. This enabled me to focus on the interview process rather than being distracted with taking comprehensive notes (from past experience of interviewing I have been unable to capture all details of an interview). Audio-taping allows a better and detailed examination of the data and an accurate record of what is said, and avoids accounts being constructed from memory. It also allows a thorough examination of the data and the possibility of scrutiny of data by others, as well as secondary analysis (Bryman, 2008: 451). It also preserves the sequence of the talk (Silverman, 2001: 162). The drawback is that interviewees may feel self-conscious or concerned about their opinions being captured. Although, all the participants agreed to be audio-taped, the key difficulty was that a few participants spoke very quietly. Where it was appropriate, I paused and politely asked the interviewee to increase their volume. This caused a break in the flow of the interview, but I was able to pick it up again quickly.

I considered using a tie pin microphone; however from past experience I had found that tie-pins can cause interviewees to feel conscious. Using an additional piece of equipment also means ensuring that it is working, e.g. ensuring the battery is charged and all connections are secure so the recording is successful, which can add stress to the process. I also considered digital audio-recording as it gives better quality recording, eliminating the 'hiss' of a cassette player when playing back, making it easier to transcribe. I did not employ this method as it would mean listening to the audio files on a computer, which was not appealing. Instead, I used a cassette player with a review function that aided the transcribing.

I explored the use of voice recognition software to assist the transcription, but this was not an option as the software requires sensitising the voices that are recorded in order for the audio to be converted into text. As a consequence I decided to transcribe the interviews so I could get familiar with the data and pick up details such as tone or emphasis and ensure the Ayurvedic terminology, particularly the Sanskrit words, which could easily be missed or misunderstood, were picked up accurately.

I transcribed the interviews in phases in order to maintain a fresh rather than tired approach. It took on average two to three days to transcribe one interview. I aimed to transcribe soon after the recording, while the interview was still fresh in my mind, in order to minimise errors and prevent them from accruing but this was not always possible. I transcribed the first eleven interviews and the remaining nine were transcribed by a professional transcriber at the University, who has transcribed interviews for other research projects and was therefore familiar with rules around confidentiality. I communicated my requirements and sent her an example of my transcript and a template. I checked the transcripts for accuracy of the Ayurvedic terminology and Sanskrit words.

The interviews generally lasted between one to one and a half hours, though two of the interviews with busy visiting practitioners were thirty minutes. I transcribed them verbatim. Although this was time-consuming, it included all the data and gave me the opportunity to become familiar with it as opposed to doing selective transcribing. I kept all the original recorded data in a locked box. The hardcopy transcripts contained initials so I could identify them for the purposes of analysis. I stored the electronic versions on computer and password protected them.

I started all the interviews with a warm up question, 'What is Ayurveda'. This not only allowed for an easy way to start the discussion, but also to develop an understanding of the range of meanings Ayurveda carries in the UK.

3.5.4 Interview considerations

Participants may feel comfortable and disclose information that could leave them feeling vulnerable, for example sensitive or challenging issues concerning their practice. I mentioned at the beginning of each interview that participants could stop at any time. During the data collection phase there was no specific support mechanism for Ayurveda practitioners to seek support after they had been through an interview which has forced them to reflect about their practice. This process of reflection may have left participants becoming aware of issues they had not reflected on prior to the interview (Eyles, 2009: 35). I wrote memos about what impact I may have had as a researcher on the research process; for example, initially I had certain preconceived ideas about what some of the practitioners with a medical or BAMS background might say. I was aware of this and endeavoured to maintain a neutral stance during the interviews by being aware of my non-verbal communication and body language.

3.5.5 Researcher safety

The practitioners were met either at their home or at their clinic. I was aware of my own safety as a female researcher going alone to visit my participants; however, as I knew most of the participants as acquaintances and I did not anticipate any risks that could have been of concern had they been strangers. I interviewed one practitioner that I did not know; however, this was in a clinic based within a busy shop during the afternoon. I had also given my details to a friend as a precaution and in case of an emergency.

3.6 Participant Observation

Participant observation is a naturalistic form of inquiry where people's behaviour and dialogue are noted in the form of 'field notes'. The researcher can take on a variety of different roles depending on the covertness of her involvement. Gold developed a classification of the different roles that participant observers may adopt depending on their degree of involvement or detachment with the members of the social setting (Bryman, 2008: 410). The four roles include: the complete participant, participant-as-observer,

observer as participant and the complete observer. [78] My role loosely fitted into the 'observer as participant' category , and the participant observation method was employed to document the APA (Ayurveda Practitioner Association) and BAAAP (British of Association of Accredited Ayurvedic Practitioners), and other related significant events, to gain insight about the issues facing practitioners in the UK and develop an understanding of the context of their practice. Some CAM events related to this research were also included. The aim was to collect additional information to support the data from the interviews as the aim was to explore individual experiences and also to gain insight into the Ayurveda community. Observing and documenting events helped to establish the social and professional context of the practitioners. The Ayurveda events were held on an occasional basis during the year, e.g. APA offered two main events per year with an additional two one-day workshops, and BAAAP offered one conference per year with additional occasional local meetings.

The advantages of participant observation were that it permitted the possibility of 'seeing through others' eyes', though it does often require a prolonged immersion in the social setting to fully grasp the social setting. Much behaviour is better understood through observation, e.g. criminal and deviant activities understood through participant observation. Interviews alone do not capture the context of a situation. Participant observation is more unstructured than interviews which have an inherent element of structure, thereby imposing external ideas or expectations on the situation and participants. The unstructured nature of participant observation is more likely to allow unexpected topics or issues to be uncovered. In addition, it is a naturalistic method as it occurs in the natural context of the topic being investigated. This is important in this study as my aim is to understand the practitioners' authentic perceptions of their own practice in the UK. By attending their events I listened to their discussions to get an understanding of the issues that influence them.

[78] Gold's classification (Bryman, 2008: 410)

1. The complete participant becomes fully immersed in the social setting as a covert observer, and his/her true identity is not known to the members.
2. The participant as observer's role is the same as the complete participant, except that his/her identity as a researcher is known to the members.
3. The observer-as-participant acts mainly as an interviewer, with some observation. So there is little participation.
4. As a complete observer the researcher does not interact with members.

Often, a researcher's presence can cause discomfort, which indicates the relations and concerns of the people being observed, and should be recorded. In this regard, I was already familiar with the events having attended them over the years as an Ayurveda student. Therefore, I was an insider. I did not make explicit that I was attending as an observer participant. My participation as a researcher was not overt which may be considered unethical; however, I found that I was not observing people's behaviour or interactions, rather noting the themes that the speakers were presenting. I did not attend the meetings with a proforma or preconceived themes in my mind. Rather, I made hand written notes of the discussions and talks that took place during the meetings that I attended. I tried to take verbatim notes of what was being said. I typed up the hand written notes and analysed the data and allowed themes to emerge.

Participant observation requires the researcher to become part of the social scene so that the researcher is accepted to some degree. This period of moving into the research setting is both analytically and personally important. For the researcher, it is important to regard the normal as unfamiliar. As described in Chapter two (see page 56), my status as a practitioner researcher and insider was to some extent a disadvantage, as it did not create a fresh curiosity, and initially I took for granted many features that may have been recorded by a researcher new and unfamiliar with the events. After realising the disadvantage, I became aware that I need to sharpen my observations and make them as an objective researcher rather than as an Ayurveda student/practitioner, and record my experiences in order to objectively observe the cultural universe which my participants occupy.

One of the main advantages of participant observation is its flexibility. Fieldwork is a continual process of reflection and alteration of the focus of observations in accordance with analytic developments. As I have progressed with the literature review I have referred back to my field notes and interpreted the data again. In addition, participant observation often employs the unstructured interview as a routine part of its practice (Bryman, 2008: 389, 466). In my experience these two methods were compatible: observation guides researchers to some of the important questions they want to ask the respondent, and interviewing helps to interpret the significance of what researchers are observing.

3.7 Limitations of interviews and participant observation

Both data collection methods have limitations. The interview is considered a weak research method as it elicits the 'official' account which describes the norms and values and ideals that interviewees think should take place rather than what actually does happen. Participants give views that they think the researcher wants to hear or distort the information to protect themselves or their profession (Redwood et al, 2012: 4). It is also difficult to know to what extent the information practitioners give about their practice relates to their actual practice. My experience as an insider enabled me to overcome this weakness to some extent as I was able to judge whether interviewees were giving official accounts or not, and this did not appear to be the case. This is because the interviews were more like a conversation between two practitioners, therefore non-hierarchical, and the interviewees were willing to engage with the conversation style interview. It is also likely that some of the practitioners and academics knew me as an Ayurveda student completing my course dissertation, and therefore their participation was an act of benevolence.

The limitation of observation is that people may become self-conscious and self-aware and act in a way different to their own norm. Observation is also limited as it focuses on external behaviour, therefore does not allow insight into what people are thinking or feeling (Bryman, 2008: 465-66). Some researchers suggest that it is necessary to know the native language to gain a true understanding of the social setting. I was at an advantage as I have trained as a practitioner and therefore able to understand the issues as well as language, concepts and terminology used by practitioners during events.

Both interviews and participant observation are considered unnatural events as they may have a reactive effect on the data collected (Bryman, 2008: 467-468). Interviews create data which exists as a result of the researcher's intervention: it is 'researcher provoked'. Silverman (2001: 159) argues that 'no data is untouched by human hands; even observations are turned into field notes'. Bearing in mind the limitations, interviewing was selected as the main data collection method to gain the 'insider perspective'. The interviews were supplemented by observation of events and discussion with others in the field in order to capture the wider context of Ayurveda practice.

3.8 Data Saturation

It is difficult to know when theoretical saturation is reached as there is no clear criterion to assess the adequacy of the sample (Bryman, 2008: 462). For example, Guest et al (2006: 65) provide helpful guidance; they found that they reached data saturation after twelve interviews as they had a homogenous sample and a very narrow research question in their research study. Therefore a variety of factors affect the number of interviews required before saturation is reached.

The perception of quality also depends on the personal experience of researchers and the discipline they work in; for example, one academic from the Arts faculty suggested that the four pilot interviews had sufficient data for a doctoral thesis, while an academic from the science discipline said I needed a minimum of twenty interviews. I collected data from twenty interviews and several events, which were sufficient to develop an understanding of the changes in practice and the role of spirituality in the practice.

3.9 Conclusion

I undertook a qualitative approach to explore my research goal. I remained flexible and open to the demands of changing needs of this project and adopted a reflexive approach which enabled me to complete it.

I employed a range of data collection techniques, including interviews with a variety of practitioners and experts in the field, and attended a number of different events to add depth and breadth to my discussion. The discussion in Chapter seven illustrates the need to collect data from a range of sources in order to gain a nuanced understanding of the area of study.

The next chapter describes in detail the procedure undertaken for the qualitative analysis of the data.

Chapter four Data Analysis

4.1 Introduction

The previous chapter described the process of data collection. This chapter takes the next step to describe the process employed to analyse the data. Though I adopted a thematic analysis approach to guide this research, I used Charmaz's (2006) guide to the data analysis as it provides a clear and structured framework. The coding and analysis began after the third unstructured practitioner interview was completed.

4.2 Initial Coding

The first round of analysis is the initial coding. The aim of this is to study fragments of data. This process reduces the data to a smaller set of themes/categories, i.e. it is a process which fractures the data. The initial round of coding analysis was done by hand. A hard copy of the transcript was taken and read through line by line. Sections of the text that were of interest were highlighted and codes written in the margin. The initial codes were of a descriptive nature (see table 4.1.).

Table 4.1 Example of transcript with descriptive codes:

Portion of Interview with AKR	Descriptive coding
1. My interview questions are in bold. 2. The practitioner's responses are in normal type. I have highlighted and portions in red that are of interest and being coded. (These are also underlined). 3. My thoughts as I am coding are in blue. (Also in square brackets).	
Q When you heard about it what was your understanding at that time? Ah, No, I'm not really knowing much about Ayurveda at that time, but I just knowing that it's just a herbal medicine, a natural medicine. That's it. [The concept of 'natural' comes up a lot in most of my interviews]. **Q And what was the opinion of the people that were using it?**	Ayurveda (Actual Knowledge vs familiarity)

Uh, because I think the main thing which I was interested, it doesn't have any side effects, that's what the first impression I got and the other thing is it can help if any person if they are not help by any other medicinal field like allopathy especially, modern medicine. Most of the people what I was seeing there, if people are taking medicine long term like 4 years 10 years for diabetic, such people when they come to Ayurveda, they really got benefitted. Yeah that's what I heard about. [The common reasons for using CAM and Ayurveda in studies include: No side effects and patients who are dissatisfied with biomedicine to turn to CAM/Ayurveda].	Ayurveda (Definition as: -Herbal medicine, -Natural Medicine, -No side effects) -Used when biomedicine fails, -Effective when biomedicine fails,

The line by line coding was very time consuming. As I became familiar with the data I was able to scan through larger portions, e.g. a segment of the data or a paragraph to identify codes (see appendix 10 for a full transcript). A list of preliminary descriptive codes emerged from the first seven practitioner interviews (see table 4.2).

Table 4.2 List of preliminary codes

Ayurveda (general) Ayurveda treatment Ayurveda in India Authentic Ayurveda Ayurveda versions Advertising Ayurveda community Associations (APA / BAAAP) Books – popular Biomedicine Clients Communication Consciousness	Consultation Consultation in India Consultation issues Competition with other CAM Classical texts Cause of disease Education Experience of Ayurveda Finance Freedom of Speech in the West Future of Ayurveda Health	Holism Herbs Healing Integration of Ayurveda and Medical conditions Medical practitioners Practice of Ayurveda Research Regulation Spirit/Soul Spirituality Venue

4.3 Focused coding

The second phase of the analysis is the focus coding. This is used to identify and develop categories of interest. Data labelled with the same code from the different transcripts was

drawn together. This is illustrated below with the code 'spirituality'. The data segments labelled as spirituality were collated and then grouped into categories such as definition of spirituality, mechanism of spirituality, and recommendations of spirituality (see table 4.3).

Table 4.3 Category of spirituality

Spirituality code : Definitions of Spirituality
General **Spirituality** for me is, I think everything is the same. Different different people but at the end it's the same message. **Spirituality** truly is not any connection with religion. It's a pure pure form. In one word a detachment, in a true sense. So that you are not unhappy by sorrow and you don't become extremely happy when you get something good in your life and you don't become frustrated or sad when you don't get something in life. So it's kind of detachment to things. So you are doing your 100% in life, but you are not attached. When you are not attached you will always be free from fear and a lot of those things which leads to doing something without integrity …..taking time with yourself…. being with your soul, understanding the need of the soul that is necessary in **spirituality**. For me it's tied up with a sense of meaning, ... it's tied up with a sense of relationship with things, it's tied up with a sense of relationship with to a bigger ??? in the picture, to the divine, It's about remembering ???? in our lives. So it's remembering really. Um there is a **spirit** or soul within each individual which has a role for the persons health, and in the direction of their life. Now and into the future and a link with the past. My own personal perspective is that there is a divine, connected into some cosmic consciousness. **Yoga and Meditation** I consider yoga is an important point. And when I deal with the yoga sometimes, patients ask about meditation. If they ask, then I go with the meditation. I think that's what **spirituality** is for me…….. … **Spirituality** is related to simple taking a deep breath or keeping themselves quiet, or non-alcoholic .. also a part of **spirituality**. But we don't use any terminology for spirituality or we don't use any God or Goddess name. Just use these basic things. ***Daivavipashraya -*** … in Ayurveda there is *daivavipashraya* chikitsa which is **spiritual**. It is not only to attract the westerner to use spirituality no, no, not at all. A is spiritual. On the contrary these people are running away from spirituality and they want to make Ayurveda a sophisticated, modern medical science. And then prescribe Ayurvedic capsule, Ayurvedic injection. This is unauthentic.

I think you cannot deny the connection, the very strong connection with spirituality, if you look at the different ways of treatment, Ayurveda mentions very clearly, this is an important way, when you cannot determine the cause, when known ways don't work, then you resort to *daivavipashraya* but even otherwise .. it is very much a part of it.

Within each of these categories the data were further grouped into subcategories. For example mechanisms for spirituality, i.e. how it may help in the healing process, was put into subcategories (see table 4.4).

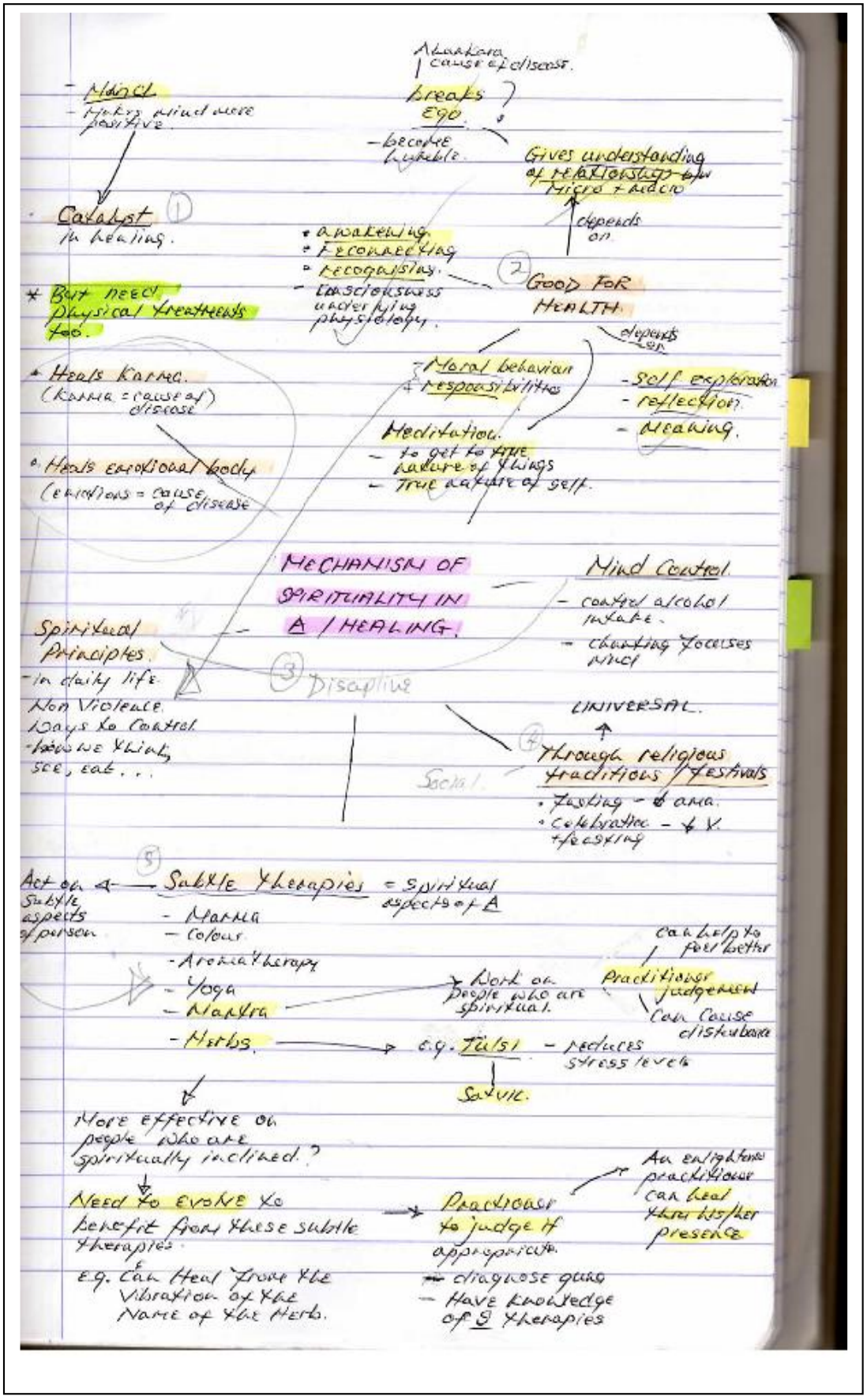
Table 4.4 Subcategories of spirituality

Spirituality code: category mechanism of spirituality: subcategories
Acts as a catalyst Heals karma and emotional body Opportunity for reflection Makes mind more positive Gives a frame of mind / Discipline Breaks ego Subtle treatments Herbs for spiritual healing Different effects of different spiritual practices

4.4 Diagramming

I found it useful to sketch diagrams for different sections of the data, to see how the subcategories linked together, and how the role of spirituality began to emerge (Richards, 2005: 76). See fig 4.1 Example of diagramming.

Figure 4.1 Example of diagramming



I employed alternative ways to understand the data and the relationships between the categories. For example, I wrote the categories on small pieces of paper and then placed them in various clusters to see how they fitted together. The advantage of this method was that it enabled me to work in a very fluid way as I could easily move the categories and create new clusters and see how the data may relate in different variations (see fig 4.2).

Figure 4.2 Example of clustering the categories

4.5 Memo writing

Memos are theoretical notes about the data which enable the ideas to grow and become complex. They help to develop new relationships, make conceptual connections between the categories, which leads to richer data (Richards, 2005: 73-75). Writing detailed memos is a crucial part of the analytical process which accelerates the process of analysis (Strauss and Corbin, 1998: 110, Charmaz, 2006: 72). Below is an example of a memo.

Example of Memo – Mathew's script – 12.1.2011
He was drawn to Ayurveda because it is both pseudo-scientific and very soft. Sciences are often referred to as hard. Have harshness about them. He sees Ayurveda as having both the hard quality of science and soft qualities of massage/meditation. He said earlier that it is all encompassing in terms of philosophy, now he is saying it in terms of the opposite qualities. Ayurveda simultaneously hard and soft.

His education course was not helpful, so he drew upon his previous experience of other CAM, i.e. drawing information from all directions to enable him to practise Ayurveda. This is likely to modify the Ayurveda that he offers. This could make his practice better (integrated with another CAM) or worse (diluted/ 'mish mash')?

Lack of sufficient understanding of what to recommend is serious in terms of the health care being offered to patients. I wonder if the UK graduates, because of their lack of clinical training, are substituting the 'medical', aspects of the consultation/recommendations with 'softer' recommendations of yoga/meditation etc. because of their insufficient clinical training. This would mean that Ayurveda in the UK is 'spiritualised' because of the education course which is not providing sufficient clinical experience, therefore the practitioners include the 'spiritual' elements. This would be an alternative explanation to Warrier's (2009) paper which suggests that the UK Ayurveda is 'spiritualised' because the UK practitioners are inherently 'Spiritual Seekers' and therefore they are spiritualising Ayurveda.

In writing this memo I had an insight about why the UK graduates may adopt a 'spiritualised' approach and discovered an alternative plausible explanation that has not yet been offered in the literature. Writing the memo enabled me to make the link between the quality of the Ayurveda education and the version of Ayurveda practised by the Spiritual Seekers. Below is another example of a memo.

Example of Memo 2 – theoretical idea - after supervision discussion about social changes 27.7.10
Ayurveda deals with the microcosm (individual) and the macrocosm (universe). Postmodernism is about individualism. People who seek holistic healing are interested in the self as the individual and their own healing. Ayurveda deals with both levels. At the clinical level the individual is unique and dealt with as individual according to his/her unique constitution. At the philosophical level, Ayurveda offers the idea of connection with the universe. Therefore, Ayurveda encompasses the needs for individualism and universalism. The *Panchamahabhuta* theory explains 'oneness' from physical / gross/ matter to subtle e.g. from the earth element to ether element. From the individual to the greater cosmos. This is why it is all encompassing. It is through the qualities of the elements that we are one. The modern periodic table of elements will also say the same! ☺

In this memo, I was trying to understand social trends and how they link to the increased interest in Ayurveda. This gave me an insight into how this may link to the underlying *Panchamahabhuta* theory, which may be a way of defining spirituality in Ayurvedic terms.

The discussions with my academic supervisors during my supervision sessions also served as opportunities for insights. I recorded and transcribed the sessions and kept the transcripts of the supervision sessions as theoretical memos.

4.6 The Participant Observation data

I attended a variety of Ayurveda and related events (appendix 11) and took field notes which I typed up after each event. I coded the typed scripts for each event. The data collected during the events gave insights into the collective thinking and issues concerning the Ayurveda practitioners as a community. This observation data contributed to developing a wider understanding of the Ayurvedic context in the UK and complemented the interview data by giving greater insights into the collective anxieties and fears of the practitioners as a group. As a group they tended to discuss issues around regulation, whereas on an individual basis they discussed issues around setting up a practice.

4.7 Considerations

While analysing my data, I was aware that English was a second language for all of the Indian interviewees and aware that this may have influenced their use of the words spirituality and religion. In addition, the majority of the Indian interviewees described themselves as Hindu and have had a very different understanding of the concepts of religion and spirituality. Much of the literature I have reviewed comes from participants with a Christian worldview. However, the Indian practitioners, like their European colleagues, also tended to separate the concepts of religion and spirituality (see Chapter seven) and there did not appear to be any obvious differences in the way they described their personal beliefs in Chapter seven, though this was not specifically examined.

In some sections of the thesis, I have used verses from the Ayurveda classical texts such as the *Charaka Samhita* to indicate what may be considered the traditional or scholastic view of Ayurveda. I was aware that discrepancies arise between different translations from Sanskrit to English because the words in Sanskrit are polysemic. Wujastyk (2001: 18) discusses the challenges of translating ancient texts. For example, the word *daivapashraya* is translated as divine therapies as well as spiritual therapies; thus words referring to non-material treatments, divine, religious or spiritual are used interchangeably. This is likely because concepts of religion and spirituality may have been understood in a very different way when these texts were being codified in written form.

I have emboldened certain parts of the practitioner quotes to highlight a point that I think is important, therefore the emboldened part of quotes are my emphasis. I refer to the interviewees in this study as the practitioners and use both terms interchangeably.

4.7.1 Practitioner categories

In order to include a range of Ayurvedic practitioners I initially identified four types for my sampling strategy (see page 67). As mentioned in Chapter one there is a gap in the literature pertaining to Ayurvedic practitioners who have qualified with BAMS degrees in India, and then migrated and set up practice in the UK. I initially referred to these as 'biomedicalised practitioners' because the literature on Ayurveda suggests that in India it has undergone a process of biomedicalisation, based on the *mishra* (mixed) ideology of integrating Ayurveda and biomedical practices. My second group were a subcategory of the biomedicalised practitioners that practise in India and in addition travel abroad, giving talks and consultations. I referred to them as 'visiting practitioners' and they were of interest because they travel from one country to another, meeting patients living in different environments and cultures. The third category included the UK graduates who have qualified in Ayurveda. I initially applied Warrier's (2009: 6) label of 'spiritual seekers' to this group. The fourth group was a sub category of this group, and included practitioners who studied Ayurveda in the UK, but have prior training in biomedicine. They may either be GPs or from the allied medical professions (e.g. pharmacists). They were of interest because they have trained in a system based on a reductionist philosophy, but have now 'converted' to a system based on a holistic worldview.

I developed these four categories to ensure a wide range of practitioners, rather than the opinions of any one sub-group. The four categories highlighted the different types of practitioners, but the findings of this study show that the boundaries of these categories are blurred, and often the practitioners fall into at least two different categories (see table 4.5).

Table 4.5 Types of Ayurveda practitioners in the UK

Practitioner	'biomedicalised' S. Asian graduate	Visiting Practitioner	Spiritual seeker	UK graduate	Medical convert
Dr Rajesh	x		?		
Dr Priya	x		?		
Dr Dhani	x		?		
Dr Shalini	x		?		
Dr Karan	x		?		
Dr Neha	x	x	?		
Dr Lokesh	x	x	x		
Dr Suraj	x	x			
Hannah			x	x	
Thelma			x	x	
Aarti			?	x	
Brian			x	x	
Pritesh			?	x	x
Dr Ben			x	x	x
Dr Kishore			x	x	x
Dr Devi			x	x	x

Table 4.5 shows that practitioners are not a homogenous group; rather, they present complex patterns of training and personal interests which influence their approach to healing. The four categories I initially suggested were inadequate to describe the variety of Ayurveda practitioners. For example, Dr Rajesh is a biomedicalised practitioner from India. He may have a personal religious faith, but does not bring that into his consultations, though he may make spiritual recommendations if a patient is interested. Dr Neha is a visiting practitioner, who has a clinic in India and also offers consultations abroad. Her approach was mainly focused on 'physical' conditions, though she was able to discuss the role of spirituality in her practice. It is likely that she has a personal belief, though it was not discussed during the interview. As in the case of Dr Rajesh, she did not fit the description of a spiritual seeker by Warrier's (2009: 6) definition as she did not study Ayurveda as part of her personal spiritual quest. Dr Lokesh is also a biomedicalised and visiting practitioner. He did not choose to study Ayurveda as part of his spiritual quest; however, he has embraced a spiritual approach to Ayurveda and promotes Ayurveda as a spiritual science, therefore I would define him as a spiritual seeker.

Aarti is a UK graduate, and although she said it was 'Divine Guidance' that led her to studying Ayurveda, her overall approach did not fit the description given by Warrier (2009: 6). Her practice was mainly focused on dealing with 'physical' issues, though she included

yoga techniques, which may be the spiritual dimension of her consultations (see Chapter eight).

Brian did fit the 'spiritual seeker' description well, as he was exploring Eastern philosophies and through his seeking came across Ayurveda. However, Pritesh, also a UK graduate, did not fall into the spiritual seeker category, though he subscribes to a religious practice. He combined aspects of his medical training with Ayurveda. Dr Ben, although a medical practitioner by training, like Brian, could be described as a spiritual seeker as he was searching for answers to life, after having graduated as a biomedical doctor and finding that Ayurveda gave him some answers.

It became apparent that there was a need to re-define the category of 'spiritual seekers'. Some people are spiritual seekers and take up Ayurveda as part of the journey, e.g. Brian and Dr Ben, while others may be spiritual seekers but did not initially take up Ayurveda for that reason e.g. Dr Lokesh. There are practitioners who have their private religious or spiritual beliefs, but these are not explicit in their Ayurvedic practice. If their patients show an interest in spirituality, then they may include spiritual advice as part of the treatment. For example, one South Asian graduate practitioner described the shift in the role of spirituality in his practice as he gained experience of working with patients. He began working as a biomedicalised Ayurvedic practitioner; however, over time as he gained personal insights into healing, and his focus broadened, he started to adopt a more spiritual approach to health and well-being. Dr Kishore had a similar observation about the changes in his approach as he was maturing with experience.

I was cautious about my judgements as these were based on information I had taken indirectly from interviews, rather than from direct questions about their personal beliefs, or observations of their actual consultations. There was a possibility that the practitioners may have a different emphasis in their practice. The diversity of the practitioners and the diversity of their approaches to Ayurveda reflected my previous personal experiences of meeting with and observing practitioners (see page 44). Further research should include more South Asian BAMS practitioners for better understanding of this group.

Having re-examined my original categories, I differentiated the practitioners according to where the practitioners trained. I referred to the practitioners trained in India as BAMS

graduates and those trained in the UK as UK graduates as the two groups are distinguishable according to the criteria described by Warrier (2009: 5). These include factors such as motivation to study Ayurveda, age, and previous experience.

UK graduates included BSc and MSc graduates from Middlesex and BA graduates from TVU and other UK courses. I continued to refer to those with a biomedical training as medical converts to highlight some interesting features of their approach. I refer to the BAMS graduates also as South Asian or Indian graduates. My revised categories are presented in table 4.6

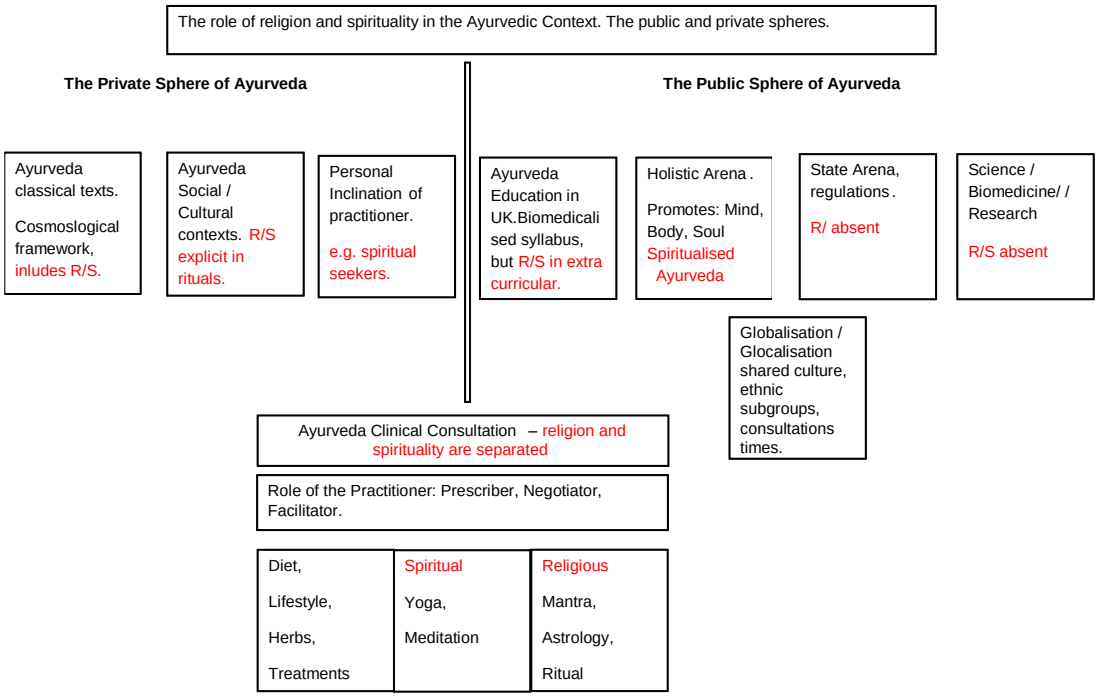
Table 4.6 Revised categories of Ayurveda practitioners in the UK

Practitioner	South Asian graduate	Visiting Practitioner	UK graduate	Medical convert
Dr Rajesh	x			
Dr Priya	x			
Dr Dhani	x			
Dr Shalini	x			
Dr Karan	x			
Dr Neha	x	x		
Dr Lokesh	x	x		
Dr Suraj	x	x		
Dr Manoj	x	x		
Hannah			x	
Thelma			x	
Aarti			x	
Brian			x	
Pritesh			x	x
Dr Ben			x	x
Dr Kishore			x	x
Dr Devi			x	x

The Indian and UK graduates may have had different initial motivations for studying Ayurveda, but through practice and experience I suggest that they may gravitate to similar outlooks and offer a holistic version of Ayurveda. The South Asian practitioners may have a personal interest in religion and spirituality, though it may not reflect in their initial reason for studying Ayurveda. However, over time they may incorporate their personal religious and spiritual inclinations in their practice. This is possible because Ayurveda has a spiritual dimension indicated by its description of the *purusha* (human being / person) and treatments which include *daivavipashraya* (discussed further in Chapter eight).

4.7.2 Map of the data

As my analysis and understanding of the data developed, I realised the relationships were complex. In order to deal with the complexities I developed the following diagram which enabled me to map out and make sense of the data which included practitioners' often contradictory behaviour and accounts.



I discuss this diagram in detail in Chapter ten to explain the findings which indicate that practitioner behaviour changes across different environments.

4.8 Conclusion

Initially, I was drawing on my own preconceived ideas of what is spirituality to code the data. On reflection, I had selected data segments in this category, although the participant had not used the word spirituality. I therefore went back and revised my coding for data to only include segments where the participant had used the words spiritual or spirituality. This illustrates the point made by Charmaz (2006: 10) who emphasises the role and interaction of the researcher with the data during the data analysis process.

The next chapter sets the scene by describing how Ayurveda practitioners 'negotiate the landscape' in the new UK environment.

Chapter five Negotiating the landscape

5.1 Introduction

In Chapter one I examined the literature on Ayurveda to show how differing social and political influences have resulted in variations of Ayurveda, ranging from biomedicalised to spiritualised approaches. The aim of this chapter is to set the scene by examining the social and political influences experienced by Ayurveda practitioners in the UK and to understand the strategies they develop to 'negotiate the landscape'.[79]

I analyse the practitioners' personal understandings of Ayurveda and the role of the ancient texts in their contemporary practice. This is followed by an examination of practitioners' perception of their relationship with the State, biomedicine, and scientific research. I discuss the ways they manage the differences between the different paradigms in order to practise an ancient healing system in the UK environment. I end the chapter by assessing to what extent the following quote by Sharma (1995) is applicable to Ayurveda practitioners in the UK:

> The position of CAM practitioners is full of contradictions.
> (Sharma, 1995: 176)

5.2 Practitioners' personal beliefs

Scholars write about Ayurveda, and yet include the question, 'What is Ayurveda?' (Reddy, 2002: 110; Das, 1993: 61 and 2001: 157; Benner, 2005: 189), indicating that the term itself does not necessarily mean a clearly definable system. Although Ayurveda is generally translated as 'the science of life' (Wujastyk, 2001: 3), it has been conceptualised as Hindu medicine,[80] anticolonial medicine, and the traditional medicine of modern India (Alter, 2005: 24). The *Charaka Samhita* defines Ayurveda as the knowledge or science for longevity. All the interviewees in this study were asked to define Ayurveda and the responses indicate that Ayurveda carries a number of meanings.

5.2.1 Practitioners' understanding of Ayurveda in UK

The consensus of the interviewees was that Ayurveda is a holistic system of healing that takes into account factors that manifest at all levels: body, mind, spirit, community and the environment. It is a science of life, a body of information that perhaps needs to be formally

[79] A phrase suggested by my research supervisor Professor June Boyce-Tillman.
[80] For example Sharma (1995: 220) defines Ayurveda as 'An ancient Hindu system of medicine, based on a humeral and constitutional conception of the body'.

learnt, while it is also wisdom that is innate in people. It is a way of understanding and connecting to the world around them. Thus UK practitioners' understanding of Ayurveda included elements on opposite ends of a spectrum. Medical convert Dr Devi illustrates:

> Dr Devi- Well, Ayurveda's obviously traditionally known as the Science of Life. **It's much more than – much more than medical science**. I mean, it is regarded as medical science, **but it's really knowledge of how to live; how to live healthily and happily, so it covers every dimension, physical, psychological and spiritual, so whatever can be conducive to a happy and healthy life**. So that's why it's a kind of perfect, complete science. Not just a medical science that's targeting disease, but actually looking at what is conducive to health and how the sort of psychological state of mind and spiritual wellbeing is part of and important to that as well. So it's very complete.

Ayurveda was also described by some practitioners as an Indian system with its roots in India and the knowledge based in the *Vedas*. For that reason it was located within a specific geographical area and tradition. Medical convert Dr Ben described it as universal,[81] as the wisdom is found in all cultures and traditions and gave the following example to illustrate the Ayurvedic health perspective on Christian festivals in the UK, and explained how religious festivals had underlying connections which enabled good health. According to him Ayurveda is based on principles which can be interpreted and applied to other traditions making it universal.

> Q - is that an issue in a country which is predominantly Christian ?
> Dr Ben - Absolutely not, because you are not talking to them [patients] in religious terms. You are talking about health and congratulating them. **Grace before meal, a brilliant health strategy from Ayurvedic point of view they warm easily to your perception of the value of their tradition. So that's the beauty of Ayurveda, you just help them recognise what they have.**
> Q Any other examples ?
> Dr Ben - …. and Easter has to be a transition from *kapha* season to *pitta*. There used to be an autumn festival that's gone. They were all timed appropriately for our health. That's what all these festivals were all about. A day of rest once a week, Sunday, a brilliant strategy for *vata* balance. **The fast on Friday, of course, why shouldn't we, get rid of a bit of *ama*.** That's what is was all about. **Originally, the seers of the Christian tradition, they were talking the same truth, they were giving similar strategies to balance, integrate mind, body.** Because how can you be spiritual if you've got a headache. It's just not on. If you go into a monastery you couldn't have a more Ayurvedic ritual. **So the saints that established the various monastic traditions were operating from the same wisdom.** The beauty of Ayurveda is that it just simplifies and universalise. It's everywhere.

Interestingly, Murthy (2010: 53) reported tensions in his study of Ayurveda in New Zealand, tensions relating to the concept of ethnicity and Ayurveda. His participants felt that classifying Ayurveda as an Indian medicine was a barrier to its acceptance in the healthcare

[81] Woodhead and Heelas (2000: 386-387) define universalisation as a major trend in religions in modern times has involved a shift from religions stressing difference to religions stressing universals. Modern times, in the West, have favoured universalisation. This may be due to various trends in modern times: the rise of democracy and the rise of the ethic of humanity. The values associated with these include 'equality' and 'respecting others'.

system in New Zealand, but at the same time they argued that it is embedded in Indian culture and often incorporates Indian cultural practices such as chanting and meditation. Some of the practitioners in Murthy's study felt that they needed to promote an exotic image of Ayurveda in order to show the authenticity of their practice. Thus the 'Indian' element of Ayurveda is both a barrier as it identifies it as a foreign practice outside of India, but also makes it appealing by demonstrating its authenticity.[82'83]

The findings here did not suggest the tension found by Murthy; rather, the UK graduates tended to locate Ayurveda's origin in India, but also describe it as universal. It may be argued that each geographical 'place' in the world is being realigned to the new global realities. Places are being reassigned, their boundaries being dissolved, but the movement is two way, so movement is to the global as well as back to the local, place bound traditions (Reed, 2003: 126). This may explain why practitioners linked Ayurveda to India and the *Vedic* truths,[84] and at the same time globalised it. Also, the process of universalising Ayurveda may be occurring here so that Western practitioners can defend their association with Ayurveda, and South Asian practitioners can justify their practice outside South Asia.

5.3 Practitioners' perceptions of Ayurveda

The personal beliefs of the practitioners illustrated that Ayurveda is not simply a system of medicine. Many interviewees presented Ayurveda as a subject which is broader than medicine, healing or a science as they perceived it as a subject which is significant to all aspects of life. UK practitioner Hannah described Ayurveda as an overarching umbrella term that includes all areas of knowledge: [85]

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[82] Murthy (2010: 7) describes five factors that influence the position that Ayurveda takes in New Zealand. These are: 'Otherness' of Ayurveda as it is perceived as a foreign traditional healing system, after effects of colonial suppression in India, ethnicity, struggle for professional and public credibility, lack of government support, and lack of evidence base research.

[83] Alter (2005: 24) says that to a great extent the discourse of nationalism and politics permeates modern conceptions of 'traditional' medicine;for example; the practice of Chinese medicine in India and Ayurveda in China may be problematic in terms of nationalism. How would each system be understood theoretically within the context of its transplanted practice? Alter (2005: 21) argues that medicine is politicised on a number of levels. Medicine is deeply permeated by culture and cultural values, but medical systems/science claim to be based on universalist principles of health and well-being, defined in pan-human terms and in terms of natural laws that transcend culture.

[84] Warrier (forthcoming) describes Vedic truths as including yoga and pranayama, *jyotish* (astrology), gemology, vastushastra. They come from the Vedic corpus, a body of knowledge which is believed to contain a variety of ancient esoteric insights from the Indian subcontinent.

[85]Kimberley Lau argues that what is implicit in popular discourses is that there is a belief in personal transformation through alternative, non-western paradigms of health and wellness (Partridge, 2005: 6).

> Hannah - Well it [Ayurveda] just means everything. It means histology; it means biology; it means history; it means geography; it means cosmology. You know, it's all in there, and I can't see where it isn't.

Several interviewees explained that Ayurveda cannot be defined only as 'medicine' as it touches all areas of life and goes beyond the conventional understanding of health and well-being. It is not only confined to treating disease, but rather about maintaining health and having optimum function and an excellent quality of life. South Asian graduate Dr Dhani described its holistic nature:

> Dr Dhani - What is Ayurveda? For me, Ayurveda is a typical science of life. You can live Ayurveda at any age, anywhere, whatever you're doing, and it really works……**It works to balance yourself to make you happy.**
> Q - O.K. And when you say "balance", that's a very interesting word.
> Dr Dhani - Balance is not only the physical balance, but the emotional and spiritual as well.

According to Murthy (2010: 5) the Ayurvedic perspective of health is based upon the relation of the individual and nature, microcosm and macrocosm, thus rendering the translation of Ayurveda as 'the science of life' inadequate. He argues that the purpose of life in the Ayurvedic context is to achieve *moksha* (liberation) through righteous living, and health is the foundation of this process. Hence, health takes on a different meaning in the Ayurvedic context compared to that in the biomedical context which tends to focus on physical and mental health. Ayurveda is holistic, and using the term 'Ayurvedic medicine' excludes the all-encompassing meaning.

All interviewees perceived Ayurveda as a way of life which needs to be experienced and lived by the practitioners. According to Warrier (2011a: 80) Ayurveda is very much a living tradition in India, and constitutes an important part of the conceptual universe of most South Asians. South Asian graduate Dr Priya emphasised the importance of living Ayurveda:

> Dr Priya - So, for me, it's a whole lifestyle mind-set. So everything fits in place. Right food; right diet; right lifestyle, and then taking herbal medicine when there is a need, or doing meditation and doing yoga. So it's all just part of the wheel. **So it's a big thing. It's not just about treating fevers**…. You cannot practise as a practitioner if you're **not living it.**

The findings also showed that practitioners perceived Ayurveda as a scientific system where 'science' may refer either to the *Vedas*, the books of knowledge or modern science such as quantum physics. Ayurveda was represented simultaneously as a system of medicine, a way of life embedded in a culture and as universal. As Stahle (2010: 245), who undertook a study of Ayurveda practitioners in Sweden, suggests:

> It would be appropriate to comprehend Ayurveda not as a unified, bounded tradition, but as a field that necessarily differs among cultural contexts and also to a certain extent among different individuals in the same context.

The practitioners represented Ayurveda as having various unique features. One of these is that it is a comprehensive system as it employs different approaches to treatment. The practitioners in Warrier (2009: 7) and Stahle's (2010: 248) studies also describe Ayurveda in the same way. Murthy (2010: 50) reports that the Ayurveda practitioners in his study also describe Ayurveda as a comprehensive system of healing. They feel that it goes beyond any system of medicine as a way to treat disease, therefore classifying it as a complementary or alternative system of medicine was putting limits around it.

The practitioners also mentioned the long history of Ayurveda as an important aspect which distinguishes it from more recent biomedical and CAM practices. Zysk (2001: 13) describes this as a feature of 'New Age Ayurveda', a strategy used to sell Ayurveda in the US. Ayurveda practitioners hold the view that the long history is a validation of the practice-based evidence approach.[86] The longer the time period that a system has been in practice the more evidence there is to support it. This is in sharp contrast to biomedicine which is a relatively new science. 'Old' was associated with wisdom, as time allows for knowledge to mature into wisdom. South Asian graduate Dr Rajesh illustrated this point:

> Dr Rajesh - The only uniqueness in Ayurveda compared to other therapies maybe, one is the history which has got strong history like 5000BC back. I think no other medical field has got at the moment....
> Q - Why is that important?
> Dr Rajesh - **I think authenticity and how the strong base it has got**. That maybe we can see, otherwise how it has got so strong base. How the history it has got so strong. If you read the textbooks and they talking about the herbal medicines and how they and especially when they talk about the disease and disease conditions, sometimes it is amazing, that 5000 years back, how they know about such a disease and the explanations. And when we compare the modern textbooks, it is almost right. I think, sometimes I feel sometimes modern explanations are wrong. Because they come up with new new things and they tell that we are these new things, but doesn't happen in Ayurveda. **I have not seen one single mistake until today in Ayurveda textbooks**.

This quote echoes a common perception among practitioners that the classical texts hold perfect knowledge.[87] This perception reflects the process that Partridge (2004: 77)

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[86] Practice based evidence is an understanding of how well treatments work established through many years of clinical practice: promoting the value of service users', carers' and practitioners' experiences which are often marginalised by the emphasis placed on research.
[87] Though there were instances of poor practice, the underlying reason was, however, related to the practitioners following incorrect procedure and not following the treatment guidelines.

describes as 'romanticising the pre-modern', and that many people in the occult milieu[88] feel that the contemporary world can learn from pre-modern and primal cultures, and even consider the modern period as a regression rather than a progression of human understanding of the nature of reality. According to the occult milieu, the key to authentic spirituality is the resurgence of ancient traditions. Occulture has a strong sentimental attachment to the past. The belief is that the ancestors used to live in a harmonious symbiotic relationship with nature, and had access to wisdom and spiritual power. The ancient wisdom is seen to be uncorrupted and unrepressed by the external dogma, rationalism and authority of later institutionalised religions. The ancient cultures are treated as spiritual and cultural paradigms.

According to Partridge (2005: 5), for some people the quest for truth, spirituality and a new way of life needs to take into account the wisdom imparted by the sacred people of the ancient era, as they carry authority and inspire faith as modern science does for other people. References to pre-modern cultures act as a guarantee of the truth and authority to which they are attached. Practitioners of CAM traditions which have their origins in ancient and Eastern systems, make the remote age a verification of their value. The interviewees also said that the religious and spiritual dimension makes Ayurveda unique. To what extent and how this is incorporated in clinical practice is discussed in later chapters. I next discuss the relevance of the ancient Ayurveda texts in the UK practice.

5.4 Role of Ayurveda classical texts in contemporary practice.

The practitioners indicated that the classical texts continued to hold relevance and they often refer to them in their clinical practice (Newcombe, 2012: 6). Their authority endures as they contain the foundation of knowledge for Ayurveda. The principles described in the ancient Ayurvedic texts were relevant and formed the basis of Ayurveda, but practitioners were clear about the need to re-interpret them intelligently so the ancient information is appropriate for current social context. There is a need to think about the socio-historical circumstances in which they were written. In Ayurvedic terms the *Charaka Samhita* was

[88] Partridge (2004: 4) suggests that traditional religion has declined in the West, but the West has not become fully secularised. Rather, another religio-cultural milieu has taken its place. He suggests both secularisation and sacralisation are occurring simultaneously. Spiritualities are emerging that are different to the traditional religions. They come from popular culture – the occult milieu, or what Partridge calls occulture. He uses the term 'occult' to refer to a vast spectrum of beliefs and practices with their roots in Eastern spirituality, Paganism, Spiritualism, Theosophy, alternative science and medicine, popular psychology, and the paranormal. Occulture is the new spiritual environment in the West.

written during a *kapha* time, i.e. the pace of life was much slower and less stressful. As a consequence the recommendations in *Charaka Samhita* are applicable to a *kapha* society and lifestyle. Modern society is perceived to be dominated by *pitta-vata* qualities, which means that the information in *Charaka Samhita* needs to be adapted accordingly. South Asian graduate Dr Neha described the importance of intelligent interpretation:

> Dr Neha - For good health what do you need to have. And that comes from *Charaka* straight away, you know. For me it is very important. Charaka Samhita is the main thing, but what's happening is that the application of all of these principles of Charaka, in every chapter of Kayachikitsa, if you look, disease*, jwara, swasa, kasa*. They have applied as per the time, at that time. **So that time was more *kapha* time, less stress, more slow. So they applied it in a more *kapha* manner to balance *kapha*. That application if you try to use now which is happening most of the time, then it doesn't work**. You have to apply these principles looking at today's context, and today that one? is different, completely different. So your focus has to be same principles, but **now *pitta vata* problems are higher, emotional problems are higher.** Agni low practically 80% people have that, because we have such sedentary lifestyle, so many facilities, we hardly exercise, we have cars, we have trains, we have this we have that. That time it was not like this. People used to walk, they had to walk. They had to work in a field, which is not now. We have to understand sedentary lifestyle always brings *ama,* and *agni* low. So all this we have to consider and think from this point of view. Then ?Then I think this will be a very effective clinical practice.

In addition, the practitioners said that herbs mentioned in the texts may no longer be available, in which case substitutes need to be found, which leads to improvisation of the recommendations (discussed in Chapter six). The practitioners said they referred to the texts to get information about a disease or particular treatments, for example *kayachitsa*, or read them to confirm information found in other sources. The classical texts are enigmatic as on the one hand, they hold knowledge that was coded in Sanskrit *slokas,* which needs to be decoded, giving a sense of mystery and a process of deconstructing is required to unlock information that is exclusive. On the other hand, practitioners said they refer to them on a day to day basis, suggesting that the knowledge is easily accessible; therefore the classical texts were simultaneously mysterious and open.

In summary, the practitioners' personal beliefs about the Ayurveda highlight that it is not only medicine, rather a way of life and the classical texts continue to hold a position of authority. These features enable Ayurveda to sit comfortably in the holistic health milieu where health takes on meanings beyond the biomedical frame. I next examine Ayurveda practitioners' encounters with the State, biomedicine and modern research in the UK.

5.5 The State influence

In Chapter one (see pages 21 and 45) I described the role of the British Government in relation to healthcare. In Britain, the State is paramount in shaping the healthcare market

as the NHS is a state organisation. Nonetheless, a considerable amount of care is available through the informal sector, and an increasing number of consumers seek care from the private and CAM sectors which do not get state funding. Thus, it is the policies of the government which decide what is permitted in terms of health (Cant and Sharma, 1999: 127).

The following excerpt from the CAMbrella report entitled '**Legal status and regulation of CAM in Europe.** Part I - CAM regulations in the European countries (Wiesener et al, 2012), gives a brief overview of the legal and regulatory status of CAM in the UK:

> **The United Kingdom**
>
> **8.39.1 The legal and regulatory status of CAM and CAM practices**
>
> Under Common Law all practitioners have a duty of care towards their patients, and non-medically qualified individuals are prohibited from curing or treating specific illnesses and medical conditions, for example cancer and venereal disease (301). The Health and Safety at work Act 1974 places a statutory duty of employers to ensure the health and safety of people affected by the various activities undertaken on their premises (301). According to the House of Lords' report 2000 5.9.(301). "The Common Law right to practise medicine means that in UK anyone can treat a sick person even if they have no training in any type of healthcare whatsoever, provided that the individual treated has given informed consent".
>
> Osteopathy and chiropractic are statutorily regulated while acupuncture and other CAM treatments are voluntarily regulated (or not) depending on the associations/groups (234). The UK Government has announced that it is planning to statutorily regulate practitioners supplying unauthorized herbal medicines on a one-to-one basis (after an individual consultation) under the aegis of the Health Professions Council. Both statutory and voluntary regulations are based on minimum standards for practices. However, for voluntary self-regulated practitioners there are no legal sanctions against practitioners who fail to meet these standards (302).
>
> The Government's Command Paper Enabling Excellence (February 2011) stated that the Council for Healthcare Regulatory Excellence (CHRE) was to be given new powers to accredit voluntary registers of health professionals who are currently not regulated by statute. These powers will be enacted when the Health and Social Care Bill becomes law, and the CHRE is expected to commence the implementation scheme in the autumn of 2012 (303).
>
> On 1 March 2012 the Law Commissions of Scotland, England & Wales, and Northern Ireland published a joint consultation "REGULATION OF HEALTH CARE PROFESSIONALS", seeking views on how the regulation of health care professionals in the UK and social workers in England can be made clearer, simpler, more modern and more consistent. Chiropractic and osteopathy are listed among the regulated professions in question (304).
>
> Non-medically trained homeopaths, acupuncturists, and herbal medicine practitioners are all registered and self-regulated in their own individual councils. A number of other disciplinary groups of non-medically trained CAM practitioners are registered under the banner of the Complementary and Natural Healthcare Council (CNHC). CNHC has put into place the policies and procedures necessary for an effective running of a regulatory body, including an on-line multi-disciplinary register that opened in January 2009 (305).

8.39.2 The governmental supervision of CAM Practices

In England the Care Quality Commission, established under the Health and Social Care Act of 2008, regulates health and adult social care under the Care Standards Act 2003 (302). Similar inspectorates are established for the other UK states, but they do not regulate CAM services under current legislation (302).

Anyone may practise and provide various CAM treatments as long as they do not claim to be a medical practitioner registered under the Medical Act or claim to cure diseases as proscribed by the law (301). The above mentioned groups fall outside the governmental health supervision systems.

8.39.3 The reimbursement status of CAM practices and medicinal products

A number of private health insurance companies cover some CAM treatments in their policies but many private insurance companies will only reimburse treatments carried out by statutorily regulated practitioners. Some acupuncture treatments (largely for pain) is covered mainly by private insurance companies in the UK (106). Some acupuncture, anthroposophic medicine and homeopathy treatments are also provided by the NHS (60,106). Some therapies are available through the NHS in pain clinics and terminal care environments but the vast majority of CAM provision in the UK is within the private sector and is not covered by medical insurance.

8.39.6 Ayurveda

Ayurvedic medicine is not statutorily regulated in the UK but Ayurvedic practitioners supplying unlicensed herbal medicines on a one-to-one basis are set to be statutorily regulated under the Health Professions Council along with other traditional or herbal medicine practitioners. There are approximately 200 qualified Ayurvedic practitioners in the UK most of whom are registered with one of the two existing voluntary regulation bodies: either with the Ayurvedic Practitioners Association (APA) or the British Association of Accredited Ayurvedic Practitioners (BAAAP). The only currently existing training course is the 4-year integrated MSc programme offered by the College of Ayurveda in conjunction with Middlesex University. Middlesex University has re-validated this programme for another 5 years in 2011 and intends to accredit the course through the EHTPA Accreditation Board before statutory regulation commences in 2013 (309).

According to Sharma (1995: 113), CAM professionals practise in a 'curious context' in Britain, because they have widespread public support and a small degree of medical acceptance, but they do not have full support to practise. They are 'based on a negative right', i.e. the right to practise something which is not yet prohibited. She (1995: 99) also notes that the medical profession is supported by the State which demands proof that can be understood by the public, is convenient for administrative and bureaucratic processes and serves political interests. The government's interest in CAM is related to 'cost effectiveness', rather than patient choice.[89]

[89] Sharma (1995: 122) notes that CAM does get support from various groups: consumer associations, biomedical professionals who also practise or support CAM, manufacturers of herbal/natural remedies and the All Party Parliamentary complementary and alternative medicine group.

5.5.1 Regulation of Ayurveda as a Profession[90]

As mentioned in Chapter one, in India, Ayurveda is one of the six systems of medicine officially recognised by the Indian Government (Murthy, 2010: 16). Professionalisation is inherent within the tradition of Ayurveda, whereby the protected title of '*vaidya*' was given to practitioners who had completed a long apprenticeship (Langford, 2002: 101). This continues in the form of a BAMS degree from teaching institutions where successful graduates continue to be awarded this protected title.

The Ayurveda community in the UK has made efforts to keep the status of Ayurveda practitioners protected through voluntary self-regulation (Pole, 2008; 223, Warrier, forthcoming). The Ayurveda organisations, through voluntary self-regulation, have adopted many of the features of professionally led statutory regulation. A university degree programme has been set up and two professional organisations (APA and BAAAP) have been established, both with a register of practitioners, a code of ethics and complaints procedures.[91]

The fundamental reason for the regulation of the CAM practitioners is to safeguard the public, and at the same time it ensures occupational advantage through professional closure. The voluntary system, however, lacks the statutory protection of title, leaving open a gap for laypersons without suitable training to practise Ayurveda. Despite the Ayurvedic community's attempts to safeguard its professional status and reputation and the public from poorly qualified people claiming to be practitioners, the absence of statutory regulation means a lay person can set up a practice without a licence or any formal qualification and is not subject to any checks. In Britain, practitioners are subject to common law, but with increased use of CAM, common law is not seen as sufficient (Cant and Sharma, 1999: 132). Statutory regulation appeals to practitioners as it gives status and privilege. In addition, the Ayurvedic community stresses professional responsibility over professional appeal. Although Ayurveda may be growing, which would appear to be a good

[90] 'Profession' is used to distinguish certain kinds of occupational services from others. The features of a profession include: members organised into a group who have standards of practice, coordinate or oversee training, and define codes of conduct for their members.

[91] Previously, patients would choose their practitioner by word of mouth and recommendation i.e. the charisma of the practitioner and the perceived success of the treatments influenced the decision. Though this continues to be the primary way in which patients select practitioners, Cant and Sharma (1999: 152) suggest that increasingly the State is identifying which practitioner is the 'expert' based on training, credentials and internal organisation, suggesting that the patient's experience is less important.

sign for the profession, the concerns over lack of regulation are also growing. One practitioner at an event raised the following concern:

> The focus needs to shift now. We are seeing new Ayurveda clinics everywhere, but the future of Ayurveda seems very doubtful. **- though Ayurveda is seemingly expanding, it is not necessarily good because of the lack of regulation and protection, anyone can currently set up**.
> (BAAAP conference, 10.7. 09)

Though the Ayurveda community has made great efforts towards voluntary self-regulation, UK graduate Aarti expressed the need for robust statutory regulation, as she had observed that people having been on short training courses with inadequate qualifications are able to get insurance and set up as Ayurvedic practitioners:

> Q - What are the chances of being regulated?
> Aarti - I feel, unless the profession is regulated, regulated quickly, we are doomed …. In [name of town] alone about 20 or 30 clinics have come up and we have received so many applications from people who are not properly qualified.
> Q - Are they local people from the UK or from India?
> Aarti - They have originally come from India, but they want to become a member so they can get their insurance, get a job and work in a clinic and also..
> Q - They don't have the BAMS qualification?
> Aarti - **No. no. Some of them just 6 months training. Somebody who would be prosecuted, I have got letter from solicitors, because he has got the insurance, this is what I told our insurance companies, 'It's very dangerous what you are doing, because unless they are registered with an organisation and they have been vetted, their qualifications have been checked, you give them insurance, you don't know how much liability you are taking on'**.

Murthy (2010: 25) described a parallel situation in New Zealand. The practitioners were in a situation where the onus is upon them to campaign for the sake of a protected title and public safety. The opinions of the UK practitioners at one event were:

> The government may not give statutory regulation. **We must campaign to get regulation for professional standards, otherwise anyone can say they are an Ayurvedic practitioner.**
> (BAAAP conference, 25.6.10).

Significantly, Ayurveda practitioners in this study felt that the Government does not care about them:

> On 16th February 2011 the Department of Health said only practitioners will be regulated to supply unlicensed herbs NOT any profession, so there is harmony between the UK and EU law. **Therefore the Government is not interested in Ayurveda practitioners as professionals.** Acupuncturists are not included as they do not use herbs. Therefore, practitioners will not get a protected title.
> (APA multi-track event, 14.5.11)

Thus the lack of regulation is perceived as a safety risk to the public and the reputation of the profession, and serves to keep CAM on the margins of healthcare, despite the increase in public demand.

5.5.2 Regulation of herbal medicine

The Medicines and Healthcare products Regulatory Agency (MHRA)[92] is the government agency responsible for ensuring that medicines and medical devices are safe. The MHRA is an executive agency of the Department of Health. The European Union (EU) herb law, the Traditional Herbal Medicinal Products Directive (THMPD)[93] came into force on 1 May 2011. Since then, it has been illegal to manufacture therapeutic herbal products that do not have a Traditional Herbal Registration (THR), although shops in the UK were permitted to sell their remaining stocks of unlicensed herbal medicines. The purpose of the THMPD was to stop the sales of poor quality or unsafe herbal products. According to the MHRA, the consumer had to guess what is safe and research shows that consumers think that whatever is deemed to be 'natural' is safe**.** Some traders were taking advantage of the situation and selling poor quality and unsafe products.

The following summary from the CAMbrella report entitled 'Legal status and regulation of CAM in Europe. Part 2 – Herbal and homeopathic medicinal products' (Fonnebo et al, 2012), gives a brief overview of the regulations around medicinal products in Europe

> **Summary**
> Medicinal products are not defined as a part of health policy, and can therefore be regulated at the EU level. The individual states within the EU/EEA area are therefore no longer free to uphold deviating national regulation of medicinal products in violation of the following three EU directives:
>
> 1. *Directive 2001/83/EC of the European Parliament and of the Council, of 6 November 2001* (on the Community code relating to medicinal products for human use).
>
> 2. *Directive 2004/24/EC of the European Parliament and of the Council, of 31 March 2004* (amending, as regards traditional herbal medicinal products, Directive 2001/83/EC on the Community code relating to medicinal products for human use 2001/83/EC).
>
> 3. Directive 2004/27/EC of the European Parliament and of the Council of 31 March 2004 (amending Directive 2001/83/EC on the Community code relating to medicinal products for human use).
>
> Other amendments on specific topics applicable to all medicinal products have been made in 2003, 2010 and 2011:
>
> * *Directive 2002/98/EC of the European Parliament and of the Council of 27 January 2003* **(setting standards of quality and safety for the collection, testing, processing, storage and distribution of human blood and blood components** and amending Directive 2001/83/EC).

[92] MHRA (2013) [online]. [Accessed 29.12.12]. Available from the World Wide Web: http://www.mhra.gov.uk/#page=DynamicListMedicines
[93] MHRA (2013) [online]. [Accessed 29.12.12]. Available from the World Wide Web: http://www.mhra.gov.uk/Howweregulate/Medicines/Herbalmedicinesregulation/index.htm

* *Directive 2010/84/EU of the European Parliament and of the Council of 15 December 2010 (amending,* as regards **pharmacovigilance**, Directive 2001/83/EC on the Community code relating to medicinal products for human use).

* *Directive 2011/62/EU of the European Parliament and of the Council of 8 June 2011 (amending* Directive 2001/83/EC on the Community code relating to medicinal products for human use, as regards the **prevention of the entry into the legal supply chain of falsified medicinal products)**.

Herbal medicinal products marketed without authorization before Directive 2004/24/EC came into force could continue to be marketed until April 30 2011 under transitional measures defined in this directive. After the expiration of this time limit, all previously unauthorized herbal medicinal products must have a registration or marketing authorization according to directive *2001/83/EC - and amended by Directives 2004/27/EC and 2004/24/EC*
- before they can be marketed in the EU/EEA states.

Registrations or marketing authorizations for herbal and homeopathic medicinal products are always given at the national level, but a mutual recognition procedure can be used in some cases. Herbal and homeopathic medicinal products are subject to the same requirements as other medicinal products regarding manufacturing procedures, technical quality of the product, and all other requirements with the possible exception of documentation of efficacy. There are five administrative procedures that can be followed to obtain a registration or a marketing authorization for these products: standard marketing authorization, well-established use authorization (for herbal medicinal products only), two simplified registration procedures (one for homeopathic medicinal products and the other for traditional-use registration of herbal medicinal products) and a national registration procedure for homeopathic medicinal products. The simplified registration procedures and the national registration procedure for homeopathic medicinal products allow alternative documentation of efficacy.

Homeopathic medicinal products covered by a registration or authorization granted in accordance with national legislation on or before 31 December 1993 and herbal medicinal products already authorized in accordance with Regulation (EEC) No 2309/93 or supplied in response to a bona fide unsolicited order can be marketed irrespective of the two directives.

These uniform regulations aim to supply citizens with a predictable standard of all medicinal products (including herbal and homeopathic) across Europe. Several stakeholders raised concerns before the rules were implemented. The concerns focused mainly on leaving European citizens without access to beneficial products, and the establishment of unnecessary additional regulatory bureaucracy around well-known medicinal products with a long tradition and a well-known safety profile.

In general, the European legal system for herbal and homeopathic medicinal products differs from the legal system surrounding all other aspects of CAM practice. The regulation of clinical practice and practitioners appears to be as diverse as possible in Europe. At the same time, the medicinal products these practitioners will be prescribing or recommending are regulated uniformly across the same geographical area. This appears to be inconsistent and European politicians at both the national and EU level need to closely consider whether regional or EU-wide harmonization of CAM practice and its medicinal products could further optimize the healthcare of European citizens. In the frame of free circulation within the EU, calls for these considerations have been articulated in resolutions by both the Council of Europe and the European Parliament.

It is inevitable that any regulation of natural medicines will have a profound effect on the practice of those forms of CAM that are based on the administration of substances to the patient. Any kind of restriction to supply or prescribe such remedies will restrict the freedom of many therapists to practise at all (Sharma, 1995: 105). The findings which illustrate the impact of restrictions are described in Chapter six.

Practitioners who use herbs as part of their treatments can prepare their own remedies using single herbs, and third party medicines can be prescribed through a 'specials scheme'. Although this Directive appeared to be a positive step towards ensuring public health, a number of problems were perceived. As discussed in Chapter two (see page 54), the fundamental issue is the mismatch of paradigms. According to Ayurveda, the distinction between food and medicine is almost non-existent, and at best blurred. The definitions according to the modern paradigm appear bizarre and lack consistency causing confusion in the Ayurvedic community. Practitioners during different events raised similar concerns, for example:

> **The food vs medicine distinction is nonsense.** Nobody knows clearly the definition of food supplement.
> (APA multi-track event, 14.5.11)

> **If a food e.g. garlic is put in a capsule, it still remains a food**.
> (Ayurveda Symposium, 28.3.11)

Another practitioner highlighted the irony of the definitions of food and medicine as they change according to the form they take:

> **Getting a license is very complicated;** therefore it is better to learn to combine simple herbs, *churnas, kwaths* etc. **The problem with capsules and tablets is that they are seen as medicines.**
> (APA AGM, 15.5.10)

Further, definitions of food and medicine change according to the country. UK graduate Hannah described her frustration:

> Hannah - …… I went to Holland on a course for two weeks and it's really sickening that they can still prescribe everything in the whole of Europe, **and it's to do with nomenclature, inasmuch as over there it's called 'food' and over here, it's called 'medicine', and that's the split.**

In addition to the difficulties around differing definitions, practitioners found communication from the MHRA had at best been confusing and unclear:

> Need one positive list of what is safe and evidenced. **Need clarity of what is safe and clear definitions.**
> (BAAAP conference, 10.7.09)

The process of getting herbs licensed (THRs) was seen as expensive, making licensing near impossible for most herbal remedies.

> £10K (ten thousand pounds) to £70K (seventy thousand pounds) for single herb. £350K (three hundred and fifty thousand pounds) for five ingredients. Therefore, prohibitive costs in preparing dossiers. Polyherbal combinations too complex.
> (Ayurveda Symposium, 28.3.11)

Moreover, the interviewees had serious doubts that the current licensing process will achieve its aims of public safety from a CAM perspective:

> 80% (eighty per cent) of products being regulated are synthetic – contain acetone, etc. none have natural plants. The regulation is a farce!
> (Ayurveda Symposium, 28.3.11)

> The THR cannot guarantee that a medicine is not fraudulent.
> (Ayurveda Symposium, 28.3.11)

Furthermore, the interviewees expressed concerns that patients will find ways to get their herbal remedies, which counteracts the purpose of the EU directive which is to safeguard the public.

> Won't be able to use formulae, only single herbs. All suppliers will go out of business**.**
> **Patients will use internet to get herbs, but could be an issue of getting good quality herbs.**
> (Ayurveda Symposium, 28.3.11)

Some practitioners may find ways around ordering the medicines, as UK graduate Hannah reported:

> Q - I would have thought that there was one kind of guideline, considering they're following European laws.
> Hannah - So now you have to ask your patients to order their medicines - you want to be legal…….. from Europe.
> Q - So that's the way round it? So they get the medicine from Europe?
> Hannah - Yes. Now is that, like, bizarre, or what?

This was echoed by Reed (2003: 127), who found in her research of Asian women that the transcultural flow of health goods to and from India came via the Asian diasporic network. The network enabled them to draw on syncretic types of medicine from a multiplicity of locations.

The forced restrictions meant that some practitioners simplify their practice and recommend weak alternatives that are readily available, for example prescriptions based on 'kitchen pharmacy'; though effective these may not have the same rapid healing response as the first choice herbal remedies. Also, due to restrictions, some practitioners

discussed the possibility of making increased referrals to India, thereby supporting the medical tourism trade (discussed in Chapter six). UK graduate Thelma exemplified this option:

> Thelma - No, because they're cutting down. So, instead of following the formulae, you have to compromise because you are only allowed to prescribe what's there. I mean, **I might recommend, if people really did need something quite serious, that they consider going to India.**

Though a referral abroad may be beneficial for patients who have not found relief for their medical conditions in the UK, the risks may also be increased, particularly for vulnerable patients, as standards of treatment and care may differ from those in the UK.

The Ayurvedic practitioners in this study, like the MHRA, were keen to protect public safety, but in the opinion of the practitioners it appeared that the legislation would only be effective to some extent in ensuring this aim. Many practitioners were sceptical and felt that the underlying reason for this legislation was not about public safety, rather about politics.

> The British Medical association is very powerful. It will not let any other system in. Therefore we need to get in. It's not about science or medicine. It is about politics.
> (BAAAP conference, 25.6.10)

> Public safety is only superficial. The protection of the pharmaceuticals is the underlying agenda.
> (APA multi-track event, 14.5.11)

They also felt the processes involved were unfair:

> Pattern of **scapegoating,** herbal products e.g. **a few cases blown out of proportion** e.g. heavy metal contamination. **The baby is being thrown out with the bath water !**
> (Ayurveda Symposium, 28.3.11)

Further concerns reflected the poor relationship between CAM (and Ayurvedic) practitioners and the Government. According to Wujastyk (2005: 176), the British government perceived that 'CAM was something to be tolerated, controlled and regulated and made safe, not because of its potential health benefits, but solely because patients want it'. A positive relationship is crucial for public health, the common aim of the Government and CAM practitioners. Public demand for CAM means that CAM Practitioners are important stakeholders in the Public Health arena; however, the practitioners in this study indicated mistrust of Government. For example, one practitioner made the following comment:

> Law of the bureaucracy – when politicians say they are doing one thing they are doing the opposite.
> (Ayurveda Symposium, 28.3.11)

Murthy (2010: 58), in his study of Ayurveda in New Zealand, also found that some of his practitioners felt that the 'current interest by the government authorities in regulating CAM practice was a conspiracy '…. a concerted plan to marginalise modalities which are not in line with orthodox medicine.' In short, on the one hand Ayurveda is considered to be potentially unsafe, yet on the other hand it is not significant enough to be regulated (Murthy, 2010: 25).

5.6 Influence of European Commission

Some practitioners felt that this problem had come out of 'Europe' (by which they were referring to the European Commission). Other practitioners, however, felt that the issue was more sinister and the underlying drive was the 'western reductionist mind set' being imposed on Asian culture. The following quote exemplifies a common feeling among practitioners:

> This problem has come out of Brussels. The cause is a misunderstanding of the definition of food and medicine and inappropriate scientific tools imposed to test herbals.
> (Ayurveda Symposium, 28.3.11)

The EU directive was perceived to be ill-informed and this may be due to the fact that there are comparatively fewer people of South Asian origin in the rest of Europe as compared to the UK:

> In Europe less Indians, therefore less practice of Ayurveda and yoga. It will hit us hard in the UK.
> (Emergency meeting on Ayurveda, 10.7.10)

This has detrimental consequences for the Ayurveda community in the UK. Similarly, Murthy (2010: 50) found that Ayurveda as a foreign and traditional system was disadvantaged in New Zealand as there is a lack of recognition of other traditional systems.

The practitioners perceived the British Government to be lacking in understanding and unsupportive of Ayurveda. They felt the government does not care about Ayurveda, nor is it interested in regulating the profession. The consultation efforts are deemed to be biased. Further, the underlying agenda pertaining to regulation was not seen to be about public safety, but the protection of the pharmaceutical industry. Overall, there was apathy about the political situation. In addition, practitioners said that the decision makers in Europe are

not in touch with the reality of acquiring THRs (Traditional Herbal Registers) which is why the process is expensive and unfair.[94]

Thus the findings show tension between public demand for CAM (Sharma, 1995: 36-41), and Governments' restrictions against CAM (Sharma, 1995: 96-106). Regardless of the legislation and the possible agendas, the concern for public safety still remains unresolved to the satisfaction of all. Imposing legislation that is deemed to be inappropriate by practitioners is not the answer as the public continues to be at risk of unsafe medicines.

In summary, the practitioners perceived the State as oppressive and felt marginalised due to a lack of understanding of Ayurveda. This raises the question, how do practitioners practise Ayurveda in an unsupportive environment? The findings show that the practitioners have developed a number of strategies in order to practise within an environment where restrictions are imposed and these are discussed in detail in Chapter six. I next examine how practitioners perceive their relationship with the biomedical profession.

5.7 Relationship with biomedicine

As mentioned in Chapter one, CAM is defined by the level of political acceptability and biomedicine in the UK currently enjoys mainstream status due to Government support (Saks, 2008: 29). The British Medical Association is powerful and the pharmaceutical companies are dominant, and the two together create a strong barrier for any other healing system to enter the healthcare arena.

CAM is positioned either as compatible or as incompatible with biomedicine (McClean, 2005: 2).[95] Some therapies are perceived as suited for use alongside biomedicine and have

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[94] See www.cambrella.eu for current efforts to regulate CAM in Europe. Portugal will be regulating several CAM therapies, and this is a challenge for both practitioners and government. "We strongly believe that this is a good opportunity to collaborate, and if one EU country, such as Portugal, regulates CAM in a way that fulfils the wishes and interests of the European CAM community, this can be useful for other EU countries as well," Carvalho says. "Thus we hope that the CAMbrella findings can provide our parliament members and professional bodies with the most up to date information regarding CAM."

[95] Cant and Sharma (1999: 68) outline the different ways in which CAM is aligned to biomedicine. Firstly, CAM training incorporates medical science in the curriculum. This is supported by the British Medical Association (BMA) who say that this allows dialogue between the CAM and biomedical practitioners. Secondly, some CAM groups use scientific language and concepts to explain why their therapy of healing works. This has been done either by drawing on biomedical knowledge or the converse, by criticising the biomedical paradigm and proposing a different scientific paradigm such

gained a degree of respectability (see page 46), though not in the way that biomedicine claims state legitimacy. Other New Age therapists and spiritual healers may reject the biomedical model, and hold a radically different perspective on health, illness and the body.

Ayurveda practitioners in this study had varied perceptions of their relationship with the biomedical profession. Some felt alienated by the attitudes of the mainstream biomedical practitioners to the extent that the differences appeared to be irreconcilable. As one practitioner said at an event, the biomedical profession perceives the two systems 'like oil and water. Don't go together.' (BAAAP conference, 25.6.10), suggesting that incompatibility is determined by biomedicine.

For some Ayurveda practitioners the separation was so stark that they felt that the mainstream biomedical profession positions Ayurveda as an enemy at war. One campaigner made the following comment:

> The issue is an "epic battle of a clash of worldviews, scientific reductionism vs herbal holism."
> (BAAAP conference, 10.7.09)

Newcombe (2012: 2) suggests the problem is exaggerated by the hegemonic position of biomedicine and the views of its supporters who are unwilling to consider any system of healing that does not fit their view. One leading campaigner remarked at an Ayurveda meeting that the scientific framework imposed is causing a clash with Ayurveda and Traditional Chinese Medicine:

> Traditional medicine does not have claims like 'this product gives relief for colds/coughs'. Instead Ayurveda products say this increases Agni in the liver i.e. **Allopathic language being imposed on Ayurvedic drugs which doesn't fit.**
> (Ayurveda Symposium, 28.3.11)

The perceptions of the Ayurveda practitioners are not unique; rather the biomedical profession's long standing hostility to CAM has been noted, according to Sharma (1995: 107):

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as quantum physics. Thirdly, some CAM groups have adopted modern research methods including the randomised control trial (RCT) to find evidence for their therapy. Ayurveda institutions in India have adopted this approach.

> … at the professional level, orthodox [biomedicine]medicine had been extremely hostile to, even contemptuous of complementary medicine in general and this long standing hostility had shaped many entrenched positions both in the orthodox and non-orthodox camps.[96]

Even recent research[97] undertaken by CAMbrella reported similar hostile attitudes which suggest that the negative relationship continues:

> Unfortunately the academic medical society in Belgium is very critical towards CAM. We try to unite both kinds of CAM practitioners in one professional organisation, but the medical doctors practising CAM don't want to cooperate with non-medical CAM practitioners because they fear that they will not be taken seriously by the medical society.

In summary, the Ayurvedic community in the UK is in an environment where it feels supported by the holistic milieu, but marginalised by the State and perceives hostility from the biomedical profession. The Ayurveda practitioners have adopted strategies to lessen the differences in a variety of ways. I mentioned in Chapter one, that biomedicalisation of the training courses was one strategy. In addition, practitioners continue to find ways even after they graduate and set up their practices, which I discuss next.

5.7.1 Strategies to emulate biomedicine

The majority of the Ayurveda practitioners in this study, regardless of the differences between Ayurveda and biomedicine were keen to apply modern methods to their practice in the hope of validation and acceptance by the mainstream. This comes from the *mishra* ideology (see page 88), whereby some practitioners accept the integration of Ayurveda and biomedicine. This has been occurring in India; for example, a spokesperson from the Himalaya Company[98] based in India, said they apply modern technology to developing their products, interpreting the traditional system in the language of modern science. Their aim is to mainstream Ayurvedic products by validating them through modern science.

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[96] The BMA (1986) published a report on CAM, which confirmed that biomedical professionals were 'inexorably hostile to anything which did not conform to its own notions of treatment and efficacy and confirmed their sense of operating from a beleaguered position' (Sharma, 1995: 107).

[97] CAMbrella newsletter: www.cambrella.eu

[98]See Himalaya Herbal Healthcare (2011). [online].[Accessed 16.3.13]. Available from the World Wide Web:
http://www.himalayaherbals.com/aboutus/index.htm "This legacy of researching nature forms the foundation of Himalaya's operations. Himalaya uses the tools of modern science to create pharmaceutical-grade Ayurvedic products. We have pioneered research that has converted Ayurveda's herbal tradition into a complete range of proprietary formulations dedicated to healthy living and longevity. Today, these products have found acceptance with medical fraternities and serve the health and personal care needs of consumers in 82 countries".

Nisula (2012: 130) showed that Ayurveda practitioners incorporate biomedical instruments and diagnostic procedures as part of their practice in India, because they carry symbolic power related to medical expertise. This highlights the hegemony of modern medicine as it is the yardstick against which all other systems are measured. South Asian graduate, Dr Karan, demonstrated his use of modern measurements to validate his own treatment results.

> Dr Karan - the clinical training during the internship was very important with modern parameters … I can tell a patient to go for investigations then give herbs. After three months check the results. Microscopically, those herbs work. **If modern science has proved something you cannot deny it.**

Although many of the Ayurveda practitioners reported perceiving hostility from the biomedical professionals, the medical converts felt their training and links with the biomedical field had several advantages. For example, UK graduate Pritesh reported on the benefits of his connection with the mainstream biomedical profession:

> Q - …and how do you explain Ayurveda to them [patients] ?
> Pritesh - Ah..... I don't try and do that .. not too much, I just go briefly into the *doshas*, very briefly, I don't go into detail, unless they want to know about it. **Most of the time, I think it's because I am a [allied medical professional] they don't question me too much. If I say this, this and this, they'll accept it.**

Another practitioner, made a similar comment:

> I call myself a 'Holistic GP'. I meet challenges from the medical fraternity, **but I get respect due to background as a 'biomed'**
> (BAAAP conference, 25.6.10).

These comments indicate that the public are more likely to place their trust in a person who they perceive to be part of the mainstream biomedical profession. Having a scientific background engenders both trust and respect.

Ayurvedic practitioners recognised the advantages of biomedicine. One area where most Ayurvedic practitioners tended to agree is the ability of biomedicine to deal with situations which are either emergencies or high risk. South Asian practitioner, Dr Priya, described her experience of how patients juggle between choosing different systems of medicine in India:

> Dr Priya - I was practising. I was working in gynae and maternity, which is where I practised for five years (in India).
> Q - Was that in an Ayurvedic Hospital?
> Dr Priya - It wasn't. It was a normal hospital, because we don't have particularly separate gynae and maternity Ayurvedic hospitals. I mean, **my hope was that when I passed from here, once I opened my own clinic, then I will do what's needed to be done for emergency from an allopathic point of view, but I will use a lot of Ayurveda with it,** so a lot of Ayurvedic herbs for you know gynae and maternity. But because it's such a – it's a very sensitive subject. You know, **nobody wants to take a chance with their pregnancy; nobody wants to take a chance with a new-born, so you can only do so much Ayurveda with it.**

> There is a lot you have to depend on modern medicine because it's an emergency situation, so like C-section and lots of other things.

As an 'insider', medical convert Dr Ben also praised certain aspects of modern medicine.

> Q - last question, the current medical system, does it contribute in any way ?
> Dr Ben - The use of classic medicine will decline**. But there are so many aspects to modern medicine which are so fantastic. Surgery for a blocked artery. It's unbelievable the technology. There are many many aspects of medicine which will continue for a while.** All that will happen is that the Ayurvedic paradigm will come to a fore and the Ayurvedic principles will give an integration to the various medical and complementary practices paradigm within which you can choose a program. Can choose from all the range of health strategies.

Nonetheless, adapting to the modern framework did not always guarantee a clear route. A speaker from another manufacturing company said that they also apply modern technology and their products undergo many stages of vigorous tests. Despite this they have faced problems with MHRA, suggesting that conforming may not necessarily get the acceptance that is desired (Ayurveda Symposium, 28.3.11).

In spite of the perceived hostility from the mainstream, most practitioners in this study indicated hope for an integrated healthcare system in which they work alongside biomedical practitioners. For example, UK graduate Thelma was positive about the future:

> Q - But, at the moment, do you think there's a chance of Ayurveda integrating with modern medical ?
> Thelma - **I do, absolutely, yes. I just think it needs to be a little bit more understood and practised**, and people getting good results from it.

Warrier (2011: 18) found in her study that most Ayurveda practitioners were open to the use of biomedicine and valued the contribution it has made in helping certain conditions, but they criticised its narrow focus on curing, its reductionist approach, and its emphasis on biomedical drugs as the sole method of treatment. In contrast they perceived Ayurveda as a superior and more complete system which is holistic. Supporters of the Eastern holistic traditions do not reject biomedical authority completely or the importance of evidence based medicine to validate CAM (Newcombe, 2012: 9).

To summarise, the Ayurveda practitioners in this study presented a complex relationship between Ayurveda and modern medicine. The interviewed practitioners often felt they were negotiating between hostility and partnership with their biomedical counterparts, and have reconciled to adopting ways to emulate the biomedical profession. I next analyse the Ayurveda practitioners' attitudes to modern research.

5.8 Perceptions of research

The need for modern research emerged as a contentious area among the UK Ayurveda practitioners, partly due to the lack of funding available for Ayurveda, as well as disputes around appropriate research designs. Some practitioners felt this modern imposition was unnecessary while others said they would accept modern scientific research wholeheartedly to improve their practice, therefore the attitudes ranged from cynicism to enthusiasm.

5.8.1 Ayurveda is safe and it works

The findings showed that some practitioners were baffled by the current requirements of evidence that Ayurveda 'works'. For them, experimental research was unnecessary as they do need to prove the efficacy or safety of Ayurveda. South Asian graduate Dr Shalini indicated her puzzlement:

> Q - Do you think there needs to be more research Ayurvedic products, because that's one of the issues? They feel there isn't enough research to prove their safety and efficacy, and so on.
> Dr Shalini - I know, but that's so silly because **this practice has been there since five thousand years**. It's just they want on paper that thirty years – isn't it thirty years debate how they want it on paper that this had been introduced and given out from since thirty years safety of the patient. It's hard to get that data, isn't it. **This custom is surviving from five thousand years. That's enough proof. People are taking it.** You know, it's herbs. So, I don't know. I don't have much knowledge about how this is going to work, what sort of, you know, research is and the proof they have to supply. But now it's really tough, and it's going to be tough for the manufacturers, basically, to get a licence for the herbs, but – no, no. I don't have much idea about this.

Research in parallel systems of Eastern medicine such Traditional Chinese Medicine (TCM) has highlighted similar concerns around research. Robinson et al (2012: 611) suggested that alternative approaches to the standard evidence based medicine hierarchy of approaches may be required to construct evidence which takes into account TCM's historically and culturally distinctive characteristics. TCM has a different conceptual and theoretical basis compared to modern medicine (see page 54), and acupuncture treatment extends far beyond needling, with the practitioner being a component or contributor to the treatment. As a result, many acupuncturists are suspicious of 'evidence based knowledge' and rely on their education, training experience and expert opinion to inform their practice.

Bivins (2010: 177) writes in her book on the history of alternative medicine that this attitude of assuming that medicine from other cultures could and should be assessed by Western science and accepted only when in tune with Western scientific models is a

feature of twentieth and twenty first century responses to cross-cultural medicine. According to Bivins (2010: 34), the tension between evidence-based medicine and practice-based medicine stems from the Enlightenment period when experiment overtook experience. The Ayurvedic practitioners in Murthy's study also emphasised 'the importance of practice based evidence in traditional systems of medicine as opposed to evidence based medicine' (Murthy, 2010: 61).

5.8.2 Ayurveda is scientific

Many Ayurvedic practitioners perceive Ayurveda as a system that has a scientific basis. For example, Deepak Chopra, has been influential in situating Ayurveda within the paradigm of quantum physics. UK graduate Thelma described her perspective:

> Q - In terms of, say, the pharmaceutical companies or scientists – they have a particular paradigm which they…..
> Thelma - Absolutely.
> Q - What's your opinion on that?
> Thelma- Well, the curious thing with that is that, **if you read books like Deepak Chopra, you've got the quantum theory, which goes back to – starts with Einstein, in the 1920s.** Did you go to that meeting where that scientist … well, he was illustrating, **the Newtonian way – is what most modern chemistry is based on, and this is the way that chemical drugs are sort of manufactured…. ….from this kind of theory, but it's a limited theory, whereas the Einstein theory is going beyond it, and this is going back to Ayurveda, so you're seeing… I mean, it's just that modern medicine hasn't really caught up with the …**, and **they are actually going off on a wrong tangent with their medicines. They need to stop and take on board that this new scientific discovery is actually going to lead them back to the very premise really of Ayurveda.**

This illustrates the many meanings that are carried by the concept of science.

5.8.3 Research for quality and credibility

Other interviewees were cautious, but felt that there is a role for research and that is to assure quality standards of herbs, rather than to measure their efficacy.

> Q How important is research in Ayurveda?
> Dr Rajesh: I think it is very important. There are a few reasons at the moment. The research many not be important in Ayurveda for earlier days. Today also it may not also be important, but it is important for specific reasons why. We don't know how the **soil is contaminated**, or **how much the medicine potency is, what potency these medicines have**. I think to identify the proper herbs the potency of the herbs and once the herbs are manufactured what quality they have. The **quality control** has to be done on Ayurvedic herbs. That be one think and I think the authenticity of the Ayurvedic drs ..?
> Q apart from that is there any research necessary in Ayurveda?
> Dr Rajesh: Ah.. **I don't feel like research is very necessary in Ayurveda unless to clarify this science to other people science**. I don't know if its required for the public, I don't know that.

In addition, some practitioners in this study felt that research is necessary to convince the 'non believer' scientists. UK graduate Aarti shared her thoughts about research:

> Aarti - I think research is very important, particularly because the whole thing is now, no matter if you say it's been working for thousands of years, but research has to provide the evidence. Without the evidence, people are not going to **westerners** are not going to modern **medicine** is not going to accept it. So we have to. **Yes it's a pity, but we have to do it.**

Similarly, Sharma (1995: 99) reports that many CAM practitioners want scientific research for public credibility, but have concerns about methods such as randomised controlled trials as they are inappropriate or irrelevant to assessing CAM. Most practitioners rely on the clinical benefits that their patients experience as their evidence. The treatment outcomes sustain their practice, rather than laboratory based experimental research. On the ground level it is likely that a patient will recommend a practitioner through word of mouth if they have benefited from a treatment. Sharma (1995: 127) found that most users are pragmatic and eclectic; they are more interested in efficacy rather than theory. Medical convert Pritesh described this scenario from his own experience:

> Pritesh - A lot of it because I would come across it daily, like even last week, last week I had this patient, now he has been suffering from acne. so many, ... **he goes to the doctor, they gave him something, he's fine for a few months then it flares up again**, and he has really got fed up, so I said, and he's also got it back here now, so I said do you want to try something. He says yes. I want to get rid of it. I don't want it coming back, no point in coming back is it, as I am already taking medicines. **All I did was give him a *neem* wash**. He took it on a Friday, Sunday evening he rang, he says it has made a lot of difference. I said what in 2 days? He said yes in 2 days, it has made a difference. Then i spoke to him on Thursday, I said how are you? He says its gone ....**.. it's daily I come across it.**

UK graduate Aarti described a similar experience where the outcome of a treatment is key for patients rather than experimental research results.

> Aarti - Now I get both. You know Asians have English friends and I also have English yoga students. So **even though for them its alien to start with, but they get the benefit, they are happy to come in. Again, particularly the therapies. There are so many people suffering from back problems, and if they get the benefit of *Kati basti* they want to come again.**

For practitioners, treatment outcomes are the proof of Ayurveda's efficacy. The proof is in the healing, not the results of a research trial. The Ayurveda practitioners in New Zealand in Murthy's study (2010: 53) had comparable opinions whereby 'credibility amongst the public is more important for Ayurveda than credibility from government authorities'. Similarly, Robinson et al (2012: 611) found that professional acupuncturists were more likely to perceive experience-based evidence as important and downgrade the value of evidence produced in research trials. They reported that previous research in Australia

indicated that professional acupuncturists' interest in research declined as they developed their clinical experience.

5.8.4 Research is necessary

Research is a contentious area among the UK Ayurveda practitioners, but given the current financial burden on the NHS, solutions are required to deal with the crisis situation. Low cost CAM treatments are one possibility as the cost effectiveness is appealing (Bivins, 2010: 185), however referring patients for CAM still incurs costs, one estimate being up to thirty five million pounds per year (Wye, 2012). This means an evidence base for Ayurveda is required, and could be a determining factor for its wider recognition and acceptance.

In India there has been a concerted effort to use modern research techniques to undertake scientific research on Ayurveda (despite the difference in paradigms). The Ministry of Health and Family Welfare has an Ayurvedic research wing, the National Ayurveda Institute for Research (Murthy, 2010: 17). The two main governmental health research councils are the Central Council for Research in Ayurveda and Siddha (CCRAS) and the Indian Council of Medical Research (ICMR). Both undertake research projects to develop an evidence base for Ayurveda. CCRAS has thirty-eight research centres in India and many collaborative projects with universities and hospitals, and undertakes literary, clinical and drug research in Ayurveda which is funded by the Indian Government.

Some practitioners have endeavoured to explain the Ayurvedic concepts in modern scientific terms. For example, Hankey (2001: 567) in his paper 'Ayurvedic physiology and Etiology: *Ayurvedo Amritanamm* interprets the *doshas* and their functioning in terms of contemporary biology and physical chemistry' relates the *doshas* to the modern scientific framework of systems theory, phase transitions and thermodynamics (see also Hankey, 2005a, 2005b, 2005c).

5.8.5 By-passing research

The findings showed another strategy that some practitioners were adopting by taking a pragmatic route around the differences in paradigms and overcoming the perceived hostility from the biomedical profession mentioned earlier. Medical convert Ben suggested a way forward is to work with GPs directly.

> Dr Ben- …. **my thinking was eventually to get the doctors to refer patients. ….. I did do talks for doctors in Scotland and had quite a lot of success. 10 % of doctors attend talks**

on Ayurveda. Might lead to a huge response, lot of referrals and consultations. I thought far better to devote the energies to dissipate Ayurveda and as people come to their GPs.
Q - what do you hope the GPs to do who are converted to Ayurveda ?
Dr Ben - Refer to us because we are the experts. And those who are very interested take training.
Q - In what circumstances would they refer?
Dr Ben - **They have got a lot of patients they are fed up of seeing.** Because they are not making any progress and those are the ones they want to get off their books. Because GPs … they know their limitations. If they felt something is good, helpful for these chronic conditions, they would be more than happy to refer. But have to be actually convinced, there is evidence to show it works…..there is peer pressure and lack of scientific research.

UK graduate Aarti illustrated that developing a relationship with GPs and gaining their trust had resulted in her getting referrals on the basis of positive treatment outcomes.

Aarti - **I have helped several GPs with their own problems and they get converted. They are happy to try those things. They are actually phoning and asking us for help. I think the more we interact with western medical professionals and the more evidence they see, not just research, it's personal interaction**. E.g. my next door neighbours, both doctors. The wife came to the conference and she knows what I am doing, so it is that sort of thing. She also knows the type of person I am. She knows, I will not be doing anything, you know .. it's through **trust** as individuals and through evidence of efficacy**, evidence of success.**

Aarti - I had a patient with very bad psoriasis for past 12 years, ears bleeding, whole body a mess. She had been under a GP for 14 years, they had good relations. I did not expect the results we achieved in such a short time. 3 months. **So that GP his own niece is suffering. He is happy to send his own niece to me. These are the type of things.**

Aarti - My own GP refers some patients to me. She was one of the senior doctors in the practice, she has retired. When she saw third degree burn and a week or ten days later no scars, she said **'If I hadn't seen both situations with my own eyes, I wouldn't have believed it. And the only thing the person was doing was applying fresh Aloe Vera gel.'**

GPs may trust Ayurvedic practitioners if their system works, though it is not the accepted authority. They accept and put trust in another system, because they know the limits of their own system. Cant and Sharma (1999: 99) say that though the official voices of the biomedical profession call for more scientific testing of CAM, a large body of general practitioners refer their patients to CAM or offer it themselves, which shows that they are not waiting for research to endorse CAM. Cant and Sharma (1999: 121) also suggest that many GPs in UK are eager to practise CAM, despite lack of evidence for proving their efficacy. [99,100]

[99] Partridge (2005: 26) suggests a mechanism for this how this acceptance may occur. As CAM began to be introduced, nurses took an experiential and pragmatic approach to it e.g. if acupuncture worked, then it would be hard to discard it just because it *should not* [authors emphasis] work according to medical theory of cell, organ, system and integrated systems. If past life therapy cured major neurotic patterns, psychiatrists and psychologists decided it did not matter whether the past lives were 'real' or not. If the therapy worked it would be used. Partridge says that this approach is in line with the subjective turn and contemporary occulture and the range of therapies are drawn from wellbeing occulture.

Given the emphasis on treatment outcomes, it appears that building relationships is one way around the research barrier. It seems that despite the formal requirements of objective experimental evidence, at a practice level, GPs will consider clinical evidence. In practice when working with patients who are suffering, the clinical significance is acceptable over and above statistical significance. Further, building a relationship based on trust is important and may override formal requirements. Murthy (2010: 72) suggests that the focus has been on the scientific validity of CAM as a prerequisite for integration with the mainstream, but the political, social and cultural factors that contribute to health care provision also need to be addressed.

In addition, the majority of CAM users are directed to CAM practitioners by recommendation from friends, family or local networks, rather than by advertisements or through media (Cant and Sharma, 1999: 35). This supports the findings that 'word of mouth' is an important route for patients to find a practitioner. Reed's (2003: 133) study also showed that people use CAM on the recommendation of family and friends. CAM users tend to depend on personal recommendation as this gives the reassurance that the practitioner is 'tried and tested', and tend to be disinterested in the credentials of the therapist (Cant and Sharma, 1999: 48).[101] Austrian journalist and cancer patient Kurt Langbein reported that patients take a pragmatic approach to CAM:

> "Patients look for professionals whom they can trust in their efforts to come to terms with their illness. Trust needs more than the perfect chemo or the impeccable surgery and it needs more than being a nice person. It needs expertise in methods and procedures that enable the patient to meet his own challenges and it needs people who are not afraid of patients. Much of the medicine we encounter is afraid of the patients as persons". http://www.cambrella.eu/home.php?il=213

To summarise, some practitioners and Ayurveda institutions in South Asia have resigned to adopting modern research frameworks in order to find evidence to support the efficacy of Ayurveda, and much effort is being made to make Ayurveda a parallel system of medicine to biomedicine. The attitude to modern research is different on the ground, whereby

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[100] Barnum (cited by Partridge, 2005: 26) describes a circular process by which occultural influences become a part of everyday life. For example, a medical professional is introduced to a new therapy; the therapy for whatever reason, works; it is adopted; the worldview of the practitioner shifts in order to accommodate the new worldview; the worldview is reinforced; a broader range of therapies is introduced, and so on. The conclusion is 'there must be something in it' which implies there must be something in the worldview in which it is embedded. In this way, previously exotic occultural beliefs and practices are contextualised and detoxified. This process may happen over many years, but is an important one.

[101] This indicates that the emphasis on professionalization and training is more of a state imposition rather than a consumer expectation.

practitioners feel practice based evidence is more significant and are communicating directly with mainstream medical practitioners by sharing clinical experience.

Nevertheless, CAMbrella has collaborated to develop a roadmap for future European research in CAM that is appropriate for the health care needs of EU citizens, and acceptable to the EU Parliament as well as national research funders and healthcare providers. According to this group, research is required to establish credibility and to be accepted by European parliament, national research funders and healthcare providers.[102]

> "We will enable meaningful, reliable comparative research and communication within Europe and create a sustainable structure and policy". www.cambrella.eu.

The need for research is contentious whereby practitioners regard practice based evidence as significant for their clinical work, while at a political level there is a need to comply with requirements to standardise information about CAM treatments. This tension is exemplified by how practitioners assign authority to the Ayurvedic texts and modern research findings, which is discussed next.

5.8.6 Classical text vs. research

Although the Ayurveda community agree for one reason or another that research is of importance, either to assure quality standards or to convince the mainstream establishment, most practitioners said they would question research if it were to contradict the teachings of the classical texts. Medical convert Dr Ben gave his sceptical view of research that contradicted the texts. Rather than accepting the texts as wrong, he would question the interpretation of the texts as that could be the cause of the discrepancy:

> Q - If you were present with research which contradicted the text, which will you accept?

[102] CAMbrella was focused on academic research groups which do not advocate specific treatments. The specific objectives were: to develop an EU network involving centers of research excellence for collaborative research; to develop consensus-based terminology widely accepted in Europe to describe CAM interventions; to create a knowledge base that facilitates our understanding of patient demand for CAM and its prevalence; to review the current legal status and policies governing CAM provision in the EU and; to explore the needs, beliefs and attitudes of the EU citizens with respect to CAM. The aim is to create a roadmap that will enable a sustainable and prioritised EU research roadmap for CAM. CAM is very prevalent within Europe but the picture of CAM use across the whole EU is unclear and CAM research is not coordinated and with no strategic plan, resulting in significant evidence gaps for CAM regarding prevalence, effectiveness, efficacy, safety and costs. By establishing a solid evidence base, European citizens and medical/non-medical healthcare providers will be able to make informed decisions about CAM utilisation, and future European health care challenges such as chronic diseases, healthy aging may be addressed within the CAM field.

> Dr Ben - What will I accept ? I would accept that my understanding of the classical text was strange, wrong. I would have to rethink. But I wouldn't accept necessarily that the scientific research was invalidating the ancient texts. The ancient texts should be read in Sanskrit by someone enlightened for totally correct interpretation. But that's where scientific research will be very helpful. To see our own misunderstandings of the texts.

Dr Ben went onto explain the difference between the sources of classical knowledge compared to modern research (see page 54). His explanation was that the knowledge in the texts has been revealed through people deemed to be enlightened, who access higher levels of knowledge and truths through their intuition which are accepted as authoritative sources of knowledge in this tradition. The personal authoritative qualities of the person accessing the knowledge are more important than the intellectual abilities of a researcher seeking the truth through modern research. Here, a person who has spiritual or *satvic* qualities is deemed to be trustworthy and therefore an authority and perceived to be closer to the truth and therefore having access to the truth. If a person has the qualities of truth then he/she is deemed to be closer to the truth.

> Dr Ben - People who were enlightened could experience how consciousness manifested and when they put it down in simple form in ancient texts they have been proven through millennia to be right. So if one little piece of scientific research comes along and says its wrong, well let's see how much of modern medicine survives another hundred years and how much of all this scientific research is validated. If you talk about scientific research, it is a evolutionary process, over decades, and decades and truth only gradually begins to emerge over one hundred to three hundred years. So yes, research on Ayurveda after three hundred years will be saying yes, they were right after all. One piece of research here or there, two thousand years of validated pragmatic experience.

UK graduate Aarti, asserted that the research results are likely to be wrong due to the poor fit between the modern methods and the holistic Ayurvedic paradigm and lack of research to date that has contradicted Ayurveda. Her reason for accepting the research would be if the classical texts were no longer applicable in the modern world due to changes in environment, climate, soil etc.

> Q - if you found in a research paper, the results contradicted the information that is given in the texts, which one would you accept?
> Aarti - Um..... that's a difficult one, because if they are giving results using modern techniques, don't as we know, they don't fully apply. We have to find a different way, because we are treating the individual so if the same... so far I feel not many things have been found not to work, whenever they have done extensive work. Most times the claims have been justified.
> Q - but in the situation if there was a contradiction, which one will you feel 'I'll accept' research, or I'll stick to accepting the text?
> Aarti - I would still inclined to accept the text unless it can be proved that the potency of the herbs is now so different that they don't work anymore.

Medical convert Pritesh said that he would not immediately accept the research. He would have to ensure that the modern research was not flawed in any way and question its validity, before being able to accept it.

> Q - …. If you came across a piece of research which contradicted what the texts say about something then what would you accept as the truth?
> Pritesh - ..... um..... it depends what it was and .. I would look at it both again, reassess both of them, but .. I would try and find an explanation for it, if there was one, if not then I'll have to accept the research. I would have to because that's how it works because even more in medicine. They do research they find new data and it changes so you have to look at Ayurveda with the same hat.
> Q - So in that case, what would be the reason for accepting the modern research?
> Pritesh - ..... Because it's something that's measured, but then again I think it's wrong because that's based on something it's fixed, we measure something, it's based on observation and then I think to myself, but that was observed as well. So I would really look at it, look at how it was measured, whether there was something wrong with it. If there wasn't anything, I'd still accept it, I'd still accept the research.

The practitioners' quotes highlight the tension between their personal beliefs as illustrated in section 5.2 above and their need to negotiate with the demands of the new environment and working with different epistemologies.

Pordié (2012) reported in a seminar on his field research on the Ayurvedic drug company Himalaya in India that innovation in Ayurveda is the driving force of this industry. The situation is dynamic as this industry re-invents Ayurvedic remedies through overlapping medical cultures (biomedicine and Ayurveda) to create mixed epistemologies, thereby transforming ancient remedies for the global market. The re-invented remedies are different from the classical formulations and used by both Ayurvedic and biomedical practitioners. Pordié (2012) found that the Ayurveda Practitioners (*vaidyas*) are only involved in the very early stages of the creation of new formulations based on information from the classical texts. For example, a plant is chosen for its indications, a new formulation is created, and then the scientists standardise it to enhance the active components and further development. Pordié's (2012) research illustrates the complex situation of different epistemologies being mixed in India.

To summarise, the findings of this study show that different epistemologies are at play, and this is evident by the way Ayurvedic practitioners accept the classical wisdom as it has stood the test of time. Their faith comes from a personal relationship with the knowledge which they have applied and which has helped their patients. They accept a different epistemology which accepts the truth through different channels outside of the remit of modern research tools. For them, scientific research is questionable, as it is evolving and

continues to change. For them to accept it instead of the texts could only happen if the world had changed so much that the texts were no longer applicable.

5.9 Other strategies - Linking opposites (hyphenation - hybridisation)

The findings of this study indicate that practitioners situated themselves in the Ayurvedic paradigm but also connect to the biomedical paradigm. This strategy is interesting for two different reasons. First, I argue that this is necessary for credibility. The practitioners hold the Ayurvedic tradition as authority for internal credibility, while connecting to science for external credibility. Secondly, connecting to two distinct paradigms results in a system which holds paradoxes which are appealing to the human mind. I describe this as 'linking opposites' and suggest it gives Ayurveda an attractive quality, as one does not have to choose either/or, but can retain both seemingly opposite elements. A good example is of Maharishi Ayurveda (appendix 1a) which has been presented as a traditional and authentic version of Ayurveda, but has also been explained in terms of modern science (quantum physics). I argue that this is one of the reasons for the success of Deepak Chopra's books which have been international bestsellers. Dr Lad uses this strategy of 'linking opposites' during his seminars and consultations. For example:

Linking Ayurveda to modern concepts:

Dr Lad – Globulin is *ojas*, liver enzymes are *tejas*

Linking spirituality to biology:

Dr Lad – Ganesh is the remover of obstacles, this prayer will release neuropeptides

Linking the body and mind:

Dr Lad - Herbs and *pranayama* release anger due to psychological trauma

Linking the individual to the universe:

Dr Lad – Our consciousness is part of the universal consciousness

Pordié (2012) reported from his research of the Himalaya Company in India, their use of scientific marketing directed specifically towards biomedical practitioners, which brings credibility to the company. Himalaya has contemporised Ayurveda by validating it through modern scientific research. Ayurveda discourses are embedded in biomedicalised frameworks. The reformulation regime for developing new herbal products is based in a biomedical framework. Despite being embedded in the biomedical framework, Himalaya still promotes Indian nationalism and its great ancient Indian culture, indicating that Ayurveda practitioners work in multiple realities, which illustrates fluid identities and the need for different validities.

5.10 Fluid Ayurveda

Some of the interviewees described the purpose of Ayurveda for health maintenance and prevention of illness. This emphasis is because Ayurveda is perceived as an all-encompassing system dealing with many aspects related to health, but also modern medicine has created a vacancy (Abbott, 1998)[103] for CAM which offers preventative treatments. Reddy's (2002: 105) study of Ayurveda in the US shows that different aspects of Ayurveda are promoted: Ayurveda as a system of dietary restraint, of naturalistic massage, of metaphysical science, or of spiritual practice (though Reddy does not clarify the difference between metaphysical science and spiritual practice).

Reddy's (2002: 100) findings illustrate that the focus can shift to different aspects of Ayurveda depending on the context. I argue that the perception and representation of global Ayurveda as a comprehensive system, with many treatment modalities, is a key feature for its survival outside of South Asia. It appears that Ayurveda is a fluid system which can change according to the environment. Practitioners access different aspects according to need and circumstance.

Although I argue that Ayurveda is a fluid system, some literature also suggests that biomedicine is also a fluid system. Given the biomedical professions dislike for CAM systems, I next examine the changes occurring in biomedicine which is developing in ways to become more holistic like most CAM systems.

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[103] Abbott (1998), in his book 'The System of Professions', explores questions about the role of professions in modern life. The questions include: Why should there be occupational groups controlling expert knowledge? Where and why did groups such as law and medicine achieve their power? Will professionalism spread throughout the occupational world? Abbott builds a general theory of how and why professionals evolve through comparative and historical study of the professions in nineteenth- and twentieth-century England, France, and America.

5.10.1 Biomedicine becoming holistic[104,105]

According to Brady et al (cited by Reed, 2003: 11), Western and non-Western medicine should not be seen as binary oppositions as it is a false dichotomy and biomedicine is becoming more holistic and incorporating elements of religion and spirituality into its approach. It is no longer a straightforward task to draw the line between biomedicine and other forms of healing as there is no simple binary division of healthcare (Cant and Sharma (1999: 121).They report that biomedical practitioners claim that biomedicine is holistic as it attends to the whole person (page 100-101). Groups such as the British Holistic Medical Association, say that biomedical holists stress the mind-body link, the importance of the patient's own subjective experience, and the need for compassionate physicians. Sharma (1995: 94) reports a high level of interest in CAM amongst GPs, and some have training in CAM. CAMbrella's recent research on CAM in Europe reports an example of CAM becoming part of healthcare hospitals in Paris.[106]

A further example of the mainstream healthcare's move towards adopting holistic approach is of Prince Charles accepting an invitation from the British Health Secretary, Alan Milburn, to oversee the design of new NHS hospitals. Several important DH publications have had a clear emphasis on developing spirituality within the context of healthcare: Patients Charter (1991); Meeting the spiritual needs of patients and staff (1992); Your guide

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[104] According to Sharma (1995: 7), the term 'holistic' refers to treatment of the whole person. It is used synonymously with CAM, but biomedical practitioners also claim to use a holistic approach. The term 'holistic' does not in itself distinguish between CAM and biomedicine. Sharma (page 72) illustrates the use of the term with the following example: diverse issues such as poor digestion, nervous tension, ear problems, and bad breath are linked using a holistic framework.

[105] Sharma (1995: 111) – in the medical context holism refers to the kind of care which treats the patient as a whole. This has 2 implications: firstly the person should not be treated as a mechanical body, but as a person in a social context with psycho-social and even spiritual needs in addition to physical needs. Secondly, at a professional level there is a need to address over specialisation i.e. different people dealing with different systems.

[106] Cambrella newsletter- www.cambrella .eu: The Paris hospitals have adopted a strategic plan to include, evaluate and integrate CAM in their services. The 'Assistance Publique – Hospitaux de Paris' (the organisational body for the public hospitals of the City of Paris. It is the largest hospital system in Europe, employing about 90,000 health professionals) will include CAM services in their routine care programmes. Additionally AP-HP tries to better the knowledge about possible contributions CAM might have in treatment strategies: lack of clinical research is stated in a report from May 2012 that lays the ground for the strategic plan and gives detailed implementation recommendations for CAM in a public hospital environment. Dr. Catherine Viens-Bitker was in charge of the report and is now heading the implementation process. While many patients, especially those with chronic conditions, use CAM in private practices in the city, the hospitals have no structured knowledge about the possible benefits of these treatments. And while many health professionals have included CAM practices in their personal professional portfolio, the public hospital system does not profit from this expertise. The plan is to develop CAM in the Parisian hospitals along four lines: best practices, research, TCM and occupational health.

to the NHS (2001); NHS chaplaincy meeting the religious and spiritual needs of patients and staff (2003) (Partridge, 2005: 28)

In addition, nursing has been an area within the biomedical field which has been open to considering the patient's personal spiritual beliefs (Sharma 1995: 94). Watson (1995) said that models of nursing emphasise the acceptance of the interdependence of the physical, spiritual and environmental aspects of patients' lives. In addition, some nurses have trained and practise certain CAM therapies. This may also give them another area of expertise. Other scholars such as Barnum (1996) have also shown that spirituality is 're-entering the domain of nursing interest and practice' (Partridge, 2005: 27).

The changes are occurring at all levels of the biomedical field; for example, a study of oncologists illustrates that the roles of biomedical practitioners are no longer clear cut as health care modalities are borrowing from each other, resulting in a blurring of identities. Broom and Adams (2010) illustrate this with an example from their research on the reconfiguration of the role of oncologists who are adapting to and co-opting ideas about the individual and patient centred consultations. They argue that as a profession they are absorbing aspects of CAM practice and ideology as they seek to address the limits of their own profession. An alternative view may be that biomedical doctors do not perceive CAM as a threat to their own position. They assimilate CAM practices such as acupuncture into their body of knowledge to limit competition (Cant and Sharma, 1999: 101).

The shift towards the integration of spirituality and healthcare has been significantly aided by political interest which is a reflection of wider cultural and social shifts.[107] However, I argue that although biomedicine maybe taking a more holistic approach and a blurring of identities may be occurring, the underlying paradigms remain distinct. For example, the basic premise of Ayurveda is that a person has a metaphysical component (*purusha,*see page 32), whereas the biomedical model does not recognise this.

The findings showed that Ayurveda practitioners keep one foot in the Eastern paradigm and the other in the Western paradigm, in order to negotiate between an ancient system

[107] Partridge (2004: 52) suggests that the interest in spirituality is an example of re-enchantment in the way that medicine, a modern science based profession is witnessing a rise of interest in New Age healing. E.g. Nurse's Handbook of Alternative and Complementary Therapies. Holistic approaches to illness and 'the spiritual' are increasingly being explored and utilised in mainstream medicine.

embedded within a cosmological holistic framework and modern science based on reductionist philosophy in order to find a place in the modern world. The shifts are occurring in both directions, as biomedical practitioners are adopting and adapting non-biomedical techniques into their own practice (Cant and Sharma, 1999: 182).Therefore, neither biomedicine nor CAM is a simple entity. Both are a complex of subgroups and interests and overlap to different degrees (Cant and Sharma, 1999: 84). Neither CAM nor biomedicine is monolithic.

5.11 Conclusion

The aim of this chapter was to describe the way in which Ayurveda practitioners negotiate the landscape in order to transplant an Eastern system of healing into a new environment. I refer back to the quote by Sharma (1995: 176) at the beginning of this chapter. The data shows that Ayurveda practitioners take pragmatic steps and develop various strategies to manage the contradictions they face as a result of being transplanted in the West. One of the principles of Ayurveda is to adapt to 'time, place and circumstance'. Ayurveda cannot be seen as static, but as a process, and Ayurveda practitioners actively shift positions and construct their identities according to the context. This may reflect the postmodern perspective which suggests that the postmodern subject has no fixed identity. The unified, completed, secure and coherent identity is a fantasy.

From the patients' perspective, Reed (2003: 14) suggests that health choices cannot be constructed as single narratives but change according to time and context. The implication is that practitioners need to be responding to the changing health choices, and this can only happen if practitioners remain flexible and practices are fluid.

The fluidity is evident on both ends, as biomedicine, though based on a reductionist paradigm, is incorporating features of a holistic approach to healthcare, in response to public demand, and while Ayurveda based on a holistic paradigm is changing and responding to the state restrictions. The two distinct systems are changing in ways that appear to blur the boundaries between them, though the underlying paradigms of both systems remain distinct. Biomedicine continues to be based on reductionism, which enables it to be tested by modern research methods and keep its hegemonic position through validation by science. Ayurveda, despite the changes through biomedicalisation in India (and to some extent in the training programme in the UK), continues to be based on

humoural theory and balance between the microcosm and macrocosm and appeals to sections of the population seeking a holistic approach to healing.

The findings showed that fluidity and flexibility are not only important as survival strategies for marginalised systems such as Ayurveda, but also for dominant systems like biomedicine to keep their hegemonic position.

In the next chapter the changes to clinical practice that occur when an Eastern system of healing is transplanted to the West are discussed.

Chapter six Simplification or Spiritualisation? The processes shaping Ayurveda practice in the UK

6.1 Introduction

In Chapter one I briefly outlined the changes that have been occurring to Ayurveda practice through history, showing it to be a dynamic, interactive system. In Chapter five, I showed that Ayurveda practitioners in the UK negotiate a landscape made up of the holistic milieu, the State, and the biomedical profession and have developed various strategies to manage the various contradictions presented to them. The influence of the holistic health milieu provides a context in which Ayurveda can flourish as a system of healing for the mind, body and soul, whilst the Ayurveda practitioners perceive the State as imposing restrictions on their practice. In this chapter I examine the changes to Ayurveda clinical practice in a new environment in the UK and illustrate how Ayurveda practitioners adapt to the different circumstances, and what strategies they adopt to survive.

The academic literature on global Ayurveda describes two distinct processes of simplification and spiritualisation as significant in shaping Ayurveda practice in the West. Some scholars suggest that the process of spiritualisation has resulted in a spiritualised version of Ayurveda in the West (Zysk, 2001: 11, Reddy, 2002: 99, Warrier, 2009: 1, Zimmerman, 1992: 221). Practitioner researchers suggest that a process of simplification has resulted in a simplified practice in the West compared to South East Asia (Svoboda, 2008: 127, Welch, 2008: 137, Pole, 2008: 216, Bruwer, 2009: 24-26). Alter (2005: 122) suggests that State restrictions are likely to be driving the changes for the simplification of practice.

Warrier (2011b: 11-17), in her study of UK graduates, identifies three transformations in the practice of Ayurveda in the UK. According to her findings, the spiritual seekers (who I refer to as UK graduates, see page 82) have assimilated Ayurveda into a paradigm of seekership which has led to the following three changes: Firstly, Ayurveda has become a system for enhancing self-knowledge for individuals seeking an understanding of their *prakriti* or Ayurvedic constitution, which enables them to know their individual psycho-somatic type. Secondly, Warrier suggests that Ayurveda has become psychologised and

recast in a mind-body paradigm.[108] This is a result of the way in which Ayurveda has been popularised by the popular writers Lad, Svoboda and Chopra. These changes are resulting in a practice –orientated spirituality. Thirdly, Warrier reports that the spiritualised and psychologised forms of Ayurveda offer an implicit critique of modernity (in terms of modern lifestyle) and biomedicine.

Given the various interpretations, I have examined whether practitioners in the UK embrace the spiritualised version of Ayurveda or another version. Reddy (2002: 128) suggests that it is important to look at the actual clinical encounter to understand the transformation of Ayurveda in the West, which I do next.

6.2 What is shaping Ayurveda in the UK?

Given the various influences, I examined whether practitioners in the UK embrace the spiritualised version of Ayurveda or another version. The findings of my study show that the processes of simplification and modification are shaping the practice of Ayurveda in the UK. Simplification of practice is occurring both in quantitative and qualitative ways, and the process of modification includes the hyphenation and hybridisation of Ayurveda with other healing practices (see Fig 6).

[108] In parallel, Carrette and King (2005: 117 - 118) argue that the psychologisation of yoga erases the cultural context and institutional setting of the practice. By detaching yoga practices from the culturally specific belief systems of Asia, they can be universalised for a global context. This may be seen as the development of a more universal spirituality, but this does not leave yoga in a free floating decontextualized state. Western psychology is not culturally neutral as it has its own metaphysical context and value system. Therefore yoga is recoded in terms of modern psychological discourse and the individualist values of western society into which it is transplanted. In this way yoga loses much of what is counter-cultural, transformative and challenging to western cultural norms. Instead it is secularised, de-traditionalised and oriented exclusively to the individual.

Fig 6. **Processes of change in the practice of UK Ayurveda - The Simplification and Modification Model.**

Fig 6.1 The processes of quantitative simplification at the clinical level.

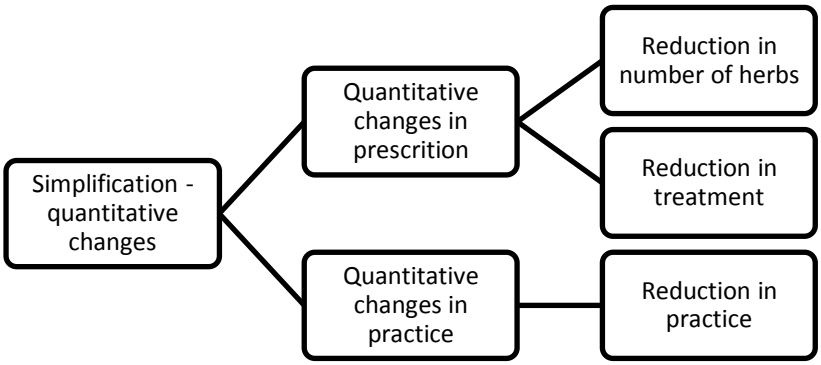


Fig 6.2 The processes of qualitative simplification at the clinical level.

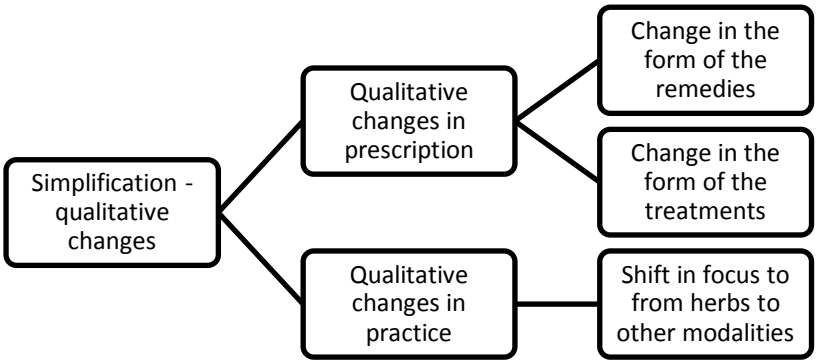


Fig 6.3 The processes of simplification at the ideological level.

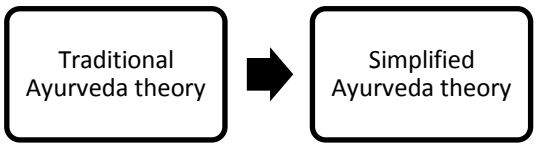
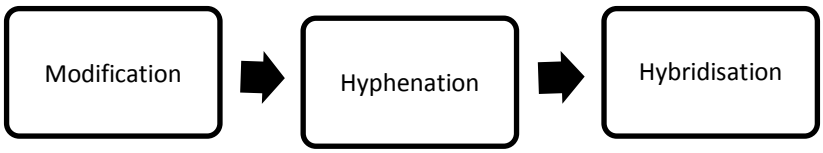


Fig 6.4 The processes of modification at the clinical level – Hyphenation and Hybridisation.



6.3 Quantitative Simplification of Ayurveda practice.

Quantitative simplification is occurring both in the prescription, which includes a reduction in the remedies and treatments that are prescribed, and in the range of medical conditions that are treated. Fig 1.1 outlines the quantitative simplification of the practice.

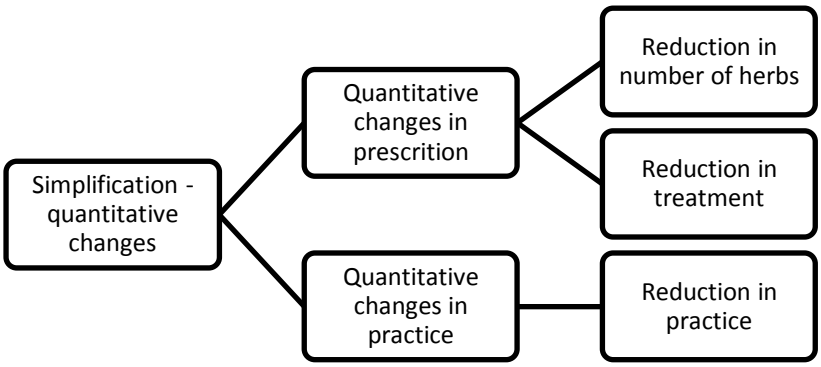


Fig 6.1 The processes of quantitative simplification at the clinical level.

6.3.1 Quantitative Simplification – reduction in number of herbs

Practitioners described resorting to using remedies which have a reduced number of herbal components, i.e. changing from multi herb remedies to single herb remedies. South Asian graduate, Dr Dhani, described her predicament:

> Dr Dhani - The motto I have, because of all the things going on around here – you cannot prescribe this herb, or you cannot prescribe that herb, you keep on going and checking it **and I just have decided that I give more of the simple herbs** …..

In addition, with the implementation of the EU Directive 2011, ready-made remedies were banned, and as a consequence practitioners cannot prescribe remedies made up of a combination of herbs, they are required to make up the prescriptions using single herbs. The findings show that this has not deterred the Ayurvedic community, as one practitioner commented at a meeting:

> [We] will need to go back to the old way of combining herbs
> (APA multi-track event, 14.5.11)

The implication of the regulations and subsequent limitations is that practitioners are 'going back to basics' and making up their own formulae rather than relying on ready-made combinations. Therefore the nature of the practice is changing as they purchase single

herbs and make up their remedies. Practitioners are optimistic and working creatively to find ways around the restrictions in order to continue their practice.

Pordié (2012) examined the formulation regime at Himalaya, a large Ayurvedic pharmaceutical company based in India, and found that simplification was also occurring in developing herbal products for the global market. Fewer or single herbs were used instead of the classical multi herb formulae. Therefore simplification as a result of globalisation is also occurring in India.

6.3.2 Quantitative simplification – reduction in treatments

Practitioners gave examples of simplification taking place in ways other than changes in the herbal prescriptions, including changes to the treatments. Ayurvedic *Panchakarma* treatment is a key method of treating medical conditions, involving a series of processes lasting from several days to weeks, which aim to cleanse the mind-body system at a very deep tissue level. In the UK, few practitioners have clinics with facilities to carry out the long complex procedures. Practitioners described employing simplified methods based on principles of detoxification in an attempt to achieve similar outcomes. For example, South Asian visiting practitioner, Dr Neha, explained how she uses a modified technique to achieve detoxing effect:

> Q - Are there any alternatives people can try without the panchakarma here?
> Dr Neha - Yeah like the detox plan that I always give to the people. 2 or 3 days of just ginger water fasting then 5 days of *moong* soup fasting only, then another 10 days of *moong* and vegetables only, then slowly slowly coming back to normal diet …

6.3.3 Quantitative Simplification – reduction in practice

Practitioners described changing from a comprehensive clinical practice treating a wide range of health issues to a focused clinical practice treating limited health issues. South Asian practitioner, Dr Dhani, described her predicament of being restricted in choice of treatments and as a consequence focuses on what she believes to be the key aspects of health such as ensuring good digestion and prescribing simple herbs:

> Dr Dhani - … **we go only on the digestive system as much as possible**, once you've done check on that.

Here, the practice is changing at the stage where the practitioner decides what he/she will treat, whereas above I described the simplification occurring at the stage of what the

practitioner is able to prescribe. Hence, there are changes at different stages of the practice.

Research on acupuncturists in Europe has shown similar changes in practice as they tend to specialise in certain areas, for example focusing on treating children and gynaecological issues (Robinson et al, 2012: 610). Other research shows that the acupuncture practice in Europe is skewed towards musculoskeletal pain and away from the more serious internal problems. This indicates a tendency for CAM practitioners of Eastern traditions to develop specialised practices in Europe, which is ironic considering a key feature of CAM is to employ a holistic approach and treat the individual as a whole rather than specialise and treat the individual in parts.

In addition to simplifying practice through compromising and finding substitutes for Ayurveda remedies and treatments, some practitioners mentioned qualitative simplification by adapting their practice by adopting alternative treatment modalities.

6.4 Qualitative Simplification

Qualitative simplification refers to the change in the nature of the remedies, treatments or practice.

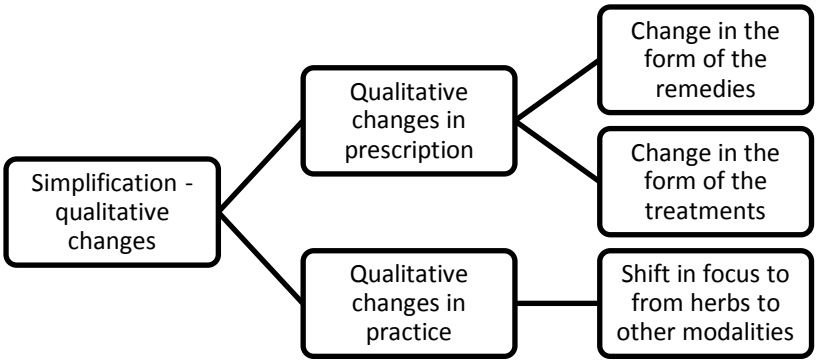


Fig. 6.2 The processes of qualitative simplification at the clinical level

6.4.1 Qualitative simplification of herbal remedies

Pole (2008) writes that practitioners are forced to find alternatives to substances that are banned in the UK. This is resulting in practitioners having to use simple formulae, as the traditional remedies produced in India are unavailable and do not meet the quality and safety requirements of the European Union (Pole, 2008: 217). Pole (2008: 222) suggests that practitioners need to use more simple forms of medicine such as *churnas* (powder) and *kshayas* (decoctions), or even try new forms such as tinctures. This is contrary to Zimmerman's (1992: 211) argument that Ayurveda pharmaceutical process has been intentionally simplified to make it appealing to the West.

Qualitative simplification also refers to practitioners changing from complex forms of medicine to simple forms of medicine due to non-availability of herbs which are endangered. Pole (2008: 216) argues that environmental pressures are leading to many plants becoming endangered species and therefore unavailable for use as medicines. A full Ayurvedic pharmacopoeia is neither available nor approved for use by the regulations in the UK, which automatically limits the clinical recommendations that can be made and may affect the efficacy of the treatment.

6.4.2 Qualitative simplification of treatments

Practitioners gave examples of qualitative simplification of their treatments by changing the nature of their treatments, from using complex treatments to using alternative treatments with the aim of achieving similar outcomes. For example, UK graduate Aarti explained how she uses cleansing techniques from the yoga tradition which are easier to administer compared to the more complex Ayurvedic detoxing techniques:

> Aarti - I tell my Ayurvedic patients what yoga exercise they can do. Like I do not practise *vamana* **but I do use yogic technique of *kunjal*, it's a substitute**, what you call in Ayurveda '*sadhya vamana'*, 'easy'. Is a yogic *kriya*. But in yoga, you don't do the massage and the *snehana* and the *swedana,* before the *kunjal*, but I find with the *snehana* and the *swedana* and then the *kunjal*, it works much better. So I combine it.

Therefore UK graduate, Aarti substituted a much shorter and simpler yogic technique for a much longer and complex Ayurvedic treatment. The practitioners demonstrated how they are developing their practices in creative ways, by finding alternatives and substitutes in order to achieve their goal to help patients.

UK graduate, Pritesh, gave an example of prescribing a simple laxative to achieve the effect of the *virechana* procedure which can be described as a form of purgation. So practitioners are compromising the traditional treatments in order to achieve outcomes:

> Q - So really to have an authentic practice you need to be able to offer *panchakarma*?
> Pritesh - I think so, but then sometimes when I look at it, I think we don't need to do all of it. Sometimes I've found, like my son had very bad acne, so I said why don't you just take a laxative, one laxative every two weeks, and I said to myself that's like *virechana*. **So you could sort of compromise and do it that way**.

6.4.3 Qualitative Simplification of practice

Practitioners described qualitative modifications through shifting focus from Ayurveda herbal remedies as key treatment to focus on other Ayurveda treatment modalities (diet, lifestyle, counselling, yoga etc.).

As Ayurveda has several treatment modalities, practitioners were able to find ways around the restrictions by using alternatives, and modified treatments. The onus is on the practitioners to be creative and decide how they want to use the different aspects of Ayurveda in their practice to move forward. One practitioner commented at an event:

> Ayurveda is so broad, so many healing techniques, we will have to get creative and use other ways to help people
> (APA multi-track event, 14.5.11).

This happens in a number of different ways: in terms of the recommendations they make, the focus of their practice, and the incorporation of other Ayurveda or CAM modalities. Medical convert, Dr Ben, described how other modalities could be employed:

> Q - Your role of herbal medicine. Can Ayurveda be practised without herbal medicine?
> Dr Ben - Absolutely. When you are thinking of **lifestyle routine, diet and digestion, the mental aspects, the emotional aspects, spiritual aspects, yoga and range of therapies in panchakarma**. So many, it will continue. Herbs are only one aspect, but we want Ayurveda to be holistic.

In parallel, research on the changes in TCM practice found that individual practitioners work very differently in Europe compared to China and use practices which in themselves are diverse and may include; herbal medicine, acupuncture, cupping, [109] moxibustion,[110] tuina,[111] qigong[112] and dietary therapy (Robinson et al, 2012: 604).

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[109] In cupping therapy, cups are placed on the skin to create suction. The cups can be made of a variety of materials, including: glass, bamboo or earthenware. Supporters of cupping therapy believe the suction of the cups mobilizes blood flow to promote the healing of a broad range of medical ailments.

Most Ayurvedic practitioners associated yoga and Ayurveda as related systems and many said they incorporate yoga as part of their recommendations. Yoga is taught on BAMS courses in South Asia and is also included in the UK Ayurveda training courses. This appears to be common to global Ayurveda in other countries, as Murthy (2010: 26) found in his study of Ayurvedic practitioners in New Zealand and Stahle (2010: 247) in his study of Ayurvedic counsellors in Sweden. The recommendations may be to perform certain yogic exercises, or breathing techniques:

> Yoga is a part of Ayurveda – so we should sharpen our skills in these other areas and have a wider eclectic practice
> (APA multi-track event, 14.5.11).

Yoga has played a significant role in introducing Ayurveda to a wider group, going beyond the Indian migrant community. Yoga popularised in the West has been a route to introducing Europeans to an Eastern tradition and philosophy, Sanskrit vocabulary and an alternative method of well-being (Newcombe, 2008b). Through yoga, people have become familiar with a different paradigm and vocabulary, which has facilitated the understanding and acceptance of Ayurveda.

6.5 Simplification at Conceptual level

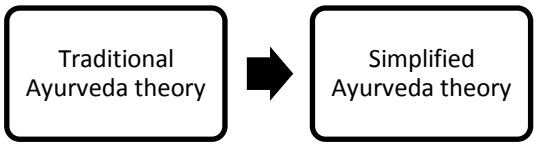

Fig 6.3 The process of simplification at the conceptual level

In addition to the quantitative and qualitative simplification of remedies, treatments and practice during the consultation, practitioners described simplification of Ayurveda at a conceptual level. For example, they said they that instead of giving complex explanations of Ayurveda theory they give simplified explanations of Ayurveda theory.

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[110] Moxibustion is a form of fire heat treatment that stimulates specific acupuncture points of the body. The term is derived from the Japanese "mogusa" meaning herb and the Latin "bustion" meaning burning. A small, cone-shaped amount of ‘moxa’ is placed on top of an acupuncture point and burned on the skin.

[111] Tuina is a specialised system of Chinese medical bodywork. The emphasis of Tui Na (tuina) is to identify and change soft tissue that has become pathological or problematic as well as correct dysfunctional movement patterns. It relies on the same understanding of the body as acupuncture; it is sometimes called acupressure, though it is a far more developed system than simple acupressure.

[112] A Chinese system of physical exercises and breathing control related to tai chi.

The ideological simplification of Ayurveda has been noted elsewhere. For example, Bruwer (2009: 24) describes the process of simplification in her MSc dissertation in which she examines how Ayurvedic practitioners incorporate Ayurvedic dietary principles in their consultations in a western context. Most introduce basics like '*ghee*' (clarified butter) and '*khichari'* (rice and lentils cooked together) as part of their recommendation, while only a few went as far as explaining the six tastes suggesting simplification both at a clinical and ideological levels. The Swedish practitioners in Stahle's (2010: 253) study reported working in a similar manner, making small changes that could have a significant impact in the long-term.

Svoboda (2008: 127) describes the practice of Ayurveda in the United States as becoming a simplified version of the practice in India. He illustrates this process by describing the focus on the three *doshas* (humours) in the West as a conceptual oversimplification.

6.6 Modification –The processes of hyphenation and hybridisation - with treatments outside of the Ayurvedic tradition

Practitioners described how they incorporate other healing modalities into their Ayurveda practice. I use the term hyphenation here to denote two distinct treatments or remedies from different healing systems that are prescribed together. I suggest that this is the first step in mixing and matching treatments. The second step is hybridisation, when a meshing of the different systems occurs at a theoretical level to produce a hybrid treatment or remedy.

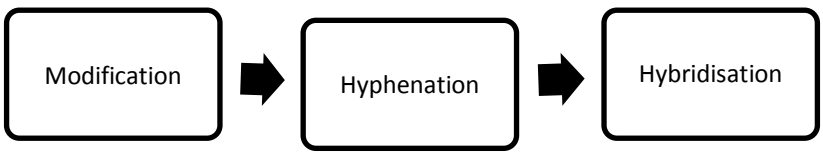

Fig 6.4 Changes in the practice of Ayurveda in the UK - The processes of modification at the clinical level.

6.6.1 Hyphenation – going outside the Ayurvedic treatment to incorporate other CAM practices

Ayurveda promotes the change of practice according to time, place and environment. In line with this, some practitioners are taking advantage of herbs that are common to both the Western and Ayurvedic pharmacopeia. South Asian graduate, Dr Priya, described how she brought together Ayurvedic and Western herbal remedies:

> Dr Priya - … And **that's why my practice probably is slightly different from many people here because I use Ayurvedic herbs as western herbs.** I mean, their preparation is western. I use many tinctures. I don't use Ayurvedic classical formally apart from *triphala*. I don't stock any of those, so I don't give any of these classical medicines. I've never used them. I use *guggul* a lot but I use it as a tincture.

UK graduate Hannah described a similar approach and integrated Ayurvedic and local Western herbs in her practice:

> Hannah - … So I mix that – you know, my Western stuff – with the Ayurvedic stuff, so she's very high *pitta*. She's even got – she's got freckles; She's really small; she's got ginger hair; got a pretty hot temper. So she's getting the anti-*pitta* regimen, **but then I've married it up with herbs that I can use here. So it's horse chestnut ……. So all those things come together really, so I'm not a pure Ayurveda really.** But then, I think I am possibly, because **Ayurveda – I think it is semi-permeable.** It's like the English language. It can allow for the other things to come in it.

In addition to combining Ayurvedic and Western herbs, Hannah brought together Ayurveda and her training in modern nutrition:

> Hannah - The difficulty there has been in having access to the medicines and knowing that you're using an alternative that's only, like, one sixteenth of the possibilities. **So it's had to be more about, you know, dietary counselling which fits in with my degree in nutrition, so that's how I've really managed without a lot of medicines.**

The examples illustrate that consultations are becoming less standardised, and more individualised. This is in terms of treating patients according to their individual constitution and the practitioners selecting treatment tropes according to their personal inclination. For example, medical convert, Dr Kishore, described his practice which includes biomedicine, Ayurveda, Chinese medicine and yoga:

> Dr Kishore - If somebody books an appointment, then I have the room and then I call the client over there and **the first appointment is about one hour,** and **detailed history-taking and making the primary diagnosis, and all other treatments are subsequent to that primary diagnosis**, which could vary from **herbal massage to herbal therapy**, including a few of the ….. *Panchakarma* treatment and – plus **yoga therapy, …..** so I combine together Chinese medicine, Ayurvedic medicine as well as – on the back of modern medicine stuff is there, so I know where the client is coming from so, given **all those dimensions, equally**

> **respected, then I likewise go for the healing part for a particular person on the individualised basis.**

These findings illustrate that the Ayurveda practitioners are adopting the process of hyphenation, as a consequence of the restrictions in the UK environment. It was unclear to what extent Ayurveda was different to the systems it hyphenates with and to what extent it is similar, and this is an area for further research (Alter, 2005: 6). Robinson et al (2012: 604) also report numerous differences in practice, training and regulation between East and West. They (2012: 610) note that EU acupuncturists are more likely to use other CAM techniques combined with acupuncture, although this is likely to vary between EU countries. These findings highlight how acupuncture, like Ayurveda, can be practised as part of a pluralistic medicine, either integrated with Western medicine, as in China, or with other CAM, as generally seen in Europe.

6.6.2 Hybridisation - combining at the theoretical level.

A few practitioners have been adopting this classical advice and making use of local western herbs in their practice:

> Ayurvedic practitioners are herbalists though we use yoga etc. we are surrounded by herbs, growing all around us. Therefore get to know all these local herbs.
> (APA multi-track event, 14.5.2011)

For example, Dr Hans Rhyner[113] has a clinic in Austria and grows local herbs in the surrounding gardens. He prepares fresh decoctions for his patients as required. Like Hans Rhyner in Austria, Anne McIntyre, a Western herbalist and Ayurveda practitioner in the UK, launched her book, *Dispensing with Tradition. A Practitioner's Guide to using Indian and Western Herbs the Ayurvedic Way* and offers an example of a hybrid practice by applying the principles of Ayurveda to local herbs.[114]

Interestingly, Pordié (2012) reports from his research that hybridisation is occurring in India, and illustrates this with his findings from the Himalaya Company which employs both Ayurvedic and biomedical processes to develop new Ayurvedic remedies. The reformulation process involves formulating remedies according to biomedical disease descriptions, homogenising preparations, then simplifying for mass production. The

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[113] Ayurveda Rhyner (no date) [online].[Accessed 9.1.13]. Available from the World Wide Web: http://www.ayurveda-rhyner.com/

[114] McIntyre, A. (no date). AnneMcIntyre.com[online]. [Accessed 26.4.13]. Available from the World Wide Web: http://annemcintyre.com/books/

formulation and description of plant properties are taken from the Ayurvedic texts and then re-formulated to create new Ayurvedic formulations for biomedically defined ailments. The new formulations are stabilised, then given a trademark and labelled as Ayurvedic medicine. These products appear to be closer to hybrids, rather than hyphenated products, as the Ayurvedic and biomedical processes are difficult to separate. Pordié (2012) found that some scholars feel that the Himalaya reformulation regime is a corruption of the tradition, leading to issues around what is authentic Ayurveda.

Hybridity is a disputed term in postcolonial studies. Hybridisation takes many forms including cultural, political and linguistic. The word hybrid has biological and botanical origins, e.g. in Latin it means the offspring of a tame sow and a wild boar (Young, 1995: 6). In the nineteenth century it was used to denote the crossing of people of different races, i.e. people of mixed race, and in the twentieth century it refers to cultural hybridity. Young (1995:18) writes that the hybridity is being used to characterise contemporary culture.

Hybridity can imply a range of different meanings: contrafusion and disjunction as well as fusion and assimilation. Young (1995: 5) writes that historically there has been little attention to the mechanics of the process of cultural contact. In archaeology the models have been of diffusion, assimilation or isolation, but not of interaction or counteraction. Models have also come from study of languages, e.g. hybrid forms such as Pidgin and Creole, which suggest a different model from the power relation of dominance of the coloniser over the colonised. However, the term hybridity carried negative connotations in relation to imperial and colonial discourse on the union of different races. Hybrids of language or different races of people were perceived as threatening forms of degeneration and perversion. Young argues that at the turn of the twentieth century, ‘hybridity' had become part of a colonialist discourse of racism.

A different view on hybridity is that most postcolonial writing has focused on the hybridised nature of postcolonial culture as strength rather than a weakness. It is not a case of the oppressor obliterating the oppressed or the coloniser silencing the colonised. In practice, it stresses the mutuality of the process. Bhabha (1994: 54-56) stresses the interdependence of coloniser and colonised. Bhabha argues that all cultural systems and statements are constructed in what he calls the ‘Third Space of Enunciation'. This suggests that claims to the inherent purity and originality of cultures are not viable. In this space, the notion of an international culture is based on cultural hybridity rather than exoticism or

multi-culturalism. The binary understanding of culture is replaced by the hybridised nature of cultures.

Bhabha (1994) writes that the Western way of viewing the human world, as composed of separate and unequal cultures, rather than as an integral human world, perpetuates the belief in the existence of imaginary peoples and places e.g. 'Christendom', 'The Islamic World', 'The Third World'. To counter such linguistic and sociologic reductionism, post-colonial praxis establishes the philosophic value of hybrid intellectual-spaces, wherein ambiguity replaces truth and authenticity; thereby, hybridity is the philosophic condition that most substantively challenges the ideological validity of colonialism.

According to Bhabha, hybridity is an active moment of challenge and resistance against a dominant cultural power (Young, 1995: 23). This moment is a 'hybrid displacing space' which develops in the interaction between the indigenous and colonial culture and deprives the imposed imperialist culture of authority and of its own claims to authenticity. In contemporary terms, this notion of hybridity is used in relation to a new cultural hybridity in Britain, a transformation of British culture into a compounded, composite mode. Hybridity denotes fusion as well as dialectical articulation, i.e. doubled hybridity. It works simultaneously in two ways: firstly in an organic way, hegemonising, creating new spaces, structures, scenes. Secondly, in an intentional way, diasporising, acting as a form of subversion, translation and transformation.

Hybridity in the global Ayurvedic context needs further examination for a detailed understanding. It is a product of limitation, but at the same time denotes creativity and pragmatism.

I have shown that many practitioners are reconciled to the fact that they need to change their treatment protocols in order to survive. They find ways to deal with the medical conditions by using a limited range of single herbs or other weaker alternatives. Some practitioners have changed the range of conditions they deal with; others are seeking out herbs that are available locally and including them in their personal *materia medica* to increase their choice of remedies, while others have sought out new approved suppliers. The use of simple herbs and learning how to combine them to make effective remedies is transporting practitioners back to the days before the large scale readymade herbal products became available. They are re-learning the skills that the traditional practitioners had prior to the pharmaceuticalisation of Ayurveda (Banerjee, 2008).

The paradox that has emerged from these findings is that these processes, which have the effect of simplifying the traditional practice of Ayurveda, are resulting in a situation whereby there is an increase in complexity of UK Ayurveda as some practitioners are shifting their focus from herbal treatments to using other treatment modalities. This may be by focusing more exclusively on adjusting a patient's diet and lifestyle, using a 'kitchen pharmacy' which involves making home remedies from spices found in a traditional South Asian kitchen, or advising on yoga techniques as a substitute. What is clear is that the practice is becoming increasingly diversified as each practitioner is developing his/her practice according to his/her preferred interest and skill. For example, a patient may go to one practitioner whose focus may be on nutritional advice, while another may emphasise the practice of yoga. With such diversity, patients' satisfaction with their Ayurvedic encounter will depend much more on whether they have consulted with a practitioner who shares the same focus on treatment as the patient.

The findings also show that the herbal regulations are not prohibiting practitioners from practising Ayurveda in the UK. Rather, they are re-shaping the practice through processes of simplification, modification, hyphenation and hybridisation, and forcing it to diversify into multiple variations of the tradition. Herbs are an important part of the tradition, but other healing modalities such as yoga in the UK version of Ayurveda are also gaining importance.

Robinson et al (2012: 605) shows parallel findings for TCM whereby concurrent use of acupuncture and herbal medicine is more likely in China, with herbs being the main therapeutic TCM modality. In China, both acupuncture and herbal medicine are taught during TCM training, with specialisation occurring later. In the West, only around one-third of acupuncturists use herbs. Although Robinson et al do not report on why this difference is occurring, it may be related to the perceived safety concerns and the influence of EU regulation on herbal medicines.

Some Ayurvedic practitioners are adopting another strategy to overcome the lack of facilities and treatments available in the UK. They recommend patients with complex problems to go to India for *panchakarma* treatments (though the frequency of these recommendations is not known and may not be very often). Reed's (2003: 126) findings show that her interviewees of Asian origin gave accounts of travelling between UK and

India for health matters. She suggests that people access plural healthcare in plural contexts enabling them to carry out, what she terms 'syncretic' practices in a plurality of locations.

Reed (2003: 12) defines syncrecy in this context as the mixing and matching of different types of health remedies and medicines i.e. the creation of new combinations of medicines in health care.[115] Reed (2003: 10) argues that it is important to explore ideas of syncrecy and hybridity when looking at migrants[116] or even transplanted systems.[117] Syncrecy is opened up in local and global contexts.[118] She (2003: 2) describes globalisation as the intensification of time-space compression, and the transcultural flow of goods and people; as a result boundaries dissolve and crossover is easier. Therefore, movement and widening accessibility of health products across the globe becomes easier and at the same time move back to local place bound traditions. Globalisation is characterised by the interplay between local and global processes.

Heelas (1998: 5) describes this 'pick and mix' approach in other contexts in relation to how people select tropes in their spiritual lives; for example, mixing shamanism and Christianity, or religious and non-religious ideas and practices. Heelas gives the example of Prince Charles hunting (traditional practice) and also talking to trees (New Age practice). Heelas

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[115] Reed, (2003: 14) suggests syncrecy may suggest a 'state', or some kind of purity, or a reification of 'between cultures', therefore needs to use a fluid framework of syncrecy. Gilroy (1993 in Reed, 2003: 14) argues that syncretic forms are never repeated in the same way; instead they are re-worked and re-inscribed differently in differing contexts. Reed uses the framework of syncrecy as an analytical tool to look at the way the West and non-West are seen as mixed, locally and non-West. This enables the development of a suitable paradigm.

[116] Reed (2003: 13) argues that British Indians are affected by both cultures, not stuck between two cultures. They have a hyphenated or syncretic identity. The identities of British born minority ethnic groups are fluid and multiply located, complex and dynamic. Identities are seen as 'hybrid', 'syncretic', and 'hyphenated'. Hybrids are a characteristic of transplantation.

[117] Reed (2003: 1) says people are free to draw syncretically on all kinds of health products and services i.e. they use a 'mix and match' of products and services. Reed (2003: 123) explores location, space and globalisation. Reed suggests location is important in influencing heath choices. Her interviewees were all based in Leicester, giving them access to a variety of health remedies. The connection and access to resources in India extends their plurality of medicines. These connections are strengthened by processes inherent within globalisation, fostering the transnational flow of syncretic health goods.

[118] Keller and Islam (cited by Reed, 2003: 17) undertook research on the incidence of diabetes among Bangladeshis in the UK. They found that people mix western and non-western health discourses, indicating that people make complex choices about healthcare. The respondents integrated traditional foods with international diet, dealing with the dialectic of local and global. Studies of health choices of ethnic minority groups show various patterns of use of Western and non-Western medicine. Eade (cited by Reed, 2003: 17) finds that migrants/minorities draw on a plurality of medicines. This drawing in a number of discourses is part of the dynamic and contested process of cultural construction as immigrants adapt to the conditions of urban life.

also suggests that hybridity is a popular term among postmodern theorists, for example Zennis is a hybrid of Zen meditation/yoga and Tennis. [119,120] Therefore the process of hyphenation and hybridisation may be a result of globalisation or a current social trend, though I argue that this mixing has been evident throughout history (see page 35).

Thus the UK Ayurvedic practice is multifaceted, combining various techniques (Warrier, 2009: 14). Stahle (2010: 248) reports similar changes in Sweden where various Ayurvedic techniques such as massage, diet and lifestyle are combined with other methods of personal spiritual development or maintaining fitness and well-being. The difference between Stahle's study and this one is that the UK practitioners are trained to deal with medical conditions in terms of being qualified to prescribe remedies, whereas the Swedish counterparts training focuses primarily on diet and lifestyle counselling.

Warrier (forthcoming) describes the immense diversity of socio-cultural traditions, national backgrounds, holistic therapies and networks that make up the British Ayurvedic community. Practitioners all feed their ideas, symbols and meanings from their own cultures to contribute versions of Ayurveda. Indeed, as I suggested in Chapter one (see page 44), from my personal experience it is the practitioners' training and personal inclinations that shapes their practice. It is therefore necessary to look at the diversity of the individuals who practise Ayurveda to understand the influences shaping the UK version of Ayurveda. Many come with expertise in other healing systems, different forms of yoga, and meditation which all flow into an integrated form of healing, as they are open to sharing with each other.

Although Warrier (forthcoming) suggests that Ayurveda practitioners in the UK adopt an open and inclusivist ethos, my findings indicate that other factors such as regulations

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[119] For example see: ZENnis (no date) [online]. [Accessed 18.8.13]. Available from the World Wide Web: http://zennis.net/. This website has the following description: "**ZENnis™** is a practice that integrates the breathing and relaxation methods of yoga with the movements and rhythm required in tennis.

[120] For another example see: Wholistic Tennis / Zennis Tennis (no date) [online]. [Accessed 18.8.13]. Available from the World Wide Web: http://zennistennis.com/. The website has the following description: "What is wholistic tennis or zennis? Zennis is the integration of Zen and tennis. The goal of tennis is to win, while the 'goal' of Zen is to live without fear. The methodology by which one lives or plays without fear is by bringing awareness to the fear that already exists within us on a deep cellular level. Wholistic tennis is the integration of the inner and the outer and for my purposes is synonymous with zennis. The inner being playing from a place of centeredness without fear and the outer being material success."

influence the nature of the practice. As a result, practitioners combine Ayurveda with other modalities in order to fill the gaps that are created through not having access to the full range of Ayurveda remedies and not being able to offer a variety of Ayurvedic treatments. Therefore, the practitioners adopt new techniques from other systems and make them a part of their repertoire. I therefore argue that one of the factors for the eclectic versions of Ayurveda is the result of the regulatory restrictions on herbal medicines which leaves practitioners with limited opportunities to practise. The eclectic Ayurvedic versions are not simply a celebration of globalisation but a reflection of the regulations of herbal medicines. If there were no restrictions on herbal products, and Ayurveda could be practised in its full form as it is in South Asia, then it is less likely that such integration of different systems of healing would occur. The impact of the changes to Ayurveda practice on the nature of the Ayurveda consultation is discussed next.

6.7 The standardised consultation changing to a more individualised one

6.7.1 Ability based practice

At the point of making treatment recommendations, the South Asian graduates tended to say they rely less on the knowledge they learnt on their BAMS course syllabus as the classical formulae are unavailable in the UK; rather, they have to find alternative options. In India, from my observation, practitioners tend to base their treatment protocol on information they learn regarding the best remedy for a particular condition, knowing that it is available. Therefore, the prescriptions now depend on the practitioner's ability to use the Ayurvedic principles to develop an effective treatment protocol. Thus treatments tend to be standardised within the individualised Ayurvedic framework.

In the UK, practitioners cannot rely on learnt information from the text books as the remedies are unavailable and full treatments are not possible. Instead, they must have the ability to use logic based on the principles of Ayurveda to develop a treatment protocol. This suggests that treatments are likely to be even more individualised than those in South Asia. South Asian practitioner, Dr Shalini, described the challenge she faces:

> Q - Can you tell me about what differences you've encountered between, what you were doing in India and what you're doing here in the UK.
> Dr Shalini - Oh, it's **the vast difference is the product choice.**
> Q - Ah, right.
> Dr Shalini - The condition symptoms are going to be the same all over the place, but like if you think of the product itself, it's a vast difference. **We get branded products.** There are a huge range of products available, like, you know, single herbs and combinations, traditional – everything. **It's just at your doorstep. You just need to prescribe and give the**

> **prescription, which was so easy there.** Here, as a practitioner, I've found that very difficult. Still I'm finding nowadays it's more difficult than – yes, it's just basically if I take a consultation I have to think how the patient is going to get the maximum benefit, you know, with the herb I'm going to provide. I have to arrange the herbs at the moment, so **it's just too much pressure at the moment,** selecting the herbs which are available here, and that can give a maximum benefit to the patient. **It's just double work, actually. But at home, like it's traditional – O.K. it's anaemia or something, give *this* preparation. It's always in your mind what to give, what to give, you know. Here, I have to think a lot,** choosing the herbs and obviously limited – really limited – medication you can give out.

Dr Rajesh echoed the same problem in his experience:

> Q - and is that a sufficient range do you feel ?
> Dr Rajesh - No not really, no. they got a **limited range. But in Ayurveda we got a lot of herbs,** a lot of preparations are there. **They don't have half.** No.
> Q - so how do you manage your recommendations ?
> Dr Rajesh - Ah, anyway **it's not so difficult because patients are less**. It's only when the patients increase then the problems start. But still if you get a very particular case of a conditions then if I got, **if I make a list of ten herbs and then I make take the 3rd or 4th choice sometimes, I may miss the first or second and may have to opt the 3rd choice. Because the first is not available** exactly. Anyway 3rd medicine also suitable, but **if the first medicine available it will be more beneficial for the patient.**
> Q - so you have to modify.
> Dr Rajesh - Exactly, **you have to modify**. It **may alter slightly results** when you get to patients.

In India, Ayurvedic practice is based on learnt information, whereas in the UK, the practice is changing to one that relies on the practitioner's ability to apply the principles. The impact of shifting practice from a learnt system to a principle-based system is that the standardised practice in India is changing to a more individualised patient-centred practice in the UK. Other factors that may be influencing the nature of the consultation are discussed next.

6.7.2 Lack of shared culture in UK

Treatments in South Asia were more likely to be standardised because in general the practitioner and patient have a shared culture, therefore the practitioner is familiar with the patient's diet and lifestyle and will recommend the standard treatment. Svoboda describes this phenomenon aptly in his book, 'Ayurveda. Life, Health and Longevity', (Svoboda, 1992: 31):

> 'Ayurvedic thought is part of the conceptual universe of every Indian who thinks like an Indian, and has been part of India's collective consciousness since, probably, prehistoric times'.

In the UK, particularly in the larger cities, ethnic and cultural diversity means a greater variation in diet and lifestyle. This means the practitioner is less likely to have a shared culture with the patient and each individual must be understood, and a treatment protocol is prepared accordingly.

South Asian practitioner, Dr Shalini, described the research she had to do in order to understand the new culture when she started practising in London. This involved understanding the effects of different cuisines on the patient's physiology:

> Q - And does that make a difference to, you know, what you might recommend, for example, if the clients are not Asian? Are there differences between your ……, recommendations depending on the ethnicity or background of ….?
> Dr Shalini – Yeah …… the medicine is the same; the herbs I choose are the same, like according to the condition and, you know, that would be – I choose the same, more or less the same herbs. There isn't any difference for choosing the herbs, but **when I give out diet advice and the healthy lifestyle advice, I need to know their lifestyle first. What sort of food they eat. So it was a bit of training for me as well in the previous years that – to go, like, a bit like what Caribbean food is. What it does. How does it react? What sort of, you know, forced effect does it have? I did have that – I got quite a few literature and I read about it; about every – like, Chinese; about Japanese; about, you know…. the Mediterranean food. So it does depend on that. I can't say, like, what food I can give easy advice about diet change or dietary conditions to Asian people because I know what they are eating.** I'm so – I don't have to think a moment either ??? take that, but with all these other, you know, I need to ask them to maybe I can e-mail you tomorrow, and that's what I do with every patient anyway.

South Asian graduate, Dr Karan, described a similar experience:

> Q what is the difference in the recommendations you make here vs India?
> Dr Karan - **Diet and lifestyle is completely different here. When I came here I had to research the diet, what kind of things people eat. Some things I had not even heard of and now I know. For example humous. In India you don't get such a thing.** I had to go and look it up. Chick peas … not a good preparation overall when you are suffering from XYZ diseases. So I had to research into it……. Then I put in Ayurvedic diet and lifestyle.

Bruwer (2009) reported that UK graduates experience similar difficulties in applying Ayurvedic knowledge to European diets. Hence, there appear to be at least two reasons why the global Ayurvedic practice is becoming more individualised in the UK. Firstly, practitioners no longer rely on learnt knowledge; rather their decisions are based on their ability to apply the Ayurvedic treatment principles. Secondly, the shared culture between the practitioner and the patient in India means that the practitioner needs to spend less time explaining the treatment.

6.7.3 The consultation time and shared culture

Longer consultations are seen as better for the practitioner- patient relationship (Frank and Stollberg, unpublished) and deemed to be more authentic according to the UK graduates, compared to the 'production line' style consultations in India (discussed in Chapter nine). UK graduate Brian described his perception of treatments in India and Sri Lanka as being shorter in consultation time than in the UK. He asserted that these do not allow for an egalitarian patient practitioner relationship to develop:

> Q - And in your opinion, do you think Ayurveda can be practised in different ways ? Some people explore the spiritual dimension, while some people don't involve that in their practice as much. Is there one right way ?
> Brian - ……. But I have seen, practice in the UK, my experience of practitioners is that you give the client time, you give them a whole range of diet and lifestyle modalities, which cover all these dimensions, give them a whole list of things for them to go away and think about and practice. **Whereas in India and Sri Lanka, treatments I have seen there are shorter, treatments are not exploring, ??? very symptomatic, very quick in out because there is a very long line of people they have to do it like that. So it's not exploring your emotions, where you are at, where you are going. Bang, bang, bang ! a bit like going to the doctors in the UK, that kind of experience.** So I see them being, for me it's got to be about the bigger picture, there has got to be some time to concentrate on the particular person.

As a consequence of the lack of shared culture and people's knowledge of Ayurveda, practitioners in the UK have to spend time explaining Ayurvedic principles to their patients; it is inevitable that because they spend more time listening to and understanding the presenting problems of the patients, the relationship takes a different stance. South Asian graduate, Dr Rajesh, explained that in India, the consultation times are short as there is a shared knowledge between the practitioner and patient of the diet and lifestyle, and patients only come for the prescription of remedies. Therefore, the relationship follows a different model:

> Dr Rajesh - I think,... I don't know. We are not changing anything how we treat patients. But one thing which I observed. In India we normally use 10-15 minute consultations, but here normally it's a one hour consultation. And we go detail about their daily routine and their diet, and what they take and everything we advise. That's the only difference.
> Q - and do you think that's better or not...
> Dr Rajesh - It's slightly better in one way. In one way it's better. The reason maybe, we get people who are really interested in Ayurveda. They know tell about Ayurveda and whatever we tell the patients they follow it properly and the results speak sometimes, good here ...
> Q - if you're only spending 15 minutes in India and 1 hour here, then what difference does that make to the recommendations?
> Dr Rajesh - Yeah, I got your point. Why 15 minutes in India, why it's one hour here. Because in India people has normally got the background of Ayurveda basically. Because they know the lifestyle, they know the diet, and they know almost 50%-60% of Ayurveda when they come to my clinic and they may only require medicines and if I tell you take these vegetables, normally they know that. **But here it's entirely different science**. Sometimes the lifestyle, that is plays an important role and that could be one of the reasons why it takes a long time.
> Q - so it doesn't make a difference to your actual diagnosis?
> Dr Rajesh - No. It doesn't make anything.
> Q - 15 minutes is enough in India ?
> Exactly
> Q - but it's the explanation that takes the time here?
> Dr Rajesh - Exactly, exactly.

The differences in the length of the consultation depend on the ethnic subculture. For example, a first generation South Asian Ayurvedic practitioner, Dr Khush, offers fifteen minute 'production line' style consultations in Southall, Middlesex, an area predominantly

populated by Asians, serving first generation Asian patients. Here, the impact of shared culture and prescriptions of ready-made remedies allow for short consultations. This illustrates the impact of glocalisation in the UK (Stollberg, 2001: 7). [121] Although in general CAM consultations are long, in this local situation the standard is not applied as the local need does not require it.

Two other reasons may explain the need for long consultations. Firstly, Ayurveda is alien to the host culture, so the healing system itself is not very well understood, and also not easy to understand. As a consequence, practitioners have to take time to explain the theory and recommendations. Secondly, the BAMS course in India emulates the biomedical course in many ways (Langford, 2002: 99) and the Ayurvedic students emulate the relationship style that biomedical practitioners have with their patients thus keeping consultations short. In contrast, in the UK, the Ayurvedic graduates are categorised as CAM practitioners and display characteristics of that holistic milieu.

Thus treatment outcomes in the UK depend on the Ayurvedic practitioner's ability to find alternatives, and to understand the diversity of diet and culture rather than standard treatments from textbooks that they might apply in South Asia. Further to this, practitioners said that the classical texts are very important for their clinical work (see page 98). However, in practice, the clinical relevance for prescriptions is questionable as many remedies described are not available.

It has been possible to transplant Ayurveda in the West because it is based on principles that can be modified according to a new environment. This would not be possible if it were based on a fixed system of knowledge. Visiting practitioner, Dr Lokesh, illustrates:

> Dr Lokesh **- So we want to propel it, Ayurved**[122] **to the western world. When you go to the Rome you do as the Romans do.** When you go to America then do as Americans do. You cannot start using *tribhuvan kirti* which is a very powerful medicine to there and they will put you in jail. They will think you are killing the people. To bring there authentic Ayurveda it will take time. Perhaps 2 decades. Who knows?
> Dr Lokesh - yes because we have to mould according to the environment, according to the situation. We cannot bring the whole Ayurveda to the west. They will destroy. They will say no. So .....
> Dr Lokesh- you know, **even highly qualified BAMS doctors cannot practise Ayurveda as he practises in India. If he or she comes to the US or England he has to follow their rules and**

[121] Glocalisation is a combination of the words globalisation and localisation which refers to a global standard applied to a local situation.
[122] Indians often pronounce Ayurveda as 'Ayurved' as the 'a' is not emphasised.

their regulations. So all Ayurvedic practitioners, Ayurvedic scholars they have to put aside their so called concept of authenticity and look at the reality and then practise Ayurveda.

Ayurvedic practitioners do not want to be tied down to any paradigm. They are open to an integrated approach and use whatever works to enable a person to heal. They take a fluid approach to healing:

> Dr Karan – whatever 'pathy works……

6.8 Conclusion

According to Alter (2005: 6), when medical knowledge moves across boundaries, it does necessarily lose some of its character as the medicine of a particular region or state. In the case of Ayurveda, scholars such as Meulenbeld (1995: 1) have outlined the changes in Ayurveda through history, and Warrier (2011: 2) specifically points to the changes and exchanges that began during colonial times, suggesting that the version of Ayurveda that came to UK had already been influenced.

In the West there are a number of factors that lead to simplification of practice. Svoboda (2008: 127) writes that this is due to the commodification of Ayurveda:

> '.. Ayurveda is only likely to develop within a commercial framework; and commercial activity provides one avenue for the NAMA (the National Ayurvedic Medical Association) and other Ayurvedic organisations to communicate meaningfully with the general public. Difficulties arise, however, when fidelity to the subject being studied collides with the drive to simplify and commodify.'

Cant and Sharma (1995: 105) point to the impact of the State restrictions which inevitably impact on the practice, while Welch (2008: 137) suggests that the changes are due to the lack of education in the West as well as access to the remedies:

> '… At present, Ayurveda must be an adjunct practice, as no full five or six year courses of study are available (or even possible) in the West, licensing is practically non-existent, and the full pharmacopoeia is neither available or approved for use by drug-regulating agencies in the West. Thus for the moment at least, what we have in the West is an altered form of Ayurveda.'

There are variations in the way Ayurveda is practised across India, with different schools of Ayurvedic practice, and different regional traditions (Warrier, 2011a: 83). Further variations arise from practitioners holding different ideological positions ranging from *sudha* (pure) to *mishra* (integrated with biomedicine), adding further to localised variations.

The findings of this study show that practitioners are able to adapt Ayurveda in order to practise in the UK environment, through the processes of simplification, modification, hyphenation, and hybridisation, thus showing its fluidity and flexibility. In the UK, Ayurveda is continuing to change in response to external influences and producing even more individualised versions.

Both Reddy (2002: 129) and Warrier (2009: 1) suggest as a result of their empirical fieldwork that global Ayurveda is shaped by New Age, in the US and UK respectively. Further, Warrier (forthcoming) concludes that spirituality is central to shaping the UK version of Ayurveda. She argues that spirituality plays a significant role in influencing the development of Ayurveda in Britain. According to her, *'spirituality is a crucial means by which the APA and its members mediate the relationship between Ayurveda and biomedicine, often in novel and creative ways'* [italics my emphasis]. The findings of this study indicate that the holistic health milieu and the New Age may have enabled the positive reception of Ayurveda in the UK, as suggested by Reddy (2002: 100) and influenced its form which I discuss below.

As a practitioner researcher, my interpretation of the findings is from a practitioner perspective. As Charmaz (2006: 10) says:

> "neither data nor theories are discovered. Rather, we are part of the world we study and the data we collect. We *construct* [authors emphasis] our grounded theories through our past and present involvements and interactions with people, perspectives, and research practices …….. any theoretical rendering offers an *interpretive* (authors emphasis] portrayal of the studied world, not an exact picture of it."

These differences in interpretation are apparent in the perspectives of academics and practitioners. For example, academic scholars such as Zimmerman (1992), Zysk (2001), Reddy (2002) and Warrier (2009, 2011b) emphasise the global versions of Ayurveda as being the result of processes of spiritualisation and the influence of the New Age. Whereas, practitioners like Murthy (2010), Bruwer (2009) or myself emphasise the regulatory frameworks and restrictions on the clinical practice as the underlying factors bringing about the changes in practice.

I suggest that the scholars have provided insights into the wider social and cultural influences that impact on the image of Ayurveda, whereas practitioners have provided

insights into the specific factors that impact on the actual clinical practice. One way to understand the different perspectives may be to use a framework used by Brownwell (2005: 138) to differentiate between the form of Ayurveda (its appearance) and the function of Ayurveda (its clinical practice).[123] This distinction between form and function of a system is helpful in explaining the findings of this study. If Ayurveda is distinguished in terms of Ayurveda as form (beauty, spirituality) vs. function (remedies, health) then it is reasonable to argue that the influences of the holistic health arena shape the form of Ayurveda practice i.e. the spiritualised appearance, whereas the state restrictions shape the content of Ayurveda practice i.e. the simplified prescription. In parallel, the distinction between form and function for biomedicine helps to explain that biomedicine can also change in form in adopting a more holistic approach (see page 128), without making any changes to the function (underlying theory).

The distinction between form and function also helps to explain the relationship between Ayurveda and biomedicine. Ayurveda does not pose a challenge to biomedicine if the 'form' of Ayurveda is emphasised (spirituality, beauty), whereas if the function (system of medicine) is emphasised, then it becomes a challenge to biomedicine (Newcombe, 2008b). I argue that scholars like Warrier (2009), Reddy (2002) and Zysk (2001) describe the outer form of Ayurveda in the West as being spiritualised, rather than examining the changes to the function of Ayurveda. Practitioner researchers like Pole (2008) tend to describe the function of Ayurveda in the West and suggest it to be a simplified version. The emphasis on either the form or function of Ayurveda result in the different approaches to Global Ayurveda which I described in Chapter one (see page 40).

In the next chapter, the relationship between religion and spirituality in different Ayurvedic contexts is examined and the definition of spirituality in the clinical context of Ayurveda is analysed.

[123] Langford (2002: 98) also uses the form and function framework to explore the relationship between the curriculum and the educational knowledge and practices in the classrooms and wards, in the Ayurvedic teaching hospitals in India.

Chapter seven The Relationship between Religion and Spirituality across different Ayurvedic Contexts

7.1 Introduction

In the previous chapter I analysed the influence of the holistic health milieu and the state restrictions on the Ayurvedic consultation. In this chapter I consider different approaches to religion and spirituality, and analyse data from this study taken from four different Ayurveda contexts: educational, political, social and professional (clinical). I demonstrate how religion and spirituality are fluid concepts and change according to their context.

7.1.1 The nature of religion

I begin by contextualising my findings in the contemporary debates about religious terminology to show the differences in scholarly opinion and that the concepts of religion and spirituality are highly contested. Scholars like Rudolf Otto and Mircea Eliade, [124] ,[125] argue that religion is *sui generis* making it unique and irreducible, and incomparable with any other social institution or practice, and thus cannot be explained by naturalistic theories of religion.

The alternative perspective is that religion is a human construct, and can be studied with reductionist, naturalistic theories derived from social sciences. It can be argued that even scholars who favour non-reductionistic approaches have little choice but to reduce it, since their cross-cultural work necessarily must use comparative categories, in which the language of participants is reduced to the language of the analyst. McCutcheon (2003) critiques the discourse that religion is a *sui generis* phenomenon and the history of religion is a discipline. He analyses the ideological basis for the *sui generis* argument, claiming that it has been used to construct religion in a form that is ahistorical, apolitical, fetishised, and sacrosanct. He argues that during the 1950s and 1960s this claim helped to create autonomous departments of religious studies, jobs, and publication outlets. Surveying the textbooks available for introductory courses in comparative religion, McCutcheon writes

[124] Rennie (2011: 5) argues that Eliade never made the claim or used the words *sui generis*[italics] religion.

[125] Rennie, (2011: 13) argues that Eliade's perspective on the study of religion is about the (ap)perception of experience as meaningful. This is partly why the religious cannot be reduced to the economic, the psychological, the political etc. To interpret Eliade's 'non—reduction' as the ontological autonomy of the sacred or the '*sui generis* 159discourse' merely perpetuates and compounds overly-simplistic readings of his understanding of the sacred and the real.

that they uniformly adopt the *sui generis* line. As a result, they are not just uncritical but actively inhibit the emergence of critical perspectives. On the geopolitical scale, the study of religion as an ahistorical category participates in a larger system of political domination and economic and cultural imperialism.

The claim that religion or religious experience is *sui generis* implies that it is unique and ahistorical with a universal essence. This does not explain the fact that many people in the world do not subscribe to any religion and describe themselves as humanists, Marxists or atheists. This indicates that religion is not innate, but is instead a matter of choice and socialisation (Nye, 2008: 15). In addition, 'religion' is an English word which does not easily translate into all other cultures. For example Native American groups do not have a word for religion as a separate sphere of existence (Nye, 2008: 16-17).

Nye (2008: 20) argues that religion is not a *sui generis* category and does not exist as something on its own. There is no essence of religion. Instead it is a term with a multitude of meanings to be understood with reference to other human activities. In summary, for those who believe religion is *sui generis*, the concept of culture is set apart from that of religion. Others see religious practices as a subset of cultural behaviours that can be explained in precisely the same manner as all other cultural attributes. I will discuss below the relationship between culture and religion in the context of Ayurveda practice in the UK, but first consider the problem of defining religion.

7.1.2 Problems in defining religion

The term religion is employed in many ways. For example, Martin and Catto (2012: 374) illustrate the multivalent understanding by comparing religion and secularisation: when religion is related to superstition, the secular is defined as rational and scientific. When religion is related to violent conflict, the secular is seen as peaceful, and when religion is seen as repressive, the secular is seen as liberating. Therefore, the definition of religion is a fluctuating process (Arweck and Beckford, 2012: 354).

It is even suggested that the term religion is useful only for academic study rather than something that does exist in the world. Nye (2008: 17) says that rather than trying to find a definition of religion, it is better to work on the assumption that in many cultural contexts there is a field of activity that is labelled as 'religion'. This avoids the need to find a single

definition and to say that it has a particular essence or that is plays a specific role in social, cultural or psychological life. It might be more useful to say it can be defined more or less successfully.

The notion of religion is complicated, as it refers to a number of different concepts and practices and is linked to culture (Nye, 2008: 2). Religion should not be considered an abstract concept, but viewed as an aspect of cultural activity since religion permeates day-to-day life. As well as a set of ideas and beliefs, religion is a framework for lived experiences and daily practices (which I discuss in Chapter eight) and therefore may be a tool for understanding differences among people across the world (Nye, 2008: 3).

The word religion has different applications: for example it can be used as a noun or an adjective (Nye, 2008: 8). Religion maybe used as: a common and general aspect of humanity found in all or most cultures; specific religions (e.g. Buddhism, Christianity); an adjective as an aspect of something else e.g. a religious building, and as a verb, as an action or practice. It cannot be assumed that the experience and practice of religion in different parts of the world and in different historical times will be similar (Nye, 2008: 9). Therefore the concept of religion needs to be applicable across contexts. It needs to be broken down into religions, as specific traditions.[126]

Harvey and VIncett (2012: 157) draw attention to alternative spiritualities which are becoming mainstream, and add complexity to this field. Alternative spiritualities include a

[126] This has led to different religions being described as 'world religions' and classified according to their texts, foundational ideas and histories. However, this perspective considers religions to be discrete and bounded i.e. different from each other: it misses a lot of information, religion as a lived experience, and suggests that all people of one religion are the same. This world religions paradigm also excludes some traditional religions e.g. traditional religions of Africa which are made up of many traditional cultures. The problem with the world religions paradigm is mainly around classification of cultures and traditions and is primarily a political activity. The differences are from a western perspective and it is important to consider cultural issues, political conditions and also geographical contexts. The geographical perspective starts with a geographical point such as India and explores Hinduism within the complexity and diversity of Indian culture and society. This enables discussion of the many different Hinduisms emerging out of the different geographical and cultural locations in India. A study of Hinduism could also start in another place, for example, in Britain and explore the life and culture here (Nye, 2008: 13). A similar consideration is required for changes in religion through history. Emphasising the plurality and diversity of religious traditions breaks down the basic assumptions of particular religions into more complex and realistic models e.g. Christianities, Hinduisms etc. each specific to particular places and contexts. This overcomes the need to collate small-scale religious cultures into larger categories. Here the starting point is religions rather than a singular universal concept of religion.

wide range of groups, practices and beliefs under this umbrella term. Nye (2008: 204) writes that although people are losing interest in Christian practice, religiosity is still present in many different alternative forms, e.g. minority religions and new religious movements which include pagans, Hare Krishnas, New agers, scientologists. The Unification Church, ISKCON and Soka Gakkai are products of globalisation as they are transnational movements. They are traditional religions practised in the context of hybridity by people within the globalised contexts of multicultural and transnational communities.

Having briefly reviewed the issues relating to the nature and definition of religion in the literature, I next examine data from different Ayurvedic contexts to explore the nature and definition of religion and spirituality and discuss the above issues in relation to this study.

7.2 Religion and spirituality in the educational context of Ayurveda – examples from the SDM College in Hassan and Middlesex University in the UK.

I observed during my internships in India that the Ayurvedic training courses, despite having a biomedicalised syllabus, are embedded within a cultural framework in which religion and spirituality are explicit. Philosophy and Sanskrit are taught in the first year and religious rituals are part of the social culture for the students. For example, the SDM College[127] in Hassan in India began the academic year with Hindu prayers to honour Dhanvantari, the deity of Ayurveda, and welcomed the new intake of students with a special ceremony to mark the beginning of their journey. A similar ceremony dedicated to Dhanvantari took place when I joined the Ayurveda College in the UK. One of my course tutors began his lectures by reciting a verse from the *Astanga Hrdayam.* Ironically it was this tutor who took a biomedical approach to teaching Ayurveda.

Throughout the biomedicalised Ayurveda course, there were various religious and spiritual events from the Hindu culture. These included extra curriculum seminars by invited speakers on topics such as astrology and a one-day workshop on the benefits of different Sanskrit mantras and other such *Vedic* truths. In parallel, speakers also presented sessions on diseases from a strictly biomedical viewpoint. In short, there was a mix of influences regarding the different approaches to healing.

[127] Vedic Society. World Panchakarma Guide (2007) [online]. [Accessed 30.12.12]. Available from the World Wide Web:
http://www.panchakarma.com/sdm-college-of-ayurveda,-hassan,-karnataka-p-281.html

Although the syllabus may have been stripped of the religious and spiritual elements (Warrier, 2011a, 84; Leslie, 1976: 363), these remained in the social context of the training. Consequently, the social cultural context of the education both in India and the UK is steeped in various forms of religion and spirituality. The cultural context of Ayurvedic education is one which allows for religion and spirituality to be expressed in various forms. When the students qualify as practitioners, their social context continues to be embedded in a framework which contains religious and spiritual elements. Before examining the social context, I analyse the way religion and spirituality manifest in the political context through the observation of a campaign meeting.

7.3 Religion and spirituality in the political context of Ayurveda – an example of a campaign meeting

A mixed group of Ayurvedic practitioners and supporters, predominantly first generation Indians met in the summer of 2010 in order to discuss the campaign against the impending EU directive to ban herbal remedies which included Ayurvedic herbal compounds. This meeting included representatives of various Hindu and community organisations. A well-known yoga guru from India, *Swamiji*, who had gained international recognition through his promotion of yoga through Asian TV channels and international yoga camps, was requested to lead this campaign. *Swamiji*, in his orange robes and wooden slippers was a symbol of renunciation, embodying meanings of authenticity, purity and detachment for many Hindus. Here, the religious symbolism embedded Ayurveda in the Hindu tradition. Ironically, after listening to various speakers suggesting that Ayurveda is a part of *Santana dharma* and Hinduism, *Swamiji* advised the audience not to relate Ayurveda to religion as '*religion causes problems'* [my emphasis].

Even amongst this group, there was no clear agreement on how Ayurveda should be presented to the British Government. Some participants felt that Ayurveda should be declared an integral part of *Santana dharma* and Hinduism as it is part of their daily health routine and the practices are sacrosanct. Taking this route, they felt they would be able to get support from the Government's Diversity agenda. Others were clear that Ayurveda is not part of a particular religion or culture, and argued for their fundamental human right to choose Ayurveda as their medicine of choice. The flier for this campaign meeting gave both messages. The right to choose health care is a fundamental human right and Ayurveda is part of the religious practice of Hindus. The majority of the audience were first generation

Asians and research indicates that older generations are more likely to use the term religion rather than spirituality (Cohen and Koenig, 2003: 215).

What was of most interest was that *Swamiji* perceived Ayurveda as a pragmatic system of health care and prevention which in common sense terms should be adopted by the NHS in order to reduce the burden on the overly strained health budget. Hence, Ayurveda was perceived as a sensible solution for NHS managers and policy makers to meet the demands of the sick British population and a way to deal with the financial crisis in the public health care sector. Thus, Ayurveda was also being stripped of the religious and cultural identity and perceived as a tool to provide economic benefits.

In summary, the findings from this specific context indicate that religion carries multivalent meanings. It is part of a tradition and carries a sense of history and cultural identity; it is a way of life and a lived experience, but it can be a source of conflict. Thus, the data supports the scholarly approaches which suggest religion is a dimension of culture. The social context of Ayurveda is described next, which includes seminars, meetings and conferences which provide practitioners with the opportunity to meet at various points throughout the year. These events provide practitioners with continuous professional development and at the same time allow them to get updated on changing Government legislation, as well as to meet friends and colleagues.

7.4 Religion and spirituality in the social context of Ayurveda – examples of two Ayurveda practitioner events in the UK.

I examine two Ayurvedic practitioner events in the UK to illustrate the way in which religion and spirituality manifest in the social context of Ayurveda. Arweck and Beckford (2012, 353) write that the social perspective is important because collective gatherings bring people together for shared activities which express shared beliefs and emotions in forms that vary across time and space. The social perspective gives insights into the social characteristics in the collective activities and is essential to understanding how ideas and activities are organised and reproduced across time and space. Finally, communication is a social process which involves the creation, exchange and circulation of ideas, information, teachings, attitudes, codes, moods and feelings which are important to that particular group.

Ayurveda practitioner events, whether a conference or a day of seminars with the aim of providing members with continuing professional development (CPD) certificates are typically linked with various phenomena and paraphernalia that can be identified as part of the Hindu tradition; for example, a traditional fire ceremony, *yagna,* to begin a CPD day. In May 2010, I attended a CPD event organised by the Ayurveda Practitioners Association at a community venue in North West London. A Hindu priest was invited to conduct a fire ceremony to begin the day. The priest in traditional Indian attire of cotton *dhoti* and *kurta* came with all the paraphernalia required for the ritual.

The priest recited Sanskrit verses and approximately thirty practitioners, mainly white British/European gathered around the sacred fire with feelings of great reverence and intrigue. They eagerly took part in making offerings of *ghee* and *samagri* to the sacred fire. The priest explained the significance of the ritual in Hindi which was translated into English by an Indian practitioner in the audience. The ritual ended by everyone reciting the *Gayatri mantra* and having *tilak* applied to their foreheads as a blessing. This ceremony was described in the programme flier as:

> *Yagnas* bring atmospheric harmony through the *Vedic* science of resonance. Using *mantra*, invocation and fire, waves of coherence are created which radiate outwards from wherever they are performed. They are a very special ceremony and we warmly welcome you to participate.

The description is not overtly religious, though it mentions the '*Vedic* science of resonance' indicating an association with the *Vedas* which fall within the remit of Hindu scriptures and *mantras*. Instead it uses words such as 'harmony and waves of coherence' which have a universal appeal. Thus, a Hindu ritual conducted by a Hindu priest was used to begin the day, as a marker of worldwide harmony and coherence, without direct reference to religion. The flier also described the lunch as 'Blessed and provided by Hare Krishna group'.

Food is crucial in the Ayurvedic tradition. It is significant that it was advertised as being 'blessed' which means it had been transformed from a gross material product to one that is sublime and divine. Hare Krishna devotees[128] are known for their vegetarian food which is *satvic* in content, strictly vegetarian and cooked in a particular environment and blessed so that it becomes *prasadam,* or *the mercy of God.* Food and spirituality have a strong link as spiritual progress is enhanced through the development of *satvic* qualities which come

[128] 'The Hare Krishna' see for example: Bhaktivedanta Manor (2009) [online]. [Accessed 10.4.13]. Available from the World Wide Web: http://krishnatemple.com/home/

through the food we eat, the lifestyle we lead and the attitudes we hold. The lunch was not explicitly described as a spiritual meal, but the links are obvious to Ayurvedic practitioners.

Another one-day conference organised by the British Association of Accredited Ayurvedic practitioners (BAAAP), began with a prayer to *Dhanvantari*, and a *deep,* light made of a cotton wick in *ghee* was lit by the invited chief guests. This was followed by a short classical dance, *Bharatnatyam,* as an invocation to *Ganesha,* a Hindu deity. The programme organiser explained the significance to an ethnically mixed audience, the majority South Asian practitioners and various guests:

> Before any auspicious event always pray to Lord Ganesha to remove any obstacles (BAAAP conference, 4.6.2010).

Here, the blessings of a Hindu deity were invoked so that the conference would run smoothly. The link with the Hindu tradition was overt, and accepted, as Ayurveda is expressed as part of the Indian cultural and religious tradition.

The CPD conferences and seminars included presentations on a variety of topics. For example, the one day BAAAP conference 2010 included the following talks:

BAAAP conference 2010 : programme of events

- Role of the Indian Government in the preservation of India's Heritage – Speaker from the Indian High Commission
- Working together to raise our profile – Speaker from BAPIO
- Combining Ayurveda and Modern Medicine – Practitioner
- Ethical Issues in Health Care – Educator
- Role of Spirituality in Ayurveda – Educator
- Changing Face of the Ayurvedic [drug] Industry. Meeting challenges of Quality, safety and efficacy – Director of Ayurvedic Drug Manufacturing company in India
- The Traditional Herbal Medicinal Products Directive – Speaker from the MHRA
- The Complementary and Healthcare Council – Chief Executive
- Stress management – Practitioner
- Ayurvedic management of Stress – Practitioner
- Panchakarma in the management of Parkinson's Disease – Practitioner

The programme illustrates the range of topics from political and ethical to spiritual, ending with a presentation on a clinical disease.

To summarise, the Ayurvedic practitioner events are set within a framework that has religious and spiritual aspects. I argue that whether these practices are defined as religious or not, or labelled as universal, they form part of the fabric of the Ayurveda practitioner events. Next, I examine what happens to religion and spirituality in the Ayurveda professional context.

7.5 Religion and spirituality in the professional (clinical) context of Ayurveda

All the interviewees in this study were unanimous in saying that they felt religion and spirituality play an important role in health and healing and are an important part of Ayurveda, though what is included in their consultation varies. According to medical convert, Dr Kishore, a genuine Ayurvedic practitioner is one who necessarily includes the religious and spiritual element in his /her work:

> Q - I was asking because it's often felt that the Ayurvedic courses, both in India and in the UK, have biomedicalised, so, **the spiritual element has been minimised quite a lot, and obviously it seems from you that you feel that, it's a very important element…**
> Dr Kishore - Yes. It may be biomedically orientated, but the main thing is that we – **if you are a true practitioner in Ayurveda .. oh, you shouldn't have ignored this vital component.**

What is of interest is that despite their belief in the link between religion and spirituality and health (examined in detail in Chapter eight), the practitioners interviewed were clear that spirituality and religion are separate concepts and they are referring to spirituality in their practice, not religion. South Asian graduates, Dr Neha and Dr Rajesh, described their thoughts:

> Q - And what's your definition of spirituality?
> Dr Neha - I always think, it's a very interesting question. I need a little time to think on that. **For me spirituality truly is not any connection with religion**. It's a pure pure form.
>
> Pritesh - …… You have to bring spirituality in a different way to ....if you say spirituality you say *ahimsa* [non-violence] don't kill anything, **it's the principles**, try and bring those in somehow, **rather than actual religion.**

Dr Neha viewed spirituality as an essence, whereas Pritesh understood spirituality in terms of ethical principles. These quotes illustrate the multivalent meanings carried by the concept of spirituality which I explore in further detail below. First, I consider a number of possible reasons for the stark separation of religion and spirituality: religion and science being seen as separate, religion as a private matter, the impact of negative media, and the biomedicalised training, some or all of which have influenced the separation in the clinical context.

7.5.1 The separation of religion and science

First, practitioners may want to keep religion at bay because they want Ayurveda to be seen as a credible and scientific system of healing. I showed in Chapter five, that many practitioners straddle between paradigms and are keen to integrate with mainstream biomedical healthcare. I also showed that Ayurveda as a CAM practice in the UK sits on the edge of the healthcare system, vulnerable and not understood by the mainstream biomedical profession. UK graduate, Thelma, summarised the plight of the community:

> Thelma - Want to establish Ayurveda as a real medicine.

Carrette and King (2005: 14) say that in the West, religion and science were separated and polarised which suggests that if an activity is religious then it cannot at the same time be scientific, and if it is scientific then it cannot be religious. I illustrate this point with a quotation from MacEoin (1993: 110-112) which shows that religion and spirituality are perceived as problematic in the medical field and likely to be a hindrance in the acceptance of Homeopathy:

> The philosophy according to which a homeopath practices must have significance to the patient … it may be surmised that the majority of lay homeopaths in this country have some form of religious or esoteric commitment … it is hard to find lay homeopaths who do not subscribe to New Age ideals of some kind …[while] this esotericism seems to have been much diluted by a broader rationalist trend … **what worries me is the possibility that this leaning towards metaphysics instead of rational, empirically based medical practice may retard the process of broad political and scientific acceptance of homeopathy for decades, if not indefinitely** …. Patients may feel concerned to hear of practitioners relying on intuition …. And there are real; grounds for supposing homeopathy might as a result become ghettoised and restricted.
> (MacEoin 1993: 110-112).

Although other authors may argue that science and religion overlap, it appears that a dichotomised view of religion and science exists for practitioners and they juggle between detaching their practice from being overtly religious, in order for it to be credible in scientific terms, and including the religious and spiritual element to be holistic and appealing to people seeking holistic healing.

7.5.2 Religion as a private matter

It is also possible that Ayurvedic practitioners do not want to be seen to be giving religious advice as part of their consultation, as it may be deemed as forcing religious views on another. The privatisation of religion refers to the general tendency for religion to be practised as an individual or as a private pursuit, rather than in a more communal or social

network. It is up to each person within a secularised society to practise his or her own private religion (Nye, 2008: 202).

The practitioners were clear they do not want to undertake any activity which may suggest that they are imposing religious ideas upon their patients during their consultations. Medical convert, Dr Devi, illustrated her concern:

> Q - And do you incorporate any kinds of ritual advice – in the work that you do?
> Dr Devi - …… **I'm not someone to preach**, and I don't think that would be correct to do that anyway, but I just work with the patients. If it's something important to the patient, then I will start looking at that and if it's – if someone's open to that, then I'll start to explore.

It may also be that practitioners see religious and spiritual matters as private which the patients have to explore themselves. It is their personal journey. South Asian graduate, Dr Neha, and UK graduate Brian, illustrated their perspectives:

> Q - Do you incorporate any spiritual practices yourself?
> Dr Neha - …….. **So every person is different, so they have to, I tell them to find out something good for them. Explore a couple of things and whatever is making you feel good, go for it.**

> Q - Do any of your clients expect you to be exploring these dimensions ? as you said Ayurveda has a spiritual dimension. Do any of your clients come with any expectation ... to go beyond the physical issue they have come with?
> Brian - Yeah, I think some of them are more open, who have explored that side of themselves and done courses, chakras, things like that. **But it's probably how you put things to people. Give people some activities to encourage them to explore the spiritual side without necessarily spelling it out in too much detail. Depending on the person and how open they are.**

In addition to the lack of instruction in religious medical treatments, some practitioners did not perceive it as their role to prescribe religious activities or rituals, though the *Charaka Samhita* mentions *daivavipashraya (*religious and spiritual treatments) as part of the treatment.

7.5.3 Religion, Health and the Media

Nye and Weller (2012: 49) write that 'controversies in contemporary Britain are strongly mediatised'. Given the media's attention to any news that may be deemed controversial, another reason that practitioners distinguish between religion and spirituality in their practice may be because the media has highlighted cases where religion has been seen as unrelated to health and the health practitioners' role. For example, a nurse called Caroline Petrie was suspended for offering to pray for a patient. The negative attention around religion in the medical context may result in practitioners who are struggling to be

accepted as serious health professionals being wary of including religion into their practice. The following quote highlights how the NHS separates the professional duties of a nurse, patient's health and religion:

> Alison Withers, Mrs Petrie's boss at the time, wrote to her at the end of November saying: 'As a nurse you are required to uphold the reputation of your profession.
> 'Your NMC (Nursing Midwifery Council) code states that "you must demonstrate a personal and professional commitment to equality and diversity" and "**you must not use your professional status to promote causes that are not related to health**".'
> http://www.dailymail.co.uk/news/article-1133423/Nurse-faces-sack-offering-pray-sick-patient.html [accessed 7.2.12, 19:49]

The following quote from an Ayurvedic practitioner's discussion forum[129] on Facebook shows that some practitioners also perceive Ayurveda and religion as separate topics:

> .....I request all the members of XXXX group to please NOT post anything related to religion in the group. These are Professional groups and I would like all its members to only talk about Ayurveda/Herbs/Natural Medicine.....Lets keep our personal profiles to talk about personal or religious stuff. (www.facebook.com accessed 18.5.12, 15:00)

In parallel, Alter (2005: 61) cites an example of UK practitioners of traditional Chinese medicine who refer to *xie* as a medical phenomenon causally related to illness and disease. They were less comfortable about describing it as demonological causation. Although evil is the most common translation of *xie*, the majority of practitioners reject it as this concept is perceived as too rooted in religious belief.

7.5.4 Practitioners' biomedicalised training

Furthermore, some of the Ayurvedic practitioners, like their biomedical counterparts (Hassed, 2008: 955) did not feel they have had sufficient training to offer religious and spiritual advice in their consultation as neither the courses in India, nor in the UK, include adequate instruction on this aspect. Others felt that this aspect goes beyond formal education and requires traditional training from a guru and the individual to have special qualities such as intuition. South Asian graduate, Dr Priya, expressed her reservations about being a 'religious Ayurvedic healer':

> Dr Priya - I think you have to be positioned and you have to be destined that way …… because I don't think you can train yourself for that. …….
> I mean, because if I start now, it would take me a lifetime to get to him [referring to Dr Lad], and I don't have that much life left now …… You have to be in touch with your own consciousness on a more spiritual or higher level.

[129] At the time this quote was accessed, this Facebook discussion forum included 192 Ayurvedic practitioners, the majority being BAMS practitioners based in India.

7.5.5 Religion and spirituality inherent in the Ayurvedic consultation

An alternative explanation for religion not being overtly manifest during the Ayurvedic clinical consultation may be that it is an undeclared part of the process. It is possible that some practitioners do not differentiate religion and spirituality as separate concepts from their work and prescribing herbal remedies is a spiritual act. In this case, there would not be a need to prescribe rituals. For some practitioners, the whole consultation processes may be a spiritual act. UK graduate, Thelma, described her practice as '*punya veda*', the practice of Ayurveda as a virtuous act, (resulting in good *karma* in the future).

UK graduate, Brian, made the same point that his spiritual approach is intertwined with his consultations:

> Brian - **I can't divorce the way I deal with clients with my own feelings about life. So I try and live my life in the way I understand Ayurveda to be and not make a separation. So I see my clients like that**. So you can't help but be ... have that kind of thinking informing you. **There's a spiritual dimension to life we're all are connected. So I don't draw a line.**

To summarise this section, I have shown from these examples that the relationship between religion and spirituality changes in different Ayurvedic contexts. In the educational, social and political settings, religion is made explicit through prayers, rituals and ceremonies. However, in the professional context there is a stark separation between religion and spirituality, and religion is detached from the clinical practice (though there are exceptions which are discussed below).

The data here shows that observing only one context gives a distorted understanding of the role of religion and spirituality in the Ayurvedic environments and I suggest that this is the reason why some scholars, e.g. Warrier (2009), have concluded that Ayurveda appears in a spiritualised form in the West. Their conclusions are based on the social context of Ayurveda which is embedded in a religious, spiritual framework, whereas the clinical (professional) context departs from this to align with a biomedical frame. Again, these findings support the contemporary debates which advocate religion as culture. The relationship between the concepts of religion and spirituality are discussed further.

7.6 The relationship between religion and spirituality

The relationship between religion and spirituality lacks clarity as a variety of different perspectives currently exist, making it a rich and complex area of study. Authors including

King (2009: 2), and Heelas and Woodhead (2005: 5) write that the term religion is often popularly defined as a fixed system of ideas while spirituality is increasingly being associated with the personal, subjective aspect of religious experience. This has been a useful heuristic for some researchers, though Wuthnow (1998) argues that care needs to be taken as any polarisation ignores the fact that all forms of spiritual expression manifest in a social context and most organised faith traditions influence personal beliefs. It is too simplistic to think of religion as 'bad' and spirituality as 'good'. Moreover, most people experience spirituality within an organised religious context.

Spirituality is understood as the search for the sacred and may happen within a religious context (Hill and Pargament, 2003: 65). Here 'the sacred' refers to metaphysical phenomena and it is the sacred non-material element that distinguishes religion and spirituality from other phenomena, and is the common denominator for the two. While some researchers differentiate between religion and spirituality, others such as Hampton and Weinert (2006: 28) perceive them as synonymous, as both seem to have a similar effect on health and quality of life, i.e. religious membership improves quality of life and reduces mortality in those with chronic health conditions.

Another option is that being extrinsically religious relates to adopting religious behaviours and attitudes that are institutionalised. Being intrinsically religious or spiritual relates to having a sense of meaning, holding a strong commitment to a religious ideology, belief in God or core values such as love and compassion (Hassed, 2008: 955). Therefore religion and spirituality overlap but are not identical.

Many writers consider religiosity in terms of church attendance, religious affiliation and so forth, though these are not necessarily reflections of spirituality which can be expressed in many different ways that have little to do with rituals and organised religion (Coyle, 2002: 593).Thus the relationship between spirituality and religion is contested as it has been described in various combinations (MacLaren, 2004: 460) and there is little consensus about the definitions and how to distinguish between them.

Authors including Carrette and King (2005: 24), Heelas and Woodhead, (2005: 5), King (2009:2) also cite various meanings that are attached to religion and spirituality, for example: ethical reflection, social justice, righteous economy, charity, oppressive,

dogmatic, sense of community, ethical virtues. For the purpose of analysing the findings of this study, I refer to a study by Russinova and Cash (2007: 272) which suggests three possible relationships between religion and spirituality:

1. Spirituality is the broader term and includes religion. Spirituality is the personal quest to obtain answers about life and may or may not be associated with religion. Religion is the organised system of beliefs and rituals. King (2009: 2) also writes that spirituality is often understood to be wider than religion, suggesting that religion is a subset of spirituality.

2. Religion is the broader term and includes spirituality. Spirituality is the search for the sacred that represents the core of religion. Ammerman (2013: 276) concludes from her empirical study that religion includes the spiritual domain. Religion is a political category and part of culture. [130]

3. Religion and spirituality are separate but overlapping constructs. Spirituality is non-material and private. Religion is material and public, but can be private. David Tacey (King, 2009: 16) writes about the radical split between religion and spirituality. He suggests that religion and spirituality have changed places and the latter is the new higher authority, the arbiter of social identity and human interaction. However the paradox is that religions still possess a spiritual core, so the two are still interrelated.

I have added a fourth possibility to Russinova and Cash's models:

4. Religion and spirituality are distinct concepts and do not overlap. Harvey and Vincett (2012: 156) suggest that spirituality inhabits a different space in society and has a different status from traditional forms of religion (e.g. world religions). It can be seen as truly alternative to majority religion and culture and has played an important role in supporting minority identities, e.g. women. Other scholars also think that spirituality may replace religion as it is 'a better fit with present day needs' (Sheldrake , 2013: 204). However, Sheldrake outlines a number of problems in making a sharp distinction between religion and spirituality. Firstly, a too simplistic understanding of human

[130] Culture is that aspect of thought and behaviour in social groups that is learned and capable of being taught to others; culture can include: language, customs, worldviews, moral/ethical values, and religions.

progress has been discredited due to many of the twentieth century horrors (wars, genocide, nuclear threat). Secondly, the status of religion in the current age is complex and some people turn to conservative forms of religion to make sense of their lives. Thirdly, the religion versus spirituality debate is culturally one-dimensional as it mainly applies to Western societies. In addition, as already discussed, there are problems in defining and distinguishing the terms religion and spirituality (see Ammerman's 2013 study described below). Sheldrake suggests that this distinction depends on a caricature of religions such as Christianity, which is equated with institutional Church and related to dogma and authoritarianism. King (2009: 2) writes that sometimes religion and spirituality are considered two separate independent spheres which exist exclusively of each other. However, she suggests that such a sharp distinction is not helpful for the development of the personal and social transformations.

I have shown that the Ayurveda practitioners' views of the relationship between religion and spirituality is complex as they understand that these four relationships are not necessarily clear cut, but with fuzzy boundaries. The findings of this study clearly show that it is necessary to recognise this fourth relationship as it appears in the Ayurvedic medical context, which is a very specific context related to Ayurveda's position against biomedicine and the state. People commonly define religion and spirituality as overlapping but distinct i.e. overlapping with regard to personal beliefs but distinct in terms of the institutional nature of religion. Russinova and Cash (2007: 275) identify two sets of descriptors that differentially define religion and spirituality:

a) Core characteristics describing the impact of religion and spirituality, table 7.1,

b) Functional characteristics describing the nature of religion and spirituality, table 7.2.

Table 7.1 Core characteristics of religion and spirituality (from Russinova and Cash, 2007: 275)

Core characteristics of religion – the nature of religion	**Core characteristics of spirituality – the nature of spirituality**
Organised, structured, institutional, formal, hierarchical	Informal character
Communal – community	Personal character
Ritualistic character	Awareness of one's own soul
Doctrinal character- principles, system, set of beliefs	Personal relationship with transcendence
Dogmatic - rigid	Exploratory character
Extrinsic character – experience is external	Intrinsic character
Man – made (sic)	Awareness of universal life force
	Sense of universal connectedness
	Continuous character

According to this study, the core characteristics of religion tend to refer to external factors, while the core characteristics of spirituality tend to refer to the internal life of an individual. This suggests that by nature, religion is externally imposed, whereas spirituality is inherent.

Table 7.2 Functional characteristics of religion and spirituality (from Russinova and Cash, 2007: 275)

Functional characteristics of religion – the impact of religion	**Functional characteristics of spirituality – the impact of spirituality**
Supporting, comforting	Compassion and acceptance of others
Judgemental	Meaning - finding
Disempowering	Empowering
Fear inducing character	Promoting harmony and balance
Socially divisive	Letting go of control
Socially acceptable behaviour	Promoting healing

The functional characteristics of religion as popularly perceived tend to be somewhat negative, whereas the functional characteristics of spirituality are positive, suggesting that the impact of the two constructs is on opposite ends of a continuum. The nature and impact of these two constructs may mean that they can be non-overlapping and separate as I have suggested above.

The definition of religion and spirituality depends on the degree of self-perceived religiosity (Russinova and Cash, 2007: 281). People who perceive themselves as religious are more likely to see religion as an extrinsic experience, whilst those who do not perceive themselves as religious are more likely to see religion as dogmatic and prescriptive. Therefore self-perceived religiosity affects the meaning attributed to religion and spirituality. Religious people perceive religion and spirituality as interconnected, while non-religious people consider them as separate.

What becomes clear is that the multidimensional nature of these concepts and diversity of meanings needs to be accepted as a single definition does not fit the diversity of perspectives (Russinova and Cash, 2007: 282). I next consider my findings described above, and show how the relationship between religion and spirituality changes across the different Ayurveda contexts. I argue that the context needs to be considered, to understand how the functional characteristics as described by Russinova and Cash (2007: 275) manifest in different contexts.

In the political context, I argue that Ayurveda is associated with religion in terms of human rights and culture because it is structured, organised and more clearly defined than

spirituality. It relates to a whole community and therefore carries greater political weight than spirituality, which is often used to refer to the individual's personal experience (see table 7.1). Despite the negative connotations that have been attached to religion, some of the core and functional characteristics are important for a context in which people have united to campaign, because a religious community can be perceived as one institution in opposition to the Government, another institution. Dressing Ayurveda with a religious identity is crucial in this situation as religion carries the connotations of tradition, legacy and power to confront the imposition of the European Directive. The findings suggest that despite the problems inherent in the term religion, it is a useful concept, in certain contexts.

Nye (2008: 183-185) writes about the social forces shaping religion in the contemporary world. Current global structures are produced by recent colonial history. Globalisation refers to the complexities of the new world order and is about the flows of people, goods, information and ideas across boundaries and continents and the particular local responses to these flows. Religious traditions are embedded within the forces of globalisation. Localisation is the process by which a sense of the local and distinct is produced. It is sometimes the opposite of globalisation and called glocalisation. Localisation can be expressed through nationalism. After the breakdown of colonial powers, power was transferred through the construction of political nation states. Religious organisations and identities are often a part of national identities. E.g. Hindu nationalists advocate India as a nation, culture and place that is defined historically by its Hindu-ness.

The advice by *Swamiji* to detach religion from Ayurveda relates to another functional characteristic of religion, which is that it can be socially divisive. According to Swamiji, religion should be used with caution as it can be useful if used with care, but damaging if used without due consideration.

In the social context, the Ayurvedic practitioner events are set within a framework that has religious and spiritual aspects, though it is not necessarily made explicit. It may be a particular ritual such as a fire *yagna,* the recitation of Sanskrit prayers, or worship in the form of a dance. Vegetarian food plays a significant reminder of *satvic* qualities, required for spiritual progress. I argue that whether these practices are defined as religious or not, or labelled as universal, they form part of the fabric of the Ayurveda practitioner events. Whether Ayurveda is described in terms of Indian culture, or whether it is broadened and

universalised (see page 94), it is connected through ritual and community, the core characteristics of religion and harmony and connectedness, the functional characteristics of spirituality.

The distinction between religion and spirituality in the Ayurvedic context became clear in the professional consultation and reflected the trend of separation of the two concepts in wider society and in mainstream healthcare context. However, Ammerman (2013: 258) explores the popular claim that spirituality is an alternative to organised religion. Her research findings in the US suggest that the either/ or distinction does not capture the reality and the complexity of the relationship between religion and spirituality (described in detail below).

I have shown that different Ayurvedic settings provide significant insights into the perceived relationship between religion and spirituality, as the link between Ayurveda and religion changes dramatically from one context to another. In the campaign meeting there was a request that Ayurveda be declared a part of Hinduism. In the practitioner event meetings, the religious rituals and symbols are important as they provide a communal and cultural identity; however, they remain undeclared. In consultations, practitioners entirely divorced religion from Ayurveda.

Religion in the form of Hindu ceremonies and rituals continue as part of Ayurvedic culture, but spirituality is permitted in the consultation. The findings also indicate that the practitioners lay understanding of religion implies the traditional model of religion which tends to carry negative meanings. For example, Woodhead and Heelas (2000: 310) report that in the eighteenth and nineteenth centuries most enlightened thinkers expected religion to disappear by the 20th century. Religion was associated with superstition, fetishism, unproveable beliefs, and a form of fear.

In summary, the findings of this study suggest that religion depends on the cultural and socio-political context, and therefore it is a construct rather than *sui generis*. This is in line with Sheldrake (2013: 1) who writes that spirituality has an impact on culture and is also influenced by it. Nye (2008: 200) makes a similar note about religion: 'there is nothing inherent' about the 'nature' of religion and the religious aspect of culture is integral to and inseparable from the wider cultural picture. Religious traditions in the contemporary world are embedded within the process of modernity. All religions are shaped by forces such as

post-colonialism, multiculturalism,[131] globalisation, nationalism, ethnicity and transnationalism[132] (Nye, 2008: 210). Further, the findings show that religion carries a range of meanings and is not a discrete concept that can be easily defined.

Having established that in the professional context practitioners do include spiritual recommendations, in the next section I explore how practitioners define spirituality.

7.7 The definition of spirituality in the Ayurvedic context

The Ayurveda practitioners' understanding of spirituality is examined in relation to their clinical practice (professional context). I examined the ways in which spirituality has been defined and discuss key features from an Ayurvedic perspective. The changes that have occurred from the *daivavipashraya* (religious and spiritual treatments) described in the classical text *Charaka Samhita,* to the contemporary religious and spiritual recommendations made by Ayurvedic practitioners in the UK, are also analysed.

Sheldrake (2013: 3) suggests that 'spirituality' is a word that defines our era. The interest in spirituality has certainly been growing in recent decades, but despite the attention it has received, no one agreed definition has been found. This may be because it appears in a variety of different contexts in contemporary society including education, ecology and health and there are various approaches to it such as secular spirituality, and feminist spirituality (King, 2009: 1).

The lack of clarity in conceptualising spirituality may be one reason why it has been so popular (Carrette and King, 2005: 1); it is vague and can carry multiple meanings. Its ambiguity allows it to operate across different social and interest groups. They say that the word spirituality is used in so many contexts that it is difficult to know precisely what people mean by the term. The striking feature of this term is that it crosses popularly accepted divisions between religious and non-religious realms of life (page 30) and I show that this is a significant feature of spirituality in the Ayurvedic context.

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[131] Nye (2008: 192) defines multiculturalism as the combination of nationalism, ethnicity and religion. All reflect each other, and none are a fixed category.

[132] Transnationalism is the movement of people across the globe for a permanent or temporary settlement. Transnational communities are groups of people who are linked across national boundaries by a common culture and a common sense of belonging. For example, the transnational Indian community has a sense of having their common ancestral roots in India.

Carrette and King (2005: 25) argue that the meaning of 'spirituality' has shifted throughout history. Therefore, the word 'spirituality' cannot be used as if it has some fixed or definitive meaning that is free from debate. Carrette and King (2005: 30) say it is useless to try and find an 'authentic meaning' as socially constructed ideas have a variety of contested meanings (page 30). According to them, trying to give spirituality a universal meaning ignores the historical and cultural uses of the term. It is useless to give spirituality an overarching definition as it misses the specific and historical location of each use of the term. There is no point from history or outside of history from which a fixed and universal term can be determined. The emphasis on truth and authenticity is misleading. Instead, one should ask what are the socio-political effects of the decision to classify practices as 'spiritual', and who benefits from this construction? Other scholars like Heelas (1998: 459), also regard spirituality as indefinable as it is beyond the remit of intellectual inquiry and they think that it is futile to try and define a vague term like spirituality, and better to look at its function. Partridge (2005: 1) also considers 'spirituality' and 'culture' as dynamic, rather than static concepts.

7.7.1 Different forms of spirituality

In the vast literature defining spirituality, a diverse range of experiences are recorded and classified as spiritual. For example, Beck (cited by Carrette and King, 2005: 48) cites a wide range of contemporary meanings: insight, love, integration of mind body spirit, optimism, energy, a sense of transcendence, acceptance of the inevitable. Miller and Thoresen (1999: 7) describe 'spirituality in the silicon valley' which includes 'mountain biking at dusk, quiet contemplation of nature, reflection on the direction of one's life, a feeling of intimate connection with loved ones'. Carrette and King (2005: 1) describe various meanings including: a resource for wholeness, healing and inner transformation. It is something which provides liberation and solace in a world which seems meaningless. Spirituality is generally associated with private and 'other worldly' mystical pursuits, though some people such as Annie Besant (1847 – 1933), socialist and theosophist, associated it with social reform, political activism and the pursuit of economic and social justice (page 41). Carrette and King suggest that the term spirituality has now become the 'brand-label' for the search for meaning, values, transcendence, hope and connectedness in capitalist societies (page 32). It is a merchandising label for all sorts of undefined ideas about the self, inner self, wholesomeness and quality of life (page 53). Spirituality can be mixed with anything, and as a positive but vague cultural trope it has the ability to inject any product with a 'wholesome

and life-affirming' quality (page 46). It can have simple meaning such as 'increased awareness' to more specific references such as traditional meditative disciplines. According to King (2009: 3), the characteristics of whatever is deemed to be spiritual include anything life enhancing, holistic and supportive of human well-being in the widest sense.

Sheldrake (2013: 3) suggests that contemporary literature includes the following four approaches to spirituality: attention to the holistic; the quest for the sacred; a quest for meaning; the concept of thriving (I discuss the latter three in the next chapter).

Ammerman (2103: 260) describes spirituality as a culturally constructed discourse. She maintains that spirituality is a cultural phenomenon rather than what its psychological or theological essence may be (page 262). She explores what people mean when they use this term in an empirical study which includes a sample of ninety-five adults in the US with a range of religious and non-religious affiliations. They identified eleven meanings for spirituality:

- A religious tradition – identifying with or participating in a religious tradition
- Ethics – Living by the golden rule, acting as a caring person
- God – Acknowledging and experiencing Divine presence
- Practices – Activities in pursuit of spiritual development
- Mystery – Things that cannot be explained by ordinary means
- Meaning – Wholeness and purpose in life
- Belief – Believing in God
- Connection – Transcendent sense of connection to others
- Ritual – Symbolic invocations of spiritual presence
- Awe – Transcendent sense of wonder and beauty
- Self – Sacred inner uniqueness of the person

Source: Ammerman (2013: 263 – 264)

Ammerman found that the participants employed multiple definitions e.g. awe and God, ritual and mystery, meaning and morality, suggesting that the cultural world that they occupy supplies them with multiple ways to indicate the things that belong to the spiritual realm. Further analysis identified cultural packages: theistic, extra theistic, ethical and 'belief and belong' spiritualities.

Theistic spirituality is about God, practices which develop one's relationship with God, and mysterious encounters. Across denominations, the Christians actively engaged in their congregations, talked about spiritual life in religious terms with a focus on God. The Neo-pagans also talked about different deities, whereas the non-affiliates were less likely to employ theistic terms to describe spirituality. Theistic spirituality is a product of the specific interactions and cultural activity sustained in particular religious institutions.

The extra theistic package is spirituality in terms of a different kind of transcendence, beyond the ordinary, where the spirituality is located in the self, in connection to community, in a sense of awe of the natural world and various forms of beauty. These have been described as 'immanent' as they need no authority beyond the person's own experience. Both the religiously active and the religiously indifferent relate to the extra-theistic spirituality (page 270).

Ammerman suggests that her findings compare with European studies (despite methodological differences), showing that spirituality is culturally packaged. The theistic and extra theistic definitions represent spiritualities that occupy distinctive, but overlapping cultural locations. However, the common ground across both definitions is that real spirituality is about living a virtuous life which is characterised by helping others. Three quarters of the sample identified spirituality in moral terms. This ethical spirituality exists both within and outside religious communities.

Ammerman (2013: 273) found that the definition of spirituality as belief and belonging relates to believing in God and doctrines about God as well as being part of a religious tradition i.e. religiosity. However, the results are mixed regarding whether this kind of spirituality is good or not. Both the religious and secular participants include these indicators in their understanding of spirituality. This is because of the dual meanings they carry. Believing can either refer to devout spirituality or superstition. Belonging can refer to a positive identity or being trapped in an authoritarian tradition. The religious participants tend to connect belief and belonging together as a positive expression of spirituality, whereas non-religious people relate to repressive regimes. Ammerman (2013: 273) concludes that there are distinct discourses about spirituality, each within its own cultural locations. The caution that needs to be taken in reading Ammerman's findings is that it is from the US and a similar study in the UK may produce different results.

Fuller (cited by MacLaren 2004: 460) argues that secular spirituality has had a widespread impact on Western culture. This began from the Enlightenment era with the rise of rationalism and science and rejection of religion, but not the existence of God. According to Fuller, the effect of the secular spiritual quest has to some extent stimulated the widespread interest in alternative healthcare.

7.7.2 Definition of spirituality in healthcare

Although some scholars argue that spirituality cannot be defined, others suggest that the way spirituality is defined is important as it shapes the way its role is understood in the life of a person and a community. This means there is a need to have a contemporary understanding of spirituality in healthcare. MacLaren (2004: 458) argues that there is a need for a definition that is universal, but one that also allows for the uniqueness in individuals.

According to Collins (2006: 254), there is no conceptual consensus for a definition of spirituality that is coherent across all the different health professions. If there was an agreed definition then it would be possible to link all the health professions e.g. biomedicine and also CAM. Partridge (2005: 29) argues that along with the growth of the holistic milieu, research shows that educators and academics tend to work with holistic definitions of spirituality and the nursing literature refers to the totality of the person as encompassing body, mind, and spirit. Whereas it could be stated that body refers to physiological elements of the person and mind the psychological and emotional elements, it is less clear what is meant by the spirit.[133] In Chapter one I briefly outlined the literature on what some academics have described as 'spiritualised' Ayurveda in the West. I now examine the meanings of spirituality in UK Ayurveda.

Warrier's (2009: 6-8) research based on interviews with UK Ayurveda trainees who she describes as 'spiritual seekers' illustrates that they are different in all respects to the students who apply for Ayurveda admission in India. For some spiritual seekers, Ayurveda is the culmination of their quest for truth and meaning. For others, it is a holistic system of healing and fits their view of healing. They are dissatisfied with biomedicine and its reductionist/exclusivist philosophy and turn to Ayurveda which is holistic and inclusivist.

[133] Although I refer to mind, body and spirit, Ayurveda addresses also the social and environmental influences on health. The social and environmental factors are inherent in the Ayurvedic approach to health.

Warrier (2009: 11) reports from her study that spirituality carries multiple meanings. Spirituality is seen as the domain of personal seeking, freedom and experimentation with ultimate truths. Thus it is perceived as opposite to religion which is marked by institutional control, constraint and dogma. This is in line with the subjective turn suggested by Heelas and Woodhead (2005: 2-4). The subjective turn is a turn away from the life lived in terms of external objective roles, duties and obligations, and a turn towards a life lived by reference to one's own subjective experiences.

Warrier's findings show that spirituality is often represented as linked to self-knowledge, self-discovery, and the recovery of the 'authentic' self. Here the self relates to nature as the microcosm to macrocosm. The spiritually realised person is one who has cleared all psychosomatic 'blockages' and is perfectly attuned to nature's rhythms. Spirituality is linked to self-empowerment, i.e. by living according to the principles of Ayurveda one can gain mastery over oneself and realise one's human potential to the full. Here, spirituality is not about the other worldly quest for liberation central to most Indic traditions but striving for the good life in the here and now.

In order to analyse my data, I examined a variety of models of spirituality including the following: spirituality having two interconnected dimensions; the vertical dimension representing the personal relationship with the transcendent (God, higher consciousness) and the horizontal dimension representing relationships with oneself, others and nature. In this model, spirituality has been reduced to two dimensions differentiating between the physical and non-physical (Stoll, 1989).

A model of spirituality having three dimensions includes categories of intrapersonal, interpersonal and transpersonal connectedness (Buck, 2006: 290). Delaney's (2005) model of spirituality also includes three categories: self-discovery, relationships and eco-awareness. Boyce-Tillman's (2013) research reveals a six –fold model which identifies six main areas in which people have an experience of God. First, interGaian (concerned with the relationship to the other-than-human world); second, intrapersonal (within ourselves); third, interpersonal (relations with other people); fourth, extrapersonal /ethical (our relations with the wider world, the global context); fifth, the metaphysical (the experience of God as a voice inside, as an answer to prayer, or as a vision or guiding principle); and

sixth, narrative which 'refers to the fund of 'story' in which an individual 'dwells' and that constitutes the primary reference for religious identity'.

Coyle (2002: 591) developed a trichotomy of approaches to spirituality by reviewing the literature on spirituality and health and identifying the essential attributes of spirituality. I employed Coyle's (2002: 591-592) model of spirituality as a framework to analyse the findings of this study and understand how spirituality is defined in the Ayurvedic context, as it offers a trichotomy of approaches: the transcendent, value guidance and structural behaviourist approaches. In the transcendent approach, some form of transcendence is an essential feature. According to the value guidance approach, spirituality is within any value that gives life meaning and purpose. The structural behaviourist approach focuses on actions and behaviours that are associated with religion. The three approaches were sufficient to explain my data, the structural behaviourist approach being particularly important as it addressed the behavioural recommendations that practitioners make during a consultation which I describe next.

7.7.2.a The transcendent approach

The transcendent approach described the type of spirituality which promotes a positive, calm, peaceful harmonious state of mind, a belief in oneself through connectedness with the divine who gives meaning, purpose and hope. It helps people to accept adversity, and cope with change.

Many of the interviewees in this study said they believe there is a God or a divine being, who is working at a greater cosmic level. For example, South Asian graduate, Dr Dhani, shared her thoughts:

> I have suffered many shocks throughout my life in a very small age, but it's the spirituality which has helped me, and that spirituality or the faith in the God it has all come from the base of Ayurveda which I have been learning since my childhood.

Ayurvedic practitioners also referred to spirituality as the essence of a human being, which can be described as the *atma* or soul. This is understood to be eternal, non-changing and is the non-material or transcendental part of the person which connects to God/Transcendence. It is the essence of a person which has the quality of sameness and allows for a connection with all others and also gives a sense of continuity.

This may be from a state of being that is the essence of being human, to an external form of divinity. It is also the relationship with oneself and others. It is simultaneously a part of the inner world of the person and the outer world as well as one that is beyond the human world. Spirituality was also interpreted as practices that enable one's spiritual development.

The idea of attaining *moksha* emerged, which is generally understood as gaining liberation from the material world and going to a spiritual level, indicating the belief that there are two distinct realms, and the soul can go from the material to the spiritual realm. Spirituality was understood as an act of remembering. This referred to remembering one's true nature, that the individual is in actuality the essence or the soul and not the material body. When one remembers this, then one is able to become detached from the material world. This process of getting to know oneself was tied up with the act of remembering which indicated that it may not be about finding something new, but becoming aware of what there already is within. Remembering takes one on an inner journey to knowing oneself. Brian illustrates his understanding and shows the multiple meanings all interrelated:

> Q - How do you define spirituality?
> Brian - ..... for me it's tied up with a **sense of meaning**, ... it's tied up with **a sense of relationship with things**, its tied up with **a sense of relationship with to a bigger … picture, to the divine** …… so **it's remembering really**.

Spirituality defined as relationships was important and discussed primarily in two different ways. They could either be a connection with others or everything, i.e. the individual and something that is external. Relationships could also be with one self in terms of that which develops when one begins to know oneself on the inward journey and begins to understand one's own needs. Visiting practitioner, Dr Neha, emphasised this:

> Q - and what's your definition of spirituality?
> Dr Neha - …….. And of course **taking time with yourself**. Being with your soul, **understanding the need of the soul that is necessary in spirituality**.

Relationship could be described and interpreted in Ayurvedic terms as the relationship between the microcosm and the macrocosm. This included others as family and community, the eco-system as well as the entire cosmic realm. A few practitioners, who discussed spirituality as values, are described next.

7.7.2.b The value guidance approach

The value guidance approach places emphasis on values such as love and compassion, through which people find meaning and purpose in life. These may help the patient to

understand their experiences and take control. These qualities are important in Ayurveda and described in the classical texts. Few practitioners mentioned spirituality in terms of values, maybe because they are understood as inherent to the nature of the role and behaviour of the practitioner. Nevertheless, medical convert, Dr Kishore, described the connection between love and healing:

> Dr Kishore - Yes, because **when you have spirituality, then you find yourself in a state of spiritual wellbeing, a rite whereby you start loving all your nearest people and, larger still, in the society.** So, when all those intimacies are going around, **then it is very much healing to each other.** So it is an act of ritual **- a knit together feeling.** It is very much expanding into a dimension which is a need of the… which is a call of the need, and we have to find our potential and bring into that field the direction to keep expanding.

Most of the interviewees tended to describe the spiritual recommendations they make during a consultation in terms of the structural – behaviourist approach which is discussed next.

7.7.2.c The structural-behaviourist approach

The structural- behaviourist approach to spirituality examined behaviours such as church attendance and religious commitment which may provide a source of social support and encourage healthy behaviours. However, it found no automatic relationship between religiosity and the benefits of transcendent spirituality.

The Ayurvedic practitioners in this study tended to mention religious and spiritual techniques that they may be using in their own personal practice. Medical convert, Dr Ben, who had trained with Maharishi Ayurveda mentioned Transcendental Meditation as a technique that he recommends, while UK graduate and spiritual seeker, Brian, described encouraging his patients to reflect on their life, to look at the 'bigger picture' and use techniques such as journaling and meditation for self-reflection . Medical convert, Dr Kishore, said that he advised people to use *mantras* as his personal quest had led him to study their effect on healing, whereas medical convert, Pritesh, said that he would advise people to adopt practices of non-violence and vegetarianism or control their behaviour in terms of intake of alcohol. I would argue that the implication of this diversity of spiritual recommendations is that a satisfactory clinical encounter will depend on a good match between the patient and practitioner's spiritual expectations and inclinations. For example, if the practitioner prescribes journaling and self-reflection as part of the spiritual recommendation, but a patient is seeking knowledge of *mantras,* then there is a possibility that the patient may not be fully satisfied with the Ayurveda consultation.

The majority of interviewees mentioned prescribing activities such as yoga and meditation as spiritual recommendations, which are practices that enable one's spiritual development. South Asian graduate, Dr Rajesh, illustrated this:

> Q **-** What role do you feel spirituality has in the practice of Ayurveda these days?
> Dr Rajesh - I think it depends on the patient's interest. If they are interested in spirituality then I think we can touch that point because, background of religion plays an important role. We don't consider religion when we treat a patient. Different religion people and religion has got its own spirituality points, therefore I don't touch that point in detail about spirituality when I deal with patients**. I consider yoga is an important point**. **And when I deal with the yoga sometimes, patients ask about meditation. If they ask, then I go with the meditation. I think that's what spirituality is for me.**

In the Ayurvedic context, behaviours such as yoga or meditation were frequently mentioned as spirituality or spiritual practices. Stahle (2010: 253) reports from his study of Ayurvedic counsellors in Sweden that his participants also tended to recommend meditation and yoga. Warrier (2009: 16) shows from her study of UK graduates that yoga and meditation are prominent in the recommendation packages; they were seen as ways to enhance self-awareness, and to strive for healing and transformation.

Sheldrake (2013: 220) writes that one aspect of contemporary spirituality is the priority given to spiritual practices rather than complex theories. This 'turn to practice' has appeared in a range of academic fields. Previously, texts may have been the focus, but now equal attention is given to practices. The practices may include different forms of meditation, physical movements such as tai chi or yoga, disciplines of frugality and abstinence (e.g. from meat or alcohol) and spiritual retreats. The positive aspect of practices allows the individual direct access to spiritual experience.

The structural-behaviourist approach is a useful framework in this context for defining spirituality, as Ayurveda practitioners referred to practices such as yoga and meditation as spiritual treatments. Health research measures behaviours such as church attendance have a social component, whereas Ayurvedic practitioners most commonly recommend yoga and meditation which focus on the individual and 'going inwards'. Warrier (2011 b: 16) suggests that the Ayurvedic seminars and CPD events refer to the need for practitioners to develop 'practice orientated spirituality'. This involves a process of cultivating self-awareness and compassion through personal practices such as daily meditation, observation of silent retreats, yoga and self-reflection in order to enhance their qualities as healers. But, as Warrier suggests, these endeavours were not unique to the UK graduates

that she describes as spiritual seekers. My findings indicate that South Asian graduates are also interested in self-development to enhance their role as Ayurvedic practitioners.

> Dr Priya - …. Need to practice Ayurveda…

These three approaches offer different ways to understanding spirituality and may not be mutually exclusive. Whether a healthy lifestyle is adopted, or a calm state of mind is developed, or a patient is better able to cope with adversity depends on the content of each of these three approaches. Practitioners need to explore how patients experience the benefits from their particular system/s.

Thus, Ayurvedic practitioners interpreted spirituality in different ways, though according to Coyle's model, the transcendent model and the structural behavioural approach were mentioned more frequently in this study. The Ayurvedic definitions tended to overlap considerably well with those found in the healthcare literature. The key difference appeared to be the inclusion of spiritual practices such as breathing, yoga and meditation as definitions of spirituality.

7.8 Changes from classical *daivavipashraya* to contemporary *daivavipashraya*

I next discuss the spiritual practices that are 'prescribed' during an Ayurvedic consultation and consider the changes that have taken place from the *daivavipashraya (*religious and spiritual treatments) in the *Charaka Samhita* to modern day *daivavipashraya* of UK Ayurveda. See table 7.3.

Table 7.3 Comparison of *daivavipashraya* in the classical texts and this study.

***Daivavipashraya* (religious and spiritual treatments) in the classical texts.** (Ca/su/11/v54)	***Daivavipashraya* (religious and spiritual treatments).** Findings from this study 2010-11)
"…..incantation of mantras, talisman, wearing of gems, auspicious offerings, gifts, oblations, observance of scriptural rules, atonement, fasts, chanting of auspicious hymns, obeisance to the gods, going on pilgrimage etc….."	Yoga, Breath (*pranayama*), Meditation, Self-reflection, (If guru trained - astrology, gems, fasts, mantra, *vastu* …..)

The most common, contemporary spiritual recommendations that Ayurvedic practitioners made included yoga, meditation and *pranayama* (yogic breathing). A few techniques such

as journaling as an aid for self-reflection, and *mantras,* were mentioned but only if the practitioner was comfortable in prescribing these to patients. Spiritual traditions must be considered in their context as the origins and development of spiritual traditions reflect the circumstances of time, place and psychological state of the people involved, and embody values that are socially conditioned (Sheldrake, 2013: 12).

The finding raises the following question: why is yoga prescribed as the modern spiritual recommendation considering it has been secularised in the West? I next explore what secularisation means in the British context and show that the situation in Britain is complex.

7.8.1 Secularisation in the UK

Woodhead (2012: 1) writes that religion in the first part of the post war period in the UK was mainly influenced by its relation to the state. The relationship with the market gained importance after the 1970s, a key factor being the formation of the welfare state. Religion seemed to have disappeared in the decades from the 1960s to the 1990s, and during this period secularisation was prevalent. [134] However, religion had not died; rather it was changing form outside the control of the state and church, in relation to the opportunities being given by the media and the market.

Weller (2008: 105) draws attention to the fact that the concept of a 'secular state' does not have a clear and shared meaning among those who use it. Just as religion can be understood in varied ways so can the concept of 'secular'. For example, Weller (2008: 106) includes a list of some of the understandings of a secular state developed by Dopamu which include:

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[134] Woodhead (2012: 8-9) writes that secularism was aligned with the belief in the epistemological priority of science and its ability to deliver reliable knowledge which is superior to other forms of knowledge. The position that many positivists maintain is that science holds the key to all knowledge and what cannot be known by scientific means must be dismissed as nonsense. … the power of science, especially the natural sciences is supported by money and politics through massive research investment and other forms of state legitimation. Scientific medicine under the guise of the NHS took over from the traditional forms of healing and care. Though much of this power and prestige remains, public confidence in the ability of science to deliver a perfect society diminished. Woodhead (2012: 10) says that alliances between the business world and science have challenged the idea that science is value free. A loss of confidence in secularism was also influenced by a loss in faith in the welfare state and new global ideology of neoliberalism (page 11).

A state where: -religion is suppressed -religion is not given official recognition -Government is neutral in matters of religion -there is freedom of worship -no religion is imposed on the people or there is no State religion -advancing science and technology have limited the sphere of influence on religion. -there is a waning of institutional religion or where fewer people regularly attend religious services. -there is a separation of religious from political, legal, economic or other institutions.

(Source: P. Ade Dopamu cited by Weller, 2008: 106)

In addition, secularisation may be just as value- laden as religion. The definition of 'secular' depends on the definition of religious, which varies on the perception of religion in society. This is why secularism varies so widely across different national and political contexts (Woodhead, 2012: 4). Sheldrake (2013: 210) writes that the word 'secular' was not originally the opposite of 'religious' as it meant 'the here and now' and referred to priests who work in the everyday world rather than live in monasteries.

In the West, there has been the view that modernity is antagonistic to religion, therefore there is a decline of religion (Nye, 2008: 201). However, this refers only to certain traditions of religion in Western culture, i.e. Christian churches. Therefore secularisation refers to the decline of Christianity in the West, not a general decline of religion. Further, secularisation refers not only to numbers, but to the role of religion within contemporary society. Religion (Christianity) has lost the social significance that it once had. Secularisation is the process by which religious institutions, actions and consciousness lose their social significance (Nye, 2008: 202).

Weller (2008: 52) suggests that secularity with an indifference to religion is very much a part of the plurality of contemporary UK. Nevertheless, there are some secularists who are concerned about giving religion a prominent role in public life; for example, the British Humanist Association and National Secular Society argue that religions should not be privileged and the state should adopt a neutral position with regard to the religious commitments and identities of its citizens (Weller, 2008: 105).

Post war Britain has been shaped by secularisation which has been the dominant framework suggesting the decline and privatisation of religion. Recently, this has been

challenged by desecularisation theories which suggest that religion has been revived and deprivatised (Woodhead, 2012: 3). Secularisation theories suggest that as societies modernise they inevitably secularise. But research has given mixed results and secularisation is so established that it shapes how agendas are set, research questions are asked, survey questions are framed, and data collected and analysed.

In contrast, Woodhead (2012: 2) suggests that it is only an assumption that Britain is considered a secular country as religion has become a private matter with no public or political significance. Rather, Woodhead takes what she describes as an integrated approach which suggests that religion is integral to the wider changes in global economy, politics, media, and the law. According to the integrated approach, the secular cannot be ignored. Both religion and secularism have shifting meanings and are not static and timeless.

In post war Britain, the state has taken over many of the functions and resources of churches and religious voluntary bodies. Minority religions have become more prominent since the 1980s and alternative spiritualities have also been growing in the same period. Religion has been on the agenda since the 1990s in government policy, legislation and legal cases in the media because religion never disappeared (Woodhead, 2012: 7).

Woodhead (2012: 11) writes that in the post war period in Britain there has been movement from Christian to secular, to multifaith, and they are not smooth transitions, but rather they co-exist at different levels of society e.g. secularism being dominant at state level and multifaith at local or regional level. Woodhead suggests that these phases may be better understood as a complex set of ongoing competitions for power between different groups in society associated with different ideologies and interests. During the post war period, different interests gain greater visibility and power (page 12). Therefore, post war Britain is both religious and secular.

As regards the relationship between secularisation and yoga as a spiritual recommendation, Carrette and King, (2005: 117) suggest that the widespread popularity of yoga in the West is largely linked to its secularisation. The secularisation process began in 1930s in India, when teachers started to adapt traditional yoga practices for the general public. BKS Iyengar transformed yoga into a popular practice for the West. He transformed it as a physical regime designed to promote relaxation, exercise and good health.

Yoga was traditionally an exclusive system for spiritual development, which has now become a mind-body health technique, with a research literature on health benefits (Carrette and King, 2005: 114).[135] Singleton (2010: 1) through his scholarly study of the social factors influencing the development of modern yoga arrives at a similar conclusion: that the focus on the physical postures is a feature of modern transnational yoga rather than a reflection of classical yoga. De Michaelis (2008: 15) further adds through her academic study of modern yoga, that it has been secularised and rationalised to Western expectations, and has been accommodated in two spaces: at the margins of health and fitness and in the sphere of alternative medicine.

Alter (2005: 126) writes that in the ancient world Ayurveda and yoga were quite separate and rarely if ever interacted. He said that the current demand for Ayurveda and yoga in the West seems to be driven by a New Age orientalist desire for esoteric eastern knowledge (page 129). What are for sale are purity, wellness and enlightenment.

In contrast, Partridge (2004: 57) suggests that many new religions and spiritualities effectively incarnate their theologies in contemporary western culture, thereby sacralising the secular. This does not mean that they trivialise religion and transform it into something that lacks depth and significance. New forms of spirituality address concerns current in the cultures in which they are evolving. This may involve the utilisation of new practices, beliefs, ideas. Hence, terms and ideas such as reincarnation, *chakra*, *karma* and *prana* are entering mainstream Western thinking and being reinterpreted and adopted by Westerners seeking to develop their spiritual practices, and this is not secularisation.

There is a need to distinguish between sacralisation and secularisation (Partridge, 2004: 55).[136,137] Some scholars may see a process as evidence of secularisation, while others

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[135] Carrette and King (2005: 22-23) argue that traditional spiritualities had a transformative power with an emphasis on self-sacrifice, the disciplining of desire and recognition of community. The new business spirituality has the goals of productivity, work efficiency and the accumulation of profits. The primary function of contemporary business spirituality is the perpetuation of the consumerist status quo, rather than a critical reflection upon it. Carrette and King (2005: 119), argue that the metaphysical, institutional and societal dimensions of ancient yoga traditions are largely lost in the translation and popularisation of yoga in the West. The ancient techniques of introspection and self-control designed to transform one's mind away from false identification with the individual ego, instead are adapted to relieving daily stress. The goal of the Hindu yoga tradition is to overcome selfish attachments through the practice of rigorous regime of psycho-physical techniques to turn the consciousness inwards, and not to reinforce one's sense of an embodied self.

[136] Partridge (2004: 3) suggests that both secularisation and sacralisation are occurring together.

perceive it as sacralisation. The boundaries are malleable and blurred; for example, religious imagery can be used in secular ways, i.e. a crucifix can be worn as jewellery or as a statement of religious conviction. Partridge (2004: 55) gives an example of the Monastery of Christ in New Mexico where the monks have acquired computers and are connected to the internet. Questions that arise include: does the monastery become less sacred because it has computers? What is secular technology? What constitutes a secular artefact? What is sacred and what is secular?

An alternate view is that there is religious and non-religious spirituality (Carrette and King, 2005: 50). This reflects its effectiveness in carrying multiple meanings across the secular-religious divide and spirituality has flourished because it has found a place in secular markets (page 43). The findings of this study suggest that the recommendations of yoga and meditation are better described as 'non-religious spirituality' (Carrette and King, 2005: 50), rather than secularised (Partridge, 2004: 55) as the religious component remains implicit and can be drawn upon if required. Given the personal beliefs of the practitioners, it is less likely that the recommendations are secularised, meaning that religion has been completely removed.

It should be noted that practices such as yoga and meditation are recommended as part of *dinacharya,* the daily routine for maintaining good health (Broom et al, 2012: 117). In order to maintain health, one is expected to follow a health promoting lifestyle which includes spiritual practices in the early morning.[138] Some basic training in yoga is included on BAMS courses in South Asia, as well as on the Ayurveda courses in the UK and are generally prescribed as part of the *yuktivipashraya* physical therapies for health promotion, or for remedial purposes as part of the daily routine.

As I showed at the beginning of this chapter, practitioners tend to separate religion and spirituality in the professional clinical context and while they may enthusiastically take part in religious ceremonies which are part of the social Ayurvedic context, they exclude religion from their clinical setting, only allowing in what might be deemed as spiritual. What might

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[137] Partridge (2004: 57) says that mystical religion / self-spirituality fits with the beliefs and values of modernity.

[138] Yoga has been popularised in the West (Newcombe, 2008) and has also gained popularity India and amongst South Asians living outside of India through Indian TV channel by Indian yoga guru Swami Ramdev. Other personalities like Sri Sri Ravishanker have also in the past promoted yoga and breathing as techniques for improving health and spiritual development.

have been defined as religious practices, e.g. yoga and meditation, are now detached from the religious context and converted into health techniques, with an aim to make them culture-free, in order to give them universal application, like biomedicine. This is illustrated by Dr Murli who said he was an atheist, but that *daivavipashraya* was important, and he gave an example of prescribing meditation as that was good for the mind. This illustrates that modern spiritual techniques are acceptable because they can be both spiritual and pertaining to the sacred, but at the same time be categorised as non-religious spiritual. This perhaps is the unique quality of spirituality that it is simultaneously sacred and divine, but at the same time can manifest as material and secular.

Heelas (1998: 5) suggests that the de-regulation of the religious realm and cultural emphasis on freedom and choice results in intermingled and interfused forms of religion, resulting in the 'religious-cum-secular'. Heelas (1998: 3) further says that the boundary between sacred and secular loses its hold in many alternative therapies and healing provisions. He says that this is an example of de-differentiation of modernity with regard to the secular –sacred boundary, i.e. the religious has become less obviously religious and the secular is less obviously secular.

What is noteworthy is that yoga and meditation have already been popularised and accepted in the West and at the same time they can be linked back to spiritual traditions. Therefore, they can be categorised as *daivavipashraya* and satisfy the classical requirement to treat the unknown, while at the same time there are versions that have been commercialised and secularised and detached from religion, so that they can fit into the professional context. It is a matter of perception, whether yoga, meditation and so forth are seen through a religious lens or a secular one.

This illustrates how on the one hand Ayurvedic practitioners continue to claim the classical texts as their authority, as discussed (see page 98); but on the other hand in the specific context of recommending *daivavipashraya*, the practitioners have reinterpreted the traditional religious prescriptions (amulets, pilgrimage etc.) and now prescribe yoga and meditation as the modern religious and spiritual prescriptions. This indicates that in circumstances where it is deemed appropriate, practitioners hold onto the religious and spiritual dimension, but interpret it in a way that is appropriate to their current context.

Another question that arises is the significance of the change from classical *daivavipashraya* to contemporary *daivavipashraya.* One way of interpreting the change may be that in the classical texts *daivaviprashraya* or religious and spiritual treatments addressed issues at soul level (*atma*) and aimed to clear *karma* to enable good health through prescriptions of atonement, magic charms or charitable donations as these treatments were specifically prescribed for diseases with an unknown cause.

Contemporary Ayurvedic spirituality refers to developing a calm (*satvic*) mind, which helps to achieve good health. According to Patanjali's *Yoga Sutras* the purpose of yoga is to still the mind. Therefore, spirituality in contemporary Ayurvedic terms may be to calm the mind, as a calm mind enables health. However, some scholars may argue that it is not possible to distinguish between the effects of the spiritual treatments on the soul and the mind.

Although religion and spirituality are separated in the Ayurvedic medical context, there are some practitioners who do prescribe traditional '*daivavipashraya*' treatments. Dr Lad's annual seminars are the most popular APA events. He talks about God and philosophy, and often looks at the astrology chart of a patient and prescribes mantras, gems and other rituals as required by the current cosmic influences. His sessions are popular and people find his holistic approach appealing. It may be that the traditional religious and spiritual treatments carry an element of authenticity for some audiences, and exotic appeal for others. Participants describe his approach to Ayurvedic treatments as 'whole'. Dr Lad has had guru training and accomplished in the traditional *daivavipashraya* remedies. This is further evidence for the concept of theistic spirituality which Ammerman (2013) describes in her study. Further, the findings support the approach that scholars such as Woodhead (2012: 2) take that religion continues to be an integral part of the social landscape in Britain.

Medical convert, Dr Kishore, is another example of a practitioner who is comfortable about the religious and spiritual element of his practice. He does not differentiate between different religions that his patients may be following. For him, spiritual practices are beyond the confines of religions and can be practised by people from other traditions:

> Q - So somebody who is, for example, a Christian who visits church, would you still recommend the mantra?

> **Dr Kishore - Why not? I mean, *mantra* doesn't have to be necessarily from the Eastern religion. They can chant their own *mantras* if they want to…….I mean, it is a universal thing. What somebody can think if they're doing some meditation, they can visualise even their own sacred hymns or sacred symbiotic representations. It doesn't matter, even they can focus on the cross – on Christ's cross.**
> Q - So each individual can use their own…?
> Dr Kishore - Yes, I would never enforce … **Let them just find their own way**, or I will try with them to discover a potential of these practices and **let them make their own decision later on, once they know what other benefits are there from the Eastern culture.**

Similarly, Alter (2005: 107) cites the example of traditional Qigong masters who purposefully maintain position as religious healers. In this way they retain a sense of awe and authority and distance from science.

Whether Ayurveda is identified with Indian culture or whether it is broadened and universalised, practitioners connect it to religion through the core characteristics of ritual and community and the functional characteristics of spirituality, which are harmony and connectedness. By detaching religion from the clinical consultation, practitioners by-pass religious differences and dogmas, and work in a spiritual zone where the boundaries between different systems are less clear.

7.9 Shared culture

In the previous chapter, I observed that shared culture between the patient and practitioner impacts on the nature of the consultation. I argue that in India, due to the shared religious narrative, practitioners if inclined can include religious and spiritual aspects in their consultations. For example, a Hindu BAMS practitioner treating a Hindu patient can, despite his/her biomedicalised training, discuss *daivavipashraya* because they share the same religious narrative. When the same BAMS practitioner comes to the West he/she may not share the same religious beliefs with the patient, but can offer spiritual advice, if the patient is showing interest. Thus, the South Asian practitioners move from utilising the communal core characteristics of religion in India, to the universal core characteristics of spirituality in the UK. Similarly, the UK graduates draw upon their personal interest in spirituality and may bring this in to the consultation using vocabulary that fits the situation.

7.10 Conclusion

The findings of this study show that within the Ayurvedic context in the UK, the relationship between spirituality and religion is influenced by the cultural and socio-political context. This is evident by way religion is explicit in some contexts, e.g. the political context in which

first generation Hindus embed Ayurveda in the Hindu tradition. It is implicit, but an important cultural aspect of the educational and social environments of Ayurveda students and practitioners, both in India and the UK. However, the key change occurs in the clinical/professional context in which many practitioners either completely exclude religion or replace it with spirituality. This context is influenced by the way Ayurveda practitioners position themselves as health practitioners and align themselves with their biomedical counterparts. Therefore, the findings support the approach to religion which advocates that this concept is a social construct.

I would argue that the concept of religion is useful for some people, despite the negative connotations associated with it, as it holds positive meanings and is able to provide a social and collective identity. Religion describes certain aspects of human activity and is a key cultural concept, and the study of religion and culture helps make sense of the contemporary world, making it a useful and necessary category (Nye , 2008: 19).

The findings show that the term religion is not a neutral or unproblematic concept. Its meanings are constantly constructed, reconstructed and disputed and bound up with political struggles, interests and social shifts (Woodhead, 2012: 24). The findings provide evidence for the existence of many 'spiritualities'. Traditional spiritualities are defined by traditional religion whereas contemporary spiritualities are secular, newly created and rooted in experience (King, 2009: 4)

The findings support both secularisation and sacralisation. In India, Ayurveda in the Government run institutes appears in a secularised form. However, in the UK there is evidence of both secularisation and sacralisation within the Ayurvedic context, and it is the spiritual and in many cases the religious aspects of Ayurveda that appeal to consumers, particularly for those seeking a metaphysical dimension to their healing which they do not find in biomedicine.

The difference between my findings and some of the literature on global Ayurveda which suggests that Ayurveda has spiritualised in the West, may be because the scholars have only considered one context where they have examined the form of Ayurveda (see page 154).

In the next chapter I consider Ayurveda practitioners' personal beliefs about the link between spirituality and health and their decision making in relation to recommending spiritual treatments.

Chapter eight The Role of Religion and Spirituality in the Clinical Context

8.1 Introduction

In the previous chapter, I explained that my research findings show that practitioners distinguish between religion and spirituality and these concepts carry various meanings. In this chapter, I examine Ayurveda practitioners' perceptions of the link between health and spirituality and analyse their understandings of the mechanisms by which religious and spiritual treatments operate to enable healing. I also investigate the circumstances in which practitioners recommend religious and spiritual treatments in the Ayurvedic clinical context. I end the chapter by assessing to what extent Ayurveda practitioners in the UK comply with the following quote by a senior Ayurvedic practitioner who indicates that increasing spirituality is beneficial for health:

> We should reduce the intake of three 's' – saturated fat, salt, and sugar, and **increase the other 's' – sports, salads and spirituality**.
> (Hollen, 2005: 88)

8.2 Religion, spirituality and health.

Bowman (1999: 181) asserts that an interesting feature of twentieth century spirituality has been its link with healing. People want to be healed rather than saved, as healing is the new salvation. Interestingly, the link between religion and health is emphasised by the founder of modern psychology, William James in his 1902 published lectures (Seeman et al, 2003: 53). Sir William Osler [139] also describes the benefits of faith in the British Medical Journal in 1910 (Chatters et al, 1998: 689).This idea of the metaphysical influencing the physical has been replaced to some extent by germ theory, vaccines, and surgery which obscures the importance of the social and cultural factors related to health and well-being.

An emphasis on the understanding of the influence of religion and spirituality on health began to re-emerge due to public demand in the 1960s, and there is a growing literature in mainstream healthcare which indicates a positive relationship between spirituality and health (Hassed, 2008: 955). The concept of spirituality has received increased attention in nursing, psychiatry and occupational therapy (Tse et al, 2005: 181). In the nursing context, spirituality is not only important in terms of the care given to patients, but also in terms of

[139] Considered the founder of modern Western biomedicine – see Chatters et al (1998: 689).

the nurses as individuals whose personal spirituality may be an unspoken element which may improve the quality of the care they provide (Tse et al, 2005: 181).

The growing literature on the relationship between religion, spirituality and health is indicated by publication of articles in prestigious journals (Thoresen, 1999: 292). In some parts of the UK, Government policy has required NHS managers to establish policies of spiritual healthcare appropriate to a multi-cultural society (MacLaren, 2004: 457). Heelas and Woodhead (2005: 67) say that there have been moves in the NHS, official and unofficial, to introduce aspects of spiritual care. Trainee nurses learn about spiritual care. Hospital mission statements use terms which indicate spiritual sensitivity e.g. care for 'whole' person. Some GPs refer patients to CAM practitioners, while some GPs themselves train in CAM modalities (see page 126).

According to Fuller (cited by MacLaren, 2004: 460) the secularisation of Western medicine has caused people to look for holistic health practices which treat people as spiritual beings. Healthcare grounded in alternative spirituality has much to offer practitioners. Some authors argue that the absence of spirituality in modern medicine has led to an increasing disenchantment of both doctors and patients and spirituality can re-enchant the practice of healthcare (Collins, 2006: 254).

Research in this area is showing that spirituality and religiosity are important contributors to both physical and mental health in terms of prevention, improvement and recovery as well as the ability to cope with illness and adversity (Hampton and Weinert, 2006: 27, Hassed, 2008: 955, Coyle, 2002: 589, Cohen and Koenig; 2003: 215, Hill and Pargament, 2003: 64).

It is important to note that the literature also highlights the negative aspects of religion and spirituality which may have a detrimental impact on health (Fallot, 2007: 264). These may manifest as negative religious coping linked to: greater affective distress, increased anxiety, increased depression and lower self-esteem. Religion may also cause increased interpersonal strain, conflicts with God, struggles with belief, imperfect striving, and experience of rejection, marginalisation, and abuse of power. Belief in sin may erode self-esteem. Being part of a congregation may be a source of stress rather than support.

According to Ellison and Levin (1998: 713) some coping styles give positive results; for example, coping in collaboration with God. But other coping styles may have negative impacts e.g. passively leaving the responsibility for resolving crises entirely up to God can lead to pathological health related consequences. Other negative coping responses include: "righteous anger", prayers for divine vengeance, and feelings of divine abandonment.

Practitioners may also hold negative views of religion and spirituality such as the patient being dysfunctional, neurotic, and having rigid irrational belief systems. They may feel that religion and spirituality is beyond their expertise and feel a lack of knowledge, or lack of confidence. Practitioners may find spirituality confusing because of the many versions on offer in the 'spiritual marketplace'. In addition, there is an increasing tendency to draw elements from different traditions, therefore a need to understand the individualised spirituality of each person. Some professionals from religious communities have concerns that religion and spirituality are being reduced to secular concepts and/ or religion and spirituality are being used as instruments, and their purpose is lost.

There has been increased research in a range of academic fields including sociology, psychology, health behaviour and health, education, psychiatry, gerontology and social epidemiology (Ellison and Levin, 1998: 700-1; Francis et al, 2008a). However, some may argue that compared to the importance of religion and spirituality in the population, it remains understudied. This may be due to a number of reasons including the lingering influence of Freud who described religion as a 'universal obsessional neurosis', therefore marginalising and pathologising religion in medical and psychological education and practice (though later Jung saw the search for meaning as the central human motivation, Hassed, 2008: 955).

Other likely reasons may be that religion and spirituality are not seen to be of central importance in health research because the biomedical model of health is based primarily on the physical body.[140] Religion and spirituality may also be perceived as an area outside of scientific study, and when studied, they have been included as add-on variables and

[140] Although the research on religion and spirituality and the impact on health indicate a positive relationship, it must be noted that there are several weaknesses (Thoresen, 1999: 295; Ellison and Levin, 1998: 709 – 715, Hill and Pargament, 2003: 70, Cohen and Koenig, 2003: 230 - 32). Buck (2006; 288) summarises the methodological difficulties with existing studies which include: the construct of spirituality, issues of measurement, design of the studies, and the analysis of the data, making clear that that there are problems at all stages of the research process.

quite often the measures are brief, single item and imprecise global indices such as frequency of church attendance. These are likely to weaken the association of religion and spirituality variables with health variables, resulting in smaller effect sizes, than would be the case if better and more reliable measures were used. Also, the complexity of the relationship between the two is overlooked. They are complex variables which involve cognitive, emotional, behavioural, interpersonal and physical dimensions. Having said this, even simple measures have been robust in predicting health outcomes, and Hill and Pargament (2003: 65-66) suggest that there is something inherent within the religious and spiritual experience itself which influences health.

8.3 Mechanisms of religious and spiritual practices

In order to explore Ayurvedic practitioners' understanding of the mechanisms of religious and spiritual treatments I employed Ellison and Levin's (1998: 703) seven explanatory mechanisms for the impact of religion and spirituality on health. I used their framework to compare findings from the mainstream healthcare literature and the findings from this study. The seven mechanisms are:

1 Regulation of lifestyle and healthy behaviours

2 Social resources

3 Promotion of positive self-perceptions – e.g. through developing a close personal relationship with the Divine who loves unconditionally

4 Coping resources (to stress) e.g. prayer and meditation may help person to reassess the meaning of the illness

5 Positive emotions (love, forgiveness) - emotions may be expressed through psychoneuroimmunological or neuroendocrine pathways and affect physiological systems.

6 Healthy beliefs – having the belief or expectation that religious practice will benefit may result in positive health outcomes.

7 Other (spiritual healing, distant prayer, healing bioenergy).

These are described in greater detail with examples from the healthcare literature to illustrate each mechanism, and compared to the findings of my study. See table 8.1 for a summary.

Table 8.1 Comparison of mechanisms of religious and spiritual practices on health from healthcare literature and this study.

Ellison and Levin **7 explanatory mechanisms**	**Mechanisms from healthcare literature**	**Mechanisms from the findings of this study**
Healthy Lifestyle behaviour.	Healthy habits	Spirituality as a discipline
Provision of social resources	Social support / supportive relationships	Social mechanism
Promotion of positive self-perception	Self Esteem / resilient sense of self	
Coping responses (to stress)	Ability to cope	
Positive emotions		Positive values
Healthy beliefs	Transcending illness Trust in God Perceived closeness to God Hope Positive Mind Change of perception Orientating and Motivating Forces	Framework / personal meaning Positive impact on mind Change in perception
7.Other mechanisms		Increase in *satvic guna* Spirituality as a health tonic Spirituality as a catalyst Patient practitioner relationship Other subtle mechanisms e.g. astrology

8.3.1 Regulation of lifestyle and healthy behaviours

This mechanism works through controlling the mind which results in behaviours that are deemed to be conducive to health; for example, controlled intake of alcohol, adopting a non-violent way of life as well as controlling one's thoughts and senses in relation to sense objects. Ayurvedic practitioners emphasise disciplined diet and lifestyle. Medical practitioner,Pritesh, shared his view:

> Q **-** Do you think there is a link between spirituality and health?
> Pritesh **-** Yes, I think it is, definitely think there is. Not spirituality, **but the principle of it. Because it gets you in that frame of mind, because there are certain things you will not do.** And that will help, like ....alcohol, they say in moderation is fine, but even in moderation it still affects your mind, I think it does have some part, or the principles.

Focussing the mind is seen as a key for activating good health. The focus may come through activities such as meditation and chanting. Thoresen's (1999: 292) findings show that some religious groups live longer, for example Mormons and Adventists, and suggest that this could be due to healthier habits such as no smoking or no drinking. It is unclear whether non-religious groups who do not drink or smoke would have the same outcomes on longevity.

8.3.2 Social resources

Longo and Peterson (2002) demonstrate that spirituality acts as a significant source of social support which involves others, a higher power and a sense of being and belonging in a community. Social support acts to buffer the impact of a specific stressor. Research shows the support from members and leaders of a spiritual/religious group has a number of health benefits. The support can be a valuable source of self- esteem, information, companionship and practical assistance that buffers the effects of mental illness. The spiritual or religious community appears to function by protecting individuals from the effects of social isolation and social exclusion. They can offer spiritual support during adversity, provide and strengthen family networks.

Thoresen (1999: 292) found that members of some religious groups such as Mormons and Adventists have longer life spans, and suggests this may be due to strong family support. However, for these religious groups, healthy lifestyle, as described above is also possible factors to good health, so it would be necessary to untangle the effects of healthy lifestyle and social support. According to Fallot (2007: 266), practitioners perceive spirituality as working through supportive relationships which give a sense of belonging and attachment. He found that patients' perceptions of religion and spirituality are associated with important social support and community (Fallot, 2007: 263). These give a sense of belonging and acceptance and a sense of connectedness. Other mechanisms include finding inspiration, [141] and feeling empowered.[142]

A few Ayurvedic practitioners described the social mechanism. This operates through religious and traditional festivals and practices. Medical practitioner, Dr Ben, described examples of this, and at the same time illustrated points raised earlier about Ayurveda having a universal appeal, being applicable to all cultures and traditions, and separate from religion. Here he described a social/cultural model for health:

> Q - Any other examples?
> Dr Ben - Christmas is a wonderful strategy for balancing *vata* in *vata* season. A lovely heavy meal. Lots of rest, lots of family, home, comfort, warmth. What more could you do to balance *vata* in the *vata* season.

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[141] Hampton and Weinert (2006: 30) describe faith as an important chronic illness management tool. In one study, women showed willingness to use spiritual resources during a crisis and in daily life. Women shared faith with each other by sharing Bible verses which led to connecting through a commonality and finding inspiration from the messages.

[142] Coyle (2002: 595) suggests altruism empowers patients as they help others through the strength they find in their own spiritual practice.

Interestingly, Dr Ben relates the activities of Christmas having a direct impact on Ayurvedic physiology through the *vata dosha* and weather /season. However, for this mechanism to be plausible, activities of other religious festivals throughout the year would also need to be related to balancing the Ayurvedic humours.

8.3.3 Promotion of positive self-perceptions

Longo and Peterson (in Tse et al, 2005: 184) suggest that self-esteem is often considered an important element of coping and recovery from mental illness. According to Faull and Mills (2006: 788), practitioners perceive spirituality as something which gives a resilient sense of self and overall sense of well-being leading to health; similarly, patients' perceptions are that spirituality strengthens the sense of self and self-esteem (enhanced personhood, empowerment) (Fallot, 2007: 262). Ayurvedic practitioners in this study did not specifically mention self-esteem as being directly affected by spiritual practices.

8.3.4 Coping resources (to stress)

There appear to be a number of ways that enhance a person's ability to cope with an illness. It may be through beliefs and activities that enhance coping with life stresses (Fallot, 2007: 266), prayer and social support[143], finding meaning and purpose[144], strength and new perspectives.[145] Patients perceive religion and spirituality as having distinct coping responses, behaviours and activities that mitigate distress. Coping strategies were prayer, attendance at religious services, worship and meditation. These help in coping with symptom severity (Fallot, 2007: 262). Despite the positive benefits, Fallot (2007, 264) also describes the negative impact of religion and spirituality; for example, these may include patients expressing anger at God, questioning God, feeling punishment and discontent with religious communities and leadership (see above).

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[143] Walton et al (cited by Hampton and Weinert, 2006: 28) found that women with chronic illnesses used prayer to find inner peace and to connect with others for support which brings a sense of comfort which results in an improved ability to cope with illness (Hampton and Weinert, 2006: 28).

[144] Spirituality contributes to finding a sense of purpose and hope in the context of illness, and developing attitudes that help to motivate people leads to better coping which enables them to overcome their illness (Hampton and Weinert, 2006: 28).

[145] Spirituality has been seen as a coping mechanism where the meaning of events can be evaluated and interpreted in the light of the individual's spiritual belief system, which leads to enhanced, positive coping. An individual gains strength and has a new perspective from the spiritual beliefs to deal with the adverse situation (Longo and Peterson cited by Tse et al, 2005;184)

Ayurvedic practitioner, Dr Neha, described a very different coping mechanism. For her, detachment allowed a way of being in the world without having to experience negative emotions. Dr Neha explained the importance of detachment:

> Q - and what's your definition of spirituality?
> Dr Neha - ……. In one word a detachment, in a true sense. So that you are not unhappy by sorrow and you don't become extremely happy when you get something good in your life and you don't become frustrated or sad when you don't get something in life. So it's kind of detachment to things. So you are doing your 100% in life, but you are not attached. When you are not attached you will always be free from fear and a lot of those things which leads to doing something without integrity.…….

Detachment was not mentioned in the literature review as the majority of the studies on religion, spirituality and health have been focused on the Christian groups. Detachment was not mentioned as a central concept in these groups, whereas it is an important one in the Hindu tradition. There is a need for more studies of the impact of different religious and spiritual traditions on health.

8.3.5 Positive emotions

Coyle (2001: 592) suggests a trichotomy of approaches to understanding spirituality which include the transcendent and structural behaviourist approaches (see pages 181-183). The third, the value guidance approach, places emphasis on values such as love and compassion, through which people find meaning and purpose in life. These may help the patient to understand their experiences and take control. Medical convert, Dr Kishore, based his healing work on this approach to spirituality:

> Q - So, basically, you know, spirituality enables us to love?
> Dr Kishore - Yeah, yeah. **To love, compassionate, intimate relationships.**
> Q - And that brings about the healing?
> Dr Kishore - Yes**, that transforms the healing,** absolutely.

It may be that more practitioners could have discussed this mechanism as being an important component of healing, but see it as an implicit and integral part of the process, and therefore did not discuss it explicitly. Perhaps on direct probing more details may have been given.

8.3.6 Healthy beliefs

Having the belief or expectation that religious practice will benefit, may result in positive health outcomes. The medical profession describe this as the placebo effect. Practitioners described four mechanisms which I have placed in this category, indicating the importance of having a positive belief. According to my categorisation, healthy beliefs can have a

number of different meanings: personal meaning, trust in God, transcending illness, and hope, which I describe next.

8.3.6.a Personal meaning

A healthy belief in terms of personal meaning may refer to religion and spirituality, providing overarching frameworks that orient them in the world and provide motivation for living. Religion and spirituality can provide people with a sense of their ultimate destination in life. They give goals or spiritual strivings which may be empowering, as well as provide stability, support and direction. Within this framework, health may be regarded as sacred (Hill and Pargament, 2003: 67-68). Research has shown that people experience less stress and conflict, and derive greater satisfaction and meaning from aspects of their lives which they view as sacred.

Spiritual motivation has positive psychological implications. Higher levels of intrinsic religious motivation have been associated with better mental health, self-esteem, meaning in life, family relations, and a sense of well-being (Hill and Pargament, 2003: 67-68). This is a view that underlies the Ayurvedic approach as it is every person's *dharma* (inherent duty) to take care of their health as the body is a temple for the soul.[146] The *Charaka Samhita* states that good health is required for spiritual pursuits which are the ultimate goal of life. UK graduate Brian expressed his belief:

> Brian - ..... To be healthy is important, to include that element [spiritual] so people understand their part in **the bigger picture**. There is a meaning to their life. Their life is precious. To inform their moral behaviour and responsibilities as well.

For the Ayurvedic practitioners, a particular religion or a specific spiritual practice is not of significance; rather the meaning that it holds for the patient is valued and encouraged as this is seen to be the key ingredient. This aspect of the treatment is entirely patient-centred as medical convert Dr Devi reported:

> Q - What kind of spiritual practices would you feel are helpful in your work…?
> Dr Devi - I think everything – all spiritual practices. Everything is, and it depends what is suited to the person because not everybody will be comfortable with meditating and some people are more devotional and some people prefer to meditate; some people prefer to serve. So whatever you can – **whatever you do, in God's hands it's going matter.** You know, I feel a lot of things have been described in the text, like *puja* or pilgrimage, or in different things like that. **Everything has its role and everything is in a way up to the person.**

[146] Presentation on Ayurveda and Spirituality. BAAAP conference (10.7.09)

Having this approach allows the practitioners to work in an eclectic way, with patients from different traditions.

8.3.6.b Trust in God

Here, healthy belief refers to the conviction that God/higher power has an all-encompassing knowledge which will help patients to counter the uncertainty they experience in the diagnosis, symptoms and prognosis, the stages of a disease which cause fear, discomfort, pain and suffering. Having the trust that all is taken care of can dispel the uncertainty and enable them to heal (Coyle, 2002: 594).[147] UK graduate Brian described his belief in a Divine power:

> Brian - **Um there is a spirit or soul within each individual which has a role for the person's health**, and in the direction of their life. Now and into the future and a link with the past. My own personal perspective is that **there is a divine, connected into some cosmic consciousness.**

Hill and Pargament (2003; 67-68) report that people who claim to have a close connection with God experience a number of health related benefits: less depression, higher self-esteem, less loneliness, greater psychosocial competence and give better self-related health scores. These findings are not explained by non-religious factors, which may suggest that a trust in God adds a unique component to the adjustment to stressful situations.

8.3.6.c Transcending illness

Healthy belief in this context refers to a conviction that illnesses can be transcended, either through connecting with others or the Divine, [148] or through belief in God or the Divine.[149] Although Ayurvedic practitioners expressed religion and spirituality in terms of

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[147] Coyle (2002, 595) says there is a growing recognition that a patient's belief in God and their religiosity/spirituality is an active-cognitive process rather than a passive submissive one. Just as values like Marxism guide action, in the same way transcendence and religiosity/spirituality may result in activity; for example, they cite a study in which HIV patients said their spirituality enabled them to question conventional drug therapy and ask for treatments more suitable to their mental and physical needs.

[148] Hampton and Weinert (2006: 27) claim that spirituality is a means by which people can connect either with others or a higher power. This allows them to transcend the illness state and also provides a sense of meaning or purpose to life. Transcendence of illness is important because it helps people look beyond their current state of health to connect with a higher power / or other individuals and use the strength from that connection to manage their illness and ultimately achieve purpose in life (Hampton and Weinert, 2006: 28).

[149] Having a belief gives connectedness, self-transcendence, and meaning and may enable a person to manage their illness.

Transcendence (see page 181). Medical convert, Dr Kishore, indicated his belief in connecting with others and God:

> Q: …. Do feel that spirituality has a role to play within Ayurveda?
> Dr Kishore: Yes, it is a big role, spirituality, because the whole of the science of Ayurveda is coming from a great philosophy in India…. *Samkhya* philosophy where the *Purusha* is a choiceless .. energy, and the *Prakriti,* an unmanifested form, they blend together but when you have to negate the body, mind and your consciousness – everything going back to merge with Nature, you have to go beyond to merge with *Purusha*, and that is what spirituality is. So you have to dissolve your mind and body, and that dissolution brings you back to your true self, and that is what it is.

Here, Dr Kishore describes coming back to 'your true self' which refers to a state of health and well-being, as the true self is a disease-less state of being.

8.3.6.d Hope

A healthy belief can mean having hope as it refers to an individual's perceptions of the future. It is closely linked to anticipated outcomes about one's life. Hope can enhance an individual's sense of purpose and meaning in life. It can also offer a motivational pathway towards achieving and maintaining goals. Hope is generally a self-generated, emotion-focused (cognitive) coping process, influenced positively or negatively by the environment and personality traits. Spirituality can provide people with a sense of hope which lends greater strength to persevere in pursuit of goals, support and direction in critical times, and the strength to cope with the adversity associated with mental illness.[150] Hope helps people to adapt to and cope with illness as it focuses the mind on future outcomes important to the individual.[151] Medical convert, Dr Devi, describes her experience with one patient:

> Dr Devi - We're not talking religion, you know….. anyway now she is much better and **she's very strongly connected, and I think that the one therapeutic thing for her – the most therapeutic thing for her was her ability to reconnect to faith. I think it was her faith that actually carried her through and her faith has helped her more than anything else**…

However, in direct contrast to hope, Fallot (2007: 265) describes that religious or spiritual experiences may result in despair. This may be a result of negative beliefs of divine abandonment, condemnation or retribution which may have a negative impact on recovery.

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[150] Fallot (2007: 266) found that practitioners perceive spiritual acts as giving a sense of purpose that in turn gives hope, whereas patients perceive spirituality as giving a sense of hope, which leads to purpose and well being (Fallot, 2007: 263). Tse et al (2005: 183) suggests that spirituality can enhance health as it gives meaning to everyday life.

[151] Coyle's (2002: 595) studies show that hope enhances adaptive capacities of people with chronic illnesses, and the elderly. Hope is a 'spur to action'. Hope motivates people, can help to expand or revitalise interests and may alter personal outlook i.e. provide respite from the despair of the illness.

I have shown that Ellison and Levison's healthy belief mechanism has a variety of meanings including a personal meaning as a spiritual striving or duty, trust in God taking care of them, the conviction that disease can be overcome, and having hope for the future.

8.3.7 Other (spiritual healing, distant prayer, healing bioenergy).

The Ayurveda practitioners in this study indicated a good understanding of the way religious and spiritual practices influence the mind. The outcome may be a change in the quality so it becomes finer and sharper or a change in the activity levels so that it becomes calmer. It may change in function so that it becomes detached to the adverse situation, or stops negative thoughts and allows positive ones to be generated.

Spiritual practice → mind becomes finer, calmer, greater clarity [152]
Spiritual practice → disengages mind → detachment
Spiritual practice → stops negative thinking → more positive
Spiritual practice (e.g. chanting) → focuses mind

According to Ayurveda, the mind and body are one system (Ranade, 2005: 141-142). The mind is described as a subtle aspect of the gross material body. As a result, treatments such as *panchakarma* which appear to be powerful physical detoxification treatments working on the body, have a powerful detoxing effect on the mind as emotional and psychological blocks are cleared, often resulting in radical transformations in the person. The mind is described as being present throughout the physical body and is influenced by the commonly described *doshas* and can also be accessed through over one hundred energy points (*marma* points) around the body. The practitioners described direct connection with the mind and body, outlining psychobiological pathways that illustrate how a spiritual practice may directly influence the physical body. A change in the quality or function of the mind has a direct impact on the physiological processes of the body.

Spiritual practice → calm mind → better digestion / better immunity → good health.
Spiritual practice (*pranayama*) → improved body functions (lungs) / better mind (reduces anxiety / panic)
Spiritual practice (*pranayama*) → better sleep patterns / balances energy
Spiritual practice (meditation) → balanced *doshas /* reduces stress
Spiritual practice (meditation) → better nervous system function

Medical convert, Dr Devi, explained why a spiritual practice is fundamental in the Ayurvedic healing system, and the impact it has on the mind:

[152] I have summarised mechanisms from the data and presented them as word equations whereby the arrows (→) indicates what practitioners perceive to be a causal relationship. For example, spirituality practice causes or leads to the mind becoming finer, calmer and develop greater clarity.

> Q - .. do you think there is a link between spirituality and Ayurveda?
> Dr Devi - Oh, gosh – **yes. It's fundamental. It's really fundamental, because without a kind of spiritual health or philosophy, then the mind doesn't function clearly and the body is also not functioning clearly.** It's not seeing – it's not like, you know, not grasping or understanding the knowledge. **You don't see the truth clearly, so in the context of spiritual, the mind becomes more and more *satvic***, so the more you practise, the more you have spiritual practice or opening, the more **the mind becomes finer – refined and more *satvic* and a *satvic* mind gives a sense of stability to the mind and clarity, and it's protective against in a rather… against disturbance.** And if mind is disturbed .. this can be done because it goes from the most subtle to the gross . So spiritual is really ..

The Ayurvedic practitioners described a number of mechanisms which I have placed in this 'other' category. These include spirituality as a health tonic, changing the quality of the mind (increasing *satvic guna*), as a catalyst, as a key ingredient of the patient - practitioner relationship as well as other subtle treatments using astrology, gems, mantra all based on adding 'the missing vibrations' in a person's energy field.

8.3.7.a Spirituality as a health tonic

Spirituality was in general deemed to be good for health, like a health tonic that can be taken daily for the maintenance of well-being. UK graduate, Brian, explained:

> Q - And can you tell me a bit more about what you mean by spiritual perspective?
> Brian **-** Um there is a spirit or soul within each individual which has a role for the person's health, and in the direction of their life. Now and into the future and a link with the past. My own personal perspective is that there is a divine, connected into some cosmic consciousness.

This general tonic mechanism also included activities such as reflection and self-exploration to search for meaning as well as awakening, reconnecting and recognising one's own true nature. The understanding may be about oneself, but also the relationship between the self and the universe, i.e. the micro and the macrocosm.

> Q **-** can you give me an example of an activity?
> Brian - Let's say Journaling, encouraging people to write a journal, to put down their thoughts, what happens to them. Starting to get them to think about… bringing things out from an emotional level**. One thing is to get people to get people to write their life story, what's happened in their life. Reflect upon the whole thing. So they can start to see their life as having some sense, continuity, flow to it.**

The Ayurvedic practitioners described the need to disengage the mind and have a new outlook as important. UK graduate, Thelma, discussed the several merits of meditation as an invaluable method for good health:

> Thelma - Once the meditation has taken place and there's been that pause, **you can then have a fresh look at life and just get on with things in a new way.** I find that that happens, and so stress is stopped. But it calms so many other things down. I mean, you don't want me to start quoting all the research do you?

According to Thelma, there is research evidence for the benefits of meditation. By referring to research, she is validating meditation as a technique that is deemed to be effective through scientific methods.

8.3.7.b Increase in *satvic guna*

According to the Ayurvedic model of health, the *guna* or quality of the person is crucial for health and wellbeing (Ranade, 2005: 141). The psychological quality of *satva,* often translated as goodness, truthfulness, or stability, is desired as it is a *satvic* mind that is the crucial coping mechanism. A *satvic* mind is steady in all circumstances, including adversity, enabling a person to detach and retain a clear perception about reality. A *satvic* mind is strong, focused, and undisturbed by stress, nor does it succumb to worries and anxiety. When the mind is steady, the body automatically becomes calm which enables healing to take place. A disturbed and stressed mind leads to a disturbed and stressed body which does not allow healing to happen.

> Spiritual practice → increased *satva* → focused mind → discipline / healthy habits → health.
> Spiritual practice → increased *satva* → see the true nature of things and self.

Practitioner Thelma highlights the benefit of meditation on the mind:

> Thelma - So, when you have meditation, **meditation kind of takes you into the depths of your being, however deep the meditation is, and it gives you a peaceful situation so that the *doshas* actually can become normalised**, you know, and you reach a state of ….. There's also the mental ***doshas*** of ***satva, rajas, tamas*** and the meditation, if you're in a ***rajasic*** state, on the go, stressed, or whatever **– it can really bring you to some peace. It creates a space so that the body gets a rest.** It's said, actually, that if you have meditated for half an hour, sometimes it's better than having, you know, two or three hours' sleep, and it's also a state of restful awareness. It's not just – it's not just being still or going to sleep. It's actually doing something else to the body and the mind, and then there can be **clarity**….

A *satvic* mind is fundamental and develops through a *satvic* diet and lifestyle as well as spiritual practices. A number of practitioners described yoga, meditation and pranayama as their spiritual recommendations which increase the *satvic* quality of the mind.

> Spiritual practice (yoga etc) → **calm mind + increase in *satva*** → better health

This shows that Ayurvedic practitioners perceive spiritual practices as having a direct impact on the body.

8.3.7.c Spirituality as a catalyst

Some spiritual practices act as catalysts to enhance the effect of the Ayurvedic treatment. Visiting practitioner, Dr Neha[add ,] recalled her observation of her patients:

> Q - …. You mentioned Ayurveda is also linked to the soul. Mind, body, soul. Do you feel there is a link between spirituality and health?
> Dr Neha - Very much. I have done research in *panchakarma* and people who do chanting and meditation of any kind that they believe in along with *panchakarma*. **Their results are 40-50% greater than people that don't do any meditation practices.**

Ayurveda treatments work better in conjunction with spiritual practices as they aid the healing process by making the mind positive.

Despite the general positive view of spirituality, some practitioners were clear that spirituality alone is not sufficient to deal with medical issues. On the one hand, spirit and matter are one and non-different. On the other hand they are distinguished, and the healing of the physical body is regarded as of primary importance. Once the body is healed and the mind-body system is in balance, only then is a person ready for spiritual practices. Visiting practitioner, Dr Neha, explained:

> Q - And what's your opinion about the role of spirituality in Ayurveda?
> Dr Neha - Both go hand in hand and both go together, and if you say only with Ayurveda I will heal something, I would say yeah, but if you have spirituality, healing is faster. But some people go in extreme direction and just with my mind I will control the disease but that's not possible. There are so many problems that are so physical, you have to remove physical toxins, move them out of the body. That's very extreme things that alone cannot work. But if you have spirituality on your side, Ayurveda works better.

Here, Dr Neha emphasises treating the whole person, starting with the physical issues and spiritual practices as supporting this.

8.3.7.d The role of the practitioner and the patient practitioner relationship

Similar belief systems facilitate the patient-physician spiritual interaction and bring greater confidence in the relationship. Patients want their physicians to explore questions of religion and spirituality and faith with them. If approached appropriately they can contribute to the patient - practitioner relationship. The spiritual dimension is a fundamental aspect of human functioning, which positively affects healing and health, and should be an active component of healthcare. Openness about religion and spirituality is important in the therapeutic relationship.

Ayurveda offers an understanding of the role of the practitioners and patient practitioner relationship, whereby healing can occur through the interaction of the patient and practitioner. UK graduate Thelma described the way in which the interaction may work at a subtle level:

> Thelma - …. **According to Maharishi Ayurveda, the consciousness of the doctor meets the consciousness of the patient, and it's through this interaction of consciousness that the cure is actually taking place.**

I discuss the patient practitioner relationship in greater detail in Chapter nine.

8.3.7.e Subtle mechanisms

I placed an array of other mechanisms together as 'subtle mechanisms' because, as the title suggests, they act on the subtle aspects of a person. According to visiting practitioner, Dr Lokesh, they include *marma*, colour, aroma and *mantra* therapies as well as yoga and herbal remedies. Both yoga and herbal remedies were seen as treatments for the physical aspects of the person, but also subtle, hence they work on multi-dimensional levels. This highlights the difficulty in applying biomedical classifications to Ayurveda. The biomedical paradigm dichotomises physical and subtle, whereas in Ayurveda they are part of one system:

> Q **-** In your opinion what is the role of spirituality in Ayurveda?
> Dr Lokesh - Ayurved is spiritual science. Ayurved is very very meditational. It goes together with *astanga* yoga, *yama, niyama, asana, pranayama, pratayhara, dharana , dhyana and Samadhi*. Even *tanmatra chikitsa* and *shabda chikitsa* contains mantra ... *sabda*. *Sparsha chikitsa* contains certain *marma chikitsa marma* therapy. *Rupa chikitsa* is colour therapy *rasa chikitsa* or *rasa shastra* , including *rasa virya* , *vipaka* including herbology. *Gandha chikitsa* aromatherapy. So when we look at all these Ayurved is very spiritual and we teach spiritual side of Ayurved to the students. Unfortunately Ayurved that is taught in India is not spiritual. It very mechanical. It is like modern medicine .... which is very good ... not bad, they teach only anatomy, physiology, this, this and this, but then in reality what happens once that student get BAMS degree, he uses that degree to practice allopathic medicine. This is my observation, I may be wrong. But this is my observation, they use BAMS, the majority of the student and they practise allopathic medicine. Then why you learn Ayurved? On the contrary this is not authentic.
> So Ayurved is very spiritual .... very rational and very .... transformal. It can transcend the person.. transform the person. Just by learning Ayurved ..... you can change the life of an individual. *Dharma, artha, kama and moksha. Dharma* the righteous duty, *artha* the monetary success, *kama* fulfilment of positive desires and *moksha* to bring enlightenment. These are the goals of Ayurved.

Herbs were placed in this category of subtle mechanisms because of their particular *gunas* (qualities). For example, South Asian graduate, Dr Rajesh, said that *tulsi,* holy basil, has *satvic guna* (the quality of goodness) and enhances the *satvic* qualities in a person. This also helps to reduce stress.

> Dr Rajesh - …. my interest is on stress and stress management is most of the interest part. And when I see the stress and if I take 100 individuals who has got stress and it has got 100 causes, different causes. Therefore a person has got any reason stressed and one of the reason the physical, spiritual or mental body is involved. Definitely that has got connections. More than that some of the herbs which I mentioned in Ayurveda. **Like oils, they have got the ability to deal with spiritual things also. There are good herbs which deal with the spiritual things, for example *tulsi*, the Indian basil which deals with mostly**

> **spiritual things. There are a lot of herbs which can be used as spiritual healings in Ayurveda.**

Subtle mechanisms also work on the emotional body and clear *karma*. These mechanisms directly link to the cause of disease as located at an emotional level or in the mind, often cited by practitioners. The first verse of the *Astanga Hrdyam* describes emotions such as passion and anger as being the cause of disease.

The use of subtle therapies depends very much on how evolved the patient is as well as the practitioner. According to Dr Ben, a spiritually evolved patient can heal through the vibration of the name of the herb. And a spiritually evolved practitioner can heal a patient through his/her presence:

> Dr Ben - There are for example mantra therapies. Those will work on people that are more spiritual. As Maharishi pointed out initially we use herbs, but as we evolve we will use the sound of the herb. The name of the herb will contain the essence of the vibrations, which when we are enlightened enough we can absorb on that level.
> And ultimately when we are fully there the Ayurveda physician, by virtue of his enlightenment, whoever comes into his presence will realign their awareness.

Traditionally, religious and spiritual practices called *daivavipashraya* mentioned in *Charaka Samhita* were used when all other known treatments had failed. Some practitioners may turn to spiritual and subtle treatments when the patient is not responding to the initial treatment. South Asian graduate, Dr Karan, described using astrology in cases where Ayurvedic and yogic treatments had not produced the desired healing.

> Dr Karan - …… If Ayurveda is not giving effect. If yoga not giving complete effect, it means there is something else, which is in the *Vedas*, timing is very important. The law of *karma* is very important, then you have to go to astrology which works on the sixth, seventh, eighth, ninth senses, beyond our five senses. It works on a different plane. So you make use of it.

Overall, there was an acceptance that healing can happen in many ways and at many levels. There may even be occasions when it is beyond the practitioner's ability to help the patient through known methods based on logic and reasoning. UK graduate, Hannah, described the possibility that she leaves open when working with patients, which suggested that in this approach not all healing can be accounted for through scientific explanations, which has implications for research:

> Q - And how does Ayurveda kind of relate to that aspect – that spiritual aspect?
> Hannah - Well, the realisation that the two – both the practitioner and the patient – are on a journey together and something can fruit out of that; just the connectedness; just the acknowledgement, that that person sitting in front of you is part of the oneself and I've often felt that the positive regard that I have for another**, it can create a miracle, and I always leave a space for that to happen, and I've often been very surprised that, through**

> **that aspect – attitude that I have with a patient, what can arise out of that, and it's often nothing to do with cognitive, rational thought.**

I have presented the various methods and mechanisms from a brief review of the mainstream healthcare literature and my own findings. It shows that one method can operate through different mechanisms; for example, having purpose or meaning can lead to transcending illness, and a positive mind can lead to healthy behaviours, developing inner peace or increasing self-confidence. Also, different methods can result in one mechanism; for example, prayer, social support, having a meaning or purpose and positive attitude can all improve the ability to cope, which in turn impacts on health.

As cited above, Hill and Pargament (2003: 66) suggest that there is something inherent within the religious and spiritual experience itself which influences health. What is also clear is that a robust understanding of the ways religion and spirituality connect to an individual's health is required. Further research could explore whether any secular mechanisms could produce the same outcomes.

To summarise, the Ayurvedic practitioners described a variety of mechanisms which have some overlap with those in the mainstream healthcare literature. These include social support and healthy habits as well as beliefs that enable one to cope. However, they also describe some mechanisms that did not appear in my review of the healthcare literature (though they may have been described in studies not included in the review).[153] These mechanisms included religion and spirituality as being a catalyst and thereby speeding up the healing process, and religion and spirituality as a health tonic, which has a preventative function of helping to maintain health. It may function on subtle levels and there may be unknown mechanisms outside of the scope of the biomedical model. Ellison and Levin (1998: 703) reviewed the mainstream literature and include an 'other' category for mechanisms currently unknown and not understood. In Ayurveda, these unknowns are categorised as *daivavipashraya* and include religious and spiritual practices. A key mechanism that was often cited was the way in which religious and spiritual practices impact on the mind. This was a distinct finding that emerged from the Ayurvedic data. The patient practitioner relationship was also represented as means of healing.

[153] The literature on spirituality and health was from databases: AMED, psychinfo, and pubmed using the keywords: health, spirit* and religious*.

The concept of religion and spirituality in Ayurvedic healing is being used in many different ways. It enables the mind to become focused. It may be a technique that works on the mind to make it positive which in turn speeds up the healing. It provides a general route to health and well-being which is based on going within oneself through self-reflection and for knowing one's connection in the macrocosm. Religion and spirituality are also interpreted as the principles one may employ as a way of life, such as the principle of non-violence, as a guide to the way one thinks or perceives the world and as the rules for activities such as eating, alcohol intake and moral behaviour. Religion and spirituality are seen as tools that work on the subtle aspect of the person. Ayurveda describes a person (*purusha*) as soul, mind, senses and body. Many of the subtle therapies such as colour therapy or aromatherapy appear to work on the level of the senses.

Although Ayurvedic practitioners draw a clear distinction between religion and spirituality as discussed in Chapter seven (page 143), there are areas where the distinction is blurred, i.e. activities such as going to the temple to bow to the deities or engaging in religious festivals and tradition which are conducive to health. For example, religious fasting detoxes the body, social celebrations are an opportunity for people to come together and feel connected which has a positive benefit. I next examine the circumstances in which practitioners consider prescribing religious and spiritual treatments to their patients during an Ayurvedic consultation.

8.4 When do practitioners recommend spiritual treatments?

Many scholars suggested that global Ayurveda in the West has transformed into a 'spiritualised' version (Warrier, 2009: 1; Zysk, 2001: 10); therefore it might be assumed that treatment recommendations will be of a spiritual nature. The findings of this study however paint a different picture. Despite a belief in the positive impact of religion and spirituality on health, practitioners did not indiscriminately offer religious and spiritual advice to their patients. This may be because Ayurvedic practitioners reported that this aspect was missing from their training, though the BAMS courses tend to include modules on Indian philosophy in the first year. The UK courses also include a module of Sanskrit and introduction to Indian philosophy, though practical application of *daivavipashraya* was missing from the training. Religious and spiritual reccomendations depend on various factors such as patients' interest or their need which I discuss next.

8.4.1 Patient's interest

South Asian graduate Dr Rajesh said he would consider recommending practices deemed to be spiritual such as yoga or meditation, but only if the patient shows interest and initiates the conversation. He said:

> Dr Rajesh - **…. if the patients are interested** in the meditation or anything like that then I may advise go to the meditation classes also or yoga classes also. This way, the herbal medicines physically, and the yoga meditation, spiritually and mentally and diet and which deals with the whole body.

It must be noted that not all patients choose CAM for religious and spiritual advice; for example, Newcombe (2012: 4) described different types of CAM users. According to estimates, fifty per cent of CAM users are interested in spirituality, leaving the remaining fifty per cent using CAM for other reasons, such as their discontent with biomedicine and biomedical drugs. Frank and Stollberg's (2002: 227) study of Ayurvedic patients in Germany found that the main reason they chose to consult an Ayurveda practitioner was because of their dissatisfaction with biomedicine, rather than seeking Ayurveda for spiritual advice. However, this study was based only on fourteen patients in Germany, therefore further research is needed to understand the factors which lead patients to choosing Ayurveda in the UK. The findings in Chapters six and seven showed that the Ayurveda consultation in general is not necessarily a spiritualised event.

8.4.2 Perception of need

Other practitioners said they make a judgement about whether it was appropriate and this was assessed in different ways. Visiting practitioner, Dr Neha, described how she made a decision about whether there was a need for a spiritual recommendation. If a disease or illness was deemed to be *karmic*, then an appropriate remedy may be prescribed to clear the cause. It appeared that in this circumstance that Dr Neha was talking about practices such as chanting a *mantra* which may be deemed a religious practice.

> Q - Do you incorporate any spiritual practices yourself?
> Dr Neha - If there is specific need. When I feel it is coming from some kind of karmic incident in life or this person needs, then I would definitely advise them to go for, and do some spiritual practice that fits them, because every person is different. For example, some spirituality has strong chanting practice, so people who are depressed, people who have loneliness in their life, they will always feel better, it's like a therapy for them**. But some people are extremely anxious and over restless. For them chanting is kind of disturbing. They need more calming and more soothing meditative practice. Quiet meditative practices. So every person is different, so they have to, I tell them to find out something good for them. Explore a couple of things and whatever is making you feel good, go for it.**

8.4.3 Positive application

Like Dr Neha, most practitioners were cautious about the use of recommendations that could be deemed as religious practices. For example, a *mantra* is suitable for a person who already has a religious and spiritual practice; therefore the practitioner needs to make a judgement about the suitability of the patient. Despite being subtle, *mantras* were seen as highly powerful and when prescribed appropriately can enable healing; however, if prescribed incorrectly can cause disturbance, as described by visiting practitioner, Dr Neha. UK graduate, Brian, emphasised that a judgement may also be made about the patient's capability to positively apply a spiritual practice in their daily routine.

> Q **-** so there hasn't been any cases where you have thought 'this might be a good client to give a mantra to' or is it your own inhibition at the moment ?
> Brian - Not an inhibition, whether it is appropriate, **because I wouldn't want to give it to anybody who wasn't going to use it positively.** I am studying *Jyotish* at the moment and it is a part of that. A lot of mantras. So that's going to come up more and more, the extent to which I recommend mantras. I guess there is the simpler ones….. which I have done with people ……. maybe in the future (laughs).

As previously described, some religious and spiritual practices can have a negative effect, therefore practitioners are cautious.

8.4.4 Generic recommendation

Some religious and spiritual activities were considered suitable as generic recommendations as a positive part of the daily routine. For example, meditation could be recommended as a standard treatment. In other cases the practitioner may mention meditation, and leave it to the patient to nurture, if interested. UK graduate, Brian, illustrates this point:

> Q - do you incorporate the spiritual dimension in any other way as well ?
> Brian - ..... meditation, teaching people meditation.
> Q - what kind of things would that be for?
> Brian - Well as a general practice that everyone should follow.
> Q - as part of their daily regime?
> Brian - Yeah, part of the daily regime, to reducing stress and also from my perspective as a way of ??? to get to the true nature of things, the true nature of themselves. So always trying to encourage meditation. And going into meditation through pranayama ???
> Q - focusing on breath?
> Brian - Yeah, without necessarily pointing out what's going to happen. But knowing its going to take them down a certain path. If they wanted to go further, I have taken meditation groups before, where specifically doing meditation take things quite a bit further.

8.4.5 Unknown causes

UK graduate, Aarti,described the purpose of using *daivavipashraya* in cases when the cause of an illness cannot be identified through the logical means of physical therapies (*yuktivipashraya*):

> Aarti- … Ayurveda mentions very clearly, this is an important way, when you cannot determine the cause, when known ways don't work, then you resort to *daivavipashraya,* but even otherwise it is very much a part of it.

Therefore *daivavipashraya* give practitioners the space for practitioners to acknowledge circumstances beyond their understanding. This also suggests that the limits of Ayurveda practice are not clearly defined and practitioners can deal with situations about which they are unclear. This may also mean that patients may be given hope of relief from their problem; even after all physical treatments have been exhausted.

8.5 Prerequisite for spiritual recommendation

Medical convert, Dr Ben, confirmed that an important consideration is whether a patient is physically and psychologically ready to receive a religious and spiritual recommendation. Any religious and spiritual practice requires mind/body balance. The judgement will also consider the presenting medical issue. For example, if a patient has a medical condition as a result of *kapha* (earth energy) imbalance, this needs to be brought into balance first before making religious and spiritual recommendations, while a medical condition caused by an imbalance of *vata* (combination of air and ether energy) may be deemed more suitable for treatment using subtle or religious and spiritual treatments.

> Q **-** How do you make the judgement about whether you are going to talk about it ?
> Dr Ben - If someone comes in here with major concern about weight and get more energy, is too depressed anyway. So often with *kapha* problems it's less relevant. So no point in approaching it. But if they come back for a consultation 2 to 3 times and they are starting to get where they want to go, then when you are better balanced in body and mind you start talking and they might have an interest in it. So then they want to hear about it. So in the fullness of time.

Patients must be interested in spirituality, but also be physically ready for it. It is not simply a matter of suggesting that a patient takes up a spiritual practice. The role of the practitioner is to diagnose the readiness of the patient. The practitioner has to make a decision about when to suggest spiritual practice.

8.6 Conclusion

I began this chapter with a quote by the Head of the Department of an Ayurvedic Hospital in India, where he advised the conference attendees to increase sports, salads and spirituality, thus indicating that spirituality is beneficial for health. Although the practitioners described and perceived Ayurveda as holistic, and showed they have a good understanding of the mechanism of spiritual treatments, the findings show that practitioners carefully consider the appropriateness of recommending (religious and) spiritual practices and only do so in specific circumstances. Their priority is to deal with the medical condition in order to establish a mind-body balance through diet, lifestyle and remedies. They differentiate between religion and spirituality and describe Ayurveda as a spiritual science, but often hesitate to bring religion and spirituality to their practice. For example, visiting practitioner, Dr Neha, said spirituality is part of daily life, but she gives space to her patients to find a practice that suits them. I argue that this contradiction between practitioner's personal beliefs and their behaviour in the clinical context indicates their need for credibility as medical practitioners in healthcare.

Contrary to Reddy's (2002) research which showed that practitioners in the US experience professionalising dilemmas with regards to their identity as medical practitioners or religious healers, the data from this research shows that the majority of Ayurvedic practitioners in the UK appear to be clear about their role as holistic health practitioners rather than religious healers. The majority of practitioners do not change their role in order to circumvent legislation; rather they change their practice in order to fit into the new environment as shown in Chapter six.

In the next chapter I explore the relationship between the Ayurvedic practitioners and patients, and examine practitioners' perceptions of authenticity.

Chapter nine The Role of the Practitioner and Authentic Ayurveda

9.1 Introduction

In the previous chapter I examined the Ayurveda practitioners' beliefs and decision making in relation to religious and spiritual treatments. In this chapter I analyse in greater detail the different roles of the practitioners as prescribers, negotiators and facilitators. Following that I investigate UK Ayurveda practitioners' definitions of 'authentic' Ayurveda, and show that a new meaning of authentic has emerged to describe the UK versions of Ayurveda.

9.2 The role of the practitioner – Prescriber, Negotiator, Facilitator

The Ayurvedic practitioners in this study described their role as multifunctional; they were expected to juggle many separate jobs and functions. This included interpreting Ayurveda and contemporising it so that it was suitable for the new environment. It involved setting up a business, promoting and inspiring people as well as working with integrity as a professional. It required knowing the regulations and legislation and working responsibly within the legal framework.

Within the consultation, the practitioners felt they were expected to act as an instrument, bringing the healing through from a divine source and although they believed the patient has the wisdom to heal, the practitioners were required to remind, encourage and motivate the patient to comply with treatment recommendations in order to return to a state of good health. The practitioners were required to have full conviction and demonstrate total faith through living Ayurveda and personal experience. Therefore, it was not simply a job, but a way of life for the practitioners (see page 96).

Stahle (2010: 245) found in his study of Ayurvedic lifestyle counsellors in Sweden, that the term 'coaching' was often used to define their personal role. He suggests that by using this term they position themselves 'somewhere on the borders between the functions traditionally employed by the professions of priests, medical doctors and psychologists.' People are seeking help for a range of reasons from physical disease, mental illness and social distress, or are curious about a holistic way of life. In this context, Ayurvedic health counselling is related to what Paul Heelas calls the 'spiritualities of life' (Woodhead and

Heelas, 2000: 116); that is, ways of life in modern Western cultures which value the quality of one's own life and subjective well-being.

9.3 The patient-practitioner relationship

The relationship between the CAM practitioner and their patients is a key factor in treatments, and the popularity of complementary medicine is attributed to a more satisfying, personal relationship, compared to brief and technical consultations in biomedicine (Frank and Stollberg, unpublished). [154] Some people argue that interactions in CAM represent a more humane and holistic approach. Others claim that the perceived benefits of CAM are placebo effects produced by the practitioner-patient relationship. For example, Professor Alan Silman, medical director of Arthritis Research UK said:

> "Complementary therapies are largely chosen by the patient and quite often paid for by the patient, **and the relationship between patient and practitioner seems to be crucial in the effectiveness of the treatment.** As a research organisation, apart from undertaking research about the value of individual therapies, **we wish to focus on how this relationship, which may be part of the placebo effect, can help to give patient benefit**." (Silman in Arthritis research UK, 2013: 4).

CAM users value the therapist because they value the egalitarian relationship between the practitioner and client, and feel encouraged to take responsibility for their own health (Sharma, 1995: 80). Qualitative studies show that patients respond to being treated as equals and desire a participative relationship with their practitioner (Hewer, 1993). This becomes possible when a system takes a holistic approach, seeking to understand the person's total health profile (their spiritual and emotional responses as well as their experience of their social situation). The role of the practitioner is described as a key ingredient of the therapeutic encounter (Paterson and Britten, 2004: 800). Patients place great importance on the therapeutic relationship, and the practitioners need to use their own personal skills to establish safe, respectful and reliable therapeutic relationships, and offer comfort and care. Optimal healing occurs when there is mutual respect and a positive resilient relationship (Frankel et al, 2005). The medical competence of a doctor is only useful in a cooperative and confidential atmosphere (Hardinghaus, 2005). The result of the therapy is based on the success of building up a human relationship (Wilda-Kiesal, 2003, Faraclas, 2003).

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[154]This unpublished paper was available on the world wide web: http://www.uni-bielefeld.de/(en)/soz/iw/pdf/stollberg_frank_docpat.pdf [online]. [Accessed 22.4.13]. I contacted one of the authors, Frank Stollberg for publication details but was informed it is an unpublished paper.

Gale (2008: 14) gives a useful account of different models of patient-practitioner interaction: the paternalistic model and the consumer model, which represent two ends of a spectrum of control and trust. The paternalistic model involves patients surrendering to the expertise of the practitioner and relies on the principle that the professionals are altruistic and to be trusted. The consumer model requires individuals to take responsibility for selecting the best person to treat their condition. In the UK, there have been policy moves towards a consumerist model of healthcare provision. The partnership model involves giving and receiving as there is negotiation between the patient and the practitioner. The patients retain responsibility for their own healthcare and the practitioner is seen as trustworthy, and there is a joint assessment of goals and treatments.

In recent decades there has been a decline in the 'paternalistic model' in which the medical practitioner is the authority figure making the decisions while the patient is passive and compliant, and the partnership model has been preferred as it is seen to promote patient empowerment as partnership is central to new developments in the NHS healthcare sector (Gale, 2008: 14). In a partnership encounter the patient shares in the decision making because the practitioner and patient have an egalitarian relationship (Frank and Stollberg, 2002: 226). However, Gale (2008: 14-15) raises a number of potential problems with this model including: power, the patient as a genuine partner informed consent, and victim blaming.

Interestingly, Frank and Stollberg (unpublished) argue that Ayurvedic consultations are long and personal, but not necessarily harmonious and that conflicts arise when patients act too passively in terms of lifestyle changes. They suggest that the practitioner-patient relationship varies across the different modes of CAM; encounters tend to be both patient-centred and paternalistic. I examine the Ayurveda practitioner patient encounter next.

9.4 Negotiation and compromise for patient compliance

The Ayurvedic practitioners in this study described going through a process of negotiation and compromise with their patients during the consultation to agree suitable recommendations that the patient can follow in order to achieve maximum patient compliance. Biomedical convert, Pritesh, illustrated the way he negotiated with his patients with the following example:

> Pritesh - I think it's the diet. That's the stumbling block. I find the main problem with the diet. In the end what I say to them is, OK if you can't stop it, try and restrict it or reduce it. Try and work in that way.
> Q …. And what's the role of the patient during the consultation? Do you get them involved in the decisions?
> Pritesh - I do, because what happens is there are certain things I tell them not to do, but you tell me if you are going to do it or not. Then they tell me Ok if they are eating meat 3 times per week, like I say try and cut it down or stop it, they say I can't do that, try and do it once a week or something. **Then we try and compromise**, rather than not do it at all. Like certain foods, they say I can't stay away. Like this girl I had and she had severe asthma and ice cream she couldn't stay off it. I said OK fine can you cut it down. I will try. I said Ok. Try and cut it done and at the same time try and replace it with yoghurt, yoghurt ice creams. She said OK I will try that. It's somehow trying to get them to cut down.

An egalitarian relationship allowed this process to occur whereby the practitioner and the patient can speak and listen to each other on an equal basis and agree the treatment plan. UK graduate, Thelma, explained the importance of negotiating:

> Thelma - And it's also **patient compliance** because, if they don't take your advice, or if they don't do what you say, then it's not going to work, is it?
> Q - No.
> Thelma - So it's **giving someone something to do that's within their capability, and that's why listening to them is important, like what they like to eat, so that you can just change it slightly or re-arrange the time and the pattern. Little things like that help.**

The UK Ayurveda graduates tended to say that their role is to listen to and empower their patients as illustrated by medical practitioner and spiritual seeker, Dr Ben:

> Q - And what is your role in this process?
> Dr Ben **-** Merely a mirror. I am just a mirror. They come, they reflect. I'm just a reflector. I am guided by their insights; I am guided by their intuitions. I am guided by what they recognise as their needs. In so far as I can reflect back what they know they should be doing, I am succeeding in practising Ayurveda.

In Stahle's study (2010: 253), the Swedish Ayurvedic counsellors describe themselves as 'a coach or guide of lifestyle rather than as a therapist in the manner of a medical doctor'. This is supported by previous studies of Ayurvedic practitioners who described their role as empowering patients (Bruwer 2009: 38; Pole 2008: 224). As mentioned, one of the factors that draw patients to choosing CAM treatments is the attention to the individual and the patient focus. The paradox here is that the ancient classical text describes the practitioner-patient relationship in different terms:

> The physician should treat all his patients like his children. He should take care of their health and keep them away from miseries, if he is desirous of dharma (virtues) par excellence…….
> Ca/chi/ch 1/v52-62 (Sharma and Dash, 2001, vol 3: 68)

This 'parent-child' relationship implies that the practitioner should take charge, be protective, as a parent is towards their child. This appears to be in line with the paternalistic model rather than the partnership model.

> They nurture cordial feelings exactly like the mother, father and kin towards all creatures. Physicians having such qualities give life to patients and cure their diseases.
> Ca/Su/ch 29/v6-7 (Sharma and Dash, 2001, vol 1: 589)

This verse reiterates the parental role of the practitioner. In a context where equality and empowerment are important, being like a parent suggests that the practitioner has the power in the relationship. A practitioner needs to be able to skilfully express his/her authority without becoming authoritarian, as that does not facilitate a good therapeutic relationship. There appears to be a disparity in the role that the Ayurvedic texts describe and the current favoured model. This divergence may be explained by time, place and circumstance, whereby a parental model may be useful for certain patients, but less applicable for others.

An alternative view may be that the ancient seers were in fact insightful in describing the practitioner role as that of a parent. Broom and Tovey (2007) explored patients' experiences of CAM by using diaries over a period of time in order to get deeper insights of CAM use in their daily lives. Their findings reveal that patients did not necessarily enjoy the responsibility placed upon them for self-healing and found it to be a burden, giving rise to feelings of guilt when they are unable to comply and maintain discipline in following recommended regimes. In the light of these insights, I argue that a practitioner who is more supportive, caring and nurturing is welcome. The UK graduates, in particular, claimed that they took the responsibility of empowering their patients. They did not leave their patients to struggle on their own; rather guided them through the journey. The same practitioner, Dr Ben, goes on to illustrate this point:

> Q - What type of factors brings about the healing in your experience?
> Dr Ben - … assuming responsibility, altering the perception of the disease process and worries and concerns and the disempowerment that brings and the realisation of how much they can do and the determination to do something to help me. That is profound and very powerful. But of course if they don't know how to take care of their digestion, they are still going to create the same digestive problems. If they don't know about the lifestyle. **First thing is to motivate the person, once you have them motivated, get them making some changes.** If they don't do it or they just come back, and they've done some of it but not enough, which is then motivation for going forward for a bit more.
> Q - Motivation and on their part compliance?
> Dr Ben - Absolutely, **but it's up to us to give them the motivation and compliance.** Keep them prepared for the change.
> Q - and is that sufficient for all the different ranges of issues that you might be dealing with ?

> Dr Ben - ... **because that's what Ayurveda really is. It's empowerment. And if you haven't empowered the patient, they're not going to succeed in Ayurveda. You have to actually motivate them and give them the information they need and in the process they are taking ownership of it.** They will never lose that. They will do something, they will feel better. They will never forget that and you empower somebody and ten years later they will come back because they got better the last time. So I think that's what is important.

Frank and Stollberg (unpublished) found that conflicts arise during the interaction between the doctor and the patient when patients' expectations do not match the German version of Ayurvedic concepts. They report that frequent conflicts arise with patients who are not ready to actively transform their daily lives and habits. In response, practitioners have to negotiate the treatment terms.

The findings here show that a variety of different practitioner-patient relationships exist simultaneously, which need to be understood and described. Warrier (2009: 15) highlights the contrast between the relationships that Ayurvedic practitioners and patients have in South Asia compared to those in the UK. This depends on the professional roles that the practitioners adopt. It is suggested that in South Asia, practitioners emulate the biomedical role, whereas in the UK, they are more like counsellors. For the South Asian practitioners trained in India, their role has changed from being prescribers of standard remedies to practitioners who negotiate individualised recommendations.

Frank and Stollberg's (unpublished) study compares the patient practitioner relationship in acupuncture, homeopathy and Ayurveda. Their findings illustrate that the paternal model of the physician-patient relationship is rarely considered compatible with the idea of patient-centred medicine, but the patients' accounts clearly show that they felt that their needs were met and their perspectives considered in the medical encounter. Therefore, consultations in complementary medicine appear to be paradoxical: paternalistic and patient-centred.

I argue that in the current context, the patient practitioner relationship cannot be adequately described by any one rigid relationship model. My analysis of the data indicates that patients require a patient-centred consultation and support throughout the treatment phase. I suggest that the practitioner-patient relationship models need further examination. The current social trend indicates that the paternalistic model has been rejected; however, there may still be a place for a paternalistic model in which the practitioner aims to develop a cordial relationship and be caring and protective. Gale (2008:

20) also suggests that hybrid models need to be considered to indicate the reality of patient –practitioner relationships.

9.5 Practitioner's role when prescribing spiritual practices

I next look at the role of the practitioner patient relationship in the religious and spiritual context. In the biomedical context, D'Souza (2007) suggests that religion and spirituality are important in the medical encounter because by excluding these elements, the patients core coping and support system may be ignored, which may be crucial for recovery and well-being. Also, by including religion and spirituality, the practitioner shows that s/he is interested in the whole person, thus enhancing the patient-practitioner relationship and increasing the impact of the therapy. This does not mean that health care professionals have to learn about how religion and spirituality influence patient needs and recovery. D'Souza says practitioners should avoid 'prescribing' or imposing religious beliefs or activities on patients as in-depth religious counselling should be done by trained clergy or therapists. Rather, the practitioner needs to be culturally tolerant, non-dogmatic and avoid imposing their own personal views. If a practitioner does not have a personal belief, s/he should still inquire about religious and spiritual issues. Research shows that patients wish to discuss spiritual issues with their physician during certain circumstances, such as when dealing with mental health problems or major and life threatening illnesses (Hassed, 2008: 956).

I suggested above that the role of the practitioner was influenced by shared culture (see page 193). I now examine this again in relation to religion and spirituality in the Ayurvedic clinical context. The data shows that in this aspect of the consultation the role of the practitioner diminishes as the authority figure, and is guided by the patient.
Medical convert, Dr Devi, described her approach:

> Dr Devi - …… Everything has its role **and everything is, in a way up to the person.**
> Q - So would you tend to leave it to the patient to decide what they want to pursue or would you ever recommend a particular practice?
> Dr Devi - Well, **I kind of would explore with them** what their taste was and encourage them – encourage them to go deeper.

This is in line with Heelas and Woodhead's (2005: 28) research findings. In their study of the holistic milieu in the UK, they found that practitioners do not want to tell their clients what to think, do, believe or feel. Instead they emphasise the importance of 'serving' their participants, helping, guiding, supporting, working with, encouraging, enabling, nurturing,

facilitating and steering. They are participant centred, believing that "they've got to find out what works for them". Participants are provided with the freedom to exercise their own authority to heal themselves. When discussing religion and spirituality, practitioners see themselves in egalitarian, sharing reciprocal relationships. Langford (2002: 244) writes that of the three types of therapy, only *yuktivipashraya* requires the intervention of a qualified practitioner, the other two types could be administered by the patient or members of the family or friends, or 'a practitioner who specialises in mediations with unseen realms'.

The findings indicate the complexity of the Ayurvedic practitioner-patient relationship. The practitioner takes the lead and acts as the prescriber in relation to deciding medicines and therapies as they have the authority to do this through the virtue of their training. The practitioner acts as a negotiator when diet and lifestyle need to be recommended, and aims to negotiate with the patient to agree the optimum plan for patient compliance. The practitioner acts as a facilitator if the patient requires advice of a religious and spiritual nature and may suggest that the patient explore a suitable practice themselves. Thus the findings show that the consultation involves a number of complex interactions and the practitioner's role changes and depends on what kind of treatment is being recommended.

Summary

As there is a lack of standardised training in *daivavipashraya*, I argue that an important driver is the practitioner's personal inclination to what is prescribed. The Ayurvedic practitioners in this study tended to mention religious and spiritual techniques that they may be using in their own personal practice for example, medical convert, Dr Ben, who had trained with Maharishi Ayurveda mentioned Transcendental Meditation, while UK graduate and spiritual seeker, Brian, described encouraging his patients to reflect on their life, to look at the 'bigger picture' and use techniques such as journaling and meditation for self-reflection. Medical convert, Dr Kishore, said that he suggested people use *mantras* as his personal quest had led him to study their effect on healing, whereas medical convert, Pritesh, said that he would suggest people adopt practices of non-violence and vegetarianism or control their behaviour in terms of intake of alcohol. The implication is that there should be a good match between the patients' and practitioners' expectations for a satisfactory encounter.

Given the necessary changes that are occurring in Ayurveda practice (discussed in Chapter six) and the changing role of the practitioner, I next explore practitioners' perception of concept of authenticity in the context of UK Ayurveda.

9.6 Authenticity and global Ayurveda

I described the importance of the classical texts in Chapter five and different versions of global Ayurveda in Chapter six, as new hyphenated Ayurvedic practices are appearing. In this section I describe practitioners' perceptions of authentic Ayurveda. Warrier (2009: 16-18) discussed the concept of authenticity by identifying three different forms.

The first type of authentic Ayurveda is shaped by the needs of different groups of people in South Asia as compared to the West. In South Asia, Ayurveda is used to provide remedial medicine to vast numbers of people for quick cures for an array of physical ailments; hence a biomedicalised version is appropriate in this context. This is markedly different from the West where patients' problems result from emotional and mental blockages; therefore a holistic, spiritualised version is appropriate in the UK. Both versions of Ayurveda are authentic as they serve different purposes.

The second way of understanding authenticity is to compare the traditional Ayurveda of the past with modern biomedicalised Ayurveda. Here, the UK spiritualised version is represented as a revival of the ancient tradition, and the biomedicalised version a modification disconnected from its holistic origin. Stahle's (2010: 254) Ayurvedic counsellors and Warrier's (2009: 17) Spiritual Seekers share this view of authentic Ayurveda as being the traditional holistic system. Authentic is linked to what is perceived to be the original version.

Warrier offers a third definition of authentic which is based on a nationalistic and exclusivist ideology originating from one particular group, therefore a minority view. According to this view, Indians are the true owners of Ayurveda. This is in line with the idea that Ayurveda is part of the Indian culture and way of life. Murthy (2010: 57) writes that his practitioners highlighted the link between ethnicity and authenticity. They felt that Indian Ayurvedic doctors tend to portray ownership by virtue of being Indian. One participant in Murthy's study describes being denied membership of a voluntary regulatory organisation on the grounds of being trained in Europe rather than India.

Langford (2002: 9) writes that early colonial orientalists located authentic Ayurveda in the classical texts rather than in the actual practice of Ayurveda, which they perceived as reflecting a decline from the golden age. Although the ancient texts and long history contributed to one definition, practitioners of this study at the same time have taken authenticity out of the ancient texts and situated it in the day-to-day clinical practice. They have placed it in the hospitals and treatment sites in India, as well as in their own clinics in the UK, but for very different reasons.

The interviewees in this study located authenticity in the practices which offer full *panchakarma* treatments which require an inpatient facility and a range of resources, as medical practitioner, Pritesh, described:

> Q - in your opinion what is authentic Ayurveda?
> Pritesh - I think authentic is, like *panchakarma*, going for all the treatments. Now that is authentic because that is according to the texts. But then when you go to India nowadays, they don't practise that way, it's changed, it's not being practised that way. So I would say authentic would be doing the examination, then the treatment according to it is like, *virechana* whatever.

According to Pritesh, an authentic practice is defined by full *panchakarma* treatments, which would mean that none of the versions offered in the UK can be classed as authentic, though modified versions are acceptable, provided the principles[155] are kept intact. On the other hand, the modified versions of global Ayurveda practised abroad are necessary for the time being as they will flourish into authentic practices once the profession gains recognition and acceptance in foreign lands. This is exemplified by the Indian visiting practitioner, Dr Lokesh, who has spent many years propagating Ayurveda in the West:

> Q - Do you feel that Ayurveda can be practised in different ways and still be acceptable?
> Dr Lokesh - ….Somebody goes to western world and he started a little oasis of Ayurveda and now there are so many little little schools of Ayurveda. And everyone teaches his or her way of Ayurveda calling it Ayurveda. Some people practise Ayurveda in 5 star hotel as only *snehan* and *svedan* and call it Ayurveda. Some people do skin care and call it Ayurveda. I think it is OK for the time being because if you object them, then the name of the Ayurveda .. who will use it? Anyhow they are saying it is Ayurveda then fine, but the real people one day will come to know what is authentic Ayurveda and they will go to that. I am not saying our Ayurveda is authentic and their Ayurveda is not authentic, let the people decide that, what is authentic and they will choose go to that school or that university where they receive authentic Ayurveda and there they will study.
> Q - and it's acceptable?
> Dr Lokesh - I'm a very flexible person, I think, it is not one to judge them, they are doing something, they love Ayurveda, they are earning their bread and butter under the name of Ayurveda. Let them . Slowly they will also realise they don't know Ayurveda one day they

[155] *Prakriti/Vikruti* paradigm, *Tridosha* and *Triguna* theory, recommendations according to time place and circumstance.

> will learn Ayurveda and make it more authentic. **But if we object them now, then it will not develop.**

Dr Lokesh understands these current versions as a 'foot in the door' which will in time be fully established. The key issue for the foreign versions is that the basic principles and philosophy must not be changed.

Though full *panchakarma* is deemed an important feature of authentic Ayurveda practice, a patient-centred practice is also important, which the UK graduates did not think is a key feature of the practice in India. The patient-centred model is found in the West. Placing authenticity in the global patient-centred holistic versions allowed the non-South Asian practitioners the opportunity to justify their own models of Ayurveda. Brian illustrated this position:

> Q - and in your opinion, do you think Ayurveda can be practised in different ways ? some people explore the spiritual dimension, while some people don't involve that in their practice as much. Is there one right way?
> Brian - …….. I have seen, practice in the UK, my experience of practitioners is that you give the client time, you give them a whole range of diet and lifestyle modalities, which cover all these dimensions, give them a whole list of things for them to go away and think about and practice. Whereas in India and Sri Lanka, treatments I have seen there are shorter, treatments are not exploring … very symptomatic, very quick in out because there is a very long line of people they have to do it like that. So it's not exploring your emotions, where you are at, where you are going. Bang, bang, bang ! a bit like going to the doctors in the UK, that kind of experience. So I see them being, for me it's got to be about the bigger picture, there has got to be some time to concentrate on the particular person.
> Q **-** People who are doing it as you described in India, 15 minutes consultation, symptomatic. Is that Ayurveda as well?
> Brian- **I wouldn't say it was in the full spirit of Ayurveda**. It's a sort of 'Pragmatic Ayurveda'. [Laughs]. It's adapted according to circumstances, but it doesn't really fit with our notions of the past and how it was in the past.
> Q **-** I was asking you about the different kinds of practice and you mentioned your experience of Sri Lanka. What would you say is Authentic Ayurveda?
> Brian - Gosh, **Authentic Ayurveda would be, well I think Ayurveda would be what we think according to the scriptures, given appropriate time, availability of the herbs, going through the diagnostic processes. I think that would be authentic.** Have I experienced that? As I was saying, in India and Sri Lanka, I have seen treatments which might be effective, **but not necessarily authentic in the sense I don't think they are holistic taking into account a whole person or giving a range of modalities as part of the treatment**.

The Ayurvedic practitioners in this study located authentic practice in a number of places, in relation to its long history and origins in the classical texts, in the clinical practice of *panchakarma*, the philosophy and principles as well as in the new emerging versions of UK Ayurveda. Authenticity therefore resides simultaneously in many places. It remains firmly established in the classical texts as they have an authoritative status (see page 121). It has now spread into the clinical practices which offer full *panchakarma*. However, authenticity also resides within the globalised versions of Ayurveda abroad which offer patient-centred

holistic consultations in line with current CAM trends and in congruence with the spiritual seekers' worldviews participation in the healing process and a holistic approach to health and well-being. Stahle's Swedish Ayurvedic counsellors hold similar views (Stahle, 2010: 254).

Pordié (2012) reports from his study of the Ayurvedic pharmaceutical company, Himalaya, that the Ayurvedic experts (*vaidyas)* were only consulted at the beginning of the production process. Their role was to refer to the classical texts for information about the properties of herbs, after which modern biomedical processes were employed to develop the formulations. What is interesting is that the Himalaya Company perceives itself as the manufacturer of authentic Ayurvedic products. It seems that the referral to the classical texts, regardless of how brief it is, is sufficient to make the products authentic.

Langford (2002: 64) describes the etymology of 'authenticity'. When it first entered the English language in the fourteenth century it was synonymous with 'authoritative'. In the fifteenth century it took on the meaning of 'reliable'. By the eighteenth century it referred to 'genuine'. I suggest that in the twenty-first century, in the context of globalised Ayurveda, the current meaning of authentic is overlaid with a new meaning. The Ayurveda practitioners in the UK are defining authentic as 'superior'. Authenticity has taken on the meaning of relative superiority.

Ayurveda practitioners themselves locate authenticity in that which they believe to be superior. Thus, a full clinical practice in India is superior to a limited practice in the West and therefore authentic. But a patient-centred practice in the West is superior to a 'production line' consultation process in India and therefore authentic. The new definition of authenticity in the Ayurvedic context helps to explain the three types of authenticity distinguished by Warrier (2009, see above).

Narayan (cited by Reed, 2003: 13) argues that there is a need to discard emphasis on pristine authenticity as hybridity, innovation and global connections need to be considered. The findings show that UK Ayurveda practitioners are responding to a dynamic situation and developing multi-dimensional understandings of Ayurveda as seen in Chapter five and of authenticity as seen here.

9.7 Conclusion

Ayurveda practitioners have developed a new meaning for authentic Ayurveda, in order to deal with their predicament of who they are and what they do as a new and emerging profession in the West. The tension is that they must keep their relationship with the ancient texts and full practices and at the same time justify their work which has adapted and changed shape in the global context. They do this in two distinct ways: firstly by considering their simplified, modified and hyphenated practices in the West as a temporary solution and 'a way in' to the Western healthcare environment, which will eventually transform into authentic practices, once the profession is regulated. Secondly, by redefining authentic as 'superior' in relation to the holistic approach of their globalised practices which are in line with current trends in CAM.

What is noteworthy is that the UK practitioners in this study focus on the type of clinical practice as being important. They compare the comprehensive clinical practice in India and their own limited practice in the UK. I argue that this indicates their key identity as holistic medical practitioners rather than as religious healers. Authentic Ayurveda is whichever version is superior and all versions are superior depending on the perspective. Practitioners' new meaning for authenticity further indicates their underlying need for credibility and validation in the UK environment.

Chapter ten Conclusion

10.1 Introduction

I began this research with a desire to explore the practice of Ayurveda in the UK. I undertook a practitioner- researcher approach to examine the changes in practice that occur as a result of the transplantation from the East to the West, to provide insights into an under researched field. In addition, I was curious to understand how practitioners of a system of traditional medicine that purports to heal the 'mind, body, spirit' actually address this in the professional clinical consultation. I had an interest in what the different roles of spirituality might be during the Ayurvedic consultation and this became the key research question. I opted for a qualitative thematic analysis approach to analyse the emergent themes.

10.2 My contribution

I have made a number of significant academic contributions to the field of global/UK Ayurveda, which also contribute to the field of CAM studies as UK Ayurveda is situated within the CAM milieu. I have also made significant contributions to the field of Religious Studies which includes studies of Ayurveda as part of the Hindu tradition.

10.2.1 Contribution to the fields of CAM and Ayurveda

The findings provide a multidimensional definition of UK Ayurveda, highlighting the complexity of Ayurveda practitioners' situation, whereby they negotiate between different paradigms and highlight the tension they hold between continuing to accept the classical texts as authority and dealing with the pressures to accept modern research to validate their practice.

This is the first study to identify the process of change in the practice of UK Ayurveda and developing The Simplification and Modification Model to describe these changes (see Chapter six). This detailed examination of the changes occuring in UK Ayurveda practice has enabled me to challenge academics such as Zysk (2001), Zimmerman (1992), Reddy (2002) and Warrier (2009) who have suggested that the process of spiritualisation has been key in shaping Global Ayurveda. My insights as a practitioner researcher enabled me to consider the influence of regulations which these scholars had not considered.

The empirical findings in this study reveal the need to distinguish between the form and function of Ayurveda as distinct aspects to show that while spiritualisation may have influenced the form of Ayurveda, the function has been shaped by the process of simplification and modification. This again has enabled me to challenge the above scholars who have only focused on the form of Ayurveda.

In addition, the findings enhance the understanding of some of the factors which influence the length of the consultation time. I analysed the impact that a lack of shared culture has on the consultation time which had not been previously considered. A shared culture between the patient and practitioner results in a shorter consultation time, whereas a lack of shared culture between the two results in a longer consultation time.

My analysis of the complexity of the roles that Ayurvedic practitioners play during a consultation, changing from prescribers, negotiators to facilitators depending on the requirements adds to a growing body of literature on the role of the practitioner and how it impacts on the patient – practitioner relationship, as this is considered a key ingredient in the therapeutic encounter. I also examined the concept of authenticity in relation to UK Ayurveda and showed that it is a relative term which justifies their practice, which adds an original stance to the topic of authenticity in the field of global Ayurveda.

10.2.2 Contribution to Religious Studies and Ayurveda

The study has gone some way towards developing significant insights into the nature of religion and spirituality to show that these are social constructs by analysing the changes in the relationship between religion and spirituality through examples of different Ayurvedic contexts. This included considering political influences, which had not been included in previous studies.

This work contributes to existing knowledge of spirituality by identifying different definitions of spirituality that Ayurvedic practitioners hold and showing that they can be described by Coyle's model (2002) which includes the transcendence, value-guidance and structural behaviourist approaches. This is important as my findings support the idea that spirituality is a plural term with multivalent meanings.

In addition, I have contributed to the field of Hindu studies and global Ayurveda by analysing the changes to *daivavipashraya* to show that modern day spiritual treatments include referral for yoga and meditation, which have already been popularised in the West.

10.2.3 Contribution to the study of Spirituality, CAM and Ayurveda

The empirical findings gained by examining Ayurveda practitioners' beliefs in detail provide a new understanding of how spiritual practices influence health. They also highlight the detailed understanding of the mind and the impact of subtle treatments among practitioners, which is ironic given that the Ayurvedic training in India and the UK has been biomedicalised. Further, I assessed the circumstances in which practitioners make spiritual recommendations to show that in general Ayurveda practitioners address physical medical conditions and perceive themselves as holistic medical practitioners rather than as spiritual healers. This is significant as it contradicts the suggestion that Ayurveda has spiritualised in the West.

My findings clarify that Ayurveda practitioners have a clear understanding of what spirituality means in their practice. This is a significant contribution to the field of CAM as although most holistic healing traditions claim to address the mind, body and spirit, it is unclear what is actually meant by spirit.

I next consider some of the themes that have emerged from the analysis.

10.3 Fluidity, credibility and the paradox of 'Time, Place and Circumstance'

As I analysed the data I found that the theme of fluidity kept recurring and argue that this relates to Ayurveda practitioners' need for credibility which I relate to trustworthiness and expertise in an environment in which they are marginalised as health practitioners. These themes emerge through various movements across different geographical spaces, through time and across socially constructed dimensions of the private and public spheres. Practitioners negotiate between multiple realities, which have resulted through different, but hierarchical, ways of knowing.

In my introductory chapter I was critical of Zimmerman's suggestion that Ayurveda in the West has lost its fluidity (see page 21). I outlined a number of practical reasons for the 'loss of fluidity' in Ayurvedic pharmacy. The paradox is that through this journey of examining UK Ayurveda, the data shows that Ayurveda is indeed fluid, but I argue this is not a 'romantic' notion, rather it is a strategy of survival in an environment in which it is not part of the mainstream healthcare system.

10.3.1 Fluid Ayurveda

I have used the term fluid throughout this thesis to refer to the ways in which Ayurveda practitioners are flexible in their practice and able to adapt to their environments. In this study I show that they employ a range of techniques in their practice, ranging from biomedical, to CAM to those of a spiritual nature.

Fluidity is exemplified by the adaptations to practice resulting from the movement across geographical boundaries. It is captured by the way practitioners negotiate between biomedical and traditional Ayurvedic paradigms (see Chapter five). The fluidity is exemplified in the clinical practice through the Simplification and Modification model showing accommodation to local culture and geography (see Chapter six). The concept of fluidity is also demonstrated by the way that practitioners include and exclude what they perceive to be religion or religious (see Chapter seven).

The movement across time from the ancient classical text *Charaka Samhita* to the current study illustrated the changes in *daivavipashraya* (see Chapter seven). Here practitioners adapt the traditional religious practices to contemporary notions of spirituality and popular practices. Fluidity is also apparent in the way that practitioners adapt their role within a consultation. It revealed that practitioners play multiple roles depending on the level of responsibility that is required for the prescription and the nature of the prescription (see Chapter nine).

What is interesting is that fluid aspects of biomedicine are also emerging, resulting in a blurring of boundaries between 'holistic CAM' and 'reductionist biomedicine'. The increased popularity of CAM and people turning away from biomedicine has resulted in policies pertaining to biomedicine incorporating the attractive features of CAM. This illustrates a dynamic situation, with movement across different systems, adopting each other's desirable features. Through this journey what has emerged is that practitioners emphasise or de-emphasise the different aspects of Ayurveda depending on the context, flowing between spiritualised and biomedicalised approaches to healing. This allows Ayurveda to be a fluid system, essential for its survival both in modern India and the West.

10.3.2 Credible Ayurveda

I argue that a broad and fluid identity is important for a marginalised system of healing. This enables practitioners to adapt their practice to one that they perceive as being credible. Fluid changes enable practitioners to seek credibility and this has emerged as a key requirement for the practitioners in the UK environment. This is indicated by the universalisation of Ayurveda, so that it is applicable and accepted in the West, as well as the acceptance of modern techniques and technology (though this stems from the *mishra* ideology, see page 101). The need for credibility was seen most clearly when practitioners' faith in the Ayurveda classical texts was challenged by scientific research. Here, credibility split into internal or private credibility as Ayurveda is aligned with the classical texts which are a source of knowledge that is accepted as truth by the Ayurvedic community. External or public credibility is achieved by aligning with modern science and research which is a source of truth in the wider community. Globalisation compels practitioners to bring together syncretic elements to meet different needs for credibility. It emerges from the data that this is a basic need in a context where Ayurveda is not currently regulated by the Government, and a marginal practice.

The paradox is that the dynamism and changes that have produced UK Ayurveda are based on the ancient principle of 'time, place and circumstance'. The practitioners hold onto the ancient wisdom for validation, yet it is this classical principle which requires change and adaption to new situations and environments that has produced new approaches to Ayurveda in the UK.

10.4 Fluidity, credibility and the role of religion and spirituality in the Ayurvedic context

The academic literature on religion and spirituality is rich with a variety of contested connotations for the concepts of religion and spirituality (for example see Taylor, 1998). The data from this study provided fascinating insights into the relationship between religion and spirituality across different Ayurvedic contexts. The following well-known quote, though taken from fiction, aptly conveys how words can indeed have many meanings.

> Humpty appears in Lewis Carroll's *Through the Looking-Glass* (1872), where he discusses semantics and pragmatics with Alice.
> "I don't know what you mean by 'glory,' " Alice said.
> Humpty Dumpty smiled contemptuously. "Of course you don't—till I tell you. I meant 'there's a nice knock-down argument for you!' "

> "But 'glory' doesn't mean 'a nice knock-down argument'," Alice objected.
> **"When *I* use a word," Humpty Dumpty said, in a rather a scornful tone, "it means just what I choose it to mean—neither more nor less."**
> **"The question is," said Alice, "whether you *can* make words mean so many different things."**

My analysis of the data showed that spirituality is an important component of the Ayurvedic practitioners' perception of UK Ayurveda. The spiritual component has the effect of universalising Ayurveda so it achieves the status of a perennial truth. Dr Dhani said, 'Ayurveda balances physical, emotional and spiritual' and Dr Priya stated that it has to be lived and experienced. These ideas fit well with the subjective turn whereby the individual's own personal experience is paramount. The New Age features 'romancing the pre-modern' and 'linking to a remote age' (see pages 98) were evident when practitioners described the classical texts, and they continue to hold them in a position of authority.

Religion and spirituality manifest in various forms in different Ayurveda contexts. In the educational and social contexts, religion and spirituality manifested explicitly in a variety of Hindu religious expressions. To cater for the Western Ayurveda practitioners, these Hindu traditions were interpreted in vocabulary that universalises the underlying principles; for example: harmony and connection with nature, the microcosm and macrocosm. Practitioners assigned various definitions to the concept of spirituality in terms of transcendence, relationships, principles and behaviours and described a variety of mechanisms to explain how spiritual treatments may enable healing.

When Ayurveda was discussed at campaign meetings, which I referred to as the political context, responses showed that the concept of religion was favoured over spirituality as beneficial attributes which included unity, tradition, power and individual wellbeing (human rights) were attributed to it in this context. At the same time, traditional religion was deemed to be divisive and possibly troublesome and needing to be used with caution. These paradoxes in the data exemplify the fluid, dynamic and changing nature of concepts and showed the importance of the context in which they appear.

The most interesting change emerged in the Ayurvedic clinical consultation which practitioners align along biomedical lines and place it in a scientific framework. Here religion was assigned meanings that suggest it is different from science. The data showed that religion is presented as unscientific, not related to health and a private matter for

patients to pursue. In this circumstance there was a clear demarcation between religion and spirituality. Spirituality was the acceptable form of religion. The 'religious-cum-secular' nature of spirituality became apparent and I argue that the secularised aspect of spirituality allowed it to appear in the Ayurvedic 'medical' clinical consultation which was aligned to the biomedical framework. This showed the fluidity of Ayurveda in relation to science in the clinical consultation. The findings showed that spirituality and the process of spiritualisation as discussed by Warrier (2011: 8) did not appear to be the key influence shaping the clinical consultation.

In addition, the data highlighted the changing role of the practitioner in relation to what they were prescribing. Practitioners appeared to take greatest responsibility for prescribing remedies, but withdrew their responsibility as prescribers and acted as facilitators when supporting their clients to take up a spiritual practice. In addition to examining the meanings assigned to religion and spirituality, I analysed the findings to see how the changes could be explained. The different meanings of religion and spirituality that have emerged indicate that these concepts are context-specific and influenced by the prevailing social trends. One way to make sense of the complexity is to consider them in the public and private sphere which I describe next.

10.5 The private and public sphere of Ayurveda and the search for credibility

One way of understanding the varied and complex findings described above regarding the role of religion and spirituality in the Ayurvedic context may be to consider them in terms of the private and public sphere (see fig 10.1). Weller (2008: 105) suggests that according to the sociological model of society, a distinction between the public and private spheres is a means of managing religious and cultural plurality. Woodhead and Heelas (2000: 332) regard the public and private distinction as crucial to all conceptions of the modern social order and religion itself is intrinsically connected with the modern historical differentiation of private and public spheres. This distinction between the private and the public in relation to religion has been discussed by authors such as Carrette and King (2005: 13, 54-86), and Reed (2003: 114) and serves as a useful way to consider the findings of this study.

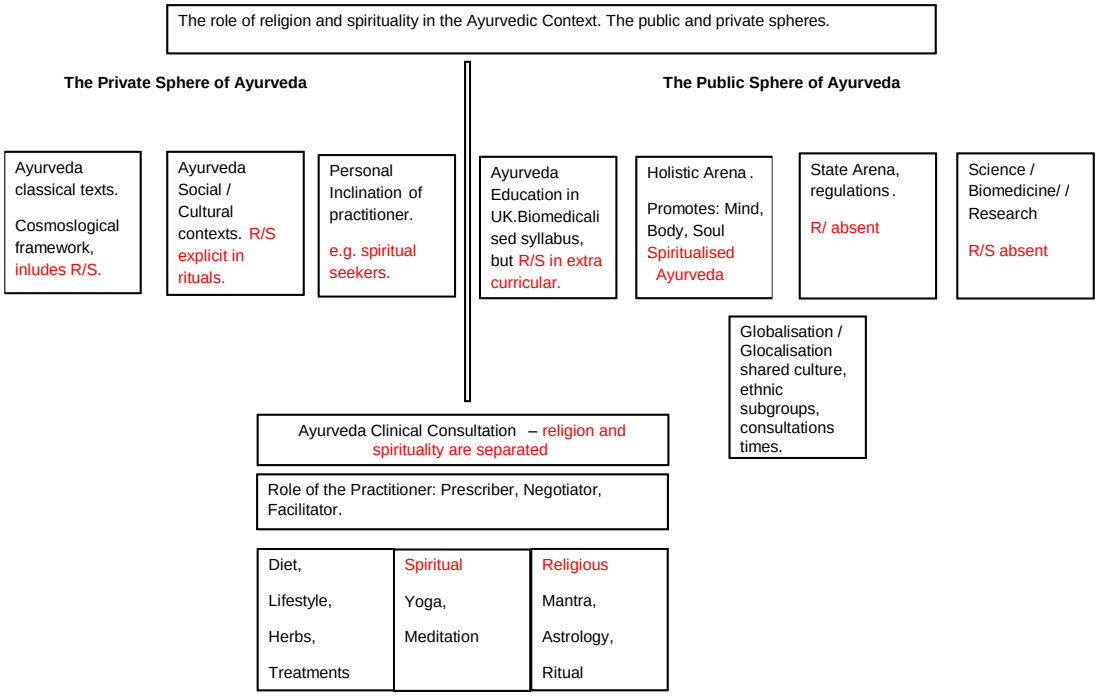

Fig 10.1 The Public and Private sphere of Ayurveda.

I argue that religion and spirituality operate across two different social spheres: the private sphere includes the social and cultural context in which the Ayurvedic educational training is embedded both in the UK and India, Ayurvedic practitioners' social context and their personal inclination and beliefs. I have shown that in the private sphere religion and spirituality are explicit and manifest in many different forms including traditional Hindu religious and cultural forms and nuanced understandings of how spiritual practices can influence healing.

However, the relationship between Ayurveda, religion and spirituality changes in the public sphere. The public sphere consists of two distinct influences; the holistic health arena and the State arena (see Chapter five). The holistic health arena promotes Ayurveda as a holistic, spiritual system of healing while the State arena imposes regulations which have the effect of restricting Ayurveda practice. The impact of the State arena is primarily on the use of remedies, and does not directly influence the holistic nature of Ayurveda practice. Nonetheless, the State recognises the modern scientific paradigm and supports approaches based on empirical evidence. Therefore, in order to gain State recognition, there is an implicit need to align with the modern scientific paradigm. Therefore, Arendt's (cited by Bhabha, 1994: 15) more cautious view which distinguishes the public and private spheres as 'the distinction between things that should be hidden and things that should be shown'

seems to fit well here. I situated the Ayurveda clinical consultation at the interface of the private and public sphere.

Scholars like Warrier (2009), Zysk (2001) and Zimmerman (1992) have described Global Ayurveda in the West as a spiritualised version. An analysis employing the public and private framework shows that Ayurveda is influenced by the holistic arena which supports a spiritualised version. However, the framework also shows the influence of the State regulations which play a central role in shaping the clinical practice, and is in line with explaining the simplified versions described by practitioners such as Pole (2008) and Bruwer (2009). I suggest that the influence of the State has forced Ayurveda to diversify in the UK, as practitioners seek to supplement their restricted practices by selecting tropes from different healing modalities in order to survive. Thus more paradoxes emerge. Firstly, the simplification of practice is in fact increasing the complexity of different approaches to Ayurveda practice in the UK. Secondly, specialisation and focused practices indicate the irony of CAM in the West. One of the key appealing factors of CAM is the holistic approach, yet practitioners are beginning to specialise in certain areas, one of the factors that has turned patients away from biomedicine.

10.6 Different ways of knowing, politics and fluidity

The underlying drive to be fluid appears to be related to different ways of knowing which I discussed in Chapter two. Scheid (2012: 27) writes that current hierarchies of knowledge assume that there is a best way of knowing the world. Asian medicines focus on the individual and subjectivity of knowing. A non-hierarchical approach to knowledge management avoids these assumptions by placing different approaches to problem solving on an equal par, but as Scheid (2012: 29) points out, social systems have an inbuilt bias towards framing problems that reflect epistemological, economic and social biases that make up that system, and according to Flower et al (2012: 142) 'Evidence is now inextricably linked to power'. In Chapter two, I argued that the Ayurveda ontology and epistemology are embedded in a cosmological paradigm (though now influenced by Western science based on the Cartesian model), and illustrated the difference with the scientific perspective of reality and knowledge. In Chapter five I gave examples of how Ayurveda practitioners struggle between the different paradigms and how most find themselves keeping one foot in each paradigm resulting in a range of practices along a

continuum. This fits the variety of practices I described from my personal experience (see page 44).

Robinson et al (2012: 609) maintain that such variation in practice is not surprising given the differences in education and training available to practitioners of Asian medical systems like TCM or in this case Ayurveda. Birch and Lewith (2008: 16) suggest that the variability of TCM practice and theory can be traced back to the Asian philosophical approach. The modern scientific approach is based on an 'either-or' logical theory and an absolute truth, whereas the traditional Eastern approach is open to multiple ideas of being 'correct', showing there are many ways of knowing, though the modern scientific approach now dominates, as the only way of knowing.

Clarke (2005: 5) writes that the hierarchy of ways of knowing tends to be connected with a hierarchy of political power. Boyce -Tillman (2005: 10) suggests that there is a clear link between those who hold power and which 'ways of knowing' will become subjugated. According Saks (2008: 29) biomedical, scientific hegemony is related to political support.

I stated in Chapter one that the biomedical profession based on science was supported by the State and the scientific paradigm is at the top of the hierarchy. I gave examples in Chapter five of how this knowledge and power are playing out and how the Ayurvedic understanding of the world is being subjugated. The example of how food e.g. garlic is described as medicine by the regulators (see page 106), shows the oppressive nature of the power knowledge hierarchy and the plight of the practitioners who are left bewildered by the imposition.

Boyce-Tillman (2005: 11) writes that those who are dominant put systems in place to see that they remain in power. This is exemplified by the biomedical profession and the State who demand proof of effectiveness of treatments using scientific research methods, in particular the RCT (randomised controlled trial), which is considered the 'gold standard' method to collect evidence, despite the concerns raised by the CAM professions. Isabel Stengers sums up the issue:

> 'What – apart from the exercise of power - is the sense in examining something that in order to fit into specific research paradigms has been distorted to such an extent that it is no longer really what it is claimed to be?'
> (Scheid, 2012: 24).

The interviewees of this study indicated that religion and spirituality is an important element in the definition of, and perception of, Ayurveda and has an important role in healing. This distinguishes Ayurveda from many other healing systems, but what transpires from this study is that practitioners at the same time perceive the core practice of Ayurveda as a medical system. Thereby, practitioners negotiate between different paradigms, by remaining embedded within the holistic framework of traditional Ayurveda in their private sphere, but also dis-engaging with various aspects to present a core medical system for their appearance in the public sphere. When something moves from one place to another and decontextualizes, then it has to be fluid. As Warrier (2011a: 88) writes, Ayurveda, and systems like it:

> ……. are caught up in a global competition over resources, markets and knowledge systems, where the big players such as the well-established biomedical pharmaceutical industry, and the state and other forces that back them, continue to occupy an almost invincible position of power and authority.

According to Foucault, this fluid nature is a feature of subjugated systems, and is a strategy of resistance to the dominant system (Rouse, 1994: 108). The dominant culture does not have to be fluid, though as I have discussed biomedicine is showing fluidity, perhaps as a strategy to keep its hegemonic position.

10.7 The Practitioner and the Academic perspective

I employed an academic framework to investigate a broad range of factors that influence the Ayurveda consultation in the UK. This study is rich as it includes insider and outsider perspectives, academic as well as practitioner, in order to gain a better understanding of UK Ayurveda practice. The difference in literature seems to arise because academics take a macroscopic view, looking at societal changes and trends. Practitioner researchers on the other hand tend to take a microscopic view, looking at factors that have a specific impact on practice. I suggest that both perspectives together give a more realistic and holistic picture.

I included a range of Ayurvedic practitioners (see page 89) and examined different Ayurvedic contexts: educational, political, social and professional (see Chapter seven), in order to gain insight into the 'public and private' sphere of the Ayurveda community. I combined different methods: for example, observation gave insights into the Ayurvedic community's thoughts and fears about the Government, and the impact of regulations,

whereas the one to one interviews enabled practitioners to express their individual issues, for example the problems in setting up a practice.

I adopted a qualitative approach in order to explore this area which was largely un-researched. The data showed that both Ayurveda and the concepts of religion and spirituality are fluid. The scientific approach presupposes that a theory can be developed and the world is ordered and structured rather than fluid. The findings of this study indicate a world in which concepts are fluid and context-dependent, and boundaries are becoming increasingly blurred and the data is full of paradoxes. This leads to the conclusion that the world cannot be defined by clear rigid laws. I next consider the implications of my research findings on the training of Ayurveda students in the UK.

10.7.1 Implications for education

In Chapter six I showed that the clinical practice of Ayurveda is becoming increasingly individualised and prescriptions depend on the ability of the practitioner to apply the principles of Ayurveda and select the suitable remedies from those that are available. This finding has significant implications for the education and training of Ayurveda practitioners in the UK. Warrier (2009) reports that the UK training courses are based on the Indian BAMS syllabus. I argue that it is no longer adequate to transplant the Indian syllabus to the UK environment. The findings suggest that the syllabus should reflect current clinical practice and the changes that are taking place as a result of the transplantation of Ayurveda to the UK. The syllabus needs to be adapted according to the changes taking place in the clinical practice as a result of the regulatory restrictions, different climate, culture and lifestyle. The clinical training needs to reflect the impact of the environment and lifestyle, and the limited pharmacopeia. There needs to be an emphasis on developing the student's ability to apply the principles to their new environment, rather than only learning information from the classical texts.

10.7.2 Implications for research

Scheid and Macpherson (2012: 4) identify the division and lack of communication between the humanities and natural sciences as a major hindrance to solving the world's problems, and specifically research into CAM. Clinical researchers need to understand the diversity of practice, e.g. enquiry is disjointed. Scholars in the humanities tend not to engage directly with practice or make use of the primary texts, while natural scientists are unwilling to

engage with scholars in the humanities and social sciences. Clinical researchers tend to think of the effectiveness of medicine in naturalist terms.
Scheid (2012: 34) suggests the need for interdisciplinary research drawing on humanities, social and natural sciences, to disentangle the intermingling of nature, culture and politics in medicine, which any knowledge management perspective takes for granted. Wujastyk (2005: 170) also emphasises the need for interdisciplinary approach to study traditional medicines such as Ayurveda.

There are further implications from this study for research on Ayurveda. I have suggested that as a result of simplification, modification, hyphenation and hybridisation, the consultations and treatment recommendations are likely to be more individualised than the relatively standardised recommendations in South Asia. Thus, research on Ayurveda in the UK will need to take the new approaches into account by using appropriate research methods that are sensitive to the individualised nature of the prescriptions and treatment packages. Furthermore, the effectiveness of the simplified treatments in the UK may be compromised compared to the full treatments in South Asia. Flower et al (2012: 139-156) discuss a range of methods that can be employed to construct an evidence base for traditional systems of healing like Ayurveda.

10.8 Recommendations for further research

10.8.1 Patients' perspective

I described my initial experience of Ayurveda consultations as disappointing (see page 16) as I had developed expectations of what it should be, and the findings show that there is considerable variation in the practice of UK Ayurveda. This indicates that patients are likely to come with anticipation of a particular type of experience and a good match is required for the encounter to be successful.

There is little research on Global Ayurveda from the patient's perspective. Future research needs to consider why people who are consumers choose Ayurveda. Do they choose Ayurveda because they perceive it as a spiritual system of healing as suggested by the American literature? It is important to understand their expectations and experiences of an Ayurvedic consultation, so that practitioners can offer suitable consultations.

10.8.2 Observation of consultations

My findings are based on interviews with Ayurveda practitioners in the UK. Future research will benefit by including direct observation of consultations which could give insights into the role of religion and spirituality in the practice of Ayurveda. Direct observation would allow for a detailed examination of how practitioners make decisions about treatment recommendations, to understand how they apply the principles with a limited range of remedies, western herbs and other modalities. A survey could also be employed to get a wider range of responses on practitioners' beliefs and practices.

10.8.3 The marketing of Ayurveda

In relation to direct observation of consultation, an analysis of how Ayurveda is being marketed in the UK may reveal the difference between 'form' and 'function' (see page 154). Scholars suggest that global Ayurveda manifests in a spiritualised version, while my findings suggest that other processes influence the practice. Analysis of the advertisements will show which versions of Ayurveda are being sold and whether this matches clinical practice. This will enable a better understanding of the relationship between the form of Ayurveda and the function of Ayurveda in the UK.

10.8.4 Comparison of South Asian and UK Ayurveda graduates

A larger sample of UK practitioners would allow comparison between the consultations of South Asian graduates and UK graduates in the UK. The aim would be to explore how background motivations and training influence the perception of disease, consultation style and recommendations. Comparing the two groups of practitioners would allow an understanding of whether the clinical practices of the two different groups converge to a similar kind of practice over time.

10.8.5 Comparison of Ayurveda practitioners of different faiths

I have suggested that personal inclination is important in the type of practice offered. I also showed that different practitioners incorporate advice which is influenced by their own faith. Comparison using a larger sample of Ayurvedic practitioners of different faith traditions and no faith, would give further insights into how personal faith influences their practice and what spiritual recommendations they would consider.

10.8.6 Examination of spirituality in other CAM

Ayurveda has its roots in the Hindu tradition and practitioners tended to define spirituality in relation to practices from the same tradition e.g. yoga, meditation etc. An examination of how spirituality is defined by other CAM systems which claim to address mind, body, spirit will reveal other meanings of spirituality in therapeutic contexts.

10.9 Ayurveda in the UK

My research identified a number of paradoxes in contemporary approaches to the practice of Ayurveda in the UK. These may be a result from the transnational movement from India to the UK, though Ayurveda in India also contains paradoxes, for example Pordié (2012a: 199) writes about the curious case of spas in India, and in his seminar Pordié (2012) reported his research on Ayurvedic pharmaceutical company. He suggested that paradoxes are occurring as a consequence of the dominance of Western culture around the globe.

The problem appears to be that Ayurveda is being forced to fit into a biomedical mould, and is being defined as medicine from a different paradigm. However, as I described from my experience of growing up (see page 15), Ayurveda is part of a culture and a way of life and as the practitioners described in Chapter five (see page 96) it encompasses all the different aspects of life as well as being a system of healing. As such Ayurveda is fluid, messy, and consequently paradoxical.

The findings here show that reality cannot be explained in neat scientific terms. A holistic view of reality is difficult to fit into a post-Enlightenment logical paradigm. That is why it appears fluid and therefore messy. The positivist paradigm does not handle paradoxes well and has difficulty supporting fluid systems like Ayurveda. Although positivism has been evolving and its claims to objectivity have been challenged (Crotty, 1998: 29), it continues to underpin the healthcare system in the UK, and the continued valorisation of RCTs (randomised controlled trials) and EBM (evidence based medicine) are the proof of this. As Cant and Sharma (1999: 80) observe:

> In postmodern terms – the diversification of knowledge is occurring and the revival and growth of multiple ways of knowing about health and illness and how to deal with sickness. But, in reality modernist and orthodox standards are still applied to different knowledge forms. (Cant and Sharma, 1999: 80)

Given that economics is a key driver in healthcare decision making about what treatments are supported, the State makes decisions about populations and not individuals and requires proof of efficacy, effectiveness and safety. Therefore, the government supports ways of knowing based on positivism, because it is seeking economic and political advantage. Thus, scientific research methods that consider populations receive state support. It seems that there is little chance of Ayurveda being supported as it is a system that focuses on the individual and would require complex research procedures for validation.

Some practitioners and researchers from the biomedical profession are beginning to accept that it is necessary to explore other traditions of healthcare, based on other paradigms, to fill the gaps that biomedicine has been unable to meet. For example, Professor Vikram Patel, in his plenary speech at the recent International Congress for Complementary Medicine Research (Patel, 2013), said it is a fundamentally flawed assumption to think that the biomedical model is the only way to understand health. There is a need to consider traditional systems of healing that have been used through history.

The government is currently piloting a programme to give people their own personal health budget. In a recent seminar 'Evaluation of the personal health budget pilot programme', [156] the results of the evaluation showed that a number of the participants used their personal health budgets (PHB) to purchase complementary treatments. If this trend continues then it is possible to predict an increase in CAM users in the UK. These may be a new breed of CAM user, as they did not purchase CAM until they received their own PHB. One implication may be that CAM use will experience further increase as a result of patient demand.

CAM and Ayurveda practitioners may be marginalised for political and economic reasons, but it seems that consumer demand may keep them from disappearing from the margins of healthcare. In addition, the practitioners will continue to adapt to a dynamic, fluid world in order to cross back and forth between multiple realities. Ayurveda practitioners identify themselves as health practitioners, as part of their need for credibility and change their practice in order to survive in a new environment. I end with the following quote by the scholar Jan Meulenbeld:

[156] Personal Health Budgets. NHS England (2013) [online]. [Accessed 5.3.13]. Available from the World Wide Web: www.personalhealthbudgets.dh.gov.uk

> I am convinced that the rich heritage of Ayurveda will not easily be obliterated and disappear from Indian soil, because the long history of Ayurveda gives evidence of its flexibility and adaptability to ever changing circumstances. (Meulenbeld, 1995: 1-10)

Meulenbeld says that Ayurveda will not disappear from Indian soil; the findings from this study illustrate further the flexibility and adaptability to even greater changing circumstances, suggesting that Ayurveda will not disappear from British soil.

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APPENDIX 1a Summary of selected academic articles on global Ayurveda

Examples of spiritualised Ayurveda in the academic literature - Maharishi Ayurveda
see Humes (2008), Jeanotat (2008)

In the 1980s, Maharishi Mahesh Yogi, a guru from India, introduced Maharishi Ayurveda (MAV), one of the many forms of Ayurveda, into the West. Jeannotat (2008: 285) writes that, according to the Maharishi, the true knowledge of Ayurveda was fragmented or lost due to India's turbulent history. Misinterpretation of the Indian tradition was the main cause of the past and present spiritual degeneration. I place MAV in the spiritualised category because the cause of disease is identified at the religious and spiritual level and Transcendental Meditation (TM) is part of the treatment prescription. According to MAV, TM was part of the original practice of Ayurveda mentioned in *Charaka Samhita* – ca.sa.1.130-150. Interestingly, MAV also explains Ayurveda in terms of modern physics. Humes (2008: 321) suggests that Maharishi created a new paradigm of Ayurveda; 'a traditional science yet verifiable under allopathic methodology i.e. simultaneously authentic and cutting edge'. This is something that the other paradigms have not achieved. I describe this paradox as 'linking opposites' a theme relating to connecting opposite paradigms (or which are perceived to be opposite) which emerges in my findings and will be discussed later. Perhaps as a result, it is probably one of the most successful models of globalised Ayurveda and could be considered the first adaptation of Ayurveda for the West.

Humes (2008: 309) offers a number of reasons for the success of this particular version of Ayurveda. It focuses on the promotion of philosophy and the spiritual practice of transcendental meditation (TM) which is a central feature of the treatment process. The Maharishi group found a unique way to explain health through quantum healing and the unified field, ideas taken from quantum physics. They set up centres to promote MAV as a gentle form of healing. Perhaps the most interesting feature is that despite their claim to offer the original and traditional version of Ayurveda, they adopted the '*mishra*' integrated ideology for education, an ideology which incorporates modern biomedical technology for a professionalised system of Ayurveda. This suggests that aspects of modernity can be incorporated into a traditional model without jeopardising its authenticity (which I discuss in Chapter nine).

Jeanotat (2008: 300) identifies the socio-cultural factors that enabled the development and establishment of MAV. They include the public criticism of biomedicine and at the same time the increasing interest in CAM, growing interest in spirituality, particularly New Age and Eastern types (Reddy, 2002: 100). Overall, TM seemed to fit into the New Age worldview of the time. In addition, the Maharishi group intentionally employed strategies to promote the TM movement: Their aim was to make TM global, they employed prominent figures in the TM/MAV movement, in particular Dr Deepak Chopra whose bestselling books brought positive attention. They also employed experts with exceptional skills in Ayurveda from India to impress the public, and used New Age methods such as seminars and retreats to disseminate knowledge.

Examples of spiritualised Ayurveda in the academic literature - New Age Ayurveda
See Zysk (2011), Reddy (2002), Warrier (2009)

Zysk (2011)

Zysk (2001: 13) argues that writers like Deepak Chopra, Vasant Lad and Robert Svoboda were prominent among authors who have written books describing the basic principles of Ayurveda for a non-medical western audience and presented a spiritualised form of Ayurveda to the West. Zysk calls their versions 'New Age Ayurveda' which he defines as classical Indian medicine imported to the West by non-Indians.

Zysk argues that holistic medicine has a spiritual dimension which supports the ideals of New Age and Ayurveda which appealed to 'New Agers'. This version of Ayurveda developed out of the ideologies and practices of Lad, Svoboda and Chopra which were in common with the New Age movement of the time; hence Ayurveda in the US has been defined by Vasant Lad, Robert Svoboda, Maharishi Yogi and Deepak Chopra who are linked through their common acceptance of the principles of New Age which include: attributing a remote age to Ayurveda, making it the source of other medical systems, linking Ayurveda closely to Indian spirituality, especially yoga, making Ayurveda the basis of mind-body medicine, and claiming the scientific basis of Ayurveda and its intrinsic safety. It is because of this link with the New Age that I have categorised it as spiritualised Ayurveda. Zysk concludes by saying that the transformations that have occurred in Ayurveda reflect western attitudes and concerns rather than internal development. Zysk does not give examples of New Age Ayurveda practice nor offer any empirical evidence.

Reddy (2002)

Reddy (2002: 97-121) in her ethnographic study of four Ayurveda centres in the United States, draws her conclusions from empirical data. She refers to 'transplanted' Ayurveda in the US as shaped by American medical culture and CAM religious culture, in particular New Age culture (page 99). She argues that the result of these two factors is that the main professionalising dilemma for Ayurveda practitioners is whether to emphasise the religious aspect of their activity or present themselves as medical practitioners. This suggests that the practitioners' role is fluid as it can span both religion and medicine.

Reddy reports that in the past two decades there has been a distinct ideological shift towards spiritualisation and this has influenced CAM, exemplified by a marked increase in the metaphysical content of holistic healing during this time and increased reliance on New Age techniques. Economic factors and politico legal constraints have also contributed. Good and Good (1992) have shown that when Asian systems are transplanted elsewhere, the cultural authority underlying their professionalization is neither science (as it was for biomedicine) nor nationalism (as it was in their countries of origin), but metaphysical sources of authority. Reddy concludes that Ayurveda in America can be treated neither as a monolithic entity nor as a static one. As the body of Ayurvedic knowledge shifts in ideological emphases from the medical to the metaphysical, and as its professionalizing strategies succeed in gaining legitimacy, Ayurvedic practice itself is transformed into an American composite.

Warrier (2009)

Warrier (2009: 1) has undertaken empirical research on Ayurveda in the UK. She argues that 'Ayurveda in its spiritualised form' is the product of what Heelas and Woodhead (2005: 2) describe as the subjective turn in Western societies, a move away from submission to external religious authority towards reliance on personal experience and experimentation in matters relating to faith, the realm of the sacred, as well as morality and visions of the good life. Warrier (2009: 6-7, 11-16) outlines a number of reasons why the UK version of Ayurveda is spiritualised. Primarily, she describes the UK graduates as 'spiritual seekers' as their personal preoccupation with spirituality leads to a preoccupation with 'healing' traditions. Many engage with different holistic traditions as part of their seeking, having become dissatisfied with biomedicine. They see the cause of disease as outward manifestation of deeper emotional and spiritual problems. Warrier elegantly captures the paradox that westerners are drawn to study Ayurveda for mystical/ esoteric learning but the Ayurvedic curriculum in the UK is based on a biomedicalised scientific paradigm. She goes on to describe the influencing factors and types of practices that the spiritual seekers offer in the UK, thus providing details about the spiritualised version of Ayurveda in the UK. This study provides insight into part of the practice, but does not take into account the practitioners from South Asia who are settled in the UK, and have set up practice.

Warrier (2009: 10) argues that UK graduates get their understanding of Ayurveda not only from classroom lectures, but also from popular books on Ayurveda (by authors such as Chopra, Lad,

Frawley) who promote spiritualised versions of Ayurveda in the US, and spirituality and yoga are central to most of these popular works. The UK graduates practise forms of Ayurveda which combine unique and novel elements of popular spiritualised Ayurveda and biomedicalised Ayurveda. They may work in clinics, or set up spas and retreats, offer counselling, write self-help books or run workshops. The clinics display decorative items, textiles and images from South Asia, mantras, soft lights, flowers, candles, incense to create an impression of a calm relaxed haven away from day to day stress. The consultations are long as they take time explaining the Ayurvedic worldview, including advice on diet, lifestyle best suited to the individual *prakriti* (the individual mind-body constitution according to Ayurveda based on the influence of the *doshas*). The different kinds of Ayurveda practice share in common the concern with healing and empowering the individual, not merely curing disease, therefore promoting self-awareness and self-responsibility. Yoga and meditation are key recommendations, and seen as crucial for enhancing self-awareness, healing and transformation. Warrier (2009: 18) concludes by saying that in the UK, Ayurveda is about holistic healing rather than remedial medicine.

Examples of simplified Ayurveda in the academic literature – Simplified Ayurveda
The simplification of Ayurveda can occur either at an ideological level or at a practical level.
see Zimmerman (1992), Svoboda (2008)

Zimmerman (1992) - Flower Power Ayurveda

Zimmerman (1992: 209) argues that Ayurveda in the West is associated with non-violence which is an attractive value of modern times. It excludes the violence of emetics and purgatives of classical Ayurveda. The modern emphasis is on the gentle aspects, thus transforming classical Ayurveda into a gentle *flower power* version for the West. The aim of the new version is rejuvenation through gentle processes. Thus Zimmerman argues that Ayurveda has undergone a process of simplification at an ideological level.

Svoboda (2008)

Svoboda (2008: 125-128) describes the transformation of Ayurveda in the US as one of simplification in order make it fit into the new Western environment, rather than spiritualisation. Complex rejuvenation procedures such as *kaya kalpa* (transformation treatments) are equated to Ayurvedic beauty treatments offered by health and wellbeing spas. There is a focus on *prakriti* and therapeutic procedures such as massage, and at a conceptual level the three *doshas* (*vata, pitta* and *kapha)* are promoted as the essence of Ayurveda. Svoboda is apprehensive about the future of Ayurveda, suggesting that it is fated to be commercialised like yoga, and commodified and absorbed into the multi-billion dollar herbal supplement industry. He argues that there is a simplified, commercialised, version of Ayurveda in the West rather than a spiritualised version. Saks (2008: 37) describes a similar alteration of acupuncture knowledge. In the West it has undergone a simplification and medicalization and as a consequence it is justified by neurophysiological theorising rather than the traditional theory of yin yang.

Hybrid Ayurveda – A mix of Ayurveda and biomedicine in Germany
See Frank and Stollberg (2002)

Frank and Stollberg (2002)

Frank and Stollberg (2002: 224) attribute the growth of Ayurvedic practice in Germany to positive media attention as it was presented as something exotic rather than necessarily spiritual. Bivins (2007: 179) also suggests that therapies that are most different to biomedicine rise most quickly in popularity.
Stollberg (2001: 1) explains that in Germany all CAM is practised by qualified biomedical practitioners.

He suggests that as a consequence Ayurveda is a form of hybrid medicine. In contrast, in the UK CAM can be practised by lay people who can do a short course and set up businesses (the lack of regulation is discussed below). The practice will be significantly different as there are fewer processes of hybridisation with biomedicine in the UK. Further research could explore what a hybrid Ayurvedic practice would entail in Germany and how this might be different to a biomedicalised practice in India.

Hence, Ayurveda is a living science, continually developing, and Frank and Stollberg suggest glocalisation is occurring: transformation and hybridisation, i.e. local changes being made to global changes, in order to make it fit into a specific setting. Ananda Chopra (2008: 243-255) describes his Ayurveda practice at the *Klinik,* an integrated CAM hospital in Germany. He does not perceive Ayurveda as a spiritual discipline or 'New Age' therapy but rather as a medical continuation of an ancient tradition.

Commodified Ayurveda / Self Help Ayurveda
See Alter (2005)

Alter (2005)

Alter (2005: 17) offers an alternative explanation for the popularity of Ayurvedic practitioners like Lad and Chopra, which is ideologically opposite to the spiritualised form of Ayurveda:

> the legitimisation of Asian medicine through discourse of science has made it possible to transform discourses of health into commodified regimens of medicalised self-help and because of this people such as Deepak Chopra and Vasant Lad have thrived through their Ayurveda self-help books. Self-help is made relevant to public health in a context where stress, drug addiction, bad eating habits, inadequate exercise etc. are understood as medical problems of great importance,

Alter argues that it is the self-help culture that has contributed to the rise in popularity of CAM rather than the attractiveness of spirituality. Cant and Sharma (1999: 108) suggest that some pharmaceuticals may see CAM as a new opportunity for profit as the re-emergence of CAM has created novel commercial opportunities. Although these are interesting arguments they are not explored further in this thesis.

APPENDIX 1b Summary of articles on global Ayurveda in the academic literature

Version/Model of Ayurveda	Main Proponent/s	Example of this version/model.
India		
Different Models in Urban Indian city		Tirodkar – sociological study 1) Traditional Practice - clinic 2) Modern Practice - clinic 3) Commercial – Spas 4) Self Help – books, internet
Different types of medicine in Indian Pluralistic medical system.		Leslie Charles 1) Ayurveda of Sanskrit classic texts 2) Unani medicine of classic Arabic texts 3) Syncretic medicine of traditional culture 13th 19th C 4) Professionalised Ayurvedic and Unani medicine 5) Biomedicine 6) Folk medicine 7) Popular-culture medicine 8) Homeopathic medicine Q Are these based on evidence?
US		
Maharishi Ayurveda (MAV) Spiritual/scientific	Maharishi Yogi – Indian Guru	Jeannotat/Hume (08) - Spiritualised Ayurveda with TM but also described in terms of quantum physics – popularised by Deepak Chopra. Simultaneously 'Authentic and cutting edge'.
Maharishi Ayurveda (MAV) Flower Power Ayurveda	US practitioners, MAV	Zimmerman (2002) – Gentle form of Ayurveda as Violent aspects (purgation, emesis) taken out of practices Does not consider legal/practical/educational factors
New Age Ayurveda	Lad, Frawley and Chopra popularised New Age Ayurveda in the US	Zysk (1992) – their ideologies based on 4 characteristic of New Age to meet needs of the spiritually hungry westerners. All had gurus, therefore spiritually inclined?
Spiritualised Ayurveda	Ayurveda practitioners in US and educators	Welch 08 - Spiritual quest of Ayurveda seekers in US

		Is this true of ALL practitioners? Including those from India?
Simplified Ayurveda	The commercial practices in US eg spas	Svoboda (08) – Ayurveda is simplified i.e. *Tridosha* and *Prakriti* are the essence. It has to be simplified to communicate to people of an 'alien' culture?
Self help Ayurveda	Popular authors like Chopra, Lad	Alter (2005) – Health transformed into commodified regimens of self-help. Part of the 'self help' trend? Traditional health promotion aspects of Ayurveda are about 'self-help' ?
Different sub traditions: Depend on professionalising dilemma	Ayurveda practitioners	Reddy (2002) – Ethnographic study of 4 centres Professionalising dilemma – to be medical practitioners or religious healers? Versions: 1.System of dietary restraint (purification) 2.naturaltalistic massage 3. Metaphysical practice? 4. Spiritual practice?
Germany		
Maharishi Ayurveda (MAV)		Frank and Stollberg - glocalisation
Hybrid of biomedicine	Ayurveda/Biomedical Practitioners	Stollberg – Only biomed practitioners can practise CAM in Germany therefore inevitable Ayurveda will be a hybrid. No examples ? how different is it to modern 'biomedicalised' Ayurveda Maharishi taken Ayurveda to Germany
UK		
Spiritualised Ayurveda	Spiritual seekers (UK Ayurveda graduates)	Warrior (09) – subjective turn, spiritual seekers seek Ayurveda. Does this represent Ayurveda practice in the UK ?
Modified/Simplified	Western Ayurveda practitioners	Bruwer (09) – dietary advice is adapted due to cultural difference. Focus on mind/body connection Only UK graduates interviewed. What about

		1st generation Indian practitioners?
Modified/Simplified	Practitioners	Pole (08) – practical limitations influence practice e.g. herbs unavailable, simple alternatives used

APPENDIX 2 – Summary of theoretical approaches according to Crotty (1998) in relation to Ayurvedic approach to knowledge.

Objectivism

Objectivism suggests that meaning, understanding and values are objectified in the people under study, and that objective truth can be studied. This notion that truth and meaning reside in their objects, independently of any consciousness, has its roots in ancient Greek philosophy. This thought persisted in the scholastic tradition throughout the Middle Ages and peaked during the Enlightenment period. The belief that appropriate methods can be used to know the objective truth has been the epistemological basis of Western science (Crotty, 1998: 42).

This objectivist epistemological approach may be seen in clinical Ayurveda. For example, the classical texts include descriptions of the signs and symptoms of diseases. These have been written down in the texts and students learn these as objective knowledge.

Crotty (1998: 18) describes positivism as a theoretical perspective that links to objectivism. Positivism developed during the Enlightenment period and claims to give unambiguous and accurate knowledge of the world. Turning to the origins of the word positivism, the traditional use for the term 'positive' was to posit something, for example 'positive religion' referred to religion that had divine truth posited in it, rather than found through speculation. In this sense of the word, the knowledge of Ayurveda has been posited by the Gods into this tradition of healing. Therefore, in the traditional sense, knowledge was given. However, in terms of modern science, the contemporary understanding of positivism, knowledge comes from direct experience, not speculation. The observation is scientific observation using scientific methods.

The direct experience refers to information gathered through our senses.

Logical positivism suggests that only statements that can be verified are meaningful, and only that which is experienced through our senses is verified knowledge. This approach excludes metaphysics, ethics, aesthetics, and religious beliefs as they are unverifiable through empirical methods (Crotty, 1998: 26). Science takes scientific knowledge to be accurate and certain, and therefore contrasts with opinions, beliefs, feelings that are understood through non-scientific methods. The world perceived through science is systematic, well organised, regular, constant, uniform and absolute. But this is not how the real world is experienced. As Crotty points out, this approach is an abstraction (page 28)

and he further points out the issue with the positivist view is the status that positivism gives to scientific findings, i.e. the claim that scientific knowledge is completely objective and only scientific knowledge is valid. Therefore post positivism looks for probability rather than certainty, and objectivity to a certain level rather than absolute objectivity.

The trigger for the changes from positivism to post positivism arose from Heisenberg's uncertainty principle which defies the positivist claims to certainty and objectivity (Crotty, 1998: 29). This is because it is impossible to determine both the position and momentum of a subatomic particle with any real accuracy. This means that it is not possible to predict a future state with certainty, and also the observed particle is altered through being observed. This challenges the idea of the observer and the observed as independent of each other. Bohr looked at how sub-atomic particles are, and his research shows that a new view is required as they cannot be described by classical concepts like position and momentum.

Popper takes a different stance to human knowledge (Crotty, 1998: 31). He argues that scientists make a guess and then find they are unable to prove themselves wrong. They come to a conclusion through the process of induction. According to Popper, a theory can only be provisionally accepted as true. Therefore scientific truths are only provisional statements as scientists have been unable to prove them false (page 33).

Hume adds that knowledge is based on an assumption that whatever regularity is observed today will remain the same in the future (page 32). Feyerband takes the position that scientific findings are only beliefs and should not be privileged over other kinds of beliefs. Therefore scientists sit along a continuum with regards to the status they give to their findings and claims (Crotty, 1998: 40).

Constructionism

The constructionist approach to knowledge holds that there is no objective truth waiting to be discovered. Truth or meaning depends on our engagement with the realities in our world. The mind is required to construct meaning. Different people may construct meaning in different ways to the same phenomena (Crotty, 1998: 9).

Constructionism mirrors the concept of intentionality which suggests that when the mind becomes conscious of something, it reaches out to and into that object. Therefore there is a relationship between the conscious subject and the object, which is shaped by consciousness (Crotty, 1998: 44). It is out of this interplay between the subject and object

that meaning is born. This approach suggests that there is no true or valid interpretation (page 47). Different people inhabit different worlds or realities. Their different worlds constitute for them diverse ways of knowing and meanings and distinct realities (page 64).

This constructionist approach to knowledge can also be seen in the Ayurvedic perspective. For example, Maroof (2003: 87-109) explains that people with different Ayurvedic constitutions react to the same situation in different ways. He gives the example of how people of different Ayurvedic constitutions respond to being stuck in a crowded elevator. A person with *vata* constitution will get anxious, a *pitta* constitution person will respond by getting stressed and angry, whereas a *kapha* constitution person will remain patient and relaxed.

Social Constructionism emphasises the social origin of meanings which are embedded in social systems and people learn the meanings that have already been established. Fish says that people inhabit pre-existing systems. Geertz sees culture as a source of human thought and behaviour. Culture is a system of significant symbols which are given (Crotty, 1998: 53). They are already present in the community into which an individual is born and remain even after death. Therefore people are born into a world of meanings and as a consequence historical and social perspectives are necessary to understand the meaning at any given place and time (page 54). All reality is socially constructed, including ideas and emotions, though some distinguish between social and physical phenomena (and therefore social and natural or physical realities) and limit the construction to social realities (page 55). According to Giddens and Blaikie, there is a difference between the work of social scientists and natural scientists (page 56). I discuss this later in the chapter.

Crotty (1998: 57) distinguishes between constructionism and constructivism. Constructionism refers to the approach where the social dimension of meaning is at centre stage and the focus includes the collective generation and transmission of meaning. Crotty suggests that constructivism is the approach where social dimension of meaning is not at centre stage and is useful for epistemological considerations focusing exclusively on 'the meaning-making activity of the individual mind'. Giddens and Blaikie have a constructivist view of scientific knowledge of the natural world and a constructionist view of scientific knowledge of the social world (page 58).

In this study I investigate both the individual practitioner's perspective on their practice as well as the practitioners as a collective group, thereby both constructionist and constructivist approaches are incorporated.

According to Mead's symbolic interactionism approach, every person is a social construction. We are constructed as a result of our interaction with society. Social constructionism is relativist as people make sense of the world, in a historical and cultural context (page 64). This relativist approach is important in this study as I have shown in Chapter one; Ayurveda has been transformed by historical and cultural influences, from modern Ayurveda in India to global Ayurveda in the West. The historical, social context of the UK practitioners is important as their perceptions are influenced by the current influences on their practice.

Subjectivism

Subjectivism is the philosophical tenet according to which the subjective experience is all important. According to subjectivism, meaning does not emerge between the interplay between subject and object but is imposed on the object by the subject. The object makes no contribution to the generation of the meaning; rather the meaning is imported from somewhere else. Crotty (1998: 10) says that meaning can come from a variety of sources, for example, from dreams, the conjunction and aspects of planets, religious beliefs and so on. So the meaning comes from anything but an interaction between the subject and the object. This subjectivist approach to knowledge is also seen in Ayurveda, as meaning from astrology and religious beliefs is described. For example, the *Charaka Samhita* describes one possible cause of fever to be the anger of the Gods, or eczema to be a result of past karma.

Crotty (19998: 66) links the subjectivist approach to interpretivism which he categorises as a theoretical perspective and an uncritical form of enquiry. The interpretivist approach explores culturally derived and historically situated interpretations of the world. Weber argues that the human sciences are concerned with understanding (*Verstehen*). Weber emphasises the need to focus social enquiry on the meanings and values of the individual and their subjective meaning 'complex of action'.

Dilthey suggestes that natural and social realities are different kinds of reality and their investigation requires different methods. In studying nature, science looks for consistencies, regularities and rules. In the natural world the focus is on abstract

phenomena, which exhibit quantifiable, empirical regularities. In studying the human world, social science is concerned with the individual, the idiographic, and an individualising method is required. The social world tends to focus on those aspects which are unique, individual and qualitative.

Crotty (1998: 71) refers to three historical streams of interpretivism: hermeneutics, phenomenology and symbolic interactionism. This latter approach understands meaning in broad cultural terms, and culture is seen as a meaningful matrix that guides our lives. Symbolic interactionism comes from Mead (a pragmatist philosopher and social psychologist). In Pragmatist philosophy (page 74) culture and experience are almost interchangeable terms, so seeking the meaning of experience is an exploration of culture. It focuses on the nature and genesis of a shared world, intersubjectivity and communication.

According to Mead, a person is a personality because he/she belongs to a community and absorbs the institutions of that community into his/her own conduct. He says, 'we owe to society our very being as conscious and self-conscious entities, for that being arises from a process of symbolic interaction.' This interaction is through symbolic gestures. People need to be able to adopt the standpoint of others. Children do this through imitative acts and acting out the role of others during play (page 75).

The central idea of symbolic interactionism is putting oneself in the place of the other. In methodological terms, the research participant's view of the actions, objects and society has to be studied. The situation must be seen as the research participant sees it, the meanings of the objects and acts must be determined in terms of the participant's meanings. The researcher would need to see the social world from the perspective of the participant (page 75).

The role taking is the interaction, and it is symbolic interaction because of the significant symbols, language and other symbolic tools that people share and through which communication occurs. Through dialogue one becomes aware of the perception, feelings and attitudes of others and interprets their meanings and intent. Ethnography as a key research methodology is employed in this theoretical perspective. Grounded theory, another research methodology has also developed from symbolic interactionism. This is a specific form of ethnographic enquiry which develops theoretical ideas through a stringent process to ensure that the data develops directly from the data rather than from any other source. I discuss this later in this chapter.

Critical enquiry

Crotty (1998: 59) describes critical theory, an approach which is suspicious of constructed meanings given through culture, as they serve hegemonic interests. Each set of meanings relates to particular power structures and harbours oppression, manipulation and injustice. Critical enquiry (page 113) is in stark contrast to interpretivism which seeks to understand as it explores the situation in terms of interaction and community, whereas critical enquiry research explores conflict and oppression, seeks to challenge and bring about change (E.g. Karl Marx, Michel Foucault). For Karl Marx, the starting point for change was not abstract ideas about the world but concrete social reality, as all social life is essentially practical (page 117).

Critical enquiry focuses on power relationships within society in order to expose the forces of hegemony and injustice (page 157). Critical forms of research call current ideology into question and initiate action for social justice. The researchers interrogate commonly held values and assumptions, challenging conventional social structures and engaging in social action. Although power structures and hegemonic interests emerge as key factors for shaping Ayurveda practice in the UK, I do not adopt a critical theory approach as this is not the focus of this research.

Postmodernism

Crotty (1998: 183) categorises postmodernism as a theoretical perspective linked to the subjectivist epistemology. It emerged in 1960s (or before). Postmodernism encompasses a broad variety of developments in philosophy, social science, architecture, the arts, literature, fashion and other areas.

Postmodernism is a rejection of what modernism stands for i.e. it refuses the totalising and essentialist orientations of modernist systems of thought which purport to be based on generalised irrefutable truths about the world; postmodernism rejects the entire epistemological basis for any such claims to the truth and clarity, certitude, wholeness and continuity. Instead, postmodernism relates to ambiguity, relativity, fragmentation, particularity and discontinuity and permits mess (compared to the arrogance and pomposity of the Enlightenment mode of thinking). In the Postmodern approach, the subject is decentred, and identity is deleted, so a stable self-conception does not exist (page 185).

Rue describes postmodernism as a philosophical orientation that rejects the dominant foundational program of the Western tradition. According to him, there are no absolute truths and no objective values. Local truths and values may exist but they are not endorsed (page 192).

All kinds of divisions and distinctions have dissolved due to mass media, mass marketing, mass capitalisation, mass commodification, mass entertainment, rapid transport systems. There is dissolution of differences and distinctions, and fragmentation takes the place of totality and completeness. Instead of clarity, distinctions and logic, there is irony, parody, and playfulness (194).

Postmodernism takes the view that reality is not presentable (page 212). The postmodern world is simultaneously and paradoxically a world of massification and of fragmentation. The distinctions are dissolved but without them there is no sense of how the whole fits together. There is no metanarrative that brings things together.

The postmodern approach also helps to explain the complexity of Ayurveda which traditionally did not have a boundary between itself as medicine and as way of life, or as an art or as a science, nor as prescribed medicines or as home remedies. Therefore Ayurveda sits well in a postmodern world where concrete boundaries and distinctions are blurred.

To conclude, I have briefly described different epistemological approaches of the social sciences and theoretical perspectives as designated by Crotty (1998). It is apparent that, from an Ayurvedic perspective, no one epistemology fully describes the Ayurvedic approach to knowledge. An Ayurvedic epistemological stance is complex and combines a range of social science epistemologies. Ayurveda is based in a cosmological paradigm (despite biomedicalisation) and describes the universe in terms of qualities which link the microcosm (the individual) and the macrocosm (everything within the universe) and principles of 'like increases like' and 'opposites decrease' emerge from this understanding. For example, the winter weather has qualities of being cold and wet, which are *kapha* qualities. These affect the same qualities in a person through the 'like increases like' principle. As a researcher I need to take an epistemological stance and base my research within that paradigm. As an Ayurvedic practitioner my approach to knowledge resonates with, for example, the view that Clarke (2005: 1) takes: there are different ways of knowing and no one way of knowing is superior.

APPENDIX 3 Demographic details form

Interviewee name: .....

1. **Gender** (please circle) : female male

2. **Age** (please circle): 21-25, 26-30, 31-35, 36-40, 41-45, 46-50, 51-55, 56-60, 61-65, 66-70, 71-75, 76-80, 81-85, 86-90.

3. **Ayurveda qualifications -** if applicable please circle):

   BAMs (India/SriLanka) BA/BSs/MSc(UK)
   Other .....

4. **Other qualifications** (please state subject and level):

   .....

5. **Profession:**
   Current.....

   Previous .....

6. **Religion or Spiritual affiliation:**
   .....

7. **Ethnicity (please tick):**

White British White Irish
White other
Mixed – White & black Caribbean, Mixed – White & black African ,
Mixed – White & Asian, Mixed –other,
Asian or Asian British – Indian, Asian or Asian British – Pakistani
Asian or Asian British – Bangladeshi Asian or Asian British – Any other Asian background
Black or Black British – Caribbean, Black or Black British – African,
Black or Black British – Any other black background
Chinese Any Other – please specify
Not stated

APPENDIX 4 Data Source 1 - List of Interviewees

Practitioner (Pseudonyms)	S. Asian graduate	Visiting Practitioner	UK graduate	Medical convert	Other	Date and place of Meeting
Dr Rajesh	x					12.7.11 - Clinic, London
Dr Priya	x					2.6.11 - Home, East London
Dr Dhani	x					22.6.11 - By Phone
Dr Shalini	x					30.6.11 - By phone
Dr Karan	x					30.6.11 - Clinic, Reading
Dr Neha	x	x				18.11.10 - Clinic, Watford
Dr Lokesh	x	x				2.10.09 - Seminar venue, Watford
Dr Suraj	x	x				7.6.12 - Seminar venue, Harrow
Dr Murli	x	x				25.9.11 - Café, Central London. (informal).
Hannah			x			30.6.11 - Home, Reading
Thelma			x			7.6.11 - My Home, Harrow
Aarti			x			5.7.11 - Home, Harrow
Brian			x			22.10.10 - Seminar venue, Watford
Pritesh			x	x		4.7.11 - Home, Wembley
Dr Ben			x	x		18.10. 10 - Clinic, West London
Dr Kishore			x	x		21.9.11 - By phone
Dr Devi			x	x		15.10.11 - Seminar venue, Watford
Vina					X academic	5.8.11 - Meeting room, Central London
Dr Terence					X academic	7.6.11 - My Home, Harrow
Dr Anup					X biomedic	13.7.11 - My Home, Harrow

APPENDIX 5 Project information and Consent Form

PROJECT INFORMATION SHEET

Study Title: The Practice of Ayurveda in the UK. Patient and practitioner perspectives.

Introduction: I am a postgraduate student at the University of Winchester and am undertaking research for a PhD degree.

The aim of my research is to explore people's expectations and experience of Ayurveda. This will be done by interviewing people who have/are having Ayurvedic consultation(s)/treatment(s).

Ayurvedic practitioners and other key people in the field will also be interviewed.

The results of the research will give a better understanding of Ayurveda practice in the UK.

Contact for Further Information: You can contact me if you have any further questions about this research project. My contact details are: romila.santosh@winchester.ac.uk or telephone 07967 685144.

If you are happy to participate in the research, then please sign the attached interview consent form.

Romila Santosh
Postgraduate researcher

Interview consent form

Please read the following:

- I have been informed about the general goals and methods involved in this research project.
- I understand that my participation includes consent for up to two interviews of approximately 1 hour.
- My participation is completely voluntary and I can withdraw at any time.
- I reserve the right to refuse to answer any specific questions and to discuss any experiences I hold to be private.
- Interviews will be audio-taped.
- All the identifying information gathered during the research will be held in a secure location and in total confidentiality.
- I understand that no individuals will be identified in any publication or public presentation drawing on my interview material, and pseudonyms will be used where necessary.
- According to the Data Protection Act (1998) the interview tapes and transcripts will be stored in a locked filing cabinet, and once the project is complete, these will be shredded and/or destroyed.
- The quotes recorded during interviews may be used in the final report.
- I understand that I can ask for information about the project at any time, and that I can have access to the final report.

I hereby agree to participate in the research project, and acknowledge that I have received a copy of this consent agreement.

…… …… .....

Participant's Name Participant's Signature Date

Contact details of participant's GP .....

.....

Researcher's signature …….

APPENDIX 6 Interview Schedule 1 – Practitioners

Introduction

1. What is Ayurveda?

Education

2. How/when did you first hear about Ayurveda
3. What was your reason for studying Ayurveda?
4. Where did you study?
5. How was your course / tutors?
6. Was there any particular emphasis on any particular topics/approaches?
7. Did you specialise in any particular area?
8. Were you satisfied with your course? What was missing/ How could it have been improved
   Are there any differences between what you learnt on your course and your clinical practice?

Practice

9. When did you start practising? How many years has it been?
10. How do you describe your practice? (Modern or traditional or both?)
11. Where do you practise – locations? Any issues?
12. Is Ayurveda your main profession? If yes, do you practice F/t or P/t? If no, do you have any other another profession?
13. Do you practice any other CAM?
14. Were there any factors that affected your decision in how you would practise Ayurveda? Government regulations, legal, getting herbs etc.
15. Where do you get your supplies from? Equipment, remedies etc.
16. Any issues?

17. How do get your continuing professional practise?
18. Are there any differences in what you were taught and how you practise? What are these difference and why?
19. How have you changed your practise to fit into the UK? If yes, what changes?

20. How did you brand your practise?
21. What is your marketing/advertising strategy? What influences it?
22. Does Ayurveda have a unique selling point? What is it?
23. If there were no restrictions, what would be your ideal Ayurvedic practise?
24. What are the implications of the EU directive in Apr 2011 on your practice? Will you still be able to practise ? How will you modify your practise?

Patients

25. How do your patients come to you?
26. Who are your patients? (by disease, by ethnicity, by gender, etc.)
27. Why do your patients choose Ayurveda?
28. Which issues do you treat most commonly?

Consultations

29. Please describe in detail the consultation process that you follow?
30. Do you offer treatments? If yes, which ones?
31. Do your patients get involved in treatment decisions? How, give examples.
32. Do people come back for follow up? If yes, how many? If no, why not?

Beliefs / Attitudes

33. In your personal experience / opinion what do you think causes disease? Give examples of patients?
34. In your personal experience / opinion what do you think are the important factors to good health? Give examples of patients?

35. In your personal experience what factors enable a patient to get better? Give examples.
36. What are important aspects of treatment? E.g. Diet/lifestyle/medicines .....
37. What factors affect your decision about treatment for a patient? Physical, psychological, spiritual
38. What is your opinion of panchakarma? (A violent treatment-Zimmerman, 1992)

Modern medicine

39. How similar or different are the understandings of the workings of a human in Ayurveda vs biomedicine? What are the similarities? What are the differences?
40. In your opinion what is 'authentic Ayurveda'?

Spirituality

41. Is there a link between spirituality and health? If yes, what? How?
42. What are your views about the role of spirituality in Ayurveda? Give examples.
43. Do you incorporate spiritual practices in your practice? give examples

44. In your opinion can Ayurveda be practised in different ways? What are they? Is there a right way to practice Ayurveda? (Traditional, new age, integrated...)
45. Do you see yourself as working in a complementary or alternative way to biomedicine?
46. What do you feel you are able to offer patients that others cannot?

Classical Texts

47. How important are the classical texts in your practice? Give examples.
48. Do the classical texts have any influence on your practice? How? what?
49. Do you refer to them? When? How often?
50. How do you interpret the classical texts for your practice? Give examples.

General

51. Are you part of any professional association? Are there any benefits of being a member? What?
52. As a practitioner do you need any support to be successful? What kind of support?

53. Do you subscribe to any Ayurveda journals/newsletters? Which ones ? how are they useful ?

54. How important is research in Ayurveda?
55. If research results contradicted Ayurveda, which would you accept?

56. What is your advice to someone who wants to become a Ayurveda practitioner? Would you recommend it? Why/why not?

57. Do you have any regrets about becoming an Ayurvedic practitioner? Have you had thoughts of giving it up? Why? What made you continue?

58. Are there any other issues affecting your practice? How are you dealing with them?
59. What is the future of Ayurvedic practice in the UK / Europe? What are the chances of being regulated?

BAMs graduates from India

What is the difference between your practice in India and in the UK?
Types of problems, types of clients, your recommendations

What changes did you make to practice in the UK?

60. What were your intentions/aspirations of practicing Ayurveda in UK?
61. Have you had to make any compromises? If yes, what are they?
62. What are the key factors in order to practise in the UK compared to India?

BAMs practitioners/ Allopathic practitioners

63. Is there any difference between the two systems? What are they?

64. How do you reconcile modern biomedicine and Ayurveda?
65. Do you think of problem in biomedical terms or Ayurvedic terms

66. Can the two be completely integrated at a theoretical level? If yes How? If no, why not?
67. Can the two be completely integrated at a clinical level? If yes, how? if now, why not ?

APPENDIX 7 Additional questions on Spirituality

1. Do you think there a link between spirituality and health?
   - How does spirituality help?

2. What are your views about the role of spirituality in Ayurveda practice?
   - What is the role?

3. Do you incorporate spiritual recommendations in your practice?
   - For which medical issues do you prescribe spiritual treatments?
   - Which spiritual practices you recommend? Give examples
   - How do you decide these will help the issue/patient?

4. Are spiritual recommendations appropriate for all patients?
   - How do you decide if appropriate / inappropriate?

5. What factors affect your decision about treatment for a patient? Physical, psychological, spiritual

6. Do you take into consideration the patients religious and spiritual beliefs?
   - How do you make this judgement?
   - Do your recommendations change according to your patients personal beliefs e.g. Atheist?

7. Do your personal religious and spiritual beliefs influence your Ayurvedic practice?

8. Did course cover *daivaprasraya*? When, How, What to use?

9. How do you define spirituality?

APPENDIX 8 Interview schedule for academics

1. What is the definition of 'spirituality'? Is there an agreed definition? Or what are the issues in trying to define it.

2. Sociologists have been looking at spirituality, but from a Western perspective. What difference, if any, would an Eastern/Hindu perspective make?

3. Is there a Hindu definition of spirituality? What is it?

4. Some academics have suggested that Ayurveda has been 'spiritualised' in the West.

a) Do you agree?

b) In your opinion what does this mean?

c) What does/could 'spirituality' mean in an Ayurvedic context?

d) Do you consider Ayurveda to be a spiritual system? If yes why? if no why? (Give references)

e) What are the key characteristics that would allow Ayurveda to be described /defined as a spiritual system?
E.g. Charaka Samhita mentions that the subject of Ayurveda (the *Purusha*) is mind, body, senses and soul, does this automatically make Ayurveda a spiritual system as it involves the soul?

5. Is there any empirical evidence to support the idea of Ayurveda being practised in a spiritualised form in the West?

6. It seems that the Indian government adopted/supported biomedicine at Independence making it the dominant system after independence in India, though Ayurveda was part of the pre-independence nationalistic agenda. I would like to understand why this is, in particular as some academics suggest that biomedicine's influence/impact was in fact quite limited to Europeans or Indian elite and not widespread among the masses?
Therefore why should biomedicine have been given the dominant position after independence?

7. What are the key questions that need to be explored from the patients' perspective?

8. Does Mayur / the European University still offer Ayurveda training in the UK? What, where, what level ...

APPENDIX 9 Criteria of a successful interviewer

1. **Knowledgeable**: is thoroughly familiar with the focus of the interview
2. **Structuring:** gives purpose for the interview; rounds it off; asks whether interviewee has questions.
3. **Clear:** asks simple easy, short questions; no jargon.
4. **Gentle:** let's people finish; gives them time to think; tolerates pauses.
5. **Sensitive:** listens attentively to what is said and how it is said; is empathetic in dealing with the interviewee.
6. **Open:** responds to what is important to interviewee and is flexible.
7. **Steering:** knows what he or she wants to find out.
8. **Critical:** is prepared to challenge what is said – for example, dealing with inconsistencies in interviewees replies.
9. **Remembering:** relates what is said to what has previously been said.
10. **Interpreting:** clarifies and extends meanings of interviewees' statements, but without imposing meaning on them.

Reference: Kvale (1996, in Bryman, 2008: 445)

APPENDIX 10 Interview transcript

Practitioner transcript 1. My interview questions are in bold. 2. The practitioners responses are in normal type. I have highlighted portions in red that are of interest and being coded. 3. My thoughts as I am coding are in blue.	**Open/ descriptive code (1st level of coding)**
Q First of all I am going to start off with a warm up question. What is Ayurveda in your opinion?	
What is Ayurveda ? (laughs). OK, I think it is a science of life which really helps prevention and healing of the disease of mind, body and emotions. Mind, body, emotions and soul. So that is what Ayurveda is.	'a science of life' Prevention, Holistic (mind, body, soul)
Q And I'm going to start of by asking you about your practice in the UK, compared to your practice in India. Are there any differences?	
Yeah, in India we use all 6 tools, because we have a full fledged clinic, so we do full 5 weeks panchakarma and we give them precise diet, then we give marma treatment, everything. Here we don't have panchakarma facility really, I mean, at least there are a couple of people doing full panchakarma, but very few. Our style of panchakarma is a little bit different, so that's one thing that is missing for me and the 2nd thing practising here is much more, quite different from India. There are 2 groups of people who come to see me, one is the Britishers and Europeans and the other is what we call the NRI or Asians. So Asians also, there are a few people who are really committed. They do the diet very well, but many other Asians are not ready to change there lifestyle so easily .... and they are mostly looking for some kind of a quick fix thing, but many of the diseases come with, they have nothing in allopathic, nothing offered to them, at the end they do it.	Full practice Limited practice Types of patients. European patients. Asian (NRI) patients. Ethnicity of patients and compliance Quick Fix Rejecting biomedicine.
Very easy for me to work with Britishers and Europeans, because generally when they commit to something they will do it. So the results are more predictable, while Asian community, for them it is difficult to change their food habits and difficult to take the herbs regularly, as a culture there is slight kind of, difference, they will execute only 70% of my advice not 100%. They will not follow everything. That itself, they will think they have followed everything. So its a bit of a challenge you know.	Ethnicity, compliance and treatment outcomes.
Q Why do you think that is, that there is this difference, that in some ways Ayurveda is part of the Indian culture, so why would they find it more difficult compared to Europeans where the culture is a bit more different?	Ethnicity, culture and attitude.
It's a trait as a community, to , in terms of their level of commitment in general in everything. Coz Europeans and Britishers, their level of commitment is always much higher in comparison to Asians, as a culture.	Comparing Indians in India and in UK.
Q so it's like an attitude ?	
Attitude.	

Q Do you find that in India as well ? Very much also, yes. I would say yes. But in India there is one small difference, in comparison to the Indians living here. Indians who live here they are too much dependent on the medical system here. So they are very afraid to do something against the doctors' advice. Or do something different to what they have advised. That's also another fear factor. Coz they are afraid they will have no support from the medical system if we don't follow that advice. Britishers don't carry that fear for some reason. I don't know why. They sometimes choose to go on their own path. In India that does not exist, they make their own choice and that's why, ...I think its easy. But still level of commitment if you look attitudewise is the same.	Dependency on biomedice. Fear. Factors affecting choice. Going against biomedicine.
Q that's fascinating... And I don't want to offend any community, that's not my purpose. But we are just looking at the results, but interestingly even the Asian community is now becoming very aware of holistic healing and they are going in the direction of this kind of lifestyle change and everything. Much better, much available to do that, than several years ago. Yeah.	Increasing awareness of holistic healing
Q Interesting. You mentioned the difference that there is no panchakarma here. What difference does that make to your practice? Cos, real *panchchakarma*, with real *vamana, virechan* and *basti* is done in the right manner, creates right remarkable results in several chronic problems where allopathic has no answers to offer, like very very chronic arthritis, MS, infertility, Parkinson, paralysis. Then autoimmune problems, skin problems. All of these things, with panchakarma all of these problems are much accelerated than just with the herbs and the diet. That is the difference.	Full treatments Biomedicine – gap Panchakarma – fast results
Q are there any alternatives people can try without the panchakarma here. Yeah like the detox plan that I always give to the people. 2 or 3 days of just ginger water fasting then 5 days of moong soup fasting only, then another 10 days of moong and vegetables only, then slowly slowly coming back to normal diet and in general taking ... we believe because I am coming from a lineage which is always believing in the principle of reducing ama as a first step, so when you do this kind of fasting regimen, ama is reduced very quickly.	Alternative treatments in UK =**Simplification**
Q so in terms of the actual advice you give are there any changes in in terms of the recommendations you make here in the UK in any way. Yeah because the food is different, so definitely, in comparison, you need to give a different recommendation, then I give, a little bit of changes are there.	Lack of shared culture, Adapting advice
Q Such as ? Such as, here ama is much higher in comparison to many other places, because probably people don't have much time to exercise, especially Asian community, and British and European people have Vata problems more, and ama as well. But vata and	Ethnicity and type of medical problems

ama combined together and Indians are suffering more from ama diseases and finally that leads into a lot of things like diabetes, cholesterol and BP and um, low immune system, auto-immune problems or arthritis. So my advise would always be always to do this detox.	
Q OK, just going back, when you first went abroad from India, what were the main differences when you first came to the UK?	
First time when we came it was in 1995, and at that time it was very difficult, because the herbs were not, there rules were not clear for the herbs, so it was a bit of a challenge. And we didn't really meet a lot of patients at that time. It was more Europeans and Britishers. So i used to I would say, each trip we met more that 200, 300 Europeans/Britishers, but, so their problems are always more mental and emotional, in comparision to, and suppression of emotional rather than anything else. Like emotional suppression and mental and emotion and vata related. While, now I am seeing more NRI's and Asians, who live in Britain for many years 20, 30 years. They are basically same as Indians who live in India. There isn't much difference in the problems. So I guess genetics and food habits always creates a kind of a culture. So that's the difference I saw.	Lack of herbs Regulations unclear Ethnicity and classification of problem (European = emotional)
Q I am going to change the subject a little bit. You mentioned Ayurveda is also linked to the soul. Mind, body, soul. Do you feel there is a link between spirituality and health?	
Very much. I have done research in panchakarma and people who do chanting and meditation of any kind that they believe in along with panchakarma. Their results are 40-50% greater than people that don't do any meditation practices. That kind of difference I have noticed in a group of 20 people that we observed. 20 of this kind, and 20 without meditation. And we saw that people who did any kind of meditation, like Hare Krishna people, Baba Ramdev we have several such people coming, their results are definitely almost 50 % more than other people.	Spirituality and health **Mechanism** – spirituality accelerates healing, Increases healing.
Q What is the reason, the cause?	
Because most of the disease we have are also karmic, and they are also connected with our emotional being. Our emotional experiences in life. Both combined together. So when we have any meditation practices, spiritual practices, it definitely heals the karmic effect and it also heals the emotional impact of your life. And mind is always more positive and positive mind has better results than negative mind.	Cause of disease = karmic **Mechanism** = spirituality clears karma, heals emotion, makes mind positive
Q And what's your opinion about the role of spirituality in Ayurveda?	
Both go hand in hand and both go together, and if you say only with Ayurveda I will heal something, I would say yeah, but if you have spirituality, healing is faster. But some people go in extreme direction and just with my mind I will control the disease but that's not possible. There are so many problems that are so physical, you have to remove physical toxins, move them out of the body, make it problem. That's very extreme things that alone cannot work. But if you have spirituality on your side, Ayurveda works better.	**Mechanism –** spirituality is a catalyst – accelerates healing Spirituality enhances Ayurveda treatments
Q Do you incorporate any spiritual practices yourself.	**Decision making** –

If there is specific need. When I feel it is coming from some kind of karmic incident in life or this person needs, then I would definitely advise them to go for, and do some spiritual practice that fits them, because every person is different. For example, some spirituality has strong chanting practice, so people who are depressed, people who have loneliness in their life, they will always feel better, it's like a therapy for them. But some people are extremely anxious and over restless. For them chanting is kind of disturbing. They need more calming and more soothing meditative practice. Quiet meditative practices. So every person is different, so they have to, i tell them to find out something good for them. Explore a couple of things and whatever is making you feel good, go for it.	If need **Mechanism** of spiritual practice Spiritual practices, Role of the practitioner. Empower patient to find a spiritual practice.
Q is that only in India, or do you give that kind of advice abroad ?	
More here actually, because in India, kind of **spirituality is part of life**. In a way, because we always go to the temple, although it's a ritual but at the end of the day, when you go to the temple you are bowing down to someone. So you are definitely, at least breaking your ego, first of all. Even if it is a physical ritual act. But you are definitely becoming more humble. And there are always some mantras, so when you chant mantras your mind is automatically focussing on one thing. That itself is a therapy. **So in India, you don't really have to advice anybody so much**. But here, it is kind of sometimes lost. So if needed I would tell them.	Spirituality inherent in life Spiritual recommendation in India, Shared culture
Q Is that with both your Asian and European clients ?	
Both. Yeah, both.	
Q and they both accept it ?	
Most Europeans come to Ayurveda because they are connected with some spiritual path and they are interested in more natural healing. They are on the path to holistic thinking. So i think most of them are connected anyhow. Some of them are not which happens many times. If I feel they need something, I will tell them. Some people are Christianity focused, then OK, if you have stopped going to the church then start going again, it will help you. Laughs.	European patients = 'spiritual seekers' Reason for choosing Ayurveda – natural Spiritual/religious recommendations
Q what kind of reactions do you get ?	
Nothing. I mean if some people are, some people will think, some people realise, yes it was helping me. So I would encourage everyone to go on their path and find their own path very clearly. Spirituality for me is, I think everything is the same. Different different people but at the end it's the same message.	**Role of the practitioner -** Patient empowerment
Q and what's your definition of spirituality ?	
I always think, it's a very interesting question. I need a little time to think on that. **For me spirituality truly is not any connection with religion. It's a pure pure form**. But I would say in one word a detachment, in a true sense. So that you are not unhappy by sorrow and you don't become extremely happy when you get something good in your life and you don't become frustrated or sad when you don't get something in life. So its kind of **detachment to things**. So you are doing your 100% in life, but you are not	Relationship b/w religion and spirituality. Religion and spirituality = separate **Definition of Spirituality** = detachment

attached. When you are not attached you will always be free from fear and a lot of those things which leads to doing something without integrity. At the end if you are not attached to the end result, then, ultimately, living in this society you don't have to take sanyas. And of course taking time with yourself. Being with your soul, understanding the need of the soul that is necessary ? in spirituality. I would say one minus million is spirituality. You're focusing on one thing and a million things are gone. Yeah.	
Q I just want to check, how much time do you have? 7 minutes. We started at 8 O'clock.	
Q what is the importance of the classical texts like Charaka, Sushruta ?	
Very important, very important because they have given the basic principles of Ayurveda, like my practice is focused on 5 main principles. I) the doshas, level of doshas, 2) ama and agni, whether agni is good or not, whether ama is there or not. Where it is located and where it is blocking. 3) Vata moving in which direction, because vata always brings doshas and everything in the place where it causes problems. If vata doesn't move then doshas and toxins cannot move. So I will always look at abnormal movement of vata, 4) dhatus, tissues, 5) srotas if they are blocked or if they are clear, and tissues if they are sufficient, if they are clean or polluted. Those principles are what we call rog vinishchaya. They are the principles of health. For good health what do you need to have. And that comes from Charaka straight away, you know. For me it is very important. Charaka Samhita is the main thing, but what's happening is that the application of all of these principles of Charaka, in every chapter of Kayachikitsa, if you look, disease, jwara, swasa, kasa. They have applied as per the time, at that time. So that time was more kapha time, less stress, more slow. So they applied it in a more kapha manner to balance kapha. That application if you try to use now which is happening most of the time, then it doesn't work. You have to apply these principles looking at todays context, and today that one? is different, completely different. So your focus has to be same principles, but now pitta vata problems are higher, emotional problems are higher. Agni low practically 80% people have that, because we have such sedentary lifestyle, so many facilities, we hardly exercise, we have cars, we have trains, we have this we have that. That time it was not like this. People used to walk, they had to walk. They had to work in a field, which is not now. We have to understand sedentary lifestyle always brings ama, and agni low. So all this we have to consider and think from this point of view. Then ?. then I think this will be a very effective clinical practice.	**Role of the classical texts** Modern Interpretation of classical texts
Q A lot of people say research is important nowadays to prove things, do you think that is necessary for Ayurveda? See research is very important because ... several ways of research. Research have so many aspects. We do a lot of research. We have a team of almost 15 scientists working on several projects in India.	Role of research in Ayurveda
Q in your clinic ? Yeah, we have more than 100 clinics worldwide, and a factory. We make more than 200 formulas and we are exporting to Europe for more than 20 years now. So we have to	Research for Legislation

follow a lot of standards in order to be at par with the needs of the European legislation, always. So research is really important in my opinion. One, from the point of view of the standardisation of herbs, because it's very funny, but this is the truth, adultration then wrong time picking of the herbs, if you pick for example kutaj in August, you have no, there is this main alkaloid, in kutaj, is completely absent. It will never have any effect. If you pick it in February, it is completely full. So you have to do research for standardising of the herbs. Then second, research has to happen in terms of toxicity study, because at this time our kidneys and the liver are already loaded by the chemicals we have taken since birth. Antibiotics are just like popping pills. Children just take them every couple of weeks. They are already loaded by the toxins, so some of the herbs not toxic earlier I think are probably toxic now. I have seen that in my practice, some of the herbs are not good for this time, you cant use that. Heavy metals are not good for this time, you cant use that.	Research for standardisation of herbs Research for safety, quality
Q The bhasmas ?	
Yes, the heavy bhasmas, like mercury. Minerals are OK. The rasayana, lead no.	
Q so you wouldn't use them in your practice ?	
Not at all. Never. In fact **we have a machine to test each and every product**, to make sure, because even the herbs are polluted sometime. We test them, they have to be free from these heavy metal impurities, then only the products go to any part of the world including India. Even in India we don't sell them. I am very strict about it. This time is like this. We have to be. Also there is complete absence of any lab methods to find if bhasmas are made as per Ayurvedic texts. When the bhasmas are prepared in the right way, then there is organic and inorganic link created, which makes them really safe for the body. In comparison, to the heavy metals like lead taken as it is, they are poisonous. But there is no way you can really find that each and every molecule has converted into this organic and inorganic link. So there is no lab which can do that, we tried to find, it is very expensive. So that's why I don't believe in bhasmas. And I think there are beautiful herbs if given in the right does, exactly herb, not adulterated and pure, they work better than bhasmas.	Using technology Technology
Q Really ? Many people say bhasmas are the ..	
In our practise we have treated more than one million people around the world. I think our experience combined together is of several vaidyas (laughs), because of the way in which we work so many people come. So we have been blessed by God, that people keep faith and then they come. So from that experience I am saying.	Personal belief in God = Transcendence approach
Q as you know we are probably going to have problems with the herbs in the UK, because of the regulations.	Ayurveda community
Yeah, that's true. That should be sorted out. As a community, the Ayurveda community should come together. Which is a little bit difficult because they are more busy back biting than coming together. I am sorry, you may not write it in the research laughs. I always think the regulation is important. It should come. And we should put a lot of efforts to educate the authorities, so that they will actually bring the right regulation. Because without regulation you know people, I think deserve to get the quality product.	Regulation Educating the authorities – for right regulation. Changing regulation

If it is not regulated it will not come. So I think it is necessary to regulate, but we have to put a lot of effort to educate the authorities so that they will understand the herbs and make regulations based on this understanding. I have done that several times in the past. In Italy we did it in 1995. I made a whole presentation with two more companies. And it worked. That impacted the regulation and they put all the herbs in regulation of food supplement when they made the first law of food supplement in Italy in 1993. Laughs. Interview interrupted. Interview ended.	

APPENDIX 11 Data Source 2 - List of meetings / seminars / conferences attended

Date	Event
April 2009	CAMSTRAND conference, Middlesex University
July 2009	British Association of Accredited Ayurvedic Practitioners conference (BAAAP)
October 2009	Ayurveda Practitioners Association (APA) – Dr Lad seminar
October 2009	Science and Medical (Scimed) conference , Berlin, Germany
May 2010	APA – Multi-track event
June 2010	BAAAP conference
July 2010	Ayurveda Emergency Campaign meeting
October 2010	APA – Dr Lad seminar
March 2011	Ayurveda Symposium (Save our herbs meeting)
March 2011	CAMSTRAND, Southampton
April 2011	BAAAP seminar (Prof Warrier)
May 2011	APA – Multi-track event
May 2011	Regulation and Professionalisation in CAM: historical perspectives and contemporary concerns. International Conference, Birmingham.
February 2011	CAM and sociology seminar, University of Westminster
March 2012	Spalding conference on Indian Religions, Oxford
June 2012	British Herbal Medical Association (BHMA) - Annual meeting
June 2012	BAAAP workshops (Dr Shetty)
October 2012	East Medicine Seminar, University of Westminster
March 2013	Personal Health Budgets Evaluation Seminar
April 2013	International Congress for Complementary Medicine Research (ICCMR 2013), London.
2010 - 2011	Monthly CAM seminars, CAM research Group, Southampton

Glossary

A

Ahimsa	Non-violence.
Agni	Fire, digestive fire, metabolism.
Ama	Toxins, undigested food which is considered raw or uncooked.
Astanga Hrdayam	Vaghbhata condensed and reorganised the *Charaka Samhita* and *Sushruta Samhita* to produce the *Astanga Hrdayam*. It is one of the three ancient classical Ayurvedic texts.
Atharvaveda	One of the four ancient scriptures of the Hindu tradition.
Atma	Soul, spirit, the non-material aspect of the individual person.

B

Bhagavad Gita	The Bhagavad Gita translated as the 'Song of God' is one of the religious scriptures of the Hindu tradition. Spoken by Krishna to Arjuna during the Mahabharata.
Bhaisajya Kalpana	Text book which deals with Ayurvedic Pharmacy.
Bharatnatyam	Classical Indian dance form.
Bhava Prakasha	The Ayurvedic text which specialises in medical formulae .

C

Chakra	Energy centre in the subtle body according to yogic anatomy, wheel.
Charaka Samhita	One of the three ancient classical Ayurvedic texts. The *samhita* refers a compendium of medical knowledge complied by *Charaka*. Wujastyk in his book 'The Roots of Ayurveda' (2001: 39-42) gives a brief outline of the history of the texts, suggesting it was compiled around 1,500 BCE. It contains information on general medicine.
Chikitsa	Treatment of disease.
Churna	Ayurvedic medicine in powder form.

D

Daivavipashraya	Spiritual therapies (also translated as divine or religious therapies), used when other treatments are ineffective or when the underlying cause in unknown.
Deep	A light made of a cotton wick usually soaked in *ghee* or oil.
Dhanvantari	The deity of Ayurveda.
Dharma	Duty, religious duty of a person. One of the four purusharthas (four goals of life).
Dhoti	Cotton garment wrapped around the waist to cover the legs. Men in India wear it instead of trousers.
Dinacharya	Daily routine that promotes health and well-being.
Dosha / Doshas	Bodily humours, subtle forces, bio-psycho-energies , 3 different humours are described in Ayurveda: *vata, pitta, kapha.*

Droni	An item of equipment used in Ayurvedic treatments to pour a stream of warm oil onto the head of a patient.
G	
Gayatri Mantra	A special mantra considered highly potent and traditionally only chanted by people advanced in their spiritual practice.
Ghee	Clarified butter.
Guggul	A type of gum or resin used in Ayurvedic remedies.
Guna/s	Quality, attribute, in Ayurvedic treatment three psychological qualities are *satva, rajas* and *tamas* and twenty other qualities are used in the diagnosis.
Guru	An enlightened teacher, a mentor.
Guru- Shishya	Traditional Indian system of learning, a teacher or *guru* took a small number of students and educated them in his home. Mentor-disciple lineage.
H	
Hakim	Practitioner of Unani medicine.
J	
Jwara	Fever, heated.
Jyotish	The *vedic* science of astrology, pertaining to light / stars.
K	
Kayachikitsa	Internal medicine, treatment of the body.
Karma	Action, different actions of herbs.
Kasa	Cough.
Katibasti	A treatment generally to treat lower back pain.
Kaya Kalpa	Rejuvenation technique.
Khitchari	A dish made of rice and lentils cooked together.
Kshaya	Decoction (plant crushed and boiled in water).
Kunjal	A treatment in the yoga system to clean the body.
Kurta	A garment for the upper body.
M	
Madhava Nidhana	An Ayurvedic text which specialises in diagnosis.
Manovaha Srotas	Subtle channels of the mind.
Mantra	A sequence of words which produce a particular sound vibration, a sound yielding an energetic effect.
Marma	Are specific pressure points around the body, energy points.
Mishra	Mixed, integrated.
Mimamsa Philosophy	Founded by Jaimini to analyse and understand truth. It has influenced investigation in clinical practice of Ayurveda. The teachings include many methods to attain God through rituals and sacrifice. In Ayurveda this translates as rituals such as burning

	candles and incense, offering flowers, sprinkling holy water all of which have healing power.
Moong	A type of pulse that is easy to digest.
Moksha	Liberation from the cycle of birth and death.

N

Neem	A bitter tasting plant which has anti-sceptic properties.
Niyama	A rule, routine. One of the limbs of Astanga yoga.
Nyaya Philosophy	Founded by Gautama which pertains to method, plan, logic. It deals with reasoning. According to Nyaya philosophy there are four sources of valid knowledge.

P

Panchakarma	Five cleansing actions – therapeutic procedures to detoxify the mind-body system at deep tissue level.
Pragnya Aparada	Translated as 'Intellectual Blasphemy', i.e. when a person knowingly makes the decision to something that is harmful.
Prakriti	Nature, constitution, genetic blueprint.
Prana	Life force energy, breath.
Pranayama	Controlled breathing techniques, regulation of *prana*.
Punya Veda	Virtuous.
Purusha	Human being, person.

R

Rajas	One of the three qualities, a quality of the mind, translated as action, dynamism, passion, agitation.
Rakta dhatu	Blood.
Rasa dhatu	Plasma, chyle, lymph.

S

Samagri	A mixture of different plants that are offered as sacrifice during a fire ceremony.
Samskara	Subliminal impressions of a person's thought or experience that get imprinted in the subtle body .
Sanatana Dharma	Translated as the eternal duty or law. Some followers prefer to use this term rather than Hinduism as it comes from within the tradition, whereas the term 'Hinduism' is perceived to be imposed by missionaries during the colonial period.
Sankhya Philosophy	*San* means truth and *khya* means to realise therefore *Sankhya* means to realise the truth. Founded by Kapila provides the basic philosophy of Ayurveda. It gives the 24 principles in the manifestation of the universe.
Sarangdhara Samhita	The Ayurvedic text which specialises in pharmacy and pharmaceutics.
Sarpagandha	A herb, traditionally used to lower blood pressure.

Satva / Sattva	One of the three qualities, a quality of the mind, translated as goodness, truth, harmony, purity, intelligence, light, positivity.
Satvic	Good, Truthful, Peaceful, Harmonious.
Satvavijaya	Psychological therapies.
Shirodhara	An Ayurvedic treatment which involves pouring a stream of warm oil on the forehead. This brings about deep relaxation.
Shodhana	Cleansing / detoxing procedures.
Sloka	A verse.
Suddha	Pure.
Sushruta Samhita	One of the three ancient classical Ayurvedic texts. Wujastyk in his book 'The Roots of Ayurveda' (2001) gives an outline of the history. Compiled 1,500 BCE. It contains information on surgery.
Swasa	Difficulty in breathing e.g. asthma, dyspnea.
T	
Tamas	One of the three qualities, a quality of the mind, translated as ignorance, heavy, dark, inertia, dullness.
Tantra	This word has many meanings, but in this context, it refers to spiritual practices or rituals which work with energy / prana.
Tilak	A mark made of paste (e.g. of sandalwood) and worn on the forehead or other parts of the body. Different styles of tilak denote devotion to particular deity.
Tridosha theory	Describes the way the three *doshas* (humours) *vata, pitta, kapha* operate in the person.
Triphala	A common herbal remedy made of 'three fruits'.
V	
Vaisesikha Philosophy	Founder Kanada, pertains to the knowledge specific aspects of concrete reality. Therefore knowledge is gained through observation and critical logic. It also describes the atomic theory of existence, which suggests that the entire universe is composed of atoms.
Vaidya	Professional title given to qualified Ayurvedic practitioner.
Vamana	One of the five panchakarma treatments. Emesis.
Vastu	The science of space and direction, it has its origins in the Vedic literature. It is generally described as the sister science of Ayurveda, along with Vedic Astrology (*Jyotish*) and Yoga.
Vedanta Philosophy	*Veda* means knowledge and *anta* means end, therefore Vedanta means the end of knowledge. Founded by Bhadarayana. There are two schools of thought: *Dvaita* which considers God and the individual as separate and *Advaita*: which considers God and the individual as one.
Vedas	Four ancient Indian books of knowledge : Rigveda, Yajurveda, Samveda, Atharvaveda.
Virechana	One of the 5 panchakarma procedures. Translated as Purgation.

Y

Yagna	A ritual involving some kind of sacrifice. The fire ceremony involves offerings to the God of Fire.
Yama	Rules of social conduct, the first limb of Astanga yoga.
Yoga philosophy	Expounded by Patanjali, yoga means union of the lower self with the higher self. Or the union of human with God. Ayurveda has incorporated the physical exercise and breathing techniques and meditation for healing purposes.
Yuktivipashraya	Physical therapies – diet, lifestyle, bodywork techniques.

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