

Ayurvedic medicine in Germany

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Introduction

While Ayurveda is popular in the German mass media and in the wellness area², it is rather small in the medical sphere. This becomes evident by the following figures:

German heterodox medical associations, 2003

German physicians with their own practice	117,000
4 medical acupuncturist associations	29,400
<i>Association for Classical Acupuncture and TCM</i> (non-medically qualified)	1,050
Central Council of Homeopathic Physicians	4,000
Ayurvedic Physicians and non-medically qualified personnel (Maharishi Mahesh Yogi)	120

In the last years, acupuncture treatment was mostly covered by public health insurance companies. A definite decision to integrate it into the normal treatment schemes is expected for the next months. And physicians who completed an acupuncture course may officially add acupuncture to their title. But there is no official recognition of Ayurveda at all. Nevertheless, private insurance companies partly reimburse their members for Ayurvedic treatment. But these schemes cover only a small part of the population, the better off.³

The Maharishi Mahesh Yogi group dominates the medical Ayurveda market. Maharishi designed an Ayurveda for the West. He softened the harsh Indian purgation therapy, and concentrated on nutrition advices and on massages and oil applications (cf. Stollberg 2001). These applications may be the essence of his success. Maharishi's speciality is the

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² Conrad (1994) states that wellness is widely considered as a virtue in modern society. For some individuals it even has the aura of a secular path to salvation.

³ In 1995, the health insurance companies of the public scheme comprised 88,5% of the population, the private ones 9% (cf. www.gbe-bund.de/pls/gbe/ergebnisse).

transcendental meditation, which is clearly advertised in Deepak Chopra's popular book.⁴ There are a few clinic wards and a few physicians practicing Ayurveda outside the Maharishi organisations.

Studies on heterodox medicine mostly focus on the practitioners, on their motivations, their education, their relation to the professional organisations. Even recent studies conceptualise heterodox as an alternative, and not a complementary medicine (cf. Saks 1992; Saks 2003), and interpret CAM as a social movement (cf. Brown et al. 2004 and the respective volume of *Sociology of Health and Illness*). As for Germany, there are no empirical studies about users and practitioners of Ayurvedic medicine.

Methods

Robert Frank and I performed an explorative study in this field (2002). We interviewed 15 Ayurvedic physicians – 3 out of them did not belong to the Maharishi organisations - and 14 of their patients. The interviews were conducted in 2002, and lasted between 40 and 85 minutes each. Because we reached the patients via their doctors, we must assume that dissatisfied patients are under-represented in this study, and that the perceived efficacy of Ayurvedic medicine and eventual disagreements during the clinical encounter are not representative of all Ayurvedic patients.

Results

1. Firstly I sketch our results regarding the patients. As in previous studies (cf. Kelner & Wellman 2003), there was a significant gender imbalance, with ten out of the fourteen patients being female. Four of the fourteen participants were managers or business consultants. While all of them were employed in the service sector, only one worked in a setting remotely connected with heterodox medicine: the sale of natural textiles. Half of the patients interviewed had a university degree. This is hardly surprising, as previous research has shown a high level of education among heterodox patients. Expectations are also met when we look at their complaints: Most of them were chronic, non-life-threatening diseases like allergies, chronic back pain, rheumatism or skin-diseases, while three patients suffered from diseases less common in heterodox medicine: Crohn's disease, cancer and an eye-disease with imminent blindness. Three patients reported that they sought Ayurvedic help for coping with *stress*. There was a strong variation in the duration of the diseases. Some of the patients went to see an Ayurvedic physician within three to six months after their complaints started, while others had been suffering for decades before they sought Ayurvedic help.

Previous studies on heterodox patients have focused on the variables that initially led to the use of heterodox medicine. In our data, the limitations of biomedicine played a more significant role than the appeal of Ayurvedic concepts, which patients knew little about. The final decision to use Ayurveda was highly influenced by members of the respective personal network, a factor which has not received a high degree of recognition in previous studies on heterodox medicine. It would be interesting to see whether this is specific to Ayurveda and other marginal modes of medicine. We also interviewed patients using acupuncture (cf. Frank & Stollberg 2004 b). Their choice was partly influenced by their personal network, too. But a convenient access to the physician and financial issues (reimbursement of acupuncture treatment by the insurance companies) were important factors for acupuncture and not for Ayurvedic patients to choose the respective treatment.

As advice from close friends or relatives only leads to *trying out* Ayurveda, legitimacy has to be achieved by further means. This does not necessarily imply that a speedy cure is required,

⁴ See Chopra 1989 (orig. American 1987). The author is a disciple of Maharishi Mahesh Yogi, and a physician working close to Boston.

but Ayurvedic physicians have to give the impression that the treatment is *actually achieving something*. In Ayurveda, one of the methods available for this purpose is pulse diagnosis. Many participants reported their first pulse diagnosis to have been a turning point in their treatment, describing it as an utterly convincing, slightly magical experience:

I was intrigued! Just by taking the pulse she told me so many things about myself. I thought: 'This is impossible!' And she even proved it by using an ultrasound scan, because she told me that my gall bladder was in bad shape. And she was right! I had mild pain in my upper stomach, and she felt that. She said: 'Let's do an ultrasound – I'll show it to you.' And there it was. My gall bladder was full of grit. I was so impressed and amazed that someone could feel the pulse and recognise the diseases you have. (AyuPatient 13)

In Ayurveda, these kinds of experiences at an early stage not only promote trust and legitimacy, but they also motivate patients to change their lifestyles, particularly in terms of diet. Other means of achieving this are the panchakarma treatment and the personal interactional style:

I had stopped smoking in 1980. And I went for the panchakarma treatment in 1992, and during the 'emperor's bath' it started smelling of smoke. One of the therapists said: 'There is no one smoking in our place, is there?' It got stronger, and finally we saw there were black trails in the massage-oil – This black stuff was coming out of my pores and it was like lying in a cold ash-tray. If you think of how long nicotine remains in the body – this was twelve years after I had stopped – then it is quite remarkable how you can purify the body with Ayurveda. (AyuPatient 8)

For most of the participants, these experiences were very influential, and their Ayurvedic physician soon became their first choice in health care. But this choice is limited to chronic diseases:

I have decided that he is my GP now, but in an emergency situation, I would always go to the closest biomedical physician. On holidays abroad or in an acute crisis situation on the weekend, I wouldn't hesitate for a minute about calling the ambulance and going to hospital. One thing is the emergency, the other the chronic disease. You have to separate the two mentally. (AyuPatient 7)

Therefore, twelve of the fourteen patients conform to Sharma's (1992) type of 'stable users', while we could identify only two 'eclectic users', who still use several other heterodox modes of medicine on a regular basis. While it seems possible to apply Sharma's typology to our interviewees, this is not the case for other models commonly used to describe heterodox patients. Ayurvedic patients do not readily fit the mould of the 'active consumer' (cf. Kelner & Wellman 1997). They certainly show a high level of activity in implementing the nutritional advice given by their physicians – they regard the opportunity to become actively involved in coping with their disease as an important asset of Ayurveda. However, it does not matter to them that they do not have control over decisions or information. To be guided by their physicians appears to be more important to Ayurvedic patients than autonomy when it comes to their own health. Ayurvedic patients neither aspire to gain deep insight into the logic of Ayurvedic healing, nor do they seem to be particularly interested in getting involved in the medical decision-making.

The doshas and everything are pretty complex. You have some idea of where you fit in. And with spices – there is so much you can theoretically do, and I do bother with it to a certain extent. My physician gave me a book on it and I leaf through it every now and then, but it is all so complex. (AyuPatient 12)

There is little evidence of joint or informed decision-making in Ayurvedic medicine. The most suitable model seems to be the paternalistic model inspired by Parsons (1951), because all decision-making control is centred on the physician. While the Parsonian model of the physician-patient relationship is rarely considered compatible with the idea of patient-centred medicine, the accounts of our participants clearly show that they feel their needs are met and their perspectives considered in the medical encounter. Therefore, we can present Ayurvedic consultations in paradox terms to be paternalistic *and* patient-centred. As Frank (2001) has shown for homeopathy, these kinds of paradox combinations of different sociological models are common in heterodox medicine, and are likely to differ for each particular medical system. There is no such thing as *the* heterodox medical interaction, and we might even find different forms of interactions in Ayurvedic institutional settings other than the ones presented here. It is conceivable that patients have different expectations in non-medical Ayurvedic settings, or that in Ayurvedic health-centres (where panchakarma treatment is offered to in-patients), more consumerist attitudes can be observed.

There is little infrastructure to distribute Ayurvedic drugs. Import regulations are tight, and some physicians import drugs from India indirectly via the Netherlands. Others tend to rely exclusively on advising their patients about nutrition and life-style from an Ayurvedic perspective. Therefore, communication becomes the central feature in German Ayurveda.⁵ Patients describe these events as pleasant experiences, emphasising their long duration and the personal nature of the Ayurvedic encounter.

She convinced me with her personality, a trustworthy person and a physician who gives the impression of having time for the patient. That was extremely important to me. If it takes half an hour, it takes that long. If it takes five minutes – fine. But she never gives the impression: ‘The waiting room is overcrowded. Get lost!’ She is always so calm. (AyuPatient 5)

Despite the multitude of instructions, which include dietary restrictions and daily oil applications, patients do not feel pressured by their physician. Instead, they value the opportunity to actively cope with their disease by contributing to its cure or the alleviation of symptoms. Thus, patients seem to fit the mould of the ‘active consumer’, because they are highly motivated to assume responsibility for their own health. However, if we look at their behaviour as regards seeking information, a different picture emerges. Patients did not generally collect a significant amount of information on different methods of treatment. Even their knowledge of Ayurveda was scant when they started treatment.

I have to say that I fully trust her. Would I make enquiries elsewhere? – No. I’m fine with what she tells me, and she explains it in a way that I understand. There are so many books available. If I started looking for a book, I don’t know where I would end up. So I wait until she tells me. (AyuPatient 13)

Only two out of ‘our’ patients conform to the idea of the ‘active consumer’. They are tremendously active in seeking information about heterodox medicine and now have a commanding knowledge of the subject.

⁵ For the difference between Ayurveda in Kerala and in Germany see Frank 2004: 244ff.

Then I started looking for better ways of coping with my pain. I tried out several relaxation techniques, and I went to a clinic of natural medicine. I took a lot of natural remedies. What else? As I have to support my spine, I do shiatsu and yoga. Once a week, I get acupuncture done, but not just for the spine. I found a really good physician for Chinese medicine – a real Chinese physician from China whom I trust for the time being. Even though I am always sceptical, the treatment has had positive results, even if they're not quite the ones I expected. But there has been no breakthrough yet. (...) Nowadays there is the Internet. And I also study. There is this new 'naturopathy' course at university, which incorporates Chinese medicine, and also Kneipp⁶, sauna, steam baths etc. I like to try things out, you know. (AyuPatient 4)

For all other patients, the physicians are the gatekeepers of Ayurvedic knowledge, and they control the extent of their patients' awareness. They introduce Ayurveda to them, choose the books and translate Ayurvedic terminology into terms their patients can understand. They supervise the socialisation process whereby their patients become acquainted with Ayurveda. Most patients appear to be perfectly content with a completely passive role in this respect.

2. I now turn over to the Ayurvedic physicians. Which had been their motives to choose Ayurveda? A distinctive aspect is their personal relationship with Indian culture. Six of the fifteen Ayurvedic medical doctors interviewed in this study reported that they have first been drawn to Indian culture and became aware of Ayurveda in this process. The attraction of Indian culture paved the way for their Ayurvedic practice.

I was always close to India as my grandmother had so many paintings of India hanging on the wall. Her brother-in-law had been to Indonesia with the Dutch and was deported to the Himalayas. There he met Heinrich Harrer⁷, worked with him and prepared his escape to the Dalai Lama. And he painted all these pictures and told so many stories. I always knew that this is where I wanted to go. So therefore, the interest in India preceded the interest in Ayurveda. (AyuPhys 9)

We can see how these physicians perceive Ayurveda to be intimately embedded in Indian culture and philosophy. This motivational pattern corresponds to their style of medical practice. They try to adopt a rather purist approach to Ayurveda, attempting to combine it as little as possible with biomedicine or other forms of heterodox medicine (Frank & Stollberg 2005). This correlation of practice styles and motivational patterns is in contrast with medical homeopaths. While there are varying types of homeopathic practice⁸ among them (Frank, 2001), their motivational backgrounds are rather homogenous.

As there are no standardised courses in Ayurveda in Germany, physicians have to decide on their own how to acquire Ayurvedic knowledge. Most of the physicians who turned to Ayurveda for reasons of their inclination for Indian culture and philosophy, studied Ayurvedic writings on their own, while three of them combined this approach with extended periods of practice in Ayurvedic hospitals in India. One of them even became a Bachelor of Ayurvedic Medicine and Surgery (BAMS) in India after her graduation in biomedicine.

⁶ Sebastian Kneipp (1821-1897), a priest who is still widely known as a healer using water and herbs. There are many Kneipp societies in Germany.

⁷ Heinrich Harrer became famous by writing the novel 'Seven Years in Tibet'.

⁸ Medical homeopaths in Germany segregated their patients into categories of homeopathic and biomedical patients, complemented a predominantly homeopathic practice by few biomedical strategies for diagnostics or focused on homeopathy and condemned biomedicine.

Unlike in homeopathy where different forms of experiential background complemented each other, we rather find different *types* of motivations among Ayurvedic physicians. The participants in our study reported *either* their proximity to Indian culture *or* an already existing fondness of heterodox medicine. Nine of the fifteen physicians have already practised Western or Asian forms of heterodox treatment before becoming aware of Ayurveda. Therefore, turning to Ayurveda did not open up a completely new career path for them as it did for 'indophile' Ayurvedic physicians or medical homeopaths. It rather extended the range of heterodox methods which they offered to their patients:

I believe you have to be born to practise in this way, including a passion for nature and naturopathy. You see, I grew up in the countryside. My mother used to treat me with herbs and later I went to extra courses in homeopathy and acupuncture while I was studying medicine. (AyuPhys 13)

These two sets of motivations – proximity to Indian culture, existing heterodox orientation - could be complemented by further aspects. Again, we find critical attitudes towards biomedicine. While medical homeopaths attacked the therapeutic effects of biomedical strategies, Ayurvedic physicians rather reject biomedical *philosophy*. They appraise biomedicine as being too technical and not patient-centred.

It was caused by biomedicine. I used to work as a radiologist and became so frustrated by that. It is so hostile to the patients, so inhumane. I was working with MRT where you push the patient through the pipe and that's it. Nobody is talking to him! (AyuPhys 9)

Contrary to the technical, analytical approach in biomedicine, the Ayurvedic physicians in our study perceive the possibility of achieving a synthesis by Ayurveda. Because of the holism of Ayurvedic concepts, there is a chance of transcending fragmentary perspectives of biomedicine.

I am just convinced that modern medicine dissects the human being and we desperately need a supplement. We have to take the whole person into account and this is the only way in which medicine can be satisfying for the physician as well as for the patient. (AyuPhys 13)

Finally, a number of participants in our study experienced Ayurveda's efficacy before practising themselves, even though this was not as pronounced as for medical homeopaths. Three of the fifteen interviewed physicians reported their personal experiences to be a significant part of their motivations to study Ayurveda.

I fell seriously ill. While biomedicine was helpful for a while, I had to complement the treatment by other means to become healthier. Ayurveda worked really well in that respect. (AyuPhys 1)

Discussion

In another study (Frank & Stollberg 2004 b), we found the following characteristics of German patients using acupuncture:

1. They chose to use acupuncture because of a convenient access to the physician, of personal network recommendations, and because of financial issues (acupuncture treatment was paid by the insurance company)
2. Their criticism of biomedicine was mild. They criticised its limited efficacy in chronic diseases and the side-effects of its drugs.
3. Their use of acupuncture treatment was clearly complementary to biomedicine.
4. Their indifference to Chinese medical knowledge was high.
5. They integrated their explanations of the efficacy of acupuncture into widely shared explanations like 'it stimulates circulation' or 'it works along nerve fibres'.

Comparing these results with those from the Ayurvedic patients, I can state:

1. The Ayurvedic patients mostly chose their physician, because people from their personal network recommended doing so.
2. Their criticism of biomedicine was in few cases sharper.
3. Some of them tended to use their Ayurvedic physician as their general practitioner.
4. Their indifference to Indian medical knowledge was mostly high; they trusted in their physician and his/her knowledge.
5. They integrated their explanations of the efficacy of Ayurvedic measures into commonly shared 'materialist' explanations.

Things clearly differ regarding the physicians. The motivations of medical doctors for practising acupuncture are significantly different from their Ayurvedic colleagues, even though the data on medical acupuncturists' are more diffuse than those on homeopathic and Ayurvedic physicians' motives (cf. Frank & Stollberg 2005). Critical attitudes towards biomedicine were mentioned by two acupuncturists, even though they were markedly milder than the views of Homeopathic and Ayurvedic physicians. One acupuncturist was interested in heterodox medicine before becoming aware of acupuncture. Interviewees also reported rather contingent reasons for their interest in acupuncture, e.g. "a friend/colleague told me about it" or "completely by accident". Heterodox practice does not appear to be deeply rooted in their biography, and there is little indication that starting to practise acupuncture marked a turning point in their career. It would be no surprise if many doctors had economic considerations in mind before choosing acupuncture as the heterodox mode of their choice. It is hard to decide whether the vagueness of medical acupuncturists' answers on their motivations is an indication for this interpretation.

As a last point, I will discuss Ayurveda in Germany as a phenomenon of the glocalisation of medical knowledge. The glocalisation of Ayurvedic medicine in Germany is a heterogeneous process. The German media and Maharishi health centres portray Ayurveda as a gentle, massage-based therapy. Ayurveda is de-contextualised and fragmented. Ayurvedic medicine is then re-contextualised in a discourse of luxury, recreation and wellness. Anthropologists rarely approve of this version of Ayurveda, accusing it of being non-authentic and commodified (Schmädel 1993). Zimmermann (1992) called the panchakarma-treatment offered at Maharishi's health centres a 'flower power Ayurveda'. However, the concept of glocalisation challenges the notion of the cross-cultural transfer of cultural elements in a pure and authentic fashion.⁹ As the term *glocalisation* incorporates the idea of local populations actively taking up and modifying components of cultural globalisation, it implies that cultural

⁹ It is questionable whether these pure versions of Ayurveda ever existed. It appears that Ayurveda has always been in a process of hybridisation and exchange with other modes of healing, such as Unani (Leslie, 1976). Thus, it is not surprising that the very same authors are also highly critical of the contemporary Indian versions of Ayurvedic practice (Zimmermann 1992, Schmädel 1989).

forms – such as medical knowledge – do not cross geographic boundaries without being changed. Instead, transcontinental diffusion involves transformation and hybridisation.

A second important agent in processes of glocalisation is the physicians practising Ayurveda. They employ multiple strategies of reconciling the conceptual tensions between biomedical, Ayurvedic and other heterodox modes of treatment. These strategies range from loose combinations to tightly fused new forms of medical knowledge (Frank & Stollberg 2004 a). Their patients appear to be less creative. As their primary concern is to cope with their ailments, patients de-contextualise Ayurveda by focusing on drugs and nutritional advice received from their physicians. Ayurvedic patients show creativity when it comes to measuring and explaining Ayurveda's effectiveness. They (re-)combine elements of Ayurvedic treatment with biomedical or naturopathic modes of medical thinking (purification; *Entschlackung*). In all other areas, Ayurvedic patients largely rely upon the information provided by their physicians, which appears to satisfy their curiosity about Ayurveda. Again, we might find different patterns of glocalisation of Ayurvedic knowledge in other settings, and a comparison with patients of Maharishi's health centres or patients of non-medical Ayurvedic practitioners might provide further insights into the culture of Ayurvedic patients in Germany.

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