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Medical Pluralism as a Matter of Justice

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Abstract
Culture, health, and medicine intersect in various ways—and not always without friction. This paper examines how liberal multicultural states ought to interact with diverse communities which hold different health-related or medical beliefs and practices. The debate is fierce within the fields of medicine and bioethics as to how traditional medicines ought to be regarded. What this debate often misses is the relationship that medical traditions have with cultural identity and the value that these traditions can have beyond the confines of the clinical setting. This paper will attempt to bring some clarity to the discussion. In so doing, it will delve into some controversial areas: (1) the debate around whether liberal states ought to embrace multiculturalism, (2) the existence and nature of group-differentiated rights, (3) the question of whether healthcare systems ought to embrace medical pluralism, and (4) what this would entail for policymakers, clinicians, and patients. Ultimately, I argue that liberal democratic states with multicultural populations ought to recognize medical pluralism as a matter of respecting group-differentiated and individual human rights.

Keywords Human Rights · Multiculturalism · Medical Pluralism · Philosophy of Medicine

Introduction

In the vernacular, calling a society "multicultural" is simply a descriptive term, indicating that the society contains people of more than one cultural background. However, politically speaking, multiculturalism is a normative and prescriptive term. It describes a "politics of recognition," as some have called it, aimed at cultural accommodation and representation of marginalized groups within a given society. This dual usage of the term can mean that many societies are multicultural in fact but not multicultural in terms of policy. We can see a parallel duality in the use of a term like *medical pluralism*. Almost every human culture has developed its own medical tradition, making the medical landscape's natural state abundantly diverse. Yet, in modern societies, it remains an open question whether healthcare systems will embrace this diversity or promote a single tradition as the only official and legitimate medicine—leaving the others on the periphery.

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In this paper, I aim to demonstrate that there are serious ethical consequences to the marginalization of certain traditions of medicine, given their connection with other aspects of culture and identity. For clarity, I will confine my discussion to the context of modern liberal democracies with multicultural populations—like the United States, Canada, and the United Kingdom.

In these nations, Western biomedicine (a system that applies biology and biochemistry to medical practice) dominates the healthcare system, and so-called complementary or alternative medicines (known by the acronym CAM) are often regarded with suspicion. The debate is fierce within the fields of medicine and bioethics as to how traditional medicines ought to be regarded. Some have argued that there is no such thing as "alternative medicine," only "alternatives to medicine" (Schneiderman 2000; Louhiala 2010). Other thinkers have pointed out that this is often said with the ethnocentric implication that the only *real* medicine is Western biomedicine (Morreim 2003; Kirmayer 2011; Kidd 2013). This debate is complicated by the fact that, in the West, CAM has become a catch-all term, home to traditions as vastly different as Traditional Chinese Medicine (TCM) and crystal therapy.

What this debate often misses is the relationship that medical traditions have with cultural identity and the value that these traditions can have beyond the confines of the clinical setting. For historians and anthropologists (Good 2008; Winkelman 2009; Burri and Dumit 2010), the importance of these traditions can seem obvious, while some Western doctors have come to see these other styles of medicine as a threat—as part of an anti-intellectual, anti-scientific trend, or simply as ineffective and harmful (Offit 2015; Pigliucci and Boudry 2013). There are valid concerns on both sides of the debate—the proliferation of pseudoscience and charlatanry are genuine concerns when it comes to public health, but ethnocentric bias and the resulting epistemic injustice are also valid concerns. So, how can we balance these contrasting interests?

In this paper, I will attempt to bring more clarity to the discussion. As the first step, I will argue that traditional forms of medicine are valuable for more than merely their ability to produce conventional positive and measurable health outcomes—like lower instances of disease or increases in longevity. Medicine is both an applied science and a social institution, in many cases overlapping with religious, cultural, and other value systems and sources of identity. Thus, medical traditions have value as part of the fabric of cultural heritage. This makes it morally problematic for those in power to discount the legitimate contributions and perspectives of other medical traditions. Additionally, I will argue that the discriminatory treatment of traditional medicines runs against the liberal value of self-determination and interferes with patient autonomy.

Liberal multiculturalism

To set up the discussion of medical pluralism that will follow, it is necessary to first understand the arguments for and against multiculturalism in other domains. Multiculturalism has been a topic of discussion in the realm of political philosophy for decades, and in that time, there have been many arguments put forth, both defending and critiquing it. Some have argued for multicultural policies on communitarian grounds, as did Charles Taylor (1995). On the communitarian account, individuals come to know themselves or develop an identity at all only through membership in a collective. Thus, as Taylor says, without recognition of cultural identity, "a person or a group of people can suffer real damage, real

distortion, if the people or society around them mirror back to them a confining or demeaning or contemptible picture of themselves" (Taylor 1994, 25).

Others argue in favor of multiculturalism through a liberal egalitarian framework, notably Will Kymlicka (1995, 2009) and Anne Phillips (2007). For liberals, the value of central importance is autonomy, and their defense of multicultural policies naturally finds its roots in the defense of self-determination. On the other end of the debate, cosmopolitans like Chandran Kukathas (1992, 2003) and Anthony Appiah (2005) have argued that peaceful coexistence between different groups requires indifference to culture rather than policies of accommodation, in addition to pointing out that "cultures" themselves are not discrete or static entities. Meanwhile, post-colonial theorists (see Coulthard 2007) criticize multiculturalism for reproducing rather than transcending the old injustices of the colonial system, and feminists (see Okin 1998, 1999, 2005) have argued that multicultural accommodations may perpetuate other forms of injustice like gender discrimination.

Much of the discussion about multicultural policies has focused on immigrants who are ethnic or religious minorities (e.g., Muslim migrants in Europe) or on minority nations (e.g., Catalans, Basque, Welsh, Québécois) and indigenous peoples (e.g., Native peoples in North America, Australia, and New Zealand), with special focus on religious accommodation and language rights (Song 2020). It is not my main objective here to argue for the embrace of multiculturalism in every area nor to defend multicultural policies from these criticisms. Rather, I want to point out some of the valuable contributions the discussion of multiculturalism has brought forth and demonstrate the relevance of these insights in the realm of healthcare policy and medicine.

Indeed, I share some of the concerns of multiculturalism's critics, specifically regarding the ways that arguments for the self-determination of groups can turn a blind eye to in-group oppression and discrimination towards minorities within minorities (for example, members of the LGBTQ + community within fundamentalist religious sects). Multicultural policies may not be the best way forward in every aspect of political life. Nevertheless, defenders of multiculturalism get some things right about the importance of culture. As Phillips (2007) explains, the argument for multiculturalism begins with recognizing that people's cultural identities *matter* to them. From there, the case can be made that ignoring or disparaging people's cultural identities (especially those of vulnerable minorities) does them harm. It seems especially problematic to discriminate on the basis of culture, given that one's cultural membership is often unchosen. Respecting people's cultural identities aligns with liberal values like freedom (the ability to live according to one's own principles) and tolerance (respect for others' choices) (Phillips 2007). This has the implication that in societies with culturally diverse populations, it is not appropriate to expect everyone to adopt the practices and beliefs of the majority or dominant group, and this obviously has public policy implications.

Medical minorities: "CAM" and multiculturalism

In the realm of healthcare policy, there has been considerable resistance to incorporating other cultural perspectives in a way that I will argue reveals ethnocentric bias and perpetuates injustice. The aspects of culture that traditionally receive the most attention from the multiculturalists are language and religion, with notable examples found in Canada,

such as the French language in Quebec or motorcycle helmet law exemptions for Sikhs. The implications of multiculturalism in the realm of healthcare and medicine have received comparatively less attention. This is a gap that I will try to remedy here.

In this sphere, Kymlicka's contributions may still hold some relevance for how a liberal multicultural state should interact with and meet the needs of its various people groups. For instance, immigrants and linguistic minorities need additional accommodations in the form of translators to attain the same level of access to healthcare as the wider population. As for religious groups, accommodations in healthcare are already widely accepted (though not always without criticism)—as in the case of religious exemptions from vaccinations in some parts of the United States. It is already a widely established practice that doctors should respect the religious beliefs of their patients in the name of patient autonomy, even when this conflicts with what the conventional treatment may be (as with Jehovah's Witnesses and blood transfusions, etc.). Even so, the interactions of minority groups with the healthcare system are not always without friction.

As L. J. Kirmayer writes in "Multicultural Medicine and the Politics of Recognition,"

> Cultural differences may impede access to health care, accurate diagnosis, and effective treatment. The clinical encounter, therefore, must recognize relevant cultural differences, negotiate common ground in terms of problem definition and potential solutions, accommodate differences that are associated with good clinical outcomes, and manage irresolvable differences. Clinical attention to and respect for cultural difference (a) can provide experiences of recognition that increase trust in and commitment to the institutions of the larger society, (b) can help sustain a cultural community through recognition of its distinct language, knowledge, values, and healing practices, and (c) to the extent that it is institutionalized, can contribute to building a pluralistic civil society. (Kirmayer 2011, 410)

Anne Fadiman's (1997) ethnography of the Hmong immigrants in California, *The Spirit Catches You and You Fall Down*, vividly portrays both the importance and the difficulties in cross-cultural healthcare. The phrase that Fadiman used as her title is a word-for-word translation of the Hmong term for epilepsy. Even with only the title phrase to go on, it is clear that communicating ideas about the origins of disease and biomedical methods of cure between a Western medical system like in the United States and Hmong immigrant communities is a steep task. As the book describes, the linguistic and cultural gap was so wide that even for the American doctors to imply that a Hmong patient had a kidney or heart problem could not be done without insult (Fadiman 1997). The only organ the Hmong traditionally acknowledged (in humans, at least) was the liver. In part because of the deep cultural taboo on dissection, there were no words for other internal human body parts, so the only words left to explain the disease as Western medicine understood it carried with them the implication that the patient was partly animal (Fadiman 1997).

Fadiman's book and articles like Kirmayer's help to underscore the need for healthcare systems to get better at cross-cultural interactions. As a matter of practicality and efficacy, cultural accommodation in healthcare is necessary for effective care. Indeed, it is nothing radical to claim that it is unjust for ethnocentric bias or other forms of discrimination to prevent a person from receiving medical care. Without provisions like medical translators, options for religious accommodations, etc., medical practitioners simply cannot adequately meet the healthcare needs of their patients.

While many now recognize the importance of accommodations for patients with different cultural backgrounds, the relationship between different cultural *traditions* of medicine

has still been much neglected. It is still highly controversial as to whether healthcare systems themselves ought to embrace medical pluralism or reject it. As it is now, many healthcare systems in liberal multicultural states are at fault for stacking the deck against certain valid forms of medicine that belong to minority groups. Giving these minority medicines the moniker "complementary" or "alternative" sends the message that they are not equally legitimate. But the problem extends beyond terminology. Ignoring medicine's relationship with culture and social structures leads to ethnocentric discrimination. This is problematic because it can lead to the medical contributions of less powerful groups being unjustly discounted, to the detriment of all.

Again, examples like the Hmong immigrants in Fadiman's book demonstrate the complex relationship between language, culture, and medicine. Just as cultural beliefs interact with health and shape how individuals and groups relate to the healthcare system, they also produce healthcare practices themselves. Medical traditions are often deeply embedded in their home cultures, inextricably entwined with beliefs about the good life and the shaping of identity. Given this nature, we ought to take seriously the question medical pluralism poses for liberal multicultural societies. As Kirmayer (2011, 410) puts it, "Cultures are associated with distinctive ways of life; concepts of personhood; value systems; and visions of the good that affect illness experience, help seeking, and clinical decision-making."

Conceptions of health and medicine are not identical or easily reconciled with one another across cultures. Where Western biomedicine sees *nerves* and *organs*, TCM sees *meridians* and *qi*, and Traditional Indian Medicine (Ayurveda) sees *doshas* and *chakras*. These differences are more than merely linguistic since there is much more attached to the idea of *qi* than there is to a concept like nerve endings. *Qi* has spiritual and metaphysical connotations that have no counterpoint in biomedicine (Kaptchuk 2000). Furthermore, where organs are discrete objects within a person's body, having concrete and defined boundaries, *qi* is intangible and general (at least in some sense also universal), possessed by organs, persons, and even inanimate objects.

Even the goals of these medical traditions are slightly different. Though they all aim toward increasing human health, the understanding of that goal is shaped by the different ontological commitments and metaphysical assumptions (e.g., where Western medicine is focused on organ function, TCM is concerned with harmonizing the *qi*) (Kaptchuk 2000). Naturally, along with those differences in orientation come different views of what kinds of behaviors come under the purview of the medical. These kinds of differences make each of these medical traditions fundamentally incommensurable with one another, which carries the implication that attempts to evaluate the efficacy and validity of traditions like TCM or Ayurveda by the conventions and standards of Western biomedicine are doubly suspect.

I will expand on this epistemic aspect of the status of medical traditions later in this paper, but for now, I will reiterate the point that medical traditions like TCM and Ayurveda are just as much a part of cultural identity as language and religion. Thus, lumping these medicines into the catch-all "CAM" belittles these traditions in a way that is unjust. The concerns for justice when it comes to culture and medical minorities do not stop at terminology, however. As I will demonstrate in what follows, this ethnocentric bias harms everyone, not just because it disparages the medical contributions of minority groups but because it also unjustifiably infringes on patient autonomy. But before we get to that, it is helpful to address the nagging question for any multicultural policy: What are the relevant group distinctions to make?

Discerning relevant groups

So, what does it look like in practice to protect minority groups from discrimination? The multiculturalists have an answer, but it will bring us to a new area of controversy—that of so-called group rights. Within liberal democratic states, the idea that individuals have certain rights that the state is obligated to respect is generally accepted. However, the idea that certain *groups* could also possess rights is more contentious. As the argument goes, if the existing systems are set up to privilege the majority or dominant group (intentionally or not), then some group-differentiated policies may be necessary to ensure the same range of freedoms and opportunities are afforded to minority groups. Thus, rather than being special rights that give minorities privileges that the majority does not enjoy, group rights are intended as a counterbalance to existing inequalities.

Still, some worry that the creation of group rights will lead to the oppression of individuals within those groups. Multiculturalists, like Kymlicka (1995), try to avoid this problem by making a distinction between inwardly directed and outwardly directed group rights, meaning a group is not justified in placing restrictions on its own members. Groups do not have any inward-facing legitimate authority to coerce their individual members into behavior for the sake of the group. Rather, group rights have an outward force—protecting the group from imposition by the state (Kymlicka 1995, 34–48).

That still leaves the question open as to what constitutes a "group" in the relevant sense. Drawing the boundaries of groups and deciding which groups are relevant and which aren't is a fraught process and often arbitrary. Ethnicity or culture are often thought to provide "natural" bases for groups, but in practice, these can be difficult to define since cultures are not monolithic wholes that endure stably through the ages—something many critics of multiculturalism have noted. Cultures come and go, mix and mingle, evolve and change.

Kymlicka (1995) put forth one possible answer to the question by proposing three groups that he argues liberal multicultural democracies ought to accommodate: (1) indigenous populations, (2) regional minorities, and (3) immigrants. To give a summary of his view, Kymlicka argues in favor of the strongest protections for indigenous peoples because their situation is unchosen—having been coercively incorporated by a larger state. In contrast, since immigrants freely choose to migrate to the new country, states are justified in encouraging them to assimilate, as long as the state, in turn, fulfills its duties to provide the immigrants with the same range of life choices and the same level of democratic participation afforded to the rest of the population (Kymlicka 1995). Though Kymlicka's view is not without its detractors, the logic behind his divisions seems clear. Since these groups enjoy comparatively less power within the larger community, these provisions help to make up the difference in power in the political realm, where the ultimate object is to ensure that everyone has the same opportunity to enjoy the same range of freedoms. At the same time, defining the categories based on a relationship to the state or majority avoids specifying particular groups, whose status and situation may change (for example, if Muslims became the majority rather than the minority within the US or UK). But given the nature of medical traditions, we will need to appeal to other criteria to identify the relevant subjects of inclusion.

An embrace of prescriptive or normative medical pluralism means making room in the healthcare system for traditions of medicine beyond Western biomedicine in terms of what is covered by insurance policies and what forms of medical treatments are legally available. Naturally, this begs the question of which medical practices to include. Because of the evolving nature of both culture and medicine, it is neither useful nor desirable to provide

a definitive list of exactly which medical traditions should be considered legitimate and which should not or to specify exactly what status or what degree of integration would be ideal between the various traditions in a particular nation's healthcare system. Instead, what I will offer here are some broad conceptual ideas that can help guide the discussion in a way that avoids the problem of ethnocentric bias.

First, we ought to identify the relevant sense of a cultural group for the present discussion. Echoing Kymlicka's taxonomy, many of the relevant medical traditions are attached to identifiable indigenous or immigrant cultures. Some medical traditions are also closely tied to religious beliefs and practices, like Unani medicine with Islam. However, not all minority medical traditions arise from what we would typically think of as a "culture" in the lay usage of the word. Within the United States, for example, chiropractic is a homegrown American tradition—not one that came from "another culture" in the same sense that we might say that TCM entered the American medical scene. Yet, chiropractors do, in some ways, represent a distinct medical culture of their own. As a community, they meet many of the common criteria we think of as "cultural"—they share common values, methods, training, and even a common language to describe illness (e.g., "subluxation"). Thus, for the purposes of this paper, I take this and other similar practices to meet the standard for a minority medical "culture." Though for other reasons (elaborated on below in the section Putting pluralism into practice), chiropractic methods may not merit the same degree of accommodation as other traditions (e.g., indigenous medicines).

Next, we must distinguish which practices properly count as *medical*. Within the field of the philosophy of medicine, which has been attempting to answer this question, there are two main schools of thought: some argue that medicine is best thought of as an applied science, while others view it as a professional community and social institution (Kaldjian 2014). Although full consensus has not been reached, a group of scholars convened by the Hastings Center affirmed both views, saying that "medicine has essential ends shaped by more or less universal ideals and kinds of historical practices, but its knowledge and skills also lend themselves to a significant degree of social construction" (Kaldjian 2014, 7). As L. C. Kaldjian summarizes:

> The great variability of medicine's goals over time and across cultures … makes it difficult to identify a single set of inherent values that would determine a common and enduring set of goals. Medicine on this view is seen as "an ever evolving fund of knowledge and a changing range of clinical practices that have no fixed essence" and are characterized by "scientific and social malleability." (Kaldjian 2014, 7–8)

For my purposes here, I will echo this view, with some small modification: medicine is best thought of as a professional practice aimed at promoting health and alleviating illness (however that may be defined). Importantly, this practice also must not inflict harm in the normal course of its exercise.[1] One may argue that defining medicine this way also imposes potentially ethnocentric standards on what is considered medical and what is not. After all, many traditional medicines are informal, lacking the professional element that would fit my proposed model here. Additionally, the notion of what it means for something to be harmful itself may vary culturally. Nevertheless, I will argue that these two criteria are reasonable boundaries to embrace.

For any effective policy to be implemented, it must be able to define its terms. Thus, medicine cannot be allowed to include anything and everything from mom's chicken soup to gene therapy.[2] Inflating the term will do no one any good. Further, as it is my intention here to discuss which forms of medicine people are owed access to as a matter of justice within a liberal state, the medical tradition's relationship to that state is the one most at

issue. The state does not (and should not) prevent your mom from bringing you soup when you are sick. But neither should the state compel her to do so as a matter of respecting your right to healthcare. Most informal healing or health-promoting practices (providing that they are non-harmful) can be permitted to function outside the official domain of medicine. It is better for everyone involved to avoid the complications of creeping medicalization.

As to the discussion of non-harm in medicine, I acknowledge that what is considered harmful can vary culturally (see Muyskens [2022] for a lengthier discussion). Yet, as I have confined the arguments in this paper to liberal states, I will justify this criterion for cultural accommodation with an appeal to some Rawlsian concepts. Namely, whatever is taken to be impermissibly harmful should be arrived at through public reason. Within a liberal state, Rawls argues, citizens must commit to the norm of public reasons—meaning they must be able to argue for their views in ways that are accessible to others that do not already share their preconceptions (Rawls 1996). As Lief Wenar (2021) puts it, Rawls's "reasonable citizens" are reasonable in that "they are unwilling to impose their own comprehensive doctrines on others who are also willing to search for mutually agreeable rules."

In a recent article on the subject of non-harm in bioethics, Abram Brummet (2019) discusses the difficulty of resolving moral conflicts when doctors and patients hold different conceptions of harm underpinned (or, in his words, "tethered") to different metaphysical beliefs. He argues that despite an ostensible commitment to neutrality regarding moral-metaphysical positions, especially those that fall under a protected category like religion, in practice, bioethics cannot avoid holding or imposing some metaphysical commitments of its own (Brummet 2019). I acknowledge that the understanding of non-harm in the biomedical tradition is itself culturally embedded and not value-neutral. However, as mentioned, as long as this norm can be defended through public reason, I take it to be an acceptable imposition within a liberal society. Applying this to the present case, this would mean that even if there are some cultures or medical traditions that do not share the goal of non-harm or that conceive of harm very differently, liberal states need not accommodate them if the traditions cannot justify their position in the realm of public reason.

Finally, an additional relevant criterion is cultural significance. There are many culturally significant practices that are not relevant to the present discussion of medical pluralism, either because they are not health-promoting or because they lack the professional element that transforms a healing practice from a folk remedy to a medical tradition. Similarly, a health-promoting practice that is non-harmful but also culturally irrelevant (like the outdated practice of medieval humoral medicine) is unnecessary to include.

Many who would resist the inclusion of other traditions of medicine alongside Western biomedicine worry about giving credence or legitimacy to practices that are, by their assessment, dangerous. I am willing to admit that some traditions of medicine are ineffective, some maladaptive, some dangerous, and some all of the above. For example, the Biami of Papua New Guinea attribute many illnesses to the work of sorcery (or *sanguma*), which has the unfortunate consequence that curing the illness requires hunting down the "guilty" sorcerer, torturing or killing, and then sometimes eating the person (National Geographic 2011). These are not the kinds of practices I am interested in defending or promoting, hence the essential criterion that a practice must first do no harm. Practices that are understood as part of a tradition of healing but expose patients or others to unnecessary risk can be rightly prohibited by a liberal society, over and above their cultural significance.

Objections

Settling on these three criteria may initially be surprising—especially given the conspicuous absence of empirical support. A notable consequence of this view is that traditions need not get the theoretical explanation for their remedies scientifically correct in order to be properly considered medical or to be genuinely therapeutic and valuable. This is a feature that some bioethicists will find problematic. In her 2016 article, "No Understanding No Consent: The Case against Alternative Medicine," Arianne Shahvisi argues that it is unethical for medical professionals either to offer or to endorse "alternative medicine" treatments. She rests this argument on the importance of informed consent in medical ethics and goes on to claim that since there is no known (scientific) causal mechanism behind CAM treatments, endorsing them widens a problematic epistemic disparity between doctor and patient—undermining trust in the field of medicine as a whole (Shahvisi 2016).

To respond to this, it is important to point out that it is not always the case that "CAM" practices lack empirical evidence—even if the language used in the theoretical explanations is not couched in the terms common to Western biomedicine. As the historian David J. Hufford (2010) succinctly put it, "debunking the explanation does not debunk the remedy." As an example, Hufford (2010) describes one of the techniques used in TCM to prevent breach births (which happen when the baby is not oriented correctly in the womb for safe birth). The treatment involved burning an herb (*moxa*) and holding the smoke at an acupuncture point located on the woman's little toe. Through clinical trials, the technique outperformed other methods of treating breach birth as well as the control group (Hufford 2010). The TCM remedy worked, despite having no satisfying scientific explanation. Medical systems do not have to get the causal explanations right to be useful.

Moreover, there have been other scientific studies that found acupuncture to be clinically effective in treating migraines, osteoarthritis, and other forms of chronic pain (Linde et al. 2009; Manheimer et al. 2010; Vickers et al. 2012). Admittedly, these examples only go to support TCM—not other practices that fall under the CAM umbrella. Yet, this only further corroborates my earlier point that lumping so many practices together is unhelpful and unwarranted. I will admit that not all CAM practices are equally supported, and it is not my intention here to defend them all. Only those that meet the above-stated criteria—being health-promoting, non-harmful, and culturally significant.

Additionally, a lack of understanding or an inability to explain why any given treatment is effective does not, in fact, widen any unjust epistemic gap, nor does it undermine medicine as a practice. After all, how many patients really understand the medical-ese that physicians use to explain conditions and treatments? And even if they did, the fact remains that many of the causal mechanisms behind many conventional medical treatments' effectiveness are as opaque to physicians as they are to patients. Haavi Morreim's (2003) article, "A Dose of Our Own Medicine: Alternative Medicine, Conventional Medicine, and the Standards of Science," elaborates on this point. She argues that critics who wish to hold CAM to the same scientific standards as Western biomedicine ("conventional" medicine) will be sorely disappointed in light of the deficiencies to be found in Western biomedicine as well. She writes,

> Standard medicine is not nearly so scientific as is usually assumed. Among other factors, there are far too many phenomena to study; limited research resources are often directed as much by political and commercial interests as by medical needs; actual practices do not reflect well the science that has been gathered; the most pristine sci-

> ence is often the least useful in the real-world care of ordinary patients. (Morreim 2003, 222)

She goes on to say conventional medicine "can sometimes be more 'guilty' than CAM of wasting money, engendering false hopes, and of even causing harm" (Morreim 2003, 222). This is true even considering the undeniable successes of modern scientific medicine in the realms of antibiotics, surgery, etc. There is much that conventional medicine does well, but it must be acknowledged, Morreim argues, that "much of actual clinical practice does not and never can measure up to the scientific standard to which critics of CAM would like to hold alternative medicine" (Morreim 2003, 222).

Another reason some are hesitant to embrace traditional medicines is the suggestion that any effect these treatments seem to have is merely psychosomatic, easily explained by the placebo effect (Torcello 2013). Again, however, to fairly apply this criticism will call into question many accepted procedures within Western biomedicine as well. As the medical anthropologist Daniel Moerman observes in his book *Meaning, Medicine and the "Placebo Effect,"* the term *placebo effect* is imprecise and often unhelpful, covering too broad a range of phenomena. It is used to refer to inert medicines but also the psychosomatic and emotional responses of patients to medical care—what Moerman renames the "meaning response" (Moerman 2002). Because the term is used to refer to inert medicines like sugar pills, many people assume that placebos have no effect at all. However, this is not the case—as the "meaning response" indicates. The experience of knowledge, symbols, relationships, and meaning have real biological consequences, and what is labeled "placebo" can nevertheless induce healing effects through these other pathways (Moerman 2002). As he goes on to describe, there are, in fact, many practices within conventional Western medicine that derive their effectiveness from the "meaning response," up to and including heart surgery (Moerman 2002, 3).

To be logically consistent, if the presence of a placebo invalidates something as medical, the critics of CAM practices will have to admit a great many practices that will have to be abandoned—and abandoned despite real effects on patient wellbeing. This is why I argue that therapeutic power matters more than empirically verifiable causal explanations. Thus, in the interest of fairness, the medical traditions that meet the criteria of being health-promoting and non-harmful should be afforded equal regard within healthcare systems, regardless of the particular historical or cultural points of origin.

As a separate point of contention, some will no doubt argue that my comparison between medicine and other aspects of culture is overstated. Medical traditions do not seem to have the same degree of "unchosen-ness" as other aspects of culture. First of all, rather than being "in the person" as other aspects of cultural identity may be, medical traditions are tools. If what is morally wrong about discrimination on the basis of culture is that it places people at a disadvantage because of circumstances beyond their control, then medicine may seem strange to include. After all, most people are quite happily "medical omnivores"—people will take advantage of whatever medicinal resources are at hand, and of these, they will tend to choose what is most effective. Where there are multiple options, they will choose what most aligns with their preferences, which may be idiosyncratic, guided by personal quirks as often as by cultural upbringing.

What is at issue here, however, is not which medicines people actually choose—or who chooses what medicine. Rather, it is a question of what people are able to choose and what options they are given in the first place. Treating non-Western traditions of medicine as

either illegitimate or unnecessary luxury goods reflects not only an ethnocentric bias but a paternalistic attitude that is ill at home in liberal democracies.

Between autonomy and non-harm

As I have argued, the second-class status of non-Western traditions of medicine (which meet the criteria described above) harms everyone. It harms the members of the minority groups associated with those medical traditions by disparaging their contributions, and it unjustifiably infringes on patient choice. Still, the opponents of medical pluralism often cite the potential harms of alternative care (whether directly or due to opportunity costs). One prominent example would be a case like that of Steve Jobs. He was diagnosed with pancreatic cancer, a kind of cancer that is often difficult to treat. Jobs was lucky enough to have one of the less severe kinds and to have caught it early. Yet, he chose to treat his condition with acupuncture and a vegan diet instead of following the doctor's recommendations to begin radiation and chemotherapy (Elkind 2008). Many credit this decision with his eventual death.

Here, I will acknowledge there is a legitimate worry. However, I would locate the source of the problem differently. Negative health outcomes of this kind do not by themselves indicate that acupuncture is not medicine any more than they indicate that veganism is unhealthy or dangerous. Rather, scenarios like this call for a more careful examination of the claims that medical practitioners (from any tradition) can make and raise awareness of the importance of medical literacy on the part of patients.

Living in a liberal multicultural society means we ought to have respect for the choices made by reasonably informed adults, whether or not we would make those choices ourselves (Phillips 2007). Along with respect for autonomy comes allowing people to make choices for themselves that may, in the end, have regrettable outcomes. People, individuals, or whole cultures are sometimes wrong about health. When reasonably informed adults are wrong, there are few options for liberal governments to intercede while respecting the autonomous choices of their citizens. However, because medicine is a relationship involving both a patient and a practitioner, it is not only the patient's autonomy that is at issue; it is also the conduct of the practitioner. This other half of the medical relationship is a better focal point for regulations to protect patients from harm, as I will explain.

Multiculturalist philosophers like Kymlicka (1995, 2009) and Phillips (2007) have made strong arguments for why liberalism ought to embrace at least some multicultural policies. But their arguments are constructed for the political sphere, not the medical. As a political philosophy, liberalism holds autonomy as the primary value. But when we enter the medical realm, it is necessary to acknowledge some unique constraining factors, and these will necessitate that, for at least some of the time, autonomy will be subordinated to the principle of non-harm.

Within the field of medical ethics, there are a handful of moral principles doctors and bioethicists have settled on as essential guidelines for ethical care: non-harm, beneficence, autonomy, (and, more recently, justice) (Beauchamp and Childress 2019). The principle of non-harm is one of the oldest, going back to Hippocrates in Ancient Greece. A commitment to non-harm means not only do doctors commit to not actively doing injury to their patients, but they also have a duty to not engage in malpractice, which requires more than merely not intending harm to the patient. Avoiding malpractice includes keeping up to date

on the best medical knowledge, carrying out their practice to the best of their ability, and behaving ethically.

Unlike non-harm, autonomy is a relative newcomer to the principles of medical ethics. Until very recently, it was the norm in most societies (even the US) to practice medicine paternalistically. Patients were not always fully informed of their condition—diagnosis included. Cancer patients were often not told their diagnosis for fear this would make them less able to cope with it. Most of us agree today that informed consent and patient autonomy are valuable and preferable to the paternalism of the old days. But embracing patient autonomy does not mean that autonomy is king among medicine's guiding ethical principles. Medicine is a relationship, by definition involving more than one person. As such, autonomy and its preservation cannot be the only operating value. People who assume medical or quasi-medical roles must adhere to the ethical principle of non-harm. This is an institutional duty, not an infringement on their personal autonomy or on the autonomy of their patients. This means that all medical practitioners, regardless of their given tradition, are obligated to fully and accurately inform patients of the realistic risks and benefits of the treatments prescribed. Overpromising the benefits, omitting the risks, or otherwise obfuscating the prognosis violates the principle of non-harm.

Returning to the case of Jobs, we can argue that as a matter of patient autonomy, he ought to be allowed to choose what treatment he prefers. At the same time, medical practitioners (of any tradition) ought not to be allowed to claim things that are not true. Jobs did nothing wrong, and a liberal society must respect the choices he made for himself. However, if his choices had been based on misinformation, then this would have actually undermined his autonomy as well as put him in harm's way. Holding practitioners to higher standards better serves both medical principles. In this way, we can protect patients from bad medicine without limiting their choice or making ethnocentric judgments about which medicines deserve legitimacy.

Recognizing medical pluralism need not entail surrendering to pseudo-medicine and bad medicine. In fact, protection from bad medicine and pseudo-medicine is consistent with liberal values. No one mistakes the respect for informed consent on the part of the patient for a disregard for the expertise of the doctor. Similarly, requiring regulation for pharmaceuticals, herbs, etc., is not an infringement on autonomy but actually a defense of it. Obligating the providers of medical care to disclose all the relevant information empowers patients' autonomy. Not only are pseudo-medicine and bad medicine inadequate to meet people's right to health, but whether it is the result of medical misinformation or greedy snake oil salesmen, pseudo-medicines are guilty of failing to respect informed consent as well (Shahvisi 2016). There is no injustice done to individuals or groups when pseudo-medicine and bad medicine are prohibited. However, if autonomy is all that matters, it is hard to make that case, which is why the medical principle of non-harm is so vital. It should be within a person's rights to consent to a pseudo-medical practice, like crystal therapy—but for a practitioner to claim that crystals can cure cancer is unethical, and so the practitioners should not be allowed to do so. This aids in the preservation of the freedom of patients to choose among treatments that are real—not fraudulent.

Putting pluralism into practice

Having laid out the moral case for medical pluralism, it is now important to discuss (at least in brief) what the embrace of such a norm might look like in practice. As mentioned in earlier sections, a number of currently accepted best practices already make cultural, linguistic, or religious accommodations when it comes to patients' beliefs and identities. But embracing medical pluralism, in the sense that encompasses multiple *traditions* of medicine, requires additional action at the institutional and policy levels, as well as a shift in consciousness for many medical practitioners (regardless of which tradition of medicine they practice).

Writing about distributive justice, political philosopher Michael Walzer argues, "the principles of justice are themselves pluralistic in form [and] different social goods ought to be distributed for different reasons, in accordance with different procedures, by different agents; and that all these differences derive from different understandings of social goods themselves—the inevitable product of historical and cultural particularism" (Walzer 1984, 6). When examining the implications of medical pluralism, the question of who owes what to whom naturally breaks down differently than when addressing the just distribution of other kinds of social goods. Additionally, because of the complexity and variety of healthcare systems across different countries and contexts (single payer vs. free market, etc.), it is impossible in this paper to give specific advice for each system or to give one definitive recommendation for all contexts. Yet, I will attempt to provide a couple of illustrative examples that gesture at what pluralistic policies can look like at various levels and contexts.

Law and policy

To begin, I will discuss what actions are demanded at the level of law. Here, it will be useful to return to the political questions of which groups are in need of which kinds of protections or accommodations. I have argued that liberal multicultural states ought to recognize and accommodate any medical tradition that is both non-harmful and culturally significant. However, *what kind* and *what degree* of recognition or accommodation justice would demand again depends on other factors.

To briefly reiterate some earlier points, Kymlicka identified indigenous people, immigrants, and regional minorities as groups with valid claims to group-differentiated rights within a liberal state. Among these, he argues for the strongest accommodations for indigenous peoples since they were forcibly incorporated into the larger state. Using Kymlicka's arguments as a springboard, I argue that medical pluralism would demand the most protection to be afforded to indigenous medical traditions for similar reasons. In the North American context, native people were forcibly incorporated into a larger colonial state (e.g., the United States or Canada). Given the pressures to assimilate to the new dominant culture and the lack of any feasible opportunity to refuse, many of their valued traditions, including religion, language, and medicine, were eroded or lost. In the present, funding and support for the preservation of indigenous medicines as part of that cultural heritage should be offered to the surviving members of those communities. This level of accommodation would be at the extreme end, reserved only for those traditions in danger of extinction through past instances of coercive or imperialistic

measures. As for other traditions of medicine, whether home-grown medical minorities or imported from elsewhere, a general policy of tolerance by the state (provided the practices are non-harmful) is sufficient.

Pluralism vs. integration

When it comes to the topic of pluralism with respect to different *traditions* of medicine in a healthcare system, some additional complexities emerge. Within this context, there are roughly three options for healthcare systems in dealing with a pluralistic medical landscape: (1) the state could endorse one paradigm alone or above others, (2) the state could adopt an integrative approach, or (3) adopt a mosaic-style approach. I have already argued that the first option would be unjust. So, I will confine the arguments in this section to weighing the merits of integrative vs. mosaic-style approaches.

In the medical context, an integrative approach entails a blending of multiple traditions into one system. That would mean that within one hospital or healthcare facility, there are multiple styles of medicine on offer or one practitioner that can prescribe multiple modalities of medicine (or both). In contrast, a mosaic-style approach does not attempt to blend traditions within the system but rather permits multiple systems to coexist. While I would argue that both approaches are preferable to medical hegemony due to the very deep paradigmatic divides between some medical traditions, I would favor the mosaic model. This stance has been echoed by some practitioners of traditional or ethnic medicines who highlight the incommensurability of values and perspectives across different medical paradigms (refer to the section "Medical minorities: 'CAM' and multiculturalism" above).

While integration may at first seem to help provide patients with the widest array of non-harmful treatments from which to select, it has two significant disadvantages. First, integration can, in fact, undermine the ability of each medical tradition to maintain its unique identity and cultural significance. Rather than accommodating diversity, integration can actually result in a process of dilution and assimilation—something that many medical minorities are actively attempting to resist (see Churchill 2000).

Additionally, integration also places some additional cognitive burdens on medical practitioners that exceed what is required morally and may, in fact, undermine doctors' abilities to practice effectively. As mentioned earlier, there are already many multicultural accommodations that have become widely accepted into guidelines for best practice, including access to medical translators, culturally sensitive care, and protections for religious objections to certain kinds of care. Importantly, this also includes doctors' rights to conscientiously object to certain treatments under certain circumstances (see Pilkington [2021] for more on the subject). In a medically pluralistic society, doctors should invite patients to incorporate their values and traditions into decision-making about their care (to the degree that doing so is relevant) and ought to recognize that it can be actively beneficent for clinicians to incorporate a patient's traditions (e.g., their group-based values and metaphysical commitments) into medical decision making. Doing so can promote better health outcomes, patient compliance, and trust between the doctor and the patient, as well as between the patient and medicine as an institution.

Yet, on top of this, the integrative approach would seem to further demand that clinicians operating in Western biomedicine embrace or incorporate traditional medicine within their practice. Given the existing pressures and demands of the job, I see this as an undue cognitive burden to place on physicians. It is not possible, especially given the incredible diversity of medical practices and incommensurability of paradigms, for every physician

to successfully integrate multiple traditions. The integrative approach is thus overburdensome to doctors and undesirable to minority traditions. Instead of attempting to integrate multiple diverging medical paradigms, it would be preferable to adopt a norm of epistemic humility, open-mindedness, and respect for other traditions (without necessarily adopting them).

To sum up, an embrace of medical pluralism as a matter of justice means that liberal states should tolerate the sale and practice of all non-harmful medicines, and access to these medicines should be available in medical insurance policies. Additionally, where valued medical traditions of indigenous cultures are under threat, support should be provided for their preservation. Meanwhile, medical practitioners (whatever their tradition) should strive to be culturally literate and sensitive to their patients' beliefs.

Conclusion

There are still many areas worth exploring about the intersection of medicine and culture, and I can hardly hope to have addressed all of them here. Yet, as I have demonstrated in this paper, protecting traditional medicines as part of one's cultural heritage is important for several reasons. Morally speaking, we ought to prevent ethnocentric bias and the attending injustices out of respect for the autonomy of minority groups. Pragmatically speaking, if we are interested in promoting human health, we ought to avoid throwing the baby out with the bathwater in cases where minority medical traditions have therapeutic benefits to provide. Furthermore, medical pluralism is worth embracing because it promotes patient autonomy by providing the option to choose or combine medicines and techniques from a range of traditions. Thus, liberal states with multicultural populations ought to recognize medical pluralism in their healthcare policy as a matter of justice. With a better understanding of traditional medicines and their role in the cultural fabric of minority communities, policymakers in diverse societies will be better able to construct policies that effectively and ethically serve these communities for the benefit of all.

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Endnotes

[1] See Muyskens (2023) for a further discussion of harmfulness in medicine, as well as Muyskens (2022) for an exploration of harmful cultural conceptions of health.

[2] As I have argued elsewhere, medicine (in the political arena) is best thought of as a relationship with several necessary elements: the patient, practitioner, treatment, and theoretical explanation (Muyskens 2023). Within this framework, the professionalization of the practitioner serves the interests of justice even if it may exclude some traditions. Such features are important in protecting patients' interests and rights; everyoneis better off with the assurance that the person helping them in their hour of need has been accredited and trained and is accountable to some transparent set of standards.

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