

medical mimesis: healing signs of a cosmopolitan “quack”

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“Someone who feigns an illness can simply go to bed and pretend he is ill. Someone who simulates an illness produces in himself some of the symptoms” (Littre). Thus feigning or dissimulating leaves the reality principle intact: the difference is always clear, it is only masked; whereas simulation threatens the difference between “true” and “false,” between “real” and “imaginary.” Since the simulator produces “true” symptoms, is he or she ill or not? The simulator cannot be treated objectively either as ill, or as not ill. Psychology and medicine stop at this point, before a thereafter undiscoverable truth of the illness. . . . What can medicine do with something which floats on either side of illness, on either side of health, or with the reduplication of illness in a discourse that is no longer true or false? [Baudrillard 1988:168]

In the above passage from *Simulacra and Simulations*, Baudrillard uses the example of illness to distinguish between falseness and simulation. In this article, I shift the focus from the example of illness to the example of cure. Baudrillard asks (and, more importantly, deconstructs) whether a simulating patient who produces true symptoms is ill or not. In this article, in turn, I ask whether a simulating doctor who produces true wellness is a doctor or a quack. Just as simulated illness tends to erode the distinction between true and false illness, so it is argued here that simulated cure tends to erode the distinction between true and false medicine. Actual healing through false medicine has been framed by modern medical science within the concept of the placebo effect. This concept, however, allows simulation to be bracketed off to one side of medical practice, leaving the dichotomy of truth and falseness intact. Baudrillard’s analysis of simulation and, even more tellingly, Taussig’s analysis of the mimesis involved in any act of signification, suggest, on the contrary, that simulation is integral to medical practice, troubling the binary of truth and falsehood that is a foundation of scientific knowledge. In this article, I draw on the analyses of Baudrillard and Taussig to trace the mimetic intricacies of medical simulation in the practice of an Ayurvedic doctor in an Indian metropolis.¹ The “magical” ability of the sign, identified by Taussig, to “spill over” and reconfigure the referent, accounts for the ability of the doctor’s pulse diagnosis to reconfigure the patient’s illness (Taussig 1993:233). Further, the commodity value of pulse reading as a sign of traditional wisdom and the political value of pulse reading as a precolonial practice not assimilable to European-styled medical training, account in part for the doctor’s enormous popularity and commercial success. Ultimately, it is clear that the market-driven and politically motivated mimesis at the heart of the doctor’s signifying practice disturbs not only the notion of medical authenticity so crucial to biomedicine but also the notion of cultural authenticity crucial to anthropology.²

Drawing on recent insights into mimesis, I address the question of authenticity in indigenous medicine through an ethnography of an Ayurvedic pulse reader. I trace the conflicting rhetorics of authenticity spun by the doctor, the colleagues who consider him a quack, and myself. Ultimately I question the rituals of signification by which distinctions are drawn between medicine and placebo, doctor and quack, expertise and gimmickry, and between authentic cultural object and consumer-oriented copy. [medicine, mimesis, semiotics, Ayurveda, India, quackery]

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I first heard about Dr. Mistry from one of his patients.³ The patient told me that Dr. Mistry was a specialist in *nāḍī parīkṣan* (pulse examination). Through pulse, he was able to diagnose not only which of the three *doṣa* (basic forces in the body) was disturbed but also the exact symptoms the patient was experiencing. The patient said that Dr. Mistry had accurately diagnosed his problems and had given him medicines that had an immediate beneficial effect. I was intrigued. I had come to India to trace the differences between the standardized Ayurveda taught and practiced in modern institutional settings and any Ayurveda practiced outside such settings.⁴ Since the elaborate type of pulse diagnosis Dr. Mistry was reputed to practice is not taught in Ayurvedic institutions, he seemed to fall into the second group, frequently referred to as "traditional." I did not assume, however, that Dr. Mistry could be considered a traditional *vaidya* (Ayurvedic practitioner). I was skeptical of this category for both theoretical and practical reasons. I had come to understand that tradition is a category invented in recent times as a counterpoint to modernity, and I also knew that Ayurvedic hospitals and colleges modeled on biomedical institutions had existed for the better part of a century. It was very rare to meet a practitioner who had not had any encounters with such institutions.⁵ Nonetheless, Dr. Mistry's exclusive reliance on pulse diagnosis was clear evidence of his distance from institutional Ayurveda.

Some months later I met a young Ayurvedic doctor who told me she had worked with Dr. Mistry for a few years after completing her Bachelor of Ayurvedic Medical Science, the minimal degree that allows a student to set up practice as an Ayurvedic doctor. She encouraged me to call Dr. Mistry but cautioned me that he would not be able to explain his method of reading pulse. This was one of the frustrations that, she explained, prompted her to leave his employ. When she handed me one of his cards, I noticed a long string of letters after his name. The familiar B.A.M.S., held by his assistant, or the M.D. or Ph.D. held by most senior doctors of Ayurveda in his generation were missing. Instead there were other letters with unknown referents. There was also the word *Ayurvedacarya*, a credential that was granted to some practitioners of previous generations who had either received licenses based on long years of practice or who, in the early days of institutionalization, had taken a standard exam under the auspices of the All-India Ayurvedic Council, usually after some years of study under the guidance of a senior *vaidya*. According to other doctors with whom I spoke, this exam had become almost totally corrupt by the 1950s. Dr. Mistry, I later discovered, had taken the exam in 1974 or 1975. When I asked the young doctor to explain the string of letters, she said, "That is another problem. He doesn't have a degree in Ayurveda. This I know." She went on to say, however, that she had learned a great deal about pulse diagnosis in his clinic simply because she had had the opportunity to examine 100 or more patients in a day. Later I mentioned the garland of degrees to Dr. Upadhyay, a private practitioner with an advanced degree who is well respected in institutional Ayurvedic circles. "I know," he said. "Actually he's a fraud."

When I finally met Dr. Mistry and received permission to observe his medical practice, I was aware of several levels of contradictory information: the testimonial of the satisfied patient, the qualified recommendation of the partly dissatisfied employee, and the denunciation of another Ayurvedic doctor. In other words, I was, in spite of myself, already caught up in the question of whether Dr. Mistry was an authentic Ayurvedic doctor or a quack. I say "in spite of myself" because my training in medical anthropology had instilled in me a certain discomfort with the concept of quackery. As I understood it, quackery is a concept used by medical practitioners and others to discredit medical practices other than biomedicine (which is sometimes also termed modern medicine, cosmopolitan medicine, or allopathy). Some biomedical doctors consider all Ayurveda to be a kind of quackery, based on a bogus view of the body and dispensing treatment the biological effects of which are scientifically unproven. As a medical

anthropologist, however, I was prepared to put biological efficacy aside in favor of symbolic efficacy. Medical anthropologists are generally less interested in whether or not a particular medicine actually cures disease than with the question of how that medicine constructs or reproduces the physical or social body. Following Lévi-Strauss's seminal analysis of a Cuna healing song in "The Effectiveness of Symbols," most medical anthropologists place an emphasis on cultural efficacy, achieved through symbolic manipulations, which overshadows or explains physical efficacy (Lévi-Strauss 1963a). It is perhaps partly for this reason that the question of quackery has rarely been addressed in medical anthropology. Quackery seems to have as much claim to cultural efficacy as any scientifically validated medical practice.⁶

Yet this view of quackery, which assimilates it to descriptive accounts of cultural belief, overlooks the contested nature of medical truths at the local level. Pigg (1996) has pointed out that while outsiders may tend to assume a seamless social consensus regarding the efficacy of a particular local medicine, local people often sustain a lively discourse on the genuineness or falseness of particular practitioners or instances of cure. Such local critical discourses raise the possibility of a secondary level of quackery. On one level, Ayurveda or any other nonbiomedical practice may be considered generically true or false by a whole host of authorities including biomedical doctors and development workers. On another level, particular Ayurvedic doctors or other types of practitioners may be considered true or false within their own medical field. According to what criteria should anthropologists interpret these claims of truth or falseness? What, moreover, is the connection between such claims and the commodification of cures or the cultural politics of medical systems? These were the questions that haunted me when I visited Dr. Mistry's clinic for the first time.

The clinic is on a shady suburban street of a major Indian city. Even before the clinic opens at 11:00 a.m., a crowd of patients gathers on the steps and spills out into the street. Within a few hours, there are 40 or 50 people milling in the waiting room, collecting their case forms at the reception desk, or picking up bottles of pills from the dispensary counter. In small consultation rooms off the waiting room, Dr. Mistry's assistant doctors, numbering two or three at any given time, talk to patients and take their pulses. Above the crowd is a large digital display that flashes luminous red numbers corresponding to the tickets held by waiting patients. Similar to displays seen in Indian banks or fast food restaurants, this display announces the number of the patient who will be seen next. On the walls are enlarged photocopies of notification letters for "awards" that Dr. Mistry has received from the vanity publishers of biological reference works. Also on the walls are a number of framed colored photographs. All of them feature Dr. Mistry with some prominent political or religious figure. In one, he is taking the pulse of a past winner of the Nobel Peace Prize. There are also photocopies of articles about Dr. Mistry from tabloids in English, Hindi, and regional vernaculars.

While I was waiting to meet Dr. Mistry for the first time, one of his assistants brought me several such articles. The reportage was based on interviews with Dr. Mistry and his enthusiastic patients. A few of the articles described Dr. Mistry's relationship with his guru, a Tibetan who, up until his death, had practiced Ayurveda in a village outside the city. Dr. Mistry and his partner, a woman doctor whom he considers the expert in the theoretical and pharmaceutical sides of his practice, later elaborated the story of Dr. Mistry's apprenticeship. According to them, when Dr. Mistry first opened his practice, he was frustrated by the hit-or-miss diagnostic process. Then one of his ex-patients told him about a *swami* (Hindu monk) who diagnosed simply by touching the patient's pulse. Every day this swami was visited by 300 patients. According to Dr. Mistry, the swami once lived at the borders of India and Tibet where he had picked up medical tips from wandering *sadhus* (renunciants). Dr. Mistry decided to learn the swami's method. As reported in one of the laudatory articles, it took three months to convince the swami of Dr. Mistry's sincerity. When the swami finally accepted him as a disciple, he put him to work sweeping the floor until (according to one photocopied article) his ego had "softened and

dissolved." Dr. Mistry's partner told me that Dr. Mistry studied *nāḍī parikṣān* with the swami for three years "whenever he could get time and all that." After the swami felt a patient's pulse, Dr. Mistry would feel it himself and try to reconstruct his guru's reading. Today his own students use the same method to learn pulse reading from him.

The purpose of the advance publicity handed to me and posted around the lobby for the patients was clearly to promote Dr. Mistry as a particular kind of healer trained in secret powers by a guru. While promotion in some form is a necessary part of any medical practice, Dr. Mistry's tactics seemed heavy-handed to me even at this first visit. As I will discuss further on, his commercialism lacked the subtlety and seeming objectivity of most professional medical commercialism. This lack is partly due to the fact that in the subtext of his publicity, the commodities for sale were not only the medicines and therapies but also the doctor himself. Both he himself and certain signs of traditional authority such as the forest-dwelling guru, the charismatic religious leaders, and the esoteric ability to read the pulse, were fetishized. Thus the imperatives of capitalism make it possible for the use value of his practice (healing illness) to be obscured for me by the dense semiotics of the exchange value.

When I was at last ushered into Dr. Mistry's office that first day, I witnessed the ritual of patient consultation that I was to observe over and over during the coming weeks. Dr. Mistry's consultations with patients rarely take more than five minutes. He greets them with a smile and reaches for their wrist across the table. He presses three fingers close to the outside bone of the wrist the way any Ayurvedic doctor can be observed to do. After a few seconds of silence, he offers the diagnosis. The patients generally agree to the diagnosis and add a few more complaints. Following the pulse reading of new patients, Dr. Mistry records the results on case forms with a series of specialized notations. There are close to 15 different notations of which Dr. Mistry commonly uses probably half. Each one refers to a particular characteristic of the pulse that in turn refers to a particular condition of the body. In addition to the pulse characteristics pertaining to the three *doṣa* (*vāta* or *vāyu*, *pitta*, and *kapha*),⁷ there are characteristics pertaining to moisture, dryness, and pace as well as conditions such as low immunity, poor circulation, liver problems, or arthritis. Later I learned that particular combinations of the more general characteristics may encode a particular disease. In a box on the case form, Dr. Mistry writes down the main complaints agreed to or volunteered by the patient. The pulse reading is recorded only on the first visit. On the opposite page of the case form, a running tab is kept on improvements and changes in medicine.

For new patients or patients with new complaints, Dr. Mistry quickly selects one of 14 prescription slips stacked in slots against the wall. Each one is organized around a related group of illness problems. For example, one is entitled "Heart Mind Blood Pressure," another, "Kidney Pus Liver," another simply "Vayu," another "Pitta," another "Prameha/Madhumeha," the Sanskrit terms associated with urinary disorders and diabetes, respectively. On each slip is a list of anywhere from 8 to 35 medicines. Some of the most common medicines are found on several slips. The names and, as I learn later, the formulae have been developed by Dr. Mistry and his partner, who handles the pharmaceutical side of his practice. They are, for the most part, based on the classical formulae in early Ayurvedic texts but varied in specific ways. Dr. Mistry rapidly checks off six or seven medicines on the chosen list, inserts it in the case folder, and hands it to the patient who will collect the medicines from the dispensary counter in the lobby. For return patients, he usually makes any necessary adjustments on a previous prescription slip already stapled into the case folder.

Dr. Mistry nearly always makes some promise regarding the cure. In one case, he told a diabetic woman that she would gradually be able to stop taking insulin. "I promise you, diabetes will disappear," he assured her. "And the pain in her legs?" her son asked. "The pain in her legs will go away within 15 days," Dr. Mistry replied. He does not always promise absolute cure. Once I heard him caution the parents of a mentally disabled boy that he could produce only

75 percent improvement, not 100 percent. The boy will grow taller, he promised; he will be able to work by himself. The parents commented that there was no treatment in allopathy. Dr. Mistry agreed but added, "We can treat." There is, in fact, no illness that Dr. Mistry refuses to treat. He even claims some success at curing AIDS. His patients are discouraged from talking at length to him about their illness. Dr. Mistry told me at one point, "I don't listen to people. . . . What is important is what his pulse is telling me." He believes that the patients are prejudiced by allopathic, that is biomedical, notions. When a reporter for a Hindi daily asked him why he did not question the patients about their complaints, he replied that the symptoms fluctuate according to the individual and the individual's psychological state. "Through pulse exam," he was quoted as saying, "I can disentangle the symptoms and find the root." At the end of each consultation, Dr. Mistry rings a bell under his desk, signaling his assistant to send in the next patient. He makes a mark on a ledger on his desk where he records the number of patients seen each day. He told me that his daily record exceeds 400.

The first several times I visited Dr. Mistry, he repeatedly sent me into a side room to hear stories of cures from patients of his choice. These stories had at least two twists of plot in common. At the beginning of the stories, Dr. Mistry amazed the patients by reeling off their symptoms after simply feeling their pulse. At the end of the stories, he cured their illnesses, either completely, they said, or 80 to 95 percent. Over time, I learned that Dr. Mistry encourages his patients to measure their cure in terms of percentages. "How much *fayda* [benefit, improvement]?" he would ask, "70 percent, 80 percent, 90 percent?" He would write the patient's reply on the case form and circle it. While other doctors I observed also asked patients to rate their cures in percentages, Dr. Mistry requested this more consistently. Usually his prompts suggested very large percentages. The lowest percentage of improvement I ever observed him record was 15 percent in the case of a brain tumor.

The day I met Dr. Mistry, he showed me a photo album documenting a recent trip to Europe. Some of his European patients had brought animals for treatment, including a large python. In the album was a photograph of him holding the animal and smiling broadly. He explained that at first he had searched for the snake's pulse near the head but had finally found it near the tail. Some days later he told me that his friends in Europe had written that the python was much improved. At that time, I thought to ask him the animal's problem. He said that the python was suffering from excess pitta, the *doṣa* associated with heat. I joked, "How can a snake suffer from excess pitta? It's cold-blooded." He laughed and said that it must have eaten a mouse that in turn must have eaten some pitta-aggravating food.

I left Dr. Mistry's clinic that first day, and on many subsequent days, in a state of wonder. Compared to the other Ayurvedic practices I had observed, his practice had, for me, a surreal quality. His clinic was evocative of a number of contradictory images. The digital display was reminiscent of fast food restaurants in Delhi. The speedy patient consultation was reminiscent of hectic outpatient departments (OPD) in Ayurvedic hospitals. Perhaps the strangest and most unnerving resemblance, given the clinic's urban setting and professional appearance, was to a colorful tent in a Himalayan hill station where I met an itinerant *vaidya* whom I will call Kaviraj Kumar.

In northern India, Kaviraj was a widely used title for *vaidyas* up until the 20th century. It is still in use by a few *vaidyas*, usually those who have no university education. There were several ways in which Dr. Mistry reminded me of Kaviraj Kumar. For one thing, both of them had decorated their clinical spaces with various kinds of testimonials. Some of these testimonials were framed degrees and certificates issued by dubious institutions, mimicking the signs of authority to be found in the offices of professional doctors, whether allopathic or Ayurvedic. But there were other forms of testimonials as well. Like Dr. Mistry, Kaviraj Kumar had photo albums full of pictures of himself with famous people. Both were shown with national politicians, but Dr. Mistry was also shown with world religious leaders, while Kaviraj Kumar

was shown with Hindi film stars. This difference in choice of authority was appropriate to the difference in their personal styles and clientele. Kaviraj Kumar identified himself with charismatic heroes and catered to villagers with minimal education. Dr. Mistry identified himself with saints and catered to urbanites with spiritual leanings. The basic method of appeal, however, the evocation of a higher cultural authority, was much the same. Like Dr. Mistry, Kaviraj Kumar made what seemed to be extravagant promises of cures for difficult diseases. He even offered, in his promotional flyer, a contract whereby the patient would pay nothing until the cure was achieved. In the next sentence, however, he stated that patients with faith would certainly pay cash. Both Dr. Mistry and Kaviraj Kumar claimed to diagnose solely according to pulse, and both insisted on reading the pulse when the patient's stomach was empty. Both of them maintained that they had learned *naḍī parikṣān* during apprenticeships to adepts.

Kaviraj Kumar was the first Ayurvedic practitioner I met who practiced amid rumors of his quackery. One of my Indian friends told me that he would never go to a doctor "like that." Another said that a friend's condition had worsened after taking Kaviraj Kumar's medicines. Others simply laughed when I told them I was observing his practice. Like Dr. Mistry, Kaviraj Kumar had his own formulae for particular ailments. In his case, however, they had been passed down from Himalayan *ṛṣi* (sages) who lived 600 years ago. They were written on laminated pages in a booklet entitled (in Hindi) "The Catalog of Indian Śilajit Tonics of the Himalayas," a booklet which, Kaviraj Kumar told me, can be copied only once in five years. Śilajit is a medicinal mineral that oozes out of the rocks in high mountain ranges such as the Himalayas. In Ayurveda, it is used for a number of different complaints ranging from diabetes to sexual debility. In one of my conversations with Kaviraj Kumar, he showed me a chunk of śilajit that he referred to (though we were speaking in Hindi) with the English word *refined*. It was a polished black rock, astonishingly light, with smooth glassy facets, breaking easily like flint. He suggested that I should take some to strengthen my brain since I am a scholar. After some hesitation, I agreed. He weighed out five tola (a unit of weight equal to about 13 grams) and ground it for me into a coppery black powder. He told me to take it twice a day with milk and cautioned me not to eat lemon in the meantime. As a matter of fact, I had no intention of ingesting the śilajit. What I wanted to do was test it. A few days later, I took the powder to another Ayurvedic doctor who had been raised in a reputable Ayurvedic household and was well acquainted with the Ayurvedic pharmacopoeia. He smelled the powder, tasted it, mixed it with a little water in his palm, and told me that it was not śilajit. He said that real śilajit smelled different, tasted different, and did not dissolve so easily. He also said that real śilajit was as black as tar even when ground. He said that the śilajit I had bought was probably boiled sugar with a few other ingredients. I concluded, with some reluctance, that Kaviraj Kumar was a quack.

I still found myself, however, troubled by two questions. First, what did it mean to say that Kaviraj Kumar was a quack? Suppose he himself believed the śilajit was authentic and had been cheated by his suppliers. Or suppose he had sold me fake śilajit only because I was a rich foreigner who was not seriously ill. In those cases, would I still consider him a quack? Moreover, if the śilajit was false did that mean that the recipes in the booklet were also false? Did it mean that he had no knowledge whatsoever of Ayurveda? While I was sitting in his tent, he told one patient to come back after 5:00 p.m. because the pulse had to be checked on an empty stomach. I considered this to be a piece of information that was true. That is to say, it was information that was recorded in revered Ayurvedic texts on pulse diagnosis and could be confirmed in conversation with other *vaidyas*. If his śilajit was false, was his background equally suspect? Was his relationship with his guru as fictive or distorted as the relationships he claimed to have had with ex-chief ministers and movie stars? Was his practice mythologized? Or was his falseness localized and confined to the śilajit itself? Where did his quackery reside?

I decided that Kaviraj Kumar was a quack because the medicine he sold me was not the real article but an imitation. Whether I (or rather someone who had not been taught to mistrust the

use of photo albums in medicine) could nonetheless have experienced a curative effect from that medicine, a sudden clarity of mind, perhaps due to Kaviraj Kumar's considerable charisma, or to the persuasive authority of 600-year-old formulae developed by a ṛṣi in a cave, or the sheer glassy beauty of the śilajit in my hand, was irrelevant. There had been a serious slippage between the sign, the name śilajit, and its referent, a chunk of boiled sugar.

Taussig's extensive investigation of mimicry, no less than Baudrillard's analysis of the commodity as sign (both owing much to Marx's analysis of commodity fetishism), makes it clear that the śilajit disappointed me because it turned out to be no more than a simulacrum. According to Baudrillard, an object's exchange value is never exhausted in its function. Any object has what he calls "an excess of presence," an extra value as a sign of cultural capital (1988:32). In Taussig's terminology, the commodity "spills over its referent" in what he refers to as "mimetic excess" (1993:233). Until it proved to be sugar, the medicine I purchased had all the fetishistic glow of śilajit, its name, and its glassy elegance. It had, in fact, the full exchange value of śilajit. Had I not paid 100 rupees? Because it was the wrong chemical compound, however, the use value had been, in one instant, both inflated and deflated. If I had not tested the śilajit, it would have remained an object that was culturally (if not also medically) potent.

Baudrillard and Taussig differ on the character and disposition of excess. Baudrillard suggests that the commodity's excess of presence is exhausted in the expression of social prestige or status. Taussig, on the other hand, suggests that the commodity's excess of presence is nothing less than a kind of magic in which the commodity, its fetishistic advertisable glow, acquires the power of the object of which it is supposedly a commodification (Taussig 1993:16). To put it crudely, śilajit as an Ayurvedic commodity acquires the power of śilajit as a rock. In fact (though perhaps fact is not exactly the right word), at some level imitation śilajit acquires the power of real śilajit. A well-read layperson once commented to me that he did not believe that śilajit was actually an ingredient of all the Ayurvedic medicines for which it was listed as an ingredient. He believed that even reputable Ayurvedic drug companies must be substituting other ingredients. This mimetic excess of the medical label, if not true for śilajit, may yet be true of other medicines such as *brahmi* (*Centella asiatica*), which is widely used for neurological disorders among other things. One Ayurvedic doctor told me that there was not enough brahmi in the world to account for the amounts of brahmi listed on hair oil labels. Of course every commodity is not an imitation in the same way that Kaviraj Kumar's śilajit was an imitation. But the imitative qualities of commodities in general make it that much more difficult to identify the particular imitativeness of the śilajit. The question becomes even more complex when indicators of falseness more subtle than medicinal substances are considered, indicators, that is, such as photo albums.

A few weeks before my purchase of the śilajit, a friend and I had watched a group of traveling snake charmers, playing their sonorous instruments to entice the serpents out of baskets, inviting the crowd to offer rupees to the king cobra, the representative of Śiva, and, at the same time, charging ten rupees to a foreign woman for a snapshot. My friend commented that it was always the poorest village people who were scammed by the snake charmers. It occurred to me, however, that these people were not simply being scammed but were paying the snake charmers to put on a show and officiate at an act of worship. Perhaps Kaviraj Kumar also was selling a performance and a mystical relationship, if not to gods, then to one's own body. Medical anthropologists routinely discover the value of ritual medicine in such psychological or social effects. The problem was that Kaviraj Kumar did not seem to be practicing ritual medicine, but rather Ayurveda, which is argued to be a science. He had bottles of medicine sporting the labels of a reputable Ayurvedic pharmacy arrayed alongside other bottles containing fake śilajit and other *jadi-buti* (medicinal flora and fauna). Juxtaposed to his colored pictures of gods and goddesses were framed certificates that mimicked the gilt-edged degrees in the offices of professional doctors. Professional medical science is not expected to involve overt showman-

ship which, insofar as it is instrumental, is expected to be the province of magic. The fact is, of course, as medical anthropologists have demonstrated, medical science does involve showmanship from the color-enhanced photographs of microscopic pathology to the opening of the draped body in the operating theater (e.g., Knorr-Cetina and Amann 1990; Martin 1994). Professional medicine's show does not, however, usually include photo albums full of famous patients. Medical science, as will be elaborated later, usually disguises its simulacra as natural or functional objects, as bodily organs, for example, or surgical tools. It is not expected to display them with casual ingenuousness, like obvious advertising ploys. It might be said that science's most dazzling show is its illusion of objectivity.⁸

This brings me to the second troubling question: what had motivated me to test the śilajit? By the time I met Kaviraj Kumar, I had already spoken to numerous vaidyas and visited numerous dispensaries, and yet I had never before been moved to test any practitioner's knowledge or medicines for their truth. There may have been many motives for testing the śilajit, but prominent among them was surely Kaviraj Kumar's framed certificates from obscure and dubious medical associations and his testimonial photo albums. It is unlikely that I would have thought to test his medical authenticity had his cultural authenticity been clearly intact. Kaviraj Kumar was, however, neither pure Ayurvedic doctor, nor pure pulse-reader, neither pure professional nor pure folk practitioner, neither pure scientist nor pure magician, as I have been trained to understand these terms.

I have pursued this diversion into Kaviraj Kumar's tent because the same thing that motivated me to test the śilajit also led me to ponder the truth or falseness of Dr Mistry's cures. Here also were the suspect certificates and boasting photographs. Here were the prototypical guru story and the mystique of pulse diagnosis coexisting with Ayurvedic degrees and Ayurvedic drugs. Might not Dr. Mistry, like Kaviraj Kumar, prove to be an imitation? In order to come to a deeper understanding of the particular mimesis of the science or magic practiced by Dr. Mistry, it is useful to first trace the mimesis in the surrounding social field beyond both his office and Kaviraj Kumar's tent.

mimetic entanglements

Institutional Ayurvedic practice itself is involved in a complex mimesis. While it continues to invoke and indeed to invent a unique view of the human body and of disease, it also imitates the institutional structures of modern European medicine. Anderson (1991) has pointed out that the national institutions of Europe were exported around the world as part of the colonial project. He and others have also noted the peculiar ambiguities of this project. For the colonizers, as Homi Bhabha (1984) has elucidated, the ambiguity lies in their contradictory need to promote the institutions of national citizenry in the colonial setting while simultaneously denying the full humanity of the colonized. For the colonial and postcolonial subjects, as Chatterjee (1993) noted, the ambiguity lies in their contradictory need to fashion institutions that match and communicate with those of other nations, while simultaneously creating and defending a unique national identity. Mimesis plays an important role in both these paradoxical projects. Bhabha notes that the motive behind Macauley's Minute of 1835—which, in Anglicizing the highest levels of Indian education, ended a brief period of British sponsorship of Ayurvedic medicine—was to create mimics, Indian elites who would be almost the same as their English ruler, but “not quite,” “not white” (Bhabha 1984:126, 130). In the medical field, this mimic was to be the Indian practitioner of European medicine. The 50-gun salute ordered by a British official to celebrate what was publicized as the first dissection of a human cadaver by an Indian marks the inauguration of this medical mimicry.⁹

But if the official and primary mimic was to be the Indian biomedical doctor, another secondary mimic soon arose. In turn-of-the-century publications, Ayurvedic practitioners

vociferously criticized the mimicry of European lifestyle and medicine, which, they declared, was ruining the health of the country (e.g. Śarma 1908; Śarma 1910; Vaiśya 1919). It soon became apparent that in order to fight this mimicry at the level of bodily practice, it would be necessary to enact a kind of mimicry at the level of institutional practice. By the end of the century, Ayurvedic doctors had begun to found professional associations, colleges, and pharmaceutical firms (Leslie 1992). They had begun also to write textbooks organized according to a modern medical division of subjects. In establishing parallel institutions, Ayurvedic practitioners established a parallel medicine, a parallel science, a professional Ayurveda.¹⁰ Over time, the gap between Ayurveda and a host of indigenous practices with which it had once been closely associated was hardened and essentialized into the gap between the professional and folk sectors of Indian medicine.¹¹ Initially, professional Ayurveda was a mimicry that seemed too out of step with modernity to appeal to the elite group who were designing the independent nation. New nationalist forms, political parties, conventions, and committees would be meaningless without a national content, however. In the 1920s, Ayurveda received the official support of the Indian National Congress as one of the manifestations of Indian culture, of the primordial national essence that would be represented by the national state.

Bhabha notes that the effect of mimicry of the colonial power by the colonial subject was to mock the "monumentality of history," its "power to be a model" (1984:128). It was inevitably to parody, for the colonist, those nationalist institutions that were supposed to be exportable and reproducible: constitutional law, standardized languages, newspapers, universities, science, and medicine. Bhabha is interested in the consequences of this mockery for the colonizer, whose imagined fullness of presence is necessarily shattered by the partial mirrorings of the colonized. Yet it is not only for the colonizer that the monumentality of history or science or other master narratives is parodied but also for the colonial and postcolonial subject. As soon as they are mimetically seized, the tools of history, science, or the state take on the glint of icons. They can no longer be understood as simply functional (indeed many seem clumsy and inappropriate in their new environments) but must be understood also as evocative of the power of the modern.

Bhabha argues that the mimicry of the colonial or postcolonial subject is metonymic in that it only partly reproduces the (always already no longer intact) original. It therefore, as he writes, "creates a crisis for the cultural priority given to the metaphoric" (1984:130). Linking Bhabha's work with Taussig's, I would like to suggest that this is the same crisis that the idea of sensuous, mimetic signification creates for the idea of arbitrary signification. In metaphor, which is comparable to arbitrary signification in its dependence on cultural convention, the sign ideally substitutes for and represents a clearly separate referent. In contiguous signification, however, the sign siphons away some of the essence (Taussig would say some of the power) of the fragmented referent.¹² If Ayurvedic science is metaphorically like biomedical science, it would confirm biomedicine's priority, separateness, and "power to be a model" (Bhabha 1984:128). If Ayurvedic science is metonymically or only partially reproductive of biomedical science, then it tends rather to challenge biomedicine's systemic integrity. This colonial and postcolonial disruption of the original by the copy is the larger context within which Dr. Mistry's mimesis is played out.

Just as the more educated Ayurvedic practitioners seek legitimacy by imitating European medicine, so inevitably folk practitioners (a newly separated category) seek legitimacy by imitating professional Ayurveda. Kaviraj Kumar, with his framed certificates and rows of jars bearing pharmaceutical company labels, is a case in point. Closer scrutiny might well reveal that he and others have also begun to imitate themselves, or rather the image of themselves projected back at them by a cosmopolitan populace undergoing a wave of interest in folk medicine. When, for instance, I first asked Kaviraj Kumar where he learned Ayurveda, he gestured toward one of his suspect certificates. When I asked later if he had also learned from

a guru, he said yes. A few days later when I asked who had taught him *nāḍī parikṣān*, he replied, "an old man." It occurred to me that he might have begun to realize that I thought that a genuine pulse reader would have learned his art from an old man rather than, say, a correspondence course. It may be a modern inevitability that a person, learning over time what constitutes his or her authenticity, begins to imitate it. The old man guru becomes a legitimating sign just as much as the booklet of recipes, the framed certificate, or the photographs.

In Dr. Mistry's practice, the levels of mimicry become even more entangled. If Kaviraj Kumar is, through his suspect certificates, mimicking the accoutrements of professional Ayurveda, then Dr. Mistry, through his equally suspect certificates, seems to mimic the folk practitioner's mimicry of the accoutrements of professional Ayurveda. He also mimics the professional practitioner directly, for example, in his extremely modern factory where gloved and uniformed workers operate shiny steel machines to turn out uniform rows of capsules. He further mimics the folk practitioner himself, not only through his photo albums, but also through his privileging of pulse diagnosis and discipleship to a guru.

It is widely acknowledged in the Ayurvedic world that the elaborate form of pulse diagnosis practiced by Kaviraj Kumar or Dr. Mistry is a fast dying art that is not and never has been taught in 20th-century Ayurvedic colleges. Any Ayurvedic student can read the predominant *doṣa* in the body through the pulse. But none of them can diagnose 300 different diseases, detect a history of homosexuality or the onset of arthritis, or trace the entire etiological narrative of the illness entirely from pulse as Dr. Mistry claims to do. For this reason, pulse diagnosis holds a particular mystique in contemporary Ayurveda. It has become one of the quintessential signs of the traditional *vaidya*. The power of this sign is pervasive despite the fact that pulse examination is not even mentioned in the oldest Ayurvedic texts.¹³ Curious Ayurvedic professors asked me whether Dr. Mistry could really read pulse. Ayurvedic students worried aloud to me that the public would not accept them as Ayurvedic doctors because they could not diagnose diseases solely from pulse. Later, I was to meet another practitioner who also relied on pulse diagnosis. Unlike Dr. Mistry, however, he refused to exploit its mystique. He encouraged his patients to tell him their ailments before he read the pulse. He was uncomfortable with patients who regarded pulse reading as a form of magic. While Dr. Mistry considered it important to predict the symptoms from the pulse, this doctor was only concerned to detect the underlying pathology through the pulse. He used pulse as a diagnostic tool, not as a sales pitch or even as a psychological boost to healing. He was, however, obviously aware of the magical aura of pulse diagnosis. He said that he had stopped reading complaints from the pulse because some patients believed he had a *siddhi* (supramental power). He was wary of becoming a *mahārāj* (in this context, a superhuman legend).

Ordinarily medical anthropologists interpret as medical syncretism the kind of eclecticism that blurs the genres of folk and professional (e.g., Leslie 1992). The concept of syncretism implies, however, that two or more distinct and internally consistent traditions meet and intermingle in a largely mechanistic process. Taussig has outlined a different way of understanding medical practices that draw their imagery from diverse cultural practices. He suggests that what seems like syncretism is actually a particular moment in an ongoing intercultural mimetic and counter-mimetic reverberation (Taussig 1987:218). Nineteenth-century orientalist preferred to conceive of Ayurveda as a secular and empirical medicine that confirmed the notion of classical and secular origins of modern civilization. Ayurvedic knowledge involving fabulous animals or possession by, for example, celestial musicians was bracketed out as magical and projected into the realm of popular medicine. Thus the study of Ayurveda became a site for the consolidation of modern science against superstition. Prakash has noted that this dichotomy was subtly displaced in certain Indian settings, where displays of scientific knowledge tended to evoke not only objectivity but also a sense of wonder (1992:155). Nonetheless, contemporary cosmopolitan Ayurvedic practitioners continue to reproduce this dichotomy, dividing Ayurveda

as secular and empirical from the magic of folk medicine. Dr. Mistry plays on this binarism in flagrant ways. The signs of professional and folk medicine circulate dizzily through his clinical landscape.¹⁴

One day a teenage girl suffering from liver cancer came to the clinic with her parents. The parents were worried because the girl had recently been in a lot of pain. Dr. Mistry predicted that the pain would lessen. Her parents said that she did not like the diet that Dr. Mistry had prescribed. Then Dr. Mistry sent the parents out of the room. He began to ask the girl about her enjoyments, her pleasures, her happy memories. Eventually she told him about a time that a close friend embraced her. As they spoke, Dr. Mistry pressed a place on her wrist with his finger. Then he admonished her to eat a simple diet of rice, *dal* (cooked dried beans of several varieties), and vegetables. He sent her out of the room, called the parents, and promised them that she would now eat properly. He called the girl back into the room, pressed the point on her wrist and asked her to recite the foods she should eat, which she did. He told the parents not to worry. After the girl left, Dr. Mistry turned to me and asked if I had heard of "anchoring." When I said no, he informed me that there were four parts to Ayurveda: medicines, *pancakarma* (the purification therapies), *marma cikitsa* (treatment of particular sensitive points in the body), and anchoring. He said that 80 percent of illness is psychological. This patient's parents, he told me, are totally "negative." He said, "They have been anchoring the girl that she is not going to live." By pressing on her wrist while she remembered the experience of her friend's embrace, he claimed to have anchored her in a positive memory.¹⁵ Whenever she feels discouraged or disinclined to eat her rice and dal, she can press the same point and relive the happiness of embracing her friend. Then she will want to live.

Afterward I was amazed that Dr. Mistry thought I was ignorant enough to believe that anchoring is one of the four parts of Ayurveda (which, in any case, is classically divided into eight parts). Much later I asked his partner where he learned this technique. She laughed and said that he is fond of reading self-help literature published in the West. She said that he had learned the technique from an American patient who practices Neurolinguistic Programming. She added that Caraka, author of one of the seminal Ayurvedic texts, discusses some of the same psychologically oriented methods that have been used by Dr. Mistry.¹⁶ For example, Caraka wrote that a physician should always sit up straight and smile. Neurolinguistic Programming (NLP) is one of a host of Western new-age therapies that attempts to wed the magic of folk practice to the science of professional medicine (e.g., Bandler 1981). Like many other such therapies, it works on the body and the mind. Dr. Mistry's adoption of such practices suggests yet another level of mimetic vertigo: the mimicry of professional practitioners mimicking folk practitioners. Not the least astonishing aspect of this last mimicry is that he establishes anchoring as one of four original parts of Ayurveda.

the cunning of form

During my period of observation of Dr. Mistry, I had a long conversation with Dr. Upadhyay, the doctor who had warned me that Dr. Mistry was a fraud. I hesitantly voiced the idea that Dr. Mistry might be only partly a fraud. I reminded him that many Ayurvedic graduates with perfectly legitimate degrees might actually be poorly qualified to practice Ayurveda. Dr. Upadhyay replied that we were talking about someone who, unlike Ayurvedic graduates, might not know the locations of the liver and the spleen. I mentioned that hundreds of doctors with minimal Ayurvedic knowledge had received degrees during the early years of modern Ayurvedic education. Dr. Upadhyay countered that those doctors who obtained questionable degrees for the sake of the survival of Ayurveda could not be compared to someone who had obtained questionable degrees for the sake of commercialization or making money. Dr. Upadhyay also contrasted Dr. Mistry with those rural practitioners who have some knowledge of local plants

but no formal Ayurvedic education. Such practitioners, he said, are legitimate because they are healing people in areas where other doctors are not available. In Dr. Upadhyay's view, then, Dr. Mistry's mimicry of both professional Ayurvedic doctors and bona fide folk practitioners is quackery because, in his belief, it is driven by mercenary motives.

Dr. Mistry, on the other hand, declared to me that he has made enough money and that he is now simply on a mission to save Ayurveda. In that mission, he feels that his detachment from a medical knowledge based on the location of livers and spleens is one of his strongest qualifications. He believes it is he who is saving Ayurveda by not allowing it to be contaminated by modern pathology. He says that his guru taught him to "forget allopathy." One day a patient arrived whose arm was trembling severely. He was convinced that he had Parkinson's disease and malaria. Dr. Mistry had his assistants massage his arms and feet with warm bundles of herbs and with a powder containing ginger. Dr. Mistry told me that the patient's feet were cold while his head was hot. Therefore he had to be "rebalanced." Otherwise he would become paralyzed. After warming the feet, the assistants cooled the head with an application of ghee (clarified butter). Later Dr. Mistry explained that what the patient thought was all a "game." The problem was not Parkinson's or malaria but an increase in the patient's *apana* vāyu (the type of vāyu considered to regulate the release of urine, feces, semen, menses, and fetuses). Once his feet had been warmed and his head cooled, he felt much better.

Dr. Mistry then launched into a crusader's speech. He said that a physician should "think in Ayurved, dream in Ayurved. . . . Whatever we do," he said, "we write Ayurvedic diagnosis, Ayurvedic treatment. . . . Otherwise," he said, "we'll all start thinking this way [that is, allopathically] and the whole Ayurved will be lost." He said that he had started a campaign to return to the "basic principles" of Ayurveda. During an emergency, he said, most doctors begin to think in allopathic terms. He, however, does not think that way. He considers where the vāyu is moving, what the pitta is doing, and so on. When someone asks him at a conference whether he can cure alloplasia, he replies, "Why are you calling it alloplasia?" He finished his speech by declaring that if he treated a patient according to allopathy he would be "cheating" him. The criticism of Ayurvedic institutional practice, where allopathic diagnoses are frequently integrated with Ayurvedic diagnoses, is implicit. According to Dr. Mistry, it is the mimicry of allopathy found in institutional Ayurveda that is a kind of quackery. One of Dr. Mistry's former assistants who also knows Dr. Upadhyay from his lectures, told me that Dr. Mistry's knowledge of Ayurveda was very superficial compared to that of Dr. Upadhyay. Interestingly, however, Dr. Upadhyay does not emphasize that Dr. Mistry is ignorant of Ayurveda but, rather, that he is ignorant of anatomy.

In a later conversation, Dr. Upadhyay compared Dr. Mistry's practice to that of a shaman or a Zulu healer. When I commented that there might be some benefit in such healing practices, he agreed but said that what he objected to was the mixing of such practices with systems such as Ayurveda. He said Dr. Mistry reminded him of some healers from the United States whose presentations he had heard at a conference on holistic medicine. These healers had horrified him, he said, by telling the audience in prissy tones, which he imitated for my benefit, "now put your arms over your head and imagine that you are flying like a bird." He said he was appalled that such people could consider themselves practitioners of holistic medicine. Dr. Upadhyay said that if Dr. Mistry called himself a faith healer, then he would not find him so objectionable, but "he is using the name of Ayurved." According to Dr. Upadhyay, Dr. Mistry's faith-based practice is a misrepresentation of the scientific and systematic essence of Ayurveda. He says that Dr. Mistry's Ayurvedic signboard and his professional facade belie the folk-medical content of his technique. He does not deny the possibility that Dr. Mistry's practice could have medical efficacy. He concedes that he may have somehow learned something about pulse diagnosis; he concedes further that some of the many medicines Dr. Mistry dispenses to any given patient (in what Dr. Upadhyay terms a "shotgun approach") are bound to be beneficial;

he even concedes that the faith Dr. Mistry inspires in patients probably contributes to their cures. What disturbs him, I infer, is not Dr. Mistry's medical inauthenticity but rather his cultural inauthenticity. In other words, what disturbs him is what disturbs me about the fake *śilajit*, the slippage between sign and referent, because in this case the sign, Ayurveda, is one that is invested for Dr. Upadhyay with a very particular meaning. Dr. Upadhyay says that an authentic Ayurveda does not indulge in the magic associated with what he calls "faith healing." Dr. Mistry, on the other hand says that an authentic Ayurveda should bear no trace of allopathy.

Dr. Mistry was fond of saying that he practiced "110 percent Ayurved." Ultimately it is this extra ten percent, this excess of meaning "spilling over the referent" (Taussig 1993:233) that challenges scientific and social scientific rituals of signification. The two aspects of Dr. Mistry's practice that make him most susceptible to the charge of quackery are his recruitment of images from magical medicine and his commercialistic style. As Taussig has shown, both magic and the techniques of advertising make obvious the mimetic aspects of signification that are hidden in modern science. He argues that in the act of signification and representation, the sign or the image gains power over the referent or the object. This is, he points out, the elementary principle of sympathetic magic in which the copy gains power over the original in the very act of imitating it. The copy, because it can never be a perfect copy, is always sliding between the sensuousness of its contact with the original and the arbitrariness of its representation of it (Taussig 1993:17). Taussig notes that while contact occurs in every act of signification, modern science and modern commerce obscure this contact by the illusion of a copy, a sign that is independent and distinct. He points to Marx's analogy between vision and commodification. Marx explained that just as, in vision, the object seems to be, in Taussig's words "its own self-suspended self out there" and not the collision of light waves with the retina, so the commodity also seems to be an independent entity and not the thing shaped by the laborer (Taussig 1993:22). Thus the sensuous contiguity of use value is obscured by the arbitrariness of exchange value.¹⁷ Nonetheless, Taussig insists, "the commodity yet conceals in its innermost being not only the mysteries of the socially constructed nature of value and price, but also all its particulate sensuousness—and this subtle interaction of sensuous perceptibility and imperceptibility accounts for the fetish quality, the animism and spiritual glow of commodities, so adroitly channeled by advertising" (Taussig 1993:22–23). He writes, "The swallowing-up of contact we might say, by its copy, is what insures the animation of the latter, its power" (Taussig 1993:22).

The moments of contiguity that constitute modern medical diagnosis are not difficult to detect: the handling of the organs by the anatomy professor or the surgeon, the sound waves of the sonograph bouncing back from the organs, the lights of the x-ray penetrating the skin, indeed the surge of the pulse against the physician's fingers. In an early article on the semiotics of pulse, Daniel (1993) noted the indexicality (in Peircean terms) of these acts of signification.¹⁸ Yet all these moments of contact, it seems to me, are less important than the final pictures that stand in for, substitute for, and supplement body and disease.¹⁹ I remember watching a group of physicians huddled around a sonography machine in an Ayurvedic hospital. While the patient lay neglected on a cot just beyond a half-drawn curtain, they manipulated the machine, causing the ghostly image of the patient's organs to turn and shift on the screen so they could interpret the shape of the spleen. As Taussig has noted, the whiteness of the coats and walls and draped cloths of the operating theater serve to sanitize and disguise the entry of the surgeon's hand into the body (Taussig 1993:32). Sympathetic magic is, in fact, inherent in any medicine in that healing always involves the reinvention and the reinscription of the body for the patient, whether through incantations or anatomical explanations or through Dr. Mistry's etiological narratives of *doṣa*.

The mimesis of sympathetic magic, Taussig tells us, is not erased in modern science or modern medicine but simply used on the sly. Baudrillard could be speaking of modern medicine when he notes, "It is the cunning of form to veil itself continually in the evidence of content. . . . That

is its peculiar magic" (Baudrillard 1981:145). While scientific representation may depend on indexical relationships and tactile moments, it is ultimately driven to obscure its contiguity with objects. Otherwise science risks the possibility of revealing that it has disturbed or perhaps even conjured what it has touched. The difference between sympathetic magic and science is that the magician freely admits, in fact insists, that he has affected the object in the act of imitation. The scientist, however, must guard against any possible backwash from the sign toward the referent. It is essential that sonograms and x-rays be understood as pictures and not as sensuous exchanges of substance.²⁰ Otherwise it might become dangerously obvious that a sonogram takes on an aura of its own, spilling over the referent, constructing the patient out of pale shifting phantoms.

Taussig argues that advertising and certain kinds of modern art evoke the hidden sensuousness of the sign, restoring contiguity to the copy. The advertising image, he notes, explodes with a tactile force on the mind. The sign is no longer simply representation: it is barrage, impression, and physical sensation. Significantly, biomedical doctors in private practice (with the exception of cosmetic doctors who sell appearance more than health) have typically not advertised themselves in a way that bombards the subconscious with imagery.²¹ We are bombarded, to be sure, by the eerie icons of stethoscopes and anatomical diagrams and plastic intravenous tubes. These are objects, however, that are typically supposed by practitioner and patient alike to be entirely functional and without fetishistic glow. That is to say, they are supposed to serve and correspond to the body's dynamics. Pharmaceutical salesmen do advertise, of course, perched on chairs in doctors' offices, flicking through their glossy full-color schematics of the effects of drugs on the body, a blur of curving arrows, cross-sectioned kidneys, and block-print letter claims.²² Biomedical doctors themselves, however, generally do not advertise, except by a discreet listing of services. Such discretion has become a sign of professionalism for urban Ayurvedic doctors as well. Practitioners who advertise more extravagantly are suspected of being quacks.²³ The signs of science are considered by scientists and others to have a special objective relationship with natural objects. When these signs are recruited for advertising images, they risk seeming like simulacra, manipulated solely for the purpose of making money.

Dr. Mistry has no compunction about advertising. He hands sheaves of photocopied articles about himself to his patients. These articles compile not discreet listings of services but hyperbolic listings of personal attributes. Indeed, Dr. Upadhyay told me that Dr. Mistry worked in advertising before he turned to medicine, although Dr. Mistry never confirmed it. On several occasions, he commented to me that he is not a businessman. Yet one of his patients once told me that he asked Dr. Mistry why Ayurveda, despite its antiquity, was so little known and appreciated. Dr. Mistry replied that Ayurveda was not adequately advertised. When I asked Dr. Mistry's partner about this comment, she tactfully replied, "Advertising wouldn't be the proper meaning." She explained that Ayurvedic doctors must have faith in Ayurveda. She assured me that all of Dr. Mistry's publicity is by word of mouth. Dr. Upadhyay, on the other hand, says that the head of a particular Ayurvedic professional association told him that Dr. Mistry paid him 10,000 rupees in exchange for every invitation he received to participate in a scientific seminar. Dr. Mistry once showed me a video he had produced of a seminar on pulse diagnosis, promising that it would explain many things. At least 50 percent of the video was devoted, however, not to information about pulse but to testimonials by Dr. Mistry's apprentices and patients, many of them Europeans or North Americans.

from function to fetish

The apparent ambivalence about advertising is probably to be expected in a medical practice that wanders between the master categories of science and magic and between the effectiveness of substance and the effectiveness of symbols. One day when I arrived at Dr. Mistry's clinic, he

told me that he had had a "horrible experience" the previous day. For the first time in his life, he said, he was really afraid. "I never get afraid normally," he said. "I stay very. . . ." He hesitated then, and I suggested the word "calm" and he said yes. On this occasion, however, a woman had arrived with very advanced kidney stones. Her stomach was distended, and she hadn't urinated for two days. She started screaming from the pain while sitting in Dr. Mistry's office. Dr. Mistry told me, laughing, that her family had expected him to perform some magic. Fortunately, he said, he suddenly remembered a treatment his guru used to do for kidney stones involving an oil massage and a medicine to redirect *vāyu* (the *doṣa* associated with air) in a downward direction. A few minutes after Dr. Mistry administered this treatment, the woman went in the bathroom and passed out two or three small stones in her urine. She was smiling and dancing, Dr. Mistry said, and I was giving thanks to God. Here Dr. Mistry implicitly denies that he performs magic, yet at other times, he manages to hint that he actually does perform magic.

On another of my visits, a dialysis patient arrived from a city on the other side of the country. His allopathic doctors had recommended a transplant for his one remaining kidney. He had come to Dr. Mistry because he did not want surgery, and yet he also did not want to remain on dialysis. Dr. Mistry promised that through his medicines, the kidney would eventually regain its function. He cautioned, however, that the patient must continue dialysis for the time being. A few days later, the patient returned complaining of nausea. When Dr. Mistry asked if he had received dialysis, the patient said no. Dr. Mistry became stern, saying, "I told you very clearly. You must take dialysis. . . . Repairing the kidney will take time." Then he said he would give the patient a medicine to add to his bath water that would immediately induce urination. He told him, however, that this was a one-time temporary solution, and he should arrange for dialysis the very next day. Two days later the man returned to the clinic a third time. He claimed that he had still not received dialysis. He said he was urinating and eating and felt no need for dialysis. Dr. Mistry said, "Wonderful." He turned to me and said, "Magic." He still insisted to the patient that he should get dialysis when he returned to his home. Meanwhile, he sold him six months worth of medicine. After the patient left, Dr. Mistry told me that his guru used to tell patients to use the therapy he had prescribed instead of dialysis. Now, for the first time, Dr. Mistry had tried it and it worked. "It's magic," he repeated again. He said that when he had discussed the case with his partner, she had told him, "You are killing that man. You should force him [to undergo dialysis]." Dr. Mistry asked, "How can I force him?" He said he had also consulted with a kidney specialist who had predicted that, without dialysis, the man's feet and stomach would swell. When Dr. Mistry informed the specialist that none of these symptoms had occurred, the specialist was amazed. Dr. Mistry said that the specialist asked, "What did you do?" and then added, "It's magic."

One day over lunch, Dr. Mistry told one of his students and myself a whole series of stories that had the effect of simultaneously asserting and denying his magical abilities. One infertility patient told him that her own guru had told her that if Dr. Mistry simply touched her stomach she would become pregnant. Dr. Mistry told us that since she believed this, he had to touch her stomach even though he thought to himself, "This is horrible, illogical, nonscientific." Then, he said, she became pregnant. In response to the student's question, he told us that the woman had taken medicines for infertility. He told us that his guru had warned him that at a certain stage of his career, patients would believe he possesses a *siddhi* (supramental power). If he begins to believe this himself, he said, then he will lose his "gift" and he will have to start practicing "wrong tricks." He went on to say that eventually one does develop *siddhis*.²⁴ He himself used to materialize jewels in his hand like Sai Baba (a well-known spiritual guru), but he stopped because, he asked us rhetorically, what is the point? Dr. Mistry's messages about magic, then, are mixed. Patients believe he performs magic, and so he pretends he does; if he begins to believe in his magic, he will lose it; if he loses his magic, he will have to start faking

it; magic is horrible and unscientific, but it works; he gave up performing magic years ago. The oscillation here between magic and science, between real magic and pretend magic, is itself slightly hypnotic.²⁵

He also reinforces the sense of magical performance in his practice with bursts of playfulness or laughter at moments of extremity. When Dr. Mistry's assistant informed us that the kidney patient still had not taken dialysis, Dr. Mistry turned, laughing, to me and said he did not know what the problem was and that he would have to find out; in other words, he did not know why the patient had refused dialysis. On another occasion, a suicidally depressed patient in his office wept, threatening to throw himself under a truck if he were asked to leave the clinic. Dr. Mistry sent him into another room to join a second depressed patient who had been taking his medications for ten days. He said to me, "I will make them mix, talk. Something might come out, I don't know," and he laughed. At that moment, and at those moments when he turned to me palms up helplessly and said "magic," I had the disorienting feeling that we were joined as twin spectators at his amazing not-to-be-believed clinic where anything might happen. His surprise and amusement at these times lent a certain unexpectedness, superfluity, and excessiveness to his cures.

It is not only Dr. Mistry's medical treatment that takes on a certain fetishistic aura in his own discourse but also himself. After sitting in his clinic for several days, I realized that he never diagnosed any patients with excess kapha (the doṣa associated with phlegm) even when they suffered from asthma and other upper respiratory problems that other doctors would consider to be classic kapha disorders. When I asked why he never detects excess kapha, he replied, "There are not kapha people on this planet." He went on to say that 80 percent of the people in the world have excess pitta. Only one in 200,000 people has a predominance of kapha. Those people, he adds, are so healthy that they do not require medicine. The only problem kapha people experience is a slight tendency toward bulkiness, he said, gesturing to himself. He explained that the reason there are so few kapha people is because of the pollution and chemicals in the environment. Chemicals are hot whereas kapha is cold. Then he told me about certain techniques he had devised for conceiving kapha children. He characterized these children as calm and cheerful. He said that because he himself is kapha, he is able to remain very fresh and energetic. A kapha person, he asserted, can work for hours without becoming irritated. "It is like a zen master," he said. Thus Dr. Mistry regards himself not simply as a purveyor of health but also as an embodiment of health. Over lunch, he warned us of the pitfalls of believing one is god. He implied that he had personally seen too many godmen fall ever to be tempted to think of himself as one. What he lacks in godliness, however, he projects in a splendid iconicity, glowing with kapha, the source of not only a disease-free life but also the transnational serenities of zen.

Dr. Mistry's ambivalence about magic and equivocation about advertising are linked to one another in that each derives meaning from his emphasis on faith as crucial to cure. His partner had implied to me that the misimpression of advertising arose from Dr. Mistry's faith in himself, and in my conversations with him he sometimes seemed to imply that the impression of magic arises from his patients' faith in him. Their faith is largely inspired by his pulse reading. When I entered his office for the first time, he was with a married couple and a small child. After taking the child's pulse, he told the father that the boy was suffering from asthma. After the family left, he informed me that now the father had full confidence in him because he had correctly assessed the child's problem. Weeks later, in response to my questions, his partner was listing the most important aspects of pulse examination. The first item on the list was to create the patient's trust. The patients, she told me, must believe that they will be healed. "Pulse, in a way, is a tool to bring that faith, mainly," she said. Part of Dr. Mistry's great popularity, she said, was due to the fact that "instantly he can produce that faith." She added, "To generate confidence in the patient that he is going to be cured, that itself generates the healing process." Later she said that the

people who come to their clinic have usually been suffering for so long that they have lost any hope of being cured. The moment they are given faith "things start working." She said what Dr. Mistry had said earlier, that 80 percent of illness is psychological. All of the aspects of Dr. Mistry's practice that smack of quackery can be understood as working to construct an atmosphere of faith: the photographs, the effusive newspaper articles, the suggestions of magical powers, even the awards. It is pulse reading, that sign of the quintessential and missing traditional vaidya, that is the centerpiece of this collection of faith-inspiring objects.

Dr. Mistry told me his guru used to call the ordinary Ayurvedic diagnosis (which involves taking a detailed history and examining tongue, eyes, urine, and skin, in addition to pulse), the "maybe" diagnosis. Now, Dr. Mistry claims, his diagnosis is totally without guesswork. Many patients, including a few who had not been hand picked to talk to me, told me Dr. Mistry's diagnosis was amazingly accurate. A few disillusioned ex-patients told me that his diagnosis had seemed vague. Dr. Mistry himself once said that the pulse is like a computer: if one knows how to operate it, one can operate it; it is not magic. His most frequent analogy for pulse reading was the operation of a television set. In order to receive the information broadcast through a particular channel, it is necessary to know which button to press. Similarly in order to receive the information about illness moving through the channels of the body, it is necessary to know where and how to press the patient's wrist. Although it hardly exhausts Dr. Mistry's phenomenology of pulse (as will be seen below), the analogy is intriguing, not least because the television medium is one of those instances of signification that Taussig might say evokes the hidden sensuousness of the sign. It is also a form of signification based on the photographic image. Through editing, manipulation, juxtaposition, and so on, this image accumulates meanings that exceed its subject.

Dr. Mistry's pulse readings are not simply or even primarily diagnoses but rather, as his partner told me, the first acts of healing. Pulse reading sparks the faith that fires the healing process. When Dr. Mistry recognizes the patient's current symptoms from the pulse, his prediction of the course of the cure gains credibility. The sign that is the pulse reading seeps back to affect the referent, the illness, exactly as in sympathetic magic or the powerful images of advertising. One patient told me that, although she had been warned by friends against Dr. Mistry, she continued to consult him because he, unlike other doctors, had correctly assessed her problems. I commented that he seemed to be an expert at inspiring faith in his patients. "Yes," she exclaimed, "so what if he has a big ego? I give thanks for his big ego," she said, raising her eyes skyward. It is his "big ego" that has enabled him to cure her migraines. Even Dr. Mistry's self-aggrandizement, then, his own excessiveness as a sign, is vital to the healing process. What Lévi-Strauss wrote of the Brazilian sorcerer applies equally to Dr. Mistry: "Quesalid did not become a great shaman because he cured his patients; he cured his patients because he had become a great shaman" (Lévi-Strauss 1963b:180).

In the video of his pulse seminar, Dr. Mistry explained that "pulse reading has nothing to do with logic"; it is not "figuring out." It is not the kind of knowledge whereby a person sees smoke and concludes there is fire.²⁶ He asserted that the "basic principle is awareness and it comes from meditation." Meditation, he further explained, means to focus on one thing without being distracted by others. Then he switched off the video for a moment to explain further. If he is distracted by other things when he is examining the patients, then he is "just trying to impress them, and trying to impress is a dangerous thing. . . . Everything becomes like a gimmick and not genuine." Later he repeated this idea again and added that there is a "subtle line between gimmick and truth." It seemed that he was alerting me and the student who was also present to the fact that he walks this subtle line, this razor's edge in his practice. If for one instant he loses his meditative focus, then his ability to read pulse might dissolve into gimmickry.

Over the weeks, I had become increasingly puzzled by the fact that Dr. Mistry recorded the patient's pulse only on the first visit and not on any subsequent visits. Eventually, I asked him

how he was able to assess the patient's improvement without referring to the entire sequence of pulse readings. He said, "Ah yes, good question, good question." He seemed not to have considered this problem before. After a pause, he replied that he is concerned only with what is happening in the patient's body at the moment. Later I asked the same question of his partner and received much the same answer. She said, "Pulse is what is going on at that moment"; she added that pulse reading is like zen, thus implying that it involves a meditative stillness. Through pulse, Dr. Mistry told me, he was able to reconstruct the whole chain of events, the entire etiology of the illness, from first cause to immediate complaint.

Given this explanation, the question then becomes why Dr. Mistry bothers to record the pulse even on the first visit. It would seem that the most obvious reason would be to allow Dr. Mistry's several students to compare their diagnoses with his own diagnosis and with the patient's litany of complaints. Once I was observing Dr. Mistry's partner with a patient. In the box on the case form reserved for pulse notations she wrote "p+++" for excess pitta and "v+++" for excess vāyu. After hearing the diagnosis, the patient said she was not suffering from acidity but rather from gas. Dr. Mistry's partner then moved the symbol for excess pitta, which is considered to be a source of acidity, below the symbol for excess vāyu, which is considered to be a source of gas. I realized then that the pulse code on the case form is expected to parallel precisely the complaints of the patient. Because Dr. Mistry fills out the case form after discussing the complaints with the patient, he is able to assure that the pulse symbols as recorded for his students perfectly correlate with the symptoms. Ultimately, it seems that the pulse symbols refer less to the referent, to the illness, or the cause of the illness, than to those other signs, the discomforts of the patient. The importance of pulse is not so much to signify the disorder as to divine the complaints.²⁷ In Dr. Mistry's practice, then, the pulse neatly exemplifies the self-referentiality of the sign discussed by Baudrillard. Pulse is a simulacrum that owes its meaning not to its use value, its relationship with an objectively real disease, but to its exchange value, its relationship with those other signifiers, the symptoms.

When Dr. Upadhyay and I were discussing whether Dr. Mistry could really be considered a quack, he said at one point, irritated by my equivocations, "A fraud is a fraud is a fraud." In the successive moments between the repetitions of the word *fraud*, however, a whole landslide of slippage can occur. During my association with Dr. Mistry, I had to discard one definition of quackery after another. Quackery could hardly mean simply a mimicry of medicines or methods or qualifications, since such mimesis is essential to the training and identification of any medical practitioner. Quackery could also hardly mean a mimicry with intent to deceive, since deception may be used beneficially to inspire the trust of the patient. The deceptive manipulation of certain potent signs may occur in any kind of medicine. An Indian friend told me once that the family and the family allopath had deliberately refrained from telling her mother-in-law that she was suffering from cancer because the word itself would have killed her at once. Finally, quackery could not even be mimicry with intent to deceive for mercenary motives, since any doctor can be expected to have a few such motives. Quackery seems to be composed of qualities that slip back and forth between falseness and authenticity, continuously infecting each other.

Bhabha observes that the partial resemblances of nationalist institutions produced in the colonies inevitably parodied the monumentality of history (1984:130). Similarly, in Dr. Mistry's practice, the partial resemblances of professional and folk medicine and of modernity and tradition parody both the monumentality of science and the monumentality of culture. In the play of simulacra at his clinic, the originals of either scientific medicine or ritual medicine become impossible to retrieve. Carolyn Nordstrom has pointed out that much of Ayurvedic practice defies classification as either folk or professional medicine (Nordstrom 1988). What I have tried to unravel here are some of the mimetic entanglements involved in this defiance. Baudrillard has commented that Disneyland exists to conceal the fact that the United States is Disneyland (1988:172). Similarly, one could say that magical medicine exists to conceal the

fact that professional medicine is also magical. As a possible technician of magic who has entered the world of professional medicine, Dr. Mistry seriously upsets this act of concealment.

Because Dr. Mistry mimics not only the professional doctor honored by science but also the folk doctor essentialized by anthropology, the force of his parody extends beyond medicine to social science. Dr. Upadhyay forewarned me about allowing my picture to be taken with Dr. Mistry. Yet if I recruit doctors in my knowledge-making practices, how can I object if they reciprocate? If I write this article on Dr. Mistry to try to argue certain insights about signification, then why should he not take my photograph to try to sell his drugs, each of us milking the other for all of our possible exoticism? I did not object, therefore, when Dr. Mistry's assistant took my picture sitting next to Dr. Mistry listening to a patient. Taussig tells of the jolt he experienced when he saw the plastic intravenous tubes and bluish x-ray lamps hung against the walls of the mystical healing center (Taussig 1993:248). These signs of science drained so thoroughly of functional meanings glowed all the more excessively with fetishistic meanings. If there is anything comparable in Dr. Mistry's clinic, any sign that, for me, spills over its referent so completely as to erase it, then perhaps it is the photograph I have not yet seen of myself sitting with Dr. Mistry, the photograph of the interested white foreigner, one more sign glimmering from the photo album, arousing in patients the faith that allows them to be healed.

notes

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1. This article emerges from a larger project considering the modernization of Ayurveda in 20th-century India.

2. While in this article I take a semiotic approach to quackery in order to interrogate the notion of authenticity, I do not mean to trivialize the problems of either medical malpractice or medical capitalism.

3. This name is a pseudonym.

4. For a discussion of some of the problematics and early outcomes of this type of research, see Langford 1995.

5. Ivy has clarified that to insist that tradition is "invented" is simultaneously to imagine that it might have been "authentic" (1995:21). My practical and theoretical reasons for distrust of tradition are traceable to the fact that history itself is the reverberating play of a tradition-modernity binary. Thus the most traditional of Ayurvedic doctors are defined through their relationship or lack of relationship to modern institutions.

6. Another means of evaluating the truth-claims, medical or otherwise, of cultural others was offered by F. Allan Hanson (1979). Hanson suggests a third alternative to objectivist or cultural relativist assessments of reality, an alternative he calls contextualism. Contextualism involves a recognition that, just as visual images of material objects are conditioned both by the properties of the objects themselves and by the optical apparatus of the seer, so knowledge is always contingent on both external reality and the epistemology of the knower. Reality, therefore, is neither purely constructed nor purely independent of construction (Hanson 1979). Related moves have been made in the cultural studies of science. The position of Lynch and Woolgar, for example, is that "representations and objects are inextricably interconnected" and that "objects can only be 'known' through representation." For them, unlike for Hanson, however, evaluation of truth-claims "involves competition between representations, not between representation and an 'actual object'" (Lynch and Woolgar 1988:111). One problem with Hanson's paper, at least for this contemporary reader, is the assumption, prevalent at the time of his writing, that one can determine the boundaries of cultural worldviews. The usefulness of contextualism, which suggests that all truth claims should be evaluated according to their own cultural order, fades somewhat if that cultural order cannot be delineated. Would one, for example, contextually evaluate Dr. Mistry's practice according to the precepts of a nonhomogeneous urban Indian middle class, or according to the precepts of a statistical sample of urban Ayurvedic doctors, or according to Dr. Mistry's own precepts (and, if so, at which moments of the conversation) or according to the precepts of some other cultural matrix?

7. Vata is associated with wind and all movement within the body. Pitta is associated with fire, bile, digestion, and metabolic processes. Kapha is associated with water, mucus, and the substances and infrastructure of the body.

8. Scholarly literature is replete with documentation of the rituals, aesthetics, and historical contingencies that shape medical scientific truth. For just a few examples, see Arney and Bergen 1984, Hahn 1982, Haraway 1991, Lock 1993, Martin 1994, Rhodes 1991, and Young 1980.

9. Actually Śuśruta, who is considered the father of Ayurvedic surgery, described a method of dissection a few thousand years ago. It is not always so easy to distinguish the original from the copy. In addition, sprinkled through the colonial and postcolonial eras are examples of mimesis moving in the opposite direction to the mimesis discussed in this article. Arnold points out, for example, that British doctors made use of Ayurvedic remedies for certain tropical illnesses (1993:51, 181).

10. A further mimetic complication is that a very large number of the graduates from these institutions dispense allopathic rather than Ayurvedic medicines. Doctors with whom I discussed this issue set the number as high as 85 percent and sometimes higher. Waxler (1984) reports similar figures for Sri Lanka. It is partly the public awareness of this problem that gives rise to rumors accusing Dr. Mistry or other controversially successful doctors of adding steroids to their medicines. This level of mimesis was actually first encouraged by the British who engaged *vaidyas* and *hakims* (practitioners of Unani medicine) simultaneously to represent indigenous beliefs and enact allopathic means of epidemic control (Arnold 1987).

11. Twentieth-century histories of Ayurveda often lament the descent into magical practices during the colonial era and call for a return to the scientific Ayurveda of the classical age. See for example Banerji 1981. Zimmermann contests the factuality of such histories, finding classical Ayurvedic therapy to be a mix of rational and ritual therapies as well as empirical and magical theories (1978, 1987). More importantly, Chatterjee traces the contingency of such histories, discussing how the construction of an Indian classical past followed by a medieval decline echoes European historiographic projects (1993:95–115).

12. Cohn, Daniel, and Ramanujan have each in their own way suggested that South Asian processes of signification themselves offer a challenge to the (European) cultural priority of metaphoricality and arbitrariness. Cohn (1985) has noted that for Indians signs carry substance. Daniel (1984) and Ramanujan (1989) have argued that South Asian knowledge privileges iconicity over arbitrariness and metonym over metaphor. Inden, on the other hand, critiques the notion that Hindu thought hinges more on icons and images as a European attempt to access a lost and romanticized epistemology (1990:127). This controversy is echoed to some degree in recent criticism of Mitchell by Coronil. Mitchell suggests that the distinction between copy and original, signifier and signified are meaningless in a precolonial Egyptian signification in which all phenomena both imitate and are imitated (1988:61). Coronil (1996) writes that such narratives reproduce the metaphysical binary of East and West. In a related argument, Prakash (1990) cautions against postorientalist histories that embed the study of Asia in an overarching project of disturbing the European episteme. The third world then risks becoming once again "a good thing to think with about the 'West' " (Prakash 1990:408). There is no easy resolution to these controversies. Mitchell himself denies that he means to invoke an enchanted premodern or oriental world where words were not yet separate from things (cf. Foucault 1970). He clarifies that it is the very dualism of the West that allows the imagination of such an antecedent nondualism (Mitchell 1990:566). In this article, my intention is to follow Taussig's precedent, as I understand it, of tracing these contrasts not to any cultural essences but rather to cross-cultural resonances that arise in colonial and postcolonial encounters (Taussig 1987, 1993).

13. Pulse diagnosis was introduced into Ayurveda during the 13th century, primarily from Tantric and Unani sources (Upadhyaya 1986).

14. Appadurai's (1990, 1991) observation that differences can no longer be "taxonomically" ordered in today's "global ethnoscapes" makes it clear how categories such as folk and professional, however heuristically useful, have become harder to sustain as they are so hedged with qualification.

15. Anchoring the patient by pressing the wrist is unrelated to reading the pulse at the wrist.

16. It is not clear what passages of Caraka Dr. Mistry's partner would cite to substantiate this claim. For insanity and possession, Caraka does advocate the use of encouraging words (Sharma 1981, volume 1:170, 177), but I know of nothing in Caraka akin to anchoring.

17. By contrast, Baudrillard would presumably argue that the priority of exchange value is mystified by the enhanced simulations of use value in certain types of advertising.

18. In brief, an index is a sign that is contiguous with its referent.

19. The verb *supplement* is used here in the Derridean sense of the simultaneous representation and replacement of the object, which implies its insufficiency unto itself (Derrida 1976:145).

20. There is no space here to address adequately the enormous complexity of the medical image. Sonograms and x-rays have a semiotic status similar to that of photographs, which, as Barthes notes, present an uncoded, denotative natural analogue of a scene that is, however, irretrievably embedded in coded, connotative, and cultural messages. The analogical aspect of the photo creates the impression of a direct image of nature, unmediated by culture. Similarly, sonograms and x-rays seem to be analogons of the inner organs partly because they are produced mechanically and appear to be absent of codes. "The mechanical," Barthes tells us, "guarantees objectivity" (1977:44). Yet in actual fact, the intelligibility of such images depends entirely on a nonanalogical sign, the anatomical drawing. Barthes cautions that drawings are never analogons partly because they reproduce only what is considered significant (1977:43). Anatomical drawings thus reproduce only individual organs, or a particular system such as the circulatory system. An

actual photograph of an open cadaver would be more confusing. Again its medical intelligibility would depend on historically conditioned drawings of the body. There are many illuminating ethnographies of scientific image-making practices. See, for example, Knorr-Cetina and Amann 1990 and the articles in Lynch and Woolgar 1990.

21. This is much less true of health care conglomerates which, at least in the United States, increasingly employ television and direct-mail advertising that is densely layered with semiotic messages.

22. In the United States, such sales promotions take place when patients are absent. In Ayurvedic hospitals, however, they take place in crowded outpatient departments. The sliding of medical sign into advertising icon seems to lose much of its scandalous edge in Ayurvedic settings.

23. This is true for both allopaths and Ayurvedic doctors in urban India. It is less true in rural areas, where a more self-conscious performativity is sometimes an expected part of healing practice.

24. I have taken the liberty of associating magic with siddhis despite the connotative differences between the two words. Dr. Mistry utters the English word *magic* in ironic and delighted tones, reflecting his awareness of the dismissive or performative registers in which the word would ordinarily be used. He utters the Hindi or Sanskrit word *siddhi*, on the other hand, with great seriousness, reflecting his awareness of the philosophical and spiritual registers in which the word would be used. Nonetheless, it is probably fair to say that in South Asian contexts magical or extranatural effects are very often associated not simply with manipulations of objects but also with supramental powers on the part of the manipulator.

25. There are interesting similarities between the touches of magic in Dr. Mistry's practice and those in certain post-Mao practices in China as discussed by Farquhar. Both play on the unscientific longings of patients, but Mistry's use of magic is ambivalent while that of the Chinese doctors is defiant of the exaggerated secularism of state socialism (Farquhar 1996).

26. This is an example commonly given in Ayurvedic textbooks for the means of knowledge known as *anuman* or inference (e.g., Tripathi 1994:158–159).

27. The extent to which the particular relationship between signs or symptoms and illness (which informs biomedical diagnosis and which is enforced by modern diagnostic technologies) is reproduced in Ayurvedic practice varies from practitioner to practitioner. For a preliminary discussion of this issue, see Langford 1995. A more extensive discussion may be found in Langford 1998.

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