

# Law and Time

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## **6 Traditional medicines, law and the (dis)ordering of temporalities**

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## 6 Traditional medicines, law and the (dis)ordering of temporalities

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### Introduction

In this chapter, I explore the regulation of alternative and traditional medicine, in order to reflect on how particular temporalities shape, and are shaped by, the interface between law and medicine. This chapter makes two key points: first, it argues that both biomedicine and law have relied on a particular sense of ‘modernity’ as a linear temporal process; in turn, this has been key in developing both crude, and more subtle, social patterns of power, dominance, and exclusion that continue to impact on contemporary societies. Second, it argues that as law increasingly engages in the regulation of other types of medicine, it continues to emulate biomedical models and assumptions as to what ‘modern medicine’ should look like, including its temporal features. This chapter is written as I am starting a large investigation of the multiple ways in which traditional and alternative medicines apprehend and are apprehended by law in several states in Europe and Africa.<sup>2</sup> Although the project has several aims, my interest in the field came, in part, from the ambivalent and complex ways in which the idea of ‘modernity’ seemed to be shaping the field and, in turn, how law and medicine as institutions were involved in this ambivalence. It is useful, to ‘set the scene’ of this chapter, to return to this briefly.

In 2012, as I was carrying out fieldwork in Ghana on a different project, I learnt of the relatively recent and ongoing efforts made by the Ghanaian government to ‘regulate better’ the field of traditional medicine and, indeed, as some of my informants were putting it at the time, to ‘modernise’ some of its features. In those conversations, constant push and pulls appeared between a variety of understandings of what modernity meant in the postcolonial context of Ghana, where vast sections of the population navigate between a poorly resourced biomedical system and more accessible traditional healers (a mixed category in itself, as I return to later). But I was also intrigued by the turn to law and regulation (broadly understood) that was being operated through governmental responses. This was particularly interesting because one finding from the project I was undertaking was that, in the field of pharmaceutical distribution where laws and regulatory systems were numerous, my informants all underlined the lack of practical effectiveness of the law and their powerlessness in implementing much

of it (Cloatre, 2013). In this context, the idea of setting out to regulate the even messier, even more complex field of traditional healing through a new set of centralised regulatory tools, was for me very interesting. I became curious to understand better what it meant for the state then, and for its individual actors, to reach out to law in order to rearrange such a previously unregulated field. A multiplicity of narratives was clearly at play there, carrying expectations that were about law, and about medicine, and about what each of them should look like and do in contemporary times.

A couple of years later, as the Ebola crisis broke out in West Africa, some of this ambivalence around traditional medicine and what it meant in present days reappeared: while in the early days of the Ebola crisis, traditional practices (of healing and burial) were pointed at as being responsible for the fast spread of the epidemic, the success of public health interventions to tackle it were later thought to have been possible only because of the ultimately effective enrolment of traditional healers by public health officials (Busch et al, 2015). There, tensions were again at play in relation to what past ('tradition'), present and future were made of: for initial commentators, the line between the ancestral and what was 'adequate' to contemporary healthcare appeared relatively clear. But as it became obvious that 'modern' public health systems may need 'traditional' healers and that they constituted important actors of contemporary public health, those narratives were, again, challenged.

Of course, those events are part of broader patterns: the WHO has developed strategies and plans for traditional medicine (or at least some sections of it) to be revalued in public health systems (WHO, 2005). All over the western world, patients are being drawn towards a range of alternative or traditional medicines (and sometimes, although not always, away from biomedicine) (House of Lords, 2000; Academie de Medecine, 2013). At stake in those stories and movements, are conflicting understandings of 'modernity': clearly, for a very vast set of people around the world, the future was not only or purely biomedical and clearly traditional medicines were neither settled in the past nor fixed. For them, modernity is arguably multidirectional rather than linear – it is about twists and turns and borrowings across time and space and about redefining futures as we experience them. For sociolegal scholars, this raises another series of questions that link to the core of legal temporalities: if looking more closely at those debates, they are all deeply entangled with claims about what law should do, and what law is for, in contemporary societies and their relation to medicine. This raises important questions: What do efforts to 'modernise' traditional medicine through law (as was the case in Ghana, or as the WHO suggests) *mean*, where both tradition and modernity in medicine are so layered and unsettled? And what do such efforts *do* to medical practices? These questions are particularly interesting because law has, for a long time, arguably embraced biomedicine as the true face of modernity, as I illustrate later. Contemporary movements therefore need to be understood against a particular background in which law has reinforced biomedicine's reliance on its own sense of uniqueness as modern knowledge system.

Conceptually, this chapter rests on preexisting engagements with the temporal dimensions of medical practice, in medical anthropology and Science and Technology Studies (STS) (Adams, Burke and Whitmarsh, 2014). Medicine is envisaged as a field in which time ‘matters’: knowledge practices are inherently shaped by particular, often divergent, senses of temporality; at the same time, they become conditioned by series of temporal assumptions predominant in the practice of medicine. The chapter seeks to put these questions of medical temporalities in conversation with reflections on legal temporalities: interrogations of the temporal movements that animate law and that, in turn, come to condition its creation, its practice and its effects on social relations. On both counts, my analysis is influenced heavily by ideas derived from STS, most notably those derived from Actor-Network Theory (ANT), that emphasise the fluidity, fragility and multiplicity of social relations (Latour, 1991; 2005). When thinking about time, at the nexus between law and medicine, the chapter makes two sets of contributions to the study of legal temporalities: first, it uses the law/medicine nexus as a site to demonstrate that time is folded, rather than linear. Its movements are not fixed or predefined and are, therefore, always open to renegotiations. While the folding of time in medicine *per se* has been carefully explored by others, the significance of this in relation to law have been given less attention. Second, it looks at events at the crossroad of law and alternative/traditional medicine in order to demonstrate that legal temporalities are performative: more than embedding time as social reality, law participates in creating new states of being and new relations. The temporalities at play in medical practices, and in the law surrounding it, are never fixed or fully determined, but revisited as practices themselves come to be reshaped or experienced. Throughout, the chapter argues that the close relationship between law and biomedicine, and their shared assumptions about the nature of modernity in medicine, renders some of these movements, and some of the politics they entail, less visible than they maybe should be.

The structure of this chapter reflects those two sets of concerns: first, it explores the question of ‘modernity’ in medicine and how it has been embraced by law. Second, it reflects on how efforts to regulate traditional medicines impact on the very temporalities of the practices they seek to regulate (and, in turn, on the broader socialities of these practices).

## **Modernities, law and medicine**

In this section, I argue that law and medicine, as institutions, have relied on a shared idea of modernity in medicine as a linear process that does not reflect the lived realities of temporalities in medicine and rests on a fixed understanding of time itself as unidirectional. This shared understanding of what constitutes ‘modern medicine’ has had deep political ramifications. In addition, as patient demands and some public discourses with regards to alternative and traditional medicines evolve, the inadequacy of the straightforward ‘modernity’ narrative at the interface between law and medicine is made increasingly visible.

***Modernity in the law and medicine nexus – challenging linearity as dominant narrative***

The idea of scientific rationality as a cornerstone of modernity has long been essential to the constitution of biomedicine as institution. If looking back at the history of the progressive establishment of biomedicine as the main system of healthcare in Western Europe, a few features can be highlighted. First, and as a somehow simplistic summary, biomedicine has rested on the joint ideas of rupture and linearity in its institutional development. It has increasingly sought, on the one hand, to position itself as ‘radically different’ from the other preexisting (and often coexisting) systems of therapeutic practices and, on the other hand, to position itself as a field defined by a linear process of experiment, discovery and advancement. For biomedicine, as for science more generally, the process of scientific progress is one of a linear move from error to truth or from uncertainty to established knowledge. Biomedicine has grown institutionally, in part, by portraying itself as located along a linear timeline that starts with ancestral practices, to become something radically different as it becomes ‘scientific’ and has followed since then a progressive evolution towards ever increasing knowledge. This idea persists, if under increasing pressure, in the deployment of ideas of tradition and modernity in relation to therapeutic practices today. Importantly for our purpose, the possibility for biomedicine to continue to position itself as radically different, and undeniably ‘modern’, has been facilitated by law. Indeed, the history of biomedicine is also a history of entanglement between a powerful medical institution and a state recognition that has, largely through law and regulation, enabled it to occupy a unique and protected place, for reasons that were almost never purely scientific. This raises at least two issues: one is analytical, in that the reality of time in medicine and of medicine over time is more complicated than dominant narratives suggest. The other is political: these dominant narratives have enabled law and medicine to work jointly as institutions of state power, in turn generating deep patterns of exclusion, appropriation and violence. I turn to these now, before reflecting on some implications of the notion of modernity at the nexus between law and biomedicine for contemporary regulatory practices.

Detailed histories of the long coexistence of a multiplicity of healers with biomedicine in Europe and North America have illustrated how their relationships were always about more than knowledge making, certainty or new discoveries. Of course, this feeds into a broader challenge that STS scholars have brought to the idea of modernity, and of linearity, in scientific development: the production of science, and in turn the evolution of available knowledge, is always subject to deep socio-political patterns and far from the often assumed idea that knowledge becomes settled when it has achieved a higher form of ‘truth’ (Hess, 2003; Pinch and Bijker, 2012). In the context of medicine, as elsewhere, the relationships between different knowledge systems have been deeply shaped by professional interests and strategies, by the relative positioning of different groups in society, and in relation to state powers, and by other

political stakes (such as, as one example, the relations between Church and State in revolutionary France) (Ramsay, 1999; Bivins 2007). Crucially, historians have demonstrated that the organisation of biomedicine as a dominant field of knowledge long preceded the medical discoveries that now constitute its key knowledge base: biomedicine as an institution started establishing itself, and claiming its superiority over other systems, before it had made the breakthrough discoveries that would lead to its biggest therapeutic successes. It is important to keep in mind, therefore, that the processes of exclusion that I describe below simply cannot be read as only the effects of the successful advancement of particular forms of knowledge over others (Saks, 2015; Wahlberg, 2007).

Importantly, too, the uniqueness of biomedicine as symbolic of modernity has also been built on the assumption that could be opposed to a set of practices that are 'traditional'. This idea of what Bruno Latour (1991) has named for other purposes 'the Great Divide', between the moderns and their Others, has been extensively discredited: this imaginary of a fixed traditional sphere, opposed to a determinately modern biomedicine, and separated by a clear line dependent on an evolutionary vision of time, simply cannot be sustained in light of the lived practices of medicine. Far from being static, stuck in time or untouched, most 'traditional' medicines have changed over time and continue to be frequently revisited. They have also, and have been since their early encounters, been complicated by exchanges with biomedicine itself, other imported therapies and with global and governmental interventions (Adams, 2002; Hampshire and Owusu, 2013). The sense that 'traditional' medicine is such is itself the product of particular historical and political movements. Indeed, the use of the term 'traditional' remains politically loaded in a number of ways (sometimes also being reappropriated by its users) and grounded in heavy assumptions about the relationship between medicines and modernity.

### *'Progress' as a tool of dominance in the history of medicine*

The self-projection of biomedicine as an undeniable example of modernity is important to reflect on because of its political implications. This narrative participated, historically, in sustaining multiple processes of (dis)empowerment, in which particular forms of knowledge, and particular social groups, came to thrive or be dismissed. In those processes, law played an influential role. If taking apart the idea that biomedicine is an objective pillar of social advancement and that it is a unique form of knowledge that others cannot and should not challenge, it becomes easier to see some of the social processes at play in the expansion of biomedicine as tool of social control (English and Ehrenreich, 2010). With this in mind, challenging linear visions of time and modernity in medicine and their taking up by law *matters*: where law and medicine have embraced linear understandings of modernity as (scientific) progress, the outcome has always been more than 'just improving' the delivery of healthcare. Rather than seeing biomedicine as purely the outcome of a rational model of scientific development, it may be more analytically and politically telling to view it

also as an institutional site of political power, enhanced and facilitated by its embracing by law as exemplary site of modern knowledge.

There is no space here to do justice to the complexity of histories of exclusion that surround biomedicine, but a few points of example are worth focusing on. In Europe, while multiple practices of healthcare coexisted for centuries without a clear sense of hierarchy, or clear interventionism from the state (Bivins, 2007, 2015; Wahlberg, 2007; Cooter, 2008; Saks, 2015), the emergence of biomedicine as the primary source of healthcare was associated with the progressive dismissal of, and restrictions to, other types of medicine. In this process, it is no coincidence that those who emerged as holding a dominant role in therapeutic practices were, mostly, educated white men; those who became framed as lesser therapists were also those who could not access the professional circles that constituted biomedicine because of class, resources and gender. As what is today biomedicine grew as an institution, the social constitution of particular fields shifted, and professional boundaries and hierarchies became constituted: child-birth shifted from the domain of midwives to that of (mostly male) obstetricians; nursing and medical practice became divided along gendered line; the knowledge of (mostly female) herbalists became devalued. In those processes, legal, as well as professional regulation was always crucial. It determined who could practise what and what labels they could use; it mediated relationships, entitlements and responsibilities; it enabled decision making to shift across professional and, in turn, social groups (English and Ehrenreich, 2010). Regulatory interventions contributed to shaping the way in which particular practices could be maintained, promoted and defined and, in turn, contributed to reimagining the temporal development of medicine as a story of evolution. For a long time, an effect was to reinforce the power of a class of predominantly white men in defining not only the boundaries of legitimate and illegitimate knowledge and practice in healing, but also the very nature of temporal evolution in medicine (with some of these patterns still influencing practices today).

If Europe is a useful terrain to observe power shifts around gender and class in medicine, the dangers of adequating biomedicine with a sense of linear modernity and its embracing by law, are most visible in the context of colonial expansion. European states actively and through both legal and practical interventions rewrote what they saw as ‘forward-thinking’ or ‘modern’ medicine (Cickawy, 1998; Hess, 2003; Bigon, 2012). Indeed, biomedicine became one of the key tools used by colonisers to promote the narrative of modernisation that they relied upon in establishing their power over local populations in colonised territories (Vaughan, 2001; Echenberg, 2002; Langwick, 2011). It also became one of the key tools of dominance used to reshape communities and populations and to acquire power over individual bodies: colonial states, relying both on new (if still uncertain) forms of medical knowledge, and on purpose-built regulatory apparatus, used medical interventions as highly problematic, yet powerful, tools of population management (Bado, 2006). Violent practices were justified on the basis of newly developed medical theories, and newly acquired knowledge, that were dependent on an idea of biomedicine as the only valid,

modern way of handling public health. In this context, health systems and practices that preexisted colonialism were often actively denounced, sidelined or attacked as relics of pre-modernity (Bruchhausen and Roeckle, 2002). Importantly, this narrative was not aligned with the state of knowledges: biomedical knowledge at the time was still very fragile and uncertain and, indeed, many theories relied upon were later disproved.

At the same time, as they were pushing away particular sets of practices as belonging to another, more backward, era, colonisers would find some inspiration in these practices or in the substances used that generated the first cases of what became known as bioprospecting. Here, the construction of modernity and ‘tradition’, or ‘tradition-as-backwardness’, are co-productive stories of power; they are also stories of mutual, if deeply unbalanced, exchange. On the side of colonial states and biomedicine, this exchange was in the form of appropriation. At the same time, local medicines, while resisting and often rejecting biomedicine as violent expression of imperial power, were also often influenced by it, integrating some of its elements in their own practices (Baronov, 2010). As Vincanne Adams (2002, p. 665) reminds us for example of ‘Indian and Chinese medical scholars of earlier generations who sat on the edges of, or in the full throes of, Euro-American colonialism, and who responded by proposing alternative sciences based on their own traditions, all the while internalizing biomedical professional forms and epistemology.’

An important feature of those movements, for the purpose of this chapter, is the interlocking of a particular type of medical and legal temporalities in the idea of ‘modern’ medicine. Effectively, although contexts vary at closer scrutiny, law and medicine as institutions have worked to co-produce a particular sense of modernity as linear and unidirectional, paved essentially by the discoveries of modern medicine. Legal systems could support this by preserving the professional spaces of medical practitioners, shaping them and the spaces of the Others, but also protecting and rewarding certain types of knowledge-products over others, through intellectual property (Coombe, 2005). I return below to how this interlocking of law and medicine impacts on contemporary attempts to regulate alternative and traditional medicines, especially where they have not been recognised or engaged by the law before.

### *Contemporary challenges to ‘modernity’ narratives*

If looking at movements around alternative and traditional medicines worldwide at the moment, the past, present and future of medicine is being challenged and indeed the idea of biomedicine as the main form of modern healing is harder to sustain. As more patients are driven away from biomedicine and towards alternative sources of care, the dominant narratives put forward in law and biomedicine about what constitutes modernity are increasingly revisited: the resurgence of alternative and traditional medicines since the 1970s in Europe and North America and arguably in a more generalised way in the last 15 years or so, suggest that at least some groups of patients want to redefine imaginaries of modern



medicine as being more than enhanced visions of biomedicine – to them, the future needs to somehow drive away from medicine as a top-down, science-based and mostly industrialised enterprise (Fadlon, 2012; MacArtney and Wahlberg, 2014). Discourses suggesting a return to a more ‘natural’ way of healing have been frequent. While the response of states has varied – from the liberal UK system to the much more restrictive French system, for example – the idea that ‘modern humans’ may not be tending towards only one type of (western science-based) medicine has progressively become common place (Wahlberg, 2007). The WHO, in setting up the need for traditional healing systems to be reengaged and better valued in designing public health strategies, is similarly challenging the assumption that healthcare systems should be moving towards biomedicine and its imaginaries, leaving behind ‘ancestral’ practices, in the way colonial states were arguing not so long ago. Overall, for many patients, and at least some regulators, modern times call for a return to practices that biomedicine had seemingly pushed aside.

This has created visible pressure on regulators, as predominant ideas of ‘modernity’ are being challenged. In turn, looking at some of the contemporary debates surrounding how law should approach systems other than biomedicine provides some fascinating examples of how this narrative continues to play in unchanged terms in some public debates.

Transcripts from a 2013 special commission in the French Senate offers such examples. As brief background, France has a particularly restrictive (if not uniquely so) approach to alternative or traditional medicines. To summarise it briefly, criminal law does not allow anyone who is not a qualified medical practitioner (or, for certain acts, belongs to associated professions, such as nursing, midwifery or dentistry) to ‘diagnose’ or ‘treat’ patients. Anyone else who engages in such activities can be charged with ‘exercice illegal de la medecine’, which carries a fine and prison sentence. Alternative medicines, such as acupuncture or homeopathy, may be legally practised, but only by those who are also medical practitioners (and have followed further specialised training in those practices) (Cloatre, 2018). Therapists such as Traditional Chinese Medicine practitioners, naturopaths and ayurvedic healers may only operate within the strict limits set by the law, for example by providing well-being advice rather than diagnosis, energy boosters rather than treatment. They are also under the surveillance of Miviludes, a peculiar French agency whose main purpose is to monitor sects (the understanding being that alternative medicines are seen by the French authorities as a common entry point into sects). This has led to two sets of debates in France. First, some challenges by alternative practitioners to try to have their professions or practices recognised by the state. And second, attempts by sections of state institutions to reinforce yet further the protection of vulnerable patients against ‘les derives sectaires dans la santé’ (which could be translated as ‘sectarian excesses/abuses in the health sector’). In 2013, a Senate commission was constituted with the latter aim and proceeded to a series of interviews with representatives of health communities and public institutions in charge of both health and/or sectarian matters. The transcript of those debates is a rich illustration of the strong narratives that frame medicine as both radically different from

other therapeutic practices and the result of a progressive and linear evolution that it would be dangerous to challenge. As one example, a quote from one of the participants reads (Sénat 2013, p. 75): ‘The XVIIIth and XIXth centuries have seen the transition from l’Hotel Dieu to the public hospital. The legacy of the Enlightenment has enabled the development of Western, scientific, medicine. The XXst century may see a descent from the Public Hospital to the altar of gurus. The Lights would then be extinguished by the sectarian obscurantism that imaginary therapeutic methods participate in disseminating to an eager, suggestible, public!.’

Postcolonial contexts add a further layer of complexity to these temporal entanglements and to the various tensions at stake in determining what it means to be modern. Against the background of violence through law and biomedicine, in the name of modernity introduced earlier, postcolonial states have had to rethink how local medicines may fit in the institutional settings of contemporary public health (Fassin and Fassin, 1988). Those negotiations are, fundamentally, about rethinking the relationship between the imagined spheres of tradition and modernity, while negotiating with the messiness of diverse everyday practices. This is done in a context of the complex historical relationships introduced earlier, but the broader political stakes of locating state regulatory strategies within global health governance. This has produced a range of responses. For some states, traditional medicine has been re-embraced as a key component of an alternative modernity and a shared national identity (Wahlberg, 2006); for others, it remains seen as a problematic and less worthy set of practices that need to be pushed aside. Often, however, it sits somewhere in between, as potentially valuable but only when meeting certain conditions that the legal system is expected to determine. As I argue below, those conditions are often so closely inspired by biomedicine and its modes of making that the outcome is far from genuine alternative futures and knowledge making.

To sum up, current multidirectional moves towards a fluid modernity in therapeutic practices and the expectation that law should continue to intervene in setting boundaries between legitimate and illegitimate healing systems creates genuine challenges for the law. One aim of my project is to reflect on these pressures: how do legal systems reconcile supporting ‘biomedicine in its modernist projection’ with other forms of therapeutic practices? Here, the challenges are both about the present – what do we imagine valuable medical knowledge to look like in contemporary societies? – and the future – where do we see trends in healing moving in the times to come? In doing so, however, law continues to operate on a series of assumptions about what modernity within the challenge should look like – and here it is still ‘more like biomedicine’.

### **Regulating medical temporalities: Legal temporalities as productive of new realities?**

The particular relationship between law and biomedicine, and its rationalisation through the notion of modernity, have had an impact on what law imagines ‘modern’ medicine to look like: often, for law, ‘modern medicine’ can be proven

in the particular scientific ways that biomedicine relies on; emerges from a particular process of research and development; rests on particular methods of learning and transmission of knowledge and on particular forms of institutions. In this section, and with this in mind, I would like to focus on the way in which legal interventions constrain the temporalities of medicine, reshaping alternative systems to look more like, and function more as, biomedicine than they may otherwise. The section argues that law's embracing of biomedicine as the model of modernity towards which all systems should tend continues to impact on how it deals with other therapeutic systems – even when it appears to be recognising the possibilities of an alternative in medicine.

A few points of background and clarification are helpful here. First, the relationship of practices other than biomedicine with law varies across jurisdictions: while some states have clearly established systems of recognition and regulation of some medicines other than biomedicine, for others only biomedicine is formally surrounded by state regulation. There, other practices may be prohibited through a strict regulation of substances, processes or professions they rely on (although often, in practice, still used too) (WHO, 2005; McHale, 2015). Often, however, some form of traditional, folk or alternative medicine is left outside of the regulatory sphere and practiced with no clear engagement from the state (Stone, 2010). Even when states regulate certain forms of traditional or alternative medicine, some practices always remain outside the regulatory sphere – for example family and community healing practices carried in the private sphere will often remain outside the control, and interest, of the states (Barimah, 2013). Movements in regulation are therefore complex to map out, but also become complicated choreographies in which the spaces of regulation/non-regulation and forms of regulatory influences are constantly being redefined, both spatially and as legal and medical practices change over time. At the same time, it is fair to say that in a majority of contexts (both in Europe and through colonial expansion), legal systems have, at least since the 19th century and, as developed above, enabled biomedicine to establish itself as the main system of healthcare provided to population. This is important for understanding some of the questions raised in this section.

It is useful to specify as well that in my research, I am interested broadly in practices other than biomedicine (under the broad – and inevitably unsatisfactory – label of 'alternative and traditional' medicines). It may to some make little sense to refer in the same space, to practices as diverse as (for example) acupuncture, herbalism, homeopathy and the more localised forms of African healing that coexist on the continent. It also complicates yet further some attempts to map out the regulatory field. At the same time, this complicating of the field is also what enables its very diversity to be seized: temporalities of law in relation to medicines are complex because the field is plural and many different 'things' are happening at the same time, in very different ways, yet under a common umbrella of 'healing and healthcare'. One of my aims is precisely to disrupt the apparently neat categories or processes on which discourses surrounding medicine often rest and to emphasise messiness and diversity. In addition, much as these different

practices appear to differ from one another, they all tend to be in a position of relative subordination towards biomedicine as the predominant, state-recognised form of medical care: they often (albeit with geographical exceptions) share a position of ‘subaltern’ in both healthcare and law.

Finally, it is also worth noting at the outset of this section that temporality is a key element of differences and divergences between systems of medicines: temporalities of health and treatment practices, of production of medicines, of the relationship between medical practitioner, patient and disease, are a key point of difference between how different therapeutic and knowledge systems operate. For example, these mean that the positioning of medical practitioners within health processes may navigate from a logic of prevention to a logic of intervention once disease has been established – a diseased body may similarly be either where medicine needs to intervene or where medicine has already failed (Ecks, 2013). It also means that the temporal links between disease-diagnosis-treatment that biomedicine tends to rely on are less linear in the context of traditional practices that rely on a circular process of experimental treatment as diagnosis or that understand disease as being a symptom of longer term imbalances (Adams, 2002). Finally, it means that the temporality of treatment and healing itself varies – ayurvedic medicine, like traditional Chinese medicine or Tibetan medicine, for example, will not necessarily be expected to yield immediate short-term results, as it seeks to address the underlying long-term causes of disease as opposed to its visible symptoms (Tsey, 1997; Awah and Philimore, 2008). Consequently, treatment becomes conceived as a slow-process, as opposed to a short course of medicines with a view to immediate change. As I return to below, this will mean that systems of evidence and perceptions of efficacy may also vary – something that law may not easily accommodate. Paying attention to the question of time in legal movements and, in particular the idea that legal temporalities are productive of their own realities, enables us to see that attempts by law to engage with new therapeutic practices also reshape the very nature of those practices and their own alternative temporalities.

A few examples can be used here to open up some of those questions: first, the question of training and registration of health professionals; second, the idea that medicine needs to be ‘evidence based’ and largely dependent on clinical trials as the central way of proving reliability and safety; third, and underlying all this, that medicine should be able to prove its own effects within particular time frames (Barry, 2006; Iyioha, 2010). When those temporal assumptions are applied to other forms of medicine, they almost inevitably efface the particularities of the medical systems they regulate, reshaping both medical practices and the nature of what becomes the new ‘unregulated’ spaces of medicines. Effectively, as alternative and traditional medicines become regulated, pluralistic past and presents are turned into shared futures in which all medicines need to conform to shared modes of operation if they are to persevere: in the transmission of knowledge; processes of evidence making; and industrial production. Medicines can operate and travel if they have the power to be replicated over time in ways that can be packaged and traced.

A first example we can use is that of the regulation of the medical profession and its relation to how the temporality of learning and of treatment are envisaged through it. The regulation of professions in medicine typically happens through systems of certification and training – which may be more or less organised by the state itself or by professional associations. For example, schools of ayurvedic medicine are now well-established in India, training for homeopathy is integrated in some medical schools in Europe and some schools of pharmacy in Ghana have created streams for herbal and traditional medicine alongside pharmacy degrees. While the process may provide some guarantee of uniformity in the knowledge acquired by practitioners, it also transforms processes of learning, processes of selection for practice and processes of transmission – the outcome of which is inevitably to produce a new form of medicine or a newly emerged ‘modern traditional medicine’. The generational underpinnings of transmission in forms of traditional medicine that have relied on apprenticeship from a young age are also progressively erased in this process – as the links between personal experience and learning experience become reshaped in the context of university training (Adams and Kaufman, 2011). Underlying these changes are significant assumptions about regulation. As states intervene to reshape professional training (and indeed, although this is opening other questions maybe less relevant to my purpose here, as professions themselves seek to self-regulate), regulatory systems return to the formats of transmission that they have become familiar with in the context of biomedicine. Regulatory movements are also illustrations of the powerful yet discreet workings and influence of biomedicine as an institution and of law and biomedicine as engines of a particular sense of shared modernity.

Similar yet possibly more complex movements are also at play in the certification of substances and medical processes. As mentioned earlier, biomedicine is based on particular underpinnings in terms of the temporality of disease, treatment and effects – as Stefan Ecks (2013) documents in his work in India, and as developed earlier in this chapter, it is commonly seen as ‘quick’ medicine: its drugs are seen to produce immediate effects on symptoms without necessarily seeking to address long-term conditions. As a result, systems of evidence in medicine have become organised around a temporal logic that suits biomedicine, as the dominant health system in terms of its influence on state decisions, if not in terms of its patients’ uptake. Clinical trials in which pre-identified symptoms are shown to be alleviated by a particular treatment are therefore the main way by which the effectiveness of medical products is proven – the gold standard of evidence. Vincanne Adams (2002) documents how this may end up being problematic for medical traditions such as Tibetan medicine that do not necessarily put emphasis on short-term effects, as well as for traditions that more heavily seek to associate substances with, for example, spiritual engagement. Similarly, the methods of production of certain forms of drugs used in traditional medicine may not suit those that are predominantly used by biomedicine and therefore the folding of these into mainstream forms of regulation and ordering may again not be immediately suitable – as an example the slow process through which ayurvedic or homeopathic medicine in their most original practice are produced

are unlikely partners to the system of testing, verification and certification that most ‘mainstream’ pharmaceutical products are subject to. Importantly, those features, imported from biomedicine and transmitted through regulatory systems, are not simply about knowledge or ‘treatment’ making: they are also about creating abilities, or inabilities, to access the industrial markets of the global economy.

Where does this leave non-biomedical forms of medicine in the face of law? For some practitioners and for some substances, meeting such new standards and frameworks set by new regulatory systems may just not be possible: often, this will mean that activities can only remain aside of the law, as a new form of illegal but persistent activities that states are known to let exist – indeed, in the context of medicine, an unregulated sphere always operates, either in discreet public spheres or in the home and through informal and individual exchanges of treatment. For others, legal accreditation will mean inevitable transformation (Davey, 2014). Forms of ayurvedic medicines have become standardised and produced in formats and scales that make them easier to approve, although critiques may say they bear little resemblance to original products. Herbal medicines can be transformed and repackaged, from plants to industry-produced tablets in which lab-manufactured pills based on plants have been developed, that seem to bear only distant relations with traditional practices. One of the characteristics of herbal products may therefore be, as Vincanne Adams (2002) points out, that they become caught between existing in their original state in the fragile sphere of illegality or non-recognition, or becoming accepted only once transformed to the point that they may be unrecognisable. While research has shown how the process of industrialisation transforms medicines, ayurvedic medicine being a case in point, it should therefore be remembered that much of these transformations are dictated by the regulatory demands that are placed on industrialised production and that assume, among other things, that distribution, use and results should respond to particular temporalities (Pordié and Hardon, 2015; Pordié and Gaudillière, 2014).

The implications of those various movements are multiple. First, regulatory systems continue to assume a certain degree of uniformity in ‘modern medicine’. That uniformity operates in tension with continuous demands for pluralism in health practices that are both therapeutic and, arguably, political: those demands are also about being able to move away from the idea of modernity as scientific and industrial, that western states have long assumed, but this aspect is commonly effaced as regulations seize new fields. Second, assuming the model of biomedicine is not simply about assuming one way of proving knowledge over another: it also has implications for determining who may move across global markets and how and who is to be included in those or not. Third, this has implications at local levels, in allocating what others have termed biocitizenships: for example, the law is not just about regulating professions, but also about shaping the legitimate healer, the legitimate user and the legitimate interlocutor of the state in making future regulatory decisions. In those movements, the very notion of what traditional medicine may be or what it means are constantly being reshaped as terminologies and practices become relabeled and transformed to fit the needs of various publics, demands or beliefs or, indeed, regulatory pressures.

## Conclusion

Overall, in those movements for legitimacy of medical practices, a key feature is the permanent imposition by biomedicine of certain assumptions about how bodies work, how knowledge can be proven and how treatment should be legitimised, that are themselves resting on particular notions of modernity and linear times. While the dichotomies between nature and society, irrational spirituality and rational science have commonly been pointed out as some of the key elements that make it difficult to conciliate biomedicine with other forms of medical knowledge, the assumptions that different practices make about the times of medicine and about bodily temporalities also seem significant in the fostering of these differences. While law as an institution has responded to and helped shape biomedicine since at least the 19th century in Europe, it has also participated in reinforcing particular temporalities in medicine. As the question of the regulation of practices other than biomedicine is seized again by contemporary states, these conflicting temporalities continue to require adjustment and questioning. In these choreographies of legitimacy, recognition and persistent practice, the question of modernity in medicine is also entirely reopened: from postcolonial states' reengagement with pre-colonial practices of medicine, to global pressures for 'adequate' regulation, to the new faces of medical pluralism that have been generated in western states through global movements and multicultural patient communities, definitions of what constitutes both the present, but also the imagined future of medicine continue to shape state strategies and create tensions between understandings of how progress should be imagined in medicine. While biomedical research continues to play a key part in the projected future of most actors of public health (patients, researchers, officials or practitioners), for others the future of medicine may depend on the possibilities for alternative forms of healthcare that are less heavily entangled in neoliberal industrial strategies and temporalities than biomedicine, as it is currently framed and regulated, would suggest. Conflicting visions of modernity in medicine may therefore also be a significant site to explore broader tensions in understandings of both the pace and the political underpinnings of projected social futures.

Throughout this chapter, I aimed to engage with the challenge of thinking about, and thinking with, legal temporalities and I would like to end this chapter by offering a few concluding thoughts about what such approach can offer to thinking about law in the context of medicine (and, maybe, more generally). A particularity of the field is the apparent effacement of legal temporalities behind those of medicines and those of science: as the first part of this chapter aimed to demonstrate, an idea of modernity that is arguably, in many ways, specific to science, although often successfully reified by science as quasi-independent, has been embraced by law in the contexts explored here. This makes the identification of temporalities that are embedded in law difficult, but also necessary: the process of political construction at play in the normative movement is made more visible by unpacking the assumptions about time that law has rested on, seemingly 'neutrally'. Once this idea of neutrality through the assumption that time

is linear and given is unpacked, it becomes possible to view some of the unexpected effects of the law, in addition to and aside of what it explicitly sets out to regulate – which, arguably, remains one of the key contributions sociolegal scholars can continue to make. The question of ‘what else is the law doing?’ becomes informed by a critical perspective on its performative nature in relation to what it often presents, and what we often take as given, including the temporal framing of social relationships. As we continue to unpack the multidirectional workings of law in social processes in general, and in relation to medicine in particular, a focus on legal temporalities can continue to open up new critical routes. Of course, it cannot tell us ‘everything’ about the complex workings of law in action: but it can at least contribute to understanding better both the complexity of law in its making (always full of politics and always more socially complex than the neutrality it aims to portray) and in its deployment (always multiple, contested, and performative of the very realities it sets out to regulate).

## Notes

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