



## Rescuing Folk Remedies

### Ethnoknowledge and the Reinvention of Indigenous Herbal Medicine in Britain

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### Rescuing Folk Remedies

#### Ethno-knowledge and the Re-invention of Indigenous

#### Herbal Medicine in Britain

*Ayo Wahlberg*

Obtain [a] 7lb toffee jar and pack the comfrey leaves as tight as you can in it. Then forget it for at least six months. The leaves will have become a ball of 'Goo' and I add stink to high heaven. Pour the liquid into a much smaller jar for immediate use as a cure for sprains and the like. Leave the old stuff in the large jar and top up with new leaves the following year. Now how true this next bit of info is I'm not sure. But the 'know-alls' reckon that the second growing of the plant - first leaves are from about March the second from around August - these are the true healing ones. To me they are both the same, and stink just as badly. (H.G., Liverpool, aged 70+, in *Remembered Remedies*)

Neem is very good, because I'm diabetic, it helps me to control my diabetes. My friend has managed to get me some neem leaves from India, and I have been using it to control my diabetes. I mix it with my tea and I drink it, it keeps the sugar level down. I remember when I was little, I had chicken pox, and my

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mother kept me indoors for 3 days and then she boiled some neem leaves in water. And she washed me with it and I was fine. (S.M., Bradford, in *Plant Cultures*)

If there is one thing that is agreed upon in an otherwise highly contested field of herbal medicine, it is that peoples and cultures all over the world have been using plants to treat their ailments for a very long time – the proverbial roots of medicine. This has certainly been the case in the British Isles and indeed there is a long history of organised herbal medicine practice which survives to this day to show for it. Ever since the founding of the National Association (later Institution) of Medical Herbalists (NIMH) in 1864, around the same time that the General Medical Council was established in the United Kingdom following the 1858 Medical Act, learned herbal practitioners have had their schools, codes of practice and representative organisations. Yet, despite such a legacy of formalisation, it is only as recently as 2001 that statutory recognition became a realistic option for herbal practitioners. In the intervening century and a half, organised herbal practice suffered numerous defeats as well as more or less concerted actions to wipe it out at the hands of lawmakers and biomedical professional organisations (Brown 1985; Griggs 1997; Saks 1992).

But, there has always been another side to herbal medicine in the British Isles, namely folk remedies and family healing. These are all those home recipes for aches, pains, rashes and ‘nerves’ which have been prepared in British kitchens for centuries, often passed down orally from mother (mostly) or father to daughter or son and some times recorded in a rich archive of herbals, some of which became bestsellers in their

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time with others remaining within family circles in the form of ‘kitchen books’ (Hatfield 2005). It is also these same remedies that through the times have been variously accorded the discourteous tags of “old wives’ tale”, “superstition” or “folk belief”. Yet in the last century or two, massive transformations in British society resulting from processes of industrialisation, urbanisation and more recently globalisation are feared to be putting knowledge of such indigenous folk remedies at grave risk of extinction. To begin with, a good part of herbal medicine has itself come to be modernised and industrialised to such an extent that a new generation of urban or ‘black bottle herbalists’<sup>1</sup> are seen by some to be at risk of losing touch with the land. Moreover, oral traditions of handing down family remedies are seen to be rapidly dying out as a growing proportion of British people come to live in busy urban settings where ‘quick fix’ over-the-counter pharmaceuticals are readily available for their day-to-day aches and blues. And finally, following decades of trans-Atlantic and continental influence, an ongoing consolidation of a ‘multiethnic Britain’ has meant that herbal medicine is no longer solely practiced in its ‘western’ form. Instead, medicinal plants are increasingly being imported into especially urban centres to stock not just practices of Traditional Chinese Medicine, Ayurvedic medicine or Tibetan medicine, but also of western practitioners of herbal medicine who have integrated imported Asian and Latin American species into their repertoire of healing plants. Amidst such a pluralisation of herbal practice in Britain, British herbal medicine has had to in a sense re-invent itself as ‘western herbal medicine’<sup>2</sup>.

In this chapter, I will examine how one might account for the much celebrated late-twentieth century revival of herbal medicine in the United Kingdom – according to the NIMH ‘enthusiasm for this ancient form of medicine has never been greater than it is

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today' (2007); a revival that is often traced back to the 1968 Medicines Act. In sociological studies of complementary and alternative medicine (CAM) it has been common to suggest that it is in the failures of biomedicine that we can find the causes and motivations for the revivals of not only herbal medicine but also many other forms of complementary, alternative or folk medicine such as acupuncture, homeopathy, osteopathy and aromatherapy. In these accounts, the reductionism, dehumanisation, toxication and alienation associated with a bureaucratised, impersonal and chemical biomedicine are seen as symptomatic of a broader range of side effects attributed to a 'modern way of life' emerging from processes of modernisation, urbanisation, industrialisation and globalisation (see Cant 1996, Coward 1989, O'Connor 1995, Sharma 1992). It is as antidotes to such life-enfeebling and soul-battering side effects of modernity that forms of complementary and folk medicine have in recent decades been promoted. As such, the revival of herbal medicine in the British Isles taps into a much broader critique of modern society which spans concerns about the negative impact of increasing environmental degradation and pollution as well as processes of clinical, social and cultural iatrogenesis that are seen to have transformed individuals "into unfeeling spectators of their own decaying selves" (Illich 1976: 35; see also Szersynski 2005).

Indeed, some have argued that herbal medicine may well be next in line if ongoing efforts to professionalise and modernise herbal medicine are not put on hold. Herbalist Peter Jackson-Main has argued that '[b]y defining herbal medicine as a graduate entry profession, there is a danger that the emphasis on academic learning may eclipse traditional values and practices' (2005: 97), while Jagtenberg and Evans have suggested that '[i]n a rapidly changing field, it is globalization that comes in the guise of

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science, technology, and progress that is more likely to destabilise the traditions of Western herbal medicine' (2003: 325).

Somewhat in contrast, what I will be arguing in this chapter is that what might be thought of as a kind of disciplining and normalisation of herbal medicine have been integral to its revival in the United Kingdom. The point I will be making is that processes of industrialisation, professionalisation and modernisation should not be seen as somehow antithetical to an 'authentic' herbal medicine, but instead are elements of an ongoing recasting and rectification of herbal medicine (cf. Bachelard 2001; Canguilhem 1988). This is not say that there is no such thing as 'good' herbal medicine as compared to 'bad' herbal medicine, rather it is to say that what is considered 'good' and 'bad' in any kind of medicine is a problem which is historically locatable and dependent on social practices and procedures for validating, assuring and safeguarding which in turn are always subject to contestation and rectification.

In the following, I will show how herbal medicine came to be actively re-invented in the United Kingdom from about the mid-twentieth century onwards. The analysis is based primarily on documents from herbal medicine practitioner associations, official government bodies, individual herbal practitioners, ethno-botanists as well as from various inter-disciplinary initiatives such as the *Remembered Remedies* and *Plant Cultures* projects. There are three parts to the chapter: the first concerns longstanding attempts to unify what has been described as a fragmented group of herbal medicine practitioner associations; the second concerns the twentieth century transformation of herbals into pharmacopoeias and the resulting emergence of 'herbal medicinal products' as a new legal category; and the final part concerns urgent efforts to record oral herbal

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traditions before they die out amidst increasing urbanisation and globalisation. And what will be a consistent theme throughout this chapter is that of ambivalence towards what 'modern life' in the UK has to offer herbal medicine and vice versa. It should be noted that it will not be a part of this chapter's errand to evaluate whether herbal medicine in the United Kingdom is better or worse off today compared to any other point in history. What I will instead be empirically accounting for are some of the conditions of possibility that have made space for herbal medicine's recent 'renaissance in the modern world' (Mills 1993: 17).

### **Fragmentation and the Disciplining of Herbal Practice**

As already noted, the organisation of herbal medicine practitioners into associations which look after the interests and training of its members in Britain goes back at least to 1864 when the National Association of Medical Herbalists (now NIMH) was formed. And ever since its Memorandum of Association came into force in 1895, they have distinguished between qualified and unqualified herbalists, actively sought 'to train Medical Herbalists', worked 'to repress malpractices', as well as investigated cases of 'unprofessional conduct' through a General Council of Safe Medicine (Brown 1985; NIMH 1979). In lobbying for a Medical Herbalists Bill in the early part of the twentieth century, the Association argued that 'it is our desire to compel a standard of Education and Registration so that the public shall be enabled to differentiate between Bona Fide [sic] Herbalists and those who trade on the name'<sup>3</sup> (cited in Griggs 1997: 262). Yet, this distinction did not gain any kind of official sanctioning during the first half of the twentieth century and was firmly opposed by the medical establishment (Wahlberg

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2007b). The proposed Medical Herbalists Bill (which would have given them statutory recognition as a medical profession on par with biomedical doctors) was denied by the British Ministry of Health in 1923, among others, on the grounds that it is ‘doubtful whether a trained herbalist is any less dangerous than an untrained one’ (Chief Medical Officer cited in Larkin 1992: 117). In an increasingly hostile environment, they also struggled to finance a herbal medicine school that could ensure consistent training standards for its members. And then in 1941, a new Pharmacy and Medicines Act revoked the right of herbalists in the United Kingdom to supply herbal medicines directly to patients on the grounds of protecting the public, in effect making it illegal for herbal practitioners to practice. Indeed, Griggs has argued that what British herbalists faced in the period spanning the end of the nineteenth to the mid-twentieth century was nothing short of ‘continuous... harassment, vexation and attempted legal suppression by the medical establishment’ (1997: 234).<sup>4</sup> The situation had become so dire by the late 1960s that, as Griggs notes, there were only a handful of ‘formally’ apprentice-trained medical herbalists left.

All this would change, however, in 1968 when, following intense lobbying, medical herbalists secured the so-called ‘Section 12 exemptions’ in a new Medicines Act, relieving herbal remedies provided through one-to-one consultations with herbalists and ‘traditionally prepared’ over-the-counter herbal medicines of the expensive safety and quality requirements that other medicinal products would have to adhere to. Quite soon hereafter, sales of herbal medicines, the number of schools providing training in herbalism and consultations with herbalists, rebounded in tandem with an otherwise growing ‘crisis of modern medicine’ (Griggs 1997; O’Sullivan 2005; Saks 2003). By the

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end of the twentieth century, herbal medicine was considered to be among the ‘big 5’ of complementary and alternative medicines in terms of prevalence of use and practice, alongside osteopathy, chiropractic, homeopathy and acupuncture (House of Lords 2000). It is precisely this increased use of herbal medicine, coupled with traditions of self-regulation dating back to the formation of the NIMH as well as herbal safety issues arising from the Section 12 exemptions that would make it a priority candidate (following on from the statutory recognition of osteopathy and chiropractic in 1993 and 1994 respectively) for recent regulatory efforts to protect the public from its ‘dangerous and incompetent’ practice at the turn of the millennium (see House of Lords 2000; Wahlberg 2007b).

The NIMH, by far the largest of herbal practitioner organisations today with over 500 members (Great Britain. Department of Health. European Herbal Practitioners Association. Prince of Wales's Foundation for Integrated Health. 2003: 12), has in many ways pre-empted the debates which since the 1980s have increasingly placed practitioner competency and qualifications at the heart of the ‘CAM question’ (see British Medical Association 1993; British Medical Association. Board of Science and Education. 1986; House of Lords 2000). Already in 1991, the NIMH introduced a binding Code of Ethics, Code of Practice and Disciplinary Procedures, which was followed up by the formation of an NIMH Accreditation Board in 1994 to assess standards in the training of Medical Herbalists. And, the title of ‘medical herbalist’ has itself always served to distinguish trained practitioners from lay practitioners.

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Training to become a medical herbalist by an NIMH-accredited institution in the UK today includes courses in the theories and practices of both herbal and biomedicine, including anatomy, physiology and pathology, not least because:

If we want to continue to enjoy our right in this country for trained Medical Herbalists to have the right of primary diagnosis (a licence which is unique in Europe and perhaps even in the ‘developed’ world), we have to acquire a high level of orthodox clinical skills. To this end, the first two years of the course contain, alongside Herbal Science, a fair degree of Anatomy, Physiology and Pathology (The Scottish School of Herbal Medicine 2006)

Yet, the NIMH has certainly not been alone in endeavours to organise and train herbal practitioners, as further to them, the past century has also seen the formation (and in some cases gradual demise) of a Society of United Medical Herbalists of Great Britain (1877), a Society of Herbalists (1927), a Botano-Therapeutic Institute (1931), an International Register of Consultant Herbalists (1960), a British Herbal Medicine Association (1964), a College of Practitioners of Phytotherapy (1982),<sup>5</sup> and an Association of Master Herbalists (1996). Common to these many different organisations has been that most of their members have been practitioners of a tradition of herbal medicine indigenous to Britain (albeit with abundant trans-Atlantic and continental influences and interactions) whose father figures include Gerard, Culpeper and Coffin. Yet the members of these organisations have not necessarily always seen eye-to-eye with some suggesting that a rationalised phytomedicine or ‘black bottle’ herbal medicine is the best way forward and

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others resisting the growing industrialisation and modernisation of the cultivation and production of herbal remedies (see Brown 1985; Griggs 1997; Jagtenberg and Evans 2003).

In more recent years, an additional component of new medical pluralism has manifested itself in the UK, i.e. the consolidation of various herbal medical practices rooted in the cultural traditions of immigrant ethnic communities, such as Ayurveda, Traditional Chinese Medicine and Traditional Tibetan Medicine. Consequently, during the past two decades, a Register of Chinese Herbal Medicine (1987), a College of Tibetan Medicine (1993), an Association of Traditional Chinese Medicine (1994), an Ayurvedic Medical Association (1996), a British Ayurvedic Medical Council (1999), a British Society of Chinese Medicine (2001), and even a Unified Register of Herbal Practitioners<sup>6</sup> (1997) have also been formed. Indeed, it was as these different organisations were establishing themselves throughout the late 1980s and 1990s that the term ‘western herbal medicine’ was coined to cover a tradition of herbal medicine particular to North America, Great Britain and Australia.

In 2001 a Herbal Medicine Regulatory Working Group was formed as a joint initiative of the Department of Health, the Prince of Wales’s Foundation for Integrated Health (PWFIH) and the European Herbal Practitioners Association (EHPA). One of its key tasks was to address this plurality/fragmentation. The Working Group, which further includes representation from no fewer than 11 herbal medicine organisations representing some 1,500 practitioners, was given a mandate to come up with proposals for the statutory regulation of the herbal medicine profession as a whole. In 2003, the group published a range of recommendations for how a self-regulated Council of some form

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could be given the legal right to determine minimum levels of competence for those wishing to be registered as ‘medical herbalists’ (with due specifications for Western, Chinese and Ayurvedic forms of it), standards of ethical and responsible practice of herbal medicine, as well as disciplinary mechanisms for excluding and/or penalising ‘unacceptable professional conduct’ by registered herbalists (Great Britain. Department of Health. European Herbal Practitioners Association. Prince of Wales's Foundation for Integrated Health. 2003: 17-21).

And so we can see how an important part of the herbal medicine revival in the UK has been a series of efforts to finally officially sanction what an albeit fragmented group of herbal practitioners, led by the NIMH, had been lobbying for since the nineteenth century – a state-sanctioned mechanism to enable the public ‘to differentiate between Bona Fide [sic] Herbalists and those who trade on the name’. What is more, the fragmentation that has characterised herbal medicine practice for centuries in the UK would take on a new twist in the globalising 1990s as a whole range of ‘non-Western’ therapies became established features of especially urban centres. At the time of writing (summer 2007), herbal medicine was in line to become only the third non-biomedical therapy (following osteopathy (1993) and chiropractic (1994)) to become statutorily recognised in the UK.

### **From Herbals to Pharmacopoeias**

It is an oft-cited wisdom that if a remedy is still around after centuries of documented use, then there must be something to it. It is common to see references in contemporary literature about herbal medicine to its use by ‘ancient civilisations’ some ‘3,000 years

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ago' (Chevallier 1999: 81, Mills 1993: 5). Yet such persistent invocation of 'long-standing use' has also led regulators at the Department of Health to argue that 'the medical herbalist is at fault for clinging to outworn historical authority and for not assessing his drugs in terms of today's knowledge' (cited in British Medical Association. Board of Science and Education. 1986: 110). This tension between historical authority (continuity with an ancient past) and scientific authority (the need to re-evaluate herbal medicine in light of present knowledge) was recently captured in the European Council's Directive on traditional herbal medicinal products which argued that a long tradition of use 'makes it possible to reduce the need for clinical trials, in so far as the efficacy of the [herbal] medicinal product is *plausible* on the basis of long-standing use and experience' while also insisting that 'even a long tradition does not exclude the possibility that there may be concerns with regard to the product's safety... [and] quality' (European Parliament 2004: 5, emphasis added). It is a tension that has also characterised the revival of herbal medicine in the United Kingdom.

As is the case in many other parts of the world, the British Isles are home to a rich archive of books describing plants and their medicinal properties, known as 'herbals'. They can be found scattered throughout the past centuries of publishing history, from John Gerard's *Herball or General Historie of Plantes* (1597), Nicholas Culpeper's *The English Physitian* [sic] (1652), Elizabeth Blackwell's *A Curious Herbal* (1739), William Withering's *A Botanical Arrangement of all the Vegetables naturally growing in Great Britain* (1776), Robert John Thornton's *A Family Herbal* (1814), to Albert Isaiah Coffin's *A Botanic Guide to Health and the Natural Pathology of Disease* (1852). The result of meticulous study by their authors these oft-reprinted books and many other

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similar herbals have been instrumental in the subsequent botanical identification, classification and description of medicinally used British plant species. Yet, it was these very books that would end up banished to the fringes of medicine by the end of the nineteenth century, rejected by a growing medical profession as nothing more than collections of old wives' tales that still relied on the doctrine of signatures or astrology for explanations of efficacy. And although the synthetic drugs of modern medicine were ironically enough often developed through the isolation and chemical transformation of single active compounds found in plants, medical doctors were quick to contrast their 'purified' medicines with the 'messy' or 'impure' remedies of herbalists as part of their marginalising strategies.

At any rate, it was precisely to counter such charges that herbalists set about publishing a series of updated reference books in the early part of the twentieth century. In 1905 the National Association of Medical Herbalists published the first *National Botanic Pharmacopoeia*. Fifteen years later, in 1920, Mathew Robinson published *The New Family Herbal*, underlining that any notion of 'the government of Herbs by the sun, moon and planets, has been exploded by modern science; and is now regarded by persons of ordinary capacity to be absurd in the extreme' (cited in Brown 1985: 81). And in 1931, Maud Grieve and Hilda Lyle published what they called *A Modern Herbal*, arguing that '[a]ll serious Herbalists have long realized that a new Herbal is badly needed – a herbal which must include the traditional lore and properties of plants, *and* the modern use of properly standardized extracts and tinctures which were unknown in the days of Gerard and Parkinson, and even in the days of Culpeper, and which have been made possible by the development of modern chemistry' (Grieve and Lyle 1931, emphasis added). These

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updated reference books covering more than 800 herbs – listed according to botanical name, botanical family, synonyms, parts used, botanical description, constituents, indications, medicinal action, medicinal uses, preparation and dosage – marked important steps in the transformation of the long-standing ‘herbal’ into a monograph-based pharmacopoeia of herbs and herbal remedies. It was a transformation that relied on a comprehensive mapping out exercise of botanical enlightenment, designed to put order into the rich yet sometimes chaotic, unsystematic, unscientific and even unwritten records of medicinal herbs that have been used for centuries.

It would not, however, be until 1965 that efforts to prepare the current *British Herbal Pharmacopoeia* began. As Griggs has shown, during the drafting of the 1968 Medicines Act, the British Herbal Medicine Association (BHMA) (an interest group of herbalists, manufacturers and retailers formed in 1964) had been informed that ‘a herb for which a monograph appeared in any standard reference book and was not poisonous’ might be exempted from the kind of safety and efficacy evidence requirements that were a precondition for pharmaceutical medicines seeking market authorisation. What is more, while the 1968 Medicines Act did end up exempting from licensing those non-industrially produced herbal remedies sold without any written recommendations as to their use, manufacturers of herbal remedies were not exempt of an obligation to ensure quality and were thus in urgent need of a scientific reference book to which they could refer (see Griggs 1997: 281-85).

In response, the BHMA quickly put together a Scientific Committee in 1965 made up of pharmacologists, botanists, pharmacists and physicians, who were set the task of bringing order to the rich, yet dispersed and sometimes outdated, information that was

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available from the various herbals, as well as other sources of literature on the safety, efficacy and also quality of various medicinal plants. Their work comprised of enlightening forays into a variety of herbals, recorded case studies and journal articles, in order to chase bibliographic leads and systematically map out individual medicinal plants according to available information on their botanical description, vernacular names, history, medicinal uses, chemistry, indications, side-effects and recommended dosages.

The fruits of the BHMA Scientific Committee's labours came in the form of the first *British Herbal Pharmacopoeia*, which was published in stages starting with 115 herbal monographs in 1976 followed by a further 83 in 1979 and 34 in 1981 (Griggs 1997: 282-83). The *British Herbal Pharmacopoeia* was the first of its kind in the West, but has since been followed up in Germany where 380 monographs were published by Commission E in the period 1983 to 1995;<sup>7</sup> in the USA where the development of an *American Herbal Pharmacopoeia* was initiated in 1994; at the European level where the European Scientific Cooperative on Phytotherapy published 60 monographs in the period 1997 to 1999; and more recently at the international level where the World Health Organization has published three volumes of monographs on selected medicinal plants since 1999.

The point to be made is that, whereas herbals and treatises have undoubtedly played a key role in the identification and classification of medicinally useful herbs, the aim of monograph-based pharmacopoeias has been much more one of assurance and safeguarding. That is to say, while herbals and their authors continue to be celebrated for the important contributions they have made, these herbals certainly do not constitute authoritative references on issues of safety, quality and efficacy as far as regulatory

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authorities are concerned. As recently argued by the British Pharmacopoeia Commission, a ‘monograph, taken as a whole, should provide a reliable basis for making an independent judgement as to the quality of the substance in the interests of the protection of the public’ (2004). Hence, the ordering and updating of information on medicinal plants and herbal remedies as witnessed in the mapping out efforts of medical herbalists and pharmacologists in the United Kingdom and indeed throughout the world – i.e. the conversion or updating of herbals and treatises into monograph-based pharmacopoeias – has been a crucial part of the ongoing revival of herbal medicine.

At the same time, further to consolidating a documented reference base, the emergence of herbal pharmacopoeias has also facilitated twentieth century efforts to standardise and modernise herbal remedies. While leaflets and packaging labels in, for example, Holland & Barrett outlets often present herbal medicinal products as ‘100% natural!’, ‘organic’, ‘conventionally grown’ or ‘wild crafted’, a lot has happened since the days of John Gerard, Nicholas Culpeper and Albert Coffin. Over the past century or so, medicinal plant cultivation and processing has transformed into a highly-technologised, multi-million dollar industry (Richter 2003). Inspired by the pioneer work of German natural products chemists and companies in the 1920s and 1930s,<sup>8</sup> the industrialisation of medicinal plants into what have come to be known as ‘phytomedicines’ has developed into a global activity with supply chains spanning all the world’s continents. Indeed, the late twentieth century ‘boom’ in herbal medicine, often cited as evidence of the growing popularity of alternative and traditional medicines, refers in large part to rapid rises in the sales figures for phytomedicines throughout the 1980s and 1990s (see Gaedcke and Steinhoff 2002; Richter 2003). As a result, as any

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herbalist will point out today, it is important to distinguish between such mass-produced phytomedicines which are often standardised against a certain single active ingredient (such as hypericin or hyperforin in St. John's Wort) on the one hand, and the dried, comminuted or crushed starting materials (leaves, buds, flowers, stems, bark, etc.) from which extracts and tinctures are prepared by medical herbalists in consultations (or by herbal remedy producers such as Neal's Yard Remedies) on the other. Where quality was in the past (and to some extent continues to be by some medical herbalists) controlled by an individual herbalist who strolled the countryside, smelling and feeling the texture of medicinal plants before plucking them, today, quality is often controlled in high-tech laboratories against plant constituent profiles known as liquid chromatographic 'fingerprints' (see Jagtenberg and Evans 2003; Wahlberg 2008b).

Nevertheless, whether in the form of its original starting material (fresh, dried or comminuted leaves, stems, flower buds or bark) or as industrially-produced capsules, tonics or tablets, herbal medicines that are sold for health-related purposes and/or make health-related curative claims have increasingly become subject to safety and standardisation requirements, as a means to assure users and to protect them from the potential dangers that are both inherent to the 'natural' herbs but also augmented by industrial production practices in the form of contamination and adulteration risks. If we look at the past few decades worth of measures to regulate the production and sale of herbal medicinal products in the United Kingdom, it is clear that safety and quality concerns have been at the fore, much more so than the purported (lack of) efficacy of these products. In the wake of increasing sales of herbal medicine products and in contrast to claims of a gentler, kinder and more natural herbal medicine, regulatory

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authorities are increasingly advising consumers, firstly, that ‘natural does not necessarily mean safe’ and, secondly, that in some cases these medicines are turning out to be ‘not so natural after all’. A report from the UK Herbal Medicine Regulatory Working Group outlines the reasons why:

For a long time... medicines law... left herbal medicine essentially unregulated in terms of quality and safety... But in recent years, along with a rapid expansion of the herbal sector, questions have arisen about the quality and safety of some herbal products. These questions have been variously associated with (a) adverse effects resulting from the inherent toxicity of certain herbal ingredients (natural does not always mean safe); (b) misidentification or substitution of one plant species for another, in some cases leading to the substitution of a safe with a toxic species; (c) adulteration of herbal medicines with prescription-only drugs or heavy metals; (d) microbial or fungal contamination of herbal remedies; (e) discovery of possible herb-drug interactions which may interfere with or confuse the results of treatment; (f) insufficient information provided to the consumer concerning the safe use of a herbal medicine (Great Britain. Department of Health. European Herbal Practitioners Association. Prince of Wales's Foundation for Integrated Health. 2004: 142).

And so, in the ways outlined here, the industrialisation of herbal medicine has certainly played an important role in the late twentieth century revival of herbal medicine, quite

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tangibly so as sales figures of herbal medicinal products are often used to verify the revival. At the same time, for many practicing herbalists, this drift towards what is seen as 'rational phytotherapy' is something to be worried about. In many ways this tension is not resolvable, for how can an urban herbalist ensure quality when relying on medicinal plant products which may come from any corner of the world rather than on self-procured plants 'from the wild'? Ready-made tinctures, capsules or tablets are no longer 'raw materials' but rather are 'herbal medicinal products' and as with any other mass-produced product, quality control is key. Herbal pharmacopoeias increasingly provide the technical details that can allow for a laboratory-based form of quality control and in the process they often identify particular active ingredients found in a plant as important markers for quality, even if herbalists insist that whole plant extracts rather than single active ingredients are the key to ensuring safety and efficacy. As a result, the rationalisation and scientificisation of herbal medicine is seen as necessary for a modern, urbanised United Kingdom by some and lamented by others who are concerned about a 'hollowing out' or 'reduction' of an 'authentic' and/or 'ancient' form of herbal medicine that is based on whole plant extracts.

### **Documenting Wisdom: the Rise of Ethno-knowledge**

Yet, as already noted the formalised and rationalised practice and production of herbal medicine in Britain has only ever been one part of the story when it comes to herbal remedies and healing. Indeed, for a long portion of the past two centuries it has arguably been the least important part, since especially rural populations in the nineteenth and early twentieth centuries were often mostly self-reliant when it came to their daily

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medical needs (Hatfield 2005). Plants have long been the most important component of what Hatfield calls 'domestic medicine' which she describes as a 'do-it-yourself collection of first aid [for] mostly ordinary, often illiterate, country people' (2005: 9-10). While important components of the herbal medicine revival have been increasing formalisation and rationalisation of its practice and production as we saw above, the majority of people who have used plants as medicine in the United Kingdom have not sought out trained herbalists for consultations, instead they have relied on family remedies which were often orally passed down through the generations or perhaps recorded in ad hoc kitchen books which remained within families (Griggs 1997; Hatfield 2005). Even in contemporary urbanised Britain it is striking to note that in recent surveys while some 7% of people claim to have used herbal medicine in the past 12 months, only about 1% say they have visited a herbalist for a consultation (House of Lords 2000: 1.17; O'Sullivan 2005: 184).

Still, it remains important to distinguish between an approach to herbal medicine where individuals get their remedies either through herbal consultations or more likely over-the-counter from high street outlets on the one hand, and an (albeit 'dying') domestic medicine on the other. On the urban front, it is interesting to note that the medical herbalist is highlighted as an expert who can assist otherwise unknowing consumers. For example, in a 2002 BBC interview then NIMH President Trudy Norris cautioned that:

What we are concerned about is that lots of people self-prescribe in an inappropriate way... We are not against commercial herbal remedies bought

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for self-medication, but urge people to find out as much as possible before self-prescribing. In the market place matters of health and illness can create vulnerability. The practitioner's main focus is the actual health needs of the patients over and above any consideration of profit. This can not always be said of the entire supplement market (BBC News Online 2002).

Since then, an annual Herbal Medicine Awareness Week has been organised, a Herbal Health Advice Line has been opened to allow members of the public to get in touch with a local medical herbalist for expert advice, local walks with qualified herbalists to learn about the properties of medicinal plants growing in the UK have been organised, and a revised edition of the booklet *Making Sense of Herbal Remedies* has been published advising consumers to choose their products carefully and to always seek advice from a qualified medical herbalist when in doubt (NIMH 2004; Norris 2004).

When it comes to domestic medicine, a much more profound transformation took place in the twentieth century, the effects of which can still be witnessed today. What Hatfield refers to as 'domestic medicine' would be called 'folk medicine' by many. But her choice of terminology is not accidental: 'the very word 'folk' has come to have a patronising ring to it, and too often accounts of folk medicine concentrate on the bizarre and the fanciful. This has built up a picture of folk medicine as a collection of odd anachronistic rituals, practiced by the ignorant and superstitious' (2005: 5). For Hatfield, nothing could be further from the reality of rural Britain, as she has worked to systematically document how domestic medicine in fact 'represents the essence of plant wisdom of many centuries, and it is our loss if we dismiss this wisdom too lightly' (ibid.).

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It is only in very recent years through the efforts of ethno-botanists such as Gabrielle Hatfield and David Allen as well as through multi-disciplinary initiatives such as *Remembered Remedies* and *Plant Cultures*, that ‘folk’ or ‘domestic medicine’ has come to be approached as a national treasure, as something with a value for the nation and therefore as something worth saving before it is lost to an increasingly urbanised, industrialised and globalised world. In 1999, a number of researchers from the Royal Botanical Gardens at Kew, the NIMH, the Herb Society, the Chelsea Physic Garden and Neal’s Yard Remedies joined forces to form a research group called Ethnomedica. A few years later this group launched an urgent new programme which they called “Remembered Remedies – Researching the Herbal Traditions of Britain”. Their rationale for doing so was clear:

150 years ago Britain was still mainly a rural society. Lives and activities were defined by the seasons and everyone knew the names and uses of several common wayside plants. Within two generations of the industrial revolution most of the population had moved into cities. As people developed an urban lifestyle they lost contact with the land and their practical herbal traditions. Not just forgotten but no longer accessible – where was the nearest dandelion, dock, healing tree or stream for watercress?...The loss of local knowledge – be it about plants or anything else – is one of the side-effects of globalisation and rapidly changing societies. While this issue is recognised in the tropics, and is receiving a lot of attention from those concerned with development and the conservation of cultural and biological diversity, it is not

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the case here at home. The UK has long been industrialised and ranks among the most developed of regions. Yet studies have shown that fragments of knowledge passed down through a long oral tradition still exist among older people. Its value increases the more it is lost as time passes. (Ethnomedica 1999)

How then has it been possible for what, for many decades, were considered the old wives' tales, superstitions or folk beliefs of ignorant rural people to be transformed into a valued national resource worth documenting for posterity? To answer this question it is necessary to recount two crucial events within the discipline of anthropology in the twentieth century for reasons which will become clear in the following. The first concerns an epistemological break with nineteenth century evolutionary anthropology (see Wahlberg 2008a), and the second concerns the emergence of new methodologies with which to verify this break.

What is sometimes referred to as Victorian anthropology was informed and organised by an evolutionary logic. According to Spencer, Lubbock, Morgan and others, the world's peoples could be classified and ranked according to their collective states of maturity – e.g. civilised, barbarians, savages. The child-like simplicity and ignorance of the savages, it was argued, was demonstrated by their rudimentary tools, 'mono-syllabic' languages and animistic religions (Wahlberg 2007a). Accordingly, what was described as 'primitive medicine' was seen as nothing more than superstitious ritual with little 'true' health benefits resulting for the 'savages'. By the turn of the twentieth century, however, this logic came to be disputed by a new kind of anthropology which was based on

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cultural immersion and ethnography. Rivers, Malinowski, Boas and many others would reject the hypothesis that ‘savages’ were immature and simple, arguing instead, based on their in depth field observations, that their practices and rituals were highly rational and informed by as complex a reasoning as that which could be found in the ‘West’. What was different was the worldviews or lifeworlds of people living in different cultures across the globe. As argued by WHH Rivers: ‘the practices of these peoples in relation to disease are not a medley of disconnected and meaningless customs, but are inspired by definite ideas concerning the causation of disease’ (1924: 52; 51), and Erwin Ackerknecht: ‘primitive medicine is not a queer collection of errors and superstitions, but a number of living units in living cultural patterns, quite able to function through the centuries in spite of their fundamental differences from our own pattern’ (1971: 120).

What these and other twentieth century anthropologists needed then were new methodologies for accessing the lifeworlds, ideas and cultural patterns of the ‘savages’. As a result, throughout the twentieth century ethnographic methodologies of participant observation, in depth interviewing and overall immersion were developed and refined as a means of accessing the worldviews of those peoples whose history was not documented in any archive – in Malinowski’s famous phrase, the goal was ‘to grasp the native’s point of view, his relation to life, to realize his vision of his world’ (1922: 25). At the same time, and in tandem with these developments in anthropology, the twentieth century also saw the rise of a whole range of new ethno-disciplines, from ethno-botany to ethno-pharmacology and ethno-ecology. What makes them ‘ethno’ sciences is their common focus on culturally transmitted traditional knowledge not only as a matter of cultural heritage, but also as an important ally in the search for ecologically, industrially and/or

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medically relevant plants or minerals. Their task is to document, through interviews, oral histories and participant observation, how certain groups or cultures use the flora and fauna around them for medical and other purposes.

Now, these two anthropological events have certainly had an effect in the British context when it comes to herbal medicine. To begin with, as suggested by Hatfield, it is not only the ‘savages’ of faraway lands that have been considered ‘simple’ and ‘ignorant’ through the past centuries. Rural people in so-called ‘civilised’ countries have often been described in similar terms when contrasted to the ‘educated’, ‘civilised’ elite of the urban centres. It is these ‘country people’ who were seen as clinging on to outmoded, superstitious or backward healing remedies. So much so that, ‘in our present century, elderly people with knowledge [of domestic medicine] usually have not passed it on to the next generation, for fear of being laughed at, or simply because they feel such information is not of interest to anyone’ (Hatfield 2005: 12).

For projects like *Remembered Remedies*, it is exactly this information that is of great value and interest. In the three-year period 2003-2006, over one thousand records of medicinal plant use were gleaned from oral histories and survey cards that had been distributed widely by groups of researchers as well as by the Kew gardens. The Ethnomedica research group has trained over 40 volunteer collectors through specialised training courses: ‘The art of taking and recording an oral history is a specialized skill. It is more than listening, it is the task of hearing everything and collecting the details without prejudice or the need for them to make immediate sense; encouraging memories and reminiscences without leading’ (Ethnomedica 1999). The information collected so far has been collated and organised, allowing researchers to produce a list of the top 20

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most-mentioned plants (see Table 1). These included feverfew, dock, comfrey, onion, sage and nettle. Scientists at Kew gardens have also been able to use the information gathered as a means of screening potential plant candidates for further phytochemical research into therapeutically active compounds. For example, Professor Monique Simmonds of Kew gardens explains that ‘sage is a herb that has been connected with wisdom down the ages, and now for the first time we can see whether it really helps with cognitive ability, or memory’ (cited in Revill 2005).

**Table 1: Top 20 plants recorded by Ethnomedica 2003-08**

Plant	Main use
<i>Rumex</i> – dock (377 records)	Stinging nettle
<i>Allium cepa</i> – onion (187 records)	Antibacterial
<i>Urtica dioica</i> – nettle (147 records)	Tonic; Rheumatism
<i>Symphytum officinale</i> – comfrey (126 records)	Bruising; bones
<i>Sambucus nigra</i> – elder (123 records)	Coughs and colds
<i>Taraxacum officinale</i> – dandelion (116 records)	Warts
<i>Tanacetum parthenium</i> - Feverfew (78 records)	Migraine
<i>Brassica oleracea</i> – cabbage (71 records)	Mastitis
<i>Chamaemelum nobile</i> (65 records)	Sleep
<i>Citrus limon</i> – lemon (59 records)	Coughs and colds
<i>Allium sativum</i> – garlic (57 records)	Antibacterial
<i>Lavandula x intermedia</i> – lavender (57 records)	Insommnia
<i>Salvia officinalis</i> – sage (56 records)	Sore throats
<i>Aloe vera</i> – aloe (48 records)	Skin ailments
<i>Solanum tuberosum</i> - potato (47 records)	Burns; Warts
<i>Zingiber officinale</i> - Ginger (37 records)	Stomach problems
<i>Rubus idaeus</i> - Raspberry (37 records)	Childbirth
<i>Sempervivum tectorum</i> - Houseleek (31 records)	Burns; Sore eyes
<i>Vicia faba</i> - Broad Bean (27 records)	Warts
<i>Petroselinum crispum</i> - Parsley (26 records)	Breath freshener

Source: [www.kew.org/ethnomedica/](http://www.kew.org/ethnomedica/)

Another project, *Plant Cultures*, is similarly using interviews and oral histories to document the uses and meanings of South Asian plants because ‘Asian food, medicine, religion, music and film have all had a big impact on Britain’s cultural landscape [and] British Asian communities form over 4% of the population of England and Wales, and

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over 25% of the population of cities such as Leicester' (Plant Cultures 2007). The project has listed 25 of the most popular plants such as chilli pepper, coconut, curry leaf and neem with descriptions of their medicinal uses as well as narratives from British Asians on how their families have used them.

And so, we can see how in Britain ethno-sciences have been deployed as a specific means to document, organise and archive for posterity the kind of information about the medicinal uses of plants that is otherwise seen as at risk of being lost as yet another side effect of globalisation and modernisation processes. These ethno-sciences have relied on a range of methodologies which all have in common the targeting of everyday peoples' 'ideas', 'beliefs', 'memories' and 'wisdom'. This task has been cast as an urgent rescuing mission that, for every day that passes, is becoming more and more pressing. Informal herbal medicine use has become a national resource which a number of researchers and projects are now actively trying to chart out and document. Old wives' tales have been transformed into oral histories.

### **Conclusion: Modernisation and its Side Effects**

It was the philosopher Michel Foucault who once argued that the 'blackmail' of the Enlightenment has led to a rather dichotomised *impasse*: you are either 'for' or 'against' it; 'you either accept the Enlightenment and remain within the tradition of its rationalism, or else you criticize the Enlightenment and then try to escape from its principles of rationality' (Foucault 1997: 313). Perhaps this is Western herbal medicine's dilemma today. On the one hand, there can be no question that if there has been a late twentieth century herbal medicine revival in the United Kingdom as is often claimed, then this

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revival has in large part been facilitated by the formalisation of its practice, the modernisation of its production and not least the rationalisation of its use. As pointed out earlier, for some this has been a necessary adjustment to the comprehensive social transformations that have occurred in the United Kingdom following two centuries of urbanisation, industrialisation and most recently globalisation. Yet for others, these developments are a cause for deep concern, especially if they lead towards a 'reductionist' and 'dehumanised' form of herbal medicine where herbs become 'mere' pills to be taken as quick fixes.

Some might argue that a way to bypass this formalisation and rationalisation is to go 'back to the roots' of herbal medicine and seek out and rescue the 'original' country remedies and folk recipes that have been used for centuries by especially rural peoples. Yet, we must as a minimum, ask ourselves whether such a project to rescue folk remedies can avoid the blackmail of the Enlightenment. For, is not the effort to meticulously and systematically document domestic medicine using ethno-methodologies not contributing to its disciplining and rationalisation? Is it possible to 'merely' document when such knowledge is, for example, to be incorporated into pharmacological research into the active ingredients of some of the most commonly used medicinal plants? And what of those herbal medicine practitioners and users who resist efforts to formalise and rationalise it? Are they to be seen as hindrances to an inevitable progress or as persons with genuine concerns about the directions that herbal medicine is taking in the British Isles? These are the kinds of challenging questions that are being debated today, by herbal practitioners, regulators as well as lay users of herbal medicines, and we can be

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sure that the dilemmas of modernisation are unlikely to be entirely resolved any time soon.

What I have, nevertheless, shown in this chapter is how the late twentieth century revival of herbal medicine is perhaps more accurately accounted for and described as a re-invention of herbal medicine. Today's herbal medicine is certainly not that of Culpeper's or Coffin's day. Not only is herbal medicine practiced and used in an entirely different socio-economic and epidemiological context today, it is also subject to 'globalising' forces and influences from other traditions of herbal medicine to a much greater extent. As a result, indigenous herbal medicine in Britain has recast itself as 'Western herbal medicine'. Even if this term has by now lost much of its salience due to various global influences, it nevertheless remains in use as a way to distinguish it from Chinese, Ayurvedic or Tibetan herbal medicine. This re-invention has not so much been some kind of an ideological shift, rather it is best described in terms of its mundanity; that is to say in the various practices of formalisation (such as the moves towards statutory recognition), rationalisation (such as the transformation of herbals to pharmacopoeias) and documentation (such as the ethno-botanic efforts to chart domestic medicine in the UK) that have made it possible.

### **Endnotes**

[1] I owe this term to Sue Evans, herbalist and lecturer in herbal medicine at the Southern Cross University who informs me that the phrase is often used in reflexive discussions amongst herbalists in Australia concerning how to be an 'urban herbalist'. The term refers to the alcoholic extracts of plants which are often stored in and dispensed from

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dark glass bottles. I am also grateful to Nina Nissen for pointing out that in the United Kingdom many urban medical herbalists would certainly not consider themselves a 'black bottle herbalist' and indeed they often specifically distinguish themselves from those 'phytotherapists' who might rely on such extracts (more on this later).

[2] For example, Barbara Griggs's classic *Green Pharmacy* (1997) was originally subtitled "a history of herbal medicine" in 1981 but by its 3rd edition in 1997 this had been changed to "the history and evolution of Western herbal medicine". See also Holmes's *The energetics of western herbs: integrating western and oriental herbal medicine traditions* (1989) which was one of the first published works to distinguish between western and Chinese herbal medicine in this way. 'Western herbal medicine' often refers to that form which is practiced in North America, the British Isles, Australia and New Zealand, although such a distinction has become increasingly fluid and blurred in recent decades with global influences.

[3] Compare this to the preamble of the 1858 Medical Act which states that 'it is expedient that Persons requiring Medical Aid should be enabled to distinguish qualified from unqualified Practitioners' (Great Britain. Parliament, 1858).

[4] To the great frustration of herbalists, as Brown reflects citing the president of the Association who in 1927 lamented that: 'there have been occasions when depression has seized me, and I have realised how powerful are the forces arrayed against us' (Brown 1985: 86).

[5] The College of Practitioners of Phytotherapy was originally named the School of Herbal Medicine, then the College of Herbal Medicine, then the College of Phytotherapy until finally settling on its current name in the mid 1990s. My thanks to Nina Nissen for

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reminding me of these name changes which in themselves indicate some kind of movement.

[6] For indigenous British, Chinese and Ayurvedic herbal practitioners.

[7] As was the case in the UK, the 1965 European Council directive on medicinal products sparked a national review of medicines regulation in Germany, eventually leading to the passing of a Second Medicines Act in 1976. In order to ensure that all medicines sold on the German market were in compliance with this new act, the German Federal Institute for Drugs and Medical Devices (BfArM) established 15 commissions to review available quality, safety and efficacy data, the so-called Commission E being responsible for the review of herbal medicines.

[8] See Timmermann (2001) and Kenny (2002) for discussions on how companies like Madaus, supported by the National Socialist regime took the lead in researching and industrially developing herbal medicines.

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