Towards a transcultural medicine: Reflections and proposals based on the experience in Takiwasi[1]

Jacques Mabit Bonicard and Jesús M. González Mariscal[2]

This article is based on the conference paper "Articulation of Traditional Medicine and Western Medicine: The Challenge of Coherence"[3] that Dr. Jacques Mabit presented at the Regional Seminar-Workshop on Public Policies and Experiences in Health and Interculturality, organized by the Ministry of Public Health and the Development Unit of the North, in Quito, Ecuador June 2004.

Abstract

The current picture of medicines in a globalized world in crisis invites us to reflect on how different logics of tradition and modernity match or disagree in the field of health. Traditional indigenous medicine, where shamanism often plays a key role, appears at this juncture as a salient environment for the analysis and production of new models of health and well-being. This paper presents an explicit proposal for intercultural dialogue in order to open a transcultural paradigm for building a medicine to meet the new challenges of contemporary societies. The main elements of this proposal are necessary epistemological reflection, the analysis of the social reality and implicated power relations, ethics, and the logic of articulation and openness to the complexity of the human being and to life.

Keywords: interculturality, shamanism, traditional medicine, epistemology, transcultural.

Introduction

Takiwasi is a pioneer center in the construction of an intercultural therapeutic model for the treatment of addictions. A multidisciplinary team of doctors, psychologists, and traditional healers work together to restore the health of patients who come to this Therapeutic Community (TC) in the Peruvian Amazon. Its founder and current president Jacques Mabit, a medical doctor from the University of Medicine and Medical Techniques of Nantes (France), studied Tropical Pathology in Belgium (IMT- Antwerp) and Naturopathy in an academic program of the University of Paris XIII (Bobigny). The latter two specialties allowed him to begin establishing closer relationships with traditional medicine practitioners from countries in the Global South. In the framework of a Franco-Peruvian cooperative agreement, he worked for 3 years (1980-83) as director of the hospital of Lampa, a small village in the Peruvian Altiplano. Due to the extreme logistical limitations and lack of human and technical resources of the hospital, he was compelled to turn to local resources available outside the health institution. There he discovered the richness of traditional indigenous medicine of Peru. He became part of a Multisector Health Committee that articulated actors proceeding from different professional areas (e.g., agriculture, justice, education, etc.) and socio-cultural backgrounds (indigenous Quechua, Caucasians, mestizos, men

[1] Original article: *"Hacia una medicina transcultural: Reflexiones y propuestas a partir de la experiencia en Takiwasi",* Published in Journal of Transpersonal Research, 2013, Vol.5(2), pages 49-76. Translated from Spanish by Fabio Friso, reviewed by Olivia Marcus.

[2] Takiwasi Center, Tarapoto, Perú. See authors' biographies at the end of this article.

[3] Original title of the conference: *"Articulación de las Medicinas Tradicionales y Occidentales: el Reto de la Coherencia".*

and women, peasants and professionals, etc.). Afterwards, Dr. Mabit wrote his thesis for the Doctorate in Medicine on the basis of this experience, developed within the guidelines of Primary Health promoted by the WHO. Thanks to this experience, and the dialogue and work shared with healers, midwives, bonesetters and other specialists, he discovered the efficacy and efficiency of their knowledge, as well as their expertise in the respective fields and the authentic service provided to the communities. At the same time, he recognized that these traditional knowledges, whose results he could directly verify, did not correspond to nosographic, diagnostic or therapeutic categories transmitted by a Western academic education. Rather, these traditional concepts and practices were placed in a kind of blind spot, an area ignored by western medicine.

After the experience in Peru, he was put in charge of some evaluation missions of health projects on behalf of several European NGOs. Through this charge, he visited and worked in depressed areas in several countries (Burkina-Faso, Tunisia, the Philippines, Bangladesh, among others), where he continued to recognize the presence and relevance of traditional medicine in various cultural forms. In each case, traditional healing techniques represented an essential resource for local populations.

In 1986, he decided to start a personal exploration of the practices of traditional medicine, having found that anthropological reports were not sufficient in accounting for the efficacy of these practices. In some cases, traditional practices even fell into contempt or were reduced to being characterized as mere 'local beliefs' without major significance on health outcome. For this work he chose the to establish himself in the Upper Amazon Basin of Peru, introducing himself to the teachings of the master healers of this region, starting with the mestizos and indigenous *Quechua Lamistas* and *Chazutino*s in the region. After 6 years of full-time dedication to the learning and self-exploration of this knowledge, he decided to found a center that could demonstrate the possibility of efficiently articulating western knowledge and indigenous knowledge.

Dr. Mabit observed that local drug addicts, often indigenous young men trapped in drug abuse, turned to local healers to get cured. The department of San Martín was known to be the first area for production of toxic derivatives of the coca leaf and drug trafficking in the whole of Latin America in the 1980s. A large portion of the population of San Martín was captured by drug addiction, a pathology that was culturally unknown to the region before the coca boom. Surprisingly, traditional doctors adapted their practice to this new evil, using various detoxifying medicinal plants and some others plants with psychoactive effects such as ayahuasca. Dr. Mabit found himself facing a completely different approach to the treatment of drug addiction, one that considered that the modification of states of consciousness not as negative in itself, but potentially extremely therapeutic, depending mainly on the modality of induction. With an awareness of the awful results that often come with conventional addiction treatments, he decided to choose drug addiction a focal point to demonstrate the importance of and interest in the articulation between different medicinal practices. As a result, the Takiwasi Center for the Rehabilitation of Drug Addicts and for Research on Traditional Medicines was legally constituted in 1992 as a therapeutic community recognized by the Ministry of Health of Peru.

In addition to receiving addicted patients in a residential treatment modality (about 1000 to date), Takiwasi progressively implemented seminars and *dietas*, with the idea of offering a sensible response to the growing interest in the field of shamanism and sacred plants. People from diverse backgrounds come to Takiwasi in search of self-knowledge and in the therapeutic model they find some sort of "initiation" to the discovery of their inner worlds. While patients, seminar and *dieta* participants, and visitors who get in touch with the center throughout the year come from very diverse backgrounds, the majority are from Latin America and Europe. Thus, Takiwasi has become an international reference for people who want to know the shamanism of the Upper Amazon Basin in a safe, reliable, and honest context, where a team of doctors, psychologists and

healers work together to offer a respectable expression of the encounter of different medicines. In addition, Takiwasi has organized several meetings between master healers from different regions, gaining significant relevance in the world of traditional medicine in Latin America (see Annexes 1 and 2). For example, in October 2013, Takiwasi brought together researchers, psychiatrists, physicians, anthropologists, psychologists, and other experts in health and shamanism for the construction of the first scientific research protocol on the effects of the use of ayahuasca and traditional Amazonian medicine in the treatment of addictions.

Current panorama of the fields of medicine

The great advocate for traditional medicines in Peru, Dr. Fernando Cabieses (2003), neurosurgeon and founder of the National Institute of Traditional Medicines of the Ministry of Health of Peru, warns us that the question of the integration or articulation of Traditional medicines with public health is a field that has to deal with dogmatic confrontations, long-established interests and angrily disputed territories. We are, from the beginning, face to face with a political minefield.

To understand the difficulties of this complex territory, the first theme to take into account is the illusory nature of the two supposedly fixed and delimited fields of Traditional medicine and Western medicine. We understand that both categories are composed of practices and concepts that flow beyond the boundaries of these categories. Although this dichotomy serves as a didactic reference, their borders in fact always appear diffuse, imprecise, ill-defined, and rather than stable are in continuous movement, being crossed by an incessant dialogue. As a principle, medical systems are dynamic: all forms of therapeutic practice evolve, add new knowledge, modify others, and abandon what they consider obsolete. Further, traditional medicines are marked by a plural character due to the diversity of their manifestations, as well as to the different conceptual frameworks that contain them, even within the same national territory. In reality, there is no clearly defined category that can be called "traditional medicine"; thus, we should speak of "traditional medicine" as an always open, dynamic, and unfinished concept.

On the other hand, modern medicine is generally associated with the dominant allopathic model, although we increasingly see how non-allopathic practices are being introduced in state hospitals in Western countries (Di Raimundi, 2013). Several doctors trained in the allopathic school system add unconventional postgraduate courses to their training, opening a gap in the internal logic of their initial conceptions. What we call ‘modern’ medicine, however, is inherited from generations of traditional medicines of different origins, ranging from Celtic to Arab, nurturing even on the botanical knowledge of the American shamans (Furst, 1976, Cabieses, 2007, Schultes and Hoffman, 2002). The list of "parallel" or "alternative" medicines encompass more than 300 disciplines in the new guide published by the United States National Institute of Health (NIH). An increasing number of allopathic doctors articulate other therapeutic specialties, such as homeopathy or neural therapy, with their mainstream allopathic resources, despite belonging to different conceptual models. What to think when a conventional doctor practices a traditional medicine from another culture (such as Chinese acupuncture) in an ultra-modern clinic? Or when a dentist uses hypnosis to anesthetize his patient?

In the same way, we find therapists from Western countries that have turned to shamanism, *curanderismo*, or indigenous traditional medicine to enrich their conceptions of health and disease, which often in turn enrich their therapeutic practices (Nathan 1999; Coppo, 1999; Abbott and Hui, 2010). However, in the face of this hybrid, dynamic reality, there are continuous absurd attempts to set precise limits to be able to express, on top of that fantasy, radical discourses. The simplistic concepts of radicalism always require a dual system that allows demonizing or idealizing the "other" under the rules of the projective game. The temptation of oversimplification stems from mental rigidity and it often comes from fear of change, of openness, of the

inexhaustible genius of life that laughs at schemes and closed systems. To build a way of thinking open to complexity, articulation, association, connection, and integration of dynamic systems into a vital ensemble, the worst enemy is mental rigidity and the underlying fear of the new, the evolving, the unceasing change of life. In an operation of this magnitude, nobody will get out unharmed or completely intact. To abandon dogmas leads us to encounter the position that sustains us in front of a chaotic, relative world that is in a constant process of creation.

Along this path we can glimpse a new horizon of the articulation process that we call interculturality or transculturality. While interculturality allows us to cohabit with different and even contradictory paradigms, which does not cease to be a quite difficult and sometimes exhausting balancing exercise, we want to highlight the contemporary need to go beyond "culture" to find ourselves in the realm of what is purely human and transcultural. What unites us beyond cultural forms? What makes us belong to the same human family? What defines us as humans? What medicine can be conceived beyond cultural borders, without the need to erase them, in order to reach the fundamental substrates of our deep nature as living beings, spiritual beings, transcendent beings? Beings endowed with intelligence?

The great challenge involves giving birth to a new paradigm fertilized by both the "traditional" and "western" models, with all the previously discussed nuances (Llamazares, 2011). We consider that for this it is necessary to work in at least two complementary levels: at the individual level, where each person has to face the internal rigidity that contributes to blocking the emergence of new, inspiring forms of life and collective health; and at a conceptual and global level, for the identification of the collective unconscious dogmas that individually govern our thinking and acting (and our medicines in this particular case). In this way, we can discover the convergent spaces between the different paradigms and make the qualitative leap of consciousness, both individually and collectively, that will allow us to leave our permanent state of ignorance.

The necessary connection: confrontation or articulation?

In spite of the previous reflection on the difficulties involved in the strict categorization of different medical practices, for the sake of language and didactics we will assume that there are essentially two main currents: Western medicine and Traditional medicine.

In general terms, Western medicine corresponds to developed countries and Traditional medicine to developing countries (Pérez and Argueta, 2011). We want to make two remarks on this topic. On the one hand, the differentiation between regions based on the supposed levels of economic development presents contradictions and weaknesses. This approach is built on the myth of permanent development and of endless progress, one of the main axioms of Western thought (Iggers, 1965). We now know that Western-style economic growth cannot be applied throughout the planet due to its high social, energy, and ecological costs. Moreover, the proposals of "sustainable development" are moving towards the "necessary decrease" of the westernized societies to avoid the exhaustion of the planet's resources (Latouche, 2003). Nevertheless, it is generally believed that western medicine is more developed than traditional medicine and, therefore, that traditional medicine only survives by the state of "backwardness" in a process of inevitable "development" (Martin, 1990). In this way, it is only a matter of time before Western medicine takes the place of traditional practices, considered the remains of ignorance and underdevelopment. As a consequence of all this, the people who propose to pay attention to traditional medicines often are considered retrograde and, in the case of being Westerners, they will be suspected to want to maintain intentionally the "backwardness" of the people of the Global South, denying to them access to modernity.

We want to point out the conceptual mistake that consists in believing that traditional medicines are defended and chosen because of deficiencies in economic or technical capacities. This model assumes that modern medicines represent the ideal, obvious, and natural end of the evolution of medicine. Let's briefly see what is the current situation of Western medicine and its relation to the myth of the endless progress in which it is conceived. We will give only a few brief hints, despite that the subject merits a long discussion with detail.

First, the idea of Western medicine as an attribute of the 'first' and 'second' world, while the third world has to be satisfied with indigenous "backward" practices, no longer fits with the new conceptualization of "world" economies since the notion of a "fourth world" emerged in the in the 1980s (Wresinsky, 1987). The so-called fourth world is constituted by millions of people with no job and in a material situation of extreme precariousness. These are people who do not have easy access to modern health services because they are not within their reach. Paradoxically, in the United States, 40% of the population cannot access the most advanced medicines (Wilkinson, 1996).

The weakening of the human provoked by the Western lifestyle, which is extremely stressful and perverse, generates a growth of 15% every 10 years in neurodegenerative and immunodeficiency pathologies (e.g., cancer, autoimmune diseases, AIDS, Alzheimer, Parkinson) (Pritchard, Baldwin and Mayers, 2004; Grosman, 2011). This neurophysiological weakening causes a recrudescence of emerging infectious diseases; for example, a study by Jones et al. (2008) published in *Nature* emphasizes that the prevalence of these conditions have multiplied by 4 in the last 50 years, with a significant acceleration since the 1980s. Furthermore, the collapse of the "ground" resistances of the modern citizen who is exposed to increasing forms of environmental toxins (chemical, electro-acoustic, sound, visual, psycho-emotional) facilitates the emergence of several previously unknown and noninfectious pathologies that nevertheless fit now in the category of emerging diseases, thus leaving patients without a satisfactory therapeutic response (Cambayrac, 2007). Without effective treatment of these pathologies, the prescription of anti-symptomatic palliative medicines (e.g., analgesics, psychotropics, and corticoids) is increasing, all the while generating ever-growing dependencies. The degradation of physiological functions leads millions of people around the world to a permanent state of dependence on drugs, with prescription drugs being the second source of addiction after cannabis on a global level. It is this part of population that recently has been characterized as the "fifth world". The physiological misery is no longer an exclusive of the undernourished people of the Global South, but it also involves the malnourished people of the North.

Another dramatic result of western medicine is iatrogenesis, or the harmful consequences of medical practices, which reaches incredibly high numbers. For example, in the geriatric department of the Hospital of Nancy in France, it is estimated that 50% of the elderly suffer some sort of complication due to previous treatments. In the emergency services of England, between 18 and 25% of cases are due to the effects of misused medications (overdoses, alcohol mixtures, etc.). It should also be noted that these official numbers probably underestimate the real extent of the events. Surgical services, with their heavy emphasis on asepsis, induce the evolution of extremely aggressive and treatment-resistant germs, which have become one of the greatest risks for serious over-infection (sepsis). Nosocomial (hospital) diseases are experiencing a real boom, representing 20% of the 335 emerging diseases studied by Jones and colleagues (2008). Starfield (2000) states that in the United States there are 225,000 to 280,000 deaths per year attributed to iatrogenic disease. Medical practice is the third cause of death in this country, to which must be added other debilitating consequences such as disabilities, chronic pathologies, or dependence on prescription drugs. The same author points out that 20 to 30% of medical prescriptions are contraindicated. In view of these data we can affirm that modern medical practice undeniably generates high social and economic costs.

Abysmal expenses of Western medicine are so high that developed countries themselves are not able to afford them (Grosman, 2011). Health costs have increased by 2000% in the last 50 years in the United States (Schieber et al., 2009). Medical insurance services are becoming increasingly exclusive of 'high-risk' populations, often refusing to enroll people who suffer from chronic pathologies that cannot be cured by modern therapeutics, such as degenerative diseases, drug addiction, and mental illness. When not refused, these populations pay a dramatically higher premium for their healthcare costs.

About 30 years ago, people of developed countries began to mistrust the promises of the medical system, especially because of the unfulfilled expectations regarding certain diseases such as cancer, which kills one of every four people in Western countries and at a global level is responsible for 13% of the death rate (Jemal et al., 2011). Every 5 or 10 years the propaganda-driven medical community announces its imminent solution: cancer is said to be of infectious origin, then viral, then genetic. However, general cancer mortality continues to increase while cases are declared among ever-younger populations, and the techniques for treatment remain a resounding failure in many cases (Morgan, 2004). The suspicion that western medicine does not hold all the answers is culminating into a forceful rejection by ever-growing parts of the population. In the case of vaccination, for example, there is growing support among active associations that refuse to accept mandatory administration, since benefits have not been scientifically proven. For example, Narayanan (1999) questions the effectiveness of the BCG vaccine against tuberculosis, which is based on distorted or incomplete data, and for which the protocol for administration has changed. Historical and epidemiological studies indicate that tuberculosis began to decrease since 1880 in Europe thanks to positive changes in environmental conditions such as improved ventilation and sun in rooms, augmented sanitation systems, clean drinking water, and better nutrition, long before the introduction of the anti-tuberculotics (Hargreaces, 2011; McKeown, 1979). When these medicines appeared in the 1940s, the decrease in the incidence of TB did not accelerate, but rather followed the movement initiated previously. Indeed, due to drug resistance and socio-environmental factors, TB cases have started to grow again in developed countries despite vaccinations.

The "appearance" of AIDS raises enormous suspicions since the nosographic description does not correspond to a new disease but to a new association of already known symptoms. Can the considerable economic investment that this represents – the largest in the history of medicine – justify the fact that all the requirements of a serious scientific investigation have been avoided to the point that today there is not a single study that demonstrates the cause-effect relationship between HIV virus and the manifestation of immunodeficiency in patients? (Duesberg, 1996). Or that they intend to present old medicines of the 1960s, such as AZT which was rejected because of its high toxicity, as new innovations against the AIDS virus? Or that we accept an infectious explanation that puts all the immunology upside down (up to now the seropositivity indicated a protection against the virus and not a lack of protection towards it)? (Giraldo, 2002).

The many patients who ask their doctors for a less aggressive treatment and refuse to take antibiotics for every cold has led to the search for "mild" medicines. In 2002, the WHO noted that half of the population in France or Australia turned to complementary medicine at least once, while up to 70% of the population resort to these alternatives in Canada (WHO, 2002). The demand for medicinal plants is regaining great vigor, despite the fact that there has been an attempt to eliminate herbalists' shops. There is no doubt about the renewed interest by western users in phytotherapy: the South-North trade exchange in medicinal plants grew from 100 million US dollars in 1979 to 6billion in 1994 and to 35 billion in 2003 (Cabieses, 2003). The large pharmaceutical laboratories already anticipated this movement and, curiously, they were equipped with phytotherapeutic drugs' subsidiaries (Cabieses, 2003).

The discovery of new molecules by the classical selection system (screening) has become extremely expensive (Orlando, Abreu, & Cuéllar, 2008). It takes about 10 years of research and 150 million US dollars to put a new certified product on the market (Goozner, 2005). Only a few large companies can take on this effort that often exceeds the capacity of the governments' budget. To cut costs, laboratories have created a new type of "explorer" that travels through the jungles of the South of the world looking for information about traditional medicinal plants from the people who use them. This indirect recognition of traditional medical knowledge lacks acknowledgment of local ingenious More "direct" recognition would imply the payment of royalties to the indigenous peoples who discovered those "molecules", but of course laboratories are not willing to support this. Rather, the avid strategy of transnational pharmaceutical companies such as Monsanto (USA), includes storing as much plants as possible in cold chambers and lyophilization to gain access to their genetic code (Shiva, 1996). Faced with a possible difficulty to legal access the medicinal plants, the reserves of botanical genes will allow these companies to patent their "discoveries," meanwhile they must pay royalties to the indigenous users and initial suppliers of the raw material from whom the material has been taken.

In the face of this context, insurance companies began to show a special interest in so-called alternative medicines, since they considerably reduce their costs and demonstrate high efficiency. In countries such as Switzerland and Germany, insurance companies recognize a large number of these unconventional disciplines and reimburse the cost of consultations and therapies to people who choose this option. Many doctors, aware of the limitations of western therapies and being pressured from the users, were forced to add to their classical training medical techniques placed beyond the allopathic framework, such as Traditional Chinese Medicine. In France, for example, there are thousands of acupuncturist doctors, some who even practice this discipline in hospitals despite not being endorsed by the Academy of Medicine (Fagon, 2012). This demonstrates a clear articulation between Traditional Chinese Medicine with modern European medicine.

The National Institutes of Health of the United States has cataloged to date more than 300 "alternative" or "complementary" medical practices, and the list increases day by day. The introduction of these practices inevitably leads to the "opening" of the allopathic model and the emergence of new conceptual gaps in medical thinking, which are finally contributing to the desired "articulation" between different medicines.

For all these reasons briefly evoked and what we have experienced in our practice, we consider that there is great ambiguity in the Western approach to traditional medicines. Paradoxically, while this system is running out, public health continues to pretend to rule, be in charge, evaluate, question, and dictate rules in a unilateral manner. The imbalance of means and power between allopathic medicine, which is officially recognized and is predominant in the Ministries of Health, and the ancestral empirical practices of popular use, requires for its articulation to be extremely slow and controlled. Due to this power imbalance, the "integration" between medicines risks the "disintegration" of traditional medicines wherein the political, economic, and psychocultural power of modern medicine absorbs the 'choice' aspects of traditional practices, discarding the others. The great part of the "integration" carried out so far has consisted in adding the weakest to the strongest, which has finally "swallowed" the first. Western aggression, in its insatiable desire for conquest (FTA, Monsanto), warns us to take precautionary measures to avoid destructive integration processes and maintain a cautious and well-controlled articulation. What is clear is that there are mutual advantages to this articulation: the well-being of health users.

Based on the experience we have accumulated in over 27 years spent in the upper jungle of the Peruvian Amazon, we can affirm that traditional medicines, in relation to Western medicine offer several advantages since they:

- Are generally low cost
- Present a great efficacy and efficiency
- Have a great ability for cultural adaptation
- Demand a light logistic handling
- Generate little aggression to the ecology
- Are endowed with a great reserve of knowledge obtained through thousand year-old empirical research

As we pointed out earlier, laboratories know exactly the economic benefits of taking advantage of this extensive body of ancestral knowledge. The sophistication of vegetable preparations such as ayahuasca or curare is still a mystery to western knowledge (Narby, 1999). Modern medicine has already benefitted from much traditional knowledge over the generations of establishing itself. Quinine is exemplary of this history as it allowed westerners to withstand the malaria introduced by Spanish conquerors (the tree appears in the national coat of arms of Peru) (Castro, 2007). Similarly, digitalis has been an essential contribution to cardiology (Méndez, 1991), while curare allowed doctors to perform internal surgery interventions (Savare, 1966), and coca provided local anesthetics for ocular surgery (Dagnino, 2006). The list is extensive: up to 70% of medicines derive from traditional phytotherapeutic knowledge (Bruneton, 1993). It is not an exaggeration to say that modern medicine would not exist without the essential contribution of ancestral empirical knowledge. But there is also an immense nosographic, clinical, and therapeutic field of traditional knowledge that goes far beyond the few molecules extracted from medicinal plants. Traditional medicines are not limited to a wise use of botany, and there is a vast reserve of knowledge that remains very unexplored: energy pulses, the effect of temperature variations on menstruation, the importance of odors in psychic alterations, processes of energetic regulation of the body, techniques of birth control, uses of toxic substances, cures for snake bites, effects of the moon on the psyche and the preparation of medicines, among others. Research into these topics could enormously enrich modern medical science it could overcome rigid cultural biases and its psychological resistance to pay attention to the rational basis of these practices.

Among countries with weak economies, the rational exploitation of medicinal plants represents an enormous potential source of wealth. The use of local plants would reduce the need to purchase imported medicines, while the export of processed vegetal products, whose market is growing exponentially, would benefit local economies. However, royalties for patents on such knowledge and products require a strong protection policy. The articulation of both medicines, if it were only a benefit for the western world, would be highly criticized, since it would be the equivalent to a death penalty for non-western cultures. Nevertheless, we believe that with all the necessary precautions, this articulation is a condition for the safeguard of traditional medicine and indigenous cultures. The advantages that western medicines can provide to traditional medicines consist essentially in the contribution of its powerful technical apparatus and rational conceptual schemes. All the technological capacity can be made available to the study of traditional medicines to demonstrate their effectiveness.

In France, Professor Bernard Herzog (1987), head of the radio diagnostic service of the University Hospital of Nantes, demonstrated with modern technology (radiography, tomography, magnetic resonance imaging, scintigraphy, etc.) the accuracy of healers' diagnoses about the position of certain pathologies such as tumors and inflammations.

In Lima, Dr. Víctor Reyna (2002), chemistry professor at the University of Lima, compared the results of "*soba del cuy*"[4] with radiographic diagnoses of the patients, thus demonstrating the high

[4]This is a traditional practice done by healers in the Andes, generally using a cuy (guinea pig), but occasionally with flowers or other materials. It is a diagnostic tool in which the healer or curandero rubs

degree of convergence between the results of traditional empirical methods and modern techniques.

Pharmacological studies on psychoactive plants considered sacred in traditional medicine have shown that their active ingredients are similar to neurotransmitters found in the human brain. Dimethyltryptamine (DMT), for example is banned for being a narcotic (psychoactive substance without therapeutic use) by the Convention on Psychotropic Substances (Vienna,1971), while healers have used it for millennia to cure mental problems thanks to its presence in several plants. Dr. Rick Strassman (2001), American neuropsychiatrist, demonstrated that the pineal gland (until recently considered as a "vestige" of evolution without physiological function) secretes this alkaloid and its production reaches its peak in extreme psychic states (near-death experiences, mystical states, etc.).

French researcher Dr. Hubert Larcher (1990) did something similar by studying the "abnormal" phenomena of the physiology of mystics, even in the post-mortem state (Thanatology). He examined the effects of total and permanent fasting for months or years, preservation of the corpses, odors and oils emanating from the body of some saints, etc.

Nevertheless, we believe that there are only very few studies of this nature that reveal the coherence of traditional methods and their practical validity. The creation of a joint approach aimed at finding the common ground of these repositories of knowledge dispersed in time and space would give the possibility of developing a synthesis that facilitates the emergence of a new paradigm. The technical apparatus of Western science seems valid to provide, in this possible articulation, maximum efficacy in cases of individual emergency (intensive care, surgery, neo-natal infections, etc.) or collective emergency (earthquakes, floods, etc.). The power of mass dissemination of the western medical system must be used to face large-scale public health problems such as goitre and cretinism caused by iodine deficiency of mountain salt or the dissemination of good hygienic and sanitary practices for the prevention of neo-natal tetanus. In the same way, these means of mass dissemination could be placed at the service of traditional medicine for the dissemination of practices of popular and public scope (for example, indications to deworm children at home with simple natural products available to everybody), the training at distance of traditional medicine practitioners (health promoters, midwives, bonesetters, etc.), the creation of networks, the exchange of information, the establishment of archives, etc. The need at this level is clear and it is enough to see the extraordinary success of the natural health book of M. Lezaeta Acharán (1971) with its extensive list of references, low cost and extremely popular in Latin America. The same thing happened with the great book *Where there is no doctor* (Werner, Thuman and Maxwell, 1995).

Certainly, one of the strongest and most essential contributions of modern Western knowledge is its ability to categorize and systematize data. To do so, it is enough to point out the interest of botanical classification with scientific language that allows us to extricate ourselves from the complex entanglements of local categories and their numerous dialects. For example, the word *yajé* designates both the Banisteriopsis Caapi (vine) and the Psychotria Viridis (shrub) or the Diplopterys Cabrerana (shrub) according to the different Amazonian regions. On the other hand, the same plant can have an endless number of names: more than 20 registered just for Banisteriopsis Caapi (Friedberg, 1965). The ability of Western rational schemes of putting everything in order can enormously facilitate understanding and communication, not only between the indigenous world and Western world but also among the multiple ethnic groups existing within the indigenous world that, of course, do not constitute a homogeneous and unified

---

the animal over the patient's body and then analyzes the body of the guinea pig to see what is wrong with the patient.

entity. The use of western categorizations does not suppose the total identification with their conceptual categories, and neither does it exempt us from the effort of redefining categories of the indigenous world. It would be unfortunate and reductionist to analyze the symptomatology expressed by the natives only with European nosographic criteria and limits, considering that the empirical practices have their own dynamics of approaching the body, suffering or healing. Rather, it is necessary to appeal to the instruments of Western conceptual logic and not to its applications within the Western cultural field. Indeed, we must consider the inverse: that traditional medicines' approach to body-mind relationships could provide Western countries with instruments for understanding the definition of psychic identity (mental health) and physical identity (immune disorders). It is in these two great areas where pathologies are constantly increasing and no efficient therapeutic responses exist, despite enormous research efforts. The solely rational models in which this research takes place manifest to be unsuitable to explain and address the subtle field of psychosomatic connections.

Each cultural space is supported by collective psychic contexts, symbolic forms of expression, and processes of representing reality. In this field, states of consciousness play a fundamental role, along with the tools that alter or modify consciousness. Every culture integrates substances or techniques that induce altered states of consciousness that contribute to building a "vision" of reality or cosmovision (Furst, 1976). The violent approach of the Western world to the indigenous world carried out 500 years ago produced forms of mutual illicit appropriation of the sacred instruments that generate the metaphysical representation of the world and the location of the human being. Alcohol became the destructive poison of indigenous cultures from the Andes to the aboriginal Australians and native North Americans. The spirits of the Occidental world, the regenerating blood of God, became the brew of the death of the indigenous world. Meanwhile, tobacco, Amazonian medicine par excellence that represents a spirit of fortitude and teaching, engendered similar destruction among European populations: 60,000 deaths per year in France, half a million in the world (Mabit, 1994). The sacred coca, queen of the Andes, teacher of wisdom, was transformed into the evils of cocaine, cocaine paste, and crack.

In the field of addictions, traditional medicine proved to have much more effective resources than those of Western medicine. For example, in the 1980s, 90% of Canadian First Nation people living in reserves suffered from alcoholism, yet this dramatically reduced to 10% in just 10 years with the application of traditional ritual and spiritual recovery methods. Similarly, Peruvian psychiatrist Mario Chiappe (1974) became interested in the traditional treatment of alcoholics on the northern coast of Peru. He observed that after five years of being treated, more than 60% of these persons were no longer considered alcoholics (Chiappe, 1968). His research was published by the Pan-American Health Organization (PAHO), indicating the salience of these findings for the treatment of alcoholism (Chiappe, 1979).

We ourselves, at the Takiwasi Center in the upper jungle of Peru, are interested in the treatment of drug addicts with the resources of traditional medicines used among Andean-Amazonian peoples. In our years of treatment and research, we have found treatment outcomes to be highly superior to those obtained by conventional methods of modern medicine (Giove, 2002).

After this brief tour of the relationships between traditional medicine and modern medicine, we consider it very clear that the Western world needs the indigenous world in the same way that the indigenous world needs the Western world. We are essential for each other, this being a vital condition for everyone's survival. Although it appears that the 'modern' world continues to dominate, marginalize, and destroy the indigenous world, there is substantial evidence presented in this essay to demonstrate that things are not so simple. The Western world is a giant with feet of mud that is falling down, while the indigenous world has learned how to resist centuries of oppression and continues with its head raised. However, indigenous communities alone cannot

reverse the destruction of the environment or individual health but must integrate western conceptual elements. As the world lies in ruin and confusion, nobody will save himself alone. Rather, humans must move from an attitude of confrontation toward an inevitable, measured, and controlled articulation between social and spiritual values. It requires opening our minds to an ecumenical dimension in the broad sense of the word.

Epistemological models

The first step for a possible articulation of the two medicines presented involves the deepening and recognition of their conceptual models so that the points of convergence and divergence are revealed. What we find out is that the same practitioners of both medicines, immersed in their daily tasks, often ignore the great lines of force that give coherence to their daily practice. This deficiency in the training of specialists entails the risk of distorting the practices and, therefore, as far as the articulated therapy of these medicines is concerned, a cheap and superficial syncretism is produced instead of a rich and deep synthesis. The individual and collective awareness of these underlying western and indigenous models is necessary to allow an epistemological review that redefines territories and leads to a true melting in a relevant new paradigm that rejects the vague mixes that generate confusion. In other words, from the confrontation of each medicine in its logical space we can achieve a viable, clear, and enriching articulation.

Another obstacle we come across in this work for the articulation of these medical practices is the common assumption that traditional medicines are nothing more than the conglomerate of empirical recipes added over time and without real logical foundation. While rational empiricism may be granted to Chinese acupuncture or Indian Ayurvedic medicine, the ostensibly 'less-structured' therapeutic practices such as shamanism and Andean or Amazonian medicine tend to be maintained in a position of little value to western scientific audiences. Nevertheless, traditional healers of the Americas recognize themselves as "doctors" and even "wise men" and take pride in their "science". To clarify, we put forth the following definition of a science: "A coherent body of knowledge, consistent with reality, of rigorous internal logic, equipped with a methodology for knowledge transmission, research techniques and the expansion of knowledge" (Mabit, 1993: 5). After a simple analysis of the criteria contained in this definition we see how traditional medicines respond perfectly to them and, therefore, deserve the title of "sciences" (PAHO, 2006: 15). In fact, these are millenary practices with proven effectiveness. Indigenous pragmatism would have discarded long ago, without any doubt, the therapeutic practices that did not cure anyone. Only a racist approach can lead to think that indigenous peoples are so stupefied that they continue to get cured by ineffective methods. These populations have survived, grown, and produced cultures and results long before the arrival of European men and western medicine (PAHO, 2006). For the rest, it is enough to look at the practice *in situ* and its results in order to verify its effectiveness. Further, we already pointed out how Western medicine was built on the foundations of traditional medicinal techniques and continues to do so today.

To state that the effectiveness of the traditional medicine is due mainly to suggestion or placebo effects and works only in the cultural contexts where people 'believed' in it (PAHO / WHO, 2002, Martín, 1990), are only a form of denial of its real effectiveness, which in many cases has not yet been proven. We know that suggestion is included in all therapeutic processes in all cultures, thus it is always part of the therapy. In the Western world this has become known as the "placebo effect" (and its opposite "nocebo effect"), which has been shown to contribute largely to treatment outcomes, even from seemingly superficial elements such as the white lab coat worn by doctors, the "magic" of the syringe, and the impressiveness of the hospital system (Deyn and Dhooge, 1996; Kiene and Kiene, 1996; Hróbjartsson and Gotzsche, 2001; Hyland, 2003). The "suggestion"

so often evoked by Western doctors lacks in-depth studies and reliable demonstrations. It is a 'comfortable' word that is often used to discredit traditional healers, thus exempting their work from the obligation of proving results. It proceeds by way of affirmation and not by demonstration, that is, it goes against the requirement of rationality and the scientific method claimed by its detractors. In this context of Western domination, the self-conviction of its official scientists is a proof in itself, but it is not valid in the eyes of its own science. When a Westerner speaks of "believing or not" in traditional medicine, he infers the right to proof of efficacy and denies beforehand the universal dimension of his knowledge. He places traditional knowledge in the field of faith and then criticizes the indigenous person for his 'pre-logical' or 'magical-religious' thinking, where he imprisoned him.

It seems necessary to have a calm and respectful approach to traditional medicines, one that does not solely rely on hyper-rationalist prejudices that ultimately reveal themselves as self-contradictory. From the field of the philosophy of science, Karl Popper (1962) long ago denounced the paradox of over-reliance on hyper-rationalism as an unsustainable form of logic that inevitably leads the Western world to establish its own science as a religion. A religion with a magical mentality that always tends to project its own imperfections on others, with great priests always untouchable by criticism and whose users are invited to blindly believe in their opinions.

The body of indigenous knowledge is expressed in a metaphorical language that belongs to the symbolic "melodic" functions of the right hemisphere of the brain. Westerners first developed the rational, epicritic, and categorization functions of the left hemisphere (Sacks, 2009). Therefore, there is an initial inadequacy between these two languages that is solved with suspicious ease when considering that "the other is incomprehensible". This is equivalent to considering that "Chinese" is incomprehensible to those who do not speak it, even though Chinese is perfectly understandable to the Chinese people. Chinese is, in fact, totally coherent and understandable, provided you learn this language. If there is something incomprehensible, it resides in those who do not understand the language, not in the language itself. The same happens between the different "languages" of medicines that correspond to ways of understanding reality that are fundamentally different. It is time to realize that reality is one, but that different ways of approaching it coexist. And these approaches, instead of leading us to contradiction, guide us to discover complementarity. One of the ways to solve this apparent problem is to study the language of the other and to train translators or interpreters. Westerners are thus invited to overcome the formalities of academic language to delve into the richness of traditional indigenous analogue language. It is the space of the broad indigenous worldview that sets the limits or draws the conceptual framework in which traditional medical practices are located and explained. Tales, myths, and legends constitute the "encyclopedic dictionary" in which every life experience finds its location and its semantic dimension.

Traditional medicines are extremely dynamic and its practitioners know how to incorporate into their model elements of other practices, cultures, or medicines (PAHO, 2006). They have been constituted in this way, in the same way that Western medicine has done it. They are constantly enriched by the contributions of others and their own discoveries. Thus, they incorporated elements of European medicine provided by the Spaniards, with the result that many of the medicinal plants currently used by American healers are of European origin, although they do not know it (e.g., verbena, plantain, chamomile, horsetail herb, among others) (Patiño, 1963). Since ancient times, traditional medicines have involved systems of initiation and transmission of knowledge, to the extent that we can say there have been real schools hidden in jungles and mountains. (Grim, 1983; Brown, 1994). The *ayahuasquero* Aquilino Chujandama, from the Chazuta village next to the Huallaga River, told us how he had spent nine months with a score of other young people studying in the school of a teacher in the deep of the Amazon jungle. He remembered with tears in his eyes, being over eighty years old, the hard discipline of that learning

that included diets and fasts, intaking plants, isolation in huts, study of the chants, and so forth. Behind "folkloric" appearances, there is an extreme accuracy in practice, a great demand for dedication, strict obedience to the teacher, and strong self-discipline. These factors express an identical rigidity of thought, inner attitude, and ethics in its principles.

Starting from our own experience, we want to give testimony of the authentic scientific values of traditional knowledge according to the criteria previously defined. The more we went deeper into this empirical science, the more we were fascinated by the wide point of view of the traditional approach. We were surprised by its unsuspected ramifications in all areas of human knowledge, we were shaken by the potential of its knowledge, and we were convinced of the accuracy, growing rigor, and extreme complexity so well camouflaged in ease and simplicity. Thus, we come to believe that traditional medicines are true sciences in the full sense of the word.

Now, by recognizing traditional medicine as a science, we give it the same limits as all sciences. The scientific method precisely described by the French physician Claude Bernard (1966) in the nineteenth century appropriately admits that science cannot tell the truth but can tell what it does not consider to be false at a given time. This definition is essential to dispel the phantoms of omnipotence from all science, especially Western science. Any scientific statement is by definition temporary, until proven otherwise or, in any case, until it is modified, complemented or corrected. In no way can a science become the judge of another science, because in this case it would violate its own principles, losing its internal coherence and transforming itself into a dictatorial system or a religion. The pretense to validate ancestral empirical sciences through the methods of modern Western science violates the very postulates of Western scientific knowledge. Both medicines can be reciprocally evaluated, confronting themselves in the field of research and on how to measure results in a healthy scientific and democratic debate. But when it comes to assigning to one of them the right to give its approval to the other, judgment is lost, locking the human being into a unilateral system of thought in which only one of the visions has the exclusivity of " saying the truth ".

This contradictory dynamic is currently seen in the repeated attempts of western thought to qualify, regulate and control traditional medicines (see for example Guerra, Torres and Martínez, 2001). It becomes urgent, then, that medical students become aware of the epistemological models that sustain their knowledge, in order to appreciate their successes while at the same time discovering their failures. Being unaware of these gaps, of the natural limits of any system, plunges the medical doctor into an ignorance that leads to arrogance. Extreme arrogance leads to foolishness.

Practitioners of Western medicine largely ignore the axioms and postulates of the science they practice, since epistemology is not part of university teaching. They then end up believing that what is taught to them is the pure truth and that, consequently, everything that is not taught to them is false or belongs to a fantasy world. Rigid minds are fabricated, with limits in rationalist interpretation that lock reality in a binary or dualistic system that pretends to respond to everything that happens.

Western medicine is inscribed within a global system of rational and dualistic thinking. It maintains a pretension of objectivity as a system of observation of the reality, discarding the "interferences" of subjectivity. It is prescribed to the linearity of time and establishes the axiom of infinite progress. It establishes itself as a logical form of deduction through the linear cause-and-effect relationship. It approaches its objects of study through an analytical process appealing to the instruments of criticism, categorization, and serial classification. Aristotelian logic (the excluded middle), Cartesian logic, and later Newtonian logic, established the great pillars of Western thought (Llamazares, 2011). This scheme of thought has fundamental consequences in

medical practice, such as the concept of duality of body and mind, the rational approach to the mind by Freud's psychoanalytic method, the Darwinian concept of continuous evolution, or the tendency to look for pathological causes in the material dimension (genes, bacteria, viruses, etc.) as an external aggression that the body receives, wherein the body is considered an entity isolated from its environment.

Each one of these points deserves a developed discussion, yet we content ourselves, for the moment, with simply making note of them. However, we believe it useful to insist on one of them that seems essential to us: the dogmatic exclusion of the spiritual dimension made by Western scientific thought. The religious or sacred component constitutes a new taboo of a science that paradoxically establishes itself as the dominant religion (Nelkin and Lindee, 1998; Ellul, 1977; Simon, 2006). The rationalist reductionism that characterizes modern science establishes a spiritual blindness that is very harmful to health, which cannot do without this dimension so fundamental for the human life. We try to reduce all problems that involve existential or metaphysical questions to a mental question. Spirituality would be a by-product of the mind, a work of the psyche. However, religious and spiritual factors have a powerful influence on the disease experience and representation. Scientific studies on this issue agree that, in at least 80% of cases, this influence has been positive, while approximately 15% have been negative (Larson, Levin, Levin and Koenig, 2005). Dr. David Larson of the University of Duke, together with H. G. Koenig and M. McCullough (2001), have been able to summarize more than 12,000 studies on this subject in the book *Manual of Religion and Health*.

At the same time, psychiatric studies that take into account the spiritual or religious variable in their measurements are scarce. In the five years between 1978 and 1982, less than 1% of the quantitative studies in psychiatry published in four of the largest journals of Anglo-Saxon psychiatry includes one or several measures of the patients' religious commitment. Only 3 of 2,348 studies examined are centered on a religious variable (Larson, 2005). The North American neurologist Oliver Sacks (2009) points out that for 10 studies on the left brain there is only one on the right brain. You will find what you are looking for. These imbalances indicate a lack of interest or prejudice by scientific research in this field that discredit the statements made about the lack of meaning of traditional medicines.

The WHO has introduced the spiritual dimension into the list of essential factors for full health. It considers six dimensions important for the quality of life in all cultures:

- physical factors
- psychological factors
- level of independence of the person
- social interactions
- setting in each one is placed
- spirituality/religion/belief of each person

In the same way, it points out that, according to the order of importance at the level of public health, mental pathology has become a world priority, replacing the great endemic illnesses of half a century ago such as malaria, tuberculosis, and leprosy. However, “in terms of mental health, 40% of the countries lack a specific policy, 30% do not have a program and in 25% there is no legislation in this regard", as if this type of suffering does not deserve the same response as organic pathologies (WHO, 2001:7). In November 2003, the Vatican held the 18th International Congress of the Pontifical Council of the Health Pastoral on the subject of nervous depression, since it is currently "the deadliest disease of mankind, the first cause of death" (Lozano, 2003: 1). Pope John Paul II added that in his opinion "depression is always a spiritual test" (John Paul II, 2003). Dr. Ronald Kessler, together with P. Berglund and O. Demler (2003), published a study on global depression in the *Journal of the American Medical Association* that reveals there are

some 150 million depressed people in the world and that this pathology affects both the countries of the North and those of the South. It reaches the figure of 10% of the total population in the United States, Russia, and India. Unipolar depression is the first source of disability worldwide. This alarming news deserved to appear on the cover of *Newsweek* (June 21, 2004) with the title: "Sad Planet: depression has become a globalized disease". The magazine made an extensive coverage of this topic, insisting on the universal nature of this highly invalidating pathology. It is noteworthy that the gloomy outlook of a world without meaning and stable values generates a collective depression. The functionality of a materialist life does not satisfy spiritual needs. Precisely, traditional medicines restore a space for the transcendent dimension in the dynamics of health, taking into consideration the spiritual factor in their therapies. They cover the blind spot of the discriminatory Western system, which eliminated from its field of attention the need for human beings to live semantic experiences, that is, to live as carriers of meaning. In the Western worldview there is a "blind spot" at this level.

In the teaching of traditional medicine and, in general, in indigenous education and training, initiatory experiences allow subjects to enter modified states of consciousness where they deal with transpersonal dimensions of life. They experience in their own flesh the discovery of aspects of the living that lie beyond the usual perceptions, beyond their body, their thoughts, and their feelings. That "other world", however, is not separated from "this world" and there are spaces that guarantee the interface, for example, medical-religious ceremonies where the ritual assumes the role of bridge between those worlds. There is a kind of "technology" of the sacred that allows a healthy and safe come-and-go between the two worlds.

The decapitation of the spiritual dimension of human beings introduces them into a particular form of indefiniteness in life. On the somatic level, as we have already noted, the disturbance of psychic identity entails a disturbed immunity. It is not surprising, then, that immunodeficiency pathologies lead the list of diseases in the modern world along with major depression (WHO, 2011). In our personal experience, it is striking that during ayahuasca sessions patients with immunodeficiency reveal an incomprehensible sadness ("I am so sad it feels like I am dying ") in a specific way. On the contrary, by recovering the spiritual dimension and discovering the sense of their lives, an improvement in immunity with clearly marked clinical indicators is produced. In this way, while mental illness and immunity disturbances represent fields of pathology where modern medicine shows great weakness, in traditional medicines they appear as one of their strongest points.

It is noteworthy that the epistemological model in which allopathic medicine is based refers to concepts of physics that are obsolete within modern science itself. The conceptual framework of the western medical practice of the general doctor could be compared to the diagrams of thermodynamics and, in particular, to the second principle of thermodynamics that supposes an irreversible entropy within a closed system. In other words, this medicine has not yet been able to assimilate the discoveries of the twentieth century in physics and integrate the concept of open systems where negentropy is feasible. Up to now, relativized thinking has not been integrated. It got stuck in the 19th century Pasteurian model. In the era of lasers and quantum physics, it has not been able to introduce even the notions of energy more than in the form of counting the calories in the diet.

Interestingly, ancestral medicines show a marked coherence with relativized thinking (Apffel-Marglin, 2011; Barad, 2007; Beauregard and O'Leary, 2007). The latest contributions of the different modern scientific disciplines recognize the "word of the shamans" and contradict that of the doctors! For quantum physicists, what healers affirm is consistent with their models of apprehension of time, energy, and space. For this purpose, it is very interesting to read the adventure of the professor of quantum physics of the University of San Diego, Fred Alan Wolf

(1991), who dramatically loses his son in an accident and seeks to "reconnect" with him through shamanism, where displacements outside of Euclidean space-time are possible. This search led him to directly contact with Amazon healers and to discover the coherence between the systems they practice and his academic discipline.

In fact, without pretending to be specialists in a discipline of such complexity, we can point out some of the general characteristics of quantum physics (Nottale, 1998) that we also find in traditional medicines:

- The lack of fundamental separation between observer and observed and, therefore, the impossibility to affirm that there is an absolute objectivity, since the subjectivity of the subject that observes an experience in the development of a non-linear time always intervenes.
- Living systems are always open, there is always a degree of uncertainty, an open possibility, a partial impossibility of prediction.
- The odds never contain a single obligation. Everything is possible at all times. The "possibilities" coexist.
- The possibility is open for the existence of parallel universes.
- The Energy and Matter exchange ($E = mc^2$) allows us to glimpse the possibility of materialization and dematerialization processes.

In addition to this, other contemporary disciplines show coherence with the conceptual frameworks of traditional medicines. This resonance does not stop attracting attention and awakening interest. I want to briefly quote some of them:

- Neurophysiological models. For example, the concept of "controlled hallucinations" introduced by Richard Gregory (1965), which brings us closer to the notion of perception by contrast and the interest of defocusing procedures to better see the usual reality.
- Models of the physics of the chaos by the Nobel Prize winner Ilya Prigogine (1996), (Spire, 2000), which were taken up by the psychologist Manuel Almendro (2003) in his book "Psychology of Chaos", within the transpersonal field. He opens perspectives on the possibility of a qualitative leap in an emerging crisis when a living and open system reaches a maximum point of instability. In the concept of the human being as an open system he offers a negentropic way out to psychological or spiritual crises.
- Transpersonal psychology models of Stanislav Grof (1983, 1984) with his proposal of the perinatal matrices, or of Ken Wilber (1990, 1996) with his spectrum of consciousness.
- Models of structural analysis of dreams for the interpretation of the phenomena of consciousness and especially of the visions induced in initiatory rituals (Maunaury, undated, Ruiz, 2010).
- Molecular biology models that reveal similarities between DNA and the "cosmic serpent" (Narby, 1999).
- Models of animal biology such as the morphogenetic fields of the British Rupert Sheldrake (1984), which lend themselves particularly to clarifying the methods of traditional learning and transmission of knowledge, as well as the operations of the matrices of medicinal plants or "mother spirits".
- Cybernetic models of information systems, open and alive (Maturana and Varela, 1979; Varela, 1992). These models allow the human being to be conceived as a system in charge of managing the amount of information he receives at each moment, especially at the psychic level. They clarify the function of intentionality in ritual practice as a support for the reorganization of information.

- Neuroanatomical models such as the triune brain of MacLean (Newman and Harris, 2009) that establishes a coherence between neuropharmacology of the brain and ordinary mental processes in traditional medicine, the use of master plants with active principles similar to neurotransmitters and visions induced by psychoactive plants (comparison between the "snake" of ayahuasca and the "reptilian brain" of the paleo-encephalon).

This last proposal reminds us of the difference we pointed out earlier between the development of the right and left cerebral hemispheres in indigenous and Western cultures. Misunderstanding and even dissociation between hemispheres or conceptual worlds can find a solution in the "limbic bridge" that connects the two hemispheres at the base of the brain (Orlando, 1964). Its location symbolically indicates the need to go deeply, to the root of our psyche, to the most hidden, where the most archaic perceptions are found. The corpus callosum, the seat of psychic "humor" (Belmonte, 2007), reactivated by the fecundation of both hemispheres considered as complements and not opposed, by restoring the dynamics of open -and therefore alive- systems, gives us the hope of being able to change the prevailing deadly sadness into life-giving joy.

This step implies that first the therapists and then the citizens shall allow the opening of processes of self-criticism and self-exploration in their lives. The work on this deep brain is not reached by rationality (cortical brain, superior mammals, conscious ego), nor by the psycho-emotional approach (intermediate brain of the lower mammals, individual unconscious), but by non-ordinary states of consciousness and psycho-spiritual approach of the physical body (reptilian brain, archeo-brain, collective unconscious).

Proposals

We believe that we have to promote certain proposals to facilitate a model of slow and steady articulation between the different medicines. These proposals must come from the official state agencies and the institutions committed to Public Health. We believe that there are several spaces that, since they are not exclusive, can be opened simultaneously and almost independently. We describe them below.

1. Create possible meeting spaces

The creation of meeting spaces between both medicines would allow a cautious approach where knowledge and mutual evaluation can occur, as well as the possibility of an articulation without violence. For this, small pilot projects would be given priority, so that they can be subject to more rigorous control. Examples can be projects with a methodology of diffusion and progressive development that have the capacity to be multiplied, reproduced in other contexts. We think that the slogan *small is beautiful* is still valid when we talk in terms of development. So, we consider that meetings of this kind can be possible in the following spaces:

The clinical field. This is the pragmatic field where the confrontation with the reality of the suffering of the patient is identical for everybody. In short, it is at this level of immediate and practical reality where the best cooperation can exist, since the judgement of the clinical result is undeniable. Did the patient improve or not? Were they cured or not? Are they satisfied with the health service or not? Was the care given during labor a success or not? Experimental spaces of mixed attention, localized or delocalized (with mutual references), in primary health, general medicine or specialized care can be created. We have the example of the treatment protocol for addicts and alcoholics at the Takiwasi Center on our side, or the *Tjon Tam Sin* Addiction Treatment Center run by Romeo R. in Suriname. At Takiwasi, our daily work revolves around traditional healers, who have a well-defined space in the therapeutic process. Over time, a

relationship of mutual respect and friendship has been built, which makes intercultural collaboration possible without any problem. Besides, several ongoing projects of the same nature already exist in different countries of the Americas (Ecuador, Colombia, Chile, Peru, Mexico, etc.) that deserve to exchange and better disseminate their experiences.

It is worth emphasizing that it seems to us an illusion to want to generalize these experiences quickly, since both the official health structures and the mindset of the majority of health workers are not prepared for such acceptance. The psychological resistances, often protected by rationalized pretexts, should not be underestimated. It seems preferable to strategically choose projects supported in well-defined spaces and with highly motivated people. The quality of human resources is fundamental here and can condition greatly the success of such projects. Initially betting on quality leads to quantity in the medium term. On the other side, betting on quantity and massive projects does not necessarily entail quality and there is a risk that these projects degenerate until the quantity is also lost.

The field of Prophylaxis. The cooperation between the different health agents in mass prevention campaigns, such as the reduction of goitre and cretinism or the prevention of infantile tetanus, would be greatly benefited by intercultural dialogue. You can get very interesting results in the short term.

The field of Mental Health. We always find traditional medicines on the border between psychological problems and spiritual problems (between "psi" and "spi"). The intervention of this type of medicine can be of great help in compensating for the deficiencies of Western mental health, reduced every day more to a psychiatry of "biological" containment. The works on the transgenerational heritages of the British psychologist K. Mc All (1989, 1994), those of the French physician Sergui Thigou (2002) exploring Tibetan traditional medicine or the first investigations of Transpersonal Psychology are good examples (Grof, 1983 and 1984), as well as the studies by the French Jesuit Eric De Rosny (1981, 1996, 2002), initiated to an African tradition in Cameroon. It is urgent to establish mental health policies that include both medicines. We must remember that 40% of the countries in the world lack a mental health policy.

The field of Ethics. There are basic values held by both medicines that can be shared, such as patient care. The medical schools have their specific codes of conduct, while the indigenous groups have begun to consider the formulation of their own codes. Thus, the Union of Indigenous Yageceros Doctors of the Colombian Amazon drafted a Code of Ethics called "The Beliefs of the Elders " (UMIYAC, 2000), which has been established as a model in this field and could serve as an inspiration for other groups. It has already been considered for approval and dissemination in several indigenous meetings, such as that of the International Network of Traditional Doctors of Ayahuasca (abbreviated in Spanish as RIMTAY), which also issued an interesting pronouncement (see Annex 1). These documents can become instruments of self-control for practitioners of traditional medicines (see Annex 2 and Annex 3). Similarly, in 2012, health professionals from the Western world saw the need to propose a manifesto as a code of ethics regarding the use of American Indigenous Traditional Medicines (see Annex 4).

The field of Epidemiology. Traditional health representatives should not only collaborate with conventional epidemiological evaluations, but also formulate their own evaluation instruments. In practice, they are true field epidemiologists who can account for a different perception of reality and health problems. In this area of human suffering, subjectivity plays an essential and undeniable role, as well as the predominance of the functions of one cerebral hemisphere over the other (for example, in the representation of time and space and the body outline). The symptomatology may vary according to the cultural context and requires for the data collection

instruments to be very refined so as not to fall into established criteria on other people's standards (for example, the size-to-weight ratio among children).

The field of Dialogue. We believe that it is necessary to "liberate" the word in all the spaces of our multicultural and multiethnic Latin American societies. As we already pointed out, nobody will come out unscathed from this process, yet evolution is necessary. The old local system of "councils" would take the form of open Health Forums in all organizations and levels (local, regional, national), so that the different actors of civil society – from users of health services to representatives of churches and various associations, unions, and NGOs – can take the floor. The withholding of feelings of frustration degenerates into violence, and this is only capable of generating more violence. Learning based on open and honest dialogue is marked by the negative antecedents of the imposition from the public and official sphere. The liberation of the word is in itself capable of bringing a better atmosphere of social peace and favoring a controlled discharge of violence in efficient democratic frameworks. It is striking to note that in this "sad planet" where there is a massive depression shared by all peoples, studies show that in non-Western cultures verbalization therapies have excellent results (Pepper and Cunningham, 2004). The previously confiscated right to expression and dialogue must be returned to the peoples as an imperative and vital need.

2. Promotion of mixed training

We believe that the introduction of epistemological reflection in academic education is essential. Future professionals must be able to contextualize and relativize their knowledge to place it within the Western paradigm, so as to avoid the terrible errors of rationalist, positivist, and materialist reductionism. This is a cross-cutting issue that concerns all disciplines, not just those of health.

This theoretical preparation would go hand in hand with field works carried out with an open mind and the possibility of self-experimentation. It is about being able to introduce new methods of non-exclusive learning, as well as new forms of communication. The direct knowledge and the experiences that send us back to the functions of the right brain, make possible the opening of consciousness to new perspectives of apprehending reality and formulating solutions to complex and challenging problems. The mastery shown by traditional medicines in controlled induction techniques of consciousness expansion allows the discovery of unsuspected and extremely enriching approaches. Takiwasi's experience in this field is very encouraging.

Being in the field favors the live and direct encounter of the different actors of society despite their socio-cultural differences, and also does not allow sterile escapism into evanescent theories, but rather forces a pragmatic confrontation with concrete situations. In this way, it creates solidarities, establishes affective bonds, colors the academicism of vital emotions, polishes idealism, and roots it with the weight of everyday life. It is there where individual vocations are born and human resources are forged with a strong motivation.

Likewise, the members of each ethnic group must know the cultural roots of their people, their ancestral worldview, their epistemological postulates.

What could indigenous health actors say about their medicines if they did not go through a minimum of personal initiation into their tradition? In order to defend against the overwhelming power of the Western system and to get rid of the fascination that it often generates (with its derivatives of idealization or demonization), it is also necessary to know the weaknesses and limitations of this model. As we have already pointed out, a young indigenous person must be able to reevaluate his cultural inheritance knowing the wealth that it encloses and the coherence of its contributions with the latest advances in modern science, especially relativist thought. For

this, in addition to the experiential transmission in the field, the attempts to establish Indigenous Universities and Apprenticeship Programs seem interesting. However, it is necessary to know how to distance themselves from Western models so as not to copy them or reject their methodological instruments by purely systematic opposition. In this scheme of articulating the two sciences, extreme stances seem neither adequate, pragmatic, nor productive, and presents a sharp lack of discernment. A process of differentiation, as in psychological growth, does not mean massive and violent rejection nor a blind adherence to the models (parental in one case and cultural in the other), but the gradual elaboration of a culture's own criteria for selecting what should be saved or discarded from the reference models. For example, we believe that networks (such as the UMIYAC and the RIMTAY models) between ethnic groups are valid for learning, although the NGO-type model is not a traditional method and rather belongs to western processes that tend to universalize traditional practices. Equally useful, as proposed by the Indigenous University of Quito, encourage the use of electronic learning at distance, so that a semi face-to-face training is allowed that does not force the indigenous student to move away from his or her community and live in urban centers where they dissociate from their roots.

3. Broadening of the research perspectives

Funding for research in health must include evaluations of traditional medicines in order to make visible the evidence for their efficacy. The active participation of traditional health agents would considerably reduce costs and cover a wide range of data.

As for the validation of the properties of medicinal plants, we already pointed out that classical methods of evaluation (namely RCTs) are economically unattainable. In addition, they are mainly aimed at identifying the active ingredients that are useful to the pharmaceutical industry for the production of synthetic medicines. However, more economically and conceptually feasible methodologies are being used to holistically evaluate the use of plants for therapeutic applications. These methods of evaluation not only offer economic advantages and reduction in the time to market, but also provide better access to rural populations with low economic resources and avoid most harmful side effects that come with the chemical recipes. These short evaluation systems have already been developed in countries such as China and Mexico. Some specialized NGOs, such as Enda-Caribe with its Tramil program (Weniger and Robineau, 1988), have extensive experience in this field and have already published numerous results of their research. The Tramil publications are based on traditional popular knowledge derived from the most specialized sources (healers) to collect and systematize local knowledge, and finally return it to the populations from where it comes. Thus, when there are identical and repeated data on the same plant, they obtain valid results thanks to the strategy of empirical observation.

We suggest establishing comparative evaluation systems of treatment results in pathologies determined by both medicines. The risks of each treatment, as well as its side effects, costs, accessibility, and so forth, will also be evaluated so that appropriate health policies can be established. The partial evaluation of an isolated technical intervention cannot account for its efficacy in the field. What is the use of a complementary examination machine if no one can assume the cost of their tests? Why insist on the nutritional value of vegetables in high-altitude communities where vegetables do not grow and are not part of the ancestral diet? Dr. Rosa Giove of the Takiwasi Center thus began a comparative work to evaluate the four most frequently attended pathologies in the Peruvian High Amazon: dislocation, rheumatism, delivery care, and acute gastroenteritis.

We also believe that traditional medicinal procedures merit much deeper exploration because, as previously mentioned, they correspond surprisingly often with the most modern advances in Western science. They could inspire sophisticated research protocols and contribute to the

elaboration of bold hypotheses that possess the benefit of a thousand-year-old empirical validation that has proven to have a high efficacy index. In this way, it would be also possible to show the coherence of traditional knowledge and encourage greater respect for the people who produce it.

4.- Recommended legal interventions

In our opinion, it is important to prioritize the non-intervention of governments concerning legal policies for the practice of traditional medicines, as well as for the recognition of their agents. To abstain is the best service that the government could provide to the community. The only acceptable intervention should aim to protect the space of these practices and encourage self-regulation in the same way that associations of psychoanalysts, psychotherapists, or professional colleges mandate responsibility for the ethical supervision of their members. This protection would make it possible to compensate for the current asymmetry that gives the economic, legal, cultural, and pedagogical power to Western medicines, in addition to the considerable economic pressure of the health market and especially of the pharmaceutical industry. Neither the governments, nor the indigenous groups, nor the traditional health agents would obtain any benefit from the attempt to govern and control traditional medicines. The possible "abuses" of practitioners of traditional medicines (rape, fraud, etc.) should be regulated by the current criminal justice system as for any citizen, since it does not require any special legislation. Conventional legal systems lack the material, cultural, economic, moral, and technical capacity to address most health-related concerns addressed by traditional practices. We shouldn't forget that in Peru and Ecuador, 30% to 40% of the population exclusively uses traditional medicines, while in India the rate is 70%, and up to 90% in Ethiopia (WHO, 2002). What law could determine whether "*mal aire*" (bad air), "*susto*" (fear), or "*brujería*" (witchcraft) has been the correct diagnosis? What western doctor is able to evaluate the validity of the title of "*curandero*" (healer), "*maestro*" (master) or "*yachak*" (shaman) conferred to an indigenous person? Leaving the space open and avoiding excessive monitoring seems to us a measure of good sense. It is preferable to help the indigenous initiatives to establish their own systems of regulation and self-control. The elaboration of codes of ethics, the promotion of associations of health agents (e.g., midwives, *sobadores* or bonesetters, healers, *ayahuasqueros, vegetalistas*), the realization of exchange and training events, the construction of networks, the publication of health manuals, the establishment of indigenous regulatory councils or circles of elders, the assignment of scholarships for indigenous youth, the establishment of repertoires of health agents (with its record of their traditional training, specialty, etc.) the establishment of referential cost indicators, and many other factors all go in this direction.

We have to remember that the overview presented at the beginning of this article shows the active miscegenation of health knowledge and of the multiplicity of medical practices that far exceed the simplistic division between the two fields of traditional medicine and western medicine. Any attempt at legislation could not avoid confronting this complex tangle in which complementary or "parallel" therapies, traditional non-indigenous medicines of America, modern currents of the "New Age", etc. overlap. In this context we can find healers who misuse antibiotics and doctors who prescribe plants without knowing their conditions of use (necessary diets, for example), as well as the prescription of pure active ingredients that denaturalize the indications of the plant as a whole. We consider it necessary to limit access to certain specialized technical gestures that entail an important risk. Just as minimum training is required to perform a surgical act or prescribe neuroleptic drugs, we must accept the possibility that a council of *ayahuasqueros* may disqualify a western, mestizo, or indigenous person who does not have the minimum training to pretend to cure with ayahuasca.

Protecting traditional medicines also means protecting the resources and life conditions of indigenous peoples. An indigenous people without their own territory or with a polluted

environment simply ceases to exist. The government has to offer the legal conditions that allow these populations and cultures not only to survive, but to thrive. Policy-makers who have the capacity to make legal decisions that affect these communities have to think of this not only as a need of the indigenous peoples, but as a vital necessity for themselves and their descendants. The best agents of ecological protection are those who have been living for centuries or millennia in the same contexts that they want to protect and that also ensure the survival of the whole society.

As regards the resources of medical practices, it is urgent to create centers for protection against biopiracy. These entities should be constituted within a regional framework (Andean, Mesoamerican, etc.) for greater strength and resources. Traditional medicine must activate mechanisms to patent its knowledge and avoid the voracious predation of the pharmaceutical industry. In order to do so, it could be supported by existing legal instruments such as the Convention on Biological Diversity of 1993, the Bonn Directives of 2002, and the Regional Biodiversity Strategy of 2002. The institutions in charge of this should preferably coordinate with NGOs active in the field and with the World Intellectual Property Organization in Geneva (WIPO, 2001). We cannot stop pointing out that certain indigenous groups, which are mistrustful for having experienced the international norms and their application, are already establishing private seed banks to protect their own biodiversity, thus preventing the eventual future obligation to turn to the transnational companies of agribusiness to be able to source seeds from their own regions. In this field, the attempt of the world's lobbies to impose genetically modified seeds (GMOs: Genetically Modified Organisms) puts current biodiversity in serious danger, with obvious aims of establishing an economic dependence on this industry and, in turn, giving rise to avoidance strategies that resemble those of civil disobedience. Therefore, within this same dynamic, and especially in the negotiations of free trade agreements (FTA-FTAA), it is necessary to standardize access to genetic resources and the fair and equitable distribution of their benefits.

The economic resources that low-income countries can access from the sale of medicinal plants should not be ignored. The benefits should be distributed among the indigenous peoples who discovered their uses and organizations linked to traditional medicines. In the same way that an oil or mining tax is agreed upon in certain regions and certain institutions, a minimum royalty in this area of export would finance many development projects for the promotion of traditional knowledge. In this sense we also suggest promoting a local industry of the preparation of medicinal plants, and not only the sale of raw material or the extraction of active ingredients.

For the value assessment of all this knowledge it would be appropriate to create a WHO Collaborating Center for the study and use of medicinal plants. Although Latin America is the area with the greatest biodiversity on the planet, none of the 20 such centers in the world are located in this region. An Andean regional strategy would also be convenient at this level.

Health users are ultimately the final recipients of any public health strategy. We believe that one of the best ways to install a system that ensures user satisfaction as a priority is the free therapeutic option. Of course, this option supposes an honest competition of service networks that would allow the user to have a true choice among their options and, therefore, it would entail a regulation of the competition rules (as regards to use of advertising media, access to social security, regulation of network constitution, etc.). It must be noted that, at this time, this policy is defended in Western countries by ever-increasing groups of users who claim that the patient can freely choose the medicine that he or she considers appropriate. This assumes greater personal responsibility for health and, therefore, preventive and prophylactic attitudes. It forces the groups that offer these services to be efficient, be culturally adaptive, lower their costs and expenses, and to encourage prevention. This system makes it possible to demonstrate an evaluation by the users of the services offered. An effective therapy will have no difficulty in establishing itself. This will make it possible to demonstrate the resistances of Western medicine disguised as "security"

concerns, that tries to avoid this type of evaluation at all costs since they could end up disadvantaged by it.

Conclusions

As we have seen, the process of articulation of Western and traditional medicines faces a variety of resistances and pressures, but at the same time it emerges as a need for society as a whole.

The status of Western medicine as dominant is supported by huge economic interests, to such an extent that certain multinational companies have a budget that surpasses that of certain countries in the Global South (Bauchet, 2003). On the other hand, these same companies are more and more criticized by groups of citizens of Global North (Forcades i Vila, 2006) and even by notable representatives from the scientific community (Even and Debré, 2012), thus unleashing sharp debates and strong resistance. One result of these tensions is the gradual emergence of an objective and strategic alliance between the peoples of the South of the world, the Third World, and the Fourth and Fifth worlds. Borders can move and they do not separate so much the "rich" countries from the "poor" countries, but rather the beneficiaries of the *status quo* of the prevailing system, both from the North and the South, from the people excluded and marginalized. The growing number of frustrated and dissatisfied people, tired of and disappointed by an agonizing, unjust, and amoral Western system can be found both in the South and in the North. The world economy is based on a *per se* amoral dynamic, as some famous economists demonstrate (Latouche, 2003). Economic pressures must find a response at the level of civil society and strategic alliances between institutions and groups in the North and the South of the world.

Besides making explicit all this distressing scenario, we believe that it is also necessary to insist on the challenge of psychological resistance, which is not less powerful than economic power, with which it is actually intertwined. Overcoming the blocks of fear and arrogance is an extraordinary challenge that demands an extraordinary investment of energy. If confronting economic power appeals to global and collective means that are sometimes complex and long-term, the confrontation of psychological resistances can start now and at the individual level, for oneself. There is no long-term effective collective movement if it is not supported by the sum of "free and responsible" citizens. Moreover, several collective liberation movements have relied on a few highly motivated and prepared leaders. We shall remember for example the power of Mahatma Gandhi to crystallize crowds around him, to show the power of non-violence, and to liberate a country as big as India from the dominion of the British Empire. Investing in the serious preparation of leaders, for example within indigenous peoples, is an extremely profitable operation and an extremely effective tool.

The work on oneself corresponds to a demand for personal evolution that is equivalent, in westernized societies, to the initiatory processes of traditional societies. Self-knowledge must lead to a better definition of personality, of vocation, of one's own belief system and limits. It involves a process of openness and mental flexibility, inspires patience, fosters humbleness, and generates authentic compassion towards others. For this, the initiatory spaces must be correctly and gradually reactivated in traditional societies and, at times, re-created again in the modern spaces where they were eradicated.

Applying these proposals to the field of health will mean that health agents can recognize the corresponding limits of their practices and to where they should refer their clients when necessary. If the healers identify a "man's disease" (harm), they will treat it; but if it is a "disease of God" (natural) that escapes their healing power, or a surgical emergency, or a great organic deficiency, they will know how to send their patients to the medical post. Likewise, the doctor is obliged by

the ethical responsibility to take into consideration the psycho-spiritual factors in the medical consultation or, in its absence, to refer his patient to the appropriate persons (healers or religious leaders). If the doctor recognizes that a client has "*susto*", he will avoid giving addictive tranquillizers and rather propose a simple "*soplada*" or "cleaning" of the *yachak* that will solve the issue effectively, in a short time and at a reduced cost. The obstetrician will abstain from intervening if the pregnancy is normal and the parturient wants to give birth with a local midwife of recognized trajectory.

To become fluid, this relationship of collaboration needs to be based in an exchange of education, training, and apprenticeship. Direct experimentation is a good teacher. It is desirable to see the healers in front of the microscopes and the doctors taking ayahuasca. These are reciprocal initiations. The obstetrician will learn how to attend a crouching delivery while the midwife will improve the prophylactic hygiene of neo-natal tetanus. The physiotherapist or orthopedic surgeon will manually reduce "injuries" (luxation, dislocation) without the need to put in plaster while the surgeon will discover modern methods of massage, osteopathy, or chiropractic. Modern physicians will compare the data of reading the pulse with the information of the traditional doctor in this same diagnostic act.

The articulation of medicines is, above all, a live and direct meeting of people who were educated in different medicines. If we have seen how one of them exalts the functions of one cerebral hemisphere and the other of the other hemisphere, in the end the work consists of re-harmonizing left and right brain, restoring the balance between the feminine and the masculine. The other person then becomes a revealing mirror of the deficiencies of oneself, but this needs some courage to be accepted. It requires courage to transform the fear of what is different and alien into the desire to know it, discover it, and appreciate it.

Westerners and indigenous people are invited to leave behind the sickly dualistic thinking in which the "evil" is projected outside, in the other. In allopathic medical thought, as its descriptive term indicates, the physical "evil" is "allogenous" (external: virus or bacteria) according to the Pasteurian doctrine. On the psychological level, the alien is in my unconscious (my "other self"). A body-mind separation was established that fragments (neurosis) and even dissociates (psychosis) the human being. The "shadow" of western rationalism hides in the secret space of their consciousness: the denied spiritual dimension. For this reason, traditional initiatory therapies that include an exploration of the unconscious through modified states of consciousness may be particularly important for Westerners. For the indigenous world, the projection of "evil" takes place in the member of the other group, of the other tribe, clan or family. This fosters a hidden defensive and offensive system that is managed in wars through practices of witchcraft, magic or sorcery. The liberation of "evil" happens in this case through the verbalization that gives access to the liberating word that structures the discourse, rationalizes the emotions and gives access to the individual conscience and the personal unconscious. It is worth saying that we can be therapists reciprocally for each other if enough trust is established.

Therefore, the spaces that allow to frequent, know, appreciate, value, and maybe love each other, have an essential value. The walkway between the two hemispheres is constituted by the corpus callosum and the limbic bridge that define the "mood" of a person, his emotional background tonic. Like love in the heart, it symbolizes a center of convergence, an irreplaceable space of encounter and union.

REFERENCES

Abbott, R. B., Hui, K. K., et al. (2010). Medical student attitudes toward complementary, alternative and integrative medicine. *The Journal of the American Osteopathic Association*, 112 (7), 437-446.

Almendro, M. (2003). *Psicología del caos*. Madrid: La Llave.

Apffel-Marglin, F. (2011). Re-entangling the Material and the Discursive, Quantum Physics and Agential Realism, in F. Apffel-Marglin, *Subversive Spiritualities. How Rituals Enact the World*, (pp. 55-63), New York: Oxford University Press.

Barad, K. (2007). *Meeting the Universe Halfway: Quantum Physiccs and the Entanglement of Matter and Meaning*. Durham: Duke University Press.

Bauchet, P. (2003). *Concentration des multinationales et mutation des pouvoirs de l'État*. Paris: CNRS.

Beauregard, M. y O'Leary, D. (2007). *The Spiritual Brain: A Neuroscientist's Case for the Existence of the Soul*. New York: Harper Collins Publishers.

Belmonte, C. (2007). Emociones y Cerebro, VII Pro-grama de Promoción de la Cultura Científica y Tecnológica. *Rev. R. Acad. Cienc. Exact. Fís. Nat.*, 101 (1), 59-

Bernard, C. (1966). *Introduction à l'étude de la médecine expérimentale*. Paris: Garnier-Flammarion.

Brown, M. (1994). Portals of Power: Shamanism in South America. *The Latin American Anthropology Review*, 6 (1), 47.

Bruneton, J. (1993). *Pharmacognosie, Phytochimie, Plantes Médicinales.* Paris: Lavoisier.

Cabieses, F. (ed.) (2003). *Ayer y Hoy: Las plantas Medicinales*. Lima: Universidad Científica del Sur.

Cabieses, F. (2007). *La salud y los dioses. La medicina en el antiguo Perú.* Lima: Universidad Científica del Sur.

Cambayrac, F. (2007). *La vérité sur les maladies émergentes.* Paris: Marco Pietteur.

Castro, J. (2007). La Malaria en el Nuevo Mundo: de los Orígenes al Siglo XXI. *Comunidad y Salud*, 5 (1).

Chiappe, M. (1968). Técnica del tratamiento curanderil del alcoholismo. *Anales del V Congreso Latinoamericano* de Psiquiatría. Colombia.

Chiappe, M. (1974). *Curanderismo: psiquiatría folklórica peruana*. Tesis de Doctorado en Medicina, Universi-dad Nacional Mayor de San Marcos, Lima.

Chiappe, M. (1977). El empleo de alucinógenos en la psiquiatría folklórica. *Boletín de la OPS*, 81 (2), 176-186.

Coppo, P. (1999). *Etnopsichiatria.* Milano: Il Saggiatore.

Dagnino, J. (2006). Los cirujanos y la cocaína. Ars Medica, *Revista de Estudios Médico Humanístico*, 14 (14).

De Deyn, P. P. y Dhooge, R. (1996). Placebos in clinical practice and research. *J. Med. Ethics*, 22 (3), 140-146.

De Rosny, E. (1981). *Les yeux de ma chèvre*. Paris : Plon.

De Rosny, E. (1996). *La nuit, les yeux ouverts.* Paris: Seuil.

De Rosny, E. (2002). Un ministère chrétien de la voyance à Douala ou « soigner la repésentation », en R. Massé y J. Benoist, *Convocations thérapeutiques du sacré*, (pp. 353-373), Paris: Karthala.

Di Raimundi, R. (2013). Il Bellaria sperimenta la meditazione tibetana. *La Repubblica*, sabato 5 gennaio, Bo- logna. www.ausl.bologna.it

Duesberg, P. H. (1996). *Inventing the AIDS virus.* Washington, D.C.: Regnery Publishing.

Ellul, J. (1977). *Le système technicien.* Paris: Calmann- Levy.

Even, P. y Debré, B. (2012). *Le guide des 4.000 médicaments utiles, inutiles ou dangereux.* Paris: Le Cherche- midi.

Fagon, J. Y. (2012). *Médecines Complémentaires à l'Assistance Publique – Hôpitaux de Paris*. Paris: Rap-port.

Forcades i Vila, T. (2006). Los crímenes de las grandes compañías farmacéuticas. *Cuadernos Cristianisme i Justicia*, 141.

Friedberg, C. (1965). Des Banisteriopsis utilisés comme drogue en Amérique du Sud. *J. Agric. Trop. et Bot. Appliquée*, 12, 9-12.

Furst, P. T. (1976). *Hallucinogens and Culture*. New York: Chandler & Sharp Publishers.

Giove, R. (2002). *La liana de los Muertos al rescate de la Vida: Medicina Tradicional en el Tratamiento de las Toxicomanías. 7 años de experiencia del Centro Takiwasi.* Lima: Devida & Takiwasi.

Giraldo, R. (2002). *SIDA y agentes estresantes.* Antioquia: Universidad de Antioquia.

González, J. M. (2011). Etnografía de un encuentro. Chamanismo transcultural en la Ciudad de México. *Journal of Transpersonal Research,* 3 (2), 70-84.

Goozner, M. (2005). *The $800 Million Pill: The Truth behind the Cost of New Drugs.* Berkeley: University of California Press.

Gregory, R. L. (1965). *El ojo y el cerebro: psicología de la visión*. Madrid: Guadarrama.

Grim, J. (1983). *The Shaman: Patterns of Religious Healing Among the Ojibway Indians.* Norman: University of Oklahoma Press.

Grof, S. (1983). *Royaumes de l'inconscient humain*. Paris: Editions du Rocher.

Grof, S. (1984). *Psychologie Transpersonnelle.* Paris: Editions du Rocher.

Grosman, M., Lenglet, R. y Sullivan R. (2011). Menaces sur nos neurones (Actes Sud). *Lancet Oncology*, 12 (10), 933-980.

Guerra, M., Torres, D. y Martínez, L. (2001). Validación del uso tradicional de plantas medicinales cultivadas en Cuba. *Rev. Cubana Plant Med*, 2, 48-51.

Hargreaces, J. R., Boccia D., Evans, C.A., Adato M., Petticrew, M. y Porter, J. (2011). The Social Determinants of Tuberculosis: From Evidence to Action. *American Journal of Public Health*, 101(4), 654-662.

Herzog, B. (1987). *L'Imaginaire Cancéreux.* ¿Paris?: Maisonneuve.

Hróbjartsson, A. y Gotzsche, P. (2001). Is the placebo powerless? An analysis of clinical trials comparing placebo with no treatment. *N Engl J Med*, 344, 1594-1602.

Hyland, M.E. (2003). Using the placebo response in clinical practice. *Clin Med.* 3 (4), 347-350.

Iggers, G. (1965). The Idea of Progress. A Critical Reassessment. *The American Historical Review*, 71 (1), 1-17.

Jemal, A., Bray, F., Center, M. M., Ferlay, J., Ward, E. y Forman, D. (2011). Global cancer statistics. *CA: A Cancer Journal for Clinicians*, 61 (2), 69-90.

Jones, K. E., Patel, N. G., Levy, M. A., Storeygard, A., Balk, D., Gittleman, J. L. y Daszak, P. (2008). Global trends in emerging infectious diseasesnes et al. *Nature*, 451 (7181), 990-993.

Juan Pablo II (2003). *El desafío de la depresión.* Discurso en la XVIII Conferencia Internacional del Consejo Pontificio para la Salud, Vaticano.

Kessler, R., Berglund, P. y Demler, O. (2003). The Epidemiology of Major Depressive Disorder: Results from the National Comorbidity Survey Replication (Ncs-R). *Journal of the American Medical Association*, 289 (23), 3095–3105.

Kiene, G. S. y Kiene, H. (1996). Placebo effect and placebo concept: a critical methodological and conceptual analysis of reports on the magnitude of the placebo effect. *Altern Ther Health Med*, 2 (6), 39-54.

Koenig, H. G., McCullough, M. y Larson, D. (2001). *Handbook of Religion and Health.* New York: Oxford University Press.

Larcher, H. (1990). *La Mémoire du Soleil: Aux frontières de la mort.* Paris: DésIris.

Larson, D. B., Levin, J., Levin J. S. y Koenig, H.G. (2005). *Faith, Medicine, and Science: A Festschrift in Honor of Dr. David B. Larson.* New York: The Haworth Pastoral Press.

Latouche, S. (2003). *Justice sans limites: le défi de l'éthique dans une économie mondialisée.* Paris: Fayard.

Lezaeta, M. (1971). *La Medicina Natural al alcance de todos.* Buenos Aires: Kier.

Llamazares, A. M. (2011). *Del reloj a la flor de loto: Crisis contemporánea y cambio de paradigmas.* Buenos Aires: Del Nuevo Extremo.

Lozano, J. (2003). Actas del 18vo Congreso Internacional del Consejo Pontifical de la Pastoral de la Salud.

Mabit, J., Campos, J. y Arce, J. (1993). Consideraciones acerca del brebaje Ayahuasca y prespectivas terapéuticas. *Revista Peruana de Neuropsiquiatría,* 55 (2), 118-131.

Mabit, J. (1994), *Plantes-poisons ou Plantes-médecines?* Conferencia presentada en el Coloquio Internacional "Droga y Medio Ambiente" organizado por Medio Ambiente Sin Fronteras (ESF) y el Ministerio Francés de Investigación, París.

Martín, J. A. (1990). La eficacia de la medicina tradicional. *Revista de Folklore*, 116 (10b), 39-40.

Maturana, H. y Varela, F. (1980). *Autopoiesis and Cognition: The Realization of the Living.* Boston: Reidel.

Maunaury, M. F. *Rêve, Sida et Individuation.* Not published.

Mc All, K. (1989). *Healing the haunted.* London: Darley Anderson.

Mc All, K. (1994). *A guide to healing the family tree*. Scotland: The Handsel Press Ltd.

McKeown, T. (1979). *The Role of Medicine. Dream, Mirage or Nemesis?* New Jersey: Princeton University Press.

Méndez. R. (1991). Doscientos años de digital. *Salud Pública*, 33 (3), 285-295.

Morgan, G., Ward, R. y Barton, M. (2004). The contribution of cytotoxic chemotherapy to 5-year survival in adult malignancies. *Clin Oncol (R Coll Radiol),* 16 (8), 549-60.

Narayanan, P. R. (1999). Fifteen years follow up of trial of BCG vaccines in South India for tuberculosis prevention. *Indian J Med Res*, 110, 56-69.

Narby, J. (1999). *La serpiente cósmica: El ADN y los orígenes del saber*. Tarapoto: Takiwasi.

Nathan, T. (1999). *La influencia que cura.* Buenos Aires: Fondo de Cultura Económica.

Nelkin, D. y Lindee, S. (1998). *La mystique de l'ADN.* Paris: Belin.

Newman, J. D. y Harris, J. C. (2009). The scientific contributions of Paul D. MacLean (1913-2007). *J. Nerv. Ment. Dis.,* 197 (1), 3–5.

Nottale, L. (1998). *La relativité dans tous ses états.* Paris: Hachette.

Organización Mundial de la Propiedad Intelectual (OM- PI) (2001). *Intergovernmental Committee on Intellecual Property and Gentic resources traditional knowledge and folklore, Second Session*. Ginebra: WI- PO/GRTKF/IC/2/11

Organización Mundial de la Salud (OMS) (2001). *Atlas de recursos en salud mental en el mundo.* Ginebra: OMS.

Organización Mundial de la Salud (OMS) (2002). *Perspectivas políticas sobre medicamentos de la OMS, nº 2*. Ginebra: OMS.

Organización Mundial de la Salud (OMS) (2011). *Causes of death 2008 update*. Ginebra: OMS.

Organización Panamericana de la Salud (OPS) (2006). *Medicina indígena tradicional y medicina convencional.* San José: OPS.

Organización Panamericana de la Salud / Organización Mundial de la Salud (2002). Pautas generales para las metodologías de investigación y evaluación de la medicina tradicional. Ginebra: OPS/OMS.

Orlando, J. C. (1964). Sobre el cerebro visceral. Documentación histórica de una prioridad científica. *Rev Arg Neurolog y Psiquiat,* 1, 297-301.

Orlando, A., Abreu, I. y Cuéllar, A. (2008). Estrategias en la selección de las plantas medicinales a investigar. *Rev Cubana Plant Med,* 13 (3).

Patiño, V. M. (1963). *Plantas cultivadas y animales domésticos en América equinoccial III: fibras, medicinas, misceláneas.* Cali: Cali, Imprenta Departamental.

Pepper, T. y Cunningham, J. (2004) Sadplanet: depres- sion has become global disease. Breathing new life into talk theory. *Newsweek,* June 21, 40-45. (Cover story).

Pérez, L. y Argueta, A. (2011). Saberes indígenas y dialogo intercultural. *Cultura y representaciones sociales*, 5 (10), 31-56.

Popper, K. (1962). *La lógica de la investigación científica.* Madrid: Tecnos.

Prigogine, I. (1996). *El fin de las certidumbres.* Barcelona: Andrés Bello.

Pritchard, C., Baldwin, D. y Mayers, A. (2004). Changing patterns of adult (45–74 years) neurological deaths in the major Western world countries 1979–1997. *Public Health,* 118 (4), 268-283.

Reyna, V. (2002). *La soba del cuy en la medicina tradicional peruana.* Lima: 2ª ed. del autor.

Ruiz, I. (2010). *Progresión onírica y análisis estructural de los sueños.* Madrid: Alboran Editores.

Sacks, O. (2009). *El hombre que confundió a su mujer con un sombrero.* Madrid: Anagrama.

Savare, J. (1966). Histoire du curare: Jean Ve- llard, histoire du curare. Les poisons de chasse en Amérique du Sud. *Revue d'histoire de la pharmacie*, 54 (191), 316-317.

Schieber, S. J., Bilyeu, D. K., Hardy, D. R., Katz, M. R., Kennelly, B. B. y Warshawsky, M. J. (2009). *The unsustainable cost of health care*. Washington DC: The Social Security Advisory Board.

Schultes, R.E. y Hofmann, A. (2002). *Plantas de los Dioses: Orígenes del uso de los alucinógenos.* México D. F.: Fondo de Cultura Económica.

Sheldrake, R. (1984). *A New Science of Life.* London: Paladin Books.

Shiva, V. (1996). *Biopiracy: The Plunder of Nature and Knowledge.* Boston: South End Press.

Simon, S. (2006). *La nouvelle dictature médico-scientifique.* Paris: Dangles.

Spire, A. (2000). *El pensamiento de Prigogine: La belleza del caos.* Barcelona: Andrés Bello.

Starfield, B. (2000). Is US Health really the best of the world? *Journal of the American Medical Association,* 284 (4), 483-485.

Strassman, R. (2001). *DMT: The Spirit Molecule: A Doctor's Revolutionary Research into the Biology of Near-Death and Mystical Experiences*, Vermont: Park Street Press.

Thigou, S. (2002). *La violence faite à l'esprit: Per- sonnes multiples et perversions*. Paris: Qetzalpodi.

Umiyac, Unión de Médicos Indígenas Yageceros de la Amazonía Colombiana (2000). *El pensamiento de los mayores.* Putumayo: Umiyac.

Varela, F. (1992). *De cuerpo presente. Las ciencias cognitivas y la experiencia humana.* Barcelona: Gedisa.

Weniger, B. y Robineau L. (1988). *Elementos para una farmacopea caribeña: investigación científica y uso popular de plantas medicinales en el Caribe.* Seminario TRAMIL 3, Enda-Caribe, La Habana.

Werner, D., Thuman, C. y Maxwell, J. (1995). *Donde no hay doctor: una guía para los campesinos que viven lejos de los centros médicos.* México D. F.: Pax México.

Wilber, K. (1990). *Los tres ojos del conocimiento: la búsqueda de un nuevo paradigma.* Barcelona: Kairós.

Wilber, K. (1996). *El proyecto Atman: Una visión transpersonal del desarrollo humano.* Barcelona: Kairós.

Wilkinson, R. (1996). *Unhealthy Societies: The Afflictions of Inequality.* London: Routledge.

Wolf, F. A. (1991). *The Eagle's Quest.* New York: Summit Book.

Wresinski, J. (1987). *Grande pauvreté et précarité économique et sociale.* Rapport présenté par Joseph Wresinski, Journal officiel. Avis et rapport du Conseil économique et social, 28 février 1987. Avis adopté le 11 février 1987.

BIOGRAPHY OF THE AUTHORS

Jacques Mabit, is a medical doctor, founder and president of the Takiwasi Center (Center for the Rehabilitation of Drug Addicts and Research on Traditional Medicines), Doctor in Medicine by the Medicine and Medical Techniques University of Nantes (France), Graduate in tropical pathology (IMT-Antwerp) and naturotherapy (University of Paris XIII). After a first experience in Africa within health projects of the Belgian Technical Cooperation and the association "Brothers of Men", he arrived to Peru in 1980 to be in charge of the Hospital de Lampa (Puno) as head of mission of "Doctors Without Borders". This experience will awaken his interest in the systems and practices of the Peruvian traditional medicine, whose efficacy he can clinically verify day after day. He then decides to study these ancestral resources in primary health since 1986 as an associate researcher of the French Institute of Andean Studies (IFEA). Then he will go on to practice through long years of apprenticeship with traditional doctors in different regions of the Peruvian Amazon. In 1992, he founded the Takiwasi Center where intercultural medicine is practiced, nourished by traditional and modern knowledge. Between 1996 and 2001, he was designated as expert researcher of the National Institute of Traditional Medicine of Peru, for which he served as director of the San Martín region. For his research he has also been designated honorary member of the Association of Psychologists of Peru and extraordinary professor of the Scientific University of the South (Lima). He participates in the board of the Department of Transcultural Psychiatry of the Peruvian Psychiatric Association and has been elected as a Fellow of the Ashoka Foundation in recognition of his inspiring work as a "social entrepreneur". Web page: www.takiwasi.com Email: takiwasi@takiwasi.com

Jesús M. González Mariscal, has a degree in psychology by the Complutense University of Madrid (Spain), a master's degree in anthropology by the University of the Americas-Puebla, (Mexico) within the "International Agreements" program of the UCM (Complutense University of Madrid). He is also ad honorem Doctor in Sociology by the Benemérita Autonomous University of Puebla, within the scholarship program of the National Council of Science and Technology (Mexico). Researcher on traditional indigenous American medicine and its applications to the field of psychotherapy, with special interest in the dynamics of production of subjectivities, new spiritualities and therapeutic practices in urban contexts from the encounter with shamanism. He participated in the project "Processes of divination, healing, reparation, propitiation in the context of shamanism of indigenous peoples" (Conacyt 2009/2012), led by Dr. Antonella Fagetti. He is currently working as a clinical psychologist and therapeutic coordinator in Takiwasi "Center for the Rehabilitation of Drug Addicts and Research on Traditional Medicines". Email: kinkunse@gmail.com

ANNEX 1
Declaration of Tarapoto. Traditional medicine and sacred plants

We, diverse traditional doctors and participants from Peru, Ecuador, Colombia, Venezuela, and a representative from Gabon, Africa, have met at the Takiwasi Center in Tarapoto, Peru, from the 12th to 16th of November, 2001, for the "International Encounter of Master Healers who are Practitioners of Ayahuasca (yagé, nepe, caapi or natem) and Iboga". The purpose of our encounter is to share the same spiritual dimension, which revolves around the wisdom of sacred and medicinal plants.

After realizing ceremonies with our medicinal plants, especially Ayahuasca and a ritual of Gabon, as well as reflecting on the problems which affect our traditional medicines, and with reference to the "Declaration of Machu Picchu about democracy, the rights of indigenous peoples and the fight against poverty", signed by the presidents of the Andean countries in Lima on July 29, 2001, we declare the following:

- We affirm that our traditional medicine is a fundamental value of our peoples and can contribute, in an important way, to the integral health and spirituality of humanity.
- We regard the knowledge offered to us by the sacred plants which we have inherited from the ancestral peoples of indigenous nationalities to be the basis of the development of traditional medicine.
- We believe that the health of mankind depends on caring for and conserving nature.
- We emphasize that the knowledge, practices and resources characteristic of traditional medicine are the collective patrimony of the originary peoples and maintain that no one has the right to establish systems of industrial property over them.
- We are concerned about the grave situation in which the originary peoples live as they lose their territories, their traditional ways of life, their culture and their traditional medicine due to the influence of the outside world.
- We want Traditional Medicine to be recognized and valued in a correct form by western science.
- We categorically reject the incorrect use and manipulation of the sacred and medicinal plants employed in traditional medicine.
- We are especially concerned about quackery, the new modalities of shamanic tourism and the trafficking of plants and cultural symbols.
- We denounce those responsible for the usurpation being sought with the patent on Ayahuasca.
- We forcefully protest against the indiscriminate destruction of natural resources, ecosystems and the biodiversity which harbors the wealth of traditional medicine.

In the light of these reflections we who gather here commit ourselves to:

1. Denounce the injuries being done to our cultures, our traditional medicine and our sacred plants.
2. Help conserve and recuperate nature, as well as care for medicinal plants.
3. Defend and ensure respect for the sound use of our sacred plants and restore the systems of control for learning and transmitting the ancestral knowledge of traditional medicine.
4. Seek suitable mechanisms to consolidate and improve the practice of traditional medicine for the benefit of mankind.
5. Promote, in each of our countries, processes for the defense and consolidation of traditional medicine.
6. Develop programs of health which allow for cultural reaffirmation and an adequate linking of traditional medicine and modern medicine.

7. Disseminate the present Declaration and our aims to governments, international organisms, mediums of social communication and our peoples and communities
8. Urge governments to formulate policies that protect and promote traditional cultural and medicine
9. Undertake specific actions before the World Intellectual Property Organization (WIPO) for the recognition of collective international property rights in the face of the private appropriation of this common patrimony.
10. Create an International Network of Traditional Doctors of Ayahuasca or Yagé for the exchange of information, knowledge and resources which will allow for the strengthening of traditional medicine, as well as form an executive committee to coordinate the activities set forth here.

Given and signed in Tarapoto, Peru, on November 2001.

ANNEX 2
Declaration of Yachac

We, Yachac Runa, traditional doctors, Quichua followers and apprentices from Pastaza, Tena and Napo, have met in the Omaere Ethnobotanical Park, in the city of Puyo (Ecuador), from January 17 to 19, 2002, to continue talking about the defense and strengthening of our medical tradition, after the International Meeting we had in Peru (see "Declaration of Tarapoto", Takiwasi, November 2001).

This meeting has been a great opportunity to reaffirm our commitment to continue searching for the recognition of our wisdom and the enormous value of our sacred plant: ayahuasca or yagé. Also, we have been able to share with other doctors, apprentices and followers, know each other better and make new friendships. That is important for us. Likewise, they have been pleasant moments to remember our beloved Taitas brothers of Colombia, especially those that constitute the Union of Indigenous Yagé Doctors of the Colombian Amazon (UMIYAC). Thanks to their valuable initiative and the documents that have sent to us, we have been able to guide our conversations and be guided by their example. We take this opportunity to send our most friendly and fraternal greeting to them, hoping that in the near future we will all be closer to strengthen each other.

After these three days of meeting and having performed our healing ceremonies or rituals with ayahuasca, we decided that it was important to write this Declaration to put in evidence some of our most important thoughts.

1. We are persuaded that the best way to defend our medicine and make it better known is, first of all, by seeking the union among all the indigenous doctors who practice the wisdom related to ayahuasca. We believe that from now on we must have a common thought and leave aside all that in the past has kept us separated or divided one from the other.
2. We affirm that ayahuasca is our sacred plant. It is a gift from God. It has always been preserved by our grandparents and ancestors with much suspicion, care and respect. Now, we are very concerned by seeing how they are treating our sacred plant, using their name to do business or selling it to anyone. Likewise, we are concerned by seeing how our territories and cultures, which form the fundamental basis of our medicine, are being destroyed.
3. We do not reject people with a desire to know, as long as they have good intentions and understand that it can only be used as our tradition teaches. But we do not admit doing business with our sacred plant, neither we can nor the tourism agencies.
4. We commit ourselves to offer our services first of all to our indigenous brothers and our communities. Also, we are persuaded that our medicine can benefit all of humanity. Therefore, we will pay attention to all those who request and recognize our services as doctors.
5. But, now we know that we have to put order in our own house, establish some basic rules of conduct and behavior to be able to guide our brothers, doctors, apprentices and followers who wish to join us.
6. From now on we will seek to support and take care of each other. Also, we will look for ways to reprimand those of us who break the rules of conduct and distort the practice of our medicine.
7. We want to invite all our brothers ayahuasqueros doctors, followers and apprentices of other indigenous nationalities of Ecuador, to strengthen the UNION that we all need to restore the dignity of our medicine and contribute to the restoration of the integral health of our indigenous peoples and, finally, of the whole humanity.

Puyo, January 19, 2002

ANNEX 3
Declaration of the Taitas meeting

In Yurayacu, Caquetá, Colombian Amazonian piedmont, indigenous territory of the Ingano people, between June 1 and 8, 1999, we the traditional indigenous doctors - Taitas, Sínchis, Curacas and Payés - have met for the "Taitas meeting".

In the event participated representatives of the Inga, Kofan, Siona, Kamsa, Coreguaje, Tatuyo y Cari and Carijona peoples. This meeting was held behind closed doors.

We want to thank the Ingana organization Tanda Chiridu Inganocuna (ORINSUC), that hosted and made possible the meeting. We want to thank also the non-indigenous brothers of the Amazon Conservation Team -ACT- who have joined our cause and contributed with technical and financial resources to make possible this historic meeting.

After 500 years of conquest, dispossession and death for our communities and our knowledge, for the first time we, the traditional indigenous and Colombian yagé doctors, have been able to meet, exchange knowledge, establish friendships and unite for a common cause and a common thought.

After eight days, in which we have reflected on our medicine, performed three yagé ceremonies and visited the ancestral stone of Yurayacu, we, the taitas, declare:

1º In Amazonian piedmont region still survive several indigenous peoples, who received, as a heritage from the ancestors, wisdom in medicinal plants, knowledge of the jungle and ability for the management of the sacred vine: the yagé.

2º We consider that yagé, medicinal plants and our wisdom are a gift from God and a great benefit for the health of whole the humanity. This meeting can be our last chance to unite and defend ourselves. We are not moved by economic or political interests.

We are obliged to show our values to the world with determination and seriousness. As children of the same father and as brothers who live on Mother Earth, we want to speak to all and offer our contribution so that life, peace and health may be possible.

3º Now indigenous people are realizing the importance of our wisdom and the value of our medicinal and sacred plants.

Many of them are desecrating our culture and our territories, trading yagé and other plants, dressing like natives and acting like charlatans. We see with concern that a new form of tourism is being promoted to deceive foreigners with supposed taitas or "shamans" services in several villages of the Amazonian piedmont.

Even many of our own indigenous brothers do not respect the value of traditional medicine and walk around in towns and cities making business with our symbols and deceiving people.

4º Somebody wants to patent the seeds and become his owner. Government members want to declare yagé as a narcotic plant and prohibit its use for humanity.

At the same time, we denounce that many anthropologists, botanists, doctors and other scientists are conducting experiments with yagé and medicinal plants without taking into account our ancestral knowledge and our collective intellectual property rights.

5º We denounce the outrage committed with our Tatuyo brothers from Yapus, Vaupés, who, while on their way to attend this meeting, were robbed by the authorities of the yagé they brought to share during the ceremonies.

6º We demand respect for our territories, our indigenous medicine and for taitas or traditional doctors.

We ask to understand that our medicine is also a science, although not in the same way that Westerners think of it. We Taitas are true doctors and with our knowledge we have been able to contribute effectively to the well-being of our peoples for centuries.

Moreover, our medicine goes beyond the body and seeks health in the mind, in the heart and in the spirit.

7º We demand the immediate suspension of the patent application submitted in the United States by Mr. Loren Miller. For us it represents an abuse and a serious desecration to our sacred plant. We declare that yagé and medicinal plants we use are part of the collective property and heritage of the indigenous peoples and any use in the name of the well-being of humanity must be done with our participation in the benefits derived from it.

8º We ask for the legal recognition of our autonomy in our peoples' health management, in accordance to our uses and customs.

9º We need to recover our territories and our sacred places. The jungle is for us the source of our resources. If the jungle come to an end, medicine and life are over.

10º We request support for our cause. The non-indigenous people can help us consolidate the unity and the defense of our traditional medicine, because it has been demonstrated that they also benefit from the wisdom of the Taitas.

11º At the end of the meeting, the Taitas have committed to work for the unity and defense of traditional medicine and to offer with dedication our services for the health of indigenous peoples and humanity.

12º We, the Taitas, commit ourselves to begin a process of certification of indigenous medicine's practitioners and to establish our own code of medical ethics. By this we will allow to easily recognize the difference between taitas and charlatans.

13º We are also available to organize health brigades for the indigenous peoples of Colombia and America who request us.
Being aware that non-indigenous require our services as doctors, we propose to build Hospitals of Indigenous Medicine, so that they can have easier access and in more appropriate and natural conditions to the way we work, always related to nature.

14º We, the Taitas attending this meeting, have decided to become the Union of Indigenous Yageceros Doctors of the Colombian Amazon, UMIYAC, and designate our own leaders to carry out the different actions to which we have committed and that will represent us before the world, the governments and the institutions.

For the purposes of disseminating this Declaration and the results of the meeting, we present a publication and an audiovisual record that we want to make public through our own

representatives. The copyrights of these two instruments are property of the Union of Indigenous Yageceros Doctors of the Colombian Amazon, UMIYAC, and no use will be allowed without our consent.

We want to give a special greeting to our Taitas brothers who, for different reasons, could not be with us in this meeting. While thinking about them we have tried to take decisions that also represent them and we invite them to join from now the Union of Indigenous Yageceros Doctors of the Colombian Amazon, UMIYAC, and the process that we have started.

To our indigenous brothers we want to explain that the union of the Taitas does not seek to compete with or replace the important role of the indigenous organizations that currently represent us. On the contrary, we want to offer our service and support to strengthen your purposes.

We want to express gratitude to the brothers who in other countries have called for an agreement to defend our medical tradition, medicinal plants and yagé; we hope that our union will allow them to support us in a more effective way.

In this end of a century we are experiencing a dramatic time of violence, hate, poverty, injustice and diseases. Being at the gates of the new millennium we see the opportunity to close and heal this sad time for humanity.

We want to offer our participation in the construction of a time of hope, health and happiness. We are persuaded that yagé and medicinal plants of our territories and cultures, being a gift from the Creator, can help to make the healing of the world come true.

We, the Taitas, sign here to certify it. Yurayacu, June 7, 1999.

ANNEX 4
An alert about American Indigenous Traditional Medicines (AITM)
(http://www.manifiesto-mti.takiwasi.com**)**

1. AITMs represent a profound knowledge of the human being and communication and communion with Nature.

For hundreds of years, indigenous peoples of the Americas (Peru, Colombia, USA, Ecuador, Brazil, Mexico, Bolivia and Venezuela, among others), from numerous ethnic groups (Ashaninca, Shipibo, Siona, Coreguaje, Navajo, Mazatec, Huichol, etc.) have carried out investigations and therapeutic processes, which defy western scientific methodologies. Their pragmatic results represent an undeniable patrimony for humanity and nevertheless, many plants have been taken advantage of by western industry, frequently without due respect and acknowledgement.

The AITMs offer a treatment addressed to the totality of the human being. They imply an ancient knowledge, expanding unstoppably today. However, they are not easily understood by Western mentality, and for this reason action is needed, involving both worlds in order to avoid fraud and disastrous misunderstandings. Furthermore, they are today the objects of study in Western psychology and medicine because they address the whole body, the mind, and consciousness. Many professionals accept and validate this inheritance, and abundant scientific literature is available on this subject.

It is important to note the convergence between the knowledge of AITMs and the most forward models of contemporary science (neurosciences, psycho immunology, molecular biology, quantum physics, etc.) which makes consulting the AITMs not a nostalgic return to the past, but rather a fecund path toward the future.
For these reasons, The AITMs should be recognized, protected, studied, and promoted to their full extent.

2. The AITMs approach disease and healing in an open, complex, and profound way, penetrating into the mystery of existence.

The use of certain plants, which has been transmitted for many generations with methodological respect and with indications and precautions based on necessary knowledge, opens up a path that turns out to be surprising at times and still posits many questions. It offers invaluable therapeutic resources, in fields where conventional allopathic medicine still has serious limitations (mental health, auto-immune system diseases, degenerative pathologies), and allows health professionals, researchers, and the public in general, to find a new meaning in life.

Of the hundreds of plants utilized, a small group is characterized by their ability to produce altered states of consciousness (ASC). We wish to underline the present alert concerning the latter aspect.

3. Psychoactive teacher plants and the care regarding altered states of consciousness (ASC).

i. The sense of emptiness resulting from unchecked consumerism and the individualistic materialism of Western society generates an intense search for other, different experiences. Many forums are already talking about a crisis of civilization.

ii. Teacher plants that produce altered states of consciousness (ASC) are being unscrupulously utilized by false healers and "shamans" guided by a profit motive, and that does

not include other abuses of a sexual and power-seeking nature. Opportunists, both Westerners and local, exploiters of indigenous traits, disguised, and inflated with self-appointed titles of shamans inventing false genealogies, exploit the growing market of anxious clients in need of healing, knowledge, and existential meaning.

iii. Teacher plants like ayahuasca are being fraudulently commercialized, as the use of them requires, both at the physical and psychological level, an essential preparation (purges, diets, diagnostic filters, etc.) and the utilization of guides and monitoring which these AITMs have highlighted for over hundreds of years of empirical investigation.

iv. Both the depth of knowledge as well as the "newness" of AITMs for the modern mind, highlight the difficulty that many Westerners encounter in discriminating true healers from false ones, including being able to unmask opportunistic Westerners who, due to pathological inflation, can be lead to abusive extremes. Therefore, it is necessary to rely on health professionals, sincere therapists, and committed researchers, who being familiar with these AITMs thanks to of years of preparation and training, can offer ethical soundness, solvency, and adequate and well-founded guidance to those wanting to learn the tradition of AITMs.

v. We join together with movements such as those of the Colombian indigenous Ayahuasca masters or "Taitas" (UMIYAC) in their protest against the fraudulent use which can generate grave consequences, and their proposals for ethical codes and careful and proven methodologies.

vi. We recognize that the extension of this abuse takes place in European as well as American and Asiatic (Australia, Japan) countries, being that in the last few years so-called "shamanic tourism" has given rise to amoral opportunists as well as those simply ignorant of the risks they expose themselves and their patients to.

4. Signers of this Manifesto.

The signers of this Manifesto, professionals accredited in their respective disciplines (psychology, medicine, anthropology) as well as politicians of all tendencies, intellectuals, religious persons, and the public in general, wish to contribute to having society become conscious of this immense patrimony and promote adequate means for preserving the ancestral knowledge of destruction and abusive exploitation, that it be studied and put at the disposition of the majority, being that this indigenous tradition represents an invaluable support in attempting to have this post-modern society move away from the crisis of values in which it is currently immersed.

We propose that the following regulations be carried out with respect to the use of these plants:

i. Accreditation of those centers where their use is transmitted with experience and integrity.

ii. Accreditation of health professionals with qualifications and practitioners in the tradition of AITMs recognized by their equals, in order to contribute to the creation of bridges of investigation and cooperation between both fields of knowledge

iii. Establish these accreditations (i and ii) through recognized associations of practitioners of AITMs and in conformity with the ethical codes elaborated by these.

iv. Promulgation of public education on the beneficial use of AITMs as well as underlining warnings about the abuse and degradation of practices put in place in the last few years.

v. Invite the research laboratories, universities, and academic institutions respectful of indigenous traditions to support and finance projects and research about AITMs; also invite different churches to open up to and enrich themselves with the spiritual contributions offered by AITMs.

vi. Call upon the governments of the Americas, the political classes, clerics, intellectuals, and society in general, requesting their support of this Manifesto.

vii. We hope that national governments such as those of Peru, Colombia, Ecuador, Bolivia, Brazil, Venezuela, USA, Canada and other regional governments such as San Martin (Peru), which have shown awareness and support for the cultural patrimony of these AITMs, also give support at national and international levels to the indispensable recognition and respect toward the use of these medicines, ancestral and current.

viii. It is crucial that Western science be honest, more open and inclusive, and that it recognize these indigenous methodologies that, although distant from centers of conventional power, constitute an authentic and legitimate expression of the evolution of the human being faced with the mystery of our existence.

It is just and necessary.

Promoters of the Manifesto

Manuel Almendro. Doctor of Psychology. Clinical psychologist.
Member of the EFPA (European Federation of Psychology Association).
Director of Oxigeme. Center for a Psychology of Conscience.
Telephone and Contact. 34 91 445 65 65 Madrid. Telephone 34 679 10 86 14. Barcelone, Spain.
E-mail: correo@oxigeme.com
Web: www.oxigeme.com

Jacques Mabit. Medical Doctor. Specialist in Tropical Pathology and Natural Medicine.
President and Founder of Takiwasi Center, Tarapoto, Peru.
Honorary Member of the Peruvian School of Psychologists. Professor Extraordinaire of the Scientific University of the South, Lima. Permanent Fellow of the Ashoka Foundation
E-mail: takiwasi@takiwasi.com
Web: www.takiwasi.com

Eduardo Gastelumendi. Psychiatrist and psychoanalyst.
Ex-President of the Peruvian Psychiatric Association.
Titular Member of the Peruvian Society of Psychoanalysis (SPP) and The International Psychoanalytic Association. Professor in Seminars of the SPP Institute.
Chief co-editor of the Neuropsychiatric Journal. Member of the International Neuropsychiatric Association.
E-mail: egastel@rcp.net.pe