

Choosing Ayurveda as a health care practice in Argentina.

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Abstract

This article analyzes the process of adoption of Ayurveda as a healthcare practice in Buenos Aires, focusing on sociocultural dimensions and material aspects which either facilitate or discourage the following of this foreign medical tradition. Ayurveda is an ancient Indian medicine whose popularity has been on the rise among the Argentinean middle and upper classes. Introduced as a ‘lifestyle’ medicine, it resonates with the new health consciousness of individual responsibility in health maintenance and improvement. Based on in-depth interviews conducted with 20 followers of Ayurveda in Buenos Aires, the article shows that it attracts New Agers, adherents to food-driven subcultures, and patients dissatisfied with the limitations of biomedicine. Followers develop new skills for self-understanding, self-healing, and wellbeing. As adherents to a foreign medical approach, however, they adopt Ayurvedic practices in flexible ways, and some even hold critical views on the elitist market niches of Ayurvedic specialists and products.

Keywords

Ayurveda, choice, complementary and alternative medicine, healthcare

Introduction

Originating in India, Ayurveda is one of the oldest medical systems in the world. The Sanskrit word Ayurveda means ‘science of longevity,’ and it is not only a medical system for the prevention and treatment of disease, but also a way of healthy living (Lavekar and Sharma, 2005; Wujastyk, 2003). The aim of Ayurveda is to integrate body, mind, and

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spirit, taking into account the interconnectedness between the individual and his or her social and natural environment (NCCAM, 2013).¹ Ayurvedic treatments have balancing and cleansing purposes, which include the use of herbs, compounds of animal origin, minerals, diet, physical exercise, massage, breathing techniques, and meditation. They are tailored to the individual constitution (*prakriti*) according to the balance of the *doshas*, the social milieu, and daily and seasonal cycles.²

The key agents in the contemporary cross-national diffusion of Ayurveda have been the Indian diasporas, Western health professionals trained abroad, and international spiritual organizations. The global dissemination of Ayurvedic medicine has also been aided by popular and specialized literature, the press, the Internet, and the expanding international market for beauty products and remedies manufactured by Indian pharmaceutical companies (Bode, 2006; Smith and Wujastyk, 2008). Smith and Wujastyk (2008: 2–3) describe the most recent trend of ‘global’ Ayurveda as an acculturated and reinterpreted healing modality associated with the New Age movement, in which elements borrowed from Eastern spirituality and the commoditization of health and wellbeing are paradoxically combined.

However, despite the vast amount of international literature on complementary and alternative medicine (CAM), research on Ayurvedic patients in Western countries has been scant (Warrier, 2011) and has focused on the Global North. Frank and Stollberg (2002) analyze how patients develop trust in Ayurvedic physicians in Germany, and explain treatment effectiveness. The authors argue that most patients show little interest in looking deeply into the theoretical principles of Ayurveda, and that physicians operate as gatekeepers to socialization into this foreign medical approach (Frank and Stollberg, 2002: 238). In this article, based on a qualitative study conducted in Buenos Aires, Argentina, we analyze why people resort to Ayurveda and adopt it as a healthcare practice, focusing on sociocultural dimensions and material aspects that either facilitate or discourage patient engagement in this foreign medical tradition.

Reasons for choosing complementary and alternative medicine

The theoretical explanations for the use of CAM have pointed to different sociocultural dynamics. For some authors, it expresses dissatisfaction with the limitations of biomedicine for treating chronic conditions, as well as a pragmatic choice from several care alternatives in a context of a growing therapeutic pluralism (Fadlon, 2005; Quah, 2008). For example, Fadlon (2005) suggests the notion of the ‘smart consumer,’ who maximizes the use of therapeutic resources – including biomedicine – in an environment of increasingly diversified health markets. Conversely, other authors argue that CAM utilization indicates a more general criticism of biomedicine grounded in the preference for environmental and body care modalities that favor non-aggressiveness, a holistic concept of health and wellbeing, personal responsibility, and the search for less asymmetric therapeutic relationships. The use of CAM is generally related to New Age and holistic health movements, and to other therapeutic subcultures and forms of cultural innovation among the middle and upper social classes (Astin, 1998; Carozzi, 2000; Douglas, 1994; Sointu, 2012).

Since health has become a major concern in Western contemporary societies, people build their identities mainly around the question of how successful they are at attaining healthy lifestyles (Cockerham, 2005; Crawford, 2006: 402; Lupton, 1996). As the life course becomes more 'open and malleable', 'an active and self-directed way of life is expected from the individual' (Beck-Gernsheim, 2007: 123). Several authors note that CAM amplifies holistic notions of care, and those of individual autonomy and empowerment (Crawford, 2006; Goldstein, 2000; Lowenberg and Davies, 1994). However, while some analysts emphasize the counter-hegemonic potential of CAM against biological reductionism and the cultural and institutional dominance of biomedicine (Douglas, 1994; Wolpe, 1999), other scholars are critical of the holistic movement. They put emphasis on the fact that the medicalization–healthiness continuum is permeating different spheres of everyday life, and that there is a dramatic increase in individual responsibility regarding the search for an ideal state of psychophysical and spiritual wellbeing, stressing also the 'adjustment' between the values promoted by many types of CAM and neoliberal ideology (Crawford, 2006: 410–411). For example, Sointu (2012) argues that holistic discourses have a normalizing effect on the construction of subjectivities, which is embodied in the values of individualism, personal responsibility, and self-exploration.

Giddens (1991, 2003) takes a middle ground in this debate. For Giddens (1991) late modernity is characterized by increasing reflexivity, shown at the macro-social level of institutions and also by agents' everyday actions. Due to the diversification of options available, brought on by cultural globalization, greater access to information and the mediation of experience by expert systems, healthcare practices are seen as 'markers' of lifestyle options and identity building. The lack of a final authority in health matters empowers subjects to decide on a course of action (Giddens, 1991, 2003). Decisions, however, are not free of ambivalence, anxiety, and uncertainty for the individual in a post-traditional order; they are the result of a combination of skepticism and conditional support as well as a combination of 'faith' and enthusiasm in expert systems and specialists. As stated by Giddens (1991, 2003), while market forces do influence projects of the self in contemporary capitalist societies, agents are not passively manipulated by such forces (see also Arnould and Thompson 2005; Melucci, 1996). Being reflexive consumers, they have the capacity to react in creative ways to the commoditization processes which affect their lives, and the capability of discriminating among available types of information and increasingly diversified care resources.

Drawing on Giddens (1991: 80–88) and Pescosolido (1991), we see social agents' healthcare practices as markers of lifestyle choices attached to plural lifeworlds, which are influenced by group pressures, social networks, cultural preferences, and socioeconomic circumstances. While the consumerist approach depicts social agents as calculative and dispassionate, sociocultural theories understand healthcare choices as intersubjective and sociocultural processes involving rational and affective components (Illouz, 2009; Lupton, 1997). Furthermore, patients usually have incomplete knowledge about treatments and need to rely on doctors for advice, which places in doubt their capability to make informed choices in an autonomous way (Gabe, 2013; Gabe et al., see introduction to this special issue). Choices are also dynamic. This aspect is particularly salient in the sphere of CAM utilization, since ideas about health and healing may shift over time as people gain familiarity with CAM, or get disappointed with unconventional

means of healing according to the perceived effectiveness of treatment, the interaction with the specialist, and contextual factors (Sharma, 1996). Structural conditions affect people's capacity to choose (Gabe et al., this issue). As Cockerham (2005: 55) states following Weber, health-related practices are based on choices available to people according to their life chances.

Ayurveda in Argentina

Despite the lack of available data on users and practitioners, there is currently some consensus on the growing diffusion of Ayurveda among representatives of the Ayurvedic professional network. The press has also nourished the image of Ayurvedic medicine as gaining momentum in the country (Freidin and Ballesteros, 2012). The media have described the expanding market of Ayurvedic products and professional services as a local expression of the global 'boom' of CAM and healthy food movements, while local branches of international spiritual organizations have been instrumental in the spreading of Ayurveda, as have yoga centers, integrative clinics, and health food stores.

Ayurvedic physicians prescribe personalized therapeutic plans that consist of dietary adjustments and daily routines of self-care, including physical exercise, meditation, and yoga. Treatments may also incorporate a variety of natural remedies and massage. The use of imported Ayurvedic medication is limited in Argentina due to its lack of availability and the absence of state regulation. Consultations and treatments are not covered by health insurance plans, the social security system, or the public sector; therefore, patients have to pay for them out of pocket. This circumstance makes the choice of Ayurveda a deliberate act of consumption outside the healthcare system (Kellner and Wellman, 1997: 204). A consultation with Ayurvedic physicians is usually very expensive, and it is difficult to get an appointment with the best rated doctors as the waiting time for the first visit is about six months (Freidin et al., 2013).

After presenting the methods, we address the reasons why people want to see an Ayurvedic doctor and how they go about it. We then describe different modalities of engagement in Ayurveda. And finally, we show how stable followers develop flexible Ayurvedic practices according to their cultural preferences and the local way of life, and also hold critical views regarding the commoditization of this foreign medical tradition.

Methods

During 2010 and 2011 we interviewed 17 women and three men who had made a consultation with an Ayurvedic physician in Buenos Aires. These physicians held a degree in biomedicine and were trained in Ayurveda in Argentina and/or abroad. To contact potential interviewees we first asked Ayurvedic physicians, who we had previously interviewed, to refer patients to us. Additionally, we resorted to a snowball sampling strategy through recommendations in our personal and professional networks, purposely diversifying the initial and subsequent contacts to achieve variety among the interviewees. Eighteen of the interviewees were reached by following the latter strategy, which allowed us to avoid the potential bias that the selection of patients by their physicians might have introduced in the sample. We conducted semi-structured, in-depth interviews that lasted

between 60 and 90 minutes, and were fully transcribed. We carried out qualitative thematic analysis through progressive coding, while comparisons across cases were aided by the construction of matrixes and analytic memos (Huberman and Miles, 1994).

The interviewees' ages ranged from 26 to 68 years. They belonged to the middle class in terms of educational and occupational background. Five of them were CAM practitioners: three psychologists who also received training in some CAM (bioenergetics, meditation, etc.), and two yoga instructors. The interviewees had followed Ayurveda for periods ranging from one month to 12 years. Two subjects dropped Ayurvedic medical consultations and practice after a short trial period.

Reasons and routes to seek an Ayurvedic doctor

The interviewees resorted to doctors who specialized in Ayurveda for different reasons: (1) to treat a chronic condition (digestive and sleep disorders, ovarian cysts, an abnormal twitch of the eyelid, nasal obstruction, allergy, herpes, and infertility); (2) to control risk factors (high cholesterol and/or blood sugar level); (3) to relieve menopausal symptoms; (4) for prevention and health maintenance; (5) for guidance on diet (vegetarianism and veganism); and (6) in order to lose weight. Those who consulted for a specific health condition were either concerned about the adverse effects of conventional treatments (e.g., hormone replacement therapy for the menopause), or were dissatisfied with them because they had provided symptom relief and failed to get to the root of the problem. The critical attitude towards biomedicine shows reflexivity in the use of therapeutic resources in a sociocultural context in which there is an increasing awareness of alternative care modalities (Sharma, 1996; Williams and Calnan, 1996). Those interviewees consulting for health maintenance and wellbeing were young individuals who defined themselves as being 'healthy' and were familiar with other CAM. Prior involvement with 'lifestyle diets' (Astin, 1998) and regimes in which food is seen as a 'medicine' (Chen, 2009) forged cultural affinity (Ruggie, 2004) with Ayurveda.

Two interviewees had tried Ayurvedic treatments in India before seeing an Ayurvedic doctor in Buenos Aires. Their encounter with Ayurveda was unplanned and happened during a holiday trip or a spiritual journey. As Langford (2002) shows, spiritual tourism is one of the ways in which Western travelers discover this medicine in its native context. After experiencing Ayurvedic treatments abroad, these interviewees navigated the local world of Ayurveda, advised by acquaintances and relatives, like those who encountered Ayurveda in Buenos Aires. Social networks were the main channel for obtaining information about Ayurvedic doctors and treatments, as has been reported for other CAM (Kellner and Wellman, 1997; Valente, 2000; Wellman, 2000). Relatives, friends, co-workers, clients, and classmates functioned as advisors. In some cases, they simply satisfied the curiosity of people who were looking for holistic care and information on this medical approach.

The practice of yoga has been a key 'bridging' activity to Ayurveda in Buenos Aires. Since yoga and Ayurveda share the same philosophical roots as Vedic Sciences, some yoga instructors are personally and/or professionally connected with Ayurvedic doctors. 'My yoga teacher was beginning her own exploration with Ayurveda, and because yoga was beneficial to me, that's how I got into Ayurveda,' commented Pedro, a 31-year-old

political scientist.³ In two cases a homeopathic doctor introduced Ayurveda to his patients. As it was in keeping with their own interest in the medicinal use of food, these interviewees were willing to incorporate Ayurveda into their healthcare practices.

Modalities of engagement in Ayurveda

The modalities of engagement in Ayurveda were dynamic, depending on biographical circumstances, cultural affinity with alternative medicines, the perceived benefits of treatments, and patient–doctor interaction.

Two interviewees abandoned Ayurvedic practices after a short trial period. Pedro did not find a solution for his nasal obstruction and allergy, and attributed the lack of effectiveness to the Ayurvedic doctor's dogmatism. He was also disappointed in the interaction with the physician, whom he described as distrustful of the patient's adherence to the therapeutic plan:

If she heard me on the phone at noon, and I sounded congested – when *pitta* is predominant because of the highest position of the sun, and the mucus governed by *kapha* supposedly comes down – she would get angry at me and doubt my word that I was following the plan. ... I found that she had a rigid [Ayurvedic] approach. (Pedro)

Alicia, a 52-year-old astrologist, went to an Ayurvedic doctor seeking to achieve mind–body purification through Indian dietary practices. She recalled such a quest as one among many other spiritual explorations through bodily regimes. Being an experienced CAM user, she found that everyday Ayurvedic practices were too rigid: the suggested eating and sleeping times were in conflict with her work schedule, and also disruptive of her social life. Her feeling about Ayurveda, as a paradoxically 'unnatural' regime, led her to question the accuracy of the *dosha* diagnosis. She also pointed to a cultural mismatch when trying to explain the organization of her everyday life according to Ayurvedic principles:

It was so rigid that at some point I felt silly trying to do the routines, because I was forcing myself to have habits that were unnatural to me. ... The food you eat, the spices, the schedule of the meals are rigid and strict ... and you need a strong will to make your life fit that of the Indian people. ... I don't know how anyone could hold this practice for long. (Alicia)

This example shows how local ways of life may discourage the adoption of Ayurveda despite ideological affinity. However, the rest of the interviewees were satisfied with the adoption of Ayurvedic medicine as a healthcare practice, but they engaged in this medical tradition in different ways, as is shown in the following sections.

Pragmatic acculturation and limited practice

Four interviewees adopted Ayurveda as a personalized treatment to help them overcome a health problem, the emotional and physical discomfort associated with the menopause, or to lose weight. Their engagement with this foreign medicine was pragmatic. Even if they became stable followers of Ayurveda, they were not interested in looking deeply into its healing principles. 'The truth is that I am not a fan of this medicine, not to the

point of spending all day reading about it. What I can say is that it worked for me,' commented Clara, a 58-year-old retired English teacher. Similarly, Andrea (45 years old, social worker) stated, 'I was searching for an alternative to help me with my digestive condition, but I am not interested in becoming an "expert" in this medicine, nor in finding explanations of how it works.' These attitudes support the argument of pragmatic acculturation (Quah, 2008) when people resort to a foreign medical system. In this borrowing dynamic, users choose treatments they consider helpful in solving a health problem without necessarily adopting the conceptual paradigm or cosmology those treatments are based on (Quah, 2008: 419).

These interviewees had not had any prior experience with CAM utilization or, if they had, it had been occasional and unsuccessful. They decided to consult an Ayurvedic doctor following the advice of friends and co-workers who were patients of the referred specialist. They complemented Ayurvedic treatment with regular medical check-ups, and biomedicine remained their first choice of treatment for other chronic conditions, as the thesis of limited dissatisfaction with biomedical care among CAM users suggests (Fadlon, 2005). The lack of effectiveness of conventional treatments or the fear of side-effects led them to alternative medicine. Efficacy and a satisfying doctor-patient relationship facilitated their becoming stable followers of Ayurveda.

As described by the interviewees, the Ayurvedic doctor established a therapeutic bond that respected the needs and individuality of the patient. It was a patient-doctor relationship in which elements of autonomy and paternalism coexisted. Autonomy was implied in the limits negotiated by the patient regarding the point up to which it would be wise to resort to Ayurveda in order to treat different ailments, consistent with the patient's own hierarchy of therapeutic resources. Whereas paternalism was displayed when delegating the limited process of enculturation into a foreign medicine to the educational role of the specialist (see also Frank and Stollberg, 2002) or, alternatively, when patients concealed from their doctor the fact that they did not comply with some of her or his recommendations.

Cultural affinity and the Ayurvedic lifestyle

Contrary to the pragmatic patients, most of the interviewees defined their engagement in Ayurveda as a lifestyle choice which encompassed various practices and daily habits (meditation, yoga, eating and sleeping routines, etc.). They were quite knowledgeable of the Ayurvedic paradigm, and defined Ayurveda as a pathway to conscious self-care and self-awareness, and as a medicine of 'consciousness':

My concept of health is more oriental, i.e., health is a dynamic state. ... I don't wait to get sick to go to the doctor's office. ... And Ayurveda integrates many things; it is like a lifestyle. (Lola, 32 years old; astrologist, visual artist and musician)

Physicians will ask you how you sleep, eat, eliminate bodily wastes, whether you clean your tongue, all that very basic stuff nobody really cares about ... and prescribe the remedies depending on your weakness or imbalance. In Ayurveda everything relates to your habits, to whatever you do in your everyday life. (Julia, 50 years old, yoga instructor)

As Warriar (2009: 438) points out, a better knowledge of Ayurvedic principles shapes a new form of self-awareness, which allows its followers to read and interpret their own

mental and physical processes. To this end, they generally integrated some learning from other forms of CAM they were familiar with, or in which they had some professional training. Cultural affinity or philosophical congruence, as Astin (1998: 1548) puts it, made Ayurveda appealing to them due to its compatibility with their spiritual orientations and health beliefs. These interviewees were fluent in Ayurvedic terminology and articulate when linking their practices to the Ayurvedic paradigm. For them, Ayurvedic precepts worked as an interpretative framework for self-understanding and as a means of 're-skilling' (Giddens, 1991) for self-care and health maintenance:

You begin to understand a lot of things and to realize which things are good for you and which are not; for example, why some people are imbalanced in summer while other people are imbalanced in winter, because we are part of a whole and everything affects us. It helps you understand yourself much better ... and based on that knowledge, you learn how to help yourself re-establish the balance. (Maria, 31 years old, yoga instructor and Ayurvedic massage therapist)

For these interviewees, their first care option was alternative medicine. They resorted to biomedicine in instrumental terms for diagnostic tests, annual check-ups, acute conditions, and emergencies. Biomedicine was their last choice for treating chronic ailments in which CAM had proven ineffective.

The interviewees' experiences with other CAM constituted 'holistic cultural capital' (Sointu, 2012) in the interaction with the Ayurvedic physician, facilitating mutual expectations as to personal responsibility in healthcare. For some of the interviewees, the Ayurveda specialist became their primary doctor, while for others, they played the role of an important advisor in their health network. The effectiveness of the therapeutic plan and their confidence in different CAM specialists would come into play in their preference for pluralism or 'holistic eclecticism' (Sharma, 1996). For example, Maria had an Ayurvedic physician but also a trusted homeopathic doctor, even though her Ayurvedic physician practiced homeopathy. Similarly, Alejandra, a 60-year-old psychologist, consulted with a specialist in Chinese medicine to treat a hiatal hernia.

Although the interviewees valued the less asymmetric relationship with the Ayurvedic physician, the moment the effectiveness of the treatment for a chronic condition was no longer effective and they needed to choose an alternative course of action, both the treatment and the bond with the specialist were called into question. It was in these situations that the therapeutic authority of the physician was required. As Sharma (1994: 2) shows, in the 'equation of responsibility' which typifies several CAMs, there is a balance between the empowerment of the patient to exercise control over their own health and the confidence the patient has in the expertise of the specialist to lead them through the therapeutic journey. In such a situation was Andrés (43 years old, psychologist) who had successfully treated an infertility problem and genetic hypercholesterolemia with Ayurveda, until it stopped being beneficial for the latter. On the one hand, he attributed the ineffectiveness to his distrust of the treatment, 'The moment I start having doubts, my system produces cholesterol.' On the other hand, Andrés felt uneasy as he was forced to take the initiative of searching for allopathic treatment alternatives by himself:

All the research related to cholesterol I had to do by myself. I told him [Dr X] I wanted to talk to him about this because my father also has genetic hypercholesterolemia [and] he ended up with a bypass If I didn't come up with the need to research for biomedical alternatives, he was not going to take the initiative. (Andrés)

Discontinuous practice

Two interviewees did not become stable users of Ayurveda despite their cultural affinity with this medical approach. Intermittence was due to working or social schedules that prevented adjusting everyday routines to the Ayurvedic plan, in spite of the observed benefits. Or it was due to the interviewees' therapeutic eclecticism, which turned the Ayurvedic medical consultation into an instance of exploration within a larger frame of searching for wellbeing and holistic care. Luisa (26 years old, undergraduate student of anthropology) became interested in Ayurveda, both for the vital role given to food and because she wanted to find a specialist who could lead her on the path towards holistic care. Reflecting on her commitment to Ayurvedic practices, she concluded that she considered them as a group of resources and tools which she could activate on demand, according to her changing care needs:

I'm not committed to it [Ayurveda]. But I keep it in mind, let's say, as a tool, right? When I feel that some of it could be useful or helpful to me, I use it at that very moment, but I don't go like, 'Oh, yes, I practice Ayurveda' I took other paths, did some other things, too. Life kept leading me to what I needed. (Luisa)

What the literature often identifies as 'consumerist' behavior can account for the experimentation with CAM (Fadlon, 2005). In Luisa's case, however, it was a learning process in which she attempted to identify shifting care needs and to make use of different therapeutic resources. It was a care pattern built around the value of autonomy concerning the choice of different specialists and health approaches, which gained significance within a wide range of therapeutic experiences (Sharma, 1996). These followers resembled the *empowered pragmatics* described by Sointu (2012: 127–128); as eclectic CAM users, they drew from each therapy what they found most convenient for their health needs and most suitable for their life projects.

Cultural adjustments and situational flexibility

Stable followers stressed that they followed Ayurvedic practices without 'fundamentalism,' meaning that they were flexible in their practices. Some interviewees compared their practices to those of an imaginary 'authentic' Ayurveda follower, or to the Ayurvedic lifestyle they had had the chance to witness in India. Andrés, for example, wondered if he was *really* practicing Ayurveda and concluded that, as a borrower of a foreign medical tradition, he was just 'scratching the surface':

I first thought Ayurveda was unattainable, because it was a way of life. Even today, I think that I'm just scratching the surface I don't know, perhaps I'm too exacting. . . . I know that Ayurveda comes from the Vedas, the ancient wisdom codified in the Vedas and that it includes

massage, breathing techniques, thoughts, meditation, yoga, *pranayama*, food. And I do all these things, actually, but I wonder how close I really am to Ayurveda. (Andrés)

Likewise, Ana (30 years old, co-owner of a small consulting firm) said that it was impossible to follow a 'pure' Ayurvedic lifestyle in Buenos Aires since, as a therapeutic practice transplanted into another sociocultural milieu, it demanded adaptation to local ways of life:

I have followed Ayurveda in my own way. ... There are things that I say, OK, if I were in Kerala, I could do them, but here, with my way of life, it's impossible. Waking up at dawn and following my biological biorhythm is not easy for me; but sometimes I do follow all this more closely and I do feel the benefits. ... But I don't follow a pure Ayurvedic life regime, so to speak. (Ana)

Biographical transitions and the constraints of everyday life led some interviewees to deviate from *ideal* Ayurvedic practices. Lola, for example, began to freeze her meals instead of eating fresh food after she had a baby and her personal time priorities changed. She saw this adjustment as a means to maintain an emotional balance in her life. Her workplace also limited her ability to perform some daily routines, such as having lunch at noon in a suitable eating environment.

A flexible engagement with Ayurveda was also a lifestyle choice that stable followers deemed necessary in order to preserve family rituals and socialize with friends who did not share their health practices. They sought to reach a balance between their personal health pursuits and their social and family life. In this sense, their decision-making did not follow instrumental rationality, as the consumerist health approach postulates (Gabe, 2013). Instead, their choices were guided by family and social bonds and cultural values. As Illouz (2009: 386) argues, emotions infuse consumption and lifestyle choices with cultural meanings; they help explain how actors assign priorities, and give them a sense of autonomy and agency. Maintaining shared simple pleasures that revolved around food and reinforced family and social ties was regarded by the interviewees as a 'healthy' choice. For example, Juliana (30 years old, visual artist) enjoyed the Ayurvedic food regime but commented that she also liked drinking wine with her grandfather during their weekly meetings, 'I don't want to abandon this ritual even if alcohol isn't good for me because I'm *pitta*.' The consumption of other foods and beverages that should be avoided according to Ayurvedic principles also reflected the decision to be more flexible about dietary principles for the sake of personal gratification, and because of a desire to reaffirm cultural identity. For example, Mercedes (31 years old, music teacher) should have avoided *mate*, a hot beverage that is part of Argentina's culinary identity, but she kept drinking it, reluctant to give up her cultural loyalties (Douglas, 1994):

Wait a minute [she said to the doctor], I am Argentinean ... and in the evenings I drink *mate* with my buddies; I don't know ... it's part of my life.

Critical views of the commoditization of Ayurveda

Sointu (2012: 39) argues that in Western societies CAM is a care option within an economic and cultural context marked by consumerist behavior. Nonetheless, in our study,

some of the interviewees shared a critical view of the local market for CAM and of some niches of the Ayurvedic professional network. Their complaints included the commoditization of oriental spiritual practices, which have been reconfigured as anti-stress techniques in the Western world. Pedro, for instance, questioned some techniques of Ayurvedic meditation related to the transcendental meditation method:

This meditation practice is part of something that is truthful and genuine; a genuine experience of an ancient tradition linked, let's say, to a business enterprise and a new discourse on stress management, which is very appealing [in the West]. (Pedro)

Pedro was critical regarding the cost of medical consultations and the location of Ayurvedic professionals in middle and upper class neighborhoods. There were also some claims about snobbishness and frivolity in the CAM market. Claudia (56 years old, architect) said about massage offerings, 'in general, all this stuff is expensive, like massage. ... In a nutshell: there is something like a boom of foolishness.' When assessing the elitist features of the Ayurvedic market, these interviewees acted as critical consumers and due to ideological objections and/or material constraints, they developed selective consumption practices. Their reluctance to buy some commodities shows how followers negotiate their involvement in Ayurvedic market niches (Arnould and Thompson, 2005). Agents are not passively manipulated by market forces; as reflexive consumers, they have the ability to discriminate among available types of information and increasingly diversified care resources (Giddens, 1991, 2003).

Discussion

Our study shows that Argentinean followers of Ayurveda adhere to the cultural imperative of health and wellbeing as goals to be achieved through individual effort and personal responsibility (Crawford, 2006; Lupton, 1996). Ayurvedic medicine is defined as empowering and re-skilling (Giddens, 1991), for providing practical tools and therapeutic principles for self-care according to different modalities. Faced with the individuation process of contemporary Western societies and the concomitant reflexive construction of the self, with its ramifications for health and body care, Ayurveda is appropriated as an interpretative framework based on individuality and personalized care. Owing to the legitimacy granted to oriental medicines and to their universal truths, as heralded by its Western followers, which diverge from the reviewable character of Western scientific knowledge – what Giddens (1991) calls a re-traditionalization dynamic – Ayurveda serves as an 'anchor' for healthcare. Similarly, Sointu (2012: 143) argues that the notion of 'oriental wisdom' acts as an organizing and legitimizing principle for many forms of CAM.

Nonetheless, the adoption of Ayurveda as a lifestyle medicine poses some difficulties in Buenos Aires. The therapeutic plan may come into conflict with working and/or family life, and other spheres of sociability. Flexible adjustments help strike a balance between the individual pursuit of health, biographical circumstances, and the demands of the social and cultural environment. Furthermore, ideological objections to some elitist features of the Ayurvedic market and material constraints lead to a selective consumption of professional services and products.

We can conclude that the choice of Ayurveda in Argentina shows some elements of 'consumerism' (Gabe, 2013; Lupton, 1997), such as the active role of the patient regarding decisions about healthcare. Agency is observed in the resistance to passive acceptance of either biomedical or holistic treatments. However, even if autonomy in the selection of therapeutic resources was valued by the interviewees, we have shown that healthcare decisions were not taken by a dispassionate and calculating agent but in the context of their health social networks (Pescosolido, 1991), and that emotional elements and cultural preferences did play an important role in their decision-making. Moreover, interviewees modified Ayurvedic practices intentionally, sometimes to preserve social bonds and everyday simple pleasures, even if these alterations were to result in 'suboptimal' health outcomes. It was a choice that helped them keep a healthy lifestyle by weighing up other priorities in the context of their life projects (Lupton, 1996). Nor does it seem to be the case of agents making decisions in conditions of full information, as there were some people with little in the way of a holistic background and interest in learning about the Ayurvedic paradigm. Finally, although the Ayurvedic medical consultation facilitates patients' empowerment, some paternalistic elements may coexist. This is shown either when patients delegate the process of enculturation into this foreign medicine to the physician, or in instances when the treatment ceases to be effective. When this happens, even patients who develop a great competence for self-care in the course of time still expect the physician to play an active role regarding a course of action. Instead of 'shopping around' for treatment (including biomedicine) in an autonomous manner, patients may require the physician's guidance. Undoubtedly, both emotional and rational aspects play a part in their expectations of proper care (Illouz, 2009; Lupton, 1997; Sharma, 1994).

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Notes

1. The theory of Ayurveda assigns all matter/energy interactions in the world to five primal elements or 'states of existence': earth, water, fire, air, and ether. These elements manifest in the human body as three physiological forces called *doshas* (*vatta*, *pitta*, and *kapha*), which underlie Ayurvedic diagnosis and therapeutics (Singh Khalsa, 2007: 134–135). Disease is the product of *dosha* imbalances.
2. The codification of Ayurveda dates back at least 2000 years, and its philosophical roots date back to the Vedas. Ayurveda developed as a living tradition with the writing of new medical texts and the exploration of new paradigms. It experienced profound transformations under the British rule with the introduction and official support for Western allopathic medicine. During the 20th century, as part of a national project of Ayurvedic revival and the modernization of

India, the structure of teaching Ayurveda began a process of standardization, through the creation of universities, hospitals, and pharmaceutical companies (Smith and Wujastyk, 2008).

3. The interviewees' names are pseudonyms.

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Résumé

Dans cet article, nous analysons le processus d'adoption de l'Ayurveda en tant que stratégie de soins de santé à Buenos Aires en nous concentrant sur les dimensions socioculturelles et les aspects matériels qui facilitent ou entravent la pratique de cette médecine traditionnelle étrangère. L'Ayurveda est une médecine originaire de l'Inde antique dont la popularité a augmenté dans les classes moyennes et supérieures de l'Argentine. Présentée comme une médecine « du mode de vie », cette approche rejoint la récente sensibilisation à la responsabilité individuelle dans le maintien et l'amélioration de la santé. À la lumière d'entretiens approfondis menés auprès de 20 adeptes de l'Ayurveda de Buenos Aires, nous montrons que cette approche attire des novices, des partisans de sous-cultures axées sur l'alimentation et des patients insatisfaits par les limitations de la biomédecine. Les adeptes développent de nouveaux savoir-faire contribuant à l'auto-compréhension, à l'auto-guérison et au bien-être. Toutefois, en tant qu'adhérents à une approche médicale étrangère, ils adoptent l'Ayurveda d'une manière flexible et certains émettent même des opinions critiques sur les niches élitistes du marché des spécialistes et produits ayurvediques.

Mots-clés

Ayurveda, choix, médecine complémentaire et alternative, soins de santé

Resumen

En este artículo analizamos el proceso de adopción del Ayurveda como una práctica de cuidado de la salud en Buenos Aires, focalizándonos en las dimensiones socioculturales y en los aspectos materiales que facilitan o desalientan el seguimiento de esta tradición médica foránea. El Ayurveda es una medicina milenaria de la India cuya popularidad ha ido en aumento entre las clases media y alta de Argentina. Introducida en el país como una medicina de 'estilo de vida', resuena con la nueva conciencia de la salud acerca de la responsabilidad individual en su mantenimiento y cuidado. Sobre la base de entrevistas en profundidad realizadas a 20 seguidores del Ayurveda en Buenos Aires, mostramos que atrae a seguidores de la Nueva Era, a quienes adhieren a subculturas alimentarias, y a pacientes insatisfechos con las limitaciones de la biomedicina. Sus seguidores desarrollan nuevas habilidades para el autoconocimiento, la autocuración y la búsqueda

de bienestar. Sin embargo, como seguidores de un enfoque médico foráneo, adoptan las prácticas ayurvédicas en forma flexible, y algunos incluso critican los nichos elitistas del mercado de los especialistas y los productos ayurvédicos.

Palabras clave

Ayurveda, cuidado de la salud, elección, medicina complementaria y alternativa