INTRODUCTION

This book is a history of popular and conventional medical practitioners in Costa Rica, a dynamic periphery of Latin America. It begins in the late colonial era when none of the fifty thousand inhabitants of this southernmost province of the kingdom of Guatemala had access to a titled physician, surgeon, pharmacist, or midwife. In the early 1800s, all Costa Rican medicine was popular medicine. The book closes in the 1940s when the figure of the qualified medical doctor, once extraordinary and alien, was a part of everyday life for a great many Costa Ricans. A people approaching the one million mark were increasingly likely to be treated by licensed doctors and allied health practitioners numbering over a thousand. Almost half the legislators of this relatively prosperous coffee republic were medical doctors, and in 1940 Costa Ricans had elected by an overwhelming majority Dr. Rafael Angel Calderón Guardia, a charismatic physician whose populist program was built on the introduction of medical benefits under Social Security.

The story told here, however, is not the rise and triumph of the modern biomedical doctor. Instead, the book documents the exploits of an ever wider variety of healers over this long period, and maps the interactions among them in a modern medical universe characterized by increasing stratification and heterogeneity. By 1940, schooled and titled practitioners had made an indelible mark on health care in the country, but these included not only doctors in medicine and surgery, not only midwives, pharmacists, and nurses, but also homeopaths, osteopaths, and spiritists. Moreover, the indigenous curer, the empiric midwife, the *curandero* who specialized in herbal medicine or minor

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surgery, and the home caregiver were still vital figures in the Costa Rican pantheon of practitioners, even if most such healers had modified their repertoire over the preceding century through a growing familiarity with conventional medical practice. Meanwhile, after 1875, Chinese and Afro-Antillean healers arrived in sufficient numbers to introduce powerful new medical traditions to the country. By the mid–twentieth century, this variety of practitioners ministered to a suffering public that tended toward an eclectic approach to illness, capable of comfortably combining an understanding of germ theory, humoral conceptions of common complaints, a belief in the efficacy of homeopathy, and a knowledge of the healing power of saints, spirits, and modern surgical instruments.[1] *From Popular Medicine to Medical Populism* explores the role of practitioners in creating this Latin American world of medical pluralism.

Over the past fifteen years, some excellent work has been done on Latin American medical elites in the century after 1850. Scholars have revealed the emergence of world-class medical scientists and institutions in a variety of settings. They have effectively undermined the notion that Latin American science was "passively derivative" of metropolitan trends, while showing how the politics of medical research on the periphery ultimately limited its global scientific impact and subverted its institutional evolution.[2] A small number of studies have broached the subject of medical professionalism in the region, likewise illustrating that the timing and form of this process depended as much on local political and medical conditions as they did on the adoption of international trends.[3] On the other side of the divide, while curanderos, shamans, and spiritists in Latin America have been intensely studied by anthropologists, properly historical treatment of popular medical practice in the nineteenth and early twentieth centuries has only recently begun.[4] A number of other topics central to the new social history of medicine have been brushed on with promising results: the stature of conventional and popular healers, the role of gender and ethnicity in the formation of practitioner identities, the emergence of a medical marketplace, and the politics of medical regulation.[5]

The following pages combine all these perspectives in an effort to gain a holistic view of medical practitioners in a Latin American society over an extended period of time. The risks of this approach have become obvious to me as this study progressed, but I think they are far

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outweighed by the potential rewards that can come from putting together for analysis domains that are usually observed in isolation. It is no longer controversial to claim that the difference between "irregular" and "regular" medicine is historically constructed rather than reflective of any essential beliefs or practices. The two domains define their identities in terms of one another, in ways that are mediated by social and political engagement. As a result, they are highly unstable: one era's quackery may be another's conventional practice, and vice versa. Yet conventional and popular medicine in any given period still tend to be studied separately, and so their dynamic relationship is rarely reconstructed.[6]

By taking the long view and including as broad a range of practitioners as possible, I hope to show that the rise of a Costa Rican health system oriented by biomedicine and professionalism was strongly influenced by the dynamic interchange between popular and official medicine. The relationship between the two domains was neither as well-defined nor conflictive as one might suppose. Conventional medical practitioners and institutions became more numerous and powerful over time, sometimes swallowing up or fatally weakening popular rivals in their wake, or more rarely suppressing them directly. But throughout this period, strong forms of popular and alternative medicine survived, renewed themselves, or appeared for the first time in the practices of unlicensed healers. These, in turn, were often reincorporated into the sphere of official medicine by governments that persisted in finding ways to license irregulars and thus recruit them into the expanding web of state power. The official biomedical array that assumed its modern form in the 1930s and 1940s still resonated with popular refrains.

The book's nine chapters cover two main phases in Costa Rican medical practice. The first stretches from the late colonial period to the end of the nineteenth century. A growing variety of practitioners of both sexes, many ethnicities and nationalities, and multiple specialties and approaches emerged in the context of increases in population, international commerce, and overall social wealth—these latter two being part and parcel of a booming coffee export economy. Although by midcentury a small community of titled medical doctors formed, it was unable to impose norms on the medical universe. The heterogeneity of healing practice was officially enshrined in the young republic's system of medical regulation and unofficially promoted by state

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tolerance for those practicing medicine without a license. Even as physicians, surgeons, and pharmacists acquired greater professional cohesion and political power starting in the 1870s, the government continued to undermine the medical monopoly they sought by practicing tolerance and selectively appropriating popular medical practitioners into the state's incipient health network.

During the second phase, which extends from the 1890s to the 1940s, physicians and public health experts with growing international connections built an official medical apparatus as an integral part of public power. The drive for professional monopoly was successfully undertaken by an elite of medical doctors who were also members of the Costa Rican oligarchy; this process of professionalization was inseparable from the consolidation of the nation-state, and discourses and images drawn from new medical science were fundamental in solidifying the positivist ideology that shaped and justified the goals of the liberal polity. The institutions of state medicine created during these years promoted the "medicalization" of everyday life. Childbirth was transformed into a clinical procedure that while still largely occurring in the home at the outset of this period, was overseen by titled midwives schooled according to a biomedical model. The population was introduced en masse to the "germ theory" through sustained public health campaigns, and the vast majority of Costa Ricans were subject to a blood and fecal exam by agents of the state, followed by a laboratory-based diagnosis and cure of a disease through targeted pharmacological attack on a specific microorganism, the pernicious hookworm.

Boundaries between conventional and "irregular" medicine were more sharply drawn during this period, as were divisions among a growing number of titled allied health practitioners, with medical doctors more clearly at the apex. Nevertheless, popular as well as new nonstandard medicines thrived, and pharmacists happily acted as general practitioners in managing the common complaints of their clientele (even as they filled prescriptions from physicians and curanderos alike). Though unlicensed practitioners were now subject to persecution by a state formally committed to enforcing professional monopoly, this policing was generally tepid. Indeed, the public power often found ways to license irregular healers in order to extend state medicine into rural areas that were without a physician. And if many popular healers now seemed to imitate physicians more closely, doctors also made conces-

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sions to popular health beliefs in order to consolidate their position in the expanding medical marketplace.

Orientations

While a basic division between conventional and unconventional medical practitioners is inevitable and plays a crucial role in defining medicine at any point in time, a consideration of the full spectrum of healers is essential in order to see how that frontier is drawn and redrawn over time. Some healers in Costa Rica clearly practiced on one or the other side of this divide; others are less easy to categorize and displayed an eclecticism that drew from both domains of medicine. With the rise of a more tightly regulated medical profession toward the end of the nineteenth century, these eclectic healers were to be found increasingly on the alternative end of the spectrum. Occasionally they assumed counterhegemonic positions in relation to official practitioners, especially in opposing the monopoly of medical doctors. This book argues, however, that more often than not they served as intermediaries between official and popular medicine. This ultimately meant that a large number of popular healers played significant roles in negotiating the hegemony of biomedicine, translating key notions and ranges of behavior from official medicine into the vernacular while maintaining sites of popular medical practice that promoted pluralistic configurations.

This broad thesis does not easily fit into the literature on conventional and popular medical practice in Latin America. Though the dynamic is only just beginning to be reconstructed in properly historical terms, scholars frequently suggest or assume that the continent's politics of health have been marked by a binary opposition between popular medicine and biomedicine—one that became increasingly rigid as the revolutions in surgery, bacteriology, and medical professionalism gained momentum over the latter third of the nineteenth century. The curandero and shaman are imagined in open combat with the biomedical ideologue.

In 1970, the medical anthropologist Irwin Press noted a "developing stereotype of *the* curandero's style and function," one that was becoming an institution in the Latin Americanist's repertoire; a veritable homage to the peasant milieu which represents Latin America at its 'purist.' "[7] The classic popular practitioner is associated with a healing

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culture derived from an indigenous or African past as well as the practice of an empirically derived and orally transmitted medicine. The popular medical "system" is characterized by the centrality of magical and religious elements, humoral understandings of illness, herbal remedies, and a close healer-patient relationship in which the healer is of the community and outside the cash nexus.

So, for example, Lynn Marie Morgan's fine recent study of primary care in Costa Rica proposes that "prior to the introduction of biomedicine, indigenous and traditional healers practiced their craft, while a rich herbal pharmacopoeia provided the first line of attack against disease." This Arcadian world entered a period of crisis in the late nineteenth century when a new generation of biomedical physicians, themselves members of the capitalist oligarchy, allied with "two wealthy and powerful United States organizations — the United Fruit Company and the Rockefeller Foundation — . . . gradually [transforming] the health infrastructure and dominant models of medical care along the lines of the germ-theory model of disease etiology, using disease-eradication techniques perfected during the Spanish-American War."[8] Here, typically, the ideal curandero is more sharply defined through juxtaposition with another developing ideal type: the biomedical doctor. The biomedical doctor is defined by his learned, written, and theoretical understanding of disease conceived of in biological, rational, and secular terms; a therapeutic arsenal of pharmaceuticals; official certification by political elites; and an aggressive drive to dominate the medical marketplace. Also crucial to this juxtaposition is that the biomedical doctor represents an alien, neocolonial system of medical control while the popular healer expresses an authentic local culture that is capable of offering resistance to a colonizing biomedicine.[9]

Such a perspective echoes the work on the history of public health done in the 1970s and 1980s in a climate heavy with dependency theory. Its most distinguished exponent, Juan César García, maintained that Latin American states and oligarchies began to promote state medicine in the late nineteenth century in a way that reflected their dependent political economies. That is, their efforts to sanitize port cities and improve the constitution of agricultural laborers directly responded to the needs of imperial powers and the agro-export bourgeoisie as they sought to accelerate capitalist production and the insertion of Latin American economies into the world market.[10] This view meshes with the

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anticolonial thrust of recent scholarship on medicine and empire—a strand of cultural studies that derived much of its inspiration and rhetorical power from the general coincidence of two broad yet related historical processes during the second half of the nineteenth century. While the medical profession, bacteriology, tropical medicine, and public health were consolidated in the West, the countries in which this matrix was most successfully articulated were the same ones that created a new imperial order in Africa, the Asian subcontinent, Southeast Asia, and the Caribbean.[11]

The Latin American case was left out of important studies on imperial medicine, perhaps due to the lack of a clear and discrete moment of biomedical intrusion. Because of the early and hybrid colonial experience of Latin America, "Western" medicine was "indigenous" to the region long before its biomedical guise was fully donned.[12] Moreover, as a number of recent studies of the Rockefeller Foundation in Latin America have shown, it is not always possible to portray the arrival of U.S. public health institutions in the region in such a straightforwardly imperial fashion. Without losing sight of the general backdrop of unequal geopolitical relations between the United States and host countries, scholars have given center stage to questions of how foundation missions were transformed through their engagement with concrete local conditions.[13] As this study reveals, even in peripheries like Costa Rica, established groups of medical and public health practitioners were there to greet the agents of imperial public health with their own agenda. Costa Rican physicians had discovered that hookworm disease was endemic to the country in 1895, some years before researchers made the equivalent finding in the United States, and the Costa Rican state authorized a local treatment campaign for hookworm disease in 1906, even before Rockefeller philanthropy decided to make hookworm the focus of its foray into public health work in the U.S. South. When agents of the Rockefeller Foundation arrived in Costa Rica in 1914, the organizational model and solidity of funding that accompanied them were novel, but they brought little that was new in epistemological or scientific terms.

Nevertheless, the dependency and neocolonialism perspectives remain compelling for Latin America, where popular medicine so often overlapped with subordinate ethnicity, and where after 1850 the medical elite were frequently members of both the agro-export oligarchies

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and positivist governments. The liberal modernizing states of Latin America, in finally establishing political control over disparate indigenous, black, and mixed-race population groups in the urban barrios and rural areas, displayed real similarities to the contemporary European colonizing regimes of Africa and Southeast Asia. These "civilizing" programs generally involved the imposition of authoritarian public health measures that met popular resistance. One classic episode of such biomedical intrusion in Latin America was the 1904 mandatory smallpox vaccination campaign in Rio de Janeiro that provoked serious riots and general resistance to yellow fever control measures. A fine recent study by Sidney Chalhoub has made a strong case that the "vaccinophobia" motivating some of the rioters was partly based in Afro-Brazilian medical beliefs.[14]

Studies like Chalhoub's, as well as David Sowell's pioneering history of the popular Andean healer Miguel Perdomo Neira and the tumultuous 1870 confrontation between his followers and the medical elites of Bogotá, offer detailed historical confirmation of the powerful rebellious and counterhegemonic strains in the region's popular medicine. It may well be that the characteristics associated with the ideal type curandero are also those most likely to motivate such episodes of resistance. The focus on these dissident dimensions of popular healing is also a response to the traditional historiography of Latin American medicine—much of it written by physicians—that typically derided the alleged superstition and ineffective, when not actually dangerous, therapeutics of popular practitioners.[15] Contemporary scholars have tried to understand popular medicines on their own terms, while turning a more critical and skeptical gaze on the supposed virtues of biomedicine.[16]

This trend has obscured a significant part of the spectrum of Latin American healers. In his study of the Argentine medical profession in the second half of the nineteenth century, Ricardo González Leandri notes that physicians of the era concentrated their attacks on precisely those rural curanderos who closely corresponded to the ideal type I have outlined. They "converted this sector, which represented only a fraction of irregulars, into the stereotype of the activity." By making "curanderismo" synonymous with superstition and miracle cures—with "el médico de la bolita" (the doctor of the crystal ball)—physicians could more easily exalt their own allegedly special attributes.[17] Modern scholars have inverted this perspective to good effect, revaluing impor-

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tant dimensions of popular medicine. In doing so, however, they may also adopt a restricted, bipolar field of vision.[18]

Concentrating too heavily on the ideal type curandero, according to Irwin Press, risked "a rather monolithic and limiting approach to curers and curer-related phenomena" in which more mundane illness is relegated to a minor position and "a wide range of practitioners is ignored or assigned to some residual category such as 'marginal' or 'limited.' "[19] Though Press was referring to a wide range of *popular* practitioners, I think it can equally be said that by focusing on the biomedical zealot, a diverse array of conventional, certified practitioners is also excluded from view. The historian of popular and professional medicine in France, Matthew Ramsey suggests that the concept of a modern "official medicine" is not nearly as self-evident as one might like to think. "We can perhaps agree in recognizing it as a domain in which the activities of certified expert practitioners of medicine intersect with the activities of certified experts in the production of scientific knowledge. But this is very abstract, and the key question of how, historically, such a domain was constituted in different social and political contexts has not received the sort of attention that scholars have devoted to . . . the development of the modern medical profession and the construction of scientific authority."[20]

In this spirit, the following study tries to move beyond the binary framework that currently governs the view of medical practice in Latin America. It proposes that popular medicine was not synonymous with oral tradition, unlettered empiricism, and religious and magical belief, nor was conventional medicine practiced by a homogeneous group of highly trained biomedical ideologues applying alien techniques and medicines. It calls into question the dichotomous representation of popular practitioners as authentic expressions of the local community versus biomedical doctors as agents of neocolonial intrusion. I will also challenge the idea that official medicine engaged in a consistent campaign to suppress and eradicate popular medicine. Though such a fantasy existed in the minds of many an official medical zealot, and was often on the formal government agenda, it never came anywhere near fruition. The relationship between popular and conventional practitioners was characterized by coexistence, complementarity, and dialogue more than outright rivalry and ideological warfare.

Perhaps more important, the state never consistently displayed an

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interest in suppressing irregular medical practice. Indeed, one of the most intriguing and paradoxical findings of this study is that although the professionalization of medicine was an essential part of the formation of the Costa Rican liberal state, that same public power persistently subverted professional monopoly by finding ways tacitly and explicitly to certify untitled healers to practice medicine. Moreover, police and judicial agents were generally soft on unlicensed medical practitioners—so much so that one can speak of an informal, but widely accepted state policy of tolerance in this domain. It was through such "everyday forms" of negotiation among agents of the state, medical professionals, and popular practitioners that the contours of modern medical hegemony were established.[21] On the one hand, the empirics tolerated and licensed by the state were generally those who practiced conventional styles of medicine. The state, in this sense, did not call into question the legitimacy of conventional medicine as defined by the professional community of doctors, but it did throw into doubt the legitimacy of professional monopoly. On the other hand, though a majority of popular practitioners appear increasingly to have emulated key elements of conventional medical practice, precisely because they were not subject to professional strictures they maintained autonomous sites of popular medicine that might—and often did—exceed medical orthodoxy without necessarily threatening its dominion.

Comparative Relevance of the Costa Rican Case

Among the laudable qualities of the specialized historians of medicine whose work appeared in the wake of Aristides A. Moll's monumental 1944 compendium *Aesculapius in Latin America* was their transcontinental scope.[22] The insistence on a comparative perspective has been revived to excellent effect in the recent work of Marcos Cueto and Nancy Leys Stepan. Inspired by these efforts, I have made a concerted attempt to situate the Costa Rican case through comparative references in order to make this book as much as possible an "embedded" case study of medical practitioners in Latin America.

I propose that the history of medical practitioners in Costa Rica might be taken as representative of an important Latin American "mid-range." This proposition will surprise readers who best know Costa Rica for its alleged "exceptionalism." The label is accurate to the degree that

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Map 1. Costa Rica. Courtesy of Fabrice Lehoucq and Iván Molina.

a highly literate populace, long periods of unbroken electoral democracy, infrequent military intervention in politics, and a state that has consistently displayed mild reformist tendencies are all, sadly, exceptional in Latin America. On the other hand, one does not have to search too carefully in the country's past to find essential ingredients of the Latin American polity. The country's colonial period was marked by a conflictive Spanish and Native American cultural encounter with the admixture of an African slave population. The development boom of the nineteenth century was based on the cultivation and export of a single crop: coffee. This was subsequently "complemented" by the rapid implantation of a banana enclave on the Caribbean coast, crucible of the United Fruit Company that made Costa Rica the original banana republic. The development between 1880 and 1914 of Limón province, attracted a large Afro-Caribbean population. Beginning in

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Table 1. Costa Rican epidemics and related phenomena, 1805–1927

1805	Threat of smallpox: first vaccination campaign
1814	Malaria and hepatitis in Cartago province
1816	Smallpox in Nicaragua: first quarantine of ship in Puntarenas
1823–1826	Official concern over leprosy leads to building of Lazareto (completed 1835)
1831	Smallpox (worst epidemic of century)
1832	Cholera in Mexico: creation of Juntas Generales de Sanidad
1836–1837	Cholera in Nicaragua: creation of cordon sanitaire on border
1839	Fevers in Cartago and Heredia
1845	Infant cholera (summer diarrhea) throughout country
	Smallpox in Guanacaste
	Fever among coffee carters journeying from Central Valley to Puntarenas
c. 1850	Typhoid (remains endemic thereafter)
1852	Smallpox in Cartago and subsequent localized outbreaks throughout country
1853	Yellow fever in Puntarenas
1856–1857	Cholera claims 8 to 10 percent of populace
1860	Yellow fever in Puntarenas
1861	Whooping cough
1862–1863	Smallpox in Puntarenas and Guanacaste
1863	Whooping cough and measles (simultaneous)
	Typhoid (virulent upsurge)
1865–1866	Scarlet fever in San José, Alajuela, and Cartago
1867–1868	Smallpox in isolated areas
1869	Yellow fever in Puntarenas
1875	Smallpox in Limón
1881–1882	Yellow fever in Puntarenas
1884	Smallpox in isolated areas
	Cholera in Europe: preparation of quarantine islands on each coast
1888	Dysentery in Heredia
1891	Smallpox in isolated areas
	Whooping cough and influenza (simultaneous)
1892–1893	Whooping cough: 8,000 child deaths attributed to disease
1895	Infant cholera, measles, and mumps (simultaneous)
1895–1896	Yellow fever in Puntarenas
1898–1899	Whooping cough in San José and Cartago

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Table 1. (*continued*)

1899–1900	Yellow fever in Puntarenas, spreads to Alajuela; quarantine of Alajuela
1902	Smallpox outbreak in isolated area
1919–1920	Influenza pandemic reaches Costa Rica: 2,300 deaths attributed to disease

Sources: Lachner Sandoval, "Apuntes de higiene," 190–200; República de Costa Rica, *Memoria de Gobernación y Policía, año 1920* (San José: Imprenta Nacional, 1921), xxii; and República de Costa Rica, *Memoria de Salubridad Pública y Protección Social correspondiente al año 1927* (San José: Imprenta Nacional, 1928), vii–viii.

the 1870s, an oligarchic liberal state was constructed according to positivist principles, and though the political balance of forces promoted the evolution of a functional electoral democracy, the system was fragile and succumbed to military dictatorship between 1917–1919, and later to civil war in 1948. In these terms, as much revisionist historiography has shown recently, Costa Rica is as exemplary a Latin American country as it is an exception.[23]

Costa Rica's population, typical of Latin America as a whole, grew significantly in the second half of the eighteenth century and continued to increase at an average rate of 1.5 percent per year throughout the nineteenth century, growing sixfold to reach 300,000 in 1900.[24] The country's coffee boom, beginning in the 1840s, integrated Costa Rica more closely into the global network of maritime commerce dominated by English capital. The trend was intensified after 1880. With the building of a railroad that linked the Central Valley to the Caribbean coast, and the rise of banana cultivation in Limón province, Costa Rican society was drawn into the Caribbean and North American web of shipping and human migration spun by the dynamic banana companies.

Costa Rica's nineteenth-century disease ecology closely resembled the classic patterns of other Latin American countries in the throes of export booms and foreign market integration. During the period of this study, smallpox, malaria, yellow fever, typhoid, and cholera posed the greatest epidemic threats to the country on a schedule that would not have seemed unusual to its continental neighbors. Dysentery, malarial fevers, and syphilis were endemic, and they accounted for the largest

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share of adult deaths. Diarrhea, malnutrition, and a tight cycle of whooping cough epidemics decimated an infant population that was also jolted periodically by infant cholera (summer diarrhea), scarlet fever, diphtheria, mumps, and measles.[25]

Obviously, Costa Rica's historically Hispanic and mestizo cultural ballast separates it from countries in the continent that have strong African and indigenous social bases like Peru, Mexico, Guatemala, and Brazil (though it resembles mixed-race cultural spaces within these same countries). The dynamic of Costa Rican medical practices is, in many respects, drastically different from that found in such countries. Also, the very development of a cultural and political order in Costa Rica based on consensus rather than conflict has undoubtedly promoted a similar muting of confrontation in the medical realm. Nevertheless, even in these terms I think the study of Costa Rica might offer a significant alternative perspective. Studies in countries with strong indigenous and African medical traditions have led to the equation of Latin American popular medicine with the figures of the shaman and herbalist, subordinate ethnicity, and counterhegemonic cultures. Studying Costa Rican popular medicine provides a picture of that other, perhaps less spectacular but no less important domain of common Latin American healing—one that more often than not complemented and emulated the realm of official medicine, even while contesting its pretensions to monopoly and final truth.

As for conventional medicine, the Costa Rican story is, in crucial respects, more representative of the Latin American experience than that of the places that have received the lion's share of attention from scholars: Mexico City, Rio de Janeiro, and Buenos Aires. Such metropolitan centers, with their deeply sedimented and variegated communities of titled practitioners, as well as their institutional network of hospitals, schools, and regulatory agencies reaching back into the colonial past, make them exceptional indeed in the continental scheme of things. The Costa Rican case thus allows one to perceive the evolution of medical practice in a secondary, Hispanicized zone of Latin America with residual and peripheral indigenous and African influences. At the same time, it allows an appreciation of the evolution of medical politics in a Latin American nation-state. If there is any country suitable for a study of medical practice at the national level over the long haul it is Costa Rica, since its relatively small size makes the evidence potentially

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manageable — though whether or not I have succeeded in managing it is a question I will leave for the reader to decide.

A Note on Terminology

The quest to provide a definitive terminology for differentiating between the two basic domains of the medical universe has not led to any consensus. There has been a move away from using such terms as "irregular," "folk," and "traditional" medicine due to the mildly pejorative or antiquarian overtones they carry. Terms such as "alternative" and "nonstandard" still nonetheless suggest that mainstream, standard medical practice is the yardstick (while generally begging the question of exactly what constituted standard medicine in any period).[26] In fact, as the following pages reveal, the only accurate labels are "licensed" versus "unlicensed" practitioners, and this distinction generally, but not always, corresponded to that between the medicine whose authority came from the people (which I refer to as popular medicine) versus the medicine whose authority came from state, professional, and academic officialdom.

I use the terms "empiric" and "curandero" throughout this study when referring to practitioners of popular medicine. No pejorative overtones are attached to either term, though in Western medical history, empiric in particular is often used as a synonym for charlatan, and Costa Rican medical elites sometimes used both terms in a derogatory way to signify quackery. Even in official medical discourse, however, the terms were also used neutrally. For example, from the 1840s through the 1880s, the state granted licenses to a variety of healers authorizing them to practice as "empirics in medicine" (*empíricos en medicina*) in any part of the country that was without a titled physician or surgeon, the designation of empiric simply being a recognition that they had demonstrated knowledge and competence in the art of medicine. There was no hard-and-fast distinction between the kind of healer who might be called an empiric and the one that might be labeled a curandero. Empiric tended to suggest someone who had acquired some formal knowledge of healing through study and apprenticeship with more conventional types of medical practice, while curandero tended to connote a more rustic healer who practiced in their locale (a distinction that I tend to employ here). Nevertheless, even in the 1860s, the country's

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leading medical regulator, referring to the authorization of empirics, stated that "the law permits authorizing *curanderos,* and the selling of certain classes of medicines, in the areas where there are no *profesores.*"[27] Here, curandero is interchangeable with empiric.

The use of profesores is particularly curious in Costa Rica, where there was essentially no medical school throughout my period of study. In the Iberian tradition, all doctors in medicine were *facultativos*—that is, members of the official medical body that would also serve as the faculty of the university should one exist. This terminology was simply adopted by the emergent community of official practitioners in Costa Rica, regardless of whether they were bachelors, licentiates, or doctors of medicine or surgery. At the nineteenth century's end, it was incorporated into the name of the country's first true professional body: the Facultad de Medicina. Of course, the idea was always there that eventually its members would serve as the staff of a medical school, though one was not functional until the 1960s.

Finally, from the 1840s onward, Costa Ricans employed the term "*farmacéutico*" to describe a schooled and titled preparer and dispenser of medicines. I have translated this throughout as "pharmacist," while translating the generic term "*boticario*"—which referred to an untitled preparer of medicine, though often one who was knowledgeable and experienced due to a conventional apprenticeship—as "apothecary." Other clarifications are made as necessary in the text.

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