7 Plural Medical Systems

Complexity, Complementarity, and Conflict

> **Throughout this century and even before, there has been a general assumption—even a conviction . . . that folk and popular systems of health beliefs and practices would inevitably decline in modern and industrialized societies. . . . Yet this has not been the case.**
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> **—Bonnie Blair O'Connor (1995:1)**

Introduction and Overview

In the previous chapter, we examined the concept of ethnomedicine and conceptions of health, illness, and medicine in family-level foraging, village-level pastoral, and chiefdom societies. We move on in this chapter to consider the phenomenon of medical pluralism in complex societies by examining it in two locales in developing societies, namely, a village in the Bolivian Andes and a city in Java, Indonesia, and then in a technologically developed society, namely, Australia. We then examine various typologies of plural medical systems but particularly stress the concept of a dominative medical system, which points to the fact that medical systems do not exist in a vacuum but rather reflect the class, racial, ethnic, and gender relations and inequalities of the wider society. In a dominative medical system, several different healing traditions coexist in the same society, but one tends to be more closely aligned with the dominant social groups in that society and to be the dominant healing tradition as well.

Indigenous or tribal societies exhibit a diversity of healing beliefs and practices as well as an array of different kinds of healers, but these tend to be rather loosely organized and often reflect idiosyncratic patterns resulting in part from the fact that healers commonly are secretive about their medical knowledge. In contrast, state societies manifest the coexistence of a highly elaborate array of medical traditions at both the conceptual and the practice level, a pattern that health anthropologists call medical pluralism. In other words, the medical system of state-level societies tends to be made up of various medical subsystems that coexist in a social environment that ranges between extensive cooperation and open conflict.

We present three case studies of medical pluralism in three distinct sociocultural settings. The first is a small village in the Bolivian high plain (altiplano) based on ethnographic research done by Libbet Crandon-Malamud, the second is an administrative/university city in Java based on ethnographic research done by Steve Ferzacca, and the last is Australia based on social historical and ethnographic research conducted by Hans Baer (2009).

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A Case Study of Medical Pluralism in a Rural Area in a Developing Society: The Altiplano of Bolivia

A classic case in research in medical pluralism is based upon Libbet Crandon-Malamud's (1991) ethnographic fieldwork conducted between 1976 and 1978 on medical pluralism in Kachitu (pseudonym), a rural town on the Bolivian altiplano. Kachitu is the center for a canton consisting of some sixteen thousand Aymara Indians living in thirty-six *communidades*. The town proper has some one thousand residents consisting of three ethnoreligious groups: Aymara peasants, Methodist Aymara, and Catholic mestizos (those of mixed European and indigenous blood). Before the Revolution of 1952, the mestizos, who constitute about half the population of Kachitu, supervised the labor of the Aymara on behalf of the national elites, who generally resided in La Paz and other cities. Since the revolution, the mestizos have been seeking to avoid poverty and are a socially fragmented ethnic category that includes teachers, small shopkeepers, and poor occasional agricultural laborers. Before 1952, the Aymara, who make up another third of the village, lived in Indian communities that were heavily taxed or on haciendas (plantations).

Some Aymara were miners and some performed personal services, such as domestic work, for mestizos. Many Aymara peasants migrated to Kachitu from the haciendas upon acquiring land through fictive kinship ties with mestizos. Following the revolution and land reform, others moved to town and claimed land on the outskirts that had been confiscated from the mestizos. The Methodist Aymara are converts or descendants of converts to the Methodist church, which established a mission in Kachitu in the early 1930s. The Methodist Aymara attended mission schools and became entrepreneurs who took over local administrative and political offices when the revolutionary government threw the mestizos out of these positions. They function as the economic and political backbone of Kachitu. Crandon-Malamud (1991) argues that the people of Kachitu tend to conflate ethnicity and social class, noting that Aymaraness, mestizoness, and even Methodism constitute "masks for social class."

Themes

Crandon-Malamud identifies four themes that permeate the dialogue about medical etiology and diagnosis in Kachitu—pervasive hunger, subordination, victimization, and exploitation—within the context of the Bolivian political economy. Pervasive hunger is a by-product of race and differentiates the purportedly white elites from mestizos and Indians as a means to justify unequal access to the political process and economic resources. The second theme entails an economic system that exploits Indian labor, the third consists of caudillo (strong authoritarian leadership) political structures that suppress dissent on the part of

rural mestizos and Indians, and the fourth is conflict that exists between mestizos and Indians.

Medical Subsystems

Five different medical subsystems are used by those in Kachitu, depending on the diagnosis: Aymara home care, shamanistic or *yatiri* care, mestizo folk home care, biomedical clinical care, and hospital care in La Paz. Crandon-Malamud examines the intricate ways that the residents of Kachitu utilize the local plural medical system for purposes of establishing their sense of cultural identity and obtaining the few resources available to them. Contrary to the wishes of biomedical practitioners and indigenous healers, decisions concerning illness etiology and diagnosis tend to be made primarily by patients themselves, their families, and other interested parties. Biomedical physicians who practice in Kachitu must abandon many of their preconceptions and adjust themselves to the local belief systems if they expect to establish rapport with their patients. The various medical ideologies in Kachitu function as options that address different types of ailments. As Crandon-Malamud (1991:202–3) observes, "All things being equal, if one has tuberculosis, one goes to the physician in the Methodist clinic; if one suffers from khan achachi, one goes to yatiri; if one has a stomach upset, one resorts to medicinas casera [home care]." (*Khan achachi* refers to a sickness stemming from a phantom, *khan achachi*, who consumes meat, alcohol, and other gifts that it demands from people.)

Kachitunos, regardless of their social standing, tend to be pragmatic when it comes to seeking medical treatment. Medical dialogue serves as an idiom by which a person identifies his or her ethnic identity within the larger context of Bolivian society—one that is characterized by frequent economic crises, unstable governments, and military coups. Mestizos in Kachitu who find themselves downwardly mobile may, in essence, gain access to greater health care by turning to Indian indigenous medicine. Crandon-Malamud argues that they use medical dialogue, namely, debate about the most appropriate explanations of disease etiology and therapies to eradicate disease, as a mechanism of empowerment in the face of overwhelming external oppressive political-economic forces at both the national and the international level. Unfortunately, this medical dialogue has served as a rather limited form of empowerment and in reality serves more as a coping mechanism than an oppositional fulcrum within the larger Bolivian political economy and the global economy.

Status of Health Care in Bolivia in the Pre-Revolutionary Era

Health services in Bolivia underwent a serious decline during the 1980s. The infant mortality rate at the time was the highest in Latin America, with a national average of over 200 per 1,000 live births in 1985, as high as 650 per 1,000 live births in some rural areas, as opposed to 150 per 1,000 live births in 1975

(Morales 1992:135). Furthermore, half of the children between ages one and six were malnourished; 60 percent of school-aged children manifested goiter and 45 percent anemia due to iodine and iron deficiencies, respectively (Morales 1992:135).

Cuts in government spending contributed to a lack of potable water in 65 percent of urban households. Between 1960 and 1990 life expectancy in Bolivia increased by only five years, from the mid-forties to about fifty, some twenty years less than more developed Latin American countries (Klein 1992:280).

To no small degree, Bolivia's health problems and other socioeconomic problems emanate from a national social structure in which "the wealthiest 5 percent control 39 percent of the national income and the poorest 20 percent, only 2 percent" (Morales 1992:203), a situation which in part was corrected by the coming to power of a left-wing populist political party and indigenous president in 2006.

Social and Health Conditions in Bolivia after the Election of Indigenous President Evo Morales

President Evo Morales and his governing Movement Towards Socialism (MAS) party have adopted a policy of "communitarian socialism" and proposed a "Law of Mother Earth," which stipulates living in harmony with nature. Morales called for Socialism of the South or Indigenous Socialism that includes ten "commandments." These call for the eradication of the capitalism in order to "save the planet"; ending wars that have benefited empires, multinational corporations, and selected families; developing "relations of coexistence" among the countries of the world; treating access to water as a human right; developing "clean energies"; respecting Mother Earth; treating "basic services, such as water, electricity, education, health care, communications, and collective transportations" as human rights; consuming only what is necessary and seeking to consume local products; promoting "cultural and economic diversity"; and developing a "communitarian socialism that is in harmony with Mother Earth" (Derber 2011:135). The Bolivian legislature established eleven new rights for nature, including the right to life and for existence, the right to clean water and air, the right to be free from pollution, and the right to "not be affected by mega-infrastructure and development projects that affect the balance of ecosystems" (Bell 2016:81).

The MAS emerged as the political arm of the indigenous-peasant movement based in the department of Cochabamba in the mid-1990s and models itself upon an "assembly-style, rank-and-file democracy of peasant unions in region" that consisted in large part of coca growers who opposed the U.S.-supported "drug war" in the region (Webber 2011:3). Over the course of its ascent, the party has become more moderate as an urban, mestizo middle-class intelligentsia has assumed influence. The MAS has also sought to appease the capitalist class in the eastern section of Bolivia in terms of the assembly's governance structure, in part to stave off a secession movement. Garcia Linera, whom

Morales chose as his vice president in 2005, developed the notion of "Andean-Amazonian state capitalism."

In 2006 Morales signed a law that nationalized Bolivia's natural gas reserves and required all foreign energy companies to renegotiate their contracts so that they would benefit the Bolivian people (Derber 2011:138). His administration embarked upon a program of "nationalization without expropriation," which nationalized oil and natural gas reserves within Bolivia but did not want multinational corporations in the hydrocarbon sector to cease operations, but enter into joint ventures with the government (Kaup 2015). Under this arrangement, foreign direct investment in Bolivia increased from $281 million in 2006 to $1.75 billion in 2013. In addition to providing financial support for social programs, the government's profits from the hydrocarbon sector have substantially increased international monetary reserves in Bolivia.

Bolivia has embarked upon a program of food sovereignty by promoting local and sustainable food production, which seeks to allow peasants to obtain ownership of seeds, thereby breaking them for dependence upon agribusinesses that dominate seed production. Morales withdrew Bolivia from the World Bank and the International Monetary Fund and undertook nationalizing the oil, natural gas, and lithium resources, a move that required altering the constitution (Vattimo and Zabala 2011).

In January 2009, the Bolivian people in a national vote of 61.4 percent approved a new constitution declaring that Bolivia constitutes a "pluri-national state, communitarian state" based on respect and equality for all and a policy of providing communal access to water, work, education, health, and housing for all.

Despite the best of intentions, the movement toward implementing Morales's vision of socialism has been slow and patchy. Bolivia under Morales has preserved private property rights, not undergone serious land reform measures, and experienced fiscal austerity. In 2011 Morales slashed fuel subsidies in order to reassure foreign investors. Also the Morales government provides hundreds of millions of dollars in loans, export subsidies, and tax incentives to wealthy agricultural exporters and has expelled landless indigenous squatters from large agricultural estates (Petras 2011:15). In essence, despite MAS's stated commitment to socialism over the long run, Bolivia between at least 2005 and 2010 followed a "reconstituted neoliberalism" based largely on exports of natural gas, oil, and mineral resources (Webber 2011:232). Furthermore, while Morales initially embraced direct democracy, many coca growers upon whose support he relied in his ascent to the presidency feel that he has "slipped into old fashion patronage politics, rewarding friends and pushing opponents" (Grisaffi 2013:49). Despite Morales's capitulation to neoliberal pressures and retreat from participatory democracy, there still exists a left-indigenous collection of critical thinkers committed to the transformation of Bolivia into a highly equitable and environmentally sustainable society.

On the positive side, poverty in Bolivia has been reduced from 60.6 percent of the population in 2005 to 43.5 percent in 2012 (Fidler 2014:18). Under the Morales government, by 2012 life expectancy increased to 67 years, and infant mortality dropped to 33 per 1,000 live births (UNICEF 2013). Literacy has increased tremendously and there has been expanded rural electrification and access to employment, education, and health care. The Bolivian government has created small state-owned enterprises that allow local producers input into their operation, and has allocated more than thirty-five million hectares of land as communal land or indigenous territories.

Perhaps the most profound contradiction of the "socialism for the twenty-first century" experiment in Bolivia is, on the one hand, ongoing reliance on fossil fuels for generating revenue, much of it for needed social programs, and, on the other hand, the government's defense of Mother Earth. The case of Bolivia is a profound illustration that socialism cannot be achieved in one country, especially one on the periphery of the capitalist world system, and that the construction of socialism for the twenty-first century will have to be a process occurring in numerous countries.

Under the Morales government, indigenous medicine has achieved notable headway, particularly in terms of the institutionalization of indigenous medical associations and the licensing of indigenous healers. Even prior to the Morales government, in 1984 with the creation of the Bolivian Society of Traditional Medicine Bolivia became the first Latin American country to start the process of legalizing indigenous medicine (Babis 2014). A new constitution approved in a referendum in 2009 explicitly acknowledged the rights of indigenous people, who comprise about 60 percent of the population (the highest percentage of indigenous people in all of the Latin American countries), "with a special chapter devoted to indigenous medicine" (Babis 2014:290). In 2012 a National Register for indigenous medicine commenced with a unit for indigenous medicine in the nine provincial health offices. Accreditation under the registry requires that a practitioner show evidence of birth in Bolivia, be over thirty years of age, possess a certificate from their indigenous community or indigenous association, have practiced for at least five years, and submit treatment reports for the practitioner's last ten patients.

Situated between biomedicine and indigenous medicine one finds a relatively new category of health practitioners situated in Bolivian cities called *los naturistas* (LN) who seek to integrate indigenous medicine and natural medicine (Bruun and Elverdam 2006). They generally are mestizos but treat both mestizos and indigenous people. In addition to relying heavily upon herbal medicine, LNs may use biomedical devices such as sphygmomanometers, or refer their patients to a biomedical physician for ultrasound or other tests, with the latter referring the patient back to the LN.

A Case Study of Medical Pluralism in an Urban Setting of a Developing Society: A View from Central Java

Steve Ferzacca, an anthropologist based at Lethbridge University in Canada, adopts a meaning-centered perspective, described in chapter 1, in seeking to unravel "phenomenological meanings of plurality of health care and perception in lives" (2001:5) among residents of Yogyakarta in the Republic of Indonesia. This city is the site of Gadjah Mada University (the country's first postindependence university) as well as many other colleges, institutes, and vocational schools, and it is a mecca of the classical arts, dance, music, and literature. In addition to visiting various biomedical clinics in Yogyakarta, Ferzacca conducted ethnographic research in Rumah Putri, a neighborhood within a subdistrict of the city consisting primarily of working-class people and lower-middle-class clerks, teachers, and public servants. Like various other countries in Southeast Asia, Indonesia, particularly under President Suharto's New Order, has promoted an authoritarian program of modernization, or *pembangunan* (development), and westernization in the form of elaborate Five Year Plans. Ferzacca (2001:210) views medical pluralism in Yogyakarta generally and among the residents of Rumah Putri specifically as a "social practice that produces hybrid forms of medicine," that is, a mixture of traditional and modern medicine, utilized by people who lead "hybrid lives." Medical pluralism in Yogyakarta is manifested largely in two broad forms: biomedicine and *pengobatan tradisional*, or traditional medicine. Biomedicine is practiced in clinics and hospitals that serve as "entry sites into modernity where exposures to the hegemony of scientific medicine takes place" (Ferzacca 2001:68). It is more or less universally available to everyone on the Indonesian island of Java, particularly in urban areas, and is situated in various settings, including private biomedical clinics, public health centers, mobile units, integrated health posts, and numerous government health programs. It is provided not only by biomedical physicians but also by nurse practitioners and health cadres. Many Javanese view biomedicine as a system that is useful in treating diseases (such as adult-onset type 2 diabetes, hypertension, and heart disease) associated with development or modernization, and hence they see it as complementing traditional indigenous and newly emerging medical subsystems.

Medical Subsystems

Traditional medicine itself consists of a wide array of medical subsystems, therapies, and practitioners, including herbalism, massage, the use of amulets and talismans, patent medicines, Chinese herbalists and acupuncturists, Ayurvedic and Unani doctors, and indigenous Javanese healers and psychics. *Dukuns*, or traditional Javanese healers, practice various forms of shamanism, divination, exorcism, magic, midwifery, pediatrics, massage, spinal manipulation or bone setting, herbalism, and counseling and, rather than being valued as culturally familiar, are often regarded with suspicion because they may seek to exploit patients or place curses on unsuspecting victims. Conversely, psychics, or

paranormals, are generally held in high esteem as paragons of modernity and development. These individuals find missing persons, perform astrology, tell fortunes, foretell the future, heal the sick, and perform rituals at various public events and rites of passage. The paranormals in particular have found a devoted clientele among politicians, businesspeople, and professional people, including members of the Javanese intelligentsia, such as professors, film and music stars, and even Catholic priests. In essence, while associated with *pengobatan tradisional*, paranormals practice a hybrid medicine that blends traditional practices with modern ones associated with Western and Eastern psychic traditions. In summary, Ferzacca (2001) argues that medical pluralism in urban Java provides a public sphere where both practitioners and patients can try to cope with everyday hardships of living under the domination of an oppressive regime intent on forcing them into modern life and the global economy.

More recently, an ethnographic research on the plural medical system in eastern Java examines treatment of mental illness, with a focus on three types of healers, namely the *dukun*, the *kyai*, and the psychiatrist (Woods 2007). The dukun is a traditional shamanic-like healer who may go into trance or serve as a spirit medium and often touches the patient, sometimes gently and other times more forcefully. He or she may provide the patient with an amulet, water blessed by a prayer or spell, paper containing a magical formula, or an herbal medicine. The dukun seeks to create balance between the patient and the cosmos. The patient is expected to compensate the dukun for his or her services with a gift or money. Dukuns do not generally belong to professional associations and tend to be viewed with ambivalence in Javanese society.

In contrast to the dukun, the kyai is also a male practitioner who often surrounds himself with Islamic symbols and attire. He may perform either in a public or private setting and interprets symptoms as emanating from transgressions against Allah or people. The kyai prescribes amulets or prayers and admonishes the patient to observe the pillars of Islam. While he is believed to have supernatural powers, the kyai has studied Islamic law, history, and texts and is ultimately a representative of Allah. Unlike the dukun, kyais belong to a number of regional or national professional associations. For his services, the patient provides the kyai with a gift, food, or money, always given "surreptitiously in an offered palm or envelope" (Woods 2007:444).

Finally, the psychiatrist, while a biomedical specialist, does not dismiss the cultural appropriateness of the treatment administered by the dukun or kyai. Psychiatrists, generally male, may see their patients in private clinics or hospitals, the latter which tend to be loud and chaotic settings in Java. They prescribe advice and medications in an authoritarian and often rushed manner and often dismiss many of the symptoms presented by their patients, although high-income patients may be treated in a more solicitous manner. Reportedly, Indonesian psychiatrists have been profoundly influenced by cultural psychiatry, particularly as manifested in the work of psychiatrist-anthropologist Arthur Kleinman.

A Case Study of Medical Pluralism in a Developed Society: The Australian Dominative Medical System

Australia, which has about twenty-four million people in an area slightly smaller than the lower forty-eight U.S. states, is unique in that it has gone further than perhaps any other developed country in providing public support for the training of practitioners of complementary and alternative medicine (CAM), both in terms of degree-granting programs in chiropractic, osteopathy, Chinese medicine, and naturopathy in public universities and in terms of partnerships that have developed between private CAM colleges and public universities that allow students in the former to upgrade an advanced diploma into a bachelor's degree. In contrast, aside from public colleges of osteopathic medicine, which in the United States have evolved into a parallel medical system to biomedicine with an emphasis on family medicine and reliance on manipulative therapy as an adjunct treatment approach, all training programs in chiropractic, Chinese medicine, and naturopathy are embedded in private institutions in both the United States and Canada. As the Australian case indicates, the manner in which medical pluralism is expressed in a particular society is significantly shaped by political, economic, and social structural forces specific to that society, a point that was made in the case of Bolivia described previously. Whereas the Australian medical system with its various medical subsystems was relatively pluralistic in the nineteenth century, early in the twentieth century, with the transformation of regular or allopathic medicine into biomedicine, the latter adopted a scientific guise to distinguish itself from heterodox or alternative competitors. The Australian medical system evolved into a plural system in which biomedicine achieved dominance over other medical subsystems, a configuration that medical anthropologists call a "dominative medical system" (Baer 2001). Table 7.1 depicts a model of the Australian dominative medical system.

Beginning in the late nineteenth century, Australia as a relatively open society conducive to maverick individuals and social experiments served as what one aptly terms a "paradise of quacks"—a veritable haven for homeopaths, herbalists, phrenologists, hydropaths, lay midwives, spiritual healers, and purveyors of home remedies and patent medicines (Martyr 2002). The nature of some of the medical subsystems in Australia is examined next.

Medical Subsystems

Osteopathy

Although initially developed in the United States, osteopathy diffused to various countries, particularly Anglophone countries, such as Canada, the United Kingdom, Australia, and New Zealand, where, unlike in the United States, it has remained primarily a manual medical system. In contrast to various other countries, the development of Australian osteopathy has been intertwined with that of chiropractic. Some Australian practitioners attempted to institutionalize a merger

TABLE 7.1 The Australian Dominative Medical System

Biomedicine

Fully legitimized professionalized heterodox medical systems

Osteopathy
Chinese medicine in Victoria

Semi-legitimized professionalized heterodox medical systems

Chinese medicine outside of Victoria
Naturopathy or natural therapies
Direct-entry midwifery
Homeopathy

Limited or marginal heterodox medical systems

Homeopathy
Massage therapy
Reflexology
Reiki
Kinesiology

Religious healing systems

Spiritualism
Pentecostalism
Liberal Catholic Church
Scientology
New Age healing

Folk and ethnic medical systems

Anglo-Australian folk medicine
European immigrant groups' folk medical systems
Asian folk medical systems
Aboriginal medical systems

of chiropractic and osteopathy as was evidenced by names of various professional bodies and training institutions (e.g., the Chiropractic and Osteopathy College of Australia). Several osteopathic colleges reportedly transformed themselves into chiropractic colleges in the mid and late 1960s.

Chiropractic

There have been at least four periods in the development of Australian chiropractic: (1) the establishment period (1918–1953), in which various groupings of chiropractors emerged in Victoria, including ones drawn from the ranks of British-trained osteopaths and others who obtained chiropractic training in the United States; (2) the period of expansion (1954–1961), which witnessed a considerable increase in the number of chiropractors trained in Australia (as well as many trained overseas); (3) the period of agitation (1961–1973), resulting in 1964 in the passage of the Western Australian Chiropractors' Act, which provided

statutory registration for chiropractors in that state and included them under private health insurance plans; and (4) the period of legitimation, which began with a federal parliamentary committee report in 1977 that recommended registration for both chiropractors and homeopaths although not naturopaths (Willis 1989). Chiropractic and osteopathy constitute fully legitimized professionalized heterodox medical systems in the sense that their training programs are embedded in public universities and one private university, namely, the chiropractic program at Murdoch University.

Chinese Medicine in Australia

Although traditional Chinese medicine was first introduced in Australia in the mid-1850s in places like the gold fields of Victoria, where Chinese migrants first settled, it did not attain widespread popularity until the development of the holistic health movement. Chinese medicine has been and continues to be a fractionated profession as is evidenced by its wide array of associations and private training programs, some of which are situated in Chinese medicine colleges and others in colleges of natural therapies. Four public universities, namely, the Royal Melbourne Institute of Technology, the University of Western Sydney, the University of Technology–Sydney, and Victoria University, offer degree programs in Chinese medicine. Despite the opposition of organized biomedicine, the Victoria Parliament passed the Chinese Registration Act in May 2000, making Victoria the only Australian jurisdiction to formally recognize regular Chinese medicine practitioners. However, Chinese medicine later obtained federal statutory registration under the Allied Health Professions Act. In essence, Chinese medicine finds itself situated on the border between fully legitimized and partially legitimized status as a heterodox medical system.

Naturopathy

The historic development of Australian naturopathy can be divided into three periods: its emergence between the 1920s and 1940s, a holding pattern between the 1950s and early 1970s, and its explosion from the late 1970s to the present under the umbrella of the holistic health movement. While the terms "naturopath" and "naturopathy" continue to be used in a variety of contexts in Australia, including academic programs and professional associations, the terms "natural therapies" and "natural medicine" have become commonplace and are applied to a wide array of therapeutic subsystems, including Western herbalism, acupuncture, massage therapy, homeopathy, reflexology, and aromatherapy. Naturopathy constitutes a semi-legitimized professionalized heterodox medical system in that it has not achieved statutory registration in any political jurisdiction. It for a while achieved some degree of legitimation inasmuch as naturopathic training programs became situated in public institutions of higher education or in partnerships with private colleges and public universities. The fact that both the federal government and certain state governments have

commissioned inquiries into various aspects of CAM also constitutes a de facto form of legitimation.

Lay or Direct-Entry Midwifery

There are a large number of nurse-midwives in Australia, as in other Western societies. The women's liberation movement stimulated development of the natural childbirth movement in Australia. Several public universities, including Flinders University in Adelaide and Monash University in Melbourne, came to offer direct-entry programs in which midwifery is offered as an undergraduate degree. Organizations that promote lay midwifery care in both hospitals and homes include the Australian College of Midwives, the Australian Society of Independent Midwives, a consumer group called Maternity Coalition, and the Community Midwifery Program, which since 1990 has been funded by the government to seek alternative models of childbirth for low-risk women (Sutton 2004:6–7).

Teaching CAM

Other alternative therapeutic systems such as homeopathy, massage therapy, reflexology, aromatherapy, Reiki, polarity therapy, kinesiology, and various other CAM therapies constitute limited or marginal heterodox medical systems in Australia. Many of these systems function as specific treatment modalities that are taught in schools of natural therapy or that are used as adjuncts by naturopaths or natural therapists in their practices. Furthermore, when the tenets of these subsystems are taught at a school of natural therapy as a specialized program of study or at a training institution that focuses on a specific therapy, such as homeopathy or reflexology, they often entail a shorter period of study and the granting of a "diploma" or "certificate" rather than a "degree" or "advanced diploma."

At the next level, one finds various Euro-Australian religious healing systems, such as Christian Science, Spiritualism, Seventh-Day Adventism, the Liberal Catholic Church, Scientology, New Age healing, and Pentecostalism. Finally, as a multiethnic society, Australia has numerous folk medical subsystems. Of these, aboriginal healing systems in particular have received considerable attention, particularly from anthropologists. In contrast, the folk medical systems of various European and Asian immigrant groups have received relatively little attention. A study of the health status of Korean immigrants in Sydney revealed that most of them take *hanbang* (which, in Korean, means Chinese medicine) herbal medicine and health food, such as ginseng and deer antlers, but also rely heavily on biomedicine (Han 2000).

CAM and Biomedicine

In the past, the Australian Medical Association (AMA) had been a virulent opponent of CAM. Despite the policies of the AMA, many biomedical general practitioners have been adopting CAM therapies, especially acupuncture, or are now willing to refer patients to CAM therapists. Discussion of CAM reportedly

has been introduced into the undergraduate curriculum of several biomedical schools. Moreover, in 1992, various biomedical physicians formed the Australian Integrative Medicine Association. Ironically, as a result of the increasing popularity of CAM, the AMA has in recent years relaxed its long-standing dismissal of CAM systems (Easthope et al. 2000).

As in other developed societies, the corporate class and the state in Australia have since the 1970s come to express concern about rising health-care costs. The growing support in various ways for CAM exhibited by the Australian government may constitute a covert strategy for curtailing rising health costs. Given that CAM subsystems often emphasize individual responsibility for health, they are compatible with the strong interest among government health administrators, health policy makers, and academics in preventive medicine and health promotion. Since the 1970s, both Labor and Coalition (Liberal and National parties) governments have encouraged citizens to obtain private health insurance and have sought to make them more self-reliant and responsible (White 2002:95). The government's support for CAM is an integral part of its neoliberal effort to divest itself of as much health-care expenditure as the Australian public will tolerate. While the federal government provides support for complementary medicine programs, which tend to be relatively inexpensive compared to biomedical schools because of their low-tech approach, for the most part it does not provide reimbursement under the guidelines of Medicare—the Australian national health plan—to complementary practitioners for services rendered.

Periodically, the issue of whether the government should reimburse complementary practitioners for their services arises. Several years ago, Medicare created new regulations that all patients with a referral from a biomedical general practitioner could receive free chiropractic or osteopathic treatment. However, the Enhanced Primary Care plan permits reimbursement for only five visits per year. Given that chiropractors in particular are prone to treat patients on a quite-regular basis, the patient will be forced to either pay for additional visits out of pocket or receive a partial rebate (perhaps around 20 percent) from a private health plan.

The future of CAM as well as integrative medicine in Australia is difficult to predict but will be subject to numerous larger political, economic, and social structural forces in the larger society. So long as CAM is not fully incorporated into Medicare, it will tend to serve primarily the more affluent sectors of Australian society. Patients who use CAM "represent a generally more privileged segment of the Australian population" (Gray 2006:245). Furthermore, although chiropractors, osteopaths, naturopaths, Western herbal medicine practitioners, homeopaths, and Chinese medicine practitioners view themselves as primary care practitioners, so long as they cannot practice in hospitals on a regular basis, they will remain subordinate partners in the Australian dominative medical system.

Integrative Medicine as a Biomedical Specialty

Integrative medicine has by and large evolved into a biomedical specialty that incorporates or even, one could argue, co-opts CAM therapies and CAM practitioners. This is highlighted by an ethnographic study with four clinical fellows (Salkeld 2014) of an integrative medicine training program at the University of Arizona. The clinical fellows, all biomedical physicians, drew upon the expertise of selected CAM therapists, namely practitioners of naturopathic medicine, traditional Chinese medicine, energy medicine, botanical medicine, mind-body therapy, manual medicine, and a sleep hygienist, as well as a few spiritually oriented practitioners, including a Christian minister and a practitioner who focused in chakra balancing and past life therapy. In assessing patients' histories, the fellows examined biomedical diagnosis, family relationships, religious orientation, nutrition, and experience with CAM, thus making their approach much more holistic than conventional biomedical physicians. While the fellows sought input from the CAM practitioners in their observations of patients, they never challenged a biomedical diagnosis in the study. Furthermore, as the researcher observed (Salkeld 2014:62), "although fellows in this case conference study felt comfortable incorporating select complementary therapies, they were reluctant to adopt explicitly different explanations for disease etiology," thus preserving biomedical dominance over CAM.

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Typologies of Plural Medical Systems

A number of social scientists have created typologies to help understand the nature of medical pluralism in complex societies of the sort described in the three cases that were presented here. Drawing on the meaning-centered perspective, one model delineates three overlapping sectors in the health-care system (Chrisman and Kleinman 1983). The popular sector consists of health care performed by patients themselves along with their families, social networks, and communities, or the "therapeutic management group" (Janzen 1978:4–5). It includes a wide range of therapies, such as special rituals, diets, prohibitions on certain behaviors, herbs, teas, exercise, rest, baths, and massage, as well as, with the rise of commercial pharmacies, articles such as over-the-counter drugs, vitamin and nutritional supplements, humidifiers, heating pads, and hot water bottles.

The second level of this typology, the folk sector, encompasses various healers who are self-trained or undergo an apprenticeship and tend to practice independently, often out of their home on a quasi-legal or illegal basis. These include shamans, mediums, magicians, herbalists, bonesetters, lay midwives, psychics, and faith healers, such as the Maprofeita healer from Mozambique shown in figure 7.1. An example of the folk sector was described in chapter 2 in the case of Brodwin's study of *houngans* in Haiti and the ways in which people make decisions about which type of healer to consult when they feel ill.

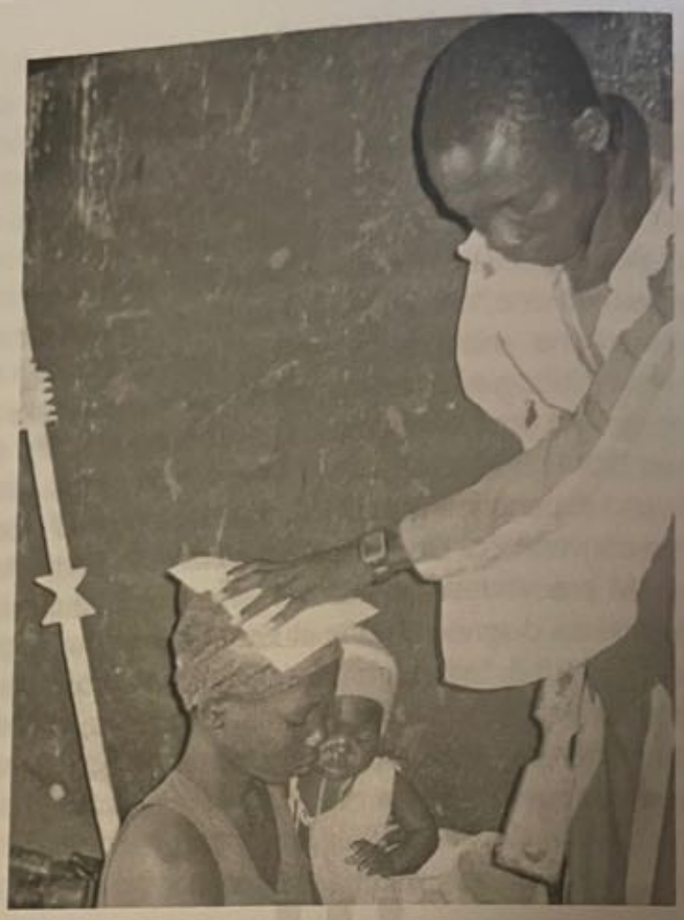

FIGURE 7.1 Maprofeita faith healer in urban Mozambique. Photo by Ippolytos Andreas Kalofonos.

The professional sector includes the practitioners and bureaucratic structures, such as clinics, hospitals, and associations, that are associated with both biomedicine and professionalized heterodox medical systems, such as Ayurveda and Unani in South Asia; acupuncture and herbalism in China; homeopathy, osteopathy, chiropractic, and naturopathy in Britain; and *Heilpraktikers* (naturopaths) in Germany. The department of surgery studied by Katz that was presented in chapter 2 is an example of one part of the professional sector in biomedicine.

Healing and History

In the previous chapter we introduced Fabrega's biocultural approach to medical systems, in which he maintains that medical pluralism is first manifested in chiefdom societies, prestate societies, and early state societies and then develops an even more elaborate form in more complex societies, starting out with empires and civilizations, such as ancient China, ancient India, ancient Greece, and medieval Islamic societies, followed by European societies and finally postmodern societies.

According to Fabrega, in state societies, sickness and health adaptation (SH) is characterized by two tiers: (1) an official, scholarly, academic medical system oriented to the care of elites and (2) a wide array of less prestigious physicians

and folk healers who treat subordinate segments of the society. The state, with its various government bodies, plays an increasing role in medical care by hiring practitioners for elites and providing free or nominal care for the poor, especially during famines and epidemics. The literate or "great" medical tradition, such as in traditional Chinese medicine or Ayurveda in South Asia, includes the formation of a medical profession, the beginnings of clinical medicine, and increasing commercialization (and technologization) of the healing endeavor.

The first literate or "great medical tradition" commenced in the ancient city-state of Sumer and its hinterland, the first instance of medical pluralism in an early state society. Sumeria, which existed between 4000 and 3000 BCE, possessed three categories of cuneiform texts that included various kinds of medical information: therapeutic or medical texts per se, omen collections or "symptom texts," and miscellaneous texts that included information on ailments and medical practices (Magner 1992:19). Sumerian physicians diagnosed symptoms by taking health histories rather than performing direct physical examination. Conversely, the "conjurer," "diviner," or "priest-healer" in Sumer society conducted a direct physical examination and used the patient's symptoms and life circumstances as omens to help diagnose disease. The Sumerian pharmacopoeia included 250 medicinal plants and some 120 mineral substances as well as alcoholic beverages, fats and oils, animal parts and products, honey, wax, and various kinds of milk.

In the centuries after Sumer, various empires and civilizations developed particularly elaborate corpora of medical knowledge, such as manifested in traditional Chinese medicine and Ayurveda in South Asia, that are incorporated into writings and commentaries that over time both exhibit an internal order and also include numerous inconsistencies. While much has been written about medical systems in Old World ancient empires and civilizations, out of which biomedicine ultimately developed, including those of Egypt, Greece, and Rome, far less has been written about the medical systems of New World civilizations and empires, such as those of the Mayas, Aztecs, and Incas.

The Aztecs, who developed an extensive empire in central Mexico that ended with the Spanish conquest in the early sixteenth century, had a complex medical system that combined naturalistic and supernaturalistic elements and included priests, shamans, and physicians (Ortiz de Montellano 1989). The state-sanctioned presence of both priests and shamans was a unique situation worldwide because of the strong antagonism that generally exists between the two. The Aztecs believed that the human body contains several souls, each with a specific function affecting growth, development, physiology, and fate in the afterlife. The three primary souls were the *tonally*, situated in the head; the *teyolia*, located in the heart; and the *ihiyotl*, found in the liver. Health depended on the relative size of each soul at any point in time and the degree of balance among the three souls. Diet and personal behavior influenced the size of each soul. Offended deities, particularly the creator god Tezcatlipoca (or one of his many manifestations), or certain animals could inflict disease on an individual. Aztec astrology posited that the equilibrium of the universe affected the human body. The Aztecs also believed that disease could be inflicted by a sorcerer through certain rituals.

The Aztec priesthood became more elaborate and specialized as the Aztec civilization and empire expanded. Various sorts of priests officiated at rituals, including those featuring human sacrifice; managed temple treasuries; taught school; listened to confessions and prescribed penance (Wolf 1999:153). Priests conducted worship of the Aztec pantheon that consisted of numerous deities, each of which had one or more temples where its idol was kept. The vast majority of priests were males, but there were some female priests who generally served briefly before marrying.

Aztec shamans were capable of sending their *tonally* on magical flights back to the time of creation or, alternatively, transforming them into the appearance of an animal. This process of spiritual transformation by the shamans was assisted by the use of various hallucinogenic plants. Shamans focused on curing ailments caused by imbalance in the relationships between the gods and humans or by the intrusion of beings from other cosmic realms into the sufferer's body.

Aztec physicians could be either male or female. Sahagun, a Catholic priest who chronicled many aspects of Aztec culture following the Spanish conquest, described the good general practitioner as being one who worked with herbs, stones, and roots; examined, experimented, and alleviated disease; set bones and administered massages, purges, and potions; bled his or her patients; and dressed wounds (Smith 2003:255).

Aztec medicine also had an array of medical specialists who focused on diagnosing specific ailments by identifying the offended deity who had induced the disease and prescribing the appropriate propitiatory ritual, which could be making an offering, confessing a wrongdoing, engaging in acts of penance, or praying. It included, as well, empirical knowledge about hundreds of medicinal plants that were applied by herbal specialists. The Aztec medical system relied on highly sophisticated surgeons, including those who served in the many battles that the Aztecs fought while enlarging their empire, some of whom even practiced plastic surgery. Aztec society also had fortune-tellers who could be either male or female and who divined by casting maize kernels and gazing in water.

Sickness and health adaptation in modern state societies worldwide is characterized by the emergence of biomedicine as a dominant and hegemonic profession. Biomedicine, in turn, is characterized by patterns of secularization, including the weakening of the role of institutional religion in public life; scientific knowledge, with its embrace of biological reductionism, including the tendency to view disease as due primarily to biological factors, such as germs; the emergence of the hospital as the center of healing and research; and the universalization of categories of sickness. For many social scientists, modernity is generally associated with the rise of advanced technology, conventional Western science, the notion of progress, rationalism, efficiency, and secularization. In this scenario, the hospital emerges as the center of healing and the "clinical gaze" in which the body is subjected to close probing and scrutiny, such as in the use of the stethoscope and surgery.

Biomedicine during the modern era became increasingly specialized with the appearance of practitioners who focused on certain parts of the body, such as the heart, the lungs, and the immunological system. Furthermore, in keeping

with a pattern of medical specialization is the "growth of the discipline of psychiatry and the increasing importance given to mental illness in the society and in conceptions of social disability, welfare, and crime" (Fabrega 1997:136). At the same time, medical pluralism in Western societies and Japan manifests itself in the continuing existence of alternative practitioners, such as homeopaths, herbalists, osteopaths, chiropractors, and naturopaths, who are held in contempt by many biomedical physicians.

Despite persisting biomedical dominance, the pursuit of alternative therapies, including ones based on Western spirituality or Eastern mysticism, manifests itself most profoundly in what Fabrega and other social scientists term postmodern societies. The postmodern world is associated with corporate globalization involving the diffusion of corporate control over economic, political, and cultural processes throughout the world; a sense of social fragmentation and uncertainty about social institutions and values; an emphasis on consumerism; a growing faith in intuition; and "hybridity," which is the blending of elements from different cultures and parts of the world. Many individuals in postmodern societies, particularly those belonging to higher socioeconomic categories, regard health as an achieved status obtained through education, prevention, and lifestyle. Further, postmodern societies manifest an "obsessive preoccupation with health and fitness" (Fabrega 1997:137), thus resulting in the phenomenon of the "worried well."

Patients of CAM

These patterns result in "dissatisfaction with physicians, with 'establishment' medicine, with the escalating costs of a more routinized and procedural approach to healing, and with tentacles of medical insurance companies," all leading to an "increasing interest in holistic medical traditions and the growth of health-promoting and life extension industries that compete with orthodox biomedicine" (Fabrega 1997:244).

Numerous patient utilization studies conducted in the United States, Canada, Britain, Australia, and various Western European countries have sought to identify the types of people who tend to turn to complementary and alternative therapies and practitioners. These studies indicate that users of CAM, aside from various folk medical systems, tend to be female, relatively young, employed, highly educated, and often but not necessarily involved in alternative lifestyles. Based upon interviews with seventeen "high performing" individuals, all of whom had tertiary levels of education, in the Canadian province of Alberta, CAM has been found in part to function as a self-care system, entailing practices such as vegetarian and vegan diets, yoga, meditation, and tai chi (Fries 2013).

At the same time, CAM has found some reception among working-class people in developed societies. One study, for example, found that many of the researcher's respondents in Oceanport (pseudonym), a suburb of an Australian city, reported that they and other household members followed a "mixed therapy regimen" in which they used a CAM therapy either prior to or in combination with biomedical treatment (Connor 2004).

CAM often overlaps with New Age spirituality and New Age Orientalism and for affluent Westerners may entail travel to health spas in developing countries, particularly India. For example, Vedic Village in India offers its clients access to five holistic physicians, two of whom have degrees in Ayurvedic medicine and surgery and three of whom have degrees in homeopathic medicine and the (Nazrul 2012). One of the holistic physicians has naturopathic training and the other five hold expertise in acupuncture. In addition to the Western visitors to Vedic Village, the site is visited by Indian middle-class professional people or wealthy business people who seek relaxation therapy (Nazrul 2012).

CAM in Denmark

Based upon interviews with forty CAM practitioners and three hundred patients of CAM clinics in Denmark, one study delineates three principal actor-networks: a technocrat network, a social-democratic network, and a neoliberal network (Johannessen 2007). The technocrat network exhibits body praxis that operates with a plumbing model in which the body is viewed as a series of pipes that "reflects technologies of drainage systems, circulation of water, heat and electricity in the house so familiar to contemporary people" (Johannessen 2007:270). In Danish CAM clinics, reflexology in particular, which entails the massage of reflex zones on the feet that are purportedly linked with various organs, follows the plumbing model associated with the technocrat network. The social-democratic network model seeks to achieve an internal balance among body organs reflective of the need for a more macroscopic balance between the body's immune system and external disease agents, such as allergens, pollutants, bacteria, and viruses. CAM therapies focused upon proper nutrition and the technologies of biopathy illustrated, for instance, by use of an "electrical apparatus showing signs of light and sound" exemplify this model, which is characterized by "principles of democracy, consultancy, and uniqueness" (Johannessen 2007:273). Finally, the neoliberal network model views the body as a computer governed by the brain that can be corrected through a process of reprogramming when an autonomous individual begins to malfunction. In order to reprogram the patient's body-mind, kinesiology with its tests of muscle strengths operates on the basis of this model in that its practitioners administer bodywork based upon patients' responses to questions about their experiences in childhood and even previous lives, substance intolerance, malfunctioning organs, and strained social relations. Patients may prefer one or another actor-network, but in reality they move between them, thus following a sort of mixed therapy regimen within the confines of CAM.

Traditional Healers in Mozambique

While CAM systems have, since the 1970s, become increasingly popular in developed societies, the high cost of biomedicine and the fact that it tends to be based in urban areas means that many people in developing societies, particularly in rural areas but also in cities, continue to rely heavily on "traditional" medical systems or on new healers who combine aspects of folk medicine and biomedicine. A study of indigenous and church-based healers in Mozambique revealed that traditional healing has been altered appreciably due to the impacts

of both colonialism and market capitalism (Pfeiffer 2005). Men, in particular, in poverty-stricken Mozambique have responded to structural adjustment policies imposed on their country by the World Bank and the International Monetary Fund in 1987 by turning to traditional healing as a means of making a livelihood. Indeed, the Mozambique Association of Traditional Healers, a government-based body to which many *curandeiros* belong, lists the availability of numerous treatments, including ones to help a client obtain a job, avoid mishaps, contact ancestral spirits, and cope with a wide array of problems of living. Some traditional healers, however, view the association as a government ploy to tax them. In response to the growing pecuniary orientation of many traditional healers, a large number of people in Mozambique have turned to Pentecostal sects and African independent churches, which syncretize or blend elements of traditional African religions and Christianity, to create healing rituals designed to help them cope with their plight.

CAM and Class

In keeping with Navarro's (1986:1) assertion that classes as well as ethnic groups and genders within capitalist societies "have different ideologies which appear in different forms of culture," it may be argued that these social categories also construct different health understandings, behavior patterns, and medical subsystems to coincide with their respective views of reality. Regarding gender differences, for example, various medical anthropologists concerned with reproductive health have argued that men and women do not always share reproductive goals and strategies. As has been observed, "Contested reproductive interests may derive from women's and men's differing experiences of pregnancy and birth, varying domestic and productive responsibilities, or discrepant material interests" (Sargent 2006:32). How men influence women's reproductive behaviors, in fact, remains an understudied issue. One possible reason for this is that earlier anthropologists viewed reproduction as a women's issue, and therefore peripheral to the discipline, a telling comment on how social factors influence the course of social research within and beyond medical anthropology, an issue addressed in chapter 2 (Browner 2001:773).

Class differences in health understandings, behaviors, and medical subsystems are also of considerable importance. Critical medical anthropologists, for example, argue that the patterns of medical pluralism found in state societies tend to reflect hierarchical and unequal social relations based on class, caste, ethnicity, region, religion, and gender distinctions found in the larger society. Thus, critical medical anthropologists argue that national medical systems in the modern world should be described as "plural" rather than "pluralistic" inasmuch as biomedicine enjoys a dominant status over both heterodox (e.g., chiropractic and naturopathy) and folk medical systems (e.g., *curanderismo* and African American spiritualism). In reality, plural medical systems may be best described as "dominative" in that one subsystem within the larger complex of coexistent medical traditions generally enjoys a preeminent status over the others. As noted earlier, within the modern context, biomedicine exerts dominance over all other complementary

and alternative medical subsystems (see chapter 1), although people are quite capable of "dual use" of distinct medical subsystems, either simultaneously or sequentially (Romanucci-Ross 1977). Thus, it is not unusual for a patient to be treated during a period of time for the same or different health problems by a folk healer and a biomedical physician (with or without the knowledge of one or both healers).

In the United States, as a result of financial backing for its research activities and educational institutions, initially from corporate-sponsored foundations and later the federal government as well, biomedicine evolved into the dominant medical system. It then asserted scientific superiority and clearly established authority over professionalized heterodox medical systems, such as homeopathy (a medical system developed by Samuel Hahnemann, a disenchanted German physician), eclecticism (a hybrid of regular medicine and botanical medicine), hydropathy (an elaborate system of water cures), osteopathy, and chiropractic. Homeopathy and eclecticism have been somewhat absorbed by biomedicine at both the organizational and the therapeutic level. Osteopathy initially constituted a manual medical system created by Andrew Taylor Still, a dissatisfied regular physician who viewed the spine as the key to good health. It evolved into osteopathic medicine and surgery and achieved full practice rights in all fifty states and the District of Columbia by the early 1970s. Chiropractic, another manual medical system developed by D. D. Palmer, an American magnetic healer, evolved into the leading professionalized heterodox medical system in the United States (and in a growing number of settings in the United States is being practiced as a junior partner to orthopedics). At the beginning of the twentieth century, hydropathy became part of naturopathy, a highly eclectic medical system that incorporated botanical medicine, exercise, dietetics, and colonic irrigations. Naturopathy declined in the 1930s but underwent a rejuvenation with the emergence of the holistic health movement during the 1970s and 1980s.

Biomedical dominance over rival medical systems has never been absolute. In capitalist societies, the corporate class historically has come to exert greater and greater influence over politicians and government bureaucrats through processes such as lobbying, campaign contributions, and the dissemination of information favorable to its positions. Nevertheless, although the state serves the interests primarily of the wealthiest class in society, it must periodically make concessions to subordinate social groups in the interests of maintaining social order and the capitalist mode of production. As a result, certain complementary and alternative practitioners, with the backing of clients and particularly influential patrons, were able to obtain legitimation in the form of full or limited practice rights. Lower social classes, ethnic minorities, and women have often used CAM therapies as a forum for challenging not only biomedical dominance but also, to a degree, the hegemony of the corporate class or state elites. CAM systems sometimes resist, at least subtly, the elitist, hierarchical, and bureaucratic patterns of biomedicine. In contrast to biomedicine, which is dominated ultimately by the corporate class or state elites, folk healing systems are more generally the domain of common people. Biomedical physicians often have significant representation on the registration boards of other health practitioners, tend to be overrepresented on

hospital and health policy advisory boards and in government health departments, and dominate health research funding.

As was the case in Australia, the growing interest in CAM therapies by corporate and government elites around the world is related to the cost of high-technology biomedicine. Even in countries where explicit financial and/or legal support is absent, governments often prefer to support CAM approaches because they focus on self-limiting diseases, that is, diseases that tend to run their natural course without treatment.

While some anthropologists have commended efforts to integrate aspects of biomedicine and CAM practitioners as constituting a key to more comprehensive and culturally sensitive health care, others have viewed the therapeutic alliance between biomedicine and folk healers as a manifestation of a "new colonialism" or a strategy to co-opt CAM (P. Singer 1977, Baer and Coulter 2008). An emancipatory therapeutic alliance ultimately requires an egalitarian relationship between various medical systems, one that transcends the hierarchical structure of existing dominative systems associated with modern societies.

Societies vary considerably in the degree to which they tolerate medical pluralism. This reality is effectively captured in a scheme depicted in table 7.2, which depicts the "range of subcultures permitted within a national medical culture" (Last 1996:380). In the case of the exclusive system, the national power structure recognizes and tolerates only one medical subculture, namely, biomedicine, as acceptable or at least dominant over alternative systems. Such a system existed in the former Soviet Union and former Soviet-bloc countries where alternative healers were viewed as feudalistic anachronisms associated with superstition and economic backwardness. In the French model, which is followed not only in France but also in francophone Africa and parts of Latin America, the national power structure recognizes only biomedical practitioners and defines alternative medical systems as illegal. In a supposedly exclusive biomedical system, such as found in Portugal, where the Medical Council forbids its members to use CAM therapies, various biomedical physicians have opted to contravene this mandate by incorporating acupuncture and homeopathy into their practices (Almeida 2012).

TABLE 7.2 **Plural Medical Systems in Terms of the Officially Accepted Range of Medical Subcultures**

Exclusive systems
Soviet model
French model
American model
Tolerant systems
British model
German model
Integrated systems
Third World systems

In the American model, which theoretically is based on free market principles, the national power structure defines "hospital medicine" or biomedicine as the dominant medical subculture legally and in terms of funding for medical education and research. Conversely, this variant permits a restricted tolerance of alternative medical systems, some of which, such as chiropractic and acupuncture, enjoy more official acceptance than others, such as herbalism and various forms of bodywork.

While giving preeminence to biomedicine, tolerant systems adopt a more or less laissez-faire policy toward alternative medical systems. The British system, which is followed not only in Britain but also in Australia, New Zealand, and many developing nations, operates on the basis of common law, which essentially states that if the law does not specifically restrict certain procedures, such as prescribing legally defined drugs, performing surgery, and signing death certificates, as exclusively the domain of the biomedical practitioner, individuals may practice an alternative medical system, such as herbalism or naturopathy. While this policy applied for a long time to both osteopaths and chiropractors, both healing groups obtained statutory recognition, in Australia in the early 1980s and in Britain in the early 1990s. Another example of the tolerant system is the German model mentioned earlier. While biomedical physicians may work within the traditions of both *Schulmedizin* and *Naturheilkunde*, Germany has a diverse group of practitioners called *Heilpraktikers* (the counterparts to naturopaths in North America, Britain, Australasia, and India) who vary tremendously in terms of their training but are permitted to practice a wide array of natural therapies as long as they have passed an examination indicating that they understand the laws regulating medical practice.

The integrated system is especially characteristic of India and China. In India, the government permits practitioners of various ancient healing systems, such as Ayurvedic, Siddha, and Unani medicine, to establish their own professional associations, training institutions, hospitals, and pharmaceutical industry and provides these systems with statutory recognition and funding. Ayurveda is based upon Sanskrit texts; Unani, or Greek medicine, on Arabic and Persian texts; and Siddha is a tradition of humoral medicine in South India. India also has two transplanted Western heterodox medical systems, namely homeopathy and nature cure or naturopathy. Nature cure, which has received Indian government recognition, made inroads into India in part due to Mohandas K. Gandhi's advocacy of dietary reforms, hydrotherapy, enemas, and mud baths (Alter 2016). Furthermore, Tibetan medicine has been practiced for many centuries in Himalayan India. Tibetan exiles established the first Tibetan medical college in Dharamsala in 1961, one that has gained world renown (Pordié and Blaikie 2014). The Central Institute of Buddhist Studies in Ladakh established a Tibetan medicine course of study in 1989, thus allowing local people to study close to home.

Indeed, in 2010 the Indian government extended official recognition to Tibetan medicine. Unfortunately, the increasing commodification of indigenous medicinal substances in recent times "threatens to rob the poor sections of Indian society of access to Indian medicine because they cannot afford the relatively expensive Ayurvedic and Unani brands" (Bode 2006:233). The poor

farmer from Bankura district in West Bengal, India, in figure 7.2, is an example of the part of Indian society whose access to Indian medicine is becoming more limited.

The People's Republic of China officially recognizes both biomedicine and traditional Chinese medicine and has integrated both to a certain degree in state-operated institutions, including some clinics, hospitals, and colleges. During the Maoist era, barefoot doctors, who were highly touted as paragons of revolutionary dedication, served as medical auxiliaries trained in both biomedicine and Chinese medicine. China also has made provisions for incorporating various indigenous or folk healers. Despite the preeminence of biomedicine in contemporary China, traditional Chinese medicine continues to be very popular and has become fashionable among young professional people in large cities, such as Beijing, perhaps a parallel development similar to the popularity of CAM among professional people in Western societies (Boeke 2014:176–77). Whereas many Chinese people view biomedicine as "fast" in its results, they view traditional Chinese medicine as "slow" but more thorough, focusing more on the roots or causes of disease than the symptoms.

In contrast to China, which has witnessed the rise of the new middle classes with disposable incomes as a result of tremendous economic growth, although massive poverty persists in particularly the rural areas of the country, many people in Russia since the collapse of the Soviet Union in 1991 have fallen into economically desperate situations. In order to cope with gaps in the national health-care

FIGURE 7.2 Impoverished small farmer dries grains in Bankura District in West Bengal, India. Photo by Anna Marie Nicolaysen.

system, older women, referred to as *babushka*, surviving on meager pensions, have turned to self-care utilizing CAM therapies. In the city of Ulan-Ude, the capital of Buryatia situated on the border of Russia and Mongolia, older women draw upon the services of the East-West Hospital, which offers not only biomedical care but also acupuncture, herbalism, hydrotherapy, massage, and even Tibetan medicine under the rubric of *restorative medicine*. This is a new specialty designed to manage chronic ailments (Chudakova 2016). Some of the women purchase Tibetan medicines, some of them of dubious value and posing a drain on their limited budgets. Furthermore, many for-profit clinics and practitioners offering CAM emerged in Ulan-Ude during the twenty-first century, an issue that also occurred in Russia and led to much debate in a country where once all health care fell under the purview of the state.

Arab Herbal Medicine in Israel

Israel is, at least for its Jewish citizens, a largely developed society with an integrative medical system in which CAM modalities have been incorporated into biomedical clinics and hospitals. In recent times, in an effort to appease its Arab citizens, most of whom live in conditions more reminiscent of a developing country, Israeli biomedicine has made efforts to incorporate Arab herbal medicine into the larger integrative health-care system (Keshet and Popper-Giveon 2013). Biomedical research not only in Israel but in Egypt, Turkey, Jordan, and Morocco increasingly has incorporated Arab herbal medicine into its purview of investigation. Conversely, even among religious Jews, a ritual blessing, referred to as "deep healing," is applied by a rabbi in dealing with personally and socially distressful situations, a practice that by and large remains outside the larger integrative health-care system (Sharabi 2014).

The Third World model is situated in many developing societies, particularly the poorest ones in which biomedicine is primarily urban based, poorly financed, and largely a privilege of elites and a small middle class. While the power structure privileges biomedicine and even makes it available on a restricted basis to the masses, it tolerates a wide array of alternative medical systems consisting of local folk healers, bonesetters, injectionists (folk healers who use syringes to inject vitamins, antibiotics, or other drugs), barber-surgeons, and midwives who serve the majority of people—a fact recognized by the World Health Organization. For example, in Mozambique, which has one biomedical physician for some fifty thousand people, there is a traditional healer available for every two hundred people. Furthermore, pharmacists in developing nations often serve as a major source of medical information and dispense drugs freely that generally require a prescription written by a biomedical physician in developed societies. In many developing societies, folk and indigenous healers have organized themselves into professional associations in their efforts to obtain greater legitimation and recognition (Last 1996).

The Third World Model in Morocco

Morocco is yet another country in which the Third World model prevails and while biomedicine constitutes the dominant medical sub-system, only 15 percent of the country's citizens were covered by the public health system, and

TABLE 7.3 The Moroccan Dominative Medical System

Medical Sub-System	Origins
European medicine/ biomedicine	Initially utilized by Franciscan priests around 1800 Authorized by the reigning sultan around 1860 to attend to the health-care needs of resident Europeans Expansion after independence from Spain in 1956
Classical Arab humoral medicine	Greco-Roman tradition spread by Nestorian Christians in the late fifth century CE throughout the Middle East
Prophetic medicine	Based upon the teachings of the Prophet Muhammad and entailing rituals designed to cure illnesses arising from failure to abide by Islamic norms and customs
Popular medicine	Consists of a great variety of medical specialists, most of whom treat a limited number of illnesses using minor surgery and administration of vegetable, animal, and mineral medical products

Source: Adapted from Dieste (2013:166–203).

still patients often had to pay for medicines and operations (Dieste 2013:209). The Moroccan dominative medical system consists of the layers depicted in table 7.3.

Under the rubric of popular medicine are found herbalists and small stores that sell vegetable, mineral, and animal medicinal products; cauterizers who apply iron and wooden tips to cleanse afflicted body organs, such as the intestines, or the nervous system; "barbers" who engage in bloodletting; bonesetters; tooth pullers; women healers who administer herbs, deliver babies, and exorcise evil spirits; and religious sanctuaries and spas linked to the healing abilities of Islamic saints. Approximately 60 percent of the Moroccan population utilizes both biomedicine and a wide array of traditional medical systems, with slightly less than 40 percent relying exclusively on biomedicine and a small minority relying only on traditional medicine (Dieste 2013).

New Directions in the Study of Medical Pluralism

Whereas the early work on medical pluralism tended to focus on levels in plural medical systems, more recent research on this phenomenon recognizes that, as Stoner (1986:47) asserts, "pluralism can now be examined as a multiplicity of healing techniques, rather than of medical systems." In a similar vein, Pool and Geissler (2005:45) maintain:

> Rather than trying to reveal "[medical] systems" we should focus on studying practice (what people actually do when they are ill or suffer misfortune). Health-seeking behavior is not simply enactment of "beliefs" within the confines of "culture" or a "system," but a creative process in which we must recognize the role of invention, innovation, and disorder.

In reality, practitioners from various specific medical systems borrow therapies or modalities from other systems, such as when folk healers in developing societies prescribe manufactured biomedical drugs or even inject them. In South Kanara, India, healers often mixed Ayurvedic medicine with biomedicine and traditional healing techniques (Nichter 1989:187–215).

In response to the growing popularity of CAM in various developed societies, biomedical physicians have increasingly been incorporating various therapeutic techniques from homeopathy, herbalism, acupuncture, and bodywork into their regimen of treatment in an effort to create an "integrative medicine." In essence, while biomedicine continues to enjoy dominance and preeminence worldwide, it increasingly has come to find itself challenged by CAM practitioners of various sorts, including professionalized heterodox ones (e.g., chiropractors and naturopaths), partially professionalized heterodox ones (e.g., herbalists and bodyworkers), and religious and folk healers. Some biomedical practitioners continue to resist the inroads being made by CAM practitioners, yet an increasing number of them are choosing to collaborate with them, but in a manner in which the CAM practitioners later face the danger of co-optation by being transformed into medical auxiliaries similar to nurses, physicians' assistants, and physical therapists.

Some anthropologists believe that the analysis of medical pluralism has reached a theoretical impasse because categorization efforts produced static functionalist typologies or employed incomparable terms (Brodwin 1996). Health anthropologists turned to concerns such as the political economy of health, biomedical domination, CAM systems in developed societies, reproduction, the mindful body, biotechnology, substance abuse, and AIDS. Aside from the issues of the shortcomings of much of the research on medical pluralism, various critical health anthropologists, as we have seen, developed an interest in how power relations shape plural medical systems. In essence, medical pluralism is a topic that continues to be of central concern in medical anthropology.

Medical Syncretism

In keeping with increasing globalization, medical anthropologists have come to find a growing pattern of *syncretism* or *hybridization*—a process in which two relatively distinct medical systems merge to form an essentially new one or at least elements of different medical systems are blended in the treatment of a specific health problem (Pool and Geissler 2005:44–45). Medical syncretism is illustrated in modern Ayurvedic medicine, which is drastically different from the Hindu medical system based on ancient Sanskrit medical texts. Ayurveda has drawn heavily upon the Galenic (Unani) concepts of Islamic medicine. Both professionalized Ayurvedic and Unani medicine have incorporated aspects of biomedicine. Ayurvedic acupuncture constitutes a fascinating example of medical hybridization, one that entails the blending of Ayurveda and traditional Chinese medicine or Taoist medicine. The popularity of acupressure and acupuncture in modern India has resulted in the development of an entity called Ayurvedic acupuncture (Alter 2005). Both Ayurveda and Chinese medicine contend that the unimpaired flow of bioenergy, *Prana* in the case of the former and *chi* in the case of the latter, are

essential to health maintenance. *Prana* flows through each and every organ of the body much in the same way that *Tying* and *chi* flow through channels or twelve regular meridians and eight subsidiary meridians, respectively.

Another example of medical hybridization entails the simultaneous use of the biomedical drug Viagra and herbal medicine in China in the treatment of male sexual impotence. Viagra initially officially entered the Chinese market in July 2000, yet for ages Chinese medicine has used *zhuangyang* herbal tonics that purportedly nourish kidney yang in order to cure impotence. One study entailed interviews with some two dozen physicians, both biomedical and traditional Chinese medical, and about 350 patients suffering from impotence or other sexually related diseases (Zhang 2007). While very few men relied exclusively on Viagra in treating their impotence, many of them engaged in a pattern of switching between the use of Viagra and herbal tonics in their treatment regimen. This switching pattern is illustrated in the case of Mr. Wang (pseudonym) who took ten herbal *yikanwan* pills (in batches of five twice a day) each day over the course of four months and took only two Viagra pills, apparently to give him an extra sexual boost (Zhang 2007:65). Even some biomedical physicians advise that herbal medicine be taken in conjunction with Viagra. While biomedicine does not support the notion that Viagra directly affects sexual desire, only the ability to have a penile erection, some Chinese patients took Viagra to increase their sexual desire. In essence, medical pluralism now operates not only *between* medical systems but also *within* those systems, in both the consultation room and the lab. Thus, in seeking to achieve and provide sexual potency in China, both male patients and physicians essentially hybridize traditionalism, which has drawn from an ancient civilization, and modernity, which has been heavily shaped by the West. These and other incidences of the blending of biomedicine and traditional Chinese medicine can be referred to as a "mangle of practice" (Pickering 1995, Scheid 2002).

Elsewhere in East Asia, Korean medicine also has undergone a process of hybridization as it has sought scientific validation for its herbal formulas. In efforts to prove the efficacy of Korean medicines, "K[orean] M[edicine] doctors blend traditional medicine with several techniques and theories of biomedicine" (Kim 2009). Korean medicine doctors and South Korean businessmen have joined to transform Korean medicine into a "transcultural medical system" that is marketed abroad, including in China, Taiwan, and the United States.

Medical Diversity

Various anthropologists have proposed the term *medical diversity* in lieu of the established term *medical pluralism* (Krause 2013). Medical diversity entails the mutual borrowing of medical beliefs and practices from various medical traditions, which may be biomedical or indigenous or hybridized forms, on the part of patients who are seeking to cure or alleviate their ailment. For example, in African countries such as Kenya and Tanzania, the healer-patient relationship occurs within in a "triangle of healing sources" consisting of biomedical practitioner, local indigenous healer, and healer-prophet-witchfinder (Parkin 2013:129). If the patient and his or her patient management group do not obtain satisfactory treatment from a local healer, they may turn to distant biomedical practitioners

and/or prophet-healers for treatment. With the increasing involvement of Chinese state companies involved in mining and agricultural activities in African countries, traditional Chinese medicine practitioners have added to the range of medical diversity. In the city of Bishkek in Kyrgyzstan, patients rely on a wide array of health practitioners, ranging from Kyrgyz spiritual healers, bonesetters, phytotherapists, Chinese, Korean, and Tibetan medicine practitioners, alongside of biomedical practitioners (Penkala-Gawecka and Ratjar 2016).

Developed societies are also characterized by a pattern of medical diversity. A case in point are spa therapists in a Norwegian health hotel who cater to relatively affluent women who feel overburdened by the stresses of modern life (Anderssen 2016). The spa therapists provide services such as massages, non-surgical body treatments, manicures and pedicures, workouts, and dieting regimens. The therapists view themselves as health workers, but of a different genre than biomedical practitioners and CAM therapists, in that they focus on the well-being of their clients rather than upon primarily their ailments. In reality, the spa therapy settings are part of a long list of different kinds of cure resorts throughout Central and Eastern Europe. For example, in the Czech Republic cure resorts have become part and parcel of *wellness tourism* in which spa therapists and wellness managers with little or no biomedical or CAM training create wellness packages for visitors (Spier 2011).

Medicoscapes

The concept of *medicoscapes* even further broadens the notion of medical pluralism. It recognizes that in their treatment of various diseases, a wide array of national, transnational, and international organizations and institutions, including entities such as the World Health Organization or the Bill and Melinda Gates Foundation, and a wide array of NGOs, along with biomedical practitioners and complementary and alternative practitioners, both professionalized and indigenous, may play a role in the treatment of specific diseases (Hoerbst and Wolf 2014). Certain individuals and groups who generally accept the legitimacy of biomedicine and complementary medicine may opt for religious or philosophical reasons to refuse certain biomedical treatment modalities. For example, in Germany where both biomedicine and *Naturheilkunde* (the art of natural healing or natural medicine) are highly esteemed, Jehovah's Witnesses routinely refuse blood transfusions, as is the case in other countries (Rajtar 2016).

The Globalization of Traditional Medicine and CAM

Just as biomedicine has become a globalized medical system due to colonialism, the migration of Europeans and North Americans to other parts of the world, many heterodox medical systems and CAM systems have also become globalized. For example, naturopathy, which had historical roots in Europe and crystalized into a distinct eclectic CAM system in the United States, has diffused to many parts of the world, including not only Australia and New Zealand but also India, South Africa, and Guatemala (Baer and Sporn 2009). Traditional Chinese

medicine is yet another example that has been diffused to many countries as a result of a global China diaspora. Yet another example of the globalization of a CAM system is Tibetan medicine, which of course made its way to India as a result of the relocation of Tibetan refugees to that country as a result of China's colonization of Tibet after the Chinese Revolution of 1949. Ironically, Tibetan doctors wearing their traditional garb instead of the white coats they wear in Tibetan clinics and hospitals treat patients in the Lhasa Holiday Inn (Janes 2002). Tibetan doctors who were trained in either Tibet or India now are found in many European and American cities. Furthermore, the Chinese government beginning in the 1970s commenced upon a program of reformulating Tibetan medicine and incorporating it into biomedicine as well as fostering the privatization of Tibetan medicine practice and production of Tibetan medicines for commercial purposes (Pordié and Blaikie 2014).

Discussion Questions

1. Compare and contrast the pattern of medical pluralism in the Bolivian altiplano, the city of Yogyakarta in central Java, and Australia.
2. Discuss the concepts of complementary and alternative medicine (CAM) and integrative medicine. Compare and contrast how biomedical practitioners use these terms in contrast to health anthropologists.
3. In what ways does Australian medical pluralism constitute a case of a dominative medical system?
4. Based upon your own experience, how is the Australian dominative medical system similar to or different from dominative medical systems in North American and European societies?
5. In what ways does the dominative medical system model apply to instances of medical pluralism in societies such as China, India, Indonesia, and Morocco? Are there instances where the model does not effectively describe medical pluralism in these societies?
6. Compare and contrast medical pluralism in early state societies and modern societies.
7. Discuss the types of people who seek out CAM therapies in modern societies, including in countries such as the United States, Denmark, Australia, and India.
8. Discuss some of alternatives to the traditional focus on levels in plural medical systems, such as the concepts of medical syncretism, medical diversity, and medicoscapes. In what ways do these approaches provide new insights into medical pluralism?