CHAPTER 20 Medical Pluralism: An Evolving and Contested Concept in Medical Anthropology

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Introduction

In contrast to indigenous or tribal societies, each of which has a more or less coherent medical system that is an integral part of the larger socio-cultural system, complex or state societies manifest the coexistence of an array of medical subsystems or a pattern of medical pluralism that is part and parcel of their socially stratified and culturally diverse nature. From this perspective, the medical system of a complex society consists of the totality of medical subsystems that generally compete with one another but sometimes exhibit cooperative, collaborative, and even co-optative relationships with one another. While various sociologists and geographers have employed the concept, anthropologists have gone further than any disciplinary group to apply and develop this concept. Indeed, despite the fact that medical sociologists have written a great deal about biomedical dominance over complementary and alternative medical systems, particularly in developed societies, they have tended to eschew the concept of medical pluralism as is evidenced by the fact that neither Cockerham and Ritchey (1997) and White (2006) included it in their extensive listing of terms utilized in medical sociology. Exceptions are Cant and Sharma (1999) and Goldstein (2004).

Some historians have begun to express an interest in utilizing the concept of medical pluralism. Ernst observes:

A Companion to Medical Anthropology, First Edition. Edited by Merrill Singer and Pamela I. Erickson.

> Medical historians have only slowly come to avail themselves of the conceptual and empirical insights of anthropological scholarship in non-European cultures... With social history of medicine came a focus on medical alternatives or 'heterodoxies', folk medicines, 'quackery', as well as on 'the patient's view'... Critical publications on the history of colonial medicine, and the present vigour and challenge of fashionable subaltern and post-colonial theories eventually caused social historians of medicine, too, to draw on anthropological perspectives and to consider the development of non-Western medical paradigms and indigenous medicine worthy subjects of historical analysis (Ernst 2002:2).

Ernst (2002) has edited an anthology titled *Plural Medicine, Tradition and Modernity, 1800–2000* which includes essays by historians as well as representatives from other disciplines, including anthropology and sociology, who examine medical pluralism in various societies, including The United Kingdom, India, German East Africa, Swaziland, South Africa, China, and the Maori of New Zealand. She aptly notes that "The cross-fertilization between medical anthropology and medical history certainly constitutes a welcome development" (Ernst 2002:2). In time given their growing interest in complementary and alternative medicine and integrative medicine (Baer and Coulter 2008), it is possible that sociologists also will more fully embrace the concept of medical pluralism than they have until now.

Charles Leslie and Medical Pluralism

Charles Leslie is well known for his organizational skills as both a symposium convenor and editor. In 1971 he organized an interdisciplinary Wenner Gren Foundation conference that met at Burg Wartenstein in Austria on Asian medical systems. Presentations from the conference resulted in a Leslie'seminal edited volume *Asian Medical Systems*. As a result, at least within anthropology, Charles Leslie was the first to conceptualize and apply the notion of medical pluralism in a systematic way. In his Introduction to *Asian Medical Systems*, he observes: "[M]edical systems are pluralistic structures of different kinds of practitioners and institutional norms. Even in United States, the medical system is composed of physicians, dentists, druggists, clinical psychologists, chiropractors, social workers, health food experts, masseurs, yoga teachers, spirit curers, Chinese herbalists, and so on" (Leslie 1976a:9).

Leslie, however, recognized that medical pluralism is an ancient phenomenon. He observes that "All the civilizations with *great tradition* medical systems developed a range of practitioners from learned professional physicians to individuals who had limited or no formal training and who practiced a simplified version of the great tradition medicine" (Leslie 1974:74). In his introductory essay to *Asian Medical Systems*, while noting that folk healers practice throughout the world practice, he noted that Asian countries, such as China, India, Japan, and Sri Lanka, are the only places where the "educated continue [their] learned traditions" (Leslie 1976a:1). Conversely, Leslie argued that the medical systems of Asian countries are quite pluralistic. In the case of China, he observes: "Practitioners ranged from physicians who had undergone long periods of training to individuals with little education who practiced a simplified version of the great tradition. Other healers co-existed with these practitioners, their arts falling into special categories: bone-setters, surgeons, midwives, snake-bite curers, shamans, and so on" (Leslie 1976a:3).

Historically, biomedicine has tended to refer to itself as *scientific medicine*, a notion that persists in the form of evidenced-based medicine which often functions as a device by which biomedicine seeks to control and even co-opt various complementary and alternative medical systems that have become very popular in recent decades in developed societies. However, Leslie insisted that biomedicine has no monopoly on science and that Chinese, Ayurvedic, and Arabic exhibit scientific characteristics in that: "They involve the rational use of naturalistic theories to organize and interpret systemic observations. They have explicit, orderly ways of recording and teaching this knowledge, and they have some efficacious methods for promoting health and for curing illness" (Leslie 1976a:7).

In his introductory essay, Leslie (1976a:6) acknowledged the fact that biomedicine or "cosmopolitan medicine progressively subordinates other forms of practice," an assertion that he demonstrated in other works to be the case in South Asia and others, including various sociologists (Willis 1989), have demonstrated to be the case around the world.

In his contribution to *Asian Medical* Systems, Leslie (1976b) created the first detailed delineation of a specific system of medical pluralism, namely the one in India. He identified eight more or less distinct medical sub-systems in the Indian medical system, namely (1) classical Ayurvedic medicine, (2) classical Yunani medicine, (3) the "syncretic medicine of traditional culture, which evolved among learned practitioners from the 13th to the 19th centuries," (4) contemporary professionalized Ayurvedic and Yunani medicine, (5) cosmopolitan medicine or what generally is referred to within medical anthropology today as biomedicine, (6) folk medicine consisting of midwives, bonesetters, various types of religious healers, and other specialists, (7) popular-culture medicine as embodied within the "institutions of mass society," and (8) homeopathy (Leslie 1976b:358–359). While there is the danger in delineating various medical subsystems of implying that each of them is a clearly demarcated entity, Leslie (1976b) recognized that in reality there is often a considerable amount of cross-fertilization between competing medical sub-systems, a process under which they draw from each other: "[I]n the modernization of Asian medicine has not been one-way process in which Ayurvedic and Yunani physicians have borrowed ideas and institutional forms from so-called Western medicine. Cosmopolitan medicine institutions have themselves developed in a distinctive manner because Ayurvedic and Yunani institutions were there, doing medical jobs Indian society wanted and needed to be done" (Leslie 1976b:366).

Leslie organized a second pivotal conference in 1977 in Washington, DC, under the auspices of the National Science Foundation and the Wenner Gren Foundation. Many of the papers at the conference touched upon medical pluralism and most of them were published in 1978 in a special issue of *Social Science and Medicine* on "Theoretical Foundations for the Comparative Study of Medical Systems" (See Leslie 1978). The conference and the subsequent special issue explored "concepts for analyzing the complex systems composed of plural medical traditions" and explored these traditions from a "broad historical and comparative perspective" (Leslie 1978:66).

In 1980 Leslie went onto to edit a special issue of *Social Science and Medicine* on "Medical Pluralism in World Perspective." In the introductory essay to the issue, he not only makes a case for the theoretical significance of the concept of medical pluralism but also for its applied utility in his observation: "Fundamental comparative research on pluralistic structures of medical systems would be an instrument of planning and also a technique for training personnel to design such programs in a realistic manner." While essays in this special issue included contributions by several anthropologists, it also included essays by a sociologist, a historian, a geographer, and a medical ethicist. Indeed, among the anthropologists who contributed to this special issue were Ronnie Frankenberg (1980), Mark Nichter (1980), H. K. Heggenhougen (1980), Margaret Lock (1980), Joan Koss (1980), and Sheila Cominsky (Cominsky and Scrimshaw 1980), all of whom went onto to become well known names in medical anthropology. While the essays in this special issue focused on societies outside the United States, such as India, Malaysia, and Guatemala, the essay by Joan Koss (1980) focused on *espiritismo* in Puerto Rico, a territory of the United States. Her essay and Leslie's following remark in this special issue reminded anthropologists that medical pluralism is an integral component of US society:

> A division of labor exists in every medical system between practitioners who represent different traditions. This in the United States clinical psychologists, yoga teachers, health food experts and Christian Science healers follow various forms of therapy... For some illnesses and kinds of patients [cosmopolitan medicine] provides less effective care than one or another alternative therapy (Leslie 1980:193).

The articles in this special issue highlighted the strong tendency around the world for the biomedical profession to resist the use of alternative medical systems, the notion that alternative practitioners are on the whole no more often "charlatans" than are biomedical practitioners; and that comparative research on medical pluralism has the potential to be an useful tool in health care planning.

Leslie organized a third conference in 1985 in Washington, DC, again sponsored by the Wenner Gren Foundation as well as the Department of Anthropology at the Smithsonian Institution, on "Permanence and Change in Asian Health Care Traditions." Selected papers from the conference were published in a special issue of *Social Science and Medicine* guest-edited by Beatrix Pfleiderer and in *Paths to Asian Medical Knowledge* co-edited by Charles Leslie and Allan Young (1992).

In recognition of not only his contributions to the study of Asian medical systems and medical pluralism but medical anthropology, Mark Nichter and Margaret Lock co-edited a series of essays in honor of Leslie. In the introductory essay to the volume, Lock and Nichter succinctly summarize Leslie's contribution to medical pluralism and medical revivalism:

> Charles Leslie's own work on medical pluralism focused primarily on Ayurvedic practitioners and the conflict and accommodation that were apparent as they were increasingly confronted with cosmopolitan medicine. He was able to show conclusively how self-conscious attempts at revivalism of an "authentic" Ayurvedic tradition were closely associated with nationalism and were in large part responses to perceived threats by forces of modernization and, by implication, "westernization," emanating from both inside and outside India. This is a topic that is of ongoing importance to scholars of Asia and elsewhere (Lock and Nichter 2002:7).

Theoretical Perspectives Interpretations of Medical Pluralism

Within medical anthropology, three rather distinctive theoretical perspectives have emerged, namely cultural interpretivism, the medical ecology, and critical medical anthropology (Baer et al. 2003). Each of these theoretical perspectives has manifested itself in an array of examinations of medical pluralism. In this section, I provide an overview of some of these.

Cultural interpretive or phenomenological analyses

Chrisman and Kleinman (1983) developed a widely used model that recognized three overlapping sectors in health care systems. Actually, Kleinman (1978) first presented a sketchier version of this model in an article that appeared in the 1978 special issue of *Social Science and Medicine* on "Theoretical Foundations for the Comparative Study of Medical Systems" edited by Charles Leslie. In Kleinman's model, the popular sector consists of health care conducted by sick persons themselves, their families, social networks, and communities. Kleinman, who has conducted research in Taiwan, estimates that 70–90% of the treatment episodes on that island occur in the popular sector. The folk sector encompasses healers of various sorts who function informally and often on a quasi-legal or sometimes an illegal basis. Examples include herbalists, bonesetters, midwives, mediums, and magicians. The professional sector encompasses the practitioners and bureaucracies of both biomedicine and professionalized heterodox medical systems, such as Ayurveda and Unani in South Asia and Traditional Chinese medicine or naturopathy, homeopathy, and Western herbal medicine in Europe, North America or Australasia. Chrisman and Kleinman observe that the three sectors in their model are not mutually exclusive ones but in reality overlap with one another. Helman (2007) applies the sectorial model of health care systems to the UK, which ranges from hospital doctors and general practitioners working under the auspices of the National Health Service to osteopaths, chiropractors, and naturopaths to diviners and religious healers of various sorts.

Emiko Ohnuki-Tierney (1984), a native Japanese anthropologist, discusses medical pluralism in contemporary Japanese society in the context of a broader examination of Japanese health related activities and beliefs. She clearly situated her perspective within symbolic anthropology and maintains that she examines "health related practices and concepts from the perspective of how they are organized according to the 'logico-meaningful' structure of the culture" (Ohnuki-Tierney 1984:3). Ohnuki-Tierney (1984:212) asserts that "[p]erhaps the single most important factor in the success of medical pluralism today is that each system has become so thoroughly embedded in Japanese culture and society." In addition to discussing popular health related beliefs and practices, she identifies two formal medical systems in Japanese society, namely *kanpo* and biomedicine, and various religious institutions that incorporate health practices. *Kanpo* relies heavily upon the regulation of daily habits, including dietary ones, and the administration of herbal medicines.

Since 1875, a physician can practice *kanpo* only after having obtained training in allopathic medicine or biomedicine. Ironically, Ohnuki-Tierney, who employs a functionalist view of socio-cultural systems, does not elaborate upon the fact that *kanpo* in

essence has become a subordinate or adjunct medical subsystem within the hierarchical structure of Japanese medical pluralism. Allopathic medicine was first introduced into Japan by the Dutch during the late 18th century but took on a German cast during the Meiji period which started in 1868. Biomedical physicians, who tend to be male, often have their offices in their homes and employ their wives as pharmacists or receptionists. They generally see patients on a "first-come, first-serve" basis. Virtually all Japanese biomedical physicians practice more than one speciality. Japanese hospitals expect family members to be actively involved in patient care, which entails a family member staying with the patient, attending to his or her needs, receiving visitors, and providing meals.

Various Japanese religious institutions also cater to health care needs. Shamanism persists in remote mountainous areas but has been subsumed into the "new religions" that appeared in Japan following World War II. Conversely, major religious institutions play a significant role in health maintenance, although the Japanese do not label the service provided by temples and shrines as medical treatment per se. According to Ohnuki-Tierney (1984:124), the "number of shrines in Japan is phenomenal, and in fact has been increasing for some time." Regular bus tours to temples and shrines often target elderly people who have experienced strokes or suffer from hemorrhoids and other chronic ailments. Ishirki Shrine in the Osaka region is known for the treatment of tumors and Nakayama Temple specializes in matters related to childbirth and infancy, including "easy and safe delivery, the healthy growth of children, and memorial services for aborted fetuses" (Ohnuki-Tierney 1984:141). Whereas Buddhist temples focus on various aspects of death, such as funerals and memorial services, Shinto shrines focus on matters related to birth, growth, and marriage. The Japanese turn to their deities and buddhas for health, prosperity, traffic safety, and other secular concerns.

Ohnuki-Tierney asserts that medical pluralism in Japan has shifted in terms of the influence of its constituent medical subsystems:

> During the premodern periods biomedicine was absent, and both institutionalized religions and *kanpo* played significant roles in health care. During the modernization period, promotion of biomedicine became a national policy, and at least at the institutional level it became the dominant system, and the practice of *kanpo* was officially discouraged. After the beginning of the postmodern period, the dominant role of biomedicine has eroded, especially with the revival of *kanpo* among the general public (Ohnuki-Tierney 1984:221).

Also, in the contemporary era, a prototypical patient varies in terms of how much he or she relies upon the three major medical subsystems over the course of his or her illness career (Ohnuki-Tierney 1984:220–221). In terms of health maintenance, the prototypical patient relies on all three medical sub-systems more or less co-equally. During the acute stage of an illness, the prototypical patient relies heavily upon biomedicine, secondarily upon *kanpo*, and the less upon religious institutions. In the case of chronic, degenerative, or fatal illness, the prototypical patient still relies heavily upon biomedicine but is likely to turn more upon both *kanpo* and religious institutions for chronic conditions or transitions in the life cycle, such as birth, marriage, and death.

Medical ecological or biocultural analyses

By and large, medical ecologists or medical anthropologists with a biocultural perspective have tended not to grapple with the concept of medical pluralism. A notable exception is Horacio Fabrega (1997), who has developed an elaborate scheme of medical systems from a biocultural approach. Indeed, his *The Evolution of Sickness and Healing* probably still constitutes the most comprehensive delineation of the biomedical approach in medical anthropology. He asserts that medicine centers around sickness and healing – an observation made by many medical anthropologists. He defines *healing* as "the culturally meaningful social responses aimed at undoing or preventing the effects of disease and injury" (Fabrega 1997:ix). For Fabrega, the integration of sickness and healing is a natural byproduct of human evolution. He introduces the acronym SH, a notion that has not been widely adopted, for referring to a hypothesized biological adaptation for sickness and healing. He maintains that chimpanzees exhibit some basic behaviors, such as the use of leaves to wipe themselves and the use of leaf napkins to dab at bleeding wounds, associated with the SH, but also observes that they exhibit some non-SH responses, such as aversion to and exploitation of sick group members. Fabrega suggests that many of the SH characteristics of chimpanzees existed in early hominid societies and that SH became more refined during the Neanderthal stages, as is implied by the presence of healing fractures in some Neanderthal remains. Asserting that "SH constitutes the foundational material for elaboration of medicine as a social institution," he posits that the provider of SH in early human societies was a highly insightful individual who possessed an elaborate knowledge of the social organization of his or her society (Fabrega 1997:70). Fabrega then introduces the notion of *meme*: a unit of cultural information which is stored in the brains of individuals and passed onto others through enculturation. With regard to sickness and healing, medical memes serve as mechanisms for orienting to, thinking about, and responding to disease and injury. Unfortunately, while the concept of medical meme may be a useful heuristic device, he provides no concrete evidence that it has any physical reality.

Fabrega characterizes SH in foraging societies as family and small-group oriented, based upon "non-systematized knowledge," and focused on immediate restoration of well being or accommodation to death through ritual activities and social practices. Village-level societies exhibit a higher prevalence of infectious diseases and a decline in general health compared to foraging societies. SH is characterized by the presence of specialized healers, elaborate healing ceremonies attended by community members, and an expansion of the sick role manifested, for example, in growing attention to psychosocial needs and sick individuals. In terms of disease and medical ecology, chiefdoms, pre-state, and early state societies are characterized by less nutritious and balanced diets, increased prevalence of bacterial, viral, and parasitic infections, and lower general health and well being than foraging and village-level societies. They also exhibit a high prevalence of gastrointestinal infections which contribute to a very high infant and adult mortality rate. However, individuals who survive into adulthood tend to live longer lives than people in small-scale societies. According to Fabrega, chiefdom, pre-state, and early state societies exhibit the beginnings of the "institution" or "system" of medicine which includes (1) an elaborate corpus of medical knowledge

which continues to embrace aspects of cosmology, religion, and morality, and (2) the beginnings of medical pluralism, manifested by the presence of healers, including general practitioners, priests, diviners, herbalists, bonesetters, and midwives who undergo systematic training or apprenticeships.

Empires and civilizations exhibit the beginnings of industrialization, considerable growth of mercantilism and commerce, social classes and occupational specialization, and ethnic, linguistic, religious, and economic diversity. These societies are characterized by high infant and child mortality rates, a growing prevalence of chronic diseases (e.g., diabetes, heart disease, hypertension, cancer), widespread malnutrition, periodic plagues, and a higher prevalence of psychiatric disorders. Conversely, adult life expectancy probably increased among the more affluent members of empires and civilizations. According to Fabrega, SH in these societies is characterized by a complex pattern of medical pluralism consisting of two tiers: (1) an official, scholarly, academic medical system oriented to the care of the elites, and (2) a wide array of less prestigious physicians and folk healers who treat subordinate segments of society. The state 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 includes the formation of a medical profession, the beginnings of clinical medicine, and increasing commercialization of the healing endeavor.

SH in modern European societies is characterized by the emergence of biomedicine as a dominant and hegemonic profession which is characterized by patterns of secularization, scientific knowledge, biological reductionism, the emergence of the hospital as the center of healing and research, and the universalization of categories of sickness. Fabrega (1997:19) asserts that the functions and aims of a medical system are shaped by systemic forces or the "dominant powers" in a society. At the same time, medical pluralism manifests itself in the continuing existence of "unorthodox practitioners, providers of 'alternative medicine'" (Fabrega 1997:135) who are held in contempt by biomedical physicians. Despite the ongoing pattern of biomedical dominance in post-modern societies, ones characterized by corporate globalization and an emphasis on consumerism, a growing public recognition of the limitations of biomedical reductionism has led to the "pursuit of alternative, unorthodox, Eastern, and holistic healing practices" (Fabrega 1997:179). Many individuals in post-modern societies regard health as an achieved status obtained through education, prevention, and lifestyle. According to Fabrega (1997:141), post-modern societies manifest an "obsessive preoccupation with health and fitness," thus resulting in the phenomenon of the "worried well."

Fabrega is to be commended for presenting a comprehensive framework that delineates the relationship between levels of socio-cultural integration and their associated conceptions of sickness and healing. However, referring only to modern European societies, without recognizing "modern Asian societies" or "modern African societies" seems rather "Eurocentric". Furthermore, his typology ignores developing societies.

Critical perspectives on medical pluralism

From a critical perspective, medical pluralism tends to reflect hierarchical relations in the larger society. Patterns of hierarchy may be based upon class, caste, racial, ethnic, regional, religious and gender distinctions (Baer et al. 2003; Singer and Baer 2007).

Medical pluralism flourishes in all state or complex or state societies, whether pre-industrial, industrial, or post-industrial, and tends to mirror the wider sphere of class and social relationships. Since the early 20th century, it is perhaps more accurate to say that national health care systems are *plural* rather than *pluralistic* in that biomedicine came to exert a dominant status over heterodox and folk medical systems. In reality, plural medical systems may be described as *dominative* in that one medical system, namely biomedicine, enjoys a pre-eminent institutional status vis-à-vis other medical systems. While within the context of a dominative medical system one system attempts to exert, with the support of strategic social elites, dominance over other medical systems, people are quite capable of the dual or multiple use of distinct medical systems.

The dominant status of biomedicine is legitimized by broad practice acts that grant it a monopoly over certain medical practices, and limit or prohibit the practice of other types of healers. Nevertheless, biomedicine's dominance over rival medical systems has never been absolute. The state, which primarily serves the interests of the corporate class, must periodically make concessions to subordinate social groups in the interests of maintaining social order and the corporate mode of production. As a result, certain heterodox practitioners, with the backing of satisfied patients and influential patrons, have been able to obtain legitimation in the form of full practice rights (e.g., homeopathic physicians in the United Kingdom, osteopathic physicians in the USA, and Ayurvedic and Unani practitioners in India) or limited practice rights (e.g., chiropractors, naturopathic physicians, and acupuncturists in North American societies, many European societies, and Australasia). In contrast to the United States, osteopathy in other countries, such as the UK, Australia, and New Zealand, continues to function as primarily manual medical system with limited practice rights. Lower social classes, racial and ethnic minorities, emerging subcultures, and women often have utilized complementary and alternative medical systems as a forum for challenging not only biomedical dominance but also, to a degree, the hegemony of the corporate class and its political allies. Homeopathy in 19th century America would have constituted an exception to this tendency in its practitioners and patients often were drawn from the upper and upper middle classes, but it became absorbed into conventional medicine during the early 20th century for a variety of complex historical and social structural reasons (Kaufman 1971). Conversely, chiropractic and herbal medicine appear to have found both its practitioners and patients initially among rural and working-class peoples, especially the former for those doing physical labor.

Despite the fact that alternative medical systems may over time achieve a certain semblance of legitimacy and professionalization in the form of licensure laws, statutory registration, government support for training and research programs, popularity among the general public, and media coverage, these gains entail the growing pressure on natural medicine providers to accommodate a reductionist theory that is compatible with both corporate ideology and the conventional medicine's model of institutional organization. Unless they are part of a major societal transformation, competing medical systems must accommodate themselves to what Wallace (1956) terms "specialized interest groups" (e.g., organized conventional medicine, corporate and government elites, and health policy decision-makers) if they are to survive and prosper. These systems will remain weak even as they grow. According to Saks (1994:100), "while access to the alternatives to medicine may be expanded, the

traditional monopolistic power base of the orthodox profession still seems highly likely to dilute the scope of what is available, even at a time when the profession is coming under ever greater challenge in an increasingly market-based society."

As professionalized heterodox medical systems, osteopathy, chiropractic, and probably naturopathy initially held out the promise of improved social mobility to thousands of working class and lower-middle class individuals as well as members of our social categories, including in some instances women and in the case of US osteopathic medicine Jews (Baer 2001). In attempting to enter the medical marketplace, as Larkin (1983:5) asserts, "innovatory groups in medical science often commence with low status, particularly through their involvement in activities [e.g., spinal manipulation or colonic irrigation] previously regarded as outside of the physician's or surgeon's role." As the new medical system grows, it accumulates:

> More and more members who are interested in making a good living and in raising their status in the outer world. In the health sphere, this means that they become more concerned with obtaining respectable (or at least respectable-looking) credentials, providing services that more clearly follow the medical model, and eventually even developing relationships with the orthodox medical world (Roth 1976:40–41).

There are historical exceptions to these patterns as evidenced by hydropathy and homeopathy which appealed to the upper and middle classes during the 19th century in Europe and North America. Hydropathy remains a very strong tradition throughout much of central Europe and was for a time incorporated into naturopathy in North America, but has become in large part a marginal modality in the latter.

I have developed a model of medical pluralism in the United States that recognizes biomedicine's institutional and economic hegemony and power differences within plural medical systems. This model is referred to as the *dominative medical system* because of the fact that biomedicine exerts dominance over other medical or therapeutic system (Baer 1989, 2001). This scheme is based on the thesis that the principal practitioners of each medical subsystem tend to be drawn from specific classes, racial and ethnic categories, and genders depending on their status in the larger society.

In my own work, I have applied the notion of dominative medical system to medical pluralism in both the United States and more recently Australia (Baer 2001, 2004, 2008a; Singer and Baer 2007). A diverse mixture exemplifying medical pluralism characterized the United States from the colonial times until the early 20th century; while regular physicians were often predominant, homeopathic, eclectic and physio-medical physicians and other "irregular" professional practitioners provided a significant portion of medical care and held positions of social respectability and of income status equivalent to conventional MDs. The domination of biomedical physicians in economic status, institutional pre-eminence and growing acceptance by the general public as medical authorities was not established until the 1930s and later. Thus, the US dominative medical system, which emerged in the mid-20th century, consists of the levels depicted in Figure 20.1. With some modification, the model of the dominative medical system can be applied to other societies.

As a result of corporate support for biomedicine, its practitioners came to consist primarily of white, upper- and upper-middle class males, although, largely due to affirmative action programs, women entered into biomedicine in increasing numbers

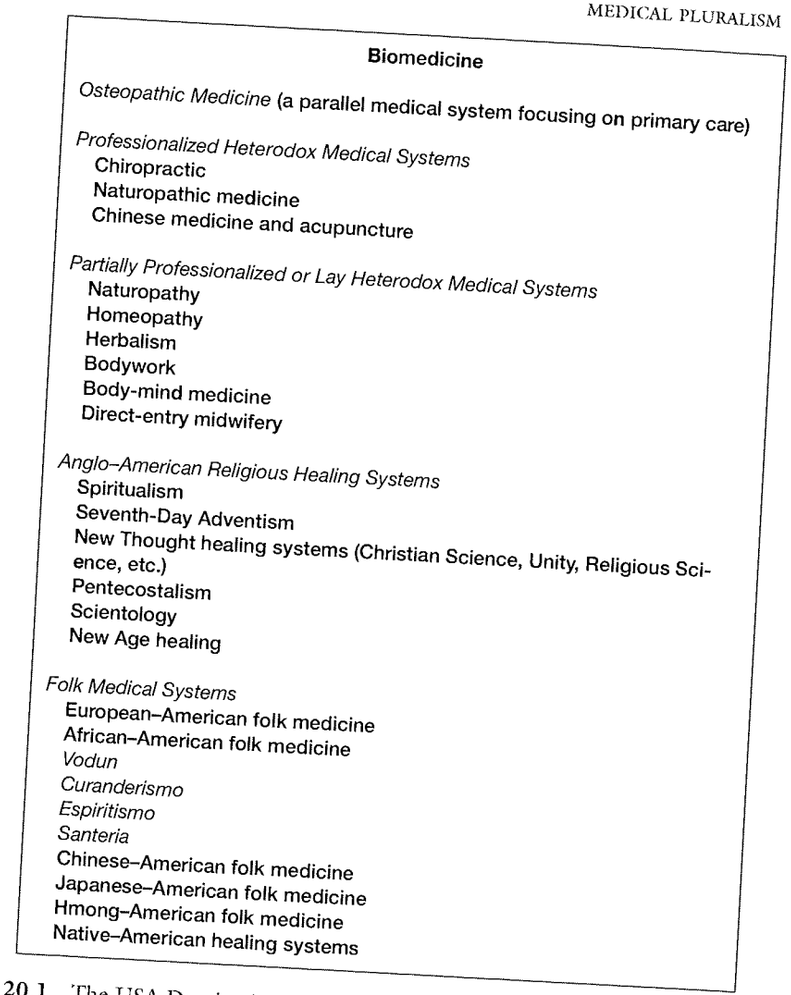

Figure 20.1 The USA Dominative Medical System. Figure by Hans A. Baer.

as did some Asian–Americans, African–Americans, and Hispanic–Americans. As professionalized heterodox medical systems, osteopathy, chiropractic, and naturopathy held out the promise of improved social mobility for thousands of white-middle- and working-class individuals, most of whom were males, who were denied access to biomedicine due to the structural barriers created by the Flexner Report of 1910. Osteopathic medicine, gutted of its traditional principles and practices and co-opted by biomedicine, eventually evolved into a parallel medical system with full practice rights in all 50 states and the District of Columbia as a result of the paucity of primary care physicians created by the increasing trend toward specialization in biomedicine. In contrast, chiropractic, which in part had its roots in osteopathy, eventually evolved into the foremost professionalized heterodox medical system in the United States (Baer 1987). Many of the prejudices against chiropractic could be viewed as derived from, or at least reflective of, class and urban-rural biases against those who

did physical labor and found benefit in hands-on therapies. Anglo–American religious healing systems provided outlets for white women seeking therapeutic roles, except in the notable instances of the physiomedical and eclectic professions which included women from their inception in the 1830s and 40s. Whereas Christian Science served this role largely for upper-middle-class women, Spiritualism and Unity did so for lower-middle-class women. Finally, folk medical systems, including midwifery and Thomsonian herbalism, have enabled working class and rural people from various ethnic groups, particularly people of color and often females, to provide lower-cost and culturally appropriate therapy for individuals at the lowest echelons of US society.

Even when biomedical physicians express an interest in Complimentary and Alternative Medicine (CAM), often under the rubric of integrative medicine, they often continue to view CAM practitioners who work in their clinics as their inferiors or subordinates. Ellen J. Salkend (2005) found this to be the case in her study of the Holistic Medicine Institute (pseudonym), a Midwestern US suburban clinic operated by four biomedical physicians who hired several CAM practitioners on a part-time basis who are expected to carry out various labor-intensive therapies.

Paralleling my own efforts to examine medical pluralism at the national level in two developed societies, Libbet Crandon-Malamud, provided a critical analysis of medical pluralism in a single community in the Bolivian *altiplano* (see Koss-Chionino et al. 2003 for an anthology in her memory). In her book *From the Fat of Our* Souls, Crandon-Malamud (1991) examined power relations embedded in the Bolivian dominative medical system in Kachitu (pseudonym), the center or *municipio* for a canton consisting of some 16,000 Aymara Indians dispersed over 36 *communidades* situated at about 13,000 feet elevation and several miles from Lake Titicaca. At the time of her research in the late 1970s, the town proper had a population of about 1,000 people consisting of three ethnoreligious groups: (1) Aymara campesinos, (2) the Methodist Aymara, and (3) Catholic *mestizos*.

> Crandon-Malamud described ethnic dynamics in Kachitu in the following terms: By the 1970s, as social divisions multiplied, the content, meaning, and significance of mestizoness, Aymara Indianness, Catholicism, and membership in the Methodist church were being culturally redefined within an environment of political and economic instability and radically changing social relations. The resulting confusion left Kachitu, and throughout the altiplano, resources are scarcer than they have ever been in Bolivian history (Crandon-Malamud 1991:19–20).

Kachitunos utilized the local plural medical system for purposes of establishing their sense of cultural identity and obtaining the few resources available to them. According to Crandon-Malamud (1991:138), Kachitunos utilized medical dialogue and curative strategies in order to "make alliances, disassociate themselves from others, exchange resources, and try to forge new identities that will open opportunities and improve their lives under conditions of extreme and seemingly unrelenting national economic contraction, regional peripheralization, and local marginalization." The three medical ideologies in Kachitu, namely shamanism, mestizo home care, and biomedicine, serve as options that address different types of ailments. Thus, "All things being equal, if one has tuberculosis, one goes to the physician in the Methodist clinic; if one suffers from *khan achachi* [sickness emanating from a phantom], one goes to the *yatiri*; if one has a stomach upset, one resorts to *medicinas caseras*" (Crandon-Malamud 1991:202–203). Medical dialogue served as an idiom by which a person defined his or her ethnic identity in the larger context of Bolivian society. For instance, mestizos who found themselves downwardly mobile within the shifting Bolivian political economy could gain access to greater health care by turning to Aymara medicine.

As people elsewhere, Kachitunos, regardless of their social standing, tend to be pragmatic rather than therapeutic purists when it comes to seeking medical treatment. Kachitunos utilized medical dialogue as a mechanism for empowerment in the face of external hegemonic forces, including that of biomedicine. Unfortunately, this medical dialogue served as rather limited form of empowerment and in reality functioned more as a coping mechanism within the larger context of the Bolivian political economy. At any rate, medical pluralism in Kachitu constituted one of many microcosms of the Bolivian dominative medical system – a national system that includes a diversity of biomedical practitioners, herbalists, midwives, and indigenous healers.

The Stance of Various National Socio-Cultural Systems Toward Medical Pluralism

The degree of medical pluralism manifested in any particular complex or state society is highly. As illustrated in Figure 20.2, Murray Last (1996) systematically addresses this reality in his delineation of three "broad types of regulatory systems that help to determine politically the nature of a state's medical culture" that in turn shape the degree of medical pluralism that exists in a particular society.

The Soviet Union constituted the prototypical example of the exclusive system in that biomedicine was the only medical subsystem that was legally recognized. Many socialist-oriented developing countries also followed the Soviet model and viewed "traditional medicine" as class-divisive and a "feudalistic practice" that prevented people from "having a proper scientific understanding of their condition and pandering instead to superstition" (Last 1996:381). The French model is followed in not only

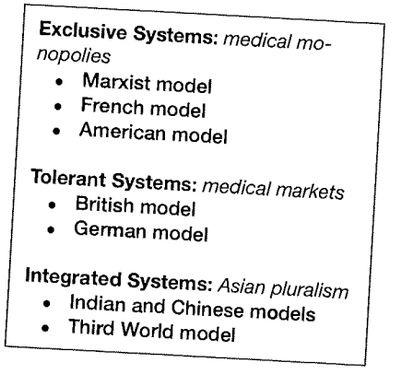

Figure 20.2 Types of regulatory systems impacting upon medical pluralism. Figure by Hans A. Baer.

France but various Francophone developing countries and some Latin American countries and "starts from the premise of centralized state control with all unlicensed healers illegal" (Last 1996:381). The American model, in which biomedicine enjoys full practice rights in all 50 states and the District of Columbia, in reality does not function as a full blown exclusive system in that various other medical subsystems, including chiropractic, naturopathic medicine, acupuncture, and Chinese medicine, massage therapy, and direct-entry midwifery, enjoy limited practice rights in all or many states. Osteopathic medicine has evolved into a parallel medical system to biomedicine in that since the early 1970s it has enjoyed full practice rights in all 50 states and the District of Columbia.

Great Britain and various Anglophone countries, including Australia and New Zealand, employ *common law* in permitting a wide array of medical subsystems to coexist with biomedicine and allow them a wide scope of practice, barring procedures that are covered under statutory registration. In the UK, Australia, and New Zealand, statutory registration exists in all political jurisdictions not only for biomedical physicians but also osteopaths and chiropractors. Conversely, naturopaths, Western herbalists, religious healers, and folk healers practice under common law. In Germany, biomedicine has for long been divided into *Schulmedicizin* ("school medicine") and *Naturheilkunde* ("natural medicine")(Roth 1976). By obtaining additional training in the form of short courses and apprenticeships, biomedical practitioners, such as my cousin who obtained her medical degree from the University of Heidelberg, can become practitioners of *Naturheilkunde*. Conversely, Germany tolerates the existence of *Heilpraktikers* or partially professionalized heterodox practitioners who are the rough equivalent of naturopaths in the USA, Canada, Australia, New Zealand, South Africa, and India. According to Last,

> [Heilpraktikers] merely have to pass an examination to show that they know the state law regulating medical practice; the actual content of the expertise they claim to exercise is not otherwise restricted or examined... Schools, however, to teach would-be practitioners the relevant, legal information to pass the examination (Last 1996:385).

As Leslie has illustrated, biomedicine coexists with various professionalized indigenous medical systems, such as Ayurveda, Siddha, and Unani as well as homeopathy, a Western import. According to Last (1996:385), "[o]ther, less systematic therapeutic systems survive without professionalization on the margins of the national medical culture and meeting specific needs that the various formal systems cannot adequately provide for." While in theory biomedicine and traditional Chinese medicine are integrated and on an equal footing in China, in reality the former has a considerably higher status and is funded more heavily than the latter. During the Maoist era, barefoot doctors, which were highly touted as paragons of revolutionary dedication, served as medical auxiliaries trained in both biomedicine and Chinese medicine. Only about 13% hospitals focus on traditional Chinese medicine. Traditional Chinese medicine is more extensively employed in remote rural areas than in urban areas or in rural county hospitals close to urban areas. Last (1996:386) argues that plural medical systems of many developing or Third World societies are integrated in the sense that biomedicine is not clearly dominant over heterodox medical subsystems that include a "very large number of local practitioners of traditional medicine, bonesetters, midwives, barber-surgeons, and so forth who have always tried to meet the health needs of the community" and a "wide spectrum of modern alternative therapies alongside a market in medical drugs imported, sometimes unmarked and instruction-less, from all over the world."

Medical Syncretism and the Transnationalization and Globalization of Medical Systems

Various anthropologists have criticized a strong tendency in the study of medical pluralism to discuss the relationship among allegedly discrete medical subsystems because it downplays the phenomenon of medical syncretism in which health practitioners and patients often blend together beliefs and practices from different medical traditions (Poole 2005:38–51; Lewis 2007). Furthermore, patients often do not clearly subscribe to one set of medical beliefs or another. Based upon interview and focus group research in Oceanport (pseudonym), a socio-economically diverse suburb of a New South Wales city, Connor (2004) found that 27 (24%) of her 111 subjects indicated that another household member had engaged in a pattern of "mixed therapy regimens" – a scenario in which "people may be using multiple types of therapists and therapies simultaneously, or shift from one type of therapy or practitioner to another in seeking to resolve their health problems." In a similar vein, immigrant groups often tend to engage in "mixed therapy regimens" in which they move back and forth between biomedicine and folk medicine. This pattern is poignantly illustrated in Anne Fadiman's (1997) account of the conflict faced by a Hmong family who encountered a confrontation between themselves and a small California county hospital over the care of their daughter who had been diagnosed of epilepsy. While the Hmong do turn to biomedicine for many health problems, they often also continue to rely on the *txiv neebs*, the "great plea bargainer for the soul, the preeminent champion in the struggle for the demonic" as did the family in this captivating account of a cultural class between a refuge family and biomedicine (Fadiman 1997:281).

Medical syncretism is illustrated in modern Ayurvedic medicine which is drastically different from the system delineated in its classic texts. It has a long tradition of syncreticism, which has drawn heavily upon the Galenic (Unani) concepts of Islamic medicine. Both professionalized Ayurvedic and Unani medicine have incorporated aspects of biomedicine. Homeopathic practices have become a standard part of Ayurvedic medicine. Leslie, who has for long engaged in this type of research, recognizes the syncretic nature of medical pluralism: "Ayurveda and Yunani tibia also borrow from each other, homeopathic medicine is used by many vaidyas... in another direction entirely, some practitioners combine Ayurveda with tantric ritual" (Leslie 1992:196).

Ferzacca (2001:210) views medical pluralism in Yogyakarta, an educational center in Central Java, as a "social practice that produces hybrid [i.e., a mixture of traditional and modern] forms of medicine" utilized by people who lead "hybrid lives." Indeed, as Alter (2005a:2) observes in the introduction to his anthology on *Asian Medicine and Globalization*, "there is a tremendous amount of historical, theoretical, applied, and practical overlap between key concepts in the various medical systems of Asia" and various forms of "Western" medicine, not only biomedicine but also homeopathy

and naturopathy, which have been incorporated into traditional Asian medical systems. Zhang (2007) also illustrates the hybridity between biomedicine and traditional Asian medicine in his analysis of patients switching back and forth between taking Viagra and Chinese medicinal herbs in the treatment of impotence. In his discussion of Ayurvedic acupuncture in modern India, Alter (2005b:42) asserts that in reality "all forms of medicine are theorized as transcultural systems." While Ayurveda has often been viewed as an example of Indian nationalism, it is a system that has diffused to other parts of the world, including the United States where it has become incorporated within the rubric of holistic medicine or complementary and alternative medicine (Baer 2004:74–78).

Many traditional Asian medical systems have been quickly globalizing and diffusing to Western developed societies. Janes (2002:268) argues that Tibetan medicine has become increasingly commodified and globalized as is evidenced by the establishment of private Tibetan medical clinics in major Chinese cities and its engagement with a "Western interest in Eastern spirituality and holistic healing." In embracing neoliberalism, China has been marketing both traditional Chinese medicines and Tibetan medicines overseas. Developments in Korean medicine, which historically drew heavily from Chinese medicine, also reveal processes of hybridity, commodification, and globalization. Kim (2009:32) has examined how three Korean medicine practitioners "actively attempted to scientize, globalize, and industrialize their clinical knowledge by associating with two laboratories and a biotech company that reached beyond local and national boundaries." The commercialized products, particularly weight loss and skin medications, mixed Korean medicine, biomedicine, and cosmetic techniques and were sold to high-status Korean women not only in Seoul but even Los Angeles and New York, two US cities with relatively large Korean populations. Chinese medicine has become very popular not only in the United States (Baer 2004:46–51) but also in Australia where it is taught in numerous private colleges, some of them Chinese medicine colleges per se and others colleges of complementary medicine or natural therapies, and in three public universities in 2000 (Baer 2007).

Conclusion

Brodwin (1996:15) asserted that the "study of medical pluralism had reached a theoretical impasse" because efforts to categorize plural or dominative medical systems "often produced rigid functionalist typologies or broke down in a welter of incomparable terms." While indeed many medical anthropologists turn to concerns such as the political economy of health, biomedical hegemony, complementary and alternative medical systems in Western societies, reproduction, the body, the social dynamics of clinical encounters, biotechnology, substance abuse, AIDS, syndemics, and the impact of global warming on health, a perusal of medical anthropology journals indicates that the anthropological examination of medical pluralism is well and alive. Indeed, an increasing global interest in indigenous medical systems and Western heterodox medical systems, such as naturopathy, has accompanied the spread of HIV/AIDS, a topic of major anthropological research (Hollen 2005). Complementary and alternative therapies have come to be viewed not so much as cures for HIV/AIDS but as strategies that potentially bolster the auto/immune system and help patients to better cope with a debilitating disease (Baer 2008b). Furthermore, various anthropologists, including Brodwin (1996), continue to examine how power relations shape plural medical systems. In short, medical pluralism is a topic that continues to be of central concern in medical anthropology.

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