

## Chapter 3

### Literature Review

In the past few decades, the focus of many anthropologists has been to study and understand medical pluralism within various societies (e.g. Staiano 1981; Frankel 1986; Romucci-Ross 1977; Kimani 1981; Greenberg 1981; Lock 1980; Young and Garro 1982; Pederson 1989; Durkin-Longley 1984). These studies provide insight into the many ways pluralism in health care develops and functions. Regarding structure, for example, two systems may exist side by side with syncretic elements (Greenberg 1981; Durkin 1988); two systems may exist side by side and share little between them (Leslie 1977); medical systems may be in flux in a highly pluralistic milieu (Pederson 1989); or biomedicine may dominate and other systems merely function on the fringes of society (Rubins 1955).

However, a 'systems' approach to the comparative study of medical pluralism (Pederson 1989:488), most often the study of biomedicine vis-à-vis other health care beliefs and practices (Landy 1977:511), is useful but problematic. Leslie writes (1980) that the concept of a medical system is an artificial construct imposed by the "division of labor within nation states (p. 191), an "artifact...of a Western way of thinking" imposed on societies in which the concept of systems holds no agency (Pederson 1989:488). It is, as well, a point made repeatedly by many of the authors included in Frankel and Lewis' (1989) anthology of pluralism in Papua New Guinea (e.g. Allen chapter 2 on the villagers of the Torricelli mountains and Barker, chapter 3 on the Maisin )

Many of these authors point out that medical pluralism is often studied from the perspective of Western medicine vis-à-vis local systems (Frankel 1989) one of "opposition and contrast" rather than 'integration' (pp.30- 32). Barker (1989), cognizant of this difference, presents his study of medical pluralism among the Maisin people of Papua New Guinea as a single "ethnographic

situation” since “Western medicine” and folk traditions were so intertwined in health care patterns (p. 69).

Blumhagen (1983) in his study of the “folk illness” called “hyper-tension” in the United States, also sees the system approach as problematic. Too often, he states, the emphasis on systems has led anthropologists to focus on the differences between medical systems and healing theories, overlooking functional similarities. He suggests one way to better understand how “healing knowledge” is used to “shape both social and personal realities” is to look at the “distribution of healing knowledge” (pp. 197-8) within a health care system – all of the components of a society which come together in effecting “the health and physical mental and social wellbeing of the population (Pederson 1989:487).”

#### Medical Pluralism, Health Care Sectors, and Explanatory Models of Illness

One way of doing what Blumhagen suggests is to divide health care systems into Kleinman’s “three overlapping sectors” -- folk, popular, and professional (1980:49), an approach that has been widely used by medical anthropologists (see Appendix A). Kleinman also proposed the use of “explanatory models” of illness as a way of understanding the belief systems held by the members of these sectors in a given society: physicians and other members of the professional sector; layman in the popular sector; and folk healers in the folk sector (p. 104). Explanatory models attempt to answer several questions regarding illness that can be summarized as: “What is happening to this person? And what should be done about it?” (Blumhagen 1983: 202).

These individual explanations of illness (Young 1983) can be thought of as a continuum that range from explaining illness in terms of external causes (witchcraft, a grudge, a chill, etc.) on the one extreme, to those that attribute illness solely to internal causes (e.g. the scientific explanations of biomedicine related to dysfunction of organs) (p.1205-6) on the other. Pluralistic medical systems are characterized by both externalizing and internalizing health belief systems (p. 1207).

Helman (1978), in a comparative study of explanatory models of illness shared by patients and their doctors, described the pluralism of general practitioners in the United Kingdom; these physicians regularly invoked lay and folk explanations of illnesses in talking with their patients (p. 108), combining both externalizing and internalizing motifs. For example, the advice of a physician to a patient suffering from “a cold” might be to “stay in bed” and “stay warm,” thus providing the antidote for the folk etiology for a cold -- the “chill” (p. 128); and while handing the patient a prescription for an antibiotic might suggest the use of an expectorant/cough medicine -- addressing another folk model of contaminating fluids in the form of “phlegm” (pp.129-130).

In a vastly different context of the Andean countries of South America, Pedersen and Barfuarti (1989) demonstrated this kind of medical pluralism using the health care sectors and explanatory models. In these regions, modern medicine developed over centuries as a result of indigenous medical traditions and the medicine of European settlers “blended...in a complex process of hybridization” (p.488). Although this biomedicine is the only official medicine, patients make use of a wide variety of traditional folk healers and new healing cults dominated by religious saints and reinforced with medical symbols (p.492). They also employ self-care through home remedies. Psychedelic plants are used in curative rituals that increasingly combine folk and religious elements (p. 492).

The professional sector has incorporated explanatory models and practices from popular and folk sectors – e.g. ascribing harmful effects to certain foods (based on humoral folk theories), and prescribing a biomedical drug along with a home remedy (p. 491). In this process of ongoing exchange, the “middle class” is increasingly demanding “scientific” explanations for illness (p. 491). Thus, the authors write that explanatory models in the popular sector are in constant flux – “a process of production, accumulation, interchange and transformation of medical knowledge which represents...a vital strategy for survival” (p. 491).

## Growth of Medical Pluralism Where Biomedicine is Dominant

In Europe, the United Kingdom, and North America the use of complementary and alternative therapies and therapists represents the fastest growing sector of health care with wide appeal to all socio-economic strata (O'Connor 1995:1-2; Cassileth 1984:111; Eisenberg 1993; Thomas 1991). Many of the reasons given to explain this phenomenon center around the laymen's assessment of biomedicine has having failed to deliver its promise of life without suffering, especially with regard to the chronically ill (Helman 2001:67). There is as well a growing awareness among laymen of the iatrogenic consequences of biomedical treatment and the untoward side effects of pharmaceuticals (Helman 2001:67).

As a reaction to this, for example, cancer (Cassileth 1984) and AIDS patients (Pawluch 2000; O'Connor 1995) have been shown to turn to complementary and alternative treatments as a way of being involved in their own care and taking greater responsibility for their treatment (Cassileth 1984: 112).

Another aspect of this phenomenon of taking responsibility Helman (2003) argues, can be explained in the United Kingdom as lay folk beliefs are changing to embrace nature as "health-giving." In the old model, "colds" and "fevers" were caused by "chills" and "germs" respectively, and nature was the villain. As a response, however, to a continuous barrage of events over which they have no control (e.g. "SARS, AIDS, civil unrest, pollution, and radioactive rain") laymen see nature as the "antidote to [these] invisible forces" (p.10). In this environment, people try to take control of whatever parts of their lives they can, including by turning away from the "unnatural treatments" of biomedical care, to more "natural remedies" of "complementary and alternative" therapies (p.10).

## The Growth of Medical Pluralism in Post-Soviet Societies

Two articles on the growth of medical pluralism in post-Soviet societies are: Rubin et al. (1995) on natural medicine and *bioterapia* in the Republic of Slovakia and Antonian (2003) on shamanism in Armenia.

Slovakia (Rubin 1995), a country undergoing to the same type of economic and political transition as Armenia, is also experiencing a surge in medical pluralism. The two major reasons cited are: the inability of the government to rebuild the failed system after the new republic was declared, and the widespread dissatisfaction with current medical practice (p. 1269). In this setting of discontent, lay interest is rapidly growing in “natural medicine” (which includes acupuncture, homeopathy, herbal therapies, bee therapy, iridology, and reflexology [p.1261]) and *bioterapia*, a form of “psychic healing” and “therapeutic touch” based on bioenergy (p. 1296). *Bioterapia* has its roots in the parapsychology that took hold in the Soviet Union in the 1960s, and gave legitimacy to the “renegade scientists” and their theories. It is this legitimacy that forms the base upon which parapsychology and its offshoots are becoming increasingly medicalized (e.g. forming institutes, working from within the Ministry of Health) and gaining acceptance by the lay population and to some degree, the professional sector (pp. 1267-8).

The second article, Antonian’s (2003) essay on shamanism, traces the pre-Christian and Christian origins of shamanism in Armenia today. She details the pagan origins of various divination practices (e.g. a spinning sieve), symbolic healing rituals (e.g. pouring of wax) and other practices such as the use of salt, animal or bird sacrifice, and Christian symbols and talismans. Present-day shamans share common features with shamans in other societies. For example, prior to becoming a shaman they go through a period of illness and suffering and are converted into healers through a dream (p. 48-9). Antonian states that the revitalization of shamanism in Armenia is a “spontaneous reaction to the stresses Armenian society has experienced since the early 1990s...war, blockades, and economic crises...” and not to a resurgence of nationalism and ethnocentrism (p. 51). In a personal communication, Antonian explained that there are no statistics on the number of folk healers,

including shamans and diviners, in Armenia. However, during the early 1990s she observed very few healers in most of the regions where she was conducting fieldwork. Over the past few years, both the number of healers and numbers of people visiting them, both men and women, has significantly increased. She theorizes that part of the reason may be the lifting of official bans on such practices (communication Sept. 8, 2003).

#### Failure of Western Health Care Initiatives in a Post-Soviet Society

Before concluding, I would like to briefly touch on work that addresses the problems of the outside observer as health care planner, work that may relate to international initiatives and my work in Armenia. In an article by anthropologist Rivkin-Fish (2000), she analyzes the failure of World Health Organization (WHO) initiatives (based on Health for All 2000) in the arena of maternal health care in St. Petersburg, Russia. Despite WHO's worthy goals of decreasing infant mortality rates and improving women's "social well-being" their failure to consider the cultural/social context of the post-Soviet arena in which they were working resulted in the failure of their initiatives, and may have even had deleterious effects.

The WHO planners assumed that the Western power relationships between physicians and patients explained parallel "hierarchical clinical interactions" in St. Petersburg. They argued for "democratization" within the clinical setting using "the language of individual agency." The WHO people had failed to understand that the social construction of the medical profession under socialism had resulted in physicians' sense of powerless vis-à-vis the established hierarchy and played out in for them around issues such as low pay and poor working conditions,. Thus, the clinical setting was used for expressing "social dominance and experiencing social power" (p. 95). None of these power issues could be solved by appealing to a physician's sense of egalitarianism.

Planners also assumed that by encouraging options for labor and delivery such as "rooming-in" and having a companion present would improve the care women received. Instead, two

untoward consequences resulted: 1) the presence of a companion made women hesitant to cry out during delivery, and thus easier to “discipline” from the physician’s point of view, but harder for the patient; and 2) hospitals imposed fees for these options, thus increasing the divide between the haves and have-nots and moving the system toward “privilege and profit” (p. 82). The final irony, the author points out, was that women themselves were never asked either by WHO planners or local medical authorities what they wanted (p. 96).