

THROUGH AN HOURGLASS

Re-thinking Ethnography of the Relationship between Biomedicine and Complementary and Alternative Medicine in Croatia

Tanja Bukovčan
Faculty of Humanities and Social Sciences, Zagreb

This paper is based on author's three-year research on the choices patients make when facing an illness, on the decisions they make in choosing a particular medical system and medical treatment, and on the reasons of the increasing popularity of complementary and alternative medical practices in contemporary Croatia. Starting from the patients' narratives and their embodied experience as presented through their encounters with illness, the paper discusses and analyzes the methodological, theoretical and epistemological realities of the co-existence of biomedicine and complementary and alternative Medicine (CAM).

Key words: complementary and alternative medicine, activism, ethnography, Croatia, medical anthropology, phenomenology

In biomedical, or as Foucault calls it, 'clinical' setting, patients' narratives are funneled down through a strict process of very radical selection of information until all the multiple contexts of patients' reasoning are reduced to one diagnosis. The diagnosis is set at the micro level of one, biomedical, reality. Anthropological thought, on the other hand, is multivocal and plural, since it encompasses human voices, which are discordant and polyphonic, and are especially so when they relate to human notions of disease, pain, wellbeing, lived experience, embodiment, etc. Hence, there seems to exist a huge epistemological gap between the two worlds of thought. How can we then research and discuss or, even more, try to find a kind of analytical reasoning which would clarify human notions of health, illness, body, life, death, trauma, suffering, in the co-existence of biomedicine and complementary and alternative medicine? We need a kind of a world between the two worlds of thought, a kind of paradoxical third reality, which could serve as the centre of the hourglass, in order to analyze the "medical" concepts in today's, medically plural, world. I will try to show, based on my own research, how medical anthropology provides the basic framework, but how every research, especially a research set in today's world of shifting meanings, rapid changes and constant questioning of the patterns we inhabit, demands a radical re-modeling and re-designing of the methodological and theoretical frameworks. In researching medical pluralism we are dealing not only with several worlds of thought, a challenge for the analysis as such, but also with new, unpredictable, contexts and newly emerging meanings, which demand from the researcher to be constantly 'alert' and constantly ready to re-shape and rethink the research steps she has taken. The hourglass of our research constantly gets turned upside down.

Starting from the patients' narratives and their embodied experience as presented through their encounters with illness, the paper discusses and analyzes the methodological, theoretical and epistemological realities of the co-existence of complementary and alternative medicine and biomedicine.

My research was mainly concerned with the analysis of decision-making process the patients make when they encounter a specific illness, i.e. the analysis and discussion of the choices they make and the reasoning behind it. I was commonly faced with the idea of multiple reasoning (Mattingly 1998). That means that the choices of healing processes, treatments and medical systems the patients would choose, were highly dependant on their background (age, gender, occupation, religious beliefs, cultural background), but also on their knowledge of popular medicine, popular knowledge of biomedicine, or, it could sometimes depend on the last commercial of a specific drug they've seen on TV or the advice they were given by their first neighbor during a joint ride in the elevator. The narrativity of their health situation surpassed by far the 'clinical' definitions of the disease. Moreover, it could be said that only small portion of their ideas about the possible causes and outcomes of their illness/disease, dovetailed with those offered by the biomedical system. However, in the words of one of my informants, a biomedical doctor, the biomedicine has also changed in the last few years, in accepting a more 'active' role of the patients and trying to include the patients' beliefs and notions about their own disease/illness in the 'healing' encounter. The idea was to provide the patients with the position of control over their own medical 'destiny' and of allocating some of the power, the biomedicine was so richly awarded, as Foucault sharply defined (Foucault 1963), to the patients themselves. However, it seemed that the patients have already 'taken over', with the process of demystification of biomedicine starting during the 1970s (Leslie 2001), or have never 'surrendered' completely, and that human notions of health and illness always surpass any given medical system.

Probing Experience

Phenomenology as applied to anthropology in the last two, three decades seemed a useful tool for analyzing this situation. Phenomenology's 'general' appeal to start analyzing any human condition from the idea of lived human experience in all its richness (Moran 2000:2), from the irrefutable fact that all knowledge is immersed and arises from lived and very much subjective experience (Moran 2000:21), could be easily detected in Merleau-Ponty's earlier work on phenomenology of perception (1962), where he proclaimed the lived body and the bodily experience and perception as pivotal to human existence in the world, "the vehicle of being-in-the-world (Merleau-Ponty 1962:71). Body and experience, or bodily experience and the world stood for Merleau-Ponty in a unique relationship, the one that was later taken up by Thomas Csordas in his idea of embodiment (Csordas 1990). Hence, it became clear to me that I was dealing with and analyzing the embodied experiences of my informants, their immediate senses and sensibilities, their concepts of pain, qualifications and quantifications of suffering, their coping with their experiences and, finally, creating narratives of their experiences. I've found the concepts of medical systems to be completely useless and the concept of medical pluralism, even though conceptually helpful, to be equally misleading in analyzing the 'lived' accounts of the lived experiences of health and illness.

Namely, the guiding principle in the decision making processes the patients, my informants, were undergoing when facing an illness/disease, was their own lived experience and they were absolutely disinterested in any divisions between medical systems and neither were they making their decisions about which system, treatment or healer/physician to use on any careful pre-consideration. It was part of their 'learned' lived experience to always visit

the biomedical physician first (that's what they did when they were children, that's what their parents did), but if, for some reason, they were not satisfied with the results (the migraines did not go away, the allergies were still there, the rash persistent, chronic pain getting worse), they would seek help somewhere else, in different forms of complementary and alternative medicine. Again, depending on their (dis)satisfaction, their subjective notion of the results of the treatment and, most directly, of what they experienced on a certain therapy (friendliness and good rapport, comfort, relief, satisfaction, being paid attention to, being listened to, confidence in the healer, atmosphere established, possible improvements, possible diminishing of pain or discomfort, etc.), they would continue with the same therapy, expand their search, or move on. They were creating their own web of 'medical systems', enmeshed and complex, seemingly arbitrary, but following a path of thick detailed experiential events, each a small answer to the question of what makes sense to them, just as Geertz explained in his more quoted version of the definition of culture in which he stated: "believing, with Max Weber, that man is an animal suspended in webs of significance he himself has spun, I take culture to be those webs (...)" (Geertz 1973:5). This definition was Geertz's seminal introduction to considering anthropology an interpretative science, a claim which he, in a way, expanded thirteen years later in his another seminal work, an epilogue to Turner and Bruner's edited volume from 1986, *The Anthropology of Experience*.

He starts from the idea that "no one (...) is ever really short of experience" and that "we all have very much more of the stuff than we know what to do with it (...)" (Geertz 1986:373). I find very useful this definition of experience as 'stuff', since it is exactly this, as I stated earlier, enmeshed and complex, seemingly arbitrary and random, but still meaning making and life designing pendulum that makes us who we are. But in dealing with experience, conceptually, analytically, is that we are 'lacking': "(...) if we fail to put it ('it' being the stuff of experience) into some graspable form the fault must lie in a lack of means, not of substance." (Geertz 1986:373). Hence, it is not that we lack experience, we have abundance of that 'stuff', but we have to devise the means to grasp it, and in Geertz's words, those who have found the means, they have 'authored themselves' (Myerhoff in Geertz 1986:373), "made themselves someone to whom attention must be paid" (Geertz 1986:373). In short, by putting our experiences in a graspable form, we are becoming the authors of our own interpretation of ourselves, and demand that the attention must be paid to our own 'authority'. (I refer here both to the position of the author and authority as jurisdiction and control.)

Questioning Methodology

Admittedly, I did not think too much of it at the time of doing my research, and if I did, my analysis would move away from deconstructing the relationship between biomedicine and CAM. Instead, while doing my research, I got caught up in a very alluring trap. As a researcher, I was flattered and a bit egotistically uplifted with the gratitude my informants, patients, were expressing to me just because I was – listening to them. I was, actually, paying attention. Sometimes they simply wanted to narrate their own etiologies of their disease (they wanted to be able to tell what they think was the cause of the disease), i.e. narrate their illness experience: death of a spouse as a cause of breast cancer, refugee situation as a cause of colon cancer, stress and anxiety as the cause of problems with thyroid gland. Not only they themselves found the cause of their disease which made sense to them, they would put it in the rationale of their everyday lives and would explain their suffering in general. Or some of

them would simply say something like: ‘*I talk, but no one listens!*’, or ‘*Nobody ever listens to me when I speak about my disease*’, or, a bit scary: ‘*I never told this to anyone, not even to my wife!*’ So, while doing my research I felt useful and I felt, a bit vainly, like I was ‘making a difference’, as a sympathetic listener and the one who pays attention.

Interestingly enough, my informants would sometimes contextualize their ‘findings’ in their encounters with the biomedical doctors, too (some of them didn’t since they feared of being stigmatized), and those who did found it important for the doctors to take them seriously, to pay attention):

I had four houses... not at the same place... but one was where we were at home and one up at the mountain and a cottage... I was building one for my daughter... we weren’t rich, but we had enough... and then, on that morning, I had to leave, with one small plastic bag in which I put my money... ha? And now you tell me!... Everything’s gone, everything!... And now they tell me I have cancer – of course I have cancer, I told him: “Doctor, you would have it, too”... and he was looking at me as if I were crazy. Maybe I am crazy, but after that everyone would be crazy!

As it is obvious from the example above, if not taken ‘seriously’, if they felt were not allowed authority over their graspable form of their lived experience, they felt disempowered, voiceless and, sometimes, stigmatized.

At that stage of my research, when I also felt a little discouraged, with little authority over what I was doing, since I felt I was just a sympathetic listener, I thought that my major problems were methodological. Hence I set out to define the specificities of qualitative methodology which should be used in medical setting with the aim to outline the guidelines for the ‘appropriate’ ethnographic methods. In my view, these would be the ones that would enable me to analyze and define the type of data which can be obtained through qualitative clinical interviews and hence provide certain qualifications and categorizations and prove useful to all the participants in the healing process (doctors and patients) and, epistemologically, to all the disciplines involved (biomedicine and anthropology).

In the growing tide of the publications on the topic, there is an increasing number of biomedical doctors writing manuals in qualitative methodology as applied to health care. They are manuals in the strictest sense of the term, since they start usually with the definition of what culture is and then provide the recipe as how to do the proper qualitative (open-ended, in-depth) interviews and data analysis. They sometimes include the guidelines as to what to wear to the interview, how to behave, or warn the potential interviewer not to show openly her/his body decorations or symbols of religious or football affiliation. Practical as they may seem, to the anthropologists used to doing fieldwork, they might appear naïve and – useless.

Training manual in applied anthropology (Carole Hill ed. 2010), emphasizes that applied anthropology is ‘not an arena for either foolish or faint hearted’. Or in *Doing Health Anthropology* (Christie Kiefer, 2007): ‘It takes courage to do action anthropology’. Even though such advice seems fairly impractical (how to make a researcher brave hearted instead of faint hearted), the quick discussion on the nature of applied anthropology which will follow later will at least explain its groundedness.

Questioning Theory of Illness

Illness narratives, or simply, patients’ stories, which I was listening to as part of my fieldwork, were theoretically already ‘an old thing’, defined by Arthur Kleinman in as early as 1988.

Arthur Kleinman (1992) saw illness, pain, healing, suffering, as very 'special types of experience', those where body, subjectivity, personhood are so much present and intertwined that it will always be difficult to analyze or conceptualize them. But, exactly because of that reason, he saw health and illness as very potent fields for examining human experience. Illness narratives were just a 'discursive counterpart' of experience and through them we could understand peoples' 'moral worlds', which was essential for finding out what exactly is at stake for the people themselves, the differences in which their explanatory models differ from biomedical model. Narrative medicine was, comparably, defined by Rita Charon, a surgeon who worked as a surgeon for more than twenty years and decided to enroll in the doctoral study English literature, since she concluded that during her years as a surgeon, she was actually listening to very complex, very structured narratives by her patients and that she felt that 'literature would help her understand medicine better' (2008).

Of course, narratives are a logical component of every qualitative research of human behavior, however, in the field of health and illness, "real-life events" like pain, suffering, fighting cancer, are experiential. They are our 'being-in-the-world' and medical anthropology's ambition is to describe and interpret human suffering in 'experience-near' concepts. The problem which appears here is the problem of defining the link between experience and discourse. The possible answer lies in Csordas's idea of embodiment (1995). Namely, experience in itself does not define a corresponding narrative, neither there is some easy-defined, simple, naïve, empirical link between experiences and the related narratives. Narratives are cultural creations, in order to describe experience, we choose from a set of pre-arranged standard narratives.

But before Csordas, other anthropologists were questioning this link between experience and discourse (Geertz 1973; Bruner 1986). Since the famous literary turn in anthropology, the idea of discourse and text as guiding principles were differently taken over by Ricoeur (1981), Foucault (1973), Marcus and Fisher (1999) and textuality was both subject and the object of the analysis. But those who tried to find the link (Bruner 1986), would always conclude that experience surpasses narrative, that "life experience is richer than discourse" (Bruner 1986:143).

In the field of health and illness, experience of pain, discomfort, hope, loss, defeat is a bodily one, but also a cultural one. Pain is chaos, telling a story of, for example, defeating pain, is a way of establishing order and control over pain. Narratives are culturally pre-ordained and can be 'captured' and analyzed. "Narrative structures organize and give meaning to the experience, but there are always feelings and lived experience not fully encompassed by the dominant story" (Bruner 1986:143). Hence, the narratives will get reconstructed, expanded, reinvented, broadened, the 'model of' will become 'the model for' (Geertz 1973), but the experience will still remain elusive.

Besides being structures of meaning, narratives are also "structures of power" (Bruner 1986:144). In other words, they always carry some models of positioning and 'political' point of reference. Strikingly enough, most of the narratives I encountered while doing my research regarding the patients' experience in biomedicine, were narratives of powerlessness, lack of control, being considered ignorant or 'not being heard'. To return to the beginning of the article: they reported not being paid attention to. Their narratives related to CAM were totally the opposite. They also reported that the pain was diminishing more after CAM treatments, that improvements were more evident and generally, the experience was more rewarding. Interestingly enough, except for only two informants, none had any bad-experience events in biomedicine. I wanted to analyze the background of this negative narrative and

non-negative experience in biomedicine and to find the origin of the 'patients as ignorant Others' narrative, which patients were telling as the dominant narrative related to the role of patients in biomedicine.

Furthermore, medical phenomena through times and places were a junction of social interests, political interests and cultural meanings. In our culture, health has climbed to the highest values and has gained an inviolable position. This is sometimes referred to as medicalization of society (term from 1970ies), in which an increasing number of phenomena related to human well being are handed over to medicine, which gets jurisdiction over them and monopoly to solve them. In recent works some theoreticians (Hunsaker-Hawkings 1999) compare the position of medicine in today's Western society to the position of religion in former years. Broadly speaking, religious worldview which was dominant in the past was replaced by the dominant scientific worldview and hence the parables of life and death changed hands from religious to medical authorities. Every human being fears death (or ill-health), every religion has a system of dealing with death and potential afterlife and has its own ways of prevention of misfortune. Or, more concretely, medicine is today the dominant way of death-prevention and doctors are today the masters of life and death, the image which is frequently employed and accentuated. It was this dominant narrative that my informants have readily accepted.

Trouble with Ethnography

According to Roland Barthes, "of all learned discourse, the ethnological seems to come closest to Fiction" (Barthes 1977). Bruner, on the other hand, calls ethnography a special "genre of storytelling" (Bruner 1986:139). While writing ethnographies, we 'force' discourse over the lived experience, through a series of negotiations with our interlocutors, ourselves, text and culture. In choosing Fiction, we are barring the device of our own knowledge-making process. Hence, I will outline here briefly the 'classical' ethnography which was the initial 'output' of my fieldwork.

When asked what is the first reaction when encountering an illness, the majority of my informants would report going to biomedical doctor. This differs significantly from Kleinman's findings that home, or popular sector, was the primary health sector patients would choose. The reason for this is that, until 1990s, Croatian health care system was state funded. There was only one medical insurance "company" – the state. University clinics, day care clinics, public health facilities, physicians and specialists from all walks of medicine were accessible to anyone with a job or to a family member of that person. Hence, since biomedicine was so 'handy', it was the first choice and still remained so 20 years later.

However, if they felt biomedicine did not help them, people would turn to CAM. CAM, on the other hand, was almost totally non-existent in Croatia before the 1990s. The reasons were again political, socialism was the state ideology and socialist state had confidence in 'progressive' science. Religion or non-materialistic ways of thinking were, as one of my informants emphasized, "considered regressive".

According to my informants, there is a long list of diseases and illnesses that biomedicine could not cure, but different types of CAM could, such as: allergies, asthma, chronic diseases of the pulmonary tract, chronic diseases accompanied by pain lasting for years (arthritis), whole post operational care (heart attacks, kidney or breast-cancer operations), problems

with digestive tract, migraines, heartburn, anxieties, feelings of unhappiness, dissatisfaction, varicose veins, etc. Also illnesses the biomedicine did not recognize as one of the interlocutors put: “The tests say I’m fine, but I don’t feel fine”.

Frequent clients of different CAM practitioners were also cancer patients who, as one practitioner said himself, were using CAM as the last resort.

One of the central questions of my research was how the patients’ experienced and narrated the differences between biomedicine and CAM and how they chose the ‘medical pathway’ which they followed, i.e. their decision making process. In explaining the difference in their experience of biomedicine and CAM, my informants would commonly list the ‘usual narratives’ about the side effects of biomedical drugs we are not aware of, and could kill us, about antibiotics and anti-depressives being prescribed too much too often, about cruel, cold and distanced treatment of biomedicine, about not being paid attention to, etc. Interestingly enough, almost none of them had any real examples of being badly treated, but they emphasized that what they experienced as the worst element was that they were not having any control over how they were being healed or cured, or over the whole medical process in general. Hence, the feeling of powerlessness and lack of control were the key elements in their experience of biomedicine.

The experience they commonly singled out in CAM as the novel and distinct as compared to biomedicine was spirituality. Most of them said they had no idea that would happen, but were commonly satisfied that it did. However, that spirituality could range from (re) emergence of Catholicism to the reports such as: “we are not only the body; there is something out there, now I feel it”. The importance of Catholic faith from today’s appearance of CAM in Croatia will be discussed later, but here I would like to mention that this also had certain political background. Namely, during socialism, people went to church but secretly, “on the side”. After 1990s, when the right-wing government took power, going to the church suddenly meant that you were “the real Croat”:

I don’t go to church every Sunday like these new believers ... nobody went to the church before ... now they are showing their faces in the church ... and believing is something else ... that’s why I don’t go to church now ... but I am a strong believer.

This “true” spirituality, devoid of politics, they claimed they’ve found in CAM. Their decision making process about different healers or therapies were never meticulous, detailed research of what is out there, it was emotional, some would say ‘intuitive’. They said they saw a healer on TV, saw his/her add in the newspapers the moment they felt pain or felt they need help and that was enough. Furthermore, if their experience was positive they would stick to that person, emphasize the “close” relationship they’ve established, praise him/her and – experience improvements. Sometimes, the more unexplainable and ‘miraculous’ improvements they reported experiencing, the less questions they were asking about how that was possible.

Conclusion

There are several points to be discussed here. I will relate them to the idea of embodiment as Csordas defines it: “indeterminate methodological field defined by perceptual experience and by mode of presence and engagement in the world” (Csordas 1999a:145).

First of all, the idea of medical pluralism as seen in the context of Croatia (and anywhere else, I would argue, but in different forms) is the consequence of global, political, financial conditions. As varied as: rising medical markets, post-socialism, political and religious institutions working together, spirituality as an issue in postmodernism, notions of body, etc. So, I don't think we could ever list all the changing faces of medical pluralism.

Hence, analyzing this situation, from the point of view of the patients, what they focused on was the embodied experience of the healing process they were a part of. This claim was proven by their accounts that they did or did not go to church, did or did not believe in God, considered some healers weird or magical, this was all completely irrelevant to them.

Something in this healing process, from pure participation in it, going in and out of it, made their embodied experience influence their religious experience, or maybe vice versa, but the result was the experienced improvement. From their point of view, 'everything was better', from analytical point of view they were mostly talking about emotions (of joy, hope, happiness), mental states (calm, reassurance), and lastly, about physical outcomes. It seemed that CAM touched some self-help, self-care button in all of its patients and changed their lived experience.

The explanation of 'miracle' is here embedded and embodied in bodies and minds of each of those individuals who made a choice how to feel, simply, 'better'.

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U središtu pješčanog sata.
Etnografija odnosa biomedicine i
komplementarne i alternativne medicine u Hrvatskoj

Sažetak

Članak se temelji na trogodišnjem istraživanju izbora koji pacijenti čine kada su suočeni s bolešću, odluka koje donose u izboru određenog medicinskog sustava i medicinskih praksi, te razloga rastuće popularnosti komplementarne i alternativne medicine u suvremenoj Hrvatskoj. Polazeći od priča pacijenata i njihovog utjelovljenog iskustva koje je predstavljeno kroz njihov susret s bolešću, članak propituje i analizira metodološke, teorijske i epidemiološke stvarnosti su-postojanja biomedicine i komplementarne i alternativne medicine u Hrvatskoj.

Ključne riječi: komplementarna i alternativna medicina, aktivizam, etnografija, Hrvatska, medicinska antropologija, fenomenologija