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UDK 39:615.89

615.89:39

Original scientific paper

Received: January 3, 2008

Accepted: February 11, 2008

# ‘I Want to Choose whom I Love and Where I go for Treatment’ – Activism in Complementary and Alternative Medicine Research in Croatia

*On the basis of recent (2004-2007) research on complementary and alternative medicine and medical pluralism in Croatia, this paper questions the role of ethnology and cultural anthropology in society, the role of ethnologist/ethnographer as culture’s critic or activist, the possibilities of the applied medical anthropology and the link between ethnology/anthropology and activism.*

**Keywords:** complementary and alternative medicine, activism, ethnography, Croatia

Different forms and types of alternative and complementary medicine<sup>1</sup> have become an unavoidable item on offer on Western health care markets and a part of everyday cultural practice. Shops,

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<sup>1</sup> At the moment there is not a standard and widely accepted definition of complementary and alternative medicine in medical anthropology (Goldstein 2004), probably because medical humanities were not the first discipline to attempt to define these concepts – clinical medicine (often called biomedicine, scientific medicine, conventional medicine or Western medicine) defined CAM (complementary and alternative medicine) as an alternative or a complement to itself. The concepts also entered everyday vocabulary before medical anthropologists dealt with them more seriously. Therefore it seems useful to analyze vocabulary definitions in order to detect the ‘common’ meaning these concepts have in our everyday culture. According to Oxford English Dictionary ‘alternative medicine refers to any form of medical therapy which is not considered conventional by the (Western) biomedicine, such as herbalism, naturopathy and crystal therapy. Complementary medicine refers to any form of medical therapy which does not be-

products, schools and practices of different forms of alternative medicine have been present for a couple of last decades in the majority of European cities. One of the largest quantitative researches of complementary and alternative medicine use was done in the US (Eisenberg et al 1990, 1997, 2001) and according to it in the period from 1990 to 1997 the number of complementary and alternative medicine users rose for almost 50%; according to another research from 2001 (Eisenberg et al 2001), it turned out that the percentage of population using CAM (including those who used different methods for prevention of disease and improving quality of life) rose to almost 70% of all of the adult population of the USA! The situation is quite similar in Europe and according to the official WHO data for several European countries from the end of the 1900ies show that roughly 20-30% of the population of Western European countries have used different forms of CAM while 70-80% of population are interested in the possibility that their health insurance covers some forms of alternative medicine (Gazdić, Berce-Bratko, Šinkovec:2002).

The above-described phenomenon of co-existence of several therapeutic practices which patients (clients) can chose freely, defined as medical pluralism, is today considered to be the dominant characteristic of medical reality in the majority of the world countries (Leslie 1976, Helman 1984, Kleinman 1980, Benoist 1996, Hsu 1999, Krause 2006). It is more accurately defined as parallel and simultaneous existence of therapeutic and healing alternatives. In Western societies these are biomedicine, different forms of complementary and alternative medicine (usually referred to as CAM) and, in most cases revitalized, forms of traditional or folk medicine.

Contemporary researches of medical pluralism were conducted in the USA (Eisenberg et al 1993, 1998, 2001; Goldstein 2004), UK (Cant i Sharma 1999) most Western European countries (Lazar 2006, Johannessen 2006, Barry 2006, Frank i Stollberg 2006, Sigfrid Grønseth 2006), in many Asian countries (Leslie 1976, Cohen 1998), and in some African countries, Nigeria (Körling 2005), former Zaire (Janzen 1978), South Africa (Gilbert 2004). They all conclude that in all these cultural situations and contexts biomedicine remains as only one possible choice of ways of healing which people can chose and which, in the case of many Asian and African countries is not even primary (in Asian countries due to long tradition of their own medical systems and in African countries due to the fact that biomedicine was frequently unavailable and not present in certain areas), and the one which is always supplemented and complemented by some other different forms of treating illness and improving health.

My following arguments on the link between contemporary alternative medical practices and activism are based on my recent research (2004-2007) which dealt with

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long to scientific medicine, but which can be used together with it in treatments of disease, such as acupuncture and osteopathy'. (The New Oxford Dictionary of English)

The key organization dealing with human health, World Health Organization has also become aware of the factual existence of unconventional medicine and its significance for human health throughout the world (according to Who, one third of world population and more than half of the poorest regions in Asia and Africa do not have any (!) access to biomedicine), and has been faced with the need for its definition. According to WHO, 'complementary and alternative is a supplement to allopathic medicine and in some countries CAM means the same as traditional medicine'. (<http://who.int>)

interrelatedness and co-existence of biomedical and non-biomedical systems in the city of Zagreb, the capital of Croatia where, because of its size and importance as the largest urban centre in Croatia (1,2 million people) the alternative medical practitioners and practices were the most visible in everyday life, shop windows, newspapers (adds and articles) and media. This process of adoption and introduction of CAM to health care offer in Western European countries started roughly some 20 years ago, and in Zagreb the process was evident after the fall of communism during the 1990ies and the introduction of capitalist market economy. The starting point of my research were the patients and their attitudes towards illness, health, wellbeing and suffering which highly determined their choice of therapies and their reasons for the selection of specific therapies, healers and/or medical systems, as well as the factors (cultural, social, generational, educational, religious, political-ideological, financial) which determined their choice: whether people were using alternative medicine (CAM) just for specific reasons, for only some diseases but not all, in some specific situations in life, whether that was a 'new' cultural thing, almost a fashion or at least a hip and trendy thing to do (new age).

Since most of the past research of other medical systems in sciences dealing with culture research in South-Eastern Europe was done in the tradition of ethnology of Central European tradition (Volkskunde) dealing with rural European past, most of the written material was comprised of descriptive ethnographies, and hence in this research I was borrowing theories and methodology from medical anthropology and based my initial hypotheses on works of Arthur Kleinman, Cecil Helman, Nancy Scheper-Hughes, Charles Leslie, Eisenberg, Elizabeth Hsu etc.<sup>2</sup> In creating a sample of my informants I started with the largest organization of alternative practitioners and healers, called HUPED (Croatian Federation of Natural, Energy and Spiritual Medicine - CFNES). The organization was founded in 2000 and is actually the only professional organization of CAM healers and practitioners in Croatia, with around 400 current individual members (healers and practitioners) and another 2000 members who are joining through their smaller associations (association of reiki practitioners, acupuncturists, different new age groups, etc.) Using the snowball method, I started with the president of the organization and sampled out 10 healers who wanted to participate in the research and then conducted semi-structured or, in majority of the cases, open interviews, with 10 clients of each of these healers.

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<sup>2</sup> This process of introduction of socio-cultural anthropology (and its sub disciplines such as medical anthropology) to the culture research in the universities and institutes all over South-Eastern Europe has been going on since the 1990ies. Even though the reasons for this are extending the scope of this article, it is important to mention here that in-depth research of one's own culture has been present in South-Eastern Europe since late 18<sup>th</sup> century. The subsequent political developments in the 19<sup>th</sup> century Europe brought about this rural and national orientation of the discipline of ethnology, but today culture research in South-Eastern Europe is again becoming as diverse in scope, research methodology and theories as its Western counterpart.

## Post-socialism - the changes in the health care system and the onset of an activist society

The post socialist period in Croatia started in the 1990ies as in other East European and Southeast European countries, and, among other changes, brought about significant changes to the official health care system. Before 1990ies, the dominant health system was state funded and almost everyone, with a job or as a family member of a person with a job had access to all the hospitals, university clinics, day-care clinics, etc. If you were paying the state-determined and more or less unified health insurance, part of the salary, all the services were free. In the period after the Second World War up to the 1990ies private clinics and doctors were almost completely non-existent, only during the late 1980ies a few private dentists and gynaecologists started working in Zagreb, but using their services was considered to be snobbish and posh. 'Normal' dentists were considered to be just 'fine'. Another thing that was completely absent from the health care system in Croatian (then Yugoslav) socialism were health care alternatives, at least in the urban regions. Some forms of traditional medicine were still used and practiced in remote rural regions, but secretly, silently and very locally.

After the 1990-ies once exclusively state funded health care system was now becoming less state funded and much more market oriented and, as the consequence, expensive to the end-users, the patients. It was a process, but the sheer idea that you have to pay for just going to the GP (the so-called participation), that you have to pay for medicines and drugs, was quite surprising, almost shocking for most of the people. The number of private doctors and specialists was increasing rapidly and the number of private practices rose from few dozens to several hundreds (paediatricians, dermatologists following in numbers) and a significant number of large private clinics was opened all over Croatia in the last ten years. The prices were by no means small.

Simultaneously, and maybe partly because of this, the non-biomedical systems were also more 'loud' and more visible, ranging from folk healers, herbalists, through exorcists and bioenergy practitioners to the practitioners of the established non-Western medical systems such as ayurveda or acupuncture, accompanied by homeopathy, reiki, other relaxation and stress relieving techniques. They were much more visible in media, as I said, in everyday life, discussed more, talked about more, politicians or celebrities who went to this or that practitioner were judged or praised (for example, the most famous is probably the former Slovenian prime minister Janez Drnovšek who got into real trouble because supposedly the bill to his ayurveda therapist, who came from Switzerland, was paid with the tax payers money).

However, even though I am analysing only the situation in Croatia (Southeast Europe) where I am conducting my research, the research data for the rest of Europe and USA show a very similar trend of rapid increase in the offer of all sorts of non-biomedical treatments, therapies and practices. But even though the word 'trend' appears in most of the articles, more serious conclusions deal with the immigration

communities, who are simply bringing their medical systems with them (Aromatica stores in LA, Chinese medicine shops in European cities). But of course, it goes without saying that the users of these systems are by no means only the members of these communities. In Croatia, immigration communities are rather small (Chinese community is just beginning to form in Zagreb), so reasons for the sudden popularity and increased cultural presence of complementary and alternative systems should be sought elsewhere.

So what is the specific ingredient of the post socialist context that contributed to the sudden upsurge of CAM? Socialism as the leading state ideology was firm on imposing its own power structure and modes of thinking and behaviour as the only valid one. State economy would rely on state education and employ state medicine. A firm and unquestionably empirical and scientific health care system just increased state's validity and strengthened its position and its absolute authority. The non-existence of market economy and consumerism also meant that your choices in life are limited, and sometimes artificially created shortages (coffee, gas, detergents) meant that you were supposed to learn to appreciate what you've got. Medicine including. Thus dogmatic, ideologically strong, and firmly established medical system meant that state ideology was also right, strong and valid. My older informants were always emphasizing how 'other' medicines, such as herbalism, which was a part of Croatian traditional medicine, could never be practiced lawfully, but only under the counters at urban markets or in rural areas and were actually banned in the socialist ideology.

Thus this rising of ideological curtain might have made these choices of different ways of thinking and modes of behaviour even more attractive and desirable in a cultural context where choices were non-existent. That might be also said of choosing Other medicines, other than the mainstream biomedicine, or in words of one of my younger (20) informants, also a gay-activist: *'Choice of another therapy is one of the basic human freedoms – I want to chose whom I love and I want to chose where I go for healing'*.

And the introduction of market economy also raised awareness of being given value for money – an attitude that was absent from socialist ideology and socialist thinking, so that now people are asking a medical output to their monetary input. Many of my informants who had prolonged (more than 5 years) experience in using CAM said that they felt that they were getting what they came for and that that was the main reason why they were returning to CAM practitioners.

Post-socialism also brought about a rise of civil society. Advocacy and activism became prominent part of everyday culture in Croatia only in the last 10-15 years and the most numerous civil rights groups are those fighting for women's rights, environmental protection, gay-rights, with now, in the last few years, increasing numbers of new age groups and centres. Some recent discussions on CAM (Goldner 2004) define CAM as a form of social movement, a type of activism, where both practitioners and clients are seen as activists forming 'a seemingly cohesive social movement that challenges Western medicine collectively' (Goldner 2004:711). That would imply that all the research and discussion on alternative medicine should actually avoid all the

institutional and organizational theories and analytic designs which are employed in a clinical, biomedical, setting and health research in general and should treat them almost as subcultures. That would also primarily brand all branches of alternative medicine as philosophical, ideological movements rather than health care systems. This view was strongly opposed by my informants from the CFNES who said that only some *milder forms of alternative medicine such as yoga and new age groups* could be seen as social movements advocating specific lifestyles and philosophies, *because their primary aim was not to heal a person who is in need. All other systems, according to my informants, are health care systems because people decide to use them when they need to be healed or cured, not when they are looking for meaning of life.*'

## Sense, sensibility and spirituality in alternative medicine

As far as combining biomedicine and CAM is concerned, for the majority of the people I interviewed biomedicine came first (but those with prolonged experience in CAM, they will primarily rely on CAM), but in case of chronic, terminal or psychosomatic illnesses, they sought alternative therapies ranging from folk healers to established non-Western medical systems. I was surprised to find out that the choice of therapy and therapists was rarely based on careful reading or internet check or some other form of obtaining information – it was based on a feeling, a hunch, most of my informants spoke about seeing a therapist on TV or reading a sentence from newspaper add and deciding on an instant to call her/him.

If asked to explain in more details their decision, they would just say that they felt something and that that feeling made perfect sense to them. Further confirmation of his/her competence, they would seek in the initial 'diagnosis' the healer would provide. If the healer's diagnosis and the description of the cause of illness made sense to them that would be a definite proof that they are at the right place. Most complained of not being told, in the biomedical setting, what was exactly wrong with them, and here they would get a detailed explanation of what was wrong, where the energy blockage exists, what stress caused it, etc. The ones who felt that this explanation made the best sense were the ones who were the most satisfied with the healer and seemed to be the best 'cured'.

The diseases for which my informants sought help from alternative practitioners were various, and no specific conclusions could be made in that direction, because the diseases were ranging from diabetes, both types, multiple sclerosis, mental retardation, impotence, inability to conceive, death of a spouse and related PTSS, hyperthyroidism, psoriasis, and a large number of cancer patients (who formed a special group and about whom the healers themselves admitted that they all use CAM as the last resort).

The majority of my informants felt that their conditions included something more than just a disease (to use Kleinman's distinction between illness and disease) and they felt that CAM is the place where this *something else* can be treated and were almost

confident that biomedicine will not even notice that 'surplus element', the X factor. Most of them would not name it, some of them would call it 'the soul', some 'my inner self', some simply 'God'. To some it was enough that CAM would admit that the death of a spouse which happened almost two years ago could still be a cause of serious and devastating illness, something biomedicine would dismiss with anti-depressives and actually take away the possibility of the patient to take control of her own life and life choices.

To conclude, most of my informants simply sensed the need for a specific CAM practitioner who would help them solve a problem they felt they had, but which biomedicine either did not recognize or to which it did not have a solution. Most of them spoke about a changed state of consciousness and an improved state of being as a consequence of seeking and obtaining CAM's help. The most satisfied were the ones whose idea and notion of their illness (their explanatory model) dovetailed with the one offered by the healer. If asked whether the explanation of their condition offered by the biomedical doctors seemed equally plausible to them, they said that all they were hearing about in biomedical setting were the consequences of their state, not its cause. Kleinman (1980) suggested that all medical systems have explanatory models, maybe we should add here Foucault's notion of doctors and patients being unwanted disturbance in this process of establishing medical gaze over the human body and claiming that there is a one-way empirical correspondence between symptoms and outcome. It seems that in this scheme of biomedical consultation, explanatory models of doctors, even though existent, and patients, expecting more, were put aside and played no role, or just a very small one, in the doctor-patient interaction.

All my preconceptions regarding the social status of individuals using CAM practices were wrong – men and women were present in equal numbers, the youngest patient I spoke to was 20 (and I spoke to a grandmother who brought her 3-year old daughter to a practitioner) and the oldest from the sample was 75. Most people were aged between 30-50. Most of them were college educated or high school graduates.

## **A different kind of ethnography**

All the above-mentioned data were obtained through prolonged, very detailed and sometimes very emotional interviews. As an ethnographer, I was faced with moving stories of loss and trauma (stories of war refugees, patients with PTSS, disabled people, people who lost their loved ones), as well as stories of miraculous healings and becoming well again (*feeling like being born again, having again the energy, being again able to get up in the morning*) which made me re-examine my position of observer, interpreter and analyst.

All the time while I was doing interviews, I had the impression that I was trying to make sense out of other people's sensibilities, most intimate feelings, notions, desires, beliefs and I would sometimes wonder whether that was a futile task. My informants would talk about intuitions, hunches, *sensations deep down*, changed states

of consciousness, or they would even frequently talk about things that they could not explain or understand but they could describe how they made them feel. However, I could not think of another way in which it would be possible to understand human notions of health, illness, disease, well being, pain, suffering and happiness in all their complexities and subtleties rather than through doing qualitative research and in-depth ethnography which was defined by Joralemon (Joralemon 1999) as 'an essential tool to understand human suffering due to disease'. In alternative and bio-medical setting alike.

Sometimes I knew that all my informants wanted was someone to listen to them, as some of them plainly told me, so in a way I was participating in the creation of the same process I was actually investigating This idea of the therapeutic aspect of trauma telling was discussed before and many psychological studies show the healing aspect of retelling one's trauma (one of the most famous one in anthropological writings dating back from the 1920ies with W.H. Rivers and his research on shell-shock victims).

But some of them were also very sceptical about sharing their CAM experience with me, since the status of CAM in Croatia is still relatively negative, and, according to the majority of my informants, they were *not likely to discuss their visiting a CAM practitioner with others, other than immediate family members*. They said some might consider them to be *fools or lunatics* and practitioners as *witches or wizards*. Not all were using strong words as lunatics, but all were all uniformly dissatisfied with the public image of CAM in contemporary Croatia.

## Towards advocacy and activism in alternative medicine research

And this is where the activism steps in. Or in the words of the president of CFNES: *Sure, what I do is activism, but only in so much as I am helping the alternative practitioners and others from that realm to get a fair position in the society, in academic community... not because I adhere as an activist to a specific worldview. People who practice and use alternative medicine are not medical minorities, alternative medicine is much more present than it seems. And they deserve to have their rights... and for all the health care systems to be treated equally. The same as biomedicine... It is also a big question of consumer protection...here we have to work with NGOs dealing with consumer protection to protect our clients...it is not like that in the West...alternative medicine there has a more normal position than here, they don't need that.*<sup>3</sup>

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<sup>3</sup> CFNES is now working on establishing a legal framework on CAM in Croatia and have already composed a draft of an Act on CAM which is to be passed to all the Parliamentary Parties for further discussion during October 2007. The research described in this article might help provide scientific insight into the problems and issues concerning CAM users and practitioners.



My path towards activism in alternative medicine was, therefore, completely coincidental. I did not intend to engage in activism nor did I design my research around studying activist groups, since, as I argued before, varieties of alternative medicine are primarily health care systems and not social movements. However, the prevailed attitude of my informants that they were stigmatized because of stating openly that CAM helped them, made me more inclined into thinking that a certain type of advocacy should lurk behind every anthropological story.

One of my favourite sentences in anthropology is Ruth Benedict's explication of the purpose of anthropology which is to make the world safe for human differences. Anthropology's unique possibility of understanding and interpreting other cultural norms and realms and its application to this very sensitive field of health and illness, which is full of emotional attitudes, opinions, beliefs, metaphors and meanings may, in the case of applied medical anthropology, suggest a necessary shift towards activism and more active involvement of anthropologists in protecting the rights of people to whom they owe their science.

*Translated by Tanja Bukovčan*