Negotiating THE Holistic Turn

The Domestication of Alternative Medicine

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This book is for
Gedi

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Introduction

In recent years, complementary and alternative medicine (often referred to as CAM in the literature) has grown tremendously in both popularity and economic importance. It is now recognized that about one third of the population of industrialized countries has had some experience with CAM. The new medical industry has generated its own field of adherents, practitioners, opponents, lobbyists, counterlobbyists, and regulations. Originally, CAM was regarded as antiestablishment, and the struggle between CAM practitioners and medical doctors has filled volumes of medical, legal, and popular scholarship. In recent years, however, the view of CAM as antiestablishment has changed. It is not the purpose of this book to address the validity of CAM, but rather to focus on social and cultural discourse and the many ways in which CAM is acquiring situated meanings within institutional and social contexts.

Terminology, in the case of CAM, is a charged issue—omnipresent in research on the subject as well as in everyday use. Choice of terminology when discussing the 'other' is highly political, never innocent, and reflects the aspirations of proponents and opponents alike. The problem of selecting the right way to talk about CAM is in fact the same as the problem of how to conceptualize it. In general, terminology used to describe therapeutic methods that do not rest on a Western, scientific rationale has reflected the hegemonic status of biomedical culture. To study the emergence of complementary and alternative medicine is therefore also to study a discourse of social distinction and signification.

In contemporary discourse, the most common terms used to refer to nonconventional medicine are also the most contrasting: "complementary" and "alternative." Practitioners seeking to join up with conventional medicine, or representatives of biomedicine seeking to co-opt and control nonconventional medicine, often use the term "complementary." The term "alternative" is more radical in that it carries the implication of one element replacing another and the concept that nonconventional therapies could, in fact, take the place of conventional medicine in many cases and perhaps compensate for its shortcomings.

To avoid the normative bias of either complementary or alternative, I have chosen to use the term "nonconventional medicine" (NCM for short) as a neutral meeting ground. I use this term whenever referring to therapies that do not draw their theoretical justification from the tradition of modern, Western science. I am well aware that the dichotomy "conventional" versus "nonconventional" is itself weighted with ideology; however, I think it would be naive to assume that a mainstream, conventional form of therapeutic action does not exist within Western society.

This study concerns itself with the dissemination, practice, teaching, and consumption of nonconventional modalities of health treatment in urban Israel. I intend to demonstrate how staff meetings of an NCM clinic are conducted in biomedical terms, how the teaching of NCM is fused with biomedical terminology, how the borders of conventional as well as nonconventional medicine are negotiated in the press, and how NCM consumers don't really seem to differentiate. The key analytical concept suggested here is that of domestication. Domestication, a process in which the foreign is rendered familiar and palatable to local tastes, can explain both the growing popularity of NCM modalities as well as the facility with which individuals move between conventional medicine and NCM modalities, and among the various NCM modalities. Although the focus of this study is urban Israel, I will argue that domestication is a major force behind consumption of medical treatments in a number of settings in Western industrialized countries as well as in low development societies. Despite very different settings, regulatory practices, and the history of contact between systems that are particular to each setting (see, e.g., Baer, 2001; Bishaw, 1991; Bodeker, 2001; Mills, 2001; Saks, 1994), many studies indicate the existence of a uniform process, one that "makes sense of medicine" for consumers. I argue that this process is domestication. Moreover, this study will suggest that domestication illustrates a dynamic process as opposed to other epistemological approaches that have described the static relationship between dominant and imported medical systems.

Biomedical Culture Revisited

Despite postmodern declarations regarding the presumed death of grand (and hence hegemonic) narratives, one such "grand narrative" is alive

and well in medicine. This global discourse of Western medicine is commonly referred to as "biomedical culture" by sociologists and has provided an instance of expansion of ideas and practices from the center to the periphery. It is important to understand the 'doxa,' the accepted ideology and practice of biomedical culture, in order to better analyze the heterodoxa (NCM). Biomedical culture encompasses the current practice and ideology of conventional medicine that has historically emerged from modern Western biology (Lock and Gordon, 1988). The point of departure for a social analysis of medicine is that it comprises not only a very comprehensive and sophisticated set of procedures, but also a body of knowledge, framing a worldview and requiring appropriate socialization, symbolism, and language (Bibeau, 1985; Huizer, 1987; Lepowsky,1990.). In other words, biomedical culture offers its practitioners an accepted way of looking at things. One of its major manifestations is the "medical gaze" (Foucault, 1967), through which the medical profession translates physical and/or mental signs into categories of health, illness, and subsequently treatment (see also Armstrong,1987; Berg, 1995). The medical gaze has been responsible, for example, for the constitution of "madness" as mental illness at the end of the eighteenth century, when "the language of psychiatry, which is a monologue of reason about madness, has been established only on the basis of such a silence" (Foucault, 1967: x).

Good (1994) further illustrates the medical gaze through medical students' descriptions of their learning and socialization process in both the clinical and preclinical years at medical school. The way a student is taught to think "anatomically," shifting the focus from the human being as "a person with an imagined life" to wondering what the person looks like underneath the skin, is a view that demands not only medical but cultural work as well. A common pathway of access to the human body taught at medical school is the microscope. Good's description of the order in which slides are shown at a lecture illuminates this point: "A slide showing the epidemiology of the disease will be followed by a clinical slide of a patient, and then by a pathological specimen. Then a slide of low magnification cell structure is followed by an electron micrograph, and from this level to diagrams of molecular structure and genetic expression" (1994: 75). Biomedicine reduces the entirety of the human body to the cellular level and explains disease through the basic sciences. This is the grand narrative of modern medicine. Against this backdrop, I will later ask whether NCM constructs an alternative reality to that of

conventional biomedicine, in which the authoritative doctor–patient relationship is replaced by a more egalitarian dyad, the biological emphasis is supplanted by a holistic mind/body outlook, and disease is treated by concentrating on systemic equilibrium rather than superficial physical symptoms.

The next stage to seeing medically is learning to talk and write medically. These are important skills aimed at imposing a certain kind of order on the disorder of human symptoms. Good (1994) discusses the medical write-up not as a mere record of verbal exchange but as a formative practice, a practice that "shapes talk as much as it reflects it" (p. 77). The write-up constructs a person as a patient, a document, and a project. A student interviewed by Good elaborated on this point:

> You begin to approach the patient with a write-up in mind . . . and so you have all these categories that you need to get filled. Because if you don't do that, you go in, you interact . . . you talk . . . you go back and you realize that you left out this, this and this and you need to go back. And when you go in with the write-up mentally emblazoned in your mind, you're thinking in terms of those categories (1994: 78).

The demand to think in terms of the write-up is in fact one of the socializing processes of medical internship. Students learn what kind of details can make the attending physicians impatient or bored: "They don't want to hear the story of the person. They want to hear the edited version" (Good, 1994: 78). Professional behavior, then, is

> Not to talk with people and learn about their lives and nurture them. You're not there for that. You're a professional and you're trained in interpreting phenomenological descriptions of behavior into physiological and pathophysiological processes. So there's the sense of if you try to really tell people the story of someone, they'd be angry; they'd be annoyed at you because you're missing the point. That's indulgence, sort of. You can have that if you want that when you're in the room with the patient. But don't present that to me. What you need to present to me is the stuff we're going to work on (1994: 78).

Medical discourse therefore is a positivistic (neutral and objective) discourse in which human subjectivity is reduced and translated into

technical terms. Waitzkin (1991) took medical constructionism further, showing how the medical profession exercises not only physical but also moral control over patients by ignoring the cues they venture as to the cause and nature of their complaint. In the process of its expansion, biomedicine assumed a dominant and distinct position. This ideology of exclusiveness rejected and did away with competing health paradigms, except for cases in which the local ethnomedicine was resilient enough to adapt to and sometimes even contain biomedicine (Bledsoe and Goubaud, 1985; Lim Tan, 1989).

The procedures of biomedicine have been propagated through textbooks and training, colonizing new territories through modern education, international organizations (such as the WHO), and governmental sponsorship. The expansion of biomedicine often went hand in hand with colonialism and is described by Comaroff as a "technique of civilization" (1993: 315) or by Baer, Singer, and Susser (1997) as part of the services provided to local communities as a humane justification for taking over their lands. In China, for example, even though Chinese medicine is probably the world's oldest body of medical knowledge and tradition dating back some four thousand years, Western medicine gained a strong foothold with the assistance of European and U.S. colonial powers in the nineteenth and early twentieth centuries (Baer et al., 1997). Whereas the globalization of biomedical culture has been part of the modernist project, administered by the nation-state and its agencies (Wallerstein, 1974), the globalization of NCM is driven by new postmodern forces such as consumerism and popular culture. The globalization of NCM, in contrast to that of biomedicine, signifies a process of greater plurality. The world does not necessarily become 'united,' but rather more fragmented and hybridized. The globalization of NCM can by no means assume integration in the naive functionalist sense (Featherstone, 1991; Robertson, 1992) due to two principal reasons. First, biomedicine has not been replaced by the competing NCM, but rather stood its ground, with NCM often adapting to it. Second, NCM itself encompasses a plethora of methods, practices, and treatments that do not embody a common paradigm.

This book focuses on a "reversed" type of globalization, in which the periphery (NCM) impinges on the center (biomedicine). A key concept in my discussion of globalization and the diffusion of global and local cultures is that of domestication, and this book will highlight patterns of domestication of NCM in the Israeli context. In this manner, this book joins a growing list of cultural studies that have rendered

the local/global interplay a key scenario of the last decade. Images of domestication, hybridization, glocalization, pidginization, and creolization, all designating synonymous processes, have become central metaphors in the study of the flow of culture (Appadurai and Breckenridge, 1988; Der Derian and Shapiro, 1989; Hannerz, 1989; King, 1991; Wilson and Dissanayake, 1996). On the one hand there are global realities, forms, and processes that permeate national borders, such as Hollywood films, soap operas, package tours, chain stores, department stores and malls, fast-food restaurants, theme parks, and alternative medicine therapies. These global forms seem to be drawing the world into a disturbing commercial sameness. However, social entities, such as nation-states, classes, ethnic groups, and social institutions in general, domesticate these global forms through local preferences and cultural patterns.

Outline of the Book

Broadly speaking, this study sets out to explore patterns by which NCM coexists with the biomedical establishment. The first chapter discusses various approaches that have characterized previous studies of NCM. I then propose a typology of patterns of assimilation and acculturation, used to distinguish between the various processes relevant to the existence of NCM. This typology of assimilation and acculturation is used as a framework for discussing four approaches that have characterized previous studies of NCM. All these approaches presented a dichotomous view of health behavior. Yet must behavior be dichotomous? Findings suggest today that many people can be characterized by dual utilization of NCM and biomedicine. In the framework of this study, I therefore adopt a theoretical conceptualization that does not resort to dichotomous categorization.

Chapter 2 discusses the field in which I conducted my ethnographic research—urban Israel. The unique combination of medicolegal arrangements in Israel along with growing public demand for NCM have led to the development of a domesticated type of NCM practiced in urban clinics, taught in colleges, and disseminated in the media. I suggest that NCM in Israel should be examined as an encounter between the global and the local, in which the periphery (NCM) impinges on the cultural map of the center. NCM in Israel is analyzed in this study so as to highlight the particular organizational pattern of