

**Biomedical Knowledge as a Tool for the Marginalization of  
Complementary and Alternative Medicine: Inquiring into the Boundaries  
of the Croatian Medical Field**

**by**

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## ABSTRACT

This study looks at the social processes of boundary-making in the Croatian medical field. I argue that biomedicine and CAM are the medical systems which are primarily systems of knowledge, practices and culture and that biomedicine as a dominant system uses discursive strategies to reproduce its hierarchies and power structures in order to maintain the boundary in the medical field and protect it from transforming, as this is not in its interest. First, I begin with the investigation whether biomedical physicians and CAM practitioners communicate and if they do, how do they communicate and what are the obstacles, on the one hand, and bridges to communication, on the other hand. Secondly, in order to explicate the aspects of the specific discursive strategies of biomedical domination over the knowledge and practices of CAM, I show the relationship between physicians' knowledge about CAM and their experience and concomitant interest in it. Third, I analyze three aspects of the boundary in the medical field – the professional, organizational and epistemological aspect. I exemplify this by examining the aspects of these dominative practices in two Croatian cities, Zagreb and Bjelovar.

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# INTRODUCTION

Biomedicine and complementary alternative medicine (CAM) healing modalities represent distinctive medical systems established on epistemologically different foundations (Johannessen and Lázár 2006; Good 1994). While the biomedical gaze is clinical and biological (Foucault 1975), the gaze of CAM is oriented primarily toward the processes of non-separation of the human being on its dimensions of body and spirit in general. It can be said that biomedical explanations of medical conditions utilize the concept of disease, while CAM utilizes the one of illness, where the first denotes the reductionistic and the second the holistic approach to explaining health-related issues (Eisenberg and Kaptchuk 2001; Kleinman 1995).

Nation-states, among other modern political entities, provide the social space for the constellation of medical pluralism, defined as the simultaneous presence of a considerable group of knowledge and practices coming from diverse medical systems. As such, the medical field of the nation-states encompasses the medical systems as subfields which “co-exist in a cooperative or competitive relationship with one another” (Baer et al 2003:9). In complex societies biomedicine is accompanied by the presence of CAM healing modalities, which are in the most cases overpowered and dominated by biomedical disease and health care systems.

Following the trends of the European countries with the socialist past, there is an increasing use of complementary and alternative medicine in Croatia, which can be illustrated with the number of people giving treatments of alternative medicine: 4, 000.<sup>1</sup> This phenomenon can be contextualized within the post-socialist transformations in the Croatian health-care system. The post-1989 period of multidimensional social changes, in which post-socialist transition significantly altered the functioning of the health-care system, also affected the position of CAM practices in Croatian society (Bukovcan 2008). Observing the historical axis of 1989, a time of transformation can be distinguished from entirely state-funded health-

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<sup>1</sup> <http://www.huped.hr/arhivaHUPEDinfo.asp#direktive> (Retrieved December 23, 2009)

care system to the introduction and further development of the market principles and the processes of economic privatization influencing the medical field. One of the concomitant changes was also a transition from nationally and locally specific practices of Croatian folk medicine to culturally non-bounded CAM practices. They became more present in the public sphere, due to the creations of civil social dimensions, such as groups of new-age movement, and due to the suppression of the socialist ideology of state's coercion on providing unified belief systems and epistemological imperatives. This allowed more individual freedom in the choice of medicine to be introduced, a phenomena as valid for Croatia as for other Southeastern European countries (Bukovcan 2008).

The CAM therapies currently existing in Croatia range from biomedically recognized acupuncture, which is even state-funded and provided as a part of biomedical pain treatment in some hospitals, to forms of energy hand-healing therapies, which are frequently regarded as quackery among biomedical specialists, and even among some CAM practitioners. However, CAM is not yet statutory regulated in Croatia and both the State and the Croatian Association of Physicians are not very much interested for this social problem. In 2004 the Croatian Federation for Natural, Energetic and Spiritual Medicine (CFNES), the only and thus the most powerful NGO in promoting the integration of CAM in the Croatian health-care system, proposed a law on the regulation of CAM and the Ministry of Legal Issues established a Counsel of Minister with the purpose of regulating the use of CAM in Croatia. A set of proposed jurisdictional claims concerning the integration was put aside for further discussion, but this discussion hasn't taken place yet. Maybe because of this CFNES has organized seven congresses on cooperation between biomedicine and CAM at Zagreb, providing a social space for the public debate. Furthermore, as there are no laws which could control who can and who can not work as a CAM practitioner, Croatia is a fertile ground for those few thousand people who entitle themselves to deal with the medical issues, both physical and spiritual, and who

don't have the appropriate qualifications but call themselves "the doctors" of CAM healing modalities (i.e. the doctor of Ayurvedic medicine). This makes this topic even more relevant due to the fact that people have to choose between the quacks and skilled CAM practitioners without any clear social guidance where to turn in the context of alternative treatment. This phenomenon sheds light on one of the main issues which medical sociologists have examined: the issue of ideologically biased health policies, which are found inadequate for decreasing social inequalities in the field of health, but on the contrary, they helped them to grow even more.

The multidimensional relations between biomedicine and CAM structure the medical field. As each medical system is endowed with its types of capital, the communication between biomedicine and CAM takes the shape of the competitive power struggles, in which different strategies by the members of the field are utilized. The rules of the game are prescribed by the most powerful members in the field – biomedicine; these strategies, as they are counter-oriented, position biomedicine on the dominant side and CAM on the dominated side of the medical field. (Bourdieu 1991). What are the biomedical strategies of domination over medical knowledge and practitioners of CAM within the Croatian medical field, and how is marginalization accomplished? I will argue that biomedicine and CAM are the medical systems which are primarily systems of knowledge, practices and culture and that biomedicine as a dominant system uses discursive strategies to reproduce its hierarchies and power structures to maintain the boundary in the Croatian medical field and protect it from transforming, as this is not in its interest. I will exemplify this by examining the aspects of these dominative practices in which those CAM therapies taken into the research sample are being marginalized by biomedicine.

I conducted research in two Croatian cities, Zagreb and Bjelovar. There is a specific reason for this. Zagreb is the capital and is the biggest city in Croatia, situated in the north-

west region with a population of 780,000. It is approximately one thousand years old, while Bjelovar is 254 years old, situated in central Croatia, with a population of approximately 42,000 inhabitants and is the administrative capital of Bjelovar-Bilogora County. One of my assumptions, coming from the literature (Bourdieu 1991), was that there would be more prestige and symbolic power concentrated in medical institutions of the capital city, as it is as such endowed with more symbolic capital. Moreover, I assumed that the relationship between medicine as a socio-cultural entity, space and social relations can be approached to if one enquires into the capital, whose medical institutions (such as medical schools and hospitals) may be regarded as more prestigious, professional, elite in the world of medical doctors, on the one hand, and into a smaller city such is Bjelovar, which has it has one hospital and one medical school, and additionally it is a kind of center-periphery relation. More laconically, I wanted to explore if there was a difference in the usage of medical discourses, as they can be seen to connect agency and structure, time and place (Holloway and Hubbard 2001), and being historically contextualized, the link between medical knowledge and practice can be addressed through them as well as the relationship between patient and a healer.

The thesis is divided into four chapters. In the first chapter I make an overview of three theoretical approaches dealing with the problematic of medicine and relate it to the topic of this study, and in the second chapter I introduce the methodology used in the research. The third and the fourth chapter are intrinsically interconnected; for the sake of easier comprehension of the analytical work and for the more clear presentation to the reader I separated one theoretical and empirical whole into two parts. In the third chapter I first introduce the subdisciplines of medical sociology and critical medical anthropology and examine the relevant theoretical frameworks dealing with the definitional and relational aspects of biomedicine and CAM in general, describing the concepts of a medical system and medical pluralism, and dealing with the definitional issues concerning biomedicine and CAM



in general. Secondly, I interweave this with the conceptualizations originating from the sociology and anthropology of knowledge, relating the phenomenon of the medical system to the concepts of a system of knowledge and practices and to a system of culture. Then in the fourth chapter I examine the data from the field in order to discuss how these strategies are perpetuated in the medical field. I divide this chapter into two parts. Each of them presents the results of the data analysis in relation to my theoretical framework. In the first part I deal with biomedical physicians' knowledge about CAM and views on patients' demand for CAM treatments, in order to explicate physicians' motivations for and against the collaboration of biomedicine and CAM. It also shows both physicians' and CAM practitioners' views on the responsibility and elements needed for the control of CAM, allowing me to connect the criteria of regulation of CAM to the criteria for collaboration of biomedicine and CAM. In the second part I present the views on the appropriate settings in which to provide CAM education and treatments, as well as the views on usefulness of CAM treatments and for what conditions. I analyze and discuss the professional, the organizational, and the epistemological aspects of the boundary in the medical field.

## 2. LITERATURE REVIEW

In this chapter I examine the sociological and anthropological perspectives on medicine. These are three sections: the first concentrates on the theoretical approaches of medical sociology and medical anthropology, the second on the sociology of professions and the third on the sociology and anthropology of knowledge.

I will develop my framework in the fourth chapter more thoroughly with the theorizations of sociologists and anthropologists of knowledge and followed by the conceptions used in the sociology of professions, both of which will be encompassed by the concepts used in critical medical anthropology. This enabled me to address the phenomena of various power-based dominating actions of biomedical doctors over CAM, on the one hand, and the dynamic aspects of medical field's boundary, on the other. Taking this into consideration, I will show how biomedicine utilizes various discursive strategies to reproduce its power structures and maintains the polymorphous boundary in Croatian medical field (Kleinman 1995).

### ***2.1. Medicine in the medical sociology and critical medical anthropology***

Critical medical anthropology is a young subdiscipline within anthropology, developing its theoretical and methodological foundations in the research endeavours of indigenous medical systems, while contemporary studies deal also with the medical paradigms of more complex modern societies, biomedicine specifically. There is an increasing body of work on the significance of investigating the alternative medical treatments within modern complex societies, accompanying the shift in anthropology in which the transition was made towards studying ones own socio-cultural background.

Sociological researches of medicine, and inequalities related to it, started with the applications of the functionalist perspective in the 1950s and in the beginning didn't deal with the social construction of the health and illness, medical systems and their knowledges, as symbolic interactionists did (such as Goffman 1961; Strauss, Schatzman, Bucher, Ehrlich and Sabzhun 1964). Rather, functionalists (such as Parsons 1951) were concerned with the interconnectedness of the social roles and institutions, the phenomenon of professionalization and social order (Germov 2002).<sup>2</sup>

The critical sociological analysis of health inequalities contributed to the better understanding how they are produced and reproduced in societies and how they are influenced by health policies and their relation to the social, economic and political phenomena (Scambler and Higgs 1999). Sociological analyses contributed to the better understanding of the relationship between political contexts and class determined health inequalities as well. Vincente Navarro, Howard Waitzkin and Barbara Watermann are some of the main medical sociologists who examined the issue of population health using marxist approach (Stifanic 1998). Navarro found that capitalism influence medical knowledge: the distribution of power in societies and the role of the state determine the way of functioning of the health care systems (Stifanic 1998). According to him, health reforms „mirror class structure and social alienation“ and class division is being reproduced in health care system; on one side, there are medical doctors who “own the power and instruments of knowledge”, and “the patients who are subordinated to the knowledge, the power of medical doctors and to the medical ideology” on the other (Stifanic 2001:840).<sup>3</sup> Navarro showed that medicine is used as an instrument of social control and as “an instrument of the reproduction of social inequalities

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<sup>2</sup> According to Stifanic (2001), sociological approaches to health can be conceptualized through four perspectives: “functional, marxist, phenomenological and radical”. He argued that they have to be used together to be able to explain the phenomena related to health and the society and its members. Through those four approaches the whole of society is examined to be able to “define health policy in concrete conditions, which directly influences health and social results” (Stifanic 2001:833).

<sup>3</sup> The proponents of dominant medical ideology and their agents research and view the disease as individually caused, not focusing on the social, political and economic relations as sources of producing and reproducing health inequalities.

and iniquities” (Stifanic 2001:840).<sup>4</sup> He argued that alienation, which is one of the main features of capitalism, is manifested in the relationship between the doctor and his patient. This is one of the main issues in the debates about the relationship between patients and doctors: the issue of bureaucratization (Stifanic 1998).

Critical sociological theories and marxist tradition had major impacts on the development of medical anthropologists’ critical approach (Good 1994). It involves different theoretical frameworks and it emphasizes the phenomenon of the social construction of medical realities. It defines the phenomena of health and disease, and concomitant medical and health care systems in terms of power relations. This reference point allows one to relationally approach the social processes taking place in a medical field in general, and biomedical control over CAM modalities in particular, and comprehend these phenomena as a political issue. As Baer and Singer (1997) described in *Introducing Medical Anthropology: A Discipline in Action*, in the context of medical pluralism biomedicine plays a role of a hegemonic medical system. As it is a dominant system, it produces, reproduces and distributes, through medical research and everyday physicians’ practice, various resources of structural power which allows it to control CAM constraining its legitimate expansion in the medical field. The research puzzle of this study is how was this hegemonic domination over the medical systems of CAM achieved.

There are several studies in the critical medical anthropology that are relevant to this study. Arthur Kleinman (1995) approached biomedicine as a system of culture, and defined the phenomenon of disease as internal to culture and related the concept of disease to the cultural meanings. He proposed the notion of “explanatory model” to be used in the analysis of categorization of diseases, saying that they are not culturally free entities, but rather

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<sup>4</sup> Historians of knowledge and medicine and anthropologists who inquire into the historical dimension of social processes related to medicine described the socio-cultural nature of the medical systems. Michel Foucault (1975) historically contextualized the development of biomedicine in the 19th century Europe and described the medical profession as being the agent who reproduce one of the social ways of institutional control and mechanisms of surveillance over the population.

explanations of reality (Good 1994:53). Among other topics, he investigated the social construction of mental illnesses in China applying the interpretive approach. Some of the comparative researches of women's health in relation to traditional medical systems and biomedicine, Margaret Lock did in Japanese society, utilizing interpretive perspective too.

Important reference points for this thesis are given by Byron J. Good and his work written in *Medicine, Rationality and Experience: an Anthropological Perspective*. He examined the problematic of the production of biomedical knowledge in medical schools in England (i.e. medical socialization), describing how biomedical students learn to see and judge the world through biomedical lenses. Furthermore, Charles Rosenberg (2002) believed that political power of biomedical elites is inherent in the monopoly of claiming the only proper ways of providing a diagnosis.<sup>5</sup> He explained that to institutionalize nosologies of diseases means to have a great amount of social power; it means to claim the ontological reality of the health and sickness, and to put into social practice the medical definitions and structure the physicians and bureaucratic relations within the medical organizations and to legitimize them in the wider society.

## **2.2. Sociology and anthropology of knowledge - the social construction of medicine**

The sociologists and anthropologists of knowledge show that medical knowledge and practices are culturally bounded, that they are not socio-culturally neutral and freed from personal or group interests. Fredrik Barth showed (2002) that medical knowledge is systemtically produced, reproduced and distributed in the society. These claims are supported

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<sup>5</sup> Rosenberg (2002:251) showed how biomedicine constructed the classification of ills and the bureaucracy who is supposed to deal with it "through laboratory tests, pathology-defining thresholds, statistically derived risk factors, and other artifacts of a seemingly value-free biomedical scientific enterprise". When he wrote about the social functions of the act of the diagnosis, he (2002:237) claimed how it holds a central position in medicine, and following the modernization of society, it advanced technologically and became more computerized, "specialized and bureaucratized".

by the theories which use the different conceptualizations of social power and control to explain how cultural systems or systems of knowledge-as-practice serve to individual, collective, or more specifically state, interests (Agrawal 1995; Haraway 1993; Pickering 1992; Shiva 1988). Due to the power of biomedicine to control human life in its core essence, it institutes the fear of death and gives the control over it to a relatively small group of professionals, who are in turn given a huge amount of social capital (Foucault 1975, Good 1994). In “Dismantling the Divide between Indigenous and Scientific Knowledge”, Arun Agrawal deals with the arbitrary divisions between different forms of knowledge, the indigenous and scientific in particular, in order to show how artificial categorizations serve to specific group interests. Keshet (2009) examines philosophies of scientific groups and the debate within them and inside the medical profession concerning applicable ways of evaluating efficacy of CAM. She also found that randomized controlled trials hold both the monopoly in the production of the biomedical knowledge and the criteria of validity of treatments by CAM (i.e. the criteria of validity of knowledge of CAM).

Furhermore, Timmermans and Kolker (2004:187) developed Freidson’s argument that knowledge is mobilized by groups of professionals and related it to the phenomena of struggle of “new contested formats of knowledge”; they called for the new way of approaching to the medical knowledge which will enable the concept of “professional power” to be explained. In this way, they argued, the transformations happening in the health-care system could be examined in the relation to the changes in the bodies of knowledge. In “Schism and Heresy in the Development of Orthodox Medicine: The Threat to Medical Hegemony” Kenneth Jones (2004) reported on the origin of dominance of medical profession using a socio-historical perspective. He used the term “orthodox medicine” which, according to Jones, grew “by claiming the superiority and consequent authority of the biomedical model and its special

relationship to laboratory science” and which is being challenged through the rejection of “the notion of objective knowledge” (2004:703).

Andrew Pickering (1992) argued that methodologies are always used in relation to specific theories, which are relational and technical constructs in their essence. He has also claimed they are always negotiational and partial, as all aspects of reality of the phenomenon can never be taken into consideration, meaning that a theory supported by methodological procedures can never be done or considered closed to further advancements or to a new knowledge. As Tesser and Barros (2008:2) said, “one notes that scientific production is a sophisticated tradition concerned with the production of knowledge and practices, connected by specific forces, social networks, interests and cultural and socio-political values”.

These referential frameworks allow a connection of a conceptualization of the power struggles between biomedicine and CAM in the medical field with the phenomenon of ideological “deviance” which is depicted and symbolized by CAM modalities in Croatia.

Different approaches of studying professionalization processes, especially Elliot Freidson's and Andrew Abbott's work on professions, provide yet another way of seeing how social change happens on the boundaries of the medical field between opposed bodies of expertise (Abbott 1988, Freidson 2001). One of the focuses of my research is put on the division of medical labor.

### ***2.3. Medicine in the sociology of professions***

Sociology of professions deals with the relationship between biomedicine and CAM, focusing on the division of labor as its explanatory priority, but also specifying the inquiry into various aspects of professionalization process such as educational system, labor ethics and licence rights and examining the power relations within these phenomena (Abbott 1988). Medical professionalization is explained in two general ways. The first one emphasizes the external effects, or the effects which professionalization in the medical field has on the other

fields. The second way consists of approaches which emphasize internal effects explaining how professionalization processes influence the medical field itself (Abbott 1988).

Freidson (2001) approached medical professionalization from the functionalist perspective and showed how professions reproduce social inequalities. He emphasized the fact that professions exercise and maintain their power utilizing various ideological and political strategies which enable them to maintain an epistemologic dominance over other systems of knowledge and their proponents (Abbott 1986, Freidson 2001).<sup>6</sup>

Abbott's theory of change within the system of professions, in which he proposed two complementary ways of approaching it, has similarities both with the perspectives of Bourdieu's and organizational sociology. One of them is Abbott's (1988) explanation about how professions change from the inside, when impulses or factors of change come from the system of profession itself. The other is the explanation of social mechanisms which change the profession from outside the profession. This can lead either to minor disturbances in the system of medical profession or to actual restructuring of its division of labor and to concomitant transformations (Fries 2009). According to Abbott (1988), the control of the distribution of power and organization of division of labor in the medical field is defined, institutionalized and thereby incorporated in the system of medical profession, as it consists of number of patterned subfields of functional specializations, by jurisdiction.

The theorists who examine social transformations taking place in the dimension of occupations within medical and health-care systems focus on two phenomena: the basic concept of professionalism on the one hand, and on the concept of medical dominance on the other. Evan Willis (2006) discussed a social position of physicians and professionalism within medicine in the beginning of this century from the reference point of political economy. While

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<sup>6</sup> This is one aspect of the struggle in the Croatian medical field, in which professionalism of biomedical organizations enable their members to control their work by maintaining the boundary with complementary and alternative medicine. They politically mobilize strategic claims which impose an understanding of complementary and alternative medicine as epistemologically unacceptable, evaluating it as quackery and as mere placebo effect.



he was describing medical dominance of the structures of the health-care systems, he examined one of the essential phenomena which critical medical anthropology is dealing with: through the politics of neo-liberalism and the phenomenon of consumerism Willis (2006) pointed out the market oriented processes and processes of industrialization of medicine, relating it to the growth in demands of alternative therapies and to the contemporary shifts regarding medical profession. David Coburn (2006) argued that social medicine theories focus on the notions of professionalism, medical power and authority due to the simultaneous actuality of politic debates concerning these issues pointing out to the key relationship between medicine and politics. He highlighted the limitations of theories of sociology of medicine which focus on the concept of medical power and professional dominance, questioning their ability to explain related contemporary phenomena in this field. He recommended using the political economy theoretical framework as being more appropriate. To be able to explain changes taking place in the relationship between medical profession and medical work and the state governance, Judith Allsop (2006) showed the influences and conditions which affected these phenomena from inside and from outside of the related structures. She argued that as the state regulates health policies more and more, the autonomy of medical profession is continually shrinking and showed how the relations with the phenomenon of dominance of biomedical knowledge ensures economic profits and social status of the profession. Alex Broom (2006:496) questioned Allsop's conceptualizations focusing on the notion of power within medicine systems, relating her arguments to the phenomena of "complementary and alternative medicine and the Internet-informed patient" which she explained by "the relative decline of the power and autonomy of biomedicine".

The concepts of medical professionalism and dominance are very important for the study of the medical field in Croatia. I don't utilize theorizations of previously mentioned authors, due to the specific aims and context of my study. However, they helped me to take

various perspectives into consideration while approaching the problematic of biomedical dominance. My research aims are to connect these theoretical approaches by offering a study on the aspects of the boundary and the discursive strategies in the Croatian medical field. I do this by utilizing Bourdieu's theory of social fields. It provides a reference point of understanding the most important properties of a medical field which I examine in this work. It also provides sociologists with conceptual tools for the empirical analysis of dynamic relations within this field, its hierarchies and transformations taking place within it and on its boundary. Thus it is useful for studying social change (Bourdieu and Wacquant 1992). Boundary-making is also important here, as I am interested in social processes which demarcate the dividing line between biomedicine and CAM. I construe them as medical systems on the opposite sides in the medical field, primarily being systems of culture to which I approach to as systems of knowledge and practice. I will try to show that certain elements of biomedical knowledge are used for the marginalization of CAM in Croatian medical field.

Before that, in the next chapter I will describe the methodology utilized in the research process.

### 3. METHODOLOGY

In 2002 in a course on medical anthropology I learned about the relationships between biomedicine and alternative and complementary medicine as two cultural systems in general, and about the issues, scopes and designs of the sociological and anthropological studies dealing with this complex and underresearched topic (Broom 2005). To put this teaching into practice I decided to deal with the subject in the form of a small qualitative interview-based research, appropriate for addressing both the subjectivity of human experiences in the the context of decision-making processes, in which biomedical doctors and CAM practitioners are engaged and needed for the objectivity when dealing with the research findings (Broom 2005). Given the focus of this topic, semi-structured interviews were recognized as the most important methods and the tools of inquiry (Bernard 1995, Broom 2005, Kvale 1996, Shensul et al, 1999). First, qualitative study based on semi-structured interviews allowed participants more freedom while talking about their experiences in dealing with CAM practices, and also allowed more interpretative space in the process of active construction of the anthropological knowledge hidden behind the narratives of meaning both for interviewer and interviewees. Second, this allowed me in the analytical part of the study to be sensitized to the similarities and differences in the meanings connected with the specific positions in the discursive conflicts regarding the relationship between biomedicine and CAM in which participants were engaged and immersed in (Broom 2005).

In this study, by approaching the multilayered boundary between biomedicine and CAM, and focusing on the professional, organizational and epistemological aspects of the boundary, I have developed an interview guideline and distinguished the interview structure in three general dimensions conducting them with three categories of practitioners in two Croatian cities: biomedical doctors, CAM practitioners and persons who have training and use both medical systems (Bernard 1995, Kvale 1996, Shensul et al, 1999). I have chosen them

for their representativeness of various strategies towards or against the transformation of the medical field and for their different power position in it. This has enabled me to contextualize their position-taking in relation to dominant medical discourses (DeVault and McCoy 2003; Neuendorf 2002).

I conducted 22 semi-structured interviews based on sets of relevant thematic in-depth questions, which lasted from one to one and half hour (Bernard 1995, Kvale 1996, Shensul et al, 1999). Regarding methodological procedures I was not so clear how will I adjust the interviews to both sides to provide a minimal degree of comparability, as I was ready for the narratives which will reflect different, basically symbolic, reference points. As this was not cognitively preconstructed, the understanding process and the course of the interviews was a common effort. The sizes of samples were relatively small – in Zagreb I interviewed four biomedical doctors (two oncologists, a surgeon and a psychiatrist), five CAM practitioners (homeopathy practitioner, shiatsu therapist, aromatherapist, bioenergy practitioner and reiki practitioner) and three doctors who have combined training in biomedicine and CAM and use it in their practice (a general practitioner and acupuncturist, doctor of general medicine, acupuncturist and homeopathy practitioner and doctor of general medicine, doctor of Japanese, Chinese and New German Medicine). In Bjelovar I interviewed four biomedical doctors (a surgeon, a psychiatrist, a doctor of internal medicine, an orthopedist), two CAM practitioners (Reiki practitioner and aromatherapist) and three doctors who have combined training in biomedicine and CAM and use it in their practice (an anesthesiologist and acupuncturist, a general practitioner and homeopathy practitioner).

To be able to interpret the relations of biomedical doctors with the CAM practitioners, and vice versa, I tried to understand the social processes in the context of position-taking in the medical field, on the one hand, and into analysis what are the biomedical strategies of

domination over medical knowledge and practitioners of CAM and how are the processes of marginalization accomplished, on the other (Bourdieu and Wacquant 1992).

Analysis of data is founded in “the constructivist ontological position” which is indispensable while inquiring into the social construction of reality, in general, and while dealing with the social situations in which participants “actively negotiate meaning” of the structure and agency present in the medical field in particular (Broom 2005, Kvale 1996).

## **4. BIOMEDICINE AND CAM – INQUIRING INTO THE BOUNDARIES OF THE MEDICAL FIELD**

I divided the fourth chapter into several sections. I first introduce Bourdieu's theory of social fields and the notions of medical system, biomedicine and CAM as an initiation into the analysis of empirical data and the discussion of the discursive strategies specific to biomedical physicians and CAM practitioners.

### ***4.1. Bourdieu's theory of social fields – structuring the medical field***

Bourdieu (1991) perceived society or macrocosmic social space as divided by the principles of relational domination into fields as microcosmic social structures and locuses of relations of power. This manifests in the multiple struggles oriented either toward preserving and reproducing or toward changing the structure of the field.

The fields “consist of a set of objective, historical relations between positions anchored in certain forms of power (or capital)” (Bourdieu and Wacquant, 1992:14-16). They emerge as a result of struggles over stakes; they are “relatively autonomous spheres of play” through which its properties, in Bourdieu's terms - rules and regularities - can be read. The field has its own historically defined and specified values and regulative principles which are empirically translated into field's boundaries.<sup>7</sup> The state of power relations between agents establishes the structure of the field. The relative autonomy of power of an agent in the field, his position and orientation in the field can not be inquired detached from the volume and organizational composition of his capital since they are defined by it: members of the field

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<sup>7</sup> This is an empirical definition of the field as a marked space of social play in which agents have possibilities to mobilize various strategies in the struggles, following or rebelling against the relative autonomy created by dominant actors in the field. Bourdieu conceptualized this process as position-taking (Bourdieu and Wacquant, 1992).

with the same amount of capital can be distinguished by their position and by their position-takings (Bourdieu and Wacquant, 1992).

This serves as a basic conceptualization of the medical field as it consists of medical institutions and organizations, differently positioned in the field's hierarchical structure. I find this to be related to boundary-making: the power of claiming what is medically legitimate, conventional and professional and what is not is the symbolic capital of those groups on the legitimate side of the boundary, meaning biomedical doctors. CAM occupations in Croatia haven't succeeded in gaining the legitimacy of medical knowledge, except acupuncture, aromatherapy and shiatsu therapy, and only on one level. CFNES and the proponents of CAM gave a jurisdictional proposition to Croatian Ministry of Legal Issues that CAM in Croatia should be statutory regulated and integrated into the national health-care system. As I stated earlier, in 2004 Ministry of Legal Issues established a Counsel of Minister with the aim of discussing these topics but the State, as a crucial factor in the professionalization of CAM, stopped this process and positioned CAM practices on the non-legitimate side of the medical field (Kelner, Wellman, Boon and Welsh 2004). I will examine this in detail later in the chapter.

The autonomy of the field, its characteristic of the principle of differentiation, points towards the existence and dynamism of field's boundaries, which can be understood as empirically reporting social processes of power struggles for the appropriation of the relevant species of capital, put into reality through material relations and symbolic constructs (Bourdieu and Wacquant 1992).<sup>8</sup> One form of capital which circulates in the medical field is cultural capital which consists of symbolic and material power which comes from medical

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<sup>8</sup> Fields empirically, like the concepts of habitus and capital, are not isolated, but relational. This means, among other, that medical field can't be approached sufficiently if not taking into an account historical changes in the country which has effects on other fields, such as changes in the economical field for example, contextualized in the processes of post-socialist transition. Fields can't be investigated in an isolational vacuum: they form relations between them, the relations of „relative autonomy”, and they differ on the basis of quantity and quality of the autonomy meaning specificity of their functioning logic as their legitimate property which they possess within the field of power (Bourdieu 1991).

knowledge and skills through the access to medical training and “their material representations, such as certifications, qualifications, and diplomas” (Fries 2009:330). As the results of my study show, and as I will later describe, this is the essential level of the struggles in the medical field as they rest upon these locuses of power from which the resources of claiming dominance over complementary and alternative medicine originate.<sup>9</sup>

Social capital in the medical field is related to making power relational alliances which enable the accumulation of power when actors engage in the negotiations in the field. Individual actors as well as organizations in the field possess different amount of social capital. When dominant actors define the value of these forms of capital, they are categorized as a symbolic capital and as a source of power (Bourdieu and Wacquant 1992; Fries 2009). Biomedical disciplines which have the most symbolic capital in the medical field are those which create the strongest relations with biomolecular science and genetics (in this study they are surgeons and oncologists) and use this symbolic resources as sources of authority over other medical disciplines and especially over the knowledge of CAM. This is exemplified by the oncologist from Zagreb, who said why she didn’t want to participate in this research, said that she was “absolutely not interested in CAM” because she didn’t “know anything about it” and that I didn’t have “anything to research at her office”. More laconically, she stated that she was “a medical professional, an expert on the international level, collaborating with the Ministry of Health and is engaged in the regulation of health-care system”. As Bourdieu wrote, in order to conceptualize, and thus methodologically correlate, the boundaries of the field, on the one hand and regarding the intrafield relations, agents in the field can utilize the strategies of capital conservation while playing by the field’s rules of reproduction of its structure; this example shows just that. The aim of the players can also be the deconstruction of the field’s functioning logic by utilizing those strategies which offer the power of

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<sup>9</sup> While all aspects of the boundary overlap each other, it can be said that the epistemologic or conceptual basis of dominance practices encompass them all.



devalorizing the capital of their rivals and of increasing the value of the capital to which they have access, in order to redefine historically variable value of exchange rate between different species of capital (Bourdieu and Wacquant 1992). CAM practitioners try to enforce this when they call upon the production of the non-mainstream scientific knowledge coming from investigations of quantum physicists as homeopathist from Zagreb insisted on:

Biomedicine is old-fashioned and very selective. The legitimization of a biomedical knowledge is established in biochemistry researches, as they mainly enquire into the chemical structure of a medicine and its effect on the body, omitting and not acknowledging quantum physics' studies about the energetic structure of atoms. They show that everything in this world is energy and that behind the atom is a vibration. This is just one of the diverse kinds of knowledge which homeopathy rests upon.

On the other hand, regarding the interfields relations, one of the characteristics of the dominant agents is their intention to have monopoly over the hierarchical structuration of the field, which is partially manifested in the specific logics of the value of the exchange rate and the hierarchization of the different species of capital which makes it “irreducible to those that regulate other fields” (Bourdieu and Wacquant 1992:97). The level of autonomy or specificity of the field is decisive in the demarcation and endurance of its boundaries: the more autonomous one field is, the membership entrance in the play, which follows uncoded and nonexplicit rules and regularities, is more restrictive and maintains the level of selective inhibition or institutionalized barrier very high, which sheds light on the utilization of the exclusionary politics in the field (Bourdieu and Wacquant 1992). This is why biomedicine and CAM as systems of medical knowledge and practices are in different contexts given different names. I will come back later to this when I analyze narratives of biomedical doctors about their knowledge and opinions about CAM.

One of the ways in which biomedicine creates autonomy and exclusivity and maintains its boundaries within a network of labor structures in the medical field are high selectivity of medical training, jurisdictional measures, control over claiming medical competence, evaluation of skills and qualifications system which enables medical doctors as a labor force

access to medical organizations in the same time constraining it to CAM groups. It has to be stressed that boundaries have both exclusive and inclusive aspects, meaning that they at the same time enable and constrain agency and communication in the field, following the rules of the field created by dominant groups or rebelling against them (Lamont and Molnar 2002).<sup>10</sup> It can be concluded that boundaries have the power to differentiate and integrate groups in various settings, the fact of which proponents of CAM are aware when they communicate with biomedical physicians and to the public in biomedical language as the language of medical professionals<sup>11</sup>, in order to “gain legitimacy and status” and which can be a sign of “the isomorphism” out of the necessity and as a indication of an accommodation strategy (DiMaggio and Powell 1983) and also as a strategy for accumulating capital following biomedical rules of the game and leading to the institutionalization of CAM due to its dominated position in the medical field.

Since the field forms a relatively autonomous social playground, “whose boundaries are dynamic borders which are the stake of struggles within the field itself” and which can’t be generally determined, but only through the methodological inquiry into specific historical case they can be defined, Bourdieu proposed to construe it as limited “space within which an effect of field is exercised” to be able to empirically detect the boundaries as they prove themselves as “the limits of the field ... situated at the point where the effects of the field cease” (Bourdieu and Wacquant 1992:100). These are the processes which have to be sociologically discovered since they are not always legally stated. Considering the boundaries between biomedicine and CAM in Croatia, they are not jurisdictionally stated because

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<sup>10</sup> For example, when The US National Center for Complementary and Alternative Medicine (NCCAM) explains the term “integrative or integrated medicine” (2006) in one part of its website they state that “integrative medicine is a total approach to care that involves the patient's mind, body, and spirit” which “combines standard medical treatments with CAM practices that have shown the most promise”, whereas in another section they that “integrated medicine” is “an approach to medicine that combines treatments from conventional medicine and CAM for which there is some high-quality scientific evidence of safety and effectiveness”.

<sup>11</sup> For biomedical communication can be said to be the standard and highly valued language variety among medical occupations. As Byron J. Good (1994:70) described, biomedical education implies “not simply the incorporation of new cognitive knowledge, or even learning new approaches to problem-solving and new skills. It is a process of coming to inhabit a new world ... in a deeper, experience-near sense”.

complementary and alternative medicine is not yet statutorily regulated, and the struggle for the legitimate criteria of its regulation, both on its material and symbolic level, is active in the medical field.

As I have chosen to use the notions of biomedicine and of CAM among other possibilities, and to approach them as medical systems on the one side, interweaving them with other social phenomena, such as boundary-work and dominance, on the other side, I find it necessary to explain the reasons for making this choice and to elaborate on these concepts more thoroughly.

#### ***4.2. Medical systems in the context of medical pluralism***

According to Foster and Anderson (1978:36-38) the medical system is composed of “disease theory system” and a “health care system”. The disease theory system embraces explanations about what health and diseases are and the understanding what causes them, while the health care system consists of social structures in the context of doctor-patient relationship (Baer, Singer and Susser 2003). Baer et al. (2003:8-9) argued that medical system comprises of “beliefs and practices that are consciously directed at promoting health and alleviating disease”, and as such is immersed in social spheres of a culture. This point allows for the medical system to be conveyed as a socio-cultural construct and as such construed as a system of culture. As it is culturally linked phenomenon, medical system has its position in society which is situated within and overlaps the economic, political and religious spheres. Biomedicine and CAM, from this perspective, can be approached as socio-cultural entities which function as systems within and through which cultural meanings are expressed (Kleinman 1995). I want to move beyond this and expand theoretically, approaching medical systems as systems of knowledge and practices, believing this is a problem related to the knowledge production, its sources and value polarization present in a medical field.

### 4.2.1. Biomedicine

The foundations of biomedicine rest upon the classifications of medical conditions into categories and subcategories, while fragmenting social relations from the health-related issues and thus perpetuating arbitrary dichotomies (Agrawal 1995), which I will show later to be as one of the techniques of claiming dominance over CAM healing modalities.<sup>12</sup> To be more specific, biomedicine utilizes biological definitions of pathological medical conditions, contextualizing them in some sort of a ahistorical vacuum, as it doesn't take into consideration all effects of culture and social relationships and suppresses in this way the fact that the state of people's health is very much "depending upon their access to basic as well as prestige resources" of one's society (Baer et al. 2003:6; Kleinman 1995).

It has to be mentioned that in biomedicine, as in the medical system, is much more attention given to actual procedures and algorithms of curing in medical technological settings such as hospitals, clinics and various specialist medical centres, while pushing aside the prevention part of dealing with the health of populations.<sup>13</sup> While reporting on biomedicine, social researchers included a wide array of taxonomies, referring to it as allopathic, cosmopolitan, western, regular, scientific or modern medicine (Baer et al. 2003:11). As Foucault (1975) described, biomedicine developed in Europe and as such is not socio-culturally neutral construct.<sup>14</sup> The scientific knowledge as an epistemologic basis of biomedicine is not in friendly relations with spiritual aspects of human practices. It can be concluded that spiritual and somatic aspects of CAM practices are linked together, which is not the case with

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<sup>12</sup> According to Alan Radley (1994:9) biomedicine "applies the concepts of physiology, anatomy and biochemistry to questions of the origins and treatment of disease. The methods of biomedicine are those of natural science, and its assumptions about the onset and treatment of disease are recognizably those concerning cause and effect relationships. It rests, therefore, upon a dualism of mind and body, privileging the latter through reducing all problems to its pathologies, which are understood as disease".

<sup>13</sup> Cartesian dichotomy between body and soul and the reductionistic explanatory mechanisms "radically separate the body from the nonbody" (Baer et al 2003:11-12).

<sup>14</sup> Baer et al. (2003:12) argue that is "constitutes the predominant ethnomedical system of European and North American societies and has become widely disseminated throughout the world". Biomedicine embraces institutionalized concepts and attitudes, which are produced and reproduced through medical education, scientific research and medical work in the doctor-patient dyadic relationship, and as such it is value oriented system of knowledge and practices (Kleinman 1995).

biomedicine, in which aspects of ideology, having its origin in the scientific knowledge, and material aspects of its practices are inherently linked.<sup>15</sup>

#### **4.2.2. Complementary and alternative medicine**

In “Varieties of Healing: A Taxonomy of Unconventional Healing Practices”, David M. Eisenberg and Ted J. Kaptchuk (2001) noted that there is no homogenous definition of CAM because it is an entity composed of distinctive healing modalities, which allows the space for many different ways of their classification and categorization. I will point out only a few of them.<sup>16</sup>

Eisenberg and Kaptchuk (2001) proposed a taxonomy which hierarchizes the CAM on the basis of their distinctiveness or closeness to biomedicine, to be able to have a look at a bigger picture of the phenomena related to the pattern of medical pluralism, while Gary Easthope (2002) next to the classification of CAM users, created an overview of CAM healing modalities.<sup>17</sup>

The World Health Organization, when it acknowledged the importance and problematic of CAM, proposed the most legitimate definition of CAM currently present in the global medical field. For the WHO, CAM is primarily an addition to the biomedical way of dealing with a disease. In this way, the WHO constricted the interpretative space in the construction of the meaning of CAM, dispossessing the term from the notion of “alternative” and from its original function and calling it “traditional medicine”.<sup>18</sup> Although the term

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<sup>15</sup> As McCarthy (1996:45) noted, and which can be connected with the structure of both biomedical knowledge and practices within various medical organizations, such as hospitals and clinics, “ideology provides the most fundamental frameworks through which people interpret experience and “live” the conditions available to them”.

<sup>16</sup> According to Yael Keshet (2009:132), CAM is the most used term by social scientists and which describes “practices that lie outside the dominant medical orthodoxy”, “a diverse group of health-related therapies and disciplines that are not considered to be a part of mainstream medical care”.

<sup>17</sup> See Table 3 in the appendix for the Gary Easthope’s classification (2002) of CAM.

<sup>18</sup> While elaborating on CAM, the WHO explained the term traditional medicine as “the sum total of the knowledge, skills, and practices based on the theories, beliefs, and experiences indigenous to different cultures,

traditional medicine combines various aspects of healing methods, such as energetic and mind-body aspects, and denotes both alternative and complementary therapies, it implies a history of the method, of its use and cultural linkage. This generic term could be appropriate to use for the medical systems such as Chinese, Japanese and Tibetan medicine, and maybe not so appropriate for the specific healing modalities which are not so old and bound to peoples, nations or old civilizations, but which could be bound to specific sub-cultural and class groups in the modern society, and as they are relatively young disciplines, such as Alexander technique, Feldenkrais and Mind-body centering.

The taxonomies mentioned by Kashet (2009:132) are the productions of The UK House of Lords Science and Technology Committee, who in the Sixth Report in 2000 classified CAM into three subfields<sup>19</sup> and the one of The US National Center for Complementary and Alternative Medicine (NCCAM) who divided CAM five categories.<sup>20</sup> This latter classification together with Easthope's (2002) serve as a foundation to my research.<sup>21</sup>

The term CAM, as used by social researchers, reports on two distinct characteristics of the healing modalities as follows. "Alternative" in CAM means that its healing modalities can serve as a total surrogate to biomedicine, denoting the possibility of the choice in the medical treatment, while the notion of "complementary" denotes the possibility of a supplementary practice that creates completeness or wholeness in the treatment. Also, in use is the term

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whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness", while presented CAM in either/or way, as it follows: "The terms "complementary medicine" or "alternative medicine" are used inter-changeably with "traditional medicine in some countries". They refer to a broad set of health care practices that are not part of that country's own tradition and are not integrated into the dominant health care system".

<sup>19</sup> See Table 1 in the appendix.

<sup>20</sup> See Table 2 in the appendix.

<sup>21</sup> According to NCCAM's classification (2006) acupuncture is an element of traditional Chinese Medicine so it fits into "whole medical systems", together with homeopathy, traditional Chinese and Japanese medicine, and New German medicine, whereas shiatsu therapy and aromatherapy are part of "manipulative and body-based practices", reiki and bioenergy are considered to be biofield therapies.

“integrative medicine” which denotes a medical system in which treatments are provided in a collaborative work of biomedicine and CAM.<sup>22</sup>

#### **4.3. Biomedicine as a system of knowledge-as-practice-as-culture**

Biomedicine is not a neutral and objective medical system which is culturally independent or socially detached entity (Farmer 2003; Foucault 1975; Good 1994; Kleinman 1995). Its division of somatic and spiritual aspects of human beings and concomitant classifications of its medical knowledge, which originate from these specific reference points, deny other views and approaches to reality basically other medical knowledges. The medical field, dominated by biomedicine, assured that its external as well as internal boundaries are demarcated sharply because no social-cultural relations can be included in the explanation of the causes of diseases, and causal factors of diseases reduced to biological processes in the body (Kleinman 1995).

The nature of knowledge, its constant state of flux and its traditional aspect – meaning histories of knowledge production, reproduction and distribution in the society – are much examined by Fredrik Barth. Barth (2002) believes that his framework allows the analysis of various forms of knowledge, from native to scientific form of knowledge, through the extrapolation of three elements of knowledge which are overlapping and co-determinous.<sup>23</sup> His conceptualization is useful as it honours two sides of the phenomenon – both structure

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<sup>22</sup> In this research not one of the informants used the term “integrative medicine”, not even the practitioners who are trained both in biomedicine and CAM and use them in their practice. What I noticed is that when biomedical practitioners use the term “alternative”, they give it somewhat a sarcastic tone which shows their attitude of non-acknowledgment and of refusal of the credibility of CAM, what is essentially different from the usage of the term by CAM practitioners, who give it more respectable tone giving away the dignity of their labor, even if it is not formally institutionalized.

<sup>23</sup> Barth (2002:3) believes there are “three faces or aspects of knowledge that can be analytically distinguished. First, any tradition of knowledge contains a corpus of substantive assertions and ideas about aspects of the world. Secondly, it must be instantiated and communicated in one or several media as a series of partial representations in the form of words, concrete symbols, pointing gestures, actions. And thirdly, it will be distributed, communicated, employed, and transmitted within a series of instituted social relations. These three faces of knowledge are interconnected.”

and agency – and allows for the explanation of how knowledge is being produced, reproduced and distributed in the social spaces. Thus, Barth’s conceptualization can be used to approach the medical system of biomedicine as a system of culture or a system of knowledge-as-practice. It can be said that biomedicine creates a specific belief or thought system, meaning its symbolic aspects, which it puts into practice in everyday action in the organizational settings, constructing the routes for manifestation of social relations, its material aspects, and thus creates specific relations to CAM.<sup>24</sup>

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<sup>24</sup> For Barth (2002:1) “the knowledge provides people with materials for reflection and premises for action. Thus the concept of “knowledge” situates its items in a particular and unequivocal way relative to events, actions, and social relationships. Knowledge is distributed in a population ... „



## 5. BIOMEDICINE AND CAM – THE STRATEGIES OF MARGINALIZATION IN THE MEDICAL FIELD

In this chapter I analyze the phenomenon of biomedical dominance and how it is exercised in practice by shedding light on the social construction of the boundaries of medical field, pointing to its state of flux and change.

### ***5.1. Biomedical physicians' knowledge about CAM - a definitional issue as a symptom of a boundary-work***

As I learned from my first informant from Bjelovar, I chose not to ask all of the physicians about their knowledge of CAM directly, as it proved to be quite inappropriate to do in all interview situations. This was emphasized in the conversation with the oncologist from Zagreb, which I will describe later in the text. When I came to conduct interviews with my informants I had to explain first “what I was searching for” and what this was study about, as they said that they didn’t initially comprehend the theme very clearly. I told them that I was interested in the relationship between biomedicine and CAM in Croatia. My answer introduced one of the main issues in the conflict between these two medical systems – the issue of incoherent body of definitions regarding CAM healing modalities. I was told that neither complementary nor alternative medicine currently exists in Croatia. The statement of my first informant – the doctor of internal medicine and epidemiologist from Bjelovar – could illustrate the problematic of co-existence of different medical systems in Croatia:

There is no appropriate alternative in medical treatment in relation to biomedicine. CAM has its place in the society, but has no place within medicine and current health-care system. You can’t expect of those two to work together in the hospital setting, because these things are irreconcilable – there is a web formed from medical equipment to specializations and subspecializations. It would be the same as if Jewish and Catholic priests would pray together in the Catholic Church.

Throughout our interview, this doctor was very irritated by my initial statement of purpose of the research and in defamatory tone used the word “alternative”, so I had to be very careful not to terminate, or restrict the natural flow of the conversation with the usage of this word. Moreover, I tried to find more neutral terms, such as “the unconventional medicine”, the expression which I started to use while referring to CAM. Unfortunately, this also proved itself to be the unsuccessful ethnographic maneuver as of young inexperienced anthropologist, who didn’t expect that will find such an emotionally burdened and controversial situation out in the field. When I started using the term “unconventional medicine” in my questions, the doctor answered that it is not medicine at all, saying that

Medics can only be those people who finish the Medical Faculty. When you say “alternative”, this word will create a nettle rash with my colleaguages. There is no possibility that some monkey without education can be alternative to me who studied for 6 years, who has 4 years of practical experience in the field, and who has 4 subspecializations. If he doesn’t have a clue about physiology and anatomy, how can he be an alternative to me? This is the established fact. It would be the same if I would say, for example, “an alternative sociologist”. Hitler was an alternative sociologist. These things are just disparate and incompatible.

Among so many interesting and relevant things this doctor expressed, he decided to describe to me in detail one of his first, and the last, experiences with CAM. Personal experiences and interest in CAM proved to be the main factors of the attitudes of openness and closeness towards CAM. For this doctor, to be professionally curious about CAM, was a dangerous pursuit, as the Croatian Association of Physicians threatened to revoke his work licence because he was taking part in the experiment of evaluating the effects of bioenergetic treatments. In the late 70s, in collaboration with a few other physicians, he conducted research with one of the most well-known Croatian bioenergetic practitioners. The research crew sent this CAM practitioner to the British Royal Society of Medicine, where they tested him to see if he had bioenergetic capabilities. As he passed the test, and as it was proven, that he has bioenergy, my informant and the rest of the doctors offered to this practitioner to choose

which medical condition he would like to cure. As he wanted to bioenergetically treat cancer, biomedical physicians forbade him this due to explicit rules preventing bioenergetic practitioners from working with cancer patients, so they collaborateively chose gangrene. They had 4 groups consisting of 33 patients, who proceeded to take medicines, but bioenergetic practitioner started to affect them with bioenergy. The following part of the interview describes the end of the experiment and the end of this doctor's interest in CAM.

What happened is that bioenergy had an analgetic effect, and that patients were freed of their pain, but what was common for all of them was that they all died suddenly. It is the truth that all those people were suffering from cardiovascular diseases and sudden death is more frequent in this field, but it makes you wonder what this bioenergy did that all these people suddenly died.

The Croatian Association of physicians sued him for the involvement in quackery and asked for his medical diploma to be revoked, but the fact that he didn't do it with the aim of creating economic gains saved him from the exclusion from the medical field. But this was not without consequences. He said that with this experiment he sealed his career in a way, because he wasn't allowed to give lectures at the Medical Faculty, and his interest in CAM finished with the end of these dramatic events.

Between the lines it can be read that the responsibility for death of people participating in the experiment, which is one one of the main material aspects of science, is given to the effects of bioenergy, whose treatments are even more underresearched from the rest of CAM practices, puhing aside the fact, as Gary Easthope (2002:336) noted, that "only a small proportion of othodox medical interventions – estimated as 15 percent – have been scientifically tested via randomised clinical trials (RCTs), and ... that only 21 per cent of conventional medicine's practices have a clear positive effect". In a deeper sense, it seems that this methodological aspect of the dominance from the side of scientific practitioners, which allows the production and reproduction of scientific facts and knowledge, enables biomedicine to create epistemological claims which are then transformed into rules of the

medical field. These have to be followed if cultural capital is to be converted into economic (Barth 2000; Bourdieu and Wacquant 1992; Good 1994; Taylor 1994). This is exemplified by the attempt of CFNES to create legal framework for the regulation, meaning the legitimacy of CAM, in which they tried to bypass all 'epistemological triggers' which could be too unconventional for mainstream biomedicine as well for the State, especially trying not to induce any kind of homologues with the religious field for example, due to the official attitude of Catholic Church in Croatia, who valorizes all CAM modalities as devil's deeds. I was personally present at a few spiritual seminars organized by the Croatian Church, in which priests actually repeated these statements. My CAM informants, and the biomedical doctors who are more open towards the collaboration with CAM think that the official attitude of the Church influences on some level the state politics and that this is one of the hindrances in the statutory regulation and professionalization of CAM. Deborah Lupton (1994:127) raises the issue of the identity shift. If CAM practitioners adjust both their conceptual classifications and practices in order to become professionalized and integrated into national health-care system, there is a tendency to lose their identity of complementary and alternative medicine, blurring the boundary with biomedicine, for example regarding the doctor-patient relationship.

Two others examples point out the importance of personal experience for the interest and knowledge about CAM. A young specialist in surgery from Bjelovar (Dr J) revealed his interest in CAM when we were approaching to the end of our conversation and after I turned off the voicerecorder. Dr J had a near death experience and was clinically dead for 9 minutes. Since that time, he says, he has been able to see when his patients will die. As he doesn't speak about this experience to anyone, especially not to his colleagues, and doesn't share his knowledge and understanding which came out of it, conversation with me was in a way a catharsis for Dr J. Although he classifies CAM into the domain of beliefs and not in the knowledge-as-practice phenomenon, he himself provides the depth of his interest in CAM.

I don't have any kind of training in CAM, but I believe it exists. When I was clinically dead, I was aware even then and was witnessing everything what doctors were saying. I was in the space which is so blissfull. It can not be expressed in words. What surprised me is that light tunnel about which people who had similar experiences as I did speak about. This tunnel of light is not horizontal, it is vertical. From that time I am asking myself why I was brought back to life.

This doctor who incorporated this out-of-body experiential knowledge, hasn't vast knowledge about CAM, but is open toward complementary collaboration of particular practices, such as acupuncture, chiropractry and herbal medicine. For him, Reiki and bioenergy, should not be part of CAM, as they are as he said, self-help techniques. Also, he received Reiki treatments, and they helped him, so he has an attitude formulated on the basis of his own experiences. Furthermore, as from the beginning he was very open and was comfortable to be with, as situation allowed, I asked about his general opinions about CAM. In the beginning, he asked what do I mean by this term, because this phrase in his opinion embodies, not mainly practices, but people who present their work as medical practices, and which for him are not medical at all; nor are these people trained to do such work, such as chromotherapy or colour healing. He was basically mocking practices and practitioners of CAM who use more immaterial techniques of healing such as bioenergy, saying that:

CAM doesn't have tangible evidence. Feel the red colour, close your eyes and I will cure your suffering. How is this possible? This is an official question – how can you with the hand crossing over one's body cure patient's cancer? I want him to show me how he did it, I want him to prove me that he did it. CAM lacks these material evidences.

While inquiring into biomedical physicians' knowledge about CAM, they reported, to different degrees, their ignorance and unawareness of the existence of significant parallel medical realities. They didn't not acknowledge the legitimacy of CAM, with the exception of acupuncture. As it is demonstrated from the narrative of the surgeon from Zagreb, the inferiority, in the sense of the lack of scientific evidence of efficacy of therapeutic procedures, is claimed to CAM, the discourse which is utilized as an 'exculpatory panacea' for biomedical

physicians' ignorance about other medical systems with which they compete in the medical field, and which is not so obvious at the first sight. Behind this strategy is hidden that which is not said, and that is the issue of the lack of the scientific knowledge about the synergic processes of CAM and biomedical medicines and the issue of security of the patients who use them.

The surgeon from Zagreb (Dr P) was very strict in these regards. He told me that when he communicates the diagnosis of the disease to his patients, they often ask him for advice about the possibilities of alternative treatment, for example, is there a way of dealing with their medical condition with different herbal remedies or can they feel better with changing the eating habits. In his own words, he said that he usually answers them like this:

I am a doctor of traditional medicine and I don't know anything about herbal medicine or other alternatives to biomedical treatment. I can't give you any advise of this kind, I can give you an advise from the perspective in which I was trained, traditional medicine. I think there is no alternative to a surgical procedure.

Then while talking on this subject, he himself was motivated to say that he thinks that CAM doesn't work, and that he doesn't believe in them; as he didn't have any experience with it, his knowledge is very poor about it and that cognitions about it hardly exist. And then, the moment of real authoritarianism came as he said the following:

I have never heard of the positive examples of treatment with CAM, but I could say that one of the negative sides of patients using it, is that they postpone surgical treatment and it happens that they come to us in a late phase of a disease when there is hardly anything that we can do. They go to herbalists who use who knows what kind of remedies considered to be an alternative to traditional medicines and to chemotherapy. Our conversation ends when they say they reach for something alternative.

Dr P doesn't hierarchize CAM practices in regards to the presence or lack of the evidences of efficacy of CAM treatments and amount of research made on it. Because he is not interested in CAM, he doesn't know anything about it, and his attitude of total refusal of CAM is to a large extent a manifestation of the absence of the cognitions about anything related to medical pluralism, meaning parallel medical systems. The absence of knowledge about CAM

therapies accompanies concurrent attitudes of refusal of CAM and physicians' inability to provide directions and informations to patients when they are curious about the possibility of alternative types of treatment. Moreover, this way of recreating limitations which could lead medical field into regression can be construed as one of the aspects of the absence of socio-cultural support for the patients, who rely on themselves to judge what is good and what is not good for them. As doctors who are more open towards CAM said, patients don't speak with doctors in general about their experiences with CAM out of their fear of doctor's temperament: that they fear doctors will get angry and belittle them. As my informants reported on, there were cases when people used certain CAM therapies after which they came to the hospital because their state worsened. But what is interesting, those people were not practitioners of CAM, they were mainly older people who do some form of croatian folk healing, or have natural abilities and concomitant knowledge needed for bone-setting for example. In Croatia, folk medicine and its remedies are still popular among rural population, on the one hand, while CAM is being misconceived as a part of folk treatments, especially when doctors speak about grannies who have natural talent to be bone-settlers and speak about them as false and uneducated chiropractors, as non-knowers of medical practice. This is in one way justified, because there are great number of self-qualified "alternative practitioners" in Croatia who use this grey zone of the lack of state control over CAM, to achieve primarily financial gains and trick the people by not giving them appropriate treatment due to their lack of sincere intentions and necessary qualifications.

Both surgeons from Zagreb and Bjelovar consider biomedicine to be traditional medicine. This is important because biomedicine and CAM as systems of medical knowledge and practices, which are inherently socio-culturally based, are in different contexts and among different groups given different names. My biomedical informants called biomedicine classic, conventional, allopathic, scientific and evidence-based and even referred to it as a traditional

medicine, while they spoke about CAM using terms such as non-conventional, non-scientific and non-evidence-based. On the other hand, CAM practitioners refer to biomedicine as Western, orthodox, classical and conventional medicine. These binary distinctions, either/or dichotomous ways of classification prove themselves to be one of the strategies utilized in the institutionalization of social boundaries in the medical field, which are dynamic and polymorphous in their essential nature (Kleinman 1995, Mizrachi, Shuval and Gross 2005). This strategy gives to the dominant groups in the medical field, the epistemologic resources and power to control the entrance and participation in the field, marginalizing proponents of CAM as outsiders (Bourdieu and Wacquant 1992; Keshet 2009; Merton 1972).

As Dr P from Zagreb concluded his opinion about the preferences of CAM therapies,

acupuncture is classical medicine and we can't call it really "alternative". But if it is classified as "alternative", then the green light goes only for it, because it is checked and proved as valid. This is manifested in the structure of some hospitals, in which some of them have anesthesiologists who use acupuncture as a way of relieving pain, so it is almost as traditional and conventional as any other biomedical branch. I can rationally justify acupuncture, while for the rest I don't have the experience and I can say they don't have real effects and they stand in the way of people getting traditional [biomedical] treatment which can help.

One of the additional reasons for acupuncture to be regarded as biomedicine is that CFNES and International society for traditional medicine Belladona from Slovenia, and in collaboration with The Academy for traditional Chinese medicine from Peking, organize the International School of Acupuncture, Acupressure and Electroacupuncture. The training in acupuncture is designated to be a part of biomedical doctors', veterinarians' and dentists' education, while Acupressure, Electroacupuncture and Tui-na therapy are offered to anyone who is interested in these healing techniques. The Commission for the medical training of the physicians of the Croatian Association of Physicians categorized and evaluated this experts' assembly for the physicians attendants as follows – active participation delivers 16 points, and passive one 15 points. Lecturers are doctors of biomedicine, an anesthesiologist, the doctor of internal medicine and acupuncturist and the doctor of veterinary science. After they finish this



training, attendants have to pass the final exam after which they get a diploma or certificate, aligned with the demands for special knowledge of Slovenian Physicians' association and with the World Health Organization. After this training is accomplished, attendants are offered a possibility to take part in the additional specialization in China at the Academy of the Traditional Chinese Medicine in duration of approximately 2 to 4 weeks.

I devoted space to these narratives because they represent important points which I would like to discuss further in the thesis. I can summarize all the answers coming from biomedical doctors in regards to previously presented problematic. Their knowledge of CAM overall is not extensive, but I find that, in different degrees, that every specialist assumes which CAM healing modality could be beneficial to use in addition to their treatment. For example, an othopedist from Bjelovar has a colleague who uses manual therapy in his practice, and Dr K recognizes this therapy to be appropriate to use in a complementary sense.<sup>25</sup> The psychiatrist from Bjelovar Dr G has a knowledge about the practices which would be the most, and those which would be the least, beneficial for her patients to combine with psychiatric treatment. According to doctor G, for psychiatric patients CAM therapies which are more focused on the somatic aspects of relieving pain, such as shiatsu theraphy, would be most appropriate, and bioenergetic therapy and transcendent meditation would be the least appropriate to use, as the latter "open the crown chakra even more, and are not good for the people who have troubles with testing reality". As it can be seen, this doctor speaks in the language of CAM, embracing the energy physiology from the energy therapies. Later in the conversation she told me that CAM, more specifically bioenergetic therapy, was one of the main reasons why she went to medical school. She wanted to expand this interest and knowledge but she said that she doesn't want to "fight with the windmills" or does lose her energy on proving something to her colleaguages and be ridiculed by them and risk her status

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<sup>25</sup> The area of application of manual therapy coincides with the one of orthopedist's, who has later in the conversation told me that he has finished a school of acupuncture but that he doesn't have conditions, mainly enough time, to use the both methods in his practice.

in the professional community. She also described to me how she treated her skin which was full of pimples only with the power of her hands and energy, but didn't provide bioenergetic treatments to anybody else except to her husband and to a friend. Personal interest and experience proved themselves to be one of the important factors which influence doctors' extent of personal and professional interest in CAM and influences the direction of their concomitant further research and trainings in CAM. From this point, my informants spoke about the criteria of regulation of and possible collaboration with CAM. All three aspects of the boundary – organizational, professional and epistemologic – are made visible in the analysis of narratives what I do next.

## ***5.2. Views on appropriate settings in which to provide CAM treatments and education***

I started to pose the introductory questions which were concerned with physicians' education and with their job. More specifically, I asked them about the amount of time spent in current practice, what do they do and what kind of medical conditions they are dealing with. They all had the same basic training in Medical school, but different specializations, subspecializations, post-graduate and PhD trainings; they were all members of the Croatian Association of Physicians, the professional organization of medical doctors which provides them with licences for working as a biomedical physician. While we were talking about their patients, I used this point as an opportunity to ask the physicians if they had patients who go to CAM practitioners. This is the point where our conversation really began.

### **5.2.1. Professional aspect of the boundary in the medical field**

The divide between skills and knowledge in the medical field serves as one of the ideological bricks in the boundary wall between biomedicine and complementary and alternative medicine. While biomedical professionals are trained in various kinds of scientific knowledge which are legitimized by Croatian jurisdictional system, the training of complementary and alternative practitioners rests on different educational systems, levels of initiation processes or even on self-training abilities as in many cases healers claim to possess an intuitive knowledge about their practice. When I asked the master of Reiki how is the therapy learned and its knowledge expanded because there is no schools for it except short courses, he said the school exists and asked do I know the story about spiritual guides. As he wanted to communicate me his reality as a practitioner and socio-cultural aspects of Reiki, he said that

The transmission of knowledge starts with the transmission of symbols. When you receive them, symbols as such are not just letter anymore. They are the meaning. They are the quantities of informations which are somewhere inscribed and which you have to master. In order to master them you have to clean yourself energetically, you have to clean your illusions and prejudices. This is how you can get to the cause. And this is what symbols in Reiki do to you.

I asked him if he was learning anatomy, physiology, religious topics by himself; he said something quite noncommon-sensical for the biomedical doctors, as they were talking about this and similar aspects of hand-healing and energy therapies.

I can't say that I learned all these things by myself. Spiritual guides taught me. It was primarily a telepathic learning, not a learning from a book. In the last 5 years I haven't read a book and I can't read them anymore. The things we learn at Reiki seminars are part of the work, but only a surface layer.

Then I asked him if he thought that medical education should integrate Reiki in their curriculum. The Reiki master explained to me how the transmission of knowledge takes place in this CAM healing modality.

The knowledge is transmitted from the master inside of me to the master inside of you. The legitimacy of Reiki is accomplished through hereditary basis of education which we get from the master. These are individual learnings, and not organized learnings.

As he said, there are a lot of Reiki practitioners who don't have the knowledge of human anatomy and physiology, and are reductionist in a way and not as qualified as he is. This master of Reiki has a biomedical knowledge of the functioning of the human body, which can be seen as a form of educational, and thus cultural capital, which enables him position-taking manoeuvres in the medical field. As Reiki shares with bioenergy therapy the positions which are the farthest from the boundary in the medical field, this allows him to gain a higher status among other Reiki practitioners and convert this capital into the economic one.

At this point sociology of work translates itself into a sociology of knowledge because "all work presupposes...the practice of knowledge": biomedical institutions established on "the social and economic organization of practice" occupationally control "what knowledge can be employed in work and how that knowledge can be exercised" (Freidson 2001:27). Every medical specialization deploys this scientific-unscientific division of knowledge and skill through demand for a training which through practice reproduces the abstract concepts of biomedical knowledge. Furthermore, this affects medical institutions when organizing the division of labour. Concomitantly, CAM is called non-professional in some circles, reflecting one aspect of boundary-making process. Doctor of internal medicine demonstrated this problematic, as he experienced it in his practice, as follows.

A medic can't be someone who finished The faculty of technical engineering, because medicine is a profession, for God's sake. It is different if someone has supernatural abilities which can be of usage to others. Then, he has to undergo to specific investigation in order to see for what conditions can his abilities be used in a beneficial way on one side, and in which situations can they be harmful.

This is also one of the strategies how the biomedical profession, as a complex and coherent system of skills, trainings and qualifications strongly linked to educational system and other ways of certification, in the course of gradual developement through phases of

social time, exercises power over the knowledge and practices of alternative medicine and maintains the expert-lay aspects of the boundary between them (Abbott 1988; Freidson 2001; Fujimura, 1998).

### **5.2.2. Organizational aspect of the boundary**

As biomedicine and CAM are founded on two epistemologically different medical philosophies, belief and thought systems, and accompanying approaches to health and illness, diagnosis and therapy, the question is how is the organizational aspect of the boundary defined. In medical organizations, such as hospitals, professional aspect of the boundary making helps this process be put into practice.<sup>26</sup> The autonomy of the medical organizations was emphasized when I asked the question if collaboration of biomedicine and CAM is attainable. The first thing biomedical doctors talked about were the epistemological differences and the lack of skills which come from biomedical education as requirements for entering the labor market. Following these interviews, it can be concluded that this serves as a foundation for claiming the social and political illegitimacy of CAM and the dominance of biomedicine over the labor market. It seems that biomedical organizations hold an epistemological monopoly and a socio-cultural (i.e. political) power; they protect the access to capital resources against competitors. The source of their power comes from the claim that biomedicine is the only legitimate medical system because it is evidence-based, meaning that it is a scientific knowledge (Agrawal 1995; Fujimura 1998; Shuval and Mizrachi 2004:6).

Dr J described his attitude towards the collaboration with CAM as follows.

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<sup>26</sup> As Rosenberg (2002:250) notes, medical organizations, especially hospitals, became social locations “for research, education, and the delivery of care ... and for the development of elite medical careers ... As disease classification is created, it organizes the relationships among machines, experts, caregivers, and patients in the hospital, creating a structure of seemingly objective priorities and practices. They have provided a language as well, enabling and structuring communication among different sectors of the health care system”. Furthermore, he showed how disease conceptualizations provide a basis for creating a social order in the hospitals (i.e. the hierarchization of social relations within its labor structures).

When I work in hospital, I have to follow rules which are formulated by my medicine, and I have to fight with it, but when I am in the role of a civilian I have an attitude which forgets the previous statement. Then I say the following – Go first to an alternative practitioner, relieve your pain at chiropractor or an acupuncturist and then come to us [surgeons]. The latter is the attitude which I put in practice only towards my friends and acquaintances. When things are official, then because of the ethical code which is something like ethical necessity, I have to advise only the treatments in biomedicine. Go first to alternative field, try everything else and then come to me. I am your last station, I cut you.

For him, there is a possibility of cooperation with chiropractors and acupuncturists, and his attitude is encouraged by the fact he has patients who informed him of the good results of synergic usage of these methods. But because of the ethical code, the unwritten rules and the professional climate which is 'prescribed' by the Croatian association of physicians, doctors who are open towards collaboration with CAM, choose not to orient their actions in that way but to follow the routes which bring them capital.

Attitudes of openness or closeness towards CAM of biomedical doctors in my research range from complete refusal, as in the case of the oncologist and a surgeon from Zagreb, to varying levels of acknowledgement and approval. At its worse, as stated by the oncologist from Zagreb, CAM and biomedicine are incompatible organizationally. Questions in which I asked for what medical conditions it is beneficial to use CAM emphasizes the construction of the organizational aspect of the boundary. Since doctors indicated the informal collaboration with CAM practitioners, I asked on what basis they chose which practitioners they send their patients to. They all agreed that personal contacts are the most important factors. One said, „if I know a good practitioner, whom I personally know and only if I am convinced that he is professional and knowledgeable enough, then I can send my patients to him.” In turn, when I asked CAM practitioners to whom they could collaborate, with which specialists of biomedicine, they reported the same. In the words of the aromatherapist from Zagreb:

It seems that I don't make such distinctions among specializations. The fact that somebody is a doctor doesn't make him a good person. A doctor has to be a normal and natural person and in a good psychosomatic condition. I have the best opinion

about the people who love their work, who respect the ethical code, who invest in their education and who have a good intention towards their patients. If these preconditions are satisfied, I find that then all therapies are good. This human factor is the most important.

It seems that in the absence of statutory regulation and official collaboration, these informal ways of communication substitute formal and official ones (Shuval and Mizrachi 2004:6).

One of the most frequent arguments of biomedical doctors against the integration of CAM into formal health-care system is the absence of cohesion among CAM practitioners, saying that they are not structurally organized and can't function without it. That is why, some of the informants said, the state didn't want to deal with the professionalization of CAM and its social inclusion in the health-care system. Furthermore, biomedical doctors stated that too complex differentiation between CAM modalities (i.e. different epistemological basis coming from different health philosophies, ways of education and transmissions of knowledge etc.) makes these processes more arduous, especially when it comes to the comparison of practices for the sake of collaboration and their assimilation into biomedical structures (Kelner et al. 2004).

Maybe because of this, CFNES responded with the classification of CAM practices, as a political move with the goal of entering the legitimate side of the field. On the one hand, CFNES organizes the CAM part of the medical field by classifying it into three broad categories – natural, energy and spiritual medicine - on the basis of means which are used in healing practices in order to bring people into balance and natural state of being. It is written on their webpage that this is the only valid way of classification and that all others are wrong because it is not appropriate to produce classifications depending on “some descriptive and too generic characteristics, such as acknowledgement from the side of official institutions, forms and length of education, groups of people who use the methods, in addition to tradition,

the possibility of commutation or supplementation to biomedicine or classical medicine or even the holism of the approach”.<sup>27</sup>

As classifications can be seen as instruments of power and the source of domination (Agrawal 1995; Bourdieu 1991), as divide and rule principles, they can also be seen as means for the construction of the resistance strategies from the side of CFNES. With the process of categorization, the CAM part of the field is dissected into subfields and the participation in the boundary making is being given. It seems that the CFNES, as it advocates the non-legitimate actors in the field, structures the CAM side of the boundary through the utilization of non-discriminatory policy, meaning an open-access to wide range of people who fit into one of the three generic categories, which is in the end a political act.<sup>28</sup> As for the chiropractry, and the most of CAM methods, there is no official licensure on the state level; professionalization of CAM is blocked, whereas this blockage serves as a firm ground for the institutionalization of the epistemologic aspect of the boundary in the medical field. Although CAM is not statutory regulated, the restriction for entrance into the legitimized educational system can be seen as a way of informal or indirect control of CAM practitioners through further emphasizing of the expert-lay division among practitioners, which in turn gives the power to biomedical doctors to claim the exclusivity in the certification of skills. Furthermore, CAM practitioners, whom are in this way ascribed the roles of outsiders in the educational and medical field, are kept away from the labor market and the boundary is achieved on organizational, professional and epistemological level.

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<sup>27</sup> See [www.huped.hr](http://www.huped.hr)

<sup>28</sup> The logics of the organization is manifested in this non-discriminatory capacity and makes visible its internal interests, as my informants complained about, when they described how CFNES utilizes this open-access politics in order to increase the number of its members, who have to pay the membership and in this way keep the organization functioning, but get nothing in return except the advertisement on CFNES's webpage. The external interests could be that in this way they protect the authenticity of their side of the field, through appropriation of classification system which is used to distinguish the CAM groups from each other, on the one hand, and through concomitant epistemologic characteristics and accompanying language of specific group (i.e. ontological differences) they position themselves in the field and communicate with the biomedical specializations, when it gets to overlapping areas of treatments for example.



On the other hand, it can be concluded that work structures of biomedicine utilize their epistemological and jurisdictional dominance through the legitimization of biomedical expertise and biomedical knowledge, as “a formal knowledge that is rooted in fundamental values”, through “active claims put forth in the public, legal, and workplace arenas” (Abbott 1988:87). It seems that this allows the biomedical profession to be exclusive and to structure of the body of medical knowledge and its translation into a system of practices, thus controlling the organizational, professional and epistemological aspect of the boundary in the medical field (Kelner et al. 2004; Lamont and Molnar 2002).<sup>29</sup>

When I asked whether CAM should be part of national health-care system, almost all of the physicians answered that they didn’t think so due to various reasons, such as the following narrative of the surgeon from Bjelovar.

CAM will never enter the field of biomedicine, because traditional medicine (he refers to biomedicine as traditional) is based on clearly tangible evidences and experiments which are iterative and CAM is everything else but this. Not one biomedical physician in the world will admit that human being has 7 chakras, that these chakras conduct electricity and light, and that’s why CAM will in Croatia always be at the margins, and will never become the main medicine, that’s why it is called alternative in the first place. Classical medicine has its origins in Greek culture, its results are tested, published in relevant world journals, scientist cite one another, on the basis of their works new methods are being established, and CAM as a system is not valued in biomedicine as an achievement.

I asked him: do you think that there is a dominance? He answered that “everything in the knowledge of biomedicine can be used as a tool for the dominance over CAM”. More laconically,

Centuries and centuries of people who cured, who did medical operations, for whom it is proved that their methods actually cure – and this is what is tangible, simple facts. Now these procedures are prescribed by WHO. The most important are centuries of experiential practice and the knowledge how and in what conditions to treat. And there are congresses, new methods and new approaches are created ...

<sup>29</sup> In some cases, the orthopedist and chiropractor deal with the same medical conditions, but while the orthopedist deals with the disease, chiropractor deals with the illness. But, biomedical way of treatment implies educational and thus cultural capital whose value is much higher than that of chiropractry, for which schools in Croatia don’t exist. It apperas that the educational system legitimized by the state provides an epistemological power when dealing with medical conditions, as it is a homologous interfield interplay: one of the obligations of the state is to provide the health and well-being to its citizens, but it has showed little interest in CAM (Kelner et al. 2004). It seems that the educational system systematically reproduces the state interests through its close connection to the social organization of the medical profession.

When I was talking to him and the other biomedical doctors, they were all claiming that there is no alternative to surgical operation when it comes to certain medical conditions. When they were talking about this, their tone of voice was giving away the fractious context of defending the status and legitimacy of their practice, in Bourdieu's words, their position. They didn't know that all CAM practitioners whom I interviewed stressed exactly the same – that there is no alternative to surgical procedures – whereas the significant difference was that CAM practitioners, as the bioenergy practitioner from Zagreb said that he

could collaborate with the surgeons, but only in the context of pre- and post-operative procedures in order to prepare the patients for the operation and to help the wounds to heal faster. CAM overall is beneficial for long-term suffering and chronic illness, pre- and post-operative procedures, relaxation and relieving of stress and many other medical conditions, as well as for many other spiritual issues which are human beings facing with throughout the course of life.

In the end, according to all CAM practitioners who participated in this research, in the context of collaboration, biomedicine is said to be appropriate for acute illness and traumatic injuries and emergent cases; surgical treatments are irreplaceable and computer analysis in diagnostics is one of its particular strengths.

### ***5.2.3. Epistemological aspect of the boundary***

It appears that the epistemological aspect of the boundary is the aspect of dominance which encompasses all aspects and holds the boundary together. CAM healing modalities are recognized as epistemologically unacceptable as they contradict and interfere with biomedical models of knowledge, which is detected from three basic discourses - the discourse of scientific research of CAM (randomized controlled trials), of placebo effects and of the diagnosis.

#### **Randomized controlled trials and placebo effects**

In biomedicine, controlled randomized trials are instruments of knowledge validation; they have the power to delegitimize other medical knowledges. The attitudes of biomedical

doctors are based on the possibility of CAM treatments to be evaluated by RCTs which can deliver the evidence of placebo effects which devalidate and delegitimize CAM knowledge and on the ability of CAM practitioners to make a proper diagnosis (Shuval and Mizrachi 2004:2).<sup>30</sup>

Biomedical doctors disregard CAM therapies in general, because “there is no scientific research about their efficacy” (i.e. they weren’t tested by RCTs).<sup>31</sup> There has much work been done about the inappropriateness of RCTs to be applied for the research of CAM therapies (Keshet 2009; Shuval and Mizrachi 2004) due to the different foundations, both material and symbolic, on which these medical systems rest upon. But here one contradiction can be observed. On the one hand, the biomedical community asks for the official scientific evidence of effectiveness and safety of CAM, while on the other hand puts constraints and sanctions on those who engage in these researches, as it was in the case of the doctor of internal medicine from Bjelovar who had almost lost his work license.

While biomedical practitioners utilize the discourse of placebo while talking about the inefficacy of CAM therapies, CAM practitioners on the other hand talk about nocebo effects of biomedical treatments, how people believe in both epistemological and existential power of diagnosis, especially negative ones, and usually their state worsens, and out of the despair they ask for more medicines. The general practitioner and acupuncturist from Zagreb, who deals a lot with the older population, claimed that

they trust so much in the biomedical point of view and trust in everything they hear from the pharmaceutical commercials and from their friends who also visit doctors too much, that they became medical consumers actually. They ask for pills for everything. I tell them that I am the doctor and tell them to walk more, to improve

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<sup>30</sup> The placebo process is considered to be a betterment in “the symptoms and/or physiologic functions of the organism as a reaction to non-specific and apparently inert factors”, and the nocebo is considered to be a deterioration in the previously mentioned (Teixeira, Guedes, Barreto and Martins 2010:120).

<sup>31</sup> Most of the biomedical doctors who participated in this research described their views on the legitimate position of CAM within the medical community, saying that they could accept these therapies if there was evidence of their efficacy and quality. Furthermore, they suggested that the responsibility for this falls into the hands of the State, that it is up to Ministry of Health in the first place to provide conditions, jurisdictional and social, for the examining of CAM on a scientific level and for the control of CAM practitioners, the real ones and for the phenomena of quackery (Kelner et al. 2004)

their life style, which can make an improvement in their conditions. They want to be cured from their old age, and that is impossible.

## Diagnosis

All knowledge has its function and use (Pickering 1992), and such is the case with the act of the medical diagnosis. According to Rosenberg, diagnosis is a medium of interaction through which medical system is legitimized and structured in the medical organizations; it connects the agency and structure, conceptual and practical. Diagnosis offers unified explanatory mechanisms which are a basis for patterned medical practices.<sup>32</sup> Without a consensus and codified classifications of the causal factors of diseases, he pointed out, for biomedical system, from education, research to hospital, there is no possibility of production, reproduction and distribution of “valid clinical knowledge” (Rosenberg 2002:245). In this way, it seems that disease classifications can serve as tools for the marginalization of those groups who don’t share the same conceptualizationa of health and sickness (Bourdieu 1991). Moreover, the biomedical way of diagnosis is highly technologically supported, which helps it to produce great amount of statistical data, which in turn seems to be objective knowledge produced by mathematical methods of inquiring into medical conditions (Rosenberg 2002:248).

Biomedical doctors claim the inconsistency on the structure of CAM practitioners, as well as the incoherence of elements of their practices, such is diagnosis. CAM modalities have their own distinctive way of diagnostics, but the difference is found in the attitude towards collaboration in regards to the aspect of diagnosis. Biomedical doctors utilize the discourse of diagnosis when they want to protect their ‘work territory’ and maintain the boundary, while

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<sup>32</sup> As Rosenberg (2002:240-241) claimed, “diagnosis is central to the definition and management of the social phenomenon that we call disease. It constitutes an indispensable point of articulation between the general and the particular, between agreedupon knowledge and its application. It is a ritual that has always linked doctor and patient, the emotional and the cognitive, and, in doing so, has legitimated physicians’ and the medical system’s authority while facilitating particular clinical decisions and providing culturally agreed-upon meanings for individual experience ... Diagnosis labels, defines, and predicts and, in doing so, helps constitute and legitimate the reality that it discerns.”

CAM practitioners talk about the diagnosis as the bridge which could connect biomedicine and CAM.<sup>33</sup> The doctors who have training in biomedicine and CAM and use them in their practice, and all CAM practitioners who participated in this research reported on the usefulness of biomedical diagnosis in their work. As the general practitioner and doctor of Chinese, Japanese and New German Medicine said:

the interaction, the communication with the biomedicine, must exist, especially in the sense of diagnostics, because then CAM and biomedical practitioners could cross-reference the diagnosis, as well as agree upon the prognosis and the further course of the therapy. This means that we could harmonize therapies so they could be of no harm to the patient, which is very much the case when there is no dialogue overall and about the synergy of the medicines.

### ***5.3. Conclusions of the analysis***

The narratives provided by my informants, both biomedical physicians and CAM practitioners, enabled me to become aware of the subtle underlying processes happening in the medical field regarding the communication between them. One of the first and most important findings was that, in spite of the fact that CAM is not statutorily regulated, some of the biomedical physicians in specific situations send their patients to CAM practitioners; thus biomedicine and CAM communicate in certain contexts, in spite of the absence of the formally institutionalized avenues and official rules of the professional and organizational collaborative communication.<sup>34</sup> These processes in a certain way 'magnetize' the social space within the medical field, constructing the cleavages in it, dividing the field on two, not so clearly as it seems, separated territories. This 'social magnetism', produced by the forces of

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<sup>33</sup> As it was mentioned before, randomized clinical trials as the only scientific way of validating the criteria of efficacy of treatments, meaning the legitimization of the medical knowledge, provides a basis for the concept of evidence-based medicine. From the nosology of the disease to the bureaucratic relations of the hospital, the act of diagnosis proves to be a social act with a great amount of power in it; it is, in Bourdieu's words, a position-taking. Biomedical diagnosis is a tool which is used to marginalize CAM ways of diagnosis and categorization of ills, due to the institutionalized power of its social function to be a medium for the manifestation of biomedical categories of diseases, which can be seen as the "symbolic instrument" (Bourdieu 1991:165).

<sup>34</sup> These phenomena served as a starting point in the process of social construction of the anthropological knowledge, as it was the collaborative act between me and my informants.

symbolic interactions (manifested in the material relations) between biomedical doctors and CAM practitioners, pulls both of them near to the specific cleavages within the field, positions them far away from it or even excludes them from the field. This is happening on both territories within the field. Furthermore, as I inquired the field more thoroughly, I came to conclusion that the medical field is divided (i.e. it is triangulated), not on two, but rather on three distinctive social spaces. The first social space is a space of biomedicine, the second is of CAM and the third, the most important for this thesis, is the social space situated in these dynamic cleavages, which I find to be the boundary within the medical field. It is both sociologically and anthropologically relevant, as it signifies a space in which social inequalities, more specifically – health inequalities, are made visible and easier to detect. Towards the end of the fieldwork, I became more and more aware of the social change happening exactly on this boundary. I found that on the one side, there are specific contextually bounded situations in which biomedical doctors and CAM practitioners collaborate (processes which enable their collaboration), and as they reported, they could collaborate officially if conditions would allow, while on the other the processes which are also active in the field are those which have the tendency to constrict or disable this collaboration. These processes are, in the context of everyday practices, run by the different interest groups which occupy specific hierarchical positions within the medical field – biomedical specialists and different subgroups within CAM. I found there are three aspects of the processes which constrain the agency of CAM and its collaboration with biomedicine - epistemological, organizational and professional aspect.<sup>35</sup> I noticed that the scope of influence of these distinctive but overlapping processual aspects define the levels according to which CAM is currently being marginalized in the medical field by biomedical doctors. The medium of the participation in these processes is not some sort of a ahistorical vacuum. Rather,

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<sup>35</sup> By aspects of the marginalization I imply the principles of opposition structuring the medical field.

engaging in them takes place both on a symbolic and material plane within the field.<sup>36</sup> The data obtained allowed me to explicate three different dimensions or domains of the marginalization of CAM. I imply that the discourses of evidence based medicine, the importance of randomized controlled clinical trial and placebo effect and the discourse of diagnosis are the indicators of the power struggles which structure the social space of the medical field, and are used as tools for the marginalization of CAM. Furthermore, I assume that these three elements of the practices of the communication between biomedical doctors and CAM practitioners – aspects, levels and discourses – structure the medical field on one hand, and the strategies of the marginalization used by biomedical doctors to keep the medical field autonomous from the CAM practitioners, overruling them claiming the non-legitimacy of these heterogenous medical systems, on the other hand.

However, it has to be said that the elements of these processes are utilized both by biomedical and CAM practitioners, bearing in mind that they have different orientations. These actions can be oriented either toward the preservation or toward the deconstruction of the rules of the medical field, which is after all, not strictly and in advance preconstructed and determined, but rather a social space in which every action is transformative, enabling and constraining the actors, in different measure, to transform possibilities into realities (Bourdieu and Wacquant 1992). On the one hand, those biomedical doctors who inhabit the farthest social positions form the polymorphous boundary within the medical field, the legitimate side of the field, overflowing with valuable forms of capital, tend to sabotage the sense of social presence of CAM as real, effective, beneficial and the most importantly - legitimate - medical systems. This is perpetuated by their attitudes of complete refusal of anything related to CAM, beginning with the doctor-patient situations in which they forbid their patients to talk freely about the experiences they had in CAM treatments and which are actually related to their

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<sup>36</sup> Static symbolic constructs, which have the relational origin and thus partially dynamic in their essence, are made active via materiality of social relations. It can be said that the biomedical procedures of diagnosis put into practice biomedical claims of the validity on one hand, and illegitimacy of ills, on the other.

current medical condition cured by that specific doctor, to the denial of the possibility of the existence of medically plural realities in general. On the other hand, CAM practitioners utilize and orient these discourses in a different way. For them, they are parts of something which can be called reactions of resistance, which they use to negotiate their identity both in a positive and negative way, claiming what they are and what they are not, in the medical field as the social space in which ideologies as basis of collective identities are contested, the phenomenon which manifests “the relationship between social meanings and power” (McCarthy 1996:45). I assume that biomedicine utilizes ideological aspects of scientific knowledge transforming them into epistemologic foundation of the discursive strategies for claiming incoherence to CAM collective identity as a medical system. I showed that in this way biomedical doctors and CAM practitioners put into the practice certain attitudes and knowledges with which they create specific social realities in the medical field. To be more specific, in this way they create medical reality and participate in the production and distribution of health inequalities (Kleinman 1995; Lupton 1994; Turza 2007).

My informants make the difference between CAM practices as follows. Acupuncture is minimally marginalized, and thus positioned on the nearest place to the boundary in the medical field. It is officially recognized and legitimized by biomedical community and the State, as it is offered in hospitals and as it is covered by additional medical insurance. It is institutionally, and thus organizationally accepted in various degrees. Acupuncture is also professionally recognized as there are schools and courses provided for learning it, which is valorized by one of the main medical organizations – Croatian Association of Physicians. Reiki and bioenergy therapy occupy the opposite position in the medical field, as they are situated on the farthest place from the boundary. They are totally marginalized; their legitimacy is discarded in all three aspects, in the medical field. Reiki and bioenergy therapy are considered to be institutionally unacceptable and unadjustable to biomedical settings. The



professional aspect of the boundary is also very strong, because biomedicine holds, in the first place, an epistemologic monopoly over other, mainly unscientific, ways of “knowing, writing and speaking” (Good 1994:71-83), meaning the intuitive knowledge in this case. Aromatherapy, shiatsu therapy and chiropractry occupy the social space in between these two extremes. They are partly marginalized.<sup>37</sup> Aromatherapy and shiatsu therapy are positioned in the middle part of the medical field, as they have succeeded to legitimize their statuses and started the professionalization process.<sup>38</sup>

Following the answers from all of my respondents, I conclude that in the absence of statutory regulation of CAM, ‘human factor’ (i.e. personal characteristics of a practitioner) and informal ways of communication substitute institutionalized ways when it comes to the collaboration between biomedical doctors and CAM practitioners (Shuval and Mizrachi 2004:6).

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<sup>37</sup> Even if there are no existing schools for learning chiropractry, I assume it is on its way to becoming professionally recognized, as many of the interviewed biomedical doctors recognized its applicability for various medical conditions. But still, organizationally it seems to be strongly marginalized, due to its absence from mainstream medical organizations.

<sup>38</sup> The schools for learning aromatherapy and shiatsu therapy are legally incorporated into the national educational system as part of the education for adults. In organizational way, as aromatherapists and a shiatsu therapist said, these practitioners can open small businesses and make their living.

## CONCLUDING REMARKS

There is a little doubt that biomedicine is a dominant medical system and that it holds a monopoly on the health-care provision in Croatia. I have showed that biomedicine and CAM are systems of knowledge, practices and culture, and argued that biomedical knowledge is utilized in the Croatian medical field as a tool for the marginalization of CAM healing modalities in order to reproduce biomedical structures and to protect the boundary in the Croatian medical field from transformation. I have also showed three aspects of the marginalization strategies – the professional, organizational and epistemological - which are manifested in everyday practices of biomedical practitioners and are socio-culturally linked to a 'biomedical way of being' (Good 1992).

As Andrew Pickering (1992) showed, the formation and usage of knowledge are not free from personal or group interests. The structure of biomedicine is formed within and very much determined by its national context (Baer et al. 2003:12). From the perspective of critical medical anthropologists, this phenomenon mirrors the power relational structures and concomitant reproduction of social hierarchies and inequalities (Baer et al. 2003; Good 1994; Kleinman 1995; Lupton 1994). Applying Barth's conceptualization and following the research results, it can be concluded that knowledge is not static, but a dynamic entity in a constant state of production and reproduction, which situates itself in the domain of social relations. This is why biomedical knowledge, as well as CAM, is constructed by social groups and is a social phenomenon which has to be approached relationally. As knowledge is produced, reproduced and distributed in the field, biomedical groups are attached to its tradition of knowledge – and the dominance over CAM - and thus the control over the medical field comes from the recreating the boundary through utilization of its three aspects. These are, on the professional level, the absence of legitimate educational position of CAM, on the organizational level the statutory regulation of medical training, and on the

epistemological level three discourses – of placebo effect, diagnosis and the importance of CRTs. In this way the discursive struggles in the Croatian medical field are perpetuated.

Furthermore, in the maintenance of the autonomy of the field, organizations serve as one of the important controllers of this process, participating in the construction of the medical reality (Good 1994; Turza 2007). Emirbayer and Johnson (2008) said that the boundaries are always in a dynamic state and are never stabilized due to the influences of developments in external fields or in the wider organizational field. As Bourdieu's theoretical framework is increasingly utilized in organizational sociology and its relational principles are applied to the methodological inquiry of organizations (Vaughan 2008), and as the medical field consists of different organizations such as schools, associations, research institutes, conferences, congresses and journals, this research can be extended in several ways. The relationship between biomedicine and CAM in Croatia can be examined through the ways in which biomedical organizations institutionalize different aspects of biomedical ideology (i.e. aspects of the boundaries), which enables these dominant groups the exclusive access to the strategies of production and accumulation of capital. This research can be situated in the context of organizational demarcation of boundaries of institutional labor structures, the dynamic aspect of its construction and the strength of the concomitant division of labor (Shuval and Mizrachi 2004). Such a study would add to a further understanding of how the medical field operates in Croatia.

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<http://nccam.nih.gov/>

The World Health Organization website  
<http://www.who.int/en/>

# APPENDICES

## The interview guideline

### General questions

1. What was your training?
2. How long have you been in practice?
3. How many patients you have? Most common problems they come for?

### Questions about physicians' experience and observations of CAM

#### Organizational domain and views on patients' demand for alternative medicine treatments

4. Do you have patients who go to alternative practitioners? Do they talk about their other experiences with you? What do they say?
5. What are the bad consequences you've observed of alternative practices? Any good ones?
6. Do you encourage CAM treatments? Do you advise your patients to use and go to CAM treatments? Why? If yes, in which circumstances?
7. Are there differences between specific CAM treatments? Do you collaborate or think more highly of certain CAM therapies? Which are the really bad ones? Why exactly?
8. Which are the ones you'd consider collaborating or that bridges are possible?

#### Questions about the statutory regulation of CAM (the criteria of regulation)

9. Do you think CAM should be controlled (Should CAM achieve statutory self-regulation)? Why?
10. What do you think are there any standards to which CAM practices have to adhere to be jurisdictionally regulated? Which are they? Why?
11. What should be the role of the State in the professionalization of CAM? Should the State support the development of CAM?
12. Whose responsibility is it?

#### Organizational domain and views of the appropriate settings in which to provide CAM treatments (the criteria of collaboration)

13. Should CAM therapies be integrated in the Croatian health care system?
14. Which are the contexts in which biomedicine and CAM could collaborate?  
Why?

#### Organizational domain and views of the appropriate settings in which to provide CAM education (the professional aspect of the boundary)

15. Should CAM therapies be taught in regulated schools?
16. Is there a legitimate place in educational system for CAM?
17. What should be educational standards for CAM practitioners?

### Cost efficiency

18. Should medical insurance cover CAM treatments? Or some of them? Why?



### Questions I didn't have to ask, but answered:

#### The positions in the debates regarding the relationship between biomedicine and CAM (The epistemological aspect of the boundary)

19. What is the role of evidence-based medicine and of randomized controlled clinical trial in biomedicine and regulation of CAM?
20. Do you think is it valuable to research CAM treatments? Why?
21. What are in your opinion the appropriate ways of evaluating CAM treatment?
22. To what degree should biomedicine tolerate methodologies coming from different disciplines?
23. What is your opinion about CAM regarding the phenomenon of placebo?
24. What is your attitude toward the collaboration with CAM regarding the diagnosis?

#### Sub-questions that arose in some interviews:

25. What do you think is the best part of the care you provide, generally? What do you think is the best part of the care you provide, specifically, by comparison with CAM treatments?
26. What do you enjoy most about your job? What are you proud of about the job you do? What is the most difficult? What is the most important thing you provide to patients when you provide care?

#### Public interest

27. Which are the reasons why so many people turn to CAM treatments? What is the meaning of public interest in CAM?

### List of Informants

#### Zagreb

#### Bjelovar

2 oncologists	Oncologist (didn't come); Internist
Surgeon	Surgeon
Psychiatrist	Psychiatrist
<b>General practitioner and acupuncturist</b> <b>General practitioner, Doctor of Chinese,</b> <b>Japanese and New German medicine</b> <b>General practitioner, homeopathist and</b> <b>acupuncturist</b>	<b>Anesthesiologist and acupuncturist</b> <b>General practitioner, Doctor of</b> <b>Chinese, Japanese and New German</b> <b>medicine</b> <b>General practitioner, homeopathist</b>
Homeopathist	Homeopathist (there is no h.)
Shiatsu practitioner	Shiatsu practitioner (there is no s.p.)
Aromatherapist	Aromatherapist
Reiki practitioner	Reiki practitioner
Bioenergetic practitioner	Bioenergetic practitioner (didn't answer)

**Table 1** The classification of complementary and alternative medicine by the UK House of Lords Science and Technology Committee (2000)

Category	CAM
Professionally organized alternative therapies	Acupuncture Chiropractic Herbal medicine Homeopathy Osteopathy
Complementary therapies	Alexander technique Aromatherapy Bach and other flower remedies Body and work therapies Massage Counselling therapy Hypnotherapy Meditation Reflexology Shiatsu Healing Maharishi Ayurvedic medicine Nutritional medicine Yoga
Alternative disciplines	Anthroposophical medicine Ayurvedic medicine Chinese herbal medicine Eastern medicine Naturopathy Traditional Chinese medicine Crystal therapy Dowsing Iridology Kinesiology Radionics

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Sources: Kashet (2009:132); see also The UK House of Lords Science and Technology Committee, Sixth Report  
(<http://www.publications.parliament.uk/pa/ld199900/ldselect/ldsctech/123/12301.htm>)

**Table 2** The classification of complementary and alternative medicine by the US National Center for Complementary and Alternative Medicine (2006)

Category	CAM
Holistic medical systems	Homeopathic medicine Traditional medicine Ayurveda
Mind–body medicine	patient support groups cognitive behavioural therapy prayer mental healing therapies that use creative outlets such as art, music or dance
Biologically based practices	herbs, foods, vitamins, dietary supplements, herbal products and the use of shark cartilage to treat cancer
Manipulative and body-based practices	chiropractic medicine massage osteopathic manipulation
Energy medicine	biofield therapies: qi gong, reiki, therapeutic touch and bioelectromagnetic-based therapies

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Sources: Kashet (2009:132); also see The US National Center for Complementary and Alternative Medicine (<http://nccam.nih.gov/>)

**Table 3** The classification of complementary and alternative medicine by Easthope (2002)

Category	CAM
Comprehensive systems	Ayurvedic medicine Anthroposophy Herbalism Hypnotherapy Naturopathy
Spiritual and Mental	Faith healers Spiritual healers Mental imagining Past-life regression Primal regression Transcendental meditation
Energy Work	Acupuncture Acupressure Crystal healing Polarity Reflexology Reiki Shiatsu Therapeutic touch
Dietary therapies	Bach flower therapies Colonics Gerson therapy Macrobiotics Pritikin diet Vitamin therapy
Manipulation	Alexander technique Chiropractic Craniosacral therapy Feldenkrais Massage Osteopathy Rolfing Tai Chi Trager Yoga
Diagnostics	Applied kinesiology Biorhythms Iridology Kirlian photography Psionics Radionics
Other	Aromatherapy Colour therapy Hydrotherapy

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Source: Easthope (2002:332)