

SOCIAL RESEARCH AND HEALTH CARE PLANNING IN SOUTH ASIA-PART 11

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ABSTRACT: *The second part of the study addresses issues raised by the notion that planning in developing countries should integrated indigenous medical resources in state funded health service system. In this perspective the author analyses here the relationship between “alternative practices” of the world today.*

Pluralism and Health Care planning

In this section I will take a comprehensive view of medical systems throughout the world in order to make generalizations which seem to me useful for understanding them, and to criticize the danger of hypocrisy on the part of well-meaning health planners from industrial countries who advise non-industrial countries to make greater use of their indigenous medical institutions. Since this advice is approved by the world Health organization and has become the common wisdom in social medicine, we need to be skeptical about it.

Research, training and practice in modern scientific medicine are carried on throughout the world. In this sense a world medical system exists. Government everywhere takes responsibility to improve this system within their borders, and to co-operate with international medical programs. Yet developing countries with limited resources cannot afford the hospital-based, urbanized, high technology, disease-oriented and intensely professionalized aspects of this system that influence medical planning in

the industrial world. The facilities they have created on this model are primarily used to serve upper class people and their clients, while effort to extend the benefits of the system to large segments of the population are inhibited and distorted by the conviction of health professionals that they should displace indigenous medical institutions, rather than build upon them. This conviction stems from a faith that “scientific medicine” is superior to other system. I share this faith, but am skeptical about the vanity that it entails and the obtuseness of believers to certain facts. We ought to be more concerned than we are by the fact that even in countries where the system has evolved to an advanced degree, it coexists with alternative medical practices. Scientific medicine coexists in the United states with Christian science, vitamin therapy, encounter groups, and so on.

Our discussion of medical pluralism requires a simple but essential distinction between disease and illness. Leon Eisenberg has drawn the distinction by writing that “patients suffer ‘illness’; physicians diagnose and treat ‘diseases’.....illnesses are

experiences of disvalued changes in states of being and in social function; diseases, in the scientific paradigm of modern medicine, are abnormalities in the structure and function of body organs and systems".(1977 :11)

It is important to note that a person may have a disease without experiencing illness. This occurs in hypertension, or when an x-ray reveals that someone has had tuberculosis and a remission without knowing about it.

Also, someone can be ill but not have a disease. one thinks immediately of conversion hysteria, but there are also severe fevers of unknown origin, and acute lower back pain that cannot be diagnosed. Most psychiatrists treat schizophrenia as if it were a disease, but technically it is a "functional disorder" and considerable debate exists with reference to it.

Eisenberg writes that "traditional healers also redefine illness as disease". I disagree with this common notion. Disease concepts in the modern sense depend on what Foucault calls the "clinical gaze". This way of looking at medical cases is a unique invention of modern medical science. The clinical gaze reduces separately observed and often measured signs and symptoms to a specific disease. Of course, one can find in the classic texts of humoral medicine some attributes of the clinical gaze, but the pattern of concepts in humoral medicine involves a different epistemology, a world view grounded in a system of correspondence. Learned Ayurvedic physicians may never touch their patients, and limit their examinations to a few questions. Family members may answer for the patients, or leave them at home and consult the physician on their behalf. Consultation may use astrology and other forms of divination,

rather than observation of signs and symptoms. The pulse is used this way in popular Ayurvedic and yunani practice.

Allopathic health professionals claim that the virtue of their system is particularly evident in the

Effectiveness of their diagnoses and treatments of disease. As the system becomes progressively

more effective- to the point of having the initial interview with a computer – the failure, or less effective aspect of Allopathy is admitted to be in the management of illness. The meaningful construction of patient and family experience are often drained away by the definition of situation as a technological malfunction.

On the other hand, the advocates of indigenous medicine admit its relative weakness in the diagnosis of disease. We have already seen that many vaidyas and hakims use stethoscopes. In the cities, purist vaidyas who would never prescribe anything but indigenous preparation may send their patients for laboratory examinations and x-ray. The literature of Africa, Latin America and other parts of Asia reports a similar combination of modern diagnostic techniques with indigenous therapies. Practitioners of "alternative therapies" in Japan, the United states and Europe also very often observe this combination.

Social scientists who compare indigenous and allopathic practices assume that while the indigenous system are less effective in curing diseases than allopathy, they are more effective in

helping to construct the illness experience. While allopathic practitioners have problems of patient compliance, they assume that laymen comply with the prescriptions of indigenous healers. I have seen very little evidence that this is in fact the case. The

effectiveness in managing the illness experience is said to be the result of congruence between the patient and the healer's concepts. In contrast to the ideal of privacy in allopathic doctor-patient consultations, the diagnosis and treatment is usually publically negotiated with the therapy management group (Janzen 1977).

These generally recognized differences between allopathic and indigenous practices described between "doctor medicine" and "village medicine". The differences are expressed in "hierarchies of resort" to one or another kind of practitioner. A favourite topic for social research seems to me very largely wrong-headed. The surveys cannot deal with the complex and ambivalent relationships between concepts, desires and action. Also, they assume, wrongly, that laymen have ideological preferences in these matters, and that they consistently follow a disease conception of illness.

Nevertheless, hierarchies of resort of some kind exist. The patterns are plain enough in the United States, for example, where we use home remedies for mild illness (the common cold, flu, upset stomach), and consult physicians for everything else, with secondary resort or last resort to indigenous medicine for chronic problems: megavitamins for schizophrenia, yoga for lower back pain, acupuncture for arthritis, and so on. The Indian urban middle class simultaneously uses home remedies from both indigenously and allopathic sources, with differential resort to specialists in allopathic and indigenous medicine according to the kind of illness, sex, age and personal preferences of the patient.

Allopathic health professionals view this division of labor in an ambivalent manner. They are against pluralism in principle, and

accuse other system of "quackery", but in fact they prefer that they do not want to bother with, or are not equipped to handle. Thus, in India the allopathic profession opposes indigenous medicine in principle, but few practitioners want to deal with, psychologists, attend encounter groups, or join mystical sects. In rural areas physicians do not want to deliver babies, so they acknowledge midwives if they in turn respect their authority. A movable point of tolerance exists that depends upon which system one is describing (India, the United States), which problem are at issue (obstetric, psychiatric), and which class of practitioners. In every system the allopathic ideal is the same, however, and this is that doctors should be the first resort. They claim the power to define illness situations, since to acknowledge the right of laymen to make their own diagnoses would be to grant them the choice of deciding whether they should consult allopathic or indigenous practitioners.

The allopathic demand for dominance of the entire medical system is total and uncompromising. To justify the demand for being first resort for all illnesses serious enough to lead to consultations with health specialists, allopathic physicians make the following arguments:

- a) indigenous practitioners cause iatrogenetic diseases. A favorite example is the dirty midwife who cuts the umbilical cord with a rusty knife and smears the stump with cow dung ash, or the curandera who recommends that a child suffering from measles be made to fast.
- b) patients lose time by first consulting an indigenous practitioner, so that their diseases often progress to a drastic stage.

- c) the wrong diagnosis of diseases by categories such as evil eye, soul loss, demon possession, or witchcraft, exploit the ignorance and superstition of patients and their families.

Indigenous practitioners view the division of labor in a very different manner. They often claim to refer patients to allopathic institutions and to go themselves. They acknowledge the utility of allopathy for particular problems in an open manner, rather than in the de facto manner of indigenous allopaths who recognize the utility of indigenous healers while condemning them in principle. But they also justify their role with characteristic arguments:

- a) they claim that the allopathic practitioners are ineffective in treating illnesses that they deny exist, such as the imbalance of hot and cold foods, sorcery, or spirit possession. They assert the reality of syndromes that doctors refuse to treat.
- b) they claim that allopathic practitioners do not understand or use some efficacious medications and therapeutic procedures: diet regulation based on humoral concept (in our society, health foods and megavitamin therapy); massage, breathing exercise; substances such as neem leaves, garlic, camphor, herb a buena.
- c) they claim that allopathic medicine is iatrogenetic, its strong medicine causing many dangerous “side effects”
- d) they assert that allopathic medicine treats the symptoms of illness, but that indigenous therapy corrects the causes.

What is the grounding for these discussions of efficacy? Allan Young asserts that “Efficacy-applied to practices intended to treat or prevent illness –can have at least three meanings, “which he calls epistemologies (Young, 1975:184). They are (1)scientific, (2)empirical, and (3) symbolic.

Allopathic medicine uses scientific research, trains practitioners in the scientific perspective of the disease theory. The judgements of efficacy of its own practices are ideally grounded in laboratory, clinical and epidemiological research. But much practice is not so grounded, and the knowledge and judgements its practitioners make of other kinds of medicine are obviously distorted by the ideology of professional dominance.

With rare exceptions, indigenous practitioners are not trained in modern scientific methods. Sophisticated elite practitioners assert the existence of an equivalent or superior science of their own, but lack the experimental methods and instrumentation of biomedical research. Despite these claims to an ancient science, the efficacy of contemporary practices are not scientifically grounded. Thus, the division of labor, and the reciprocal judgements of differential efficacy of indigenous and allopathic practitioners are not subject to scientific standards of evidence. They are based on empirical and symbolic reasoning. Laymen who resort to different systems also ground their choices on empirical and symbolic responses, rather than on a scientific epistemology.

Briefly, despite the importance of science for modern medical research, judgements of efficacy by allopathic health professionals for the most part resemble those of indigenous physicians and laymen. They are

empirical, based on pragmatic experience with different practices, and symbolic constructions that satisfy because they make sense, or seem appropriate.

Kleinman (1978, 1980), Fabrege (1974), Janzen (1978a, 1978b), Young (1975), 1981 and others have pointed out that all systems of medical belief and practice are empirically self-confirming. People everywhere live until they die, and they only die once, while in the process of living they undergo numerous illness episodes. In short, a lot of people will recover their health no matter what the specialists they consult say or do, and they will often attribute their recovery to what was done. Allopathic professionals who hope that the “demonstration effects. They can act powerfully to stupify the suffering person, purge the bowels, and so on. Divination procedures also deal with real problems of social conflict, and combined with other rituals they help to compose conflicts in well-recognized ways –but I want to save the discussion of the symbolic grounding for judgements of efficacy to make the present point that both allopathic and indigenous medicine appeal directly to the practical, empirical orientation of people in quest for therapy.

The thrust of all medical reform for over a century has been to improve the efficacy of allopathic practice by professionalizing it: to standardize and raise the quality of practice by the maximum development of scientific knowledge and technology, and thus to put the indigenous practitioners out of business. They are to be replaced entirely by a rationally organized, scientifically grounded, state regulated hierarchy of university trained health occupations controlled at the apex by professionally autonomous physicians. This is the case in the Soviet Union and the United States, in France,

Japan, Japan and Brazil. It is also the case in Nigeria and Sri Lanka, India, Korea, and Malaya. It is a world movement, intimately related to the industrialization of society. The scale and organization of pharmaceutical companies, health insurance programs, schools, hospitals, research institutes and so on, makes the medical system a major component of the economy in all industrial and in most developing societies.

Up to the first world war the dominant view in the industrial countries was that an excellent and rational division of labor existed in the world in which they exported manufactured goods to non-industrial and imported raw materials from them. Over the generations the dependent countries were to improve their productivity and standard of living by slowly building up their educational and health services, and by introducing small scale industries. But climate, race, and cultural traditions were such that they would very largely continue to import industrial products and export raw materials.

From the 18th century on this view was questioned and condemned from conservative, liberal and socialist perspectives, yet it prevailed because it pretty much described what was happening. We do not need to agree on any interpretation of industrialism, colonialism and capitalism, but only to the point that the events described by these labels provided the social context in which allopathic medicine evolved. I will now begin to call it “cosmopolitan medicine”, referring to a world system of institutions – schools, laboratories, clinics, hospitals, and regulatory agencies with similar technologies, manuals, textbooks, procedures and functions. This system is politically dominant in every nation, its

practitioners enjoy greater social prestige than any other health specialists, and it is culturally dominant everywhere. By this I mean that the symbols of cosmopolitan medicine are admired, borrowed, deferred to, imitated. From the perspective of cosmopolitan health professionals this is sheer quackery, and should be suppressed by the police

power of the state. yet “unqualified practitioners” purchase stethoscopes, syringes, and other instruments identified with allopathy, and they invent Ayurvedic injections of indigenous Nigerian medicine, or pills and tonics which they package and sell in the manner of allopathic drugs, and they borrow the medications of cosmopolitan medicine, which can be purchased easily everywhere in the world, and particularly in third world countries.

We have arrived at the symbolic epistemology, but not by discussing traditional ritual curing, which is the stock in trade for anthropologists.

The division of labor in pluralistic medical system (and all medical systems are pluralistic), is a (compromise structure”, a thing of the moment, changing as professionalization processes work to make these system more uniform, as experiences change the concepts people have of illness, and as the content of cosmopolitan medicine changes with the creation of new knowledge and new technology. The point is that all of this is symbolic. Besides being instruments, microscopes are obviously symbols and so are lab coats, building, and titles of address, or the rituals of treatment and examination. The symbolic dimensions of cosmopolitan medicine are well recognized but they are often obscured by shifting attention to the symbolism of indigenous medicine. My point is that symbols are as wild as the human

imagination, and the boundaries between different beliefs and practices are fluid. Thus, syncretic medical systems evolve that combine chemotherapy and the laying on of hands, yoga meditation and vitamin injections. Humoral theories are combined with the germ theory of disease, astrology with psychotherapy.

These things violate the sensibilities of health planners (and most social scientists). scientific symbolism –a microscope –should symbolize the authority of qualified scientists, and qualified scientists should be secular, rational, materialists. If they have another faith, it should be compartmentalized so that it does not contaminate their science, Acupuncture charts symbolize Chinese medicine, and so on. The different systems should have fixed boundaries according to their different natures. These ideological view of medicine cause the people who hold them to be shocked and offended if the way that medicine is actually practiced in New York or New Delhi is brought to their attention.

Yet , one way or another, laymen have to construct meaningful experiences of illness, and indigenous practitioners often help them. People engaged in such an enterprise have to use what comes to hand. symbolic work is what Lévi-Strauss called bricolage. In the non-industrial world planners are now saying that cosmopolitan health professionals must learn to rationalize the division of labor between themselves and indigenous medicine. But when I read this or hear it, the assumption appears to be that the health professional will co-opt the indigenous practitioners

Into a paramedical hierarchy that will dominate and regulate. The people’s Republic of china is the model. But I think that model is mythical. It is a symbolic statement of the rational health planner’s

ideal maximization of cosmopolitan health resources by confirming the efficacy of a few indigenous practices; My argument is that all the rest cannot be eliminated, particularly in societies where indigenous medicine is extensively practiced. with the centralized police power of the modern industrial state it has not been eliminated from American or European society.

If we are to avoid acting ethnocentrically in judging the relations between cosmopolitan and indigenous medical institutions in third world countries, we need to see the continuity between our system and theirs by understanding the benefits of pluralism in industrial medical system. otherwise, health planners who advice Nigeria, India or Indonesia not to try import the full scale cosmopolitan medical institutions of industrial countries, but to utilize their indigenous systems in combination with appropriately selected aspects of cosmopolitan medicine, will lay themselves open to the justified charge that they are recommending an inferior colonial version of cosmopolitan medicine and a double standard of judgement. If they do not understand the utility of medical pluralism at home they cannot legitimately recommend it abroad.

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