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RETHINKING THE CLASSIFICATIONS OF MEDICINES: A PROPOSAL FOR INTERCULTURAL CONTEXTS

†Anatilde Idoyaga Molina

Nota de las Editoras

Anatilde Idoyaga Molina (1950-2020) se desempeñó como Directora del Centro Argentino de Etnología Americana, organismo dependiente del Consejo Nacional de Investigaciones Científicas y Técnicas de Argentina. Recibió el cargo de Investigadora Superior de esa entidad científica como corolario de su extensa y prolífera trayectoria académica.

Scripta Ethnologica Nueva Epoca publica el presente artículo inédito, que refleja cabalmente los aportes innovativos del pensamiento de Idoyaga Molina en torno al fenómeno de la atención de la salud en contextos interculturales. El mismo aborda un tema de plena vigencia en tiempos del pluriverso y de resistencias a la inteligibilidad dominante. Con la claridad y agudeza teórica que caracterizaron su extensa obra, la autora nos ha legado un texto de consulta obligada que resume sus reflexiones y pensamientos, haciendo foco en la clasificación de medicinas a partir del debate teórico con otros autores y de los resultados de su labor etnográfica.

Abstract: *The article, firstly, deals with some definitions and classifications of medicines generated in the social science and biomedical fields. Then, the author proposes a systematization of medicines, incorporating new categories, as well as the notion of ethno-medical configuration, to explain healthcare in intercultural contexts. The categories introduced are biomedicine, traditional medicine, alternative medicine, religious therapy or medicine, and lay-treatment. Finally, as an illustrative example, the paper focuses on the ethno-medical configuration of the Metropolitan Area of Buenos Aires, Argentina. The goal of this systematization is proposing categories that consider the understandings and behaviors of social actors.*
Key Words: *ethnomedical configuration; medicine's categorizations; intercultural context; Argentina*

Título: Repensando la clasificación de medicinas: Una propuesta para contextos interculturales.

Resumen: *En primer lugar, el artículo aborda algunas definiciones y clasificaciones de medicinas propuestas en el campo de las ciencias sociales y de la biomedicina. Luego, la autora propone una sistematización de las medicinas, incorporando nuevas categorías, así como la noción de configuración etnomédica, que le*

permite explicar la atención de la salud en contextos interculturales. Las categorías introducidas son biomedicina, medicina tradicional, medicina alternativa, terapia o medicina religiosa y tratamiento no profesional. Finalmente, a modo de ejemplo ilustrativo, el artículo se centra en la configuración etnomédica del Área Metropolitana de Buenos Aires, Argentina. El objetivo de esta sistematización es proponer categorías que consideren las comprensiones y comportamientos de los actores sociales.

Palabras clave: *configuración etnomédica; categorizaciones de la medicina; contexto intercultural; Argentina*

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Introduction

Over the last decades, the combination of biomedicines with other (non-bio) medicines has been studied in third world societies and developed countries alike (Albuquerque, 1979; Atkinson, 1979; Bombardieri and Easthope, 2000; Csordas and Kleinman, 1996; Douglas, 1996; Eisemberg et al., 1993; Good 1987; Idoyaga Molina, 1999; 2000; Last 1996; Leslie, 1980; Saizar, 2003; Sermeus, 1987; Thomas et al. 1991; Unschuld, 1980; Vincent and Furnham, 1998; WHO, 2002). As a result, numerous concepts have been proposed, such as medical pluralism, medical systems, medical configurations, and local, regional, and cosmopolitan medicines, among others. Different conceptualizations of medicines have emerged, such as professional medicine, folk medicine, popular medicine, dominant and variant medicines, traditional medicine, complementary-alternative medicine, and others.

In this article, I propose a new classification of medicines, introducing the concept of ethno-medical configurations to understand healthcare in intercultural contexts. I discuss some classifications put forth by social and bio-medical scientists, evaluating their advantages and disadvantages. Then, I present a classification, introducing the categories of biomedicine, traditional medicine, alternative medicine, religious medicine, and lay-treatments. I justify the categories used, underlining why it is relevant in any multiethnic and multicultural context. I dwell on making clear the basis for the religious medicine category. Finally, I give a short example to show the ways in which those categories function, focusing on the ethno-medical configuration of the Metropolitan Area of Buenos Aires City, Argentina. The goal of this system is to propose categories which consider the understandings and behaviors of social actors.

These results are part of four research projects, funded by the Ministerio de Ciencia, Tecnología e Innovación Productiva (Ministry of Science, Technology and Productive Innovation) of Argentina, carried out from 1997 to 2010, focused on therapeutic complementariness and articulating cultural, ethnic, socioeconomic, and religious identity as grounds for the selection and combination of medicines. I also considered regional differences.

Pluralistic health offers and the classifications of medicines

Social scientists' classifications usually propose few and general categories while biomedical lists present more categories and sometimes focus on therapies in isolation from the medicines that involve them. Therefore, one medicine may appear in several therapy categories. In the social sciences, some classifications seem to be ethnocentric, e.g. Wardell (1972), because the definitions of the specialists and conceptions of health and sickness are referred to and legitimated -or not- by the biomedical model. In other cases, the criteria used are not completely justified, as in Dunn´s classification (1977), which seems to be based on geographical factors, but then incorporates additional perspectives. Kleinman (1980: 50) introduces the concept of a "model of health care", defined as "...a local cultural system composed of three overlapping parts: the popular, professional, and folk sectors". Popular medicine contains several layers, including individual, family, and social networks, as well as community beliefs and activities. It is the lay-practiced, non-professional, non-specialist arena, where most episodes of illness are managed. The professional sector comprises the organized health professions. In most societies, this is modern biomedicine. However, in India or China, professional medicine also entails Ayurvedic medicine, and Chinese traditional medicine respectively (Kleinman, 1980: 51-2). The folk sector integrates non-professional and non-bureaucratic specialists and tends to overlap the two other sectors. It is a mixture of different components, some of them closely related to the professional sector, and most linked to the popular sector because the specialists and the common people share the same cultural background (Kleinman, 1980:59). In Taiwan, for example, the folk sector includes shamans, fortune tellers, interpreters of the *I ching* divination system, and geomancers.

Kleinman's proposal may be adequate for cultural and local systems; however, it would be difficult to apply in the intercultural context of the Metropolitan Area of Buenos Aires city, particularly because of the category of folk medicine. In Buenos Aires, folk medicine comprises traditional healers of Western tradition; specialists in yoga, acupuncture, reflexology, astrology, and natural medicine; Catholic priests; and even shaman of the aboriginal groups of Argentina. Among these specialists, whose social statuses and roles in society are diverse, there are great differences in cultural beliefs and practices of health, illness, and therapy. The offerings of these medicines run through different social, economic, cultural, and ethnic sectors. They do not integrate a system, in which all the parts are interrelated. The three categories seem to be too few to differentiate the incidence of cultural, social, economic, ethnic, and religious factors, with regards to the concrete therapeutic access, selections, combinations, and rejections of the medicines offered.

Shifting the perspective and focusing on population dynamics, ethnic and cultural diversity runs counter to the concept of healthcare as a closed system. In the Buenos Aires Metropolitan Area, the population is mostly European-Argentines, Middle Eastern-Argentines, and Jewish-Argentines along with immigrants

from other South American countries (mainly Peru, Bolivia, and Paraguay), immigrants from the Southeast Asia (mainly from China), immigrants from the East Africa (mainly from Senegal), and some Native Peoples (migrants from North Eastern Argentina). Each group has its therapeutic preferences, its own traditional healers, lacks accesses to certain offers, and lacks knowledge and interest of certain possibilities. Consequently, this conglomerate does not function as a system.

It was Press, who criticized the use of the system concept with reference to the mere presence of the diverse elements within society, even if these elements all serve only one institutional sector, due to the notion that a system is a functionally integrated entity with intercommunicating parts (1980:46). For that reason, the author speaks of *configuration*, which integrates different medicines, classified as dominant or variant. He also redefines the notions of folk and popular medicines. According to Press, folk medicine should be limited to describing systems or practices based upon paradigms which differ from those of a dominant medical system of the same community (1980: 48). Per this definition, autochthonous medical systems, such as Ayurveda, Chinese medicine, Yanomamo, Bushman, or pre-contact Navajo, cannot be labelled as folk; instead, they must be considered as dominant medicines, and biomedicine may be labelled folk in certain contexts. Regarding popular medicine, the author suggests using the concept in two ways. The first closely approximates common usage by labelling all medical practices performed by someone other than an officially sanctioned professional as popular and does not directly contradict the paradigm of the system. A second usage would label only those beliefs and practices which, though compatible with the underlying paradigm of a medical system, are materially and behaviorally divergent from official medical practice as "popular" (1980:48-49). Bearing in mind, these definitions, Press examines the peasant Zinacatecan (México) configuration and produces seven categories (1980:50). This classification is exhaustive but complicates comparisons. Besides, in an intercultural context, all medicines may be dominant, depending on which group or sector of the population is considered.

Good (1987: 23-24) introduced the concept of an "ethnomedical system", defined as the total medical recourses available to and utilized by a society, including popular, traditional, and biomedical forms of therapy. Popular refers to lay-practices and incorporates different levels of action, such as individual-based, family-based, social-nexus-based, and community-based, following Kleinman's suggestion. Traditional medicines are those offered by a socially recognized specialist, whose practices and knowledge change from society to society. I suggest the usefulness of the ethnomedical concept, which includes biomedicine without favoring *a priori* the role of any medicine. At the same time, I follow the same observations previously completed. Three categories are not sufficient to explain the perspective of specialists and users, nor the influence of regional and global factors in local contexts. A yoga specialist and a charismatic priest perceive insurmountable differences between themselves. Similarly, a yoga consultant may not be interested in charismatic healing or in consulting a

traditional therapist. A user of traditional medicine would hardly say that charismatic healing and yoga involve the same kind of awareness and practices as their methods.

Keeping in mind medical diversity in Europe, Pascualino (1996:166) classifies medicines into three groups: a) traditional medicines, b) ethnic medicines imported by recent immigrants, -mostly African peoples- and c) new alternative medicines, linked to globalization and mass-media propaganda. I agree with the distinction between traditional medicine and alternative medicines. Nevertheless, the classification puts aside the therapeutic rituals, offered in the context of the Catholic and Evangelical Church, and introduces a new category to designate traditional medicines brought by immigrants, which are essentially as traditional as the specifically Spanish or Italian ones.

The World Health Organization recognizes distinct traditional medicines and complementary/alternative medicines (CAM). Traditional medicines include "...traditional Chinese medicine, Indian Ayurveda, and Arabic unani medicine, and various forms of indigenous medicine" (2002: 1). In countries where allopathic medicine is dominant, or where traditional medicine has not been incorporated into the national health care systems, traditional medicines are often designated as complementary or alternative medicines (*ibid*). Usually, medicines are complementary when the treatment is undertaken simultaneously with biomedical attendance, while medicines are alternative when they replace biomedical treatment, or when they are the only medicine utilized.

The WHO's approach presupposes that, in the third world, health care is restricted to biomedicine or traditional medicine, while in developed societies complementary/alternative medicines are combined with biomedicine. This view is limited because traditional medicines—in the sense of original medicines from any given country—and alternative ones—meaning traditional medicines from foreign countries—are simultaneously offered in developed and undeveloped countries, and the therapeutic strategies of patients, at least in Argentina, combine these two types of medicines (Idoyaga Molina, 2002a: 283). This is equally observable in Spain and Italy. Finally, the combination with biomedicine is not the only possible arrangement as medical combinations can exclude biomedicine. Consequently, the notion of CAM seems to be ethnocentric, and distorts the concept of therapeutic complementariness.

In the United States, the National Center for Complementary and Alternative Medicine, defines complementary treatments as those accepted by biomedicine and alternative treatments as those not accepted by biomedicine, a categorization like "conventional" medicine and "unconventional" medicine. This classification has deserved its critics (Ayers and Kronenfeld, 2010); however, I emphasize new perspectives. The Center distinguishes various types of CAM: a) natural products such as herbs and dietary supplements; b) mind and body medicine such as meditation, yoga, acupuncture, and hypnotherapy; c) manipulative and body based practices such as chiropractic and massage therapy; d) movement therapies such as Pilates and Tragger psychophysical integration; e) traditional healers who use methods based on indigenous theories, beliefs, and experiences handed down from generation to

generation; f) energy healing such as magnet therapy, qi gong, reiki and healing touch; and g) whole medical systems such as biomedicine, Ayurveda medicine, Chinese traditional medicine, homeopathy, and naturopathy.

This classification lacks usefulness because the categories are not mutually exclusive and respond to several and not contrastive criteria. It also omits the holistic view of most of the practices mentioned that involve health conceptions and practices—for instance yoga—to a technique removed from the context in which it acquires meaning—for instance meditation. Yoga might be incorporated into almost all of the categories proposed because it a) implicitly promotes a diet that can be considered a natural products therapy, b) is included in mind body therapies, c) includes exercises known as *asanas* can be a movement therapy, d) manipulates energy through breath and relaxation and can therefore be an energy therapy, and d) could be considered a whole medical system, if we accept that this type of system may be deeply rooted in philosophical and cosmological beliefs.

The biomedical categories of medicines and therapies are further complicated by introducing categories of different range, and sometimes without any specification, for instance on Barnes, Bloom, and Nahin´s list of therapies appears yoga and meditation, without any clarification of what kind of meditation -yoga, Zen Buddhist, Catholic- is practiced by the patient (2008: 2-3).

Ethnomedical Configuration

I understand healthcare as an ethno-medical configuration, referring to the total recourses available, offered and used in any intercultural context (a city, a region, etc.)[1]. I accept the social actors' points of view as therapeutic and related to healthcare. It does not matter if they mention consulting a biomedical doctor, or attending a therapeutic ritual, or avoiding a taboo. I prefer to speak of configuration, showing Press's influence. I borrow Charles Good's ethno-medical expression, underlining that biomedicine is just one approach. Finally, I take Kleinman´s concept of healthcare as an overlap of medicines. Bearing intercultural contexts in mind, I consider healthcare to be the overlap of biomedicine, lay-treatments, and traditional, religious, and alternatives medicines. I refer to lay-treatments to stress that each type of medicine, and even each medicine, can generate its own practices of lay-treatment.

Biomedicine refers to allopathic medicine and psychotherapies: officially recognized and offered in hospitals and other health units, both public and private. This category, in one way or another, is referred to and appears in most classifications, as professional, cosmopolitan, biomedicine, and so on. Consequently, it is not necessary to extensively justify its inclusion.

Traditional medicines vary from region to region, and societies recognize them as part of their culture. In Argentina, these are *curanderismo* (folk healings), brought by Europeans and other immigrants, as well as by shamans in native indigenous societies. *Curanderismo* or is widespread in Latin America and traditional in many Mediterranean countries. Shamanic institutions are traditional medical systems scattered throughout the indigenous societies

of the Americas, Australia, Sub-Saharan Africa, North and South Asia, and Indonesia. In Argentina, shamans are the therapists among indigenous societies from Gran Chaco to Misiones to Patagonia.

Alternative medicines are not traditional in the country and do not integrate the biomedical paradigm. Widespread in the last few decades, alternative medicines are more or less associated to new age phenomena, but not linked to the immigration of people. It might be said that the alternatives have migrated on their own, disconnected from social actors.

The category of alternative medicines makes it possible to distinguish the traditional medicines of any society from those recently popularized, such as yoga, acupuncture, reiki, and the like. Some alternatives have oriental origin, and are really traditional, as in the case of acupuncture, or yoga; others are more modern, such as reiki and shiatsu. Others are of Western origin, such as homeopathy and naturopathy. Finally, it is convenient to use this category because its services are mainly addressed to middle or upper classes because of the relatively high cost of alternative therapies.

In the past, a category of religious medicines would have been unthinkable. Separating the medical sphere from the religious one is part of the cultural common vision in Western secularized societies. In this frame, Dunn suggested that medical systems must include only deliberate behavior that affects health, without involving incidental behaviors with latent health functions (1977: 141). Thus, totemic taboos, ritual activities, and other customs are not medical behaviors. Medical behaviors may consist of all activities and considerations bearing on the effect of disease, but it is possible to argue that any behavior could, at some level, have some effect on health maintenance or susceptibility to disease (Press 1980: 46).

Without creating a category of religious medicine, various authors have stressed the role of religious healing and ritual therapies. McGuire underlines that ritual healing extends into middle-class communities (1998: 9-10). In a case study of suburban communities in New Jersey, USA, McGuire proposes the following categories of ritual healing: a) healing in Christian groups, b) traditional metaphysical movements, c) Eastern meditation and human potential groups, d) psychic and occult healing, e) manipulation /technique practitioners (1988: 18). Blair O'Connor noted that religious traditions have historically been closely associated with healing practices in societies around the world (1995: 15-6). In fact, myth and religion include the ultimate explanations and meanings regarding serious illnesses and death.

Csordas and Kleinman (1996) claim that religious healing is a generalized tool in health care. They argue that religious healing appears just as frequently in traditional as in complex societies. Religious healing has to do with diverse practices from shamanism to movements of faith healing. Field (2001) stressed that health and well-being conceptions—and their therapeutic side effects—and other procedures are part of the Buddhism, Jainism, and Tantric goals and worldviews.

Numerous behaviors overlap in the medical and religious spheres. The search for ritual therapies, the performance of other religious practices, and the manipulation of sacred symbols, in order to prevent and treat illness,

are conscious and growing actions in varied contexts, from shamanistic practices to Catholic charismatic and Pentecostal healings to Oriental therapeutic rituals.

Privileging the social actors' point of view abandons the reductionist vision of knowledge and practices of other societies and cultures based on ethnocentric prejudices and works to understand the complexity of illness and health experienced vividly by human beings.

The proposal of religious medicines (or therapies) as a category does not attempt to deny the manipulation of the sacred or the mythical-religious aspects and rituals that may be corroborated in traditional medicines. If religion is understood in terms of experience or encounters with the sacred, it is true that the majority of "nonconventional" medicines may involve certain religious beliefs and practices. In that case, it might be objected that the category of religious medicine becomes diluted or that it lacks of precision. Nonetheless, it gains sense when limiting the religious medicines category to the health offerings and treatments of illness and affliction carried out in the contexts of the Churches that Weber called institutionalized religions. I refer more specifically to the treatments offered through ritual therapies performed in the contexts of Catholicism, Evangelism, Pentecostalism, Judaism and Islam, which possess their own unique characteristics. In institutionalized religions, liturgies clearly define who can heal and who cannot, and which are the ways that become channels of the God to heal or solve other types of misfortunes. In other words, it is established who may be endowed with healing charisma. Significantly, these religions appear mostly in secularized societies, unlike the cases of native shamanism or medicines in Oriental societies where traditionally cosmologic-religious conceptions permeate all spheres of existence.

The religions mentioned are a part of the same cultural background, therefore their rituals and beliefs have deep links and likenesses based on the Bible. These religions have their own specialists, who serve a similar role to shamans and other therapists in the cases of other medicines. Their therapeutic ritual and religious healing activities are easily identified and can be contrasted with any other kind of religious healing performed in any local or regional medical care. The universal nature of Christianity turned these religious therapies into ecumenical offers and, even considering the syncretic processes that these practices have generated, the category of religious medicine permits distinguishing Christian ritual therapy from other ritual therapies in any part of the world. Given the universalistic nature of Christianity, it is a generalized therapeutic offering which spread throughout the world via the missionary. It is not a therapeutic offering limited by geography, only available or viable in countries of Western and Christian tradition. Religious offering are therapeutic from the social actors' point of view. Consequently, based on phenomenological insight, this category is theoretically and methodologically supported. Finally, this category facilitates the observation and description statistically significant differences in treatment (Idoyaga Molina and Luxardo, 2005)[2].

We could also add to this category the ritual therapeutic practices which have arisen through the synthesis of Christian or Muslim traditions with other cultural beliefs, such as the Churches

known as Afro-Argentine in which Christian conceptions are evident. Similar seems to be Rasanayagam´s asseverations (2006- 378-81) about the syncretism in relation to Muslim Churches in Uzbekistan. Nowadays the states attempt to monopolize the answer to the question of what it means to be a Muslim. Some of the local practices tolerated by the government would be considered heterodox by followers of a scripturalist interpretation of Islam. Such practices involve healing with the aid of spirits and a variety of new age healing ideas.

In summary, I understand religious medicines as beliefs, notions, and practices carried out in the context of ceremonies, services, rituals, and other activities addressed to the corporal and spiritual healing of the petitioners, that are supported by the beliefs, conceptions, and cosmologies of the mentioned religions.

In the case of Catholicism, activities are carried out both within the institutional religious contexts and by specialists who are not officially recognized (Viturro, 1998:133). Therapeutic actions include healings during the cults' services or in private consultations and asking clerics for prayers in the name of a sick person (this may even be done by phone to closed order nuns, such as the Barefoot Carmelites). Some healing techniques are the blessing, healing touch, prayers, contact with the tabernacle, and exorcisms. Broadly speaking, practices of the different Pentecostal and Evangelical churches are like each other and, at the same time, to those of Catholicism. Individual and collective prayer, reading of the Bible in search of explanations, healing touch, exorcism, invocation of the Holy Spirit, and trances are common practices. The latter allows the individual access to a numinous experience and direct interaction with the Deity.

In Judaism several trends exist; it is generally recognized that some rabbis, though not all, have the power to cure and carry out other transforming actions. They are usually known as *tsaddik,* implying that they are wise men. In the Hasidic congregation, those leaders having the charisma are called *rebe*. Healing techniques include prayer, the repetition of formulas, and, less frequently, the healing touch. Among Muslims, there are specific priests or imams who engage in healing more frequently. They also resort to prayer, to blessings, and to repeating formulas and spells that are sometimes accompanied by gestures indicating the rejection of illness.

Among Muslims and Jews, accesses to therapeutic rituals are limited to the persons really engaged with the Church activities and beliefs. In contrast, Catholics, Pentecostals, and Evangelical, admit into their cults any kind of people—it might even be said that the experience of being cured is a way of recruiting new believers.

Lay-treatment, also called popular medicine, is a more complex category than it seems. Referring to popular medicine, authors have emphasized its connection to popular culture as a whole (Kleinman 1980: 50) and recognized that there may be more than a singular popular medicine. Press (1980: 50) suggests at least two types—biomedical popular medicine and Zinacatecan popular medicine—and would surely accept the existence of more popular medicines in any intercultural context, minimally, as many popular medicines as there are ethnic groups. Nevertheless, this does not exhaust the types of

lay treatments that may appear in any society where alternative medicines have spread. These alternatives also generate their own lay practices. For instance, any of the yoga techniques—breathing, meditation, *asanas,* etc.—may be performed individually with therapeutic goals; the same could be said with respect to mental control, reiki, and so on. Regarding religious therapeutic rituals, the prayer group shows the lay treatments in the context of Catholicism, as well as praying novenas, making promises to saints or virgins, participating in healing missal, and so on. It means that lay-treatments derive from more than a singular coherent culture and implies that many kinds of lay-treatments are present in a particular context, and that these different types of lay-treatments may respond to different cultural beliefs and behaviors. There is not only one popular culture framing the lay-treatments, and these cultures are not necessarily closer to traditional medicines than others, even if they might be closer to biomedicine. Of course, lay-treatments involve individual, familiar, social, and community levels of practices. I prefer the term lay-treatment to popular medicine because in Spanish, the expression popular medicine is often used as a synonym of traditional medicine. Therefore, it is not associated with lay practices.

Lay-treatments are varied. Biomedical lay treatment implies the consumption of unrestricted laboratory medication and psychotropic remedies, among other possibilities, without medical prescription. Traditional lay-treatment or domestic medicine shares the paradigm of the traditional healers or *curanderos*, including home vernacular remedies such as plasters, infusions, baths, and certain therapeutic rituals of catholic roots, such as healing formulas. Alternative lay treatments entail the use of techniques learned and derived from alternative medicines, such as relaxation or mental control procedures, hydrotherapy practices, and consuming natural remedies. Religious lay-treatments include prayer groups, *novenas*, promises, healing touch practiced by a non-specialist, praying, collective healing rituals, and so on.

This proposal explains healthcare through the overlapping of biomedicine, traditional medicine, religious medicine, alternative medicine, and lay-treatments. Cultural, socioeconomic, and ethnic differences determine if the number of overlapping medicines includes all of these offerings or only some of them.

These categories allow distinguishing: a) traditional medicines from any country from the alternative medicines, spread in the last decades; and b) traditional healers from lay healers with some popular expertise, who have been confused by some Argentine and Latin American authors because their likenesses in relation to the use of cataplasms, cupping, several remedies of a vegetal origin, and therapeutic rituals of catholic roots. The category of religious medicines that, owing to their specificity and connection with some religions, is not convenient to include in the alternative medicines, as certain authors do under the category of spiritual therapies (Eisemberg et al., 1993: 247; Franco and Pecci, 2003: 112).

The ethno-medical configuration in the Metropolitan Area of Buenos Aires

In order to show the usefulness of the

proposed categories, I give a short example based on ethnographic data. Biomedicine is the legal practice in Argentina. Public biomedical and psychotherapeutic services are universal and free to the entire population through hospitals and less complex units called health centers since the beginning of the 20th century. These services guarantee biomedical attention to low-income people, as well as marginal and immigrant populations. Individuals of the middle and upper classes usually access private health services, which facilitate more efficient and less bureaucratic care, though it depends on the cost, the quality, and the services offered. The more expensive options permit the client to select the professionals out of the list of options given by the insurance company and recognize specialties that are not available in public units, such as homeopathy.

The traditional medicines are shamanisms and *curanderismo* (folk healing). The latter is more widespread and is common in both rural and urban areas. Broadly speaking, traditional healers' or *curanderos´* notions and practices synthesize ancient biomedical knowledge—many of humoral medicine origin—with European folk medical traditions and therapeutic rituals, mostly of Catholic roots (Idoyaga Molina, 1999/2000: 260; 2008: 69; Idoyaga Molina and Sarudianky, 2011: 316). This is not to deny the dynamics of history, as traditional healers incorporate and reconfigure several elements, types of services, and knowledge, allowing them to adapt to the new local and global contexts.

Shamanisms are the traditional medicines of the natives of Great Chaco, Misiones, and Patagonia. These shamanisms are very different institutions and underwent different changes due to their contact situation with white colonists (Turner, 1988). Toba and Pilaga natives, who migrated from the Gran Chaco to the Metropolitan Area, brought their shamanistic practices with them, which are offered only to natives.

In Argentina, religious healings are usual practiced in the services and other activities of Evangelist, Pentecostal, Catholic, Jewish, and Muslim groups. The Pentecostal and Evangelical Churches got believers mainly from the lower classes, though, recently, they have reached all social classes. Religious identity is a basic tool when selecting or deciding upon a combination of therapies; following the advice of their pastors, believers reject the traditional healing, Afro- Argentine cults, Catholic practices, and any other religious healings outside of their own Church (Idoyaga Molina, 1999: 23). The impact of the charismatic and other catholic groups may be noted in the entire population regardless of socioeconomic factors and levels of education (Funes, 2008: 8; Idoyaga Molina, 1999: 24). Afro-Argentine cults are widespread in Buenos Aires, having recruited individuals mostly from the lower classes (Frigerio and Carrozzi, 1992:40). However, their services—cleansings, predictions, and sorcery—are utilized by individuals of all socioeconomic levels, including the upper class. In contrast, Jewish and Muslim ritual-therapeutic practices are not open to the public; instead, they are an option only for those individuals committed to the religious groups.

The alternative medicines offered include yoga, reiki, reflexology, Ayurvedic medicine or Indian humoral medicine, aromatherapy,

chromo-therapy, gem-therapy, acupuncture, tai-chi-chuan, neo-shamanism, massage-therapy, Zen meditation, Chinese traditional medicine—incorporating Chinese humoral medicine—healing touch, shiatsu, digit-puncture, astrology, natural medicine, and qi gong, among many others. Alternative medicines are usually expensive, available only in urban contexts, and target middle- and upper-class sectors. The most accepted is yoga, followed by reiki, reflexology, acupuncture, and shiatsu. These aspects place alternative medicines out of the possibilities of the lower classes. Nevertheless, there are cheap and even free offers, especially of yoga, in Parish and neighborhood clubs and accessible options of shiatsu, reiki, and reflexology (Saizar, 2009: 24-27; Pitluk, 2006: 38). Even some hospitals in Buenos Aires offer free of yoga, reiki, qi gong, reflexology, meditation, Tibetan therapeutic music, tai-chi-chuan, and other workshops under the guise of activities to improve quality of life (Saizar and Korman, 2012: 4). From the professionals´ perspectives, yoga is recommended to patients suffering from anxiety or depression (Korman 2010: 69).

Other alternatives are less popular, like neo-shamanism, which is usually experienced by people with long trajectories in this type of therapy (Idoyaga Molina, 1997 b: 430).

To consider the strategies of therapeutic complementariness in the Metropolitan Area linked to culturally homogeneous units, I must distinguish among various groups: a) culturally conservative popular sectors mainly composed of European-Argentines and Middle East-Argentines; b) culturally modern middle and upper classes mainly composed of European-Argentines and Middle East-Argentines; c) culturally native aboriginal immigrants from Gran Chaco; d) culturally westernized and conservative immigrants from neighbouring countries, mostly mestizo; and e) recent immigrants from African and Asian countries.

The first group attends to their health mainly by overlapping traditional lay-treatment, biomedicine, and *curanderismo*. The latter involves consuming remedies usually classified in hot and cold categories, fumigating, and many therapeutic rituals, some of them associated with particular folk illnesses—calling the soul back, putting the baby inside a just dying cow, diagnosing with oil and water—and others used to heal all kinds of sickness episodes—reciting the acute spell, lighting saints and virgins, consuming blessed water (Idoyaga Molina, 2002b: 123-28). Religious medicines, such as Catholic and Evangelical, and less frequently Afro-Argentine cults, may be added if the illness episode is prolonged. Alternative medicines are rare and the last option; among them the preferred is yoga (Idoyaga Molina, 2000: 25-7; Idoyaga Molina and Krause, 2001/2: 211). Shamanism as an option is practically unknown.

Persons from the middle and upper classes combine all the kinds of available medicine and make appointments with specialists of any type of medicine. These therapeutic pathways combine traditional medicine, religious medicine, alternative medicine, biomedicine, and lay-treatments.

The most common complementariness is among biomedicine, religious and alternative medicines, and lay-treatments. Despite yoga being the preferred alternative medicine, the

variety and the frequency of medicines consulted and used is relevant. Catholic therapeutic rituals are the most selected among religious offerings due to its being the religion of most of the middle and upper classes. In this arena, it is common participate in healing Mass, while the typical therapeutic rituals are the healing touch and prayer. Less frequently, the complementariness involves only biomedicine and alternative medicine or biomedicine and religious practices. In only a few cases, patients add traditional medicine to the combination of biomedicine, religious, and alternative medicines, and shamanism is an unknown option. Finally, the most unusual behavior is to reject any medicine other than biomedicine, or to combine different medicines but avoid biomedicine.

Regarding lay treatments, all of them are used, including biomedical remedies without professional prescription. Participation in prayer groups is the most popular option among religious lay-treatments (Idoyaga Molina and Funes, 2011: 60), using healing spells, and another techniques to treat the *empacho* (blocked digestion) and headaches are popular among traditional lay-treatments (Idoyaga Molina and Sacristan Romero, 2008: 204-08), and a variety of alternative medicine procedures, such as relaxation, meditation, breathing, exercising (*asana*), auto-administration of energy practicing reiki, shiatsu, gem-therapy, and so on are used.

Toba and Pilaga Indians, immigrants from the Central Chaco, combine shamanism, biomedicine, the ritual-therapeutic practices of the Pentecostal Indian, and native lay-treatment, which has incorporated some Western traditional lay-treatment procedures because of the contact situation. In this context, therapeutic plans may occasionally include consulting a *curandero* or traditional healer, and European-Argentines and mestizos may visit a shaman (Martínez, 2007:215).

The strategies of immigrants of neighboring countries are similar; they mainly combine biomedicine, *curanderismo* or traditional medicine, traditional lay-treatment, and natural medicine or naturopathy lay-treatment, the last also being rooted in humoral medicine (Idoyaga Molina et al., 2003:174). Occasionally, some of them practice yoga through the hospital´s free offers. Finally, some of them are Evangelical believers who consequently reject traditional medicine, which is substituted by therapeutic rituals of their own Church. Those who identify as Catholics may add to the aforementioned medicines some Catholic therapeutic rituals.

African immigrants combine their own lay-treatments, biomedicine, and sometimes their own traditional medicines when they can. Others reject traditional medicine because they converted to Islam.

Chinese immigrants combine their own lay-treatments, biomedicine, and Chinese traditional medicines, especially those available in the Chinese neighborhoods, where the specialists are Chinese natives.

The perspective sustained tries to make it easier to distinguish differences among social classes, cultural, and ethnic groups. If I had used just three categories -professional, folk (or traditional), and popular-, it would have seemed that all the population of the Metropolitan Area of Buenos Aires access and combine the same medicines over and beyond biomedicine, which is not true.

Conclusions

Therapeutic complementariness strategies have increased over the last decades and include individuals from all social and economic classes, all education levels, and from different ethnicities and cultures. Therapeutic complementariness is probably a universal strategy in healthcare, leading researchers to classify medicines and to generate concepts that embrace all types of healthcare combinations. The classifications proposed by social scientists based on ethnographic work and those proposed in the biomedical fields are essentially divergent. Despite the desire to reach a consensus about healthcare classifications, one has yet to be found.

The classification presented herein is an attempt to make some clarifications of the possible limits of the three well-established categories of medicine by analyzing intercultural contexts. At the same time, a greater number of categories is necessary where multiethnic and multicultural populations coexist and try to solve their health problems in conglomerates, informed by various social actors' points of view. The lay treatments seem to be larger than the popular medicine associated with a popular culture would suggest. Further, I want to call attention to the uncritical use of some categories, just because the user referred to such expression—as meditation—without considering the wider frame of meaning in which the practice takes place.

Notes

[1] This classification was first drafted as an ethno-medical system in Idoyaga Molina (1997a).

[2] Alternative medicines are more widely used by individuals from the middle and upper classes than by individuals from the lower class, whereas religious medicines are longitudinal and are frequently used by all classes. Consequently, if we add religious therapies to a category of spiritual healing listed among alternative, the prevalence of class difference disappears. In Rigor we did not have a category of spiritual healing, but we could consider in its place Zen Buddhist meditation—which was on our alternatives list—to make clear what I am trying to explain. In other words, in a sample of 200 patients suffering from cancer, 76% were treated with at least one alternative, and 55 % were treated with at least one religious' therapy (Idoyaga Molina and Luxardo, 2005: 391-92). If we add religious therapies to a category of spiritual healing (Buddhist meditation) among the alternative medicines, it would increase the percentage of alternatives used, and would increase the percentage of the spiritual healing from 7% to 62%. The alternative percentage would increase because not all the users of religious medicine had also used alternative medicines.

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