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Culture matters: integration of folk medicine in health care in Russia*

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Introduction

The integration of complementary and alternative medicine (CAM) into orthodox health care systems and the professionalisation of these services are global phenomena. These developments place new challenges on both the governance of health care and the dominance of orthodox medicine (Saks, 2006). However, national governments and professional bodies respond in different ways to these new demands. Integration and professionalisation are driven by various forces and the success of new professional projects is uneven. This chapter explores the processes of integration of CAM into the official health care system in Russia. It places the demand for, and supply of, 'folk medicine' in the context of fundamental political and cultural changes in Russian society; this includes tensions and contradictions in the discourse of 'folk medicine' and the professionalisation of alternative medical practitioners.

We introduce an anthropological approach to the study of professions that highlights the significance of culture and context. We explore the dynamics here to answer three main questions: What is the global context for the integration of professional cultures in health care? What are the main cultural, economical and political conditions that shape the dynamics of relations between CAM and orthodox medicine in Russia? What is the nature of contemporary collaboration between CAM practitioners and orthodox doctors? We draw on material from the research project on 'The dynamics of social and professional status of traditional medicine specialists in Russia', which builds upon a larger project funded by INTAS, the European Union Fund for Eastern European research (for details see Yurchenko and Saks, 2006). The research is based on a content analysis of popular medical periodicals over the last 15 years and qualitative interviews with CAM providers who practise different forms of ethno-treatment. Here we focus on the in-depth interviews with medically qualified and lay practitioners of CAM in the provincial city of Saratov.

The chapter starts by discussing the global dimensions of the integration of CAM with orthodox health care, arguing for cross-cultural sensitivity. This is followed by an analysis of the integration of CAM services in the context of the changing Russian society and health care system. The findings from our interviews highlight the flexibility of boundaries between doctors

and healers and the diverse strategies of professionalisation in the context of Russian culture and market-driven transformations. Finally, some conclusions are drawn on culture as a resource for professionalisation.

Integration of diverse professional cultures: global dimensions and local conditions

Scholarly debate highlights the pressures for more integrated health care systems in different national contexts. Changes are driven by CAM users and specialists, by business and sometimes also by official medicine. Integration may appear in the shape of unification, incorporation or subordination of CAM practices to biomedically dominated health systems (Saks, 2006). Integration may be furthered by occupational groups at the margins of biomedically centred health care systems that promote more flexible models of professionalisation and the permeability of professional boundaries (see for instance, Hirschhorn and Bourgeault, 2005; Kelner et al, 2006; Kuhlmann, 2006; Saks, this volume). However, it is not only the non-medically qualified groups, but also doctors and other health professionals who may accelerate the ingress of CAM into health care systems, following market interests and pragmatic approaches (Saks, 2003; Shival, 1999). Existing research highlights highly diverse strategies and interests relating to the provision of CAM services and the professionalisation of these groups. For instance, CAM specialists may use potential of evidence-based practice and research in order to support arguments for the effectiveness and efficacy of these services (Giordano et al, 2003; Lee-Treweek and Oerton, 2003), but they may also oppose an evidence-based approach to specific therapies as it challenges a more holistic approach. The 'incorporationist scenario' (Saks, 2006) seems to be an outcome of different stakeholder arrangements and power relations in health care. One key dimension that may lead to the success or failure of professionalisation is the state-profession relationship and the regulatory structure of health care systems (Kelner et al, 2004). In drawing on historical analysis and a comparison of Britain and the United States (US), Saks (2003, p 89) was able to demonstrate the significance of the "differential legal terms on which the exclusionary social closure of medicine was based". His research revealed a more rapid move towards the integration of alternative medicine in the US as compared to Britain (Saks, 2003). Accordingly, tighter regulation together with market driven interests may further the integration of CAM practices.

Another important driver towards inclusion is consumer demand, although it does not necessarily translate into a 'public' interest. Kelner and colleagues (2004) assessed the views of Canadian government spokespersons on the efforts of CAM groups to take their place in the formal health care system. Their findings highlight tensions between the mandate of the state to protect the public and its obligation to respond to consumer demand (see also Saks, 2003). While expressing some sympathy with CAM, the interviews with governmental representatives nevertheless indicated hesitation and caution (Kelner et al, 2004). Another example is in the US where many CAM services are not covered by health insurance, although

they meet the needs and demands of patients (Vallerand et al, 2003). In these circumstances, integration is especially supported by the wealthier consumers (Barrett, 2003).

A third dimension that shapes patterns of integration, and the very concept of CAM itself, is 'culture'. In Turkey, for instance, the CAM integration project conflicts with earlier modernisation policies that oppose longstanding forms of religious and political culture represented by traditional healers. This has led to its marginalisation (Dole, 2004). In drawing on Asian medicine and acupuncture, Kim (2006) directs our attention towards the interaction between traditional medicine and science and introduces the notion of 'transculturalism' to grasp hybrid formations.

Globalisation shapes the provision, content and organisation of health care services. In particular, the introduction of internal markets and the politics of evidence-based medicine and medical performance further the legitimisation of certain types of services and the establishment of global standards and rules of conduct for practitioners. For example, Tibetan medicine is widespread in Europe and North America. Although Tibetan medicine is produced globally, it is consumed within a 'local' tradition (Janes, 2002). This illustration highlights that globalisation cuts deeply into local contexts via various flows of people, images, technologies and ideas; it enhances redefinitions of identity, suffering and corporeal practices among consumers and providers in different parts of the world. Mass consumption of local healing practices is structured by the laws of the global market, and at the same time these practices may be locally produced and consumed. We argue that there is a need for cross-cultural sensitivity in the study of medical practice, especially the use of knowledge about illness and treatment experiences shared by a patient and a practitioner (Seymour-Smith, 1986). We can explore the cognitive and symbolic assessments of situations, symptoms and feelings that are linked to treatment practices. We have to acknowledge, however, that medicine of any type is also an ideological practice and the symbols of healing are the symbols of power.

The health care system in Russia: from monopoly to inclusion?

Classification of the types of medical systems suggested by Stepan (1985) distinguishes monopolistic/exclusive, tolerant, mixed, inclusive and integrated medical systems according to their openness to different healing practices. A typical example of an exclusive or monopolist system is the Soviet health care system where doctors were state servants employed by the Commissariat (later the Ministry) of Health, while all other groups of healers were banned in the USSR in 1923.

Although under socialism CAM "did not fit into modernized socialized medicine based on biomedical principles" (Yurchenko and Saks, 2006, p 110), the interest in folk medical practices, especially herbal remedies, was noted in the history of Soviet medicine. In 1919, for instance, a laboratory was established in Leningrad to study the healing properties of plants and herbs. The All-Soviet Chemical and Pharmaceutical Research

Institute began systematic research into folk medicine in 1928 and, in 1931, a special All-Soviet Research Institute of Herbs and Aromatic Herbs was established, which even operated experimental laboratories in the province.

Interest in *Fitoterapiya* (herbalism) greatly increased during World War II, the 'Great Patriotic War', due to the shortage of drugs and medical services (Kovaleva, 1972; Luria and Sarkisov, 1941). Herbs were collected with the help of schoolchildren and teachers and subsequently processed on an industrial scale. While lay healers continued to perform their work underground, official medicine's interest in herbal treatment continued to grow. Pharmacies sold different kind of herbs and doctors often prescribed them due to a lack of other drugs.

The rise of CAM as a means of political and cultural change

Unorthodox remedies and services started to become more widely popular in the early 1980s. Medical schools also started offering further qualification courses in manual therapy and reflex therapy. A medical counter culture emerged in Russia that mirrored earlier developments in Western health systems (Yurchenko and Saks, 2006). The growth of CAM popularity was part of a process of liberation in Russia, and the sign of a new willingness to end the mono-ideological system of knowledge and beliefs. Soviet power was on the wane throughout the 1980s and 1990s and crucial changes took place in society, leading to the transformation of the planned economy into a market economy. The health care system was in crisis and science, industry, technology and social services lagged far behind Western European countries. Soviet medicine was starved of resources, especially in rural areas (Yurchenko and Saks, 2006). In urban areas, patients were dissatisfied with health services and technologies and with the nature of communication with medical doctors. Queuing was a way of life at the health centres (*polikliniki*) and psychologists and social workers lacked the necessary skills to assist people with diseases, traumas and other ailments (Vein, 1990).

In this climate of change, reports abounded in the mass media that either validated or repudiated the beneficial effects of telekinesis, clairvoyance, astrology, psychic power, magic, and other similar services (Romanov and Iarskaia-Smirnova, 2007). Towards the late 1980s and early 1990s numerous healers became national heroes by allegedly treating the whole population through free and accessible television and radio performances that included hypnotism, brightening water and even 'curative silences'. Such 'miracles' and 'heroes' served public demand well as a sort of 'cargocult' during a transitional period when the loss or painful revision of political ideals caused feelings of uncertainty. According to Vein (1990) diverse political, cultural and social movements began to surface, views became more polarised and the interests of many people inclined to mysticism. In 1996 the Ministry of Health of the Russian Federation – concerned with the high risk of the mass hypnosis of the wider public – approved a statute to regulate non-traditional healing methods (Ministry of Health Care,

1996), thus putting an end to curative psychics' television séances. The 'medical counter culture', however, was socialised to some extent by the earlier efforts of Soviet health care authorities. Official medicine in Soviet Russia had gradually opened up to CAM practices and methods, although the acknowledgement of CAM practitioners as legitimate agents of the health care system was still a matter of public concern and suspicion. There were attempts to replace the various healers with medically qualified CAM specialists. Yurchenko and Saks (2006) highlight that the Ministry of Health was willing to protect the public from 'quacks'; it was argued that "the supply of medically qualified doctors with knowledge of CAM therapies should be increased to the point where there would no longer be demand for lay CAM therapists" (Karpeev, cited in Yurchenko and Saks, 2006, p 112).

Culture: the symbolic and social capital of CAM practitioners

Many lay folk healers oppose medical qualification per se, as it contradicts the nature of their 'symbolic capital'. Then, as now, folk healers see themselves and their healing powers as part of a long tradition. This is reflected, for instance, in traditional Russian or exotic names - like 'Baba Ania' (Granny Ania) or 'Iverona Sigismundovna' - mysterious biographical facts and claims to have inherited a 'special gift', the leitmotiv in interviews with folk healers (Iarskaia-Smirnova and Grigorieva, 2006). The concept of professionalisation, generally perceived hitherto as a means to obtain 'ranking signs', such as diplomas, theoretical knowledge, status and higher wages, is reconsidered here in the context of the contradictions of the folkurban symbolic continuum. Notably, some of the medically qualified CAM specialists emphasised their modern and 'rational' qualifications and, at the same time, legitimised their choice of practice through the roots of their family trees and socialisation - for example, growing up in a certain, usually 'oriental', ethnic community.

An official discourse has stressed that medical diplomas are important indicators of 'real' doctors as opposed to 'quacks' (Serebriakov, 2000, p 35). However, the discourse often falls short of reality (Yurchenko and Saks, 2006). As one of our informants noted:

"There are no good or bad, right or wrong methods. There are only good or bad doctors. There are more than enough frauds that have got their diploma and are working in medicine." (Acupuncture specialist)

In 1993 a legal framework for regulating CAM services was established. This law "proclaimed that only medically qualified doctors who received state registration could practise CAM therapies. Only one group of lay practitioners was exempt, namely officially termed 'folk healers' who could prove that they had a special gift for healing" (Yurchenko and Saks, 2006, p 113). The healers, too, in order to get the right to work in the area of 'folk medicine (healing)' have to obtain an official certificate and go through the authority's licensing procedures.

The debate on 'non-traditional' medicine was at the top of the agenda during the 1990s. However, at the turn of the twenty-first century Russian popular-scientific medical journals reported irregular renewal of, and even falling, interest in folk medicine (Iarskaia-Smirnova and Grigorieva, 2006). It is interesting to note here that the contemporary Russian medical discourse runs counter to international developments. For instance, in 2002 the World Health Organisation established the first global strategy aimed at the integration of traditional and alternative medicine (Holliday, 2003).

By the late 1990s the 'industry of sorcery' had lost its democratic missionary nature and become selectively available to different social classes of consumers. It was possible to find not only such figures as a neighbourhood fortune-teller or healer from the free-ads newspaper, but also 'corporate magicians' – exclusive herbalists with exotic diplomas working in parlours known to only a small circle of the initiated. The fashion among the political and celebrity elite thereby enabled some healers to successfully turn their symbolic capital into market power.

Demand and supply: drivers towards inclusion of CAM services

While CAM providers use the media to promote their interests (see Valente, 2003, for developments in Canada), orthodox doctors make use of their power to shape the official discourse. They predict a limited demand for folk medicine and attempt to link the provision of CAM to specific ethnic and cultural groups and/or mentally ill people, effectively reducing demand. In contrast to this, however, the INTAS project data reveal that up to half medical doctors working in state or municipal health services also practise CAM. Their motives for doing so are diverse, but include "easing the workload for problems that orthodox medicine cannot solve" (Yurchenko and Saks, 2006, pp 122-3). Financial motives also play a part, as CAM services are in demand among more affluent clients, but are not included on the list of Obligatory Medical Insurance Law. Patients have to pay for these services themselves and, in addition, providers do not need expensive equipment and can even see patients at home.

However, doctors practising CAM are not only following their own particular interests, they are also responding to public demand. They are in an emerging labour market for medical professionals and take part in the new marketing strategies of pharmaceutical companies. Within the group of CAM practitioners, manual therapists, herbal therapists, homoeopaths and healers are most actively engaged in private practice. According to our interviewees, private practice can take the form of office-based specialists, specialists at a private hospital or a state medical institution, or by offering home visits with or without a license.

Survey data from 1,500 respondents in 44 Russian regions confirm the demand for CAM services: in 2002 every fourth Russian citizen consulted CAM specialists, although only nine percent said they trusted them more than those practising orthodox medicine (Fund of Public Opinion, 2002). However, the wording of the question in this survey may have heavily

shaped the responses: 'Have you or have you not appealed to the services of non-traditional medicine (folk healers, herbalists [*travnikov*], psychics, etc.)?' The illustrations given of the category 'non-traditional medicine' represent the most contested areas and less 'scientific' and 'rational' forms of 'non-traditional medicine'. Moreover, the word '*travnik*' was used to define a herbalist instead of '*fitoterapevt*'. Consequently, the list of practitioners is exclusively associated with backwardness and irrationality and may well have skewed the answers. Interestingly, this report is published on the Fund of Public Opinion website under the rubric of 'mysticism'.

A broader range of 'non-traditional medicine' and less stereotyped categories was used in another survey of 1,004 respondents in St Petersburg (Goryunov and Khlopushin, 2005). This survey revealed an overall higher demand for CAM services, which were defined as 'manual therapy, herbal treatment, acupuncture, bioenergetics and natural healing methods'. 73 percent said they had consulted a CAM specialist at least once, with manual therapy and herbal therapy the most frequent. These services were seven to ten times more popular than acupuncture, bioenergetics and spiritual healing. The preferences may be the result of the cultural identity of the consumers and also mirror the supply of CAM services. According to the INTAS data on 604 medical practitioners from three different regions of Russia, the most popular forms of CAM among the medically qualified were herbalism (51 percent), homoeopathy (28 percent) and acupuncture (13 percent), while the least popular method was healing that was practised by only 3 percent of medical practitioners (Yurchenko and Saks, 2006).

Users of folk medicine have different motives, depending on their level of income. More wealthy consumers emphasise the specific nature of the healer-patient relationship, while the less affluent say they choose CAM because it is cheap, but offers healing remedies. Rich people are more inclined to follow prestigious consumption practices by having their own personal healer or a 'famous sorcerer'; such practices are increasing, especially in show business and similar circles. We can conclude that the provision of CAM services is driven by both demand and supply led changes. The following section further explores the latter.

Pathways to integration: flexible professional strategies and the significance of culture

Qualitative interviews with medically qualified CAM specialists provide deeper insights into professional interests and power relations that influence the integration of CAM services in the provision of health care. The interviews take into account the different organisational forms of providing CAM services; six participants in the study worked in state and municipal health centres, one in a medical department of an industrial enterprise and the others in private settings.

One important finding was that most of the interviewees did not like to be called 'non-traditional' doctors; they perceived this label as derogatory and

saw it as representing an attempt to separate them from the mainstream of the Russian health care system. They criticised the division of treatments and healing approaches as a social construction and called for the integration of different perspectives:

"The term 'alternative medicine' depends on one's point of view. If we speak about a patient, there is no 'alternative' or 'not alternative' medicine. In the first place doctors have to help a patient. And we have to decide whether to use bees, to beat the drum and to conjure out evil spirits or give aspirin for headache. Irrespective of what will help, it is the result that matters. 'Folk medicine'? I don't know who has differentiated between these terms! ... How can we distinguish them? All the terms and classifications are context dependent." (Manual therapist)

CAM practitioners criticised the building of barriers between disciplines, professions and approaches in order to divide power and resources. At the same time, they stressed the differences between alternative and orthodox medicine. The interviewees stated that - in contrast to orthodox medical practitioners - diagnostic procedures are more accurate and they have more time to talk to patients. Apart from this, CAM practitioners stressed their holistic vision of 'do not just treat but cure' and paying attention to the patient's body and soul. They also stressed their distinct cultural identity, but claimed that they had a general commitment to medical ethics: "Ethics of doctor-patient relations must be upheld whatever methods one uses" (Manual therapist). At the same time, economic aspects interface with this 'moral space' and can result in different qualities of service: "A person comes here and pays money. Thus, one can treat medicine like a product and in this case it can be of high or low quality" (Hirudo therapist).

Unorthodox remedies and services were not necessarily cheaper than biomedical therapies. As Russia was entering a global market in the early 1990s commercial networks, like Herbalife, entered the market. Some medical doctors, who might have sincerely believed in the value of herbs, actively promoted such networks. However, their 'altruistic mission' could be questioned as these doctors benefited from financial rewards from these networks. Even today, medical doctors working at health centres and clinics are involved in the advertising and dissemination of specific CAM products. Some are even part-time employees of the companies whose products they recommend and prescribe to their patients. CAM specialists refer to culture and ethnicity in order to gain the trust of consumers and assure a high quality of service; one example is the ethnic Korean specialists who represent an Oriental school of reflex therapy. The findings of the qualitative interviews highlight how market conditions and cultural identity are merged into a specific strategy to promote professional interests.

CAM and orthodox doctors: signs of integration and collaboration

Relationships between CAM and orthodox doctors vary from acknowledgement and respect to conflict and scepticism, with a prevalence of the latter attitude. The widespread personal and professional prejudice of orthodox

doctors towards CAM hampers potential successful integration. Negative attitudes are supported by fears of "being accused of placing extra financial burdens on the patient" and a doctor "sometimes finds it easier to send a patient to a public service" (Manual therapist). Despite the overall suspicion on the side of orthodox medicine, some of our interviewees noted that doctors of various specialties refer their patients to them. However, as one therapist said, many "people come from polyclinics with a clear diagnosis but without any referral, just on their own" (Herbalist). The attitudes of orthodox doctors towards CAM differ from one setting to another and depend on many circumstances. Important predictors for the integration of CAM are the relationships within one institution and mutual cooperation between different specialists. A herbalist explained: "People come to my office from neuropathologists, gastroenterologists, allergists, paediatrics. In this polyclinic it is the official way. I write down my treatment method on their medical card. ... I guess a friendly attitude is the main thing here. I think it's collaboration and trust. ... Among the patients there are many doctors and their children. They are interested in the result, they continue visiting me. They show their interest, ask questions, they want to read something on the topic because it's new to them." (Herbalist)

Some signs are emerging that point towards an increasing integration of CAM services; for instance, phone calls from polyclinics "that have no specialists in acupuncture, and they just ask if it's possible to refer [a patient]" (Reflex therapist). Medical students and doctors doing courses in centres of non-traditional medicine and later referring their patients to that centre are another example of a change: "Certainly, it happens but usually these are the doctors who did a course in these centres" (Healer). A further sign of a change in attitude is represented by private health centres which integrate CAM services in order to offer comprehensive medical services in one place.

Integration of CAM services and collaboration between orthodox and 'nontraditional' doctors provide a number of benefits, but 'boundary work' and conflicting professional interests persist. According to one acupuncture specialist, despite signs of change orthodox doctors continue to distrust 'frauds' or 'rivals':

"In my opinion we have reached a step in the development of medicine when the merger of traditional and non-traditional medicine is necessary. But I don't know how much time it will take. ... Official medicine and people who are at its head do not turn to us." (Reflex therapist)

According to a one CAM practitioner, "conflicts already lie in the past but collaboration is still in the future" (Homoeopath), although herbal, hirudo and apio therapists stated that they generally had good relations with official medicine.

In times of modernisation the health system's tolerance to natural products

is not only related to tradition. It is also advanced by new patterns of preventive medicine that include unorthodox remedies. It is important to emphasise here that the market economy supports these kinds of CAM services in the Russian health system; wealthy consumers often use these services for the prestigious consumption of wellness, fitness and beauty services. Another driving force, however, is the limitations of orthodox medicine, especially in the field of chronic illnesses. Different market conditions and professional interests thus shape the various pathways towards integration.

Contextualising integration: diversity of professional interests and market conditions

Within the group of CAM providers, healers seem to be the most isolated group. One major area of conflict is the lack of evidence for their activities: "One does not know what it is. ... there is some concern, gossip abounds, rumours about this, arguments for and against..." (Healer). Overall, the healers were not satisfied with the level of collaboration with official doctors; they noted the lack of contact, mistrust, and ignorance of their practice and methods - even in the face of evidence of success. Collaboration depended on context and personal contacts and was usually limited to one institution.

In contrast, manual therapists were more optimistic about the future and stressed the importance of professionalisation and increasing integration. The number of professionals in this area is on the increase; and manual therapy gained legal recognition and was officially included in the list of medical specialties in 1998:

"The hardest things are in the past, I mean when a great number of non-specialists harmed many people, when manual therapy was not included in the list of medical specialties and everybody did what they wanted. Now we face a rapid development, collaboration with various related areas of medicine, ... fundamental research techniques, colleagues that share their experience without concern and prejudice."
(Manual therapist)

Homoeopathy shows yet another configuration of drivers, and barriers, to integration. Most importantly, homoeopathy clashes with the interests of global pharmaceutical corporations and the provision of very cheap treatment options goes against the business interests of these companies. The strategies and opportunities are highly diverse but in general CAM practitioners are keen to believe they can compete with official doctors.

This confidence was initially nurtured by an awareness of the deficits of orthodox medicine: treatment at state institutions is seldom of high quality and the situation is aggravated by red tape and sometimes rudeness. Participants in our study were also well aware that CAM methods are acknowledged and widely applied in the Western world. They believe that developments in Russia will follow these pathways and a growing interest

in CAM services will emerge by 'enlightening' people via the mass media and medical education.

Culture, integration and professional power relations

This chapter has explored the integration of 'folk medicine' into the Russian health care system in the context of the political, economic and social transformation of Russian society. We have introduced an anthropological approach and emphasised the notion of culture. The findings reveal that integration is a continuing process driven by various players and interests, as well as by global and local conditions. However, culture provides a 'reference point' for both the users and the providers of services. Within the configuration of demand and supply led changes – and professional, gov-

ernmental and public interests – culture gives CAM services legitimation and may thus serve to facilitate integration in the health care system. Our findings indicate that collaboration between orthodox and alternative medicine and the different groups of providers is largely on the increase. At the same time, 'boundary work' needs to be undertaken and attempts to monopolise power and resources have not yet been overcome.

One novel aspect, however, is that boundaries are becoming more fluid, the strategies of professionalisation more flexible and resources for constructing professional identity more diverse. Identity is not only based on an orthodox academic community, but also on experiences in a number of different professional and institutional settings. Furthermore, the success and failure of professional services and their legitimacy depend on various conditions, in particular: successful advertising, market conditions and demand from, and satisfaction of, the target group. The majority of CAM services in Russia are commercial and can be offered in self-sustained departments of state medical institutions or in the private sector. In this situation, different strategies for advancing new professional projects are combined that are often perceived as contradictory to successful professionalisation. Our findings highlight classic elements of professionalism (state regulation, academic community and professional identity), market logic (advertising, market conditions and user satisfaction), and culture used as 'social capital'. In this respect, the research provides another example of differing pathways towards professionalisation. Developments in Russia partially mirror the strategies of CAM providers observed in Western health systems (Kelner et al, 2006; Saks, 2003) and, more generally, of new professional groups operating at the margins of health care systems (see also Formadi, this volume).

Culture furnishes health care providers with 'social capital' that may even be transformed into market power (economic capital). However, CAM providers are part of a social, political and economic power system that promotes biomedical approaches. Representatives of orthodox doctors and administrators of health care organisations express their 'neutrality' and tolerance towards collaboration between traditional and non-traditional specialists; health centres employ medically qualified and certified CAM

specialists, and say there is no sound reason to ban holistic approaches. However, acknowledgement of CAM and its integration has still to be fully achieved, and CAM providers are marginalised in some areas. Most effective collaboration is developed within organisational settings – usually private health centres – that offer a combination of orthodox medicine and CAM services at every stage of treatment and rehabilitation.

In conclusion, professional groups use resources like culture and develop new strategies to professionalise; a 'public interest' in these services and improved collaboration with orthodox health care providers facilitates inclusion in the health care system. However, CAM specialists continue to be 'unequal partners' in a health system governed by biomedicine. Orthodox doctors may refer to CAM specialists as 'colleagues' but nontraditional medicine is characterised as 'grandma's methods'. This reflects the subordination of CAM services and their control by orthodox doctors and health care authorities. Consequently, culture may turn out to be a highly ambiguous resource for the inclusion of CAM services and even a facilitator of the 'incorporationist scenario' for biomedicine (Saks, 2006).

Note

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