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Heilungskooperationen. Heterogene Kooperation jenseits dyadischer Interaktionen

Healing Cooperations. Heterogenous Collaborations beyond Dyadic Interactions

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Umschlagbild | Cover Picture
Das Umschlagbild wurde von Małgorzata Stelmaszyk im Juni 2015 in der Nähe von Kyzyl, der Hauptstadt von Tuva, aufgenommen. Es zeigt den Abschluss eines Rituals zu Ehren des Geistes des Frühlings. Die Schamanin verabschiedet die Geister, die für die Heilungskooperation zusammengekommen waren.
The cover picture was taken by Małgorzata Stelmaszyk near Kyzyl, the capital of Tuva, in June 2015. It shows the final moment of the ritual dedicated to the spirit of the spring. The shaman bids farewell to the spirits who arrived for the healing cooperation.

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EDITORIAL
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THEMENHEFT
THEMATIC ISSUE

Healing Cooperations
Heterogenous Collaborations Beyond Dyadic Interactions
edited by Cornelius Schubert & Ehler Voss

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Fröhliche Wissenschaft Medizinanthropologie

Editorial

EHLER VOSS

„Es geht nicht nur um Heilung, es geht um alles“, sagte mir Grete Häusler, die mittlerweile verstorbene Gründerin und langjährige Leiterin des Bruno-Gröning-Freundeskreises während meiner ethnologischen Feldforschung zu Medialem Heilen in Deutschland. Gemeint war, dass es im Zusammenhang ihrer Praktiken um eine umfassende Erkenntnis geht, die mit den in diesem Kreis erfahrenen Heilungen bewiesen wird: die Existenz eines göttlichen Heilstroms, vermittelt auch noch nach seinem Tod in den 1950er Jahren durch den um Hilfe und Heilung angerufenen Bruno Gröning und mit ihm die Existenz eines christlichen Gottes mit allen moralischen Implikationen, die diese Erkenntnis für das eigene Handeln mit sich bringt.

Mit der Aussage, es gehe nicht nur um Heilung, sondern ums Ganze (um „alles“), hat Grete Häusler eine Grundeinsicht der Medizinethnologie formuliert: Heilungspraktiken sind immer verbunden mit dem, was oft als Weltbild bezeichnet wird: mit Ideologien, Kosmologien, Mythologien, Orthodoxien, das heißt mit spezifischen Konzeptionen von Krankheit und Heilung und ihren moralischen Ursachen, von der Verfasstheit der Menschen und ihrer Stellung im Kosmos. Und es ist ein altes Thema der Medizinethnologie, den Zusammenhang von Religion und Medizin bzw. die Kontingenz ihrer Unterscheidungen herauszustellen (vgl. Obrist, Dilger & Bruchhausen 2004). Doch während diese Einsicht in die Zusammenhänge von Religion und Medizin Grete Häusler in die Eindeutigkeit führt, in der sie die Handlungsinitiativen einzelner Akteure trennen, zentrieren, zuordnen und dadurch zwischen Gut und Böse unterscheiden kann, führt diese Erkenntnis die Medizinethnologie in die Uneindeutigkeit. Abgesehen davon, dass Religionen wie Medizinen selten kohärent und widerspruchsfrei sind, spielen im Kontext von Heilungspraktiken auch ökonomische, politische, juristische und wissenschaftliche (Macht-)Interessen bzw. Akteure eine Rolle, die sich weder kategorial noch lokal eingrenzen lassen (vgl. Dilger & Hadolt 2010, Scheper-Hughes & Lock 1987) und die in ihrem Zusammenspiel zumeist sehr ambivalente Effekte erzeugen und es auf diese Weise häufig erschweren, eindeutig zwischen Gut und Böse zu unterscheiden.

Eine solche Ausweitung der Betrachtung von Krankheit und Heilung wird häufig unter der Formel der sozialen oder kulturellen Dimensionen der Medizin verhandelt, und auch das „Ganze“ spielt dabei eine große und scheinbar vertraute Rolle, sei es als das *fait social total* der sozialanthropologischen oder als die Berufung auf einen Holismus der Kultur in der kulturanthropologischen Analyse. Doch auch die Kategorie des Sozialen und Kulturellen gerät in der Medizinethnologie zunehmend in Bewegung, und dies nicht nur durch die Herausstellung eines kulturellen oder sozialen Holismus als illusionäre Konstruktion der Forschenden, für die die – allerdings auch schon damals als „gesunkenes Kulturgut“ interpretierbare – Writing-Culture-Debatte der 1980er Jahre symbolisch geworden ist (Clifford & Marcus 1986, Schüttpelz 2017). Viele der insgesamt sehr heterogenen Forschungen, die ebenfalls seit den 1980er Jahren unter dem weiten Label Science and Technology Studies (STS) versammelt werden und häufig medizinbezogene Themen aufgreifen, zeigen, wie sich Fremd- und Selbstwahrnehmung gegenseitig erhellen können, scheinen die STS doch das Potential einer ethnologischen Perspektive viel deutlicher als viele Ethnolog*innen selbst erkannt zu haben, sodass die von der Ethnologie inspirierte konsequente Ausarbeitung einer symmetrischen Anthropologie in den STS der Ethnologie heute nicht selten selbst als Vorbild und Inspirationsquelle dient. Ein entscheidender Punkt hierbei ist nicht nur die konsequente Aufhebung der Trennung von angeblich fortschrittlichem Modernem und rückständigem Primitivem, sondern auch die von objektiver Natur und subjektiver Kultur sowie von aktiven Menschen und passiven Dingen und damit die Verabschiedung einer separat untersuchbaren Sphäre des Sozialen bzw. Kulturellen.

Wie ändern diese Einsichten die Praktiken der Medizinethnologie? Alle Implikationen des oben Genannten ernst genommen, kann eine STS-inspirierte Medizinethnologie sich nur als Medizinanthropologie verstehen und zwar in dem weiten Sinne, der sowohl Ethnographie als auch Ethnologie umschließt (vgl. LÉVI-STRAUSS 1978 [1958]), sich dabei aber nicht auf das Soziale oder Kulturelle beschränkt, sondern „Naturen/Kulturen“ (LATOUR 1998 [1991]) oder „Naturecultures“ (HARAWAY 2003) bzw. – um durch die Verwendung neuer Begriffe nicht in alte Denkmuster zu verfallen – „Kollektive“ (LATOUR 1998 [1991]) oder „Assemblagen“ (DELEUZE & GUATTARI 1992 [1980], ONG & COLLIER 2005) aus menschlichen und nichtmenschlichen Akteuren in den Blick nimmt. Nicht zuletzt vor dem Hintergrund der jüngsten Wahl des Fachverbands deutscher Ethnolog*innen, in einer kontrovers diskutierten Anlehnung an einen internationalen Sprachgebrauch den interdisziplinär verwendeten Begriff der Anthropologie in Form einer Sozial- und Kulturanthropologie zur Selbstbeschreibung zu wählen (vgl. ANTWEILER, KNECHT, VOSS & ZILLINGER 2018), wird es schwierig sein, alternativ hierzu den Begriff der Ethnologie in dem genannten Sinne interdisziplinär neu zu begründen. Zwar ging vor Kurzem die *Arbeitsgemeinschaft Ethnomedizin* mit ihrer Umbenennung in *Arbeitsgemeinschaft Ethnologie und Medizin* in diese Richtung, jedoch fiel die Entscheidung für den Begriff der Ethnologie anstelle der Anthropologie hauptsächlich vor dem Hintergrund des Wunschs, das alte Akronym AGEM zu behalten. Da viele in der heutigen Verwendung des Begriffs Ethnomedizin die Intentionen der Gründungsgeneration nicht mehr repräsentiert sahen, bringt die Arbeitsgemeinschaft ihren interdisziplinären und anthropologischen Anspruch nun durch die Kombination der Ethnologie mit dem weiten Begriff der Medizin zum Ausdruck.

Einer auf diese Weise interdisziplinär verstandenen Medizinanthropologie muss es darum gehen, „den ganzen Laden“ zu untersuchen, wie es BRUNO LATOUR (1998 [1991]: 135) ausdrückt, das heißt, nicht nur Heilung, sondern „alles“ damit Zusammenhängende zu untersuchen. Aber anders als in der klassischen Sozial- und Kulturanthropologie ist das Ganze, um das es in den STS und einer hier skizzierten Medizinanthropologie geht, vor allem der ganze Faden, dem man mit seinen Verknüpfungen folgen muss, um in einem unvermeidlich kreativen Akt einen kontroversen Ausschnitt in allen seinen Dimensionen zu verstehen, und nicht ein Territorium, dessen Muster sich als Ganzes aus der Vogelschau enthüllt. Dabei werden alle relevant werdenden Kategorien in ihren ständigen Entstehungen und Stabilisierungsversuchen in den Blick genommen sowie durch eine Symmetrisierung von Kulturen und Naturen, Menschen und Dingen, Geschichten und Gegenwarten, Fremdem und Eigenem, Globalem und Lokalem und somit auch von sogenannten Biomedizinen und anderen Medizinen, die herkömmlichen modernen Dichotomien in die Schwebe gebracht. Es geht dabei um das Herausarbeiten und Aushalten der Ambivalenz und damit verbundener Umschlagpunkte – sei es in der Genforschung, die neue Biosozialitäten schafft, welche gleichzeitig emanzipieren und ausschließen (GUELL 2011) und deren Anspruch auf Vorhersehbar- und Beherrschbarkeit sich in eine moderne Divinationspraktik verwandelt (LOCK 2005), sei es bei dem Einsatz technischer Geräte in der Klinik, mit dem eine präzisere Diagnostik und Behandlung angestrebt wird, der aber gleichzeitig dazu führt, die Ketten zirkulierender Referenzen zwischen Körper und Technik zu verlängern und die damit verbundenen Unsicherheiten teilweise zu erhöhen (SCHUBERT 2006), sei es bei Dingen wie einer Krankenakte, die Diagnosen nicht einfach aufzeichnet, sondern koproduziert und das damit verbundene ‚Vergessen‘ entscheidender Daten eine medizinische Behandlung gleichzeitig verändert wie überhaupt erst ermöglicht (BERG 1996), sei es in der evidenzbasierten Medizin, deren Anspruch auf undogmatische Beurteilungen rein nach Kriterien medizinischer Wirksamkeit in das Dogma einer zweifelhaften empirischen Methode umschlägt (BORCK 2016), sei es bei der Emanzipation von Herrschaftswissen und asymmetrischen Arzt-Patient-Beziehungen durch die Nutzung alternativer Kommunikationsplattformen, die die Patient*innen gleichzeitig zum Spielball profitorientierter Pharmafirmen werden lässt (DUMIT 2012), oder sei es bei einem Exorzismus, der das, was er austreibt, gleichzeitig mit hervorbringt (LEWIS 1971).

Eine symmetrische Betrachtung vor dem Hintergrund vervielfältigter, sich in und durch ein Netzwerk ergebender und nur in ihren lokalen Verknüpfungen ethnographisch untersuchbarer Handlungsinitiativen, bei denen keine die vollständige Kontrolle über ablaufende Prozesse hat, hilft der Medizinanthropologie, sich von den Illusionen traditioneller moderner Reinigungsarbeiten zu befreien und schützt damit vor paternalistischer Überheblichkeit, die von einer Überlegenheit moderner Institutionen ausgeht, bei der sich „gut gemeint" oft als das Gegenteil von gut herausstellt. In einer symmetrischen Anthropologie entpuppt sich der Relativismus – in Form eines relativistischen Relativismus bzw. eines Relationismus (LATOUR 1998 [1991]) – als Aufklärung. Und wie in den Entzauberungspraktiken, an denen Jeanne Favret-Saada in den 1970er Jahren im ländlichen Westfrankreich teilnahm, bleibt mit dem damit verbundenen Schwebezustand der Ambivalenz in vielen Fällen das Versprechen oder zumindest die Hoffnung einer Wendung zum Guten verbunden (FAVRET-SAADA 1979 [1977], vgl. SCHÜTTPELZ & VOSS 2017).

Für all diese Ambivalenzen und Symmetrisierungen steht der Begriff Curare, der im Lateinischen unter anderem behandeln, heilen und pflegen bedeutet, aber auch aus verschiedenen Pflanzen des Amazonasgebiets gewonnene Substanzen bezeichnet, welche auf der einen Seite in Südamerika als tödliches Pfeilgift Anwendung finden und auf der anderen Seite im Europa des 20. Jahrhunderts durch ihre Verwendung in der Anästhesie zur Heilung beitragen und damit nicht nur – wie auch die seit Jahren durch diese Zeitschrift geisternden Alraunen – auf die dosisabhängige tödliche-heilende Ambivalenz von Giften verweist, sondern mit dieser Art des Medizintransfers auch für eine Symmetrisierung der gängigen hierarchischen Unterscheidung von überlegener und einheitlich gedachter Biomedizin und unterlegenen uneinheitlich gedachten anderen Medizinen steht.

Auch das vorliegende Curare-Heft handelt von Symmetrisierungen. Das Thema *Heilungskooperationen* geht auf eine gleichnamige Konferenz im letzten Jahr zurück, die die *Arbeitsgemeinschaft Ethnologie und Medizin* in Kooperation mit dem *Sonderforschungsbereich Medien der Kooperation* an der Universität Siegen durchgeführt hat und die den Auftakt einer Trilogie darstellt, welche sich einem symmetrisierenden und erweiterten Blick auf die Heiler-Klient-Beziehung widmet. Aufbauend auf der frühen medizinanthropologischen Erkenntnis, dass die Erforschung der Heiler-Klient-Beziehung keine Aussagen über den tatsächlichen Umgang mit Krankheit der Klienten zulässt, weil dieser sowohl auf der Seite der Klienten als auch der der Heilenden oft geprägt ist von der mehr oder weniger verborgenen experimentellen Anwendung unterschiedlichster und sich zum Teil widersprechender Verfahren, sollten mit der ersten Tagung darüber hinaus vor allem auch die nicht-menschlichen Dinge, Substanzen, Götter, Geister, Konzepte, Infrastrukturen usw. mit ihren kalkulierbaren wie unkalkulierbaren Handlungsinitiativen einbezogen werden, um so zu einer umfassenden Betrachtung von Heilungspraktiken als immer schon kooperatives Unternehmen zu kommen, das nicht unbedingt eines Konsenses bedarf und welches nur vor dem Hintergrund verschiedener Infrastrukturen und Öffentlichkeiten verstanden werden kann. Der Begriff der Heilungskooperationen kann somit als Begriff verstanden werden, mit dem sich nach einer Verabschiedung getrennter Sphären des Sozialen auf der einen und des Biologischen auf der anderen, alle sich bei bestimmten Heilungspraktiken versammelnden menschlichen und nicht-menschlichen Akteure in ihrem kontroversen kollektiven Zusammenspiel untersuchen lassen (also „alles").

Die zweite Tagung zum Thema Heilungskooperationen fand in diesem Jahr (2018) unter dem Titel *Preparing for Patients. Learning the skills and values of healing encounters* ebenfalls in Siegen statt und widmete sich der Seite der Heilungstätigen mit der Frage, wie sich Angehörige von Heilberufen auf die Kooperation mit Patient*innen kooperativ vorbereiten und wie dabei explizit und nicht explizit gemachtes Wissen und Werte vermittelt werden. Eine dritte Tagung zum Thema wird 2019 unter dem Titel *Preparing for Physicians. The ambivalences of empowerment* am gleichen Ort stattfinden und die Seite der Patient*innen und ihre Vorbereitungen auf den Arztbesuch in den Blick nehmen, welche sich, wie schon erwähnt, häufig zwischen der Emanzipation von Herrschaftsstrukturen und der manipulierenden Beeinflussung durch zum Teil stark von Profitinteressen geleitete Akteure bewegen. Wir sind gespannt, wie weit sich diese Tagungen am Ende zu einem Gesamtbild fügen lassen.

Die hier umrissene medizinanthropologische Perspektive war in der Ethnomedizin seit ihren radikalen Anfängen in den 1970er Jahren bereits angelegt, und auch der Begriff der Medizinanthropologie fand damals teilweise schon Verwendung (vgl. Hauschild 2010, Kutalek, Münzenmeier & Prinz 2012, Schröder 2008, 2012). Ekkehard Schröder hat als erstes studentisches Mitglied im Gründungsjahr 1970 und später treibende Kraft der *Arbeitsgemeinschaft Ethnomedizin* sowie als Mitbegründer und langjähriger Herausgeber der vorliegenden Zeitschrift dieses Feld zusammengehalten und mitgeprägt. Ich danke ihm herzlich für sein Vertrauen und seine Unterstützung bei der Übergabe an eine nächste Generation und freue mich, ab diesem Heft im Auftrag der von nun an *Arbeitsgemeinschaft Ethnologie und Medizin* genannten AGEM als Herausgeber an der Gestaltung der *Curare* mitwirken zu können – eine Zeitschrift, die mit ihrem Namen auf ein noch längst nicht ausgereiztes, die eigene Involviertheit, Perspektivität und Kreativität anerkennendes, oszillierend in der Mitte verankertes, durch seine Paradoxien jenseits von Gut und Böse nur lachend ertragbares und, weil es um alle Kräfte geht, die uns Menschen bewegen, an Heilung zu glauben, letztlich doch optimistisches Programm verweist: Die Fröhliche Wissenschaft Medizinanthropologie.

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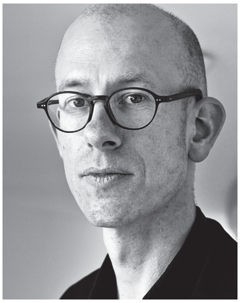

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Beyond Dyadic Interactions

An Introduction to the Thematic Issue on Healing Cooperations

CORNELIUS SCHUBERT & EHLER VOSS

This thematic issue of *Curare* presents papers from the conference *Healing Cooperations. Cooperation with and without Consensus in the Context of Illness and Healing,* which was held in Siegen, Germany in June 2016.

Researchers in the fields of anthropology and medicine are familiar with the observation that people have different and shifting explanations for health and illness and know of different approaches to maintain the former and treat the latter. Medical anthropology has long since shown that researching the dyadic relations between those providing and those seeking health services does not necessarily result in a more thorough understanding of the situated, practical, diverse, and sometimes conflicting ways of handling disease and illness. The focus on dyadic relationships within healing encounters often falls short, since many people seeking health services* are involved in a complex network of friends, acquaintances, and family members; they get advice from various professional and lay sources, and thus try different and often contradictory therapies—alternately, simultaneously, or in a synthesizing way. Likewise, there is plurality on the healer's side. Rarely is one supplier of a health service competent to cure all existing afflictions and conditions; they are usually specialized in a specific set of disorders and discomforts, as well as the treatments thereof. We see this as a fundamental characteristic of all healing encounters, no matter whether the healers are medical doctors, non-medical professionals, alternative practitioners, or any other medicine man or woman or if the patients are considered to be clients, customers or consumers. To deal with this situation, healers also often use different kinds of treatment and often pass patients on to other healers. This is not only the case in the highly specialized area of modern biomedicine, which is fragmented into differing approaches and faced with the division of the body and corresponding medical experts for specific body parts, but also among non-biomedical therapies. Healers and patients are thus confronted with a multitude of complementary and partially contradicting therapies, which then lead to open and experimental practices on both sides (cf. FEIERMAN 1985; GOOD & DEL VECCHIO GOOD 1994; Hsu 2017; JANZEN 1978; 1987; KRAUSE, PARKIN & ALEX 2014; LOCK & GORDON 1988; LOCK & NGUYEN 2010; LUIG 2007; MAIN 2016; NICHTER 1980; WHYTE 1997).

What is more, these heterogeneous and experimental practices are typically performed in a social sphere where the individual actions are evaluated, judged, and maybe even sanctioned by others. Thus, patients as well as healers sometimes have to hide the plurality of their practices if they are concerned about their reputation—for example, physicians who are afraid of losing their authority because they sometimes advise patients to see a shaman or even themselves act as a shaman outside their professional consulting hours; or patients who are afraid of impairing their relation to a special healer if the healer finds out that the patient did not follow the healer's advice and uses treatments that the healer judges to be superstitious and ridiculous (VOSS 2011). More often than not, healing practices beyond the private healer-patient interactions are a public affair, ranging from the inclusion of friends, families, or colleagues to recovery processes shared on social media. In line with ZILLINGER (2017), we conceive the publics of healing cooperations not in a dichotomy of prefigured public and private spheres, but as continuously negotiated domains of attendance, for instance in the potentially problematic visibility of doctors' orders in

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* In the following, we use the term healer to comprise all those providing health services, irrespective of the individual cosmology, ideology, and treatment. Similarly, we use the term patient to denote everyone seeking health services.

patients' files (GARFINKEL 1967: 186–207; FREIDSON 1975: 167–185).

In medical anthropology, the coexistence, interaction, and fusion of different healing methods have been discussed for a long time using concepts such as "medical pluralism" (LESLIE 1975, 1976, 1980), "multiple medical realities" (JOHANNESSEN & LÁZÁR 2006), "medical diversity" (PARKIN 2013), "super-diversity" (VERTOVEC 2007, GREEN, DAVISON, BRADBY, KRAUSE, MEJIAS & ALEX 2014), "hyperdiversity" (HANNAH 2011), "medical landscapes" (HSU 2008), or "medicoscapes" (HÖRBST & WOLF 2014). Broadening our perspective to include the diverse healing practices beyond the dyadic healer-patient interaction, we may use these concepts—even if they are partly perceived as oppositions. But this is just one step in the direction of a much deeper understanding of complex healing practices that involve a wide range of human actors, but also a possible even broader range of non-human agents such as viruses, spirits, drugs, forces, bacteria, machines, plants, genes, memes, and other media, means, or infrastructures. Pushing beyond dyadic conceptions of healer-patient relationships and past the multiplicities of synchronous and asynchronous bilateral interactions, we thus see the need to fundamentally de-center our analysis of healing cooperations. This entails looking past prominent issues such as empowerment or emancipation in professional healing encounters. It takes into account that healing practices are always ingrained with popular knowledge that adds to, contributes to, or conflicts with the esoteric or specialized knowledge of healers. And it acknowledges that the plurality of involved entities is a constitutive feature of all healing encounters.

We take our cue from the discussions sparked around the involvement of non-humans in social arrangements in Science and Technology Studies (STS) and Actor-Network Theory (ANT, cf. LATOUR 2005), that have been fruitfully extended to biomedical practices in many cases (BERG & MOL 1998). With the term healing cooperation, we aim to focus on the issues of how the heterogeneous entities must work together if they are to create successful healing encounters. Our understanding of cooperation does not presuppose any kind of harmony or shared goals between the parties involved. Cooperation does not require consensus; it may entail conflict or some form of disparate interests that become interrelated during the healing encounter (PROUT 1996). In addition to the insights of medical anthropology mentioned above, this understanding of cooperation draws on sources from medical sociology and STS, which we aim to combine. Medical sociology has studied doctor-patient relationships, mainly in biomedicine, for many decades. This line of research has questioned the patriarchic-professional model of medical dominance and control for a long time. Shared decision-making, evidence-based medicine, and new medical technologies have profoundly changed communicative patterns of the medical encounter (cf. PILNICK *et al.* 2010). Especially the convergence of medical and media technologies poses new questions of how healthcare will be organized beyond dyadic healer-patient relationships in the future (cf. LUPTON 2017). We thus consider healing cooperations to be hybrid and distributed arrangements that include a vast array of diagnostic and therapeutic technologies (MOL 2002) and information technologies (MORT *et al.* 2009) within organized settings of healthcare. However, we also see the need to extend the focus beyond the prominent study of biomedical technologies to a plurality of healing encounters. Healing cooperations can thus be understood as cooperative and situated practices with or without consensus within an assemblage of human and non-human entities. The cooperative tasks bring and hold together the bodies, ideologies, tools, institutions, and all the other agencies directly or indirectly involved. Because healing encounters are not isolated instances, but connected with personal histories, diverse publics, overarching institutions, and conflicting ideologies, we would expect manifold negotiations and articulations to take place (cf. STRAUSS *et al.* 1985). With this concept of healing cooperations in mind, we asked for contributions to the conference that examine the details of historical and current healing cooperations around the world. While many of the contributions still use healer-patient interactions as starting points for their analysis, we can also see them as exploring diverse healing cooperations and employing different theoretical framings.

In his contribution on *Bionetworking in the Context of Autoimmunity in Brazil,* MÁRCIO VILAR takes us into the quite new and broad field of autoimmune diseases and focusses on a controversy about their treatment in Brazil. The conventional biomedical way of treating autoimmunity is based mainly on suppressing the immune system, since it is assumed that such diseases can be traced back to immune reactions that affect parts of the patient's own body and result in inflammatory processes. Even if the exact cause remains unknown, the majority of medical authorities sees the body at war against itself. This kind of treatment has been challenged by other physicians who experiment with immune-stimulating drugs and claim to get good results. Against the background of his own positive experiences with immune-stimulant therapy, VILAR describes how the physicians supporting a way of therapy that contradicts the conventional wisdom cooperate, in a legal grey zone and more or less secretly and often informally through the Internet, with thousands of patients to use and to support this kind of marginalized medicine. VILAR presents a dynamic and fascinating assemblage in which lawyers, politicians, pharmacists, physicians, patients, the media, drugs, and bodies intersect in a controversy about cosmology, authority, empowerment, and innovation. And it remains to be seen how well the common suppression of stimulation will work and how far bio-networking in Brazil will change local and global treatments of autoimmunity.

HELMAR KURZ's contribution on *Healing Cooperations of Spiritism, Biomedicine, and Psychiatry in Brazil and Germany* is based on anthropological fieldwork in the two countries between 2015–2017, where he focusses on the transfer of Kardecist healing practices from Brazil to Germany by Brazilian immigrants supported by Germans. He presents four ethnographic examples from Brazil and Germany and shows in detail how healers and patients of spiritistic, biomedical, and psychiatric institutions cooperate with each other in Brazil. Even if the cooperation between spiritists and psychiatrists is often attacked, e. g. by psychiatry reformers and Evangelical Churches, spiritist practices are nevertheless integrated in public mental healthcare, and in addition some psychiatrists and physicians refer their patients to spiritistic institutions when their own therapies are not successful. In Germany, the situation is different and the cooperations between spiritism, biomedicine, and psychiatry are not established. KURZ does not discuss the attempts to establish such a cooperation in Germany, but the conflicts that appeared within a group of Brazilian and German spiritists about culture and identity finally resulted in the dissolution of the group.

In her article on *Curses and Systems of Healing Cooperation in Post-Soviet Tuva, Siberia*, based on 12 months of anthropological fieldwork in Kyzyl, Siberia in 2015 and 2016, MAŁGORZATA STELMASZYK introduces us to a cosmos that is inhabited by invisible spirits, multi-layered personhoods, and the omnipresent peril of being cursed. She describes the local healing practices of shamans, lamas, and physicians against the background of the post-Soviet situation and elaborates in detail how different healers are supposed to be competent for different illnesses, as well as how cooperation between shamans, lamas, physicians, and patients works, how they explicitly and more or less discretely refer their patients to each other, and how, even in cases where healers are opposed to each other and do not recommend trying other healing practices, a cooperation between them is often initiated by the clients who, due to the hidden and secret realm of curses, usually visit all three kinds of healers simultaneously to cover all possible sources of their discomforts.

The background of KATRE KOPPEL's contribution on *Why Chinese Medicine is Making its Way into Estonian Healthcare* is the demarcation line between biomedicine and alternative medicines that is traditionally drawn very clearly in Estonia and that led to a general practice—quite contrary to the post-Soviet practices STELMASZYK describes—of keeping quiet about visiting alternative healers, since biomedicine is regarded as being evidence-based and scientific and everything else that is labeled alternative medicine is regarded as being not evidence-based and thus not scientific. Expressing sympathy for anything related to the broad category of alternative healing may therefore cast one's reputation into question. KOPPEL did anthropological fieldwork for almost two years, and in her article, she focuses on the boundaries between biomedicine and the fuzzy category of Chinese medicine, which marked an exception within non-biomedical therapies in Estonia. Medical techniques from China were practiced by physicians already in the Soviet Union and acupuncture held a kind of privileged position among more or less secretly practiced alternative therapies all over the Soviet Union. After the end of the Soviet Union, acupuncture first declined institutionally, but in the course of time became more and more accepted and finally escaped being categorized as alternative medicine. KOPPEL follows the ups and downs of acupuncture in Estonia that can be understood only by analyzing the complex interplay of the traditional handling of Chinese medicine in the area, single charismatic brokers who advertise Chinese medicine, and the general ideological, economic, and political developments in the Estonian health care system in relation to global tendencies.

DANUTA PENKALA-GAWĘCKA's contribution on *Complementary Medicine and Biomedicine in Healthcare Systems of Post-Soviet Kazakhstan and Kyrgyzstan* is based on several years of fieldwork between 1995 and 2000 as well as from 2011 to 2013. She also focusses on the constructed great divide between biomedical and non-biomedical therapies and the various ways of collaboration between actors from both sides. Like STELMASZYK and KOPPEL have shown, PENKALA-GAWĘCKA elaborates that, even if non-biomedical treatment was present during Soviet times, the range of alternative treatment options has increased since then, especially in urban areas. She analyzes the categories in the making, emphasizing the categories' flexibility, fuzziness, and strategic applications. She shows how the process of professionalization of healing methods that are labeled traditional led to the establishment of various institutions, certifications, and official licenses and to a situation in which alternative healers were able to work in public and private healthcare institutions and in which many physicians combine their practices with alternative medical practices and often do not refer solely to science, but also to tradition in order to advertise their expertise. But against the background of changing economic, political, and religious circumstances, the situation for alternative healers became worse and the boundaries between biomedical and non-biomedical therapies were reified, especially in Kyrgyzstan—mainly through boundary work by those physicians who themselves integrate alternative healing practices in their work.

Cooperation and conflict are at the center of the contribution by PIERRE PFÜTSCH, who analyzes the institutional developments of *Paramedics in West Germany* from 1949 to 1990. Their professional formation is closely linked to a conflict over authority with physicians. On the one hand, early modes of cooperation between paramedics and emergency doctors also sparked conflict between the two parties involved. On the other hand, this initial conflict led in the late 1980s to the reformulation of the respective tasks and obligations. PFÜTSCH reconstructs the historical narrative of the conflict using letters to the editor in the German specialist periodical "Rettungsdienst", where both paramedics and physicians voice their concerns about the difficult issues of cooperation. Yet, as PFÜTSCH shows, this conflict resonates far beyond the concrete working relations between paramedics and physicians, because it includes the charity organizations that provide the rescue services in addition to the German Medical Association and political agencies from the institutional side. Only the careful maneuvering of the divergent interests and the codification in written law over time led to a settlement of this professional healing cooperation.

STEFAN REINSCH, JÖRG NIEWÖHNER, and DORIS STAAB offer an inside perspective on becoming a specialized cystic fibrosis physician in their paper on *The Ecology of Care in Cystic Fibrosis*. They employ a practice-theoretical perspective on the dynamics of learning as distributed activity. Using participant observations from a cystic fibrosis ward in a German university hospital, the paper traces how novice physicians learn to manage chronic diseases within the complex ecology of the ward. Their professional knowledge and their professional identity evolve in parallel, as they become members of a specific community of practice that is composed not only of doctors, but also of nurses and patients. Such a community essentially defines the situated healing cooperations of cystic fibrosis as it also negotiates the identities of physicians, nurses, and patients. It also formats the mobilization and coordination of numerous heterogeneous entities, from diverse human actors and their knowledge of managing cystic fibrosis to the social organization of a medical ward, the usefulness of specific drugs in the course of treatment, and the legal consequences of possible life-threatening conditions. Thus, managing a serious chronic disease cuts across the established responsibilities of the involved groups and actors, creating the need for constantly negotiating the situated healing cooperations of routine medical treatment.

In the last contribution, the psychologist CHRISTIAN ERBACHER adopts Wittgenstein's method of looking for analogues and explains his philosophical work using the concepts of philosophy, therapy, and mythology that Wittgenstein himself already used. Just as reading philosophical texts is a cooperative practice between author, text, and reader, philosophy becomes a cooperative practice of healing mental cramps through clarification and finally replacing one mythology by another in a kind of endless therapy. Even if there is similarity between philosophy and psychotherapy, they are not the same. ERBACHER thereby shows how healing cooperation turns out to be a situational and open-ended cooperative practice that does not give up hope for relief, and he is optimistic that further delving into the therapeutic aspects of Wittgenstein's work could be fruitful for healers and thus for their patients.

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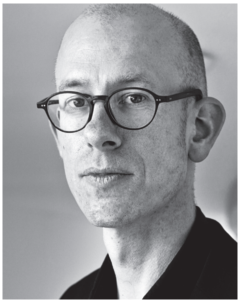

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Moving between “Chronic Diseases” and “Secret Cures”

Bionetworking in the Context of Autoimmunity in Brazil*

MÁRCIO VILAR

Abstract In this article, I explore from an anthropological Global South perspective the following question: how does the engagement of patients and physicians for unauthorized immunostimulant therapies for autoimmunity in Brazil impact the globally established biomedicine based on the use of palliative immunosuppressive drugs? My aim is to understand changing perceptions related to immunity, autoimmunity, immunological therapies, biotechnological innovation and regulation as constitutive of contemporary biomedical culture and of life sciences in Brazil. By addressing some forms of collaboration and deviance between patients with autoimmunity and physicians, I describe how they adopt and promote immunostimulant drugs as scientific innovations that meet difficulties to become legalized and that tend to be disqualified by established biomedical authorities. For it, I present a case study of regulatory experience and make a comparative digression involving respectively two immunostimulant therapies: the “anti-brucellic vaccine” (VAB—*vacina anti-brucélica*), and; the “autohemotherapy” (AHT—*autohemoterapia*). Like other immunostimulant therapies, both VAB and AHT are strongly associable with regenerative medicine and may be accessed through the informal sector. My argument is that established biomedicine has become increasingly circumnavigated in contemporary Brazil, while regenerative medicine is simultaneously emerging as a transnational paradigm shift through assemblages of life and respective moralities.

Keywords autoimmunity – biotechnological innovation – regenerative medicine – life assemblages – Brazil

Introduction: The problem

Over the last few decades in Brazil, thousands of people with autoimmune diseases and some physicians have begun adopting unconventional immunostimulant therapies. This implies that a high number of them, if not almost all, have simultaneously stopped or significantly reduced their use of conventional immunosuppressive pharmaceuticals such as Methotrexate/MTX, Interferon, glucocorticoids, and cytostatics. The reason being that immunostimulant and immunosuppressive drugs for autoimmunity are, as many of their stakeholders argue, incommensurable: they are based on contrary principles and should exclude each other to show efficiency. Although both these therapeutic models have been developed by biomedical actors, their status within biomedicine are far from equal and a struggle for legitimacy between them has taken place while both patients and health professionals come across new knowledge and practices, not always knowing whom to trust. In this article, I present and seek to understand, under this scenario, changing perceptions related to immunity, autoimmunity, immunological therapies, biotechnological innovation and regulation as constitutive of contemporary biomedical culture and, more specifically, of life sciences in Brazil. By addressing some forms of collaboration and deviance between patients with autoimmunity and physicians, which also take place through the informal sector and modern communication means, I describe how they adopt and promote immunostimulant drugs as scientific innovations associable with regenerative medicine that face difficulties in obtaining legal status and tend to be disqualified by established biomedical authorities.

Immunosuppressive drugs, also called “immunosuppressants” (Marson & Pasero 2012), are regularly prescribed by biomedical authori-

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* All translations from Portuguese and German into English were made by the author.

ties worldwide. These drugs artificially impair the immune system of people with autoimmunity to prevent or reduce the “immune reactions” that characterize their diseases’ symptoms. As part of the so-called Global South, Brazil does not figure as one of the centres for biomedical knowledge production unlike *e.g.* the UK, Germany and the USA. Consequently, established biomedicine in Brazil normally reproduces the global therapeutic model for autoimmunity. Nevertheless, despite official recommendation, several patients and experienced physicians in Brazil are dissatisfied with the side effects and long-term inefficiency of immunosuppressants and have decided to use and promote what they see as scientific innovative treatments. Numerous reports available on the internet express their fears and desires. Among these unconventional treatments, one can find those based on the opposite principle of immunostimulation such as synthetic phosphoethanolamine, vitamin-D therapy, stem cell therapies, cashew-membrane, urintherapy, collagen therapy, bee’s poison (apitherapy), and frog’s vaccine (*kambô*), etc. (see also LORIMER 2017).

“Immunostimulant-users”—as I call both patients and physicians who refuse conventional treatments and use immunostimulants to treat autoimmunity—have often dodged official therapeutic administration and adopted and promoted immunostimulants in collaboration with other actors. As people who exercise citizenship as entwined with biotechnology (ROSE & NOVAS 2005), they have been working together in confidence and changed their therapeutic orientation and practices. Notwithstanding, many immunostimulants for autoimmunity usually meet legal difficulties to become authorized pharmaceuticals, are unapproved or in some cases even expressly prohibited and, thus, considered illegal in Brazil. In so doing, immunostimulant-users become, just like the immunostimulants themselves, marginalized before Brazilian private and public health care systems, regulatory agencies, and the established medical communities (*e.g.* the regional, and federal Medical Councils). However, their collaborative work continues to proliferate, and more people who are likewise disappointed with conventional therapies and have expectations concerning scientific innovations have joined them.

In different ways, the multiple frictions which have emerged in the context of the legal disputes and informal spread involving immunostimulants as biopolitical artefacts appear not only to re-evoke the evaluation criteria adopted by established governmental, and scientific agencies (formally seen as universal and therefore neutral), but also to expose the use of immunosuppressants for autoimmunity as the current dominant paradigm (*e.g.* XIMENG 2014, CRC/IMPATH, THOMMEN *et al.* 2018). While immunosuppressants tend to easily pass through legal channels as biotechnological innovations and, thus, are good examples of accepted drugs, immunostimulants tend to meet resistance and appear risky when they are proposed to become authorized pharmaceuticals for autoimmunity. In this sense, the regulatory experiences of immunostimulants for autoimmunity in Brazil shed light on further regulatory actors (like *e.g.* the patients demands and local pharmaceutical laboratories), and respective knowledge claims, who are also interested in affecting how people’s bodies should be understood and administered.

In what follows, I explore two main questions from an anthropological perspective: how do these dissident patients and physicians (*i.e.* immunostimulant-users) experience and evaluate conventional immunosuppressive and contested immunostimulating drugs? To what extent and how do their attitudes in Brazil affect the authorized biomedicine for autoimmunity as global order?

To propose answers for these questions, I present and reflect on a case study of regulatory experience and make a comparative digression involving respectively two immunostimulant therapies: the “anti-brucellic vaccine” (VAB—*vacina antibrucélica*), and; the “autohemotherapy” (AHT—*autohemoterapia*). Like other immunostimulant therapies, both VAB and AHT are strongly associable with regenerative medicine and may be accessed through the informal sector.

Theoretical background

At least since the immune system was institutionalized as the object of immunology as a specific life science, it has convincingly expressed all the characteristics of a total social fact (MOULIN 1996). Accordingly, it has been expressing the cultural settings under which its uses and interpretations emerge (Napier 2012). Immunity as a "system," for instance, appears as a post-war biomedical conceptualization (Anderson & MacKay 2014). Likewise, as constituted and constitutive of sociocultural settings, immunity has been seen as something to be regulated through sanctioned practices, *e. g.* by medical technologies (Brodwin 2000).

As Lakoff (2008) points out, pharmaceuticals operate at the intersections between biomedicine, commerce and government. To become authorized pharmaceuticals, proposed biotechnologies have to be absorbed into an established medico-legal system that is engaged in the technical administration of life. Thus, as biopolitical artefacts biotechnological innovations pose new political and ethical questions about how life should be understood and treated (*ibid.*: 742). Like the established immunosuppressants, the immunostimulants are also drugs that directly affect a person's life. Nevertheless, they do so in clear contrast to how most authorized pharmaceuticals are supposed to act when used to influence a multiplicity of immune reactions. Hence, the uses of immunostimulants to treat autoimmunity in Brazil do not reproduce the established global biomedicine for this medical area as expected (Haraway 1991: 204–5). As I will show, mainly when considered as two among several other immunostimulating therapies for autoimmunity in Brazil, and mainly looked internationally, VAB and AHT appear as colliding threats for immunosuppressants.

That is the case even when immunostimulant-users and promoters seek to avoid critics of conventional therapy like, *e. g.*, the attempts of the scientists who developed the synthetic phosphoethanolamine not to criticize chemotherapy for cancer during a public hearing at the Brazilian Federal Senate (Senado Federal 2015). Or, when physicians who work with immunostimulant treatments state that they do not want to substitute conventional therapies and, thus, that immunostimulant therapies are not an alternative for them. Following this, to neutralize the potential disqualification and stigmatization processes, which are organized and triggered by actors engaged in global immunosuppressants, some stakeholders for immunostimulants in Brazil refuse the term "alternative medicine." VAB users, for instance, emphasize that VAB was developed according to scientific standards, and is often conducted under supervision of recognized medical professionals with expertise. They characterize and support the adoption of VAB and other immunostimulants into the Brazilian publicly funded Unified Health Care System (SUS—Sistema Único de Saúde) as "complementary medicine" (for a disambiguation see NCCIH 2016).

Nevertheless, practically all immunostimulants require from their users the avoidance or a significant controlled diminishing of immunosuppressants to function properly (Gardner 2017: 70). Besides that, while immunostimulant-users verbalize the previously unquestioned premises of established biomedicine for autoimmunity, exposing them and their potential therapeutic uses as objects of thought—thus, forcing a re-opening of immunosuppressants as objects of scientific controversies (Latour 1987, Vilar 2018)—, the immunostimulants spread as much in discursive coherence as medico-legal practices. Together with immunosuppressants, the very idea of autoimmunity as a disease itself, which needed several decades to be accepted in biomedicine, is put in question by immunostimulant-users who tend to denaturalize it as fatality.

The motivations, means and techniques which immunostimulant-users articulate among themselves, and in association with multiple institutions and professionals, *e. g.* to provide the legal apparatus for the defence of a physician, to organize and sign petitions for the approval of a specific immunostimulating therapy, to enable circulation of immunostimulants informally, and/or to share therapeutic narratives that may be taken as acceptable medical evidence, among other activities, can be seen as expressions of one or more flexible assemblages that "[…] share questions related to the definition of what is 'a life worth living'" (Sleeboom-Faulkner 2014: 2). According to Sleeboom-Faulkner (*ibid.*), "[…] In life assemblages, members share mindsets that assume moral change towards life as inevitable and experience the transgression of ethical boundaries as a normal result of developments in science and technology."

In the context of cooperation between members of life assemblages in Brazil, the internet appears as a privileged platform for the exchange of unauthorized knowledge and practices. Rose &

NOVAS (2005) and WOOLGAR (2002) argue that, as a new technology for the circulation of information, the internet can radically transform society and serve as means to engage biological citizens. One of the challenges that WOOLGAR (*ibid.*) identifies consists in knowing how people organize themselves. In the context of my research, on the internet, dynamic and interactional matrices—as each homepage may be seen—to promote immunostimulant therapies can be organized and kept *outside* the established medico-legal paths of scientific innovation through cooperation between members of life assemblages. Likewise, it is also possible for them to produce their own media content, and inventories, and to disseminate it through the internet. The internet, therefore, became an ideal platform through which people who do not know each other personally but who share common therapeutic dramas come together, and cooperate with each other, as it is often the case in life assemblages for immunostimulant therapies in Brazil.

Methodological strategies

In this article, I use research material mainly produced and collected by myself through participant observation conducted between 2009 and 2017, in intercalated periods, in several cities in Brazil including: Vitória da Conquista and Porto Seguro (in Bahia); Brasília (Distrito Federal); João Pessoa (Paraíba); Natal (Rio Grande do Norte); Guarapari and Vitória (Espírito Santo); and Belo Horizonte (Minas Gerais). Although my physical permanence in these locations amounts to approximately 7 months, I complementarily carried out a considerable amount of research on immunostimulants and their users by systematically following them on the internet; this I combine with autoethnography.

As I describe in more details elsewhere (VILAR 2018), I myself was diagnosed with psoriasis arthritis at the beginning of 2009. I followed the conventional treatment based on immunosuppression for 6 months, before experimenting with the anti-brucellic vaccine (VAB, *vacina anti-brucélica*) over three years, having obtained amazing satisfactory results. Both experiences enabled me privileged access to two different worlds within biomedicine and to learn from their respective actors—mainly physicians, patients, and their relatives, webmasters, and immunological drugs themselves—and, through it, to know about their interactions with Brazilian regulatory institutions. In my present attempt to apprehend changing perceptions in contemporary biomedical culture, I here mainly posit myself as an immunostimulants-user and stakeholder.

As explained above, along with my presentation of some ethnographic findings, I analytically conceive patients with autoimmunity and their families, physicians, and other actors, who use and support the use and liberalization of immunostimulants for autoimmunity in Brazil as compounding life assemblages (SLEEBOOM-FAULKNER 2014: 2). *I. e.* provisional sets of entwined networks and/or communities of people who see the processes of developing, promoting, and adopting scientific innovation as eventually requiring the transgression of established institutional, and moral boundaries (see also DELVECCHIO GOOD 2003). In consonance with it, I heuristically apprehend the collaborative work between these life assemblages for immunostimulants as comprising “bionetworking activities.” SLEEBOOM-FAULKNER defines bionetworking activities as those non-scientific collaborative works that are conducted by and among a plurality of actors (stakeholders, market agents, patient groups, universities, clinical offices, media etc.) which “underpin the scientific ones” (2014: 160).

All in all, when I follow unauthorized immunostimulants through participant observation, digital methods and archive research, they guide me through unofficial paths of scientific innovation in the Global South that connect new communication technologies, informal economies, local moralities, health care demands, and emerging regimes of truth.

Article’s structure

This article is divided into four sections. First, I describe how global biomedical authorities see and officially re-present autoimmunity as “chronic,” including how, according to them, it should be treated. In the second section, I describe two contrasting therapies based on immunostimulation, which according to immunostimulant-users have been successfully employed in Brazil for the treatment of autoimmunity, though most informally and experimentally. I concentrate on one of them and use the second as a comparative digression. In so doing, I take them as examples of discontinuity in relation to the hegemonic therapeutic model for autoimmunity described in section one and focus on key moments of their regulatory experiences. In the third section, I thematize how unauthorized and/or tabooed knowledge and therapeutic practices circumnavigate among immunostimulant-users outside official pharmaceutical circuits. For it, I focus on the cooperation among members of life assemblages for immunostimulants by using four categories (patients, physicians, mediators, and immunostimulants), and identify implications of their bionetworking exchanges. Finally, I briefly resume aspects of mutual affections between the conventional immunosuppressive and the contested immunostimulation therapeutic models on the context of local-global tension.

My hypothesis is that when one focuses on the negotiation dynamics of medico-legal regimes in Brazil under the impact of immunostimulating therapies for autoimmunity as a contested innovative biotechnology, in which patients, physicians, socioeconomic and governmental actors are involved, it becomes possible to highlight significant aspects of how law, science and society shape their boundaries and co-constitute the legal and the illegal (Jasanoff 1990, 2004; Faulkner *et al.* 2012). Moreover, I suggest that recent changes of perceptions and attitudes related to autoimmunity in Brazil, when considered internationally, can be seen as local expressions *and* part of the emergence of the regenerative medicine as a transnational shifting paradigm (Kuhn 2012, Webster 2013).

"Chronic diseases" as biomedical definition

Considered by the World Health Organization as one of the greatest causes of disability in the world, reaching from 5 % to 10 % of the world population across all ages, and increasing mainly in urban centres, autoimmunity comprises over four hundred conditions, as diverse as psoriasis, lupus, Sjörgen syndrome or arthritis (WHO 2017, Policy Department of European Parliament 2017, Langer 2015, Cooper *et al.* 2009). According to A. D. A. M. Medical Encyclopedia, "an autoimmune disorder occurs when the body's immune system attacks and destroys healthy body tissue by mistake" (MedlinePlus 2015). In other words, "when you have an autoimmune disorder, your immune system does not distinguish between healthy tissue and antigens. As a result, the body sets off a reaction that destroys normal tissue" (*ibid.*).

The exact cause of autoimmune reactions remains officially unknown. However, independent of the cause, one knows that the immune reactions are inflammatory processes that can potentially occur in each part of the human body (Melchers 2006: 18). Although the autoimmune diseases may unexpectedly come and go, alternating states of control and of exacerbation, and are therefore unpredictable, they are defined by world biomedical authorities as "chronic;" *i. e.* as diseases that remain for a lifetime. Officially, there is no known guaranteed prevention for most autoimmune disorders, and there is no scientifically recognized treatment which helps to cure autoimmunity. There is only treatment to relieve its symptoms. Given that, physicians normally advise patients with autoimmunity that they "have to learn to live with it" (Andrews 2011, Anderson & MacKay 2014: 92–115).

By transforming people with autoimmune symptoms into chronic patients through diagnostics, physicians relocate them from common lifetime to a distinct spatiotemporality that is characterized by imminent risk of *self-damaging* and, therefore, must be biomedically monitored and modulated (Greenhalgh 2001). For decades, biomedicine has largely employed immunosuppressive palliative drugs to control inflammations and to relieve the symptoms of autoimmune reactions. The treatment of rheumatoid arthritis, a classical autoimmunity, can illustrate the modus operandi. In their medical guide, which can still be found in German medical offices, Lackinger and Weiss explain that:

> The treatment is carried out during acute inflammatory crisis [also called exacerbations and/or immunological overreactivity] through anti-inflammatories and pain-relieving medications (analgesics, nonsteroidal or steroidal anti-inflammatory drugs, *e. g.* corticosteroids). As a long-term treatment of autoimmune rheumatic disease, one

> starts nowadays already at an early stage with a base therapy to prevent so much as possible long-term consequences such as joint damage. […] (LACKINGER & WEISS 1992: 85)

Published two decades ago, these basic therapeutic proceedings are the same today. The BRITISH SOCIETY FOR IMMUNOLOGY (2012), for instance, states that the treatment for rheumatoid arthritis "is largely symptomatic and provides pain relief, reduces inflammation and slows down further damage to the joints. For those patients with more severe damage, surgery is often performed." Furthermore, even the newest pharmaceuticals offered in rheumatologic offices (like the so-called "biologics" such as Adalimumab/Humira, Etanercept/Enbrel, Rituximab/Rituxan, etc.) are marketed as "scientific innovation," although they operate through the logic of reaching symptomatic relief through immunosuppression.

The statement published on the consulting homepage of PAPAA—"[…] a joint venture between the Psoriatic Arthropathy Alliance (PAA) […], and the Psoriasis Support Trust (PST) […] to establish the principal resource of information and help for people with psoriasis and psoriatic arthritis in the UK" (PAPAA 2015)— reproduces the logical similarity:

> The "Biologics" are relatively new entrants into the field of psoriasis management and are made from biological (human or animal based) proteins rather than artificial chemicals, much in the way that insulin was made from animal sources in the past.
>
> Biologics are different from other medications for psoriasis and psoriatic arthritis as they are designed to block both diseases in the immune system rather than waiting to treat the symptoms of the disease.
>
> It is thought that overactive cells in the immune system set off a series of events in the body, eventually causing psoriasis to develop on the skin and arthritis symptoms to develop in the joints. Biologics work by blocking the action of specific immune cells that cause these cells to misbehave by either reducing the number of these cells in the skin and blood or by blocking the activation of the immune cells or the release of chemicals from them. […] (*ibid.*).

In Brazil, biologics were enthusiastically received as promising innovations. Despite their very high costs, they were immediately adopted and spread quickly. At least until the 2016 coup d'état, the Brazilian Federal Government provided the inclusion of mainly three kinds of biologics to be made available to poorer patients for free through the SUS (BRATS 2012). However, as "blockers" of "specific immune cells," they differ from older immunosuppressants primarily through their composition as containing animal or vegetal elements. In the end, biologics are still in charge of preventively punishing immune cells that may bring themselves and other cells to *misbehave*. Thus, in principle, they are different and *newer* biotechnologies scientifically conceived *for the same* immunopolitical purpose and function; the hegemonic biomedical understanding of autoimmunity and of what should be done to tackle it remain unaltered.

Likewise, even the aim of using nanomedicine to treat autoimmunity in a near future seems to be previously limited by the long-term biomedical search of the best instruments to treat it by suppressing specific metabolic activities of one's body. As GHARAGOZLOO *et al.* (2015: 1003) wrote in an article in which they focus on "nanomedicine-based delivery strategies of biological immunomodulatory agents for the treatment of autoimmune disorders," these agents are taken as potential "novel nanomedicine approaches for inducing immunosuppression and immunological tolerance in autoimmune diseases in order to modulate aberrant and pathologic immune responses" (*ibid.*). The modulatory action of the nanomedicine-based agents, which the authors mean, are clearly of immunosuppressive order. Like the biologics, they present a potential technological refinement of the same: a new generation of immunosuppressants (*ibid.*).

In all these therapeutic biomedical approaches, the tasks and ordinary practices of physicians basically consist of: first, recognizing and identifying the symptoms which a patient presents among hundreds of classified autoimmune diseases; second, treating these particular symptoms with the appropriate immunosuppressants to bring them under control, and; third, monitoring, managing and trying to reduce as far as possible the multiple side effects of the employed immunosuppressants, which tend to occur frequently and continuously in the course of conventional treatment as a kind of chain reaction. "Cure" remains outside the language and therapeutic horizon of possibilities of most established physicians.

It is commonly accepted among most physicians and medical scientists—to the point that it is normally not even an object of discussion—that strengthening the immune system, in contrast to conventional therapies based on immunosuppression, could only lead to an aggravation of the symptoms, given that the inflammations are seen as "overreactivity." Therefore, immunostimulating treatments are for established biomedicine out of the question. Despite its variations, this standardized knowledge on autoimmunity is found everywhere where biomedicine plays a predominant regulatory role, and it is considered as having universal validity.

Nevertheless, for at least the last 70 years, medical scientists have also been trying to develop other ways to treat autoimmunity and to *rehabilitate* one's immunity (VERONESI 2008 [1976], MULLEN 1977, MELCHERS 2006: 18). Among these efforts are attempts to treat patients with immunostimulation. However, rheumatologists, dermatologists and other physicians, who are systematically trained to employ and promote immunosuppressants, rarely say something about these other possible medical futures to their uninitiated patients, while they repeatedly emphasize the inevitable risks of autoimmunity when these are not treated with immunosuppressants (COHN 2000: 207–8).

Also, in Brazil, medical scientists have been developing another understanding about how immunological disorders occur and how they should be treated. Countering the established biomedical notions of chronicity and causality related to autoimmunity, patients, stakeholders and unauthorized substances have been helping these medical scientists to co-materialize a political economy of hope (NOVAS 2006) founded on the expectation of cure by immunostimulation as therapeutic possibility. Through their bionetworks, which expand rhizomatically, immunostimulants-users and stakeholders generate a concurrent biomedical future regarding autoimmunity.

To illustrate this, I shall now consider aspects of the regulatory experiences, medical trajectory and informal circulation of an immunostimulating therapy for autoimmunity in Brazil called the "anti-brucellic vaccine" (VAB, *vacina anti-brucélica*). To better understand the VAB case, I will also briefly report on another immunostimulating therapy known as the "autohemotherapy" (AHT, *autohemoterapia*) as to provide a comparative digression.

"Secret cures" as biomedical deviance

On 21 October 2005, the Brazilian federal government's Official Gazette (*Diário da União*) published the resolution n° 2.629 of the National Health Surveillance Agency (ANVISA, *Agência Nacional de Vigilância Sanitária*). The head of the Collegiate Board of Directors of ANVISA called for "the seizure, nationwide, of the product 'vacina anti-brucélica,' manufactured by the professional Dr Genésio Pachecho DA VEIGA" (ANVISA 2005a: 76). Its enunciated reason was that "the product does not have registration/notification and the professional is not in possession of an Operating Business Permit to manufacture it, not having therefore corresponded to the ANVISA's regulatory requirements" (*ibid.*) While, at the first sight, the ANVISA's prohibition of VAB appears to be a standard judicial-administrative procedure, it proves to be a more complex issue when one observes what happens next.

The ban of VAB immediately sparked strong reactions. The office of ANVISA began to receive complaints from every corner of Brazil, most of them from patients with autoimmunity and users of VAB. The production and commercialization of VAB was stopped. Supporters of VAB reacted on the internet: an account was created on a social network called *Orkut* (later, another one was created on Facebook and is presently active). At least one discussion forum was created (*e. g.* on the homepage *InForum*), and a VAB group was founded on *Yahoo!*. On personal blogs and forums related to autoimmunity, patients and ex-patients posted about their personal experiences with VAB. Many of them claimed that their autoimmunity—diagnosed as "chronic" by physicians—were cured or significantly ameliorated thanks to the VAB therapy. Although the ANVISA interdicted VAB to protect the "population's health" from the potential danger of an unregistered drug, VAB users saw this act as an interruption of a successful and necessary therapy.

One month after the prohibition, Dr Veiga, the most publicly known VAB's manufacturer, an immunologist and one of the few Brazilian specialists on the treatment of brucellosis in humans, published an article on the homepage of the Brazilian Association of Biomolecular and Nutrigenomic Medicine (ABMB, *Associação Brasileira de Medicina Biomolecular e Nutrigenômica*). Another physician, Dr Felippe, a physiologist who works with regenerative medicine and coordinates the ABMB, co-authored the work (Felippe & Veiga 2005). In their article, they detailed the clinical trial they conducted in 1988 on the effects of VAB on people with rheumatoid arthritis in São Paulo. 377 people who presented the symptoms of rheumatoid arthritis according to the American Association of Rheumatology, participated in the study. As they reported:

> In the course of [VAB] immunotherapy, 80 % of the patients presented a great improvement or complete regression of joint pain, inflammatory signals, functional impotence and general symptoms. It was noted the disappearance of subcutaneous nodules in half of the treated patients [...]. The congestive deformities, *i. e.* those reversible also disappeared in 40 % of cases.
>
> The patients' self-assessment of clinical improvement, without the interference of the physician, showed a good performance of immunotherapy: 79.5 % indicated excellent and good results, 16 % regular, and 4.5 % bad or very bad [...].
>
> Note that after the immunological approach, it was possible to suspend corticosteroids and antiinflammatory in 40 % of patients. 54.5 % was possible to reduce such medicaments and by 4.5 % of the patients, the need for such drugs remained unchanged. [...] (Felippe & Veiga 2005: n. p.)

VAB aims to strengthen the defence-system of its users through stimulation using a specific vaccine which contains dead "Brucella"—a type of bacteria found in many animals, and which causes brucellosis. Here I would like to make a historical digression concerning the development of VAB and its transformation into a biotechnological innovation to treat autoimmunity. How did VAB come to be what it was in 2015?

From BRUVAC to VAB

VAB was first presented by Dr Veiga's homonymous uncle and renowned researcher of Institute Oswaldo Cruz, Dr Genésio Pacheco, in two articles, which were co-authored by Dario Simoni da Silva and by José Gonçalves da Silva, originally for the treatment of brucellosis in humans (Pacheco *et al.* 1969, Pacheco 1970). It was registered and commercialized with the name "BRUVAC" as one among many different types of vaccines against brucellosis that use either living Brucella or dead ones, or a mix of both (*e. g.* Mello 1978). For at least the next 20 years, both uncle and nephew co-authored a minimum of 12 scientific works on brucellosis in humans, mainly between 1943 and 1947, *e. g.* in *Revista Brasileira de Medicina*, *Brasil-Médico* and *Medicina, Cirurgia, Farmácia*. As one of the very few—maybe the only—physician specialized in treating humans with brucellosis in Brazil at that time, Dr Veiga systematically used the BRUVAC attending people of the whole country at his own medical office in Rio de Janeiro.

For most of that time, he was frequently confronted with other physicians who did not believe that brucellosis was a serious disease of epidemiologic level in Brazil. As Dr Veiga often explained to me, and Dr Mello later confirmed (personal communication in June 2017), this controversy happened mainly because the symptomatology of brucellosis taught at the medical schools in Brazil, in the last century, was based on its most common European variant which is caused by the Brucella *melitensis,* present in goats. The problem was that, in Brazil, brucellosis was and still is mostly provoked by the types *abortus*, of ox, and *suis*, of swine, which present quite different symptoms. In addition, brucellosis is a highly contagious disease, it spreads very quickly and is very difficult to diagnose, which contribute to making brucellosis often invisible as a public health problem. It was only in 2001 that the Brazilian Federal Government implanted the "National Program of Control and Eradication of Brucellosis and Animal Tuberculosis" (PNCEBT, *Programa Nacional de Controle e Erradicação da Brucelose e Tuberculose Animal*) (MAPA 2006: 15).

In 1985, a few years after his retirement, while revising the literature on brucellosis Dr Veiga came across the text of MEISELAS *et al.* (1961) where the authors described an experiment involving patients with arthritis and vaccination with Brucella. After the authors have injected different types of "*gram-negative bacteria*" in the patients, they noted that only through the inoculation of "*Brucella antigen,*" occurred a very particular immunological modification: At the same time as the production of a certain type of antibodies (19-S) was stimulated by the arthritis patients, their symptoms became weaker or disappeared. The results are resumed as the following:

> 1. Forty-one patients with various rheumatic diseases and 27 control patients were inoculated with Brucella vaccine. As a group the patients exhibited a significantly greater rise in antibrucella agglutinins compared with the controls. Some overlap in both groups was present. 2. Alterations were noted in other antibody systems-anti-red cell (Coombs), anti-thyroglobulin, and possibly in the influenza antibody and rheumatoid factor-after this primary stimulation in some of the patients with rheumatic diseases, but no titers for these antibodies were noted in the control patients. 3. The effect of brucella antigen in these patients may be related to the damage that this organism can produce on mesenchymal tissue. (MEISELAS *et al.* 1961: 1880)

Earlier, as Dr VEIGA was treating his patients with BRUVAC, he perceived that those who also suffered from some rheumatic disease had their symptoms relieved. Hence, Meiselas' experiment showed to him that the relieving of rheumatic symptoms by his own patients was not just a coincidence: The increasing of certain antibodies stimulated by the inoculation of Brucella antigen explained the reason. Encouraged by this possibility, he started an adaption of the BRUVAC, conducted the clinical trial and began employing it to treat autoimmunity.

Dr VEIGA presented VAB once at a Brazilian Rheumatology Conference in 1996. The present rheumatologists could not accept using a vaccine due to its immunostimulant effects to treat autoimmunity: this was as inconceivable at that time as it is today. Nevertheless, VAB was, in fact, not a "vaccine" anymore if one defines vaccine also through its use and not only through its composition. *I. e.* as "biological products containing one or more antigenic substances which, when inoculated, are capable of inducing active specific immunity and protecting against the disease caused by the infectious agent which gave rise to the antigen" (ANVISA 2005b: 59). Despite that, Dr VEIGA kept calling it the "anti-brucellic vaccine," as it was already known among his patients. This persistence apparently reinforced the tendency of other physicians to refuse VAB as a potential innovative treatment for autoimmunity. As Dr MELLO explained to me, VAB is rather a "lysate of Brucella" (*lisado de Brucelas*).

VAB as regenerative medicine

From physicians who use VAB to treat patients with autoimmunity I heard two basic explanations, which they sometimes combine. Some of them emphasize the effect of the vaccine as a means of purification. That is, the vaccine helps the body to *detoxify* itself from elements that disturb its immune system (BOUCINHAS 2012). Others—like Dr VEIGA and Dr FELIPPE—prefer to speak of the *rehabilitation* process that is provoked by the regular infusion of dead Brucella due to their special immunological properties. A third explanation that I found elsewhere as related to immunostimulants in general is that these *distract* the immune system of damaging itself. All such supporting doctors argue that the cause of the immunological disturbance lies precisely in the weak state of the immune system, which can sometimes be made visible by monitoring the quantity of blood white cells (VERONESI 2007 [1976]). The "immunological tolerance"—what prevents an organism from "attacking itself"—can be broken when one's immunity is within a deep state of debilitation and, therefore, no longer able to produce enough antibodies. The overreactivity of immunological cells becomes rather part of a chain reaction within a broader deterioration process.

According to Dr VEIGA, when the number of antibodies (particularly, of macrophages) grows through stimulation by using VAB, the body begins to recover its skill to distinguish between its own and strange cells again, and therefore the immune system stops attacking its own body. The pain is then gone because the inflammation is gone. In this sense, through applications of this vaccine that begin with small doses, which are gradually increased over a long period of time, one’s immunity *relearns* to act in a healthy way, protecting itself again. Similar to “allergy shots” (Kirchheimer 2016, American College of Allergy, Asthma and Immunology 2016), the whole VAB treatment usually takes two or three years and, until recently, it was divided into two phases: first, it was injected subcutaneously and, then, carried out further through intramuscular applications.

Following Dr Veiga and Dr Felippe (2005), many VAB users compare VAB with conventional therapies. They are clearly aware that immunosuppressants only control symptoms by impairing the immune system, slowing down the patients’ metabolism and corporeal functions, to *retard* further developments of autoimmunity. They affirm that these treatments, on which modern biomedicine is based, mostly worsen the patients’ state of health, rather than improve it. Furthermore, some VAB users argue that the ANVISA did not allow the registration of VAB because no rheumatologist had participated in the clinical trial.

In any case, the characterization of established biomedical therapy for autoimmunity presented by Dr Veiga and Dr Felippe, and by other VAB users, is not controversial. Indeed, the authorized treatments offered and administered by rheumatologists share the same discourse: conventional therapies aim to slow down the inevitable progress of the autoimmunity by controlling the symptoms through immunosuppression. But when established physicians state that immunostimulating treatments for autoimmunity are dangerous and should be excluded, the therapeutic use of VAB consequently becomes highly controversial. Here, the ANVISA prohibition of VAB echoes this among other established biomedical premises as being universally valid.

Catching wind of a potentially legitimate controversy, some journalists—mainly from “alternative vehicles”—interviewed and wrote articles about Dr Veiga and *his* vaccine, as VAB became known. According to most of these journalists, the ANVISA’s prohibition of VAB is an injustice against autoimmunity sufferers made to favour the interests of pharmaceutical industry (*e.g.* Rabelo 2007a, 2007b, personal communication in April 2017). In contrast, most physicians and mainstream media ignored the reactions of VAB-enthusiasts. They let the law speak for itself, thus dismissing possibilities of discussion and halting the emergence of VAB to a broader level.

Autohemotherapy

The silence strategy of immunosuppressants defenders in the context of the VAB case can be partially understood when one looks at the autohemotherapy (AHT). AHT is another medical therapy for autoimmunity that is also based on immunostimulation. Rather than using a vaccine, AHT uses the patient’s own blood to strengthen his own immunity. Like VAB, AHT falls under the regenerative medicine category that covers “[…] the set of sciences and technologies involved in the collective project meant to coax the body to repair itself and potentially to extend the lifespan” (Hogle 2007: 859).

When a low-budget video promoting AHT, which had been informally sold on DVD on the streets of Brazil and which was later released on the internet (Martinez & Sarmento 2004), was called to the attention of medical and governmental authorities, they opposed it and the ANVISA prohibited the practice (CFM 2007, ANVISA 2017, Silva da Costa 2017). The DVD shows an interview with Dr Moura, who has been working with AHT for several decades in both public and medical service. In his interview, he reports several cases of cure or amelioration of different diseases through the employment of AHT. Dr Moura learnt it from his father, who was also a physician, and who had adopted the AHT earlier as a means to help patients recover faster post-surgery. Dr Moura was then heavily criticized in public mainly by pharma-lobbyists and accused of “ideological falsity” at a national level. He was also threatened with the loss of his medical licence and being sent to jail. However, despite the intimidations against Dr Moura, the mainstream media’s portrayal of the AHT as polemical and risky has only helped to popularize it, and the AHT has been systematically adopted outside medico-legal circuits.

In 2007, on the state and municipal stage of the “XIII National Conference for Health” (*XIII Conferência Nacional da Saúde*) in Espírito Santo, where Dr Veiga lived, both VAB and AHT were presented by a religious delegate as two therapies that should be included into the SUS due to their low cost, high effectiveness and absence of side-effects. The delegate's proposal was unanimously accepted in the first ballot, in which the organizers—*i. e.* the agents of the "Municipal Health Office" (*Secretaria Municipal da Saúde*)—did not participate. However, when the organizers did vote in the final round of the conference, the proposal was rejected (Coimbra 2007, also Geovanini 2009).

Since ANVISA's prohibitions, VAB and AHT therapies were relegated to invisibility, where the therapies have been carried out by both medical professionals and patients illegally, and in precarious and risky conditions. In the following years, Dr Veiga has been fined by ANVISA twice (2006: 32, 2007: 63) and received more intimidations.

From VAB to CAE

However, the tide began to turn for VAB in the last years. In 2012, after more mobilization for VAB, and to protect Dr Veiga before the law, Cheila Pimenta, one of his ex-patients, initiated a petition at AVAAZ—a civic organization that supports activism on a global level—for the regularization of VAB that achieved 15,656 signatures. Her brother, who is a lawyer, informally assisted Dr Veiga in judicial matters. Dr Veiga was sued again by ANVISA and a new trial was scheduled for November 2015 but postponed until 2017. Later, the court case has been closed. During this time, VAB was temporarily available to the public again, though with a new composition and form.

Negotiations between Dr Veiga and private laboratories, which are mainly involved with the veterinary industry, took place mediated by Cláudia Ludolf, his daughter and animal breeder. The two first attempts failed after the interested laboratories, which were at the beginning very impressed with the results of using VAB to treat animal diseases (*e. g.* "*canine distemper"*), realized that VAB contained dead Brucella as its main raw material—*i. e.* a substance that should be eradicated from the country per the PNCEBT, and for whose maintenance and use they needed to obtain a special permit. Finally, a new deal with another private laboratory, localized close to Belo Horizonte, in Minas Gerais, and directed by the medical scientist and nuclear physicist Dr Rosa, was moved forward.

As Ludolf told me, she and her father were convinced that ANVISA would never approve of any pharmaceutical containing Brucella to treat people due to the PNCEBT. Moreover, notwithstanding the fulfilment of all further ANVISA's requirements for the approval of VAB, it would take between 10 and 13 years to achieve regularization in Brazil. Two main strategies were then adopted to create a gateway for VAB in the formal market: to reformulate its compound and form; to register it and patent it first in the USA. The first measure would overcome the barrier rose by the PNCEBT. The second would paradoxically accelerate the process of authorization in Brazil given that the Brazilian regulatory sanitary authorities tend to regularize pharmaceutical products coming from USA much faster than to approving its own national medical innovations.

Dr Rosa and Dr Veiga developed *another* drug out of VAB while excluding the Brucella endo protein from it. After he isolated the components of the VAB's formula, he was able to identify those amino acids that are specifically responsible for the stimulation and strengthening of the immune system, preserving the organizational principle that assemblage the amino acids in a particular manner that boosts the production of antibodies. In collaboration with Dr Rosa, Dr Veiga replaced VAB as an injectable solution by drops of what they renamed as the "Complex of Essential Amino Acids" (CAE, *Complexo de Aminoácidos Essenciais*) to be administered under the tongue. Until now, however, many users refer to it as "the vaccine" (*a vacina*).

Ludolf defines CAE as an "evolution" of VAB (from now on VAB/CAE). In its clinical trial, as coordinated by Dr Rosa and conducted at a clinic in São Paulo, VAB/CAE was recently used by more than 3.000 patients in one year. With help of VAB/CAE users and stakeholders, his daughter, and other actors engaged with the judicial rehabilitation of the VAB/CAE, and with informal assistance of some ANVISA's officers, Dr Rosa and Dr Veiga recently reached the liberalization of VAB/CAE officially as "manipulated product." Crucial for this achievement, however, seems to be the forging of a new promissory identity for VAB/CAE (Gardner 2017: 71).

On 13 October 2016, both father and daughter inaugurated the “Instituto Dr Genésio Pacheco da Veiga,” as financially supported by their broader family, at which other physicians are now officially working with CAE as substitute of VAB that is now produced by Dr Rosa and his laboratory team in Minas Gerais. Furthermore, two further associated clinic offices, which are going to be opened by Brazilian physicians living abroad and who positively experienced and promote VAB/CAE, will soon act as branches of the Institute Genésio Pacheco da Veiga offering, prescribing and administering VAB/CAE, respectively, in London and in Lisbon. Dr Veiga, who had taken VAB for decades, could still witness the acceptance of VAB/CAE before he died, a few months after having completed 102 years old, at the beginning of 2018.

Yet, the regulatory experiences of VAB/CAE and AHT provoke a series of questions. How do these *not-disciplined patients* and *not-recommended physicians* seek to overcome isolation, tabooisation and invisibility? While seeking to improve their health and professional status, how do they exchange unauthorized knowledge, personal experiences and innovative biotechnologies when there is a lack of institutional support? In what follows, I will explore key aspects of collaboration and exchanges of VAB/CAE users to highlight how they impact upon and re-organize biomedical knowledge.

Circumnavigations of knowledge, materials and practices

In the context of marginality, those physicians and patients who use immunostimulants found on the internet an ideal platform for continuous exchange of unauthorized medical knowledge, materials and practices. Within the forums that they created for the discussion of different immunostimulating therapies, one finds reports of personal experiences with immunostimulants and questions of people looking for further information. Likewise, personal blogs act as vehicles for information, and have a high number of visitors. Mainly, ex-patients with positive therapeutic experiences with immunostimulants act as mediators between interested patients and physicians. The latter produce, co-distribute and administer immunostimulating pharmaceuticals from their laboratories. In addition, several amateur tutorial videos have been posted on “*YouTube*,” which present and give support to a myriad of physicians and immunostimulants— *e.g.* by entering the names “fosfoetanolamina sintética,” “vacina anti-brucélica,” “autohemoterapia,” “vitamina D.” Through these informal means, contact details of immunostimulants providers are informed, words of encouragement are exchanged, and critiques of established institutions are shared.

For instance, Patrícia Britto posted in 18/06/2015 on her Facebook profile about her experience with VAB/CAE:

> [Dear] Friends, I couldn’t stand the excitement. I need to share it with you. I have been using the vaccine for one year and eight months. I visited again the rheumatologist just to make routine exams and had a big surprise when opening the results … Neither Lupus nor rheumatoid arthritis appear in my diagnosis … […] I’m perplexed [and] I don’t know what to say, I can only thank God for having placed Doctor Genesio Pacheco [da Veiga] in my life … and the support of all my family […] mainly my husband […] It was his faith that found the vaccine […] and saved me … […] trust in the vaccine. It works.

Five days after posting this message, Patrícia uploaded the results of her examinations from one month earlier. She wrote from Brás Cubas, in São Paulo, but most VAB/CAE and other immunostimulant-users are spread all over the country, and even outside it, without knowing each other personally. She also provided the phone number of Dr Veiga, just as many other VAB/CAE users did.

In the case of VAB/CAE, due to the eventual geographical distance between the physician and the user, the treatment can be conducted by phone, after which the VAB/CAE producer and/or distributor will mail VAB/CAE-ampoules through regular postal service as travelling biotechnologies. At that time as it should be injected, the user had to learn how to apply it or be helped by a local medical professional with the applications, given that it is not easy for uninitiated people who do not have the appropriate medical skills.

In addition, during its clandestine period, as with other immunostimulating therapies, VAB/CAE could also be directly administered in specific medical clinics by engaged professionals, as I learned during my fieldwork in two cities in north-eastern Brazil. The application of VAB/CAE was, then, carried out in secret in fear and hope. Hence, a fundamental condition to this collaborative work between patients and medical professionals is to assure mutual security. Medical professionals run the risk of losing their medical licences, paying fines, becoming isolated and stigmatized within medical community, or in the worst case, of being imprisoned. How can they develop mutual trust?

Protection can sometimes be achieved through prestige and respect among local sanitary authorities, who sometimes close their eyes to the illicit medical practices involving immunostimulants for autoimmunity.

Physicians as biomedical dissidents

The following ethnographic notes, taken out of my field diary, offer a picture of these collaboration networks at local clinics:

> 21/06/2014
> I learned about the AHT and of other immunostimulating treatments as current practices within (and as constitutive part of the) medical informal sector in the city of *A*. There is an old established pharmacist (a known and respected person also in neighbouring cities). He is not only engaged with AHT, but also involved with VAB. There are several people making use of VAB under his supervision within the ambulatory department of his pharmacy/drugstore, and outside it. He was afraid to talk about that with me and did it only in a reserved and careful way at the beginning.
>
> I came to him through my mother's physiotherapist, who knew him and who told me that many people used to get pharmaceuticals there, which otherwise they could not find elsewhere and could not access without a doctor's prescription. However, he only really began to talk with me about the applications of VAB and AHT after I mentioned a nurse friend of mine who worked at his ambulatory, whom he trusts […].
>
> 19/07/2014
> [Beyond the pharmacist in A.] A physician in the city of *B*. (200 km from *A*.) who was a professor of a local university for many decades published, in 2012, a short article about and in favour of VAB in a local newspaper. Nowadays, he is retired but still works at his own private clinic, at which he makes use of AHT, and VAB. Because the former is also not recognized and, thus, an illegal therapy, he explained to me a tactic to dodge the law and sanitary vigilance: instead of speaking about "autohemotherapy" he refers to it as "ozone-therapy" (*ozônioterapia*), which is the same but "covered" with other proceedings, which do not change the results at all. Normally, the blood is just taken from the vessel's patients to be immediately reinjected into his muscles. With the ozone-therapy however, the blood goes through a filtering process with ozone before it is re-injected into the person's muscles. This clinician and retired professor explained to me that it changes nothing, but it makes the whole therapeutic proceedings seem like treatment "in experimental character" and, therefore, officially tolerable.
>
> He further explained to me that he has been applying VAB for a long time. When I asked about pressures on the practice, he answered that there were very few. They were limited to discussions within internal committee reunions with colleagues, but nothing in the public sphere or any threat of ANVISA [This contrasts with the experience of Dr Veiga and of the pharmacist in city *A*, who was sought by the sanitary police two or three times at his drugstore, despite his name in the city]. But, as he told me, given the fact that he is a renowned physician, one of the founders of that health department at the university, and someone who was always well financially supported, no one wanted to "buy a fight" with him due to VAB. Not least because they conduct VAB therapy in secret and without disturbing other authorities. In his words, […] "no one wants to prejudice someone, who brings financial resources and prestige into the university." […]

In general, information and access regarding unauthorized immunostimulants for autoimmunity is difficult for people to obtain at the local clinics where immunostimulation is practiced, unless a potential patient knows "a trustworthy person" who may mediate the contact between them as potential users and medical professionals who administer immunostimulants clinically. If a person does not expect professional help for properly using immunostimulants, and must learn by themselves, it is always possible to appeal to ex-patients or current users on the internet. One way or another, by now, most potential immunostimulant-users have already begun to change their perceptions concerning the established networks of healthcare for autoimmunity.

The adoption of immunostimulants becomes subversive when patients begin to switch from immunosuppressive treatments to unauthorized immunostimulant ones, and medical scientists begin to adhere to it, though with great precaution. In this context, both are changing their scope of medico-legal risks in the context of the multiple normative struggles around unauthorized drugs. Instead of exposing themselves to those risks normally linked to the use of immunosuppressants, *e.g.* to their side-effects and the return of the disease in a more aggressive form, immunostimulants-users prefer to face different forms of risks; such as the risk of being denounced for using illicit pharmaceuticals, or of being cheated.

Users and potential users of immunostimulants

On a layman level, the dialogue below appears emblematic of how interested people may learn from each other, change and express their perceptions about their diseases or those of their relatives, and close persons. It is from a website for people with multiple sclerosis—an autoimmunity normally treated with a drug called “Interferon,” an immunosuppressant—who consider themselves cured thanks to the “Vitamin-D therapy,” an immunostimulating treatment. Contrasting with VAB/CAE and AHT, Vitamin-D therapy—a new immunostimulating therapy that consists in administering high doses of vitamin D3 to patients—met as imported biotechnology no problem to become authorized. However, it is object of controversies in Brazil between some rheumatologists, who argue against it, and some neurologists, who act in favour of its broad adoption. The queries on the website are not limited to multiple sclerosis but include other types of autoimmunity. My rationale for including it here is to show how people begin to oppose the current official medical discourse on autoimmunity as chronic.

[1st movement: searching for information] Theresa Ferreira sent the following question in 15/04/2012:

> Good afternoon,
> I would like to know how I could treat my mother, for she has chronic rheumatoid arthritis and feels much pain since she was 8 years old. Today she is 73, and she has a great difficulty to go to São Paulo to carry the treatment. […] I would like to know how you could make a medical evaluation of her and treat her. […]

[2nd movement: response] Ten minutes later, “vitamindforanothertherapy” (*vitaminadporumaoutraterapia*) answered:

> Theresa, this website is kept by enthusiast patients of the [vitamin D] treatment, and not by the physicians themselves. For the medical evaluation which you need, I suggest you call one of the physicians listed above; [However] I can anticipate [to you] that, yes, very probably they [the listed physicians] are going to be able to help your mother with the arthritis, for that is an autoimmune disease, just like multiple sclerosis.

[3rd movement: further comment] More than one year later, Andréa Cigerza added:

> Congratulations for whom gave an answer for Theresa regarding her mother’s problem. I entered in this website because of the multiple sclerosis’ problem of my neighbour […] and, to my surprise, I was informed that this same treatment with the Vitamin [D] is also good for arthritis (which is my case, actually). […] [I hope you] continue helping other people even without knowing them personally.

The participants of the dialogue above, as other immunostimulants-users, break the Cartesian boundaries raised by medical scientists to keep the myriad of autoimmune diseases independent and distinct from each other, classified only according to the specificity of their symptoms, and as different problems to be treated separately. Likewise, on a broader level, several immunostimulant-users who participated in similar exchanges are simultaneously producing, collecting and comparing therapeutic and institutional evaluations. With it, immunostimulants-users politically participate in the co-production and organization of medical evidence and contra-evidence (Akrich *et al.* 2013: 17–8); *e.g.*, as a particular video produced by an ex-patient with multiple sclerosis posted on the internet shows (Cunha 2012).

These exchanges demonstrate two mutual implications. First, when switching from an established therapy to a tabooed one, people with autoimmunity and physicians seem to dodge the established medico-legal regime in Brazil. Second, by this same movement, they also change and partially assume the ways they understand and conceptualize their autoimmunity and possibilities of treatment, and their medical institutional environment and forms of engagement (GREENHALGH 2001, LAW & MOL 2004).

Mediators

Some observations relayed to me by an activist informant and webmaster help to show how the scenarios described above are intertwined. Escobar (own pseudonym) administers a frequently visited webpage in Brazil which offers information about immunostimulating therapies (VAB/CAE, AHT and others), and serves as a space for people to report their therapeutic experiences. "Secret Cures" (*Curas Secretas*), as his blog is called, was created by him after he saw his:

> dying wife become completely cured within two years of treatment through a simple restrictive diet—eliminating all pro-inflammatory and industrial food –, suspending any drugs and doing physical exercises five times per week, associated with autohemotherapy; thus, a complete change in her life habits! [03/02/2014, personal communication]

Catarina, his wife, had been diagnosed with Lupus, rheumatoid arthritis and Sjögren's syndrome. Following her recovery, he realized that several physicians who had said to them that there was no possibility of cure, "either do not have that knowledge [of healing] or were too ambitious to share it." Regarding his motivation to create and manage his website, he confirms that:

> the blog is indeed a very good reference. I do not sell anything, I do not recommend anything, I do not allow propaganda. I only tell my story of struggle and success. It [the homepage] was created [by me] to welcome my debt to God for having totally healed my wife through this treatment.

As I asked him about the collaboration, exchange and relationships in general not only between patients, but also between patients and physicians (DELVECCHIO GOOD & GOOD 2000), he explained that:

> For some ambitious physicians, or even for some modest physicians, who are limited and imprisoned in their own dogmas and paradigms, we are often seen as liars, charlatans or just "mad"—even if the medical professional in question has never read a unique line about us [our therapeutic experiences]; that is what is funny … They believe [in it] only when they themselves, their sons or dear relatives become ill; then they come to us asking for information … I have known two physicians who were terminal patients and [who] are completely cured! Arthritis and lupus. There are other stories … of relatives, sons, etc. Completely cured. But when the one, who is sick, is the patient, then it is very easy to say that nothing can be done, and that the person has to learn to live with the pain!

Although I am citing Escobar and his activities to inform and promote immunostimulant therapies for the treatment of autoimmunity through his own homepage on the internet, it is important to keep in mind that each satisfied immunostimulant-user, or engaged medical professionals, is a potential mediator between immunostimulant drugs and patients seeking recovery.

The ethnographic observations on bionetworking activities that I reported here seem to support this argument. A person diagnosed with one or more autoimmune diseases, and who can potentially become a user of unauthorized immunostimulant, will probably not find information about related therapies at their town's clinics, even if these therapies are practiced there. Due to fear, these practices take place in secret. Access to them can be reached through the internet, or through personal relationships that involve trust, and that likewise do not rarely take place outside clinical and ambulatory environments. Therefore, informal and formal paths of biotechnological innovation may appear here as unfolding from and framing each other. By this movement, it is possible to observe that informal personal relations, based on trust, and impersonal exchanges of experiences on the internet, based on commonality, substitute medical offices as mediators between patients and the authorized immunological therapies, dodging the immediate adoption of immunosuppressants to which patients are normally directed when they go to conventional physicians.

One observes that, on the one hand, members of life assemblages for immunostimulants also contribute through their bionetworking activities to re-insert the perspective of cure through other therapeutic means into public debates on "chronic" diseases and, thus, to directly confront the established biomedical narrative on autoimmunity as inevitable destiny. On the other, the very perspective of cure, as part of another immunopolitical agenda, becomes possible through the existence and performance of immunostimulants themselves.

Immunostimulants

Along their multiple trajectories, immunostimulant drugs become travelling biotechnologies that provide terrain and language through which negotiations of immunological politics take place (SCHNITZLER 2013), such as the possibility of talking about a cure.

As mentioned in section 2, physicians who employ VAB/CAE, *e. g.*, argue that the cause of the immunological disturbance lies in the weak state of the patients' immunity, and not in its overreactivity, which should rather be seen as a consequence of a broader immunological deterioration process. When they argue that the immunity of patients can be rehabilitated through controlled contact with Brucella, because Brucella help their bodies to *regenerate* themselves, they directly challenge the established biomedical conception of immunity as being only a defence system which looks to protect the *self* from the *non-self* through distinction, avoidance and elimination (ANDERSON & MACKAY 2014). VAB/CAE users, therefore, are learning from immunostimulants that the self-regeneration of a body's person is reached through its adequate interaction with one or more *others*. That corroborates what Napier has been arguing for decades (*e. g.* 1992: 139–75, 2003). Taking the use of stem cell therapy to treat "*Fanconi anaemia*," he explains that:

> A cure becomes possible because, rather than suppressing immune responses, we reshape them by encouraging and feeding novel viral information—information of a new type that one day may well lead to therapies for what were once incurable genetic disorders. (NAPIER 2012: 3)

In the case of VAB/CAE, the *other*, with its *novel information*, used to resiliently re-teach or recommit the immunological cells of patients with autoimmunity are dead Brucella. For instance, MELLO argues (1979: 679) that the efficiency of the different vaccines used to prevent brucellosis, independent of their type, lie on their gradual application and desensitization procedures. Dr Rosa explained to me, for his turn, that VAB/CAE helps to "remind the immune system how it used to be at the time of its intrauterine life" (personal communication, May 2017).

The plurality of immunostimulants used to treat autoimmunity show that this *other*, to which NAPIER refers, can be made out of multiple sources ranging from poisonous and allergen substances (type-II collagen, apitoxin, *kambô*, mygalin etc.) or minerals (vitamin D3, magnesium chloride, etc.) to a person's own tissue (stem cells, blood, etc.). This multiplicity of agents engaged in the co-regulation of the patients' bodies confirms that immunity, "[…] appears to be exploring otherness as much as defending itself […]," as ANDERSON & MACKAY (2014: 148) state in support of NAPIER's theory of immunity as a "search engine" of difference that helps one's body to adjust to its environment (2003, 2012).

While immunostimulants disseminate an*other* immunopolitical agenda (DAVIS *et al.* 2016), they also co-articulate their own adoption spaces (GARDNER *et al.* 2017) by re-organizing established institutions. Bionetworking, as cooperation between diverse actors, including physicians, patients, mediators and unauthorized materials to promote contested scientific innovation, seems to imply transformation processes that take place by re-coding and co-opting already existing infrastructures (*e. g.* juridical, communicational, and scientific ones). So much so, that the making of biomedical worlds appears as being propitiated through exclusion as much as through commonality (CALKINS & ROTTENBURG 2017).

In particular, immunostimulant-users for autoimmunity seem to address their health problems as interpersonal experiences of social suffering and hope (KLEINMAN 1995: 95–172). Instead of being considered as isolated or detached from society, unauthorized immunostimulants for autoimmunity around which life assemblages are formed rather arrange, through their multiple exchanges with diverse sectors of Brazilian society, rhizomatic channels of circulation *outside* established healthcare networks, and simultaneously *inside* and *through* these same healthcare networks, being legally constrained by multiple pharmaceutical circuits in turn. Hence, the struggles for therapeutic legitimacy for immunostimulants extend themselves over and through informal markets without necessarily becoming *parallel* to established pharmaceutical circuits.

To resume, if one observes how unauthorized immunostimulants become systematically employed by unsatisfied patients and physicians, and how stakeholders build their own pharmaceuticals circuits, some ways through which established biomedical institutions are being increasingly circumnavigated become clear. At the same time, the set of medico-legal frictions which emerge from these reciprocal contestations seem to reveal the conventional uses of immunosuppressants to treat autoimmunity in contemporary Brazil, normally taken as self-evident, as a contested totality, in decline.

Conclusion: Biotechnological innovation in Brazil, global medical order and regenerative medicine

As I have demonstrated, each time when immunostimulant pharmaceuticals interact with people's bodies to treat autoimmunity, they subvert and challenge an established medico-legal order, its actors and structures. VAB/CAE and AHT, and other immunostimulants for autoimmunity in Brazil, like synthetic phosphoethanolamine against cancer (VILAR n. d.), affect and are affected by a whole set of interconnected global institutions built to support immunosuppressants, and which in turn is supported by them. Furthermore, those immunostimulant therapies developed in Brazil as biotechnological innovations seek to find their way towards the "Global North," challenging the established global economy of technological innovation (MEDINA *et al.* 2014, ROTTENBURG 2013). Through their bionetworking activities, members of life assemblages for unauthorized immunostimulant therapies, in Brazil, contribute to introject local discontinuities into the established global order for autoimmunity. In so doing, their cooperation work turn perceivable how questions concerning drug approval and regulatory science also points to the involvement of a plurality of local actors (physicians, patients and their relatives; governmental actors; market agents, stakeholders, etc.), their own worldviews, criteria and means of regulation, which are not taken into account by objective, transparent and universal scientific criteria usually associated with biomedicine (HARDING 1998).

A crucial point here is that while established medical authorities fundamentally see a body at war against itself that must be forcefully pacificated when they look at autoimmunity—an idea strongly associable with the predominant "Western illusion of human nature" as described by SAHLINS (2008), according to which humans are inherently evil—, they overlook the increasing tendency to understand one's own body as constantly engaged in interaction with and assimilation of others, of *non-selves* that co-constitute its immediate environment as much as the very *self*. This tendency becomes more visible when one considers the use of immunostimulants to treat autoimmunity in Brazil as part of changing perceptions in biomedical culture related to the global advent of regenerative medicine.

Concerning the possibility of regenerative medicine being itself a new paradigm, WEBSTER observes that it

> [...] is breaking new clinical boundaries in terms of its biological/material goals and processes but it is socially located in a regulatory and commercial context that means that changes will be incremental and move at different paces on various fronts [...] and that early adoption is most likely to be within hospitals as part of the existing "*hidden innovation system*." At the same time, [... regenerative medicine] has posed some significant problems for the regulatory domain, and is [...] a "novel experimental site of contemporary bio-politics." [...] (WEBSTER 2013: 220)

In Brazil, as I have experienced so far, the term "regenerative medicine" does not circulate, in general, among members of life assemblages for immunostimulants. Instead, cure is broadly used, circulated, exchanged, re-written, reinforced and newly uttered among immunostimulants-users who, in cooperation with each other, cross the borders officially administered by established biomedicine to, paradoxically, re-make biomedicine. Following this, it is possible to see “cure” as a concept that, along with immunostimulants and associated marginal biomedical knowledge, materials and practices in Brazil, delineates the boundaries of immunostimulants-assemblages as opposed to the idea of “chronic” (or *forever-ill*), which lays the biomedical ground on which “immunocompromised persons” are produced.

When apprehended as co-constituting *immunostimulant-assemblages*, the medico-legal constraints related to VAB/CAE and to AHT, and other immunostimulants to treat autoimmunity in Brazil, appear as interlinked and encompassing numerous complex changes and conflicts that have occurred in the last decades in different places, such as courts of law, scientific environments, and formal and informal economies (Chen *et al.* 2013). Thus, the regulatory experiences of and bionetworking activities for VAB/CAE, AHT and other immunostimulants, considered internationally, can provide crucial insights: first, into changing perceptions and practices towards immunity, autoimmunity and immunological therapies, which have taken place within biomedical culture and life sciences in Brazil; second, into the development of informal pharmaceutical economies; and, finally, into a relation between these both and the emergence of regenerative medicine as a transnational process.

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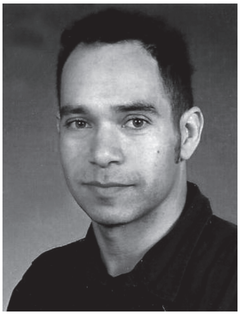

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Transcultural and Transnational Transfer of Therapeutic Practice

Healing Cooperation of Spiritism, Biomedicine, and Psychiatry in Brazil and Germany

HELMAR KURZ

Abstract This article investigates transformation processes of local practices of healing cooperation when transferred from one context into another by means of migration and transnational networks. Healing practices within Brazilian Spiritism and practices of healing cooperation with psychiatric and biomedical health professionals will serve as an example. An introductory anthropological discussion of distinct theoretical approaches to healing cooperation will serve as a starting point, before exploring explanatory models of health, illness, and healing within Brazilian Spiritism. Case studies from Marília/São Paulo and Itabuna/Bahia in Brazil will facilitate the understanding of healing cooperation of Spiritism, biomedicine, and psychiatry. In a further step, the implementation of Spiritist healing practices by Brazilian immigrants and local supporters in Germany will be of central interest. Case studies from Munich/Germany will show that transference of healing cooperation from one context to the other is possible, but that due to different contexts a diversification of discourses and practices will take place. However, the discussion of the presented data will show, that the outcome of transnational transfers of healing practices and models of healing cooperation does not so much relate to social, cultural, or religious frameworks, but to individual resources, personal expectations, and political processes.

Keywords cultural psychiatry – complementary and alternative medicine – CAM – spiritism – migration – Brazil – Germany

Transcultural and Transnational Transfer of Healing Cooperation

Due to globally increasing numbers of psychiatric diagnoses and insufficient therapy resources especially in the Global South, the World Health Organization demands efforts towards cooperation of so-called traditional/religious and scientific/secular health professionals in local contexts (WHO 2014). At the same time, processes of migration and globalization facilitate the transnational and transcultural transfer of religious ideas and related healing practices around the world (KIRMAYER 2006, CSORDAS 2009, BASU *et al.* 2017). This correlation raises the question, how not only distinct culturally and religiously informed therapy approaches, but even models of healing cooperation might be globally transferred from one local context to the other. It implies the need for a closer look at actual practices of healing cooperation and their transformations within transnational networks of healing.

According to KLEINMAN (1988a,b), explanatory models shaping disease categories, illness experiences, and related social implications are not static but dynamic and flexible within a given cultural context and social situation. KIRMAYER (2014) assumes that there has always been a constant exchange, circulation, mutual transformation, and proliferation of distinct medical systems. He observes an increasing demand within Western societies for so-called complementary and alternative medicines (CAM) as a hybrid integration of various and sometimes antithetic therapeutic practices and discourses (*ibid.* 33). BAER *et al.* (2013: 368) criticize relations between CAM and biomedicine as asymmetrical but acknowledge the subversive powers of local healing traditions, challenging biomedical hegemony and political implications. Both, KIRMAYER (2014) and BAER *et al.* (2013) draw a picture of opposing medical systems that challenge and compete with each other. EEUWIJK (2010) criticizes this approach and postulates to focus on practices and dynamics of diversity, where difference does not necessarily imply opposition but enables complement (*ibid.* 140). Transnational networks of healing cooperation would contribute to new complex and heterogenic practices, integrating aspects of the local and the global (*ibid.* 157 f.). Accordingly, KRAUSE *et al.* (2012) stress the importance of investigating related processes of therapeutic diversification regarding interaction, entanglement, and fusion of different therapeutic actors (*ibid.* 15 ff.).

CSORDAS (2017) describes a case of healing cooperation between academically trained mental health professionals and native spiritual healers within a Navajo reservation in the USA. According to him, the establishment of a local psychiatric unit which integrates indigenous spiritual concepts and practices would enhance the success of therapy. In addition to pharmaceutical and psychological treatment, he stresses the importance of a sweat lodge where patients would encounter and deal with disturbing spirits which are interpreted as at least one cause of affliction (*ibid.* 132 ff.). Inferentially, local religious and psychiatric explanatory models can complement, inspire each other, and fuse into new practices of cooperation. BHABHA (1994) would describe such intersections as "third spaces" where controversial approaches and interpretations develop towards alternative and innovative resources. Accordingly, religious and psychiatric explanatory models do not necessarily exclude each other, but can produce complementary spaces of healing cooperation (KURZ 2015: 177).

Medical diversity in Brazil may serve as an example for the coexistence of multiple psychiatric institutions and their intersection with diverse religious movements specializing in the treatment of emotional, spiritual and mental distress. HESS (1991: 162) refers to a spiritual continuum which comprises of Afro-Brazilian religions and Spiritist institutions in their attempt to restore mental health in terms of spiritual transformation. Mediumistic practices are central to the healing process, integrating individual, social and spiritual aspects. Initiation into religious communities such as *Candomblé* (KURZ 2013, SELIGMAN 2014), *Xangô* (HALLOY 2012) or *Vale do Amanhecer* (PIERINI 2016) provides an embodied learning process towards altered perceptions and experiences of self and social relations (see SCHMIDT 2016). However, many patients who seek and find relief within mediumistic and religious healing practices will not become mediums themselves, and this clientele is usually overlooked within academic studies on practices of spirit possession and mediumship (KURZ 2017: 202 f.).

This latter observation is especially important regarding *Kardecism*, another form of Spiritist practice within the Brazilian spiritual continuum. Due to the self-denomination of Kardecists as Spiritists (*espírita*), I will use the terms *Kardecism* and *Spiritism* as synonyms throughout this article. Kardecism originates in various 19th-century European Spiritist currents which were finally unified and codified as a Spiritist doctrine by French scholar and Spiritist Hippolyte Léon Denizard Rivail (1804–1869), using the pseudonym of Allan Kardec. By the end of the 19th century, Kardecist doctrine also reached Brazil and partly fused with indigenous and Afro-Brazilian spiritual practices and concepts. Kardecism shares with these traditions and Anglo-Saxon Spiritualism the idea of mediumship, that is communication with spirits through sensitive individuals. It differs from the latter by its concepts of reincarnation and karma, which shift the focus towards personal spiritual progress throughout many lives. In Brazil, Kardecists developed a focus on healing and well-being, partly due to the aforementioned intersection with other spiritual practices. However, they do not engage in practices of spirit possession and provide spiritual healing in a more institutional and allegedly "scientific" way (ENGLER & ISAIA 2017).

Kardecism became a resource for the Brazilian (mental) healthcare system and for healing cooperation between institutions of Spiritism, biomedicine, and psychiatry (see KURZ 2015). Healing cooperation here integrates many actors and actants: patients, healers, spirits, study groups, books, voices (see KURZ 2017). However, throughout this article I will mainly refer to healing cooperation between Kardecist and official medical institutions and persons, a delimitation that sometimes is blurred by the fact that a psychiatrist might be Spiritist and academically trained medical doctor at the same time (*ibid.* 198). Throughout the 20th century, Kardecist-Spiritist associations have administrated many inpatient psychiatric hospitals and remain doing so, opposing current Brazilian health politics and its deinstitutionalization strategy of shifting mental healthcare from in- to outpatient treatment (Ministério da Saúde 2007).

US-American medical anthropologist Theissen (2009: X) sharply criticizes Spiritist psychiatry in a Foucauldian way, arguing that it seems to her as a national project of paternalistic social control by white elites. She interprets Kardecism as an institution where psychiatric diagnosis promotes a moral judgment instead of sustained treatment (*ibid.* XIII) and accuses psychiatrists of referring to moral transgressions and responsibilities of their patients (*ibid.* 129 ff.). Even though her argument provides some interesting aspects, she misinterprets her data due to severe methodological failures. To start with, she declares right in her very introduction her private rejection towards the object of research. Further, her main informants belong to the Brazilian antipsychiatry movement, and she does not describe any observation of healing practices, nor does she refer to interviews with patients and family members. Thus, she lacks insight into the therapy process and misses to recognize its potential for personal (spiritual) transformation and development of agency (see Kurz 2017: 202 ff.). Moreover, her critique of a national project of social control developed by white elites does not bare any evidence. Taking into account the Brazilian national census of 2000 (IBGE 2000), the denomination to Spiritism of persons of different ethnicity reflects the national average. It relates more to aspects of education, literacy and regional fashion than to race, gender, or socioeconomic position (*ibid.* 37, 43, 50 f., 93 ff.; see Schmidt 2016: 47 ff.).

Brazilian psychiatry reform is progressing (Ministério da Saúde 2007, Goulart & Durães 2010), but resources for outpatient and community care are hardly and insufficiently developing (WHO-AIMS 2007, Mateus *et al.* 2008, Bernardo & Garbin 2011). With their partial autonomy from public health policy and the devotion of volunteers, Spiritist psychiatric hospitals increasingly become the only remaining spaces of inpatient mental healthcare, providing medical and spiritual support at the same time (see Kurz 2017: 197 ff.). While both refer to the same institution (*Hospital Espírita André Luiz*/HEAL in Belo Horizonte, Minas Gerais), US-American psychologist Bragdon (2012) in contrast to Theissen (2009) praises the efficacy of healing practices within Spiritist psychiatry in terms of spiritual transformation and development of personal agency and new perspectives in life. She even argues for their universal importance and their implementation into regular North-American psychotherapy (Bragdon 2004).

From the perspective of medical anthropology, discussing the transnational expansion of Spiritist healing practices does not mean to postulate their universal validity but to assume that they are universally transformable, integratable, and contestable according to patients' needs and experiences. In the case of Spiritism, this might be obvious, since it combines different global concepts, such as German philosophical currents of the early 19th century, Mesmerism, Christian ethics, Anglo-Saxon Spiritualism, and Asian concepts of reincarnation and karma (Sawicki 2016). However, throughout the 20th century, it has been strongly influenced by Brazilian religious culture and sociopolitical developments (Schmidt 2016, Engler & Isaia 2017).

By introducing some case studies regarding Brazilian Kardecism and related practices of healing cooperation, I will argue that illness explanatory models and healing practices—in contrast to paradigms in cross-cultural/transcultural psychiatry (see Kleinman 1988a; Machleidt 2013)—are not reducible and exclusively linked to social and cultural frames or contexts, but also refer to personal expectations and individual resources. They should not be reduced to local *idioms of distress* (Nichter 1981), *cultural metaphors* (Kirmayer 1993), or *culture-bound syndromes* (Littlewood 2000), but referred to as people's individual experiences in certain life situations. Thus, in revising the concept of *idioms of distress*, Nichter (2010) suggests that personal resources and emotional aspects should be integrated into the understanding of different explanatory models and therapy systems. For the context of Brazil, Schmidt (2016) has proven that denomination to certain religions and related healing practices is not reducible to ethnicity, social status, cultural background or gender, but to aspects of individual (embodied) experience. From the perspective of critical medical anthropology (see Scheper-Hughes 1994, Farmer 2003), I also consider temporary political frameworks independent from larger sociocultural contexts central to the experience of illness and treatment.

I will introduce and discuss different sites of (attempted) healing cooperation between Spiritism, biomedicine, and psychiatry regarding personal experience and I will outline dynamics of transformation of these healing practices due to contextual political processes. The data presented is based on qualitative research (participant observation, narrative and semi-structured interviews, media research) in Brazil and Germany conducted between 2015 and 2017. From October 2015 to April 2016, I participated in Kardecist healing practices within the Spiritist psychiatry *Hospital Espírita de Marília* (HEM) and the associated Spiritist study center *Centro Espírita Luz e Verdade* (CELV) in Marília/São Paulo and conducted thirty interviews with Spiritists, health professionals, patients, and family members. From October 2016 to April 2017, I participated in Spiritist healing practices within the Spiritist study and healing center C*entro Espírita Claudionor de Carvalho* (CECC) in Itabuna/Bahia and conducted fifteen interviews with Spiritists, health professionals, and patients. Marília and Itabuna resemble in their local importance as political and economical urban centers in an agricultural environment, with approximately 200.000 inhabitants. They differ in their regional socioeconomic contexts: while Marília is located in the relatively wealthy Southeastern state of São Paulo, Itabuna belongs to the economically lesser developed Northeastern state of Bahia.

In Europe, the request for spiritually informed therapies is on the rise (see VOSS 2011, SINGER & BAER 2012: 143 ff.) and this increasingly accounts for Kardecism, too. For example in Germany, Brazilian communities established Spiritist centers in various major cities, most of them associated with the *Deutsche Spiritistische Vereinigung* (DSV, "German Spiritist Association"). Already for a few years, some of their members are discussing the possibility of not only providing spiritual support for Brazilian immigrants and open-heartened Germans but also to develop further therapeutic supplies according to the healing cooperation models in Brazil to be implemented into German healthcare. From July to September in 2016 and 2017, I conducted participant observation and fifteen narrative interviews within the Spiritist study center *Grupo Espírita de Estudos Allan Kardec* (GEEAK, "Spiritist Study Group of Allan Kardec") in Munich, where I was able to observe contested approaches and positions regarding the integration of Spiritism into German religious and health related approaches, which would eventually initiate the separation of the group.

Refining the initial question regarding the development of healing cooperation, their transformation, and the prospect of integration in Germany, several new questions arise: How do the different actors practically establish and experience healing cooperation? How do these practices relate to secular, religious and/or spiritual explanatory models? How do Spiritist explanatory models contribute to the cooperation and interaction with psychiatric categories, and who contests them? How are they implemented in different cultural contexts like Brazil and Germany? What impact do political developments and processes of migration have on the (transnational) transformation of these practices and discourses related to health, health-seeking behavior and healing cooperation?

I will first introduce Spiritist explanatory models and healing practices within their local historical contexts before presenting four vignettes of case studies (one each in Marília and Itabuna, two in Munich). I altered the names of my research participants, and the fact that they are all female does not indicate any tendency towards a more prominent gender profile within Kardecism. On the contrary, as aforementioned, affiliation to sex, gender, ethnicity or social class does not play any major role in the decision to become a Spiritist (see SCHMIDT 2016: 47 ff.). I will thus conclude with the discussion of my argument that it is—independent from social or cultural belonging—the quest for explanations, coping strategies, and solutions for human conditions and experiences, along with some (health) political aspects, which inform processes of transnational and transcultural transfer and transformation of models of healing cooperation from Brazil to Germany.

Spiritist Explanatory Models and Healing Practices in Brazil

It is especially within institutions of Kardecism where healing cooperation of Spiritism, biomedicine, and psychiatry are established. Kardecists do not perceive themselves as members of a religious community but of a philanthropic movement approaching spiritual aspects with scientific standards (PRANDI 2013: 59). The term relates to Allan Kardec, who fuses concepts of Mesmerism, Christian ethics, parapsychology and oriental religious concepts into an ontology of the human spirit. Reincarnation and the urge of personal progress throughout many lived existences are central to Kardec's doctrine, translated from original French into various languages, and reproduced within a vast record of Brazilian Spiritist literature throughout the 20th and early 21st centuries. Allegedly, it bases on messages from deceased individuals, or in emic terms, "discarnate" spirits. Kardec, but also Brazilian authors like Adolfo Bezerra de Menezes, Francisco Cândido "Chico" Xavier, and Divaldo Pereira Franco reveal the proposed purpose of life: to correct past (life) mistakes and to develop towards an individual who practices (self-)love and charity (see MOREIRA 2013).

Despite the fact that Kardec is more interested in the etiology of the spirit world and its relationship with the world of the living (see KARDEC 1986, 1996), in his "Journal of Psychological Studies" (1858–1869) he also discusses cases of behavioral disorders, suicide attempts and changes of sensory perception (see MOREIRA-ALMEIDA & LETUFO NETO 2005: 572). Without rejecting the biological, psychological, and social causes of mental disorders, he adds the spiritual sphere regarding negative influences of discarnate spirits ("obsession") (*ibid.* 570). Bezerra de Menezes (1831–1900) integrates these ideas into early Brazilian mental healthcare discourses (BEZERRA DE MENEZES 1920). His main argument relates to the question if there might be an explanation for mental distress without any organic brain defect (*ibid.* 3). Deducting from Kardec's teachings and his personal studies of philosophical writings on the human existence, he postulates that humans consist of a spirit (soul), a material body, and, as a connection between both, the human brain (mind) (*ibid.* 64). In a further step, he reflects on experiences of mediumistic sessions and argues that the spirit survives death and might influence other living beings, for example as obsession, which would fluidly interrupt or influence the spirit-brain-connection of the afflicted person (*ibid.* 65 ff.). He thus states that "madness" can be either of organic reasons or due to spirit obsession (*ibid.* 120 ff.). Himself not being a psychiatric practitioner, Bezerra de Menezes suggests that once there is a twofold cause of insanity, treatment modalities also should be differentiated in terms of biomedical and spiritual approaches (*ibid.* 582). The first psychiatrist who turns this theory into practice is Inácio Ferreira de Oliveira (1904–1988), director of a Spiritist psychiatric hospital in Uberaba/Minas Gerais from 1934 to 1988. He implements combined treatment, including mediumship training and participation of patients within mediumistic sessions (see HESS 1991: 187 f.). In this way he creates a model for a new orientation within Brazilian psychiatry, as between 1930 and 1970 around fifty Kardecist psychiatric hospitals evolve in Brazil, mainly in the state of São Paulo (MOREIRA-ALMEIDA & LETUFO NETO 2005: 572). With some modifications, this approach is still valid in the beginning 21st century, and Bezerra de Menezes is honored as the spiritual mentor of many Spiritist mental healthcare institutions in Brazil. His tripartite model of a person has been further developed to the spirit (soul/mind), the material body, and the "perispirit," a semi-material energy field which connects spirit and body and is central to contemporary Spiritist healing practices (see KURZ 2017).

Complementary to this, Divaldo Pereira Franco (*1927) develops another approach. The famous Brazilian medium and long-time figurehead of the *Federação Espírita do Brasil* (FEB, "Brazilian Spiritist Federation") claims that the spirit of the post-medieval nun Joanna de Ângelis produces through him her "Psychological Series" (FRANCO 1997, 1999, 2002), linking Kardecist approaches to transpersonal and Jungian psychology (see MOREIRA-ALMEIDA & LETUFO NETO 2005: 584). Patient's current and past life experiences are central to this approach, as they would unconsciously influence thoughts, acts, and behavior. Ethical behavior and reflexive introspection become more distinct health practices than dealing with external spiritual influences (*ibid.* 585). Suggested therapy models are mental hygiene and spiritual development through the lecture of the "Gospel According to Spiritism" (KARDEC 2008) and Christian discipline as a resource for self control (FRANCO 2009: 20 f.), including moral education, training and reformation, charity, and prayer.

Additionally, "disobsession" (as a form of "gentle exorcism") could enhance the personal moral development by indoctrinating disturbing spirits and helping them to find their way back to the spiritual realm (*ibid.* 98, 115). Fluidal treatments, like energetic laying-on hands treatment ("*passe*") and drinking spiritually energized water for the sake of vitalization of the energy fields, would sustain complementary support. They should not be perceived as a miracle or magical healing, but as a guide towards gradual personal progress (*ibid.* 26). Another important Brazilian medium is Francisco Cândido "Chico" Xavier (1910–2002), who published several hundred psychographic books with over 20 million copies only sold in Brazil. Especially his works with the "ghostwriters" Emmanuel and André Luiz have been influential in the development of Brazilian Spiritist healing practices. The latter is the main character of "Nosso Lar" (Xavier 1944), one of his most famous works, which as a movie (Assis 2010) became a blockbuster in Brazil. The main topic is the life and death of medical doctor André Luiz, who develops from a suffering towards a helping spirit and becomes an inhabitant of a colony in the spiritual plane with a hospital where afflicted and afflicting spirits are treated—an idea that is essential for the disobsession process.

The importance of Spiritist explanatory models and healing practices for the Brazilian healthcare system is undeniable, as Kardecist perspectives on mental disorders exert considerable influence in Brazil and promote explanatory models for related experiences (Moreira-Almeida & Letufo Neto 2005: 570). Already over thirty years ago, Stubbe (1987: 176) argued that the Brazilian healthcare system does not provide sufficient therapy resources, especially regarding psychological and psychiatric afflictions. The more recent WHO-AIMS (2007) report on the mental health system in Brazil shows little improvement: the psychiatry reform since the early 2000s leads to the closure of inpatient psychiatric hospitals without providing sufficient outpatient resources. Additionally, patients do not agree with biomedical psychiatric treatment approaches, once that bodily, cultural and psychosocial aspects are ignored, and therapy often is reduced to expensive medicalization (Leibing 1995, Rabelo & Souza 2003). These are some reasons why Spiritist healing practices provided free of charge are of such high significance in complementing the official health sector (see Stoll 2003, Greenfield 2008, Kurz 2017), even though until today not being officially accepted as complementary therapies (see Ministry of Health of Brazil 2008).

Fig. 1: Hospital Espírita de Marília, Photo: Helmar Kurz.

Healing Cooperation between Spiritism and Psychiatry

Marília in the state of São Paulo is a historic center of Brazilian Spiritism and accordingly consists of a high density of Spiritist institutions. An elected council of actors within the network of about a dozen Spiritist centers of Marília has administrated the psychiatric *Hospital Espírita de Marília* (HEM) since 1956. It offers treatment for up to 250 psychiatric patients within various emergency, long-term, and short-term units which are divided into sub-units according to gender, age, health insurance affiliation, diagnosis and personal resources. HEM is affiliated with the public Brazilian unitary health care system *Sistema Única de Saúde* (SUS), but also offers special accommodation and treatment facilities to patients with a private health plan. Additionally, a day clinic for patients with resources at home, and an asylum for mentally disabled individuals without any social resources are maintained, the latter being a charitable act of the hospital as no official funding exists. The asylum and SUS units are in a marginal state, because of lack of official funding, and HEM is only able to maintain its services with donations and the income of the private health plan section. Employed psychiatrists spend a few hours a day here, since they also affiliate with the public hospital of Marília or their private clinics. Treatment mainly reduces to pharmaceutical and occupational therapy, complemented by efforts to maintain basic psychological and physiotherapeutic supply, at least for patients who can afford a private health plan. Volunteers of the close-by *Centro Espírita Luz e Verdade* (CELV, "Spiritist Center of Light and Truth") and other Spiritist centers of Marília contribute their leisure time, energy, and empathy to fulfill HEM's promise to "treat people with love." They read and discuss Spiritist literature with patients, provide *passe* to them (laying-on hands as energetic treatment), and perform disobsession without the patients being present (for more details see Kurz 2017).

Case Study I: Ana Paula

In 2013, Ana-Paula is in her late forties and works as a clerk within the city administration of Marília, taking care of public healthcare issues. She is of Catholic background, married, has two children, and lives with her family in their own house.

"Then out of the blue and without any reason, I suffered a heavy depression. I got lost in time and space, did not know where I was, and forgot about anything. I could not take care of myself, and my family did not know what to do." (Interview 2015–11–15)

She stays about a year in the private health plan unit of HEM. In addition to medical treatment and occupation therapy, she starts to attend lectures on the "Gospels According to Spiritism" (Kardec 2008) by the Spiritist volunteers. Those come here every morning and sometimes in the afternoon to read out and discuss spiritual issues and aspects of (self-)love, (self-)responsibility and the need for moral change to facilitate personal progress. Ana-Paula listens for the first time about the survival of the soul, karmic issues and the possibility of obsession by revengeful spirits of past-life enemies. Medical treatment hardly shows any progress, but Ana-Paula enjoys the daily lectures and discussions and experiences relief during the *passe*. Even though they hardly had any contact with Spiritism before, the family starts to think that her affliction might be due to an obsessing spirit. After a few months with only gradual therapy success, she may leave HEM once a week to attend fraternal care and an eight-week-treatment in CELV. On the first meeting, a Spiritist volunteer without any psychological education discusses her case with her in spiritual terms and passes on a message from the spirit world, which seems to confirm the influence of an obsessing spirit. Ana-Paula learns that it is her responsibility to change her situation but that she will receive spiritual support. For the following two months, she attends a weekly one-hour lecture on Spiritist doctrine, receives the lay-on-hands energetic treatment, and drinks fluidized water. She starts to read Spiritist literature and gradually gets better, while still taking her medication. Finally, she is even released from HEM and returns home, but after a few weeks, she experiences a relapse. Ana-Paula repeats the eight-week-treatment twice, but only when she starts to attend study groups at CELV and to participate in various charity activities towards less fortunate people, she enjoys sustained relief. By 2015, she feels "new-born," and the attending psychiatrist who is a Spiritist herself further reduces her medication. Ana-Paula starts working again, continues participating in the activities of the Spiritist center and wants to contribute to the therapy of psychiatric patients as a volunteer herself.

HEM and CELV constitute an example of symmetrical and almost symbiotic healing cooperation between Spiritists and psychiatrists. The administration of HEM organizes the cooperation between biomedically educated psychiatrists, other health professionals, and voluntary, religiously oriented individuals who are associated with the various Spiritist centers of Marília and act as spiritual therapeutics. In the case of Ana-Paula, we are able to observe a complementary therapy of "medicalization and evangelization," resulting in her full recovery after engaging in Spiritist practices and becoming a volunteer herself.

It should be mentioned, that during my fieldwork HEM developed from a sole psychiatric hospital towards a general clinic. According to the administration of HEM, the psychiatry reform of Brazilian health policy does not financially cover psychiatric hospitals anymore, in contrast to psychiatric units in general hospitals. Thus, with the support of donations and volunteer workers from the Spiritist community of Marília, in 2016 a surgical unit has been established, warranting the status as a general clinic with a psychiatric unit and thus financial funding by SUS.

Healing Cooperation between Spiritism, Psychosocial Assistance, and Biomedicine

The *Centro Espírita Claudionor de Carvalho* (CECC) in Itabuna/Bahia is located in a rather poor neighborhood which might be referred to as a *favela* ("slum"). It is one of about half a dozen local Kardecist centers in Itabuna, but the only one offering elaborated healing practices. The spirit of deceased medical doctor Claudionor de Carvalho incorporates in chief medium Marcos and spiritually treats patients, especially those who suffer from symptoms related to diagnoses of depression or cardiovascular problems. On Mondays, he receives patients and decides if they need spiritual treatment at all. This way, he offers complementary therapy to biomedical approaches without demanding the discontinuation of conventional therapy. He requires that patients participate at least once a week in the lecture of Spiritist doctrine before their treatment, and follow certain dietary, sexual and behavioral restrictions according to their energetic state. Treatment continues for at least eight weeks, but can even continue for years. People diagnosed with spiritual problems will receive energetic treatment in terms of an elaborated form of *passe* focusing the *chakras* of the patient by about twenty assistants.

The center resembles a private clinic with a waiting area where people read or listen to Spiritist doctrine, examination rooms and offices, and a therapy room with six beds where patients lay down to receive spiritual treatment in a quiet atmosphere with darkened, greenish light and mellow music in the background. Information of any patient is logged in a personalized file, and they are supposed to write a diary where they report their daily practice and spiritual progress. According to this, Dr. Claudionor will give instructions for the future treatment. On Tuesdays, he receives patients with cardiovascular and related problems and actively participates in the treatment, going from bed to bed, checking the state of the patients and, according to him, performing spiritual surgeries by applying different wadding with liquids and band-aids (for hospital mimicry in Spiritism see KURZ 2015). After that, his assistants will perform *chakra* treatment as on Mondays, according to a detailed application manual. If Dr. Claudionor diagnoses influences of obsessing spirits, these are dealt within disobsession meetings on Thursdays. A group of mediums and assistants will meet for several hours, and the procedure is always the same: three people will sit together, a medium, an instructor, and a secretary. The secretary will read out the case from the personal patient's file, and immediately the medium will receive the obsessing spirit and reveal its motives. The instructor will then get into a conversation with the spirit, trying to get more information and to convince the spirit of its wrong behavior, in best case having it passing on to the spiritual plane, where it will get further help by supporting spirits. The secretary notes every detail in the patients' files so that Dr. Claudionor afterward will be able to decide about future steps. His medium Marcos stresses the fact, that this is a clinic, not a religious site, and that many medical doctors would send their patients here when not knowing anymore how to treat them, especially when dealing with chronic diseases. Treatment is free of charge, but donations are readily accepted. Other acts of charity are performed on Wednesdays, when the people of the relatively poor neighborhood come to listen to spiritual lectures, have a free soup, and have their children being attended by social workers and other volunteers to discuss life issues, school problems, or just spend the afternoon in a friendly and relaxing atmosphere. Families, whose members come every week, receive donated staple foods once a month.

Case Study II: Renata

Renata is 35 years old, unmarried, and mother of a five-year-old daughter. She works as a nurse at the public hospital of Itabuna and has a Master degree in public health studies. She criticizes the conditions of the Brazilian health system and "her" hospital in specific:

"It used to be a great hospital, where everyone was attended but due to recent health policy it is on the level of cavemen." (Interview 2017–02–17)

Renata relates to herself as a medium, and she has attended sessions in various Spiritist centers since she grew up with a Spiritist mother. However a few years ago, she stopped working as a medium due to exhaustion from work and the education of her daughter. This is when, in her terms, she started to feel that she was becoming "crazy." She mentions diagnoses of depression and anxiety, which she initially has had treated by a psychiatrist, but then she decides to visit the CECC. Dr. Claudionor diagnoses that her affliction has been due to her undeveloped mediumship, which allows spirit obsessors to fluidically and energetically harm her perispirit (subtle, energetic body), and thus her body and mind. For many months, he and his helping team which includes psychologists, physiotherapists, teachers, and former patients take care of her. She attends study groups and lectures and slowly starts to work as a medium again, even within the disobsession meetings. More than that, Renata helps to establish the project "Francis of Assisi," a family health project taking care of problematic children of the *favela* environment. She and other Spiritist volunteers visit families' homes and provide psychosocial support. With her nursery skills, she also provides first aid and amnesic for people in need and maintains a network of medical doctors who treat people for free, aside from the public health system which would mean long ways, extended waiting, and marginal treatment (see KURZ 2017: 197 ff.). One of these doctors, a Spiritist herself, even visits CECC once a week to provide free diagnosis and medication. Relating to this, Dr. Claudionor's medium Marcos assures that he only treats the spiritual part of the problem and that he leaves the somatic aspects to his "earthly colleagues."

Contrary to Marília, Itabuna offers marginal living standards to the majority of its inhabitants, including a high rate of unemployment and restricted access to official healthcare. CECC addresses people of the *favela* environment not in terms of complementary treatment but as a substitute for the marginal official healthcare. However, we can observe healing cooperation in a sense that spiritual and academically trained health professionals support each other in this context of failed national health policy. For the patients to seek assistance in CECC it is not the cultural aspect of belief in spirits, but the economic and infrastructural factors which drag them there. On the side of the volunteers, we meet healed former clients and some wealthy contributors who wish to establish a place of care within an uncaring environment.

Transnational Encounters and Transformations: Spiritism in Germany

Spiritist biomedical doctors and psychiatrists organize within the *Associação Medico-Espírita* (AME, "Association of Spiritist Medicals"). AME members travel around the world and participate in international medical congresses to discuss Spiritist approaches to health and healing. In Germany, the organizers of the annual *Psycho-Medizin-Kongress* ("Congress for Psycho-Medicine") in Bad Honnef attune to Spiritism and regularly invite Brazilian speakers to discuss Spiritist explanatory models and healing practices with the objective to integrate them into German health care. For example, in 2016, around 150 German and Brazilian descendant listeners followed lectures on reincarnation, obsession, mediumship, and energetic aspects of therapy. Some members of different German-Brazilian Spiritist groups continually engage in the discussion of these concepts, as those of the *Grupo*

Espírita de Estudos Allan Kardec (GEEAK, "Spiritist Study Group Allan Kardec") in Munich. GEEAK, existing for about twenty years, recently gained the status of a legal association, and intends the practice of "Christian-Spiritist belief by fraternity, prayer and the joint study of spiritist philosophy according to Allan Kardec." About fifty to sixty members regularly participate in lectures and study groups of Kardecist doctrine, mediumship training, and energetic treatment (*passe*). Twenty percent are Germans, while the other eighty percent are Brazilian immigrants with legal residential status. Brazilians without legal status cannot become members because the chairpersons do not want to risk the status of a registered association. However, any person in distress is welcome to experience spiritual and psychosocial support, and it is mainly young female Brazilian immigrants seeking relief of a subjectively experienced distressing cultural environment (regarding the female gender of the majority of Brazilian migrants see MARGOLIS 2013: 103 ff.). GEEAK is one of about fifteen Spiritist groups in Germany organized within the *Deutsche Spiritistische Vereinigung* (DSV, "German Spiritist Association") which is part of the *Conselho Espírita Internacional* (CEI, "International Spiritist Council") which again is dominated by the *Federação Espírita do Brasil* (FEB, "Brazilian Spiritist Federation"). DSV aims to provide solidarity and fraternal unity, support, and coordination of Spiritist practices in Germany. Members engage in various "pro-life projects," confronting abortion, suicide, or euthanasia. In 2016, they hold their annual meeting in Frankfurt/Main alike a scientific event with keynotes, lectures, presentations, workshops, and book tables. The meeting mainly serves the communication of Brazilian Spiritist communities in Germany, and a much-contested topic is the importance of German language within these communities. While some participants argue that the Spiritist centers should be a refuge for Brazilians to maintain their cultural identity, others declare them as spaces of integration and distribution of Spiritist doctrine within the German context. Further, the aspect of spiritual support and possibilities of healing cooperation in line with Spiritist doctrine *and* in accordance with German healthcare restrictions are becoming the focus of continued and controversial discussions between different protagonists of GEEAK. In 2017, some Brazilian and all German members leave the group to create a new project aiming at the "debrazilianization" of Spiritist practices and the establishment of healing cooperation in terms of a "holistic bio-psycho-social-spiritual approach." The basic idea is that Spiritism is not regarded as a Brazilian cultural practice, but a universally valid and scientifically rooted way of life which has only been "preserved" in Brazil (see XAVIER 1938) and now would have to be distributed to the world again. Thus, it would have to be purified from any cultural specificities (like a strong Christian connotation in Brazil) to make it accessible to everyone. But once again, the personal level of individual experience has to be taken into consideration to understand the meaning of Spiritist (healing) practices for different people involved.

Case Study III: Fernanda

Fernanda is from the city of São Paulo, 32 years old, and studied industrial design in Brazil. Born into a Catholic family, since adolescence she has developed an atheist and antireligious worldview. In 2009, at the age of 25, she enters Germany with a student's visa to study German language and culture. However, she never attends university classes but starts trying to work within her profession. But as her Brazilian academic graduation is not accepted in Germany, she ends up feeling exploited in low-wage internships, which humiliates and frustrates her a lot and leaves her depressed. According to her, she restarts to believe in God in Germany, since she has been suffering so much and needs something to hold on and to support her. In 2013, she meets her future German husband Peter, who emotionally supports her and warrants her legal status in Germany. From 2014 on, she starts to frequent GEEAK. She actively participates in the Brazilian and German lectures and study groups, convincing her husband to accompany her in the latter. To Fernanda, participation within GEEAK has been crucial to get back to tracks, as she did not know anymore how to deal with her situation as a skillful and ambitious young woman who with her immigrant status became marginalized in German society. Nowadays, it is important to her to support others who are having comparable experiences, and she believes that GEEAK provides some possibilities to do so:

"Since I have been there, I did an inner reform. I have been working on my inner self … a lot by reading and lectures … I learned a lot … and I think, that helped me a lot … it made a major change. Back in the day, I have been lofty and full of mistakes, which I have been able to work them out … now I am more humble … and I learned that with Spiritism. […] It was a relief to work on myself, because I saw, that the world will not change that easy … so I have to change my perspective on the world." (Interview 2016–09–28)

Fernanda believes that the Spiritist practice and community helped her to overcome her problems in terms of finding ways to deal with them. She is now an independent, self-employed graphic designer and has been enjoying interacting with Brazilians and Germans within GEEAK. She is shocked and sad when she learns that the group will split in 2017, and finally renounces herself from any activity within GEEAK due to this disappointment.

Fernanda's example supports my argument that cultural aspects in terms of a peer group are of certain importance, but personal expectations, individual resources, and political contexts are central to the transnational distribution of models of healing cooperation. Various researchers investigating the context of migration and (mental) health argue that cultural resources of religious and therapeutic practices support the integration process of immigrants into a new cultural system, especially within a hostile political context regarding immigration (see EICHLER 2008, HUSCKE 2013, THIESBONENKAMP-MAAG 2014). This is partly also true for Kardecism in Germany, but here we also observe a process which aims at the integration of spiritual aspects into a national healthcare system devoid of cultural connotations, reflecting an ongoing debate of the political restrictions within the German healthcare system, and the wish for a symmetrical relationship between biomedicine, psychiatry, and alternative or complementary medicines (CAM).

Case Study IV: Heike

Heike is a German, 55 years old, unmarried woman and works in the service unit of a public transportation company. She perceives herself as a medium and describes her mediumship as an inner voice, which since the age of six, warns her of dangerous situations and also helps her with daily decisions. She believes that she has the ability to travel to the spiritual world in her dreams and is able to communicate with the spirits of deceased persons. She has been reading literature on mediumship and new age spirituality all her life and came to GEEAK more by accident, researching for additional information on the internet. It would help her to talk to people who share, understand and appreciate her experience, and that she is able to develop her knowledge about it through the lectures and study groups. She has participated in GEEAK since 2012, a time that she describes as very sorrowful. Within a few years, she lost her parents, a friend, and a colleague, which has made her suffer a lot. Other unlucky events and difficult experiences have added up and left her desperate. When she becomes a member of GEEAK, she enjoys the attention and empathy of the new peer group. Especially the *passe* is soothing and helpful to her. Heike believes that it was her misfortune that brought her here, and that God gave her all these issues to resolve and spiritually develop. She perceives the studies and discussions as a regeneration of her inner self, which also helps her to deal with difficult life situations and to avoid stress. She participates in a mediumship training and disobsession group and claims that this is what she always wanted—having the possibility to help afflicted spirits, but also to release negative energies and influences, which she would accumulate in her daily life. To her, it is her vocation, and she is happy that she is able to realize it within this community:

"I am here to carry out my obligations and this mediumship has not been given to me for nothing. It feels right, and there have to be people to increase the vibration of this planet. For this, we have to deal with the spiritual beings, and there are not enough people doing so. I feel that this is right." (Interview 2017–06–13)

Heike is one of the members of GEEAK who will split and participate in the new group, something that leaves her very sad, but to her is due to contrary expectations and objectives of members and participants. In her opinion, many Brazilians would rather create "their little nest to hide in," while other members are more ambitious regarding the implementation of Kardecist doctrine into German (health) discourse and practice. She considers it to be a cultural problem and criticizes the approach of Brazilian Spiritists who only talk about God, Jesus, and Kardec. There would be many possible paths, and she wants to do what feels good and right to her. Asked about the interrelation of Spiritist practice and health, Heike declares that she does not perceive it as therapy, but that it definitely helps to be more attentive to oneself and to reflect on causes and effects of personal problems.

Both, Fernanda and Heike, refer to GEEAK as a place of well-being in a difficult life situation, but their narratives differ regarding their personal experiences. Fernanda suffers from a hostile political context regarding integration of immigrants and develops a clinical depression from which she is only able to recover through a support group with a reference to Brazilian solidarity practices, even though Spiritism has not been her life orientation before. At the same time, participation in the German study group helps her to integrate into the new cultural context, and she is very disappointed about it's loss by separation. Contrary to her, Heike has spiritual experiences which she cannot communicate to others without the danger of being labeled as mentally ill, and she is seeking a place where she can express her experiences. These different narratives reflect a general pattern of diverse pathways to Spiritism in Brazil and Germany. However, like many other long-time Brazilian and German members, she is annoyed by the impact of Brazilian (religious) cultural aspects and wants to adjust Spiritist practice to the German context and its healthcare requirements.

Healing Cooperation of Spiritism, Biomedicine, and Psychiatry in Brazil and Germany

The vignettes of Brazilian case studies reveal a variety of healing cooperation models, which integrate Spiritist explanatory models into general (mental) healthcare. HEM is a psychiatric hospital, which affiliates with the public healthcare system, but is administrated by a Spiritist council and supported by volunteers from various Spiritist centers. Not all of the staff members are Spiritists and psychiatric treatment focuses medicalization and occupation therapy. However, its administration and many of the part-time working psychiatrists pursue a complementary Spiritist approach. The case of Ana-Paula draws a picture of the symbiotic healing cooperation of Spiritism and psychiatry, according to the needs and expectations of the patients. Still, this model is highly contested. First, psychiatry reformers condemn extended inpatient care, and the public healthcare administration does not tolerate sole psychiatric hospitals anymore. Second, members of charismatic evangelic churches specifically reject Spiritist practices and work against them whenever possible, including many staff members of HEM who identify as Evangelicals. But Spiritist explanatory models and related practices like lectures, study groups, fraternal assistance, energy treatment and disobsession play an important role in Marília, and various actors like medical doctors, psychiatrists, and Spiritist volunteers engage in maintaining them as a form of complementary therapy.

The CECC in Itabuna pursues a different approach. Medium and chairperson Marcos perceives it as a clinic for spiritual affliction which may or may not correspond to psychiatric and/or somatic illness. Thus, he only treats people with spiritual issues and passes other patients on to Renata, who organizes free conventional treatment. On the other hand, some psychiatrists and medical doctors pass their patients on to CECC when lacking therapy progress. Those health professionals in Itabuna who cooperate with the Spiritist center do so for different reasons: either they are Spiritists and believe in the necessity of complementary treatment, or they believe in the necessity of charity as a religious obligation. In Spiritist terms, this would also contribute to their personal spiritual evolution. Others are simply aware of the desolate state of the Brazilian healthcare system and try to act according to their Hippocratic Oath, putting the patients' well-being first.

The Brazilian psychiatry deinstitutionalization reform of early 21st century, the insufficient efforts of various Brazilian governments to improve the public healthcare system, and the recent political and economic crises are resulting in a marginal medical supply, especially for the disadvantaged members of Brazilian society. Spiritist and other religious institutions and healing practices fill this gap in cooperation with the aforementioned dedicated health professionals. Healing cooperation of Spiritism, biomedicine, and psychiatry thus seem to be a local phenomenon, according to the special cultural, social, and political context of Brazil. How does this correspond to the situation in Germany?

In general, many Brazilian immigrants appear to perceive Spiritist centers in Germany as "places of well-being" (see FERRARO & BARLETTI 2016) where they are able to reflect on daily experiences and find social support within a "Brazilian environment" as a community of people with similar experiences. Practices of Spiritist centers in Brazil and the GEEAK in Munich resemble each other except in the integration of the German language. Many participants like Fernanda are aware of the psychosocial health aspect which addresses an inner transformation and dedication to new spiritual practices in way of self-healing (see KURZ 2017: 203 f.). Fernanda experiences relief from a disturbing condition that could have easily resulted in severe mental health problems due to the specific form of structural violence immigrants are suffering from in Germany. She also experiences integration by participation in both a protective Brazilian and a more challenging mixed peer group.

The German and "progressive" Brazilian members are devoted to ongoing and continuous dissemination of Spiritist doctrine and healing practice within German culture. The case of Heike provides several insights which are important for the analysis of Spiritism as an example of the transnational and transcultural transfer of healing cooperation from one context to the other. First, in both cultural frames experiences of distress play a certain role in the decision to engage in Spiritism and a life-long dedication to it. Second, Spiritist explanatory models may be very prominent in Brazil, but they are not limited to it's national borders. Concepts of spirit obsession, energy treatment and personal transformation through spiritual devotion are global phenomena, which might differ in their local form but are similar in their content (see LITTLEWOOD 2000). Spiritist ideas regarding (mental) healthcare have been developed in Brazil throughout the 20th century but they are rooted in Central European practices and discourses of the 19th century. They have been mainly ignored for a century but never completely disappeared in Europe (SAWICKI 2016). But due to Brazilian immigration and transnational Spiritist networks, they are revitalizing again. Interestingly, in Germany, and especially within GEEAK, a tendency of "debrazilianization" of Spiritist practice is observable in terms of reapplying it to the German context. This dynamic leads to permanent conflicts within the group and finally to it's separation. Even more interestingly, it is the German group that is seeking ways to implement Spiritist practices into German healthcare according to the Brazilian model and is checking legal ways to do so. They are in line with other actors such as the organizers of the *Psycho-Medizin Kongress* who engage in the development of healing cooperation of Spiritism, biomedicine, and psychiatry in Germany. Thus, besides the correlation of different experiences related to political aspects of migration and health policy in Germany, these processes reveal a dynamic of contested identity politics regarding the "Brazilness" of Kardecism in Germany. Only the future will show how far they will succeed in their implementation of Brazilian models of healing cooperation into German healthcare.

Various researchers have investigated the global circulation of local healing practices (see ZANINI *et al.* 2013, BEAUDEVIN & PORDIÉ 2016) and distinct models of healing cooperation in certain (sociocultural) contexts (see KRAUSE *et al.* 2014, PENKALA-GAWĘCKA & RAJTAR 2016, contributors of this issue). However, to my knowledge, no research so far has focused the implementation of models of healing cooperation from one context to another. Regarding a general theoretical approach towards transnational and transcultural transfers and transformations of healing cooperation, I recommend comparison with related phenomena as an interesting and enriching challenge to contemporary medical anthropology and related interdisciplinary research projects.

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CECC: Facebook/CECC – Centro Espírita Claudionor de Carvalho
CEI: http://cei-spiritistcouncil.com/
CELV: http://celvmarilia.org.br/
DSV: http://www.spiritismus-dsv.de/
FEB: http://www.febnet.org.br/
GEEAK: http://www.geeak.de/
HEM: http://www.hem.org.br/
PSYCHO-MEDIZIN: http://www.kongress-psychomedizin.com/

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Turbulent beings

Curses and systems of healing cooperation in post-Soviet Tuva, Siberia

MAŁGORZATA STELMASZYK

Abstract In this article, I engage with the notions of illness and healing in Kyzyl, the capital of the Autonomous Republic of Tuva in Siberia. In so doing, I show how a variety of medical conditions, such as strokes, comas, and tuberculosis, are often conceptualized through a prism of curses. In these instances, illnesses are considered as a symptom and a consequence of wider sociocosmic politics which involve spirits and humans alike. Consequently, while suffering from curse inflictions, the victims often find themselves in a state of overall physical and emotional disturbance, described as being 'in turbulence'. Given this, in the presence of a medical condition, diagnosis, cure, and recovery are often concurrently sought from medical doctors, lamas, and shamans, and the clients undergo simultaneous treatments from all three practitioners. In this article, therefore, I show how illnesses triggered by curses bring together different actors, such as medical doctors, lamas, and shamans, and how in the context of post-Soviet Tuva, these actors, with their distinct epistemologies and engagements with the world, produce a platform of cooperation rather than that of antagonistic possibilities.

Keywords illness – healing – occult practice – curse– personhood – Tuva

Introduction

"You know, the beauty of our city lies in the fact that you walk around and everything seems normal to you. And yet, you are unaware that it is behind these walls, in whispers, in curses and negotiations with spirits that our lives unfold". When I first heard this sentence, mentioned by one of my informants and friends, I was unaware to what extent it would shape my further research. I first arrived in Kyzyl in early November 2015 and, at the time, was mainly interested in conducting fieldwork on the proliferation of shamanic societies and schools for shamans in post-Soviet Tuva. As my work progressed though, I began to realize that, indeed, there was an element of secrecy surrounding the lives of Kyzylians. Unfortunately, Kyzyl and its people, like the massive layers of ice and snow on the Yenisei river, remained silent and unmoved by my persistent attempts to get behind the sociocultural scenography carefully crafted for outsiders. It was not until a few months later, in early spring, that I was accidentally introduced to the very subject of this article.

I had just finished a meeting with the students of English philology at the state university. We talked mostly about the Scottish referendum and Harry Potter. The students expressed their particular interests in the tensions between the Scots and the English, somehow comparing the political dynamics in the United Kingdom to the hidden frictions between Tuvans and Russians. Sajana, who had invited me to the event, was an enthusiastic headmistress of the English language department at the University of Kyzyl. After the meeting, she gave me a ride home and we spoke about my research interests. I mentioned shamanic practice and briefly recalled my friend's comment from the beginning of the fieldwork. We continued to drive in silence until we reached the city center. Then, Sajana pulled the car over to the side of the road and told me a story about her sudden onset of illnesses every summer. This story marked the starting point of my foray into the complex and mysterious realm of cursing. It also brought my attention to ways in which diverse afflictions are dealt with; in particular, the ones that are suspected to be triggered by curses. This article is concerned with forms of cooperation with and without consensus amongst different practitioners, including shamans, lamas, and medical doctors, who are confronted with difficult medical conditions in post-Soviet Kyzyl.

Materials for the article were gathered during a twelve-month fieldwork conducted in the capital of Tuva and constitute part of a PhD thesis dedicated to the notion of curse. While investigating the mechanics of cursing in post-colonial milieu, I have also looked at different ways of conceptualizing illness through certain practitioners and their clients. In particular, I focused on the shamanic perception of affliction and observed how, despite significant epistemological differences, shamans cooperate with lamas and medical doctors in the process of removing illness. While gathering data, I worked primarily with one shaman and became closely acquainted with her network of clients. Such an approach might raise issues of generalizability and breadth of my findings. Nevertheless, without gaining the trust of the shaman (which is a difficult process) who had an established reputation within the community, I would have no access to the experiences and stories with which this article is concerned. My friendship with the shaman constituted a form of a confirmation and guarantee to the people I interviewed that I was someone that could be permitted into their flats and into their stories without causing any undue harm. Thus, it was only through a close contact with a particular shaman that I could unveil and grasp the characteristics of illness triggered by cursing and follow the ways in which it was confronted.

After the Soviet disintegration, like in many other parts of Siberia (see, for example, GRANT 1995, PEDERSEN 2011, SSORIN-CHAIKOV 2003), abrupt shifts in the economic and political landscapes had dramatic implications for the everyday lives of Tuvans. As stressed by my informants, people in Kyzyl struggled with rapidly increasing unemployment and poverty, triggering violence and crime. These challenges were also accompanied by the sudden proliferation of occult phenomena. In short, perpetual suffering and misfortune, including diverse ‘physical’ and ‘mental’ afflictions, became associated with widespread instances of cursing.

The proliferation of occult practices in post-colonial milieu occupies a critical position in anthropological discussions that concentrate on analyzing “modern” political, economic, and social forms in post-colonial realms while emphasizing the notions of global capitalism and wealth (COMAROFF & COMAROFF 1999, WEST 2001, SCHRAM 2010), politics and power (GESHIERE 1997, ASHFORTH 2005), doubt and uncertainty (BUYANDELGERIYN 2007, BUBANDT 2014), ontological transition (PEDERSEN 2011), inventiveness (Swancutt 2012), urban sociality (DELAPLACE 2014, HÖJER 2004), and cultural revivalism (BALZER 2002, 2005, 2008, GRANT 1995). In the context of Tuva, the onset of occult phenomena and illnesses increased by the Soviet disintegration has been approached through focusing on the intertwining between state institutions (ZORBAS 2013) and shamanic societies (LINDQUIST 2005, PIMIENOVA 2013, STEPANOFF 2014). In this article, I contribute to these studies by showing how illnesses, conceptualized through curses, generate a particular network of cooperation amongst different practitioners.

The readings of illness through the prism of curses have particular implications for the processes of diagnosis, treatment, and cure. In Kyzyl, suffering clients tend to concurrently visit medical doctors, lamas, and shamans in order to secure the most efficacious outcomes. Consequently, in this article I engage with the efficacy as well as constraints of different epistemologies and practices employed in the presence of sudden illness associated with curse, and discuss their patterns of (co)existence and co-dependency. In short, I show how experiential knowledge of shamans silenced by the Soviets merges with philosophical trainings of the mind and thought exercised by lamas and biomedical and scientific knowledge offered in hospitals. In doing so, I also show how this merging constructs a platform of cooperation rather than that of fractures and conflicts. More than that, I demonstrate how curses constitute social actions which allow us to grasp wider sociocosmic dynamics involving humans and spirits alike, and which remain intimately interlinked with the experiences of illness described as being in “turbulence” (Rus. *turbulentnostb*), metaphorized in Tuvan as “swirls” (*ezinneldir*) and “whirls” (*duvulendir*). In this way, I seek to show how an examination of the phenomenon of curse in Tuva allows for a rethinking of treatments of illness which flatten its understandings to bounded and isolated units of “the body” and “the mind.” Conversely, I argue, that within the context of curses, sick bodies constitute "a dynamic trajectory by which we learn to register and become sensitive to what the world is made of" (LATOUR 2004: 206).

In order to substantiate my discussion, I first provide a brief description of the ethnographic context of Kyzyl while exploring three case studies which illustrate the process of dealing with different, particularly challenging medical conditions by both patients and practitioners. Thereafter, using a short vignette, I discuss the mechanics of cursing in Tuva and show how curses bring together notions of illness and personhood in an explicit fashion. In this way, they challenge readings of disease as contingent on an essential differentiation between the body and the self. Finally, while engaging with different healing practices, including medical doctors, lamas, and shamans, I demonstrate how within the ethnographic context of post-Soviet Kyzyl, these practices come together with and without consensus while producing a platform of complementarity rather than exclusivity.

Kyzyl

In order to get to Kyzyl, one first needs to travel through the Sajan mountains. The first view of Tuva is from the top of a mountain, when an enormous space of scattered hills suddenly opens up to reveal a long straight road leading to the capital. Kyzyl emerges abruptly from behind a hill when a taxi or a bus takes a sharp turn to the west at the end of this road. Each time I saw Kyzyl, I always thought it looked like a space station, an unfinished architectural project left on a distant deserted planet. In winter, the city, like any urban area in Tuva, is covered in dark and black clouds of soot. In summer, the streets are tormented by constant sandstorms and winds. The suburbs of the city consist mainly of small wooden houses, whereas the city center is distinguished by grey blocks of flats, often accompanied by fields of metal garages and massive electric power lines hovering over the city. The heart of Kyzyl includes a neat modern shopping mall with a sign in English reading "I love Tuva." A university building, a cultural center, and numerous government establishments are also found in the vicinity of the main square. Nearby is a park boasting the Centre of Asia monument, a few hotels, and a coffee shop catering mainly to tourists from Russia. Most buildings and roads are marked with endless cracks and deep holes giving the impression as if the city is being slowly consumed by the underlying steppe. Younger generations tend to leave Kyzyl and seek education and employment in other Russian cities, such as Krasnoyarsk, Novosibirsk, or Irkutsk. Those who decide to stay often stress the importance of family ties, as it is mainly through kin that one obtains some financial stability and general support in Tuva. Life in Kyzyl, as a majority of my informants stressed, is challenging in many respects and often remains hard to understand for outsiders.

Before the arrival of the Soviets, the Tuvans were a nomadic group consisting mainly of reindeer herders and hunters, as well as horse herders and pastoral nomads. The process of Sovietization initiated a variety of transformations in economic and social structures, including collectivization, sedentarism, eradication of clan systems and religious beliefs, codification of language, and universal education (see, among others, GRANT 1995, FORSYTH 1992). Given its remote location behind steep mountains, Tuva, unlike other indigenous territories in Siberia, managed to exist in a state of perpetual isolation during the Soviet period. Thus, the Tuvans have retained some of their traditions, such as shamanic practice, throat singing, and the Tuvan language (*ibid.*). Nevertheless, urbanization decreased the mobility patterns among Tuvans, and currently most live and work in the cities, such as Chadaan, Tura, and the capital, Kyzyl (PIMIENOVA 2013). Changes in living patterns, from migrating in small *aals*—an essential productive group referring to both a single yurt with a family and their animals or to a group of households moving together (VAINSHTEIN 1980: 243)—to existence in crowded blocks of flats concentrated in one place, has had a variety of implications for the social interactions among Tuvans, including the proliferation of cursing practices and diseases, such as alcoholism, depression, tuberculosis, and HIV, among others.

Healing cooperation: Sajana, Arzaana and Alexandr

Tuvans do not talk about curses. Cursing phenomena constitute a murky element of everyday happenings, the existence of which is ambiguous and about which anyone rarely talks to strangers. Indeed, at the beginning of fieldwork, my informants pretended they did not hear my questions or angrily waved their hands towards the mountains stressing that a curse was a “dirty thing” (*hirlig chyyl*) coming from “there” (*mynaar*), most often implying the Russians. Despite my interviewees’ assertions, magical business, as it was referred to by one of my friends, seemed to be blossoming in Kyzyl. The local markets, which sold everything from meat, cheese, fish, and clothes to jewelry and mobile phones, flourished with women called “gypsies” by Kyzylians. Every day, dressed in long dark skirts, their heads covered with colorful scarves, these women, the majority of them immigrants from Uzbekistan and Tajikistan, eagerly stopped people and offered different practices, including curse detection and infliction. A variety of posters displayed on the fences and walls of the buildings around the city encouraged future clients to call if they had queries about their love life, health, business, or curses. Television programs were interwoven with colorful adverts featuring fortune tellers boasting their magical services. My informants’ resilience and apparent obliviousness to these practices was fairly astonishing. Any questions about curses were consistently met with laughter and assertions that it was the doings of the Uzbeks, the Tajiks, or the Russians. The first person who decided to openly speak with me about cursing was the aforementioned Sajana. As we sat in the privacy of her car, she slowly started to unveil her story. Sajana described how, a few years earlier, she was competing for the position of headmistress at the English language department of the University of Kyzyl. The choice had narrowed down to her and another female teacher. Sajana won the appointment, which seemed to trigger her opponent’s anger. When Sajana returned from holiday, she suddenly became sick. The doctors struggled to find the cause of her condition; however, after a week she recovered and felt fine. A year later, around the same time, Sajana suddenly fell into a coma. Similar to her illness the year before, she recovered within a few days and woke up feeling perfectly well. Another year passed, and this time my informant was told she was suffering from leukemia only to ‘miraculously’ improve within the week. Encouraged by her husband, Sajana met with the family lama, who gave her a string with sutras to wear as protection. She always wore it while traveling and always remembered to share it with her children and husband. Despite the lama’s help, however, Sajana still felt weak at times and worried about her family. Eventually, she decided to contact a local shaman. The shaman came to Sajana’s office in the early morning before anyone else arrived and instantly informed Sajana that she was suffering from a powerful curse inflicted by her rival from three years before. The shaman conducted a “cleansing ritual” (*aryglaashkyn*) and provided Sajana with a personal “token” (*eeren*) that she was supposed to always carry with her for protection. Sajana claimed she never had any health related problems again.

Sajana’s story is but one example of a form of cursing battles constantly taking place “behind the walls” of the city. While continually following the shamans and gathering stories from my interlocutors, I have discovered how people in Kyzyl are incessantly engaging in occult practices, seeking revenge, trying to secure job positions, or ensure protection on a regular basis. These practices, as explained by my friends and informants, result in different illnesses, such as strokes, alcoholism, chronic bodily deformations, infertility, or tuberculosis.

After the collapse of the Soviet Union and throughout the 90s, Tuvans lived through a period of turbulent and unforeseen transformations (Zorbas 2013). According to my interlocutors, neither the police nor any other state institution seemed organized enough to control pervasive chaos and fear. In fact, it was the police and doctors themselves who encouraged people to seek help from shamans. This, in turn, led to the institutionalization of shamanic practice and the concentration of shamans in the capital (Pimienova 2013, Stepanoff 2014). In turn, hopeless state institutions were often replaced by shamanic societies run by the shamans, who seemed to have more power in dealing with different afflictions and providing justice (Zorbas 2013: 97). Nevertheless, with time, these shamans have become, as stressed by my informants, greedy businessmen. As a result, a network of individual shamans has been established. Today, even though shamanism triggers different responses among Kyzylians, shamanic practice is considered to be the last resort in treating diverse fatal conditions. This, however, does not imply that shamans agree to treat every medical problem. In fact, medical doctors, lamas, and trusted shamans communicate with each other and, depending on the symptoms and causes of affliction, exchange and recommend patients with one another. This process also happens without consensus from different practitioners, when desperate sick people and their families seek help from anyone who is willing to offer it. Interestingly, shamans provide a very clear differentiation between illnesses triggered by curses and medical conditions resulting from other causes; for instance, when given afflictions constitute a part of the patient's "fate" (*chol*). In these cases, they often send their clients to doctors or, occasionally, lamas (in cases associated with behavioral issues) and stress that the condition does not require help from a shaman, but rather a different practitioner. Moreover, if the patient's condition is severe and cannot be improved, because, for instance, the person is suffering as a result of deeds committed in previous lives, then the shamans may refuse to treat the person. These forms of cooperation, instigated by the shamans, are illustrated in the following two case studies.

Working with the shaman Ajny and participating in her daily meetings with clients, I became familiar with the case of Alexandr, his wife, and daughter. Alexandr was brought to Ajny by his family while suffering from an inexplicable stomach ache. The family, driven by the shaman's impeccable reputation, was convinced that the problem was caused by cursing and could be successfully managed through a curse deflection ritual. Nevertheless, upon the man's arrival the shaman instantly recognized some sort of a dark substance in his stomach. After conducting divination, she revealed that Alexandr was not suffering from a curse infliction. Instead, his condition was a part of his fate and constituted a case for a medical doctor. The family left deeply disturbed, and accused the shaman of malpractice. A few months later, we found out that Alexandr died from stomach cancer. His wife and daughter visited Ajny again and, while profusely apologizing, asked her to conduct a cleansing ritual for the whole clan.

Another story concerned Arzaana, a newly married retail assistant. Arzaana was deeply troubled by her husband's unpleasant behavior. As she explained to Ajny, the man suffered from sudden outbursts of anger and violence followed by a flair for drinking and a lack of interest in any activities. The shaman associated these symptoms with depression. After conducting divination, she decided that her services would not be very efficient. She explained that the condition was a consequence of a curse inflicted due to the victim's deeds performed in previous lives. She suggested that Arzaana and her husband should visit a lama, Bajchak, instead. As Ajny explained it to a surprised woman, lama Bajchak was a specialist in teaching people why they behave in a certain way and how their actions might harm others (a practice which can be easily compared to a form of psychological treatment). It was, according to the shaman, the most promising way of confronting this form of a curse which extended into previous lives, rather than being caused by a current conflict with another person. Arzaana left disappointed; nevertheless, she promised to follow the shaman's advice. Unfortunately, we never heard back from Arzaana, and I was therefore not able to find out whether she fulfilled her promise and whether her husband got any better.

These short case studies illuminate how, in the presence of diverse afflictions, victims may seek help from different practitioners while hoping to quickly alleviate their suffering. More than that, these afflictions are often associated with instances of cursing (see also ZORBAS 2013). Before discussing further how this processes develops a network of cooperation with and without consensus amongst different practitioners, it is essential to understand what it means to suffer from affliction triggered by curses and what kind of implication this has for conceptualizations of illness and its treatment. Thus, in the next section I provide a short summary of how my informants have described to me their experience of being cursed and, consequently, being sick.

What curses are

Curses in Tuva are described as floating energies (*kyshter*) which bring disturbance upon the victim. The Tuvans recognize two main types of curses; *chatka* ("curse") and *kargysh* ("gossip"), actualized through muttering bad words (*ass-dyldy-bile*) and thinking bad thoughts (*bodal-sagyzzy-bile*). Nonetheless, both *chatka* and *kargysh* are used interchangeably with reference to curses in general, and often, especially in shamanic hymns and chants, as one expression *chatka-kargysh*. Differences between the two are subtle and in fact, it is only the shamans who could easily provide a clear differentiation between them. *Chatka* occurs when a person intends to harm another person; however, in order to do so, one must turn to a strong shaman for help (*shydaldyg ham*). Inflicting *chatka* is mainly intended to result in a broken leg, a stroke, a prolonged disease, and, in the worst cases, death. *Kargysh* can be invoked without shamanic help and is often followed by spitting (*dukpuzu*) or throwing *(dovuraa*) sand or soil. *Kargysh* may result in sudden misfortune and a decline in wellbeing. Among other types of curses recognized by the Tuvans, the most difficult to deflect is the clan curse (*doora nugul*), which can affect descendants in both female and male lines. It holds for at least seven generations and is inherited by blood. Clan curses are usually associated with a variety of perpetual problems, ranging from obstacles in relationships to poverty or general constant turmoil in life, and commonly ascribed to all forms of disabilities that children are born with, such as autism, bodily deformations, or deafness.

Curses, when inflicted, gain their potency immediately. Moreover, they are said to operate within a time frame that reaches far into the past. In short, the possibility of suffering from curses is contingent on the previous lives of the victim. In this way, curses are intimately intertwined with the Buddhist karmic system which determines one's susceptibility to curses by the deeds one had executed in previous lives. Given this, people who suddenly fall ill and subsequently die are described as those who in their previous life had intended to kill by lying, gossiping, or wishing death upon another person. In a similar manner, the aforementioned disabilities, if not accounted for as a clan curse, are often considered to be a result of an attempt to curse or harm someone in a previous life.

The agency of inflicting misfortune and curse in Siberian cosmologies is often attributed to aggrieved ancestors (HUMPHREY 1996), neglected spirits (PEDERSEN 2011), or to human-human interactions (SWANCUTT 2012). In Tuva, the machinery of curse is a complex matrix of relationships which involve people and spirits alike. Curses acquire their initial potency explicitly from the bad intentions of the humans. However, the mechanics of curse require at least three actors for the curse to be successfully inflicted. This triadic relationship involves the victim, the curse caster, and the spirit which inflicts curse on behalf of the cursing person. In short, people have no agency in casting curses, as they have to be carried out by one of the spirits. In most cases, this procedure requires the simultaneous presence of the shaman as clients turn to them to summon the spirits, as well as ensure particular results of curse i.e. death, broken limbs, addictions.

The spirits responsible for inflicting curses come from the group of *aza* ("evil") spirits associated with dark forces. They are referred to as *Chetker* and *Buk*, and are seen to work for the shaman or along with him or her in the process of curse infliction. *Chetker* spirits are meant to come from the "country" (*oran*) where the yellow river flows, where *aza* spirits sit in circles in front of their yurts and smoke pipes. *Buk* spirits live among people, linger in the streets or wander around the steppe. Both spirits are attributed with particular physique. *Chetker* is described as having only a half of the face as well as decomposing or rotten body whilst *Buk* wanders in dirty, shredded clothes. Once the spirits hear ill words spoken or notice a nasty look cast by a person or find themselves directly summoned by the shaman, they begin to inflict harm upon the victim by placing them in a state of turbulence, often equated with being sick.

The experience of illness

In Tuva, when someone is under the influence of a curse, people say that they "run down the roads like a tornado" (*oruk ezinneldir mangnaar)*. The spirits inflicting curses enter the body of the victim through the head (*besh)* and nest in the stomach, intestines, or chest. As my informants explained, they particularly like to "stick" (*hyrbalanyr*) to the physical body. Sometimes, rather than entering the body, the spirits begin to live with the victims, observe them, and follow them in their everyday routines. Whilst doing so, they are said to take on different forms—becoming animals such as dogs, serpents or mice, or on other occasions, transforming into a beautiful woman or taking on the physique of deceased relatives.

Once inside the victim's physical body, the spirits begin to interfere and "disturb" (*üreer*) the client's emotions, their interactions with other people, and their health while causing "whirls" (*ezinneldir*) and "swirls" (*duvulendir*), described also as turbulence. People suffering from curses may become unpredictable in their decisions and reactions, doing and saying things uncharacteristic of their usual behavior. Their behavior is meant to resemble the erratic waves of the wind. Victims can do things without remembering their actions. They often feel paranoid and convinced others are staring at and talking about them. Sometimes people feel deeply disturbed and become unwilling to engage in their usual activities.

Simultaneously, the physical body begins to become polluted and curses are expected to sediment in the form of mud (*hir*). The physical dimensions of curse are diverse; however, the most common symptoms are having a different smell, changes in skin color (the skin may become yellow), and bags under the eyes. Some people may have red, silver, or gold breath (especially near death). The inner organs might be crushed or moved and sometimes may turn black. Along with the sudden onset of different medical conditions, such as heart attacks or strokes, it is very common to additionally suffer from drinking problems, clumsiness, violence, and aggression, as well as vivid dreams in which spirits might try to kill the victim. These symptoms, especially with strong death curses, may result in death.

Sociocosmic drama

The crucial reason why the spirits are eager to help in inflicting curses is that, similarly to people, they struggle with their own being. Their own countries are economically tormented and destroyed and they feel poor and lonely. Casting curses allows the spirits to become closer to the spaces where humans live. As the shaman explained it to me, the human country is very appealing as it seems rich and economically stable. Consequently, living in, on, or around human physical bodies is "like being in a five-star hotel with all the associated luxury." The process of curse deflection, which relies heavily on sending the spirit back to where they came from, is, therefore, very dramatic. The spirits cry and howl, they often beg the shaman to stop and ask why the shamans are being so cruel, or why they do not let them stay. It is common for the spirits to use physique of a deceased relative and, in this disguise, accuse the shaman of keeping the deceased away from his family. In the shamans' descriptions, these emotionally dense negotiations can be grueling and tormenting for both the shaman and the spirit.

Moreover, there are also particular ways through which people try to protect themselves from *aza* spirits, often based on the combination of trickery and amulets. After each curse deflection ritual, the shaman provides the client with a special token which is sometimes inhabited by a protective spirit. These tokens, however, have to be blessed annually with juniper otherwise they may lose their protective energy. There are further methods by which *aza* spirits can be tricked. For instance, wearing a hat the other way around or wearing clothes inside out while traveling is the best way of fooling *Chetker* and *Buk*. There are, concurrently, particular methods of protecting children which also apply to the foreigners who decide to closely interact with the shamans. These tricks include placing soot on one's nose while walking at night or caring a protective token, such as the palm of a bear. Very often children are called *öjze cögleer* ("horrible names"), for example "you shit boy" (*myjak ool*), "glutton boy" *(hymtak ool),* or "blue stomach boy" (*kok hyryn)*. These names are supposed to disinterest spirits willing to inflict any harm upon the children.

Indeed, the phenomenon of curse in Tuva constitutes a sociocomsic drama which is predicated not only on conflicts between the humans, but also on the tensions which directly concern the spirits. On the one hand, people in Kyzyl are dependent on *Chetker-Buk* spirits to inflict curses, while also constantly engaging in different ways to trick them to avoid becoming victims themselves. On the other hand, spirits strive to live around people and interfere with their lives while protesting and lamenting when deprived of this possibility by the shamans. In this way, illness, rather than being perceived as a particular kind of physical or mental disturbance, is associated with the unfolding of wider sociocosmic dramaturgy which involves spirits and humans alike and constitutes an imminent aspect of Tuvan sociality. In order to fully grasp this process, it is essential to discuss the Tuvan conceptualization of personhood, which represents neither a holistic image nor is pervaded by the concepts of mind, body, and soul understood as discrete and isolated parts.

Suffering bodies, cursed person(hood)

When I asked one of the shamans what it means to be a person, she told me that people are like growth rings in the trunk of the tree. Indeed, according to my informants, every person is meant to be constructed from numerous interdependent layers gathered around one central point, *sünezin* ("soul"), producing thus a concentric model of a person, a point to which I will return to later in this article. While *sünezin* is considered static (*shimchenir chok*), the following layers can be high (*bedik, uzun*), meaning robust, or low, (*kyska, chavys*), that is, weak, depending on a variety of factors, including the presence of illnesses and curses. Before I engage with the implications of this structure for the further analysis of illness and healing in the ethnographic context of Kyzyl, I first provide a brief description of the layers that come together in order to produce a person in Tuva.

Every *sünezin* remains strictly connected with *sülde* ("emblem"), the following layer. *Sülde* is always meant to be high, that is, strong, and indicates whether a person finds themselves in a state of overall balance or disturbance. Often, if *sülde* is lowering, people become particularly clumsy and lose the ability to work with their hands. Subsequently, if *sülde* is low, it indicates that a person is vulnerable and easy to manipulate, can quickly become sick, commit crimes, or turn into an alcoholic. Another layer, *sülde-sunezini* ("the state of the body"), indicates whether the person is healthy or suffering from a physical illness. The next layer, *kudu-sunezini* ("consciousness"), reveals illnesses that in biomedicine would be associated with the mind, such as depression. Finally, the *tura-coruu* ("physical appearance") layer refers to peoples' general conduct in everyday life. If it is low, the person stops taking care of themselves, becomes "dirty" (*hirlig)* and wears shredded clothes. Low *tura-coruu* leads to further problems with education, work, and communication with other people. When the Tuvans describe what constitutes a person, they concurrently mention *sagysh* or *sagysh satpa* ("thoughts", "plans, dreams"), a layer which indicates the person's ideas, and goals, as well as unfulfilled plans or promises. Apart from *sagysh/satpa,* the Tuvans recognize *setkil* ("mind"), which refers exclusively to thoughts, as well as *setkil endeves* ("emotions"). All of these aforementioned layers are held together by breath (*thyn*). Colored breath usually indicates the person is nearing death. The shamans recognize silver breath (*serch thyn*), which indicates that *sünezin* is about to leave the body as well as gold (*ak*) and red (*kyzyl*) breath, which imply imminent death or the presence of curses. People can still breathe without *sünezin,* nonetheless, death is highly expected. Once breath is cut off, each layer of the person begins to separate. *Sünezin* and *sagysh satpa* linger between the spaces of humans and spirits whilst the rest of the layers vanish and the physical body is disposed of and forgotten. After *sünezin* leaves the body, it takes seven days for it to realize it has been separated. It then embarks on a journey, usually guided by a shaman, to seek a place where it can be reborn. After forty-nine days a ritual is conducted during which the gates to the previous life are closed by a shaman, and a *sünezin* is reborn as either a spirit, a human being, or an animal, and the person who passed away is not to be mentioned again afterwards.

In Tuva, similarly to other animistic cosmologies (see, among others, PEDERSEN 2011, TAYLOR 1996, WILLERSLEV 2007), body and soul are not grasped in terms of essence and appearance where the latter becomes a vessel for the former. Instead, a prototype of a person is defined by "a variable outer physical covering and a constant inner being" (ARHEM 2016: 14). Being reborn as a person (*kizzi*), rather than spirit (referred to by their proper names, for instance, *chetker*) or animal (*amytan*), is considered as the highest possible privilege. Every being has *sünezin,* which remains eternal (*mönge*). Humans differ from spirits by having breath and blood (*han*). Subsequently, humans are differentiated from animals by humans' aforementioned concentric structure in which corporeality, emotions, and cognitive processes remain imbricated in one another through *sünezin*. Once *sünezin* is reborn as a person, it becomes an immobile center, an essential grain around which the following layers may grow and develop. In other words, in order for the life to happen, a person has to be centered, that is, rooted, and in this way it requires a “point of origin” (TSINTJILONIS 1999: 640). Given this, personhood constitutes a concentric structure with people separated from each other not because they are bounded by, for instance, skin and thus possess a clearly differentiated inside and outside. Conversely, rather than being closed to the outside and thus essentially different, people “are turned in on their own center” (POULANTZAS 1980: 101). As a result, they remain perpetually open and thus susceptible to the feelings, wishes, and actions of others. Consequently, social interactions become a key contributor to the individual’s health and sickness rather than remain discontinuous with it.

Subsequently, the concentric structure of Tuvan personhood illuminates how mind, soul, and body, even though recognized among Tuvans, are not perceived as discrete, independent or isolated from each other. This perception of a human being challenges the readings of illness as associated with the mind or body alone prevailing in the Cartesian concepts of the autonomous “self”, “individual” etc. (SCHEPER-HUGHES & LOCK 1987: 9). Unquestionably, illnesses triggered by curses generate concrete physical images and affect concrete bodily organs, such as the heart or limbs. Nevertheless, these sick bodies are not abstracted from the social situation in which bodily acts are involved. For instance, malfunctioning livers or kidneys are not considered as a cause of illness, but rather as a symptom of tensions entailing humans and spirits alike. In this way, sick bodies are a part of the overall evidence of the presence of a cursed personhood and, crucially, the embodiment of wider sociocosmic politics.

This specific conceptualization of illness and personhood has particular implications for the forms of diagnosis, treatment, and recovery. As in the case of Sajana, Arzaana, and Alexandr, many Tuvans in the presence of sudden or chronic illness often seek help from different practitioners, including medical doctors, lamas, and shamans. In the final section of this article, I discuss how these practitioners, with or without consensus and despite different understandings of disease, produce a platform of cooperation rather than that of exclusion.

Cooperation with and without consensus

During my stay in Kyzyl, I came across four hospitals, three of which were dedicated primarily to children’s care. The most modern one, with a new building and working website, was exclusively dedicated to birth and prenatal care. Children are considered by Tuvans to be the highest form of wealth, and are treated with great care and respect. The hospital which took in adults was situated in an old Soviet building, and incited dread amongst my informants. It was often overcrowded and understaffed, as the majority of the trained doctors prefer to leave Tuva and find a better job somewhere else. Indeed, being admitted to a hospital was something my informants preferred to leave until the very last minute. Moreover, getting proper treatment often required additional payments. As a result, when suffering from a medical condition, my friends and informants preferred to visit not only doctors, but also lamas and shamans in order to secure the most efficient treatments and results.

It is common for the doctors to invite recognized shamans to the hospital, where they help in the most challenging or fatal cases (ZORBAS 2013: 93). It is not unheard of, as I was told by Ajny, for doctors to visit shamans themselves, albeit always in deep secrecy. Sometimes, doctors who are feeling hopeless about further treatments or overloaded with cases would discreetly encourage their patients to visit trusted shamans. This was the case of one of my informants, Sulchuk. Sulchuk was a young German language teacher who already had two daughters, but was hoping to have more children. A few months before arriving at the shaman’s office, she had been told she suffered from a complex injury to her ovary, resulting in infertility. While her doctor gave her no chance of ever getting pregnant again, she also discreetly suggested trying another option, like visiting a trusted shaman. Taking her doctor’s advice, Sulchuk arrived at Ajny’s door. After a lengthy divination procedure, the shaman revealed that Sulchuk suffered from a curse inflicted by her friend. The woman responsible for cursing turned out to be jealous of Sulchuk’s stable and healthy family. The shaman performed a short cleansing ritual while brushing off invisible “dirt” (*hir*) from Sulchuk’s stomach and head. They agreed to conduct an outdoor ritual during which the shaman would ask for the spirit's help in removing the curse. Two weeks later, the ritual was conducted in the presence of Sulchuk's family members. A few months after, I accidently ran into one of Sulchuk's relatives who happily announced that Sulchuk was indeed pregnant. The story of Sulchuk did not constitute an isolated case. While working with Ajny, I learned about her brother, also a shaman, who had incredibly strong powers in dealing with critical medical cases. Given his well-established reputation, Ajny and her brother would receive in their yard, from time to time, ambulances with fatally sick people, sent to them by desperate doctors. While working with Ajny's family, I became aware of her heart problems. Interestingly, she insisted on visiting doctors in different hospitals, mostly outside of Kyzyl, emphasizing that it was a medical condition stemming from her fate and, thus, had to be dealt with by a doctor.

The system of cooperation entails not only doctors and shamans, but also lamas. Introduced in the eighteen century during the Manchu empire (PIMIENOVA 2013: 121), Buddhism led to a quick development of Buddhist clergy in Tuva. As I noticed during my fieldwork, most of my friends and informants were declared Buddhists, which did not prevent them from visiting shamans. Shamans are considered to offer practical, immediate solutions whereas lamas are expected to provide teachings and temporary protections. Even though lamas have a very skeptical approach towards curses, in some cases, they do encourage their clients to see a trusted shaman with whom they are usually good friends. This happens, in cases like Sajana's, when a person suffers from an onset of regular recurring medical conditions that cannot be explained. In a similar manner, if a shaman's client suffers from an affliction which makes them, for instance, suddenly aggressive, like in the case of Arzaana's husband, then the shaman might direct the person to a chosen lama. According to shamans, it is the lamas that work best with peoples' personalities and troubling behavior. Moreover, shamans and lamas often meet together to discuss the different ills of society and cooperatively seek solutions to the variety of problems tormenting their clients. Interestingly, as emphasized to me by Ajny, amongst doctors, lamas, and shamans it is the latter that are considered as the ones with the most thorough understanding of peoples' sufferings, as they regularly visit Kyzylians in their homes and families.

Within the ethnographic context of Kyzyl there are certain overlaps between shamans, lamas and medical doctors in terms of not only patients' exchange and referral, but also methodologies and patterns of practice. For instance, in the 90s, it was common among the shamans to receive a certificate at the end of their training (PIMIENOVA 2013: 128). These certificates, resembling a medical doctor's diploma, stated the shaman's specialization, such as eye problems, fertility, and so on (*ibid.*). Currently, given gradual disinterest among people towards formally organized shamanism, these trainings and thus certifications are no longer occurring. Nonetheless, as I have witnessed myself, on some occasions, shamans continue to codify different ritual proceedings in a form of personal notebooks which they use when interacting with young adepts of shamanic practice, most of them coming from Europe or North America. In these notebooks, each ceremony description is followed by clear indications of which aspect of the client's life it may influence and how one should prepare for it. This methodological cooperation extends concurrently to shamans and lamas. For instance, shamans base their divination practice as well as future predictions solely on the astrological calendars that are annually prepared by lamas. Consequently, shamans and lamas often jointly participate in a variety of ceremonies, for example deflection of clan curse, in order to strengthen or multiple the efficacy of their practice (LINDQUIST 2005). During these rituals, my informants described lamas as the quiet practitioners who offer prayers and protection whereas the shamans were seen as expressive and creative negotiators who directly engage with the spirits and whose behavior is unpredictable.

The forms of cooperation between shamans, lamas and doctors may also occur without consensus. For instance, one of my informants, after a very complicated surgery, was adamant to visit a shaman in order to ensure recovery and the safe prolongment of his life. He suffered from some kind of liver failure which, according to a shaman, was triggered by curse. His doctor, on the other hand, insisted that the man's condition was caused by excessive drinking and poor diet rather than cursing. This, however, did not stop the patient from seeking additional help. In a similar way, many of my informants, while dealing with different illnesses, despite being given a clean bill of health or receiving a full explanation regarding the causes of their predicament from doctors, would still seek shamans' support in establishing the cause of their suffering and making sure it does not return. Interestingly, apart from doctors it is also lamas who criticize and discourage continuous visits to shamans. As one of the lamas summarized it, it is easier to rely on cursing rather than facing the actual issues causing the problems.

Despite these tensions, as indicated above, people in Kyzyl usually seek help from all three practitioners in order to cover every possible angle of their predicament, from medical to sociocosmic. Like in cases of Sajana and Arzaana as well as my other informants looking for additional protection after their surgeries, this constitutes the most efficient way of confronting diverse afflictions. These afflictions may originate from the deeds performed in previous lives, be associated with current instances of cursing as well as reflect one's fate. More than that, as one of my informants explained it to me, people in Kyzyl often believe that medical treatments have limitations. As a result, it is common to assume that it is only the shaman who can truly and fully heal a patient, as they are the practitioners who understand what it means to be a human being. Consequently, rather than focusing exclusively on a sick organ, like medical doctors, the shamans concentrate on the wider network of interactions which bind the victim, the spirit, the family, the place they live in a sociocosmic knot, the knot which when carefully navigated may allow for a successful cure. Moreover, interactions with spirits and people and thus, possible exposure to curses, are constituent of everyday sociality in Tuva rather than incompatible with it. In short, the instances of being cursed are not associated with a system of beliefs, but rather are approached as the aspect of everyday social interactions. Given this, any medical issue triggered as a result of curse infliction has to be confronted not only by a doctor, but also by a shaman in order to ensure full and successful recovery.

Conclusion

In conclusion, within the ethnographic context of Tuva conceptualizations of illness are tied to the mechanics of curses, which are in turn embedded in sociocosmic politics. This challenges readings of disease as confined to the workings of the body or the self alone. The concentric structure of a person becomes disturbed and thus turbulent as a result of illness triggered by curse, which, in turn, has wider implications on the treatment options that patients look for. In the challenging context of post-Soviet Kyzyl, different practitioners—shamans, lamas, and medical doctors—seek one another out in mutual support and cooperation while struggling to alleviate their patients' suffering. More than that, given diverse causes of medical problems, patients prefer to simultaneously visit different practitioners in order to secure the best possible results. Consequently, Tuvan society weaves together different forms of practices and engagements with the world—spirit and human alike. In the presence of sudden and fatal illnesses or chronic afflictions associated with curses, biomedical approaches overlap with the experiential knowledge of the shamans, and philosophical understandings of suffering offered by the lamas to produce a unique healing landscape of complimentary opposites rather than antagonistic possibilities.

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“My Dream is to Bring Together Chinese and Western Medicine”

Why Chinese Medicine is Making its Way into Estonian Healthcare

KATRE KOPPEL

Abstract In recent years, Chinese medicine has become a popular therapeutical practice in Estonia. This is not surprising from the perspective of users as different health-related, lifestyle and well-being teachings have found many adherents after the collapse of the Soviet Union. However, what is intriguing is the fact that Chinese medicine is gaining increasing attention by healthcare professionals too. In the Estonian context, Chinese medicine is regarded as an alternative medicine from the point of view of biomedicine and the state. Due to historical reasons and the post Soviet context, alternative medicines are usually stigmatised by biomedical practitioners. Regardless of the explicit tensions between biomedicine and alternative medicines, Chinese medicine seems to enjoy higher acceptance than some other alternative medicines. Hence, the current situation, which can be described as a change of position regarding Chinese medicine in the Estonian health landscape, is relatively extraordinary. In this paper, I argue for three reasons why the position of Chinese medicine is currently changing. Firstly, the positive reception of Chinese medicine can be regarded as a favour from the state that has implemented regulations on acupuncture. Secondly, the reasons can be found in the current health policy and in the challenges that the Estonian healthcare system is facing. Thirdly, it is the mainstreaming process of New Age spirituality in Estonia and the way it changes the perception of the body that helps Chinese medicine to find its way into Estonian healthcare. The article is based on almost two years of ethnographic fieldwork in Estonia.

Keywords Chinese medicine – healthcare – medical diversity – former USSR – health policy – new age spirituality – Estonia

Introduction

Estonia has been considered to be fertile ground for studying religious and spiritual developments (Remmel & Uibu 2015, see also Heelas 2013). Indeed, the strong position of spiritual and folk beliefs combined with a low level of Christian practice, results of both a Soviet and pre-Soviet history, have made Estonia a complex and multilayered field of study. But similarly to religious and spiritual developments, observing the changes in the Estonian health landscape evokes intriguing questions.

In Estonia, the significance of institutionalized religion is low (Ringvee 2014). But interestingly, after the collapse of the Soviet Union, different health-related teachings have turned out to be more effective than traditional religions in introducing religious and spiritual meanings and frames (Uibu 2016a: 269). These health-related teachings and therapeutical practices, encompassing either trends from New Age spirituality (Sutcliffe & Gilhus 2013) or folk beliefs or both, help to fill the gap that exists in the religious and spiritual domain in post-Soviet Estonia. In the Estonian context, spiritual, health-related and lifestyle or well-being teachings are all blending into one, and it is difficult to make a clear distinction between them. Furthermore, regardless of the Soviet atheist campaigns that successfully fought against the Christian church, folk beliefs and especially folk medicine survived the Soviet period relatively intact (Remmel & Uibu 2015: 13). For example, the tradition of self-medication and especially the usage of herbal medicine continued during the Soviet era and after (Sõukand & Kalle 2010, Kõivupuu 2014, Raal, Relve & Kõivupuu 2018).

Also another aspect that makes research on health-related beliefs and practices fascinating in the Estonian context is rooted in the heritage of Soviet scientific-materialistic philosophy. The Soviet materialistic ideology emphasised the demarcation of science and non-science by drawing clear boundaries, at least in public discourse, between biomedicine and medical alternatives, or alternative medicines. Any kind of medical diversity was officially rejected by state institutions and by biomedicine: an example of the triumph of science enjoying a prerogative status (Singer & Baer 2012: 133). It would, however, be wrong to claim that no other healing modalities than biomedical were used. As research in former Soviet countries has shown, in practice medical diversity existed in the Soviet Union (Lindquist 2006, Honey 2012, Penkala-Gawęcka 2016), and Soviet Estonia was no exception. In addition to herbal medicine, practices like visiting a folk healer occurred throughout the Soviet era despite state prosecutions (Kõiva 2014). Also, in the 1980s a growing interest in Oriental medicines and meditation emerged (Kõiva 1996).

Although in practice medical diversity existed, the rhetoric of scientific materialism and undoubtedly the privileged position of biomedicine during the Soviet period have remarkably tensioned the relationship between biomedicine and medical alternatives in Estonia. For example, in contemporary Estonia the label "alternative medicine" carries a relatively negative connotation, referring to a wide spectrum of different therapeutic and healing practices that have not been able to establish a privileged relationship with the state as biomedicine. From the perspective of sceptics and critically-minded healthcare professionals, "alternative" refers particularly to the lack of evidence-based proof on the efficacy of a treatment method, and often methods located outside the official state healthcare receive the label very easily (Tikk 2005, Ernits 2017). My own research on media representations of alternative medicines as well as other research (Uibu, *forthcoming*) has shown that the practitioners and users of alternative medicines try to contest, avoid or reject the label and often prefer to use a variety of other concepts.

The tension between biomedicine and medical alternatives has also been pointed out by other recent studies. Many patients in Estonia who use therapies that could be defined as alternative do not discuss them with their physicians, since these patients realise that alternative medicines are excluded from the field of expertise and interests of biomedicine (Lubi, Vihalemm & Taba 2016). My own interviews with patients who suffer from chronic diseases confirm similar attitudes, as do healthcare professionals who are interested in alternative medicines: they have repeatedly told me that patients are usually surprised if a healthcare professional approves alternative therapies. Moreover, these same healthcare professionals, who work for the state-funded healthcare system but are interested in or practise alternative medicines, know that they have to be careful when recommending alternative health therapies to patients, since the allowance and expectation is to recommend evidence-based treatments only (see also Uibu 2016a: 270).

If there is explicit tension between biomedicine and medical alternatives, cases of "deviant insiders" (Dew 2000), "heretics" of medicine (Martin 2004) or "from doctor to healer" (Davis-Floyd & St. John 1998) become extremely thought-provoking topics to study. Healthcare professionals who practise some alternative methods represent medical diversity particularly well as they borrow, mix and work with different ideas, practices and styles from different treatment modalities. In Estonia, there have been and there are such physicians who are simultaneously "insiders" and "outsiders" of biomedicine. One of the most significant examples is Dr Luule Viilma (1950–2002) who was a gynaecologist, and a very charismatic and popular spiritual teacher and healer in the 1990s. Till this day she is the best-selling author of spiritual self-help books in Estonia. However, back in the 1990s she was highly controversial. She gained massive popularity among patients in Estonia, as well as having followers in neighbouring countries such as Finland, Latvia and Russia, but at the same time she also encountered enormous hostility, especially from the Estonian biomedical community, resulting in her losing her doctor's license (Uibu 2016a, Uibu *forthcoming*; see also Kõiva 1996).

Approximately 20 years later, another very charismatic and popular physician emerged: Dr Rene Bürkland (born in 1974), a practitioner of Chinese medicine and the bestselling author in 2016 in Estonia. Having a medical degree from the University of Tartu, Estonia (2006), and a degree in Chinese medicine from Beijing University, China (2009), he is the founder of the centre for Chinese medicine, which has become one of the biggest centres providing Chinese-medicine-related health services in Estonia. Besides providing treatment, he has also become a recognised teacher of Chinese medicine. However, interestingly enough, he has never faced similar contempt as Dr Viilma faced 20 years ago. On the contrary, if the Estonian media published stories of Viilma titled "Psychic is an irresponsible healer" (LAANEPERE 1996) or "Watch out, PSYCHIC!" (ARUJÄRV 1999), then in Bürkland's case there are headlines such as "Our own Oriental wise man" (ELSTROK 2015) or "Two-year-long queues, bestselling books: What is the phenomenon of the healer Rene Bürkland about?" (PUBLIK.EE 2016). Remarkably, under Bürkland's supervision Chinese medicine, which is perceived as an alternative medicine by the state and most of the healthcare professionals, is slowly but firmly making its way into the Estonian state healthcare. Compared to other alternative medicines, Chinese medicine seems to enjoy higher official acceptance. Besides conducting courses for healthcare professionals at his centre, Bürkland has also held training days at state hospitals in the capital of Estonia, Tallinn, since 2016. This is a rare undertaking in the Estonian context to this date.

It could be argued that one of the reasons why the reception of Viilma and Bürkland differs so drastically can be found in the strategies they apply to introduce their teachings. While Viilma presented herself as a spiritual teacher and healer who was preaching her own teachings (UIBU 2016a), Bürkland has quite neutrally defined himself as a doctor or specialist in Chinese medicine. Regardless of his own interpretations, he often claims that what he is teaching is not his own but "classical Chinese medicine". When Viilma was at first sceptical and later explicitly negatively minded towards biomedicine and therefore opposing her teachings to biomedicine, Bürkland has become a spokesperson for integrative medicine and emphasises that his "dream is to bring together Chinese and Western medicine" (FILIPPOV 2016). It also could be argued that Viilma's teachings encompassing ideas from Christianity to New Age spirituality and from parapsychology to Eastern philosophy (UIBU 2016a: 274) were explicitly "too spiritual" for biomedically minded healthcare professionals. In his lectures to healthcare professionals, Bürkland has introduced clinical evidence-based approaches to Chinese medicine alongside with Taoist philosophy. Furthermore, only subtle references to New Age spirituality can be detected, giving the impression that Chinese medicine is secular and scientific only.

In this paper, however, I would like to argue that Bürkland's positive reception by healthcare professionals is not only based on his charisma or the strategies he has chosen for representing and framing Chinese medicine. Instead, I argue that the reasons why the position of Chinese medicine is currently changing are rooted in the relationship Chinese medicine has with the state, in the current health policy and in a particular spiritual context. In the paper, I will firstly delve deeper into the case study and point out some of the most crucial aspects regarding the relationship between the state and Chinese medicine. Secondly, I will focus on the interviews I have made with Estonian healthcare professionals and analyse their critiques of biomedicine. I explore how boundaries are made, shifted, crossed and reconfigured between biomedicine and Chinese medicine by different actors, such as healthcare professionals, practitioners of Chinese medicine and the state. By doing this, I aim to demonstrate how the position of Chinese medicine has changed in the health landscape as well as how the position of Chinese medicine is perceived by healthcare professionals.

I am aware that the concept 'Chinese medicine' is fuzzy. Within this article, Chinese medicine is understood as a contemporary perception of historic Chinese medicine, which is shaped by a particular cultural and social context as well as individual interpretations of every practitioner and user. In the Estonian context, Chinese medicine is regularly known by different treatment practices like acupuncture, herbal medicine, massages, qigong, cupping, moxa-therapy and food therapy. From a philosophical point of view, practitioners introduce Chinese medicine in the framework of a Taoist philosophy; however, teachings of New Age spirituality are also present. A somewhat newer and rising trend in public discourse, mostly due to Bürkland's activity, is to introduce Chinese medicine as a particular way of life aiming to improve an individual's wellness.

The paper is based on almost two years of ethnographic fieldwork in Estonia. In the spring of 2016 I started my fieldwork on Chinese medicine as a continuation to my earlier research on spiritual health-related practices. By 2016 Rene Bürkland had become unquestionably the most famous "healer" and practitioner of Chinese medicine in Estonia. Since then I have been conducting (participant) observation at public events like book presentations, radio broadcasts, training events, and lectures held by Bürkland. These events have been targeted at either healthcare professionals or a wider audience, both aiming at popularising and introducing Chinese medicine. Attending the events has helped me to understand the specifics of the choices that Bürkland constantly makes, for example which language and expressions to use, which topics to cover while speaking to different audiences, and how to represent the material on Chinese medicine. Since 2016, I have also conducted media and to some extent social media ethnography. I have collected news stories written by and about Rene Bürkland which have been published in the Estonian media from 2009 until 2017 as well as selectively news stories on Chinese medicine and acupuncture from the period of approximately 20 years. I have regularly read newsletters and watched video messages issued by Bürkland's health centre, and observed the centre's Facebook page. All this data has assisted me in bringing out the most crucial aspects of the current research topic. Furthermore, it has also provided the general context for this article.

The data that I analyse in the second part of the article was collected in 2017. I made nine in-depth, semi-structured interviews with healthcare professionals who had either attended Bürkland's training courses on Chinese medicine for healthcare professionals or had attended some other (public) lectures given by Bürkland. I conducted the interviews in Estonian, recorded and transcribed them and later translated the chosen extracts used in the article into English. The names of the participants are pseudonyms. At the beginning of every interview, I asked the participants to define eight concepts—conventional medicine, traditional medicine, alternative medicine, complementary medicine, integrative medicine, folk medicine, belief medicine, natural therapies—to make them reflect on the relationships between biomedicine and other forms of medicine. Hence, overall, the discussions revolved much around the positions and roles of alternative medicines, including Chinese medicine in particular.

From the theoretical point of view the paper relies on the concepts developed in the fields of medical anthropology and folkloristics. One of the points of departure revolves around the concepts of medical pluralism and medical diversity. Coined by anthropologist CHARLES LESLIE (see 1976, 1980), medical pluralism has, within the last thirty to forty years, shaped research in medical anthropology and sociology remarkably. However, already since its very introduction, the concept has also been widely criticised (PENKALA-GAWĘCKA & RAJTAR 2016: 129), and more recent academic discussions have favoured the concept of medical diversity instead. While medical pluralism is mainly understood to consist of separate systems of medical practices and forms of knowledge that coexist together and interact with each other, medical diversity draws attention to the mixture and intersections of different therapeutical practices (KRAUSE, ALEX & PARKIN 2012: 8). As anthropologist DAVID PARKIN (2013: 125) writes, the concept of medical diversity refers to the mutual borrowing of ideas, practices and styles between them. So instead of studying medical systems the focus has shifted to studying practice—what people actually do, by highlighting the roles of invention, innovation, and disorder (POOL & GEISSLER 2005: 45). Considering the two research traditions of medical pluralism and medical diversity, scholars have become continually interested in how boundaries are reconfigured through intersecting markers of difference (KRAUSE, ALEX & PARKIN 2012: 8).

Similar trends have taken place in medical folkloristics too. The 1970s signify the emergence of a relational perspective on health in folkloristics, meaning that different modalities of healing are seen in relation to each other. From the earlier approach of health belief systems (O'CONNOR & HUFFORD 2001), the emphasis has moved to the exploration of the shifting and relational boundaries that constitute multiple lay and official epistemologies and practices (BRIGGS 2012: 338). In other words, the approach of health belief systems views both biomedicine and nonconventional medicines as equal, but still as different health belief systems, and is interested in interconnections between these systems. The exploration of the shifting and relational boundaries, however, has entailed questions such as how boundaries are made between biomedicine and other modalities of healing, who makes the boundaries and who crosses them, and which "boundary objects" (Star & Griesemer 1989) provide the means to both recognise boundaries and translate across the social worlds they define (Briggs 2012: 337–338).

In addition to this, I am also motivated by folklorists (Primiano 2012, Bowman &Valk 2012, Kivari 2016) who have done research on and have theorised the concept of vernacular belief. I approach the intersections of different therapeutical practices as a field where various actors and their voices, in the form of many, often conflicting, attitudes, opinions and statements, encounter each other. Some of these expressions are suppressed, marginalised and neglected, and look for legitimisation and acceptance in dynamic ways. Others demonstrate their hegemony. Within these processes, boundaries are constantly being made, reconfigured, shaped, and shifted by different actors.

Chinese medicine in Estonia—practitioners and relationship with the state

Chinese medical techniques were already practised in Soviet Estonia. These techniques were imported to Soviet Russia by Chinese ethnic communities (Lindquist 2006: 34). Similarly to trends in Western countries, acupuncture particularly gained attention by medical doctors. As far as is known, Vera Paklar is on record as being one of the first Estonian physicians who attended an acupuncture course in Moscow and started to treat patients. Her acupuncture set from the 1960s–1970s is currently possessed by the Estonian Healthcare Museum. On the other hand, Oriental philosophies became increasingly attractive. In addition to study programmes in Eastern languages at the Tartu State University (currently University of Tartu), also study circles dedicated to Oriental philosophies were founded in the 1970s (Kulmar 2007). In the 1970s–1980s, these circles attracted young students of whom several later became acupuncturist and practitioners of Chinese medicine. Among others, for example, there was Lembit Kuhlberg, who attended one of the aforementioned study circles in the 1970s as a biology student. After being fascinated by traditional medicine and especially Chinese medicine, he graduated from the university for the second time as medical doctor and became an acupuncturist (Ansko 2013).

In the 1980s, interest in Oriental philosophies together with Oriental medicines and meditation increased generally in society (Kõiva 1996). Moreover, the authorities of Soviet Estonia were increasingly favouring acupuncture because "health officials in Moscow" perceived it effective in treatment and potentially cost-efficient (Dudarenko 2007). In 1979, the Methodical Centre for Reflexotherapy was founded in Tallinn by the Ministry of Healthcare of the Estonian SSR, coordinating the work of acupuncturists in the ESSR. In 1983, the Association for Acupuncturists was formed uniting the 16 acupuncturists who were working in Soviet Estonia (see EAA web). This is also the period of institutionalisation and professionalization of acupuncture. Only medical practitioners with at least three years experience in clinical work could learn acupuncture. Local practitioners attended courses mainly in Moscow and Leningrad, but also in other Republics of the Soviet Union, less in China however. Since 1979 acupuncture as a speciality was part of reflexotherapy, then internal diseases, and later of neurology.

Regardless of being alternative to biomedicine, acupuncture was definitely in a privileged position all over the Soviet Union compared to some other healing therapies which were practiced semi-underground (see e. g. Lindquist 2006: 34–35), and this was the case already before Perestroika. Medical acupuncturists were working at state clinics of ESSR (see EAA web). However, we should not forget that it was the Soviet period, meaning compliance with scientific materialism. Practicing acupuncture had to be done under the label of science and for this reason acupuncturists had to be medical doctors. Similarly, medical specialists worked in the Institute for the Preservation of Lenin's Body to study and experiment with non-Western medicine (Lindquist 2006: 35); or the Baltic Dowsers' Association was formed to study an imperceptible "force" (or "radiation") coming out of the ground which was believed to have an impact on human health and cognition (Kivari 2015).

The collapse of the Soviet Union marked the beginning of a new period in Estonia. Former institutions required adaption to new settings and re-organisation. After some years of a pause in its activities, in 1993 the successor of the Association for Acupuncturists—the Estonian Acupuncture Association—was founded to unite medical professionals practising traditional Oriental medicines. Since 1994 the society has been a member of the International Council of Medical Acupuncture and Related Techniques. Nonetheless, acupuncture was declining institutionally. If in the 1980s acupuncture as a speciality was part of neurology, then in 1993 in the new healthcare system it was grouped under rehabilitation methods where it has stayed to this day. Around the same time, fuelled by a philosophical, religious and spiritual liberation (Altnurme 2006), several new-comers entered the health landscape. In the same year, 1993, one of these new-comers, the Estonian branch of the international Neijing School, opened its doors and started training people in Chinese medicine with and without a medical background. One of the graduates in the 1990s was Rene Bürkland. The Neijing School not only brought Chinese medicine to its students but also introduced trends from New Age spirituality more broadly. Nowadays, for example, in addition to Chinese medicine, the Neijing School also offers courses and seminars on astrology, neo-shamanic drum making and different meditations and massages.

In 1997 acupuncture faced another institutional decline. Since the formation of state financed health insurance system in the beginning of 1990s, acupuncture was listed as state-financed treatment method, just as it used to be during the Soviet period when healthcare was free for everyone. Until the exclusion from the list of the Estonian Health Insurance Fund, many Estonian acupuncturists were working at state clinics, as rehabilitation doctors though. After 1997, when the state did not reimburse the costs for the service anymore, many of these acupuncturists became private doctors (EAA webpage). As one among other health practices located outside the state funded healthcare, acupuncture was offered by private practitioners according to the principles of the free market economy. In 2004, the Estonian Society for Classical Chinese Medicine was founded, primarily to teach Chinese medicine. Although, according to the statute, the society accepts all people as members "who are deeply interested in Chinese medicine," members mainly comprise of both Estonian and Russian speaking medical professionals, including Rene Bürkland. It is crucial to mention the foundation of the society as it also reflects the changed position of Chinese medicine and medical acupuncturists. In the 1990s Estonia witnessed rapid pluralisation of different healing practices (see also Uibu, *forthcoming*). It was a period of boom for spiritual healers and "witch doctors" (see also Kõiva 1996). Due to the institutional decline of acupuncture, in this new context of medical and spiritual diversity, medical acupuncturists were forced to draw a clear boundary between practitioners who had a medical background and the ones who did not. Hence, the Estonian Society for Classical Chinese Medicine was founded by medical acupuncturists, to keep the professional level of Chinese medicine as well as acupuncture.

Another change that medical acupuncturists have undergone due to the institutional decline of acupuncture has been the adaption to the health market. During the Soviet times and in the 1990s, and even in the beginning of 2000s, medical practitioners who practised Chinese medicine mainly called themselves acupuncturists. However, approximately in last ten years they have found it more suitable to use labels like "practitioner of Chinese medicine," "doctor of Chinese medicine" or "specialist in Chinese medicine." By being excluded from the state-funded healthcare, and, thus, being marginalised, it seems that medical acupuncturists have been forced to demonstrate more explicitly the diversity of techniques of Chinese medicine to compete with a variety healing practices that are found on the Estonian health market. In 2009 Rene Bürkland with his centre for Chinese medicine entered the market, at first representing himself as acupuncturist and general practitioner, later as doctor of Chinese medicine.

However, comparing Chinese medicine to some other practices that are present on the Estonian health market, for example Reiki healing, homeopathy, different breathing techniques, or even osteopathy and chiropractic, there is one more crucial difference. Since 2006 legal regulations have been enforced on acupuncture by the state. Out of all other Chinese medical techniques, the state regards acupuncture as specialised medical care and a healthcare service requiring the implementation of the Health Service Organisation Act (2001). The Health Service Organisation Act applies only to biomedical health services or services accepted as part of "real" medicine. Usually, non-biomedical health services that are provided by practitioners of any kind of alternative medicines are not included in the Estonian health regulations since these practices are not considered to be official healthcare services, by neither practitioners or officials (see also TIKK 2005, LAI *et al.* 2013). This is also one of the reasons why practitioners of alternative medicines usually do not apply for official activity licences issued by the Health Board, in order to offer their services as healthcare services; however, theoretically it could be possible (see also MAARITS 2017). The 1990s witnessed a drastic growth of different health providers, and, unlike in the Soviet period, practitioners without a medical education began to use acupuncture to treat their clients. Before 2006, there were no particular legal statements, which is why it was ambiguous from a practitioner's viewpoint whether acupuncture was considered a healthcare service or not and whether the activity licence was needed. Since 2006 though, by the verdict of the Supreme Court of Estonia, acupuncture can be practised by licensed medical doctors only if it is done for the purpose of economic and professional activities (*i. e.* acupuncture is offered as a service).

It is worth mentioning that the main debate related to the court case and the final verdict were based to a large extent on one question—whether acupuncture is a healthcare service or an alternative medicine. In the Soviet period, alternative medicines were the healing methods that were excluded from the state-funded healthcare as they were ideologically inappropriate, meaning not scientific. Since the 1990s the same logic has been applied—alternative medicines are the methods that are not evidence-based and are located outside of the healthcare system. After the exclusion from the list of the Estonian Health Insurance Fund in 1997, acupuncture lost its privilege entirely and was basically downgraded to the family of other alternative medicines. So following this principle, in court the accused, a practitioner of Chinese medicine, claimed that acupuncture was an alternative medicine. The court analysis, on the contrary, made it clear that acupuncture is a "procedure that involves penetration to the human body and if not carried out according to the rules (incl. ignoring hygiene requirements), it can pose a serious risk to human health" (The Supreme Court of Estonia, verdict, 2006), and, thus, should be considered a health service.

So it could be said that the state "saved" acupuncture from the status of an alternative medicine. And indeed, even the Estonian Medical Association whose official attitude towards alternative medicines is sceptical, if not hostile, regards the use of acupuncture "justified to some extent and accepts it as part of medical activity" (TIKK 2005, see also VÕSUMETS 2015). This, of course, does not mean that acupuncture would enjoy the privileges of biomedical health services. Although being a health service, acupuncture is not listed as state-funded health service. Also, this does not mean that healthcare professionals would consider the usage of acupuncture self-evident. Numerous times during my fieldwork I witnessed Bürkland discussing the safety and efficiency of acupuncture as well as qualification and professional level of acupuncturists with healthcare professionals.

Except acupuncture, licensing regarding alternative medicines basically does not exist or is very vague in Estonia. As mentioned above, usually, alternative medicine health services are not considered to be official and state regulated healthcare services, by either practitioners or officials. Recently some debates have been raised about licensing. Published in the Estonian Public Broadcasting news, according to a statement by a representative official of the Health Board, the principle is that as long as there is no threat to life or health, alternative medicine services could be offered by practitioners and consumed by users (MAARITS 2017). The Health Board and the Estonian Consumer Protection Board interfere only in the case of any violation. For example, they would interfere if a practitioner claims that the alternative health practice is an official legitimate healthcare service or the practice/product has medical features that it actually does not have. If someone promises “to heal,” the Boards consider it as not definite enough and usually do not interfere (*Ibid.*). Regarding Chinese herbal medicine, massages, qigong, moxa-therapy, and food therapy, then these practices are considered to be part of alternative medicines and no legal restrictions other than the Health Board’s statement mentioned above are enforced on practitioners.

Since 2008, however, the Estonian Qualifications Authority has issued occupational qualification standards for Chinese natural therapists. From the perspective of the state, though, these qualification standards are nothing too solid because actually they “neither allow nor prohibit” anybody to become a Chinese natural therapist (Maarits 2017). In other words, one can be a Chinese natural therapist without reaching an occupational qualification standard as long as the “therapist” has enough clients or the clients accept the practitioner without particular qualification. Also, it is relatively easy for organizations and individuals to apply for licenses to conduct in-service education, which is why there are many providers who offer courses on different health-related practices and teachings and give out certificates. Often Chinese medicine with its techniques is incorporated in a wider spectrum of practices of New Age spirituality or of contemporary folk medical practices. Moreover, one of the indicators that validates the qualification of the practitioner is simply the name of the teacher (or master) or belonging to professional associations of alternative medicines. In the context of free market economy, spiritual and medical diversity, the level of qualification and skills, approaches to and representations of Chinese medicine vary a lot among practitioners.

If thinking about the current position of Chinese medicine on the landscape of Estonian healthcare and the developments it has faced from the beginning of the 1990s, a quite complex picture opens up. Nonetheless, I would like add one more aspect. At this moment, Chinese medicine seems to undergo another change. Under the supervision of Rene Bürkland, great interest in Chinese medicine has emerged, and not only by users but also by healthcare professionals. The medical portal Med24, an important and reliable source of information for latest medical, healthcare and health policy news, has published seven articles about Chinese medicine within the last two years. It rarely happens that medical portals or local medical journals publish something about alternative medicines, and, moreover, in a relatively neutral manner. Just recently, in 2018, the portal published its 10 most read articles in the last ten years, and the most read one is an interview with Bürkland, one where he states that his “dream is to bring together Chinese and Western medicine” (Filippov 2016). However, when looking back at 20-, 15- or 10-year-old statements by medical acupuncturists, Bürkland is actually saying nothing new or revolutionary. These medical acupuncturists have craved after the bond with biomedicine and the state for the last 20 years. They have also claimed that Chinese medicine, in their opinion, should be combined with biomedicine. But why, unlike others, has Bürkland been holding training days at hospitals in the capital of Estonia since 2016? And why have statements of “bringing together Chinese and Western medicine” previously remained marginal or standalone attempts without any significant results? In the context where alternative medicines are usually stigmatised by biomedical practitioners, why are healthcare settings becoming more open towards Chinese medicine?

Healthcare professionals’ encounters with Chinese medicine

In 2017 I made nine in-depth, semi-structured interviews with healthcare professionals who attended Bürkland’s training courses on Chinese medicine for healthcare professionals, except for one person who instead attended Bürkland’s public lecture and participated on a training day of cupping under the supervision of another practitioner of Chinese medicine. The participants I interviewed for the study are all trained as either as nurses or midwives, except one participant who is trained as a medical doctor but now, after her career as a MD, works as a health consultant. The sample of this study is characteristic of the present situation. As typically shown by other research (Cant & Sharma 1999, Fadlon 2006), nurses and midwives are more interested in alternative medicines than medical doctors. Regarding the Estonian case this is also very significant. In 2016 when I attended Bürkland’s training day for healthcare professionals at one state hospital in Tallinn, out of 95 registered participants only seven were medical doctors. For my research I managed to make contacts only with nurses and midwives. This clearly demonstrates that medical doctors are more cautious about and reluctant to alternative medicines.

It is also worth mentioning that for me as a researcher it was not that easy to get a permission to attend the training day. When I contacted the representative of the hospital who was organising the training day and explained I was a doctoral student in folkloristics and would like to conduct a research, her reaction was: "We don't want to give an impression that we're dealing here with witch doctoring." (Fieldnotes 2016–2017) Instead, "not to give a wrong impression," we agreed that on the training day I could present myself to the participants as a medical anthropologist. Also, when later interviewing the organiser, she emphasised for several times that when organising the training day they "followed all the protocols." She admitted that organising such an event was a bold step but then immediately diminished the significance of it by claiming "there was nothing dramatic or extraordinary." This all shows that alternative medicines are still strongly stigmatized in biomedical settings, and shifting the boundaries between biomedicine and alternative medicines is done tentatively and with caution. However, the organiser made another remarkable comment:

> But of course when we were preparing this training day, for us, a starting point was our current health policy and then the needs that we have here, when working in the hospital environment.

By analysing the healthcare professionals' critiques of biomedicine's unmet needs and shortcomings, I explore how healthcare professionals themselves make and shift the boundaries between biomedicine and Chinese medicine. In the final remarks, I discuss some of the aspects of the current health policy that the organiser of the training day hinted at.

Participants

Before presenting the analysis of the interviews I briefly introduce the participants of the study. Drawing on participants' contact with Chinese medicine and engagement with and interest in alternative medicines, it is possible to distinguish different levels of involvement. Similarly to research (UIBU 2016b: 36–39) conducted on New Age/spiritual milieu, I distinguish three levels—regular practitioners, those strongly inclined towards alternative medicines, and those with a weak inclination towards alternative medicines.

The participants who could be described as *regular practitioners* are Jane, Lydia and Mare. Jane is a 27-year-old nurse who is currently studying Chinese medicine at a private school which focuses on alternative and nature therapies and massage. After graduating the school her aim is to join Rene Bürkland's training courses as she considers them more professional. She sees Bürkland as one of her role models and would like to open up a centre of integrative medicine in the future. She has read books written by the most popular spiritual and alternative healers of Estonia, including Luule Viilma. Jane has practiced meditation and is open to different alternative therapies. Lydia is a 44-year-old midwife and consultant who studied Chinese medicine in the 1990s at the Neijing School in Estonia. She has experimented with different alternative therapies, especially homeopathy.

Mare is a 57-year-old midwife who also studied Chinese medicine in the 1990s at the Neijing School, like Lydia. She has passed special training in herbal medicine for midwives and as a head of department encourages her colleagues to use different herbs too. Although she seems convinced that all alternative therapies have their own function and benefit, she makes a clear distinction between those therapies that can be appropriately applied in the fields of official healthcare and those that cannot.

Pille, Leelo and Jaanika are *strongly inclined* towards alternative medicines. Pille, a 45-year-old midwife and consultant, has been interested in different alternative spiritual and health practices since the 1990s. She has also learnt some of the methods herself. Before attending Bürkland's training course at the hospital, she had heard about Chinese medicine from her colleagues. Leelo, a 53-year-old nurse, has previously been interested in alternative therapies like aromatherapy, chiropractic and acupuncture. Since attending a course on acupuncture last year, she has been more generally interested in Chinese medicine, which is why she decided to participate in Bürkland's training course at the hospital. Jaanika, a 29-year-old midwife and consultant, attends different courses and lectures on alternative therapies, including Chinese medicine. She sees this as part of her continuing professional training. Jaanika claims that her personal aim is to integrate the views of biomedicine and alternative approaches to mitigate the current conflict that, in her opinion, exists between them.

The last three participants, Reelika, Kadri and Anna, are depicted by at the level of a *weak inclination* towards alternative medicines. Before attending Rene Bürkland's training course at the hospital, Reelika, a 49-year-old nurse, did not know much about Chinese medicine. As she explained, she participated in the training at the hospital out of curiosity: "because the course was offered alongside scientific medical courses." Kadri, a 23-year-old nurse, had a former colleague who was studying Chinese medicine, which is why she was eager to get to know more about it and decided to attend the training course. Anna, a 77-year-old MD, is currently working as a health consultant. As she claimed, during the last couple of years she has changed her attitude and has become more open towards alternative medicines. She attended the training course to widen her scope of knowledge in case some of her patients would ask about Chinese medicine.

Preventing diseases and maintaining health

In this study, regular practitioners often expressed disappointment with the biomedical approach to health and disease. These participants were generally dissatisfied with biomedical education, which they claim does not provide knowledge to assess the nuances of a patient's health condition in early stages of sickness, or even ignores these minor health changes. Reckoning this, it is not surprising that all participants regardless to their inclination told, more or less explicitly, that they lack methods for preventive treatment. For the first two "groups" of participants one of the reasons why they became interested in alternative medicines, and some of them especially in Chinese medicine, was the will to broaden the array of techniques and knowledge of preventive treatments. They have been looking for tools and instructions that they could recommend to patients so that "the patients could help themselves more," as they said. Guiding patients towards self-surveillance, *i. e.* observing the signs and learning to 'listen' to the body as a whole, was one of the main instructions picked up from Chinese medicine. Participants with a weaker inclination even considered such self-monitoring in particular to be the core of Chinese medicine. It was also common for regular practitioners and both participants with stronger and weaker inclinations to assume that close self-surveillance of the body is something natural and that nowadays people have quite often lost the ability to observe the body.

> Well, this is the thing, that the old Chinese have learned to listen to their bodies over the centuries—an ability that I believe old local Estonians also had but we have just forgotten it. All kinds of information surround us and we gobble it up but we don't listen to this particular something that could actually give us information. (Leelo, family nurse)

While I analysed the interviews a crucial question arose: who should be responsible for taking care of the preventive treatment of a patient and the maintenance of his/her health? Should a biomedical practitioner do it? Should it be the responsibility of biomedicine at all? Nurse Kadri, for example, regarded the topic of maintaining health and prevention important, but claimed that patients usually do not come to a doctor's appointment for preventive treatment. Her work in practice is more about biomedical treatment, as she perceives it.

> To be honest I actually liked the training. However, as a family nurse I can only use it when a patient comes for preventive consultation. But mostly they reach out to us when they already have some kind of troubles and they do not care whether, for example, they can drink milk or not. (Kadri, family nurse)

On the other hand, there were participants, especially with a strong inclination, and regular practitioners, who did not even necessarily regard preventing diseases and maintaining health as an area of responsibility for biomedicine. For example, midwife Mare shared the opinion that biomedical intervention in health issues is only 10 %

out of 100 of person's health, whereas 50 % of the health depends on patient's lifestyle choices. She thinks healthcare professionals as well as patients make a mistake when assuming that biomedicine should have a bigger role to play in health maintenance.

> We shouldn't forget the simple formula that only 10 % of our health depends on medicine. Health is something completely different to medicine. When we [usually] talk about health, then we dedicate too large a part of health to medicine—actually it is only 10 %. Our health depends 50 % on lifestyle, 25 % on our genetics—and we can't avoid that. A further 15 % is the environment in which we live—again we can't influence it much. Only 10 % is medicine. This formula works. We ourselves are making a mistake—by thinking differently about these percentages, we change them. (Mare, midwife)

The last statements and the participants' demand for methods for preventative treatment demonstrate that the field of preventive treatment is clearly on the margins of biomedicine. Biomedical education focuses mainly on curing diseases and maintaining health hovers on the border of what are the patient's and what are the state's healthcare responsibilities. Since preventative treatment and maintaining health is not fully perceived as biomedical matters, the boundaries between biomedicine and Chinese medicine become loose and Chinese medical techniques are seen as useful tools for patients in terms of maintaining health.

Diagnostics

When giving introductory lectures in Chinese medicine, Bürkland always tells stories of patients who end up at his clinic since they have not received any biomedical treatment. He concludes that, inevitably, there are conditions that biomedicine cannot diagnose: "A patient has a complaint. You do all possible analyses and procedures but you find nothing. You cannot come up with any potential treatment; the only thing you can tell the patient is 'let's wait'." (Fieldnotes 2016–2017) This narrative, which aims to highlight the limitations of modern technology, the slowness of biomedical diagnostics, and the fact that patients are left alone in the health system, is extremely powerful and spoke to almost every healthcare professional that participated in the study. Those who are regular practitioners or more strongly inclined towards alternative medicines took this viewpoint for granted. Some of them shared with me short stories, based on personal experience, of patients and friends who have not received sufficient help besides surveillance and/or endless referrals due to poor or unsatisfactory biomedical diagnostics.

> If blood tests are all fine, but the patient still has complaints, then the patient will get a psychiatric diagnosis; but after some time it turns out that he had some other disease. These cases do not happen every day but we do encounter them. (Leelo, family nurse)

Participants with a weak inclination admitted having faced complicated cases where they have not been able to diagnose a patient's problem. However, while Kadri and Anna shared the belief that diagnostics used by practitioners of Chinese medicine can provide valuable information, Reelika rather attempted to make a clear distinction between scientific and non-scientific medicine. She was convinced that "real" diagnoses can only be done by biomedical specialists. Reelika, the only participant who emphasised the importance of an evidence-based approach to diagnosis and considered it the core of medicine, excluded diagnostic techniques applied by practitioners of Chinese medicine from the array of methods that a biomedical practitioner could use or take seriously. She marked the area of biomedical expertise (*i. e.* diagnosing and curing "real" diseases), and the area of patient responsibility (*i. e.* prevention or period before biomedical diagnoses). During the latter, the patient, as a consumer, can decide whether to use particular alternative therapies or make some other lifestyle choices, such as introducing a healthy diet for example. In this sense the boundaries between biomedicine and Chinese medicine stay rigid and unchanged for this participant, whereas other participants were eager to reconsider, or were at least ready to negotiate, the boundaries. They were more open to making some space in the healthcare system for alternative diagnostic techniques.

Treatment

Considering treatment, regular practitioners found, as practitioners of alternative medicines often do, that biomedicine is not able to cure the causes of diseases but only to suppress symptoms. These participants share the opinion that biomedicine is very good for emergency situations and acute health problems that need a quick response. However, in their opinion, treatment with drugs should never be the long-term solution, which is why biomedical practice should definitely seek out some other methods for the treatment of chronic diseases.

> The aim is to resolve the problem so that he/she wouldn't need these drugs all the time. If, additionally, you use the right diet and herbal medicine and restore balance to the person, then you can treat blood circulation problems, you can cure type two diabetes. You can reverse all diseases. (Lydia, midwife)

Reluctance towards drug usage by regular practitioners also revealed that regular practitioners were not satisfied with the explanatory model of diseases provided by biomedicine, which in some cases finds only physiological and in other cases psychosomatic explanations for the causes of diseases. Regular practitioners shared the opinion that the causes of the same disease can be different for every patient which is why an individual approach is needed in treatment.

> For example, asthma is caused by different things in different patients and that's why it should be treated differently in every case. You have to approach every patient individually. Basically, every point on the body could work for a patient if you manipulate it correctly. (Mare, midwife)

Participants with strong and weak inclinations towards alternative medicines were also convinced that drugs cannot help in every situation. While participants with a stronger inclination supported the idea that treatment should generally begin with "simpler" and more natural methods, and that biomedical drugs should be added to the treatment step-by-step as needed, participants with a weak inclination thought that some particular Chinese medical methods, ones that are proven as evidence-based therapies, could be useful. Acupuncture was considered to be a more or less accepted method as it was perceived to be efficient for combating headaches and pains; besides, it does not cause side effects like drugs.

> I also registered for the acupuncture course because it is actually scientifically proven, the manipulation of pressure points. It is quite interesting and if it works or it should work, then this is something that I could learn. (Reelika, nurse)

While regular practitioners were especially critical to drug use for chronic diseases, participants with a weak inclination thought, on the contrary, that patients with chronic diseases should not abandon their drugs while using some alternative methods. However, considering critical attitudes towards drug usage in biomedical practice by regular practitioners, one might think that these participants were, with regard to therapies of Chinese medicine that help to reduce drug use, convinced apologists. Midwives Lydia and Mare, who have both studied Chinese medicine and both generally support the usage of herbal medicines, indicated in their interviews that the practice of using herbs in Chinese medicine should not be copied, as well as food therapy. They explained that instead of Chinese herbal medicine and food therapy, Estonians should use local herbs and eat foods that are known and grown in the local region, since people's bodies are used to them. It is a common belief in Estonia that medicinal plants grown close to home have more benefits than the ones grown farther away (RAAL, RELVE & KÕIVUPUU 2018: 10–11). With acupuncture such questions did not arise. Drawing on the understanding of the biomedical 'universal body', acupuncture was perceived to be an appropriate treatment for Estonians, because human bodies and the effects of needles are considered to be the same all over the world.

> If you manipulate meridians with needles, then it doesn't matter where the person is living. If there is a blockage in the flow of energy, you either scatter or increase the energy in spots where there is too much or too little respectively. Acupuncture will work anyway. But with herbs you should look for particular local herbs that have the same effect as herbs in Chinese medicine. It is important to know the active substances and to use local herbs as much as possible. (Lydia, midwife)

Similar standpoints to Lydia's were also expressed by some other participants in the study regardless of their level of inclination. These attitudes exemplify the selectiveness of the acceptance of Chinese medicine. Moreover, when it comes to treatment, healthcare professionals who participated in this study not only make boundaries between Chinese medicine and biomedicine but also between different Chinese medical techniques and some other alternative or folk medicine practices.

Discussion and final remarks

Even if the health landscape in Estonia is depicted by tensions between biomedicine and medical alternatives (Lubi, Vihalemm & Taba 2016; Uibu 2016a) and alternative medicines are usually stigmatised by biomedical practitioners, Chinese medicine is increasingly receiving positive attention by them. To understand why the position of Chinese medicine is currently changing we need to understand its particular social, cultural and historical context. In this paper, by exploring voices of different actors, I have aimed to demonstrate how boundaries between Chinese medicine and biomedicine are made, shifted, crossed and reconfigured in the post-Soviet healthcare landscape.

When studying intersections of biomedicine and alternative medicines, the role of the state becomes unavoidable. Medical sociologists Sarah Cant & Ursula Sharma (1999) have shown in their study how the state and policy makers can change the status of alternative therapies on the health market as well as shape the relationship between biomedicine and medical alternatives. Due to its ambivalent position since the Soviet period, Chinese medicine in Estonia is an excellent example to illustrate how changes in health policy and state regulations implemented on a therapeutical practice influence its position on the health landscape. State regulations mark important moments of reconfigurations of boundaries. After acupuncture was excluded from the list of state-financed treatment methods in the end of 1990s, the boundaries between biomedicine and Chinese medicine became sharpened, as well as the boundaries between medical acupuncturist and non-medical practitioners. Without the state's financial support, acupuncture was turned into alternative health practice located on the margin of the healthcare system. Acupuncturists became competitors with other practitioners of alternative medicines and Chinese medicine blended more deeply into the New Age spiritual milieu.

The final verdict of the Supreme Court in 2006 entailed restrictions in practising acupuncture and shifted the boundaries between biomedicine and Chinese medicine again. According to the verdict, acupuncture was defined as a health service that can officially be practiced by medical doctors only. It could be said that the state "saved" acupuncture from the status of an alternative medicine, and that this can be seen as one of the reasons why the position of Chinese medicine is changing on the current health landscape. In the context where alternative medicines are loosely or not at all regulated by the state, restrictions implemented on acupuncture have helped to maintain the level of professionalism in acupuncture. This gives an opportunity for medical doctors like Rene Bürkland to argue for the professionalism of acupuncture more broadly and also include Chinese medicine. Contrary to non-medical practitioners of Chinese medicine, a medical doctor who practices acupuncture can introduce Chinese medicine to healthcare professionals as something liminal—not biomedicine but not entirely an alternative medicine either thanks to the position of acupuncture. It is significant that one participant of this study, Reelika, who was most sceptical of all the participants, decided to learn acupuncture and registered for Bürkland's next course. In other words, the fact that Chinese medicine in Estonia enjoys higher official acceptance than some other alternative medicines can be regarded as a favour from the state, elevating acupuncture to the status of a healthcare service.

Also, the role of current health policy cannot be underestimated. After the collapse of the Soviet Union Estonia has become a capitalist consumer society. According to the logic of the neoliberal approach more individuals are expected to take responsibility for their health, conduct self-surveillance and are encouraged to take the role of consumers (Nettleton 2013: 138, Fries 2009). These trends are present in Estonian health policy too (Uibu & Vihalemm 2017). Public health is increasingly emphasising the role of disease prevention and health promotion (Lai *et al.* 2013). For around 10 years, implementation of patient-centred (or client-centred) healthcare has been one of the priorities for Estonian health policy (*Ibid.*, Population Health Strategy Plan 2009–2020). Although vaguely defined in different documents, patient-centred healthcare among other things should mean the increase of preventative treatment, counselling, patient's inclusion in decision-making, and the following of the principles of the integration of care. The implementation of patient-centred healthcare, however, has not been fully successful (Aro & Oolo 2015). Regarding the participants' attitudes of and reactions to Chinese medicine in this study, it becomes apparent that healthcare professionals lack methods for preventative treatment as well as instructions to promote health maintenance. They also encounter patients who do not receive help and due to endless referrals "get stuck" in the system or are being declined from any treatment. Hence, the shortcomings the healthcare system is facing can explain why the boundaries between Chinese medicine and biomedicine are shifting. Healthcare settings see the potential in the way Chinese medicine emphasises the role of preventing diseases and prolonging healthy life years. Chinese medicine is perceived as focusing on the individual and, thus, helps to fulfil the gap in the patient-centred approach. Also, as analysis of diagnostic techniques showed, the majority of the participants of the study could potentially perceive Chinese medicine as an alternative choice for those patients who do not receive any other help.

But the role of the state and its health policy cannot be seen as the only reasons why the position of Chinese medicine is changing. As I mentioned in the introduction, health-related teachings have become extremely popular in post-Soviet Estonia. Characteristically to New Age spirituality different spiritual, health-related and lifestyle or well-being teachings are all blending into one and it is difficult to make a clear distinction between them. It is quite remarkable that the main instruction the participants picked up from Chinese medicine is guiding patients towards self-surveillance by sensing the body and "listening" to it. Moreover, observing the signs of the body as a whole was considered something natural. This "listening to the body," nevertheless, does not seem to be "the art of listening and smelling" which the Japanese historian in medicine Shigehisa Kuriyama (1999) has described as one of the ways to know the body in Chinese medicine. Instead, the ideas related to body are rather the ones that can be found in the teachings of New Age spirituality where personal (bodily) experiences and signs of the body are perceived as the most valuable source of information that help individuals to orientate in the contemporary world (Koppel 2013, Uibu 2015, see also Barcan 2011). In his research on spirituality in Estonia, Marko Uibu (2016c: 271) has suggested that the mainstreaming process of New Age spirituality is taking place in Estonia: "/…/the visibility of alternative-spiritual ideas and the arguments that spiritual practitioners use to legitimize their choices has increased. This, in turn, makes it easier for potentially interested people to cross the perceived barrier of negative connotations and become involved in spiritual milieu, thereby fuelling the mainstreaming process." Indeed, ideas about "listening" to the body and observing its signs are not only part of the rhetoric used by spiritual practitioners, as these ideas are also visibly present in the Estonian public discourse. The fact that such ideas are widely talked about can elucidate why the Chinese medical approaches to the body presented by Bürkland are considered natural, understandable and acceptable by healthcare professionals. Hence, among other factors, the particular spiritual context of Estonia is advocating Chinese medicine finding its way into Estonian healthcare.

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Enduring or Fragile Cooperations

Complementary Medicine and Biomedicine in Healthcare Systems of Post-Soviet Kazakhstan and Kyrgyzstan

DANUTA PENKALA-GAWĘCKA

Abstract This paper focuses on relations between biomedicine and various segments of complementary and alternative medicine (CAM) in socio-economic and political contexts of post-Soviet Kazakhstan and Kyrgyzstan. While medical diversity was already present in Central Asia during Soviet times, the collapse of the Soviet Union has contributed to the further diversification of therapeutic options in this region. The author discusses changes in the official attitudes towards various non-biomedical forms of treatment, which reflect changing economic and political conditions. Initially, in the 1990s, the official support for traditional/folk medicine resulted mainly from the efforts of the newly independent states to gain legitimacy on the grounds of the cultural heritage of their titular nations. Such legitimisation is not needed anymore and, in effect, those CAM branches which are practised by healers, not biomedical doctors, have lost government backing. In this light, it seems that first attempts at cooperation between biomedical and complementary practitioners which had started in the 1990s turned out to be rather fragile. The boundary work, as the author's research revealed, is directed towards delimitation of what is perceived as scientific from methods and practices unconfirmed by "science." However, it should be stressed that despite such tensions various complementary therapies, including spiritual healing, enjoy great popularity among patients, which is partly due to the weakness of healthcare systems in Kazakhstan and Kyrgyzstan. The last part of the article addresses examples of cooperation between psychiatrists and healers in Kyrgyzstan, which proved to be fruitful in special circumstances.

Keywords medical diversity – complementary and alternative medicine – CAM – biomedicine – healing
cooperation – boundary work – Central Asia – Kazakhstan – Kyrgyzstan

Introduction

In this article I focus on relations between biomedicine and various types of complementary and alternative medicine (CAM) in Kazakhstan and Kyrgyzstan, and pay particular attention to the attempts at cooperation between biomedical professionals and CAM practitioners, including "traditional"[1] healers. I show the dynamics of these processes, marked by changes in the official attitude to non-biomedical treatments and their practitioners. Using the concepts of medical diversity, legitimacy and authority, and boundary work in the analysis, I also discuss political, economic and social factors which strongly influence these interrelations.

The text is based on the longitudinal ethnographic research which I conducted in Kazakhstan during my five-year stay in Almaty between 1995 and 2000, and in Kyrgyzstan in the course of three fieldwork seasons in Bishkek between 2011 and 2013.[2] My study generally focused on urban medical diversity and the changing relationship between biomedicine and CAM in the context of particular healthcare systems. However, in Kazakhstan I was mainly interested in the role and position of CAM practitioners, while in Kyrgyzstan I concentrated on people's perceptions of health and illness, their health-seeking strategies and practices. During my fieldwork I employed typical ethnographic methods such as semi-structured interviews and numerous talks with "ordinary people," healers and other non-biomedical practitioners, doctors, pharmacists and officials working in healthcare management. An important part of my research was participant observation—I was able to watch therapeutic encounters between medical practitioners and patients, and try some CAM therapies. In addition, I used scholarly literature, which is rather scarce on this topic, and materials from local newspapers, magazines and TV programmes. The studies in Almaty and Bishkek were conducted in different times—in Kazakhstan during the first decade of the state sovereignty and in Kyrgyzstan at the beginning of the third decade of independence. However, processes described here reveal considerable similarities in these two countries, which can be attributed, at least partly, to their common Soviet past (*cf.* HOHMANN & LEFÈVRE 2014—on post-Soviet health systems in the South Caucasus). Materials gathered in both fieldwork sites show such similarities and, at the same time, the impact of changing socio-political and economic conditions in Kazakhstan and Kyrgyzstan in the last decades on their healthcare systems, government attitudes to CAM, professionalisation of its practitioners and cooperation between biomedicine and some CAM branches.

I draw on the concept of boundary work, introduced by THOMAS GIERYN (1983, 1995) in reference to the attempts to demarcate "science" from "non-science". In GIERYN's words, boundary work can be characterised as "rhetorical games of inclusion and exclusion" (1995: 406); he points out the dynamics of these attempts, connected with "historically changing allocations of power, authority, control, credibility, expertise, prestige, and material resources among groups and occupations." This approach has been deployed to study relations between CAM and biomedicine in different contexts (*e.g.* SHUVAL & MIZRACHI 2004). What is important, researchers stress the need to examine not only the boundary work undertaken by biomedical professionals, but also CAM practitioners and patients, "in order to understand better the reasons why people are committed to boundary work" (BROSNAN *et al.* 2018: 11). It should be noted that social construction of these boundaries is closely connected with political and economic changes and power struggles, reflected in attempts to professionalise and regulate CAM. In addition, the concept of boundary work can be used to study not only conflict situations, but also inclusion and cooperation, as Gieryn's approach suggests.

In the analysis, I have also found useful the concept of legitimacy, grounded in the well-known Max Weber's typology of political power and developed in reference to the field of medical practice by GALINA LINDQUIST (2001, 2006). She discussed traditional, rational-legal (or bureaucratic) and charismatic legitimacy and showed how they may influence a healer's authority.[3] I understand authority as a dynamic relation based on respect and credibility, so it can be gained and lost, depending on many factors. Changing official attitudes to CAM have an effect on the ways of seeking legitimisation and building practitioners' authority and, in turn, their authority—sometimes grounded in great charisma—may help develop cooperation between them and medical professionals. In addition, the kind of achieved practitioner's legitimacy is important for drawing boundaries between different types of medical practice.

In this paper, first, I briefly describe the attitude of the Soviet regime to local traditional medicines and some new CAM forms arriving in Central Asia during the last decades of the USSR. The next section outlines an increasing medical diversity in Kazakhstan and Kyrgyzstan after the collapse of the Soviet Union and proclamation of independent republics. In the following chapters I present and analyse the changing position of CAM in Kazakhstan and Kyrgyzstan, describe differences in the official stance towards its various segments, and processes of professionalisation of its practitioners. The last section shows complicated relations between biomedical practitioners and healers and some attempts at cooperation between them in both countries, in different periods of their development. I focus on the case of psychiatric treatment in Kyrgyzstan, where efforts to collaborate with traditional healers can be observed. In conclusion, I discuss the specificity of boundary work in the presented contexts, the reasons for changes in the official policies and possibilities of further development of the relationship between biomedicine and particular CAM modalities.

Traditional healing and CAM in the Soviet era

It should be noted that in the Soviet Union folk healers and shamans, together with religious practitioners, for a long time were subject to persecution. Soviet regime banned traditional medical practices already in 1923 (STICKLEY *et al.* 2013) and the 1930s saw the beginning of a systematic anti-religious campaign accompanied by an intensive agitation against any forms of "backwardness" and "superstitions," including traditional healing. PAULA MICHAELS (2003: 48) writes that in Kazakhstan, "For the most part, agitation against healers meant trying to persuade the population to distrust them, but occasionally the state resorted to coercive methods, such as their arrest and imprisonment." Condemnation of healers' and mullahs' practices together with other habits of the local peoples deemed wild and backward, gave grounds for the Russian "civilising mission" (MICHAELS 2003, AFANAS'EVA 2008).

However, there were fluctuations in an official attitude towards folk medicine and other CAM practices during the seven decades of the Soviet Union, depending on many factors, such as deficiencies of the healthcare system, including insufficient medical personnel and infrastructure. More generally, the political changes induced waves of intensification or weakening of atheisation and "anti-superstition" programmes. There was a gradual relaxation observed after Stalin's rule, and then during "the late socialism" and perestroika some CAM disciplines, especially acupuncture and treatment with the use of "bioenergy" practised by *ekstrasensy*, were allowed on to the margins of the healthcare and gained popularity in the USSR. As ANDREW STICKLEY *et al.* (2013: 2) put it: "Official attitudes to non-biomedical forms of treatment softened somewhat in the later Soviet period with the recognition of some forms of CAM as a speciality in 1977 which stimulated a resurgence in alternative treatments in the 1980s." In light of this, it can be argued that there was de facto medical pluralism in those times, although some kinds of alternative medicine were practised underground or semi-underground (LINDQUIST 2006: 30). Despite a long-standing, strong anti-religious propaganda and efforts to eradicate traditional healing in Central Asia, healers, including shamans and mullahs, continued their practices, albeit usually in secret (MICHAELS 2003: 67, DUYSHEMBIYEVA 2005: 43, PELKMANS 2017: 153). My interlocutors in Almaty and Bishkek often assured me that it had been possible during Soviet times to find a good, strong shaman through informal connections. Importantly, various traditional remedies and therapies were widely used in self-treatment and illness prevention, and it was mainly women who practised such methods in the households.

Medical diversity in Kazakhstan and Kyrgyzstan since the 1990s

The collapse of the Soviet Union near the end of 1991 led to the further medical diversification in the newly independent Central Asian states. Although the concept of medical pluralism, introduced by Charles Leslie in the 1970s (LESLIE 1976) remains popular in medical anthropology, it has been criticised for many reasons (*e.g.* BAER 2004, HSU 2008) and several other terms were proposed. I prefer using here the notion of "medical diversity" instead of "medical pluralism," following DAVID PARKIN (2013: 125) who argues that the former term refers to more than the latter, as it implies not only coexistence, but also "mutual borrowings of ideas, practices and styles" between different medical traditions "and by implication more differentiated strategies adopted by patients in search of cure" (see also KRAUSE *et al.* 2012).[4] As ELISABETH HSU (2008: 320) points out, "Gone are the times where one could speak of a mosaic of clearly bounded, different medical cultures." Such a situation, leading to the considerable hybridisation of various kinds of medical practice, is observed in Kazakhstan and Kyrgyzstan. An increasing diversification of therapeutic options, enabled by the political and socio-economic transformation, is marked, on the one hand, by the revival of the local forms of traditional healing, and on the other—by opening up of Central Asian countries to the flows of various CAM ideas and products both from the West and the East.

Biomedicine undoubtedly occupies a dominant position in healthcare systems of Kazakhstan and Kyrgyzstan, but besides state healthcare and, increasingly, private biomedical institutions[5], a wide array of CAM therapies are available to the people. Based on free market conditions, various non-biomedical methods and techniques have been proliferating, especially in big cities such as Almaty and Bishkek. In rural areas the range of treatment options is not so wide and local, traditional healers play a stronger role, however, it is not rare that people come from distant regions to visit the particular CAM centres or famous healers in the cities.

Among many CAM modalities in Kazakhstan and Kyrgyzstan, there are medical traditions of titular nations—Kazakhs and Kyrgyz, as well as other ethnic groups living in these multi-ethnic countries. Spiritual and religious healing are at the core of these traditions. Kazakh and Kyrgyz spiritual healers, in addition to healing, often practise fortune-telling with the use of 41 small stones or beans—such practitioners are known as *qumalaqshï* (Kaz.), *kumalakchï* (Kyrg.). Healers-clairvoyants, those who "can see," are called in Kyrgyzstan *köz achïk, közü achïk* ("with open eyes") (Biard 2013, Louw 2017). There are also specialists (Kaz. *täwip*, *emshi*, Kyrg. *tavïp*, *tabïp*, *emchi*) who use pulse diagnostics and herbs in the course of treatment, but similarly to the others they relate their abilities to the invisible world of spirits. The most respected albeit very rare are shamans (Kaz. *baqsï*, Kyrg. *bakhsï*, *bübü*).[6] Prayers from Qur'an and Muslim prayer beads (Kaz. *täspi*, Kyrg. *tespe*) are usually applied in spiritual healers' therapeutic sessions. It is important that such practices are commonly treated as part of the local, everyday Islam (Privratsky 2001, Louw 2007), closely connected with culturally shaped identities of the Kazakhs and the Kyrgyz (*qazakhshïlïq* or *kïrgïzchïlïk*, respectively).[7] Religious practitioners—mullahs (*molda*, *moldo*) often help people who suffer from illness or other kinds of misfortune. They use Quranic verses for healing, but sometimes also utensils typical of traditional healers' practice, such as the knife (*cf.* Biard 2013). However, the nomenclature used by healers (and patients) is not stable. Mathijs Pelkmans (2017: 152–153), referring to Kyrgyz healers, rightly states that "many practitioners use more than one term to describe themselves, and in fact, their fields of practice overlap." Hybridisation of practitioners' practices is a common phenomenon, for instance methods and notions (*e. g.* bio-energy, bio-currents) which were applied by *ekstrasensy* during Soviet times, belong to the popular therapeutic repertoire nowadays. As I learned during my research, healers often avoided naming themselves and tended to describe their fields of competence in terms of afflictions which they could heal, and appropriate therapeutic practices. Besides spiritual healers there are various other practitioners of traditional kind, mainly bone-setters and herbalists—Kazakhs, Kyrgyz, Russians, Ukrainians, Tatars, *etc*.

Other popular therapies are derived from Eastern "great medical traditions" such as Chinese, Korean, Tibetan, Ayurveda and Unani. Perhaps the most popular among them are Chinese and Korean acupuncture, in several variants (Penkala-Gawęcka 2002). And last not least, there are numerous new or relatively new treatments (*e. g.* homeopathy, known in imperial Russia, but then suppressed) which arrive from the former USSR, mainly Russia and Ukraine, from the West and East, or are locally invented (*e. g.* a particular version of ozone therapy developed in Kyrgyzstan). It is worth noting that various transnational CAM technologies have recently reached Kazakhstan and Kyrgyzstan thanks to the opening up of the country to the influences of globally operating corporations.

Generally, this non-biomedical sector briefly described above may be called "complementary medicine" in the discussed contexts, because of a positive and, from time to time, supportive governmental attitude to these therapies and a common pattern of patients' help-seeking strategies. It is striking that they often resort to both biomedical doctors and healers and do not treat their practices as contradictory.[8] Initially, in the 1990s, the newly independent Central Asian republics sought their legitimacy drawing on their history and cultural heritage. Since folk medicines of the titular ethnic groups were recognised as important part of this heritage, they received a strong support of the governments in Kazakhstan and Kyrgyzstan, as well as, for instance, in Uzbekistan (Hohmann 2007, 2010; Kehl-Bodrogi 2008).[9] Together with other CAM therapies, folk medicine was regarded as complementary to biomedicine. It should be noted, however, that the official attitudes towards these therapies have been changing depending on changes in political and socio-economic conditions. In addition, particular therapeutic methods were treated differently, which I discuss later as an example of boundary work, leading to worsening the position of folk healers. Such fluctuations can be generally considered a result of the attempts at modernisation, standing in opposition to traditional healing which is viewed, from this perspective, as quackery and evidence of backwardness.

The changing status of complementary medicine and its practitioners in Kazakhstan

Nationalist tendencies which had already emerged before the proclamation of the independent Republic of Kazakhstan, favoured revalidation of Kazakh traditions, including folk medicine. In fact, it was treated then as one of the signs of the Kazakh cultural identity.[10] Subsequently, the Republican Centre of Folk Medicine was established as early as 1990 in Alma-Ata (then Almaty) under the auspices of the Ministry of Health, and later renamed the Republican Centre of Eastern and Contemporary Medicine. Two subsequent Acts of Parliament on healthcare in the Republic of Kazakhstan, issued in 1992 and 1997, approved and confirmed the position of "folk and traditional medicine" and pointed out the importance of their further development. The Centre established its branches in other big cities and many smaller, private CAM centres were opened, sometimes located in large state polyclinics or hospitals. In the second half of the 1990s some non-biomedical therapies and methods of self-treatment were included in the government programme promoting a "healthy lifestyle." Not only ideological, but also pragmatic reasons contributed to the official approval of complementary medicine. Because of a dramatic collapse of the previously socialist state healthcare system in the course of the country's political and economic transformation, marked by the introduction of free market economy, traditional therapies got support as inexpensive, effective and easily available. In the face of a severe crisis of healthcare, such methods were recommended as a valuable means to address the challenges of that time.

However, such initiatives were accompanied by the attempts to regulate and control the activities of non-biomedical practitioners. An official nomenclature classified a wide array of unconventional therapies into two categories: "folk medicine" and "traditional medicine." According to this division, folk medicine included, among others, spiritual healing together with shamanistic practices, herbal treatment, bone-setting, "folk massage" and "extrasensoric" treatment. The second category, traditional medicine, comprised such methods and techniques as Chinese and Korean acupuncture[11], homeopathy, manual therapies, hirudotherapy (treatment with leeches), apitherapy, iridology and magnetotherapy. Whereas "folk medicine" was understood, first of all, in terms of various forms of spiritual healing, "traditional medicine" referred primarily to the globalising Eastern "great medical traditions" and some other CAM branches which were acceptable, at least partly, from the biomedical perspective. Even if sometimes they might be more or less connected with local medical traditions (*e. g.* hirudotherapy or manual therapies) and the practitioners—mostly medical doctors—often combined them with some "folk" methods, they usually referred to the scientific authority as the most influential. Similarly, various CAM practitioners in the West often base their knowledge and practices on science "as a tool for claiming legitimacy" (HIRSCHKORN 2006: 548).

The measures described above served to construct or enhance boundaries between different CAM modalities, mainly on the grounds of their practitioners' sources of legitimacy and knowledge bases. Traditional medicine, in this understanding, lay—at least theoretically—within the competence of medical doctors having professional qualifications. It was in their interest to draw strict boundaries between their practices and "folk medicine," and protect them. Such demand was openly expressed, for instance, during the first Republican Conference on Traditional and Folk Medicine held in Almaty in 1997, which I was able to attend.

Traditional medicine received strong support from the government as a valuable complement to the official medicine. Some disciplines of this CAM segment were introduced to special post-graduate courses for doctors at the Department of Traditional Medicine of the Institute for the Advancement of Physicians, affiliated to the Medical University in Almaty.[12] In Turkestan, at the International Kazakh-Turkish University named after Ahmad Yasawi, the College of Eastern Medicine was opened in 1995, offering courses of Chinese, Tibetan and Arabic-Persian (Unani) medicine compiled with some basic knowledge of biomedicine. After six-year-studies a graduate received a title of the doctor of Eastern Medicine. In addition, since 2004 a six-year course of traditional medicine (Chinese, Korean and some therapeutic methods of the Kazakh traditional medicine) had been taught at the Department of East Asian Medicine of the Kazakh Medical University in Almaty, but for various reasons it was changed into a shorter postgraduate course in 2010 (GRZYWACZ 2010: 39–40). Doctors practising particular CAM modalities, for example *soo-jok* (a version of Korean acupuncture), founded their own associations, however during the above-mentioned conference in 1997 they called for establishing an association for all traditional medicine practitioners, similar to such an organisation that gathered folk healers.

Thus, the process of professionalisation of "traditional medicine" practitioners, which had already started in the late 1980s, was well advanced near the turn of the centuries. Doctors who practised those therapies achieved legitimacy in a formal, bureaucratic way. However, with the aim to appeal to a wider circle of patients, they built their authority not only on such "scientific" credentials, but also on "tradition", albeit they seemed to refer more often to the "ancient medical wisdom of the East" than to the local medical traditions (*cf.* LINDQUIST 2006, PENKALA-GAWĘCKA 2017).

The Acts of Parliament mentioned earlier and further regulations introduced by the Ministry of Health gave grounds for institutionalisation of local medical practices and professionalisation of folk healers that I observed in Kazakhstan in the second half of the 1990s (PENKALA-GAWĘCKA 2002, 2013). A set of specific rules and instructions determined procedures of traditional practitioners' legitimisation at the Centre of Eastern and Contemporary Medicine in Almaty. As it was officially stated, the main goal of the Centre was to get rid of "charlatans" and to license activities of healers who would win the approbation. After a preliminary selection of candidates, they were obliged to attend special courses and practise under supervision of medical doctors working at the Centre. A special commission appointed by the Ministry was responsible for examination and certification of healers. After passing the final exams they received two certificates, first attesting their right to conduct healing, and second giving them a title of a "professional folk healer of the Republic of Kazakhstan." In addition, this document determined a healer's domain of competence—one of four available specialties: "bio-energy therapist," phytotherapist, bone-setter and "theopsychotherapist" (a specialist in spiritual healing). Although such an attestation was expensive and approved persons had also to pay for a licence to practise, many healers applied for approbation and between 1991 and 2000 about one thousand got certificates. However, numerous others continued to work without licences or did not fulfil the obligation to renew their attestation. Near the end of the 1990s, in view of a diminishing number of candidates, the fees were reduced and the rules of certification changed in order to make the procedure easier. At the same time bureaucratic control over healers' activities increased and a special inspection unit created at the Centre was charged with the task to trace unlicensed practitioners[13] and check if the licensed ones did not exceed their qualifications.

The process of healers' professionalisation was also visible in such endeavours as organisation of conferences and congresses, and many other activities of the Association of Professional Folk Healers of the Republic of Kazakhstan, founded as early as 1991. In 2008 there were already 32 branches of the Association, with five thousand members. It organised courses and schools for healers and published a journal (GRZYWACZ 2010: 37–39).

Despite the practical advantages of getting a certificate and a license, which allowed healers to work at biomedical institutions, such a bureaucratic legitimacy was not of primary importance for them. Although they eagerly displayed their credentials—certificates and diplomas or additional documents proving their membership of various "international academies of traditional medicine," it was not essential for enhancing their authority. As I learned, what remained crucial both for them and their patients was the traditional process of gaining legitimacy. Basic components of the "traditional way" of a spiritual healer were: receiving and approving the call of spirits (first of all—ancestor spirits, *ärwaq*), assisting an experienced healer during therapeutic sessions and pilgrimages to sacred sites, and, finally, getting a blessing (*bata*) from that practitioner and protecting spirits. A common feature was a kind of "initiation sickness" (similar to the shamanic one) experienced by a "chosen" person before accepting the healing gift offered by spirits. Healers' powers, their abilities to contact with the world of spirits, were additionally legitimised if they could demonstrate having strong healers or religious persons among their linear ancestors (PENKALA-GAWĘCKA 2013). Actually, some spiritual healers whom I met in Almaty maintained that while striving for certificates, they lost part of their inherited abilities. For example, an Uighur female shaman, popular not only among Uighurs and Kazakhs, but also patients of other ethnic backgrounds, told me that she had decided to apply for attestation against the will of her spirits and was punished by them—her spiritual development was slowed down.

Attempts to institutionally regulate and control the activities of healers expressed the government policy supporting folk medicine, but at the same time aspiring to comply with the standards of the modern country. The second direction became more important when the state got stronger and there was no need to seek its historical and cultural legitimacy any more. In Kazakhstan constraints on folk medicine increased at the beginning of this century, in line with the growing "anti-charlatan" discourse emanating from medical establishment and more and more often present in the media. According to the Act of Parliament from 2003 the use of folk and traditional methods of treatment should be, generally, restricted to medical doctors, and licences for treatment could be granted to persons without a professional training only in exceptional cases. These steps unveiled the boundary work directed towards further separation of the "traditional" segment of CAM from "folk" medicine. Moreover, in 2005 the procedures of healers' attestation were passed on to the Ministry of Health. The activities of the Centre were constricted and the Association of Professional Folk Healers took some of its obligations. However, the popularity of "folk" practitioners has not decreased during the last decades, which contributed to the development of courses for healers offered by the Association, as well as the emergence of new "healing specialties" (GRZYWACZ 2010: 46–47).

In fact, formally imposed restrictions on practising any types of CAM without biomedical training were not put into effect. Recent research conducted by ASKAR JUMAGELDINOV (2017) reveals the continuing popularity of spiritual healers in Kazakhstan and further government efforts to regulate their practices. According to JUMAGELDINOV's report (2017: 193–194), the regulations issued in 2011 oblige every healer to obtain a certificate and a licence delivered by the Ministry of Health after the procedure of attestation, which takes six months of practice at a state medical institution under supervision of medical doctors. It is striking that while trying to separate "charlatans" from those who "have a gift" and regulate the activities of the latter, the authorities left the door open for further development of a variety of non-biomedical practices, including traditional forms of healing. One of the reasons for this is, presumably, the situation of healthcare system in Kazakhstan, still facing a serious crisis and calling for effective reforms, despite general improvement in the country's economic conditions. State retrenchment in the public healthcare sector, as DINA SHARIPOVA (2015) argues, has had dramatic consequences for the provision of medical services and their quality, and has led to the increase in informal payments and reciprocal exchanges.[14] The author points out such grave problems of healthcare in Kazakhstan as the shortage of medical personnel in villages and the poor level of qualifications among doctors and other medical staff (SHARIPOVA 2015: 319–320). It may be assumed that the deterioration of healthcare delivery acts as a strong incentive for people to use the services of healers and other CAM practitioners.

The position of complementary medicine and its practitioners in Kyrgyzstan

The process of revalidation of the Kyrgyz folk medicine started as early as the late Soviet period. Similar to the Almaty Centre, a big, state-run institution called the Republican Scientific and Production Centre of Folk Medicine "Beyish" (which means "paradise") was established in Frunze, then renamed Bishkek, already in 1990. It was organised on the base of the Institute of Balneology and Physiotherapy which had been active since the middle of the 1980s. Both medical doctors and healers worked at the Centre, and among available services there were such treatment methods as phytotherapy, balneotherapy and mud baths, as well as "extrasensoric" and spiritual healing.

An important part of the Centre's activity was the production of medicines based on raw plant, mineral and animal materials. Its main aim was, according to Doctor Omorbay Narbekov, the director, "to combine contemporary medicine with the experience of folk and Eastern medicine" and "to discover forgotten recipes of folk medicine."[15] During the 1990s the Centre invited practitioners of Chinese traditional medicine from Xinjiang who continued to work there for several years and offered treatment with acupuncture, Chinese massage and herbal medicines. In Narbekov's words, they managed to treat the "whole Kyrgyzstan" and to train about 70 local physicians in acupuncture and other traditional methods. In addition to Chinese specialists, also Ayurveda practitioners visited the Centre.

"Beyish" provided courses for healers and carried out their licensing. The process of healers' professionalisation was similar to what I observed in Almaty. As Narbekov claimed, over the course of five years about three thousand healers came to the Centre and a special commission involving, among others, a psychiatrist, a neuropathologist and representatives of the Ministry of Health, was created in order to check the abilities of the candidates. As a result, about 200–250 persons with some "gift" were selected. Among them were mainly *ekstrasensy*, clairvoyants, herbalists and bone-setters. Around a hundred healers from that group finished a two-year course of anatomy and physiology, which gave them the right to legally practise healing, for some preliminary period under supervision of medical doctors. A number of licensed healers began to work independently and the "most gifted" ("having the strongest gift") 50–60 persons continued to practise at the Centre.[16]

Various CAM branches, such as traditional Chinese medicine, Korean *soo-jok* acupuncture (known here since the 1980s), manual therapies and hirudotherapy gained an official acceptance and were introduced in the programme of postgraduate courses at the Kyrgyz State Medical Institute (later renamed: Academy) in Bishkek. Presently, physicians who choose the specialty of acupuncturist, hirudotherapist or manual therapist, receive professional training during four and half-month courses at the Department of Physiotherapy and Traditional Medicine of the Kyrgyz State Medical Academy. The position of those medical doctors who practise CAM and the others does not differ, at least such was the opinion of several physicians whom I asked about it. They maintained that there was no gap between "Western" and "Eastern" medicines; according to one of my interlocutors, "there is a kind of coalescence between them in Kyrgyzstan." This doctor, trained as a gynaecologist, after the basic course of acupuncture decided to continue education in this branch of CAM, which was possible at the Academy. Such specialists achieve bureaucratic legitimacy, based on the authority of science, but appeal to patients also by referring to the antiquity and richness of Eastern medicine or—as in the case of hirudotherapy—to the local folk traditions. Some of these doctors got certificates in Moscow, as a homeopath whom I met at a private CAM centre, yet others were educated in China or took an opportunity to receive training in Bishkek from, among others, osteopaths or acupuncturists coming from South Korea.

Whereas the position of CAM disciplines practised by medical professionals seems more or less secure, the status of "folk" healing is volatile. It has undergone changes that reflect revisions in the health policies connected with wider sociopolitical and economic transformations. According to a doctor who herself practised some CAM therapies, healers' attestation had been proceeded until 1996, then it was continued only on a small scale and recently abandoned. As a result—in her words—"contemporary healers are mostly charlatans, who can cheat and deprive patients of money," because there is no control instance supervising their activities. Two my interlocutors—doctors working in healthcare management who had been actively engaged in healthcare reforms in Kyrgyzstan, maintained that the efforts to regulate the healers' practices had been given up due to enormous challenges posed by implementing consecutive reform programmes.[17] In their opinion, the authorities are aware of the problem, but because of many other, more urgent tasks, this has to be left for the future.

Apparently, an official "anti-charlatan" discourse in Kyrgyzstan developed somewhat later than in Kazakhstan, but it also increased over the last decades. This change resulted in the closure of the "Beyish" Centre, whose activities had already been constricted earlier, and founding the International Academy of Traditional and Experimental Medicine in 2011. As the acting Deputy Minister of Health, SARYBEK JUMABEKOV, put it:

> Such an Academy is necessary in the country. […] The Centre of Folk Medicine "Beyish" had not fulfilled its mission […]. Quacks, *ekstrasensy* and often common charlatans, *i. e.* people distant from medicine had worked here before. Therefore it was necessary to change the Centre's status, to channel its work into a scientific direction (NICHIPOROVA 2011).

The Head of the newly founded institution, OMORBAY NARBEKOV, said that they would experiment with the traditional pharmacology of Kyrgyz folk medicine, as well as Chinese and Tibetan medicines. It was also stated that the Academy would work in close cooperation with the Ministry of Health, Kyrgyz State Medical Academy, National Academy of Sciences and some universities in Bishkek.

In the following years the Academy, officially affiliated with the Ministry of Health, has continued testing various plant, animal and mineral substances, and production of "natural" medicines.[18] It has also engaged in healthcare programmes directed at prevention and eradication of several serious diseases. In addition, it provides diagnostics and services of physicians representing several biomedical specialties as well as some CAM branches, including acupuncture, reflexology and manual therapy. I do not know if any practitioners without medical education belong to the Academy staff, although when I talked with OMORBAY NARBEKOV in spring 2012, he claimed that some particularly gifted healers would be employed at his centre after careful selection and additional training.

This institution, as its website[19] suggests, has developed successfully and even opened its branch in Almaty. However, by the decision of the Prime Minister, in November 2017 the Academy was expelled from its premises. It was offered another venue, which—in NARBEKOV's words—did not meet their needs. He said: "This can destroy traditional medicine in Kyrgyzstan, since it is impossible to create such favourable conditions for treatment [anywhere—D. P.-G.] as here" (NICHIPOROVA 2017). The Director openly accused the government officials of an attempt to take over the part of the building occupied by the Academy[20], because of their particular interests. Actually, these steps can be seen as the efforts to install several government institutions in this huge and representative building, located just opposite the so called White House (home to the President, his offices and the Parliament), which had already served for offices of some ministries earlier. But it may be also assumed that recent developments are connected with changing attitudes not only towards traditional healing, but also other non-biomedical methods of treatment which did not fully succeeded in achieving scientific legitimation. Time will tell whether it is a reasonable supposition; throughout recent decades the position of CAM disciplines practised by medical doctors seemed quite stable in Kyrgyzstan.

As regards the healers, their position has significantly changed since the beginning of the last decade in consequence of the "anti-charlatan" discourses and actions described above. Their professionalisation was interrupted. In 2011 I did not meet any "folk" healers in "Beyish," however some who used to work there before, moved to another part of the same building. The healers told me that they had been "thrown out" from the Centre, but as I learned then, they had to leave because rent payments had significantly increased. Anyway, my interlocutors were annoyed and disappointed that soon after completing six-month courses and receiving nursing certifications demanded from them at "Beyish," they lost the institutional support and had to start off on their own. In fact, it was not bureaucratic but traditional legitimacy, based on the assumed close contacts with the world of spirits, which remained essential for a healer's authority and successful practice (PENKALA-GAWĘCKA 2107). In the new situation, marked by deprofessionalisation of healers, their certificates and diplomas lay hidden in a drawer, since they had been needed before only for bureaucratic reasons. While such certificates might have been sometimes useful in the cities, in villages and small towns healers were unconcerned about gaining that kind of legitimation (PELKMANS 2017: 162).

The apparent changes in the official policy towards folk healing did not diminish the popularity of healers among the people. This is also true of urban centres. Many people in Bishkek resorted to healers' services and in common opinion there had been an enormous increase in their popularity since the 1990s. This concerns mainly spiritual healers of traditional background, who attract not only the Kyrgyz, but also patients from other ethnic groups. Although not abundant, ethnographic evidence confirms great popularity of healers in Kyrgyzstan (HEYAT 2004, DUYSHEMBIYEVA 2005, PELKMANS 2017: 148–169, STRAUCH 2017).[21] In addition, there is some statistics available—a study of the use of folk medicine in eight post-Soviet countries, conducted in 2001, revealed the highest level of healers' popularity in Kyrgyzstan: 25 % of the respondents asked healers for help (the target sample was 2000), while in Kazakhstan 11 % (STICKLEY *et al.* 2013).

Obviously, such a high level of healers' popularity is largely connected with common dissatisfaction with the healthcare system and deep distrust of doctors, usually expressed by the people (PENKALA-GAWĘCKA 2016). Worth mentioning, in the opinions of international and local experts the reforms of healthcare system conducted in Kyrgyzstan, although not entirely successful, brought about positive changes and its situation is better than, for example, in neighbouring Kazakhstan (see IBRAIMOVA *et al.* 2011). Despite this, people are mostly pessimistic about the reforms and do not trust doctors, discrediting their professional and moral qualifications. It should be admitted that such attitudes, based on my interlocutors' and their relatives' or friends' experience, but also on circulating rumours and terrible stories about doctors' misconduct, have quite reasonable grounds. Even these specialists who are generally enthusiastic about the progress in reforms, recognise several serious problems in the healthcare system. They refer to, among others, the underfunding of healthcare, an uneven regional distribution of medical facilities and doctors, poor quality of medical training and provided care. In addition, the mass economic migration of physicians and other medical staff to Kazakhstan and Russia, as well as widespread corruption (both in healthcare and educational institutions) belong to the most urgent problems. The persistence of informal payments for medical services is often mentioned as a great burden both by the officials and "ordinary" people. A gradual decrease in such payments has been noted, however, large sums are still being paid, especially to surgeons, anaesthetists and obstetricians (see FALKINGHAM *et al.* 2010).

Doctors and healers—previous encounters, current experience and possibilities of further cooperation

In the literature, explanations of increasing healers' popularity in Central Asia refer mainly to the dramatic situation of healthcare systems in the region, briefly described in the previous sections, and to the overall socioeconomic crisis inducing "uncertainties of existence" (*e. g.* HEYAT 2004, PELKMANS 2017). For example, PELKMANS (2017: 167) points out that in his research site in the southern Kyrgyzstan, Kokjangak, "the hospital was in disarray and, realistically speaking, hardly offered better medical care than some of the spiritual healers."

It should be noted, however, that these are not the only causes of the resort to healers' expertise and help. So, why do healers attract people, in addition to the aforementioned factors? As my studies revealed, the most important are, presumably, local perceptions of health and illness embedded in a wider worldview and inducing beliefs about healers' efficacy. Traditional ideas about health and illness, and especially the causes of illness, are widespread in Central Asia. They connect many afflictions with the influence of malevolent spirits and "evil eye" as well as black magic, whose particularly harmful kind is called, in Russian, *porcha*. Recognition of such etiological factors leads people to seek the help of healers, since in common opinion only they can effectively treat illness caused by this sort of agents. PELKMANS (2017: 160–161) also notices that determining the cause of a health problem has important consequences for seeking treatment, *e. g.* when the casting of a spell (Russ. *koldovstvo*) is suspected, a spiritual healer should be visited. Additionally, illness is treated as one of many kinds of misfortune and people often resort to healers in family problems or business failure. Notably, Kazakh and Kyrgyz ideas about health and illness are deeply rooted in their traditional beliefs about the world of spirits, ancestor spirits (Kaz. *ärwaq*, Kyrg. *arbak*) in particular, and their relations with the humans. A commonly shared belief that spirits actively interfere with people's lives influences health-seeking strategies and enhances the trust in the powers of spiritual healers as mediators between different worlds. Traditional healing is strongly connected with religion, because—as it was mentioned earlier—in the popular view it is part of the "real," lived Islam, despite the negative attitude of orthodox Muslim leaders to such practices. This contributes, undoubtedly, to spiritual healers' authority. In addition, economic conditions play a great role in treatment choices. Healing and many other CAM therapies are generally perceived as less expensive than biomedical treatment, since patients often have to pay even for formally free public healthcare services.

In light of this evidence, attesting to the strong position of traditional healers in the society, it may be argued that since the 1990s they have become serious rivals to biomedical professionals on the market of medical services in Kazakhstan and Kyrgyzstan.[22] As a result of governmental attempts to professionalise and control healers' activities, discussed above, medical doctors got closer to their market competitors as their teachers and supervisors at the state-run centres in Almaty (then also in other cities in Kazakhstan) and Bishkek. Licensed healers were allowed to work at biomedical institutions, and I met such practitioners both at several private medical centres and big state clinics in Almaty. However, these encounters, initiated during the process of healers' professionalisation, did not lead to stronger, enduring cooperative endeavours, partly due to changes in the policy towards folk medicine described earlier.

In this section I focus on relations between biomedical professionals and traditional healers, leaving aside contacts between the former and practitioners of other CAM branches. In fact, the latter are usually medical doctors themselves and their practices are mostly regarded as a part of medicine or at least as "almost medicine." Thus, the boundary work or "closure strategies" (HIRSCHKORN 2006) did not concern "traditional medicine" practised by doctors, as it was officially called in Kazakhstan. Generally, in the case of such CAM disciplines as acupuncture, reflexology, homeopathy or hirudotherapy, therapeutic boundaries with biomedicine have become blurred (*cf.* NARAINDAS *et al.* 2014).

Of course, inclusion of CAM practitioners into biomedical institutions "does not imply equal status compared to other health care providers" and may result in their marginalisation, as JUDITH SHUVAL & NISSIM MIZRACHI (2004: 685) noticed in the Israeli context. The healers who worked together with medical doctors, obviously hold a subordinate position. Relations between the two parties were definitely asymmetrical. At the Republican Centre of Eastern and Contemporary Medicine in Almaty, where I observed interactions between doctors and healers, the former tended to show their superior status and stress the necessity to control the healers. They were very concerned about preserving the "proper" hierarchy. One of the doctors expressed her opinion in this way: "We are head and shoulders above healers." She added that doctors should "put them in their place" if they felt too strong. Physicians conducted courses for non-biomedical practitioners, supervised their practice, checked the results and participated in examination. They often pointed out the limits of healers' capabilities. Actually, some practices were excluded from their area of competence. In Kazakhstan healers could not deal, at least formally, with oncological, contagious and mental diseases, perform surgical procedures and apply pharmaceuticals. In addition, using "wild methods" in the course of treatment, such as butchering black hen or beating patients with a horse whip, was forbidden.[23] Which methods were considered wild, depended on the doctors' decision, and especially on the opinion of the head of the ward. Healers were allowed to indicate an afflicted organ, but making a diagnosis was forbidden. Generally, they were discouraged from gaining more biomedical knowledge than was offered to them during the courses. These are examples of the boundary work directed at designating limits for the practices of non-professionals. Such attempts were observable both in delimitation of knowledge claims and on the organisational and symbolic levels (*cf.* SHUVAL 2001, SHUVAL & MIZRACHI 2004). For example, whereas the doctors employed at the Centre wore white coats, the healers were prompted to dress in traditional Kazakh clothes, so as to separate them from medical professionals and at the same time demonstrate their commitment to the national, ancestral values.

Although the efforts to separate healers, who cannot ground their knowledge on the scientific base, from doctors were clearly visible at the Centre in Almaty, there were also some attempts at cooperation between them. Their permanent contacts contributed to the hybridisation of practices, mentioned earlier. Presumably, the physicians borrowed some treatment methods from the healers, while the latter where not allowed to use biomedical techniques or pharmaceuticals in their practices. Several doctors from the Centre who combined various therapeutic methods with biomedical treatment, including folk healing or the use of bio-energy, expressed positive opinions about the abilities of certificated healers. The fact that those physicians practised some CAM therapies themselves certainly influenced their approach to traditional healers. Such was the case of a gynaecologist, an older woman, who used—besides biomedical methods—pulse diagnostics, bio-energy, purification with water, Tibetan massage, prayers and herbal treatment. These "open" doctors were eager to accept, for example, the "call of spirits," viewing it as a part of the Kazakh tradition. Moreover, some of them had experienced such revelations themselves, as the deputy director of the Centre who herself was a physician and a healer.[24] Several external members of the examination commission also praised healers' special abilities. A psychiatrist delegated by the Ministry of Health to the certification commission at the Centre admitted that after several years of contacts with healers her viewpoint had changed. This Kazakh woman, a professor of psychiatry, maintained that there were, albeit rarely, people with a special gift, such as clairvoyant powers. She claimed that mental health assessments might be mistaken and someone diagnosed, for instance, with schizophrenia, might be an "entirely normal" person whose behaviour should be taken as a sign of extraordinary abilities. She added, though, that her opinion was not shared by the majority of her colleagues from the psychiatric clinic.

Obviously, relations between medical personnel and local healers can get better or worse in particular settings. Interesting data about such interaction may be found in a report on one of the health programmes, implemented in Jambyl Region in the 1990s (KEITH 1997: 47–48). In one district of this region physicians had good contacts with healers and the latter often directed patients with serious health problems to medical institutions. However, in the other district hostility between the two groups was clearly visible. Doctors accused healers of being greedy charlatans who unscrupulously preyed upon people's credulity, while healers claimed that doctors were uneducated and could not deal with many diseases. It seems that such a situation, marked by unwillingness to cooperate or even hostility, especially on the part of medical personnel, is more common. As for Kyrgyzstan, a very negative attitude of doctors towards healers was documented, for example, by ELENA MOLCHANOVA *et al.* (2017: 8) who wrote that medical professionals "often claim that all healers are charlatans" and PELKMANS (2017: 167) who commented on Kokjangak hospital physicians' and head nurses' harsh criticism of the local spiritual healers.[25]

It can be assumed that healers employed in "Beyish" had been in a similar relationship to doctors as at the Centre in Almaty. The steps taken in Kyrgyzstan to "expel charlatans" from "Beyish" and change the name and status of this institution were described in the previous section. This kind of boundary work, however, did not reach the expectations of those medical professionals who, as one of my interlocutors—a doctor practising complementary methods—appealed for a rigorous control over healers who could work freely in the market, although deprived of the previous governmental support. This doctor claimed that the state should equally treat biomedicine and complementary medicine, but at the same time strictly monitor healers' activities. Because of the lack of such control, it is impossible, in her words, "to differentiate between a 'real' healer and a swindler."

Importantly, mental disturbances commonly were and are regarded as the result of black magic or evil spirits, therefore in Central Asia patients with psychic disorders are often treated by healers. BOTAGOZ KASSYMBEKOVA (2003) discussed complex factors which discouraged people in Kazakhstan and Kyrgyzstan from seeking professional psychiatric help. She wrote that many people in Shymkent, the "fairly traditional" city in southern Kazakhstan, turned to local healers when they suffered from mental health disorders. She added:

> Doctors and nurses may not have much faith in religious psychology, but they often shunt "no-hope cases" off to healers. They view *taeyips* as a cultural tradition that people in Shymkent and other communities created, protect, and are comforted

> by. Some even suggest that *taeyips* should consider getting formal training, so they can offer more professional help (KASSYMBEKOVA 2003: 4).

Some statistics on psychiatric patients in Bishkek clinics is available. It was estimated that 80 % of the people who came to the psychotherapeutic clinic and nearly 100 % of the patients of other mental health wards at the Kyrgyz Republican Centre for Mental Health had visited traditional healers before searching for a psychiatrist's help (MOLCHANOVA *et al.* 2008). In the opinion of psychiatrists, there is evidence of increasing trust in folk practitioners who offer their help to people with mental disorders. Molchanova and colleagues argue that from the Kyrgyz point of view "an initial psychotic episode is usually considered a 'spiritual emergence' and a patient generally has to visit […] a number of traditional healers before a psychiatrist takes care of him or her" (MOLCHANOVA *et al.* 2008: 68). Faced with such a situation, a group of psychiatrists in Kyrgyzstan started to appeal for cooperation with healers. They appreciate healers' social skills and cultural competence, and argue that their interventions have a real therapeutic value. These psychiatrists see their own role as specialists who work towards removing the symptoms of illness while healers can focus on its causes. It is stressed (MOLCHANOVA *et al.* 2008) that such traditional practitioners usually direct their patients to psychiatrists when they identify severe mental disturbances.

Noteworthy, the psychiatrists who try to develop, despite many obstacles, "community-based culturally sensitive mental healthcare services" in Kyrgyzstan (MOLCHANOVA 2014), recognise the importance of a good sociocultural expertise for their practice. They take into account, among others, traditional Kyrgyz family and clan relations, gender differences and prevailing attitudes towards people with mental disorders. They notice that "some patients with verbal hallucinations, might not only preserve their previous social status, but also acquire specific prestige in a Kyrgyz community as future-tellers (*kez-achyk*), shamans (*kuuchu*), and healers" (MOLCHANOVA 2014: 25).

In fact, first steps towards cooperation between psychiatrists and spiritual healers have already been done, with the aim to effectively help the victims of violence that occurred in 2010 during interethnic clashes in Osh. MOLCHANOVA *et al.* (2017: 8) claim: "We believe that psychiatry […] might greatly benefit from cooperation with traditional healing, and patients with stress-related disorders can receive help from a wise traditional healer." Medical professionals—psychiatrists and psychologists from multidisciplinary mobile teams created after the conflict, established cooperation with the local healers, whose help, as it was admitted, turned out to be more effective for patients than that of psychiatrists. The authors present and discuss several cases where *bubu*—a traditional female healer—helped young women suffering from various stress-related disorders that resulted from rape. From the psychiatrists' perspective, *bubu* could effectively help a victim of gender-based violence because such a healer "can operate in the same cognitive schema as his/her patient by mixing traditional rituals, prayer, and cognitive behavioural techniques, even while a healer is unaware of using them" (MOLCHANOVA *et al.* 2017: 4). Healers know well local cultural values, hierarchies in the extended family and clan, norms of proper behaviour of the man and woman, *etc*. It seems important that psychiatrists working in these settings recognised the high position of experienced, esteemed healers in their communities and tried to gain a thorough knowledge about the cultural background, local social conditions and the barriers to psychiatric services. Moreover, a good communication between psychiatrists and healers could help the former win the trust of the people, usually distrustful of mental health specialists.

It might be interesting to compare these developments with ALISHER LATYPOV's (2010) remarks on the possibility of partnership between psychiatrists and healers in Tajikistan, in the face of the deep crisis of Tajik psychiatry. He claims that the healers he talked with were eager to cooperate with psychiatrists, but in their words, most doctors did not appreciate such traditional methods. The statements of the psychiatrists, quoted by LATYPOV (2010: 439), while revealing the popularity of healers, at the same time clearly illustrate the hostility of the former towards the latter and efforts to strengthen the borders.

As regards Kyrgyzstan, supposedly the activities of the Aigine Cultural Research Centre in Bishkek gave a stimulus towards building closer connections between healers and medical practitioners, psychiatrists in particular. Since its foundation in 2004, The Aigine Centre has combined research with a cultural and educational mission, directed at preserving and reviving the Kyrgyz cultural heritage and "traditional wisdom." Within the frames of several projects researchers and practitioners—both biomedical and complementary—collaborated in order to investigate and assess the role of traditional healers as specialists dealing with health, family problems, social inadequacies of their patients, as well as providing them with spiritual assistance.[26] Participation in such projects undoubtedly helped psychiatrists and other medical professionals understand the importance and the reasons for tenacity of traditional healing. Moreover, a strong support that healers, as carriers of *kïrgïzchïlïk*, have received from several smaller organisations and associations involved in the revaluation of Kyrgyz culture might play a role.

Conclusion

Relations between biomedicine and different CAM disciplines in Kazakhstan and Kyrgyzstan may be analysed with the use of the concept of boundary work. This boundary work, understood as a dynamic process, has been shaped by political, economic and social changes following the collapse of the Soviet Union and emergence of independent Central Asian republics. During the 1990s both countries, similar to the other republics of the region, referred to the local cultural heritage in the need to legitimise the right to sovereignty. Together with a dramatic situation of post-Soviet healthcare systems, the revival of local cultural traditions contributed to the official acceptance and support for folk medicine, and CAM in general. Through the process of professionalisation, traditional healers could improve their position and work in public and private healthcare institutions.

The position of CAM specialties practised by medical doctors seems stable in Kazakhstan and Kyrgyzstan. They enjoy institutional support and have been included into educational systems of these countries. Although their knowledge bases sometimes clearly contradict biomedical knowledge, acquiring medical qualifications ensure those CAM practitioners acceptance. However, further studies could reveal if their position in biomedical institutions is equal to that of other doctors, or the boundaries are maintained.

Healers, in contrast, do not get an official backing anymore and their cooperation with doctors, formerly possible in such institutions as state-run centres of folk/traditional medicine, does not have much opportunity to develop. Changes in the official discourse and withdrawal of the support for folk medicine may be seen as boundary work, the efforts directed at separating what is perceived as scientific from methods of doubtful effectiveness, unconfirmed by scientific evidence. In this process not only epistemological, but also organisational boundaries between biomedicine and folk medicine are being enhanced (*cf*. SHUVAL & MIZRACHI 2004). The boundary work has been strengthened by those medical professionals who themselves practise CAM therapies, but strive to expose their scientific legitimacy. However, whereas the process of healers' professionalisation in Kyrgyzstan has been interrupted, in Kazakhstan it still proceeds, although under stricter conditions.

Actually, contemporary Kazakhstan and Kyrgyzstan do not require justification of their sovereignty through appeals to "tradition" and "heritage," and their governments strive to present these countries as modern and "enlightened." Therefore in the official discourse healers are more and more often presented as charlatans. In addition, since purist trends in Islam have increased in Central Asia in recent decades, traditional spiritual healing may gradually loose its strength as condemned by Muslim religion. It ought to be remembered, though, that healing is commonly accepted as part of local, everyday forms of Islam.

Despite the changes in the official approach and enhancing the boundaries, practical reasons for acceptance or at least tolerance for traditional healing have not disappeared. Healthcare reforms in Kyrgyzstan, although well advanced, still have not led to fully satisfactory results, and in Kazakhstan the situation of state healthcare system seems even worse. Healers' great popularity among the wide public, which is in part due to these circumstances and in part to sociocultural factors, cannot remain unnoticed. Hence, such practitioners are allowed to work on the market of medical services. It should be noted that the dominant critical official discourse on traditional healing is not entirely shared by biomedical professionals. A special case, which I described in more detail, is cooperation between psychiatrists and healers in Kyrgyzstan. However, the efficacy of the latter is especially valued in critical circumstances. In general, it may be argued that in today's Kazakhstan and Kyrgyzstan different modes of coexistence between biomedicine and CAM prevail, rather than the established cooperation.

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Notes

1 I put the word "traditional" in quotes since I recognise that healers' practices are highly hybridised, although they usually refer to local traditions. Having this in mind, for convenience I often omit quotation marks in the following text.
2 Part of this work involving research in Kyrgyzstan was supported by the Narodowe Centrum Nauki (National Science Centre, Poland), grant number N N 109 186440.
3 Lindquist added another type of legitimacy: "based on alterity," which appeals to "exotic" origins of CAM therapeutic methods. However, in my opinion it is rather a means of enhancing a healer's authority than a separate kind of legitimisation.
4 Another term proposed by medical anthropologists is "medicoscapes." It is mainly used in reference to the settings where transnational flows and globalisation processes are particularly strong (HÖRBST & WOLF 2014). For a more extensive discussion on medical pluralism and connected notions see HSU 2008, PENKALA-GAWĘCKA & RAJTAR 2016.
5 Among private biomedical institutions there are small clinics for less affluent people as well as big, modern medical centres which offer, for example, cosmetic surgery for well-off patients.
6 According to ASKAR JUMAGELDINOV (2016: 193) who studied Kazakh healers in Astana between 2013 and 2015, the term *baqsy* is rarely used today; healers are usually called *emshi*, and those who apply Quranic prayers—*täwip*. PELKMANS (2017: 152) notes that Kyrgyz healers avoid referring to themselves as *bakshi* mainly because they do not want to suggest that their powers "match those of the great *bakshis* of the past."
7 For similar observations on people's attitudes to healing as part of the local, everyday Islam in Uzbekistan, see RASANAYAGAM 2006, KEHL-BODROGI 2008.
8 However, for convenience, I use the acronym CAM throughout the text.
9 Such a "medical revivalism," closely associated with nationalism, was also observed in other countries, for example in India and Indonesia (LOCK & NICHTER 2002: 7–8).
10 As SOPHIE HOHMANN (2010) observed, similar strategies of "reconstruction of national identity" in Uzbekistan included, among others, the revival of traditional medicine based on Avicenna's (Ibn Sina) heritage.
11 Korean acupuncture was very popular in Almaty, especially its variant called *soo-jok* (*cf.* PENKALA-GAWĘCKA 2002).
12 Chinese acupuncture and manual therapy were included in the curriculum as early as the late 1980s.
13 They could be penalised, however inspectors usually tried to persuade them to apply for a license.
14 In SHARIPOVA's (2015: 326) words, "the primary source of help in Kazakhstan is not impartial state institutions but friends and relatives who occupy various positions in the state apparatus and public organizations."
15 These and other citations of NARBEKOV's statements are derived from the interview that I conducted with him in Bishkek in 2012.
16 Healers did not form a large group in comparison with physicians. As NARBEKOV claimed, the number of employed doctors, together with technical staff and administration, had reached over a thousand. However, I am not sure if these numbers were not exaggerated.
17 When I was doing research in Bishkek in 2012, the third reform programme Den Sooluk ("Health") had just started.
18 A number of products, NARBEKOV's inventions bearing such intriguing names as "Great Diplomat" or "Shambala," are available for patients of the Academy and other customers—some of them are quite expensive (http://anon.kg/shop/, accessed: 5.11.2017).
19 On the Academy website (http://anon.kg/, accessed: 5.11.2017), named "Meditsinskiy tsentr Akademika Narbekova O. N." ("The Academician O. N. Narbekov's Medical Centre"), there are advertisements of the products, outline of the Academy activities, photos of certificates, awards and diplomas, and videos.
20 This institution had taken a part of the building on rent from the government, as the heir of "Beyish." NARBEKOV maintained that the Academy invested a good part of its profits in restoration of the premises.
21 Nevertheless, I often heard, both in Kyrgyzstan and Kazakhstan, that "there are no authentic, strong healers anymore," especially shamans. People tended to be sceptical about the abilities of contemporary healers, but despite of this they often tried to find a reliable practitioner. PELKMANS (2017: 154) quotes similar statements about *bakshis* with "real power," whose performances his interlocutors had witnessed in the 1950s or 1960s.
22 There is also a rivalry between healers themselves, which was discussed by ILDIKÓ BELLÉR-HANN (2001) in her account of Uyghur healers in Almaty.
23 However, applying a whip was not forbidden—it could be used for expelling evil spirits.
24 SERGEY ABASHIN in his book *Sovetskiy kishlak* (2016: 444–51) thoroughly discusses an interesting case of crossing knowledge and practice boundaries on the example of a medical doctor, ex-director of the hospital in Oshoba, Tajikistan, whom he met in 2010. This doctor had had positive experiences as a patient of traditional healers and started practising non-biomedical treatment himself, mainly with the use of bio-energy.

25 On the other hand, they did not entirely condemn healers' practices and "admitted that among the charlatans and impostors were those with real powers" (Pelkmans 2017: 167).

26 http://www.aigine.kg/?lang=en (12.11.2017). The Aigine Centre issued several publications presenting the results of cooperative work and views of numerous researchers and practitioners.

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Paramedics in West Germany

Cooperations and Conflicts in a Contested Professional Field (1949–1990)

PIERRE PFÜTSCH

Abstract Cooperations are almost inconceivable without conflicts. For this reason, this contribution will analyse the mutual interweaving of cooperations and conflicts from a contemporary perspective. A concrete example is the situation of the rescue services in the Federal Republic of Germany. Considering the involvement of a variety of different players such as doctors, non-medical healthcare professions, charitable organisations and professional associations, conflicts are bound to occur. In addition, doctors and paramedics are in professions that are subject to different hierarchical levels, which is why positions of power must be taken into consideration in relation to conflicts and cooperations, alongside the methods of treatment. This contribution will analyse two different perspectives of cooperations and conflicts. On the one hand, the aim is to clarify that conflicts can occur within cooperative working methods. On the other hand, it will demonstrate that cooperations can result from conflicts and that they can be seen as a type of innovation motor. Both developments occur on the micro level, i. e. in the concrete conflict between doctors and paramedics. However, they can additionally influence the supply structures on the macro level as well. This will be exemplified by the conflicts regarding the professional law for paramedics. In concrete terms, the focus of previous discussions was usually centred on the question of which tasks should be taken over by the paramedics and which tasks should remain exclusive to the doctors. Due to the difficult situation of sources, the analysis shall be based primarily on normative sources. Readers' letters shall at least indirectly offer the perspectives of concrete participants.

Keywords paramedics – rescue system – emergency service – professionalization – cooperation – Germany

Introduction

In today's society, cooperations seem to be increasingly growing in importance, whether in the field of major international politics, in business or in the field of medical science. Cooperations primarily expect that two or more people or parties work together, thus causing an improvement in the result of the work. The same rule applies to medical cooperations. The cooperations between different parties in the medical field are intended to improve the treatment of the patient. At first glance, this seems sensible and not problematic. However, should one think in somewhat more detail about both past and present cooperations, it quickly becomes clear that a frictionless procedure only occurs in rare cases. A majority of cooperations always seem to have been accompanied by conflicts of both greater and smaller magnitudes. For this reason, a concrete examination of cooperations must always include conflicts.

This means that cooperations have only rarely been free from conflicts. This applies particularly when different medical schools are involved. For example, we can consider the "quack debate" (*Kurpfuscherdebatte*) from the end of the 19th century. In 1939, this debate led to an end of the freedom to practice through the Non-Medical Practitioners Act (*Heilpraktikergesetz*). (Herold-Schmidt 1997: 43–95) However, all kinds of conflict can occur within a "school" or "direction," in which there is general consensus on the basic issues of healing. For instance, one could consider the different viewpoints of surgeons and internists with regard to the question of whether conventional therapy or an operation should be performed. Disputes such as these gain an additional dimension with players who are located on different hierarchical levels. In addition to the different methods of treatment, positions of power within a profession are given special treatment here.

Paramedics and emergency doctors will form the core of the following examination, since they fittingly represent such a constellation based on a differing hierarchy. In Germany, paramedics are often the first people involved in the medical system that patients see in a case of emergency. For this reason, their actions are decisive for the further health of the patient. Apart from the profound relevance of their actions, the paramedics and their fight for a regulated profession are also of interest from a contemporary point of view. In the Federal Republic of Germany, the discussions about the role of non-medical treatment staff started at the beginning of the 1960s and lasted until 1989, when the so-called "Rescue Assistant Profession Act" (*Gesetz über den Beruf der Rettungsassistentin und des Rettungsassistenten – RettAssG*) was passed. Thus, there were almost thirty years of internal quarrels on the activities of the paramedic staff. At the heart of the negotiation processes of the rescue service was frequently the question of how exactly the cooperation between paramedics and emergency doctors should be organised and, consequently, the question of who is to assume which tasks within the rescue process.

Research and source situation

Whilst the history of doctors has been relatively well researched, the same can not be said for the history of non-medical professions. A small exception is nursing, whose historical development has been well researched in recent years, at least for the 20th century. However, therapists, assistants and other skilled healthcare professions have been dealt with a lot less frequently in historical research. Therefore, even research into the modern emergency services in Germany still contains major gaps. Only a short overview essay exists for the situation in the GDR.[1] For West Germany in the period after 1945, there is only the regional study by Andrea Prauße-Stangel on the creation and development of emergency doctor services in North Rhine-Westphalia[2] and a few technical pieces on patient transport, such as that by Holger Frerichs[3]. In addition, the thorough study by Nils Kessel on the history of emergency services in Germany between 1945 to 1990 should be mentioned.[4] In brief terms, Kessel records the general development of the rescue services in the Federal Republic and occasionally refers to the cooperations and conflicts involved. However, paramedics are not at the heart of his research. The rare preoccupation of historians with the emergency services in the Federal Republic of Germany is surprising, considering the potential of this field of research. However, it can also be partially explained with the difficult source situation. For example, there is scarcely any data on the emergency services in the Federal Republic of Germany, as no documents were kept at all for a very long period. Commonly, normative sources such as laws must be used, as the paramedics themselves or their professional associations kept or archived barely any written sources.

In consequence of the problematic source situation, the analysis of the normative side will hereafter primarily resort to statutory law as well as released and unreleased statements of the parties involved. However, it is essential not to display the normative and legislative context exclusively, but rather factor in the level of specific practices of negotiation. In order to comprehend the interconnection between conflict and cooperation on both the micro and macro level, ego-documents must be regarded as well. Finding letters, diaries or autobiographies dealing with conflicts between doctors and paramedics is nearly impossible to begin with. On the one hand, this may be due to the fact that this category of sources is hard to access in general. On the other hand, it can be attributed to the lack of importance usually ascribed to these kinds of conflict. Hence, they do not provide a sufficient reason to be written down. As a consequence, it is primarily readers' letters to trade journals that will be considered as ego-documents here, since they have been composed as reactions to professional articles covering the subject discussed and, therefore, do provide a specific reason for writing.

They may belong to the field of ego-documents, but their ability to make statements is considerably less than other testaments, such as diaries or private letters. Published readers' letters are not unproblematic as a source material. Furthermore, the editorial staff will always select an assortment of letters suited for publication out of all the correspondence they receive. This way, they are able to control the depiction of the state of facts concerning certain subjects. Therefore, even though there may be a great number of readers' letters dealing with the same specific subject printed in one periodical, it doesn't necessarily imply an extensive significance of the subject in a public discourse. Initially, all it amounts to is the editorial staff choosing those specific letters for publication.

Consequently, it is necessary to be aware of these possible constructions and filters when dealing with letters to newspapers. Despite those limitations, readers' letters can present a prolific source for historic research, since they allow for direct insights into the emotional state of private individuals, which would otherwise elude historians. Thus, letters to newspapers can demonstrate which topics were popular at the time, which people were involved as authors and how a periodical positioned itself to the feedback from its readers. The letters utilized here all emanate from the periodical *Rettungsdienst. Fachzeitschrift für Rettungssanitäter und Notärzte*. It was the only specialist periodical for emergency services that printed letters from readers in the first place. Based on the set of problems described earlier, it does not seem reasonable to quantify the letters as empirical material because the results would not be able to clearly measure the relevance of the subject. Instead the letters in question should be understood as a qualitative source that allows to gain insight into the negotiation of situations of conflict between paramedics and doctors on the micro level.

Conflicts and cooperations as analytical categories

Conflicts constitute an omnipresent part of everyday life and are thereby a pivotal element of our social coexistence. Ever since the 1960s, the field of peace and conflict studies evolved into an interdisciplinary line of research, which analyses conflicts on various levels. It is particularly frequently represented in political science, which prevalently examines international conflicts between countries that may even lead to war. Moreover, conflict research has established itself as an important subdiscipline of sociology, which facilitated a more distinct theorization of the term conflict as a concept. However, there will be no attempt to formulate an expansive definition of the term conflict at this point, since any such endeavour would be bound to fail due to its plethora of meaning and its vast variety of manifestations. It seems important, however, to at least agree upon one basic understanding. As a general rule, conflicts can be classified as social states of affairs that involve at least two parties and can be ascribed to differences in their social standing and/or a differing set of interests of the conflicting parties. (BONACKER & IMBUSCH 1999: 75) This concerns both the participants as well as the motives behind the conflicts. The cause of conflict can usually be attributed to the distribution of scarce resources or is often a matter of prestige (PELINKA 2016: 18). Regarding the conflicts about authority between paramedics and doctors in the field of emergency services, it becomes apparent just how interwoven these two causes of conflict sometimes turn out to be. Even though both paramedics and doctors aim to attain recognition and prestige in the field of medicine, this is inextricably linked with questions of how to distribute duties and work activities between the two parties. For instance, if duties initially assigned to doctors were to be transferred to the paramedics, these circumstances could consequently lead to a decline of doctors actively working in the field of emergency medical services. Thus, certain resources such as work and finances would have to be distributed in another way. As this example distinctly illustrates, situations of conflict are inevitably connected to questions of power. Power is a pivotal component of conflicts, since conflicts lead to power on the one hand, but beyond that power also implicates more conflict (PELINKA 2016: 20). Depending on one's point of view, conflicts can be interpreted as either conditions or processes (IDE 2017: 9). In the case at hand, the conflicts between paramedics and doctors are regarded as processes because it is most notably the development and the consequent result that is of interest. In order to differentiate the conflicts in question, it seems reasonable to categorize them. Thus, conflict research distinguishes between consensual and dissensual conflicts, between constructive and destructive conflicts and, finally, between symmetric and asymmetric conflicts (PELINKA 2016: 77–79). Particularly the latter distinction appears significant for the analysis of conflicts in the field of medicine. The differentiation between symmetric and asymmetric conflicts is predicated upon strength or rather equality between the opposing parties and, therefore, includes the inherent balance of power between them. The power relations between doctors as prestigious professionals, that stand out due to their own professional association, professional standards, autonomy and academic training on the one hand, and other non-medical health professions such as nurses, alternative practitioners, physiotherapists or midwifes on the other, were and still are strongly asymmetric. None of the other professional groups within the field of medicine even remotely achieve the status attributed to doctors. Especially paramedics, whose occupation was mostly still a voluntary one in the 1960s and who, therefore, were not able to accomplish any of the traits of a normal profession, were facing the doctors in a heavily asymmetric conflict. In spite of this asymmetry, the paramedics within this conflict succeeded in getting some changes for their own benefit under way. The transition manifests itself not least because of a cooperative collaboration between the parties in conflict. As a consequence, Bonacker and Imbusch rightly point out that the elements of cooperation and conflict within most conflicts appear to be interrelated to a varying extent (BONACKER & IMBUSCH 1999: 76). The amount of potential elements of cooperation does not least derive from the nature of the conflict. Whereas so-called zero-sum games highly restrict the possibilities of cooperation due to the fact that the losses of one party equate to the victory of the "opposing" party, the nature of cooperation games is inherently different. The possibilities of cooperation are considerably larger here, because a cooperation can amount to an overall profit for both conflicting parties (BONACKER & IMBUSCH 1999: 76). While cooperation is not considered a part of the classic analytical approach within the field of conflict research yet, it is steadily increasing its importance in recent years. The term cooperation is usually understood as the coordinated bargaining of at least two parties. These bargains aim to realise common interests (IDE 2017: 11). The interconnection between conflicts and cooperations results from the mutual cause of conflict that links the opposing parties to each other. In doing so, two possible types of interconnection emerge and can be found in the case study at hand. Conflicts can arise from a cooperation on the one hand, and cooperations can originate from conflicts on the other and, therefore, can present a potential solution for situations of conflict. However, the extent to which this possibility is applicable is inextricably connected to the cause of conflict.

Epistemological interests and procedures

The following essay will look into the interweaving of cooperations and conflicts in more detail. It aims to demonstrate how inseparable the term cooperation can be from the term conflict and that it can be highly productive to put a finer point to the observation of the mutual interweaving.

In order to do so, two perspectives of cooperations and conflicts should be presented and analysed in greater depth. Firstly, it is important to clarify how cooperations can be marked by conflicts. Which conflicts resulted from cooperations and how were they handled? In many cases, the normal, known and comprehensible interplay of conflicts and cooperations is at the root of the issue. However, just as interesting is a change in perspective, which is to be tackled in a second step. The aim is to show that not only can cooperations lead to conflicts, but conflicts can just as easily lead to cooperations. This scenario does not necessarily limit itself to the micro level. To a greater degree, such processes can also influence the supply structures on the macro level. Hence, this essay would argue that conflicts can represent a type of innovation motor for cooperations. However, before these two perspectives are indicated using the example of the rescue service in the Federal Republic of Germany, there will be a brief introduction to the history of the emergency services in the Federal Republic of Germany, in order to explain the contemporary situation and problems.

Development of the rescue service in the Federal Republic of Germany

For a long period of time, the rescue service was solely charged with moving the patient or injured person to medical aid and not with providing medical aid to the patient. This was also connected to the self-image of the doctors at that time. For this reason, the focus of the rescue service was initially only on the rapid transportation of the patient. From the point of view of the experts, personnel with special medical training was not considered a necessity, although a basic knowledge to ensure a patient's capacity for transport was indeed required. This notion remained fundamental until the end of the 1950s. This decade saw many changes which, as a consequence, also made an impact on the rescue service. On the one hand, the rapid motorisation of road traffic in and out of towns caused the number of accidents to expand sharply. Therefore, the significance of the rescue service grew considerably during this period. On the other hand, the medical developments of this period marked by a "can-do" euphoria, also registered further significant progress: At the beginning of the 1950s, the medical experiences gained from the Second World War were used to develop shock therapy with infusions and blood transfusions. This meant that it was possible to fight hypovolaemic shock, which occurred after a large loss of blood, at an early stage. The end of the 1950s entailed new knowledge in the pathophysiology of sudden death. This knowledge went hand in hand with the rediscovery of old reanimation techniques, whose use were now proven by scientific investigations: Resuscitation and external heart massage thus prevailed as primary treatment methods in case of circulatory arrest (KESSEL 2008: 63).[5]

These new forms of treatment made time an ever more important factor in the rescue process. This meant that it was possible to help even more people, provided that medical treatment was provided in good time. However, the German rescue service was facing some major problems. Even though it was possible to improve transport continuously, natural limits were reached quickly here. Due to the rising number of accidents, this issue also became increasingly present in the public consciousness. The media soon declared a state of emergency among German rescue services.[6] The rescue service was considered in need of drastic improvement and thus reform. Ever since the turn of the century, the option of performing medical treatment directly at the location of an accident had occasionally been discussed. This idea was taken up again in the 1960s, since it was the best option for saving time during the rescue process. There may have been individual pockets of resistance against this fundamental reorientation, but slowly the so-called "Stay and Play" principle managed to exceed the "Load and Go" principle (NÖSSLER 2012). The initiative of some experts meant that, in the mid-1960s, there was a slow reorganisation of the rescue service throughout the field of medicine. The medical historian Nils Kessel refers to this process a "Doctoring of the rescue service," meaning "a redefinition of the primitive, extra-clinical care by laymen with subsequent transport to a junior medical activity organised under a medical premise" (KESSEL 2008: 74).[7] Thus, according to Kessel, "the acceptance of a definatory power and the formation of a hierarchy with regard to non-academic junior personnel" (KESSEL 2008: 75) is included. As a result of this process, the rescue service was transformed into an area of medical care.

Conflicts in cooperations

In 1964, the initiative of Eberhard Gögler, the consultant of the Chirurgische Universitätsklinik Heidelberg, created the so-called Rendezvous System, which slowly took hold of the rescue service throughout Germany (KESSEL 2008: 70). This system expected that doctors and paramedics travelled to the emergency location separately and would then collaborate as required. Three years prior to this, in 1961, the doctor Friedrich Wilhelm Ahnefeld developed the so-called emergency chain, which gave a basic structure to the tasks and measures to be performed in an emergency. Furthermore, it created a plan of task allocation whilst taking into account which medical professional would be expected to perform certain tasks under specific circumstances. Providing the optimum manner of help to the patient was considered the utmost priority (KESSEL 2008: 70).[8] The rescue service thus became a field of work in which medical and non-medical staff should or had to work together.

Within this cooperative working model a variety of conflicts occurred, which can be traced back to a number of very different reasons. However, the different forms of training, knowledge and thus also the different hierarchy levels of doctor and paramedic frequently played a central role. The issue of the differing hierarchical levels was portrayed as becoming particularly problematic in the periodical *Rettungsdienst. Fachzeitschrift für Rettungssanitäter und Notärzte,* as shown from the perspective of the paramedics:

> Or you, dear GP—do you feel embarrassed when the ambulance with the red stripes drives ahead and the "professionals" with their emergency cases, ECG and other equipment race into a flat? Are you ready to work together with "them" without emphasising your "Dr" in each sentence and defending the "Alpha animal" in you and towards your clientele? (FERTIG & LANDSLEITNER 1988: 729)[9]

As seen in the preceding example, it was common that conflicts broke out due to the basic difference in perception of the other. For obvious reasons, the opposing perspective was not discussed here. Therefore, it was clear that paramedics did not accept the superior position of the doctor, which inherently was bound to lead to disagreements. Remarkably enough, the description of such behaviour does not originate from a doctor but rather a paramedic as well. Based on his previous six years of work experience, paramedic Ulrich Beinke wrote a letter on the misconduct of several paramedics who make themselves out to be more important than they actually are, solely based on their uniform and despite their lack of a professional background. According to Beinke, this behaviour can be ascribed to profile neuroses that occur for many paramedics due to a lack of prestige attributed to emergency medical services (BEINKE 1988: 36).

In a letter dating to 1986, The volunteer paramedic Klaus Wachsmuth reported that doctors switched to medical jargon on purpose in order to show their superiority to the paramedics: "Unfairly, jargon was then written on the admission form, as had been the case in the 1920s, so that the 'stupid paramedic' was unable to understand the situation […]" (WACHSMUTH 1986: 485).[10] This statement shows that in the eyes of the paramedics, the communicative behaviour of the approbated doctors was arrogant and made no contribution to a cooperative work process.

Nevertheless, doctors also made use of the opportunity to send letters to the periodical *Rettungsdienst* in order to present their way of looking at things. The doctors often criticised inappropriate technical behaviour on the part of the paramedics and pointed out their unwillingness to accept said behaviour. As shown in the following excerpt, a doctor's son offered an example for the behaviour of a paramedic in his letter:

> My father (a GP with over 40 years of professional experience) is called out to an elderly patient on a Sunday morning as part of the standby service, who is complaining about pain in the lower part of her body. After an introductory examination, the diagnosis "appendicitis" is given and a KTW (patient transport vehicle) is requested, which arrives soon after. The paramedics and ambulance staff (maximum age 21 or 25 years) storm into the flat and the following discussion unfolds:
>
> Doctor: Good morning gentlemen. This lady must immediately be transported to the surgery unit of XY hospital. I have spoken with the doctor on duty, a bed is free, here is the acceptance and the transport document.
>
> Paramedic: (After a brief glance at the acceptance) So, appendix. So, we've got to carry the old hag. Can we put the alarm on?
>
> Doctor: I do not see any need for that. I require careful but speedy transport of the patient.
>
> Paramedic: Doctor, are you sure of your diagnosis? I mean if something bursts … (paramedic means a perforation of the appendix).
>
> Doctor: (Annoyed) Young man, have I been the GP of this lady and have looked after her for more than 20 years or have YOU?
>
> This is where the argument ended. The lady is loaded into the ambulance in a grudging and disinterested manner and transported. (SCHMIDT 1986: 485 f.)[11]

Even if this example has been constructed and exaggerated, it still manages to illustrate the problems. From the doctors' point of view, the medical knowledge of the paramedics was insufficient and this is why they were not regarded as medical colleagues of equal rank, which, in turn, led to conflicts within the required cooperation. A similar example has been described by the doctor Rüdiger Katterwe. He explained a case of mistreatment regarding an 81-year-old female patient on account of a paramedic that nearly led to the death of said patient. According to Rüdiger Katterwe, the situation would have been unproblematic if the paramedic in charge had solely done the procedures he was authorized to do. Katterwe continues that any treatments extending beyond those authorized procedures, however, must be reserved for professionally trained individuals (KATTERWE 1988: 118). It is not possible to determine from the sources how often this type of conflict occurred. However, the frequency of the printed letters on conflicts between paramedics and doctors allows one to draw the conclusion that it was not an individual case.

The conflicts depicted could lead to a disruption of the cooperation between doctors and non-medical professions and consequently cause a negative impact on the work result.

Cooperations as an option for solving conflicts

As previously mentioned above, conflicts could not only occur within cooperations. Moreover, conflicts could also form the starting point for cooperations and thus be the motor for change. As indicated in the preceding letters, the conflicts between the doctors and non-medical staff in the emergency services frequently dealt with the level of expertise and thus the competence of the paramedics. With the changed perception of the function of the rescue service and its transition into a medical field, the 1960s saw an increase in public discussion about the technical training of the rescue service personnel. Said discussion soon took on concrete terms with regard to the creation of a law that regulated the paramedic profession. The first demands for this could be traced back to the late 1960s. Before then, the "training" of the emergency response staff was limited to a standard first aid course of eight double units, which was followed by a further training course of twelve double units. Thus, the medical knowledge of the responders was equal to the knowledge anyone could pick up within two weeks. As mentioned above, the discussions on this subject carried on until 1989, the year in which the Rescue Assistant Profession Act was passed. Apart from financial matters, the focus of the lengthy discussions was the question of which activities could be carried out by the paramedics and which were to remain exclusive to the doctors. The parties involved had different ideas, which led to myriad conflicts between them. However, it was not just doctors and paramedics that were involved in the discussions and, consequently, the conflicts. Additional parties such as charitable organisations were factored into the discussion as well. The following section will present the positions of the central parties in more detail.

Paramedics

One of the most important parties within these disputes consisted of the paramedics, whose positions must be differentiated between full-time and part-time workers, as they were diametrically opposed in certain issues. Until the early 1960s, the rescue service in Germany was primarily staffed by volunteer employees of the charitable organisations. These employees were primarily responsible for the rapid transport of the patients to hospital. As sketched earlier on, the changes to the rescue service into a field of medical activity also caused the requirements placed on the non-medical personnel to change. In particular, the full-time paramedics wanted to improve their training, as that was also connected to the hope of expanding their own competences and, in consequence, an increased social standing for this profession. At the beginning of this transformation process, the voices of the full-time paramedics were rare in the political discussion arena and could barely be heard. This changed in the late 1970s, when a professionalisation of the full-time rescue service personnel occurred. In 1978, Ludgar Kossendey and Ludwig Stumpf, two employees in the rescue service, created the periodical *Der Rettungssanitäter*. This periodical was primarily intended for the full-time paramedics and provided information on developments in their profession. Hence, the periodical can be regarded as a first "connecting element" between the full-time paramedics. In the mid-1980s, the periodical was retitled *Rettungsdienst. Fachzeitschrift für Rettungssanitäter und Notärzte*, in order to reach an even larger circle of readers. Moreover, the first teaching manual for paramedics was created in this period as well, which brought order and revision to the knowledge required for the paramedic profession. Probably the most important step in the professionalisation process was the establishment of the first professional association for full-time paramedics. The *Berufsverband der Rettungssanitäter e. V.* (*BVRS*) was founded in 1979. Its primary objective was to make progress with regard to the calls for occupational profiles for paramedics. In the same year, the first "Federal Congress for Paramedics" took place in Dormagen. The event was brought to life by the new professional association, whose aim was to bring together paramedics from all over Germany and to align them to a single line. In their totality, these professionalisation processes caused the full-time paramedics and their demands for a standard occupational profile across the whole of Germany to be better perceived and also recognised amongst the public. In concrete terms, they demanded the official recognition of paramedics as a legally-recognised profession based on training and examination regulations in order to efficiently control access to this profession. In the context of the disputes connected with these aims, the full-time paramedics also strove for an expansion of their tasks and competences. Some examples for the skills they included were intubations, injections and infusions.

By contrast, the voluntary rescue service personnel took an extremely critical stance against the demands of their full-time colleagues, because for them, each increase in the training requirements meant an ever-higher hurdle in performing their voluntary work. And there was scarcely any voluntary worker who had the opportunity to invest a lot of time in training or was prepared to do so for other reasons. There were certainly workers who embraced an opportunity for further training. However, these training units should be low-level and not particularly time-intensive. After the Rescue Assistant Profession Act was passed in 1989, the volunteer Gerold Hoopman wrote in a letter:

> Should volunteers now only be allowed to fill out forms or operate the steering wheel? What about disaster protection, ambulance services and all the social services which we provide on a daily basis? What use are training courses and instructions to us if we now no longer are given the opportunity to gain practical experience and to use this knowledge? […] How often is it that we are the only people who make a bigger impact through our presence than some expensive drug. A law has been passed. We are forced to meet challenging requirements. Not that we do not want to pass the course. On the contrary!!! But when? Thirty days of holiday, maybe sabbatical leave. And what about the family? What about the voluntary activities which must be tackled? In many charities, burn-out of the volunteers is inevitable and gets closer day by day. (HOOPMANN 1989: 752 f.)[12]

Two developments linked to the law are criticised in this excerpt. The first development outlines the devaluation of volunteer workers through restriction to tasks for which no further training is required and that are therefore degraded to supplementary tasks. And secondly, assuming that volunteer workers tried to complete the training course, another consequence would be an inevitable burn-out in these people.

Charities

A further key player in these disputes are the charities, including the German Red Cross (*Deutsches Rotes Kreuz*), St John's Ambulance (*Johanniter Unfallhilfe*), the Maltese Cross (*Malteser Hilfsdienst*) and the Workers' Samaritan Foundation (*Arbeiter-Samariter-Bund*). They were and still are responsible for a large proportion of the work ascribed to the rescue service in Germany and are thus the largest employers of paramedics. Even if the individual organisations and their views on the claims of the full-time paramedics differ in some areas, it can overall be seen that they were rather sceptical of the professionalisation attempts by paramedics. As a result, they prevented the passing of a rescue service act for a long time. The reasons for this were predominantly of a financial nature. The rescue services in Germany are primarily financed by the social insurance companies as well as funds from the federal states. Even into the 1970s, the rescue service was primarily staffed by volunteer helpers and untrained, full-time paramedics, so the personnel costs for the charities were very low. The charities saw two dangers in the possible introduction of a legally-controlled occupational profile: On the one hand, they feared a slow reduction of volunteer workers, who could no longer fulfil the new training directives. This departure would have to be compensated through the employment of new, more cost-intensive full-time personnel. Moreover, even in the early 1970s volunteers were still the central component of the personnel structure. In the Workers' Samaritan Foundation in 1971 for instance, 96 percent of the people employed in the rescue service were volunteers, while in the German Red Cross it was still as many as 80 percent (HAHN 1994: 45). On the other hand, the charities feared that the possible increase in the training level of the full-time paramedics would cause an eventual demand for higher wages. This is why the charities were always intent on keeping up voluntary work as a pivotal pillar of emergency medical services (MALTESER HILFSDIENST 1990). Since they didn't consider these developments to be financially viable, they remained critical of the creation of an occupational profile at a federal level for a long time. For example, even in 1986 the St John's Ambulance questioned the training period of two years, which they considerd too long. They expressed this opinion in comments on a planned law for the paramedic profession:

> However, independently of this, the question must (again) be asked as to how far the medical necessity for intensive training over a period of two years is even given. The (apparent) inadequacy of the currently practised 520-hour minimum training has, in the opinion of the St John's Ambulance, never been reliably and seriously proven. (JOHANNITER UNFALLHILFE 1986)[13]

This only changed successively from the mid-1980s. Social developments and the fact that the rescue service was maintained 24 hours a day, seven days a week, had led to an increasing necessity for the employment of full-time personnel anyway. Additionally, volunteers slowly started to withdraw from the rescue service. This meant that the cost increases expected with an occupational profile were far less radical than a decade earlier. From then on, the charities worked to create a law for the profession of the paramedic. By doing so, they answered the contentual question concerning the expansions in competence required of the paramedics.

Doctors

Doctors were also important players. On the macro level, the German Medical Association (*Bundesärztekammer*) represented the doctors both institutionally and organisationally in the discussions on the rescue service. Other representatives were the *Bundesvereinigung der Arbeitsgemeinschaften der Notärzte Deutschlands* (*BAND*) and the *Deutsche Interdisziplinäre Vereinigung für Intensivmedizin* (*DIVI*). The latter was founded in 1977 as an umbrella association of anaesthetists, internists and paediatricians. Even as early as 1980, they founded a section which dealt especially with the rescue service (LAWIN & OPDERBECKE 1999: 560 ff.). These organisations observed the attempts of paramedics to expand the competence of non-medical rescue service personnel and were also critical of them. Although one would initially expect that doctors would position themselves against the professionalisation attempts of the paramedics, this was not the case. In the public debate, both the German Medical Association and the other organisations argued for a legally-regulated occupational profile of the paramedics, because they were of the opinion that it was the only way to guarantee a high quality rescue service. In the discussions on the political level, it was the German Medical Association in particular that argued for a clear distinction between the tasks of doctors and those of paramedics. In a statement by the German Medical Association during the 1975 German Medical Assembly they said:

> Although the occupational profile of the paramedic belongs to the non-medical professions, *it must be assumed that in order to be able to handle their later task to the fullest extent, the paramedic must, during their training, learn such life-saving immediate measures that would commonly be ascribed to the scope of duties of the doctor. This includes injections, infusions and intubations, which they should have mastered fully. […]* The quality standard for training to become a paramedic must therefore be so high that the paramedic is, at all times, able to perform life-saving immediate measures such as injections, infusions and intubations. *However, the indication to do this must always remain in the sphere of responsibility of the doctor.* [Emphasis in the original] (BUNDESÄRZTEKAMMER 1975)[14]

The German Medical Association was not trying to prevent the professionalisation of the full-time rescue service staff but was saying that it should happen within clear limits and only up to a certain point. This can also be seen in the fact that, since the beginning of the 1970s, the German Medical Association was calling for the occupational term "Rettungsassistent" (rescue assistant). By using this title, the hierarchical position in comparison to the doctor could be derived semantically. With regard to the question of the competences of the paramedics, the German Medical Association demanded that the paramedics should master the execution of injections, intubations and infusions perfectly. However, they also were of the opinion that the indication for this and thus the responsibility for the execution of such activities must remain with the doctor. For the first time, there was at least the suggestion of a cooperation to solve the problem and this was brought forward for discussion. Doctors were keen to develop a pragmatic cooperation model, which should nevertheless still be subject to a certain amount of control. When discussing the draft of a paramedic law, a representative of the German Medical Association stated:

> *Mr Jachertz* emphasised that the German Medical Association saw a basic need for delimitation in the tasks of doctors and paramedics. However, this delimitation should be performed pragmatically to avoid cementation. Therefore, he welcomed that the draft took the appropriate development in the medical field into account. In this specific case, it was additionally necessary to keep an eye on the intended team work between the doctor and the paramedic. [Emphasis in the original] (NIEDERSCHRIFT 1972)[15]

Cooperations as a potential solution

With regard to the conflict surrounding the question of competencies required by full-time paramedics, the opinions of the above parties were so different in nature that it was not possible to agree on a joint course of action for a long time. It was not until 1989, and thus almost 30 years since the first discussions about the competencies of the non-medical rescue service personnel started, that a solution was created through the Rescue Assistant Profession Act. The law implemented the occupational profile demanded by the paramedics for a long time, although it did not automatically fulfil the desired demand for an expansion of competencies. The question as to which tasks the paramedics were permitted to undertake and which they were not was not included in the law. It was only this compromise that made it possible to create the law after almost 30 years.

However, the fact that in the negotiations, the term “Rescue Assistant” prevailed over the title of “Paramedic,” clarified that the government wished for a continued and clear hierarchy between doctors and non-medical rescue service staff. In addition, the law indicated that the term rescue assistant merely referred to an “assistant to the doctor” (RETTUNGSASSISTENTENGESETZ 1989), hereby clearly distinguishing the positions of doctor and rescue assistant. In the Non-Medical Practitioners Act, which defines the delimitation of medical and non-medical in Germany, it says: “(1) Anyone wishing to practice medicine without being a doctor shall require the permission to do so” (HEILPRAKTIKERGESETZ 1939). Medicine shall be understood as “any professionally or commercially practised activity for the determination, healing or mitigation of illnesses, suffering or physical damage of people” (HEILPRAKTIKERGESETZ 1939). The paramedic should thus only perform tasks which support the doctor in these activities. However, there is no specification of how support differs from the work of the doctor. It was particularly this ambiguity in the formulation of the law that was supposed to contribute to the cooperation between the two parties. Thus, the paramedic should follow the instructions of the emergency doctor. In turn, the doctor should delegate tasks to the rescue assistant. This form of cooperation usually proceeded without issues, providing that an emergency doctor was present. However, frequently this was not the case. Since the before mentioned Rendezvous System in the German rescue service expects that paramedics and the emergency doctor travel to the scene of an accident separately and, in many cases, no emergency doctor is sent to the location to begin with, the paramedic on site was often alone. In these cases, the *modus vivendi* took hold that the paramedic should exchange information with the medical head in the emergency HQ through close radio contact. If necessary, they should receive the permission to perform specific measures from them. However, this cooperation model may sound good in theory but it actually contained a range of pitfalls. Consequently, it was possible that radio contact failed or could not even be set up, particularly in rural regions. Alternatively, the emergency situation required immediate action, leaving no time for agreements between the paramedics and the doctor. In these cases, the rescue assistant could take specific measures in the context of so-called emergency competence, which were only permitted to the emergency doctor but which could save the life of the patients. However, this action was highly problematic, because it frequently occurred under unclear legal conditions. This is due to the fact that the emergency competence, from a legal point of view, represented an individual decision, so theoretically the legality of its application had to be reviewed frequently. In order to prevent this problem to a certain extent, the German Medical Association presented recommendations for emergency competence in 1992. These recommendations aimed to specify certain regulations. In a first step, they described the status of the emergency situation and then named the activities which the paramedic could perform in an emergency if no doctor was present. These procedures included, for example, intubation without relaxants, venepuncture, the application of crystalloid infusions, the application of selected medication and early defibrillation. (BUNDESÄRZTEKAMMER 1992) Acting in the sense of emergency competence was subject to the principle of relativity. That meant that the method with the least intervention but with the highest prospect of success should be applied. For instance, if breathing with a ventilation bag is rendered effective, then intubation with its greater risks is not permissible, because it is no longer relative (BUNDESÄRZTEKAMMER 1992). However, the recommendations of the German Medical Association have not been updated since 2003.

In the mid-1990s, the continuing technologization, specialisation and further development of medicine reopened questions in public debate as to whether the training of rescue assistants was sufficient for the requirements of a modern rescue service. This was followed again by long disputes, which ended in 2014 with the passing of the “Law on the Profession of an Emergency Paramedic (*Gesetz über den Beruf der Notfallsanitäterin und des Notfallsanitäters – NotSanG*)”. *NotSanG* may have been based on the Rescue Assistant Profession Act, but it also brought some new items. Firstly, the length of the training period for the new profession of the emergency paramedic was increased from two to three years, meaning that the abilities and skills of the employees were bound to be improved. Furthermore, there were changes with regard to the question of the responsibilities and the cooperation required between the participating parties. The wording of the act removed the previous designation of the paramedic as an “assistant to the doctor,” adding a distinction of the tasks into “autonomous execution” and “team-orientated cooperation” (NOTFALLSANITÄTERGESETZ 2014). As a consequence, the authorisation for interdisciplinary cooperation was particularly emphasised as an independent training objective. On the one hand, this takes account of the developments in the profession, which were characterised by an increasing division of labour, differentiation of the activities and specialisation (DIELMANN & MALOTTKE 2017: 133). On the other hand, it also reflects the high significance of the cooperation concept in the present day, which is suggested by the use of the phrase “team”. In linguistic terms, this change expresses that the title of ‘Assistent’ was given up in favour of ‘*Sanitäter*’. Therefore, it was no longer possible to discern a direct relationship between doctors and non-medical personnel. A glimpse into the periodicals reveals that these results are predicated on long-term developments and previously discussed ideas. One article in the journal *Leben Retten,* dating back to 1990, already formulated the concept of team work and cooperation as an ideal condition for collaboration. This idea is based on the Rescue Assistant Profession Act:

> If the paramedic gives a diagnosis deviating from the assessment of the emergency doctor or thinks a differing procedure to be more appropriate, it complies with good team spirit to collectively discuss the line of action in an a discrete and concise manner. The emergency doctor, however, holds the right to make the final decision. (UFER 1990: 75)[16]

Summary

Starting with the increasing significance of teamwork and cooperation over the last 20 years, this essay prompted questions about the interweaving of cooperations and conflicts in the rescue service in Germany. Ever since the start of discussions on the rescue service in Germany in the mid-1960s, the distribution of tasks and cooperation between doctors and assistance personnel have frequently been at the centre of attention. The beginning professionalisation of the full-time paramedics and the resulting demands made by them for an expansion of their competencies were a major factor in the formation of conflicts with the doctors, who saw their superiority in the field of emergency medicine as threatened. Moreover, conflicts within the cooperation were also created by the differing perceptions of the other parties. In this field, which was full of conflict and dealt with the question of the competencies of the paramedics, a form of cooperation was implemented as a solution. Cooperations can therefore not only lead to conflicts, they can also be solutions to conflicts. By implication, co-operations are inextricably connected to conflicts. Additionally, conflicts are also suitable for investigating cooperations and their innovative strength in more detail.

Nevertheless, the above essay was merely able to present a small section of the wide-ranging spectrum of cooperations and conflicts in the German rescue service. Only a more detailed investigation of the paramedic group from a micro-historical perspective would make sense for this question. Thus, the cooperation between full-time and voluntary members of the rescue service could be considered as an example, or even the relationship between paramedics and patients set against migration processes, which tend make the interactions between the paramedic and the patient more difficult. Research has not been carried out to a sufficient level in order to provide an adequate answer to such questions. From a contemporary perspective, the complex source situation would suggest the application of a questionnaire for the different groups with regard to a concrete cooperation in the sense of *Oral History*.

Notes

1 *Cf*. BURGKHARDT A., BURGKHARDT M, JANTZEN T. & KAMPMANN J. 2008. Geschichte der Notfallmedizin im Osten Deutschlands. *Notfall + Rettungsmedizin* 8, 11: 571–578.

2 *Cf*. PRAUSSE-STANGL A. 2007. *Entstehung und Entwicklung von Notarztdiensten in Nordrhein-Westfalen*. (Studien zur Zeitgeschichte Bd. 58) Hamburg: Verlag Dr. Kovač.

3 FRERICHS H. 2005. *Vom Krankenkorb zum Rettungsdienst Friesland. Dokumente zur Geschichte der Krankenbeförderung und der Notfallrettung im Landkreis Friesland 1884 bis 2004*. Jever: Verlag Hermann Lüers.

4 KESSEL N. 2008. *Geschichte des Rettungsdienstes 1945–1990. Vom „Volk von Lebensrettern" zum Berufsbild „Rettungsassistent/in"*. (Medizingeschichte im Kontext Bd. 13). Frankfurt a. M.: Peter Lang.

5 Original: „Aus den medizinischen Erfahrungen des Zweiten Weltkrieges war zu Anfang der fünfziger Jahre die Schocktherapie mit Infusionen und Bluttransfusion entwickelt worden. Damit war es möglich den Volumenmangelschock, der nach großem Blutverlust auftrat, im Frühstadium zu bekämpfen. [...] Ende der fünfziger Jahre folgten neue Erkenntnisse über die Pathophysiologie beim plötzlichen Tod. Diese Erkenntnisse gingen einher mit der Wiederentdeckung älterer Wiederbelebungstechniken, deren Nutzen jetzt durch wissenschaftliche Untersuchungen belegt wurde: Die Atemspende und die äußere Herzdruckmassage setzten sich damit als Erstmaßnahmen beim Kreislaufstillstand durch" (KESSEL 2008: 63).

6 *e. g.*: N. N. 1972. Beim Unfall bestimmt der Zufall. *Der Spiegel* 21: 52–66.

7 Original: „die Übernahme der Definitionsmacht und eine Hierarchisierung in Beziehung zu nichtakademischen Assistenzpersonal" (KESSEL 2008: 75).

8 Original: „Mit ihr wurde ein Schema geschaffen, das festschrieb, wer wann welche Aufgabe hatte, um den Patienten optimal zu versorgen" (KESSEL 2008: 70).

9 Original: „Oder Du, lieber Hausarzt – fühlst Du Dich blamiert, wenn der rotgestreifte Rettungswagen vorfährt und die ‚Profis' mit ihren Notfallkoffern, EKG und anderem Equipment in die Wohnung stürmen? Bist Du bereit, mit ‚denen' zusammenzuarbeiten, ohne bei jedem Satz Deinen ‚Dr.' hervorzuheben und das ‚Alpha-Tier' in Dir und gegenüber Deinem Klientel zu verteidigen?" (FERTIG & LANDSLEITNER 1988: 729).

10 Original: „Unfairerweise wird dann auf den Einweisungsschein ein Fachchinesisch geschrieben, wie es in den 20er Jahren einmal gebräuchlich war, damit der ‚dumme Rettungssanitäter' ja keine richtigen Schlüsse zieht [...]" (WACHSMUTH 1986: 485).

11 Original: „Mein Vater (Allgemeinmediziner mit über 40-jähriger Berufserfahrung) wird im Rahmen des ärztlichen Notdienstes am Sonntagmorgen zu einer älteren Patientin gerufen, die über Schmerzen im Unterleib klagt. Nach eingehender Untersuchung wird die Diagnose ‚Appendizitis' gestellt und ein KTW [Krankentransportwagen, P. P.] angefordert, welcher auch kurze Zeit später eintrifft. Die RS oder Rettungshelfer (Höchstalter 21 bzw. 25 Jahre) stürmen in die Wohnung, und nun beginnt folgendes Gespräch:

Hausarzt: Guten Morgen, meine Herren. Diese Dame muß sofort auf die chirurgische Abteilung des XY-Krankenhauses transportiert werden. Ich habe mit dem diensthabenden Arzt gesprochen, ein Bett ist frei, hier ist die Einweisung und der Transportschein.

RS [Rettungssanitäter, P. P.]: (Nach kurzem Blick auf die Einweisung) So ein Blinddarm, da müssen wir die Alte ja wohl tragen, können wir die mit Alarm fahren?

HA [Hausarzt]: Ich sehe darin keine Veranlassung, ich möchte nur einen schonenden und zügigen Transport für den Patienten.

RS: Herr Doktor, sind Sie sich in der Diagnose auch sicher, ich meine wenn so was durchhaut (RS meint wohl Perforation des Wurmfortsatzes).

HA: (Verärgert) Junger Mann, bin ich der Hausarzt dieser Dame und betreue sie schon über zwanzig Jahre oder SIE?

Hier endet die Kontroverse. Die Frau wird von den RS mürrisch und lustlos eingeladen und abtransportiert" (Schmidt 1986: 485 f.).

12 Original: „Soll in Zukunft der Ehrenamtliche nur noch Formulare ausfüllen dürfen oder das Lenkrad bedienen? Was ist mit dem Katastrophenschutz, den Sanitätsdiensten, allen sozialen Diensten, die wir täglich ausüben? Was nutzen uns Fortbildungen und praktischen [sic] Anleitungen, wenn uns nun nicht mehr die Möglichkeit gegeben wird, praktische Erfahrungen zu sammeln und dieses Wissen auch umzusetzen? […] Wie oft kommt es vor, daß wir die einzigen sind, die nur durch die Anwesenheit mehr bewirken, als so manches teure Medikament. Ein Gesetz ist geschaffen. Hohe Anforderungen werden an uns gestellt. Nicht, daß wir die Ausbildung nicht absolvieren wollen, im Gegenteil!!! Aber wann? Dreißig Tage Urlaub vielleicht, eventuell noch einmal Bildungsurlaub. Und war [sic] ist mit der Familie? Was ist mit den ehrenamtlichen Tätigkeiten, die bewältigt werden müssen? Eine Überlastung der Ehrenamtlichen ist in vielen Hilfsorganisationen schon vorprogrammiert und rückt Tag für Tag näher" (Hoopmann 1989: 752 f.).

13 Original: „Davon unabhängig muß jedoch (erneut) die Frage aufgeworfen werden, inwieweit die medizinische Notwendigkeit einer intensiven fachlichen Ausbildung gerade über einen Zeitraum von zwei Jahren überhaupt gegeben ist. Die (angebliche) Unzulänglichkeit der z. Zt. praktizierten 520-stündigen Mindestausbildung ist aus Sicht der JUH zu keiner Zeit zuverlässig und seriös nachgewiesen worden" (Johanniter-Unfall-Hilfe 1986).

14 Original: „Obwohl das Berufsbild des Rettungssanitäters zu den nichtärztlichen Heilberufen gehört, *muß davon ausgegangen werden, daß der Rettungssanitäter, um ihn seiner späteren Aufgabe voll gerecht werden zu lassen, während der Ausbildung auch lebensrettende Sofortmaßnahmen erlernen muß, die grundsätzlich in das Tätigkeitsfeld des Arztes fallen. Dazu gehören Injektionen, Infusionen, Intubationen u.a., die er perfekt beherrschen sollte. […]* Der Qualitätsstandard der Ausbildung zum Rettungssanitäter muß somit so hoch angesetzt sein, daß der Rettungssanitäter notfalls jederzeit in der Lage ist, lebensrettend Sofortmaßnahmen wie Injektionen, Infusionen und Intubationen durchzuführen. *Die Indikation dazu muß aber stets im Verantwortungsbereich des Arztes bleiben.* [emphasis in original] (Bundesärztekammer 1975).

15 Original: *„Herr Jachertz* betonte, daß die Bundesärztekammer grundsätzlich Wert auf eine Abgrenzung in den Aufgabenbereichen von Ärzten und Rettungssanitätern lege. Diese Abgrenzung solle jedoch pragmatisch vorgenommen und eine Zementierung vermieden werden. Er begrüße es deshalb, daß der Entwurf insoweit auf die jeweilige Entwicklung im medizinischen Bereich abstelle. Im übrigen müsse man gerade in diesem speziellen Fall die angestrebte Teamarbeit zwischen dem Arzt und dem Rettungssanitäter im Auge behalten." [emphasis in original] (Niederschrift 1972).

16 Original: „Stellt der Rettungsassistent eine von den Feststellungen des Notarztes abweichende Diagnose oder hält er eine andere Behandlungsweise für angezeigt, entspricht es gutem Teamgeist die Vorgehensweise gemeinsam, diskret und kurz zu erörtern, wobei dem Notarzt das Letztentscheidungsrecht verbleibt."

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The Ecology of Care in Cystic Fibrosis

Identification, Decision-Making and Learning in a Community Living and Working with a Rare Chronic Illness

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Abstract This paper sets out to describe how developing an identity as a member of a community organized around a rare chronic illness and becoming knowledgeably skilful in mastering the challenges of decision-making are part of the same process. We examine a community living with cystic fibrosis (CF) and their care-givers. CF is a rare inheritable disease with a chronic life-shortening course. Today, the growing complexity of care, with the resulting longevity for people with CF, governs the practicalities of day-to-day decision-making, highlighting an increasing need for interdisciplinary collaboration. Building on long-term ethnography as anthropologists and physicians, we use a practice theoretical approach to explore in a highly specialized university medical centre how patients and care-givers make decisions and negotiate meaning, and their position, within such a community of practice (CoP). Drawing on ideas from distributed cognition and knowledge-practices, we show that the CF CoP is characterized by three interrelated elements: First, by the development of a shared identity around the question how to manage and live with a rare chronic illness. Irony is used in establishing a position both outside the dominant mainstream of medicine and outside the dichotomies healthy/ill. Second, managing the condition requires collective learning in the domains of everyday life and clinical decision making, cutting across established status groups of patients and caregivers. Third, by taking experience and learning out of the individual's head and making it a procedure to be enacted in similar moments, we argue that the embodied-knowledge of prior generations is not passed on but regenerated within the contexts of novices' interactions within the social and material environment. Together, the three elements create a collectively embodied-memory culture allowing the CoP to regenerate itself and adapt within times of rapid change.

Keywords cystic fibrosis – chronic illness – communities of practice (CoP) – distributed – decision making – knowledge-practices – Germany

Introduction

Since its publication over 50 years ago, "The Ecology of Medical Care" (White, Williams & Greenberg 1961) has provided a framework to think about health-care organization, medical education and research. Its conceptualization of medicine as a social institution was inspired by diary studies and careful reporting on the part played by general practitioners. Its ideas on the stages of decision-making, when patients and their health advisors, "whether physicians, pharmacists or faith healers" (*ibid.:* 188) seek help and consultation from other medical-care resources, these ideas have resonated widely in medical literature and have found their way into textbooks and articles (Eddy 1990; Haynes, Devereaux & Guyatt 2002; BATTEGAY 2005; Saint, Drazen & Solomon 2006; Mark 2008). Yet, its focus on *applications* of medical expertise in complex institutional settings falls short of recent advances in the anthropology of knowledge and the challenges of those advances to medical anthropology (Beck 2015, Cohn & Lynch 2017). Additionally, the ecology of care may look quite different in the 21st century's highly specialized medicine and may not capture the dynamics of care under reformulated concepts of health and doctor-patient interactions.

One of those dynamics, pointed out by Clarke *et al.* (2003) is the increasing focus on biomedicine, technology and the relentless marketization of health for better or worse. With it came a growing interest in the concept of care in nursing theory and the social sciences (ROBINSON 1998; MOL 2008; MOL, MOSER & POLS 2010). Another development, discussed by DUMIT (2012: 6) is a paradigm-shift in the understanding of health and illness. Since the 1990s, the paradigm of "inherent health" and illness as a deviation from the norm was replaced by a notion of illness, in which bodies are inherently ill. A precarious-self arises which needs constant maintenance to keep symptoms at acceptable levels. These shifts have been accompanied by the growing acceptance of new concepts in doctor-patient interactions, such as "shared decision-making" and "empowerment" in medical practice. These models assume that patients are willing to and capable of making decisions about their health with their health-care providers (RAPPAPORT 1981; CHARLES, GAFNI & WHEELAN 1997).

Social scientists have undermined the cognitive framing of these health-related decisions in attempts to reframe decision-making as "distributed." The temporality of decision-making has been stretched from discrete moments of cognition to being incrementally built over many instances of time, place, and contributors (HUTCHINS 1995, RAPLEY 2008). Over the last decades, medical anthropology and sociology have benefited tremendously from debates leading to the current understanding of the distributed agency of patients and healers. The discipline moved from the recognition of patients as individual and collective agents who have a voice in conflict with the professional or physician (DAHRENDORF 1958, FREIDSON 1970, ILLICH 1976), to the idea that this agency is not a *given* but comes into being, mainly, through non-compliance (LOCK & KAUFERT 1998; GREENE 2004), and how this develops over time in a "dance of agency" with health-care providers (PICKERING 1995; CHARLES, GAFNI & WHEELAN 1997; GAWANDE 2004). In recent years, the debate has widened its focus towards the question of how agency might be understood as an emergent effect created through alliances, connections and networks. These are now understood to involve humans and texts (GABBAY & LE MAY 2004), material artefacts and technologies (PROUT 1996), other species, including domestic and research animals (HARRAWAY 2008), and relations of power and social positioning through which individual and collective agents in the health-care system are enabled or hindered in exercising influence and change (CALLON & RABEHARISOA 2008).

We would like to extend the understanding of decision-making one step further by drawing attention to the process of *becoming part* of this collective agency or community of practice (CoP, WENGER 1998). A broad definition of a community of practice is "a group of people who share a concern for something they do and learn how to do it better as they interact regularly" (WENGER 1998). The shared learning becomes a bond among the members over time. Over the last decades, CoP has become an important concept to understand social learning and knowledge integration. Originally, it was developed to understand adult learning in apprenticeships *e.g.* midwifery (LAVE 1991). Today, its use has been extended from learning *within* to learning *across* disciplinary communities in science, businesses, and medicine (REGEER & BUNDERS 2003; AMIN & ROBERTS 2008; MANIDIS & SCHEERES 2013; CUNDILL, ROUX & PARKER 2015; CRUESS, CRUESS & STEINERT 2018).

A key concept of CoP theory is that one becomes a member of a community by acquiring the skills and knowledge of that community; with this, one moves from legitimate peripheral participation to a more central position, transforming oneself as well as the group (LAVE & WENGER 1991). Sociologist MERTON has been a pioneer to point out the dual nature of medical education, whose aims are to provide those wishing to become physicians with the knowledge and skills necessary for the practice of medicine and a professional identity so that they come to think, act, and feel like a physician (MERTON 1957). Medical educators (PARBOOSINGH 2002, CRUESS *et al.* 2014; CRUESS, CRUESS & STEINERT 2018) have recently taken up this view of learning, practice and professional identity formation as inseparable.

Social scientists caution us that the growing disciplinary specialisation and division of work would "truncate both the movement from peripheral to full participation and the scope of knowledgeable skill" (LAVE 1991: 65). In specialized medical settings like emergency rooms, it has been suggested that practice knowledge is tied to CoP member's professional identities and the acceptable ends as defined by practical intelligibility. Learning then would largely be confined to "particular knowledges" and "particular relationships of learning" (MANIDIS & SCHEERES 2013: 15; CRESWICK, WESBOOK & BRAITHWAITE 2009: 6), separating identity from intended forms of knowledgeable practice.

This paper sets out to describe how developing an identity as a member of a highly specialized community organized around a rare chronic illness and becoming knowledgeably skilful in mastering the challenges of decision-making are part of the same process. We show that managing this illness requires mobilising and coordinating the CoP's distributed elements and collective learning in the domains of everyday life and clinical decision making, cutting across established status groups of patients and caregivers. The development of a shared identity related to the condition and the care of patients are sustained by temporalizing collective learning. This is achieved by taking experience and learning out of the individual's head and making it a procedure to be enacted in similar moments. The embodied-knowledge of prior generations of patients and staff is not passed on but regenerated within the contexts of novices' interactions within the social and material environment. Instead of creating unrelated, particular knowledges, the members of the CoP create a collectively embodied-memory culture, allowing the CoP to regenerate itself and to adapt within times of rapid change.

Field research in highly specialized clinical medicine

The theoretical framework outlined above has implications for research methodology. Although participant observation is central to anthropology's methodology, rendering its understanding and the kind of claims it makes about the social world (CLIFFORD & MARCUS 1986, JORGENSEN 1989), it has rarely been used as a means to expose the emergence of a knowledge-practice, like decision-making and identity formation in postgraduate clinical practice in relation to the anthropologist as subject. A few notable attempts are HUNTER's (1991) detective-like exploration of the narrative structure of medical knowledge, KATZ's (1999) illustration of the culture of surgeons and the active stance in surgical decision-making, LUHRMANN's (2000) analysis of how psychiatrists learn to understand people as they do and RISOR's (2012) study on how internal medical-residents evolve to think like doctors.

While these studies, which describe medicine as a culture or subculture and frame their analysis in terms of enriching and fascinating rituals to read about, they are limited or rather shaped by the authors' interpretation of their own roles, as at least semi-detached participant-observers. Most of the above-named authors are excluded, for lack of professional skills and qualifications, from a more active role.[1] Yet, we believe there is something to be gained by living up to anthropology's aspiration and committing "body and soul" to the practices one longs to understand (WACQUANT 2004, MYERHOFF 1978). We interpret anthropology as an entangled material-semiotic process of learning and knowing (SUCHMAN 1987) that benefits from participation in the practices one observes (MOL 2002, LAW 2004). We like to think of this research, both, as a process of becoming part of a community and of *becoming with* our research partners, or, as INGOLD (2013) might phrase it, to learn not about our research partners but with and from them.

We use a practice theoretical approach, where practices are understood as a set of sayings, doings and being organized by a pool of understandings, a set of rules and teleo-affective structures (SCHATZKI 2001: 61). Identity (of a person or learner) and meaning (of a procedure or an artefact) are conceptualized as functions of its relations and conversely, relations are functions of its meaning/identity (*ibid*: 51). This is important, as it allows to look beyond fixed social roles (physician, nurse, patient), and to foreground the relational nature of identity and practices: People perform acts of caring, healing, deciding, swallowing pills, inhaling, writing up cases, telling stories, and through these performances work on identifying as doctors, nurses or patients. Processes of identification are shaped by the practices people perform and the relations with other people that arise within these practices.

The present work is part of a long-term ethnographic study on the practices of everyday-life with chronic illness (REINSCH 2013; REINSCH & RASCHER 2015; REINSCH, NIEWÖHNER & STAAB

2016). It draws on interviews and field-notes, collected by the first author over two one-year periods in a German university medical centre specialized in CF care. The first period, 2006–2007, was part of a MD-PhD research. The second period, 2016–2017, took place during residency training in paediatrics while working on the CF ward. In between, several short-term research periods and follow-up interviews took place.

According to LATOUR (2004) and GARFINKEL (1967), field research proceeds by following the actors to explore and map the distributed networks of encounters, people, technologies, practices and decisions. We followed the principles of Grounded Theory that emphasizes the procedural and iterative nature of research where data collection and analysis proceed simultaneously (CHARMAZ 1983, CLARKE 2005).

Participant observations were recorded with field notes and later digitalized (JORGENSEN 1989; EMERSON, FRETZ & SHAW 1995). Informants were followed in their clinical and daily routines. Half of the research took place inside and the other half outside the hospital. The auto-ethnographic part of this research introduces accounts where the first author documents ways he changes as a result of working and doing fieldwork (ELLIS 2004). In using personal experience, auto-ethnographers are thought to use supposedly biased data (ANDERSON 2006). To address this critique, auto-ethnographic accounts were analysed alongside data, abstract analysis, and relevant literature (ELLIS, ADAMS & BOCHNER 2010), as well as conducting interactive interviews and focus-groups.

Narrative and interactive interviews as well as focus group sessions were used to probe in-depth into views on specific topics and contextualize cases or situations. They were held in the clinic or at home of informants, audio-taped and fully transcribed (SPRADLEY 1979). Interactive interviews were collaborative endeavours between researcher and participants, in which both reflected and probed together about issues and problems (ADAMS 2008). Focus groups were started by presenting the participants with visual and anecdotal material from the field research. Participants were asked to comment on the material, explore similarities and differences to their own experiences, as well as discuss rationales, legitimating strategies and emerging concepts (MORGAN 1997).

Conceptually, interactive interviews and focus-groups were attempts to collect new data, but also create experimental interruptions within the research process, with the intent of staging reflexive encounters between research partners (BOYER 2015). Within those reflexive encounters, emerging categories and mind-maps were discussed with medical and anthropological experts as well as patients. Additionally, triangulation and member checking were used to validate findings. Research continued until theoretical saturation was reached, i.e. no new concepts emerged after subsequent data collection.

The study was approved by the internal review board of the university hospital. After receiving oral and written information about the research project informed consent was obtained from patients. To protect the identities of participants, pseudonyms have been used throughout the research for all informants.

The ecology of care in cystic fibrosis

We describe a CoP organized around a chronic illness that is characterized by the development of a shared identity around the question *how to manage and live* with a rare chronic illness while undergoing a rapid demographic transition. This special status, a rare condition during a time of transition, requires collective learning in the domains of everyday life and clinical decision making, cutting across established status groups of patients and caregivers.

Two empirical examples are used to present the argument. The first examines the story of one of the oldest patients with CF and the history of the CF centre where she is treated. We show some consequences of growing old within a CoP organized around a rare chronic disorder and the practice which reinstates the membership in this community, including how difference can be transformed with the use of irony to create a position outside the dichotomy ill/healthy, as well as the mainstream of clinical medicine.

The second example uses an auto-ethnographic account from the first author's perspective as a physician, peripheral to the CoP, while learning to manage a critical situation in real-time, during a night shift. Here, we've focused on the question of how the distributed-actors and elements of the

CoP are mobilized in order to manage such a situation as well as the role of experience and the temporal component of the situated-learning process.

We will, thereafter, discuss some implications for the ecologies of care in highly specialized medicine, and the anthropologic role in these communities.

The community of practice organized around cystic fibrosis

Mrs. Monk is one of a number of people with CF (PWCF) who are, regularly, admitted to the hospital for exacerbations of their chronic pulmonary infection. In PWCF, the defensive mechanism, the removal of bacteria through mucociliary clearance, is impaired. As a result, PWCF suffer from chronic infections. To compensate, the other defensive mechanisms, coughing and inflammation, are up-regulated. Jointly, they lead to progressive destruction of functional lung tissue by chronic inflammation which lead ultimately to lung failure, requiring long-term oxygen therapy and, later, a lung-transplantation in the majority of people (BOUCHER 2008). In severe acute exacerbations, the number of bacteria in the airways is overwhelming, requiring treatment with a combination of intravenous antibiotics.

> On Monday morning, word has spread that Mrs. Monk was flown in by helicopter from a vacation at the Baltic Sea. During handover in the emergency room, those who do not know her already get to know her by anecdotes, told in amazement, about having a lung function of below 20 % but still working; although, she needs continuous oxygen supplementation, and, the voices turn to an exited whisper when they come to this part, that she is working several hours without using her oxygen. She is a little celebrity among the group of young doctors assembled that morning in the hospital. The reasons for this are not only her personal defiance of age and decay, but also the changing demographics of people with CF in general, of which she is an exceptional example. (Field notes)

Over the last few decades, there has been a steady increase in survival rates for those affected by CF. Today, half of the population living with CF in the US and Germany is over 18 and the predicted age of survival is still rising, enabling more and more of them to enter higher education, work and start their own families (CYSTIC FIBROSIS FOUNDATION PATIENT REGISTRY 2017, MUKOVISZIDOSE E.V. & MUKOVISZIDOSE INSTITUT 2017). No single new drug is responsible for this but a very complex therapeutic regimen that the patient has to perform at home, daily, requiring some two hours, and including up to seven medications and a more comprehensive care-team in highly specialized CF centres (SAWICKI, SELLERS & ROBINSON 2009, DAVIS 2006).

The CF centre where Mrs. Monk has been treated in excess of a decade is an integrated children and adult service, caring for 350 PWCF. Called the "Christiane Herzog Centre," in memory of a former German president's wife, who's foundation helps raise funds for CF research and care, the center is one of Germany's four largest centres of this kind. Administratively, it is part of the Department of Paediatric Pneumology, Immunology and Intensive Care Medicine of a university hospital. It grew out of a lung clinic at the outskirts of Berlin where, primarily, tuberculosis (TB) patients were treated (LODDENKEMBER 2007). As TB became less common, funding for TB treatment was decreasing, and people with cystic fibrosis became older, the unit caring for CF became the clinic's central focus (MAGDORF 2007, STAAB 2007). This shift was later accompanied by moving the CF centre to the university campus, located more centrally and part of a complex that includes the German Heart Centre, specialized in organ transplantation.[2]

The centre's staff caring for PWCF before and after transplantation is comprised of seven physicians and around 40 nurses, two psychologists working half-days plus one adjunct-psychosomatic doctor who join the team once or twice, weekly. Three physiotherapists, two dieticians and a social worker also assist. The centre is led by two heads, a paediatrician and an internal-medicine specialist, both specializing in pulmonology. The two are consulted on every case and lead rounds between three-to-five times a-week, with alternating weekends. The other half of their time is spent in the out-patient clinic with routine check-ups, follow-ups and research. One attending does the routine ward work with four residents-doctors, some of whom are in the middle of their sub-specialization in pulmonology. The remaining junior-residents are in the middle of their general paediatric training. The residents rotate to different wards every six-to-twelve months. They are sometimes called “six-months-doctors” by the patients, in contrast to the “real” CF physicians, like the centre’s heads or the nurses and psychologists who sometimes know the patients from diagnosis, often from the patient’s birth.

Participating in a CoP means partaking in its continuous reproduction

During morning rounds the day after Mrs. Monk’s admission, the following discussion between Mrs. Monk, the attending-physician, and one the CF centre heads, takes places:

> Mrs. Monk: The emergency doctor in the helicopter asked me “How old are you? You cannot have CF. People with CF are all dead by your age.”
>
> Attending: You should have given him an autograph.
>
> M: Many doctors ask me “when did you get CF.”
>
> A: Also, very popular: “how long are you going to have it?”
>
> Mrs Monk laughs, her voice is hoarse, and she is short of breath, but eager to tell her story: When I was 25, my doctor told me “You are the living miracle in Methuselah’s age. You should be long dead, are you aware of this?” – “No,” I responded.
>
> A: You should show more understanding for them; they were all listening carefully during the lectures in medical school.
>
> The clinic’s head, interrupts: It is a problem though, that it is assumed one wouldn’t get old with CF. Those with CF who are 30 and have no plans for life are now becoming depressed.
>
> M: That, I have never been told. My paediatrician told my parents: “Treat her like a normal child; she will live to a normal age.” It did not hurt me.
>
> C: The oldest patient here is 73.
>
> M: Yes, I saw her walk down the ward, without oxygen. That made me jealous.
>
> C: She also has a mild version of CF.
>
> M insists, looking around her: I would like to do that too, get loose from all these strings.
>
> C: You want to dance without oxygen.
>
> M: That I cannot do anymore even with oxygen.

Mrs. Monk is sitting in her bed, upright, breathing hard, supported by oxygen through a high-flow nasal cannula. Resulting from her years of constant inflammation, her airways have lost elasticity and, now, with her chronic infection getting worse and her sputum building up, her airways would collapse without the positive-pressure of 60l of air, blown into her lungs to keep them inflated and to allow her to breathe at all. She has two intravenous (i. v.) lines through which antibiotics and other medications are injected into her bloodstream, through a port catheter. The port is implanted under her skin, so she does not need to get i. v. catheters set every-other-day. Setting a new line has become difficult over time, since frequent i. v. antibiotics courses cause inflammation in the veins while the superficial-veins, which are easy to puncture, become thinner and then disappear. The inhalation medications and pills on the table beside Mrs. Monk are an assembly that would be poly-pharmacy for anyone. Among them are inhalations of saline to make the mucus less thick, and bronchodilators and corticoids that she has to inhale several times, daily, to reduce the inflammation. There are pancreatic enzymes in a pillbox to help digest food, vitamin replacements to compensate for malabsorption and stool-softeners to prevent intestinal obstruction.

Before the physicians and nurses enter her room, they have gone over the list of therapies and adjusted a few up or down. However, the therapeutic adjustments are not what is at the centre of today’s discussion. In the middle of her fifties, Mrs. Monk is the second oldest of the centre’s 350 patients, a fact for which she is quite proud. Old age is uncommon for people with CF and people like Mrs. Monk do not fit the stereotypic imagery of someone with a rare progressive genetic illness, where, adolescence was the unsurpassed median age until a few decades ago and which usually lead to death, by lung failure, that is: suffocation.

Faced with the doom of an exacerbation that could have led to fatal lung failure, Mrs. Monk and the two physicians are attempting to create a meaningful narrative out of the apparent amazement over this new CF old age phenomenon, not yet anchored in mainstream clinical-medicine. Mrs. Monk and her physicians have collaborated for years to defy the odds, as they are reminded by the emergency-physician. He, like many physicians, did listen attentively during lectures but, nonetheless, is unfamiliar with the developments in CF medicine after medical school graduation, as the attending doctor jokingly remarked.

On one level, the conversation does not have any medicinal relevance and could pass as unnecessary gossip. On another, however, the question arises, why are those three so eager to share this story on a Monday morning, in a crowded ward, with a clinic full of patients waiting to be seen? The functional aspect of this discussion can be located by being able to partake convincingly, in bashing other medical practitioners. Accordingly, the group assures itself that it is a valid member of a specific CoP, i.e. a community that is experienced and competent to deal with CF. As Wenger (1998: 74) reminds us, it is just as important to be a full participant in a CoP to understand the latest gossip as it is to understand the latest medical paper or innovation. The gossip excludes the emergency physician and all the others who do not know that people with CF are asked, repeatedly, "When did you get it"? Conversely, the bond between doctors and patients is reinstated through shared gossip, based on their personal experiences with the condition. It is noteworthy that membership to this CoP runs across established status groups, including experienced long term "chronic" patients, while excluding physicians without specialized experience and competence in treating CF. While this has been discussed for other contexts of chronic disease, *e.g*. ADHS and Alzheimer's Disease (Rabenarisoa, Moreira & Akrich 2014), it occurs in a particularly pronounced manner in this context.

Herein, the CF community differs from communities with a shared identity that excludes them from the "normal ones," like the hard of hearing and those professionally related to them, as analysed by Goffman (1963: 30) and others. Their shared competence or expertise resulting from shared experience and learning, rather than their stigma distinguishes members of the CoP from outsiders. We will return, later in the paper, to the question how physicians peripheral to the CoP make the necessary experiences to move to full participation in the CoP.

Living-attached in a world of compulsory able-bodiedness

Only after the group of physicians has assured itself of its membership does it turn to the challenging aspects of living with CF: People who did not believe they would live to be 30, then, become depressive by a lack of plans or they might live a life with work, family and vacations at the Baltic Sea, like Mrs. Monk; yet it is tiresome. It, simply, is living attached to lifelines (lines that keep her alive and part of the social life), lines made of oxygen, i. v. medication, delivery systems, physiotherapists who come to her place regularly, the very infrastructure of CF care. Living-attached may be without choice but the group knows how tiresome it is to be reminded that, with all that constant work to keep the CF symptoms at acceptable levels, "even with oxygen", the most existential of all medications, "one cannot dance, lightly, anymore" through life.

By alluding to the impossibility to "dance through life", Mrs. Monk and the attending are speaking of a life that is different from bare life or survival. Survival being what is assured through those very lines. What the two are talking about is life itself where life is conflated with a social life – "life as we know it" – that is threatened by the existence of the lines that attach her to the therapeutic infrastructure.

While almost everyone is able to at least *walk* through life without oxygen—that is, exempt for extreme places as on top of the Everest or under water—Mrs. Monk is not able to survive long enough in the social habitat of Homo sapiens. She is as a fish out of water or rather a human under water, making it is impossible for her to live *effortless and comfortably*.

In one of our discussions, she relates how living and working among people that look at her with less respect when she does wear an oxygen mask is exercising a repetitive effect which made her take off the mask: "People already look queer at me when I walk down the corridor to the courtroom with my mask on. They respect me less when I wear one, so I take it off during the trials."

The dilemma of disclosure at the workplace for people with potentially "invisible" chronic illness and the threats to emotional and physical wellbeing has been discussed for many conditions (Vick-

ERS 1997). What is striking in Mrs. Monk's example is that the place she takes the mask off is one where she is in a position of power. A family judge, she is, nominally, exercising the authority of the state during court processions. Yet, these are the situations when she will work several hours without supplementary oxygen.

The repetitive effect of being looked at queer with a visible difference makes her feel uncomfortable. As AHMED (2004: 148) put it, to be comfortable is to be at ease with one's environment that it is hard to distinguish where one's body ends and where the world begins. Attracting queer views repeatedly when wearing an oxygen mask is leaving impressions that made her aware of her difference.

Mrs. Monk is made aware that she is living in a world were able-bodiedness, health and happiness are presented as an ideal coupling. The accumulative effect of the repetition of this presentation of able-bodiedness, health, and happiness as an ideal coupling, and the questioning of her presentation shapes what is comfortable for people like her to do.

In retrospect, Mrs. Monk subscribes to this tight woven narrative: "Every step, having to use intermittent oxygen, later continuous oxygen and, now, non-invasive ventilation overnight, were always steps in the wrong direction … You cannot get off oxygen anymore; using it is a sign that it is going in the wrong direction, worse, not better."

Like Mrs. Monk, many PWCF that have less of a position of power, struggle with this feeling of being uncomfortable in the world. One of the adolescents we talked to told us he would never have imagined to take oxygen to school. He said he would not even let his friends carry his schoolbag upstairs when he was already huffing and puffing on the flat surfaces: "My body didn't thank me though." A young woman in her thirties reflected, that she was going on vacations with friends to the Netherlands, and only there, where no one knew her, would she start feeling at ease with the oxygen tank in public.

In the following section we will turn towards the question how this difference can be embraced and taken on via collective action where the uneasiness is not negated but transformed, creating a space outside the uncomfortable dichotomies healthy/ill.

Identification and use of irony in the establishment of a "position outside"

In the face of an existential crisis in medicine, narratives seek to temporally and meaningfully sequence the experience. Within such narratives, irony is one element that gives expression to the changing relationship between body, self and society, an experience which progressing illness invariably entails. BURY (2001: 278) has listed examples of irony in narratives which renders the expression of a positive view of the experience, by distancing the self through humour. We would like to highlight another dimension of irony, specifically, the element of the "insider-joke" observable in a number of examples.

One may be surprised by the amount of irony, sarcasm and laughter on the CF ward. In the exchange between the two doctors and Mrs. Monk, it reveals that they belong to the same "community of the initiated" or "the wise," as GOFFMAN (1963: 28) called them, by making fun of the emergency doctor on the helicopter and, indirectly, by relating their stories of similar events. One inside joke that circulated among the community on the ward went: "PWCF are like snails: slimy and slow," obviously relating to their lack of energy, shortness-of-breath and the sticky mucus they produce.

The quality of their sputum is something so central that patients have to learn to produce and judge it as an embodied knowledge practice or skill (HARRIS 2005, INGOLD 2013). It serves to evaluate the exacerbation severity by the coughing frequency variation, and the amount and colour of sputum. Sputum is visited like stool visits on gastroenterology wards. And similarly to stool visits, some physicians working on the CF ward, and peripheral to this community, were disgusted by PWCF letting their sputum stand in unlidded transparent plastic containers (yellow-green, with a purulent smell and sticky). In fact, so sticky, patients sometimes turned the containers upside-down to show how it clings to the bottom, holding it towards the audience to show how extreme it was.

In an ironic attempt to turn their situation into positive-value, some of the community of PWCF have developed a card-game, called the "CF Quartet." In an analogy to car or train quartets, PWCF are shown with their image and markers of their "performance": pulmonary function, lowest oxygen saturation, weight, height, and longest stay in the hospital.

In his book "Representation," the cultural anthropologist HALL (1997) suggests three transcoding strategies that people use to position the subaltern or colonial subject in the context of power and stigma: (1) "inversion of stereotypes" (2) "positive" respectively "revaluation" of images and (3) "representations-crossing by de-familiarizing and un-identifying." While we are not claiming that medicine stereotypes patients in the same manner in which mainstream society stereotypes the "Other," we believe these strategies are useful when analysing the situation of people with chronic illness. PWCF, explicitly, used the "deviance of the normal" as a quality. It can be seen as positive affirmation. Whether the winner of the "CF-Quartet" is the one with the best or the one with the worst performance is left vague; representations are not only representations *of* but also always representations *for*, i.e. they are worked with, played with and negotiated in a situated manner. A close look at the images chosen by the players shows that ironic play with one's sense of self and self-representation is the central element in undermining the dominant typologies of the ill as unattractive, invisible and unhappy.

This undermines the hegemonic imagery but not necessarily aims at modifying it. Neither do people with CF seem to aim for an approximation of their type, approaching the norm of the "healthy and beautiful." They do not even constitute a kind of CF-chic. Rather, it seems to be a variation of what STEPHENSON & PAPADOPOULOS (2006), building on Foucault's "aesthetics of existence," call "outside politics." Through ironic interactions, patients multiply the possibilities of experiencing chronic illness and the possibilities of being interpellated. The quartet circulates only inside the community of patients and care-givers. More importantly, it takes a "position outside" the hegemonic dichotomies of beautiful vs. ugly and healthy vs. ill. Through ironic deflection, a possibility of death (the unspeakable) is positioned centrally. It is a move towards an aesthetic of existence, in relation to death, that creatively transforms the meaning of CF. This move creates a space where the normalizing function of subjectification is undermined and where the possibility of freedom can exist.

Learning and decision-making in the community of practice

The same way as Mrs. Monk was admiring the 73-year-old lady who walked down the ward without oxygen, patients and physicians were talking about her: She inspires and sets an example. We want to turn, currently, to the question of how patients and care-givers within the CoP learn and make decisions in a way that helped Mrs. Monk become one of the oldest patients of the centre.

Mrs. Monk had started deviating from the beaten track, early. When the mainstay of therapy in the 1960's was letting children sleep in tents with moist oxygen-enriched air, her parents and paediatrician dissented the recommendations of the university hospital and went for a big box of inhalation in the back room of the doctor's office. Mrs. Monk had to go there several times per week. Later she was assigned one of the first portable devices—then the size of a radio—and that she used three times daily. We mention this to highlight that she was, then, already following a therapeutic regimen close to the intensity commonly used today.

Mrs. Monk never saw herself as someone with CF. She only had contact to other PWCF, briefly, in the 1980s, because all the others died quickly, one after another, at a time when she was in her twenties studying law and getting married.

There have recently been developments in CF care that correct the basic defect, the defective ion channel. Mrs. Monk had put great hope in this medication. The cautioning voices were taken stoically, that the effect of the medication was not the marginal increase in lung functioning by 1 % but rather the decrease in acute exacerbations. Just when her symptoms were under control, she sacrificed this opportunity to try out a new strategy to improve her condition. Over two weeks, we tried to increase the dosage but the medication was making her even more short-of-breath; so, the medication was ultimately discontinued.

We would like again to point out that, just as discussed around the question of membership to this CoP above, decision making runs across established status groups, including experienced long term "chronic" patients, while excluding physicians without specialized experience and competence in treating CF. In our numerous discussions, many young physician colleagues reflected how the process of decision making—central to the status of the physician—is "taken over" at least partly by experienced patients. A couple of weeks after starting to work on the CF ward, they began to talk about how they were being asked by a patient to rather take another vein to place an i. v. line, which they then found to be surprisingly attainable. We mused about patients who told us they already knew in advance that her exacerbation would not respond to a certain antibiotic, or patients pointing out an allergy to an antibiotic that was not listed in any of the charts, or those patients who preferred to speak about a certain topic with one of the attending physicians. This special relationship extends towards more experienced physicians as well. One of the most eminent CF physicians from the US, Doctor Warwick, reflects about the involvement of patients in therapeutic tinkering: "The thing about patients with CF is that they're good scientists. They always experiment. We have to help them interpret what they experience as they experiment. So, they stop doing their treatments. And what happens? They don't get sick. Therefore, they conclude, Doctor Warwick is nuts." (Cited in GAWANDE 2004)

We are not arguing that the fundamentally asymmetric relationship between patients and doctors is erased. Patients are not recognized as formal experts, no matter how much they know or experiment. Rather, patients within the CoP have acquired a situated knowledge—where to place an i. v., which physician to trust with a decision, or which antibiotic is helpful for them, and what might be a good situation to dispense with some therapies—drawing on prior experience. This specific knowledge makes them old-timers of the community.

While following the leads of such old-timers seems helpful to young colleagues that learn to trust them quickly, it also challenges the status of the physician within the CoP. One physician who had already finished her sub-specialisation told us, rather exasperated, that it took her two years to accept that "patients know it all better". Several colleagues mused that while they would be able to make decision themselves, they preferred *care-ful* ways of learning within the CoP, by which they understood being led through experiences by colleagues, nurses or patients that are more experienced.

As can be seen in Mrs. Monk's story, just as in the interview with Doctor Warwick above, adjusting medication and therapy related decision-making is a joint effort within the CoP. Likely necessarily so, as a team of specialized physicians could plausibly manage a patient's health without that patient's cooperation; this would certainly not be "good care" in the sense of MOL (2008), or Mrs. Monk, for that matter. The *shared doctoring* and *therapeutic tinkering* (MOL, MOSER & POLS 2010) links this CoP to professional knowledge and expertise.

To illustrate how shared distributed decision-making and shared doctoring extends into situations where knowledge is generated, or rather re-generated within the CoP, we propose delving into the field-notes describing a night shift where the first author had to mobilize and coordinate the distributed elements of the CoP, in order to manage an unfamiliar situation.

The night shift

In the middle of the night, around 3:30, a nurse awakened me. One of our patients had started coughing, badly, she said, and had already used all her codeine for that night, the medication that suppresses the cough. Drowsy from sleep, I walked to the nurses' station, studying the patient's chart. Two times/15 drops of codeine for the night, maximum, it stated, a dose just increased from the previous night and already used up, a dose at 11:00 pm the other at 1:00 am. I quickly calculated that if the effect of codeine got her through 2 hours, and the last dose was at 1:00, she might have been coughing for 30 min already, by the time I was awakened. This was some 5 minutes ago. I have to find a quick solution. I listened up. Down the corridor, I heard her coughing, mixed with the sound of the nurse's footsteps. She would return in 10 seconds to ask me to look at the patient, noting that it was really bad, now. I had learned that on this ward, a nurse asking you to look at the patient whom you are already working on means she wants you to hurry, without saying it explicitly. I felt the pressure building up to act. Therefore, I dropped the file and rushed down the dimly lit corridor, towards the open door from which the coughing came. As I approached, the sound became mixed with the oxygen bubbling and the CPAP machine hissing, a non-invasive mechanical ventilator. Not a good sign, I thought; in the evening, this patient was sitting without oxygen when I made my rounds to see how everyone was (a preparation, in case I would have to intervene suddenly in the night).

In the patient's room, the nurse sat at the patient's bedside, patting her back, talking her through every breath, gently. The patient held a mask over her mouth and nose (the CPAP's mouthpiece that pressed air into her lungs, after every breath, to keep her lungs open longer, and thusly, helping the patient ventilate, to exhale, to be specific). With nearly every inhalation, the patient, a young woman in her twenties, started coughing again, bending over, inhaling, gasping and coughing, again and again. "Can't we get her some morphine or Dipi," the nurse asked. I knew morphine or piritramid (the ingredients of Dipidolor) would be the next medication, an escalation from codeine. In addition, morphine would act quicker, since one fifth of codeine has to be metabolised into morphine first. It then suppresses the urge to cough in the brainstem, along with the urge to breathe. This was a CF Patient, with a bad pulmonary situation and NOT a patient to make mistakes on. She was so deep into a coughing spell and already on 10l/min oxygen, washing out her blood CO2, while also taking away her drive to breath. Take away too much of her respiratory drive and you will have to intubate her, a mistake to be avoided, one which I had been warned of, so many times over the past years. It was hammered into my brain.

I thought hard for an alternative medication but, standing there, I was so drawn by the urgency to help her breathe that I could not simultaneously concentrate on thinking about physiology. What she had been given the last times, I wondered. With haste, I returned to the nursing station, sifted through the old logs and saw that she had been given morphine, last time, but that she had also nearly stopped breathing. "Doses only 1/3 of normal." Possibly not enough?

With the attending-physician on the line, I scribbled notes as he dictated: Give cortisone 30 mg i. v. first. Then micro-dose 0.5 mg morphine, watch the result, give another 0.5 mg etc. As I turned, the nurse who had awakened me asked the second night-nurse to prepare the medication; she did not want to leave the patient alone any longer. The second nurse rushed for the medication cabinet, visibly in a hurrying, accidentally, dropping the first morphine bottle. They want you to speed up, I thought.

When I got the medication tray to the patient, she was in visible distress. The nurse injected the cortisone, I, the morphine, and we waited for a reaction. A few minutes later, the patient removed her CPAP mask, continuing with nasal oxygen, still coughing from time-to-time. She requested more medication and shortly thereafter the second dose; she relaxed and started to breathe regularly.

As told by my attending-doctor, I could then auscultate her lungs for possible pneumothorax, a lung collapse, which this patient had had before and which can cause a cough, too. While, a few minutes prior, it had been impossible to discern anything through the coughing and ventilator sound, respiratory sound was, alas, audible and equal on both sides.

My attending doctor then called, again, to inquire whether everything was ok, explaining at length that morphine was the most potent medication and that cortisone was a potent medication to suppress coughing. He had learned to use these while working in the intensive-care unit. He said that I had had quite a rough night; something I could not fully judge, then.

The next morning, during a quick pre-morning round where I checked on the patients who had required assistance during the night, before my day-shift hand-over, the patient with the bad coughing attack thanked me. I said I was thankful for having been able to help. Sitting down later to log my shift, I wondered how this situation had come about and why she had thanked me when it had clearly been more than I supporting through the night.

Mobilising and coordinating the distributed elements of the community of practice

Clearly, the events of that night did not represent medical decision-making as a singular cognitive event. Nor did it rely on a single individual's decisions. Instead, it required the mobilization and coordination of those present and elements of the CoP distributed over regions, time zones and sundry individuals.

Drawing on the nurse's experience that the situation would possibly get out-of-hand, the physician had gotten up, adapted his work speed and followed her lead on plausible medication. Then, he contemplated chart entries about a prior adverse medicinal reaction from that specific patient and adjusted the dose in keeping with the attending doctor's experience from prior cases. The attending doctor suggested alternative medication, cortisone, which he had learned to use, in similar cases, in a different intensive care unit. After the patient had calmed down and the resident-doctor had auscultated her lungs, he was able to discern crackles on both sides, relating what he had heard on the auscultation the evening before his night shift started, not to mention those in the hundreds of lungs that he had auscultated on patients, prior. While that excluded a pneumothorax, it would have required an emergency x-ray to be certain of convincing others of the findings. Specifically, that last bit of knowledge is embodied in a way, which was only opaquely encapsulated by the logged words "hoarse crackles over both sides of the thorax."

The written account lacked certainty and social, material and emotional relevance. An x-ray, though, can circulate, as it is founded on centuries of trust that the scientific community has invested into evolving trust in what we see (SCHLICH 1995, DUMIT 2004).

Over the subsequent months, during night shift handovers, whenever colleagues asked about emergencies and their management, I drew on this and similar situation. While talking them through the management of incessant coughing or coughing up blood, or dropping oxygen saturations, it seemed like I was, again, standing next to the patient whom I had had to manage, remembering the ventilators hissing and my swirling emotions. Though unable to transfer this embodied and tacit knowledge, I was aided in prioritizing subsequent situations. My colleagues drew on the explicit knowledge, which I, typically, reduced to two or three sentences, sometimes consulting my night-log into which I had scribbled that night's notes. Sometimes, they are explicitly referred to the guidelines of the standard operation procedures, a formalised version of such notes but a similar knowledge protocol, nonetheless.

This field note excerpt emphasizes the temporal component of the situated learning process. The task of coordination is about spatial distribution over charts, guidelines and different people, but it also shows a temporal distribution. Experience, which is what was gained, is mostly referenced as a cognitive and personal "thing," which one possesses. Here, the interactive and materialized dimensions of *having an experience* (DEWEY 1939),[3] and what Medical Anthropologists GABBAY & LE MAY (2004) call the collective construction of medical *mind-lines*, are foregrounded. This pragmatist take on experience allows us to talk about learning and passing on experience, differently, as explicit knowledge. Rather than making notes of inadequate things, knowing there is "more to it" than can be verbalized or written down, the conditions for re-enacting this distributed-agency and expertise in moments of crisis have been created.

This is the essence of our ecological argument: taking experience and learning out of the individual's head and making it a procedure to be enacted in similar moments of crisis. The embodied memories of myriads of similar crisis situations create a collectively embodied-memory culture on the ward. This culture spawns the atmosphere which patients, like Mrs. Monk, describe as "feeling at home". It also guides the novice while navigating the decision-making on the ward; thusly, helping to make new experiences. The embodied-knowledge of prior generations, that of the attending-doctor, is not passed on but re-generated within the contexts of novices' interactions within the social and material environment. To borrow a phrase from anthropologist HARRIS (2005: 198), the collective experience of the CoP acted like "a wave which carries forward the history of past actions and embodies their potential".

Discussion

In this paper, we described a CoP evolving through a rapid demographic transition that led from a hospital, at the periphery of town, where CF care was secondary, to an existential disease which held a central position in the university expansion and high-tech intervention, like organ transplantations and intracellular protein modification, mirroring a global trend towards an increasing focus on biomedicine and technology in health care. This transition happened at the same time as a shift in health and illness perspectives with the re-conceptualization of patients, as active partners in health care, has taken place in general medicine and CF care.

In our first empirical example we presented the story of one of the oldest patients with CF. We described the specific CoP, the clinical setting in which CF is treated, the development of the CF Centre and the exemplary trajectory of the patient herself. We then turned to the specificities of living and working with CF: How, during the acute treatment in the hospital, a specific knowing practice-collective is performed during morning rounds, the challenges that patients are confronted with outside the hospital during life at work, and the experience of difference based on bodily restraints and visibility of the treatment; but also, how an ironic re-definition of the dominant narratives of CF becomes possible.

In our second empirical example, we focused on the learning processes of the clinical actors. We showed how, in order to respond to emergencies, they have to draw on diverse actors and knowledge formats, without marginalizing the position of the patients. Learning to manage CF was taken out of the head of individual actors and translated into distributed learning processes, including patient and physician, nurse and chart, mechanical respirators and medications, phones and other doctors. We suggested that learning within the community of practice becomes temporalized and, concurrently, experience becomes situated and materialised.

The paper aims to show how *developing an identity* as *a member of the CF CoP and becoming knowledgeably skilful in mastering the challenges of life and work with CF are part of the same process*. We have argued that three interrelated elements are crucial to this, each of which will be discuss in turn:

First, in the development of a shared identity around the question *how to manage and live* with a rare chronic illness, CoP members use irony to establish a position both outside the dominant mainstream of medicine and outside the dichotomies healthy/ill.

As PWCF are getting older, they face new life and health-care challenges. The challenges in filling expectations are more than therapeutic complexity, which, single-handedly, poses a huge burden (BADLAN 2006). The possibility for a normal life, created through therapeutic options, may turn into a mandate to live a normal life at the expense of health and life itself (MAYNARD 2006). Freedom to choose may mean choosing continued existence over long-term survival. Embedded within this set of impossible choices is the problem of integrating oneself, an entirely medicalized life-form (ROSE 2007), in a world populated by people who do not thoroughly comprehend the implications of living life with a chronic condition (VICKERS 1997). Irony, we argue, is a form of dealing with this. Its use reinstates membership within the CF community and creates a position outside the hegemonic dichotomies of healthy vs. ill. The CF position "outside" motivates, shapes, and gives meaning to the development of the skills, which it subsumes.

Second, managing CF requires mobilising and coordinating the CoP's distributed elements and collective learning in the domains of everyday life and clinical decision-making, cutting across established status groups of patients and caregivers.

The development of the practical knowledge and skills required to care or, to borrow from DE CERTEAU (1988), the artful undertaking of inventing everyday life, with a chronic illness, places PWCF and their care-givers in a pioneering situation; few, if any, were in these situations before and have a big experience advantage (DAVIS 2006). To complicate matters, knowledge exchange among PWCF may be limited, by their vantage of not being among the sick, on the one hand, and the need to keep them isolated to avoid transmission of the strands of bacteria, which reside in their lungs (BOUCHER 2008). On the side of care-givers, the specialisation of modern medicine creates heterogeneous geographical and relational spaces that differ from apprenticeships, where identity arises as part of participating in a particular craft or social group. It has been argued recently that in CoP of acute medicine like in emergency departments, patients, nurses and doctors do not share with each other their practice knowledge due to the pedagogic arrangements that are disciplinary based (MANIDIS & SCHEERES 2013). As we have shown for the CF CoP, learning in a setting of chronic illness does cut across disciplines. Not in a formal sense, for we have witnessed no formal arrangements that facilitates doctors learning from nurses or patients, or vice versa. Rather learning occurs as an interstitial practice (LAVE 1991) embedded into activities of decision making as during the night shift. One of the reasons for this difference may be that the pedagogic arrangements and attachments or, as SCHATZKI would name them, the *teleo-affective structures* (SCHATZKI 2006: 1864) in chronic illnesses are not primarily related to the discipline, as in acute medicine, but *through the development of a shared identity,* they are related to the condition and the care of patients.

Third, by taking experience and learning out of the individual's head and making it a procedure to be enacted in similar moments, the embodied knowledge of prior generations of patients and staff is not passed on but regenerated within the contexts of novices' interactions within the social and material environment.

WEBER (1904) famously argued that situations of crisis call for charismatic leadership. His notion of charisma is not a property inherent in the charismatic figure, but considers it an interactive effect, with the group projecting its expectations, and the leader in turn responding to them. In a similar argument, LÉVI-STRAUSS (1963), in his classic "The Sorcerer and his Magic," described how healers evolve to manage situations, which they had not anticipated, through the expectations and actions of a group, which works as a constant field of gravitation in which healer and patients act. Accordingly, the expectation of swift and confident engagement during the night shift and *to care* was spawned by the nurse's expectation, the attending-doctor and the patient. The caring is done *because it is there to be done,* as KLEINMAN (2009) describes this gravitational field in his "Odyssey of becoming more human by caregiving".

A question arising from our research is what counts as evidence of *good care* (MOL 2008), or best practice, when the experience, required to care is elevated to a distributed knowledge practice. It has been argued that good care in practice is never a fixed, and cannot be judged from the outside. Rather, it is a creative process of attentive experimentation, something to do in practice as care goes on (MOL, MOSER & POLS 2010: 13). If we may not say what good care in general is, then, maybe we may say what the conditions for good care are. As a first tentative answer then, by foregrounding the process of *becoming member of a CoP organized around care,* we have illustrated that making experiences that enable healers to be careful and response-able is a dual process that includes being responsive to the expectations of the CoP and care-ful guidance by those that have made similar experiences. Temporising experience points is a second answer of what good care is: A practice not contained in the present but also assuring the possibility of its regeneration in the future.

Together, the three elements—using irony to narratively create an identity "outside", distributed decision-making and temporalizing learning to care across disciplinary boundaries—create a collectively embodied memory culture allowing the CoP to regenerate itself and to adapt within times of rapid change. This underlines the strength of the concepts of situated learning and CoP in helping to conceptualize the question how newcomers are socialized and learn "to be" (LAVE 2008), and thus allow the social reproduction of a highly specialized organization within medicine.

Beyond anthropological interest in the reproduction of social order (SCHATZKI 2001, 2006), our approach also highlights a possible role for anthropological inquiry within the ecology of care. The enduring success of the ecological concept, its "variation" and "evolution" (LEE 2001, GREEN *et al.* 2001, FRYER *et al.* 2003) may partly be explained by the resonance of these metaphors, all borrowed from biology, with biomedical practitioners' thinking. Since its initial conception, the idea of ecology of medical care has been advocated for use in research and teaching directed at improved understanding of the ways of favorably modifying it, with the objective of "reducing the time lag between advances in the laboratory and measurable improvement in the health of a society's members"(1961: 204). Here, we started from the question, widely ignored in the dominant research on medical care, how medical practitioners' and patients' acting in the world builds up a reflective experience (ROLFE 1997) that is consecutively transformed into expertise (BECK 2015), and how this is continually reproduced within a highly specialised ecology of care in times of rapid change. By this, we aim to productively intervene in the dominant research agendas on medical care. Our attempt is positioned among a growing body of research on expert cultures, that have recently moved from studying "the other" to investigating "mutually interested concerns and projects" where "the basic trope of fieldwork shifts from apprenticeship to collaboration" (MARCUS 2008: 7). While we are deeply sympathetic to such a collaborative research endeavour, we would like to revive the idea of "apprenticeship", albeit in a reflexive perspective.

In an editorial on "Friendship and Fieldwork", VAN DER GEEST (2015) argues that one can learn far more interesting things, ethnographically, by delving more into a subject than if one confines oneself to an outsider position. We are, now, following this suggestion and including auto-ethnographic elements in our analysis. While the role of auto-ethnography in anthropology is a highly debated one, with critical voices concentrating on methodology, and proponents focusing on the intended effect (ELLIS, ADAMS & BOCHNER 2010), the CoP implicitly suggested this approach on several occasions. One of the CF centre's psychologists, in order to help a patient understand her own situation better, gave a patient one of our (unpublished) papers in which, drawing on MOL (2008) we described different logics of exacerbation and care under which CF is performed. Another psychologist explained how, during a seminar for CF patient-trainers, she had used the idea of *mukoviszidieren* which translates as "*doing cystic fibrosis*", a term again floated by MOL & LAW's (2004) radical-practice theory which purports illness as not only something you are or have but something that is done. While it is unclear how much traction such anthropologic concepts may gain, both instances are hints that curating concepts in close proximity with practitioner is possible. One condition of possibility is the intensive immersion that comes with long-term research. A second, and certainly lucky, condition is the generous offer to epistemic partnership by the CoP's practitioners. A third, and possibly temporal, condition is the current state of transition and flux of the CF CoP.

The CoP perspective used in the paper, and the trope of apprenticeship, foreground the important role of experience as a form of knowledge that also needs to be managed and transferred and that must not be considered an individual cognitive phenomenon respectively. While we have demonstrated how decision-making and experience are distributed across team and equipment, reflection seems to be somewhat less subject of distribution at a first glance. Following BOYER's (2015) inquiry how reflexivity is produced within modern epistemic, social and material architectures, one might want to question further where, how, by whom and with what kind of consequences reflexivity is produced within such distributed knowledge practices. Reflexivity in the distributed knowledge practices of CF happened as musings during interactive interviews, informal discussions during coffee breaks and moments of generously available time outside busy daily work as during rounds on weekends. It was present as an interstitial practice, and its effects become visible in the recirculation of anthropological concepts within the CoP mentioned above. This appears very unlike the famously unsuccessful WTO para-site including a staged presentation and explicit reflection (DEEB & MARCUS 2011). Possibly, formally staged events outside the field are just as lousy places for anthropological reflexivity, as formal schooling settings are lousy places to learn anything in, to paraphrase BECKER (1972). The analogy may be controversial, and we do not dismiss the value of the para-site experiments. Yet our intention is to foreground the already happening reflexivity-in-the-field and the possibility to connect and participate in reflexivity-in-practice, which we believe to be a widely distributed and ubiquitous feature of contemporary science and medicine (BECK 2008).

We believe that these further inquiries would benefit from not only writing about, but also becoming part of the practices at the intersection between the theory and practice (INGOLD 2013). Anthropology as a discipline will have little to add to the practitioners' point of view in modern medicine's already highly reflexive communities, unless it engages in joint epistemic work with its research partners by irritating established thought styles and collectives and curating concepts jointly (NIEWÖHNER *et al.* 2016). Within such a co-laborative research agenda, auto-ethnography appears a useful methodological entry point because it allows us to *study sideways* (BOYER & HANNERZ 2006) when reflecting on good care, the production of a skilled identity and the reproduction of a community *from the inside*.

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Notes

1 While RISOR, himself a physician studying younger colleagues, is the exception, he points out that he refrained to actively counsel his informants unless they first laid out their course of action if he wasn't present. It would of course have been unethical had he withheld knowledge during emergencies.

2 Transplantation is one possible treatment for terminal CF but it is risky because the lungs are highly immunogenic organs, the consequence of its large surface to the outside world, accordingly exposing a high risk for rejection. Of the 25 patients who were part of the initial study-sample, ten years ago, three were successfully transplanted while three others died shortly after transplantation rejection or transplant failure. The question, whether to take transplant risk is not only a medical one but deeply embedded in the social norms of our ablest society (MAYNARD 2006).

3 DEWEY distinguishes between *experience* and *an experience*. While experience occurs continuously in interactions of living beings and environing conditions, having *an experience* by humans is characterized by the unity of emotional, practical and intellectual dimensions of the situations or events such perceived (DEWEY 1934: 39). See also BECK (2015) for a discussion of Dewey's pragmatist approach for a practice-oriented take on ecologies of expertise.

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Philosophy—Therapy—Mythology

On a Triangulated Analogy in the Philosophy of Ludwig Wittgenstein

CHRISTIAN ERBACHER

Abstract The article's main aim is to invite healing practitioners to read and interpret the philosophical writings of Ludwig Wittgenstein as relevant for their practices. It outlines Wittgenstein's philosophical orientation using his own triangulated analogy between the fields of philosophy, therapy and mythology. It is argued that Wittgenstein, throughout his philosophical life, considered philosophy as an activity for clarifying philosophical confusion. Philosophizing is thus, like medicine, a treatment for making a troubling state disappear or dissolve. Wittgenstein pointed out that his methods of philosophical clarification might be compared to psychoanalysis. Based on this analogy, philosophical clarification renders a troubling mythology harmless by using a less troubling mythology. This view can in turn shed light on the philosophical confusion that may accompany a scientific worldview. Such confusion emerges when belief in the absoluteness of scientific truth hinders acknowledgement of the truths and insights from other cultures.

Keywords philosophy – psychotherapy – Wittgenstein – Freud – Frazer

A frame for reading Wittgenstein

In this article I want to talk about the philosopher Ludwig Wittgenstein and his analogical representation of philosophy, therapy and mythology. I will be concerned mainly with reading and understanding the philosophy of Wittgenstein, yet I hope to provide some useful and stimulating thoughts for the context of practical healing. This connection may be surprising, considering how Wittgenstein is often portrayed in the wider academic community: he is regarded as a philosopher of logic, sometimes even a logical positivist who, with the *Tratctatus logico-philosophicus* (1922), provided the foundations for a scientific worldview ("wissenschaftliche Weltaufassung"—as the members of the Vienna Circle coined their program). In contrast to this "early and scientistic Wittgenstein," it is sometimes said that a so-called "later and unscientific" Wittgenstein abandoned and deconstructed the doctrines of the *Tractatus* and paved the way for postmodernity. While this is a nice plot for a short philosophical biography, such a highly condensed picture can be very misleading. I therefore begin by stating four main aspects of Wittgenstein's philosophizing which provide the frame for what I would like to explore in the following pages:

1) Wittgenstein never advocated for a scientific worldview. He lived at a time of great optimism in science and technology. His philosophizing, from the very beginning, was aimed at explicating the *limits of science* and scientific reasoning. He wanted to restrict science to its appropriate realm.
2) Rather than the contrast of an "early vs. late" Wittgenstein, many continuities characterize his philosophical development. One of these continuities is the afore-mentioned anti-scientistic orientation; another is his conviction that the goal of philosophy is *clarification*. What changed over time were his methods of clarification.
3) Wittgenstein always held that philosophical clarification is a *practice*. This is closely related to another continuity in his thinking, namely that philosophy should not be used to build theories, but to clarify our thinking.
4) Wittgenstein was an *analogical* thinker. One of his main methods of clarification was

> to find similes and objects of comparison. When juxtaposed, the objects could, he thought, clarify our thinking by illuminating each other.

The three terms in the title of this paper *philosophy, therapy, mythology* are also used as such objects of comparisons. My aim is to illuminate the relation between these three fields as conceived by Wittgenstein. If this can provide a starting point for seeing Wittgenstein's philosophy as relevant for thinking about healing and the cooperation that takes place in healing practices, then the purpose of the paper will have been fulfilled.

Philosophy, like medicine, seeks its own abandonment

Throughout his philosophical life, Wittgenstein considered philosophy to be a practice of clarification, not a set of doctrines. Even as a young man, he stated this in the *Tractatus Logico-philosophicus*:

> The object of philosophy is the logical clarification of thoughts.
> Philosophy is not a theory but an activity.
> (A philosophical work consists essentially of elucidations).
> The result of philosophy is not a number of "philosophical propositions," but to make propositions clear.
> (Philosophy should make clear and delimit sharply the thoughts which otherwise are, as it were, opaque and blurred.) (WITTGENSTEIN 1922: 4.112)

The ability to make something clear is not mystical, but an art (craft) that may be learned through training. Wittgenstein regarded his classes at the University of Cambridge as just such training, and he sometimes compared them to practicing playing an instrument. For example, he compared his lectures to finger exercises on the piano. This musical analogy came naturally to Wittgenstein because music played an important role in both his life and his philosophizing. Another realm he often chose to compare his work to was that of therapy. For instance, when Elizabeth Anscombe came to his classes with questions concerning a theoretical conception, Wittgenstein said: "Let me think what medicine you need" (ANSCOMBE 1981: ix). Then he asked her a question that made her see how it was her theorizing that had given rise to the troubling questions. Once she saw this, her theoretical problem was not solved, but her need for a theoretical solution *dissolved*. A regular attendant of Wittgenstein's lectures remembers a similar occasion:

> The first lecture consisted largely of a disclaimer that he proposed to impart to his audience metaphysical "truths," or indeed that he would be concerned to transmit knowledge at all, in the sense in which it could be said of a geographer or physicist. If that was what any member of the audience was expecting he would be disappointed. What the lectures *would* be offering was, according to Wittgenstein, more like the work of a masseur. If anyone happened to be suffering from a particular kind of mental cramp, Wittgenstein might be able to help him. (REDPATH 1990: 18)

This analogy of treating a particular mental cramp shows that the sessions with Wittgenstein were not merely agreeable afternoons where students got together with their teacher and played philosophy as if it were chamber music. The investigations he conducted were hard work for all participants—including Wittgenstein himself—and a most serious matter (although sometimes [grammatical] jokes were indeed the right treatment to relax a cramp). Moreover, Wittgenstein's treatments were never idle academic play; he was concerned about how people authentically and outside the classroom thought, or rather: how authentic thinking can be led astray as soon as people enter the classroom. This treatment could be painful, as Georg Henrik von Wright remembered:

> Each conversation was like living through the day of judgement. It was terrible. Everything has constantly to be dug up anew, questioned and subjected to tests of truthfulness. This concerned not only philosophy but the whole life. (VON WRIGHT 1989: 14)

Here we get a hint how radical Wittgenstein's way of philosophizing was. He exhibited a philosophizing that had radically turned away from the academic search for "eternal truths and fundamental principles." He substituted this search with trying to clarify specific people's specific talk. We may say that one of his lasting contributions to philosophy was precisely the fundamental insight that philosophical problems are not problems of truth but of sense, an insight that he elaborated throughout his philosophical work. Both early and late in his career, Wittgenstein held that philosophical problems arise from a state of unclarity about the sense of philosophical questions. The result of clarifying the sense of a question is not to make the question meaningful, but to cause the unclarity to disappear—just like a cramp disappears after a massage. I quote from the *Tractatus*:

> The solution of the problem of life is seen in the vanishing of this problem. (Wittgenstein 1922: 6.521)

This may be seen as a paradigm for Wittgenstein's view of what the point of philosophizing is, namely, to make philosophical problems disappear. Just as a medical doctor's aim is to make himself superfluous, philosophizing seeks its own abandonment.

Methods of clarification

How is Wittgenstein's therapeutic clarification to be achieved? According to Wittgenstein's *Tractatus* the method for clarification is "logical analysis:" logical analysis of seemingly deep philosophical questions should show that these questions are actually nonsensical. Such analysis should reveal that we cannot even know what these questions mean. A familiar example of such a question is: "How can I know that the outer world exists?" Other perplexing questions from today's academic philosophy are: "How can consciousness arise from non-conscious matter?" "How can there be free will if the universe is determined by causal laws?" or "How can we define vagueness?" In a Wittgensteinian spirit, we may say that these philosophical questions are not deep because they reach to some deep truth, but rather, that they arise because we are deeply confused about the sense of the sentences in which we formulate the questions. What is the meaning of "to know," "outer world" or "existence" in the first question? What is the meaning of "arise," "consciousness" or "matter" in the second question? What is the meaning of "defining" or "vagueness" in the third question?—The promise of Wittgenstein's philosophy is that a clarification of these meanings will make us see that the questions are nonsensical. A consequence of this acknowledgement would be that the questions, rather than puzzling us, would simply disappear.

While Wittgenstein's general philosophical orientation remained the same throughout his philosophical life, his methods of clarification changed. The so-called middle or later Wittgenstein invented a method of clarification that replaced logical analysis. According to this new method, a main source of our failure to understand something is that we lack *an overview of the use* of words. Words like "to know" or "knowledge," "to want" or "the will," phrases like "having meaning" or "having pain," and so forth, become problematic in contexts of (philosophical) theorizing, because we tend to forget how we usually use these words and phrases. If, for example, we are reminded that we use words of vagueness precisely to allow for cooperation where acute definitions are pointless, the philosophical question of how to exactly define vagueness dissolves. The philosophical clarification has thus to make surveyable the everyday uses of philosophically problematic terms:

> The concept of a surveyable representation is of fundamental significance for us. It characterizes the way we represent things, how we look at matters. (Is it a "Weltanschauung?") (Wittgenstein 2009: § 122)

Wittgenstein's idea of a surveyable or "perspicuous" representation suggests that we can gain this overview by assembling non-problematic cases of the use of these phrases as objects of comparisons, as well as intermediate cases that show how we are led from non-problematic usage to problematic questions. These objects of comparison may be scenarios of meaningful word usage, and thus the famous method of language games enters the scene:

> Our clear and simple language-games are not preparatory studies for a future regularization of language—as it were first approximations, ignoring friction and air-resistance. The language-games are rather set up as *objects of comparisons* which are meant to throw light on the facts of our language by way not only of similarities, but also of dissimilarities. (Wittgenstein 2009: § 130)

Here we have the promise of a method of clarification that is not another theory. Once we survey the use of the words that lead to perplexity when they are taken out of context and put into philosophical questions, we will recognize these questions as nonsensical. Wittgenstein describes the outcome:

> The results of philosophy are the discovery of some piece of nonsense and the bumps that the understanding has got by running up against the limits of language. They—these bumps—make us see the value of that discovery. (WITTGENSTEIN 2009: § 119)

This makes clear that for Wittgenstein the practice of philosophizing consisted in taking something away, like cleaning up a room. But here it is important *not* to understand Wittgenstein's antitheoretical dissolving of philosophical questions in a dogmatic sense, as if it would provide yet another eternal theory. Wittgenstein was very careful in all his formulations, and he was especially careful with generalizations, since hasty generalization is one of the main means by which language can mislead us into philosophical muddles.* Indeed, in contrast to imposing yet another dogma, Wittgenstein's philosophy may be said to be wholly anti-dogmatic. The employment of concepts like "language game" or "family resemblance" was meant to block our craving for essences and general truths, and to open our minds for recognizing the importance of differences between individual cases. It is therefore not surprising that Wittgenstein pinned the following note on the manuscript-page that discussed his philosophical method:

> There is not one single philosophical method, though there are indeed methods, different therapies, as it were. (WITTGENSTEIN 2009: § 133)

This note is a helpful reminder that Wittgenstein's writings—apart from the *Tractatus*, they were posthumously published from his manuscripts—may be read as examples of his attempt to create perspicuous representations meant to dissolve his troubling philosophical questions. In this sense, Wittgenstein's manuscripts are diaries of a therapeutic process.

Philosophy and psychotherapy

The remark quoted from § 133 brings us back to the analogy between philosophy and therapy, and it is this that I would like now to consider in greater detail. This analogy highlights that a philosophical problem in Wittgenstein's sense is *someone's* problem, and that the philosophical work is work on *oneself* (*cf.* WITTGENSTEIN 1977: 24; WITTGENSTEIN 1994: 52). It was Wittgenstein's trouble with philosophical questions that prompted him to invent his methods of clarification. But in order for these methods to be effective, it is necessary that a person, in the first place, is troubled by a philosophical question. Only then can the clarificatory treatment bring peace to the person and resolve philosophical disquietude. It is most important that this peace from clarification cannot be passively received; just as in psychotherapy, improvement is not achieved through taking a pill prescribed by a doctor. Rather, it is a cooperative practice in which the understanding of the patient develops over time; this understanding empowers the person to clarify his or her confusion. When making this analogy between philosophy and psychotherapy, however, we should keep in mind that Wittgenstein did not propose that his methods of clarification were treatments for psychological disorders in general or for all kinds of mental trouble. Instead he proposed a treatment for a *particular kind* of mental cramp, namely that trouble caused by questions rooted in our ways of representing the world when doing philosophy. The analogy with therapy serves as an object of comparison in order to shed light on Wittgenstein's way of philosophizing. He particularly thought of the analogy with psychoanalysis as illuminating.

Wittgenstein never elaborated a systematic account of psychoanalysis, and his relation to Freud is ambiguous. However, he repeatedly referred to Freud and returned to the topic of psychoanalysis. For instance, when he visited his student, friend and colleague (and later executor of his will) Rush Rhees in Swansea in the early 1940s, he spoke of himself as a "disciple" and "follower of Freud." Moreover, when Alfred Ayer, in a popular arti-

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* One of Wittgenstein's closest friends, the psychiatrist Maurice O'Connor Drury, identified generalizations as belonging to the "Danger of Words" (1973), as he called his wonderful little book, which seeks to show how he as a psychiatrist has benefitted from discussions with Wittgenstein.

cle, suggested that Wittgenstein conceived of philosophy as a form of psychoanalysis, it angered Wittgenstein and he said: “they are different techniques” (MALCOLM 1958: 57). At one point, Wittgenstein was especially interested in the practice of interpreting dreams, and he thought that the skills needed for practicing psychoanalysis and his way of philosophizing must be similar. He wrote the following in 1948:

> In a Freudian analysis the dream is, so to speak, decomposed. It completely loses its original meaning. One could imagine a large piece of paper with a picture drawn on it: the picture is now pleated up in such a way that pieces which were quite unrelated in the original picture are now visually adjacent and a new picture (meaningful or meaningless) results: this new picture would be the dream as dreamed, while the original picture would correspond to the latent dream content.
>
> Now, I could imagine someone who saw the unfolded picture exclaiming, “Yes, that is the solution, that is what I dreamt, but without the gaps and distortions.” In that case the solution would be constituted as such by the dreamer's recognition of it and by nothing else. It is just as when you are writing something and looking for a word and suddenly say “That's it, that's what I wanted to say:” your recognition of the word stamps it as the word that you were looking for and have now found. […]
>
> What is intriguing about a dream is not its causal connection with events in my life etc. but rather that it functions as part (indeed a very life-like part) of a story the remainder of which is in the dark. […] To be sure, as the paper unfolds the original picture disintegrates—the man that I saw was taken from there, his words from here, the surroundings of the dream from a third place, but the dream-story has its peculiar charm, like a painting that attracts and inspires us.
>
> Of course one might say that we view the dream in an inspired way, that it is we who are inspired. Because when we relate our dream to someone else, generally the imagery doesn't inspire him. The dream affects us like an idea pregnant with possible developments. (WITTGENSTEIN 1977: 68–69; WITTGENSTEIN 1994: 132–3; translation by MCGUINNESS 2002: 226–7)

In dream interpretation, elements of the dream are assembled in a way that presents a convincing story. As Brian McGuinness stresses, a crucial point of this passage is its acknowledgement of the dreamer as the judge of the rightness of the interpretation: the interpretation must be accepted by the person whose dream is interpreted. This acceptance, however, would not be evidence or proof of the correctness of the interpretation in a scientific sense. The dreamer's acceptance of the interpretation shows instead that the representation of the dream elements in that specific way is attractive and convincing. According to Wittgenstein, psychoanalysis is far from providing scientific explanations (he said that the propositions of psychoanalysis are even pre-hypothetical!)—rather, it would provide a new mythology.

Wittgenstein's statement that psychoanalysis is not a science was not meant to disregard the practice. In this respect he differed from Karl Popper, who criticized psychoanalysis for not being a science. Wittgenstein never considered it could be—he appreciated Freud's achievement of showing that it is possible to replace an older way of looking at things with a new story and to couple it with new rituals. According to Wittgenstein, it would be dangerous to think of a psychoanalytic interpretation as scientific truth, but if one could choose it as an alternative way of looking at one's life, it could be fruitful and enlighten one's thinking. The important thing is to be able to relinquish this frame of interpretation when one wants. In this sense, psychoanalysis provides an object of comparison for other ways of looking at things that may be mistaken for scientific truth. Such examples may themselves be descriptions in science, such as the Darwinian description of evolution or the world-picture of physics. Even in his early career, Wittgenstein saw these as “modern mythologies:”

> At the basis of the whole modern view of the world lies the illusion that the so-called laws of nature are the explanations of natural phenomena. (WITTGENSTEIN 1922: 6.371)
>
> So people stop short at natural laws as something unassailable, as did the ancients at God and Fate. (WITTGENSTEIN 1922: 6.372)

This passage from the *Tractatus* foreshadows Wittgenstein's later remarks on the work of James Frazer, the Cambridge anthropologist who wrote *The Golden Bough*. This brings us to the third term of comparison in the title of this paper, “mythology.”

Philosophy as uncovering the mythology of modern times

In the early 1930s, Wittgenstein asked his friend Maurice O'Connor Drury to get a copy of Frazer's *The Golden Bough* so that they could read it together. Drury—who became a psychiatrist on Wittgenstein's advice—later remembered Wittgenstein's main criticism on this work, and precisely with a view to the passage from the *Tractatus* just mentioned:

> The whole modern view of the world resting on an illusion --------- the ancients were clearer. To believe this really, to let it sink in, then we are aliens to nearly every thing [sic] that is going on around us. You cannot accept this without hurting oneself. This is indeed to turn oneself right around.
>
> Once Wittgenstein asked me to read to him part of "The Golden Bough." Fraser [sic] always treated the myths and customs he had so assiduously collected with a certain condescention [sic]. He said we must not despise them for their errors because they represented the first rudimentary thoughts from which later science was to spring. But, as Wittgenstein pointed out, these ancients had indeed already their science. Agriculture, irrigation, weapon making, etc: they were able to survive under conditions where we would now perish. No, these myths, these customs, had nothing to do with the beginning of science. They were the expression of a belief and a longing for something other than the bread and comforts of daily existence. And in so far as we have now lost these common myths and customs, so much are we the poorer. The belief that the further progress of scientific discovery and invention will bring us any nearer to the relief of our deepest needs, is a superstition worse than anything Fraser cast his pity on. (Letter, Drury to Rhees, Spring 1966: 18–9)

For Wittgenstein, the modern optimism regarding science and technology was a myth that held us captive. He saw the myth as a worldview, and philosophizing, for him, had the task of freeing our thinking from habits of thought emanating from this worldview. According to Wittgenstein, a worldview was necessarily entrenched in a corresponding way of living and speaking. He thought the way of living in modern times gave rise to the confusions in language that undergirded current philosophical problems. Wittgenstein's work was partly aimed at freeing philosophy from the idea of it being a science; or, to put it another way, to make us see how the assumption of philosophy as science and the use of scientific jargon constitute a powerful myth that hinders us from pursuing our philosophical needs, since it hinders us from being open to look at the world with fresh wonder. Thus, around the time when he was reading Frazer with Drury, he wrote the following draft for a book preface:

> I now believe that it would be right to begin my book with remarks about metaphysics as a kind of magic.
>
> But in doing this I must not make a case for magic nor may I make fun of it.
>
> The depth of magic should be preserved. –
>
> Indeed, here the elimination of magic has itself the character of magic. (WITTGENSTEIN 1967)

This passage shows us that Wittgenstein did not want to deprive science of its scientific merit. This would be completely mistaken. The point was to assign scientific thinking to the places where it belongs and to remind ourselves that we are led into confusion when we confuse the measuring rod of scientific language with the actual phenomenon, or when we imagine that such language is the only correct way to measure or represent the phenomenon.

Concluding remark

In this article, I have tried to sketch an orientation in Wittgenstein's philosophizing by elucidating the relation he saw between the fields of philosophy, therapy and mythology. It is certainly not more than a sketch: for each of the three fields, you will find connections to Wittgenstein's philosophy that go much deeper than what I have touched on here, and all the connections are explored in scholarly literature. Nevertheless, this article may give an idea of how to approach the reading in order to render fruitful Wittgenstein's thinking regarding questions of healing and the cooperation that takes place in healing practices. It thereby situates Wittgenstein in a tradition of other philosophers who have worked out a therapeutic self-understanding. Given that few thinkers have delved into Wittgenstein's manuscripts as pieces of great modern literature reflecting a lifelong therapeutic dialogue, healing practitioners would find here an open field for further elaboration.

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REPORTS

Historische Perspektiven auf die Essentialisierung und Biologisierung von Geschlecht

Bericht zum Symposium des AKHFG, 6.–7. Juli 2017, Ruhr-Universität Bochum

MIRIAM SARAH MAROTZKI

Der *Arbeitskreis Historische Frauen- und Geschlechterforschung* (AKHFG) widmete dem Thema der Essentialisierung und Biologisierung von Geschlecht aus aktuellem Anlass eine interdisziplinäre Tagung. Auch wenn die zentralen Begriffe Essentialisierung und Biologisierung dem Wortschatz der 1990er Jahre entlehnt zu sein scheinen, haben sie in den letzten Jahren eine zunehmende Aktualisierung erfahren. Entgegen den Annahmen und Ergebnissen von gut 40 Jahren Geschlechterforschung kann in den letzten Jahren eine Rückkehr der These von der geschlechtlichen Bipolarität beobachtet werden, wie sie sich etwa in den populärwissenschaftlichen Publikationen von Evolutionsbiologen wie Ulrich Kutschera und Axel Meyer niederschlägt, die sich in ihrer Argumentation auf vermeintlich (natur-)wissenschaftliche Tatsachen berufen (vgl. MEYER 2015, KUTSCHERA 2016).

Hier setzte die Tagung an, die von den Historiker/innen MAREN LORENZ, gemeinsam mit MURIEL GONZÁLEZ ATHENAS (beide Ruhr-Universität Bochum) und FALKO SCHNICKE (DHI London) ausgerichtet worden war. Einleitend führte Lorenz aus, dass die historische Perspektivierung exakt jener Topoi von Essenz und Biologie des Geschlechts, derer sich Autoren wie Kutschera und Meyer bedienten, dazu beitragen könne, die Sichtbarkeit der Gegenanalyse zu erhöhen und es den „Vereinfachern der Welt so schwer wie möglich zu machen". Diesem Anliegen kamen die Tagungsteilnehmer/innen in ihren überwiegend konstruktivistisch und diskursanalytisch ausgerichteten Beiträgen nach.

Finanziert wurde die Tagung durch den Margherita-von-Brentano-Preis 2015, mit dem Gisela Bock und Karin Hausen als Gründerinnen und der AKHFG als Verein ausgezeichnet worden waren. In insgesamt sechs Sektionen stärkten Wissenschaftler/innen unterschiedlicher Disziplinen in internationaler Zusammensetzung die Einsicht in die Konstruiertheit der Topoi von Essentialisierung und Biologisierung von Geschlecht. Die Veranstalter/innen wiesen auf die Aktualität des Themas hin, angesichts einer zunehmenden Infragestellung und Diffamierung von Geschlechterforschung aus verschiedenen politischen und gesellschaftlichen Bereichen, die häufig mit populistischen Argumentationen und Werte- und Weltvorstellungen in Zusammenhang stünde. Der Wunsch nach von der Natur geregelten Geschlechterverhältnissen scheint allgegenwärtig und Thesen, in denen die Gender Studies als verschiedene gesellschaftliche Felder umfassende Verschwörungstheorien gekennzeichnet werden, finden großes Entgegenkommen.

In der *Keynote Lecture* zeigte der Sozialwissenschaftler und Biologe HEINZ JÜRGEN VOSS (Hochschule Merseburg) an Hand von antiken Lehren über Geschlechterverhältnisse auf, dass sie sich in ihrer Auffassung über Ein- und Zweigeschlechtlichkeit durchaus unterschieden. Er plädierte für eine präzise, interdisziplinäre, quellenbasierte und nicht verallgemeinernde Analyse, die die Arbeit der Dekonstruktion nicht vereinheitlicht, sondern eine Offenheit gegenüber Gleichzeitigkeiten zulässt.

Das Symposium widmete sich in seiner ersten Sektion der Zweigeschlechtlichkeit. Wie im Mittelalter eine Essentialisierung von Geschlechterdifferenz konstruiert bzw. begründet wurde, zeigte BRUNO WIEDERMANN (Universität Tübingen) mittels einer historischen Analyse der Himmelskörper in mittelalterlichen laienastrologischen Texten und Bildern.

In der zweiten Sektion *Der Körper als Investition* stellte LARS BLUMA (Deutsches Bergbau-Museum Bochum) als Wirtschafts- und Technik-historiker die körpergeschichtlich ausgerichtete Frage nach der Vergesellschaftung des arbeitenden (Männer-)Körpers im Steinkohlebergbau an der Ruhr von 1890 bis 1980. Indem er die Knappschaft in das Zentrum seiner Überlegungen stellte, untersuchte er, wie Männlichkeit und Körperlichkeit des Bergmanns im Versicherungswesen konstruiert werden. Dabei konnte er eine Verdatung und Vergesellschaftung des arbeitenden Körpers beobachten und damit eine Praktik, die „ontologisierende und anthropologisierende Körper- und Geschlechterzuweisungen zumindest partiell dekonstruiert". Dabei, so wurde in der abschließenden Tagungsbetrachtung von GABRIELE DIETZE (HU Berlin) festgehalten, könne die Praxis der Vergesellschaftung durchaus als Alternative zu Biologisierung und Essentialisierung betrachtet werden. Der Zusammenhang von Recht, Naturforschung und Ökonomie prägte BETTINA BOCK VON WÜLFINGENS (HU Berlin) kulturwissenschaftlich motivierte Überlegungen zur geschlechtlichen Arbeitsteilung (insbesondere im Reproduktionsbereich) in der Kernfamilie Ende des 19. Jahrhunderts.

Im Zentrum der dritten Sektion stand die Rolle von *Institutionen*. Über Fallbeispiele aus dem 20. Jahrhundert exemplifizierte der Geschichts- und Rechtswissenschaftler JOHANN KIRCHKNOPF (Universität Wien) die Konstruktion von Geschlecht in der österreichischen Gerichtspraxis. Dabei fragte er nach dem Zusammenhang zwischen medizinischer Wissensproduktion und Rechtsprechung. Obwohl durch die Rechtsprechung nicht eindeutig definiert, legten die Gerichte eine binäre Geschlechterordnung unausgesprochen zu Grunde, begründeten die geschlechtliche Zuordnung aber auch über die gesellschaftliche Wahrnehmung und erwiesen sich damit, so Dietze, als „Orte sozialer Selbstvergewisserung". CLAUDIA KEMPER (Hamburger Institut für Sozialforschung) interessierte sich als Historikerin dafür, inwiefern eine Organisation geschlechtlich aufgeladen werde, resp. in wie weit sie geschlechtsorganisierend wirke. Als „neutral ausgerichtete" Organisationen böten sich nach Kemper NGOs für eine solche Untersuchung in besonderem Maße an. Mit ihrem Untersuchungsgegenstand brachte Kemper ein neues Motiv in die Diskussion ein: Auch progressiv ausgerichtete Verbände agieren nicht zwangsläufig geschlechtergerecht.

KATJA SABISCH (Gender-Studies, Ruhr-Universität Bochum) machte den Auftakt für die vierte, der *Wissenschaft* gewidmeten Sektion. Sie ging von Ludwik Flecks in seinem Buch *Entstehung und Entwicklung einer wissenschaftlichen Tatsache* (1935) entwickelten Vorstellungen von Denkstil und Denkkollektiv aus, um die wandelnden Konzepte der „wissenschaftlichen Tatsache Geschlecht" seit dem 18. Jahrhundert zu untersuchen. CHRISTINA BRANDT (Ruhr-Universität Bochum) stellte mit Donna Haraway eine Galionsfigur feministischer Wissenschaftskritik in den Mittelpunkt ihrer Überlegungen. Neben einer Historisierung der frühen Arbeiten Haraways verwies Brandt auf die Wechselwirkungen zwischen jeweils aktuellen Forschungsentwicklungen und eventuellen kritischen Gegendiskursen.

Von wissenschaftsgeschichtlich ausgerichtetem Erkenntnisinteresse wurde auch die Untersuchung der Historikerin ELSBETH BÖSL (Universität der Bundeswehr, München) geleitet, die die fünfte, den *Biologien* gewidmete Sektion eröffnete. Sie veranschaulichte am Beispiel von Körpergräbern, wie durch die Bestimmungsverfahren unterschiedlicher Disziplinen den gefundenen Toten jeweils diverse Geschlechter zugeordnet werden und dass Interdisziplinarität zu einer Revision der Ergebnisse führen müsse. Hieraus resultiere die Frage nach der Ansprachehoheit: Welcher Wissenschaft kommt diese zu und trägt nicht der stetig anwachsende Anteil der *lab sciences* bei diesen Verfahren letztendlich zu einer Biologisierung von Geschlecht bei?

Der Historiker SAŠA VUKADINOVIC (Universität Zürich) fokussierte Pariser Schriften der 1970er und frühen 1980er Jahre: Die Schriftstellerin und Philosophin Monique Wittig zeigte über literarische Strategien die Möglichkeit einer Entbiologisierung des weiblichen Körpers auf, während die Soziologin Colette Guillaumin das wissenschaftliche Konzept von *race* dekonstruierte und somit einen frühen Beitrag zu intersektionalen Ansätzen leistete.

Die abschließende Sektion der Tagung setzte sich mit der Rolle des *Populäre[n] Wissens* auseinander. Die Historikerin CHRISTINA BENNINGHAUS (Justus-Liebig-Universität Gießen) zeigte an Hand von populären Gesundheitsratgebern des 19./20. Jahrhunderts auf, welche Rolle (wissenschaftlichen) Bildern in der Konstruktion der

Vorstellungen von Geschlecht zukommt. Das Symposium schloss mit einem Vortrag der Historikerin KERSTIN WOLFF (Archiv der Deutschen Frauenbewegung, Kassel), die dafür plädierte, an jene literarischen Argumentationsstrategien, die Hedwig Dohm vor etwa 150 Jahren entwickelt hatte, wieder anzuknüpfen, um damit heute ähnlichen Argumenten für biologisch determinierte Geschlechterrollen zu begegnen.

Damit wurde der Bogen zurückgeschlagen zu dem eingangs formulierten Anliegen durch die historische Betrachtung der Biologisierung und Essentialisierung von Geschlecht für aktuelle Debatten und deren Argumentationsstrategien zu sensibilisieren. Das Symposion endete mit einer Tagungsbeobachtung der Amerikanistin GABRIELE DIETZE und der Wissenschaftshistorikerin BETTINA WAHRIG (TU Braunschweig) sowie einer Abschlussdiskussion. Erneut wurde die Deutungshoheit über Geschlecht thematisiert: Geschlecht sei durch die *life sciences* vieldimensionaler geworden (etwa die Wahrnehmung des biologischen Geschlechts als durch verschiedene Faktoren z. B. chromosomal, hormonell oder genital bedingt). Wie aber kann ein Umgang mit einer hierdurch ausgelösten Verunsicherung aussehen und wie viel Naturwissenschaft verträgt die Geschichtswissenschaft? In den Aushandlungsprozessen über die Deutungshoheit von Geschlecht, den Natur-, Geistes- und Sozialwissenschaften miteinander führen, sollte den *Gender Studies* ihr Kerngeschäft zugesprochen werden. Kontrovers wurde darüber diskutiert, wie mit diesen Deutungshoheitsabsprachen umgegangen werden kann. Kernpunkte der Debatte waren im Bewusstsein der eigenen Viktimisierung verstärkt mit und aus der eigenen Fachkompetenz heraus zu argumentieren. Auch die Forderung, stärker intersektionalen Verknüpfungen nachzugehen – aktuell wie historisch – wurde laut. Nach Überlegungen darüber, ob sich die Beiträge der Tagung nicht vielmehr um die Essentialisierung und Biologisierung von Zweigeschlechtlichkeit, denn – wie titelgebend – Geschlecht, bezogen hätten, schlug Bettina Wahrig in Reaktion auf die Diskussion vor, alternativ zum Begriff der Biologisierung, diesen weiter fassend, von einer Essentialisierung und Naturalisierung von Geschlecht zu sprechen. Die vielfältigen, diskutierten Aspekte machten deutlich, wie ertragreich neuere Forschungen auch ältere Fragestellungen diskutieren können – und machten Lust auf mehr.

Wiederabdruck mit freundlicher Genehmigung aus *feministische studien* Heft 1/2018

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Lyrik und Medizin

Bericht zur Tagung des Instituts für Geschichte, Theorie und Ethik der Medizin der Universität Ulm, 20. – 22. März 2018

FRANK URSIN & FRANK KRESSING

Vom 20.–22. März 2018 fand im Gewölbesaal des Ulmer Hauses der Stadtgeschichte die Tagung „Lyrik und Medizin“ mit dreißig Teilnehmerinnen und Teilnehmern aus dem In- und Ausland statt. Im Zentrum der Tagung standen die unmittelbaren und sehr vielfältigen Bezüge zwischen Poesie und Heilkunde, speziell zum Feld der *Medical Humanities*. Der Tagungsort war für sich schon geneigt, dichterische Assoziationen zu erwecken: Das Haus der Stadtgeschichte befindet sich in dem seit 1602 errichteten „Schwörhaus“ der ehemaligen freien Reichsstadt Ulm, von dessen Balkon aus der Oberbürgermeister einmal jährlich den Schwur auf die Verfassung des Jahres 1397 leisten muss. Dabei gelobt er, „allen Ulmern ein gemeiner Mann zu sein“. Das Gebäude befindet sich auf dem Gelände der ehemaligen kaiserlichen und königlichen Pfalz und beherbergt heute das Stadtarchiv. Dessen Leiter, Michael Wettengel, wies in seiner Begrüßungsansprache auf Mauerreste aus der Stauferzeit im Tagungsraum hin, die zur Pfalzkapelle des 9. Jahrhunderts gehörten.

Veranstalter der Tagung waren Florian Steger, Direktor des Instituts für Geschichte, Theorie und Ethik der Medizin der Universität Ulm, und Katharina Fürholzer (wissenschaftliche Mitarbeiterin). Die Vortragenden stammten aus Mitteleuropa (Deutschland, Österreich, Schweiz, Luxemburg), dem Ostseeraum (Dänemark, Lettland) und Ostasien (China, Hongkong, Japan). Auch die Themen der Tagung spannten einen weiten Bogen: Angefangen vom europäischen Mittelalter (Amelie Bendheim, Luxemburg: Liebe, Krankheit und Wahn im Minnesang) über medizinische Spottverse auf Doktor Eisenbarth und den Sanitätsgefreiten Neumann (Peter Steinkamp, Ulm) bis hin zu *Chinese illness poetry* (Birgit Bunzel Linder, Hongkong).

Die ersten beiden Vorträge von RUDOLF DRUX (Köln) und GIOVANNI RUBEIS (Ulm) zeichneten zwei Pole der Tagung vor, um die alle weiteren Beiträge kreisten. Rudolf Drux arbeitete unter anderem am Beispiel von Hans Magnus Enzensbergers *Mausoleum* (*Balladen aus der Geschichte des Fortschritts*) die seismographische Funktion von Lyrik heraus – dies sowohl für die Gesellschaft im Allgemeinen, als auch für die Medizin im Speziellen. Enzensbergers 1978 veröffentlichte Ballade hat die frühen naturwissenschaftlichen Versuche des italienischen Abtes Lazzaro Spallanzani (1729–1799) zum Thema und stellt deutlich dessen Missachtung der Würde anderer Lebewesen in seinem wissenschaftlichen Tun heraus. Rudolf Drux machte bei dieser Gelegenheit auf die weit zurückreichende literarische Beschäftigung mit der künstlichen Erschaffung des Lebens aus unbelebter Materie („Urzeugung“, *Genesis automatos*) aufmerksam, speziell des menschlichen Lebens im Sinne des „Retortenmenschen“: das Motiv des Homunculus (seit etwa 1530 nachzuweisen), der Inkubator des René-Antoine Réaumur (1683–1757, „künstlicher Uterus“ 1750) und Marry Shelleys (1797–1851) Roman *Frankenstein* (1818). Die zeitgenössische Autorin Ulrike Draesner (geboren 1962) setzte sich in ihrem Gedicht *Dolly und ich* (2000) in pointierter Form mit der modernen Reproduktionstechnologie (Geburt des Klon-Schafes Dolly 1997) auseinander und assoziiert mit der „post-Dolly“-Zeit den Verlust des Humanen – bis zu dem Zustand, dass „Menschen von geklonten Insekten nicht mehr zu unterscheiden sind“.[1]

Giovanni Rubeis wies darauf hin, dass auch Ulmer Stadtärzte neben ihrer medizinischen Tätigkeit durchaus Literatur verfassten. Er wertete am Beispiel der so genannten Podagra-Briefe des Humanisten und Ulmer Stadtarztes Wolfgang Reichart (1486–um 1547) ebenjene in Versform abgefassten Briefe als Quelle für die Medizingeschichte aus. Dieser Briefwechsel entsprach möglicherweise einem Behandlungsverhältnis. Rubeis leitete dabei die Frage, warum sich zwei Humanisten – Reichart als Arzt und sein Korrespondenzpartner Jakob Locher (1471–1528, genannt „Philomusus“) – ihre medizinischen Konsultationsbriefe in der Form elegischer Distichen auf Latein zusandten. Im modernen Sinne könnten diese Briefgedichte als eine frühe Form der „Telemedizin" gedeutet werden, auch wenn sich solche Behauptungen – ebenso wie retrospektive Diagnosen – aus heutiger Sicht verbieten. Giovanni Rubeis konnte neben der Ästhetisierung des Geschriebenen und der mnemotechnischen Funktion von Versmaßen überzeugend nachweisen, dass die Briefe in der Tradition medizinischer Lehrgedichte zu beschreiben sind. Bei solchen Briefgedichten handelte es sich um eine durchaus übliche Kommunikationsform von Humanisten – die Form des zweizeiligen Distichons war als Mnemotechnik schon in der Medizinschule von Salerno gebräuchlich.

Anett Lütteken aus Zürich verwies in ihrer Behandlung der Kurgedichte des 18. Jahrhunderts auf den Wellness-Tourismus der damaligen Zeit, wobei sie einen „weit gefassten Qualitäts- und Lyrikbegriff" ansetzte. Als Folge von „Kurmode" und Balneologie hatte sich in den damaligen deutschsprachigen Gebieten eine „Brunnenobsession" entwickelt, für die hagiographische Verlautbarungen, Frömmigkeitsbezeugungen und tradierte Topoi („Jungbrunnen") charakteristisch sind. Andererseits galten besonders das westböhmische Karlsbad (heute Karlovy Vary) und auch andere Kurorte zwischen 1650 und 1850 als „Zentrum der Lüste" – daran änderten auch christliche Perspektiven (Gesangbücher zur Einstimmung auf den Kuraufenthalt) wenig.

Peter Steinkamp (Ulm) legte die Aufmerksamkeit auf von der Forschung bisher wenig beachtete Spottverse bei Studenten („Doktor Eisenbarth") und bei Soldaten („Sanitätsgefreiter Neumann") mit jeweils überwiegend medizinkritischen Inhalten. Johann Andreas Eisenbarth (1663–1727) war ein aus der Oberpfalz stammender Handwerkerchirurg, Starstecher, Bruch- und „Sauschneider" (Nutzvieh-Kastrierer), der über durchaus beachtliche medizinische Fähigkeiten verfügte und als Wanderarzt zum Beispiel eine sehr risikobehaftete Kopfoperation bei preußischen Offizieren seiner Zeit durchführte, allerdings niemals einen Doktorgrad erlangte. Beim „Sanitätsgefreiten Neumann" handelt es sich um eine fiktive, ebenfalls ab dem späten 19. Jahrhundert in soldatischem Liedgut nachweisbare Gestalt, deren Wirken mit derb-zotigen Sprüchen („Tripperspritze", Ritterburgen für dermatologische Abteilungen) und zahlreichen Anspielungen auf Wehrmachtsbordelle verbunden war. In der zweiten Hälfte des 20. Jahrhundert war der Sanitätsgefreite sogar Objekt einer gewissen „Softpornovermarktung".

Steinkamps Analyse zeigte die identitätsstiftende Funktion der gesungenen Verse auf. Im Fall des Doktor Eisenbarth handelt es sich dabei um eine interne Medizinkritik, da sich ursprünglich Göttinger Studenten den fahrenden Wundarzt Eisenbarth als historische Vorlage für ihre Distinktion vom Wundarzt-Handwerk auserkoren hatten. Die von den Studenten popularisierten Spottlieder drehten sich vornehmlich um Behandlungen des vermeintlichen „Doktors" mit schwerwiegenden Beeinträchtigungen oder sogar Todesfolge für die Patienten. Die Figur des Sanitätsgefreiten Neumann fungierte hingegen als eine Projektionsfläche für medizinische Erfindungen und venerische Erkrankungen, die unter den deutschen Soldaten beider Weltkriege weit verbreitet waren. – Das gemeinsame Singen der entsprechenden Lieder hatte den Charakter von studentischen und soldatischen Initiationsritualen.

Die Beiträge von Barbara Wiedemann (Tübingen) und Daniel Ketteler (Berlin) beschäftigten sich in durchaus unterschiedlicher Akzentsetzung mit dem Leben und Wirken von Paul Celan (1920–1970). Celan wurde im damals rumänischen Czernowitz (Bukowina) geboren und gilt als einer der wichtigsten Vertreter der „Dichtung im Angesicht der Shoah".[2] Zentrale Bestandteile des lyrischen Schaffens Celans, der sich als „Jude nach dem Gesetz des Herzens" sah, waren die Betonung jüdischer Wehrhaftigkeit angesichts vielfältiger Bedrohungen durch die christlich-„arische" Außenwelt und das Motiv des *ziw* (hebr. „Lichtschein") – durchaus zu verstehen auch als „Gegenlicht". Obwohl Celan seit 1948 nicht mehr im deutschsprachigen Bereich gelebt hatte, publizierte er ausschließlich in dieser Sprache. Sein Leben zeichnete sich durch mehrmalige Psychiatrieaufenthalte, unter anderem aufgrund eines Mordversuchs an seiner Ehefrau, Suizidversuche und schließlich seinen Freitod 1970 in der Seine aus. Daran anknüpfend zeigte Daniel Ketteler (Berlin) den Widerstreit zwischen kreativem Inzentiv und der Parese einer Psychose am Beispiel zweier Gedichte des Autors. Anstatt zu pathologisieren verortete der Psychiater Ketteler die Gedichte historisch-biographisch, setzte zum Beispiel die Betonung von Licht und „Gegenlicht" im Werk Celans[3] in Beziehung zu „Lichtkrämpfen" nach Neuroleptika-Gaben. Kettler wies dabei darauf hin, dass traumatisierte Patienten mit dem Stift sprichwörtlich ihr Schicksal in die Hand nehmen könnten – vergleichbar einer Schreibtherapie (im Sinne des therapeutischen Effekts des sozialen Ansatzes nach James Pennebaker, geboren 1950).

Wichtige philologische Anregungen kamen in der Diskussion anschließend von der ausgewiesenen Celan-Kennerin Barbara Wiedemann (Tübingen). Hierbei zeigte sich die äußerst fruchtbare Kombination verschiedener Fachbereiche innerhalb der Medical Humanities.

Neben den zwei genannten Polen „Lyrik als Seismograph" der Medizin innerhalb der Gesellschaft und „Lyrik als Quelle" für die Medizingeschichte lässt sich noch eine dritte thematische Schwerpunktsetzung der Tagung ausmachen. ANITA WOHLMANN (Odense, Dänemark) gab einen lebendigen Einblick in US-amerikanische Medical Humanities-Kurse für Studierende der Humanmedizin. Sie diskutierte dabei die Möglichkeiten und Grenzen dieser Kurse innerhalb der medizinischen Ausbildung. Im Ergebnis erscheinen die Kurse, in dessen Mittelpunkt etwa eine Gedichtinterpretation stehen kann, dazu geeignet, angehenden Ärzten die Perspektive des Patienten näher zu bringen.

Mit der Patientenperspektive beschäftigte sich auch NILS RITTER (Berlin). Es ging um die Frage, ob und – wenn ja – wie der von Gottfried Benn (1886–1956) geprägte Begriff der „klinischen Lyrik" wiederzubeleben sei. Er untersuchte zu diesem Zweck drei Literaten in Fallstudien und fand bei Gottfried Benn (1886–1956) „nihilistische Wirklichkeitszertrümmerung", bei Alfred Lichtenstein (1889–1914) „Grotesken des Verfalls", und bei Georg Heym (1887–1912) „apokalyptische Fieber-Topographien".

Auch interkulturelle und ethnomedizinische Aspekte kamen in der Tagung nicht zu kurz: SAYED GOUDA von der Huaqiaon-Universität in der nordostchinesischen Provinz Jilin begann seine Würdigung des in Ägypten zunächst wegen seiner Poesie geschmähten Dichterarztes Ibrahim Nagi (1898–1953) mit dem doppelten Bedeutungsgehalt des arabischen Wortes *el-ṭib*, das einerseits Magie und andererseits Wissenschaft bedeuten kann. Ibrahim Nagi verbrachte Zeiten seines Lebens im Pariser Exil. Seine Gedichte von unerfüllter Liebe wurden zum einen mit verschiedenen ägyptischen Filmschauspielerinnen in Verbindung gebracht, können aber durchaus dem Motiv der mystischen, „trunkenen" Gottesliebe im Sufismus zugeordnet werden. Sein bekanntestes Gedicht *el-atlal* (die Ruinen) wurde posthum von der wohl bekanntesten ägyptischen Sängerin Oum Kalthoum (1898/1904–1975) vertont. Anschauungen des Sufismus (heterodoxen Islam) zufolge kann mystische Liebe zugleich Ursache und Heilung einer Krankheit sein – ein Motiv, das bereits in der klassischen arabischen Liebesdichtung von Leila („die Nacht") und Madschnun aus dem 7. Jahrhundert zu finden ist.

Die Sinologin BRIGITTE BUNZEL LINDER (Hongkong City University) setzte sich in ihrem Überblick zu zeitgenössischen Entwicklungen auf dem Feld der *critical medical humanities* und *illness practices* mit sozialen und psychologischen Aspekte von Lyrik, insbesondere mit Psychiatrie-Erfahrungen chinesischer Lyrikerinnen und Lyriker auseinander. Im Mittelpunkt ihres Vortrags stand das tragische Schicksal des während der chinesischen Kulturrevolution verfolgten und deklassierten Dichters Guo Luosheng (geboren 1948). Guo Luosheng ist heute als „vox populi", als der „der innere Dissident" im chinesischen Sprachraum hochgeschätzt. Er litt unter anderem an einer Angstpsychose (Reisepsychose im Sinne eines *culture bound syndromes*) und sieht Schmerz als Quelle der Poesie an (*pain as offspring of poetry*). Guo verbrachte Jahre seines Lebens in psychiatrischen Anstalten der Volksrepublik, nachdem bei ihm 1972 Schizophrenie diagnostiziert wurde. Er identifizierte sich selbst mit der Rolle des *mad dog* oder *mad man* und kann durchaus als Opfer politisierter Medizin angesehen werden, wobei seine (angebliche) Geisteskrankheit sehr kontrovers diskutiert wird – vielleicht handelt es sich dabei in einer Verkörperung des „heiligen Narren" um einen Schutzmantel gegenüber politischen Fährnissen, vielleicht wurde er von der Politik in den Wahnsinn getrieben?[4]

THOMAS AUGAIS enthüllte (auch in Vertretung von Julien Knebusch, beide Fribourg, Schweiz) Aspekte aus dem Leben des „Dichter-Chirurgen" Lorand Gaspard. Gaspar wurde 1925 in eine ungarische Familie im rumänischen Siebenbürgen geboren. Er studierte Medizin in Paris, arbeitete als Chirurg in Jerusalem, Bethlehem und Tunis und begeisterte sich gleichermaßen für die Wüsten des Orients[5] wie für die griechische Inselwelt. Im literarischen Schaffen des vielfachen Grenzgängers findet sich die Forderung, dem Menschen „als Ganzem zuzuhören“, das Motiv der „Einfühlung“, verbunden mit der Frage „Kann das Leben seine eigene Negation einbeziehen?“ und dem Ausspruch: „Jeder Chirurg fühlt in sich einen kleinen Friedhof.“

Welche Bezüge zwischen Lyrik und Medizin lassen sich insgesamt aus den verschiedenen Tagungsbeiträgen erschließen? Sicher das Schicksal vieler Dichterinnen und Dichter als Grenzgänger – als Grenzgänger zwischen verschiedenen geographischen Räumen (Gaspar, Celan), zwischen verschiedenen Kulturen, zwischen Medizin und Dichtung, zwischen Wahn und Wirklichkeit. Die dichterische Verarbeitung ihres eigenen Lebens wie des Leidens ihrer Patientinnen und Patienten eröffnet wichtige Perspektiven auf einen menschlichen Umgang mit Patienten wichtige Impulse für den Umgang mit Patientinnen und Patienten und berührt damit elementare Fragen der medizinischen Ethik – dies auch im Spannungsfeld verschiedener Kulturen und Religionen, zwischen Christentum, Islam und Judentum, Ost und West, politischen und naturwissenschaftlichen Verwertungsstrategien einerseits und patientenorientierter Empathie andererseits – verstanden als transkulturelle Humanitas in den Worten des Autors Giuseppe Bonaviri (1924–2009).[6]

Anmerkungen

1 ULRIKE DRAESNER 2001. *Für die nacht geheuerte zellen*. Gedichte. München: Luchterhand; Ibid. 2000. Twin Spin. Sonette von Shakespeare. Radikalübersetzungen. to change the subject. In HEINZ LUDWIG ARNOLD (Hg) 2000. *Göttinger Sudelblätter* (Reihe). Göttingen: Wallstein.
2 AMIR ESHEL 1999. *Zeit der Zäsur: jüdische Dichter im Angesicht der Shoah*. Heidelberg: Winter-Verlag.
3 PAUL CELAN 1970 (1.Aufl.). *Lichtzwang*. Frankfurt: Suhrkamp (jetzt Berlin).
4 ARTHUR KLEINMAN. 1988. *The illness narratives. Suffering, healing and the human condition*. New York: Basic Books.
5 LORAND GASPAR 1972. *Sol absolu*. Paris: Gallimard.
6 DAGMAR REICHARDT 2014. L’emigrante dello stetoscopio anziché della zappa. Eine Relektüre Giuseppe Bonaviris als Gründungsvater der zeitgenössischen italophonen Migrationsliteratur. In THOMAS KLINKERT (Hg). *Migration et identité*. (Freiburger romanistiche Arbeiten, Bd. 7). Freiburg: Verlag Rombach: 195–212.

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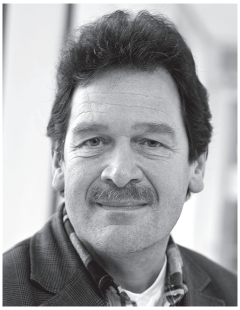

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BOOK REVIEWS

SHI LIHONG (2017): Choosing Daughters. Family Change in Rural China.

Stanford, CA: Stanford University Press, 208 pp.

When Amin Maalouf's book entitled *The First Century after Beatrice* (*Le Premier siècle après Béatrice,* 1992) was first published in English (1994), a journal article predicted that the events described by Maalouf will "unlikely to metamorphose."[1] The novel describes a dystopian future of a world in which births of male prevail over births of female children due to an unethically developed chemical. The planet becomes imbalanced because of the broken birth-ratio: once this chemical is taken only boys are delivered. The world breaks on two unjust halves: the North and the South. Violent crime in North rises and the South drops in a dark abyss of civil unrest, riots and finally, anarchy. Women become rare and in the North they face kidnappings and handling of women and girls; the maternity wards are guarded by the army and human trafficking skyrockets and the South descends into a nightmarish no-man's-land from where only a few lucky refugees escape.

At the time when Maalouf wrote his novel the first publications on selective abortions and birth disproportions were already sounding the alarm.[2] Due to the development of the prenatal diagnostic technology[3] ultrasound scanning becomes a routine in prenatal care already starting from the 1980s, hence the prenatal sex discernment of the fetus becomes possible and easily accessible. The development of the ultrasound was declared as one of the greatest advances of the 20th century in Gynecology and Obstetrics[4] but it turned out—as usually—that there is no medical marvel which can't be used and abused at the same time: societies in which for centuries a birth of a girl meant disgrace, abused this prenatal diagnostic to get rid of the unwanted births of girls. In India the ultrasound-technique gained widespread usage in the 1990s and by 1994 the first law prohibiting prenatal sex discernment was passed. China has issued a series of prohibition laws against the practices of selective abortion already from the mid 1980s.[5] These two countries faced a staggering population growth during the past centuries. An uncontrolled population growth impedes a healthy economic growth of a country. Over-populated developing countries are facing the problem of the so-called population explosion. The population growth is swallowing up a large part of the earning in national income brought about by planned economic development and overpopulation directly impacts soil erosion (MURDOCH 1980, BLAKIE 2016, etc.[6]). China alleviated its population growth problem by introducing the one-child policy in 1979; however, by 1986 when the first law against selective abortions was issued the damage was done: millions of girls were not born. Both China and India are notorious for widespread gender selective abortions—the female infanticide *in utero*. Both countries have birth sex ratios that are well off the worldwide average. In 2015, China saw 1.15 boys born per girl, India 1.12, as compared to 1.03 worldwide. The same year, China has loosened its one-child policy, one of the main drivers of gendercide or better put "femicide." Today, on the planetary level, men outnumber women by more than 66 million. And this is an unbroken trend.[7] The two most populous countries in the world are particularly highly imbalanced: India has 48 million more men than women, China nearly 42 million, accounting for 75 % of the male surplus worldwide. The damage is done. The situation is maybe not as hopeless as described in Maalouf's dystopia, however, we are far from reaching safe shores, a point to which I will come back later.

China has managed its overpopulation problem, however the byproduct was, is an imbalance in the sex ratio. In a society where boys were preferred over centuries and the birth of a girl went unnoticed in the best case, things have changed in the past 30 years. In some regions, as for instance in Central China, boys are still more welcomed at birth. Boys who later when they grow up will never marry and never—or rarely—will have sexual intercourse with a woman. In other regions, couples embraced the idea of a single child and even more so if this child is a "singleton" daughter.

SHI LIHONG's book describes how this change happened. This book is a powerful study how at least a part of the Chinese society has changed its reproductive choices and preferences. The book analyses in which manner reproductive choices, actually reproductive preferences, shifted and transformed in the past 30 years since the implementation of the one-child policy. It is a rich ethnography, abundant in ethnographic detail and well documented by additional bibliographic research. The book also has the merit of a rigorous theoretical grounding and contains a wide range of references around the globe.

The introduction starts with a description of the birth-policy campaign in China, a country which faced enormous population growth and took its consequences in the 20th century. For the purpose of economic growth and in dealing with limited resources the Chinese government introduced the one-child policy at the end of the 1970s. This policy included rigorous measures across the country in order to achieve the one-child per woman goal. Education and control were the main measures which were massively undertaken. In some cases extreme measures were implemented to control and to penalize couples who were reluctant to accept it. These actions included a close surveillance (that went down even to the checking of hygienic pads on 'suspicious' women), an obligatory taxation (with enormous fees paid by the parents who ventured into having a second child), and forced sterilization and abortion. Ideological brain-washing, compensated sterilization, free abortion and contraceptives were among the "softer" measures. Many gave up, some didn't. Some reproduced clandestinely.

However with all the efforts invested by the Chinese authorities, this situation created a demographic phenomenon today known as "the missing girls." Prenatal diagnostics and the usual corruption practices enabled couples in a quest of having a son despite the legislation which prohibited such practices to abort the unwanted female fetuses. A healthy sex ratio at birth is 103.5 of male children born on 100 females. The 113.5:100 and going up to 120:100 clearly shows that human practices caused the imbalance between sexes at birth.

Besides creating a marriage squeeze with women having the upper hand, this situation produced an immense population of men who are unable to ever have regular sexual lives or to start a family. Not to mention that it encouraged sexual slavery and boosted the trafficking of women. As Maalouf did, some scientists warned more than a decade ago, that bachelors—not having to lose anything beside their lives—could potentially be a threat to the domestic and even international security (GLENN 2004, HENDRIXSON 2004, ROSS 2010 etc.[8]).

Lihong Shi's book is dealing with a fascinating topic in the midst of this situation: she is analyzing a growing phenomenon, a sort of incongruity in the imbalanced birth ratio created by a strict demography-politics: she masterly describes and minutely analyzes an emerging reproductive pattern in which parents willingly choose and accept "singleton" daughters. The idea to explore not the problem *per se*—the problem of communities in which the one-child-policy wasn't accepted and in which a deficit of women was created—but instead to explore its success in regions where it actually worked. This is a valuable methodological lesson which should be retained and reproduced. One can potentially learn more about examining social anomalies than pondering how such anomalies were come to exist.

In her quest to discern the discourses of the emerging reproductive pattern Shi examines households with singleton daughters and questions their choices, decisions of reproduction. The consequences of choosing a singleton daughter are a response to changing familial responsibilities, life styles and to transformed social, economic and cultural environment. The author has chosen to center her research on a Lijia Village, Liaoning province in Northeast China. The province is specific in the sense that, historically, the lineage-culture was less important in communities, than as for instance, in Central China. The historical Chinese society is patrilocal, patrilineal where the lineage and the prolongation of the lineage by the birth of sons were central. Due to migration in the 19th century, this region was less impacted by the practices of lineage-culture which the Cultural Revolution of the 1960s and 1970s decimated. Shi has conducted in-depth interviews with more than 40 families, from this village and some neighboring ones, with couples about child-rearing, consumption, old-age support, marital relations, ancestral worship and family continuity and family economics. The reader has in his or her hands a book abundant in personal stories, descriptions of life-styles and personal portraits. The book is, in this sense, an ethnographic jewel.

Chapter One deals with the implementation of the birth-planning policy in Lijia village, it is a chapter, richly illustrated with personal accounts that deal with how this policy was executed and which measures were taken—from education to punishment—in order to crush the resistance of the locals and to achieve acceptance. Chapter Two describes how the preference of small family, the market economy, the emerging social life of villagers and the new ideal of life-happiness guided the couples in their reproductive choices. Chapter Three examines the changing child rearing strategies, the beliefs and practices linked to this change and the gender neutral parental support. Chapter Four analyses the decline of preference of sons and with the impact of the acceptation of singleton daughters; it covers also the gender transformation of filial piety. Chapter Five discusses the burden, mainly the financial load, of having a son in China. This burden is greatly pecuniary but also emotional, and the emerging feeling of parents being trapped in an unending financial debt in order to secure a future wedding for their son under the watchful eye of the community is masterfully painted. Chapter Six describes the fading practices of ancestral worship and the eroding effects of the belief that only sons can provide the continuity of the lineage and family.

Shi's rich ethnography is illustrated by photographs that the author took herself. The book additionally contains tables with demographic data that the author accessed through the registration records in Lijia. Furthermore, each argument or main theme whether the choice of the respondent to choose a singleton daughter or to willingly accept the one-child policy is amply illustrated with collected narratives of the villagers. What is remarkable in these interviews and what immerses the reader in the way of thinking of these people are the colorful proverbs. These Chinese proverbs illustrate in an excellent manner the feelings and the attitudes of the interviewed individuals. In that sense, Chapter Three, its title inspired by such a proverb, potentially expresses what this whole book is about. The chapter is called "choosing one tiger instead of ten mice." This paraphrase comes from the proverb used in this region: "While a tiger can block a road, ten mice are nothing but a meal for cats." This saying not only arguments in the favor of having a single child but put the accent on the quality of the upbringing that can and will guarantee the raising of a "tiger": One child, in which all the parental efforts are invested and who makes all the effort and the resources worthwhile. One cannot help but to think on how Chinese women-students outstrip young men in universities in many areas.

The book is particularly attention-grabbing for those who are interested in contemporary China but it is actually thought-provoking for all those who are either working or who are interested in child rearing practices, the transformation of societies trough demography or who study demographical problems and particularly the impact of strict governmental demographic policies. The book has the potential to serve as a blueprint in understanding how a cultural shift concerning reproductive choices can happen. Beside its opulent ethnography, demographic data, and the well-researched leading themes, the book has other, more down-to-earth merits: it is simply an interesting read, it's a page-turner.

Indisputably the Chinese one-child policy marked forever the demography of our planet. It also raised many questions of the deontology[9] how this policy was implemented. Terrible methods were used such as forced abortion and forced sterilization which were put in action in order to persevere in its execution. Its side-effects were—and still are—also terrible: the trafficking of women, especially of female-defectors from North Korea and the ethnic minority women from Vietnam (just to mention couple of examples) – are a dreadful byproduct of the one-child policy. The author also mentions another problem which is the Chinese aging population who potentially face a lonely and uncertain old age. This is all true and undeniable. There are other regions in Central China which face now shortages in women, and where the financing of the son's wedding only adds to this problem. The amounts required by women and their families from husband-candidates often can reach as much as the unbelievable amount of 50 000€. Many men will never get married and many will never procreate. This is a fact, too. The sons of these regions are punished for the "sins," the desires of their fathers by the cultural expectations that date back to centuries and become obsolete in the process. But this byproduct of the one-child policy is a boomerang-penalization of the communities which are or were reluctant to embrace social change, a change which can be resumed that baby-girls are also important as the baby-boys. Ironically, the societies in which boys were favored face disappearance in a very "Darwinian" manner …

There is not such a thing as a free lunch. These byproducts are the "price" – and a heavy one—that Chinese communities paid and which dragged China from poverty into the most important economic and possibly a cultural super-power of the 21st century. Uncontrolled population not only breaks the economic development of a country and presents enormous challenges in the internal well-being of the population in areas of infrastructure, education and health-service; it actually confines the half of the population to stay home and reduces this half, its women to an unpaid productive work. Ungratified, unpaid procreational work can be a form of slavery, in which women are not free to enter the job-market, can't provide for themselves autonomously, can't get educated, can't decide about their bodies, can't … do many other things. After 30 years of one-child policy in China that ended in 2015, we can summarize that it lifted the quality of life of Chinese women. They have now access to contraception, abortion, education, to work, to social mobility. They have now a choice. Something completely unimaginable in 19th century and even in 20th century China in which female babies were abandoned on the sideroads or were killed by their own mothers in order to avoid social stigma. We are an enormous distance from practices like foot-binding—common just three generations ago when sons were the only desirable offspring. And this alone is priceless.

Maria Vivod, Novi Sad and Strasbourg

Notes

1 John Tague's article from 1994: http://www.independent.co.uk/arts-entertainment/book-review-the-unlikely-metamorphosis-of-the-future-the-first-century-after-beatrice-amin-maalouf-1397429.html
2 Sen A. *More than 100 million women are missing,* NY Rev Books, 1990, vol. 37, pp. 61–66.
3 The Diasonograph in 1958 by Ian Donald, then Richard Soldner's machine from the mid 1960s; the routine screening starting from the end of 70s (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3987368/)
4 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3987368/
5 https://academic.oup.com/bmb/article/98/1/7/468425
6 Murdoch W. W. 1980. *The poverty of nations: the political economy of hunger and population.* Baltimore: Johns Hopkins University Press. Blakie, Piers.1985/2016^2. *The Political Economy of Soil Erosion in Developing Countries.* Routlegde
7 The data, provided by the World Bank, based on the United Nations Population Division's World Population Prospects: https://data.worldbank.org/indicator/SP.POP.TOTL.FE.ZS and https://esa.un.org/unpd/wpp/
8 Glenn D. 2004. A Dangerous Surplus of Sons? *The Chronicle of Higher Education* 50: 34. Hendrixson A. 2004. *Angry Young Men, Veiled Young Women. Constructing a New Population Threat.* (Corner House Briefing, 34). Dorset: The *Corner House.* http://www.thecornerhouse.org.uk/resource/angry-young-men-veiled-young-women. Ross K. 2010. An "army of bachelors"? China's Male Population as a World Threat. *Journal of Asia Pacific Studies* 1, 2: 338–363
9 A reviewer who was examining my review of this book raised the question of my choice to use this particular word *deontology* here. I feel that I have to underline, that this choice stems from the fact that often individual interests or desires collude with the interests of the community. The thing is that progress in a society often comes with a lot of conflict in any given society, and that the suffering of one generation can greatly impact—improve—the life of some of the future generation. Only time can tell which sacrifices and sufferings have given birth to something new, something better. This idea leads my choice to use this particular word "deontology."

Alexia Bloch (2017): Sex, Love and Migration. Postsocialism, Modernity, and Intimacy from Istanbul to the Arctic.

Ithaca, NY: Cornell Univ. Press, 274 pp.

Zunächst mag es erstaunlich erscheinen, dass eine kanadische Ethnologin über Arbeitsmigrantinnen aus der früheren Sowjetunion (Russland, Moldawien, Ukraine, Kaukasus, kurz: Former Soviet Union = FSU) in der Türkei schreibt und über die Veränderungen durch deren Mobilität. Verständlich wird es, wenn man weiss, dass die Autorin frühere Russischstudentin war und ihre Promotion in Ethnologie zu einem sibirischen Thema an einer kanadischen Universität vorlegte. Das Interesse der Rezensentin wiederum resultiert aus deren Tätigkeit als Beraterin in der Entwicklungszusammenarbeit, zu post-sowjetischen Zeiten schwerpunktmässig in Zentralasien und dem Kaukasus.

Dieses Buch basiert auf einer zehn Jahre langen Feldforschung, die mit Unterbrechungen vorwiegend in der Türkei durchgeführt wurde und Einblicke in das Leben post-sowjetischer Frauen (vorwiegend aus Moldawien und Russland) geben will, mit denen die Autorin lange und intensive Gespräche in Istanbul und zum Teil in deren Heimat führen konnte. Die Frauen arbeiteten in drei verschiedenen Sektoren in der Türkei, nämlich in der Prostitution, im Kleiderhandel oder als Hausangestellte.

Insgesamt 250 Millionen Menschen sind heute nach Angaben von UNFPA Migranten. Etwa die Hälfte derer, die heute ausserhalb ihres Herkunftslandes leben, sind weiblich. Früher war ihr Anteil niedriger, aber seitdem Frauen selbst auf der Suche nach Arbeit sind, hat sich ihre Zahl erhöht. Das geschieht nicht immer ganz freiwillig, sondern leider auch infolge von Flucht und Vertreibung. Circa 71 % aller Opfer von Menschenhandel sind zudem weiblich und viele von ihnen sind Hauswirtschaftshelferinnen (UNFPA 2018: https://www.unfpa.org/news/five-reasons-migration-feminist-issue).

Bloch geht es gerade nicht um die Opfer von Menschenhandel, sondern um die bewusste Entscheidung von Frauen, etwas in ihrem Leben zu verändern und selbst zu gestalten, nicht zuletzt aufgrund der dramatischen Ereignisse im Prozess der Auflösung der Sowjetunion. Das Buch will daher die Frauen als Täterinnen oder Gestalterinnen, nicht als Opfer zu Worte kommen lassen und in ihren Kontexten darstellen. Es geht hier auch nicht um finanzielle Rücküberweisungen ins Heimatland oder um Grenzregelungen oder Schikanen, sondern um die Erfahrungen, die Frauen in einer für sie neuen transnationalen Welt sammeln, auch in den täglichen Beziehungen etwa zwischen moldawischen Frauen und türkischen Männern, und wie sich diese damit verändern. Viele Frauen verließen die Post-Sowjetunion in Richtung Türkei zum Arbeiten, nachdem die Planwirtschaft zusammengebrochen war und der globale Kapitalismus Einzug halten konnte und damit viele, auch und gerade Frauen, arbeitslos geworden waren. Allerdings mussten sie weiter für ihre Familien sorgen. Sie kehrten regelmäßig in ihre Heimat und in die Türkei zurück und veränderten dadurch die Beziehungen der Geschlechter und die Gefühlswelt, die durch die Erfahrung des Reisens erweitert wurde. Oder, wie Bloch es ausdrückt: „In portraying mobile post-Soviet women who are reweaving a social fabric frayed with the end of socialism, I aim to show in these pages how women are reworking intimacy in a time of widely atomized lives“ (S. 5). Es geht im Buch um die einreisenden Frauen, die häufig von Türken als hypersexuell wahrgenommen werden, sich oft illegal im Land aufhalten und damit weiteren Gefahren ausgesetzt sind.

Drei Themen werden aufgerollt, die eng miteinander zusammenhängen: Post-Sozialismus, transnationale Mobilität und Intimität. Das Buch teilt sich entsprechend auf. Im ersten Teil geht es um „Mobilities and Intimacies“, im zweiten um „Intimate Practices and Global Circuits“, im dritten um „Sex, Love and Unpromising States“, der mit einer „Conclusion: On the Move“ endet. Allerdings ist die Erwähnung der Arktis im Buchtitel etwas überzogen, weil sie hier nicht wirklich abgehandelt wird, allenfalls Zentralasien (Usbekistan), das jedoch von der Arktis noch ein Stück entfernt liegt.

Der erste Teil umfasst eine ausführliche Einleitung, die den Wissensstand diskutiert und die

Feldforschung näher beschreibt. Im ersten Kapitel „Magnificent Centuries and Economies of Desire“ werden die engen und jahrhundertealten Beziehungen zwischen Russland (bzw. der Ex-Sowjetunion) und der Türkei skizziert, unterbrochen von der Zeit hermetischer Abriegelung während der Sowjetunion. Auch früher schon wurden Vergnügungsetablissements von russischen oder armenischen Tänzerinnen und Prostituierten „bespielt“, eine Tradition, die sich mit dem Zerfall der Sowjetunion fortsetzt. Daneben stellen ex-sowjetische Frauen ihre Arbeitskraft in der Textilindustrie und anderen Bereichen zur Verfügung, als billige undokumentierte Kräfte, derer man sich ohne Probleme entledigen kann.

Im zweiten Teil und zweiten Kapitel geht es um „Gender, Labor, and Emotion in a Global Economy“. Sehr detailliert wird der Kleinhandel mit Kleidung beschrieben, der in der Hand von Frauen aus der FSU (Former Soviet Union) liegt. Die Frauen kommen in der Regel zweimal im Monat für wenige Tage, kaufen ein und verbringen alles zu ihren Geschäften etwa auf Märkten in der FSU. Dabei treffen sie auf verschleierte Frauen, die ihnen ihre eigenen kulturellen Normen verdeutlichen, die auf mehr gleichwertigen Geschlechterbeziehungen und Arbeitsformen basieren. Doch zeigt die Autorin auch, dass die Händlerinnen emotional vorsichtig sein mussten, um ihre Männer in ihrer Heimat durch ihre neue Beschäftigung nicht zu sehr beschämen, da sie ihnen soviel Spass machte.

Im dritten Kapitel „*We are like Slaves – Who needs Capitalism;*“ *Intimate Economies and Marginal, Mobile Households* analysiert Alexia Bloch die Ausgangsbedingungen von Frauen in einer abgelegenen Region Moldawiens, denen gar nichts anderes übrig bleibt, als ihre Familien und Kinder zurück zu lassen, um in der Türkei zu arbeiten: „Out-migration of men and women from these communities radically reshapes intimate ties, from transforming how status is negotiated to recalibrating aspirations to reworking the very meaning of intimacy and nurturing of children“ (S. 83). Neben einer allgemeinen Einordnung der historischen und ökonomischen Umstände werden die Sichtweisen der Beforschten sehr ausführlich – und für die Rezensentin häufig zu ausführlich bzw. zu langatmig – beschrieben.

Im dritten Teil und seinem vierten Kapitel geht es um *Strategic Intimacy, „Real Love“, and Marriage*. Es zeigt, wie verschiedene Grade der Intimität mit Mobilität und „Liebe“ in Verbindung stehen, und welchen Status Frauen aus der FSU gewinnen können, wenn sie mit einem türkischen Mann eine Beziehung haben. Das reicht von „fake“-Liebe, um Unterstützung für die Familien zuhause oder ein neues Visum zu bekommen, über „kept“ Frauen (also etwa „ausgehaltene“ Frauen), die in der Türkei Unterstützung in Form von Wohnung, Kleidung und monatlichen Zahlungen erhalten, und dafür dem Mann zur Verfügung stehen müssen/wollen/können, bis hin zur „wahren“ Liebe. Anhand von Lebensberichten verschiedener FSU-Frauen werden diese verschiedenen Formen, mit ihren wirtschaftlichen Abhängigkeiten, durchdekliniert. Folgerichtig beschäftigt sich das 5. Kapitel mit *Intimate Currencies. Love, Romance, and Sex „without Hang-ups“*. Auch hier, wie in den anderen Artikeln, werden immer wieder die Ausgangsbedingungen, kommend aus dem früheren Sozialismus, thematisiert, und wie diese Verhalten, Ansprüche an Arbeit und Männer und intime Beziehungen durchdringen. Das geschieht auf der einen Seite mit soziologisch/politischen Analysen der Ausgangspunkte, um im Anschluss anhand der bereits genannten Erzählungen von Frauen aus der FSU mit Leben erfüllt zu werden.

Das 6. Kapitel zu „*Other Mothers“, Grandmothers, and the State* zeigt Bloch die „andere Seite“ derer, die etwa in Moldawien zuhause bleiben und sich um den Nachwuchs der Arbeitsmigrantinnen kümmern. Hier geht es aber auch um die Ideologien zur „guten Mutterschaft“, die von den Zeiten der Sowjetunion bis zur Post-Sowjetunion (FSU) ausgeleuchtet werden, und wie sich die „Mutterliebe“ (der biologischen Mutter natürlich) in Europa und Amerika präsentiert. Das Kapitel schliesst mit der interessanten Frage nach „Local Patterns of Nurturing or Universal Motherhood“ (S. 185). Die befragten moldawischen Frauen, die ihre Kinder in der Heimat zurücklassen, lassen sie in der Regel in ihrer erweiterten Familie aufwachsen, aber auch in anderen Kontexten, und betonen, dass sie für sie sorgen, indem sie genügend Geld für den Unterhalt der Familie und die Bildung der Kinder verdienen. Anders gewendet: die ökonomischen Verhältnisse im Neoliberalismus zwingen die Frauen, kreative Lösungen zu finden „… shaping mobile mothers' nurturing practices in a world of growing precarity, shrinking government assurances, and increase in women's transnational mobility“ (S. 187).

Im Schlusswort geht Alexia Bloch auf die starken Veränderungen in diesem Teil der Welt ein, nicht zuletzt beeinflusst durch den Krieg in Syrien und der Erstarkung des Regimes von Erdoğan in der Türkei. Dennoch lässt sie nicht ganz ihre Hoffnung sausen, wie ihr Schlusssatz zeigt: „The potent combination of transnational circuits, shifting ideals about gender and intimacy, and intimate bonds between Turkish men and Russian-speaking women is part of the unfolding story of how configurations of global capital shape personal lives but also the story of how migrants make lives for themselves despite the injustices of this newly precarious world“ (S. 192).

Das Buch endet mit einem umfangreichen Fußnotenteil (ca. 30 Seiten) und einem verdienstvollen Appendix von ca. zwei Seiten, in dem die anonymisierten Hauptpersonen bezüglich Herkunft und Lebenslauf kurz vorgestellt werden, also ihrem Woher und Wohin. Insgesamt ist das Buch natürlich für die von Interesse, die sich mit der Region befassen, aber auch für die, die sich mit der politischen Ökonomie des Körpers und von Körpern beschäftigen. Im konkreten Fall bedeutet das, wie Frauen die Folgen des Neoliberalismus zu spüren bekommen und wie ihre Antworten darauf aussehen, die sich bis tief in ihre Familien einschreiben. Letztlich werden im ersten Teil eines jeden Kapitels die historischen, politischen und ökonomischen Gegebenheiten skizziert und anhand der Fachliteratur diskutiert, um im zweiten Teil die Frauen selbst zu Wort kommen zu lassen. Auch für Genderforscher dürfte es damit interessant sein.

Katarina Greifeld, Frankfurt

Zusammenfassungen der Beiträge der *Curare* 41 (2018) 1+2

Heilungskooperationen. Heterogene Kooperationen jenseits dyadischer Interaktionen

HERAUSGEGEBEN VON CORNELIUS SCHUBERT & EHLER VOSS

Fröhliche Wissenschaft Medizinanthropologie. Editorial von Ehler Voss S. 3–7, verfasst auf Deutsch

Cornelius Schubert & Ehler Voss: Jenseits dyadischer Interaktionen. Einführung in das Themenheft Heilungskooperationen S. 8–13, verfasst auf Englisch

Márcio Vilar Zwischen „chronischen Erkrankungen“ und „geheimen Heilungen“. Bionetworking im Kontext von Autoimmunität in Brasilien

S. 14–34, verfasst auf Englisch

Basierend auf ethnologischer Feldforschung untersuche ich in diesem Artikel die Frage, wie sich das Engagement von Patienten und einzelnen Ärzten für in Brasilien unerlaubte immunstimulierende Therapien zur Behandlung von Autoimmunität auf die weltweit etablierte Biomedizin auswirkt, welche bisher auf dem gegenteiligen therapeutischen Modell von Immunsuppression basiert. Meine Absicht ist es, wandelnde Wahrnehmungen von Immunität, Autoimmunität, Person, immunologischen Therapien, biotechnologischen Innovationen und Regulierungen als konstitutiv für die zeitgenössische biomedizinische Kultur und die Lebenswissenschaften in Brasilien zu verstehen. Indem ich mich mit Formen der Zusammenarbeit von Patienten mit Autoimmunität und verschiedenen Ärzten beschäftige, beschreibe ich, wie diejenigen Akteure, die immunstimulierende Therapien als wissenschaftliche Innovationen unterstützen, legalen Schwierigkeiten begegnen und von etablierten biomedizinischen Autoritäten disqualifiziert werden. Im Zusammenhang damit präsentiere ich eine Fallstudie zu regulatorischer Erfahrung von der „Anti-Brucella-Vakzin“ (VAB, vacina anti-brucélica) als immunstimulierende Therapie und führe einen abweichenden Vergleich anhand der „Eigenbluttherapie“ (AHT, autohemoterapia) durch. Wie andere immunstimulierende Therapien sind VAB und AHT stark mit der regenerativen Medizin assoziierbar und werden über den informellen Sektor zugänglich gemacht. Mein Argument ist, dass die zunehmende Zirkulation und Annahme von Immunstimulanzien für Autoimmunerkrankungen durch den informellen Sektor und daraus resultierende Gerichtsverfahren die Position der Immunsuppressiva als hegemonisches Therapiemodell paradigmatisch bedroht und mit dem globalen Aufkommen der regenerativen Medizin zusammenhängt.

Schlagwörter Autoimmunität – biotechnologische Innovationen – regenerative Medizin – Lebensassemblagen – Brasilien

Helmar Kurz Transkultureller und Transnationaler Transfer Therapeutischer Praktiken. Heilungskooperationen zwischen Spiritismus, Biomedizin und Psychiatrie in Brasilien und Deutschland

S. 35–49, verfasst auf Englisch

Der Artikel behandelt Transformationsprozesse von lokalen Heilungskooperationen durch kulturellen Transfer im Kontext transnationaler Netzwerke und Migrationsbewegungen. Heilpraktiken des brasilianischen Spiritismus und entsprechende Heilunkskooperationen mit psychiatrischen und biomedizinischen Gesundheitsprofessionellen dienen dabei als Beispiel. Zunächst werden einführend medizinethnologische Ansätze zu Heilungskooperationen diskutiert, bevor brasilianisch-spiritistische Erklärungsmodelle bzgl. Gesundheit, Krankheit, und Heilung vorgestellt werden. Fallstudien in Marília/São Paulo und Itabuna/Bahia in Brasilien zeigen Konfigurationen von Heilungskooperationen zwischen Spiritismus, Biomedizin und Psychiatrie auf. In einem weiteren Schritt wird die Übertragung spiritistischer Heilpraktiken in den deutschen Kontext durch brasilianische Einwanderer und deutsche Unterstützer behandelt. Fallstudien in München belegen, wie der transna-

tionale und transkulturelle Transfer zur Diversifizierung von spiritistischen Diskursen und Praktiken führt. Allerdings ergibt die Diskussion des Materials, dass diese Entwicklung weniger sozialen, kulturellen, oder religiösen Rahmenbedingungen geschuldet ist, sondern vielmehr individuellen Ressourcen, persönlichen Erwartungshaltungen, und temporär eingrenzbaren politischen Prozessen entspricht.

Schlagwörter Kulturelle Psychiatrie – Transkulturelle Psychiatrie – komplementäre und alternative Medizin – CAM – Spiritismus – Migration – Brasilien – Deutschland

MAŁGORZATA STELMASZYK: Turbulente Wesen. Flüche und Heilungskooperationen im postsowjetischen Tuva S. 50–61, verfasst auf Englisch

In diesem Artikel beschäftige ich mich mit den Vorstellungen von Krankheit und Heilung in Kyzyl, der Hauptstadt der Autonomen Republik Tuva in Sibirien. Dabei zeige ich, wie verschiedene Krankheitsbilder wie Schlaganfälle, Komas und Tuberkulose oft durch ein Fluchprisma konzeptualisiert werden. In diesen Fällen werden Krankheiten als Symptom und als Konsequenz einer breiteren soziokosmischen Politik betrachtet, die sowohl den Geist als auch den Menschen betrifft. Infolgedessen befinden sich die Opfer, während sie unter dem Fluch leiden, oft in einem Zustand von allgemeiner physischer und emotionaler Störung, der eng mit den Charakteristika der tuwinischen Kosmologie verflochten ist, die von komplementären statt exklusiven Vorstellungen von Turbulenz und Gleichgewicht durchdrungen ist. In Anbetracht dessen, dass ein medizinischer Zustand vorliegt, werden Diagnose, Heilung und Genesung oft gleichzeitig von Ärzten, Lamas und Schamanen angestrebt und die Patienten werden von allen drei Praktizierenden gleichzeitig behandelt. In diesem Artikel zeige ich, während ich mich auf eine spezielle Fallstudie konzentriere, auf, wie Krankheiten, die durch Flüche ausgelöst werden, verschiedene Akteure wie Ärzte, Lamas und Schamanen zusammenbringen und wie im Kontext des postsowjetischen Tuva diese Akteure mit ihren ausgeprägten Erkenntnistheorien und Engagements mit der Welt, eine Plattform zur Zusammenarbeit statt antagonistischer Möglichkeiten produzieren.

Schlagwörter Krankheit – Heilung – okkulte Praktiken – Fluch – Persönlichkeit – Tuva

KATRE KOPPEL: „Mein Traum ist, chinesische und westliche Medizin zusammenzubringen“. Warum chinesische Medizin sich im estnischen Gesundheitssystem etabliert S. 62–77, verfasst auf Englisch

In den letzten Jahren wurde chinesische Medizin in Estland zu einer verbreiteten therapeutischen Praxis. Aus der Perspektive der Patienten ist dies nicht überraschend, da nach dem Zusammenbruch der Sowjetunion viele verschiedene gesundheitliche, Lifestyle- und Wohlfühllehren viele Anhänger gefunden haben. Überraschend hingegen ist, dass auch viele medizinische Fachkräfte zunehmend auf chinesische Medizin aufmerksam werden. Im estnischen Kontext wird chinesische Medizin von der Biomedizin und dem Staat als eine Alternativmedizin betrachtet und aufgrund historischer Gründe und des post-sowjetischen Kontexts von biomedizinischen Fachkräften oft stigmatisiert. Unabhängig von dem expliziten Spannungsverhältnis zwischen der Bio- und Alternativmedizin scheint chinesische Medizin eine höhere Anerkennung zu genießen als andere Alternativmedizinen. Daher ist die heutige Situation, die als eine Positionsveränderung der chinesischen Medizin im estnischen Gesundheitssystem beschrieben werden kann, außergewöhnlich. In diesem Artikel werden drei Gründe genannt, die zu der gegenwärtigen Positionsveränderung der chinesischen Medizin führen. Erstens kann die positive Wahrnehmung der chinesischen Medizin als ein Zugeständnis des Staates betrachtet werden, der bereits Akupunktur ins Gesundheitssystem implementiert hat. Zweitens in der aktuellen Gesundheitspolitik und den Herausforderungen, vor denen das estnische Gesundheitssystem steht. Und drittens ist es die zunehmende Etablierung und Akzeptanz verschiedener New Age-Praktiken und ihre Art und Weise, die Wahrnehmung des Körpers zu ändern, die der chinesischen Medizin den Weg in das estnische Gesundheitssystem erleichtert. Dieser Artikel basiert auf knapp zwei Jahren ethnographischer Feldforschung in Estland.

Schlagwörter chinesische Medizin – Gesundheitssystem – medizinische Vielfalt – ehemalige UdSSR – Gesundheitspolitik – New Age Spiritualität – Estland

DANUTA PENKALA-GAWĘCKA: Dauerhafte oder fragile Formen der Kooperation. Komplementäre Medizin und die Biomedizin im postsowjetischen Gesundheitswesen von Kasachstan und Kirgisistan S. 78–94, verfasst auf Englisch

Diese Studie untersucht die Wechselbeziehungen zwischen der Biomedizin und den unterschiedlichen Segmenten komplementärer und alternativer Medizinen (CAM) in ihren sozioökonomischen und politischen Kontexten in der postsowjetischen Ära von Kasachstan und Kirgisistan. Während es bereits zu Sowjetzeiten Medical Diversity in Zentralasien gab, hat der Kollaps der UdSSR zu einer weiteren Diversifizierung therapeutischer Möglichkeiten in dieser Region beigetragen. Die Autorin diskutiert den Wechsel im offiziellen Umgang gegenüber verschiedenen nicht biomedizinischen Behandlungsweisen, in denen sich auch ökonomische und politische Bedingungen widerspiegeln. In den 1990er Jahren der gerade gewonnenen Unabhängigkeit beruhte die offizielle Billigung der traditionellen Medizinen zumeist in dem Bestreben, die eigene Legitimierung auf dem Boden des kulturellen Erbes der jeweiligen Nationen zu begründen. In dem Maße wie dies nicht mehr notwendig erscheint, haben die nicht offiziellen Medizinen, wie sie von verschiedensten „nichtärztlichen" Heilkundigen praktiziert werden, den Rückhalt von Regierungsseite verloren. Vor diesem Hintergrund ist die Kooperation der 1990er Jahre zwischen der Biomedizin und dem CAM-Fragment zunehmend brüchig geworden. Die ursprüngliche Zusammenarbeit in diesem Grenzbereich hat sich, wie die Autorin darstellt, zunehmend zu einer Abgrenzungsfehde gegenüber dem entwickelt, was als wissenschaftlich gilt und was Praktiken sind, die nicht durch „Naturwissenschaften" bestätigt werden. Indes zeigt sich, dass trotz dieser Spannungen die unterschiedlichsten Therapien aus dem CAM-Spektrum einschließlich spiritueller Heilweisen sich großer Beliebtheit bei den Patientinnen und Patienten erfreuen und dies nur teilweise den Mängeln und Schwächen der staatlichen Gesundheitswesen geschuldet ist. Im letzten Teil des Artikels werden Kooperations-Beispiele zwischen Psychiatern und kirgisischen Heilkundigen dargestellt, die sich in speziellen Umständen als sinnvoll und nützlich erweisen.

Schlagwörter Medical Diversity – komplementäre und alternative Medizin – CAM – Biomedizin – Heilungskooperation – Boundary Work – Zentralasien – Kasachstan – Kirgisistan

PIERRE PFÜTSCH: Rettungssanitäter in der BRD. Kooperationen und Konflikte in einem schwierigen Berufsfeld (1949–1990) S. 95–108, verfasst auf Englisch

Kooperationen sind praktisch ohne Konflikte nicht denkbar. Daher wird in diesem Beitrag die gegenseitige Verschränkung von Kooperationen und Konflikten aus einer zeitgeschichtlichen Perspektive analysiert. Als konkretes Beispiel dient das Rettungswesen in der Bundesrepublik Deutschland, da hier mit Ärzten, nichtärztlichen Gesundheitsberufen, Wohlfahrtsorganisationen und Berufsverbänden unterschiedlichste Akteure involviert sind, unter denen Konflikte auftraten. Darüber hinaus sind Ärzte und Rettungssanitäter Berufe, die auf unterschiedlichen hierarchischen Stufen stehen, weshalb bei diesen innerhalb von Konflikten und Kooperationen neben Heilungsansichten zusätzlich Machtpositionen verhandelt werden. Im Beitrag werden zwei unterschiedliche Perspektiven auf Kooperationen und Konflikte analysiert. Zum einen soll verdeutlicht werden, dass es innerhalb kooperativer Arbeitsformen zu Konflikten kommen kann. Zum andern soll gezeigt werden, dass auch aus Konflikten Kooperationen hervorgehen können und diese daher als eine Art Innovationsmotor gelten können. Beide Entwicklungen treffen sowohl auf der Mikroebene, also in der konkreten Auseinandersetzung zwischen Ärzten und Rettungssanitätern zu. Aber sie können darüber hinaus durchaus auch auf der Makroebene die Versorgungsstrukturen beeinflussen, wie hier am Beispiel der Auseinandersetzungen um ein Berufsgesetz für Rettungssanitäter gezeigt wird. Konkret stand immer wieder die Frage im Zentrum der Diskussionen, welche Aufgaben die Rettungssanitäter übernehmen und welche den Ärzten vorbehalten bleiben sollten. Aufgrund der schwierigen Quellenlage wird in der Analyse vorrangig auf normative Quellen zurückgegriffen. Über Leserbriefe wird zumindest indirekt die Perspektive konkreter Akteure erschlossen.

Schlagwörter Rettungssanitäter – Rettungsdienst – Professionalisierung – Kooperation – Deutschland (BRD)

Stefan Reinsch, Jörg Niewöhner & Doris Staab: Die Ökologie der Versorgung bei Mukoviszidose. Entscheidungsfindung, Lernen und Identitätsentwicklung in einer Gemeinschaft, die mit einer seltenen chronischen Erkrankung lebt und arbeitet S. 109–127, verfasst auf Englisch

Der vorliegende Artikel betrachtet die Ökologie der Versorgung einer Gemeinschaft von Mukoviszidose-betroffenen und ihren Behandlern. In dieser sind die Entwicklung der Identität als Gruppenmitglied, sowie der Fertigkeiten der medizinischen Entscheidungsfindungen, eng miteinander verwoben. Mukoviszidose ist eine seltene Erbkrankheit mit einem chronischen, lebensverkürzenden Verlauf. Aufgrund des zunehmend komplexen Therapieregimes und der damit einhergehenden gestiegenen Lebenserwartung erfordern die täglichen Entscheidungsfindungen in wachsendem Maße eine interdisziplinäre Zusammenarbeit. Auf der Grundlage einer ethnographischen Langzeitstudie als Ethnologen und Ärzte in einem hochspezialisierten Universitären Setting erkunden wir, wie Patienten und Ärzte Entscheidungen treffen und deren Bedeutungen sowie ihre eigene Position innerhalb einer Praxisgemeinschaft verhandeln. Aufbauend auf Konzepten der Verteilten Kognition und Wissenspraxen zeigen wir, dass die Praxisgemeinschaft durch drei mit einander verknüpfte Elemente charakterisiert ist: Erstens, durch die Entwicklung einer geteilten Identität, welche sich um die Frage des Umganges und des Lebens mit einer seltenen chronischen Erkrankung entwickelt. Ironie wird hierbei genutzt, um eine Position ausserhalb der Hauptströmung der Medizin, sowie der Dichotomie gesund/krank zu etablieren. Zweitens, erfordert der Umgang mit der Erkrankung ein statusgruppenübergreifendes, kollektives Lernen von Betroffenen und Behandlern, sowohl im Bereich des Alltagslebens als auch der klinischen Entscheidungsfindung. Wir argumentieren drittens, dass verkörpertes Wissen vorhergehender Generationen nicht weitergegeben wird, sondern im Kontext der Interaktion von Novizen mit der sozialen und materiellen Umwelt wiederhergestellt wird. Dies erfordert, Erfahrung und Lernen aus dem Kopf des einzelnen Individuums zu nehmen, und es zu einer wiederherstellbaren Prozedur zu machen. Gemeinsam erschaffen die drei Elemente eine kollektiv verkörperte Erfahrungskultur, die der Praxisgemeinschaft erlaubt, sich in Zeiten des raschen Wandels zu regenerieren.

Schlagwörter Mukoviszidose – chronische Krankheit – Praxisgemeinschaften – Verteilte Entscheidungsfindung – Wissenspraxen – Deutschland

Christian Erbacher: Philosophie – Therapie – Mythologie. Eine dreiseitige Analogie in der Philosophie Ludwig Wittgensteins S. 128–134, verfasst auf Englisch

Das Hauptanliegen dieses Beitrages besteht in einer Einladung an Heilungspraktiker, die philosophischen Schriften Ludwig Wittgensteins als relevant für ihre Praxis zu lesen. Dafür wird Wittgensteins philosophische Orientierung entlang seiner eigenen Analogie zwischen Philosophie, Therapie und Mythologie skizziert. Es wird argumentiert, dass Wittgenstein während seines gesamten philosophischen Lebens die Philosophie als Aktivität verstanden hat, die philosophische Verwirrungen klären sollte. Philosophieren ist nach diesem Verständnis, wie die Medizin, eine Behandlung, die plagende Zustände verschwinden lassen oder auflösen soll. Wittgenstein selbst betonte, dass seine Methoden des philosophischen Klärens mit der Psychoanalyse verglichen werden könnten. Nach dieser Analogie macht die philosophische Klärung eine plagende Mythologie mit einer weniger plagenden Mythologie unschädlich. Diese Sichtweise wiederum kann nach Wittgenstein ein Licht auf die philosophischen Verwirrungen werfen, die mit einer wissenschaftlichen Weltauffassung einhergehen können. Diese ist mit einer philosophischen Verwirrung verwoben, wenn ein Glaube an die Absolutheit (natur) wissenschaftlicher Wahrheiten verhindert, dass man die Wahrheiten und Einsichten aus anderen Kulturen anerkennt.

Schlagwörter Philosophie – Psychotherapie – Wittgenstein – Freud – Frazer

Article Abstracts of *Curare* 41 (2018) 1+2

Healing Cooperations. Heterogenous Collaborations Beyond Dyadic Interactions

EDITED BY CORNELIUS SCHUBERT & EHLER VOSS

Medical Anthropology as Joyful Wisdom. Editorial by Ehler Voss p. 3–7, written in German

Cornelius Schubert & Ehler Voss: Beyond Dyadic Interactions. An Introduction to the Thematic Issue on Healing Cooperations p. 8–13, written in Englisch

Márcio Vilar: Moving between "Chronic Diseases" and "Secret Cures". Bionetworking in the Context of Autoimmunity in Brazil p. 14–34, written in English

In this article, I explore from an anthropological Global South perspective the following question: how does the engagement of patients and physicians for unauthorized immunostimulant therapies for autoimmunity in Brazil impact the globally established biomedicine based on the use of palliative immunosuppressive drugs? My aim is to understand changing perceptions related to immunity, autoimmunity, immunological therapies, biotechnological innovation and regulation as constitutive of contemporary biomedical culture and of life sciences in Brazil. By addressing some forms of collaboration and deviance between patients with autoimmunity and physicians, I describe how they adopt and promote immunostimulant drugs as scientific innovations that meet difficulties to become legalized and that tend to be disqualified by established biomedical authorities. For it, I present a case study of regulatory experience and make a comparative digression involving respectively two immunostimulant therapies: the "anti-brucellic vaccine" (VAB—*vacina anti-brucélica*), and; the "autohemotherapy" (AHT—*autohemoterapia*). Like other immunostimulant therapies, both VAB and AHT are strongly associable with regenerative medicine and may be accessed through the informal sector. My argument is that established biomedicine has become increasingly circumnavigated in contemporary Brazil, while regenerative medicine is simultaneously emerging as a transnational paradigm shift through assemblages of life and respective moralities.

Keywords autoimmunity – biotechnological innovation – regenerative medicine – life assemblages – Brazil

Helmar Kurz: Transcultural and Transnational Transfer of Therapeutic Practice. Healing Cooperation of Spiritism, Biomedicine, and Psychiatry in Brazil and Germany p. 35–49, written in English

This article investigates transformation processes of local practices of healing cooperation when transferred from one context into another by means of migration and transnational networks. Healing practices within Brazilian Spiritism and practices of healing cooperation with psychiatric and biomedical health professionals will serve as an example. An introductory anthropological discussion of distinct theoretical approaches to healing cooperation will serve as a starting point, before exploring explanatory models of health, illness, and healing within Brazilian Spiritism. Case studies from Marília/São Paulo and Itabuna/Bahia in Brazil will facilitate the understanding of healing cooperation of Spiritism, biomedicine, and psychiatry. In a further step, the implementation of Spiritist healing practices by Brazilian immigrants and local supporters in Germany will be of central interest. Case studies from Munich/Germany will show that transference of healing cooperation from one context to the other is possible, but that due to different contexts a diversification of discourses and practices will take place. However, the discussion of the presented data will show, that the outcome of transnational transfers of healing practices and models of healing cooperation does not so much relate to social, cultural, or religious frameworks, but to individual resources, personal expectations, and political processes.

Keywords cultural psychiatry – complementary and alternative medicine – CAM – spiritism – migration – Brazil – Germany

Małgorzata Stelmaszyk: Turbulent beings. Curses and systems of healing cooperation in post-Soviet Tuva, Siberia p. 50–61, written in English

In this article, I engage with the notions of illness and healing in Kyzyl, the capital of the Autonomous Republic of Tuva in Siberia. In so doing, I show how a variety of medical conditions, such as strokes, comas, and tuberculosis, are often conceptualized through a prism of curses. In these instances, illnesses are considered as a symptom and a consequence of wider sociocosmic politics which involve spirits and humans alike. Consequently, while suffering from curse inflictions, the victims often find themselves in a state of overall physical and emotional disturbance, described as being 'in turbulence'. Given this, in the presence of a medical condition, diagnosis, cure, and recovery are often concurrently sought from medical doctors, lamas, and shamans, and the clients undergo simultaneous treatments from all three practitioners. In this article, therefore, I show how illnesses triggered by curses bring together different actors, such as medical doctors, lamas, and shamans, and how in the context of post-Soviet Tuva, these actors, with their distinct epistemologies and engagements with the world, produce a platform of cooperation rather than that of antagonistic possibilities.

Keywords illness – healing – occult practice – curse– personhood – Tuva

Katre Koppel: "My Dream is to Bring Together Chinese and Western Medicine". Why Chinese Medicine is Making its Way into Estonian Healthcare p. 62–77, written in English

In recent years, Chinese medicine has become a popular therapeutical practice in Estonia. This is not surprising from the perspective of users as different health-related, lifestyle and well-being teachings have found many adherents after the collapse of the Soviet Union. However, what is intriguing is the fact that Chinese medicine is gaining increasing attention by healthcare professionals too. In the Estonian context, Chinese medicine is regarded as an alternative medicine from the point of view of biomedicine and the state. Due to historical reasons and the post Soviet context, alternative medicines are usually stigmatised by biomedical practitioners. Regardless of the explicit tensions between biomedicine and alternative medicines, Chinese medicine seems to enjoy higher acceptance than some other alternative medicines. Hence, the current situation, which can be described as a change of position regarding Chinese medicine in the Estonian health landscape, is relatively extraordinary. In this paper, I argue for three reasons why the position of Chinese medicine is currently changing. Firstly, the positive reception of Chinese medicine can be regarded as a favour from the state that has implemented regulations on acupuncture. Secondly, the reasons can be found in the current health policy and in the challenges that the Estonian healthcare system is facing. Thirdly, it is the mainstreaming process of New Age spirituality in Estonia and the way it changes the perception of the body that helps Chinese medicine to find its way into Estonian healthcare. The article is based on almost two years of ethnographic fieldwork in Estonia.

Keywords Chinese medicine – healthcare – medical diversity – former USSR – health policy – new age spirituality – Estonia

Danuta Penkala-gawęcka: Enduring or Fragile Cooperations. Complementary Medicine and Biomedicine in Healthcare Systems of Post-Soviet Kazakhstan and Kyrgyzstan p. 78–94, written in English

This paper focuses on relations between biomedicine and various segments of complementary and alternative medicine (CAM) in socio-economic and political contexts of post-Soviet Kazakhstan and Kyrgyzstan. While medical diversity was already present in Central Asia during Soviet times, the collapse of the Soviet Union has contributed to the further diversification of therapeutic options in this region. The author discusses changes

in the official attitudes towards various non-biomedical forms of treatment, which reflect changing economic and political conditions. Initially, in the 1990s, the official support for traditional/folk medicine resulted mainly from the efforts of the newly independent states to gain legitimacy on the grounds of the cultural heritage of their titular nations. Such legitimisation is not needed anymore and, in effect, those CAM branches which are practised by healers, not biomedical doctors, have lost government backing. In this light, it seems that first attempts at cooperation between biomedical and complementary practitioners which had started in the 1990s turned out to be rather fragile. The boundary work, as the author's research revealed, is directed towards delimitation of what is perceived as scientific from methods and practices unconfirmed by "science." However, it should be stressed that despite such tensions various complementary therapies, including spiritual healing, enjoy great popularity among patients, which is partly due to the weakness of healthcare systems in Kazakhstan and Kyrgyzstan. The last part of the article addresses examples of cooperation between psychiatrists and healers in Kyrgyzstan, which proved to be fruitful in special circumstances.

Keywords medical diversity – complementary and alternative medicine – CAM – biomedicine – healing cooperation – boundary work – Central Asia – Kazakhstan – Kyrgyzstan

PIERRE PFÜTSCH: Paramedics in West Germany. Cooperations and Conflicts in a Contested Professional Field (1949–1990) p. 95–108, written in English

Cooperations are almost inconceivable without conflicts. For this reason, this contribution will analyse the mutual interweaving of cooperations and conflicts from a contemporary perspective. A concrete example is the situation of the rescue services in the Federal Republic of Germany. Considering the involvement of a variety of different players such as doctors, non-medical healthcare professions, charitable organisations and professional associations, conflicts are bound to occur. In addition, doctors and paramedics are in professions that are subject to different hierarchical levels, which is why positions of power must be taken into consideration in relation to conflicts and cooperations, alongside the methods of treatment. This contribution will analyse two different perspectives of cooperations and conflicts. On the one hand, the aim is to clarify that conflicts can occur within cooperative working methods. On the other hand, it will demonstrate that cooperations can result from conflicts and that they can be seen as a type of innovation motor. Both developments occur on the micro level, *i. e.* in the concrete conflict between doctors and paramedics. However, they can additionally influence the supply structures on the macro level as well. This will be exemplified by the conflicts regarding the professional law for paramedics. In concrete terms, the focus of previous discussions was usually centred on the question of which tasks should be taken over by the paramedics and which tasks should remain exclusive to the doctors. Due to the difficult situation of sources, the analysis shall be based primarily on normative sources. Readers' letters shall at least indirectly offer the perspectives of concrete participants.

Keywords paramedics – rescue system – emergency service – professionalization – cooperation – Germany

STEFAN REINSCH, JÖRG NIEWÖHNER & DORIS STAAB: The Ecology of Care in Cystic Fibrosis. Identification, Decision-Making and Learning in a Community Living and Working with a Rare Chronic Illness p. 109–127, written in English

This paper sets out to describe how developing an identity as a member of a community organized around a rare chronic illness and becoming knowledgeably skilful in mastering the challenges of decision-making are part of the same process. We examine a community living with cystic fibrosis (CF) and their care-givers. CF is a rare inheritable disease with a chronic life-shortening course. Today, the growing complexity of care, with the resulting longevity for people with CF, governs the practicalities of day-to-day decision-making, highlighting an increasing need for interdisciplinary collaboration. Building on long-term ethnography as anthropologists and physicians, we use a practice theoretical approach to explore in a highly specialized university medical centre how patients and care-givers make decisions and negotiate meaning, and their position, within such a community of practice (CoP). Drawing on ideas from distributed cognition and knowledge-practices, we show that the CF CoP is characterized by three interrelated elements: First, by the development of a shared identity around the ques-

tion how to manage and live with a rare chronic illness. Irony is used in establishing a position both outside the dominant mainstream of medicine and outside the dichotomies healthy/ill. Second, managing the condition requires collective learning in the domains of everyday life and clinical decision making, cutting across established status groups of patients and caregivers. Third, by taking experience and learning out of the individual's head and making it a procedure to be enacted in similar moments, we argue that the embodied-knowledge of prior generations is not passed on but regenerated within the contexts of novices' interactions within the social and material environment. Together, the three elements create a collectively embodied-memory culture allowing the CoP to regenerate itself and adapt within times of rapid change.

Keywords cystic fibrosis – chronic illness – communities of practice (CoP) – distributed – decision making – knowledge-practices – Germany

Christian Erbacher: Philosophy—Therapy—Mythology. On a Triangulated Analogy in the Philosophy of Ludwig Wittgenstein p. 128–134, written in English

The article's main aim is to invite healing practitioners to read and interpret the philosophical writings of Ludwig Wittgenstein as relevant for their practices. It outlines Wittgenstein's philosophical orientation using his own triangulated analogy between the fields of philosophy, therapy and mythology. It is argued that Wittgenstein, throughout his philosophical life, considered philosophy as an activity for clarifying philosophical confusion. Philosophizing is thus, like medicine, a treatment for making a troubling state disappear or dissolve. Wittgenstein pointed out that his methods of philosophical clarification might be compared to psychoanalysis. Based on this analogy, philosophical clarification renders a troubling mythology harmless by using a less troubling mythology. This view can in turn shed light on the philosophical confusion that may accompany a scientific worldview. Such confusion emerges when belief in the absoluteness of scientific truth hinders acknowledgement of the truths and insights from other cultures.

Keywords philosophy – psychotherapy – Wittgenstein – Freud – Frazer

Résumés des articles de *Curare* 41 (2018) 1+2

Coopérations de soins. Collaborations hétérogènes au-delà des interactions dyadiques

SOUS LA DIRECTION DE CORNELIUS SCHUBERT & EHLER VOSS

L'Anthropologie médicale, le gai savoir. Éditorial par Ehler Voss p. 3–7, rédigé en allemand

Cornelius Schubert & Ehler Voss: Coopérations de soins au-delà des interactions dyadiques. Introduction dans le numéro thématique p. 8–13, rédigé en anglais

Márcio Vilar: Se mouvoir entre «maladies chroniques» et «cures secrètes». «Bionetworking» dans le contexte de l'auto-immunité au Brésil p. 14–34, rédigé en anglais

À partir d'une perspective du Sud global, j'explore en tant qu'anthropologue dans cet article la question suivante: quel est l'impact au Brésil de l'implication des patients et des médecins quant aux thérapies immunostimulantes, qui ne sont pas autorisées pour l'auto-immunité par la biomédecine mondialisée? Cette dernière étant plutôt orientée vers l'utilisation de médicaments immunosuppresseurs palliatifs. Mon but est de comprendre les perceptions évolutives qui sont associées à l'immunité, à l'auto-immunité, à la personne, aux thérapies immunologiques, à l'innovation biotechnologique et à la régulation, comme éléments constitutifs de la «culture biomédicale» contemporaine et des sciences de la vie au Brésil. En abordant certaines formes de coopération et de désaccord entre des patients atteints de maladies auto-immunes et les médecins, je décris comment ils adoptent et promeuvent les immunostimulants comme des innovations scientifiques qui rencontrent des difficultés à être légalisées et qui ont tendance à être disqualifiées par les autorités biomédicales établies. Pour cela, je présente une étude de cas d'une expérience règlementaire et je fais une étude comparative impliquant respectivement deux thérapies immunostimulantes: le «vaccin antibrucellique» (VAB, *vacina anti-brucélica*) et «l'autohémothérapie» (AHT, *autohemoterapia*). Comme d'autres thérapies immunostimulantes VAB et AHT sont fortement associables à la médecine régénérative et peuvent être accessibles à travers des réseaux informels. Mon argument est que la biomédecine établie est de plus en plus contournée dans le actuellement au Brésil, tandis que la médecine régénérative est en train d'émerger et de modifier le paradigme international à travers la combinaison des concepts de la vie et de la morale.

Mots-clés auto-immunité – innovations biotechnologiques – médecine régénérative –autohémothérapie – assemblages de vie – Brésil

HELMAR KURZ: Transfert transculturel et transnational de pratiques thérapeutiques. Coopération dans les soins entre spiritisme, biomédecine et psychiatrie entre le Brésil et l'Allemagne p. 35–49, rédigé en anglais

L'article traite des processus de transformation sur le plan local dans une coopération en matière de guérison, par un transfert culturel et ceci dans un contexte de réseaux transnationaux et de mouvements migratoires. Les pratiques de guérison du spiritisme brésilien et la coopération dans les pratiques de soins entre professionnels de santé en médecine générale et en psychiatrie serviront d'exemple. Une discussion anthropologique introductive des différentes approches théoriques de la coopération en matière de guérison servira de point de départ avant de détailler différents modèles explicatifs de la santé, de la pathologie et du soin selon le spiritisme brésilien. Ensuite, seront présentés des modèles explicatifs du spiritisme brésilien relatifs à la santé, à la maladie et à la guérison. Des études de cas à Marília/São Paulo et à Itabuna/Bahia au Brésil présentent des configurations de coopérations de guérisons entre spiritisme, biomédecine et psychiatrie. La description de la mise en œuvre de pratiques de soin du spiritisme par les migrants brésiliens et des soutiens locaux en Allemagne constitue ensuite le développement majeur de cet article. Cependant, la confrontation des données présentées montre que le bénéfice des échanges transnationaux de pratiques médicinales et de modèles de coopération de soins ne dépend pas vraiment des systèmes sociaux, culturels et religieux, mais plutôt des ressources individuelles, des espérances personnelles et des décisions politiques.

Mots clés psychiatrie transculturelle – anthropologie médicale – migration – spiritisme – médecines alternatives et complémentaires – MAC – Brésil – Allemagne

MAŁGORZATA STELMASZYK: Perturbations signifiantes. Le phénomène de la malédiction dans la Touva postsoviétique p. 50–61, rédigé en anglais

Dans cet article, je m'intéresse aux notions de maladie et de guérison à Kyzyl, capitale de la République autonome de Touva en Sibérie. Ce faisant, je montre comment les diverses pathologies, telles que les accidents vasculaires cérébraux, les comas et la tuberculose sont souvent conceptualisées à travers le prisme des malédictions. Dans ces cas-là, les maladies sont considérées comme un symptôme et une conséquence d'un système socio-cosmique qui implique des esprits et des humains. Par conséquent, les victimes des malédictions se retrouvent souvent dans un état de perturbation physique et émotionnelle intimement lié aux caractéristiques de la cosmologie de Touva, elles-mêmes imprégnées des notions complémentaires de turbulence et d'équilibre. Compte tenu de cela, en présence d'un problème médical, le diagnostic, la guérison et le rétablissement sont souvent sollicités simultanément auprès des médecins, des lamas et des chamanes, et les patients subissent des traitements simultanés par ces trois types de praticiens. En se concentrant sur une étude particulière de cas, je montre dans cet article comment les maladies déclenchées par les malédictions impliquent différents acteurs, tels que des médecins, des lamas et des chamanes; et comment dans le contexte de la Touva postsoviétique ces acteurs, avec leurs épistémologies respectives et leurs engagements avec le monde, construisent une plateforme de coopération plutôt que des possibilités antagonistes.

Mots clés maladie – guérison – pratiques occultes – malédiction – personnalité – Touva

KATRE KOPPEL: «Mon rêve est de rassembler les médecines chinoise et occidentale». Pourquoi la médecine chinoise se développe au sein du système de santé estonien p. 62–77, rédigé en anglais

Au cours des dernières années, la médecine chinoise est devenue une pratique thérapeutique populaire en Estonie. Ce n'est pas surprenant du point de vue des utilisateurs étant donné que divers enseignements liés à la santé, au mode de vie et au bien-être ont trouvé de nombreux adhérents après la chute de l'Union Soviétique. Cependant, ce qui est surprenant est le fait que la médecine chinoise est prise en considération chez les professionnels de santé. Dans le contexte estonien, la médecine chinoise est considérée comme une médecine alternative du point de vue de la biomédecine et de l'État. Pour des raisons historiques dans le contexte de l'ex-Union Soviétique, les médecines alternatives sont généralement stigmatisées par les praticiens de la biomédecine. Indépendamment des tensions manifestes entre la biomédecine et les médecines alternatives, la médecine chinoise semble bénéficier d'un meilleur accueil que d'autres médecines alternatives. Par conséquent, la situation actuelle, qui peut être considérée comme un changement de position concernant la médecine chinoise dans le paysage de la santé estonienne, est relativement extraordinaire. Dans cet article, je présente trois raisons qui expliquent pourquoi la place de la médecine chinoise est actuellement en changement. Tout d'abord, la perception positive de la médecine chinoise peut être analysée comme une faveur de l'État qui a instauré des régulations sur l'acupuncture. Deuxièmement, les raisons peuvent être trouvées dans la politique de santé actuelle et dans les défis auxquels le système de santé estonien est confronté. Troisièmement, le contexte spirituel particulier de l'Estonie fait que la médecine chinoise trouve son chemin dans le système de santé estonien. L'article est basé sur environ deux ans d'études de terrain en Estonie.

Mots clés médecine chinoise – système de santé estonien – diversité médicale – ancienne URSS – politique de santé – spiritualité du New Age

DANUTA PENKALA-GAWĘCKA: Formes de coopérations stables ou fragiles. Médecine complémentaire et biomédicine dans le cadre des systèmes de santé postsoviétiques au Kazakhstan et au Kirghizistan p. 78–94, rédigé en anglais

Cette étude analyse les relations mutuelles entre la «biomédecine» et les différentes médecines alternatives et complémentaires (MAC) dans le contexte socioéconomique et politique de l'ère postsoviétique au Kazakhstan et au Kirghizistan. Alors qu'il existait déjà une diversification des options thérapeutiques sous le régime soviétique en Asie centrale, la chute de l'URSS a permis une plus large diversification des possibilités thérapeutiques. L'auteur examine le changement de l'approche officielle vers des méthodes thérapeutiques qui ne sont pas basées sur la biomédecine, dans lesquelles se reflètent aussi les conditions socioéconomiques et politiques récentes. Dans ces années 90, après avoir gagné leur indépendance, les États respectifs fondent leur volonté de reconnaissance officielle des médecines traditionnelles sur une légitimation de leur héritage culturel. Dans la mesure où cela ne semblait plus nécessaire, les médecines «non-officielles», telles qu'elles étaient pratiquées par des praticiens «non médecins», perdirent le soutien gouvernemental. Dans ce cadre, la coopération récente entre la «biomédecine» et les différentes fractions des MAC devient de plus en plus fragile. La coopération, à l'origine champ d'intersections, évolua selon l'auteur de plus en plus sous la forme de querelles entre ce qui relève du scientifique et des pratiques qui ne sont pas fondées sur des critères de sciences naturelles. Il s'avère que néanmoins et malgré ces tensions, les thérapies les plus variées issues de l'éventail des MAC, y compris les méthodes spirituelles, jouissent d'une grande popularité. Cela tient partiellement aux faiblesses du système de santé publique. La dernière partie de l'article présente des exemples de coopérations, réussies dans des conditions particulières, entre psychiatres et guérisseurs kirghizes.

Mots clés diversité médicale – médecine alternatives et complémentaires – MAC – biomédecine – coopération guérison – boundary work – Asie centrale – Kazakhstan – Kirghizistan

PIERRE PFÜTSCH: Ambulanciers en Allemagne. Coopération et conflits dans un domaine professionnel difficile (1949–1990) p. 95–108, rédigé en anglais

Les collaborations sont pratiquement impensables sans conflit. Par conséquent, cet article analyse l'imbrication de la coopération et du conflit dans une perspective d'histoire contemporaine. À titre d'exemple, les services d'urgence en République fédérale d'Allemagne impliquent une grande variété d'acteurs: les médecins, les professionnels non-médicaux de la santé, les associations caritatives et les organisations professionnelles, entre lesquels se produisent de nombreux conflits. En outre, les médecins et les professions paramédicales se situent à différents niveaux hiérarchiques. En conséquence, dans ces conflits les positions de pouvoir se négocient – et ce en dehors de points de vue divergents sur les soins. L'article analyse deux perspectives différentes sur les coopérations et les conflits. D'une part, il convient de préciser que des conflits peuvent survenir dans le cadre de coopérations de travail. D'un autre côté, ces conflits peuvent également conduire à la coopération et peuvent donc être considérés comme une sorte de moteur de l'innovation. Les deux situations se retrouvent à la fois au niveau micro, c'est-à-dire dans le conflit concret entre médecins et ambulanciers. Mais ils peuvent aussi influencer les structures de l'offre au niveau macro, comme le montre l'exemple des conflits d'intérêts sur une loi professionnelle pour les ambulanciers et le personnel paramédical. Concrètement, la question au centre des discussions a toujours été de savoir quelles tâches les ambulanciers devraient prendre en charge et lesquelles devraient être réservées aux médecins. En raison de l'insuffisance de sources, l'analyse s'appuie principalement sur des textes normatifs. À travers des tribunes libres, le point de vue des acteurs est au moins indirectement développé.

Mots clés paramédicaux – urgences médicales – service d'urgence – professionnalisation – conflits d'intérêts – coopération – Allemagne

STEFAN REINSCH, JÖRG NIEWÖHNER & DORIS STAAB: L'écologie des soins en fibrose cystique. Identification, ménagement des décisions et apprendre dans une communauté qui vit et travaille avec une maladie chronique rare p. 109–127, rédigé en anglais

L'objet de cet article est d'analyser l'écologie des soins et des pratiques de savoir-faire dans une communauté vivant et travaillant avec la mucoviscidose. La mucoviscidose est une maladie génétique rare, chronique, et mortel. En raison d'un régime thérapeutique complexe et de l'augmentation résultant de la durée de vie des personnes atteintes de la mucoviscidose, les décisions journalières demandent de plus en plus une collaboration entre les générations et les disciplines. Cet article est basé sur une étude ethnographique de longue durée que nous avons menée en tant que socio-anthropologues et médecins dans un environnement universitaire hautement spécialisée. Notre investigation porte sur les décisions de la part des patients et des médecins ainsi que sur la discussion autour de leurs positions et sur leurs significations au sein d'une *communauté de pratique*. Utilisant des concepts de la *cognition distribuée* et des pratiques de savoir-faire, nous pensons que des horizons temporels divergents et des niveaux de personnification sont compensés par une transmission intercalée du savoir. Cela signifie que la transmission intersubjective et intergénérationnelle de certains savoirs ne nécessite pas seulement un apprentissage cognitif, mais requiert un travail de traduction et de médiation pratique de la part des personnes qui peuvent agir entre générations et disciplines.

Mots clés mucoviscidose – communauté de pratique – écologie de soins – pratiques de savoir-faire – cognition distribuée – Allemagne

Christian Erbacher: Philosophie – thérapie – mythologie. D'une analogie triangulaire dans la philosophie de Ludwig Wittgenstein

p. 128–134, rédigé en anglais

L'objectif de cet article est d'inviter les praticiens de la guérison à lire les écrits philosophiques de Ludwig Wittgenstein comme étant pertinent pour leur pratique. Pour cela, l'article entreprend de présenter l'orientation philosophique de Wittgenstein à l'aide de l'analogie triangulaire qu'il fait entre philosophie, thérapie et mythologie. La thèse de l'article est que tout au long de sa carrière philosophique, Wittgenstein a considéré la philosophie comme une activité visant à clarifier les confusions. D'après cette conception, la philosophie est donc, comme la médecine, un traitement qui consiste à faire disparaitre ou à calmer un état inquiétant. Wittgenstein lui-même affirmait que ses méthodes de clarification philosophique pouvaient être comparées à la psychanalyse. D'après cette analogie, la clarification philosophique inoffensive rend une mythologie inquiétante, et ce à l'aide d'une mythologie moins inquiétante. Cette approche, d'après Wittgenstein, peut donc mettre en lumière la confusion philosophique qu'une vision scientifique du monde peut accompagner. Une telle confusion philosophique survient lorsque la croyance dans la portée absolue de la vérité scientifique empêche la reconnaissance des vérités et des conceptions venant d'autres cultures.

Mots clés philosophie – psychothérapie – Wittgenstein – Freud – Frazer

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