IS THE ALTERNATIVE TRADITIONAL?
TRACING BOUNDARIES OF MEDICINES IN THE
DOMINICAN REPUBLIC

By

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A THESIS PRESENTED TO THE GRADUATE SCHOOL
OF THE UNIVERSITY OF FLORIDA IN PARTIAL FULFILLMENT
OF THE REQUIREMENTS FOR THE DEGREE OF
MASTER OF ARTS

UNIVERSITY OF FLORIDA

2003
Dedicated to my daughters, Paola and Amaya, who are in my every breath; and to my mom, my connection to the world.
Also, in honor of the philosophy, poetry, and music of Silvio Rodriguez.
ACKNOWLEDGMENTS

The great number of people who supported me in this effort reveals the gregarious way in which I live my life, the great people that walk this path with me, and the challenges of reconciling the many aspects of a woman’s personal growth in unconventional and ambitious ways. I will attempt to mention all of those who contributed to my accomplishments, at the same time taking responsibility for the shortcomings that even with their help, I did not overcome.

Firstly, I would not have accomplished the completion of this great task while balancing my work and family responsibilities without the loving support and encouragement of my supervisor, Dr. Sara L. Warber. I would like to express my gratitude to the professors in my committee: my chair, Dr. Hernan Vera; Dr. Anthony Oliver-Smith; and Dr. Stacey Langwick. They were all willing to work under great time constraints and remained caring and flexible. Dr. Langwick in particular, agreed to help me complete this study without knowing my qualities as a student, and still provided me with the best scholarly and personal guidance.

I would also like to recognize the great help of the people of the Center for Latin American Studies: Dr. Charles Wood, Margarita Gandia, Mirna Sulsona, Dr. Cristina Espinosa, and Wanda Carter. Their support was most valuable, as it conveyed a great deal of faith in me. My friends and coworkers at the Complementary and Alternative Medicine Research Center of the University of Michigan beautifully managed to be more ‘complementary’. A very special mention goes to Jenna Wunder and Kate Irvine, who
made both my life and this thesis better. Andrea Kaye and Rob Adwere-Boamah generously contributed their time and their minds.

My family and friends have accompanied me in the feat of living, of which producing a master’s thesis is but a small part. I am of course thankful to my whole family, the genetic line extending from Maria Hernandez, my mom; to Salome Severino, my sea of joy. My sisters, Selenys above all, Niurka, Yenny, Mercedes, and Mery; and my brother Dionis were specifically involved. My daughters Paola and Amaya; my niece Patricia, for many years my loving personal assistant; and my nephews Isaac, Fidel and Isael all helped. Members of my extended family, Amarilys and Emilia Sabino; and Karina Segura also came to the rescue when needed. My friends Fatima Jerez, Ermitte Saint Jacques, and Lorraine McLeod many times made my challenges theirs. I would like to honor the friendship granted me by Gavino Severino, Abraham Apolinario, and Ramon Tejeda, who have worked so hard at making me a better person.

I hold myself accountable to my friends and family when I write, and realize that God gave each of my brothers and sisters (part of the human family) a message for me. The help of those I failed to mention at this rushed hour has not gone unappreciated.
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Globalized representations of the relationship between Western and non-Western medicines attempt an orderly articulation of discrete, prescribed categories of *universal* and *local* knowledges. Within this frame, questions are raised about enticing issues of safety, access and effectiveness. However, a process of displacement and appropriation of epistemological and natural resources, historically associated with the (re)establishment of unequal power relationships between cultures and their attendant epistemologies and economies, suggests that we must rethink definitions of universal and local knowledges.

In this study I seek to identify the reorganization of resources, meanings and knowledges of health and health care that is at the core of this kind of interaction in the Dominican Republic (DR). I posit that changes in conceptualizations of health and in health practices are negotiated within a dynamic, politicized context that increasingly extends beyond national boundaries. Case studies of alternative medical practitioners
found their practices to embody an articulation of medical traditions, framed by the dominant paradigm that they in turn reproduced. Situated in the interface of local and global processes, they epitomize the relationship between biomedicine and non-Western medicines. Within a milieu of biomedical upsurge and heightened health concerns, alternative medicine seems to share in the allure of these foreign imports. Practitioners of alternative medicine in the DR are mostly Western-trained physicians combining conventional and unconventional methods and approaches. Their costly, private practice builds on technological advantage and the marketability of new health products corresponding to transformations in middle-class needs and lifestyles. This is, as opposed to an association with Dominican indigenous healing traditions and social or environmental conceptualizations of health problems. In this study, alternative medicine and traditional medicine refer, at least in the DR and for the moment, to two different social phenomena.

The argument built here, however, is that there is not space where they could exist exclusively. Within a climate of deliberate globalized flows of peoples, resources and cultures, individuals and groups draw from all sources to construct meanings and enact practices around health. In addition, it seems clear that those flows follow deliberate lines of power. Thus, the differential development of alternative and traditional medicine in the DR reflects greater political and economic processes. The context in which the Dominican collective conceptualizes and organizes health meanings and practices may not be in the best interest of Dominican health and epistemology, and obey instead agendas set by international, dominant discourses around health and development. These are in turn related to the preservation of global hierarchies.
CHAPTER 1
INTRODUCTION

What kinds of medical knowledge and what kinds of knowledges about medicine are being reproduced around the world? Having studied the relationship between Complementary and Alternative Medicine (CAM) and scientific medicine\(^1\) in the United States (US), I am interested in similar processes in the Dominican Republic (DR). Through an exploration of parallels and interconnections, in this study I seek to contribute to the understanding of medical systems as cultural/knowledge systems, and of their epistemological, cultural and social implications within a relational (political) framework.

In the US, CAM is being socially constructed out of a loose selection of modalities and practices by using scientific criteria as a tool for a ‘selective engagement’ in which the practices are thereby transformed. The term decreasingly refers to concepts of health and health care borne in the context of specific cultural systems and social structures, and increasingly corresponds to practices developed in close relation to the production of orthodox medical knowledge.\(^2\)

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\(^1\) Scientific medicine, biomedicine, conventional medicine, will all be referring to Western medicine. However, biomedicine is not presumed to be monolithic or fixated through time and space (Goldstein, 1999; Hess, 2001). Individual, local and practical considerations are always interacting with ideal conceptualizations of medicine, or as Kleinman (1980) asserts, they are constituted in the clinical encounter. Naming non-Western medicines under one term is even more problematic, but equally necessary to reflect the established order. Linguistic differences will attempt to convey social, cultural, political, geographical and temporal differences.

\(^2\) An argument that CAM is discursively articulated to redefine non-Western medical traditions in the Western context, but increasingly, globally, and in relation to the transformation of biomedicine, is put forward by Cornelio & Warber, (2003). See also Hess (2001).
On the other hand, the World Health Organization (WHO) has recently published a Strategy on traditional medicine.\(^3\) Regardless of the social position and cultural congruity of the medical traditions—Western\(^4\) and (all) non-Western—and of their historical relationship at each location, the current thrust seems to be one of scientific validation and integration of non-Western medicines\(^5\) and/or modalities\(^6\) into health care systems dominated by scientific medicine. Around this central idea, the WHO document seems to conceptually reorganize the social and geographical location of medicines, and attempts to normalize a language that would refer to their interaction within health systems throughout the world.

In industrialized nations, this incorporation is mostly represented as led by cultural and social transformations on the part of populations defined as dissatisfied, informed consumers open to new choices. In underdeveloped societies, validating and mainstreaming indigenous healing systems\(^7\) is posited as aiding stated goals of providing

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\(^4\) A capitalized reference to the West in this study refers to the dominant capitalist culture.

\(^5\) In the US, elements, practices, modalities are being gradually incorporated into biomedicine (preferably through scientific evaluation). Harding (1998) purports that the same has happened in Europe, where “only elements that…fit coherently into modern biomedicine’s ontology and epistemology” are borrowed (p.174). The language of the WHO document is either more ambitious or less specific, or establishing a different, discursive relationship.

\(^6\) Press’ (1980) explorations of the difference between “medicines” and “medical systems” will be used. The first refers to cultural (ideational and practical) manifestations providing meaning and means for health care; the second, to social (structural, organizational) phenomena for the same use. This analytical distinction allows us to recognize that medicines not organized into medical systems have fewer resources for social reproduction; and this does make a difference as social spaces are negotiated. Modalities are practices belonging to medicines or medical systems and which can be incorporated into others, such as acupuncture.

\(^7\) The term indigenous is not without the same kind of political and representational problems that concern this study. However, just as the terms local and global, I am using it as a working, analytical category. Indigenous and traditional will be used hereafter to refer to practitioners with no formal Western medical education. I anticipate that these boundaries will be difficult to establish.
health for all.\textsuperscript{8} Studies on these latitudes identify the orchestration of national efforts by international organizations, and report failed processes that do not manage to attend to the health needs of the particular society.\textsuperscript{9} In both cases, the transformation of health care as a different product is at stake and it is being achieved and justified by seemingly self-evident processes of need and demand.

In the US, this encounter is being debated and articulated by visible academic, government and special interest organizations. The course of action is defined as one of legitimating non-Western healing modalities through their scientific study, policy development and institutionalization. Close analysis of this progression reveals that apparently disparate interest groups are functioning within powerful and evocative conceptual frameworks. Shared cultural beliefs, such as an unabridged individualism, the indisputable validity of science and the marketability of new conceptualizations of health bring all groups to accommodate, so that those who embody CAM are as invested in its redefinition.\textsuperscript{10} The historical co-constitution\textsuperscript{11} of these values with social mechanisms and social formations places all social actors and cultural products within a context of manageable tensions. The preeminence of scientific standards and the predominance of

\textsuperscript{8} Refers to a WHO previous global health Strategy.

\textsuperscript{9} Unschuld (1980) and Bishaw (1991) in their studies on Germany and Ethiopia respectively, identify the WHO as leading, encouraging, and mandating this incorporation; also in Crandon (1983). It seems that the current policy Strategy follows a previous one that called for the “promotion and development of traditional medicine.”

\textsuperscript{10} Baer (2001) and Goldstein (1999) provide detailed accounts of these dynamics and of how they stay within the bounds of greater cultural values; Lock and Gordon (1988) develop their analysis on the relationship between “naturalism, biomedicine and individualism.” I would argue that this connection plays a key role in the safe transformation of both alternative healing systems into CAM, and biomedicine into “Integrative Medicine.”

\textsuperscript{11} This concept is derived from Harding (1988).
biomedicine are gradually reestablished in connection to the corporate transformation of the medical establishment.\textsuperscript{12}

Global representations of this enterprise propose an orderly articulation of discrete, prescribed categories of global and local knowledges that become the setting where enticing issues of safety, access and effectiveness will be debated and arranged. Yet, the WHO Strategy is not only coincident with and analogous to official publications in the US. They share terminology, conceptualizations, chronological developments and human resources,\textsuperscript{13} which brings us to question not only how are these global and local categories interacting, but, also, what exactly are the global and the local. Are they both better defined as representations of a set of relationships between unequally powerful contexts? How then, can these globalized processes be identified in the specificities of local articulations? What aspects of societies and cultures are being exchanged and to what order does this selection obey?

During a visit to the DR in 2001, I spoke to friends and relatives who worked with health and research projects and institutions about the development of alternative medicine, in light of the international events of which I was aware. I was told about my need to use the term traditional in place of alternative, and was referred to a list of Non Governmental Organizations (NGOs) and individual practitioners. Upon preliminary observation, though, I found that there were significant differences among the groups’

\textsuperscript{12}While I am making that connection based on my previous research, Starr (1982), Schmidt (1999), and Hess (2001) have identified the social and institutional transformation of biomedicine under great social forces.

\textsuperscript{13}The US counterparts are the White House Commission on CAM Policy Report (WHCCAMP; 2002) and the National Center on CAM (NCCAM) Five Year Strategy (2001). The WHO documents first establish a parallel and then collapse Complementary and Alternative Medicine, the official US designation, with Traditional Medicine.
objects of study and practice. I was struck by the presence of practitioners who were not practicing conventional Western medicine, yet they did not seem to correspond to the endogenous and/or indigenous Dominican healers to which the term traditional had been usually applied. Where the appellatives being used to refer to similar or different phenomena? Did these practitioners instead correspond to the phenomenon of CAM in the US? Observing the trendy marketability of their public presence, I speculated that they corresponded to an international category. However, along which local, social processes were they operating and what was their relation to the other Dominican medical traditions?

The practice I am concerned with in this study is that of urban practitioners of non conventional medicine who appear to have formal and/or multicultural education and background. They seem to be defining their practices as an individual amalgamation of exogenous healing traditions; advertising, introducing health food stores, instituting different modalities as part of their treatment and developing training programs for interested biomedical practitioners. Their practices are growing within a more generalized transformation of health related matters in this society, and seem to be interacting with international health objectives. In this study, I aim to highlight elements of that interaction.

**Research Questions**

Questions about the import of this practice, the practitioners’ status within the conventional health system, their relationship to rural, indigenous healers and their interaction with Dominican culture and society are central to this study: How is “alternative medicine” being (re)defined in the context of the Dominican Republic?
To what systems of knowledge do these practitioners relate and how do they validate their practices? On which cultural resources and through which social means are they advancing their incorporation into the medical system and general society? What social mechanisms and cultural values are hindering their development? How are they defined in relation to other medical practitioners?

What relationship does this process have to changes in Dominican medicines and medical system? What relationship does this process have to the scheme represented by the WHO and to processes in the US? Are these redefinitions of medicines and their relationship finding parallels in this particular context and if so, how? Are local actors drawing on these updated universal conceptualizations?

**Objectives**

- To identify the presence of different medicines in the Dominican Republic and to map out relationships between them and within the health system.
- To explore relationships between these processes and those of other social, cultural and economic sectors of society.
- To explore the relationship between these societal processes and similarly articulated, interdependent *global* developments.
- To contribute to understandings of medical systems as cultural/knowledge systems and of their epistemological, cultural and social implications within a relational (political) framework.

**Developing a Theoretical Framework**

*Knowledge is often the product of the subjugation of objects, or perhaps it can be seen as the process through which subjects can be constituted as subjugated.*

(Mills, 1997, p.21)

Three bodies of knowledge will provide the analytical tools for this inquiry. First, medical anthropological theories that define medical systems as cultural systems will afford an initial premise. They help to establish a relationship between health meanings and health practices and the societies out of which they develop. Second, the conditions for production of medical knowledge will be underscored by conceptualizations from social studies of science. They help delineate the historical development of the sociology of medical knowledge within and across societies. Finally, critical medical anthropology
places all health related matters squarely within socio-economic, political processes. This helps to bring the production of medical knowledge closer to the social conditions of its application.

To begin, defining medical systems as cultural systems\(^\text{14}\) facilitates cross-cultural studies that place those systems on equal standing (Kleinman, 1980). Shared meanings of health and illness underlie all levels of health practices. However, the general tendency has been to apply this definition to non-Western healing systems. This notion of cultural relativity has been used to identify their cultural congruity and local validity, or to facilitate the application of Western concepts in their study and translation.

Biomedicine, though, is equally built on a value system. Its persistent representation as universal, atemporal and value free, for example, can and has been identified as part of its connection to an industrial, capitalist social model.\(^\text{15}\) Occupational prerogatives, social/institutional transformations, and cultural specificities are instead traceable in its construction of a biological reality.\(^\text{16}\) A critical examination of the social and cultural character of biomedical knowledge does more to facilitate cross-cultural

\(^{14}\) Risking its association with structural functionalist theories, the concept of system will be used to refer to a network of social formations and relations. Yet, I do not conceive it as permanent and as functioning to serve the purpose of social stability. Even with this recognition, I believe the concept connotes the weight afforded to some orders and meanings by self-preserving institutions and their attendant discourse, which do manage to greatly impact the organization of social life. Actor-network theories, to address one alternative, provide fascinating details of how resources are accrued to social action. However, one is left with the idea that the social landscape is eternally dynamic and arbitrarily organized. Agency is only recognized at a very narrow individual level, constrained by immediate, pragmatic needs. Moving away from vague notions of the cultural, the social and the political space, these theories represent individuals, whether in institutionalized contexts or not, performing and articulating the translations that achieve those common spaces. However, the possibility of outcomes is clearly constrained, and the goal moved, at every step, by self-reproducing and perpetuating systems working through actants that effectively are not only human. In this study, a system is permeable, located within a global power structure. A system helps materialize and reproduce particular meanings into social institutions and organization.

\(^{15}\) See Lock and Gordon (1988).

analyses. In this study, I will conceive of relations between medical systems as epitomizing relations between the cultures with whose values they are imbued. Nevertheless, because neither medical systems nor societies are conceptualized as bounded, autonomous or exclusive, those relations will be located within different spheres of societies as much as across.

Hess (2001) has described the encounter as happening in the context of globalization, and thus, also due to the journeys of non-Western medicines across national boundaries. The encounter, imbued with contingent political and social dynamics, manifests differently at each location, while it also reproduces historical and global patterns of social change. The globalized naming, redefinition and relocation of non-Western medicines in relation to national (biomedical) health systems can be said to extend from First World nations to other global regions, together and with the same characteristics of other movements of cultural phenomena.

The boundaries of these transformations point to transnational and regional relationships across cultures and systems of knowledge that have been historically framed by political and economic power imbalances. Questions related to the designation of the practice similarly have social implications. A new, more involved and aggressive relationship between dominant health systems and non-Western medicines is demanded by increasingly concurrent worlds.

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17 Hess (2001) talks about the *containment* achieved through the transition to the term “integrative medicine” in the US. Unschuld (1980) talks about “terminological upgrading” as a strategy used by the German government to aid in a process of incorporation.
The historical development of biomedicine as scientific medicine underscores aspects of its current relationship to CAM.\textsuperscript{18} I found that relationship to be idiosyncratic to the development of modern science at the expense of other systems of knowledge as I delved into postcolonial and feminist studies of the history of science. Among other great contributions, these theories add elements of power and positionality with which questions of scientific validity, objectivity and applicability are reinterpreted as ways of organizing knowledges, meanings and resources according to power dynamics.

The work of Sandra Harding, in her 1998 \textit{Is Science Multicultural?}, will be used as a springboard for incursions into some of these concepts. Harding establishes connections between \textit{the conceptual practices of power}\textsuperscript{19} and the practical implications of knowledge, which open up \textit{thinking spaces} for localized knowers. Her theories allow us to conceive of the production of knowledge in peripheral societies such as the DR, which are traditionally seen as grounds for knowledge application. They also reveal knowledge production processes as being grounded by the interaction of peoples with their natural and social worlds. Those worlds are also seen not as enclosed and static, but already affected by historical movements of resources and power.

The universal association of knowledge with scientific and technological standards and spaces defines interactions between societies. Thus, unequal economic interactions reproduce knowledge/power dyads that (re)position societies such as the DR, and their systems of knowledge, in the disadvantaged position of object of study, as grounds for

\textsuperscript{18} Baer (2001).

\textsuperscript{19} The concept belongs to Dorothy Smith.
discovery, categorization and translation. They also become the receiver/consumer of high technology and knowledge.

Knowledge, defined as acultural and universal, travels in ways different from cultural manifestations. Biomedical knowledge accrues the power of science and technology, thereby displacing notions of the ways in which it organizes resources within and between societies. Biomedicine organizes resources through its association with particular social formations and through its discursive/epistemological structure, though the two are intimately related.

First, as Hess (2001) agrees, biomedicine (among other epistemologies rooted in modern science and Western societies) has been historically building on a relationship of mutual growth with colonialist enterprises. Biomedicine was favored by colonialism by “traveling” with/in it and growing from the “incorporation of local knowledges into its cosmopolitan knowledge archive, just as biomedicine aided colonialism by displacing local knowledges and medicines” (p.76). In today’s globalizing (and development) projects, biomedicine is also playing a role. Hess adds, “[t]he dynamic of centers and peripheries would also point to the allure and legitimating power that biomedicine has for globalist ideology” (p.75). Biomedicine, in other words, with its striking technological tools, is opening the doors of underdeveloped countries for neoliberal models of social development.

Biomedicine also organizes knowledge about the body around social and cultural difference (of power). Those differences are inscribed and reproduced in “knowledge claims.” Binary oppositions of self/other, male/female, knower/known, subject/object, knowledge/ignorance, modern/archaic, enlightened/dark, are biomedical epistemic
features that engender processes of differential allocation and deployment of power
(Harding, 1998). Representations built on these basic, powerful metaphors organize
references to our natural and social worlds into dichotomies of mutually exclusive,
fixated and polarized categories. Their power lies on their ability to lock in the
oppositional stance of these categories while erasing their internal, interactive
relationship. Knowledge and meaning organized on this principle create a closed circuit.
This notion applies to epistemologies in important ways.

If science defines objectivity (as neutrality; see Harding, 1998), as the hallmark of
scientific knowledge, any other systematic way of developing knowledge is deemed as
lacking objectivity. If science is defined as acultural and apolitical and therefore
universally appealing and applicable, then alternative ways of knowing become non
scientific the minute they engage these issues. When abstractions and isolated units
become the standard of the highest form of knowledge, immediate, experiential insights
into our contexts and our selves become just common sense, cultural manifestations, non-
epistemic abstractions of nature. This is the kind of cognitive constraint that perpetuates
the position of the peripheries as consumers—or grounds for application—of knowledge
produced in the centers. Systems and ways of knowing grow within this framework.

In her elaboration of the cognitive core of any systematic accumulation of
knowledge, Harding (1998) enumerates location (interaction with heterogeneous natural
regularities); interests (socially determined questions about natural environments);
discursive traditions (how is nature thought of, seen, spoken about); and ways of
organizing the production of knowledge. Understanding how interactions with a location
and interests can be manipulated by the conceptual practices of power and practical
implications of knowledge, and how discursive traditions and ways of organizing the
production of knowledge can be colonized, one begins to think not of difference in
knowledge production, but of the risk of subjugated, alienated knowledge, and of a
feedback loop.

The preeminence of biomedicine, as reproduced by the development projects of
which it is an integral part, predetermines the conditions for production of medical
knowledge in the DR. Just what kinds of medicines are aiding in these processes now is a
question raised by our preliminary incursion into the relationship between international
and national developments in health and medicine. Medical knowledge in the DR
interacts in this way with local natural regularities, interests, discourses and definitions of
knowledge. Thus, this study does not intend to separate pure, pristine categories of
Dominican medicine, or to identify biomedicine and other practices as impositions by
dominant cultures. It aims to see the reproduction of medical knowledges as interacting
with and recreating social spaces according to relationships of power.

Lastly, critical medical anthropology defines that relationship by insisting on the
need to understand and analyze health and health care in relationship to their social,
economic and political frameworks, in contrast to the dominant biomedical paradigm. It
allows for a “macro-analytic, critical, and historical perspective to bear on the analysis of
disease distribution and health services under a variety of systems, with particular
emphasis on the existence and significance of stratified social, political and economic
relations within the world economic system” (Morgan, unpublished, quoted in Whiteford,
1990, p. 221). In this way, the micro-individual level of resource utilization and the
impact of cultural and social forces on the individual are bridged with the macro-social
analysis of social, political and economic structures and dynamics. In this study, illustrating that relationship is more than an assertion, a conceptual tool to expand the analysis.

Thus, this analysis attempts to move counter to conventional medical and other scientific knowledges, to reveal multiple and complex relationships. Their implications are the reproduction of dominant knowledges, cultures and economies, at the expense of others. To begin, the cases studied, those of three individual practitioners of alternative medicine, will be understood as inseparable from these dynamics that, I argue, provide fuller responses to my research questions.

Finally, this work is produced with recognition that social scientific studies of alternative healing systems may not be overcoming the epistemic structures that bind their own representations if they also interact with these knowledges and their worlds without fully engaging their organization of bodies, worlds, and meanings. Following Latour and Woolgar (1979), Hess (2001) compares the differential opportunities for development of Western and non-Western knowledges as converting into differences of quality and degree in mechanisms for expansion and self-preservation, including reaffirming scientific representations. Social studies of science and medicine are part of those mechanisms.

The practice of alternative medicine in the DR will be studied through three case studies that will be interpreted with these theoretical premises. The development of their medical practices will be examined as tied to national and international health processes that are also socio-economic and political. The differential development of medical traditions Baer (2001) refers to, and which accompanies social transformation and class
conflicts, will find expression in the way they negotiate their practice. The incorporation of alternative medicine, favored by the upper end of the class structure in the US (Hess, 2001) will find similar openings in Dominican society.

**Propositions**

The study of the interaction between medicines in the Dominican Republic can be inscribed and will add insight to the following claims/premises:

- Changes in conceptualizations of health and in health practices are negotiated within a dynamic, politicized context that increasingly extends beyond national boundaries.

- These changes reproduce local and global hierarchies through unequal relationships of epistemologies, cultures and economies, which are in turn related.

**Methodology**

*Method...connotes a way of knowing...closer to what Thomas Khun describes as a paradigm—a distinctive way of orienting the world...ways of discerning and describing social reality...idioms for apprehending and representing the real...every act of seeing and saying is unavoidably conditioned by cultural, institutional and interactional contingencies. (Gubrium and Holstein, 1997 Preface)*

Methodological choices include identifying and defining a research problem, questions and propositions; establishing through which data and in which context would the questions posed be answered; aligning data collection tools, developing data analysis techniques, and finally, producing acceptable reports. Those technical choices, bounded by the standards of scientific and academic criteria, become powerful, yet unsuspected settings that de/limit what accounts may potentially be considered as knowledge.

This particular account follows Gubrium and Holstein’s (1997) ruminations on method: “Method connotes a manner of viewing and talking about reality as much as it specifies technique and procedure” (p.5). Thus, the design of this research project and the
actual application of particular tools have been placed within the scope of the same critical theories that support the questions guiding the research.

Broader methodological orientations respond to basic questions about reality; how we define it, and where we locate it. Framed by social scientific methods, I will take on demands placed by a defined theoretical/political stance. Critical medical anthropology theories define health and cultural matters through clear political and social analysis. Theories that foreground the sociological and cultural bounds of knowledge production include contextual considerations and critical analysis of discourse.\textsuperscript{20} We know as well that how we represent and convey a reality, as we study it, contributes to particular ways in which realities are reproduced. Concepts derived from these theories will be brought to interact with concepts derived from my exposure to alternative systems of knowledge/healing and to the dynamics that make up the socio-economic reality of the DR.

Case studies have been chosen as they allow the flexibility to incorporate many kinds of data and analysis. This study corresponds to the definition of \textit{multiple, exploratory case study research} by Yin (2002). His basic definition of case studies describes the boundaries and characteristics of this work: an aim to respond to how and why questions in relation to events, over which one has little control and which are a contemporary phenomenon, in real-life context. But most importantly, this method favors situations where boundaries between phenomena and context are not clear, and where multiple sources of evidence are used (Schwandt, 2001). Relationships and components

\footnote{Discourse is understood as how statements are situated within conceptual frameworks, institutional histories and broader relations of power, establishing conditions for emergence of, and delimiting what constitutes, a truth statement.}
of the DR social reality I was interested in, following theoretical constructs of knowledge and medical systems, could thus be incorporated in my analysis.

My units of analysis are therefore, participants’ individual lived experiences around the articulation of their medical practices, as well as the DR community, seen as the nexus of conflating flows out of which individual and collective realities are accomplished. The analysis will attempt to articulate their experiences as represented in their narrative; and my own, secondary effort of interpretation.

The Setting

The DR was selected because of my practical and cultural leads. My migratory status has afforded me acquaintance and mobility between center and periphery, demanding a transnational identity and cross-disciplinary perspectives. In that continuum, I was not cognizant of the status of alternative medicines in relation to the biomedical establishment in the DR.

The DR is close enough to the US so that cultural differences and commonalities, as well as social links and discontinuities, can be poignantly played out. The US is presumed to be a main source of dominant medical knowledges and products, providing a backdrop for the development and transformations of the Dominican health system. The relationship between the DR and the US economies and cultures is one of unequal power, as per my first-hand experiences. The biomedical system can be expected to be subordinate to its counterpart in the US.

Preliminary observations and inquiries into this aspect of reality in the DR guided the definition and elaboration of questions. Methods included observation, interviews of key informants, mapping out of networks, archival research, and narrative analysis of public documents and studies on this issue.
Leads provided by initially identified social actors/groups were followed to map out the interaction between different sectors. Whether any anticipated group was related to or acknowledged was taken to indicate their place in the current medical structure of the DR. Similarly, gender and racial correlations, while not directly investigated, were observed and interpreted.

The unequal interaction of the DR with dominant societies (US, Europe, Japan) will be acknowledged at the level of epistemologies and of economies. In chapter two I will begin to depict the Dominican context by providing basic information about social and natural characteristics. Officially reported Dominican health needs and health system resources will be identified as salient to the context in which alternative medical practice is developing. In chapter three, an analysis of the import of health models, the push for developmental agendas and the current development of a health reform complete the examination of the reality out of which Dominican health meanings and practices are borne. I relate these to the renewed interest on alternative medicine, and to concrete efforts at regulating traditional medicines through research and programs on chapter four. The relation between medical traditions in the DR is thus also framed by international agendas and influences. Finally, I develop the findings of my case studies on chapter five. Conclusions are elaborated on chapter six.
CHAPTER 2
THE DOMINICAN REPUBLIC

*It is impossible to over-emphasize the significance of the role played by the US in Dominican political life. Twice occupied by US troops, for 30 years kept as an alternative to Castro-Communism, the Dominican Republic has been too long too close to the US.* (Whiteford, 1990)

These case studies are to be understood in the context of health and health care in the DR. This context primarily consists of the main health care needs of the Dominican population and the conditions in which health and illness are borne. Those conditions include the material, cultural and epistemological resources with which health related matters are addressed, and similarly natured obstacles and limitations confronted by the people and by the institutional health system. In the DR though, health policy and health care are not primarily produced at the local level. The structure and function of the Dominican health system can be easily linked to internationally established health measurements, strategies and agendas, developed according to extraneous medical knowledge and standards.

Whether providing comprehensive assessments or not, international agencies delineate what is, for all purposes, the Dominican health reality. Their documents, thus, will be used extensively to depict the context in which the medical practices studied here are developed. However, I will be critical of the boundaries and relations set around and within the Dominican context by these documents, interested in revealing relationships of representations and the realities they participate in constructing.
A socio-economic account of environmental factors customarily provides the context for national and international health assessments and plans, albeit I would argue, their incorporation is itemized and the connections made are generally limited or reversed. Equally, I will begin a description of the Dominican context by providing basic socio-economic information. As I develop this depiction, I hope to overcome such limitations.

The Dominican Republic shares with Haiti the Hispaniola Island, between the Caribbean Sea and the Atlantic Ocean. It occupies 74% on its eastern side. The country has a land area of 48,442 km², and a population of 8,396,164 making for a density of 173.3 inhabitants per km², as per the 2000 Census.¹ The capital city, Santo Domingo, with 2.9 million inhabitants, represents approximately 30% of the population. Approximately 1 million Dominicans have migrated to the US, while the country receives a significant influx of Haitian immigrants.

The country is organized politically and administratively into 31 provinces and the National District, with a total of 111 municipalities and 56 municipal districts. A republican state with a democratic government, it is headed by an Executive Power, lead by the President, a bicameral Legislative Power and a Judicial Power. The population, belonging to one ethnic group, was estimated to be 67% urban and 33% rural in 2000. According to the National Health Survey conducted in 1996, 19.3% of the population was illiterate (PAHO, 1998, p.4).

The Pan American Health Organization (PAHO), in its country analyses of health systems, provides the following socio-economic profile: “While the GDP growth was

¹ These figures are estimated from the National Office of Statistics. The last census was completed in 2002. Results are not available.
reported at 6.8% in 2000, and macro-economic indicators have showed economic growth in the last several years, it is estimated that 40% of urban households and 80% of rural households classify as poor” (PAHO, 1998, p.4). The country serves a foreign debt that represented 18.6% of the GDP in 2000. “During 1996-1999 social spending as a proportion of public expenditure averaged 39%, and the proportion relative to GDP was 6%. On average, spending on health represented 8.9% of total public expenditure and 22.8% of all social spending. Public investments in social development (health, education, and social welfare) represented 5% of GDP” (PAHO, 2002, p.223).

The current government, inaugurated in August of 2000, has been credited with the enactment of the General Laws on Health and Social Security, and with an increase in national budget allocations for education and health. The PAHO 2002 country analysis also enlists the “creation of a social cabinet and implementation of measures for social compensation; the establishment of three new Secretariats—one for the Environment, another for Culture and Higher Education, and the third for Science and Technology—and integration as a full participant into the Caribbean and Central American subregional free trade agreements” (PAHO, 2002, p.223).

Mixed indicators reveal the inherent contradictions of development strategies and dependent economic growth, highlighted many times in these very same documents. The PAHO cites the 1999 National Survey of Household Expenditure and Income (ENIGH):

[i]n 1998, 25.8% of the Dominican population (21.5% of the households) was below the poverty line (monthly income of US$60 per capita), which represented a reduction relative to 1992 (31.7% of the households), but it still meant that 2.1 million people were living in poverty, 3.9% under 10 years of age…[t]he same survey, when repeated in 1999, showed that 45% of the poor households did not have piped water to their homes, 64.8% used latrines for the elimination of excreta, 64.2% did not have the benefit of refuse collection services…[i]n 1999, 66.5% of
the poor people lived in cities, compared with 47.9% in 1992. (PAHO, 2002, p.223-224)

Another condition closely related to health, and also included by the PAHO report is that of education:

In 1998 the literacy rate was 84.4% among adults over the age of 15 (83.9% in women and 85% in men). The gross matriculation rate (at the primary, secondary, tertiary, and baccalaureate levels) was 73.5% (74.3% for girls and 72.7% for boys), while 13.5% of the population aged 15 to 45 had a university-level education (18.4% in urban areas and 4.3% in rural areas). At the same time, 15.6% of the population over the age of 15 was illiterate, and the figure was nearly three times greater in rural areas (25.6%) than in the cities (9.9%). (PAHO, 2002, p.224)

**Health Situation and Trends**

Health indicators usually convey the status of the social and health systems, as much as that of the population. The health situation of a particular society must, thus, openly and dynamically incorporate the conditions of its social and health systems. Infant and maternal mortality, for example, have been associated by the PAHO (2002) “basically with problems of inequity of access, quality and organization of social services.” The inequity of the economic growth recently experienced in the country, hence, should be identified as a challenge to health goals.

The PAHO 2002 country analysis organizes its Dominican health report by age group and by type of health problem, to indicate levels of morbidity and mortality. Total life expectancy in the DR, for both genders, was estimated in the year 2000 to be 71.2 years. The crude mortality rate for the period 1995-2000 was 6 per 1,000 population, “however, underregistration is believed to be as high as 42%, which limits the usefulness of mortality rates in understanding the evolution of specific causes and their geographic and social distribution” (PAHO, 2002, p.224).
Underregistration of the death of infants under 1 year of age is even higher, estimated in 1998 to be around 60%, “and it is even higher for neonatal mortality, which in 1999 represented 80% of all infant deaths” (PAHO, 2002, p.225). During 1994-1998, mortality rates fluctuated between being mainly attributable to communicable diseases or to “conditions arising in the perinatal period,” with the latter reaching 64.5% in 1998.

The Infant Mortality Surveillance System, initiated in 1997, reported a mortality rate for children 0-4 years of 2.4%. Reporting 1999 SESPAS data, the PAHO document indicates, “the five leading causes of morbidity in infants under 1 year old were acute respiratory infections (668.8 per 1,000 infants in that age group), acute diarrheal diseases (329.3 per 1,000), parasitoses (138.5 per 1,000), anemia (66 per 1,000), and dermatitis (50.8 per 1,000). In children aged 1 to 4 years the primary causes of morbidity were acute respiratory infections (221.2 per 1,000) and acute diarrheal diseases (69.4 per 1,000).” (PAHO, 2002, 225) According to the newly established National Epidemiological Surveillance System the leading cause of death for this group was communicable diseases (40%), followed by external causes (24.6%).

While mortality rates remained stable for children aged 5-9, the deaths from the two leading causes, communicable diseases and external causes, increased from 1986 to 1998. The greatest increase, 35% is for external causes; however, external causes, as well as “conditions arising in the perinatal period,” are not defined. They can be presumably associated with the physical condition of hospitals and a lack of general safety regulations. With low educational levels, increased teenage pregnancy rates, and close pregnancies, newborns of mothers under 18 are four times more likely to die.

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2 SESPAS stands for Secretaria de Estado de Salud y Asistencia Social or the Dominican (Department of Health and Social Assistance).
Adults 20-69, which comprise 60% of the population, died most frequently of external causes, 36.2% and communicable diseases (20.7%) due to increased registered mortality from tuberculosis and HIV/AIDS, with reports on the latter highly questionable. For those aged 50-64, the declining, leading causes of mortality were diseases of the circulatory system (37%) and neoplasms (18.3%). For those above 60, disease of the circulatory system remained stable at 52%, between 1994 and 1998, while all other causes declined and neoplasms fluctuated between 14-16%.

Morbidity rates among the adult population combine the health problems of underdeveloped nations with the imported health trends of developed societies. Ongoing struggles with vector-borne diseases include malaria, associated with the detrimental conditions of Haitian immigration; dengue, endemic and multiplying through the precarious conditions for water storage; and lymphatic filariasis. In 2000, the incidence of tuberculosis was 62.4 per 100,000; HIV/AIDS rates lowered from 6.4 to 3.9 per 100,000; however, underregistration is high and social stigma, ignorance and denial rampant. Leprosy, while with considerably lower rates of incidence (3 per 100,000) is still present. Control of tuberculosis and HIV/AIDS are important components of the new health reform. Ongoing campaigns are also erected in relation to diseases preventable by immunization, such as polio, measles, diphtheria, whooping cough, tetanus, rubella and Haemophilus Influenzae (Hib). Intestinal infectious diseases were found in 65% of school age children by a 1999 survey, which was followed by a de-parasitation campaign.

On the other hand, more than 10% of all consultations, more than 6% of emergency visits and 80% of adult non-obstetric visits are due to cardiovascular diseases, with national rates of 24% for hypertension. “In 1998, cardiovascular diseases accounted for
37.5% of all diagnosed deaths” (PAHO, 2002, p.229). They head the list of causes of
death with incidence rates of 103.56 per 100,000. The numbers of neoplasms (13.1% in
1998), diabetes (4.2% the same year) and meningococcal disease (2.3 per 100,000 in
1999) are all on the rising. The same can be said for drug consumption, suicides,
intramarital violence, child prostitution and traffic accidents (PAHO, 1998; 2002).

Nutrition related diseases are reported to be on the decline, though micronutrient
deficiencies were found throughout in surveys on children 15 and under. Malnutrition
and specific micronutrient deficiencies are identified as the nutrition-related illnesses.
However, if instead these are seen as underlying other conditions, such as when
malnutrition is compounded with lowered immunodeficiency in the onset of other
diseases, then its role assumes much greater importance (Marchione, 1984). Additionally,
the incidence of food borne diseases has progressively augmented, and the PAHO
associates this trend to the modernization of Dominican life (PAHO, 1998, p.4).

Overall, the best standing health conditions seem to be maternal and child care and
immunization campaigns, with gains reported in the control and prevention of
communicable diseases. Efforts towards the organization and regularization of public
health conditions and outcomes are being enacted, beginning with tobacco use,
automobile safety, health education and adolescent health programs, nascent national
standards for air quality control, and water purification and sanitation services.

According to a comprehensive evaluation of water and sanitation services
carried out in 2000, 71.4% of the population had access to potable water through a
supply system within 500 m of the home in 1998, with an average of 83% in urban
areas and 50.4% in rural areas. At the national level, 89.5% of the population was
covered with some form of excreta disposal (20.1% by sewerage systems)—78.7%
in rural areas and 95.6% in urban areas. However, for only 48% of the population
was wastewater treated prior to being discharged. It is estimated that urban cleanup
benefits only 40% of the population in cities, and the quality of the service is rated as inadequate to very poor. (PAHO, 2002, p.231)

The Dominican Health System

The Dominican health system is comprised by the public and private sectors. The public sector includes the governmental institutions, such as the Secretariat of Health and Social Welfare, the Essential Drugs Program, the Dominican Social Security Institute (IDSS), the Armed Forces and National Police Social Security Institute (ISSFAPOL), the National Population and Family Council, the National Children’s Council, municipal offices that provide environmental health services, as well as some nonprofit and for-profit health service institutions that offer insurance, laboratory services and drugs.

As per the PAHO 2002 Country Analysis, the SESPAS includes a total of 1,267 establishments, with a tertiary level of 42 general and specialized hospitals, including those administered by beneficent organizations; plus another 126 establishments, each with 40–50 beds and at least an operating room, radiology equipment, a laboratory, a pharmacy, and ambulance service, covering populations ranging from 20,000 to 50,000 at the secondary level; and at the primary level, about 1,099 outpatient establishments, 474 of them located in rural areas:

The IDSS has 18 tertiary-level hospitals, 3 of which are regional and specialized; 25 polyclinics at the secondary level; and 211 outpatient units. The Armed Forces and National Police Social Security Institute has two complex general hospitals and 57 dispensaries located in places where there are concentrations of its population. (PAHO 2002, p.233)

Mental health services have been recently expanded to include crisis units in at least 10 hospitals, though cultural and social barriers remain. Care for the physically disabled is concentrated in hospitals in the capital city, except for the services provided by the Dominican Rehabilitation Association, which has a long tradition of consistent,
comprehensive services and has facilities in the provinces. “The country has 51 hospital pharmacies, 1,937 community pharmacies, 740 popular dispensaries that sell drugs at discounted prices, 100 national laboratories that produce drugs, and 682 warehouses for storage and distribution” (PAHO, 2002, p.233).

Drug production, however, is basic, “most supplies are imported” (PAHO, 2002, 233-234). In 1997 expenses related to infrastructure maintenance, equipment and drugs amounted to 39.3% of health operating costs (PAHO, 1998, ii). Between 1997 and 2000, total per capita expenditure on health in 1996 was US$111 (6.5% of GDP), of which US$28 was spent in the public subsector and US$83 in the private subsector. Public sector spending amounted to 1.5% of GDP. The private sector predominates in financing of the health system: 55% of the funds come directly from households, 75% of which do not participate in any insurance scheme or prepayment mechanism. According to a study of 1997–1998 national health accounts conducted by the Central Bank and PAHO, both public and private spending were concentrated in urban areas, mainly in Santo Domingo, and the monies were spent primarily for specialized and hospital care. Direct spending by households was distributed as follows: outpatient services, 59% (61% of this amount for drugs); hospitalization, 18%; oral care, 13%; and various preventive expenditures, 10%. (PAHO, 2002, p.234-235).

Out of pocket expenses include 20% insurance co-payments; most insurance companies do not cover medicines.

The public sector services 75% of the population. It is organized into different levels of management, with the SESPAS leading the system by setting standards and policy. Nine health regions supervise and support provincial administrations, which in turn comprise 31 provincial health administrations and their networks, local hospitals and health care centers. The 2002 PAHO report adds:

[a] new model is being developed to strengthen primary health care by promoting the redistribution of resources and establishing a network of primary health care units, one for every 500 to 700 families in a given area, composed of a general physician, a nursing auxiliary, a supervisor of health promoters, and voluntary promoters. These units are responsible for 25 activities which make up the basic set of health services, including prevention, promotion, disease and emergency care,
vector control, and community health education. For each of these activities there is a community health committee. As of 2000, 16 rural provinces were applying this model and benefiting 80,000 low-income families. (PAHO 2002, p.233)

The public sector services are free, including oral health, “especially low complexity, low cost (such as extractions),” (PAHO, 2002, p.233) and emphasize maternal and child care. However, general accounts indicate that patients have to purchase basic supplies when attending hospitals, and the quality of services and infrastructure, including the impact of electricity blackouts and water shortage is not accounted for in quantitative summaries of the health system.

The private sector provides services mostly for the upper income strata. It operates on a direct fee-for-service basis, at the time the services are provided, through private medical insurance (12 for-profit companies) or with systems of prepayment (Igualas), of which there are 30. It includes associations of national and small private clinical centers, a powerful medical association, most clinical laboratories, three times the number of beds in the public sector, and institutional networks and medical insurance coverers concentrated in urban areas. There are medical insurance coverage systems for specific groups (physicians, teachers, and state bank employees) that are decentralized and also operate in the urban areas.

The private sector covers about 12% of the total Dominican population, and provides the most specialized services and advanced technologies; it has also been undergoing a process of growth and restructuration. The recent inauguration of the “Plaza de la Salud,” a private center receiving state funding and under the administration of the Catholic Church has caused preoccupation within the private sector. The center boasts the most sophisticated technology in the country, and an obviously privileged position within the health system and society. Historically, there has not been any connection between
the public and private sectors. The new health reform proposes a radical restructuration into public/private enterprises.

Physicians occupy the leadership of the Dominican health system and are well paid in relation to other professionals. Salaries are not associated with evaluations on the quality or productivity of their practice, but with its location within the socio-economic spectrum of private practice, where 15% of them are said to work exclusively. The unchanging relation of non-specialized to specialized physicians in the public sector is 1-2 (PAHO, 1998, p.9). “In 2000 the country had 15,679 physicians (19 per 10,000 population), 2,603 professional nurses (3 per 10,000), 12,749 nursing auxiliaries or technicians (15 per 10,000), 7,000 dentists (8 per 10,000), and 3,346 trained pharmacists” (PAHO, 2002, p.234). There are nine schools of medicine in the country, 53 medical residency programs, of which 38% are university accredited in 20 specialties and subspecialties at 15 teaching hospitals. In 1999, there was a total of 52 graduates of a post-baccalaureate program (Postgrado) in public health.

Research facilities are almost non-existent in the country, with no organizational structure for policy-making or national strategy for research development, and no funding. The small proportion of research conducted in the country is applied research. Internet access to medical literature is scarce in generally outdated libraries. There is a paucity of medical publications, and it is just recently that the country is becoming integrated with international medical databases and having access to publication in international journals.

A recent newspaper article (Pantaleon, 2002), titled *El Ingenio: La Principal Arma de los Investigadores* (translated as *Ingenuity: the main tool of researchers*), depicted the
almost non-existent system supporting scientific medical research in the DR. “Dominican researchers coincide when listing the limitations in the development of this field. They bring up a lack of economic and logistics support” and no forum or standards for scrutiny and peer review. They complain that the health system, both public and private, teaching and service institutions, lack a defined policy with regards to health research and in relation to the needs of the population and the status of health services. All of those quoted in the article were physicians, many in leading administrative positions.

There are many indicators that point to the unregulated and precarious status of the biomedical health system in the DR, and that should be put in context with the new health reform and the position afforded within it to unorthodox medical knowledge and practices. It is estimated that around 50% of the equipment at the national level is either out of service or in a state of disrepair. Knowledge of maintenance personnel in public hospitals is empirical. High technology equipment concentrates in the urban areas in the private sector. Epidemiological data is barely beginning to be collected, processed, analyzed and diffused. Private clinical center accreditation and regulation is absent, clinical centers can just open up. Guides for diagnostic and therapeutic standards, as well as the organizational structure for the regulation of medical practice are just being currently formulated under the new health care reform. Drug prices are unregulated and raise around 10% annually; 70-75% of them are imported (PAHO, 1998).

Furthermore, public health services are not universally accessible due to significant administrative and technical limitations. There are no structures of guidance for ethical practice, and no other means of medical accountability in either the public or private sector. There are no committees for vigilance and control of intra-hospital infections.
Records for this problem are therefore non-existent, though it is a general public preoccupation given the scarcity of water, electricity and sterilizing supplies in the hospitals.

**Health Care Sector Reform**

_The development of a health system is a political and economic act, often tied to national and international political pressures._ (Whiteford, 1990, p.225)

The DR is currently undergoing a dynamic process of Health Care Reform (HCR), which is part of a regional plan lead by the PAHO and the WHO. The model is being incorporated in several countries in the region and it is presented as a regional/national approach in the documents of these international organizations. The HCR is also situated within a general developmental strategy, which is also parallel to those being developed in other countries in the region. The gestation and negotiation of the new HCR is credited to national and international organizations, including the Health Secretariat, the Technical Secretariat of the Presidency, the Presidential Commission for the Modernization of the State, the Dominican Congress, the Dominican Institute of Social Security, the Dominican Medical Association, the Provincial Council of Development (CDP), Non-Governmental Organizations (NGOs) and the Catholic Church. The international counterpart includes the technical support of the United Nations Development Program, the WHO and the PAHO, bilateral and multilateral donors such as US Agency for International Development (USAID), the InterAmerican Development Bank (IDB), World Bank, the European Union (EU), and the Spanish Cooperation.

The HCR follows the General Law on Health (GLH), approved and promulgated in 2001 (Law 42-01). The same year, the General Law on Social Security (GLSS) was approved only a few months later. The new HCR is expected to greatly modify not only
the public, but also the private health sector, and to be completed in ten years. Its main objectives are: 1) to promote decentralization of the public health sector by strengthening provincial and municipal capacity; 2) to reform the social security system to create and manage a National Health and Labor Risks Insurance; 3) to redefine a set of basic health provisions for universal access and community participation in health matters, through the creation of a National Health Advisory; 4) to reorganize health provision and financing with a public/private character; 5) to introduce a universal family health insurance with services provided by an articulated public/private network and guaranteed by the State, and 6) to strengthen the regulating role of the State while creating a legal framework to sustain it. The introduction of the new health care model gives high priority to the reduction of maternal and child mortality, adopts a policy of decentralization, and formulates programmatic and administrative standards for health care, epidemiological surveillance, drug production and marketing, and vector elimination campaigns.

The process of reform was initiated with the consolidation of the Executive Commission for the Reform of the Health Sector (CERSS). The CERSS realized the preliminary research on which the new laws are based. In the Commission sit the Secretariat for Health, the Dominican Health Insurance Institute, other agencies of the executive branch, health unions, the Congress of the Republic, and representatives of the community and the private sector. The process began with the creation of provincial and regional health directorates, increased decentralization and democratization of hospital management through the implementation of enabling regulations, the creation of hospital administration councils, committees on maternal and infant mortality surveillance, and on improving the quality of care.
The new health model builds on an emphasis on primary health care (PHC), and on the philosophy and elements of previous popular health organizations. The basic Units for Primary Health Services (UNAPS) were developed out of the previous Family Health Teams (ESAF) and utilize the structure of health promoters for community empowerment and education. The model is said to face obstacles regarding the lack of a tradition of governmental and institutional accountability and continuity; of a balanced decentralized yet relevant governmental role of policy support and implementation; deficient social and institutional service infrastructure and resource allocation; and gross inequalities in access and education, as well as disorganized urban growth.

Focusing on formalization, systematization, and institutionalization, the reform provides initial faculties and a legal mandate for administrative decentralization and community participation. Protocols for normalization, documentation and evaluation are currently being developed for technological medical services. A new model of medical services (NMA) giving priority to accessibility, efficacy, efficiency and quality is being developed. The PAHO concludes, “[d]uring 1991-2000 there was a major improvement and expansion of the physical infrastructure of the health services network in both the public and private subsectors, with the introduction of new and expensive technologies” (PAHO, 2002, p.231). The document relates the failure to regulate their management and safety, due to a lack of coordination of infrastructure. Technological medicine is never depicted as unsafe, though problems are frequently reported in the US, where there is much better infrastructure for regulation.

International agencies provide loans for social investment, together with extensive evaluations that spotlight poverty assessments and policy recommendations. Health and
educational status are the main components of such assessments. Interventions are defined in relation to national problems as defined by these agencies. Indeed, social and health databases are being put together as part of these development projects.

The new health law and the health sector reform provide the context for all health related matters in the DR. The law document is an extensive argument for the modernization, restructuration and regulation of the health care system with the objective of improving health within the framework of the Dominican Constitution. In it, health is defined primarily as a human right and as “a means for collective wellbeing,” which is “socially produced” and “intimately linked to the total development of society…thereby becoming a product of development and of harmonic action of society as a whole…” (General Health Law, 2001). In response to that right, the government assumes responsibility for the provision of “appropriate conditions,” infrastructure, services, preventive and interventionist measures. Equally, it is presumed that these appropriate conditions demand a political environment, encompassing policies and a renewed, decentralized, yet coordinated, institutional system.

The principles of universality, solidarity, equity, efficiency, efficacy, integrality and cooperation provide the basis for transformation in the areas of public expenditure, resource distribution, and social provision of the dispossessed through the taxing of those better off.  

A new organizational structure, new institutional interactions, established patient rights and responsibilities, new standards for medical human resources, the identification of priority areas and groups, and expanded functions that regulate increasing social spheres are enlisted. Some of these are quickly materializing, such as

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3 The six guiding principles closely resemble the PAHO’s guiding values: equity, excellence, solidarity, respect and integrity.
the Consejo Nacional de Salud, which channels community input, and the proposed institutes for the regulation of tobacco consumption, air pollution control and water management.

Overall, the deed details the evolution of the current health sector into a formal, institutionalized system, whereby previously neglected areas, such as social security, sanitary and educational programs, community participation, the elimination of social inequalities and the development of medical scientific research, receive mention. The new health law does not mention and, thus, it does not contemplate traditional, indigenous, or popular medical knowleges and practices. Instead, a couple of references can be identified with international health care trends and the discourse on alternative medicine. Chapter Four, Article 28-e refers to the right of the population to “adequate and continuous information, including diagnosis, prognosis and treatment alternatives.” Article 114-g reads, “to promote, with a scientific basis, the use of natural substances under regulations established by SESPAS” (emphasis added). Potentially related, two paragraphs address the regulation of 1) products containing substances with therapeutic action, such as vitamins, which will be considered pharmaceuticals and will be regulated as such (Article 119), and 2) foods that have been recognized to have therapeutic properties, which will also be consider medicines and will have to be approved (Article 126).

These measures seem to set the premises for the commodified production and consumption of alternative medicine, as it is already happening in the US, and which corresponds to the practice of the participants in this study. Neither as a community resource, nor as a social space in need of support, are traditional, popular medical
practices considered. As the government undertakes to “adequately protect every individual against disease,” through hospital and other medical services, some measures are outlined in congruence with the bio-psycho-social model, or with public health initiatives, all staying within the biomedical milieu. The text of the law contains a significant number of references to concepts found in most international health documents; namely, safety, efficacy, scientific base, and access. While the law considers much needed provisions, it can be argued that it is mostly erecting a frame for the proper functioning of what is increasingly called market medicine.

An obvious conclusion to this data would be the contrast between the country’s health needs, which are mostly related to malnutrition and to the spread of communicable disease with the continued efforts to develop a highly technological medical system. The reform, furthermore, promises to extend the more abundant resources of the private sector to the public arena, in a “redistribution of resources” whereby the opportunity to buy medical services will be extended to all. The sponsoring of the poor for accessing this privatized medical system, reminiscent of US medical assistance programs, equally subsidizes the biomedical establishment. Most importantly, as one reads through the description of the health system and its proposed modernization, a conceptualization of health as something the population must access from specific institutions comes to light.
CHAPTER 3
REGIONAL STRATEGIES AND INTERNATIONAL ORGANIZATIONS’ AGENDAS: A CRITIQUE

International Health Approaches Reconsidered

The goal of this section is to show characteristics and implications of the dependent development\(^1\) of the health system in the DR. Beyond the institutional and legal upgrading, and not in the direction officially ascertained, a profound reorganization of health resources is taking place. This reorganization provides an interesting context for interpreting the flourishing, dynamic practices of the ‘alternative medicine’ practitioners studied here. Its effects on the advance of Dominican indigenous medical knowledge may be very different, though in certain contexts the two are taken to be the same. This process, of dimensions that clearly extend beyond the boundaries of the DR, illustrates familiar patterns of the encounter between systems of medical knowledge. Through a mobilization of epistemological capital and cultural meanings, a redistribution of resources, particularly those pertaining to health, is achieved.

Ahistorical, atheoretical and technocratic analyses of health in which it is defined as technical problems requiring technical solutions, leading to administrative level recommendations provide the basis for dominant health care models (Aidoo, 1982). “Health services conceived and planned in this way are based on rational-legal legitimacy in the Weberian sense. Plans and administrative procedures arise from expediency, from rational values or both…rational values of Western science and medicine”

\(^1\) This concept is taken from Fiedler (1985).
Navarro (1984) goes even further. For him, the listing of aspects of health (or indicators) and their attendant, potential interventions as autonomous from each other, “the analysis of the variables without reference to their structural determinants,” is an apolitical representation, a political act involved in concrete power dynamics (p.473). Fiedler (1985) highlights an important contrasting point:

For the most part, the early progress in health in Latin America resulted from the increased availability and application of public health advances that differed in kind from those that marked the drastic reductions in morbidity and mortality in the European experience. Contrary to conventional wisdom (which holds that those marked reductions in infectious disease rates resulted from effective immunization) the great advances of eighteenth and nineteenth century Europe were largely the result of social reforms that alleviated some of the dirt, pollution, overcrowding, poor housing, and malnutrition that had been the product of the industrial revolution. (p. 277)

The same argument was made by Starr (1982) referring to the US context:

[t]he emphasis on personal hygiene and medical examinations was not, in fact, always a logical response to bacteriological outbreaks. The campaign against tuberculosis provides a case in point…the discovery of large numbers of people who were infected without being ill indicated that in combating the disease, strengthening resistance—for example, by improving nutrition, housing, and working conditions—might be as valuable as preventing infection. (p.191)

Navarro (1974) also supports this view with his depiction of the Latin American reality:

[i]f we look at the type of morbidity prevalent in the surveyed population (i.e. infectious diseases and malnutrition) and at the comparative effectiveness of the different health activities for combating this morbidity, it would seem that environmental health services and preventive personal health services should be given far higher priority than curative services, and particularly the hospital services. In spite of this, the production of human resources, through the medical education imported from developed societies, serves to perpetuate this hospital-oriented, curative medicine approach which only strengthens the maldistribution of resources according to type of care by replicating the consumption of health resources prevalent in developed societies. (p.17)

The HCR is purported as addressing issues of access and quality affecting the health of the Dominican poor, however, it does not begin with a conceptualization of
health that acknowledges its social origins, it does not recognize all health resources within the Dominican society, and does not propose a redistribution of those resources. Navarro associates the maldistribution of health resources to 1) the mal-distribution of all resources in underdeveloped nations, and 2) unequal relationships between developed and developed nations, or the global mal-distribution of resources. He links international health trends to developmental theories, and insist that they are popular as they rationalize and justify unequal relationships between developed and underdeveloped countries.

Development theories posit that underdevelopment is the result of a lack of the cultural and technological readiness for modernization. Navarro argues that there is too much, rather than too little cultural and technological presence of the developed societies in the underdeveloped ones, resulting in the improper allocation of resources, and the wrong focus for health service and medical education. A focus on hospital-based, technologically oriented and acute-episodic care of the dominant medical models drains resources that could reach rural, ambulatory, and social and structurally based health care measures. Furthermore, capital, Navarro argues, as well as human resources, flows on the opposite direction of general convention, precisely because of the location of the centers of medical technology and knowledge production. Aidoo (1982) corroborates with a similar analysis:

When preventive\textsuperscript{2} campaigns are undertaken, the emphasis is often placed on entreating the individual to take good care of his or her health by observing the rules of hygiene. This contributes to the reproduction of the bourgeois ideology in medicine, which disregards the economic and political etiology of disease and the requisite transformation of class society. (p.651)

\textsuperscript{2} Preventive measures, within a biomedical framework, usually refer to early intervention.
In other words, biomedicine is highly involved in these processes, both as contributor and as a beneficiary. So as biomedical constructs and the structures that support them are reinforced, it can be expected that the reform will move all medical practices in the DR more in tandem with biomedical premises, which appear compatible with dominant models of statehood.

The health reform, for instance, is a highly visible, politically valuable government enterprise. It validates the current government in multiple ways. It eases budget pressures with the influx of foreign cash for the health sectors. It creates immediate jobs for many professionals working for the many administrative jobs demanded by the reformative process and the expansion of the health sector; and for the lower status workers to perform in the direct community service.

A question to be asked is whether the health reform will be successfully implemented; and a bigger question is whether the Dominican health system really exists as such. Recent news about hospitals corroborate with general opinions about their grave state of disarray. As I wrote this piece, a news report (Ortiz Gomez, 2003) highlighted the outcry of groups involved in the health reform process, who were threatening to abandon it because of the ineptitude with which it was being put into operation, and the way it was being used for political gain. The same source reports on the government and multinationals’ opposition to locally produce medicines (Paniagua, 2003). This scenario, again, is most probably related to the greater debate over the production of generic medicines by the underdeveloped nations, which is globally pushed by the US pharmaceutical industry and its government. The health reform is about the development of a market for medical resources originating in the donor countries.
The HCR builds on the previous PHC regional project. Linda Whiteford (1990), who has written extensively on Dominican health, provides us with an evaluation of the PHC approach that may result highly illustrative of the potential difficulties of the current health reform project. Her 1990 article recounts a series of internationally established policies and their consequences. Whiteford’s central tenet is that “primary health care in the Dominican Republic is an example of how health care and development assistance have been extensions of US foreign policy used to influence foreign domestic policy” (1990, Abstract). In other words, she insists that an evaluation of PHC in the DR, through the established indicators -individual access to health care and reduced morbidity and mortality- would be negative; yet measured against other US goals and understood in relation to US-DR historical relation, the outcome of such evaluation would be different. Following Whiteford’s (1990) analysis, the HCR can be argued to serve the same purposes as the PHC model. By adopting it, “the Dominican Republic reaffirmed its historical relationship with the US, opened channels for desperately needed scarce resources, and provided employment in a time of joblessness” (Whiteford, 1990, p.221).

The PHC system, in place since the mid-1970s, and also an international model, included an infrastructure of hospitals, rural health clinics, sub-centers and health promoters and coordinators. As initially defined, “[p]rimary health care (PHC) should provide high quality, low-cost health care to dispersed populations through a network of trained, local paraprofessionals. Its objectives are to help communities improve individuals’ access to health care and to decrease morbidity and mortality” (Whiteford, 1990, p.221). Funded by the same agencies that support the current health reform, the system was elaborated and promoted as equally coherent, and managed to provide the
needed infrastructure. Yet, Whiteford (1990) and Ugalde (1984) illustrate how its failure was not so much the result of the economic crisis of the 1980s or the inefficient and corrupt Dominican health system, though these exacerbated it, but the fact that the PHC framework reproduced the general social organization of unequal resource allocation.

The HCR, clearly addressing the shortcomings and failures of the PHC incorporates measures to decentralize and actualize management, and to increase community participation in health related activities; yet, it is still based on a biomedical model of curative, expensive, technology-driven medicine, and does not advocate wholesome structural changes in living conditions, resource utilization and redistribution.

An important issue Whiteford (1990) also brings up is the power of physicians in shaping health policy and care, which inevitably reflects not only their social prerogatives, but also the defining characteristics of the modern medical profession and biomedical principles. The medical profession directs “the heavy orientation towards medical health care programs, in detriment of other more needed public health actions” (Ugalde, quoted by Fiedler, 1985, p.280). The development of medical systems responds to the demands of its prime clientele, affluent classes and their attendant values, including most physicians. This determines the reproduction of social hierarchies, the underutilization of local resources (i.e., midwives) and the design of health models that are not sustainable with local resources in the long run, and end up increasing dependency. The opposition of the medical elites to programs that redistribute health resources -including medical knowledge- is also documented by Aidoo (1982) in Ghana, Fiedler (1985) in Guatemala, Crandon (1983) in Bolivia, and Marchione (1984) in Jamaica.
But as the current social transformations in the biomedical establishment take place, conflicts between interest groups are revealed and negotiated. In his inaugural speech to the Executive Committee, December 2001, the incoming president of the Dominican Medical Association (AMD) expressed significant discontent regarding the new laws. I have decided to translate most of his very poignant ideas:

_We are aware of the sanitary environment that we receive, which is marked by the processes of execution of two new laws: the General Health Law (42-01), and the Social Security Law (87-01). Two new laws that have been borne with the mark of that new global mega-tendency that is privatization. The privatization of state institutions is the strategy of the 80s neoliberalism to supposedly heal economies...This new neoliberal wave has its own regulating mechanism: the market. But the market as a mechanism has no consciousness, to follow the words of Octavio Paz, it does not have ethics, it does not distinguish good from evil. It encourages savage competition reflected in the struggle for control over public and private resources. This is why our slogan has been, “For the defense of Public Medicine.” Public medicine is a threatened model, in a disadvantage to compete. The same model that assures us more than 8,000 jobs, that has given us the law 6097, the mandated pasantia, the graduate pasantia, the sabbatical year, the medical residencies, the sanitary..., a salary for 85% of Dominican physicians and a pension system. And it is not that we are opposed to private medicine...what we oppose is the privatization of public health services, because the Chilean failure after 20 years of sanitary reform has taught countries like ours...with less of 2% of our GNP going into the health sector, we will never have a healthy country. Cuba invests 17% and the results are evident. (Herrera, 2002)_

Following, the president commits to a long list of aims, among which a defense for retaining and improving physicians’ working conditions and the public hospital is sworn. In the contexts of these prerogatives, the medical association president vows to denounce and persecute those who would illegally practice medicine, for which a law is being gestated. The AMD is both a professional organization and a trade union. Its opposition to the reform claims that it affects the interests of the medical profession, which is

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3 Mandated year of medical service in a rural community, run throughout Latin America, which is a remnant of previous health systems development models, and which has been reviewed in studies to have a quite negative impact in the communities. Ugalde (1984), reviewed here, completed one of such studies in the DR.
contrary to the arguments just expressed by the scholars that have studied analogous settings. However, this can probably be explained by the diminished autonomy of medical doctors in increasingly corporate health systems.4

Effectively, foreign investment determines how the money is to be spent. Within the previous PHC framework, foreign investment money funded the construction of new clinics, but not the completion and maintenance of existing facilities and services (Whiteford, 1990, p.223). A recent newspaper publication quoted the Health Secretary clarifying his commitment to new hospital constructions, while the urgently needed repair of the most heavily used, old ones, remained the responsibility of the government (Pantaleon, 2003).

Whiteford (1990) boldly and directly relates the identical dynamics she found a decade ago to the “neo-colonial interests of the US.” She recounts the historical prerogatives and advances of a relationship of dependence, providing elements and connections to the articulation of the current Dominican health care system. The provision of foreign aid has responded to the fact that “US officials were convinced that foreign aid was a key to controlling socio-political developments in other countries. The US translated its foreign policy into foreign aid, and delivered that aid…(to support) family planning, and later, to support PHC” (p.224). She adds, “[f]amily planning activities were central to the idea that economic growth was undermined by a rapidly growing population…once family planning became part of US policy, program support was passed through the US Agency for International Development (AID) to specific country programs” (p.224).

In exchange for a US$7 million loan, for example, Joaquin Balaguer, a previous president radically opposed to family planning, changed his previous stance on this kind of social program. The loan determined not only the basic concepts and principles the family planning programs consisted of, but, also, how and through which institutions and mechanisms they would be executed. “PHC coupled with effective family planning was seen as a means of lowering fertility rates while maintaining the social hierarchy of the health system to create economic development” (Whitehead, 1990, p.224). Family planning continues to be part of USAID assistance packages. This has been reinforced, Whiteford (1990) comments, since medical anthropologists and other social science researchers have associated family planning with decreased mortality rates. Nevertheless, Whiteford reminds us that David Bell, the former head of USAID, when writing about the relationship between foreign assistance and foreign policy notes:

> Foreign assistance…is a primary instrument for US foreign policy. It is carefully tailored to advance US interests in each unique country situation. It is important to our own economic progress to help expand the economies of the developing countries, thus opening opportunities for large scale trade and productive investment. (1990, p.224-5)

Read here that the markets to be expanded are also biomedical, though we do not tend to think that way. Health sector development has been associated with economic development strategies by both critics and supporters. This follows the logic of relating health to social conditions, except that the focus of development strategies, as we have seen, is not the improvement of conditions that could be substantively associated with the betterment of health for the population.

**World Health Organization (WHO)**

The WHO Declaration of Alma Ata (1978) is at the root of the PHC approach, which underpins current international health plans. It established health as a fundamental
human right and participation in its planning and implementation as a right and a duty. It recognized health as a goal requiring action within many other social and economic sectors. It held governments as responsible for the health of their people and health as a precondition for social and economic growth. At the same time, it acknowledged gross inequalities in health, which it deemed unacceptable, and proposed that sustained social and economic development, based on a New International World Order, is of basic importance for the fullest attainment of health for all and to the reduction of the gap between the health status of the developing and developed countries (WHO, 1978).

Surprisingly, a WHO 1998 press release commemorating the 20th anniversary of the Declaration, admits that the world is “vastly different,” (or vastly worse, in spite of Initiatives) and that:

- economic instability, globalization and the triumph of the free market credo have meant more pressure to produce profits and a greater move to private health systems, while transnational media and marketing have also increased their influence on the way people conduct their lives. These trends have all resulted in increased inequities. (WHO, 1998)

However, the WHO’s 2002 World Health Report focuses on a central concept of risk. It defines risk as, “a probability of an adverse outcome, or a factor that raises this probability” (Overview section), a definition away from the socio-political issues identified as determining general and health inequalities. The top ten risks identified include outcomes of ill social conditions (i.e., underweight), unhealthy practices and behavior (i.e., unsafe sex; and manifestations of disease), or hypertension. As a result, statements such as “underweight alone accounts for over three million childhood deaths a year in developing countries” (Overview section), convey a sterile relationship. The social conditions behind malnutrition and hunger, as well as these powerful social ills, are displaced by this so termed “risk.” Moreover, risk assessment and health intervention for
reducing these major risks will not only have “obvious health benefits” but, also, will “promote sustainable development and reduce inequities in society” (Overview section). This relationship is contrary to the social scientific health analysis that situates health improvement as a result of structural social changes.

These health risks, furthermore, are identified as “allies of poverty and enemies of health” (Overview section). They are individually described and only occasionally directly related to “poverty,” which remains as an almost abstract concept throughout all these documents. The overview includes an account of conditions such as “changes in food processing and production and in agricultural trade policies” (Overview section), as well as the aggressive marketing of alcohol and tobacco as increasingly imposing new patterns of diet and living in developing countries. The challenge is posed to governments, which have to develop control policies for “risk management.” The taxing of tobacco and the reduction of salt content of processed foods are touted as community-wide interventions, which would be accompanied by individual, treatment-based ones.

The Report advocates defining, assessing, perceiving, scientifically researching, measuring, quantifying, communicating and increasing awareness of its identified health risks. It considers the structural factors that influence the adoption of risk control and proposes that small shifts can translate into major health benefits. Increased taxes on tobacco, one of only a couple of concrete measures identified, are presented as a bold policy so that, in closing, “reducing risks will promote sustainable development and can also reduce inequities” (Overview section).

Demanding a strong institutional and academic infrastructure for an investment in research and policy formulation, and presuming that governments have the power to set
those policies at the margin of the same international processes that the WHO itself has emphasized, the report fails to establish international interdependence and responsibility and tiptoes around palliative actions.

**Pan American Health Organization (PAHO)**

A PAHO news release identifies the new director’s policy orientation for the Americas as “public health challenges and a planned reorganization to meet long term strategic objectives” (PAHO, 2003). These policies are immediately associated to challenges for development, including “inadequate governance, outdated political and administrative structures, and difficulty in adapting to globalization” (PAHO, 2003). The conditions to be overcome signal to the Americas “becoming more urban, with significant inequalities on the health situation, deterioration of living conditions and worsening poverty” (PAHO, 2003). As per the PAHO the objective of health care reforms is “the formulation of standards, criteria and parameters for the installation and accreditation of health establishments” (PAHO, 2002, p.231).

The command could not be clearer. In what we find to be a reversed or incomplete mandate, again, governments are to take responsibility in calling “individuals, families, communities and institutions empowered to bring social justice by promoting health and protecting life” (PAHO, 2003). Reiteratively, the objectives are to “strengthen a culture of life and health and healthy settings that create optimal living conditions and greater opportunities” (PAHO, 2003).

**International Organizations and their Development Agendas**

**World Bank**

The World Bank 1995 Agenda for Reform for the Dominican Republic is based on a *poverty profile* and is developed around a *poverty strategy*. Relying heavily on recent
reports by the International Monetary Fund (IMF)\textsuperscript{5} and the IDB, its recommendations include: privatization of industrial and service enterprises, streamlining of the remaining public sector, \textit{increased outward orientation} by removing protectionist policies and regulatory barriers, the improvement of fiscal transparency and government expenditure, and the stabilization of the financial sector (World Bank, 1995a). These structural reforms, together with specific measures of monitoring living standards and poverty trends, and the decentralization of the public sector, are to engender growth with equality (Summary Overview section, p.iv). The DR was found to have a delayed liberalization process and to have one of the highest levels of trade protection in the region (Summary Overview section, p.ii). The reform program is designed to stabilize the economy and lay the foundations for export- and private sector-led growth (Summary Overview, p.i).

These apparently benign measures mix resource redistribution with increased dependence in the external world market:

The low productivity and anemic growth of the domestic economy stands in sharp contrast with the impressive performance of FTZs [free trade zones] and tourism. During 1988-93, the domestic economy averaged less than 2 percent annual growth and its total factor productivity recorded negative growth of almost 1 percent. In contrast, value added in FTZs averaged annual growth of 23.5 percent and total factor productivity growth of almost 7 percent…Clearly the enclave sectors enjoy special benefits, particular a virtual tax-free status, which are not available to the domestic economy. However, their ability to compete internationally, sustains very high productivity growth, and expands employment, suggesting that the reform effort should focus not on strengthening backward linkages, but on removing the obstacles, which hamper productivity growth in the rest of the economy. (World Bank, 1995a, Summary Overview, p.ii)

In other words, the Dominican economy should be modeled on the economy of these enclaves. Health conditions in those sectors are not necessarily better though, and

\textsuperscript{5} At the time of writing this piece, several political, corporate and service crises were being reported in the media. The IMF was “in town” to help, with a new set of structural reforms.
an export-lead economy has been associated with increased inequality and neglected
social investment. As the World Bank itself documents:

Since the restoration of macroeconomic stability in the early 1990s, the Dominican
Republic (DR) has been the fastest growing economy in Latin America…with a
1998 income per capita of US$1,770 but a highly eschewed distribution of income,
two million Dominicans still live in poverty…the DR stands out in Latin America
as the country that devotes the lowest share of its public resources to health
education and public security. (World Bank, 2000b, Executive Summary)

The export-led economy so benignly suggested by the World Bank, creates
economic, political and social structures that hinder autonomous re/generation of self-
sustained economic growth (André Gunder Frank, in Navarro, 1974, p.15). Whiteford
(1990) sequences this connection in her work on the DR:

loans of this nature buy technology, technical advice, products and services. These
loans must be paid in US dollars. The money to repay loans and the interest they
accrue can only be acquired by increased exports, increasing dependency on the
world market. Health loans and other forms of foreign assistance reflect foreign
policy, and in turn, encourage and export economy and international dependency.
(p.224)

Additionally, as Navarro (1974) well argues, GDP values are deceiving. This
measure presumes that the GNP is divided equally and everyone gets the same amount of
goods and services. GNP values can go up as a result of increased exploitation of the
disenfranchised (i.e., Navarro’s example of Brazil in the late 60s to the early 70s). The
GDP logic, he explains, is linked to the population control policies, so as to aid
underdeveloped nations by reducing the number of “capitas.”

The World Bank poverty profile for the DR indicates that “one in five Dominicans
live in poverty and almost one in ten in extreme poverty…especially…in rural areas”
where “rural poverty as almost three times urban poverty.” Compared to urban poverty,
which in the last two decades fluctuated in sync with the economy, rural poverty “showed
a rising trend” during the same period. This is the case, as the World Bank documents indicate, because the Dominican economic growth of the 90s was mostly concentrated in two industries. “Chronic malnutrition (measured as growth stunting) affected almost one in five Dominican pre-school children and was more severe in rural areas. Almost 6 percent of children suffered from severe malnutrition. Chronic caloric deficiency affected 9 percent of mothers. Poverty and extreme poverty are more likely to occur in female-headed households, especially in rural areas (World Bank, 1995b, Poverty Assessment Summaries).

The relationship between poverty and health is a fertile space for critical analysis. As per the Banco Central (translated as Dominican Central Bank; 1999), the poverty line, an economic construct just as the World Bank’s poverty and extreme poverty constructs are, is centrally based on calculations around a daily ration of calorie intake (the canasta básica), which, to begin with, varies by geographical and social differential regions. The cost of this basic ration is added to other expenses and related to family income. Poverty is correlated to three indicators, which are educational level, gender and family size. Health is said to be caused by poverty. But, if the calculations of poverty boil down to calorie consumption, then poverty does not cause ill health, they share the same causes and we could say that poverty is ill health, among other things. This understanding would deliver health assessments from a mediated relation to an increasingly vacuous and intangible concept of poverty, to the concrete paucity of food and other resources. Then, responses could be specified in more concrete terms.

Instead, public policy for tackling extreme poverty, the World Bank insists, “could focus on protecting children through the establishment of safety nets that will curtail
malnutrition, expand vaccination programs to at least ninety percent of the population, and provide safe water” (World Bank, 1995b, Poverty Assessment Summaries). Yet purported changes are vague. What “safety nets” would curtail malnutrition if not the drastic provision of income or employment that could provide wholesome food, and concomitant education and sanitation? It is good to keep this kind of questioning in mind as one reads through the verbosity of these agencies’ recommendations.

Together with its push for increased economic growth of the kind experienced in the last decade, the World Bank (1995b) states, “[p]ublic expenditures in the DR are not high by Latin American standards…[p]ublic spending on education and health…is among the lowest in the region” (Poverty Assessment Summaries). And adds, while there has been a marked shift towards “urban social spending in sectors that have relatively little impact on the poor…(that is) large and visible physical construction projects…education and social assistance have been particularly affected, while health has retained its share of spending. In health, however, about 74 percent of spending goes to hospitals while preventive health services receive only 7 percent of the total” (World Bank, 1995b, Poverty Assessment Summaries).

So, in 1998, the DR received US$30 million loan for:

the first World Bank backed health care project in the Dominican Republic, one of the most densely populated countries in Latin America and the Caribbean, whose health care indicators compare unfavorably with countries of similar per capita income…With a total cost of US$42 million, the Health Care Services Project will help decentralize the Dominican Republic health care system by transferring resources and responsibilities from the national government to the provincial governments and organizations within a framework that facilitates the integration of public and private providers…Maternal Mortality Reduction and Integrated Management of Childhood Illness strategies (were) singled out in the Bank’s 1993 World Development Report as the most cost-effective health interventions. (World Bank, 1998, Press Release)
Cost-benefit evaluations are based on the neoclassical, free market, capitalist development system (Marchione, 1984). The neo-classical development strategy accepts inequality and dependence and focuses on immediate concrete measures, which “provide empirical confirmation for the superiority of continuing dependence on health inputs from dominant countries” (p.234). As Marchione explains, the short-term health benefits of such approaches are offset by the subjection of poor countries to the vicissitudes of international intervention, and the loss deriving from the neglect of self-reliant infrastructures.

In another Press Release (World Bank, 2000c), the World Bank announced the provision of a loan of US$622,000 to purchase vaccines, “part of a US$3 million allocated for immunization campaign in the Provincial Health Services Project. The project is being administered by the Health Secretariat and the Health Sector Reform Commission of the Dominican Republic.” The loan is part of the World Bank’s “about US$3 billion invested in health projects to…improve access and quality of health care services, especially among the poor” in Latin America. Furthermore, “[i]n 2001, together with Barbados, the DR became part of an “HIV/AIDS prevention and control lending program,” receiving 25 million…The Dominican Republic and Haiti together account for 85 percent of the total number of HIV/AIDS in the region (World Bank, 2001, Press Release).

Back and forth, the Dominican economy is graded to be good enough from past provisions and initiatives to justify further borrowing, and bad enough to further need them: The 2000a World Bank Country Brief indicates that the DR has been the largest and fastest growing economy in the Caribbean during the last decade, albeit great...
differences by economic sector. It touts that the recent “Health and Social Security Laws introduced a decentralized and competitive scheme for the delivery of basic health services” but warns that “the extent to which these efforts in the health sector and the decentralization process in general will be successful largely depends on the political will and capacity of the government to reform…” (and to transform obstacles into tools for modernization.

Even with my limited understanding of these economic measures, I found their principles and objectives to be contradictory. In general, while the responsibility of the local government is correctly asserted, the new proposals set national efforts up to fail and leave them open to further criticism when they do not premise their proposed policy and structural changes on honest, comprehensive evaluations and thus propose counterproductive approaches. Under the Executive Summary of the World Bank Social and Structural Policy Review (2000b), the DR judged to be:

undergoing a gradual but steady transformation through the implementation of reforms, leaving behind the legacy of the Trujillo dictatorship (1930-61) that so strongly shaped the Dominican society. This legacy includes an enormous centralization of powers in the office of the president, weak systems for the accountability of the government actions, inefficient state-owned companies, high protection for industry and agriculture, and inordinately weak government programs for human capital formation and poverty alleviation.

True too, but critics have associated these social formations, found in other Latin American societies, with colonial and neocolonial patterns of development.

United States Agency for International Development (USAID)

On its part, the USAID documents on the DR, again, convey its central role in the formulation of the current health policy and in the health assessment on which it is based:

USAID will focus on three major areas of health risks in the Dominican population: HIV/AIDS prevention and care; child survival; and reproductive health/family planning (RH/FP). A fourth area of emphasis, and one which
provides the organizational underpinnings for the other three, is health sector reform. (USAID, 2002, Health and Population section)

It is revealing to follow the logic of their enthusiastic advocacy. The focus stops being the health of Dominicans:

These three major areas support the reform effort, through demonstration programs that (we postulate) will demonstrate the tangible benefits of decentralized health care services. Health sector reform, on the other hand, provides the structural and management justification for such decentralization to take place. Once the service decentralization demonstration programs involving public/private partnerships are shown to be effective, they can be replicated with Government and other donor resources in other parts of the country...The health reform process is a crucial aspect of the health sector development hypothesis...These changes will lead to improved effectiveness of service delivery and efficiency in the use of health sector resources. (USAID, 2002, Health and Population section)

The discourse of international organizations substitutes health care with health, and capitalist development with development (Navarro, 1974). The agenda is implicitly one of advancing capitalist development through the expansion of the health care system.

This analysis reveals the primacy of the development of a market modeled medical system in the development of the capitalist system whose global dimensions are expressed in its capacity to determine relations between localities. Inversely, it is of particular importance to think of these spaces, discourses and social formations as part of the biomedical milieu. The commodification of health and the medicalization of society, the way some of the processes examined in this chapter have been termed by sociologists, manifest in policies and social institutions, and materialize in the health practices of both patients and providers. Alternatives to the dominant medical practices are negotiated in these spaces.
In this study I attempt to bring to light questions of where and how paradigms meet. I present the case that the Dominican HCR is about the reinforcement of biomedicine and that it materializes a health model where support for a budding biomedical establishment is what is essential. Biomedical production and consumption is aimed at optimizing the benefits of the foreign and national controllers of that capital, and not at stimulating the equitable distribution of health resources. Scientific medicine may well serve developmental agendas, but it is also opening up its own new markets and redefining itself through these pathways.

Since the Declaration of Alma Ata (WHO, 1978), the need to cater to the conventional medical profession and multinational pharmaceutical industries is made clear:

Opposition from the medical industries can be directed into positive channels by interesting them in the production of equipment for appropriate technology to be used in primary health care. Any losses from reduced sales of limited amounts of expensive equipment could well be more than counterbalanced by the sale to large untapped markets of greater amounts of less expensive equipment and supplies for primary health care. (quoted in Navarro, 1984, p. 471)

Both driven and driving on internal and external market forces, the reproduction of private medicine underlies a language that incorporates social dimensions, even when they do not alter the final formula. Without identifying these intrinsic elements of dependent development and market driven medical improvements, health care models become, as it is shown in previous analyses by social scientist and the international...
agencies themselves, a recurrent process of trial and error. Qualitatively developed to serve the needs of the elite (i.e., ailments demanding costly interventions) health systems are ill suited to address the public health needs implicated by communicable, preventable diseases, which constitute the bulk of the health problems of the majority of the Dominican population.

In the context of these conditions it is good to quote John Fielder’s (1985) assertion that,

[u]ntil the mid-1960 the market based, dependent-development-conditioned structure of Latin American health systems reflected the skewed distribution of wealth in the region: most (including government) health resources were found in curative care medicine, and were concentrated in the capital cities, where they primarily served the needs of the elite. (Abstract)

For Fielder (1985), the Guatemalan situation was an exception in the adoption of the PHC approach, which was meant to rationalize the health sector. The reforms, he contends, the product of bilateral and multilateral agencies, exemplify a process of additive reform as they do not alter the fundamental structure of the systems. Fielder (1985) quotes the PAHO as noting, in 1973, that:

Most techniques of health protection are not applicable in all countries under all circumstances without modification. The blind acceptance of diagnostic, prophylactic, or therapeutic measures without consideration of the effects of local circumstances may and has led to serious error (p.5)...Adequate transfer of technology from abroad (and medicine is a technology) requires adequate selection and adaptation if inefficient, useless, or even harmful technology is to be avoided. (emphasis added; p.279)

The same PAHO document is referred to as indicating that allocated research funds had been directed not to the development of medical knowledge in Latin America, but to US goals that could be deemed questionable from a Latin American perspective. Funding lends the agenda, priority, models and organization that reproduce US health trends.
Yet, the WHO and the PAHO documents, when recommending the integration of traditional medicines into national health care programs, focus on the latter. They are occupied with defining these medicines using conventional medical standards and health system structures, and insistently propose methods for their regulation. However, much is determined by the nature of the health system and the medical resources within which indigenous knowledges are to be incorporated.

First, what are they incorporated into, and what are the implications of the process? The inclusion of traditional or indigenous medicines into these health care programs is accompanied by other elements that represent the community and the conventional medical system in question. The programs are built onto existing community hierarchies usually according to the logic of the dominant class society. Referral systems and preventive medical practices (with prevention defined as early medical intervention) are squarely based on the biomedical model, which is also inherently geared towards hierarchical and individual actions. In some contexts, only a selective incorporation of elements of traditional medicines can fit into these programs. The recognition of their value is not honest, in that it is a fragmentation of the whole system of meaning and practices, and is meant to facilitate the introduction of elements “to extract patient compliance” (Crandon, 1983, p.1282). They conceive of indigenous medicines as the use of herbs, disregarding nosological, etiological, or treatment systems.

Crandon (1983) exemplifies how traditional healing systems reinterpret within magical domains social structures and relations that are affecting the community. She contends that traditional medicines are usually translated according to their material aspects, familiarity and symbolisms, but as cultural and ideological constructions, they
are “not merely a reflection of material reality…[but] a tool by which people actively shape their environment…[their] magical dimensions mobilize necessary economic, political, nutritional and social resources at the local level…” (Crandon, 1983, p.1282).

The articulation of traditional or indigenous medicines into health systems, furthermore, is not new. These policies are equally recycled throughout the so called Third World, parallel to health models and in response to local and global dynamics. Analyses of the attempted incorporation of traditional medicines into health systems in Africa, for example, date from three decades ago. Some of these strategies have been tried in many different contexts with disappointing results, to say the least. Failures in multiple locations with different cultures, histories and economic bases should have suggested by now their profound miscalculations (Greunbaum, 1981; Crandon, 1983; Fielder, 1985; Whiteford, 1990).

The Declaration of Alma Ata (WHO, 1978), which spurred the development of the PHC, is related to the international recognition of the Chinese notion of the ‘barefoot doctor’ (Aidoo 1982). The PHC basic concepts, thus, centrally included the extension of health services to rural sections, the decentralization of health services management and the mobilization of community resources. The call for regulating and incorporating traditional medical knowledges into national (biomedical) health systems has changed, though, as some of these medicines have increasingly moved beyond the boundaries of their communities, following globalization patterns of flow of peoples and commodified cultural manifestations.
The globalized power of scientific medicine rationalizes a particular organization of material and cultural resources and social relations. Local epistemologies embedded in these are, de facto, transformed, displaced or assimilated (Crandon 1983).

...[T]he assumptions of a market economy often shape the advice international bodies give, and the solutions national physicians and planners adopt. For example, drug imports put a heavy strain on the national balance of payments.... As a solution, indigenous medicines are seen as raw materials from which chemicals may be extracted for national use...Chemicals will be extracted with technological apparatus, separated from all therapeutic ritual to practitioners and patients alike. They become a product. Once medicine becomes pills, it no longer commands the meaning of those medicines and are made more dependent, a trend some have wished to reverse through community action in health care...(MacCormack, 1981, p.423-4)

This quote makes quite a few important connections. International aid and advice determine the development of a particular kind of medical system because of their rational values and the economic strains they impose, both of which increase dependence. In turn, this establishes the ways in which local resources (i.e., unorthodox medical knowledge and practice), will be regarded and incorporated into the system. The health practices and cultural meanings of the people become a point of encounter between global and local knowledges, and, in an unequal context, multiple hierarchies–social, social, cultural and epistemological–are inevitably reinforced. The dynamics of the processes explored above mediate the relationship between the two systems of knowledge.

In his study, Ugalde (1984) recognized how the biomedical model has affected the health beliefs and practices of rural Dominicans. He states “in El Rio, the association between the intake of large amounts of medicine and good health had become part of the local culture” (p.447). Medicines become a powerful reification of biomedical principles; as Singer and Baer (1995) has suggested, in a context of ignorance, biomedical
functioning acquires a magical quality. Usage of medicines, out of socio-cultural and epistemological context, reproduces social hierarchies that bring people to self-destructive behaviors such as self-medication. This is an interesting contrast with the middle class advocacy for choice and control of decision-making, which is only possible when one is educated not only in biomedical basics, but, also, increasingly, beyond its shortcomings.

It is well known that in many countries the purchase of medicines constitutes the largest out-of-pocket health expenditures, and that the lower the income the higher the percentage of health expenditure that goes for the purchase of medicines. Our findings in El Rio are not very different… (Ugalde, 1984, Notes)

The WHO and the PAHO, as well as the leading medical governmental institutions in the US, all have written and published strategies on traditional medicines. The documents of these organizations convey the general political implications of cultural and socio-economic struggles over resources. Overall, these documents represent the perspective and interests of the developed nations through linguistic strategies that redefine traditional medical practices and their relationship to other social spheres. The first one of these strategies is the effort to collapse all traditional medical systems into one name, in contrast with Western medicine. Then, traditional medicine is taken to be the same as the social phenomena evolving in developed countries around complementary and alternative medicine (CAM), which is already the result of dynamics intrinsic to that context. Because CAM is already a fragmentation of non-conventional medicines, traditional medicines are, de facto, understood as practices and therapies, easily transported from one medical system milieu to the other. WHO and PAHO documents are increasingly using herbal medicine interchangeably with traditional medicine, for example, which sets the premises for the way Western academic and health
authorities, and society in general, will relate to traditional systems of medical knowledge.

The WHO/PAHO Evaluation Plan of Work on Traditional, Complementary and Alternative Medicine (2002), for example, already separates these medicines into categories that I could not readily understand, except to expedite the acknowledged goals of science based research, evaluation, regulation and harmonization. Traditional medical systems are also increasingly termed a resource, and there are references of CAM products and of consumers, which will presumably facilitate negotiations around their mobilization and around processes of mobilization for production and consumption.

International collaborative efforts for this “marriage of medicines,” as recently put in a PAHO article in one of its publications, referred to “growing commercial interest in modern pharmacological applications of traditional medicinal plants,” and to how, for governments in the region, “providing health care and other basic services to indigenous…communities is a major challenge that has put relations between Western and traditional medicine on the national political agenda.” The focus then turns on an interest in—not a resource of the indigenous communities—but in accessing and preserving knowledge, a more ethereal (global), less localized, more translatable kind of resource (Johnson, 2002).

“Traditional Health Systems in Latin America and the Caribbean: Base Information” An International Study by the WHO

Among the documentation of the processes of regulation of traditional medicines in the Americas, both the PAHO and the WHO include strategies that center on research. One in a series, a Technical Project Report titled Traditional Health Systems in Latin
America and the Caribbean: Base Information, includes the DR among a group of nine countries. The objectives of this particular study were to:

   a) characterize the structure of traditional health systems; b) identify the government and non-government resources available; c) obtain data on researchers, therapists and organizations involved in the development and promotion of traditional medicine; d) understand the regulatory structures of traditional medicine; and e) identify needs for future research. (WHO/PAHO, 1999, p.1)

The study recommended an ambitious list of areas of research that could be summarized as: 1) the need to account for the volume of these medicines; 2) the identification of resources needed for their production and consumption; 3) the possibility of incorporation into the formal health system; 4) their efficacy; 5) understanding their structure and symbolism to determine their susceptibility for modification according to the clinical setting; and, 6) the legal and other institutional framework necessary for their mobility into spaces of the general society.

The specialized informants in the DR were just one, a relatively young male physician or Ph.D. specializing in pharmacognosia who was not identified as belonging to any institution. It indicated that the DR has governmental and non-governmental institutions dedicated to the study of traditional medicine, but has no formal regulation. It reported 2,000 to 3,000 healers, 80% of whom were female. Therapeutic “specialties” encompassed Voodoo, Sorcerers (“Ensalmadores”) and Herbalists who work “illegally.” It indicated that healers learn in their homes, through practice and observation. Their diagnosis consists of reading urine and reaching a state of trance. Their treatments include rituals (voodoo, pilgrimages, promises, “reguardo”), elements (music, herbs, figures, tobacco, saints, incense, candles, alcoholic beverages), altars (pictures of saints, candles, bottles, bolones), their symbols are those of voodoo and the Catholic Church, and they are syncretic.
Additional findings external to the practice indicated that remuneration for services is done in kind and monetarily; that there are related events realized by NGOs, Universities, and international organizations; that there is no current patentization or registry of medicinal herbs; and that sales and collections are unregulated as well. They were reported as sold in popular markets and boutiques. The study also specified that traditional medicine is frequently combined with “official” medicine, and that the official medicine establishment relationship with traditional medicines is one of intolerance, while it related that it is “widely used” in rural areas, and “much” used in urban ones. Finally, medicinal plants were considered to be the most frequent theme explored in studies; and about every other aspect of healing systems is signaled as needing further research. This includes the traditional healing systems themselves, the role of the healers, and the systematized use of plants (see Table 1 at end of chapter).

While this study provides a general depiction of traditional medicine in the DR, especially in relation to other countries, I very much questioned a significant amount of its information. This is particularly because no information is provided about the context in which the Dominican informant finds access to such a diverse, geographically spread socio-cultural phenomena. Still, the study supports my argument that there is a system of symbols, practices and rituals through which Dominicans express their historically accumulated meanings and experiences of health that differs from that of the group of mostly physicians my participants came out of.

As per the critiques of scholars reviewed in previous chapters, almost every aspect of traditional healing related here has been translated into a formal, material category. So, we find specialties, diagnoses, elements and symbols; a sense of the space and of the structure of the relation. This information does not help us understand the basic meanings
and concepts of these practices, and/or the relations to the natural and social worlds of the rural Dominicans that participate in it. Again, I do not know if this information reveals the simplicity of the system or a limited access and understanding of it. In any case, while I question some of the information, this profile is markedly different from that of the practitioners in this study, who work in an urban setting, within a formal medical space, charge significant amounts of money and sell imported products in their own “biomarkets.”

**Current Status of Alternative Medicine in the City of Santo Domingo, DN**

The title of Olivo’s thesis (“Current Status of Alternative Medicine in the City of Santo Domingo, DN” A Thesis from the Authenticumor University of Santo Domingo. Medical School, 1995) and those of the previous source support my argument that the two groups and spaces of health related socio-cultural activity hold significant differences. However, a salient characteristic of this thesis is the very loose use of the terms, which eventually reveals common mis/understandings, linguistic processes of delimitation corresponding to social processes, and finally, the dominant viewpoint. Regardless, it provides a detailed description of the group out of which participants in this study came, and supports my general findings.

Olivo (1995) begins with the use of the US prevalent and increasingly internationally deployed *complementary and alternative medicine* (CAM). She defines it as “*technique within medical practice*…which has begun…to have a strong impact in the worldwide community, and thus, in the DR.” Just this first statement of the thesis introduction conveys the main features of the current, international approach to CAM: it is an amalgamation of techniques to be incorporated into the medical repertoire,
increasing in relevance internationally, and thus impacting peripheral communities such as the DR.

One could ponder if these phenomena are developing simultaneously all over the world, or if it is becoming a transnational phenomenon as a result of the increased, deliberate movement of cultural, social and economic assets. But given that the alternative medicines this author is referring to, as we will see, are not the more autochthonous to the DR, her statement is actually quite accurate. She explains this resurgence very precisely as well, at least in relation to the perspective of the biomedical community: it responds to a search for alternatives to some diseases, the need for methods that are more innocuous and compatible with nature, which is meaningful because of the cultural processes that have brought the dominant discourse to this issue. These make it pertinent for CAM to be assimilated and applied within a scientific framework. This is an almost literal translation of her text, and an impressively accepted rendering.

She ascertains that there is “only one medicine, which has different approaches.” In it, she then bases the call for “conventional medicine” to expand its boundaries to encompass “alternative therapies” (a term that she makes equivalent to whole systems and modalities indistinctively). Conventional medicine is the one medicine, and not one of the approaches that make that one medicine. She connects the call for this gesture to a betterment of medical practice in the DR, by allowing it to become more “scientific and rational” and contributing to a diversification of the Dominican health system. This last notion completes a narrative that matches almost perfectly the discourse of the leading US authorities on CAM. Given that scenario, the work proposed aims to identify, among
other things, the status of CAM in the DR, specifically its level of integration with allopathic medicine, and which “Centers” are working on a scientific basis, or according to “scientific truth.”

The antecedents to this current state of affairs identified in this piece go back to 1912. They comprise a list mostly of physicians, overwhelmingly working with acupuncture and herbal medicine, and with influences and connections to China, Korea, Cuba and the US. Olivo also elaborates an international history in relation to the events of the DR. Among them, she quotes the WHO in 1977, encouraging governments to give “adequate importance to the utilization of their traditional medical health systems, with regulation appropriate to their national health systems” (p.9). Olivo indicates that the same year, the WHO put forward a campaign for the worldwide promotion of traditional medicine, and that the next year it brought together in Geneva a group of experts to discuss its potential, its development and research, and subsequently, its integration with modern medicine. The international background contains, furthermore, some publications and an account of the development of diverse organizations and academic centers throughout Latin America.

The scheme developed in the introduction sets the premises for the ways in which CAM will be conceptualized, researched and interpreted. Those premises define CAM so that questions such as what are its basic conceptualizations, its origins, its therapeutic resources, as well as who are the people who practice it and how they are developing, are all responded against scientific and biomedical standards. It was asked of CAM users what is their use of techniques and technologies. This display of technological fancy invited questions about the audience for this thesis: physicians and, especially, medical
students. Medical students conducting this kind of research are sympathetic to CAM, and, necessarily, advocates for integration. This work was very much about validation of CAM within a biomedical context, and technological advancement may well be, as with one of my participants, a sure ticket to acceptability.

Olivo interviewed 50 practitioners of alternative medicine in the capital city. Summarized in Tables 2 and 3 are salient findings from her work related to these practitioners’ educational background. Table 2 indicates that the majority (58%) of practitioners were formally trained as medical doctors. Table 3 illustrates that the majority of these individuals (64%) were trained in formal settings, such as Universities and medical-based institutions.

Some of the practitioners interviewed, while urban, were located in poorer neighborhoods. Little information about them is conveyed, as many of their responses fall into the indeterminate categories. I would argue that important differences and tensions will develop within urban alternative medicine practitioners, especially as professionalization takes shape. Significant data is included in Table 4 to provide a more complete profile of her population.

Olivo arrived at a couple of conclusions worth mentioning. She interpreted the high number of imported and processed medicines with which alternative medicine practitioners work to be not only similar to the situation of allopathic practitioners, but, also, to reveal a great dependency on these therapeutic tools. She picked up on their lack of connection to a network of organizations related to alternative medicine, such as stores and organic food farms. Their practice was overwhelmingly private, 72%.
A similar percentage, 74%, is already practicing *integrative medicine*, as was found among participants in my study, and 92% of those interviewed support the integration of medicines. Interestingly, while 80% of the interviewees believed that all illnesses could be treated by alternative medicine means, only 54% of them do not use pharmaceuticals.

**The Superior Council on Natural Medicine—A work in progress**

Urban alternative medicine practitioners are collectively seeking legitimacy and control of their practice through the establishment of an organization and an educational program. These measures seem to fit in with the regulating push of the new law of general health. I was able to have access to a working document of the nascent association of alternative practitioners, which they have named the *Superior Council of Natural Medicine*, by courtesy of its president and vice president, two physicians trained in the US who are practicing alternative medicine in the DR—very similar to those in this study. The Council’s inception date is November, 2002, and it refers to a National Constitutive Assembly. Its structure includes a complete Executive Committee and provincial “colegios” or dependent associations (the word corporation was also used in the document). The statuses include formal legislation and policies around membership and professional practice.

The document lays out the organizational structure in very formal, legal discourse. The president and vice president, with whom I had the opportunity to converse, indicated that the Council is being developed with advice from a United Nations staff person who provided a template from organizations of this kind already developed elsewhere. In Chapter One, its definitions are limited to that of “medicos naturistas” or natural doctors (naturists?), not natural medicine, and they are defined as: “HEALTH professionals
struggling for healing\(^1\) exclusively through natural means” (Superior Council on Natural Medicine, undated, working document; emphasis in original).

The Council’s deed centrally mandates the promotion of natural medicines, the natural environment and resources, as well as social institutions, companies and industry that provide services related to sports, food, and help to the groups usually identified as weak: the elderly, children, women and the disabled. It then moves on to define the “official natural medicines,” enlisting around forty modalities, which go from psychotherapy, naturopathy and homeopathy, to “arcilloterapia” (mudtherapy?), “ayunoterapia” (fasting?) and “grafoterapia” (the use of graphics, or handwriting?). The list concludes with a note indicating, “And as many other techniques existing or developing around Naturalism.”

The rest of the manuscript refers to dispositions and regulation of “the profession,” consisting of criteria for inclusion, such as accreditation by the Council, clearing of legal and financial responsibilities with the Council, possessing an academic title (i.e., a Bachelors degree in Natural Medicine), legal status related to the special legislation for autonomous professional activity, and insurance for “professional responsibility.” The criteria for exclusion can be summarized as infringements against the proper practice of

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\(^1\) I have translated the original Spanish word “sanación” into healing, because that is the term used in the US, to refer to the more holistic concept around homeostasis, in contrast with curing, which is more about symptom suppression. However, there is still some linguistic refining of these two terms going on in the US alternative medicine community. (It was included as a question in one of the research projects I work for at the UM-Complementary and Alternative Research Center). I am not aware of how these things are being negotiated in the Dominican and/or Spanish-speaking contexts. In Spanish, we have the word, “curar,” which can be understood to translate literally for curing; and sanación can be said to correspond more to the term healing. But also, a traditional healer, at least in the Dominican context, would be a “curandero;” a word I would have used to refer to these practitioners, but which I had to avoid due to its negative connotations, associated with rural, indigenous (stigmatized as backwards) healers. It seems that a difference from these rural, indigenous healers is an important aspect of the boundaries being established through the creation of the Council.
the profession. Membership is deemed indispensable for professional practice. The central enunciation of rights to practice, the call for cooperation with allopathic medicine, and regulations around the naming of the practice, which are central to this document, corroborate the findings of my study.

Alternative medicine practitioners, mostly physicians, are not coming together around the defense of new conceptualizations of health, as much as they are carving a space for a new form of medical practice. Judging by the nature of their founding document, and by the results of these investigations, there are several ways in which orthodox and unorthodox health meanings and practices are being articulated that are intersected by class, location, and other social formations. Some of this data suggests great differences between the more rural practices of traditional healers, the more urban health practices supported by NGOs, and the alternative healers who are not physicians and operate in urban centers.

These differences are present even when all groups are incorporating medical traditions within the same context of biomedical dominance. The context in which medical practices alternative to the biomedical are to be incorporated is a highly politicized one; a context that for the DR is one of dependence and underdevelopment. Whether health meanings and practices are thought of as a principle for organizing society, or as a resource, they are subject to conditions of reproduction that reflect the power differentials along which the rest of society is organized.
Table 1: Survey on Traditional Medicine in the Dominican Republic

<table>
<thead>
<tr>
<th>1. Data on respondent</th>
<th>Dr./Charles Roesch</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Title/Name</td>
<td></td>
</tr>
<tr>
<td>b) Gender</td>
<td>Male</td>
</tr>
<tr>
<td>c) Age</td>
<td>44</td>
</tr>
<tr>
<td>d) Training</td>
<td>Pharmacology, Specialty in Pharmacognosia</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. Practitioners in country</th>
<th>2000-3000</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Volume of healers</td>
<td></td>
</tr>
<tr>
<td>b) Female participation</td>
<td>80%</td>
</tr>
<tr>
<td>c) Regions of most frequent practice</td>
<td>San Juan de la Manguana, Samana</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. Institutions dedicated to support and research of traditional medicine</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Governmental</td>
<td></td>
</tr>
<tr>
<td>b) Non governmental</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4. Primary therapeutic “specialties”</th>
<th>Voodoo</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Sorcerers (Ensalmadores)</td>
</tr>
<tr>
<td></td>
<td>Herbalists</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. Regulations on traditional medicine</th>
<th>No</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>6. Problems due to lack of licenses</th>
<th>Illegality of their work</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>7. Training of traditional healers</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Institutions</td>
<td></td>
</tr>
<tr>
<td>b) Spaces</td>
<td>Personal houses</td>
</tr>
<tr>
<td>c) Instruction of apprentices</td>
<td>Practice, observation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>8. Traditional forms used in the diagnosis of illnesses and disease</th>
<th>Read urine</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>State of trance</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>9. Modern technology used in the diagnosis of illnesses and disease</th>
<th>No comment</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>10. Healing rituals</th>
<th>Voodoo, Mani pilgrimages (promises), Reguardo</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) Ritual</td>
<td></td>
</tr>
<tr>
<td>b) Elements</td>
<td>Music, herbs, figures, tobacco, saints, incense, candles, alcoholic beverages</td>
</tr>
<tr>
<td>c) Altars</td>
<td>Pictures of saints, candles, bottles, bolones</td>
</tr>
<tr>
<td>d) Symbols</td>
<td>Those of voodoo and of the Catholic Church</td>
</tr>
<tr>
<td>e) Relationship to religion</td>
<td>Syncretism</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>11. Payment for services</th>
<th>In kind</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Monetary</td>
</tr>
</tbody>
</table>
Table 1. Continued

<table>
<thead>
<tr>
<th>12. Most relevant events</th>
<th>Saber Curar (NGO)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>India Course Workshop (University)</td>
</tr>
<tr>
<td></td>
<td>Latin American Seminar on the theory and practice in the application of Traditional Medicine in Formal Health Systems (International)</td>
</tr>
</tbody>
</table>

| 13. Medicinal Plants and Medications | In process |
| a) Plants registry | |
| b) Sales and control | Markets, boutiques, no control of sales and collection |
| c) Plants and medications on “essential list” | None |
| d) Medicinal plants with patent | None |
| e) Export | None |

| 14. Combination of traditional and official medicine | Frequently |

| 15. Interaction of traditional medicine with official medicine | Intolerance |
| a) Interaction | |
| b) Urban use | Much |
| c) Rural use | Widely used |

| 16. Study topics | Medicinal plants |
| a) Frequently studied | Medical anthropology, Dominican traditional health system, Role of traditional healers, Systematization of applied medicinal plants |
| b) Needing further exploration | |

Source: Traditional Health Systems in Latin America and the Caribbean: Base Information. WHO/PAHO: Division of Health Systems and Services Development, Essential Drugs and Technology, June 2002
Table 2: Formal Education

<table>
<thead>
<tr>
<th>Profession</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Technician</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Nutritionist</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>M.D.</td>
<td>29</td>
<td>58</td>
</tr>
<tr>
<td>Naturopath</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>None</td>
<td>9</td>
<td>18</td>
</tr>
<tr>
<td>Total</td>
<td>50</td>
<td>100</td>
</tr>
</tbody>
</table>

*Source: Olivo, 1995. Situacion Actual de la Medicina Alternativa en la Ciudad de Santo Domingo. Universidad Autonoma de Santo Domingo (UASD), Santo Domingo, Dominican Republic.*

Table 3: Educational Setting

<table>
<thead>
<tr>
<th>Location</th>
<th>No.</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>University</td>
<td>12</td>
<td>24</td>
</tr>
<tr>
<td>Institution</td>
<td>14</td>
<td>28</td>
</tr>
<tr>
<td>Center</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>Hospital</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>By mail</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Other</td>
<td>16</td>
<td>32</td>
</tr>
<tr>
<td>Total</td>
<td>50</td>
<td>100</td>
</tr>
</tbody>
</table>

*Source: Olivo, 1995. Situacion Actual de la Medicina Alternativa en la Ciudad de Santo Domingo. Universidad Autonoma de Santo Domingo (UASD), Santo Domingo, Dominican Republic.*
Table 4: Alternative Medicine in Santo Domingo, RD

| 1. Practitioners’ Nationality         | 92%          |
|                                      | Dominican    |
|                                      | Foreign      |
| 2. Practitioners’ Educational Level  | 8%           |
|                                      | High school  |
|                                      | College      |
| 3. Practitioners with Physician ID   | 46% (out of total sample) |
|                                      | Yes          |
|                                      | No           |
| 4. Years of CAM Education            | 72%          |
|                                      | Up to 2 years|
|                                      | Over 2 years |
| 5. CAM Specialty                     | 90%          |
|                                      | None         |
|                                      | Some         |
| 6. Illnesses that can be diagnosed through CAM | 80% |
|                                      | All          |
|                                      | Some         |
| 7. Illnesses that can be treated with CAM | 82% |
|                                      | All          |
|                                      | Some         |
| 8. Number of patients per week       | 60%          |
|                                      | 1-25         |
|                                      | 26-50        |
|                                      | 51-75        |
|                                      | 76-100       |
| 9. Percentage of used products being imported | 60% of participants |
|                                      | More than 75%|
|                                      | Less than 75%|
| 10. Use of conventional medicine     | 74%          |
|                                      | Yes          |
|                                      | No           |
| 11. Agreement with integration       | 92%          |
|                                      | Yes          |
|                                      | No           |

Source: Olivo, 1995. Situacion Actual de la Medicina Alternativa en la Ciudad de Santo Domingo. Universidad Autonoma de Santo Domingo (UASD), Santo Domingo,
CHAPTER 5
IS THE ALTERNATIVE TRADITIONAL? EMBODYING GLOBAL TRENDS

Methods

Three practitioners were selected for case studies. Social visibility and personal referrals were matched with an effort to include newer and older practitioners, potential gender differences, and distinctions in their approach, as conveyed by the way in which they come across to the general public. Potential subjects were contacted initially by phone and invited to participate in the study. They received a verbal description, and, in two of the cases, a letter was used to help gain access. Confidentiality will be protected by changing their names in order to avoid the possibility of adversely affecting the reputation of the participants. Results will be used within academic contexts and standards only.

Interviews focused on each respondent’s practice, the theory on which they base it, and in the way they have developed it in relation to epistemological and social structures. We discussed characteristics and arrangements of their practices. Practitioners were queried about their education and background, their accomplishments in their professional development, their perception of what conditions or issues have facilitated this development, and of which conditions have hindered it.

An interview guide with open-ended questions was used. Subjects were individually interviewed and audio-taped on one or two occasions. The interviews lasted one to two hours. Backup copies of the audio tapes were made and the interviews were transcribed verbatim in their original language, Spanish. The transcriptions were then
formatted for computer assisted analysis using ATLAS.ti. They were coded for common and contrasting themes, while seeking correspondence to the questions and theoretical propositions guiding the research. Individual and cross-case analysis was built on thematic and narrative profiles.

Consistency in the interviews was a secondary concern. Interviews reveal not only the very particular stories of these practitioners, but the particularities of our interaction. Gender, age, as well as social status evidently affected communication. My female, dark-skinned, lower middle class background was probably balanced by my association with US institutions, which I deliberately used. I speculate that access to these practitioners was probably easier than it would have been with some of the elite physicians in the DR. Participants may have been interested in gaining attention due to the current burgeoning status of alternative medicine practitioners. Also, closeness in age and other similarities made the interview with Dr. Junior very dynamic and different from the others:

“…interviews can also be seen to possess basic properties of all social interactions. These properties derive from both parties’ employment of their everyday, common sense knowledge of social structures to engage in such business as recognizing a question and providing an answer which will be heard as ‘appropriate’ for a particular identity…it follows that such properties should be investigated, rather than treated as a ‘problem’ standing in the way of accurate reporting of ‘facts’ and ‘experience’ (Silverman, 2001, p.94).

Effectively, I would become conscious at the time of the interviews and during data analysis, that roles and social markers played a role in the evolution of each interview. I found those dynamics to significantly identify with some of the processes being talked
about. As Holstein and Gubrium (1995) have asserted the biographical particulars are inseparable from the situated production of meaning. The matters under consideration, furthermore, result from a cooperation to produce mutually recognizable meanings; “the standpoint from which information is offered is continually developed in relation to ongoing interview interaction…[the interviewee] not only offer[s] substantive thought and feelings pertinent to the topic under consideration, but simultaneously and continuously monitor who they are in relation to the person questioning them” (Holstein and Gubrium, 1995, p. 15).

Field notes included observations of non-verbal elements of the interview, the setting, and any other unique characteristics. The research also extended to participants’ patients, collaborators and staff. Parallel, public documents, shorter interviews, publications and references were collected. I became sensible to media and lived events related to health or to the phenomenon of alternative health marketing and consumption, as well as to the more traditional health seeking behaviors and meanings that are usually oblivious to us.

**Findings**

**The Cases**

All three of these practitioners have radio or TV programs where they provide medical advice. Dr. Mario has talked on a radio program for almost two decades. Dr. Junior enjoys significant popularity within expanding social circles. Word of mouth being crucial for this kind of practitioner, it may be that Dr. Sylvia, who does not display her clinic openly, is only known in my circle. However, I could recognize her among the healers included in the only thesis written on this subject in the DR (Olivo, 1995).
Being that they constitute a group of clear limits within the capital city, I found out that they were quite aware of each other’s practice. They seem to be functioning in some sort of common space, even if the space is made up by the clients who seek this kind of medical service. As far as I was able to see, all of those, except two, were conventionally trained medical doctors. Yet again, some, as Dr. Sylvia and her partner, call themselves “doctor” because of their accomplished status, though they do not have a degree in Western medicine.

The sale of “natural products” can be considered standard in alternative or natural medicine practice. Of the three cases, two of them, Dr. Junior and Dr. Mario have a little pharmacy or area where they sell medications and natural products. Dr. Sylvia does not have a clear place where products are sold; after all, her “clinic” is in her home. However, I did see a patient paying her for products. In these little pharmacies the products sold also represent the practice as shaped by the practitioner. In Dr. Mario’s little pharmacy, imported products are repackaged into simpler, smaller containers with labels translated. Dr. Mario explained that he did so to make them cheaper, more accessible. In Dr. Junior’s office, sales include self-help, religious books, and all sorts of natural and non-natural beauty products. Both of these places sold food, which I saw delivered by local producers. One of them, with whom I did a short interview, told me he belonged to an organization of religious families concerned about health. The physicians’ Church relations clearly interact with the production and sale of these products.

Consultation fees vary according to the same kind of choices mentioned above. Alternative medicine practitioners are not covered by insurance. I could not confirm whether this was the practitioners’ or the insurance company’s decision. They all claimed
to have sliding scales. All three practitioners studied said they would not turn down a patient because of a lack of funds. I witnessed Dr. Junior’s receptionist tell a patient not to worry about money, as she never had to in the past; things would be accommodated to fit her budget.

In general, because of the way they organize their fee payments, Dr. Mario would be the only one accessible to lower income people. Again, Church connections of the two physicians impact the size and kind of clientele they receive. The same could be said for the location of their offices, or the way their services are known. In all three places I saw people of middle class appearance, as well as very modest ones. Most of the clientele was female.

The setting and schedule resemble those of biomedical practice. Interestingly, though Dr. Junior’s office is the fanciest, he appeared to be more informal and more easily accessible. In Dr. Sylvia’s home, her maid and/or daughter played the role of gatekeeper or receptionist. Practitioners remain the authority in the doctor-patient relationship, which in my experience of alternative medicine healers in the US is an important difference.

Case I: Doctor Mario

The Center is staffed by a secretary, an older, very simply dressed lady. Her appearance is that associated with a stereotypical evangelical woman in the DR. The Dr.’s wife works there as well, doing administrative work. Dr. Mario’s office is extremely simple. It is small and very modest. It has only a couple of posters on the walls; one of the digestive system, the other of the urinary system, and a last one called “Organizacion Interna.” His office includes a scale, a computer on his desk with a sign on
the side the patient sits with his email address. On the back wall, there are 5-15 diplomas, plus the Hippocratic Oath.

Doctor Mario speaks at a radio station every Tuesday and Thursday 10-11am, and has done so for the last 12 years. The program is called “Club Femenino.” It is 30 years old and is not geared to a female audience, necessarily, though it has kept that name. Dr. Mario’s appearance on the program used to be daily, and is now only twice a week. He also appears on TV on Sundays, Channel 35 at 8:30am, publishes a column in a popular newspaper, Periodico Ultima Hora, and publishes, together with other physicians, the magazine “Nutricion y Salud,” which I happened to see in display at Dr. Junior’s office and in many other places where natural products are sold. It has been published since 1983-1984. It was initially free and now costs only 20 pesos (around .30 US cents). It is published in small sized, low quality paper. “Nutricion y Salud” includes, among other things, case stories. I found a wonderful critique of the neo-liberal reform in it, running through several issues. It was titled, *The Health of the Republic*, and was written by an architect.

The doctor has offices and patients in New York, NY, US, and takes care of patients abroad through fax or the internet. During one of my visits he did a phone consultation. Dr. Mario sent his patient on the phone, who was risking a miscarriage, to “one of those stores that sell natural products, [and said in English...health food] and get this tablets called bioflavonoides.” Again, he would combine a simple language with a medical language.

I accompanied Dr. Mario to one of his Radio Shows. It was very simple and didactical. His notes, which he simply read, were old. Not necessarily outdated, but
prepared for presentation a long time ago. The focus was on an illness, on helping people understand where it came from and how to treat it with nutritional changes. All throughout, he was translating medical language to common language. He was also dispelling myths about the illness.

On the way back, the doctor, his wife and I continued talking about his work as an alternative medicine practicing physician. Asked if he saw his work as social labor, his wife volunteered: “yes, though he is not recognized.” He spoke about consciousness, ethics and about the truth winning sooner or later.

He sees his practice as being part of a general movement of medicine towards a more holistic, integrated approach. He realizes that there are economic interests that are confronting these changes, but he is confident that this is the path medicine will take. In the meantime he sees many physicians taking advantage of this moment and making a big business out of it.

Dr. Mario has been practicing for 20 years. He has never taught. He recognizes that conventional physicians do not know about nutrition. I asked Dr. Mario what he had in common with other physicians practicing natural or alternative medicine. He said they may use the same instruments but their approach is different. Asked about the most common illnesses in the DR, from his point of view, he answered: chronic gastritis, hypertension, diabetes, hypoglycemia, arthritis, and obesity. Their basis is 80% nutritional, he added.

Consultation is much cheaper at Dr. Mario than at any other Dr’s office I knew of, whether practicing alternative or conventional medicine: the first consultation—RD$300, and 200 pesos afterwards. As with Dr. Junior’s office, there were products being
delivered to this office. Patients were buying and ordering products. There is a refrigerator in the waiting area with whole wheat foods and specific nutrients, and a rack with non refrigerated food products. The waiting room at Dr. Mario’s is not air-conditioned; there is much noise from cars passing by and from industries nearby. The furniture is rather modest. There are two portraits on the walls: one is an abstract painting, the other a picture of veggies on a table.

**Doctor Mario’s patients**

His patients appeared less wealthy than those of the other two practitioners, though I am not sure if the difference is significant. They were very appreciative of Dr. Mario’s skills. (Overall, all of these doctors were very well liked by their patients.) A patient from Peru arrived as I was leaving. I asked her why she was visiting this particular doctor. She said that “they only see Adventist doctors.” Was it like this in Peru? I asked. “Yes,” she said. “I came two years ago and asked for an Adventist doctor. They are career doctors but practice naturism.”

Another patient was bringing her daughter to see Dr. Mario. She was his patient as well. She recalled coming to see him after she had been suffering from gastritis for a long time and was getting ready to get an endoscopy. A friend gave her some pill Dr. Mario had prescribed and talked to her about his approach. Her daughter suffers from a narrow valve and problems in the arteries. She has a pediatrician for this condition, at Corazones Unidos, but sees Dr. Mario for her general health. The patient said that the child’s pediatrician attributes her recovery to a miracle, but she believes that Dr. Mario has healed her by overcoming deficiencies in the child’s body.

This patient informed me of something really important and which did not come up in my conversations with the doctor. They have been holding a support group/study
group on health and nutrition for 15 years now, with Dr. Mario. She finds these groups very educational and said that they discuss books, herbs, foods. The doctor leads this process.

The patient told me there are many things people consume regularly that she will not touch; such as spaghetti, fried food, salami, tomato paste, bouillon, ketchup. She explained that COSALUP has played a role in her life too, as she learned through them about organic products. She said “the problem with traditional [conventional] medicine is that it fixes one thing and ruins another.”

A third patient was also ready for endoscopy when she came; she was suffering from chronic gastritis. This was her second visit, but, she clarified she was not there because of the gastritis, which had been taken care of months before. The patient said she had had many studies done before coming to Dr. Mario; gastroenterologists were giving up. She was there because of her sinuses and congestion. She was also recommended to Dr. Mario by a friend, who is finally pregnant, thanks to him.

**Case II: Doctor Sylvia**

Doctor Sylvia’s clinic, which is the unwritten name of her office, is in her beautiful house in a nice, middle class neighborhood. The waiting area is her front porch, an open space houses usually have in the DR. This is a particularly beautiful one surrounded by a nice garden or front yard. The house is adorned with lots of images of angels. The doctor pointed out that this had a special meaning; it is part of her making the house conducive for healing. While I was sitting in the waiting area, I noticed a patient reading a fashion magazine. Nevertheless, in this magazine, as in most newspapers, radio and TV stations, health sections have become ubiquitous. A section in the magazine reads, “Medicine-Health.”
The house is nice and spacious. There is a huge fish tank and beautiful paintings by the doctor’s daughter. The clinic includes two rooms to the side. One of them has a desk and books and all of her diplomas. The other, much bigger, includes quite a few beds and equipment and posters. The walls of her “clinic” include many more diplomas than the other two practitioners. Doctor Sylvia said that most of her diplomas were being repaired after they were ruined by moisture in the house. A woman with a difficult character, she appeared pleased that I had taken notice of her diplomas.

Dr. Sylvia indicates that she entered medical school and it conflicted with her history of “supranatural” experiences. She dropped out because of dissatisfaction with the program. She said her education and experience with healing began when she was 6 years old. Her special talents and sensibility granted her particular relationships to family members, books, art, music and the world. She had an institute when she was about 11 years old, she said, where she taught music and art. She claims she was always talented in leading people to learn, to relate.

Dr. Sylvia stated that she studied Chinese medicine. She described her training as being intense yet non-formal. She mentioned having had experiences with Shamans and other indigenous healers in other countries. I asked if she had had such an experience with healers in the DR, which she denied, and expressed that she had initially traveled to the interior seeking such experiences, but had become discouraged. I noticed a negative reaction to the word “curandero.” She said they were to blame for the negative aspects of natural medicine’s reputation, and that people like Dr. Junior were, in contrast, doing a great job in elevating its status.
Dr. Sylvia said that she diagnoses with her eyes. No measuring of blood pressure, temperature and others. She said she orders analysis “so that people know, can see, understand” Treatment focuses on food mostly, and on natural products, vitamin and mineral supplements. As I came out of the room where the desk and the many diplomas were, the Dr. was talking to a patient she had been working with in the other, bigger room. Her diagnosis included a correlation between something happening in the patient’s ovaries and throat; this was in turn connected to events in this woman past.

The Dr. said something like “I would not give you 5 pesos for your emotional and mental systems. They are very vulnerable. They are not being effective, and are instead self-destructive, focusing on what is negative.” This was connected to the patient’s frequent crying. Fear was related to a mal-functioning kidney…to self-doubt and self-judgment. She also clearly said to the patient that the only medicine she needed was her nutrition, to change the amount of oxygen. “...That is the evaluation...What do you do now? Stop 5-10 minutes. Think, talk to God about being open to change. Changes in eating habits are hard. It is not about what you like; it is not about feeding fears, taboos...”

The doctor described herself to the patient as being strict. The patient had to be ready for change. Again, she related the liver to depression. She continued:

You have to be committed to yourself. You are pure. You deserve the same attention you are giving others, and other things. Think about that and call me and tell me you are ready to take that challenge. Then we will start a process of disintoxication...And next, we will repair your cells and your genetic, mental program: Odors, colors, tastes, palate, smell, hearing...

This was the patient’s first appointment. All through this, she had tears in her eyes and appeared as if overwhelmed by many feelings. At the end she just asked, “How much do I owe you?” To which the doctor replied, “1,000 pesos.” My friend, whose mother
was being treated by Dr. Sylvia indicated, that, after being overwhelmed to know the total cost of treatment, consultations came down to 500 pesos (US$20 at those days’ rates), which is lower than that of most physicians. After the initial treatment is completed, he shared, they pay 250 pesos, and therapy sessions are 800 pesos.

Doctor Sylvia’s daughter handed me a journal where patients had written about the clinic. Most of them, maybe all, expressed life-changing experiences. They all read like testimonies supporting the doctor, or attempting to explain what was admittedly unexplainable. At the beginning of the journal there was writing by Dr. Sylvia, which asked God to grant her the power to help in harmony with changes in the universe. Her syntax and her choice of words made both me and the individual who transcribed the interview wonder about her Spanish, and made it difficult to understand.

All in all, I felt that at times she looked down at Dominicans in general and as patients—this came across strongly in the formal interview, and may be according to Latin American racial hierarchies. She insisted Dominicans are, almost ancestrally, unaware of the best way to live and to take care of themselves.

**Doctor Sylvia’s patients**

Conversations with her patients revealed a sophisticated understanding of non-conventional medicine and great faith in Dr. Sylvia:

“I found out about the Dr. at a seminar on Spiritual Growth. I have been in treatment with her for 1 ½ year, but I had been receiving alternative medicine prior to that.”

Why alternative medicine?

Because it goes more to the origin of things; conventional medicine goes more to the pain...it attends to things before they become problematic; of course, it is a slower recuperation.”
“This is the medicine that feels natural to me; I have always had this tendency to go to the origin of things. It was not about a transformation. This kind of medicine is tied to spiritual growth, but a different kind of spiritual growth, more practical; it is closeness to God, to divinity. It is a practical wisdom.”

Asked about Dr. Sylvia’s character: “It is difficult; but I got over it”

“I usually come to her first; when I get lab tests, everything she has said is always there.”

Case III: Doctor Junior

Doctor Junior was, even before I left the US, the most visible practitioner of alternative medicine in the country. People would mention him when I inquired about this phenomenon; he has a website. He was readily available in his “pharmacy” when I arrived. They just recently moved to a new, smaller location in the same middle class neighborhood. Unlike his previous one, which boasted a large sign with many labels, this one only has a small sign. I wondered if this had to do with the fact that he has a well established practice now.

Unlike conventional doctors’ offices or conglomerates, and even different from a clinic, his is a center where he works with an interdisciplinary group. However, given that his father is a retired physician, his mother is a pharmacist, and his wife is a dentist, this is also, in a way, a family business. Dr. Junior also has an administrator, a nutritionist, cooks, acupuncture therapists, and a psychologist in his staff. He is the director of a Christian radio station that also works from this site and is staffed.

He immediately and proudly gave me a tour of the facility. There is simple reception area with a TV. No literature at all in the reception area, no Zen like environment, which I, having interviewed alternative medicine practitioners in the US, expected. The reception better resembles a regular hospital or clinic waiting area.
His office is very large. It includes a nice desk with chairs, posters, and a computer on an additional, small desk. A large picture of Dr. Junior and his dad, formally dressed and resembling galleries in hospital halls, hangs on the wall.

Different from conventional physicians’ offices, and this he pointed out himself, there is equipment that allows him to evaluate and test his patients. Some of this equipment he became familiar with in Cuba, but, as he mentioned, he could not bring it to the DR from there. He has machines for evaluating strength and exercising. Exercising is one of his research interests, in particular swimming. These machines are used to keep track of patients and their strength and development. He seems to cater to athletes given his personal interests and resources.

Dr. Junior has a computerized balance that allows him to separate mass from water from fat weight. He said he had to take a difficult test and buy it expensively from the US. He has a huge poster of the Biochemical Paths, which he vowed to learn to the detail 10 years ago and which he almost completely knows now.

The center includes a psychologist’s room where music therapy is provided; an acupuncture room, where electric acupuncture is administered, as well as some beauty treatments. The kitchen is divided in a cold and a hot area. A computer provides information about patients. He talked about 21 days of initial treatment or disintoxication.

The center is very alive and dynamic. A lot of people moving around: employees from the radio station and from the center, young people, come and go with ease. A piano teacher comes to teach Dr. Junior, as well as a couple of his employees, in the dining room adjacent to the clinic.
Doctor Junior’s mother, a pharmacist, tends to what she termed a “biomarket.” She explained that this biomarket was “like a department store.” In response to my inquiries about what kind of stuff one could expect to find there, she said that very little was not natural. I asked according to what principle she bought the stuff. She said that according to what people buy, and according to what the doctor prescribes. “He uses different labels,” she indicated, “he prefers to choose what he likes of each company, and does not commit to any.”

Asked how was her process of moving from conventional practice to supporting her son’s alternative practice, as a pharmacist, she said that she came to realize that conventional drugs were a double edge sword, like cortisone. Given the presence of so many products from the Universidad Adventista Dominicana, I inquired if they were Adventistas. “No,” she replied. They were Christians and belonged to the Iglesia Metodista Libre.

At that point a delivery of a small amount of a product for helping individuals stop smoking was being made. During my several visits to the clinic, people came to the center just to buy some of the stuff. There is a frozen food section where great yogurt is sold. Dr. Junior had told me during my first visit that this was his formula I was buying, as I did every time I went. Aware that in my country most milk being consumed now is imported powder milk I asked Dr. Junior if it was made from fresh cow’s milk. He said “yes.” I was not totally convinced.

The way Dr. Junior’s treatment is organized people come in for a first consultation that includes live blood analysis, urine and saliva tests. The second consultation consists of the provision of the results, the assignment of a diet, and the prescription of the
appropriate medication. At that point patients receive a computer printout with their picture, which includes all recommendations. They can then visit the dining room or restaurant, where many come back for individually tailored meals.

A patient was paying 1,600 pesos for his first consultation (equivalent at that date’s most probable rate US$1.00=RD$24.00 to US$66.00). That is a very high amount compared to the RD$700.00 that is the average charged by regular conventional physicians, as I could find out by asking some of them. In any case, the charges included 600 pesos for the live blood analysis, and 400 for saliva and urine. Tests are not included, however, in conventional doctor’s honoraries.

Some patients were in just for therapy, and I saw those paying hard cash for that. I did see patients seemingly upset about the price of consultation. They had to provide cash at the time of service, usually between 1,500 and 2,000 pesos, many a Dominican’s monthly salary.

Doctor Junior’s patients

There were several patients in the waiting room area in my several visits to Dr. Junior’s Institute. I was able to collect some thoughts from them. They volunteered very positive opinions about the doctor: “He is the best, after God, it’s him,” one of them told me. He continued:

[But] my relationship with alternative medicine is old. I have a friend who is a naturopathic doctor. My mom is almost a naturopath too, by practice...I saw him on cable TV; he convinced me of his practice. He was talking about different illnesses, different attributes of natural medicine. I know some about it. Natural medicine is preventive medicine. I am against conventional medicine. I believe natural medicine is helpful because everything comes from the earth...It is called alternative medicine because it prevents illness.

In San Francisco, Provincia Duarte, this patient estimates there are around 15-20 practitioners. But they lack the specialties and the equipment Dr. Junior has, he said.
"Many people take natural medicine without going to the doctor. Mother Earth offers seminars."

Why do you think people are coming to use this medicine? The patient responded:

Because it is less damaging, it has no secondary effects.” What is the difference between this medicine and that of curanderos? “Curanderismo has changed. Before they would only work with herbs. Now it is mixed with Santeria, witchcraft, so much so that it has earned a negative reputation...People used to go to curanderos, then they became educated and went to ‘official medicine’ now they are getting back to it but with a clear notion.”-How is it that you call conventional medicine?

“Chemical medicine, orthodox medicine, traditional medicine; but the name is not important. This medicine simply makes sense, it comes from Jesus.

What is the difference from conventional doctors? I asked a male patient. The patient responded: “He gives you the information. It is hard to ask questions with other doctors. Besides, he has much more equipment, and he tells you. Consultations are much longer, because of the tests and examinations.” Through them, I find out that Santiago, the second largest city in the DR, has several natural medicine stores and practitioners in some of its main streets. GNC has a store and the office of a naturopath very visible in one of Santiago’s main streets. “Also many Adventistas,” she said, “they are vegetarian.”

Dr. Junior’s receptionist has also someone who can be considered a curandera, her mother. Yet, she does not want anybody to know for fear of the bad reputation curanderos have acquired. She prepares “bottles” for menstrual pains, anemia, and hair loss, mainly.

The Context

In two afternoons, my sister drove me around some 30 natural foods and supplements stores in the city of Santo Domingo, in a small area of the city, actually, middle to upper middle class neighborhoods. Many of these were part of, or adjacent to, doctors’ offices. Others, the international chains in particular, included doctors’ offices in
them. Yet others were part of NGOs, or involved community and educational efforts. This last group represented the definite minority of them.

NGOs develop a markedly different approach to popular medical practices and indigenous medicines. I was able to interview one physician working with a visible NGO, and a popular health facilitator who has been trained by a German NGO to head a little natural products production project.

TRAMIL is a research program that focused on Caribbean Popular Medicine. It derives from Enda-Caribe, a big, European NGO that works on environmental and developmental issues in the Third World. TRAMIL executed scientific studies of medicinal plants used by Caribbean populations, so as to make their use safer for these people. They published a Caribbean Farmacopea in English, Spanish and French. Its headquarters are in the Dominican Republic. The program focused on self-management of both, resources and processes by the people, incorporating research, application, and action. As such, it included a large component of workshops, trainings and exchanges and other forms of dissemination of information. Its aim was to put scientific knowledge at the service of popular medicine. Dr. Junior knew about this project.

COSALUP, started in 1983, I sought out because of health fair posters I saw in some of the food and natural product stores and markets. Upon my first visit to their offices I met with Dr. Peguero, a physician and the president of the executive committee. COSALUP has been doing health fairs since the 90s, he informs me. In them, there were several organizations involved: La Mesa, CEPAE, Ce-Mujer, among others. Dr. Peguero said that the “popular movement” for alternative medicine saw its beginnings with events organized in 1986 about the use and management of medicinal plants. He
mentioned Guadalupe Abdo as educating people in that field. An online search on Guadalupe Abdo referred me to an Argentinean project of popular education called ProHuerta.

Dr. Peguero sees alternative medicine as being part of Dominican popular culture. His organization uses medicinal plants to “educate, organize and bring participation” of the people in health promotion. They focus on change for healthy lifestyles, and see as positive outcomes of this kind of work the lowering of medical expenses for the people and increased solidarity through collective action. Part of this NGO’s policy has been to increase communication, and to support the training of traditional, popular health providers such as the curandero and the partera/midwife. This NGO, and maybe all others, do receive governmental funding.

Dr. Peguero, though, is also a conventionally trained physician. He does belong to the Dominican Medical Association. His relationship to the biomedical establishment is not conflictive. As Dr. Mario, he attributes that to the prudence with which he has handled his different perspectives and approaches. He is keenly aware of social dynamics affecting health and health care provision; much more so than the participants in this study. We talked about the changes brought about by the new health law and the health reform, and the nascent Council on alternative medicine as having an impact on popular health practices. He pointed out that an interesting indicator of the direction in which health matters were moving was the fact that the PAHO funded/directed the Health Department for many years in the past. That role is now being filled by the Inter-American Bank of Development (BID).
I also interviewed Mr. Sabino, a health promoter who administers Associacion Casa IDEA, which is funded by a German NGO. Their work focuses on the production of medicinal plants. Mr. Sabino works as an activist involved with environmental conservation and health promotion as well. Asked how he knew about plants and what to use them for, he responded, “All our lives we have known, by experimenting…” Casa IDEA has a little place right off the highway in the outskirts of the town of Cotui. It sells natural health products and I could see the places where they prepare some of this. Mr. Sabino told me they are seeking Health Department approval for their products, which they are, in the meantime, selling. They include tinctures, soaps, extracts, pomades, etc. The house is adorned with posters from the many health fairs. I found the wording on these posters interesting as the names kept changing: natural and traditional, natural, popular and alternative, and even all of them at one point.

Mr. Sabino told me about the project:

We started by recovering our medicinal plants... We have had conflicts with scientific medicine. It is part of the competition we have had, uninformed MDs unaware that the WHO is supporting this project. It has been, then, a process of conflicts and challenges... We, as patients, have had meetings with the Department of Health seeking validation for the use of alternative medicine. We have been making progress, going out to the public, appearing on TV, we have to challenge some scientists. We have actually met with some of them regarding doses. The difference between academic science and traditional practice is that we talk about plants that we know, that we trust by experience, such as the “Higuera.” We have learned to limit the use of some of them. We have a team of facilitators that work on the use and production of medicinal plants.

What are the advantages for you? “It heals, it does not harm. It is more accessible, less costly.” Conventional medicine, he says, is in contrast too costly and hard to reach. But also, “we have had conflicts with some ‘natural doctors’ as well. They are also very costly. They object that we are not qualified to speak about health.”
Mr. Sabino refers to conventional medicine as chemical medicine, or scientific medicine, which strikes me, as he is from the countryside and not highly educated. Then, I realize he has been a part of many international events sponsored by NGOs. He has received plenty of training in this area:

*I have attended a lot of training and international conferences: In Bolivia, about the development of small industry; in Costa Rica, about plant classification... We are competing with both, scientific and natural medicine. We are health vigilantes, we are struggling for health. We have also had to confront the church; they were taking as for “brujos” (witchcraft). I have attended many meetings with the church community. I use Jesus as an example. Gradually, the situation is changing.*

“Some medical doctors ridicule us because we are not legitimated,” he said. He identifies institutions and even practitioners who are working with them: a doctor in the city of Santiago, and Brigatrapo: Brigada de Salud Popular. I asked him, what about food? He responded:

*We have provided training “against” fat, salt, artificial colorants, “sopita” (bouillons). Health comes through food. We have received training on this too, from Cuban doctors. We offer workshops on food preparation, and on plant production... The “promotores de salud.” (health promoters) are volunteers. I belong to the Federacion de Organizaciones de Sambrana, Cotui, Dr.. We were already there when ENDA-Caribe came into the picture. We are already fighting against La Rosario, a multinational, on environmental pollution.*

What illnesses do you work with most commonly?

“The colds, diarrhea, skin irritations... And we have seen results. We are trained in first aid, immunization, midwifery. We meet every month”

**Analysis**

Overall, all three practitioners defined their practice by highlighting particularities of their development (see Table 5 at end of chapter). This can be related to the focus of my interviewing, but they were just as clearly engaged in a process of self-definition through accounts of how they had come to be this kind of medical provider, in response to predetermined ideas, structures and existing social groups. A salient set of such
parameters was provided by the community of practitioners of alternative medicine, which is concurrently taking form. They all conveyed their definition in relation to this group, with which they kept significant commonalities and differences.

The composition of that group can be illustrated by these three practitioners. They are all referred to as practitioners of alternative or natural medicine, and they will locate themselves within that category, understood in plural, or as a broad one. They are aware of the precarious status of that category though, and qualify it by immediately underscoring internal differences. As Dr. Mario said, when inquired whether he had anything in common with the other alternative medicine providers: “well, with the things I have mentioned…such as the use of natural resources, the emphasis on nutrition and that kind of thing…”

Dr. Junior, on his part, recognizes that each one of them is focusing on a specific modality, and insists that there are at least five areas in which an alternative practitioner must be equally trained to provide a comprehensive alternative practice. His push for the development of a graduate program on alternative or natural medicine responds to this concern: “the thing is that [the alternative medicine practitioner] cannot be hand tied, like conventional medicine, the thing is to create a physician who can handle actually six, because s/he should also manage conventional medicine…”

In addition, they defined themselves in relation to biomedicine, and provided an account of practical measures taken to accommodate within its discourse and structures, as well as those of the general society. Dr. Mario repeatedly reminded me that he was a physician, member of the Dominican Medical Association:

I was telling you that lately there is talk about integrative medicine, a combination, and it could be said that I fit into that category, because as a conventional
physician, sometimes I make use of allopathic or conventional medicine...I always considered myself as part of medicine” Or, “people ask me what kind of a physician I am, and I respond that I specialize on everything depending on the circumstances...

Delineating that relationship to biomedicine is very important for the two physicians. While Dr. Mario’s training was an apprenticeship with a Chinese practitioner in the US, this has not affected his medical status. To explain this, he remarks the difference between a natural medicine practitioner, and someone trained in orthomolecular medicine, which “is based on biochemistry and human physiology...” Dr. Junior was also trained in Cuba with methods of observation, and on modalities that have not been scientifically proven. He identifies what made the difference:

_I had the blessing, to put it somehow, that my dad is a physician...so, well, the Dr.’s son is back from Cuba...I am sure that if I had done it here, I would not have had as much impact, you know, here we have the Guaranagarix complex, everything that comes from abroad is more important...it does not matter what he studied, he came from Cuba, he is a physician._

Dr. Sylvia’s situation is a little different, and yet, she balances different aspects to convey her medical status. On the one hand she tells me:

...it is that really, I do not need a...license to work with people, since I do not do any medical intervention, I do not prescribe any kind of chemicals, eh, I only work with therapies...” But questioned about how come everybody calls her “doctor” she replies: “It’s that I am a physician, but since I am a foreigner, I cannot be this...I am a physician, because I earn, eh, emm, the work with Chinese medicine, I am a Chinese physician, I am, I work with bionenergetic medicine, I have earned my degrees, I have forty one specializations in medicine, I am an iridologist, I am an iridologist physician, I am a kinesiologist physician, I worked, and, and...they call me a doctor because I am a doctor...

Indeed, with many success stories, she boasts her status within the medical community, which calls her for second opinions and adds “I have never felt separate from the other medicines...” Non-orthodox healing and healers did not come up unless I inquired about any possible connection participants could have with “curanderos,” which is the way
traditional Dominican healers are called. Their response specified no space of overlap or of common social status. Stressing their identification with scientific or foreign traditions, they did express concern over the impact of quacks on the development of the practice of alternative medicine. But it seemed that this concern was not so much about the mostly rural or urban healers whose practice can be speculated to be very different from that of these practitioners of alternative medicine. To begin, their practices tend to be informal and concealed. Their concerns were clearly related to the practice of those who are building similar alternative practices, without formal education.

Of all three, Dr. Sylvia had the strongest feelings about this. She described the efforts of alternative medicine practitioners to form an organization as seeking to pin down practitioners outside of the circle, sanctioned by their degrees or the familiarity of working close with each other. Regardless, Dr. Sylvia’s status becomes an issue, as the organization aims to regulate the practice and to establish a hierarchical order.

Developing a professional practice, after all, depends on accomplishing a match between the services provided and the demands, more than the needs, of a community. The two most salient themes (or codes) consisted of the instances in which the practitioners related processes of deliberately naming or shaping their practice to aid in its development. Around these central themes, I marked instances in which a particular resource, such as the medical status, or personal attributes, provided advantageous premises. Obstacles to that development, as well as recourses used to oppose them, were acknowledged. In these somewhat chronological narratives, background elements and resources were made evident, while their current practices were delineated in
correspondence with past and present challenges and the accomplishments of a visibility and validation.

Indeed, more than an engagement with theoretical differences and/or with processes of bridging and reconciling paradigms, the practitioners described an artful articulation of linguistic and interactive resources. The two most salient codes across all three interviews were naming the practice (11 instances) and shaping the practice (27 instances). I found these to be intimately related, as the practitioners articulated them. They referred to the myriad ways in which healers change their practices to fit within both the medical and general community. These changes, which are fit within their particular approaches, effectively go from the process of defining and naming their practice, both during the interview and in their lived experience, to incorporating new techniques and tools. Of the three, Dr. Mario seemed determined to limit the latter, which he rejected as part of the current trend for the practice to become commercialized.

These codes were followed in frequency the two referring to the processes of accomplishing a proper alternative medicine practice. The themes were: defining alternative medical practice (12 instances) and debating the developments of the alternative medicine local scene (11 instances). These two may relate to the topics associated with the development of a profession that is not yet clearly and solidly established. Sylvia was less inclined to discuss this topic, which can be explained by her tendency to set herself as a very extraordinary practitioner and person. Her accounts of connections beyond the Dominican community brought me to ask her if she felt she belonged to an international one instead, which she not surprisingly denied; she was beyond worldly communities.
The process I tagged as *shaping the practice* includes four aspects: education, management of professional relationships, the clinical encounter, and the scope of practice. Each of these is discussed in detail below.

**Educating the General Community**

All three practitioners mentioned their involvement in public talks, whether attending to particular group activities or through mass media channels. They all see this as a way of impacting the community positively, and present it as a very altruistic activity. In their narratives, though, these are placed as aiding in a process of career development as well:

Dr. Mario: “...immediately after we came...to the country...we began a process of education through talks....we would go to wherever we were invited, and talk for free...”

Dr. Junior: “…I said to myself, the way in which I can impact is to repeat...the same experiment we did in Cuba,...so...we had a conference, in which I explained how I was going to try to block the pain without anesthesia [in a surgery where a cyst was removed from the back of a patient]...that was filmed...and published...”

**Managing a Relationship to the Medical Community**

Dr. Mario: “*in relation to the medical community, I would say that I got a normal welcome, because I handled things cautiously...I did not portray this medicine as confronting conventional medicine, but as an alternative...but without discarding the other stuff...as a matter of fact, I still don’t, because, before this, I am a physician, I have always considered myself as part of Medicine, right, so there were no confrontations.***

Dr. Sylvia: “*Now, really, is that I come in from the other side, through which there is a minimum of difference, the need for help and for self-help is not a part of medicine...I accept that, because my intention is not to struggle with differences...***

Dr. Junior, in contrast, having come from Cuba, where he functioned within a community of like minded practitioners, was generally geared more towards changing the medical community than to settling into it. He explains:
then, zass, I become in ’96 the Institute for Innovative Medicine... not as Dr. Junior anymore. What is the vision of the Institute? As any institute, to educate physicians... in the area of non-conventional methods... they were thirty in total, I functioned as a medical... advisor... in the sense that whatever dead-end they had, then I would go... I have always liked teaching, so I would tell them, no, let's get together on Saturday, to discuss the case...

To the question of whether he was remunerated financially for such intense involvement, Dr. Junior responds:

No, I was never paid for it; I did it so that this would continue to advance, it was one of the things that allowed me to be known, not so much the patients, but the physicians, whose patients I had to see... I was functioning as a laboratory, because I would not even touch the patient...”

Crafting the Clinical Encounter Itself

Asked if the questioning of the patient took a longer time in this kind of practice, Dr. Mario insists that the exchange takes longer, yet, he immediately adds that he had to admit he “did not always have enough time, the time we would like to have... thus, sometimes we see ourselves wondering what to do, if, if I see only four or five patients in an afternoon, then I would have to increase [the price of consultation] ” Dr. Mario comments that in order to balance these pressures, he developed a “nutritional profile” of 290 questions which the patient fills out at home, and which includes the many questions demanded by his more holistic approach. These questions, though the patient can fill out by her/himself because “this is done in a simple language...”

Dr. Sylvia, instead, charges per complete treatment. This is also a decision to balance the need for more time, with the need to be properly, financially remunerated:

A project is developed for the patient... I cannot charge per consultation because if I did, my time... would be too costly... so a value is provided for a global treatment... a budget is provided to the patient then, but... that budget he (sic) can pay gradually... without noticing, the patient comes 30, 40, 50 times to the clinic... and later, when the treatment is done, he is asked, now divide what you paid by the hundred consultations...
Dr. Junior, for his part, has focused on bringing together different modalities and elements. Having initially identified as an acupuncturist, he gradually included nutrition:

...I would tell them, in order to begin acupuncture, we have to first do a process of disintoxication...thus, that is how I did the first combination...I began to mix those two here, as I saw that it was important to discipline a person by sessions, through changes in their nutrition..."

But he had to bridge other aspects of it as well, including religion. So he told me about searching through the Bible for any mention of medicine, of healing. He recited a verse from Ezequiel 47:12, providing the reference, in which it is said that “the fruits would be for eating and the leaves for medicine...” In a process that he describes as emotional, Dr. Junior found that “wait, the Bible also talks about medicinal plants...” and that he then, was creating a “synthesis.” Indeed, working closer to religious and medical spaces, the process has been quite intense for him.

...back then, it is Dr. Junior, alternative physician...natural physician...in '92, '93, '94 begins the crisis that this is demonic...I said, wait, I have to defend myself here...that is when I came up with the new name, the Institute for Innovative Medicine...as something new, a new vision, a new mind of medicine...

And further, “notice that I go conforming myself as a hybrid…”

**Determining the Scope of the Practice**

After describing in detail the basis of his orthomolecular medicine practice, I asked Dr. Mario how come, with such contrasting approach, he had said he had no conflict with conventional medicine. The conflict was not within him, and he explained another way in which he had avoided it: “Oh, well, no, because in reality I do not practice, I mean, maybe there would be conflicts if I were a hospital physician, because my therapeutics would be totally different from that of the other physicians, but since my practice is private...”

To the question of whether her practice has been regulated, Dr. Sylvia responds:
Ah, no, no, I went focusing the clinic, really what is offered is a clinic of integrated aesthetics, at the level of therapies, to say something, eh, I have certifications of study...from schools in different parts of the world, that allow me to work...giving a massage, giving a talk or teaching someone how to eat, that is very different, because I am a nutritionist, I have taken eighty thousand trainings in nutrition...then, for that, you do not need...a title...but I abide by the law...I am not incurring...on the contrary, I refer my patients to them, and I work with clinical medicine, and send for lab tests, I send for x-rays, even though I am against it...I need to make people understand that this is not so odd ...I do not give injections...

And further:

here it has never been said that this is a medical clinic, it has never been said that work is done within a medical framework, I work face to face with many physicians, availed by Dominican law...but I use them as therapists...I do not complicate things, until things are legal...

But for Dr. Sylvia, the focus of the development of her practice is mostly on her capacity to transform the client through very personal resources:

**eh, the first thing that the patient does is to be in a pact with me...then they notice that there is a different energy, eh...they immediately notice that I am a physician with much self confidence, but my attributes have always been those of strength...I am very strict, very serious...to be able to help someone, one needs to have the self confidence, the character, a very defined personality to help educate another...because it is more about education than anything else...**

Again, in contrast, Dr. Junior reported getting involved at ever expanding levels.

He is concerned about medical education, "that is life, all of the enzymes, all of the vitamins...where every mineral goes...that is what physicians are afraid of, biochemistry, to grasp biochemistry, in other words nutrition...we get, maybe, four months of nutrition...” He is concerned about the production of natural medicines:

the [price of] the products is going to see the end of this practice...I just acquired a piece of land...just to grow medicinal plants...you could teach people how to grow plants, they can extract the active agents in their own houses...I keep on talking about how to access these plants...I would like to start here, with a botanist, a person who can tell them this is [name of a plant] when people come with their plant...we are going to have to get into that...
Though I found some similarities across all three cases studied, they were very different interviews and different narratives. I sought to get a sense of the issues that related to my research questions, however, I related to each practitioner very differently.

Profiles

Case I—Dr. Mario: The Socially Conscious Translator

- Translates medical jargon into common language for patients and the community in general. Does this in his radio program, and in his patient interaction.

- Has shaped his practice by carving out a space for a kind of parallel and equal practice: orthomolecular medicine. His account reveals his discovery of this ‘commonsensical’ yet thoroughly scientific approach to healing in which he has most faith.

- His relation to conventional medicine is unmistakably ‘in it.’ He sees an inevitable transformation coming to medicine, though. He is aware of the political and economic obstacles to that. He emphasizes his private practice.

- He is the least commercial of the three; charges the most modest amount for services. He defines his approach, in this and other respects, as being socially committed and morally based.

- His approach is singular (coming across clearly throughout the interview). He is not too invested in learning or combining new modalities.

- He has also developed his practice through a process of changing and educating patients, mostly individually, but also collectively, in groups that could be called educational or support groups. His practice has been built since long ago, by providing numerous gratuitous services to the community, free conferences and the like. Was one of the first non-conventional practitioners in the DR.

- His relationship to his patients is a traditional doctor-patient relation; that of a benevolent authority. He is simple in his appearance and communication; his facilities are very modest as well.

Dr. Mario has clearly situated himself within a solid, scientific, biomedical paradigm, though he is somewhat invested in the reaffirmation of the professional status of his approach. The way he deals with differences, then, which he defines as being of approach and choice of tools, is less compelling. Because he practices a "specialty" of
medicines that is scientifically supported, and even, “all of the specialties,” as he likes to define himself, he does not expect any strong confrontations. On the contrary, Dr. Mario is confident that medicine will have to move in the direction towards his kind of practice. He understands that political and economic interests are counter to that move, and, in that sense, he is also reassured by the moral and social choices that have shaped his practice. He is clearly concerned about the commercialization of medicine in both conventional and alternative medical practice.

Dr. Mario works with a couple of concepts that facilitate this stance where he remains within biomedicine while keeping such significant differences. One of them is an understanding of an intimate relationship between mental and bodily processes. For all purposes, one could say that Dr. Mario’s approach is holistic and challenges the mind-body split. However, within his explanation, the mind itself, and its interaction with the body, are taken to be one of biochemical reactions:

...okay, that person comes here from the hands of four specialists, but when I analyze what is the situation, I see that what the person has is hypoglycemia, and that the crisis of hypoglycemia is causing the palpitations, the headache, the nervousness, and even, a compulsive appetite. Those four things, then, by correcting the hypoglycemia...are going to disappear. Thus, that is the difference resulting from looking for, and seeing...the biochemical imbalance in the organism.

A concept of empiricism, on the other hand, is a resource for a simple explanation of the difference between Dr. Mario’s practice, and that of unorthodox, not formally trained healers. While medicinal plants may work by altering biochemical processes, their mechanism of action is not established. Their use, Dr. Mario said, results from repeated trial and observation. He does not see this as positive or negative, and he actually incorporates learning resulting from empirical observation in his practice, by diagnosing illnesses without testing, or utilizing medicinal plants he has just experienced
as being effective. However, it is certainly knowledge of a lower order than the scientifically established resources provided by the orthomolecular study of the effects of vitamins and minerals: “in my practice, I utilize natural resources, such as plants’ leaves, _eh, in addition to the basic, which is the use of nutritional supplements..._”

**Case II—Dr. Sylvia: The Chosen One**

- Her practice is built around the special gifts and abilities she has been granted by God, and which were obvious since she was a child. Access to her, interaction with her, her narrative, everything conveys a sense of extraordinariness, and otherworldliness. In other ways, she is a beautiful woman, physically fit, engaged in sports and other social activities, and living in a fancy house.

- The relationship between Dr. Sylvia and her patients is crucial. She is invested in transforming them at a very profound level. She calls it “genetic reprogramming” or “therapy at the level of the cells.” She is very strong, communication with her is difficult. Patients have to overcome a period of adjustment to her style. Interestingly they indicate that she needs to be strong to gain respect, and that such difficulties subside as the treatment progresses. They report that she is a devoted healer usually willing to go beyond the call of duty.

- Dr. Sylvia does not advertise, her clinic does not have any signage and she does not take any patient. She related that the people that come to her are sent by God, and that they become her way of getting new patients. “But only those that are meant to be will get there.” She has shaped her practice through her very personal approach. Her demands for nutritional and lifestyle are high. Her support and the strong focus of her practice are congruent with these demands. She is a catalyzer of changes, and a committed educator.

- There is a lot of mystique about her practice, the way her house is decorated is very important to her practice. Contrary to the other practitioners, there is much more symbolism in every aspect of her practice. However, she is careful to describe herself as practicing from outside medicine, but close to it and from an equivalent standpoint. She takes pride in relating the acceptance and access she has gained to the Dominican biomedical spaces and structures. She said that she studied in China and Tibet, and she has an extensive number of diplomas on her wall, mostly on newer, and cosmetic health related therapies.

  The doctor defines her practice as “*alternative and preventive medicine at the bioenergetic level.*” Alternative, she explains, because it incorporates different methods. Her explanation conveys more a sense of it being diverse, an articulation of methods. She
spoke about using all these methods to bring the system into harmony...referring to the body. Preventive, she added, because it deals with difficulties, not illnesses. She also said she works at the energetic level because it is the one that integrates other levels, where change can be affected the most.

Dr. Sylvia’s work is unmistakably based on principles other than those of biomedicine:

*I don’t know if you notice that my house is full of images, of angels and Jesus…their intention is to help the human being that is seeking help…that is why in my house there is no signage…that is why in my house you will never see anything that affects the psyche, on the contrary, we recuperate you self-esteem, clean your aura, which has been demonstrated here on earth…physical, mental, emotional…how they allow contact with anything that may affect your life…through an internal and external cleaning…*

Central to her understanding of health, is a concept of energy she claims every one of her clients understands, or else they could not be there. I say claim, because I found out about Dr. Sylvia through a priest whose mother she treated very successfully. Dr. Sylvia brought this woman back from the need to have weekly dialysis to leading a normal life. As I recall, they struggled with her personality and choices of treatment, and did not have to necessarily agree with her beliefs.

Dr. Sylvia’s treatment included massages and cleansings (I do not know exactly what the latter consisted of). In any case, her treatment was centrally based on food as medicine. It included a journal the patient kept, reporting in detail about the frequency and characteristics of excreta and urine, as well as the patients overall mood and physical state. In this journal, she would then write down, at every visit, a description of what the food for the patient and its preparation should be, based on the information provided by the patient. Visits were long and intense, her communication challenging and upfront. Dr. Sylvia expects a full commitment from patients to be consistent and faithful to the diet.
But most importantly, she argues, the relationship to food itself must change: “my biggest aim is not so much that they learn to prepare their food, but that they understand that the food is part of their healing...it is a concept of loving the food...” She compares the relationship one is to develop to one’s very individualized diet to that one has with a lover, and relates that her patients do achieve that state. With this new relationship, comes healing, she insists, the love for the food translates into love and respect for one’s body.

Her clients, Dr. Sylvia expects, are thus, also, a selected bunch of special individuals that are leading a different kind of life. Changes are expected at every level of their living, and, as per a book of testimonials she keeps, encompassing changes are not only the demands of her treatment, but also, the outcomes. I found in her clients a very strong sense of loyalty, though that may be the case only for those that embrace her whole philosophy, which was not the case of the woman whose case I learned about in detail. This means that Dr. Sylvia may tailor not only the diet and other manual treatments to each patient, but also, the level of engagement with her beliefs. Still, she insists: “here we work, we educate, we teach the client to leave the past behind...” She has also a position regarding environmental and social toxins which place humans, as well as animals and vegetation, at the brink of extinction. Her patients are encouraged, thus, to take cover, as when one protects oneself against a storm.

So, before a client commits to the treatment, a clear challenge to take on that intense journey is put before them. I did witness Dr. Sylvia sending a patient home to think about her evaluation, which included not only physical but also mental, attitudinal states that were self-destructive, and to come back if she was willing to basically change
her life. The patient was in tears, and told me later she was moved, compelled. Dr. Sylvia explains:

*I thought that I...was going to give people a lot of understanding through my hands...and I never thought it would be so much through, at a verbal level...obviously I transmit a lot of healing through my hands, when I am giving a massage, when I do a therapy or when I am doing a cleaning...they are one of my great powers, but in reality, my greatest power is to teach people, when they hear the way I talk, to change their behavior...*

Power is a central element in Dr. Sylvia’s relationship to her patients. It would seem that while the other physicians are trying to play down the hierarchical nature of their relationship with patients, this practitioner thrives on it. From her title, to aspects of the setting of her practice, to her interest in belonging to the medical community, and her use of both, conventional and alternative medical resources as referrals, she artfully incorporate elements of biomedicine into her practice, in accordance to her status as out of it, but in a close, equivalent position.

**Case III—Dr. Junior: The Precocious Child of Medicine**

- In contrast to the other two practitioners, Dr. Junior is on a mission set beyond his impact on individual patients: *changing medicine*. His dad is a well known medical doctor in the DR.
- Accordingly, his practice is extremely ambitious and active. This may have to do with him starting his practice not so long ago, and in such dynamic times. But, on the other end, this may make his relationship to his patients less personal.
- He is actively invested, much more than the others, in a process of naming not only his practice, but *the practice*, and of affecting its evolution. He incorporates modalities and techniques, engaging the medical and general community, but most of all, acquiring fancy technological equipment and designing a dynamic ‘innovative’ medicine center. His efforts are fit within a clear, complex paradigm that brings biomedicine to be the one being incorporated. He is careful to communicate that, though, and seems very aware of all the difficulties. He is sincerely invested in a process of impacting Dominican society. However, Dr. Junior is ambitious and competitive, and does not forget his personal rewards.
- He is very involved in the development of a graduate program on alternative medicine. His services are expensive and the limits of his practice ever expanding.
His narrative is as overwhelming with information and passion as he is overworked.

- He sees himself as an educator, yet he educates through his many efforts at engaging the medical community and general society, and less through an investment with individual patients.

- His clinic is impressively set up, and it appears that more and more he is using technology to provide built-in scientific support for his practices.

Dr. Junior works with a complex and dynamic conceptualization of health where new elements are added and relationships are expanded. In this paradigm, integration is not only possible, but absolutely necessary. Having inherited this articulation from his training on Traditional Chinese Medicine in Cuba, Dr. Junior is comfortable with methods without scientific base, or with concepts not fully understood, if they have been found to meet the needs of successful treatment; to him, that is medicine: “[energy healing] is not scientific, but they accept it and observe it, I learned that from the Cubans…the Chinese and the Vietnamese were there for a long time…everything they [the Cubans] were told they observed…” His accounts about this integrated education are not about new theoretical constructs, but about experiences of an encounter of practitioners and tools:

_The Chinese would set their needles…the thing is that when the physiologist would say morphine is being produce, adrenaline is being produced…and then blood would be drained and looked at in the microscope…the Chinese would say…yeah, right, right, as if what was happening was beyond that. There were always conflicts between my teachers…maybe I inherited that part too…within my career, there is a little, a little conflict, but, but positive…a pull from one side and the other…I can use the conventional stuff, but I can also well use the part that is totally heuristic, the bioenergetic part…_

Knowledge acquired through observation is validated by its effective application.

Dr. Junior’s practice could be defined as one of pragmatic holism. In other words, even though his understanding of health and the functioning of the human body are
encompassing and sophisticated, religious aspirations and mental states are acknowledged and understood to serve the goal of attaining physical health, to be necessarily congruent. Bringing it all together in talk, in his interactions with patients—to whom he explains things in as much detail—or in his ever growing clinic and practice; Dr. Junior embodies this integration and its tensions.

His use of technology, a very salient part of his practice, also fits in with the need to facilitate treatment, and with the integrated, pragmatic approach of his background. Asked what did all of that technology represent he referred to the “crisis” he had confronted in the early 90s, and added “it is the only thing that can survive here.” He acknowledged that he has made some choices, as he develops his career, to facilitate his acceptance in the Dominican community. Because of it, he stopped having yoga groups, hid a statuette of a Chinese healer he had received at graduation, and became, not a classic acupuncturist, as his classmate in the DR, or his Cuban professors, but a “mixed one:”

*I try a lot to mix the technological with the clinical...the main question you could ask me is...what is the most important aspect of this process for you? That I can run the tests myself, and at the same time, see the client in real time...if I send for a blood test, they are not going to have the impression of a person whose split nails I just saw, of an iris that is more marked on one side than the other...I am the one who sees that...I have more detailed information than the person to whom I sent the blood, who does not even know the patient, who is just going to send me back numbers, because it is only numbers that they provide...*

**Discussion**

A context of increasing dimensions revealed itself as closely related to these practitioners’ choices. The following is a review of some of the actors, events and phenomena that added meaning to my interpretation of these cases.
There was a distinct presence of health related matters in the media in the DR while I was there. I wondered if it had anything to do with my attention being sharpened by my interest in such matters. My finding it significant results from contrasts with my previous experiences. I should note that it was mostly advertisement of medication or trendy health related subjects. Could this be attributed to what medical sociologists have called the medicalization of society (Zola, 1994; Fox, 1994)? This occurred to me because the noticeable new manifestations of health concerns seemed to be initiated by private companies, such as media selling appealing, many times recycled international articles and research reports, and paid advertisements on the radio and TV. Could it be that health has been recognized as a hot selling article? In any case, I could also see a resistance to this trend in people who found the contradictory news and the expanding concern overwhelming. It seemed to be regarded at times with suspicion, and at others, as another middle class luxury.

Most importantly, I would argue that alternative medicines are serving the process of medicalizing society; or that they are quite compatible with that process. Regardless, this seems to be an important part of the context in which this renewed form of alternative medicine is being practiced in the DR. I am guessing that these two social developments are closely related, and that the alternative medicine practitioners I interviewed, and their practices, illustrate a form of global/local relations. These global/local relations can be thought of as providing insight into the definition of these two concepts, and help us rethink them. I am placing this aspect of my study in relation to debates I have read about in postcolonial studies. Garcia Canclini’s arguments in Transforming Modernity (1992) also came to mind. May the practice of alternative
medicine in the DR be seen as an active response to global capitalist trends? How would this apply? Would his theory be helpful in underscoring processes of adaptation and cooptation of resources both ways?

Alternative, natural and traditional medicine are referents to worlds that are increasingly collapsing. However, these names seem to be only temporarily interchangeable. It is my guess that this process may be reversed as those worlds are reorganized, or that some of these labels will become meaningless. People are, among other things, involved in the process of assigning the proper labels to the different products of current processes. Indeed, the tendency is more to think of products than of knowledges, and that, only, may privilege the use of one term over the other. When I asked Dr. Mario if he knew of the international push for regulating traditional medicine, he responded he knew about the ongoing FDA efforts to regulate vitamins and herbal supplements. Practices and meanings will probably follow the lead of material products, in the market modeled context of globalization

Globalization has to do with a deliberate effort at organizing the world economically and politically in a particular way. The presence of non-Western medical practices, of herbal medications and vitamin and mineral supplements is obvious at almost every level of society. This is so, even when their presence, the way they are incorporated into people’s lives, is also different at each level. On the one hand, judging by the reaction of people with low educational levels with whom I interacted, health-related news seems to be inevitably powerful. Health advice provided on the Catholic radio station, for example, gets the attention of the people. This practical, preventive
health advice becomes, then, a kind of competition for biomedical interventionist approaches and supports the work of practitioners such as those in this study.

Thought about as a middle class trend, though, reactions to it are mixed. Many people, judging by the growth of health food stores and alternative practitioners in lower class neighborhoods, are emulating these new health meanings and practices. At the same time, lifestyle changes impose pressures on people, and they react to them with distrust attributed to the commercialized characteristics of the health behaviors advocated.

As it has been argued in the US, this openness to new health practices may be pointing to a health crisis. The new Health Law and reform in the DR do indicate a full blown health crisis. So far, though, and as per the indicators used, it points more to a crisis in the health delivery system, than in people’s health. The social and institutional responses seem to correspond more with a particular paradigm than with the health problems that are so obvious in the Dominican population. Those responses, again, are for increased visibility and strength of medical services provision. A population more educated about the individual pursuit of health advocated by this trend of alternative medicine, including lifestyle changes and product consumption, seems highly compatible.

Nevertheless, in the context of the health sector reform and the renewed interest in health matters, the outcome for medical practices is unpredictable. It is hard to see how the in/corporation of the public and private sectors would play out with the traditional role and practice of physicians. It seemed that all involved in the production of health services, in its myriad ways, were responding to the increased dynamism of the moment. One can anticipate that hierarchization will increase. Participants’ narratives about individual efforts to solidify their practices through validation, legitimacy and
professionalization, especially in the context of similar collective efforts and other related phenomena, become more meaningful. I will bring these aspects of their narratives to a higher level of abstraction, by relating them to research and theory developed in those areas.

**Seeking Legitimacy**

The question and the quest for legitimacy are central to the renewed negotiations over coexisting, interacting medicines, especially at the level of the practitioner. In two provocative studies, MacCormack (1981) and Fassin and Fassin (1988), utilize Weber’s classification of legitimacy to analyze the resourceful and much contextualized processes through which practitioners of non-conventional medicine are seeking legitimacy. The Weberian types are: rational-legal, traditional, and charismatic. The Fassins (1988) find this classification more effective “to explain the work of redefinition of social boundaries in the medical field” (p.353). While I found these practitioners working on the boundaries of medicines, and in some ways in their margins, this taxonomy is important in that it illustrates the multiplicity of resources being utilized, simultaneously, or alternatively, by these individual practitioners. The Fassins (1988) found their Senegalese healers defining their practice within two systems and social spaces of legitimation. That is not the case for my practitioners who did not have a local community of traditional healers and patients to refer to.

“Rational-legal legitimacy arises from the idea of a society maintained through impersonal, efficient, procedures…not exclusive to the Western scientific tradition.” Traditional legitimacy develops through time as “qualities of merit, valour and holiness become associated with a corporate group such as a lineage, or a sodality” (MacCormack, 1981, p.424). McCormack finds this to be associated, in Africa, with the wisdom of
ancestral times, and reproduced through loyalty. The size and the pace of a society seem to have to do with this as well. “Charismatic legitimacy is analogous to the idea that God and His manifestations cannot be anything other than pure legitimacy. People of exceptional heroism and sanctity present a vision of hope and health. Believers follow in obedience to attain those goals. They have personal trust in the extraordinary quality of the healer and his or her revelation” (MacCormack, 1981, p.424-5).

But MacCormack (1981) talks about a kind of legitimacy that is achieved in the direct relationship between practitioner and client. In the medical encounter, thus, “people invest legitimacy in the healers to whom they turn” (p.424). The client believes in the healer, seeks his/her treatment, so “s/he can undertake the quest for health with conviction.” The healer has legitimacy to command “uncoerced obedience” from the client and to the whole system the practitioner represents. Comparable healers in places such as where I reside in the US, a University town, are more inclined to seek rational-legal legitimacy through academic/scientific means. Their clients, middle class and educated, will respond more to this kind of legitimacy. In approaching the University community of researchers on alternative healing practices, they do use their clients to gain initial recognition from the academic institution, and, then, use the connection to the University to boost their clients trust.

The relevance of patients’ trust for these practitioners’ “client-dependent practice” is obvious. Their investment in patient education is probably directed at reaping the benefits of this factor. They did take more time with patients—again, not so much Dr. Junior, and particularly Dr. Sylvia—seemed to be more available for other issues and beyond visits, and to establish a more personal relationship with clients. Dr. Mario
appeared very accessible, and held support groups with his clients. In other words, I would argue that participants in this study are invested in the development of both kinds of legitimacy, rational-legal and client related, and that, as in the case of the healers here in the University community, the two feed each other.

In the DR, indigenous, rural healers may be oblivious to scientific standards and academic recognition. It is a question posed by this research, whether through some of the changes we have identified, they are becoming aware of a changing social landscape regarding their practice. This is expressed so evidently in the inclusion of new terminology to refer to it, which brings with it changes in meaning and health practices and may make them dependent on prestige achieved by the standards of the greater society. Nevertheless, non-orthodox, traditional healers usually have alternative status markers achieved in parallel, local community hierarchies.

Again, this is not the case of my practitioners, who were mostly conventionally trained physicians, had urban and international practices–one of which built on her foreign status–and who seemed to be aware of the global market, if not policy, trends regarding alternative medicine. Their status was defined within the larger society and depended on formal social assets. These practitioners differ from traditional healers in the material and social resources at their disposal, for legitimation and development of their practice. Different from traditional healers developing indigenously in rural communities, these practitioners’ status was not achieved, but mostly ascribed. Centrally building on charismatic legitimacy, Dr. Sylvia has achieved recognition through many years of practice and patient referrals, however, she did use and display diplomas and certifications as credentials. Dr. Sylvia’s medical status was less clear, however; again,
she was invested in securing that status through several means, including those that would fall into the rational-legal sphere.

Participants in this study, regardless of medical status and to illustrate the power of legitimating processes, referred patients to other physicians, and had patients referred to them. This speaks volumes of their situation within the medical community. They sought and attained legitimation from this community by means that attest to the future of alternative medicine practice in the DR. In the Senegalese context from which the Fassins (1988) reported, which has an impressive number of traditional healers, new forms of legitimation are being sought and obtained. This is, in turn, transforming the boundaries of the different medical practices. The media and religious and political communities were involved in this process, thereby shifting the debate from the scientific sphere of influence to one of the general society.

Furthermore, the Fassins (1988) bring up two important qualities of medical systems: the dialectics of medical systems (i.e., the power at stake in health practices), and the dynamics of medical systems (i.e., permanent changes in their definition). They aim to bring attention to questions about the balance of power between practices, and the ways in which practices evolve. It is the recognition of unequal relations between medical systems that allows them to understand the differences in strategic practices of legitimation. For example, they make the point that practitioners of scientific medicine practice within standardized spaces, rely on the same corpus of knowledge and obey established ethical principles. The reality under which traditional healers operate is very different, allowing them more space for creativity, but leaving them with greater challenges. Again, the practitioners in this study seem to be operating within the familiar
context of private practice, and so closely relating to the biomedical community that in their practice biomedical standards are easily recognizable. Yet, they are deriving epistemological resources from more than one body of knowledge. It becomes necessary to look at the different elements of their eclectic practice; we will attend to this issue further ahead.

The Fassins (1988) interpret the current international interest in traditional medicine as an indication of the failure of biomedical health systems, especially in countries were they have been so precariously operating. However, the outcome of these processes is different in each context. In the DR, the traditional medicine component seems to be imported, as almost everything else. Legitimation of alternative medical practice is achieved within the biomedical social space, which is necessarily open to international changes in demand and standards.

Many of the resources and recourses participants in this study were using for shaping their practice can be said to have legitimacy as a goal. This makes sense given the emergent, burgeoning status of their practice.

**The Process of Professionalization**

Questions of professionalization involve control over the possession and the use of knowledge. Quah (1989) develops an argument for the use of an integrated approach that incorporates several conceptual frameworks for the study of processes of professionalization. This integrated approach recognizes that the actual and perceived power of professions varies among groups, times, geographical areas, and, I would argue, individual practitioners. Again, this last category may have great variability through the interaction of many different elements; greater than usual individual difference may be granted in this case.
The “process approach” focuses on the historical development of an occupation.

Some of its elements were identified in the strategies of my practitioners:

- Fulltime formal work: All of these practitioners did. A question is posed about those practicing in more humble environments. Previous personal experience tells me that they work in their homes, and go about their lives unless a client shows up. Dr. Sylvia, working in her home, had a formal space, with desks, office and therapy rooms, and a formal schedule.

- Change of name to sharpen the boundaries of the domain of the practice: An important aspect of their definition and shaping of their practice. The document of the new Council that will organize these practitioners gives relevance to this in its official document as well.

- The setting up of a national association: The National Council is being developed. Differences come up, yet every participant acknowledged it and gave it credit in the process of betterment of the practice.

- A code of ethics: Apparently built on a biomedical one, as much as many aspects of their practices. Included in documents for the development of the Council.

- The establishment of a training school or its equivalent: This is also already happening. Dr. Junior is the one most interested and invested in this one.

- Seeking legal and public support or recognition: This is happening at both the individual and collective levels. Public appearances are an important part of the practice of all three. They are all welcoming the regulations coming as a result of the health sector reform and the development of the Council.

The “structural-functional” approach focuses on distinctive characteristics and structures that differentiate professions from other occupations:

- The possession of, or claim over, a general and systemic body of theory: This is being articulated through individual and collective efforts.

- A norm of authority, that is, freedom from external control: Inherited from biomedical practice, they all recognize and/or exploit the freedom and control afforded by this form of practice, especially as they delimit its boundaries.

- A norm of altruism or the claim of being devoid of self interest: No longer necessary for medicine, this was a recurrent theme in Dr. Sylvia’s narrative. In this she is not like the physicians.

- A norm of authority over clients, or the need to have the client’s trust: Again, this can be said to be inherited from biomedical practice, which is clearly their model.
The status of the practice makes this a precarious privilege, especially for Dr. Sylvia. She is invested in that process throughout her interaction with patients and with me. She is conscious of controlling time and access.

- A distinctive occupational culture transmitted through the socialization of students or recruits: This is inexistent, and one of the great concerns of Dr. Junior. Accordingly, practices are very heterogeneous.

- The recognition of the preceding five characteristics by the law and the community: This is not clear, but they are not in any critical position either. The two physicians are in a much better place, as such, are in a much better situation. Community recognition is being achieved through exposure in the mass media.

The power approach focuses on two aspects: “the power needed by an occupation to acquire professional recognition” and “the power such profession wields once it has achieved that position” (Quah, 1989, p.451). “[T]he ability of an occupation (or its leaders) to obtain and retain a set of rights and privileges and obligations from social groups that otherwise might not grant them” (Quah, 1989, p.451; borrowed from Ritzer 1977). This includes:

- “margin of indetermination” or the degree to which a task can be routinized: Indeed, while working within a model resembling medical practice, there is significant innovation these practitioners are allowed. Given the current need to differentiate from conventional doctors, which is one of their important defining issues, I see them as continuously balancing these two.

- “control over areas of uncertainty” that is, the uncertainty of the client regarding the nature and/or possible solution of his/her problem: Relative to biomedicine, the practitioners in this study allow the time and space to withhold or display their control over such uncertainty.

- “ideology,” or how the profession justifies its “privileged status:” Again, inherited from biomedicine. This may explain why these practitioners insist on working so close to the biomedical model.

Questions of knowledge control, and power, are also relevant in processes of deprofessionalization or proletarianization. While these may not be directly relevant to the experiences of these individual practitioners, they are so indirectly, as they may be currently engaged by the medical community, especially in the US, which is again, of
great influence in the DR’s context. These processes have been related to decreased levels of consumers’ ignorance and the attendant demystification of professional activities, and to physicians becoming employees of large public and private corporations or institutions with increasing demand for democratic accountability (Quah, 1989, p.452).

The contrasts between the US and Dominican contexts are also relevant. The Dominican community does not have medical information as readily available as its US counterpart, so that physicians’ prestige is not being challenged in the same way. Also, biomedical practitioners are not under similar pressure to operate within private institutions or public corporations. I could not anticipate how this is going to change with the new health reform. These events may, again, be affecting these practitioners indirectly.

The current health reform being pushed by international organizations, which can be said to represent the interests of US elites, may well transform biomedical practice in the DR with unsuspected outcomes. Governmental interventions can be a bigger threat to professional power (Friedson 1986 as quoted in Quah 1989, p.452). However, at least within underdeveloped countries, governments are “unwilling to impose restrictions on the market forces in medical care...[or, better phrased] unwilling to interfere with international economic forces in the medical market” (Gruenbaum, 1981, p.59). These dynamics may or may not be beneficial for the practitioners of this study, who are thriving on the wave of related international advances.

On the other hand, individual manipulations of power channels are of significance in the DR context. Physicians are in many important positions in the DR, including their traditional post as head of the Health Secretariat. The profession enjoys great prestige
within Dominican culture, and their income is high in comparison to that of other professions. This advantageous position of physicians may account for the relative ease with which these alternative practitioners are finding a space within the medical community.

Quah (1989) comments, “Singaporean physicians’ internal organization emulates that of the medical profession in industrialized countries. This feature is to be expected because the practice of modern medicine in most nations has been ruled by international standards…a national medical association, an academy of medicine or its equivalent…and international recognition of its specialists…” (Quah, 1989, p. 463).

Navarro (1974) quotes the assertion of an exodus of human health resources dating to the early 1970s, indicating that 30% of medical school graduates migrated each year from the DR to the US, while in the country, at that time, half the nation’s newborn children were dying before reaching the age of five (p.13). These numbers, which can only be expected to have increased, testify to the aspirations and the nature of the Western trained medical professional in the DR.

Those who stay actively seek and reproduce biomedical standards for medical practice and health behaviors. The practitioners in this study, for example, did not seem to be confronting the infectious diseases epidemics reported in health reports about the DR. AIDS, a current, significant health problem in the DR, moving beyond the social space of particular groups, but still a problem for lower income people, was never brought up in these interviews. Their clients are mostly middle class, and, as per Dr. Mario, the illnesses they are dealing with are mostly degenerative. He listed chronic
gastritis, diabetes, arthritis, hypertension and obesity. Their patients are otherwise seeking individual, preventive measures.

In the DR, the profile of the medical practitioner is heavily associated with high standards of practice and lifestyle. A process of professionalization, thus, can be said to have those standards as its goal. The local association of biomedical practice with upward mobility, and the more fundamental dissociation of biomedicine with a fair distribution of health resources, be it epistemological or material, affects the professional development of alternative medicine under this model. The displacement of popular, unorthodox practices may be related to the social dynamics in which the former is thriving.

Finally, “[t]he ethnographic record suggests that complex societies tend to be medically pluralistic, with unorthodox and authorized health care approaches coexisting, however uneasy. In his discussion of chiropractic, Wardell (as quoted in Rubens, Gyurkovicz, and Hornacek, 1995, p.26)…identified five potential relationships between orthodox and unorthodox health care disciplines: the ‘ancillary’ profession, which is subordinate to physician supervision; the assimilated profession, in which orthodox medicine adopts a formerly unauthorized practice; a ‘parallel’ profession, whose standards, education and interventions approximate those of the dominant profession; the limited profession, which claims certain portions of the body or functions as its area of expertise…and the marginal profession, which is ‘stigmatized by a dubious theory and is unacceptable to orthodox scientists and physicians” (Rubens Gyurkovicz, and Hornacek , 1995, p.26). As these authors put forward, the experience of particular practitioners can be used to map key features in the landscape where medicines coexist. These practitioners seem to be negotiating a practice that fits between the ‘parallel’ and the
‘limited’ categories. I would argue that the development of the alternative medicine profession in such status further moves indigenous, unorthodox practices in the direction of marginality.

**Tracing Boundaries of Medicines: Medical Systems Reconsidered**

Process of interaction between global and local knowledges, when they are medical knowledges, bring us to think about how do they fit within medical systems. Press (1980) has proposed that we differentiate medicines (the bodies of knowledge and meaning) from the medical systems, which include an articulation of the former, within institutions and other kinds of social formations. Medical systems, thus, can incorporate different medicines, and their attendant practices.

But medical systems have also been described as cultural systems (Kleinman, 1980) to underscore their cultural relativity. The social scientific push has been to highlight the cultural grounds of biomedicine, which presents itself as universal and acultural. In contrast, non-Western medicines are framed as heavily determined by cultural specificity, which is constructed as opposite to an epistemological status. In an effort to bring forward their epistemological import, postcolonial theorists have insisted on looking at medicines as systems of knowledge. This brings up important aspects of internal and external power dynamics, as captured in the concept of discourse, and in reference to the mobilization of power and resources.

Building on these concepts, I propose that medicines, as knowledge systems and cultural systems that can be built into social medical systems, are not wholesome, coherent, static entities that ever exist apart from each other, except as analytical categories. When one looks at their history or contextual interactions, or at the specific context of the DR, they have developed in relation. And further, I would argue that the
health practices of individuals and groups, as these medicines interact with/in other social formations, are the prime space where medicines meet and mingle. As illustrated in the practices of the participants in this study, and of their patients and other social actors, it is in the nature of medicines to be amenable to fragmentation, under at times deliberate social pressures.

Even when a relationship of power differential and of incorporation is acknowledged, the concept of a paradigm tends to conceal elements of history and interaction. What gives a paradigm its power is its presumed preeminence, the set of basic concepts that are agreed upon, that make statements and outcomes possible, and that set the premises that engender particular questions. Systems of knowledge in the hands of individuals and groups are more dynamic, contingent, assorted from a set of resources.

The stories of the participants with respect to a vision of medical practice are a hybrid between paradigms. The elements of this hybridity can be categorized when these systems are understood as theoretical constructs and organized into a broader analytical tool: a matrix out of which practitioners, individuals and groups actually choose elements without much regard or awareness of any coherence of the paradigm and to serve instead practical needs (see Table 6 at end of chapter).

It struck me that aside from that coexistence, and in correspondence with Kleinman’s (1978; 1980) arguments about the ongoing constitution of medicines in the practice of individuals and groups, each of these practitioners is bringing together an amalgamation of medical therapies and practices without thinking too much about their philosophical and/or paradigmatic import. This individualized articulation of medical
practices, modalities, therapies and instruments is also interacting with these practitioners’ interpretations of current trends and issues. It seems to me that it would be helpful to analyze their practices by breaking them into three categories: a) basic concepts/principles; b) techniques / methods of treatment; and, c) delivery/provision, scope.

This conceptual map facilitates the recognition of all the different elements, at time contradictory, with which the practitioners enact/accomplish their practices, or with which they put together their narratives. This complicates classifications, but it does not mean, I believe, that we do not live within structures, both discursive and material, according to which (to include both the constraints and resources they provide) we organize our experiences. I would argue that hierarchical, power structures function as a sort of social gravity, facilitating the reproduction of some choices and hindering others. The processes of health sector reform in the DR are very much serving those purposes. They embody mechanisms and forces of power.

The three cases of alternative medicine practice studied here are situated and articulated within the current state of the Dominican health system. As part of it, they interact with current epistemological and cultural trends; they are affected by different levels of socio-economic structures, and respond to local health demands and choices, which are in turn, also determined by social organization. The importance of zooming in to the health reform and the greater context of alternative medical practice is the need to understand that these are articulated as part of ongoing processes of resource mobilization and social reforms according to the needs of an international biomedical system. Within this system alternative medical knowledges are incorporated, redefined and reorganized.
### Table 5: Codes-Primary Documents Relation

**Documents 1, 4-Dr. Mario**  
**Document 2-Dr. Sylvia**  
**Documents 3, 5-Dr. Junior**

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Table 5. Continued

Documents 1,4-Dr. Mario
Document 2-Dr. Sylvia
Documents 3,5-Dr. Junior

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<td>Recourse: combining modalities</td>
<td>0</td>
</tr>
<tr>
<td>Recourse: naming the practice</td>
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</tr>
<tr>
<td>Recourse: Professionalization</td>
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</tr>
<tr>
<td>Recourse: religious connection</td>
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<td>Recourse: scientific proof</td>
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<tr>
<td>Recourse: settling</td>
<td>1</td>
</tr>
<tr>
<td>Recourse: shaping the practice</td>
<td>6</td>
</tr>
<tr>
<td>Recourse: validation thru visibility</td>
<td>2</td>
</tr>
<tr>
<td>Recourse: validation recognition med.</td>
<td>5</td>
</tr>
<tr>
<td>Recourse: validation recognition gral.</td>
<td>2</td>
</tr>
<tr>
<td>Relations-medical community</td>
<td>0</td>
</tr>
<tr>
<td>Result: acceptance</td>
<td>0</td>
</tr>
<tr>
<td>Result: access</td>
<td>0</td>
</tr>
<tr>
<td>Session structure</td>
<td>0</td>
</tr>
<tr>
<td>Session time</td>
<td>1</td>
</tr>
<tr>
<td>Validation through med status</td>
<td>2</td>
</tr>
<tr>
<td>Totals</td>
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</table>
Table 6: A Theoretical Approach to Medical Practices

**1. WHAT—Basic Concepts: Health/Illness**

<table>
<thead>
<tr>
<th>Energy/Spiritual</th>
<th>Individual</th>
<th>Collective</th>
<th>Social/Physical Environment</th>
<th>Energy/Spiritual</th>
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</thead>
<tbody>
<tr>
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<td>Encompassing</td>
<td>Body</td>
<td>Body</td>
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<tr>
<td></td>
<td>Holistic</td>
<td>Body Integration</td>
<td>Body Integration</td>
<td>Body Integration</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Body/Mind</td>
<td>Body/Mind</td>
<td>Body/Mind</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Bio+Psycho+Social</td>
<td>Holistic</td>
<td>Bio+Psycho+Social</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Full</td>
<td>Community</td>
<td>Community</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Energy/Spiritual</td>
<td>Holistic</td>
<td>Holistic</td>
</tr>
</tbody>
</table>

**2. HOW—Tools/Method**

**A. Diagnosis**

<table>
<thead>
<tr>
<th>Individual</th>
<th>Collective</th>
<th>Social/Physical Environment</th>
<th>Energy/Spiritual</th>
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</thead>
<tbody>
<tr>
<td>Lab tests</td>
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<tr>
<td>Technology</td>
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<td>Technology</td>
</tr>
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<td>Physical exam</td>
<td>Physical exam</td>
<td>Human interaction</td>
<td>Human interaction</td>
</tr>
<tr>
<td>Observation</td>
<td>Collective indicators</td>
<td>Social conditions</td>
<td>Social conditions</td>
</tr>
<tr>
<td>Intuition</td>
<td>Human interaction</td>
<td>Consideration of interaction</td>
<td>Intuition</td>
</tr>
<tr>
<td>Human interaction</td>
<td>Observation</td>
<td>Observation</td>
<td>Insight</td>
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<tr>
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<td>Analysis</td>
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<td>Human connection</td>
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### Table 6. Continued

#### B. Treatment

<table>
<thead>
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<tbody>
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<td>Chemicals (direct)</td>
<td>Chemicals (direct/indirect)</td>
<td>Chemicals (direct/indirect)</td>
<td>Chemicals</td>
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<tr>
<td>Surgical</td>
<td>Technological</td>
<td>Technological</td>
<td>Technological</td>
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<tr>
<td>Physical/Human</td>
<td>Physical/Human</td>
<td>Physical/Human</td>
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</tr>
<tr>
<td>Herbs-processed</td>
<td>Group work</td>
<td>Group work</td>
<td>Group work</td>
</tr>
<tr>
<td>Foods-processed</td>
<td>Herbs-processed</td>
<td>Herbs-processed</td>
<td>Social reforms</td>
</tr>
<tr>
<td>Herbs-natural</td>
<td>Foods-processed</td>
<td>Foods-processed</td>
<td>Social changes</td>
</tr>
<tr>
<td>Food-natural</td>
<td>Herbs-natural</td>
<td>Herbs-natural</td>
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</tr>
<tr>
<td>Food-natural</td>
<td></td>
<td>Food-natural</td>
<td></td>
</tr>
</tbody>
</table>

#### C. Practice Setting/Scope

<table>
<thead>
<tr>
<th>Individual</th>
<th>Collective</th>
<th>Social/Physical Environment</th>
<th>Energy/Spiritual</th>
</tr>
</thead>
<tbody>
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<td>Private</td>
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</tr>
<tr>
<td>Public</td>
<td>Public</td>
<td>Public</td>
<td>Public</td>
</tr>
<tr>
<td>One-One</td>
<td>One-One</td>
<td>One-One</td>
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</tr>
<tr>
<td>Groups</td>
<td>Groups</td>
<td>Groups</td>
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<tr>
<td>Community</td>
<td>Community</td>
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</table>
CHAPTER 6
CONCLUSIONS

The precarious institutions of biomedical health care delivery in many underdeveloped countries have necessarily coexisted with an extensive use of unorthodox health care practices. Many of these health care systems are undergoing a thorough process of streamlining and modernization. The privately funded updating of the Dominican national health care system does not contemplate any form of alternative, indigenous or popular health care practice. Instead, through methods of health care evaluation and modernized structures for health care provision, it strengthens biomedical conceptualizations of health and advances its social transformation into a progressively private enterprise.

Within this milieu of biomedical upsurge and heightened health concerns, alternative medicine, or natural medicine, seems to share in the allure of these foreign imports. Practitioners of alternative medicine in the DR are mostly Western trained physicians combining conventional and unconventional methods and approaches. Their costly, private practice builds on technological advantage and the marketability of new health products corresponding to transformations in middle class needs and lifestyles. This is, as opposed to an association with Dominican indigenous healing traditions and social or environmental conceptualizations of health problems. The specific ways in which they develop their practices reveal important aspects of the above dynamics, and are simultaneously relative to theories about the interaction between health and society.
More than building a practice around a coherent paradigm, or struggling over the articulation of conflicting, competing health meanings, these practitioners were invested in processes associated with defining an occupation. It seems that while medical traditions are conceptual frameworks providing reference, they are articulated in practice according to immediate demands from other social formations. The processes of shaping a professional, legitimate medical practice can be interpreted along the lines developed by Friedson (1988) in his study of the medical profession.

The medical profession, developed to the level that Friedson (1988) argues it is used by all others as a model, organizes increasing spheres of social life, according to biomedical principles. In this way, the development of a medical practice provides a social space where the interaction between medical knowledges is defined by biomedical standards.

Professions are, furthermore, invested in processes of managing knowledge. They organize knowledge against other forms of social participation, such as politics or religion, conspiring, as the famous quote goes, against the laypeople and their input in social affairs. The format provided by this context would thus seem to favor orthodox knowledge.

In addition, professions, or specialized knowledges, are a particular kind of social organization with an increasing role in the ordering of human affairs. So that, contrary to Friedson’s argument (1988) that there is an aspect of the medical profession that is invested in the production of “pure” knowledge, and another that is invested in the organization around the application of that knowledge, I would propose that pressures emanating for the latter impact the former so much so that it becomes hard to separate the
two. As Friedson himself has said, “knowledge and expertise [are] abstractions realized by the activities of men (sic) organized into occupational careers and groups” (1988, Preface).

Finally, a scientific foundation overrides other qualities of biomedicine in this era, systematizing information and thereby diminishing the impact of individual practices and homogenizing the practice. This particular characteristic has an important role in securing the monopoly of the medical profession over the legitimate provision of medical care.

If we can think of medical practices as an embodiment of biomedical principles, and if we can see them in the context of the greater social processes reviewed here, which also favor biomedicine and other compatible social organizations, we can bring the relation between medical systems, whether we think of them as cultural, or epistemological, to a definite socio-political level. My findings suggest that the dynamics of that level are captured in every individual’s lived experience. As I rethink relationships between medicines as conceptual frameworks or paradigms I would argue that they are only constructed as such from certain social positions–the academy–and that they meet, and mingle, within socially defined, practical individual choices. With this in mind, I would like to review my premises and propositions.

In this study, I posited that alternative medicine is coming into being through its scientific study in the centers of Western knowledge production. The identification and social placing of alternative medicine is a current concern of authoritative institutions throughout the industrialized world. If anything, contemporary academic and governmental efforts indicate a renewed relationship between the dominant, global
biomedical and unorthodox health systems. The existing developments of globalization and the powerful workings of institutionalized knowledge can be realized in the ways this relationship is reproduced in a multiplicity of contexts.

The WHO is proposing that the term *complementary and alternative medicine* be a progressively international working label, and that it be collapsed with Traditional Medicine idioms, as it articulates the need for their incorporation into national health care systems. However, in the DR, *alternative medicine* does not represent indigenous medicines or popular health practices. Instead, it is an innovative form of medical practice, negotiated within the social space of a predominant biomedical system, which comes to share a space with biomedical and autochthonous, unorthodox responses to health and health care needs.

Discursive and other material social dynamics particular to the Dominican context were preconceived as expressing global and local interactions of polities and epistemologies. Traditional medicines do not appear in the assessments of health resources in the DR, and they are not part of national health care reform efforts. In the context of reinforcing institutions and mechanisms for medical commercialization, and while *alternative medicine* in the DR takes shape, this makes sense. The official stance towards the contrasting dynamism of *alternative practice* growth, and the decreasing visibility of rural, indigenous health meanings and practices in the DR, suggest that traditional medicines are relatively undeveloped. This was corroborated by the contrast between these practices and those of other Latin American countries, as reported in the WHO study reviewed here (even when the difference may have been due to the sources of data collection). I can offer a couple of speculative explanations, since this study was
centrally focused on what I argue is another socio-cultural phenomena, that of the development of a more urban, eclectic and biomedically framed form of non-conventional practice.

First, in attempting to locate the boundaries and interactions of medical traditions as they provide frames and meaning for individual actions, one also gets a sense of their social status. I would put forward the idea that at least three such traditions are present in the DR currently: conventional-Western medicine, alternative medicine (as constructed in this study) and popular, urban and rural health meanings and practices. I would further argue that the latter is precluded from general and academic visibility by the same dynamics I explored in this study. Those dynamics correspond to the alignment of medical traditions, and their correspondent identification by individuals and groups, with sources of power. In other words, knowledge systems are imbued with the power the groups that claim ownership to them, and benefit from structures and mechanisms of reproduction. I propose that these dynamics affect every aspect of the ways in which these medical traditions are regenerated and transformed through contact, embodied in peoples and materialized in social structures and processes.

Second, one could argue that traditional healing systems, while not existing in any pure, isolated form, coexist with/in communities that are differentiated from the dominant society. In the DR, it is claimed, there are no separate ethnic groups. Those who participate in unorthodox healing practices are marked by class, and, thus, they differentiate themselves from the dominant culture in ways that, based on general understandings of class, can be argued to be more fully encompassed within dominant culture. Even with the qualification that indigenous communities elsewhere are terribly
oppressed, I would venture to say that the cultural subsystems of the lower social strata in
the DR are situated in a more hierarchical, dependent and permeated position vis à vis the
dominant culture. Consequently, their set of shared meanings, including those around
health matters, are more vulnerable than are those of indigenous communities, which
preserve a relative sense of a competing set of values. The stigma that the dominant
society ascribes to traditional medicines in the DR only competes with the health needs
that are not satisfied by a failing biomedical health system.

In this study, alternative medicine and traditional medicine are taken to refer, at
least in the DR and for the moment, to two different things. The argument built here,
however, is that there is not space where they could exist exclusively. In this milieu of
deliberate globalized flows of peoples, resources and cultures, individuals and groups
draw from all sources to construct meanings and enact practices around health. In
addition, it seems clear that those flows follow deliberate lines of power. The
permeability and transformation of systems of knowledge is characterized by the
reproduction of power differentials and relations, which, in turn, facilitate particular
social formations and patterns of social and cultural reproduction. Those patterns can be
already identified in the social pressures that are aiding the conflation of the terms
traditional and alternative medicine in the DR, while, to follow a global pattern,
epistemologies and meanings are incorporated within newer forms compatible with
current dominant trends. The premise that local and global knowledges express relations
between unequally powerful spheres is supported by the argument that different medical
traditions do not exist in any significant way as separate from each other. This is both a
proposition and a point of arrival.
Thus, the differential development of alternative and traditional medicine in the DR reflects greater political and economic processes. The context in which the Dominican collective conceptualizes and organizes health meanings and practices may not be in the best interest of Dominican health and epistemology, and obey instead agendas set by international, dominant discourses around health and development. These are in turn related to the preservation of global hierarchies.
APPENDIX A
WORLD HEALTH ORGANIZATION DOMINICAN REPUBLIC COUNTRY INDICATORS. WORLD HEALTH ORGANIZATION


1995b. Household Archives Poverty Assessment Summaries: Dominican Republic. World Bank


1998. First World Bank Loan to Improve Health care in the Dominican Republic.


2000c. World Bank Finances Vaccination Campaign in the Dominican Republic.

APPENDIX B
PAN AMERICAN HEALTH ORGANIZATION


LIST OF REFERENCES


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Ugalde A. 1984. Where there is a Doctor: Strategies to Increase Productivity at Lower Costs. The Economics or Rural Health care in the Dominican Republic. *Social Science and Medicine* 19: 441-50


Deogracia Cornelio is currently a research associate at the Complementary and Alternative Medicine Research Center of the University of Michigan. As a coordinator of the Center’s qualitative research projects she has contributed the encompassing anthropological approach to the study of alternative medicines. She has published a paper on the Social Construction of Complementary and Alternative Medicine and has submitted for publication another article on the basic principles of biofield energy healing. Deogracia was born in the Dominican Republic. She received a B. A. in Psychology from the Autonomous University of Santo Domingo at 21, after which she migrated to the United States to pursue graduate education in 1984. In the US, she has worked in social services and social research institutions for many years. Her training and involvement with women victims of gender violence brought her back to graduate school seeking to understand the cultural roots of this pervasive social problem. The Center for Latin American Studies at the University of Florida interdisciplinary masters program promised to address Deogracia’s interests in approaching social phenomena in all its historical and contextual complexity. As she considers continuing her professional development into a Ph.D., she plans to incorporate her diverse areas of interest, including the political economy of health and illness and the socio-cultural grounds of gender violence.