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Exclusive inclusions: cancer practices in Toscana and Southern Denmark

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In a paper from 1994 Laura Nader calls for a reentry of a comparative perspective in anthropology in order to increase the awareness of the interlocking of structure and praxis (NADER L. 1994). A central point in Nader's proposal is that in order to explicate divergences and particularities, as well as, convergences and commonalities, we have to situate any praxis in its particular social and cultural structure in order first to interpret rationalities and implications of the doings and sayings of local persons, and second to compare this to other local and situated praxis forms. I have previously argued along similar lines in a critique of a prevailing tendency among anthropologists that do fieldwork "at home" to equate empirical data from other places, even other continents, to local phenomena without considering what consequences the different settings may have (JOHANNESSEN H. 2001). A similar lack of comparative consciousness with regard to structures and praxis is prevalent in present days' research on complementary and alternative medicine (CAM). A large number of investigations on CAM and effects of CAM have been published within the last years, compiling evidence of effects or lack of effects without considering the significance of the local social and cultural context in which the effects were produced. It is somehow anticipated that it is possible to use the category of complementary and alternative medicines (CAM) for a great variety of therapeutic modalities employed in various local settings with highly diverging political structures, health care facilities, etc., and yet mentally conceive of CAM as a somewhat stable category with specific treatment provisions and effects that are similar no matter where and when it is applied. The present study is an attempt to overcome this problem by generating and comparing empirical data on structures, praxis and experiences of effects regarding CAM and cancer in two distinct localities: Tuscany and Denmark. The aim is to reach an understanding of relations between structures in medicine on the one hand, and on the other hand, patients' ex-

pectations and experiences of effects of various treatment modalities. The comparative perspective helps to locate central issues in the embodiment of medical structures, the intimate relations of institutional structures and personal strategies as particular instances of a generic phenomenon. It is an exploration of situated naturalization of effects of treatments through the key concepts of discourse, institutions, praxis and embodiment.

Public structures of medicine

It may seem odd to compare Tuscany and Denmark, as one is a region of a much larger country and the other is a nation[1]. The two localities are, however, well suited for a comparative investigation of medical structures, as formal structures of public health care are constituted at exactly these levels. Tuscany has, as all regions of Italy, the right and obligation to establish regional regulations of health care within the overall Health Care Plan of Italy. Regulations of what kinds of therapy and treatments that are to be included in the public health care system are formulated on a regional level, but must include that which at the national level has been formulated as basic services (*Livelli Essenziali di Assistenza*). In Denmark the public health care system is governed by a national set of rules and regulations, and although the actual health care is organized at the regional level, all regions must follow the same rules as to who can practice, what forms of treatment that can be covered by the public health insurance, etc.

In both localities one can observe medical pluralism, i.e. several forms of medicine with particular explanatory models and forms of practice coexist. As demonstrated in previous studies, such medical systems are, however, not systems with fixed boundaries, but more like open systems of a flexible kind and with different and somewhat fluid configurations (JOHANNESSEN H. - LÁZÁR I. 2006). Plurality in treatment modalities seems to be a universal phenomenon, but the particular kinds and internal distribution is local and contingent upon legal regulations, discursive formations and the praxis of local administrators, health care practitioners and sick persons.

Complementary and alternative medicine and the acronym of CAM is a relatively new discursive construction promoted by researchers and practitioners of a variety of treatment modalities categorized as CAM. That is, the category has discursively been promoted by those that affiliate with it in clinical practice or in research. The category of CAM is difficult to characterize in a precise way, but seems to cover treatment modalities that tend

not be part of the public health care systems of Europe and United States, and tend to not be compatible with the productive modes of the pharmaceutical and medico-technical industries. CAM as a discursive category has primarily been promoted in the UK and USA, and a generally accepted and widely quoted definition states that CAM is «any diagnosis, treatment or prevention that complements mainstream medicine by contributing to a common whole, by satisfying a demand not met by orthodoxy or by diversifying the conceptual framework of medicine» (ERNST E. *et al.* 1995). This definition does not make us much wiser, but points to CAM as a structural feature in medical pluralism, a category dividing some forms of treatment from others. It is, however, important to note, that there are great differences between the distribution and discursive constructions of the medical pluralism in specific localities, and as we shall see there may be other dominant concepts than CAM in local discursive structures of medical pluralism.

Medical pluralism in Tuscany

According to national jurisdiction in Italy, only those that hold a degree from a medical faculty can be in charge of the treatment of diseases; in effects medical doctors have a disease-treatment monopoly but are, of course, assisted by a range of paramedics, nurses and other officially acknowledged health care providers. This situation implies, that legal pluralism in medicine can only take place within the circle of practitioners that hold a nationally sanctioned authorisation. There are of course alternatives to the medical treatments. In some regions the church plays a significant role in healing, as one medical doctor that had practiced in the region of Trentino regretfully mentioned, there would be instances when even the nurses would call the priest before they called the doctor. In Tuscany, the role of the church does, however, not seem to be very important in health and healing, which by some were explained by the long history of Tuscany as a socialist region with a consequential diminution of the influence and importance of the church. Other alternatives to medical treatments would be treatments provided by laypersons or persons with an education that is not included in the list of nationally sanctioned health care educations. This could be for example yoga teachers, Qi Gong instructors, lay homeopaths, unlicensed psychotherapists, body therapists, etc. In Tuscany we find such therapists and their practice is legal as long as it is in the realm of health didactics and does not concern treatment of diseases. According to the hear-say some of these non-medical practitioners do offer treatment of diseases, but as this practice is illegal nobody knows the kinds

and numbers of practitioners and practises performed. It seems that in this domain, we find the same double existence as we find in so many other domains of Italy, the economic not the least, with one layer consisting of open and legal actions, and another layer that comprises secret and illegal actions that are nonetheless well known and utilized by a large number of people.

Today, Tuscany is recognized by the EU and the WHO as a front region regarding inclusion of complementary and alternative forms of medicine, and health administrators of Tuscany are called upon as experts in this area. This is interesting, as the region is neither the first to include such therapies in the public health care, nor the region with the most expansive inclusion. In Tuscany, the process of official recognition of CAM started in 1987, while United Kingdom and Germany acknowledged and officially supported for example homeopathy and "heilpraktik" several decades before that. There is, however, reasons to suspect that the Tuscan way of inclusion is recognized as unique because it – contrary to the British and the German regulations – restricts the use of complementary treatment of diseases to medical doctors, and perhaps also because it makes distinctions between forms of therapies that are considered "complementary" and others that are considered plainly "non-conventional".

Acupuncture and Traditional Chinese Medicine (TCM) were the first forms of what was locally called *"medicina non convenzionale"* (MNC), non-conventional medicine, to be acknowledged officially in Tuscany. The regional health care plan of 1987-1992 established financial means for acupuncturists and Chinese massage experts working within the public health care system to attend upgrading courses at the School of Acupuncture in Florence. While many European and American doctors became acquainted with acupuncture and TCM after US-president Richard Nixon and his travel companions had witnessed a fully acupuncture based anaesthesia during surgery at a trip to China in 1979, few countries, if any, were as early as Tuscany in official recognition of acupuncture as part of the public health care system. The fast Tuscan recognition of TCM is probably related to the fact that the largest group of immigrants in Tuscany for decades have been Chinese, and the necessity of what is called "culture sensitive health care provision" was, and is, generally recognized and of concern to the Tuscan health authorities.

Since this first opening towards TCM, the regional health plans of Tuscany have referred to MNC in an ever more inclusive mode. The Regional Health Plan 1996-1998 expanded the formal acknowledgement to also include herbal medicine, and further recognized the need for development of the

field of non-conventional medicine in order to facilitate proper use among medical doctors. The Regional Health Plan of 1999-2001 is, however, often considered as the definitive break-through for official recognition of MNC as this plan includes the establishment of a committee on non-conventional medicine with the aim of initiating investigations of the field. The committee comprised representatives of the public health care administration and medical authorities as well as representatives of the kinds of medicine revealed to be mostly used by the population: homeopathy, phytotherapy and acupuncture. The yearly budget for research and projects initiated by the committee was € 500.000-850.000, and among the first investigations to be initiated were survey based estimates of the general use of MNC among the population, registration of clinics in the public health care system that provided some kind of MNC, as well as, a survey of the attitudes towards MNC among medical doctors. In this phase it was revealed that 19,3% of the adult population of Tuscany had used MNC within the past three years (13,1% within the last year), with homeopathy, manual medicine, phytotherapy and acupuncture being the most popular forms (LA TOSCANA PER LA SALUTE A). In a study with response from 83% of 230 invited medical doctors, it was revealed that 12% of the medical doctors had a diploma in some form of MNC, an additional 24% were interested in acquiring one, and 65% found that medical education in general should include teachings on MNC. Further, 6% declared to practice homeopathy and 4% to practice acupuncture and phytotherapy; whereas 19% would advice patients to use acupuncture, 15% manipulative medicine, 12% homeopathy, and 2% would advice phytotherapy (LA TOSCANA PER LA SALUTE B).

These initial explorations were accompanied by regional projects on development and exploration of a wide variety of non-conventional medicines within the public health care system during 2002-2004. The period from 1999 to 2004 were characterized by an open attitude to non-conventional modes of treatment in the sense, that projects on such diverse modes as yoga, homeopathy and Qi Gong were supported. The main restriction on the projects was that they should relate to activities within the regional public health care system.

In the health plan of 2005-2008 the scope of the regional interest in non-conventional medicines were narrowed down to four kinds of medicine: acupuncture/TCM, homeopathy, phytotherapy and manual medicine. These four treatment modalities were included economically in the public health care system and three reference centres (on TCM, homeopathy and phytotherapy) were established with the tasks of collection and dissemination of research based knowledge to the public as well as to health care profes-

sionals. This political move restricts the regional support to four kinds of MNC, but at the same time intensifies the economical support of the therapies and the cooperation with regional leaders within these forms of medicine. In 2007 the process of selection and inclusion of these treatment modalities seems to have been concluded for now as the regional council passed a regional legal act that establishes acupuncture/TCM, homeopathy and phytotherapy as medical specialities and as basic health services to be provided by the public health care system of the region. On the homepage of the regional health authorities these three kinds of medicine are now designated as "complementary medicines" and one finds introductions to the treatment modalities and their potential areas of competence as well as information on and links to the three reference centres. From the homepage one can also download a list of more than 50 institutions within the public health care institutions of Tuscany that provide complementary medicine.

The above sketches out some main lines of a political process in which the regional health authorities of Tuscany enters, explores, discriminates, and distributes the treatment modalities that until 1987 were left without official attention and positioned as non-conventional and non-acknowledged forms of medicines. In a Foucaultian perspective, we witness a politically orchestrated discursive reconstruction of the medical pluralism of Tuscany. A network of medical doctors, bureaucrats and politicians has, so to speak, domesticated parts of what was formerly constructed as non-conventional and not legally acknowledged forms of medicine. The process started as an open exploration of a wide field of non-conventional medicines, but gradually established more and more narrow boundaries as to what kinds of medicine to pay attention to. The process reached a peak (or an end?) by the most recent move with full inclusion of three medically provided forms of medicines in the public health care system, and a renaming, repositioning, of these forms of medicine as "complementary". At the same time, at this peak of the process, other forms of medicine are even more firmly excluded and categorized as non-conventional, and without much surprise, we can ascertain that the latter forms of medicines are most often provided by non-medical practitioners. By the political inclusion of homeopathy, acupuncture (TCM) and phytotherapy as medical specialties, the bureaucrats of the public health care system have cleverly demonstrated a will to acknowledge preferences of treatment modalities in the public and change institutional positions thereafter. By restricting the inclusion to three medically provided forms of medicine with some (although disputed) scientific basis, biomedicine and medical doctors of Tuscany have ascertained their continued monopoly in medical treatment. The bio-

medical and bureaucratic health structure has in one move demonstrated openness towards "new" doings in medicine and secured its own position of power, and as such demonstrates biopower in work.

Medical pluralism in Denmark

The official policy towards medical pluralism in Tuscany is certainly different from what we have witnessed in Denmark. Although the Danish Board of Health has paid attention to plurality in medicine since 1973, when the first committee for the investigation of "natural remedies and non-authorized treatment methods" was established, there has been limited official recognition of the field. The first committee on alternative treatment comprised one lawyer, who was also a member of the parliament, one medical doctor, one pharmacist and a bureaucrat from the ministry of health. The committee investigated the legal position of herbal medicine and homeopathy and non-authorized treatment forms in the Nordic countries, Germany and UK, and initiated a few clinical trials before it stopped its activities in 1983 (DANISH MINISTRY OF DOMESTIC AFFAIRS 1983). In 1985 a new council on "alternative medicine" was established, this time with representatives from several organizations of practitioners of those therapies that in Denmark were labelled *"alternativ behandling"* (AB) (alternative treatment), and representatives of the ministry of domestic affairs and health, Danish Medicines Agency, and the Danish Consumer Council. Only a minority of the members were medical doctors. The council has since its establishment been a forum of dialogue between the national health authorities and practitioners of treatment modalities excluded from the public health care system, but more importantly, perhaps, it has been a forum that has supported and initiated cooperation between some of these organisations, in example by the construction of a research manual regarding studies of alternative treatment, and a nationwide organisation-based registration of practitioners [(2)]. The latter has been recognized by a legal act stating that the National Board of Health can grant organisations of alternative practitioners the right to administrate the registration of its members (DANISH MINISTRY OF DOMESTIC AFFAIRS AND HEALTH 2004), but is not comparable to an authorization to practice; it is rather intended as consumer information regarding level of education and ethical rules of alternative practitioners.

Chiropractic and acupuncture has received recognition in the form of inclusion in the public health care system. Chiropractic has since 1992 – and

after decades of political struggle – been fully recognized as an independent health care practice with university based education, official authorization of practitioners and public reimbursement of treatment (Danish Ministry of Domestic Affairs and Health 1991). Since 2001 acupuncture been partly reimbursable if provided by a medical specialist as treatment of pain or rheumatism (Amtsrådsforeningen 2001), and some hospital departments have included acupuncture and visualisation primarily for pain treatment. Apart from the case of the chiropractic, these initiatives have passed without much political upheaval and there is no change in official status of any forms of medicine in the legal acts on health and health authorisations that became effective in 2007. Since the inclusion of chiropractic in 1992 the only major political acknowledgements has been the establishment of a centre for dissemination of knowledge and research on alternative treatments with a yearly research budget of Dkk 1 mio (€ 132.200), and a one-time devotion of Dkk 10 mio (€ 1.322.000).

We do not know how many medical doctors that practice "alternative" treatment modalities today, as the surveys estimating this are rather old. A survey among members of the medical association in 1988 revealed that less than 1% of the Mds employed homeopathy or herbal medicine in their practice, while 21% employed acupuncture (Lægeforeningen 1988). In another survey from 1994 among general practitioners (GPs) in the municipality of Næstved (a town of 50.000 inhabitants) it is estimated that around half of the GPs administrated one or more of the treatments classified as alternative by the researchers. The GPs use was predominantly concentrated on acupuncture (25%), hypnotherapy (21%) and dietary advice (17%), non of the GPs administrated herbal medicine or homeopathy (Mortensen H. S. 1994).

The Danish state has, however, if not recognized then at the least demonstrated tolerance of non-medical practitioners. A medical act passed in 1934 stated that anybody, with or without official authorization, was permitted to provide treatment of diseases as long as the practitioner refrains from using techniques reserved for specific professions, and although the medical legislation has been renewed many times since then, this issue has remained unchanged. Danes without any formal health education may thus treat sick persons as long as they do not employ surgery, anaesthesia, prescription drugs, midwifery, x-rays, radiation or electrical devices restricted for authorised personnel (Danish Ministry of Domestic Affairs and Health 2005: § 73-74). The kinds of treatment categorized as alternative in the Danish context is also by far most often provided by non-medical practi-

tioners. A recent survey among members of the largest associations of complementary and alternative practitioners estimated that close to 2700 persons are active and organised practitioners of complementary and alternative treatment [3] (JEPPESEN S. *et al.* 2007: 23), and revealed that three out of four of these practitioners had no officially sanctioned health education (*ibid.*: 26) [4]. Notwithstanding the large number of persons without formal health education, it was in the same survey estimated that, though many Danes seek AB for wellness or health promotion a large number use it for treatment of disease. This is confirmed in a nationwide, population based and representative study, in which 59% of those that had used alternative treatment declared to do so in order to combat a disease (LØNROTH H. L. - EKHOLM E. 2006).

The above sketch of public official structures regarding medical pluralism clearly demonstrates that the Danish configuration of plurality in medicine is quite different from the Tuscan one. As in Tuscany also in Denmark we find discursive moves that are part of a continuous exertion of power to keep biomedicine and medical doctors in control of discourses on diseased bodies, but the strategy has been different. Apart from the authorization of chiropractic and a meagre public reimbursement of acupuncture as a medical speciality in pain treatment, no political decisions of inclusion have occurred in Denmark. Instead, the Danish health authorities have followed a path of exclusion of these forms of medicine from the public health care system while at the same time tolerating the practice of non-medical practitioners. In correspondence with the policy of exclusion, a discursive construction and maintaining of the category of "alternative treatment" has taken place. Since 1985 all official and state institutional articulation on the subject has used the term "alternative treatment". This is the case with the committee under the National Board of Health, with legislation on the field, and in the case of the publicly funded centre, founded in 2000 and named "Centre for Knowledge and Research on Alternative Treatment". The discursive exclusion is double: The practices are categorised as "alternative", not "complementary" nor "non-conventional", and thus discursively positioned as something competitive and unrelated to conventional and established practice (although of course, the very term of alternative presupposes something to be alternative to) (conf. JOHANNESSEN H. 1994). At the same time the practices are categorised as "treatment", not "medicine", and thus in a double sense positioned as something different from the medical establishment, the medical doctors, science and educational institutions, and thereby as something that can be ignored and dismissed as irrelevant in health policy.

Convergence and divergence in medical pluralism

In a comparison of how the public health authorities of Denmark and Tuscany handle the medical pluralism, it stands out that both localities discursively and institutionally have created configurations that support a superior position for medical doctors vis-a-vis other kinds of practitioners. In Tuscany the strategy has been to incorporate selected treatment modalities practiced by medical doctors in the public health care system. This move has secured the position of medical doctors and at the same time signalled willingness to attend to a public demand of treatment modalities that were not traditionally included in public health care. The region of Tuscany has further gained from this move, as it is now internationally recognized as a pioneer in what in the international literature is called "integrative medicine", i.e. integration of some forms of complementary medicines in public health care. In Denmark the strategy supporting a continued dominant position of medical doctors has on the contrary implied to upkeep borders between medicine proper and other treatment modalities through a discursive construction of these other practices as "alternative", a very restricted use of these among medical doctors, and a legal right of non-medical practitioners to practice them outside the public system. The comparative perspective thus reveals two very different strategies that both support medical doctors and let the public have access to a variety of treatment modalities, and yet construct very different structures of medicine that patients and practitioners must navigate through in case of disease.

The medical structures constructed through public discourses and state institutions may be decisive but they should not be considered as determinant for local health care praxis. Michel Foucault, whose writings on power and discourse has inspired the present analysis, warns us against an understanding of power as unidirectional and as abiding in law and sovereignty. Instead, he argues for an understanding of power as the «multiplicity of force relations immanent in the sphere in which they operate and which constitute their own organisation» (FOUCAULT M. 1998: 92). This means, that power is not based in specific institutions, but practiced in social relations and exercised in the many tactical moves and discourses that make up society. An explorations of power thereby implies an investigation of who says and does what, as well as of the mutual implications between tactics and power distribution. Above I have sketched processes of political tactics regarding medical pluralism in Tuscany and Denmark, and pointed to the implied relations of force and the resulting power distribution and configurations. The specific configurations have been formed

through tactics deployed by medical doctors, bureaucrats and politicians of the Tuscan region, but although the tactics appear to be based on a strategy that seems coherent, rational and logic, according to Foucault the overall strategies are never invented as totals but constructed by myriads of tactical moves by individuals dispersed in the web of power-relations that make up society (*ibid.*: 95). Foucault writes that sexuality appears as an especially dense transfer point for relations of power, and the same could be said about treatment and diseases, health and healing, as also this domain of human suffering and experiences of relief seems «endowed with the greatest instrumentality: useful for the greatest number of maneuvers and capable of serving as a point of support, as a linchpin for the most varied strategies» (*ibid.*: 103).

Configurations in healing praxis

Let us move to another perspective: that of the persons involved in actual treatment praxis. In the previously mentioned collection of studies in medical pluralism, it was argued that patients move between different "provinces of meaning", different medical realities, when they navigate among the plural discursive constructions of medicine, and that these medical realities are embodied in the praxis and experience of the sick persons as well as the practitioners providing it. This led to the conclusion that in moving between different networks, sick persons, families and health care providers juggle with issues such as personal identity and social, political and religious power, as they seek solutions that may provide healing for the suffering body and at the same time provide for meaningful relations of the self (JOHANNESSEN H. 2006: 15). In this perspective, the body is not just an object to be treated, but also an agent, a performing self that seeks to manage displays and impressions of itself. Thomas Csordas has suggested that we consider the body as a way of being-in-the-world, as a nexus for encounters between biology, consciousness and culture. In this paper, embodiment is explored on the premise that bodies can be approached as situated agents that reflects, articulates and acts on behalf of sensations within the body itself, as well as on stimuli from the surroundings, be they social, natural or cultural. The analysis will therefore pay attention to how patients and practitioners talk and act in regard to disease, medicine, health and healing. As such the analysis can be seen as just another discourse analysis, only this time bottom-up with departure in daily life discursive constructions of disease and body. Yet, it is at the same time a phenomenological approach as the point of departure is subjective and experiential

being and acting in the world. Central questions to explore are how patients and practitioners articulate and act on different forms of medicine in relation to the body in general, and to cancer and cancer treatment in particular; whether other forms of treatment than the establishment's practice of surgery, chemotherapy and radiation therapy are considered appropriate, deployed and employed in cases of cancer; and what kinds of effects the individual expects and experiences from the various treatments.

Cancer praxis in Tuscany

Cancer is a high priority area in public health in Tuscany, as in most of the Western world, and almost all persons with this disease receive biomedical treatments. The cancer patients that participated in the present project were identified at two public oncology ambulatories, and all received biomedical treatment in the public health care system. The attitude towards the public system and the biomedical doctors among the patients was generally very positive and trustful, which seemed remarkable in comparison with two independent surveys on attitudes among European citizens that reveal the Italian population to have quite negative attitudes and expectations to the public health care system [(5)]. The results of the EU-survey contrast with responses we received from cancer patients in a questionnaire survey conducted at the oncology outpatient clinics. Among the 83% of the patients that declared to never have used any non-conventional or complementary medicine the most common explanations were, that they were satisfied with the medical treatment, and that their doctor never suggested other therapies. This does of course not imply, that the patients did not complain about the harshness of the cancer treatment. Everybody told about experiences of suffering caused by the treatment, and it was obvious to see the change that they underwent from the first of day of a new chemo series to the third or fourth day. On Mondays they walked into the hospital looking normal and fresh, and on Thursdays – after three or four days of chemo – they looked like persons that had been without sleep for several days. In general, however, the patients voiced a pronounced confidence in the medical doctors and announced with certainty that they would consult medical doctors in questions of disease and medicine, also if they wished to consult somebody about complementary forms of medicine. An example is a young man, who I met at the oncology department. He had consulted a homeopaths in Milan, and when I asked him if this homeopath was a medical doctor, he answered with great vigour: «Yes, of course», and looked at me as if I was crazy to question that. Among those that had used

some form of complementary medicine for their cancer, the ones that consulted practitioners of homeopathy, phytotherapy and acupuncture had all consulted medical doctors.

Among the 17% of cancer patients that used other forms of treatment, the most common form of treatment was herbal medicine, which was used by more than half of those that complemented the biomedical treatment with something else [6]. The widespread use of herbal medicine predominantly consisted in the use of Aloe that patients bought at local herb shops (*erboristerie*) without ever consulting a medical specialist. Many patients reported that they had been advised by family or friends to try Aloe, often in the form of a liquid mixed with liquor (*grappa*) and honey, as a means to help the body fight the disease and to enhance physical wellbeing in general. Only one patient reported to have been in contact with the regional reference centre for phytotherapy, and the medicine she acquired there with the aim of stimulating her immune system, she never took because her oncologist advised her against it due to fear that it would countereffect the chemo therapy.

An example of a person who used herbal medicine is Carlo [7] a man in his early sixties that suffered from cancer of the colon with metastases in the liver. Immediately after Carlo received the cancer diagnosis, he contacted a friend of his that had had the same disease some years before. She advised him to buy some Aloe and to go to the herb shop to ask for other relevant herbs. At the herb shop he acquired Aloe in liquid form as well as several other kinds of herbs to use for tea. He was very content with this purchase, and was confident that these herbal products were the reasons why he did not feel as uncomfortable during the chemotherapy as his co-patients seemed to be. When we visited him at his home he showed us a plastic bag full of medicines against nausea, dizziness, constipation and other symptoms, that the hospital had given him, and proudly announced that he had not used any of those. The only medications he used at home were the herbal medicines and water, he declared, and then he got up to get himself a glass of Aloe. At this point in the course of his disease, it was very important to him to come through the chemotherapy with a minimum of side-effects and to stimulate the intestine and the liver to cope well in spite of the cancer residing in these organs. He never talked about the herbal medicines as curative treatment, as he clearly considered that to be the business of the oncologists at the hospital. But he emphasised the need to stimulate the organs that were hampered by the disease, especially since they were important organs for the uptake of nutrients. He was sure that it was very important to feed the body well when undergoing such a severe

disease as cancer and the harsh conventional treatments. The story of Carlo is typical in the sense that he makes a sharp division between curative treatment of the cancer, that he expects to receive at the hospital, and complementary medicines to help him stand the hospital treatment and help his body function in spite of disease of vital organs. The other Tuscans that used herbal medicine and homeopathy expressed the same division in expectations to different forms of medicine. Many experienced that they were less badly influenced by the chemotherapy than those patients that did not use complementary medicines, but not all.

A few of the patients that I met had plural use of medicines. An example is Claudia, a woman in her mid sixties who suffered from an aggressive form of breast cancer that at the time when we met her had spread to most parts of her body. She had a long history of simultaneous use of different treatment modalities. She told us that she had consulted medical doctors in Switzerland to get anthroposophical cancer treatment, she had grown Aloe herself on the balcony of her apartment and produced a liquid of this, and she had tried Qi Gong, reflexology, massage, homeopathy, phytotherapy and various diets. Her son was very active in helping her find potential practitioners and he had brought her to several medical doctors that were engaged in experimental chemotherapy, and at the time of our last conversation, she was excited by the prospect of meeting an American doctor who came to Italy to participate in a conference. Claudia used several complementary treatments, but it is worth noting that her search for complementarities included experimental chemotherapy as well as modes of treatment that are usually categorized as CAM. Further, I found it interesting that her use of complementary treatments was not based in body representations or experiences of her body that differed markedly from the biomedical ones. She was very knowledgeable about the body as a biological entity, and she was quite articulate about her expectations to the various forms of therapy. As Claudia suffered from an aggressive form of breast cancer for which there is no conventional cure at the moment, she had set herself the goal of surviving until the right chemotherapy has been developed. With this aim she receives chemotherapy in the hope that it can slow down the development of her cancer. She used herbal medicine and homeopathy with the aims of strengthening her physical wellbeing and her ability to keep up a normal life in spite of the disease and the chemotherapy, and she used reflexology to counteract pain and stiffness after a mastectomy. Claudia talked at length about the hormonal aspects of her cancer, about blood tests and scans, about what various doctors had told her about her disease and prospects for conventional and experimental cures,

about how she prepares the Aloe, about how many different kinds of herbal medicine and homeopathic remedies that she takes, etc.. She also talked at length about how well she feels in spite of a serious and well advanced cancer, about how she compares herself with other patients she meets at the oncology ward and finds that she herself is doing quite well, how she can take the bus (and do not need to take a taxi), about how she can do the shopping and cooking as usual, etc. She firmly believed that the different kinds of medicine she used all contributed to her wellbeing and high activity level in spite of the serious disease, but it was all within a very physical and mainstream realm. She never mentioned the body's ability to cure itself if it is provided with the right substances (a frequent claim within herbal medicine); or the fundamental principles of similar cures similar, that lies behind homeopathic remedies, and she never talked about the body as an interconnected whole with important flow in the tubes of the body, as often promoted within reflexology. This woman did not seem to move between different sets of experiences of body and self. She rested well in her experience of herself as a vigorous lady and actively sought means to upkeep that, and she experienced her body as a biological feature that needed biological treatments to keep going.

Only a few of the Tuscan cancer patients that I talked with had ever heard about the regional policy regarding medical pluralism, and in spite of the relatively common use of homeopathy and herbal medicine, nobody seemed to be aware that these forms of medicine were included in the public health care system and reimbursable. Like Claudia, the Tuscan patients that used homeopathy and acupuncture found the doctors that provided these forms of therapy through recommendations from persons in their social network or through the Internet. Conversations with doctors and nurses at oncology departments correspondingly revealed that only a few of the professionals had ever heard about the official recognition of complementary medicines. The oncologists reported that they never referred or introduced patients in curative chemotherapy to any of the officially recognized forms of complementary medicine, and they were in general quite sceptical about the relevance of these forms of medicine for cancer. Especially herbal medicine was questioned due to potential counter-effects of the chemotherapy, while the belief in the potency of homeopathy and acupuncture was low in comparison with ordinary drugs.

Three issues are significant in regard to the Italian cancer patients. The first is their confidence in the medical doctors as described above and demonstrated in the praxis of consulting medical doctors also when they wanted something to complement the hospital treatment. This seems like

embodiment of the medical profession's monopoly of treatment, but not in a coercive way, not by force. On the contrary, the patients expressed a sincere trust in medical doctors and a firm belief that the MDs were the right authorities in matters regarding disease and treatment. The second issue of significance is the lack of references to alternative representations of the body. None of the Tuscan patients in this study made reference to the body's ability to heal itself or to the interconnectedness of body and mind in the causation as well as curing of the cancer. Also this issue seems to be an issue of embodiment, a naturalisation of medical discourses on disease, treatment and healing as matters referring to the physical and biological body, and the rationality of interventions aimed at direct elimination of diseases. These two issues are well illustrated in the examples above. The third issue of significance was the patients' lack of reference to the Catholic Church and religion as important for their healing, and this is only indirectly shown in the examples above, as it only appears through its absence. It was not that religion was absent in the lives of these people, as several of them stated that they believed in God, and some even told how they attend church more after the cancer diagnosis. One of the patients that we visited in her home had a large picture of Padre Pio (a sanctified priest famous for his healing abilities and other miracles) in her dining room and she talked at length about her admiration and faith in him. And yet, she as well as all other patients (except one) denied that prayer and religion played a role as part of their strategy for cancer. Religious activities seemed to belong to another part of their lives as if the old pact of division between the church and medicine, with one caring for the soul and the other for the flesh, was part of their embodied existence.

Cancer praxis in Denmark

Most Danes suffering from cancer receive conventional treatments, but a substantial number complement the conventional treatment with other treatment modalities. Surveys on the prevalence of complementary medicine use among cancer patients in Denmark estimate the prevalence to be between 36% and 76% and the most used forms are natural medicine, acupuncture, reflexology and spiritual healing (DAMKIER A. 2000, MOLASSIOTIS A. 2005, ANKER N. 2006)[8]. In Denmark we also find persons that have chosen not to receive conventional oncology treatment, and although there is no accurate numbers, we know that there are some because some of them have publicly told their stories (BIRKELUND M. 2002, DIGE U. 2000)[9]. Those that choose not to receive conventional treatment for cancer are

however a minority, and though the Danes seem to be very content with the public health care system [10], the members of a focus group of cancer patients agreed that they accepted the dreadful conventional treatments out of fear. «I don't dare to refuse it», as one person expressed it, eagerly supported by the others.

The most widely used kind of complementary medicine is what in Denmark is called "natural medicine", a category that includes as diverse products as herbal remedies and teas, homeopathic remedies, shark cartilage, Coenzyme Q10, and much more. Around half of all cancer patients in Denmark supplement the conventional treatment with natural medicines, mostly recommended by family and friends and bought in chemists' shops or in supermarkets (ANKER N. 2006: 25-28). The reasons Danish cancer patients give for their use of natural medicines are mostly that they want to counteract side-effects of chemo and radiation therapy or to stimulate the immune system after the conventional treatment. The same reasons were expressed by cancer patients that consulted reflexologists. In this the Danes resemble the Tuscans, but while the Tuscans that seek professional help regarding herbal or homeopathy consult a medical doctor, the Danes consult practitioners that are not medical doctors but educated in some complementary medical system, and in general they do not discuss these matters with medical doctors. An example is Peter, a young man with Hodgin's disease that I met at a biopathic [11] clinic. He started to consult the biopath while he was in chemotherapeutic treatment in order to strengthen his body in general and to counteract side-effects of the chemo in particular. When his mother suggested this to him he immediately agreed, and after the end of the chemotherapy he continued in order to regain full strength as soon as possible. The biopath prescribed various vitamins and minerals, herbal medicines and isopathic remedies to him, and advised him to eat vegetables in large amounts. He did not tell the oncologists about his use of complementary medicine at any point in the course of treatment and control visits, «... they don't talk about these things there [at the hospital]», as he and his mother agreed, «such things one should not at all mention there».

Around one out of four cancer patients in Denmark have practiced some kind of mental technique after they received the cancer diagnosis, the most commonly used techniques being relaxation (17%), visualisation (12%) and meditation (10%). A minority of 5-10% of Danish cancer patients have consulted what in Danish is called a "healer". This category is mixed and comprises the practices of spiritual healing, some forms of massage, prayer, laying on of hands, etc. One woman of 61 years that was in treatment for

breast cancer said, that she consulted a "healer" in order "to get peace of mind", and that she had done this continuously since she had breast surgery four years ago. She consulted a massage healer every second week and deliberately chose this kind of healing that did not imply speaking as she wanted a therapy that would make her body and self relax. She expressed confidence and security in knowing that this healer examined her body while she was healing her, a practice that the patient called a "control" and considered a way of knowing at an early stage if new cancer would be on its way. This woman, as many other Danish cancer patients, experienced alternative modalities as useful for provision of mental and emotional support, and found this imperative to stand the physical and emotional hardships of the cancer and the conventional treatment and to prevent reemergence of cancer.

Danish cancer patients repeatedly distinguish between the biomedical and curative competences of the medical doctors and the public health care system, and the general supportive competences in the alternative health care sector, and approximately half of the patients complement the biomedical treatment with alternatives that they buy as any other commodity on a private health care market. Patients also generally expressed a consumer awareness regarding the alternative therapies, and emphasised that they were critical and only used a particular product or consulted a particular practitioner if they were satisfied with the results. This is in sharp contrast to their binding to biomedical treatment, which they expressed to be based on fear of the consequences to stop the treatment even though it was experienced as extremely hard and damaging for the body, and the good results were often absent.

The distinction is also revealed in the way the body and healing are articulated, in the medical realms implicated when cancer patients talked about treatment. At one of the focus group discussions, the participants moved seamlessly back and forth between physical and emotional issues when sharing experiences. They identified common experiences of clinical encounters at the hospital characterized by doctors that were unaware of the patient's physical condition, did not care for the emotional condition, and had poor communication skills with subsequent experiences of worries for the patients. In contrast to this, the focus group agreed that to use alternative medicines and consult alternative practitioners were emotionally supportive, and all agreed that emotional support and a general emotional wellbeing are issues that are very important for one's ability to cope with disease and conventional treatment, as well as with everyday life in a time burdened with cancer.

As very few medical doctors practice alternative medicines and they are not included in public health care, the clinical practice of medical doctors reflects the division as well. So does of course the practice of alternative practitioners as they do not prescribe chemotherapy or any other conventional pharmaceuticals, nor perform surgery or use radiation therapy. Clinical institutions and clinical practice of medical doctors and practitioners of alternative medicine are separated spatially, practically, economically and conceptually through the daily praxis of practitioners.

This distinction between the medical and the alternative health care and the different ways in which they are approached as well as the differences in expectations and experiences correspond to the political distinction and exclusion of alternative medicine from the public health care sector. The distinction is thus embodied in the practice and experience of the patients, in the clinical practice of practitioners, and in the political and bureaucratic practice of regional and national health care institutions.

Exclusive inclusions and the intimacy of state and body praxis

The above comparisons of structures and praxis in medical pluralities of Tuscany and Denmark demonstrate interesting affinities between institutional structures and healing praxis in the two localities. In Tuscany the medical doctors are granted monopoly of treatment of diseases and medical doctors are those who practise the forms of non-conventional medicines that have recently been included in the public health care system. The Tuscan cancer patients predominantly use the very same kinds of medicine (herbal medicine, homeopathy and acupuncture/TCM), although this use does not seem to be directed by the official policy, as most of the patients were not aware of this very policy and they did not receive treatments within the public health care structure. The patients expressed general confidence in the professional competences of medical doctors also in terms of non-conventional forms of treatment, and they predominantly expected and experienced effects of the complementary treatments that referred to biological body and physical features such as prevention of side-effects of cancer treatments and stimulation of the immune system and other physiological processes of the body, which points to a hegemonic position of biomedical ideologies. The Tuscan patients did, however, engage in different medical realms in the sense that they expected biomedical treatment to combat the cancer and the complementary treatment modalities to strengthen the physical being-in-the-world of their body. They recognized the need for emotional support but did not seem to con-

sider this a matter of treatment and medicine and this aspect therefore cannot be considered as part of a medical realm.

In contrast to this we have witnessed a Danish configuration of medical plurality characterised by division between conventional and alternative treatment modalities in policy and discourse as well as in the praxis of patients and practitioners. Alternative treatment modalities are not included in the public health care system, and only a minority of medical doctors practice the mostly used forms of alternative treatment modalities, but these can legally be practiced and are predominantly practiced by persons without an officially sanctioned health education. Herbal medicines, reflexology and spiritual healing are the most commonly used forms of complementary medicine among Danish cancer patients, and the patients consult non-medical practitioners regarding these treatments and rarely discuss these matters with the medical doctors. The division is also present in expectations and experiences of effects, as the patients expects medical doctors to provide treatments that are aimed at curing the cancer as a biological phenomenon, while they expect alternative practitioners to provide treatments that support their bodies biologically as well as emotionally and mentally. The Danes thereby engage in medical realities that differ more profoundly than the ones Tuscans engage in, as the medical realms span from a purely conventional biomedical realm focussed on combating the disease, to a complementary realm focussed on supporting the body in biological as well as emotional terms. The Danish configuration also demonstrate hegemony by biomedical ideology and praxis, not by a monopolistic position as the one held by medical doctors in Tuscany, but through a distribution of medical realms as conventional on the one hand and on the other hand alternative realms, that are discursively positioned as different and with other ideologies than the biomedical ones.

The affinities between the political and institutional structures on the one hand and the healing praxis of patients and practitioners on the other hand cannot be explained by institutional or juridical coercion. In the Tuscan case this is revealed in the fact that hardly any of the cancer patients or the oncologists were aware of the official policy regarding complementary medicine, and in the Danish context by the fact that there is no juridical conditions preventing medical doctors from providing alternative forms of treatment. The affinities more likely reflect what the Italian philosopher Antonio Gramsci has called an organic relation between state and civil society (GRAMSCI A. 2003 [1971]: 52) and as such points to a very intimate relation between policy and praxis. The Tuscan inclusion of some forms of non-conventional medicines in the public health care system and renam-

ing of these as complementary forms of medicine are closely linked to the fact that these forms of medicine were nested in the praxis of medical doctors before the inclusion. They were carried forth to the political level by medical doctors and could be politically recognized because such recognition would not threaten the established configuration of medical pluralism, but rather enforce established relations of force in the medical world by demonstrating public concern by bureaucratic health authorities and complementary competences by the medical profession. At the same time the patients demonstrated consent with this order of things, as the long standing monopoly of medical doctors in treatment of disease was acknowledged and widely accepted among the patients. Medical doctors were generally recognized as competent in regard to complementary forms of medicine, and the patients seemed to be content with medical paradigms restricted to the biological and physiological aspects of the body.

In the Danish case, an exclusive but tolerant policy regarding alternative medicines is closely tied to the fact that very few Danish doctors employ such treatment modalities in their praxis. Instead, these modalities are nested in the praxis of non-medical practitioners outside the public health care system, and the patients readily accept and acknowledge the competences of these alternative practitioners to be different than the competences of medical doctors. The Danes seek treatment of the cancer in the public health care system and support of the body as a physical, emotional and a mental being-in-the-world through alternative forms of medicine on a private market.

The affinities between the political, the representational and the phenomenological levels of body, disease and healing thus seems to reflect an organic relation, where praxis on all levels support the same configuration; a feature that comes forward clearly in the comparison of two different configurations of policies and praxis. The praxis of policy makers, medical doctors, alternative practitioners and patients all seem to contribute to the same institutional and political order of medicine, not because there is some overall juridical or sovereign power stating that it should be that way. Rather the many tactical moves made by patient, practitioners, bureaucrats and politicians in Tuscany as well as in Denmark reveal an intimate relation between policy and praxis based on consent on the distribution of competences in medical matters in each of the two localities. An interesting lesson to learn from this is that the expected and experienced effects of complementary medicines are closely and intimately tied to political structures in the health care system in which it takes place. The political inclusion of complementary medicines in the Tuscan health care system ex-

cludes patients' experiences of emotional and mental issues as part of medical reality but do open for experiences of effects of complementary medicines in terms of improvement of physical wellbeing and support of the body. The Danish exclusion of complementary medicine from public health care provides for experiences of multiple medical realities and of alternative medicine as providing a medical reality that not only encompass physical wellbeing but also emotional and mental issues as important effects of treatment.

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Notes

(1) Tuscany is with its 22.992 km2 about half the size of Denmark and has a population of 3,5 mill compared to the 5,3 mill inhabitants of Denmark. As many health care provisions of Tuscany are open for the population of Umbria as well, we reach two structural regions Toscana-Umbria and Denmark of similar size and with similar numbers of inhabitants.

(2) Information on the The National Board's Council on Alternative Treatment can be retrieved from the homepage of the National Board of Health: http://www.sst.dk/Tilsyn/Alternativ_behandling/Sundhedsstyrelsens_raad_vedr_alt_beh.aspx?lang=da

(3) The number of active and organised CAM-practitioners equals a ratio of 50 practitioners per 100.000 inhabitants compared to 65 general practitioners and 54 dentists per 100.000 inhabitants (JEPPESEN S. *et al.* 2007: 24).

(4) Of the 2700 practitioners only 2% were educated as medical doctors, dentists or veterinarians, 13% were educated nurses, 3% were educated physiotherapists or occupational therapists, and 7% were educated health auxiliaries (*ibid*: 26).

(5) One survey shows that only 16,3% of the Italians are fairly or very satisfied with the health care system, 23,1% is neither satisfied nor dissatisfied, and 59,4% are fairly or very dissatisfied; this is the lowest level of satisfaction among the 15 EU-member states involved in the survey (EUROPEAN COMMISSION 1998: 8-9). The other survey concerns the public expectation of medical errors, and in this study it is revealed that the Italian public believed that the there is 70% chance that a patient in an Italian hospital will suffer a serious medical error (EUROPEAN COMMISSION 2006: 21).

(6) 17% of the 132 persons that filled in the questionnaire reported to have used some kind of complementary medicine after they received the cancer diagnosis. Among these herbal medicine was mostly used (52%), followed by homeopathy (30%). Also acupuncture was used by several persons, while aromatherapy, Ayurvedic medicine, massage, reflexology, relaxation techniques, spiritual therapies, and vitamins and/or minerals in high doses each were reported to be used by 1-2 persons. (JOHANNESSEN *et al*. 2008). No other therapies were reported to be used by responders to the questionnaire survey.

(7) All personal names are pseudonyms

(8) According to ANKER Niels (2006) 54% of the cancer patients that have consulted the support phoneline of the Danish Cancer Society have used some kind of natural medicine since the onset

of cancer. 37% have consulted a practitioner of alternative treatment modalities, and the most commonly consulted practitioners were acupuncturist (consulted by 20% – and of those half had a professional background as medical doctors or nurses), reflexologists (consulted by 14%) and spiritual healers (consulted by 10%).

(9) It has not been possible to find similar publications by Italian authors.

(10) According to the previously mentioned EU-surveys the Danish people are the Europeans that are most satisfied with public health care and have the firmest trust in the safety of medical treatment. 90% declare to very or fairly satisfied with the way health care is run in Denmark, 3,8% are neither satisfied nor dissatisfied and 5,7% are either fairly or very dissatisfied (EUROPEAN COMMISSION 1998: 8-9); and the Danes believe the likelihood of suffering a medical error is 41% (EUROPEAN COMMISSION 2006: 21).

(11) Biopathy is a Danish medical system based on American traditions of high-dose vitamins and minerals and German traditions of isopathic remedies coupled with herbal medicines.

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