Article

Beyond Medical Pluralism

Communicative Positioning of Biomedicine and CAM in Estonia

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Abstract

Medical pluralism does not only mean the presence of multiple therapies but also the variety of health discourses and norms. By analysing the rhetoric of active participants in the Estonian health field, we portray the diverse discourses in defining and positioning complementary and alternative medicine (CAM) in relation to biomedicine (BM). On a scale of attitudes, five different positions of CAM and BM emerge. Both ends of the spectrum dominantly represent a system-level view characterized by distinct categories, opposition, and labelling. In between, integrative positions focus more on an individual's personal needs by combining and "taking the best out of" all available knowledge systems. The presence of these competing discourses poses several challenges for health communication. Meanings offered by CAM-related health approaches are increasingly visible and influential as unlicensed health workers and laypeople contribute more to public communication due to the openness of social media. On the other hand, critics of CAM and proponents of scientific thinking have mobilized to set boundaries to defend the authoritative position of scientific medicine. Our analysis suggests that using system-level categories supports polarization, which could lead people to seek alternative explanations based on their individual experiences, and thus feeding distrust towards medicine and doctors.

Keywords

Medical pluralism, alternative medicine, sceptics, health discourse, CAM.

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The *de facto* presence of medical pluralism in all pluralistic societies results in a diversity of understanding about the position of complementary and alternative medicine (CAM) in relation to evidence-based scientific biomedicine (BM). The essence and the status of CAM are “contentious matters” (Wahlberg, 2015) contributing to the fierce contestation of expertise in the field of health (Vuolanto et al., 2020). However, in Euro-American societies, an integrative approach has increasingly been accepted with regard to the domain of patients’ autonomous choices (Coulter, 2004; Hanssen et al., 2005; Baer, 2008b; Nissen et al., 2012). Still, CAM has occasionally been criticized by sceptics because of its anti-scientific and potentially dangerous nature (Lewis, 2019; Cano-Orón, 2019). The field of health has been a major site of boundary work (Vuolanto et al., 2020), explicitly visible in cases that legitimize CAM, such as teaching homeopathy at universities (Caldwell, 2017). Furthermore, global anti-medicine and conspiracy cultures could strengthen the polarization because emerging biomedicine-critical attitudes on vaccination and public health measures are increasingly amplified by social media (Puri et al., 2020).

By analysing the rhetoric of active participants in Estonia, we portray the discourses of defining and positioning CAM in relation to BM. Diverse and polarized representations of CAM and BM in Estonia allow us to demonstrate the contestation and boundary work in the field of health. We ask the following: how are CAM and BM depicted by diverse spokespeople and in different contexts? How does boundary work manifest in (health) communication? The overview of these depictions helps in discussing some challenges for health communication and highlights some warning signals regarding the potentially increasing polarization of representations of CAM and BM. Moreover, the status of CAM in Eastern European countries is not widely known by the international community (Nissen et al., 2012; Kemppainen et al., 2017). Our paper aims to fill this gap by contributing to the study of CAM in (Eastern) European countries from a qualitative perspective.

Contestation of the Field of Health and Boundary Work

Public communication is a critical arena in affecting people’s understanding of health and medicine (Briggs & Hallin, 2016) and individual health-related decisions (Kelly et al., 2010). Recent decades have witnessed increasingly diverse health-related opinions and expert positions in the mass media (Kline, 2006; Briggs & Hallin, 2016), a greater presence of “lay experts” (Prior, 2003), as well as networks of people sharing their experiences online (Griffiths et al., 2012). This increasing diversity in the context of health has been depicted as postmodern fragmentation and the emergence of microcultures (Thompson & Troester, 2002). Internet forums and online information sharing based on personal experiences has contributed to the growing diversity of “healthcare knowledge cultures” (Keeling et al., 2013). Alternative health-focused channels hold and support specific norms and regimes of normality, including views about the status and legitimacy of BM and CAM. Distrust specifically in the pharmaceutical industry (critically called Big Pharma) has diminished trust in scientific medicine in general (Attwell et al., 2017).

Democracy and market economy support the inalienable rights of an individual to make health decisions and to use CAM (Nettleton, 2013). Therefore, diversity in health knowledge and norms is a common standard. However, the increasing popularity of CAM has stimulated efforts to

maintain the dominant position of biomedicine, such as insisting on the importance of scientific evidence regarding the safety and efficacy of CAM or opposing government support for research and education on CAM techniques (Kelner & Wellman, 2004). In addition, spokespeople who are critical towards CAM have emerged occasionally, such as the Friends of Science in Medicine in Australia (Brosnan, 2015; Lewis, 2019), or against homeopathy in British universities (Caldwell, 2017). In 2019, several non-governmental organizations came out with the “European manifesto against pseudo-therapies”, which was distributed in different languages to get signatures by scientists and health workers (Pseudoscience Manifesto, 2019). In Spain, there has been an increasingly active sceptical movement reported against complementary therapies and in favour of evidence-based medicine (Cano-Orón, 2019). Therefore, despite the pluralism at the individual level, critique and warnings have been raised at the public level, following the logic of “boundary work” (Gieryn, 1983), so that “the contestation of expertise is perhaps nowhere more pronounced than in the field of health and well-being” (Vuolanto et al., 2020: 509).

Unlike the long tradition of the legitimate presence of CAM in Western societies (Cant & Sharma, 1999), Estonia has gone through rapid changes regarding medical pluralization. The transition from the Soviet societal system to a European democratic and free-market society has rapidly moved things away from the Soviet norms, paternalistic health system and exclusive authority of biomedicine (Barr, 1996; Singer & Baer, 2011). Still, BM has an exclusive position in Estonia – no CAM therapies are funded by national health insurance and there are no actual debates or attempts to change this arrangement. Private health insurance has a very marginal role. Journalists and the main spokespeople for the medical system tend to be critical towards CAM in the media (Tikk, 2005; Koppel & Uibu, 2020). However, at the same time, there has been a constant use of CAM and various folk remedies by people for decades. Regardless of the criticism, CAM-related topics are increasingly appearing in the media as part of well-being and general body–mind–spirit discourse (Koppel & Uibu, 2020). Moreover, CAM is being introduced to healthcare professionals through training events (Koppel, 2018). Therefore, Estonia provides insights into the dynamics and tensions of the mainstreaming of complementary and alternative medicines, as well as the polarization of diverse attitudes.

Why Public Meanings Matter?

Several sociocultural processes such as marketization, as well as the emergence of new communication platforms, have made the wide variety of health-related knowledge and the supporters of CAM-related teachings more visible. Social media platforms functioning as “echo chambers” (Garrett, 2009) may contribute to the emergence of distrust and open suspicion/hostility towards biomedicine. Exposure to diverse health-related information affects understanding and health situations, choices, and outcomes (Kline, 2006). It is not possible to separate a person from the representation he/she holds based on a variety of sources, including media, books, and the internet (Kline, 2006). For instance, the perceived outcomes of CAM are reported to be better when people perceive them as trustworthy; a therapy that is recommended by experts or lay people has been proven to have better effects than one with no recommendations (Shin & Shim, 2018).

Therefore, personal understandings, meanings and perceived validity of therapies not only give “context”, but they are also strongly related to the efficacy of these methods (Moerman, 2002).

Obviously, both BM and CAM are very broad categories that are heavily dependent on the cultural context. The substance and meanings of BM are diverse on the global scale, but also in Europe (Krause et al., 2012). Although the boundaries of BM could be drawn differently, the core of BM, whether conceptualized as evidence-based (White & Willis, 2014), Western (Derkatch, 2016) or orthodox medicine (Cant & Sharma, 1999), is seen to be based on Western science and forms the foundation of the Western medical system. The term “CAM” is commonly used to refer to all those elements outside the biomedical domain. The conceptualization of CAM is always related to power dynamics – for example, defining something as alternative derives from biomedical dominance (Cant & Sharma, 1999; Baer, 2008a; Ng et al., 2016). Generally, the term “complementary therapies” is used for methods that could easily be applied in concurrence with BM, whereas “alternative medicine” means there is an either–or option. The increasingly popular concept of “integrative medicine” denotes a coordinated and pluralistic effort to address a health problem using diverse health and medical expert systems (Harnett & Morgan-Daniel, 2018). However, it is important to emphasize that the perceived positioning and particular labelling of a therapeutic practice in relation to BM is time- and culture-specific (Barcan, 2010). For example, common concepts of “integrative” or even “complementary” medicine are rarely used in Estonia, and the term “alternative medicine” to denote CAM is dominant in the public discourse (Koppel & Uibu, 2020). Moreover, the terms “alternative”, “complementary”, and “integrative” are commonly not differentiated in everyday usage, and the classification of a certain therapeutic practice under any label is very situational and subjective.

The ideological foundations, ambitions and positions of CAM are also very different. For example, many therapies and techniques labelled as CAM treatments focus on a specific aim and procedure without ambition to offer a broader health philosophy or restructure power hierarchies. These therapeutic practices, such as chiropractic or acupuncture, could simply be methods that are not validated or are validated to some extent by randomized controlled trials (RCTs) (Dew, 2000; Barnes, 2003). There is even a special – and controversial – category of “evidence-based complementary and alternative medicine” (EBCAM) (see Wilson & Mills, 2002; Ernst, 2011). However, some teachings of CAM, which are framed as part of a holistic health movement, aim to redefine the basic understandings of health, illness and healing, offering explanations that might conflict with BM’s core understandings and assumptions (Baer, 2001). Also, one broad and generally unregulated field of CAM may accommodate fraudulent and dangerous CAM treatments – “CAM-adjacent health scam” (Lavorgna & Bishop, 2019). We have observed that the act of giving definitions and setting boundaries depends on and indicates well the position and intentions of the communicator (Koppel & Uibu, *in press*).

Our study is based in Estonia – a small country in north-east Europe, which, like other Eastern European countries, witnessed rapid changes in the process of medical pluralization after decades of the centralized and exclusive medical system of the Soviet Union. The opening of the health market to international health-related teachings and therapies, as well as the changing role of the patient due to democratization, has made conflicting positions more visible (Uibu, 2020). CAM methods tend to be presented in a highly polarized way in the Estonian media and by health experts

who are worried about the diminishing authoritative position of BM (e.g. Tikk, 2005; Võsumets, 2015; Ernits, 2017). Public health-promoting institutions have launched health campaigns warning about CAM therapies, depicting them as dysfunctional, harmful and “non-healing” (*ebaravi* in Estonian) and ridiculing them publicly (see Health Board, 18 Jan 2019). International manifestos for the defence of BM have been called into action and distributed by the mainstream media (Himma, 2019). However, more integrative approaches and CAM methods that have been successful in legitimizing themselves in relation to BM are slowly emerging (Koppel, 2018; Koppel & Uibu, 2020). Furthermore, there are numerous specialists promoting CAM, and there are increasingly popular semi-public spaces, such as internet forums and Facebook groups, that support BM-critical approaches.

Data and Methods

To portray the discourses of defining and positioning CAM in relation to BM, we here conduct a meta-analysis of a broad range of data that we have collected during our research projects between 2011 and 2020. Our academic backgrounds are in anthropology and media and communication studies, which has shaped the data collection and methods we have used for the analysis. Our largest data set is an ethnographic one, which we have complemented with survey responses and a set of media texts published in the Estonian media. The combination of anthropological and media and communication study methods – although relatively uncommon – is not exceptional (Briggs & Hallin, 2016). Characteristic of anthropologists, we engage with work based on in-depth interviewing and ethnography, at the same time applying principles of media and communication studies, such as rigorous sampling and coding (*Ibid.*). While collaborating closely throughout the years, we have worked with different data sources and data collection methods, and this has enabled us to validate our research results via triangulation (Flick, 2018). Triangulation is a widely used practice in qualitative research, part of which involves researchers taking different perspectives on an issue under study or in answering research questions (*Ibid.*). Table 1 illustrates the different types of triangulation opportunities that we used in our research.

This paper is mostly based on long-term ethnographic field research we have been conducting in the Estonian CAM-related health and healing sphere since 2011. Long-term ethnography allows researchers to contextualize different types of data (including media texts) regarding people’s subjective understandings and actual lifeworlds: how the elements common in public discourse are used and what the significance of different elements presented is. For example, we noticed similar arguments and motifs appearing in media texts, in a training session or in the explanations of CAM users. Additionally, familiarity with the research field and people’s perspectives allowed us to observe and study the closer positioning of and relationships between CAM and BM as significant phenomena. The impetus for the present study came from our discussions about how the depictions of CAM and BM are very diverse, yet also contain similar elements. To make sense of these positions, we looked at our material more systematically.

Table 1. Types of Triangulation Applied in the Study

Diverse data collection methods	<ul style="list-style-type: none"> • Participant observations (period = 2011–2018) • Qualitative interviews (n = 65) • Survey (n = 248, incl. 54 qualitative responses) • Media texts (n = 431)
Long period of data collection	<ul style="list-style-type: none"> • Data collection from 2011 to 2020 has allowed to see the dynamics of the study field and "re-visit" findings.
Two researchers	<ul style="list-style-type: none"> • Two authors collected data separately and participated in different events, whereas discussing and comparing the findings were done together.
Diverse informants/perspectives involved in the study	<ul style="list-style-type: none"> • CAM users • Providers of CAM • Medical doctors • Mediators of information (journalists)

Our ethnographic presence has been both online (Postill & Pink, 2012) and offline. Almost every year we have conducted participant observations in training sessions of CAM practices, and in different seminars and public events related to CAM and healing. Despite having close contact with the research topic, we do not have any engagement with CAM methods or specific practitioners and have maintained positions as neutral observers and researchers. Throughout the years, we have conducted ethnographic interviews with 56 practitioners and users of different healing and health therapies, such as yoga, Traditional Chinese medicine, breathwork therapies, crystal healing, and Reiki. We have observed forums and social media groups that attract active users of CAM and followers of diverse non-biomedical healing modalities. Long-term ethnographic field research in the CAM-related domain has given us a broad understanding of CAM in Estonia, as well as enabling us to get familiar with how users and practitioners perceive CAM and what they value about it (e.g. see Uibu, 2020, 2016a, 2016b, 2012; Koppel, 2013).

While we began our field research studying CAM practitioners and users, our focus has also shifted over the years. Firstly, we became increasingly interested in relationships and construction of boundaries between CAM and BM. In 2016, we expanded our field research to biomedical settings, conducting participant observations at events that aimed to educate healthcare professionals about CAM. The same year, we also conducted a survey of 248 healthcare specialists (nurses, doctors, midwives, psychologists, social workers) working at the major Estonian hospitals. The survey has given both quantitative and qualitative information about the perceptions of medical diversity in Estonia, as well as the attitudes of healthcare professionals towards CAM. In this paper we have included the qualitative part of the survey – responses of 54 medical specialists to non-mandatory, open questions about personal and work-related experiences with CAM. In addition, in 2017, we conducted nine qualitative interviews with healthcare experts (mainly nurses and midwives), focusing on the relationships between BM and CAM, with the emphasis on Traditional Chinese medicine (Koppel, 2018).

Secondly, we became increasingly intrigued by studying public meanings, as well as the legitimization and delegitimization of CAM in public communication. Thus, as part of online ethnographic field studies, we have observed media texts published about CAM on both mainstream and alternative media platforms. We also have a systematically sampled data set consisting of 431 media texts published both by professional journalists and opinion leaders between 1996 and 2018. The data set consists of media texts published about three influential Estonian medical doctors who navigate between the domains of BM and CAM (Koppel & Uibu, 2020; *in press*).

Considering research ethics, we have followed the rigorous ethics protocol from the AAA (American Anthropological Association), including ensuring anonymity of our interviewees, asking consent, and introducing our research purposes and procedures to our informants¹.

After cataloguing and reviewing different data sets, we extracted the relevant texts (i.e. interview transcripts, notes of online and offline fieldwork, survey responses and media texts) that focused on the positioning and perceived relationship between CAM and BM. By coding this data using thematic analysis (Ezzy, 2002), we identified different categories that were most characteristic of diverse views and representations: definitions given to health; legitimate sources of evidence for efficacy; attitudes towards the type of “modern” institutions, such as science or medicine; and the individual- or system-based viewpoint (see categories on Figure 1). Based on the differences between these categories, we reached five “ideal types” representing the different ways of constructing the roles of BM and CAM in Estonia. We subsequently discuss these positions, providing examples characteristic to the Estonian healthcare field, and we discuss the implications of these positions for health communication.

Results: Relationships Between Biomedicine and CAM

From the Estonian empirical material, three main representations of CAM in relation to BM emerged: exclusive dominance of BM, normalization of pluralism/diversity of the health field, and the superiority of CAM teachings and practices. These three main categories are elaborated by two intermediate categories: hegemony of BM and implicit superiority of CAM. Although the positions are depicted and described as certain types, the attitudes are situated on a continuum – there is a gradual progression of understandings, as well as substantial overlap between neighbouring types.

Position A: Biomedicine as an Exclusive Dominant Authority

Biomedical exclusive authority derives from the assumption of the absolute advantage and exhaustiveness of Western scientific models, omitting other existing epistemologies and modalities. This position commonly comes from a system-level view and is binary – a therapeutic method can only be categorized as appropriate (i.e. biomedical) or inappropriate, (i.e. “alternative” or “non-healing”). The boundaries between the categories are seen as clear and unequivocal.

Figure 1. Representations of CAM in Relation to BM

Treatment is defined as biomedical activity only, and no biomedical therapeutic method nor real healthcare professional can provide the actual cure for a disease. This position does not automatically assume explicit hostility towards CAM or "alternative teachings" but only as long as the boundaries between medicine/science and belief/religion are kept.

I am not rejecting spiritual-alternative teachings. If anyone benefits from it then very good. It doesn't interfere with my work as a doctor. (Physician, male, 31–40 years old, survey 2016)

The strong and exclusive opposition between BM and CAM becomes visible, however, the moment the two domains start to interfere with each other. In this case, CAM is seen as harmful because the patients can be encouraged to abandon biomedical treatment or recommendations by doctors in favour of alternatives. In the survey responses, healthcare professionals gave examples of parents who did not allow their children to be treated and chose alternative methods instead, as well as providing examples of patients with severe diseases, especially patients of cancer, who had not found a cure because of using CAM.

I have mostly seen harmful activities: a patient with an intestinal tumour refused to have an operation and started to receive an enema with a homeopathic dilution on a daily

basis. Eventually the patient was in hospital because of regular anaemia. And then it wasn't possible to operate the tumour because it had spread too far. Then there was a diabetic who refused injections and used "grains" instead... who needed hospitalization all the time due to hyperglycaemia. (Physician, male, 21–30 years old, survey 2016)

Often these anecdotes from healthcare professionals depicted practitioners of CAM as criminals and dangerous manipulators who want to get rich quickly. CAM methods were perceived as ridiculous and users as foolish or weak because of falling into manipulators' 'traps'. The examples focused on patients' irrationality and superstitions and were sometimes presented very sarcastically.

A patient came for a medical check because his health condition had worsened, but at the same time, he didn't agree to use conventional treatment methods because the healer didn't allow him to do it. Another patient verified with a pendulum whether or not the prescribed medication was good enough for her: Nospa [a drug] was not, but Buscopan [another drug] was. (Nurse, female, 41–50 years old, survey 2016)

The exact same view on CAM can also be found in the public communication field. For example, the principle of exclusive dominant authority of BM fuelled a campaign of "non-healing", which took place in 2019 in Estonia. This campaign was conducted by the Health Board of Estonia and aimed to raise awareness of the dangers of non-evidence-based medicine. Besides representing the above-mentioned characteristics of position A, the campaign also gave a very clear description of the education, behaviour, service and verbal expressions of "non-healers" in order that "non-healing" activities could be recognized. For example:

"Personal experience" – their ["non-healers"] stories are grounded on "personal experience" in the style of "my dog was healed", "the child was miraculously healed", "it was as if the pain was wiped away by hand". They also talk about simple things in a very complex way and often use unknown or incorrect terms – for them, it is important to sound wise but incomprehensible. For example, they might use the following phrases: "strengthens the immune system", "is a natural substance", "is an anti-inflammatory substance or procedure", "changes the body's pH", "helps with everything" and "cleanses the organism". /---/ (Health Board 2019)

In general, position A does not greatly take into consideration the possibility of individual, subjective mechanisms: for example, that with some patients, evidence-based treatments might not work as well as something that has generally not been proven as efficient and is not (yet) evidence-based.

Position B: CAM under the Hegemony of Biomedicine

The intermediate category between the radical biomedical approach and integrative medicine refers to a certain mobility of boundaries that enables some flexibility for CAM to be included as complementary to BM. According to this position, the decision on the use of CAM should be made by biomedical experts; all boundaries are confirmed, controlled and reconfigured by the biomedical system and ideally should be based on clinical trials. Proof of the efficacy and safety

of a certain therapy or therapeutic method is the basis for considering an alternative treatment method as potentially complementary and part of evidence-based “real” medicine.

I'm a great believer that the only way that non-conventional medicine will become a part of regular health is through research. There are really two issues for everybody who treats patients in the Western setup – safety and efficacy – can we attend to these two issues well or well enough? (TCM practitioner, male, about 60 years old, ethnographic fieldwork at the conference ‘Opportunities in Oncology’ 2016)

Although evidence-based medicine should unquestionably hold the authoritative position in the physiological domain, it is acknowledged that people's beliefs can have a real effect – these effects are commonly placed under the label of “placebo”. Therefore, selected CAM methods can support patients (e.g. psychologically) or provide relief during the treatment process. If the method itself has no physiological effects, which means that it is not harmful either, a patient could try out something in addition to biomedical treatment.

It's more about the tremendous faith of a patient's close ones; this faith actually stems from human nature to grab the last straw to maintain hope and faith. I have seen no real results except that the believers themselves feel better. (Caregiver, female, 21–30 years old, survey 2016)

Depending on personal experiences and healthcare professionals' encounters with CAM, some health teachings are seen as positive in regard to encouraging a patient's subjective self-belief during treatment and in offering psychological or certain physical support. Usually, particular physical exercises, massages, osteopathy, chiropractic or even Reiki can be perceived as useful treatments to get some relief from joint and muscle tension and pains. Also, herbal medicine can be used to relieve colds and coughing. But as medical specialists emphasize, it is crucial to know the boundaries and not to drift across to the “wrong side”.

You should know where is the boundary that you should not go past to avoid ending up on the evil or magic side with all those mediums and clairvoyants and witches and quacks (Nurse, female, 49 years old, interview 2017)

Furthermore, the implementation of these complementary practices is seen to be controlled by biomedical professionals and/or the state. This means that the professional level, education and experience of a practitioner determines the legitimacy of him/her and must be clearly stated:

A chiropractor could carry out his procedures, but it must be transparent what education he has. Generally, it becomes a problem when a chiropractor calls himself a doctor. (Physician, female, 31–40 years old, survey 2016)

Position B highlights the importance of boundary negotiation. The survey and ethnographic data show that healthcare professionals feel that it is very important to know which methods, from the variety of CAM methods, can be used in a complementary manner, and also when and if they should be used.

Position C: Integrative Medicine as a Manifestation of the Plurality of the Field of Health

The integrative approach towards BM and CAM emphasizes their co-existence. According to the proponents of integrative medicine, the ideal solution would be to have biomedical and CAM practitioners working together and collaborating actively or have biomedical practitioners who know and can apply CAM therapies to achieve the best treatment results. The aim is to give the patient an opportunity to decide on the most suitable therapies. This position sees the great value of pluralism, which the individual should take full advantage of. Therefore, the focus is at the individual/patient level and often it is emphasized that before biomedical and more invasive treatments, a patient should try “natural” options.

...a two-week-old baby is not growing enough because of problems with breast milk. Up to now, we have used all possible natural treatment options. The mother has drunk some different teas, we have recommended that she relax /---/ However, at the very end we can still use a pill that increases the amount of breast milk. (Midwife, female, 57 years old, interview 2017)

This position also clearly separates medicine from health. Health is predominantly connected with the personal domain and a patient’s individual responsibility, while medicine is defined as a purely scientific field. Although evidence and scientific proof of efficacy are considered very important, the lack of these does not determine the usage of a therapeutic method if it turns out to be beneficial for a patient. The role of BM is regularly perceived to take care of acute health conditions and treat “serious” diseases, whereas CAM is mainly understood to be responsible for preventative care, health maintenance and the patient’s general well-being.

Serious DISEASES cannot be effectively treated with scientifically unproven or unrecognized therapies, but these methods can improve HEALTH (this is again something that is not very much in focus in modern medicine, except for the prevention of cardiovascular and some other diseases). (Physician, female, 51–60 years old, survey 2016)

Integrative medicine commonly focuses on prevention, maintenance of health and patient’s wellness and well-being. The concept of health is broad and holistic, including social, emotional and spiritual dimensions. Hence, terms such as ‘holistic healthcare’ can be used by proponents to describe the integrative approach. The proponents of integrative medicine claim to merge the best of CAM with BM, drawing on evidence-based scientific thinking. The evaluation of efficacy and safety of treatments is based on diverse indicators and research methods (subjective healing and well-being included).

For example, Traditional Chinese medicine has been introduced to the Estonian medical community as one of the potential methods to “support patients” and act as part of integrative medicine. In the Estonian public communication sphere, the discourse concerning integrative medicine has helped spokespeople of TCM to gain more access to the mainstream media and already receive a certain acceptance by the medical community.

The patient, as well as the state, wins from this [Chinese medicine], as it is much cheaper to prevent than to treat disease. In addition to this, physicians' workloads would decrease. (TCM practitioner, male, 41 years old, media interview published on med24.ee portal [the portal publishes medically "respected" material] (Filippov, 2016))

Position C gives many opportunities for CAM practitioners to legitimize CAM as part of integrative medicine. However, position C is one of the most idealistic positions to achieve, as the proponents of BM tend to be more inclined towards position B and proponents of CAM more towards position D.

Position D: Implicit Superiority of CAM

Although the general platform for this position is still an integrative approach, BM is seen as having rather narrow and limited expertise. Although not necessarily stated explicitly, BM, with its "limited scope", is perceived as subordinate to more exhaustive and holistic approaches that CAM and its teachings are seen to offer. It is highly characteristic for this position to give broad meanings to health and illness – relating them to lifestyle, morality, and particular philosophies. Therefore, health, being healthy, and 'healing' become existential issues, which should also be addressed as such.

Of course, medical experts are very highly trained, but they cannot guide you as to how to heal naturally. No school of medicine teaches the integrity of the body. (Natural health follower, female, 31–40 years old, interview 2015)

This position has different core topics; however, the emphasis is commonly on being more natural. Health is understood as a natural state of the body that "superficial technologies" tend to disrupt. When living life according to the correct principles (that commonly come from the CAM knowledge system) a person should never need BM. For example, one mother who posted a longer explanation on her Facebook profile about her CAM usage explained:

You know, we are accused constantly of not vaccinating or following medical guidance so that we are undermining some collective effort and putting everybody at risk... it is so, so silly, really. Our children are healthy all the time! I have needed a doctor once with my four children – once! And it was because my eldest son had an ingrowing toenail. (Musician, female, 41–50 years old)

Another common aspect is the understanding that personal (health) decisions should be based on the sensations of the body. The body is seen to provide the necessary knowledge for treatment and health maintenance instead of needing external experts. Therefore, health and health decisions become radically personal and individualistic matters. A positive result of treatment (i.e. the healing of a patient) is the criterion for evaluating the "efficacy" and "safety" of a therapeutic method. This perspective emphasizes the subjectivity of methods and results; scientific tests, as external knowledge, cannot be a true measure.

Very often, emotionally unhealed birth traumas prevent women from having children. And again, this is something that is completely unspoken and overlooked in our society. Of course, when someone like me comes up with this story, the elite, academic folks immediately come and ask for scientific evidence. But the proof will come to you, my darlings, in fifteen years. Because the idea that Binnie [a spiritual teacher] and I spread all the time is always ahead of its time. This thought is actually thousands of years old, but we say it out loud. We have experienced it. In our meditation, we see and feel where the problems really are. (Breathwork therapist, female, 63 years old, interview 2012)

As the example above also demonstrates, this position is supported by health teachings and teachers who aim to define health and/or illnesses differently, offering philosophies for life. Another example, Luule Viilma – a famous doctor and one of the most published Estonian authors since the 1990s – describes the social reasons behind health problems such as influenza caused by heavy-heartedness and despair. Although Viilma also mentions the strengths of BM, it is still subordinate to the broader philosophy that she provides due to BM's "narrow-minded" and "simplistic" approach.

Illnesses are far more complex phenomena than official medicine liked to define them (Viilma, 1996:24).

Position D emphasizes the importance of plurality in the health field and each individual's right, even obligation, to make health-related decisions. However, the holistic approach to human mind, body and health, as well as the variety of health teachings, defines the rules to decide what the best choice for a person is, making CAM implicitly superior over BM.

Position E: Superiority of CAM, Distrust and Scepticism Towards BM

This position is, in several aspects, similar to the previously described implicit superiority of CAM but focuses its attention more on the flaws of BM and conceptualizes CAM and BM as competing systems. Related to conspiracy theories, the proponents of this position often find that "big pharma" and "the medical industry" are globally manipulating people to increase their profit. Therefore, the position is related more structurally around distrust towards "mainstream" institutions and knowledge. Alongside this, proponents tend to question what the value of the medical profession and doctors is and whether they actually bring any good to people. They might also use deliberately offensive expressions:

With doctors I have started to doubt if it is a profession or a diagnosis... (Member of a medicine-critical social media group, female, 41–50 years old, post)

Position E represents the idea that the dominance and even monopoly of the biomedical system has several negative outcomes for people's health and "natural" being. For example, one of the core issues that stimulates conflicts is children's vaccinations, which proponents see as an unnecessary and dangerous intervention to the baby's natural immune system and health. The proponents of this position claim that CAM is safe and natural but purposely marginalized to hide knowledge of "traditional" and non-biomedical healing. Hence, the harm that BM can do should be made public.

Modern medicine is in deep crisis. Not only does it fail to cure people from illnesses, but so often makes them worse. Medicine nowadays is one of the biggest causes of death. By repressing symptoms, we lose knowledge on the actual causes of illnesses. (The opening sentences of the description of the popular Estonian Facebook group “Watch out – medicine! Attention – effective treatment!”)

Paradoxically, this position is often also supported by market-driven mechanisms because conspiracy-loaded revelations and “hidden” information can be sold effectively. The popular British journal “What Doctors Don’t Tell You” has been translated into several languages, including Estonian. Telegram.ee, a well-known Estonian alternative media platform that fuels distrust and scepticism towards BM, has published a variety of articles that question the motives of BM and science; some examples of headlines include:

Dr. Jason Fung: Corrupt Evidence-Based Medicine Earns Profit at Death (Sept 16, 2020)

Timeless. Are Heart Medications Just a Scam in the Pharmaceutical Industry? (Nov 5, 2020)

Dr Andrew Kaufman: Coronavirus Is Not Scientifically Proven, So We Have No Idea What the Tests Show (July 31, 2020)

Video! Doctors around the World: the Coronavirus is a Fraud, an Open Debate Must Take Place (Nov 7, 2020)

Position E plays out in several variants, which can vary in their understanding from more moderate to very radical. In spiritual/religious variants, health and illness are usually influenced by supernatural/transcendental powers. More secular variants emphasize the direct harm that biomedicine is supposed to do. In some cases, and especially in thematic social media groups, people express hostile attitudes towards doctors and medicine.

The Dynamics of and Tensions Between these Positions in Estonia

In Estonia, BM is presented as an exclusive hegemonic authority (position A), usually by practicing healthcare professionals, predominantly physicians, and representatives of different state institutions that deal with the regulation of health issues. A strong tradition of BM and the state’s support for it has roots in the Soviet era when BM was perceived as the manifestation of scientific progress. Treatment methods that cannot be categorized as evidence-based find severe criticism by the proponents of scientific materialism, especially by sceptics (Uibu, 2012). Moreover, critical attitudes can also be found in public discourse. For example, homeopathy, which in some countries such as the UK is quite a widely used treatment, also by biomedical practitioners, receives disapproval and is depicted as a vicious treatment method in the media by journalists (e.g. Pihl, 2018; Kuulpak, 2018; Punamäe & Kuulpak, 2018). Medical practitioners who practice CAM methods risk harming their public reputation (Koppel & Uibu, *in press*).

Similarly, strong medicine-sceptical positions have emerged recently in Estonia. Although not yet highly present in mainstream media channels, critique and even hostility towards BM has become more visible and widespread via alternative portals and especially social media and the

internet (Uibu, 2021). Facebook groups create opportunities for people to share their negative experiences, magnifying distrust, hostile attitudes and disappointment with BM, leading to “echo chambers”. Estonian Facebook groups such as “Side effects of medicine and vaccines” or “Beware – medicine! Attention please – effective cure!” have found a large number of members and followers, which has sharply risen during the COVID pandemic. Therefore, the increasing trend of anti-medical discourse (position E) seems to continue; its broader cultural relevance is not delimited to closed sectarian or specific socio-cultural groups.

These strongly opposing attitudes enhance the polarization in the Estonian health field. This polarization is further inflamed by public communication attempts to respond to the increasing visibility of CAM. For example, in 2019, the Health Board of Estonia created the clips and banners of the communication campaign of “non-healing” that aimed to demonstrate the absurdity of CAM (characteristic of position A). This, however, activated many people with good CAM experiences to share their positive stories. Some active CAM proponents even expressed delight for the campaign. According to them, the campaign demonstrated how spokespeople for BM use wicked strategies and public money to attack the actual value of CAM, so that those people who would otherwise follow integrative discourse (position C) were now inclined towards more critical and system-level positions (D and even E).

On the other hand, there are a few examples of CAM methods embraced by the BM paradigm in Estonia. One of the BM-recognized complementary treatments is acupuncture, which was already practiced by biomedical professionals in Soviet Estonia and which can currently be practiced by licensed medical doctors only (Koppel, 2018). From the state perspective, acupuncture is perceived as a healthcare service and, hence, an acupuncturist needs to fulfil the requirements of the health services. The regulations have supported professionalization of acupuncture; however, presumably also limiting and controlling the wider usage of acupuncture. This is an example of position B.

Compared to anglophone and Western European countries such as Germany or the Netherlands, in Estonia we cannot talk about an established field of integrative medicine. However, we can talk about the increased presence of integrative medicine rhetoric. Recent years have witnessed the emergence of spokespeople and CAM practitioners who skilfully apply integrative language and legitimize their expertise based on that (Koppel & Uibu, 2020).

Discussion and Conclusion

The aim of this article was to describe and systematize different views about the relationship between BM as a dominant expert system and CAM. Representations of CAM in the public discourse help to detect changes that are happening in the pluralistic health landscape. We looked at the public meanings of CAM in relation to BM from the perspective of a long ethnographic study that involved diverse data collection methods from different actors and sources in the health field over a long period (various types of triangulation). Health communication research benefits from an ethnographic approach, which reflects the lived experience and helps to convey accurate and socially valid accounts of study participants’ lifeworlds (Schensul and LeCompte, 2013). Ethnographic research entails close contact with people and phenomena that have been studied.

This broader familiarity with the field has allowed us to characterize and contextualize public communication more holistically and to discover and validate the different positions towards CAM in the pluralistic health field.

Obviously, this study had many limitations due to its qualitative and non-representative nature. Medical systems and understandings about health are culture-specific; even the basic definitions of CAM are vague and context-dependent (Ng et al., 2016). It would be worth conducting comparative research between different countries to demonstrate culture-specific similarities and differences. Furthermore, it would be fruitful to investigate the positionings and legitimization strategies with a quantitative approach that covers the whole population of a country. It would also require systematic quantitative studies and longitudinal media analyses to map the relative proportions of different discourses/positions and understand their popularity over time.

The greatest value, however, of the qualitative examination presented here is that it emphasizes the necessity to notice and acknowledge the implicit/hidden hierarchies and connections within diverse positions relating to CAM and BM. The Estonian example offers good insights since the debates over the position of CAM are frequent and polarized. Medical pluralism does not mean the presence of multiple therapies only, but it is tightly related to representations and discourses of health. Moreover, perceived hierarchies of different sources of health knowledge are inherently part of medical pluralism. By looking at the conceptualizations of CAM and BM, we constructed a scale of attitudes and identified five different positionings. Both ends of the scale represent dominantly system-level views – characterized by the construction of distinct categories, conflictual principles, and derogatory labelling. Middle positions correspond more to individual-based, micro-level views where discrepancies and co-existence of seemingly incompatible ideas and practices are more easily tolerated (and commonly not even noticed). From the subjective perspective of an individual, healing allows contradictory combinations. For patients, it is common to combine therapeutic methods without the need to use labels and without feeling conflict or contradictions (Fadlon, 2005). As a principle of an integrative approach, individuals should test what works for them and take the best from all knowledge systems available.

Secondly, the need to turn systematic attention to medical pluralism is connected to the fact that CAM-related health approaches are increasingly visible: unlicensed and/or unregulated health workers, as well as lay people, get more opportunities to contribute to public communication via social media and the internet. During the COVID pandemic, these “alternative” spokespeople and channels have become increasingly influential and problematic in the health communication field. The growing visibility of CAM and its increasing presence in scientific domains such as universities have resulted in communicative efforts through boundary work by scientists and scientific medicine (Kelner et al., 2004; Caldwell, 2017; Lewis, 2019). To warn people about CAM methods and support scientific expert/knowledge systems, public communication campaigns and statements like the “Pseudoscience Manifesto” of 2019 have emerged. Similar initiatives have intensified due to the challenges of COVID misinformation. Operating in a general communication field, these attempts either explicitly or implicitly promote the distinct and oppositional categories of non-scientific CAM and evidence-based BM.

The great pluralism in health-related norms and understandings about the legitimacy of diverse healing methods poses challenges for health communication. Our study suggests that system-level

terminology (CAM and BM as exclusive, distinct categories) supports polarization. Bounded, exclusive categories do not correspond with actual flexibility and pluralism of individual health choices. Defenders of BM from position A tend to depict CAM-related health approaches as the ultimate “other”, selecting the most extreme and demonizing examples of CAM. When addressing CAM from the biomedical or scientific position, it is dangerous to ignore or reject the subjective component of health experiences. For example, when a person (or his/her close friend/relative) has experienced pain-relief or curing effects via CAM therapies, ridiculing the usage of these methods does not help to communicate the potential threats of CAM. Rather the opposite – it creates barriers and distance. Polarization is problematic as it tends to perpetuate itself. We witnessed this with the Estonian communication campaign of “non-healing”, which, opposite to the expected outcome, activated CAM-friendly people to take system-level positions. Similarly, promotion of BM as a reliable knowledge system refers to polarized system-level thinking. For instance, the manifesto for the defence of evidence-based medicine distributed in 2019 is a demonstration of power, not an invitation to dialogue or an actual endeavour to help people to make more informed choices. Therefore, we suggest being very careful with public communication messages and campaigns due to their potential extensive and long-term negative impact.

In addition, polarized debate and the perceived need to defend one's position makes doctors and medical specialists more defensive and reluctant to express or admit any justified critique against biomedicine. This opens up the opportunity for medicine-critical people from position E to present themselves as the only and necessary critics of the impunity and overdominance of BM.

As strong ideological elements, consumer logic and the rhetoric of person-centred healthcare encourage a subjective and individual-based approach in health. In this paradigm, integrative medicine can easily establish itself without the need to talk on behalf of CAM as a distinctive system and instead emphasize the importance of well-resonating values such as individual autonomy or the subjective nature of health and lifestyle in general. This resonates well with the integrative rhetoric (positions C and D in Figure 1) but not the system-level categorization of CAM. Avoiding conceptualizations of CAM as a coherent category allows proponents of CAM to avoid speaking on behalf of all alternative methods since the field of CAM is very broad and diverse, including potentially fraudulent and dangerous alternative treatments (Lavorgna & Bishop, 2019). Our analysis of CAM-specialist rhetoric demonstrates that avoiding system-level meanings and instead emphasizing the importance of individual level by CAM is a more successful strategy for preventing conflicts and direct public attacks (Koppel & Uibu, 2020). Therefore, in public communication, especially in the mainstream media, system-level arguments seem to promise an “easy win” for the defenders of Western scientific medicine, but it is uncertain how much these public debates could affect people's personal decisions and create actual changes in their behaviour.

It must be noted that taking a position on the scale between A and E is context- and situation-specific. A doctor might take an integrative approach during a consultation with a patient but use CAM-critical system-level arguments in a social media comment or in a discussion with colleagues. In our research, in ethnographic material and interviews, it seems that medical experts tend to be more person-centred and accepting whereas public communication is more polarized. It

would be interesting to examine the “spaces” and situations that bring out different positions and attitudes more systematically.

The great differences in understanding about health and legitimate sources of knowledge could pose challenges for interactions between doctors and patients as well. Because of the relatively high polarization, Estonian doctors complain about “brainwashed” patients who believe in fraudulent CAM (position A); CAM advocates on the other hand, share stories about “narrow-minded” physicians corrupted by big pharma (position E). Opposition to biomedicine and erosion of trust in doctors creates communication barriers and could lead to health-damaging decisions. It has been demonstrated that when patients perceive hostility of a doctor towards CAM, they avoid revealing their CAM experiences and upcoming plans (Shelley et al., 2009), which is commonly also the case in Estonia (Lubi et al., 2016). In social media groups, people share stories of how they have “acted” to give a CAM-opposed doctor the impression that they are fully complying with his/her suggestions, without having any intention to do so (Uibu, 2021). Undoubtedly, this is a dangerous pattern and could prevent any “patient-centred approach that involves honest and informed discussion about the use of CAM” – something that has been suggested regarding CAM-related communication for decades (Frenkel et al., 2010: 182). Therefore, to overcome potential barriers, the invitation for dialogue and listening should be an inherent part of medical practice, and it would require extra effort from doctors and special training. As our study suggests, one (small) step here would be to avoid over-generalized system-level arguments about BM and CAM.

Notes

1. At the time we began our research, Estonian human research ethics committees focused on biomedical and genetic research, and anthropological studies were not required to apply for permission.

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