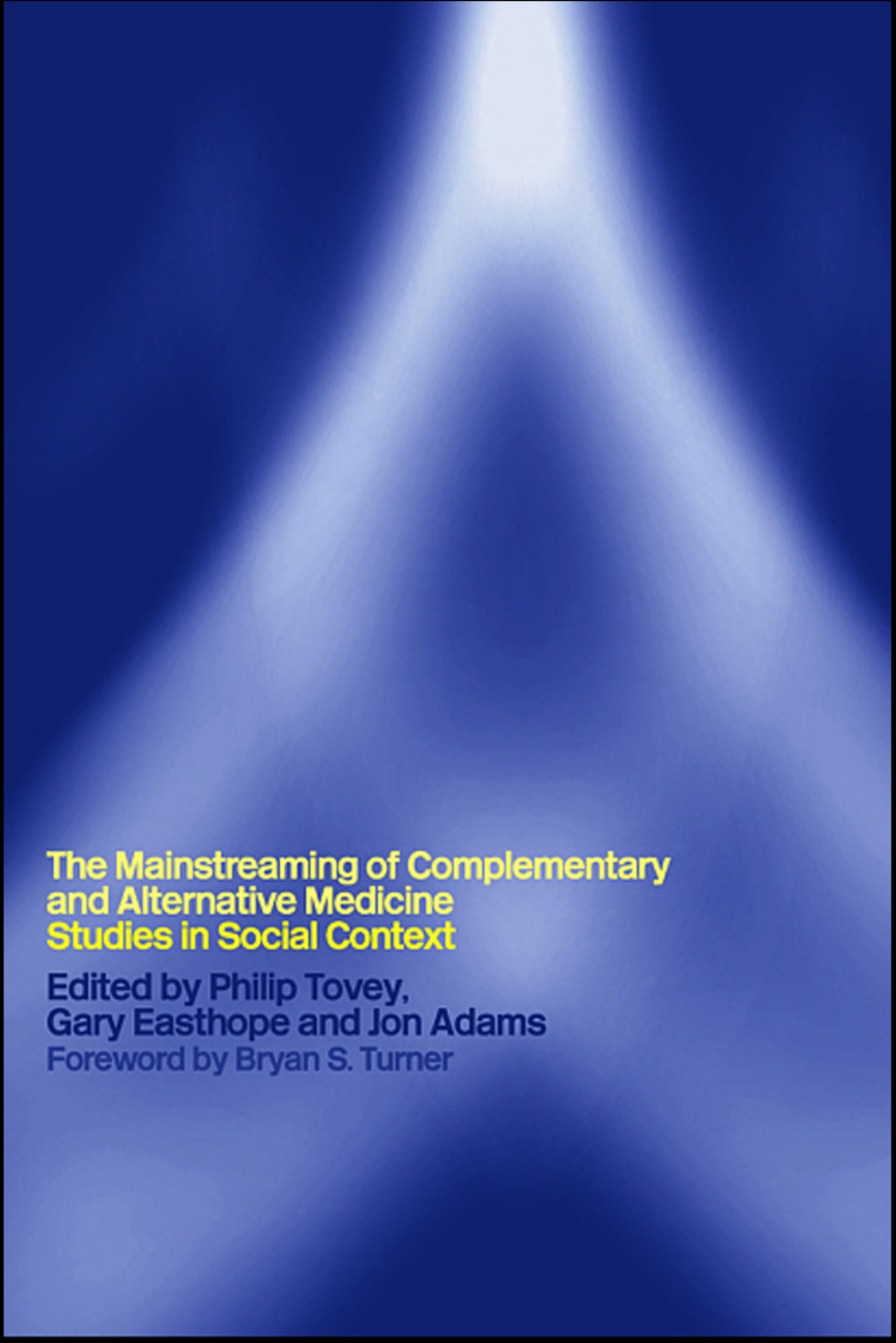

The Mainstreaming of Complementary and Alternative Medicine

Complementary and alternative medicine (CAM) is a major component of healthcare in most late modern societies. While there is increasing recognition of the need for more research in this area, it is frequently argued that such research should be directed towards establishing 'evidence' that will provide 'answers' to policy questions. However, complementary medicine is also a topic worthy of study in its own right, a historically contingent social product, and it is this sociological agenda that underpins *The Mainstreaming of Complementary and Alternative Medicine*.

Contributors to the book come from the UK, USA, Canada, Australia and New Zealand. They draw on their own research to explore issues such as who uses CAM and why; the rhetoric of individual responsibility; the role of consumers as activists; the significance of evidence-based medicine; and contested boundaries in the workplace. The book also discusses specific processes relating to CAM practitioners, GPs and nurses.

Stepping back from the immediate demands of policy-making, *The Mainstreaming of Complementary and Alternative Medicine* allows a complex and informative picture to emerge of the different social forces at play in the integration of CAM with orthodox medicine. Complementing books that focus solely on practice, it will be relevant reading for all students following health sociology, health studies or healthcare courses, for medical students and medical and healthcare professionals, as well as academic CAM specialists.

P**hilip Tovey** is Principal Research Fellow, School of Healthcare Studies, University of Leeds. **Gary Easthope** is Reader in Sociology, School of Sociology and Social Work, University of Tasmania. **Jon Adams** is Lecturer in Health Social Science, School of Medical Practice and Population Health, University of Newcastle, Australia.

The Mainstreaming of Complementary and Alternative Medicine

Studies in Social Context

Edited by Philip Tovey, Gary Easthope and Jon Adams

Routledge
Taylor & Francis Group

LONDON AND NEW YORK

First published 2003
by Routledge
II New Fetter Lane, London EC4P 4EE

Simultaneously published in the USA and Canada
by Routledge
29 West 35th Street, New York, NY 10001

Routledge is an imprint of the Taylor & Francis Group
This edition published in the Taylor & Francis e-Library, 2005.

To purchase your own copy of this or any of Taylor & Francis or Routledge's collection of thousands of eBooks please go to www.eBookstore.tandf.co.uk.

British Library Cataloguing in Publication Data
A catalogue record for this book is available from the British Library

Library of Congress Cataloging in Publication Data
A catalog record has been requested

ISBN 0-203-98790-X Master e-book ISBN

ISBN 0-415-26700-5 (pbk)
ISBN 0-415-26699-8 (hbk)

For

Passenger N—LA, FB

Annie and Frank; Sallie and Bill

Contents

Illustrations

Tables

Boxes

Notes on contributors

Jon Adams is a Lecturer in Health Social Science and co-ordinator of the qualitative research laboratory at the University of Newcastle, Australia. His main research interest is the sociology of CAM and he is currently researching CAM consumption and provision in Australia and Europe.

Heather Boon is an Assistant Professor in the Faculty of Pharmacy, University of Toronto, Canada. In addition, she is cross-appointed to the Department of Family and Community Medicine and the Department of Health Policy, Management and Evaluation, Faculty of Medicine, University of Toronto. Heather has founded the Toronto Complementary and Alternative Medicine Research Network. Her primary research interests are patients' use of complementary/alternative medicine, the safety and efficacy of natural health products, and complementary/alternative medicine regulation and policy issues.

Fran Collyer is a Lecturer in Sociology at the University of Sydney, Australia. Fran's research interests concern both the fields of sociology and social policy, and include the privatisation of public assets (particularly with regard to healthcare services); health financing and healthcare systems in Europe, Australia, the USA and Asia; the changing relationship between the nation state and the market; and science, technology and innovation.

Ian Coulter is a Professor in the School of Dentistry, University of California, Los Angeles, a Research Professor at Southern California University of Health Sciences, and a senior Health Consultant at RAND, USA. He is the Principal Investigator (PI) of the Evidence-Based Practice Center for Complementary and Alternative Medicine at RAND, and is the PI on a case study of integrative medicine.

Kevin Dew is a Senior Lecturer in Social Science and Health at the Department of Public Health, Wellington School of Medicine and Health Sciences, University of Otago, New Zealand. His research interests include CAM, occupational health and health services research.

Gary Easthope is a Reader in Sociology at the University of Tasmania, Australia. He has taught at universities in England, Ireland, Canada and the USA. He has written on education, drug use, youth, environmental movements and research methods in addition to CAM, and is currently researching heritage sailing ships, as well as CAM use amongst Australian women.

Heather Eastwood is a Health Sociologist and Lecturer in the Medical School, University of Queensland, Australia. Her research interests in CAM include globalisation, policy, service provision and consumer use.

Melinda Goldner is an Assistant Professor of Sociology at Union College in Schenectady, New York, USA. She has studied various aspects of the complementary and alternative medicine movement, including who is more likely to participate, how

activists have changed their goals, and how physicians have responded to the movement.

Kahryn Hughes is a Senior Research Fellow at the Nuffield Institute for Health, University of Leeds, UK. Her main research interests include processes of identity formation in: negotiations of definitions of care, particularly in nursing; the sociology of complementary therapies; HIV/ AIDS and anorexia nervosa; and women's networks in the context of community formation.

Merrijoy Kelner is a Professor Emeritus at the Institute for Human Development, Life Course and Aging at the University of Toronto, Canada. She leads a team of researchers in the area of CAM. Her research focuses on the ways in which several CAM groups are trying to gain a foothold in mainstream healthcare.

Philip Tovey is a Principal Research Fellow, School of Healthcare Studies, University of Leeds, UK. He has researched widely in the sociology of education and the sociology of health, and has published on CAM in a range of major international journals. He currently leads a CAM research programme that has a particular focus on cancer, and on developing a critical sociology of CAM and nursing.

Bryan S.Turner is Professor of Sociology at the University of Cambridge, UK. He has a long-standing interest in health sociology and is the author of *Medical Power and Social Knowledge* and *The Body and Society*. He is also, with Mike Featherstone, the founding editor of the journal *Body and Society*. He has also been concerned to develop the sociology of citizenship and human rights.

Beverley Wellman is a Medical Sociologist at the Institute for Human Development, Life Course and Aging at the University of Toronto, Canada. Her research focuses on complementary and alternative medicine with a special interest in the relationship between social networks, social capital and professionalisation.

Sandy Welsh is an Associate Professor of Sociology at the Unversity of Toronto, Canada. Her current areas of research include the professions, neighbourhood effects on health outcomes and sexual harassment. In addition to her work in the area of complementary and alternative medicine professions, she is a leading expert on sexual harassment in Canada.

Kevin White is a Reader in Sociology in the School of Social Sciences at the Australian National University. He has held appointments at Flinders University of South Australia, Wollongong University and Victoria University, Wellington, New Zealand. His research interests are in the sociology of health and illness, the historical sociology of health, and patterns of inequality in health.

Evan Willis is Professor of Sociology and Head of the Faculty of Humanities and Social Sciences on the Albury-Wodonga (regional) campus of La Trobe University. For most of his career he has been interested in the question of how illness mediates social relations and this has led him to an interest in complementary and alternative medicine, amongst other themes.

Foreword

The end(s) of scientific medicine?

Bryan S.Turner

The Mainstreaming of Complementary and Alternative Medicine (CAM) is a timely and challenging sociological account of the development and significance of complementary and alternative forms of medical therapeutics. These essays raise important questions about the medical profession and its clients, about the scientific claims of 'evidenced-based medicine' (EBM), and about the impact of modern (and possibly postmodern) consumer demand on healthcare and patient expectations. We need to understand these sociological investigations against the historical backdrop of the development of scientific, allopathic medicine and the consolidation of medical dominance, the early erosion of alternative systems of care, and their slow but steady revival so that what used to be the dubious practice of 'alternative medicine' eventually became 'complementary medicine' and more recently 'integrated medicine' or 'holistic medicine'. One important and problematic question is whether the growing acceptance of CAM is mainstreaming, co-opting or neutralising. What is evident, however, is that the growth of CAM represents a major transformation of the relationship between doctors and their patients, and between doctors and the larger scientific community.

The consolidation of professional scientific medicine in England was a late product of Victorian legislation and science (Porter 2001). Before 1858, physicians constituted a fluid and heterogeneous collection of learned men competing for clientele in an unregulated market. The reconstruction of the profession was achieved when the Medical Act of 1858 established a single Medical Register under the auspices of a General Medical Council. The Act united the doctors against their rivals—homeopaths, midwives, bonesetters, herbalists and itinerants. While the Act created a coherent profession, general practitioners remained underpaid and overworked, forced to be civil to their socially superior patients and to tolerate slow payments and bad debts. The general practitioner became an idealised figure—educated, long-suffering, poor, and the servant of the community.

In North America, the age of scientific medical training was launched by Flexner's (1910) report on *Medical Education in the United States and Canada*. He argued that medical education had to be based on experimental science and laboratory instruction, and that medical schools should be part of a research university. He also made recommendations about entry requirements and the length of student education. The majority of existing medical schools failed to match his criteria and forty-six closed, including those educating women and the black community. His scientific assumptions also resulted in the decline of homoepathic training and provision. Partly through constraints on the supply of doctors, the Flexner reforms increased the status and pay of

those doctors who came through the revised curriculum.

From 1910 to 1970 scientific medicine enjoyed a golden age of increasing influence, status and wealth. Research hospitals were models of scientific application, acute diseases were being eliminated, and the medical profession enjoyed the trust and respect of middle-class society. Flexner's assumptions laid the foundation for the medical model of illness, established the social conditions for medical dominance and produced the professional circumstances that underpinned the sick role (Parsons 1951). The doctor's clinical authority was unchallenged and the patient was expected to be docile and compliant. The American Medical Association (AMA) and the British Medical Association (BMA) were powerful professional lobbies that exercised significant political power on behalf of medical science, through Congress and Parliament respectively. The profession had considerable success in claiming that collectivist innovations in the delivery of healthcare would undermine the principles of individualism, self-help and self-reliance, upon which Western medicine had been built.

The end of the 'golden age of doctoring' (McKinlay and Marceau 1998) was signalled by Nixon's 1970 speech announcing a crisis in healthcare in the US: a crisis manifest in the rising numbers of uninsured Americans, the inability of germ theory to contribute to the treatment of chronic illnesses and major illnesses such as cancer and heart disease, the increasing use of alternative medicine and the growth of self-help movements.

Patient rights and consumer demand have pressured healthcare professionals to provide more holistic care. The slow but significant growth of healthcare insurance for CAM in the United states and the growing number of young doctors who do not join the AMA are regarded by some sociologists as indicative of an erosion of medical dominance (Pescosolido and Boyer 2001:183). The medical profession has also changed under the impact of technical advances in medicine and commercial transformations of medical practice (Starr 1982). We can understand these changes within the framework of the sociology of the professions. Freidson (1970) in *Profession of Medicine* argued that the success of the medical profession rested not only on its political power but also on the trust of the public. These two dimensions of professionalism are medical dominance and the consulting ethic, in which the first requires state support, and the second depends on public confidence. Both have been transformed by the growth of corporate and global medical systems. These global changes are transforming the traditional doctor-patient relationship but they are also opening up new possibilities, the future directions of which are unclear.

In terms of public trust in the medical profession, technical inventions and discoveries of nineteenth-century medicine such as immunisation established the scientific authority of medicine as a profession. For the lay public, improvements in survival rates from surgery have been especially visible evidence of the scientific basis of contemporary medical practice. Although the quality of general practice still depends in large measure on interpersonal skills that can only be fully acquired through experience rather than training, the status of medical institutions in society depends significantly on 'hard' science and technology. Medical technology presents simultaneously and paradoxically the promise of significant therapeutic improvements in the management of illness, and significant risks to the well-being and comfort of patients. This tension between the art of healing and the science of disease is part of what Gadamer (1996) has called the modern

‘enigma of health’.

Professional medicine has long been concerned to regulate, largely unsuccessfully, self-medication and ‘folk medicine’ (Bakx 1991), but it is also important to control scientific medicine. In order to gain the benefits of medical innovation, there has to be some regulation of the social and cultural risks associated with contemporary medical sciences, for example in relation to cloning, new reproductive technologies, organ transplants, surgical intervention for fetal abnormalities, cosmetic surgery, the prescription of antidepressants, cryonically frozen patients or sex selection of children. Who should exercise these regulatory constraints or governance over the medical sciences? The professions and governments are no longer able to deliver effective oversight, because the globalisation of markets makes legislative and political regulation problematic (Kass 2002). The result is an endless political cycle of risk, audit, regulation and deregulation. This cycle of political confrontations and compromises with the scientific establishment inflames lay suspicion of expert opinion and erodes the relation of trust between patients and doctors. In Britain, the BMA has been criticised for its failure to monitor effectively doctors who have been charged with criminal offences or malpractice. The nadir of trust in doctor-patient relations in Britain in recent history may have been finally reached by the revelations about Dr Shipman who, in the latter part of his career, killed hundreds of elderly patients in his care. The apparent instability and contradictions in the expert advice surrounding the foot and mouth epidemic of 2001 in Britain further eroded the authority of scientific opinion. Lay confidence in science and the food chain has been further battered by a 20 to 30 per cent rise in Creutzfeld-Jakob disease in Britain. These examples suggest that the tensions between public trust, uninsurable risk and scientific legitimacy have generally undermined confidence in expert systems (Giddens 1990; Beck 1992) and, as a result, the public has experimented with alternative and less intrusive healing systems.

Any sociological understanding of medicine in contemporary society must examine the economics of the corporate structure of medical practice and has to locate that structure within a framework of global commercial and cultural processes. The deregulation of global markets has had the unintended consequence of bringing about the globalisation of disease. For example, the return of the ‘old’ infectious diseases (TB, malaria, typhoid and cholera) will have significant negative consequences for the economies of the developing world, but they will also reappear in the affluent West as a consequence of the globalisation of transport, tourism and labour markets. It is unlikely that corporations will adopt policies of corporate citizenship sufficiently quickly or effectively to exercise constraint and to institutionalise environmental audits to regulate their impact on local communities. However, these global developments have also created new opportunities for the exercise of consumer power as a mechanism whereby the negative impact of corporate enterprise on fragile communities and environments can be challenged. Future developments of healthcare must be connected with debates about civil society and human rights. We need to realise that health—more even than employment, education and welfare—is the fundamental entitlement of citizenship, but this entitlement is often difficult to implement within a world economy where risks are global. The question of health as entitlement raises difficult political and policy questions, because there is an inevitable tension between citizenship as a bundle of national rights and obligations, and

human rights as a system of entitlement that does not rest directly on the sovereignty of particular nation states.

I have already indicated that the model of the professional doctor that shaped Parsons' approach to the professions is now obsolete with the passing of the golden age of medicine. The growth of corporate control over medical care has contributed to the decline of professional autonomy, initiative and social status. The neo-liberal emphasis on the free market and aggressive entrepreneurship has brought about a decline in the social status of general practitioners by converting many into the hired employees of profit-making, private-sector health systems. Furthermore, the contemporary development of healthcare in the US has brought about a new emphasis on medical specialisation that has undermined, or at least threatened, the occupational coherence and solidarity of medicine as a professional group. In addition to this internal division, with the growth of consumer groups and with malpractice legislation and public alarm with technological medicine, there has been a renewed interest in more holistic medical services through alternative and complementary systems. The commercialisation of medicine and the dominance of free-market principles have had the paradoxical consequence of eroding the foundations of the traditionally autonomous professional physician as an individual provider of care in a direct relationship to the client.

While neo-liberal policies may have changed the conditions under which the traditional autonomy of the medical profession was sustained, these policies have also had serious consequences for consumers. For example, in the USA poverty has increased by 30 per cent among children since 1979; between 1981 and 1982, eleven states showed increases in the infant mortality rate and also showed considerable differences between black and white mortality rates. These rising infant mortality rates are associated with an increase in poverty and unemployment, a decline in nutrition and the loss of health insurance coverage through the new limitations on Medicaid. During the same period, the private health sector has enjoyed buoyant profitability and expansion. The economic and political importance of the tax cuts under the Reagan administration was that, by reducing revenue to the state, they curtailed the ability of future governments to introduce new social welfare programmes to remove hardship, stimulate employment and restore welfare measures. As medicine has become increasingly specialised, the general practitioner has become the conduit into medical care through whom the patient is referred to specialists further down the chain of delivery. The traditional relations of trust that characterised medical practice have been eroded by the commercialisation of services and the increasing anonymity of medical practitioners in relation to patients. Patients have turned to self-help partly because they cannot afford allopathic medicine and partly because they distrust invasive medication and treatment.

The development of new reproductive technologies, genetic engineering and the enhancement of human traits points towards a 'second medical revolution' that combines microbiology and informational science. This revolution presents a major challenge to traditional institutions and religious cosmologies, but it may also present a threat to the processes of political governance. The notion of risk society provokes questions about the unintended consequences of medical change, about whether the technological imperative can be regulated, and about the relationships between pure research, commercialisation and academic autonomy. For example, pharmaceutical companies have turned to contract

research organisations (CROs) rather than universities to undertake basic research on drugs. These CROs are cheaper and also less independent than academic institutions. The academic community has argued that such research is not systematically published and is unlikely to be critical of the pharmaceutical products. In short, such 'private' research is not compatible with the public norms of publication, debate and criticism that are assumed to be essential to scientific objectivity.

Medical institutions and professions are subject to global pressures, especially from competitive insurance and funding arrangements. To take one obvious illustration, the ownership of the pharmaceutical industry is global and dominated by a limited number of corporations—ICI, Ciba and Hoetchst—which presents serious problems with respect to the regulation of the industry, the freedom of market relations and medical practice. We are also on the verge of healthcare systems that will depend on global electronic communications. One remarkable example is 'telesurgery' that involves the use of robot-assisted distance surgery. These techniques pioneered by the US military in order to provide expert medical services in the field could also make a valuable contribution to aid workers in developing societies and provide important training services for young surgeons. It is assumed that in the future patients and doctors will use broadband technologies to deliver healthcare packages to homes and hospitals. The growth of e-health will create virtual hospitals, transform health education, deliver health services to elderly or disabled patients who have limited mobility, and improve health delivery to remote rural communities. The technology and delivery systems for such innovations will be necessarily global, and it will be organised and owned by global health corporations.

Although the dominant trend of much recent medical sociology has been to emphasise the negative effects of globalisation and to regard e-health as a further commodification of medicine, there are alternative trends that indicate a growth in consumer autonomy, increased involvement of patient groups in decision-making and an erosion of medical dominance in favour of 'bottom-up' participation. For a variety of specific conditions and diseases, there has been increased use by patients of websites for care, support and information. The model of the consumer/patient lobby group was provided by the HIV/AIDS epidemic, where activists have successfully challenged medical control and shaped the nature of AIDS research and research funding. AIDS websites played an important part in organising such movements (Altman 2001). Another particularly good example is cystic fibrosis (CF). As life expectancy rates for sufferers have increased to around thirty years of age, public health-care systems have had to rely increasingly on home help and lay caregivers. There is now a range of CF websites that provide health information such as on the use of intravenous injections for home care. The result is to sideline professional medical control and to transform the nature of medical authority. With the increase in chronic illness as a result of HIV/AIDS, ageing and changes in lifestyle, the management of care may pass more and more into lay hands with the support of e-health systems. Obviously this is a mixed blessing as more care is devolved to female heads of households, but it does represent also an increase in lay power. Of course, corporate e-health will take a predatory interest in 'nativistic' or 'indigenous pharmacy', will seek to commercialise alternative healthcare and to monopolise medical knowledge and research. We may envisage an endlessly circular struggle between centralised and localised e-health, and between corporate and lay interests. The growth of

CAM will clearly be assisted by global information systems that work at a local level, because patients will be directly selecting health-care alternatives from websites.

This collection of essays raises, as I have indicated here, acute issues relating to the relation between scientific knowledge and power. This theme in contemporary medical sociology arose in response to the influence of Foucault (1973) whose historical work on the birth of the clinic demonstrated the intimate connections between the French Revolution, the growth of anatomy and the transformation of the concept of disease. Today we are going through a revolution of equal magnitude. The twentieth-century monopoly of mainstream healthcare and provision that was enjoyed by professional medicine and the dominance of allopathic science have both been undermined, but obviously not eroded, by a complex set of global processes: new technologies, changes in consumer demand, the globalisation of medical systems, the differentiation and fragmentation of scientific knowledge, the transformation of the pattern of disease and a variety of new social movements. New configurations of power are producing new systems of knowledge within which CAM will come to play an important, but probably unpredictable part. The global revolution in healthcare will in turn compel the scientific community to reconsider and redefine the ends of medicine.

References

Altman, D. (2001) *Global Sex*, Chicago and London: University of Chicago Press.

Bakx, K. (1991) 'The "eclipse" of folk medicine in Western society', *Sociology of Health and Illness* 13(1):20–38.

Beck, U. (1992) *Risk Society: towards a new modernity*, London: Sage.

Flexner, A. (1910) *Medical Education in the United states and Canada*, New York: Carnegie Foundation for the Advancement of Teaching.

Foucault, M. (1973) *The Birth of the Clinic*, London: Tavistock.

Freidson, E. (1970) *Profession of Medicine. A study of the sociology of applied knowledge*, New York: Harper and Row.

Gadamar, H-G. (1996) *The Enigma of Health. The art of healing in a scientific age*, Cambridge: Polity Press.

Giddens, A. (1990) *The Consequences of Modernity*, Cambridge: Polity Press.

Kass, L.R. (2002) *Life, Liberty and the Defense of Dignity. The challenge for bioethics*, San Francisco: Encounter Books.

McKinlay, J.D. and Marceau, L.D. (1998) 'The impact of managed care on patients' trust in medical care and their physicians'. Paper presented at the American Public Health Association, Washington DC, November (cited in W.A.Cockerham (ed.) (2001) *The Blackwell Companion to Medical Sociology*, Oxford: Blackwell, p. 196).

Parsons, T. (1951) *The Social System*, London: Routledge and Kegan Paul.

Pescosolido, B.A. and Boyer, C.A. (2001) 'The American health care system: entering the twenty-first century with high risk, major challenges and great opportunities', in W.Cockerham (ed.) *The Blackwell Companion to Medical Sociology*, Oxford: Blackwell, pp. 180–98.

Porter, R. (2001) *Bodies Politic. Disease, death and doctors in Britain 1650–1900*,

London: Reaktion Books.
Starr, P. (1982) *The Social Transformation of American Medicine. The rise of a sovereign profession and the making of a vast industry*, New York: Basic Books.

Introduction

Philip Tovey, Gary Easthope and Jon Adams

Complementary and alternative medicine (CAM)[1] is now a major part of the healthcare system in all advanced societies.[2] It is also a common part of discourse in medicine and healthcare. This growth of interest has only partially been matched by academic study of it. Indeed, over recent years there has been an increasing recognition that CAM is essentially under-researched (House of Lords 2000). However, with this recognition has come an increasing concentration on a particular form of research—that geared towards the production of an evidence base and/or an immediate relevance to policy and practice.

These research priorities are reflected in much of the work that is published on CAM. In both standard medical journals and in CAM specific publications the emphasis is squarely on the problems of efficacy and of issues to do with practice, most recently integrative practice. Most books written in the field follow this pattern, being either concerned with the demonstrable value of individual therapies (Ernst *et al.* 2001) or being written as 'how to' guides geared towards practitioners (see, for example, Vickers 1993; Downey 1997; Tanvir 2001).

However, there is a different research agenda and a further set of writings on the subject—those that can be loosely grouped together as constituting a sociology of CAM. Here the emphases are rather different. While many of the topics may seem familiar from the policy driven agenda—regulation, the evidence base, use of CAM by general practitioners (GPs), nurses and others—they are treated in a very different way. Assumptions are challenged; motives and strategies are explored. CAM is first and foremost examined as a topic worthy of study in its own right, as a historically specific social product. Phenomena are studied in their social context. It is this sociological rather than policy-driven starting point that underpins this book. While the research covered herein may provide insights of practical benefits, that is not usually its fundamental purpose.

Central to this more in-depth sociological approach is the recognition that to merely seek to quantify effect, or to establish models of appropriate practice in tightly defined situations, is to only scratch the surface of the possibilities of an academic engagement with CAM. To understand the contemporary forms and contents of CAM there is a need to step back from the often hurriedly established demands of policy-makers, and to explicitly include in analyses reference to how the arena is marked by complexity and contingency, diversity and dispute and is in a state of constant change (Tovey and Adams 2001).

So, for instance, analyses need to start from a recognition that the growth of CAM in recent decades is historically contingent and that, like orthodox medicine, it is also a social product. Unlike orthodox medicine, however, a key aspect of that contingency is that it faced, as it developed, an already firmly entrenched medical orthodoxy supported