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Mainstream Marginality: Professional Projects and the Appeal of Complementary and Alternative Medicines in a Context of Medical Pluralism.

by

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for the Degree of Doctor of Philosophy

2017

Mainstream Marginality: Professional Projects and the Appeal of Complementary and Alternative Medicines in a Context of Medical Pluralism.

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At the age of fourteen a very wonderful teacher, Judy Hirst, arrived at our beleaguered, rather dysfunctional comprehensive school in Doncaster and, in her posh, southern accent, announced she would be offering an O' Level in Sociology. She was inspiring and feisty and taught me that it was good to be different, that I could admit to doing my homework, and that sociology could transform your life and outlook. That it did. I am ever indebted to her - she was the person that encouraged me to stay on at school, to consider university, and to apply to Durham – she remains a friend.

Sociology has been a major part of my life ever since. Following my Masters degree, and in need of a salary, I looked for work, turning down a scholarship to study for a PhD. I have had the fortune to hold research and teaching posts at Kent, Keele, Roehampton and Canterbury Christ Church Universities. Each post opened up opportunities for collaboration and friendship. Phil Brown became a firm friend at Kent and our families have been connected ever since. One could not hope for a more engaging or supportive colleague as Ursula Sharma: working with her was simply a joy. It was at Keele that I first met Mike Savage, and he remains my dearest friend and advocate. Thank you especially to Ulla Gustafsson for her loyalty, her reason, her calm and her friendship. At CCCU, I could not have coped with the teaching load without the comradeship and humour of Peter Watts. More recently, as the sociology programme has grown, I have had the fortune to work with great people and Matt Ogilvie and Jennie Bristow deserve special mention.

My specialism has been in medical sociology (complementary medicine, private medicine, health promotion and mental illness in undergraduates), but I have interest also in pedagogy, community regeneration, widening participation and the graduate generation. I am committed to humane sociology - where one endeavours to change peoples' lives, even in small ways, for the better - and the teaching of sociology falls into this category. I see its transformative potential every year. This joy of teaching has emboldened me when faced with the heavy contact hours that have characterised, until very recently, my teaching posts. I have always endeavoured to squeeze out the time to undertake empirical work and publish, alongside a properly full-time teaching commitment and whilst looking after my three children.

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Mainstream Marginality: Professional Projects and the Appeal of Complementary and Alternative Medicines in a Context of Medical Pluralism.

Abstract

This narrative critically reviews my contribution to the development and maturation of a sociology of complementary and alternative medicine (CAM). Through the application of qualitative methodologies, my work has documented the emergence of a 'new' medical pluralism, focussing on the professional development of CAM as practiced by non-medically qualified practitioners and nurses and midwives, and has provided an understanding for the groundswell of appeal of CAM to both users and practitioners. With reference to neo-Weberian, Foucauldian and feminist theories of occupational formation, the research has provided insight into CAM 'professional projects', detailing the attempts to secure market share, broker trust relations, and discipline work conduct. My work has also revealed the enduring capacity of (patriarchal) biomedicine to shape CAM practice and health care delivery. As a consequence, CAM is described as being situated in a position of 'mainstream marginality' – popular, but peripherally located in state-sanctioned health care, with an appeal to groups of users and practitioners who themselves feel marginalised. As such, my work has contributed to an appreciation of the attractions of CAM and its empowering potentials, and the dynamics of biomedical power, professionalisation and professionalism in relation to jurisdictional battles for market share. Through critical reflection on my work, however, I note there is space for further exploration into: the opportunities for affective change and collaboration that can be fostered in integrated/integrative clinics; the ways in which biomedical dominance might be mutating; the different ways in which wellbeing, efficacy and evidence might be conceptualised; the possibility of integrating post-colonial theory and anthropology with sociology to produce a globalised analysis of medical pluralisms.

Mainstream Marginality: Professional Projects and the Appeal of Complementary and Alternative Medicines in a Context of Medical Pluralism.

Introduction

Druidic interest in the healing potential of homeopathy, the softening of political relations with China, and large scale migration from the Sylhet region of Bangladesh may appear disconnected, even though they share the same historical location. However, collectively, they contributed to a revival of Complementary and Alternative Medicine (CAM) in the UK, fostering a plural medical marketplace, populated by multiple therapies (largely practiced by non-medically qualified practitioners) and supported by strong consumer interest. My research has sought to investigate the occupational formation and strategic development of CAM since the 1980s and to comprehend its appeal to users. Additionally, from the 1990s, a significant number of nurses and midwives chose to enhance their work practices and extend their professional jurisdiction by integrating CAM into their therapeutic repertoire, and this provided the context to undertake research in hospitals. This thesis by publication critically reviews sixteen research outputs in this area.

Taken together, my work on medical pluralism has provided an original contribution to sociological knowledge in a number of key areas. The documentation of 'professional projects', undertaken by non-medically qualified CAM groups (theorised through the lens of both professionalisation and professionalism), has provided insight into strategies deployed to attain professional representation, attempts to secure social closure and internal cohesion, the form and role of knowledge claim-making, and the changing shape of educational practice. My work has contextualised the groundswell of appeal of CAM to both users and practitioners. This has served to highlight both dissatisfactions with biomedicine and the affective and effective appeals of CAM. Nevertheless, mapping the changing relations between CAMs and biomedicine has revealed the enduring capacity of biomedicine to shape CAM practice and health care delivery. Indeed the epistemological and political superiority of biomedicine, underscored by state support, has informed integrated medicine when implemented by nurses and midwives. Collectively, this body of work has contributed to the development of a *Sociology of CAM*.

These various researches cohere through my concept of 'mainstream marginality' (Cant, 2009), an intentional oxymoron devised to encapsulate the contradictory positioning of CAM in the medical marketplace. CAM is a 'mainstream' practice in at least two senses: firstly, practitioners have secured a strong client base and, secondly, CAM professional associations and training schools have adopted mainstream organisational, managerial and governance practices. At the same time, CAM is characterised by minimal state support and limited access to funding, has failed to secure a strong experimental evidence base, is attractive to practitioners who do not usually experience a lucrative career and are subordinated in the medical division of labour, and appeals to users who, in the majority, feel some disassociation from biomedicine. Thus, CAM finds itself marginally situated in state-sanctioned health care and appeals to groups of users who themselves feel marginalised.

'Medical pluralism' in this context refers to a very specific formation of health care practice (Cant, 2004). There has always been the possibility of choice between differing kinds of health practitioner, between consulting and self-prescribing, and there have always been multiple ways of understanding health, illness, sickness and disease. Porter's (1992) *Popularisation of Medicine, 1650-1850*, demonstrated the diversity of medical practices and techniques in Britain, with popular, folk and alternative medicines coexisting alongside with, and sometimes simultaneously practiced by, 'scientific' medical practitioners. Medical anthropologists (e.g. Kleinman, 1980; Leslie, 1976) have also revealed the contemporaneous cohabitation of multiple folk medicines alongside a range of 'learned' medicines. While medical pluralism has always been (and remains) intrinsic to many Asian, African and South American societies, the recent historiography is somewhat different in the Global North. From the 1850s, and certainly by the beginning of the 20th Century, biomedicine secured the state-sanctioned, strongest and most revered position in the medical marketplace and this involved the co-option, limitation or elimination of competitors (Larkin, 1983; Starr, 1982). By the 1970s, this epistemological authority was secured globally (Warboys, 1997). However, biomedicine's monopoly stands as an atypical historical moment, secured for a time-limited period only. In the late twentieth century, a 'new' variant of 'western' medical pluralism (Cant and Sharma, 1999) developed out of a complex array of factors, including: the spiralling costs of biomedicine; the persistence of chronic and degenerative diseases[i]; the recognition of the iatrogenic effects of some biomedical interventions; opportunities to (re)learn about CAM and revive its practice; the appeal of holistic and dialogic practice to users (Cant, 2002; 2009).

Understanding the occupational formation of CAM, and particularly the attempts to secure market share, state endorsement and the trust of key stakeholders, has been a key focus of my research. Following Larson (1977), the 'professional project' incorporates both strategies of 'professionalisation' and claims of 'professionalism'. Professionalisation refers to status aspirations and focuses upon the processes that occupations undertake to secure greater standing through attaining autonomy and market control to reap economic and social rewards[ii]. Professionalism, in contrast, refers to the ideology of expertise and service and can stand separately from profession and professionalisation in that any individual or occupational group can regard their work as professional and use this to make claims of worthiness to practice (Freidson, 1994; 2001)[iii]. Freidson, however, tends to collapse the concepts seeing the characteristics of professionalism and outcomes of professionalisation to jointly include: control over recruitment, training and work; appropriate expert knowledge; and, the ability of an occupation to control itself (ethics, disciplinary procedures)[iv]. In my research, I have found the usefulness of maintaining the distinction between these two aspects of the professional project: not in a solely Larsonian[v] way to show how professionalism is used to anchor privilege, but to regard it, additionally, as a way to police occupational spaces, and stand as a guarantor of trust that is separate from attempts to secure market advantage. More recently, I have drawn on feminist theories of professionalisation to explain the impact of patriarchal gender relations on the integration of CAM into hospitals by nurses and midwives, and the attraction of CAM practice to female practitioners more generally.

Before I explore my contribution, it is important to say something about the definition of CAM. CAM stands as a convenient short hand to cover a huge array of knowledges and practices that range from acupuncture, Ayurvedic medicine, chiropractic, herbalism, homeopathy, osteopathy to reflexology, iridology, faith healing, and so on, which all vary in terms of history, scope and therapeutic claim (Cant, 2009: 178). As such, it is impossible to talk about CAM as a homogeneous entity; it is a complex and contested terrain. Moreover, it is important to acknowledge that this nomenclature both reflects and reproduces 'Western' biomedical dominance. To be defined as 'complementary' or 'alternative' is to be conceptualised in relation to something (biomedicine), and necessarily creates not only a binary, but also, implicitly but suggestively, a hierarchy. Similarly, whereas Western biomedicine is not usually required to justify its scientific credentials (it is implicitly thought of as such), the 'scientificity' of other therapies is always subject to interrogation, most usually by biomedical criteria and

through the deployment of biomedical measures (Barry, 2006; Jackson and Scambler, 2007, Polich et al., 2010).

Therefore, my work also stands as a case study of medical politics - the terminology alone revealing the intersection of power and history, derived from the relationship with and to biomedicine. Binary terms however serve to mask differences within CAM and biomedicine and obfuscate their similarities – there is evidence of holism in biomedicine, for instance (Cant and Sharma, 1999: 101). Nevertheless, binaries are useful as they foreground power differentials and alert us to the marginal position that CAMs most usually occupy. However, I am cognisant that such naming colludes, albeit unintentionally, with biomedical professional interests and could be regarded as a form of symbolic violence (Gale, 2014)[vi].

In the following review, I outline the contribution that I have made to the sociological study of CAM and reflect upon some of the potential limitations of my work. Collectively, this reflexive analysis reveals a number of complex questions that are ripe for future research.

Research Contribution: Developing a Sociology of CAM

My first encounter with CAM was serendipitous, emerging out of a request to undertake some extra work on a pilot study based on interviews with eighteen CAM therapists (Cant and Calnan, 1991). In the analysis of the data, I drew attention to nascent CAM professionalisation projects, a hitherto under-researched area[vii]. The study revealed that practitioners were alert to the need for training, credentials and representation by professional associations. I also became aware that research into the official representatives of CAM occupational groups was absent but, as Freidson (1986) argued, necessary. In collaboration with the anthropologist Ursula Sharma, I secured funding from the ESRC to undertake cross-disciplinary research into the occupational formation of homeopathy, chiropractic and reflexology through a focus on the work of professional associations and professional schools (Cant and Sharma, 1995). My work paralleled that of Saks on acupuncture in the UK (Saks, 1992), and was followed by (and, in part, influenced) similar studies in Australia (Baer, 2006; Wiese and Oster, 2010); Canada (Hirschkorn, 2006; Hollenberg, 2006; Kelner et al., 2004, 2006; Ritenbaugh et al., 2003; Welsh, et al., 2004); America (Baer et al., 1998), the UK (Clarke et al., 2004); and elsewhere

(see, for example, Almeida, 2012). The increased uptake of CAM by nurses and midwives initiated further research into integrated care in the NHS (British Academy funded).

Considering CAM practice was legally permissible under Common Law, I was interested to understand why CAM practitioners would seek to engage in professional projects (Larson, 1977), not least because it was very likely that they would be unable to claim a monopoly in the medical marketplace or secure autonomy from biomedicine. Indeed, the active engagement in professional projects would ostensibly reduce their freedoms and alter, or even curtail, their practice. Moreover, these endeavours were being enacted at the very same time that the professional standing and authority of the medical profession was itself under scrutiny (Braverman, 1988; McKinlay and Arches, 1985). That is, simultaneously, the biomedical profession was facing increased scepticism from consumers and this cultural turn explained, in part, the renewed appeal of CAM (where consultations were facilitating very different types of relationship and trust relations). I was concerned then to investigate the processes of professionalisation and understand the value of being deemed 'professional', 'trustworthy' and 'expert'.

From the outset, I was theoretically committed to a predominantly neo-Weberian approach and, whilst this can be critiqued for over-relying on the medical model of professionalisation and for being only apposite for Anglo-American studies (Saks, 2010), I found that my empirical research resonated most closely with this approach. Freidson's (1970, 1986, 1994, 2001) work and that of Parkin (1971), Larkin (1983) and, later, Abbott (1988), were not simply a critical and welcome antidote to the tautological approach taken by functionalist attribute theorists (Barber, 1963; Etzioni, 1969; Goode, 1960; Greenwood, 1957; Parsons, 1952; Wilensky, 1964), but they made empirical sense. Neo-Weberian analysis points to the importance of market conditions, collective interests, social status, jurisdictional battles, social closure, and (scientific) knowledge claims in the securing of occupational autonomy and market share. This is not to underestimate the usefulness of neo-Marxist[viii] accounts of professions, but the essentialist reference back to capitalism and the relative neglect, in this formulation, of social and political dimensions of professionalisation were, I found, limiting. In contrast, the neo-Weberian approach focuses centrally on the contingent nature of power and position: contingencies founded on relations with the state, the public and other competitors, and foregrounds the analysis of professional tactics and strategic alliances, enabling an understanding of the differential successes of competing occupational groups in the broader medical field. It proved to be an excellent fit: the theories were corroborated by evidence and

my empirical research was not restricted by presumptions of particular attributes, functions or system/capitalist needs.

I also found that the more recent Foucauldian analysis of professions (Evetts, 2003, 2006, 2011, 2013; Fournier, 1999) could be helpfully linked to the neo-Weberian approach, enabling the analysis of professional strategies through the lens of governmentality – the ideology of professionalism serving to simultaneously and separately enable occupational closure to broker trust relations, and control work conduct. Witz (1992) had also shown that the neo-Weberian analysis of professions could/should be enhanced through an appreciation of the interplay of patriarchy in occupational formation and this too became central to my thinking.

At a practical level, researching CAMs was not straightforward. The field is complex in terms of manifold therapies and because numerous professional associations purport to represent single or multiple practitioner groups. The absence of central registers of practitioners necessarily demanded non-probability sampling and a largely qualitative, interpretive approach. My research was consequently contained in scope and coverage. Nevertheless, the decision to focus on three therapies (that varied in terms of history and therapeutic claims), enhanced external validity and provided a more fulsome enquiry than studies that have focussed upon only one therapeutic modality. The political context was fast changing and the longitudinal study of these groups enabled the study of transformation as it occurred. I used purposive and snowballing sampling methods. Purposive sampling enabled the selection of interviewees that were actively involved in the occupational formation and development of the therapies under scrutiny. Interviewees identified other potential respondents and I asked for suggestions of follow-up contacts. In total, seventy-three interviews were undertaken, lasting between one and two hours. These constituted: representatives from the three therapy specific professional associations[ix] (42); Principals of Colleges (18); Officers from each of the three Umbrella Groups (3); representatives from two patient groups, the All Party Parliamentary Group for Alternative and Complementary Medicine, the Department of Health, the British Medical Association, the Royal College of Nursing Special Interest Group, and medically qualified practitioners using CAM (10). To triangulate, questionnaires were sent to all training colleges listed by the professional associations and to all listed practitioners in one locality. This provided a means to ascertain whether the views expressed by professional associations were mirrored by trainers and grassroots practitioners[x].

I later turned my attention to the use of CAM by nurses and midwives, an area where research was lacking but imperative (Tovey and Adams, 2003)[xi]. The absence of a central register was again problematic and a snowballing sampling method was used from the outset, with new respondents contacted until the point of theoretical and data saturation was achieved (Strauss and Corbin, 1998). In total, eighteen telephone interviews were conducted, followed by a case study in one county and which yielded nine additional face-to-face interviews. Here, the focus on a type of practitioner rather than a specific modality enabled a more comprehensive documentation of the actual range of therapies used by a practitioner group.

Predominately, I have used semi-structured interviews and undertaken thematic, qualitative analysis of transcripts, policy documents and practitioner journals. In the ESRC study, Ursula Sharma supplemented this research design with ethnographic studies of CAM conferences[xii]. My intention was to develop an in-depth understanding of the complex views, experiences and activities of my respondents. To this end, I have conducted all the interviews myself, read them systematically (several times), written notes and identified emerging and recurrent trends and contradictions alongside the reading of relevant literature to locate conceptual tools to make sense of any patterning. Additionally, I have undertaken secondary analysis of the literature, using thematic analysis to organise and summarize prominent themes of both qualitative and quantitative evidence (Dixon-Woods et al., 2005).

My sociological study of CAM was situated in a context characterised by power differentials, uncertainty and, sometimes, fear. Many interviewees (CAM practitioners and nurses and midwives) felt beleaguered and cautious and yet were, sometimes, inappropriately open and honest (professionally naïve). The interviewees on occasion wanted to use the interviews to find out information about competitors and/or to present a particular account of their professional maturity. I was alert to the importance of discerning any disjuncture between public and private accounts (Cornwall, 1984) although, interestingly, one major concern was what to do with information that was potentially damaging – that is, the instances when the private accounts were sometimes too readily shared. I found myself often in difficult, ethically challenging situations, needing to reflexively consider my own 'professionalism' and objectivity as a researcher, and sometimes having to take the decision not to vouchsafe some of the data in acknowledgment of the 'double hermeneutic' (Giddens, 1987) effect of the research (Cant and Sharma, 1998).

Nevertheless, I was able to document that, from the 1980s, CAM practitioner groups, increasingly represented by professional associations, had engaged in intense and accelerated professional projects that mimicked the organisation and training of biomedicine. Radical steps had been taken to alter the delivery and codification of CAM knowledge bases through the establishment of training schools, the setting of requirements for training, the inclusion of biomedical syllabi, the validation of degrees, and the conferment of credentials through academic awards. The professionalisation projects involved social closure (Weber, 1968; Parkin, 1971) and the securing of a boundary between the trained and untrained. They also involved trying to bring disparate groups (practitioners and associations) into line – an internal campaign for cohesion, with varying degrees of success. There were also clear attempts to temper knowledge claims. Within non-medical Homeopathy, for instance, there was: a conscious distancing from the druidic foundations that had instigated the revival of this therapeutic practice in the 1970s; the careful re-framing of controversial aspects of their knowledge base, (such as the vital force); an acceptance of the need to limit their claims and withdraw public advice to avoid vaccinations (Cant and Sharma, 1995, 1996; Cant, 1996). In Chiropractic, broader therapeutic claims were jettisoned in favour of a focus on lower back pain and musculo-skeletal problems (Cant, 1996). This reframing of practice led to my choice of 'limited profession' as a descriptor (Cant and Sharma, 1996). The reflexologists preferred adopting a position of deference and subordination as their key occupational strategy and this depiction of their practice as 'supplementary' actually served to broker the greatest access to the NHS (Cant and Sharma, 1996; Cant et al., 2011). In a very short space of time, the charismatic, inclusive and non-hierarchical foundations of CAM, where knowledge transmission had been largely secured through apprenticeship, were transformed - albeit with significant sacrifices acknowledged by the practitioners themselves. Indeed, my descriptor 'reluctant profession' for homeopathy was chosen to encapsulate these dilemmas (Cant and Sharma, 1995). The study also revealed that the processes were not occurring in a uniform fashion, the experiences within Homeopathy and Chiropractic being distinct from Reflexology. As such, there was, and still is, great sense in attempting to differentiate between CAM typologies, although attempts to do this (e.g. House of Lords, 2000) are not without critique (Cant, 2009).

One of my key findings was that the professionalisation projects served both to limit autonomy and to reduce flexibility, not least because - with the exception of Osteopathy and Chiropractic - the projects did not result in the state-sanctioning of practice. Instead, CAM associations

found themselves committed to self-regulation, and practitioners found that their work was largely contained within the private sector with minimal opportunities made available to access state funding (Cant, 2009). Others have lamented the losses to CAM during this process. Baer (2004: xvi), for instance, uses the metaphor of 'taming' to describe the processes of professionalisation, and Fadlon (2004:79) asserts that the legitimation of CAM was accomplished only via a process of 'domestication', where paradigmatic shifts were nullified. I have instead described the position as one of 'mainstream marginality' – CAM is widely used but finds itself structurally disadvantaged in the medical marketplace. The usefulness of this descriptor became further emphasised in later work.

My study of the professionalisation of CAM was novel as the focus was upon the contemporaneous professional projects of groups of self-employed practitioners rather than the more usual retrospective analysis of state-employed practitioners (Burrage and Torstendahl, 1990). I also foregrounded the impact of the broader socio-political context on CAM professional projects, showing them to be shaped as much by external forces ('from above', to use, McClelland's (1990) phrase) as by the need to manipulate the market for their own ends. My ESRC funded work culminated in the book, *'A New Medical Pluralism?...'* (Cant and Sharma, 1999)[xiii] and brought together the qualitative research, content analysis of policy documents and a broad literature review to chart the actions and perspectives of the CAM practitioners, the biomedical profession, the State and users. Rueschemeyer (1987) argued that it is more instructive to analyse the comparative success of occupations through the lens of state support than professional attributes, and Abbott's (1988) important contribution to the sociology of the professions had highlighted the importance of territorial battles between occupations in contiguous positions. I concur with these perspectives as, in my view, the 'failure' of CAM to secure strong market stability can be explained, in significant part, by the lack of full state support and the ability of biomedicine to define the parameters of CAM practice.

Indeed, I have argued that the biomedical paradigm and its measures of legitimacy have remained supreme: CAM's engagement with 'science', whether it be scientific methods of assessing effectiveness (Cant, 1996), or the integration of biomedical scientific knowledges into their curricula, serve to illustrate that CAM has been shaped in biomedical terms. This is not to say there has been no shifting of ground from the biomedical profession: the BMA, for instance, engaged in a significant change in tactics. Their 1986 report was unashamedly designed to discredit *'alternative'* therapies on the grounds of their 'unscientificity'. However,

this was followed by a more conciliatory (1993) report that focussed on '*complementary'* practice, albeit with the preference that biomedical doctors supervise and/or practice CAM (Cant, 2009). The most recent period has been characterised by calls for *integrated* care. Bauman's (1992) conceptualisation of changing authority (in his case, in relation to organic intellectuals) proved useful for understanding these changes (Cant and Sharma, 1996:17): the shifts standing as an exemplar of the move of biomedicine from a position of 'legislative' and authoritative purveyor of knowledge claims to that of an 'interpreter', a moral arbiter of choices.

The durable epistemological superiority of the biomedical paradigm was reflected in my study of the integrative practice by nurses and midwives (Cant et al., 2011; 2012)[xiv]. The practitioners were acutely sensitive to the boundaries of practice *delegated* to them by the medical profession. This was shown by the careful consideration on the part of the nurses/midwives regarding which therapies they would seek to introduce. Those therapies that faced the least resistance from biomedical doctors, and those deemed to have minimal clinical impact, hence not carrying risk, were the ones most likely to be adopted. With the exception of acupuncture, there were few instances of NHS nurses or midwives practicing any CAM therapies which stood in competition with the biomedical paradigm, and certainly homeopathy was eschewed. Also ruled out were those therapies with very limited evidence bases. The ultimate dominance of the biomedical paradigm was revealed in situations when the nurses and midwives found their biomedical and CAM perspectives to be in contradiction: the biomedical stance was always the default position. The study exposed that the spaces to practice CAM and the autonomy they afforded remained bounded by existing medical hierarchies and biomedical epistemology. CAM practice was further curtailed by funding cuts and enhanced NHS governance (Cant et al., 2012). My findings mirrored research into integrated medicine elsewhere in the West: CAM has been consistently revealed to be symbolically, structurally, epistemologically and economically marginalised, with biomedicine secured as the powerful elite when a plurality of providers exist (Hollenberg, 2006; Hollenberg and Bourgeault, 2011; Keshet et al., 2013; Mizrachi et al., 2005; Shuval, 2006; Shuval et al., 2002; 2004)[xv]. However, it should be noted that some studies have highlighted more positive readings of integration. For instance, Gaboury and colleagues' (2009) qualitative investigation of inter-professional collaboration found evidence of learning opportunities, a modified burden of work and higher affective commitment in the clinics they observed. Similarly, a study of dual trained

practitioners (Hsiao et al., 2006), suggested a more open-minded approach to integration with evidence of much cross-referral[xvi].

Throughout the research, I wrestled with understanding the purpose of professionalisation for CAM. If the professional projects have been more about presentation and normative regulation than the acquisition of economic and/or social stature, how can this be understood? The concept of *professionalism* rather than professionalisation started to gain more importance in my thinking (Cant, 2009). I took my lead from Larson (1977) and her focus on the 'appeal of professionalism' which showed that the work relations and practices of the medical profession served as a rallying call for a whole set of other occupations operating within different market conditions. However, I then drew on the more recent Foucauldian approach to professionalism to explain the persuasiveness and pervasiveness of this 'appeal'[xvii]. Foucault's concern was with the historical role that professions exercise in the creation and advancement of knowledge and, as such, he did not examine closely the institutional forms through which professional practice is organised and managed. He acknowledged that practitioners – expert professionals - are the conduits of power/knowledge by virtue of their legitimate expertise and thereby enact governance of human and state affairs through the classification and surveillance of the population, and through setting standards of normalcy and disciplining deviance (Foucault, 1973, 1979, 1980, 1990). This focus on the 'problem of government' can be taken further: governmentality can refer to both the mechanisms through which state objectives are aligned to the personal conduct of subjects (the normalisation of subject-client), but also to the collective conduct of experts - the reproduction and normalisation of the subject-producer (expert/professional). The second conceptualisation enables a focus on *discipline* rather than occupational *reward* within professional projects. Specifically, drawing on Fournier (1999) and Evetts (2003, 2006, 2013)[xviii], I have argued that professionalism in CAM acts an important marketing device that works to attract and reassure customers but additionally stands as a disciplinary mechanism, a mode of self-policing in a largely private and free market (Cant, 2009)[xix].

The link between professionalism and governmentality was additionally useful in my more recent work on nurses and midwives (Cant et al., 2011), and here I showed that the practitioners deploy claims to 'competency' regarding the management of risk in CAM to extend their therapeutic repertoires and professional jurisdiction. I suggested that professionalism, as presented through the role of 'knowledgeable doer', rested 'on a distinctive style of conduct which carries the obligations to know oneself, train oneself, and police oneself in terms of

specific normative discourses' (530). The practitioners found themselves reflexively responsible for deciding what levels of training they needed, what sort of credentials were acceptable, for taking decisions about the safety, efficacy and appropriateness of CAM interventions.

My research has also permitted me to reflect on broader social changes and examine how these impact upon knowledge construction and transmission. A number of commentators have described the revival of CAM as emblematic of a postmodern condition, a radical and new social movement (Bakx, 1991; Eastwood, 2000; MaQuaide, 2005; O'Callaghan and Jordan, 2003; Schneirov and Geczik, 1998, 2002; Siahpush, 1999). In these formulations, the collapse of the meta-narrative of science (Lyotard, 1986) is seen to be replaced by recourse to subjective and individualised 'lay' knowledges, and the adjudication of such knowledge is now grounded in performativity. The rise of CAM is additionally understood through the lens of consumerism (enabled by higher levels of discretionary income)[xx], and explained in terms of the fragmentation of experience, individualisation, a focus on self-improvement, the appeal of holism, a return to nature, and the aestheticization[xxi] of social life.

My own suppositions have instead drawn more explicitly on Giddens' (1990) descriptors of late modernity (see: Cant, 1996; 2005; 2009), as they had a better fit with my data. Giddens' conceptualisation allowed me to highlight the continued centrality of expert systems in social life and to understand that CAM therapists have had to establish their own credentials and worthiness to practice in order to secure the *trust* of their clients, the state and biomedical profession. Giddens (1990, with Beck, 1992) also foregrounded the analysis of *risk*: CAM occupations, like other medical practitioners, purport to apply expert knowledge to enable their clients to deal with risk and uncertainty. This approach also focuses on reflexivity and the tendency of consumers to be more critical of expert knowledges (Williams and Calnan, 1996), and highlights the requirement that practitioners negotiate risk and uncertainty much more openly[xxii]. Indeed, in the study of nurses and midwives, I revealed that the balancing (or not) of technicality and indeterminacy was critical to claims of professionalism (Jamous and Peloille, 1970). Upscaling the risk and arguing for the need for competent arbitration enabled the nurses and midwives to make special claims to practice (claims that they were much safer than non-medically qualified practitioners), but downplaying the risks and emphasising the formulaic aspects was necessary to gain acceptance from the doctors and secure market share. The result was that the practitioners gained very limited jurisdiction in these new CAM spaces,

a situation that was further restricted by the absence of a robust evidence base, and reinforced by existing gender relations.

The study of nurses and midwives turned my focus more squarely to the question of gender, somewhat neglected in my earlier work. The study of professionalisation and professionalism should be, as Witz (1992) so powerfully argued, examined with reference to patriarchy[xxiii]. Both nurses and midwives have engaged in professional projects but the scope of their occupational practice has been determined and delegated by the male-dominated medical profession and, accordingly, opportunities to exercise discretionary control have been limited. The nurses and midwives in my study were drawn to CAM as it afforded the opportunity to resurrect affective dimensions of practice and enhance their occupational jurisdiction. However, their attempts to carve out this space were ultimately shaped by gender relations (Cant and Watts, 2014). Practicing CAM, already marginally positioned and lacking an evidence base, extended their repertoires only through the practice of lower status, feminised and caring tasks and only when permitted by biomedical practitioners. In contrast to biomedicine, perhaps the archetypal masculine science (where objectivity and analysis are prioritised), CAM with its (arguably) more feminine dimensions (empathy, subjectivity, spirituality) remains epistemologically subordinate[xxiv]. In this way, the 'mainstream marginality' of CAM is further revealed: its practice finds an affinity with practitioner groups who are themselves occupationally marginalised. This idea also finds purchase in explaining the attraction of CAM to non-medically qualified practitioners, the majority of whom are female[xxv] and tend to occupy relatively powerless occupational spaces (Cant and Watts, 2012; 2015). Women, it can be argued, are drawn to practicing CAM because of its caring, nurturing, holistic, person-centred and preventative focus, and because of the opportunities afforded to escape harmful male dominated work environments, reinvest work with spirituality, and explore alternative gender subject positions (Flesch, 2007; 2010; Taylor, 2010)[xxvi]. Viewed from this perspective, CAMs constitute a form of feminist medicine (Scott, 1998). However, this description has limits: CAM practices do not tend to offer developed career paths or much in terms of material reward and also lock the practitioners into traditionally feminine, caring, low status roles.

Empowerment and marginality have further resonance when applied to the examination of usage patterns, I suggest[xxvii]. Users in the UK, in the main: come from a discrete demographic (middle class, middle aged and women)[xxviii]; continue to use biomedicine; tend to turn to CAM for limited and more usually intractable conditions, those where biomedicine is deemed less

effective (Cant, 2005; 2009[xxix]). Research also suggests that around half of users do not actively engage with the spiritual claims of the therapies that they use (Heelas, 2007) and it is the minority, termed 'holistics' (Newcombe, 2012), who fully embrace the metaphysical beliefs[xxx]. Overall, users appreciate the lengthier, holistic, personalised and equitable health encounters that often characterise CAM consultations and the perceived alignment with less invasive, 'natural' interventions. Moreover, users report the 'experiential' evidence of efficacy. Collectively these constitute the so-called 'push' and 'pull' factors which are, of course, highly interrelated. I have theorised these motivations through the lens of late modernity finding both the perceived risks of side effects and the individualisation thesis[xxxi] to have explanatory value (Cant, 2005; 2009).

Despite the socio-demographic correlates with usage, the gender and ethnicity of users has only recently come to the centre stage of analysis[xxxii] and reveals another dimension of 'mainstream marginality', as illustrated in my review of the literature (Cant and Watts, 2012). Various studies have shown that women turn to CAM for female specific conditions - during pregnancy, the menopause and to enhance fertility[xxxiii] - all areas heavily critiqued as sites of medicalisation. Reasons for turning to CAM include: having had negative experiences of both conventional medicine and relationships with biomedical practitioners; the perception that CAM is safer and natural; the desire to boost general health, wellbeing and quality of life, and prevent illness; the perception that CAM is empowering, affording personal control over health and health care; a desire to maximise the chance of a positive health outcome, when biomedicine cannot guarantee one. CAM therefore provides a marginalised group with an internalised 'power from within' (see Keshet and Simchai, 2014), a means to resist dominant biomedical definitions, to assert ownership and self-responsibility over health, and to navigate new forms of self-hood (Brenton and Elliot, 2014; Fries, 2008; Sointu, 2006, 2011). It should be noted that this research tends to be ethnocentric, focussed on privileged, middle class women in the West. In India, for instance, it is women and the poor who use homeopathy as it is cheaper than biomedical care and their families ration the use of biomedical interventions (Broom et al., 2009; Sen and Chakraborty, 2016; Shih et al., 2008). Here, we see a curious inversion of the debate: CAM is both empowering and disempowering to women, depending on context. Marginality can also be applied to male use although this may seem counter-intuitive. Male users are not insignificant in number (Cant and Watts, 2012) and are more likely to explore CAM with regard to certain specific health issues such as prostate cancer, impotence and HIV infection (Bishop et al., 2011; Evans et al., 2007; Foote-Ardah, 2003; Pawluch et al., 2000;

Wilkinson et al., 2002): medical conditions, arguably, where men are positioned in a marginal relationship to the dominant discourse of masculinity[xxxiv].

It may be contended that marginal positioning is a defining feature of use amongst minority ethnic groups. Migration is central to understanding the renaissance of CAM as mobile populations have brought their therapeutic modalities with them (Cant and Sharma, 1999), but also tells us something about the attraction of using these practices alongside biomedicine. Nascent research in the UK (Dein and Sembhi, 2001; Healey and Aslam, 1990) has found that traditional healing, especially the recourse to the *Hakim,* was commonly used by British Asians in Bradford to assert cultural identity. More recently, Green and colleagues (2006) found that migrant Chinese women in the UK turned to CAM when discrimination or communication difficulties blocked their access to biomedicine (see also Rochelle and Marks, 2010). Reed (2003) showed that the health choices of British South Asian women provided a means by which to establish identity and difference. For instance, through casting themselves as mediators of family health and making choices about remedies, her respondents were able to assert themselves in their domestic sphere and reinforce a strong sense of cultural identity. Whilst more research is necessary, I argue that CAM can be regarded as a powerful resource through which to construct ethnic and gendered identities and to resist being bestowed deviant ones[xxxv]. Taken together, these examples suggest a resonance with CAM for marginalised users: those who perhaps find an affinity with therapeutic practices that are correspondingly 'othered' (Cant and Watts, 2012)[xxxvi].

In 1999, Siahpush argued that: 'the sociology of alternative medicine is a very young field of enquiry…in order to become a recognised area within sociology, it has to undertake more rigorous conceptual and empirical endeavours' (173). Taking my work as a whole, I suggest that I have made a major contribution to the development of the Sociology of CAM and have been a central architect of this sub-discipline during the last fifteen years. By examining status, power, professionalisation and professionalism, I have identified and made sense of the professional projects undertaken by CAM groups and those deployed by nurses and midwives when adopting CAM, throughout revealing the enduring capacity of biomedicine to shape the medical marketplace. I have been cognisant of the broader structural and contextual factors that underpin these professional projects. My concept of 'mainstream marginality' encapsulates both the opportunities and dilemmas available within CAM, and the tensions that emerge when deciding between occupational change, continuity or compromise. I have also contributed to an understanding of the use of CAM and, through a focus on empathy and empowerment, have

deepened the analysis beyond 'push' and 'pull' factors to show the picture to be nuanced and complex, arguably linked to the marginalised positioning of the main user groups.

Reflections and Critical Appraisal

In Sociology, critical appraisal is engendered by an examination of the research process, the identification of alternative methodologies and what they might offer, the acknowledgement of epistemological and theoretical suppositions employed with an exposition of their limitations, and a consideration of additional substantive areas for investigation. In the absence of formal critiques, I offer a reflexive analysis to reveal both existing gaps in my work and future research opportunities.

It is widely acknowledged that much sociological research is motivated by biographical and personal interest and as such cannot be value free (Weber, 1949). However, contrary to much other sociological work in the field, I was not a user of CAM prior to the research and have not subsequently used any of the therapies that I have researched. As such, I have not had to wrestle with the de-coupling of faith and reason that Weber warned was imperative[xxxvii]. Instead, my disposition has been one of academic scepticism, and I approach my reading of biomedicine with a similar level of doubt. Of course, incredulity is a sociological trait – once you understand the social and political conditions of knowing, it becomes difficult to suspend disbelief. I was never interested in proving the efficacy of CAM or championing a beleaguered group. Indeed, neo-Weberian theory has a tendency to denigrate (Saks, 2015: 13), with its focus on strategies and allegiances. This said, I acknowledge that my work has served to provide a voice for CAM and, in revealing the intractable power base of biomedicine, could be regarded as advocacy. There are research questions that could foster greater criticality – researching those instances when clients choose to desist from using CAM being a good example. Examining the role of CAM in the processes of medicalisation and surveillance (Fries, 2008; Lowenberg and Davis, 1994; Sered and Agigian, 2008) has provided an alternative, critical perspective[xxxviii]. Similarly, Scott (1999) argued that the focus upon wider self-holism (as opposed to wider world holism) in CAM serves to enhance individual responsibility and does not question the extent to which social and environmental structures might account for ill health. Whilst I have acknowledged these dimensions (Cant and Sharma, 1996:12) and have identified a governance

imperative in professionalism, these contributions support the development of a more critical mode of analysis.

My substantive focus on professional associations and practitioners has provided insight into the processes of occupational formation and the practice of integrative medicine. However, alternative methodologies, such as ethnography and observation, provide access to the content, delivery and reception of training and to the practice of CAM in consultations. Within the sociology of the professions there is a long tradition of examining power and politics in action, through socialisation, education, and as exercised in and through relationships (Atkinson, 1997; Bloor and Horobin, 1975; etc.). Others have undertaken such analyses of CAM and their findings have tended to corroborate (through extension) rather than unsettle my work. In her discussion of practitioner training, Gale (2008) provides a nuanced review of the ways in which the relationship between practitioners and patients is negotiated, how boundaries of professionalism are learned, and how the presentation of expertise is both accomplished and embodied. Focusing on the content of education, Givati and Hatton (2015) have shown how the concept of holism in homeopathy and acupuncture had to be modified to adapt to the demands of higher education institutions. In his conversational analysis of homeopathic consultations, Chatwin (2009) showed that whilst homeopathic practitioners may emphasise mutuality and collaboration, they draw on a number of interactional strategies to retain authority. These contributions show how 'professional expertise' is not *simply* built through collective credentials and organisational efforts to impose social closure (as I have revealed), but is *also* reproduced in everyday clinical encounters and through educational socialisation. Whilst these studies have deepened our understanding of the micro processes of power, they have not questioned the importance of professional projects as spearheaded by professional associations.

Similarly, where I have highlighted the importance of professionalism in the generation of trust relations in CAM, other work has provided important empirical substantiation of how this is enacted and achieved in practice, through the identification of the practical ways in which practitioners win trust in clinics. This research has focused on bodily and relational exchanges, and the management of space, rather than client need to see credentials or understand the therapy (Lee-Treweek, 2002; Pedersen et al., 2015). This rich analysis of the therapeutic encounter is fascinating and serves again to elaborate trust practices rather than unsettle their importance for understanding CAM professional practice, as outlined in my own work.

The sociological and empirical examination of integrative medicine is nascent and, whilst my study of the use of CAM by nurses and midwives in NHS hospitals stands as an important contribution, there is much more work to be undertaken. Indeed, the development of integrated care is the most recent and significant development in the field, but is varied in its application: it can involve the simple sharing or utilisation of different ideas, a willingness to draw on differing paradigms, or can constitute a more co-ordinated approach that fosters practitioner communication and collaboration in common practice settings. Research now needs to examine these various working relations and the types of referral patterns that are deployed in general practice, as well as in hospitals, hospices and specialised clinics. We still know very little about how CAM practitioners work alongside one another in private or state-funded integrative clinics in the UK. Indeed the NHS hospitals for integrative medicine would provide an excellent case study[xxxix]. Some recent contributions from outside the UK suggest fruitful theoretical areas for development. Keshet (2009, 2013), for instance, has drawn on the concept of 'boundary work', from actor network theory, to explain how integrative medicine works in practice.

Where I have highlighted the persistence of biomedical dominance, there is scope for further interrogation of this power dynamic. Early studies of biomedical responses to CAM pointed to greater support from younger doctors (Reilly, 1983), but there has been little recent work that has examined the differing and changing views within the biomedical profession (Hirschkorn and Bourgeault, 2005). There are at least two directions for further research. In the first place, medical dominance is a blunt concept and masks potential shifts in practitioner attitudes towards more inclusive and holistic practice. Secondly, and at the polar extreme, the recent and vitriolic attacks on homeopathy have not been subjected to sociological analysis and nor have the organised attempts to eradicate CAM from the NHS been fully evaluated[xl].

Sociologists, of course, should do more than simply focus on the vocal protagonists and critics. In the same way that sociology moved from a position of 'in' medicine to 'of' medicine (Nettleton, 2013), a Sociology of CAM needs to turn to questions of evidence, efficacy and risk. The question of efficacy is the most politically charged and is of sociological interest, not least because patients tend to continue to choose treatments without the need for clinical evidence (Broom and Tovey, 2007), yet funders (NHS and private medical insurance companies) and the biomedical profession demand experimental corroboration. Because evidence based medicine (EBM) has proven problematic for CAM[xli], there has been a tendency towards (possibly unintended) advocacy. In our edited book (Cant and Sharma, 1996), we

included chapters that pointed to the problem of biomedical measures of effectiveness. More recent research, asserting that biomedical notions of truth are socially and politically shaped, has corroborated this scepticism (see Keshet, 2009) and understands the adherence to EBM as a mode of subjugation (see Winnick, 2005), and as a means of prohibiting state-funded practice (Cant et al., 2012). Others have importantly shown that whilst biomedicine itself is not always underscored by evidence, securing legitimacy still rests on these gold standards (Jackson and Scambler, 2007; Villanueva-Russell, 2005). Overall, the questions of evidence and efficacy are key for future research, but additionally require more innovative methodologies and alternative theorizing[xlii], not least to elaborate the social construction of what stands as legitimate evidence[xliii], to examine how EBM threatens both biomedical and CAM professional judgement and expertise, and to identify different indicators of efficacy.

Relatedly, Turner (1984), Nettleton and Watson (1998) and Shilling (2003), among others, broadened the sociology of medicine in their reconceptualization of the body as a social, cultural, political, emotional and historical construction and challenged the Cartesian rationalism of modernism. Conceptualising and integrating an appreciation of embodiment is becoming more central in the Sociology of CAM and helps us think imaginatively about the issues of placebo, self-responsibility and self-actualisation. If wellbeing is understood as going beyond physical responses, then CAM can be seen to be implicated in the healing process in multiple ways. Sointu (2006), for instance, sees wellbeing as a useful way of understanding what it is that CAM offers to the individual. It permits a movement away from biomedical understandings of efficacy (as grounded in measures such as 'cure' and 'disease-free') and enables instead an appreciation of authenticity and self-determination: a restructuring of health as a subjective rather than an objective entity. Broom and Tovey (2007) found that cancer patients in their study were concerned to evaluate treatments in terms of agency, hope and control. Similarly, Baarts and Pedersen (2009) revealed the 'derivative benefits' of CAM being enhanced bodily awareness and bodily mastery, and so then, greater wellbeing. Similarly, Gale's (2011) discussion of body-talk and the construction of body-stories shows the capacity of CAM to heal differently through the dialogic composition of corporeal narratives. Barcan (2011) too explores how CAM opens up new and rich worlds of physical experience 'in which the body's senses are opened up, trained and treated as important and legible parts of both the symptom picture and the healing process' (3), and where experiential evidence is legitimated and the self-healing capacity of the body is acknowledged. These writers challenge the idea that CAM simply individualises distress and de-politicises health and suggest instead that CAM

renders possible new ways of thinking about health and embodied self to emerge. Taken together, these perspectives enable a nuanced and sophisticated understanding of the attraction and implications (including efficacy) of CAM practice, and usefully enhance my own analysis of CAM as an axis of empowerment for marginalised groups.

It is also important to reflect critically upon my use of theories of professionalisation and professionalism. I am aware that my application of these theories has been to make sense of empirical data and thus stands as 'middle range' (Merton, 1968). Indeed, Freidson (1994) lamented that the study of the professions did not sponsor the broader study of occupations and the sociology of work and my own contribution similarly lacks this broader theoretical application. It is also the case that the study of professions and professionalism is a peculiarly Anglo-American, historically-specific concern (Burrage and Torstendahl, 1990). My originality has been in the examination of the usefulness of these concepts for understanding a group of occupations that would not necessarily be defined as 'successful' professions and in showing how these claims to professionalism and engagement in professional projects still serve to police occupations and create occupational identity and exclusionary market shelters (Parkin, 1971). My approach allowed a focus on 'occupational professions' rather than 'status professions' (Elliott, 1972) and, in doing so, stretched the conceptualisation of a profession more widely perhaps than in other work. Foucauldian thinking and theories of late modernity have helped explain why professionalism holds such importance and appeal, but these are examples of grand theorising that make logical sense at the abstract level but are, admittedly, harder to corroborate empirically.

Whilst my simultaneous use of Weberian and Foucauldian analytical stances, feminist theories of professionalisation, and late modern theoretical perspectives could be critiqued on the grounds of epistemological incommensurability, I have approached theory as a heuristic device: a means of revealing multiple truths to afford a richer and more nuanced account of reality. Singular theoretical approaches are inevitably limiting in their illuminative capacity: neo-Weberian approaches draw our attention to strategies and motivations, feminist theories of professionalisation reveal gendered power differentials, Foucauldian theories reveal the immanence of power in relation to knowledge; late modernist theories highlight the deep importance of concepts such risk and trust. All reveal different dimensions of the same social phenomena, and together constitute a form of theoretical triangulation. This disposition to theory has philosophical support in the traditions of pragmatism[xliv] (theories and concepts are judged in terms of their usefulness); critical realism (where knowledge is recognised as partial,

Bhaskar, 2008[xlv]); and anarchism (scientific pluralism is seen to foster criticality, Feyerabend, 1975)[xlvi]. My approach has been to appreciate the theoretical tensions resultant from drawing on disparate theories, but acknowledge the usefulness of theoretical plurality. As such, I defend my approach of studying CAM from more than one perspective; I am comfortable with the idea that there are different, equally valid *perspectives* on reality, but recognise that this provides a creative and complex account rather than a tidy resolution[xlvii]. This said, there were other theoretical perspectives that I might have drawn upon.

I have already argued that I found neo-Weberian accounts to be more helpful than neo-Marxist ones. This was because they draw attention to the strategic methods and processes employed by occupational groups (their purposive actions) to secure market advantage and thus find a resonance with middle-range empirical analysis. However, the neo-Weberian perspective does not give as much attention to the examination of *why* autonomy and authority is granted to certain groups. Neo-Marxist accounts find such explanations through references back to capitalist relations of production and the labour process (Johnson, 1972) and stand as larger scale, structural, system accounts. Such work has also drawn attention to deprofessionalisation and proletarianisation (McKinlay and Arches, 1985; Murphy, 1990; Oppenheimer, 1973). Throughout my work, I have alluded to the mutually reinforcing processes of capitalism and neoliberalism in the renaissance of medical pluralism, but these components could have been given greater prominence, as they are in neo-Marxist writings. Han (2002) has provided a powerful application of these ideas arguing that global capitalistic and neoliberal imperatives - those that emphasise choice, individuality and profit - played their role in the expansion of a plural medical marketplace. In alerting us to commonalities across CAM and biomedicine, he revealed the trend to conformity rather than resistance but explained this in terms of economic and ideological motives and ends. For example, he showed that CAM and biomedicine share: a hierarchical doctor/client relationship with the former distinguished by their expertise, credentials, professionalism and competency; a focus on health as a commodity; clinic-based delivery; a focus on individual responsibility for health rather than calling for social and economic or political change. Certainly, more work could be undertaken to examine the role of health insurance companies (see Tillman, 2002) and the pharmaceutical industry in the rise of medical pluralism. Interestingly, the effects of the recent economic crisis on the popularity and practice of CAM has yet to be considered.

There are other useful theoretical perspectives within the sociology of the professions. Recently, Brosnan (2016), for instance, has argued that Bourdieurian concepts can enrich

theories of professionalisation – essentially arguing that those that dominate a field (e.g. medical professionals) are able to set the terms of what counts as capital (science, RCTS). In this conceptualisation, science is viewed as symbolic capital and influential networks are understood as social capital. I cannot deny the applicability of such thinking but see this as a different packaging of the same empirical evidence. Therefore, it is insightful but not necessarily more so than the neo-Weberian accounts of knowledge, closure and credentials.

If the critique of being only applicable to the Anglo-American context can be levied at neo-Weberian theories of professionalisation, then my own work can be regarded as ethnocentric. Sociology generally has been critiqued for ignoring colonial encounters (Bhambra 2007, Bhambra and Santos, 2017)[xlviii] and despite the positive reception of my ideas in the Global South, my study of medical pluralism and mainstream marginality is spatially limited and incorporates a number of taken for granted assumptions about the development of medicine. Historical and anthropological analyses have described how biomedical ideas acted as a 'tool of empire' (Lock and Nguyan, 2010: 148) – adapted and exported through settlement and implicated in the colonial demand for the imposition of Western language, culture and technology on colonised peoples. However, the study of the domination of biomedicine over CAM has largely neglected the analysis of colonialism. As an exception, Hollenberg and Muzzin (2010) argue that in integrative medicine the privileging of the biomedical paradigm is unquestioned and stands an 'an extension of Euroscience, a paradigm with a long history of appropriation and assimilation of Indigenous knowledges' (25).

I can see that there are ways in which post-colonial theorising could engender a more radical reading of the subjugation of CAM in medical pluralism. Globalisation has not simply produced biomedical homogeneity (although the global dominance of biomedicine is without question): rather, it has also fostered dialogic exchanges between traditional, non-orthodox and biomedical health knowledges that map out differently in various locales. As such, it would be preferable to talk of medical pluralisms[xlix]. Following this through, it is possible to elucidate the impact of colonialism on the shape of medical pluralism in the UK. The West's adoption of Asian medicines might be regarded as a restrained and partial appeal to a romantic *idealisation* of Eastern knowledges, one that conflates lots of differing traditions and reduces them to a singular worldview: 'a perspective based on an idealistic holistic assumption rather than an engagement with the sociological and historical reality of the tradition that they practice' (Newcombe, 2012: 208). I am referring to a form of cultural re-imagining. We know that the discursive juxtaposition of the West from the East, the Occident from the Orient, is

steeped in history, trade and a need to assert difference though boundary construction and nationalism. Where Anderson (1983) detailed how 'imagined' communities are socially constructed, Said (1979) showed how cultural representations of the differences between East and West were exaggerated and assumed hierarchical difference: otherness was equated with subjugation. Non-Western forms of knowing, and so then Asian medical knowledges, might be understood as being relegated to the margins through this additional dynamic.

Spivak's reinterpretation of the Gramscian concept of 'subaltern' could be useful here. The term is widely used in post-colonial studies to refer to persons and groups who are radically marginalised because they are positioned outside colonial hegemonic discourse. As such, subaltern status is more than a matter of simple oppression: post-colonial power relations, both material and discursive, leave the subaltern without agency. For Spivak (1988), to be heard and known the 'subaltern' can only adopt Western ways of knowing, of thought, reasoning and language. Spivak is, in fact, very critical of many progressive Western intellectuals for their tendency to reify and romanticise the oppressed colonial Other, a critique that could be levied at Sociologists of CAM. Empowerment for subaltern people, she argues, will not come through seeking to give them an authentic voice, but through challenging the post-colonial systems that position such people outside discourse in the first place. To apply this thinking still further: if the subaltern can only be heard by the oppressors by speaking the language of the rulers, Asian medicines can only be understood and known by and through a Western medical discourse. This provides new categories for thinking about medical pluralism. Post-colonial theory enables a reappraisal of the ascendance of biomedicine and alternative ways to think about the global experience of CAMS both historically and in the future.

I could also be critiqued for being too accepting of the power-based model of professionalisation which serves to reproduce a binary view of dominance and subordination and which privileges medical knowledge and status. In doing so, it has the potential to reify the non-differentiated character and professional autonomy of biomedicine, obscuring the study of more complex understanding of authority and knowledge, and I have alluded to this in the analysis above. My own research has not specifically examined the evolution of therapeutic practices in the context of increasingly pluralistic health care, the reciprocal exchanges and the mutual benefits. In the study of nurses and midwives, I showed that discourses about risk and professionalism shift according to context and that the practitioners observed a number of benefits of integrated care. However, I was still primarily focussed on the status and power

games upon which boundaries and claims to occupational territory could be made, rather than upon the value of exchange and hybridity.

Certainly, more optimistic readings of the new medical pluralism focus on syncretism and hybridity and permit an appreciation of the diversity and creativity of plural practices, providing a conceptual space by which to see CAM as a mode of resistance as well as appropriation (Gale, 2014). Wahlberg (2006) makes this point in his study of the revival of traditional medicine in Vietnam, albeit a case study taken from the Global South. While he acknowledges that traditional medicine went through a process of standardisation, regulation and scientification - 'a taxonomic drive to collect, collate and classify knowledge about different medicinal plants and traditional herbal formulas' (133) - and was incorporated into medical education, he also understands the revival from a Foucauldian perspective as a rejection of colonial bio-politics where local populations were re-educated on the use of herbal medicine. He argues that traditional knowledges, that had previously been depicted as uncivilised or quackery (in biomedical terms), found themselves revived with radical potential. He acknowledges that it is possible to view this as appropriation by expert bodies of knowledge, 'stripped of its' original value as a 'natural', 'Eastern' or epistemologically distinct form of medicine' (140), but he instead emphasises the space for resistance. There are certainly positive outcomes for consumers, with the majority of studies showing that integration is positively welcomed, the focus on collaboration and partnership deemed to be empowering (Ben-Ayre et al., 2009a; Gale, 2008; Hok et al., 2007; Smithson et al., 2012). Arguably, my focus on non-medically qualified practitioners and nurses and midwives has skewed my analysis and findings. My work has revealed how medical dominance is exercised, but I have not scrutinised the places and spaces where resistance and change may emerge. In contrast, May and Sirur (1998) showed how incorporation of homeopathy into general practice enabled new working practices and Keshet's (2013) recent ethnography of dual-trained physicians in Israel indicated new ways of assimilating contradictory knowledges and hybrid possibilities.

This positive reading of CAM is evident in Colin Campbell's (2007) detailed examination of the 'Easternisation of the West' and where he argues that the importation of value systems have deeply affected and transformed Western civilisation. The Eastern 'shaping' of Western medical practice, through the acceptance of acupressure, acupuncture, moxibustion, shiatsu, etc., are indicative of a seismic shift in the Western worldview, he opines. The search for Eastern wisdom produces concomitant changes to Western practices and the Western psyche which, he argues, is as significant a shaping of the West as was the Renaissance, the

Reformation, and the Enlightenment. It indicates a shift away from a materialistic, mechanistic, positivist, deterministic and reductionist (Newtonian style) worldview, a rejection of the dualisms between the mind and the body, mankind and nature, body and soul. Instead, holistic beliefs, with an appeal to self-determination and self-knowledge, are embraced: reason is balanced with intuition; calculation is supplemented with contemplation and individuals are regarded as imbued with a vitality, a life force.

Such an ontological shift can be seen to be accompanied by epistemological change. And different ways of knowing health are given the space to flourish and serve to transform biomedicine. In her examination of CAM, Almeida (2014) focusses on the changes made to biomedical organisation and practice and makes the case that a process of *camisation* now sits alongside medicalisation: a situation where health problems can be treated in CAM terms and within a CAM framework. This perspective, drawing on professionalisation literature, views CAM as a countervailing power (Light, 1991), acting to rearrange medical power relations, and provides a more positive reading of pluralism. Whilst I never argued that CAM was simply subjugated, I have given more attention to the compromises rather than the gains.

Seeing CAM as a mode of resistance finds support in social movement theory and many writers have pointed to the radical potentials and activism inherent in these medical practices. (Goldstein, 2000; Scott, 1998). For me, the empirical evidence in the UK cannot fully support such a reading. Notwithstanding the correlation between the renaissance of CAM and the Green and Women's movements, the radical potential seems overstated. The majority of users have limited engagement with the Eastern worldview that underpins many of the therapies they access. Moreover, the significant divisions in usage patterns mean that this way of thinking is more likely to be associated, in any case, with those users that are wealthier - those with the leisure time and resources to explore differing conceptions of health and self-hood. Medical pluralism in the UK has, I still contend, involved the very specific imagining of CAM knowledge - a prioritisation of biomedical evidence with only a limited engagement with the philosophies, ideas, world-views and vocabulary of CAM. In this way, pluralism in the UK lacks fully radical overtures, not least because of enduring power relations with biomedicine, and the resilience and dominance of biomedical epistemology. This said, broadening the analysis beyond euro/ethnocentric limits provides opportunities to see CAM implicated in the assertion of identity, in nationalistic politics and as a mode of resistance (e.g. Khan, 2006; Napolitano and Flores, 2003; Wahlberg, 2006).

Conclusions

Complementary and alternative medicine is a mainstream component of healthcare in most late-modern societies, and this historically contingent social phenomenon is worthy of, and should be subject to, sociological analyses. The Sociology of CAM is no longer in its infancy and the growing body of research both reflects and enhances key domains of sociological enquiry, acting as a case study of inequality, power and empowerment, patriarchy, governance, neoliberalism, capitalism, colonialism, individualisation, risk, trust and embodiment. My own work has contributed centrally to a number of these areas, providing an understanding of the revival of CAM and the new configuration of medical pluralism. At the level of work and organisation, I have provided detailed analysis of professional projects in a context where (patriarchal) biomedicine wields authority. Detailing the historical shifts in status from fringe to alternative, to complementary and now integrated medicine has raised important questions about the organisation and delivery of health care practice. Exploring the attraction of CAM to consumers has given insight into changing expectations of health care delivery and broader social change - the search for personal growth, empowerment and connection situated alongside elevated scepticism levied towards experts. And yet, I have shown the enduring resilience of professionalism (being able to assert the role of trusted expert) as a defining (and governing) characteristic of health occupations and health practitioners. This pervasive ideology of professionalism, the epistemological authority of biomedicine, and the emphasis upon evidence-based medicine all serve to shape the conditions of possibility for contemporary health care practice.

My overarching contribution has been to use sociology to describe and analyse the positioning of CAM in the UK - a mainstream activity, concomitantly marginalised across a number of axes. The revival of CAM stands as a significant social transformation but is ultimately bounded by: its lack of 'scientificity' (in biomedical terms); its lack of access to state support or funding and restricted autonomy; its reimagining in biomedical terms and its subsequent co-option; its appeal to marginalised (empowering the disempowered) groups; its practice by marginalised (predominately female) practitioners; and, arguably, its subaltern positioning.

Future research could focus on the comparative configuration of global medical pluralisms to identify both commonalities and local variance, and I am working on a book proposal to this end. Our understanding of the use of CAM by ethnic minority groups remains nascent and the

use of CAM by men is under-researched (a meta-analysis of male use and how this might be theorised is in progress), as are the circumstances when users choose to end their engagement. The ways in which integrated or integrative care is managed and delivered is an area that requires more empirical study and, equally, the examination of the public/media attacks upon CAM should be undertaken.

The study of CAM has given me much scholarly interest and has provided the opportunity to mature as a researcher and as a sociologist. In doing so, I have contributed to the sociology of CAM, a sub-discipline that continues to provide a rich seam of research opportunities and promises to remain central to medical and generic sociology.

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Notes

[i] The turn to CAM is associated with searching for support for disease or illness categories that are longstanding and often intractable, such as: acne (Magin et al., 2006); cancer (Balneaves et al., 2008); mental health disorders (Sarris and Lake, 2012); HIV (Littlewood and Vanable, 2008), etc.

[ii] Professionalisation refers to the processes undertaken to achieve social closure of an occupational group and thereby secure practitioners' self-interest in terms of salary, market share, power and status.

[iii] Professionalism refers to occupational, normative values.

[iv] Freidson uses the terms interchangeably and acknowledges that he does so often without distinction (see 1994:10, 200).

[v] Larson (1977), in bringing together Marxist and Weberian theory and by studying professions as interest groups who share a link to the class system and who engage in collective mobility projects, makes a distinction between professionalisation and professionalism. Industrial capitalism saw the development of the older and freer professions. Under corporate capitalism new style professions borrowed the attributes of older professions to secure higher status – credentials and specialised knowledge serving to legitimate differential rewards and privileges. The ideology of professionalism is seen to underpin this privilege.

[vi] The suggestion draws from Bourdieu and Wacquant (2002) who describe symbolic violence as the imposition of an ideology that legitimizes and naturalises the status quo.

[vii] Social scientific research at this time was nascent. Inglis' polemic *Fringe Medicine* (1964) levied an attack on biomedical dominance but did not engage in evaluation; Inglis and West (1983) provided a review of alternative practices and showed that the number of therapies and therapists was growing. Fulder and Munroe (1982) described the rise of alternative medicine in the UK and Salmon's work provided a foundational review of policy which predicted a dramatic change to health practice – 'a spectre is haunting scientific medicine' (1984:1). An empirical study of 'unorthodox' medicine had been undertaken in the USA (Kronenfeld and Wasner, 1982) and the authors called for more research by medical sociologists. In terms of the professionalisation of CAM, Wardwell (1992) had described chiropractic as a marginal profession in the USA and another American academic, Baer (1984), had undertaken a review of osteopathy in the UK (following its importation from the USA), pointing to emergent professionalisation campaigns and the important influence of strategic elites. At the time of my own work, researchers in the USA (Eisenberg et al., 1993) and the UK (Thomas, et al., 1991) were attempting to estimate usage rates and medical psychologists were thinking about what might underpin the renaissance (see articles by Furnham and colleagues). That my work paralleled the sociological think-piece by Bakx (1991) [which theorised the social and cultural shifts that might explain the turn to CAM and lamented the absence of empirical research], Sharma's (1995) review of CAM, and Saks' (1992) work on acupuncture points to the emergence of the *Sociology of CAM* as a field of enquiry in the 1990s, and establishes that I was one of the research pioneers.

[viii] The Marxist approach sees professional groups serving capitalist interests (see Navarro, 1978), agents of control and surveillance for the bourgeoisie (see Ehrenreich and Ehrenreich, 1979). What happens to the professions is understood as a reflection of capitalist relations of production (Johnson, 1972). In doing so, neo- Marxist writers look for explanations for differential market-share and competition whereas neo-Weberian focus on the mechanisms. A distinction, if you like, between the 'why' and 'how' of professional formation.

[ix] I was able to interview representatives from all 3 professional associations that represented homeopathy and chiropractic and took the decision to interview the six largest in reflexology (there were thirteen associations representing the therapy at the time).

[x] Questionnaires were sent to the Chiropractic colleges (100% response rate); 45 to reflexology colleges (67% response rate) and 13 to homeopathic colleges (61% response rate). 54 questionnaires were sent to practitioners in one locality (61% response rate).

[xi] Especially as nurses have been shown to be highly enthusiastic about CAM in contrast to their doctor (especially consultant) colleagues (Tovey and Broom, 2007).

[xii] Social scientific research pertaining to CAM is predominantly qualitative, utilising: interviews (e.g. Almeida, 2012; Brenton and Elliot, 2014; Broom et al., 2009; Fadlon, 2004; Foote-Ardah, 2003; Givati and Hatton, 2015; Kelner et al., 2004); ethnography (see, for example, Chako, 2003; Gale, 2011); documentary analysis (Baer, 1984, 1998); and observation (Chatwin, 2009; Givati and Hatton, 2015). Quantitative analysis has been restricted to those studies where the extent and pattern of use is estimated (see Thomas et al., 2001) and a small number of other surveys (e.g. O'Callaghan and Jordon, 2003). This said, there is space to conduct surveys using registers provided by professional associations, but always acknowledging that these are incomplete.

[xiii] The book has had significant and international impact in medical sociology, medical anthropology and global studies, described as seminal (Gale, 2014). For impact see: Almeida, 2016; Baer, 2008; Dinges 2014; Frank and Stollberg, 2004; Gale, 2014; Givati and Hatton 2015; Jutte, 2013; Saks 2003; Sujatha and Abraham, 2012. I argued that while pluralism signals multiplicity and diversity: the interaction of a number of different voices in any given arena and, to draw on McLennan, 'depends on an ability to characterise and problematise some prevailing monistic orthodoxy' (1995: 98), it does not necessarily signify an 'equal but different' positioning of voices, ideas and knowledges. On the contrary, pluralistic practice is rarely non–hierarchical or devoid of power relations (Cant, 2004). This is revealed most clearly in the application of the concept to medicine and the overarching conclusion of the book was that other forms of healing have only achieved legitimacy through a process of accommodation with biomedicine.

[xiv] The empirical examination of integrated practice is still in its infancy and there is little sociological work on nurses and midwives use of CAM (see review by Hirschkorn and Bourgeault, 2005) – but as an exception see, as Tovey and Broom (2007) whose study revealed nurses to be important mediators in cancer patients use of CAM. Coulter et al. (2010) reviewed research into integrative health care and showed that whilst there were a few descriptive studies there was little evaluative or observational research. Moreover, studies are thwarted in the absence of an agreed typology of integrative practice and because of the confusion between integrated and integrative medicine with their very different meanings: the former looking at simultaneous offer of practices and latter being a non-hierarchical offer than puts the patient at the centre of care.

[xv] Miztrachi et al. (2005) found CAM practice absorbed by biomedical practitioners and clear hierarchies. Hollenberg's various researches (2006, 2007, 2011) found little evidence of collaboration, with CAM practitioners limited in their roles through referrals, charting and diagnostic tests. Integration looked more like strategic co-option than a coming together of practice.

[xvi] Broom and Tovey (2007) argue that the integration of CAM into cancer treatments stand as a challenge to biomedical ways of knowing and suggest that the idea of medical dominance is too simplistic. Instead, they call for research that examines the ways in which medical care might be changing - this would require a shift from models of dominance and subordination to adaptation and evolution.

[xvii] Foucault's discussion of legitimacy is instructive here, as is the control of autonomous subjects and the exercise of appropriate conduct: expertise is critical in processes of governmentality (also see

Johnson, 1995). Larson (1990) herself embraces a Foucauldian approach in later work. The focus here was on the discipline of the profession although this was not supported by empirical investigation, an omission corrected by Nettleton (1992).

[xviii] Here the focus is not on market closure but the effects of professionalism. Fournier (1999) sees professionalism as a critical marketing device and drawing on Miller and Rose (1990) has explored professionalism as the government of professional practice 'at a distance'. Key professional controls are internalised rather than imposed – a form of self-discipline, a disciplinary mechanism that inculcates normative values, conducts and identities. Evetts (2013) points to the appeal of professionalism to facilitate occupational change as it engenders autonomous decision making and self-regulation rather than the need for the (expensive and bureaucratic) imposition of state endorsement. In other words, the ideology of professionalism is cheaper and is more responsive, self-managed and self-motivated. Also see: Noorsegraff (2009) and Svennson (2006).

[xix] Wahlberg (2007) makes a similar point when he argues that the problem of quackery is increasingly located in the 'ethical field of practitioner competency, qualification, conduct, responsibility and professional development, almost (but not quite) regardless of the form of therapy in question' (2307).

[xx] In a neoliberal economy where the economic burden of health is forever on the rise, the shift to a model of an empowered consumer taking responsibility for their own health is not surprising: making informed choices and consumers paying out of their own pocket puts the two cornerstones of neoliberalism (choice and responsibility) into the marketplace.

[xxi] A quest for perfect harmony and balance, an ambition to transform life – working on the self, aiming for self- perfection – for Foucault, of course, this would chime with 'technologies of the self '(1983) – these are at once autonomous from power regimes but also produce certain types of human being – that is, they are simultaneously liberating/provide a form of resistance providing an opportunity to re-skill (as individualised practices) *and* constraining.

[xxii] This is not to say that the focus on consumerism is unproblematic. Lupton (1997) showed how consumers can be simultaneously active and passive and therefore to reduce the understanding of the appeal of CAM to consumerism alone is probably too blunt.

[xxiii] Witz (1992) revealed the impact of gender as a structuring principle by showing that female based medical occupations do engage in professional projects employing usurpation and inclusionary, exclusionary and dual closure strategies to secure social closure, but that these are shaped by gender relations. In turn, women find themselves excluded, demarcated and contained within the medical division of labour. Nurses and midwives are accountable to and scrutinised by the medical profession.

[xxiv] In other words, therapeutic discourses are heavily gendered: CAM tend to champion an ethic of care that favours intuition and eschews 'masculine' reason.

[xxv] Interestingly the gender ratio only tips towards men in the higher status CAM professions – Osteopathy and Chiropractic (see: Scott 1998; Flesch, 2007; Taylor 2010).

[xxvi] Female medical students are more favourably disposed to CAM than their male counterparts (Greenfield et al., 2006).

[xxvii] Despite the absence of systematic and reliable surveys the available evidence (Ernst, 2006) suggest an exponential increase in use with a range of 26-75% (depending on time scale and number of therapies included - see; Eardley et al., 2012; Ong and Banks, 2003; Posadzki et al., 2013; Thomas et al., 1991, 2001; Zollman and Vickers, 1999). Most studies suggest usage rates coalese around a third of the population engaging with CAM, a similar figure (38%) reported in the USA (Barnes et al., 2008). Harris et al. (2012) suggest figures have remained stable since 2000.

[xxviii] See Bishop and Lewith (2010) for a meta-analysis of use and which points to the need for more UK studies. There is space to explore different CAM client journeys and the motivations of increasingly heterogeneous users. When I started to look at use by men, for instance, I found that their access was not insignificant and yet their experiences have been largely ignored.

[xxix] I have collated the findings of a number of empirical studies such as Adams et al. (2003; 2009); Bishop et al. (2007); DiGianni et al. (2002; 2003); Doel and Segrott (2003); Factor-Litvak et al (2004); Kang et al (2002); Furnham and Beard, 1995; Furnham, Sirois and Gick (2002); Furnham and Smith, 1988; Furnham and Lovett (2001); Sirois and Gick, 2002; Upchurch and Chyu (2005).

[xxx] Research has generally shown that users tend to make their choices on a pragmatic basis and assumed effectiveness rather than by a commitment to philosophy see Broom and Tovey, 2008; Chacko, 2003; Fadlon, 2004; MaCartney and Wahlberg, 2014) – the users are portrayed as a *bricoleurs* – choosing pragmatically between alternatives.

[xxxi] Giddens (1991) has described the project of remaking the self to be intrinsic to the life politics of late modernity. Here individuals are reflexively responsible for self-actualisation and take a critical stance in relation to expert systems.

[xxxii] In Cant and Sharma (1996: 186-7), I concluded the book with a call for more research in this area. See more recent work by Ben-Arye et al. (2009b); Eschiti (2007); Keshet et al. (2012); Rayner et al. (2009); Furth and Shu-yueh (2011). Age may also be an important axis of marginality: see indications in existing research (for example, Shiovitz-Ezra and Litwin, 2012).

[xxxiii] See Adams et al. (2003; 2009).

[xxxiv] See Connell and Messerschmidt (1995) on hegemonic masculinity and the emphasis upon independence, aggression, heterosexuality, virility and phallic power.

[xxxv] Prussing et al. (2005) interestingly showed how parents of children with Down syndrome were drawn to CAM as it offered alternative definitions of the causes and prognosis of the condition, and allowed them to construct identities as good parents in their search for support for their children.

[xxxvi] This point is implicitly corroborated in the study of CAM use amongst the elderly and who are drawn to the empowering potential inherent in the healing practices (Andrews, 2002; Cartwright, 2007).

[xxxvii] Other researchers have admitted their interest as users or as practitioners (see Barcan, 2011; Gale, 2011; Givati and Hatten, 2015).

[xxxviii] Here CAM is examined as a discursive mechanism in the governance of health and biopower – a new individualised spatialisation of medicine: in the context of overused state funded biomedicine, the shift to CAM makes sense in terms of neoliberal economies and as a means of neoliberal governance through technologies of the self. A shift from the body politic to the body personal, with the individual consumer primarily responsible for their health (or lack of it) – see Rose (2009) on the biopolitics of subjectivity and Lupton (1995) on the imperative of health which encourages reflexivity and responsibility. ‘Counter hegemonic discourses of CAM are themselves constitutive rather than being merely resistant or adaptive to government programmes for the production and management of subjectivity’ (Fries, 2008:357). Where Sontag (1978) powerfully critiqued psychological views of illness for placing the blame on the ill, CAM can also be understood in this way. Coward (1989) similarly argued that CAM failed to challenge capitalist precepts, instead bestowing responsibility to the individual.

[xxxix] Indeed a full analysis of this institution would be apposite given the recent renaming of the Royal London Homeopathic hospital in 2010 to the Royal London Hospital for Integrated Medicine (with the removal of homeopathic services) being indicative of changing relations. In Cant and Sharma (1996) I outlined the anxiety felt by the Faculty of Homeopathy about the survival of their hospitals.

[xl] In contrast, Brosnan (2016) has provided a systematic analysis of the campaigns in Australia conducted by the 'Friends of Science in Medicine'.

[xli] EBM prioritises evidence generated by randomised controlled trials usually focussed on a single intervention, but there are concerns that this reductionist methodology is not applicable for CAM therapies being paradigmatically incongruent with holism, vitalism, individualised prescribing (Coulter and Willis, 2004; Patel, 1987; Villanueva-Russell, 2005) as well as being prohibitively expensive. Keshet (2009) refers to this disjuncture as a fundamental dichotomy between two different ways of knowing and which reflects the tension between two opposing philosophical positions: reductionism and holism. Biomedical scientists use the former to establish their epistemic authority even though in practice there are is much cross over and ambiguity.

[xlii] Barry (2006) calls for a mapping of the transcendent or transformational experiences – a focus on changed lived-body experiences, the gaining of meaning.

[xliii] A sociology of efficacy, like the sociology of diagnosis (Jutel and Nettleton, 2011) stands as a central concern for medical sociology; the gold standard of RCT validates what counts as evidence but is socially contested and socially framed.

[xliv] In the work of Rorty (1979) there is an acknowledgement that scientific methods stand as contingent vocabularies and that truth statements depend on the critical frame used to make them. He further ties theoretical inventiveness to pragmatic hope. For Putmam (1987) it is the language of theory that allows us to see things but does not assure us of intrinsic properties. There is then no possibility of attaining a single or correct 'God's eye view' that is independent of any particular viewpoint.

[xlv] In the work of Bhaskar (2008), we see an acknowledgement that one cannot have an objective or certain knowledge of the world – there will always be the possibility of alternatives and equally valid accounts of any phenomenon. As such all knowledge is partial and there will be more than one scientifically correct way of understanding reality. They hold onto the idea that there is a real world to study but our understanding of this empirical world is always a construction, shaped by our perspectives and standpoints: a linking then of ontological realism and epistemological relativism in the construction of scientific knowledge.

[xlvi] In 'Against Method' (1975), Feyerabend rejects attachment to any single scientific method seeing this as limiting scientific progress and instead calls for theoretical anarchism with scientific pluralism improving the critical power of science. Incommensurability does not rule out one theory over another.

[xlvii] Interestingly Larson (1977), perhaps the key neo-Weberian theorist, draws on Marxist and Foucauldian frameworks and Witz (1992) revealed the value of combining Weberian and feminist approaches.

[xlviii] Post-colonial theorising demands a critique of colonial discursive practices, draws attention to the persistence of colonial controls and demands a recognition of the epistemic and cultural diversity of the world. This can be engendered by drawing on 'epistemologies of the south' (Santos, 2014), which reveal the spaces where colonialism has been resisted, and through 'connected sociologies' (Bhambra, 2014) which recognise the 'historical connections generated by processes of colonialism….that were previously elided in mainstream sociology…recuperating these alternative histories....providing a basis for more adequate histories of the present' (Bhambra and Santos, 2017:4). For the sociology of

CAM this would demand that the understanding of medical pluralism includes an appreciation of processes that are broader than those specific to the UK: to situate theories of professionalisation and medical hegemony in a global whole. It also requires a re-engagement between sociology and anthropology to appreciate the variety of medical pluralisms.

[xlix] Penkala and Rajtar (2016) suggest alternative naming such as 'medioscapes' (to enable reflection on the 'distinct results of ongoing globalised entanglements in the international medical arena' (129) or medical diversity, super-diversity or hyper-diversity and which allow for the acknowledgment of complex and mutual borrowing between medical traditions and which are less static than medical pluralism.