Overview

- Why is alternative medicine alternative?
- Why is alternative medicine increasingly popular?
- Does alternative medicine work?

Orthodox medicine is the dominant form of medicine because, historically, its practitioners organised themselves to lobby governments for a special status. However, alternative forms of medical therapies and medicines are becoming increasingly popular, especially among those with higher education and higher incomes. The reasons for this popularity are related to people’s search for meaning, a distrust of science, the preponderance of chronic rather than acute illness, a ‘personal’ relationship between healers and their clients, and the search for control over one’s life. Users of alternative therapies and medicines do not reject orthodox medicine but use both modalities. Alternative therapies and medicines can ‘work’ by changing the relationship of a person to his or her illness, or by producing a change in a set of symptoms. There have been few scientific demonstrations of the efficacy of alternative practices or medicines, but this is also true of most orthodox medical practices. Some alternative practices are being incorporated into orthodox medicine, and such alternative medical practices are being reclassified as complementary to, rather than alternative to, orthodox medicine.

Key terms

allopathy  lifestyle choices  risk factors
biomedicine  orthodox medicine  risk society
complementary medicine  placebo  social closure
convergence  postmodern society  social support
empirical  randomised control trials  state
iatrogenic  (RCTs)  theodicy
Introduction

In this chapter you will be introduced to the major arguments about alternative medicine and the empirical research conducted on alternative medicine. By the time you have completed reading the chapter, you should be aware that the simplistic distinction between the two medicines that sees the orthodox as scientific and the alternative as ‘quackery’ is wrong. It will also become clear that the distinction between orthodox practice and alternative practice has more to do with the relative political power and organisation of the two types of medicine than it has to do with any characteristics of their modes of treatment.

The chapter is structured around three questions. These questions are those frequently asked by anyone—layperson, doctor, or sociologist—who is at all interested in alternative medicine. The first question—why is alternative medicine alternative?—explores what distinguishes alternative medicine from orthodox medicine. The answer given provides a historical and political explanation, rather than an explanation in terms of modes of treatment. The next question—why is alternative medicine increasingly popular?—is answered by looking at empirical research on the clients of alternative practitioners and the market for alternative medicines in the context of changes in society and the nature of illness today. An answer to the last question—does alternative medicine work?—requires a discussion of what it means for a treatment to work. The conclusion to the chapter draws attention to the increasing usage of alternative treatments by orthodox practitioners, and to the re-labelling of alternative medicine as complementary medicine.

Why is alternative medicine alternative?

Orthodox medicine is a recent social invention. In the early twentieth century, it was only one among a range of medical practices. Its theoretical base was that disease was a result of an imbalance in the body. To restore balance something must be given or taken away. To decide what was given or taken, the doctor observed the symptoms and prescribed something to produce an opposite effect to those symptoms (a process known as allopathy). For example, a patient whose face was suffused with blood would be bled to reduce the blood in their body. Allopathic physicians were also committed to treating the body (biomedicine), not the minds or spiritual aspects of their patients.

The practice base of orthodox medicine was broader than its theory. Its practice was developed in the clinic or hospital. Here doctors

empirical

Describes observations or research that is based on evidence drawn from experience. It is therefore distinguished from something based only on theoretical knowledge or on some other kind of abstract thinking process.

orthodox medicine

The medical practices and institutions developed in Europe during the nineteenth and twentieth centuries that are legally recognised by the state. Central to these practices is the teaching hospital, where all new doctors are inducted into laboratory science, clinical practice, and allopathic biomedicine. These practices and institutions are now dominant in all parts of the world.

complementary medicine

A term used to describe those alternative medical practitioners and practices that do not stand in opposition to orthodox medicine and collaborate with orthodox practice. Also referred to as integrative medicine.

allopathy

A descriptive name often given to orthodox medicine. Allopathy is the treatment of symptoms by opposites.
observed large numbers of patients and began to develop classificatory schemes that grouped sets of symptoms into categories. Initially such groupings were based upon immediately observable characteristics, and nosological schemes were developed that, for example, grouped fevers into different types, dependent on such symptom characteristics as their incidence over time, to produce the categories of continued, intermittent, or remittent fevers. Later such classifications became more sophisticated, and symptoms were used as indicators of underlying theoretical entities called ‘diseases’.

The hospital, as well as providing doctors with large numbers of patients to observe, gave them much more control over their practice. Society physicians were employed by patrons, and had to defer to their patrons’ views and treat them accordingly. In the hospital, the doctor was employed by the hospital or the state and had to defer to his fellow doctors’ clinical judgment rather than that of his patient. In these circumstances, the empirical success of a treatment as judged by fellow doctors was more important than its congruence with allopathic theory.

Allopathy received a great boost when Louis Pasteur discovered microorganisms. Allopathic theory was vindicated: toxic organisms invaded the body, upsetting its balance and causing symptoms that needed to be treated by attacking the invaders. Following Pasteur’s lead, the application of laboratory science to medical practice was an outstanding feature of the development of orthodox medicine in the latter half of the nineteenth century and during the early twentieth century. Modern medicine was thus created from a combination of allopathic theory, a focus on the body, empirical clinical experience, and laboratory science. This scientific, clinical, allopathic biomedicine became the orthodox medicine in the late nineteenth century. It did not become the orthodox medicine because it had a better cure rate than other forms of medicine. It became the orthodox medicine

state
A term used to describe a collection of institutions, including the parliament (government and Opposition political parties), the public-sector bureaucracy, the judiciary, the military, and the police.

biomedicine/biomedical model
The conventional approach to medicine in Western societies, based on the diagnosis and explanation of illness as a malfunction of the body’s biological mechanisms. This approach underpins most health professions and health services, which focus on treating individuals, and generally ignores the social origins of illness and its prevention.
because its practitioners were better organised and more politically astute than practitioners in other forms of medicine, such as homeopathy. In the United Kingdom, from which Australian doctors took their lead, this organisation took the form of a coalition between three disparate and competing groups of healers:

1. **Local apothecaries**: who sold drugs and gave advice on treatment, much as drugstores continue to do in the Third World. These developed into provincial general practitioners (GPs) and were the driving force behind the development of the British Medical Association (BMA), upon which the Australian Medical Association (AMA) is modelled (Vaughan 1959).

2. **Society physicians**: who dealt with the health needs of the upper classes and were not supposed to sell drugs.

3. **Surgeons**: who were the only healers licensed to practise surgery.

This coalition created a national medical association, which lobbied governments to grant ‘doctors’ (a term that now included surgeons, physicians, and GPs) the legal right to practise their trade. There has been some variation between countries in the form that this historical development took (for the USA, see Starr 1982), with some variation in outcome. In some countries it has meant the exclusion of all other forms of medical practice as illegal. More commonly it has meant that only certified doctors could act to verify illness for work absence, insurance purposes, and other bureaucratic needs. Despite minor variations, the overall effect has been to produce an orthodox medicine supported by the state in all countries in the world. The status of orthodox medicine was further boosted by the improved morbidity and mortality rates of the twentieth century. Orthodox medicine took credit for these improvements, although we know now that they were primarily the result of clean drinking water, improved sewerage, and better nutrition rather than medical intervention (Szreter 1988).

Today, orthodox medicine and alternative medicines exist side by side, as they did last century. The dominant mode of medicine is the orthodox. From its position of strength, it can deal with its competitors in three ways. First, it can exclude them by seeking to categorise them as poorly trained quacks compared with orthodox doctors. This was the position taken by the president of the RACGP when she stated, ‘It is to nobody’s advantage that alternative medical providers with varying levels of qualifications and experience, can position themselves at the luxury end of the health care market’ (Mercury 2000, p. 5). Second, it can reformulate the alternative practices so that they sound as though they are ‘scientific’ medicine; the empirical basis of clinical practice provides doctors with this option. Thus mesmerism was reformulated in the United Kingdom as hypnosis in the early years of this century, and was allowed so long as it was practised solely by certified doctors. More recently in Australia, chiropractic manipulation has become redefined as spinal manipulation by some GPs. Finally, doctors can incorporate the alternative practice into their normal repertoire, as has happened with acupuncture, which was once an exotic alternative but is now a clinical practice for which a Medicare rebate can be claimed (Easthope et al. 1998, 2001).

Those practising alternative medicine are not passive actors in this situation. Many alternative medical associations have observed how the doctors achieved their pre-eminence and seek to emulate them. Chiropractic has been particularly successful in this. It has set up colleges to
train and certify its practitioners. It has practised usurpatory social closure by limiting chiropractic to these certified chiropractors, and has achieved this with the support of private health insurers and the state (Dew 2000; O’Neill 1994, 1995). Alternative therapists have also sought, usually unsuccessfully, to stop doctors using their techniques. For example, Judy James, the executive officer of the Australian Acupuncture Association, echoing doctors’ critique of alternative medicine, accuses doctors of being poorly trained: ‘There are doctors who go out and do a weekend course in acupuncture and think they are qualified to practise. Unfortunately, the public are led to believe that because these practitioners are doctors they know what they are doing’ (cited in Derkley 1998, p. 21).

The dominance of orthodox medicine is, however, so secure that alternative medicines, even such strongly organised alternatives as chiropractic, can only be said to exist in its shadow. Nonetheless, that shadow is very broad and has spread over a wider area. In the next section, the phenomenal growth of alternative medicine is explored before asking why this has happened.

**Why is alternative medicine increasingly popular?**

The popularity of alternative medicine is indexed by the increasing number of people who are using alternative therapies, the increasing number of alternative therapists, the growing market for alternative medicines, and the increasing number of tertiary institutions offering training for it.

Alternative therapies have always been used by a section of the population. For example, a survey in the USA of 8758 families interviewed between 1928 and 1931 found one in ten of the families were using alternative therapists (cited in Kaptchuk & Eisenberg 2001). However, in the latter part of the twentieth century and the early part of this century such usage increased considerably (for a summary of surveys of usage in many countries see Ernst & White 2000). For example, in the USA by the turn of the twenty-first century 44 per cent of the population reported using an alternative therapy (Wolsko et al. 2002). Other United States studies, in which surveys were repeated at two different times (Eisenberg et al. 1993, 1998), show visits to alternative therapists increasing by 47 per cent between the two surveys. In Australia, similarly, repeated surveys (MacLennan et al. 1996, 2002) also show increased use of alternative therapists although the increase was solely for women (from 20.9 per cent in 1993 to 26.4 per cent in 2000).

The demand has led to a growth in the number of therapists registered with the Australian Traditional Medicine Society (the ATMS claims to represent 65 per cent of all alternative therapists) from 3200 in 1994 to 9550 in 2004, and the number of accredited colleges affiliated with the ATMS, which are training therapists, grew from 17 in 1986 to 39 fully accredited colleges, plus another 40 provisionally accepted, in 2004 (ATMS 2004; Doran 1999).

It has also led to an increased demand for alternative medicines. The United States studies (Eisenberg et al. 1993, 1998) report a 130 per cent increase in use of high dose vitamins, and the Australian studies (MacLennan et al. 1996, 2002) demonstrate a 120 per cent increase in
expenditure on alternative medicines, allowing for inflation. By the turn of the century it was estimated Australians were spending over $800 million on natural supplements and $1.2 billion on traditional Chinese medicines (Collyer 2004).

Such therapies have also found favour with medical insurance companies. Private medical insurance is held by more than a third of the Australian population. In a bid to attract clients, insurance companies have competed by offering, often as extras, access to complementary therapies (Easthope 1993). In recent years, the number of insurance companies offering alternative therapies and the variety of these therapies offered has dramatically increased (Doran 1999). One company, Grand United, has even bought a share of two of Sydney’s natural health clinics (Ragg 1997).

Although most alternative therapists in Australia only have vocational training with qualifications at diploma level (Expert Committee on Complementary Medicines 2003; Hale 2002), there is an increasing move to undertake degree-level courses in universities or to have courses provided by private colleges accredited by universities. The leaders in this area were the chiropractors, who, by imposing a levy on each chiropractor, were able to set up a course at Preston Institute of Technology (later Phillip Institute of Technology) to train chiropractors and to confer degrees. This course obtained federal funding in 1982 and ultimately became part of RMIT, a university-level tertiary institution. In 1992, Victoria University of Technology began offering a bachelor’s degree in Acupuncture. In 1994, the University of Technology in Sydney began offering a Bachelor of Health Science in Acupuncture and in 1997 a degree in Chinese Herbal Medicine, both within the (orthodox) Department of Health Science. In 1995, Southern Cross University in New South Wales began offering a degree in Naturopathy. In 2000, Monash University opened a new Institute of Public Health, which, along with health economics, medical informatics, and clinical effectiveness, also has a segment on complementary medicine.

Recently there has also been growing interest in complementary and alternative medicine in orthodox peer-reviewed medical journals (see, for example, Coulter & Willis 2004), and the same journals now publish papers on the testing of alternative therapies and medicine. Furthermore, centres of alternative medicines and therapies have been established within traditionally orthodox institutions such as universities (for example the Herbal Medicines Research Centre at Sydney University in 1997 and the Centre for the Evaluation of Complementary Health Practices at the University of Queensland in 2000) and hospitals (for example the Natural Therapies Unit at the Royal Women’s Hospital in Sydney).

Governments have also been important in legitimating and controlling complementary medicine. Their intervention has been initiated and justified in the name of consumer safety. In Victoria, after adverse reactions by some patients to TCM herbs, the State government financed a study of traditional Chinese medicine (Bensoussan & Myers 1996), which led to the registration of TCM practitioners in that state in 2000. The Victorian government then set up a research project to consider registration for other complementary practitioners and the New South Wales government is soliciting comments to develop a position paper on the issue (Expert Committee on Complementary Medicines 2003). The Australian federal government, as part of its control of therapeutic goods, has set up an Office of Complementary Medicine to oversee complementary medicines, with a committee that has input from members of the industry. A more striking
federal government initiative occurred in 2003 when the Therapeutic Goods Administration (TGA) conducted an investigation of Pan Pharmaceuticals, initially in response to consumer complaints about a non-prescription travel sickness pill. In undertaking their investigation, the TGA noted a series of problems in manufacturing and quality control that ultimately led to the withdrawal of almost all Pan products from the market. As Pan was the contract supplier of over 70 per cent of the complementary medicines in Australia, the withdrawal of their products, and ultimately their bankruptcy, was a major shock to the market for complementary medicines and led to the federal government setting up an Expert Committee on complementary medicines, which reported in September 2003 (for more detail on the Pan collapse, see Easthope 2004).

In the USA the government has set up and funded an Office of Alternative Medicine at the National Institutes of Health to evaluate alternative practices. Its funding has grown from

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<th>Table 17.1 Alternative medicines</th>
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*Sources: Murray & Shepherd 1993; Stanway 1979; Trevelyan & Booth 1994; also see Healey 1996*

It is impossible to give a full list of alternative therapies as the number is vast and growing. Some of the major therapies are listed in Table 17.1 (for an alternative listing see the Expert Committee on Complementary Medicines 2003, Appendix 2).

Despite setbacks such as the Pan Pharmaceuticals scandal, the evidence from surveys demonstrates that increasing numbers of people are using alternative therapies and alternative medicines, and the increasing number of such therapists and medicines indicates the increasing popularity of alternative medicine. Various explanations for this growth have been posited: that it is a search for meaning, that people distrust science, that healers offer a more personal relationship than doctors, that alternative medicine gives people a feeling of control, and that many illnesses today are not easily treated by orthodox medicine because they are chronic or terminal. These explanations are discussed next.

The search for meaning

Health and illness are fundamental issues that all societies face. Ways of explaining illness, suffering, and death (theodicies) are central to all religions. Such modes of explanation are a central part of any cosmology, or explanation of the universe. In modern Western societies, the traditional religious cosmology that attributed illness to the work of the devil or original sin no longer has institutional support. Orthodox medicine, the main institution to deal with illness, has no developed theory to explain illness except allopathy and the theory of germs. In a society in which few become seriously ill through germs, but in which many suffer heart attack or cancer, this has little appeal. Even within the germ theory there is no clear explanation of personal misfortune—why one person gets ill in a ‘flu’ epidemic and another stays healthy. Under these circumstances, alternative medical theories that explain illness in terms of spiritual forces (spiritualism), the balance of elements in the body (yin and yang, naturopathy), or the development of life force (homeopathy) have great appeal.

The distrust of scientific experts

Science has lost its gloss, and scientific medicine has declined in status along with science (Gray 1999). Science is no longer seen as the solution but is frequently seen as part of the problem. The risk society (Beck 1992) is obsessed with the risks created by scientific actions; the environment is seen to be under constant threat from global warming, oil spills, nuclear radiation, and acid rain, all of which are blamed on science and technology. Scientific medicine has produced thalidomide as well as the bionic ear. The technological fix is increasingly mistrusted. Books such as Bad Medicine (Archer 1995) and The Trouble with Medicine (Walton 1998) document the iatrogenic toll and call upon people to become educated health consumers rather than patients.

risk society
A term coined by Ulrich Beck (1992) to describe the centrality of risk calculations in people’s lives in Western society, whereby the key social problems today are unanticipated hazards, such as the risks of pollution, food poisoning, and environmental degradation.

iatrogenesis/iatrogenic
A concept popularised by Iván Illich that refers to any adverse outcome or harm as a result of medical treatment.
The ‘personal’ healer–patient relationship

Closely related to the previous point is the fact that many, although not all, healers provide a personalised service. They spend time listening to their clients and tailor their treatment to the individual client (Easthope 1985; Lowenberg & Davis 1994). They can do this because their clientele are generally paying for the service themselves. In this way, many alternative practitioners are acting as the society physicians did in an earlier age, but in a society in which many more people can afford to pay for such personal treatment.

The search for control over one’s life

In a postmodern society, much of life is outside the control of the individual. Movements on the international money markets can dictate whether one has a job next week or even if one’s doctor will be able to treat you because he or she can get malpractice insurance (Hay 1992). In such a society, people search for areas of control. One such area is the self (Giddens 1991). People seek to control their own bodies through jogging, gymnasiums, vitamins, and alternative therapies. Healers give people the ability to manage their own disease by giving them the ability to reconstruct themselves. As one healer said in a lecture to his students, ‘Be a reflection of the person you’re treating...to be a more reliable, more secure part of themselves. So, you’re the rock, absolutely dependable, absolutely competent, absolutely sure of everything you do and as you’re reflecting them, they too can become sure of themselves’ (Easthope 1985, p. 62). The relation between illness and the level of control people have over their life is now also becoming recognised by orthodox doctors (see Marmot et al. 1997).

The nature of illness: chronic and terminal

The success of environmental controls over sewage and water—coupled with immunisation, vaccination, and antibiotics—has meant that most illness in modern societies is either chronic or terminal. By definition, neither of these states can be cured. In these circumstances the traditional practice of orthodox medicine is relatively useless. Furthermore, its procedures and the mode of payment for those procedures—the clinical examination followed by clinical intervention to produce cure—do not allow for treatment of chronic or terminal illness, both of which require long-term, intermittent intervention rather than one-stop cures. People are therefore turning to those healers who do offer such a long-term relationship: the alternative practitioners.

Empirical research in the United Kingdom (Ernst & White 2000; Sharples et al. 2003), New Zealand (Sawyer et al. 1994), Canada (Millar 1997), Israel (Shmueli & Shuval 2004), Japan (Yamashita et al. 2002), the USA (Bausell et al. 2001; Druss & Rosenhek 1999; Ni et al. 2002), Italy (Menniti-Ippolito et al. 2002), and Australia (Lloyd et al. 1993; MacLennan et al. 1996; Siahpush 1998; Yates et al. 1993) supports most of these arguments, although different studies
focus more on one aspect than another. Those using alternative practitioners are seeking explanations for their health problems. They are worried about the dangers of medical intervention and prefer alternative medicine because it is seen as drug-free and ‘natural’. They very much appreciate the personal attention they get from the alternative practitioners. They also seek control over the methods of dealing with their illness and, when they deal with doctors, want control over treatment decisions. Overall, it would appear that it is not dissatisfaction with orthodox medicine that is leading people to look to alternative medicine (Astin 1998), but rather a positive choice of a medicine that offers a natural, holistic approach and a sense of individual responsibility (Siahpush 1999).

Usage of alternative therapies is not evenly distributed among the population in any society. Large scale population surveys generally report that users of alternative therapies, compared with non-users, are more likely to be young or middle-aged, rather than old, better educated and with higher incomes, and women rather than men. They are using alternative medicine as a lifestyle choice (Lloyd et al. 1993; MacLennan et al. 1996; Thomas et al. 1991). There are also large regional variations in countries such as the USA (Eisenberg et al. 1993, 1998), Canada (Millar 1997), and Italy (Mennit-Ippolito et al. 2000), while in Australia rural women use alternative therapies more than their urban counterparts (Adams et al. 2003).

A small study of the users of alternative medicines, as distinct from users of alternative therapies (Rayner & Easthope 2001), was able to distinguish two major types of users (see Table 17.2): ‘postmoderns’ and ‘modified moderns’. Postmoderns, predominantly young women, were committed to postmodern values, were reflexive about their health, and tended to use aromatherapy and homeopathy. Modified moderns were committed

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<th>Table 17.2</th>
<th>A typology of alternative medicine consumers</th>
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<tr>
<td><strong>Postmoderns</strong></td>
<td><strong>Modified moderns</strong></td>
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<tr>
<td>Positive values</td>
<td>Holism, choice, natural remedies, individual control</td>
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<tr>
<td>Negative/indifferent values</td>
<td>Technology, expert control</td>
</tr>
<tr>
<td>Demographics</td>
<td>Female, young, single, highly educated, higher income</td>
</tr>
<tr>
<td>Behaviours</td>
<td>Gyms, outdoor activities, meditation, sports, high health reflexivity</td>
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<tr>
<td>Products</td>
<td>Aromatherapy, homoeopathics</td>
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*Source: Rayner & Easthope 2001*
to the modern values of technology and expertise but were also likely to engage, for example, in buying evening primrose oil and herbal medicines to control the symptoms of menopause.

In brief, it appears that the majority of those who use alternative medicine do so for the reasons cited above—a preference for the 'natural', an appreciation of personal attention, and a desire for control over treatment. However, there is also a considerable proportion of users who resort to alternative therapies and medicines when orthodox medicine fails to alleviate their symptoms.

Does alternative medicine work?

The question of whether alternative medicine works is much more complex than it would at first appear. An intervention by a healer can be said to 'work' in three analytically distinct ways (although these ways often overlap empirically):

1. It changes the relationship of individuals to their afflictions so that they feel more comfortable, suffer less pain, and are able to manage their normal daily lives.
2. It produces a clinically observable change in a set of symptoms.
3. It produces a change in a set of symptoms that is scientifically demonstrated to be a function of the intervention.

These three ways of 'working' can be observed in both alternative and orthodox medicine. It is important to realise that only a small proportion of orthodox medical interventions—estimated as 15 per cent (Coleman 1994)—have been scientifically tested via randomised control trials (RCTs), and the Cochrane collaboration (Berman et al. 2000) reports that only 21 per cent of conventional medicine's practices have a clear positive effect.

It is equally important to realise that an even smaller proportion of alternative medical practice has been scientifically tested. Let us look at each of these three ways of working in turn, focusing solely on alternative medicine, and speculate on how alternative medicine works in each instance. In the first instance—in which the individual's relationship to their affliction is changed—there is a redefinition of the patient's bodily or mental state as one in which healer and client agree that a healing has taken place. In a study of spiritual healing groups, healings in such groups were seen as 'events that rely on “rhetorics” of healing that encourage persons to define and redefine problems within idioms that are appropriate to healing [and] that healing must be understood in terms of treatment of lifestyle...the realisation of meaning attributed to a symptom...or the awakening into a religious world view...rather than the treatment of a pathology' (Glick 1990, pp. 162, 163). In these terms, healing works by providing a theodicy, an explanation for the affliction, which enables the afflicted to deal with it.

randomised control trials (RCTs)
A biomedical research procedure used to evaluate the effectiveness of particular medications and therapeutic interventions. 'Random' refers to the equal chance of participants being in the experimental or control group (the group to which nothing is done and is used for comparison), and 'trial' refers to the experimental nature of the method. It is often mistakenly viewed as the best way to demonstrate causal links between factors under investigation, but privileges biomedical over social responses to illness.

corrected
theodicy
An explanation of suffering, evil, and death.
There is little doubt that, in terms of clinical efficacy, many alternative healing practices work. Why they work is unclear, but that is equally true of many orthodox healing practices. Two possible explanations of such clinical efficacy have been advanced: the placebo effect and the operation of social support (including the activation of the immune response through such support).

The placebo effect is any therapeutic practice that has no clear physiological effect but that nevertheless has an effect on the patient: pain and other symptoms go away (‘Sugaring the Pill’ 1996). Work on the placebo response has demonstrated that the key features that produce a placebo effect are a feeling of uncertainty in the patient coupled with trust in the authority of the healer. People go to a healer—orthodox or alternative—when they are uncertain of their own diagnosis and prognosis, and are seeking expert advice and aid. When that healer presents as an authoritative person who gives them personal attention, and who is therefore someone that they feel they can trust, a placebo response is very likely. Most alternative practitioners, and many orthodox practitioners, present themselves in precisely this way (Easthope 1985). However, meta-analyses of clinical interventions using acupuncture, herbal remedies, manual therapies, and nutritional therapies have found they are more effective for certain conditions than placebos—for example echinacea for relief of cold symptoms (Barrett et al. 1999) and acupuncture for post-operative nausea (Berman et al. 2000). A placebo response is consequently not an adequate explanation for the success of some alternative therapies.

Social support has been implicated in the sociological view of the causes of affliction since Émile Durkheim (1951) demonstrated in 1897 that apparently individual acts of suicide produced suicide rates that varied according to the levels of such support (what he called ‘social solidarity’). A similar finding was made in a comparative analysis of modern societies (Wilkinson 1996), which found that social cohesion is a central factor in producing good health for populations. An extensive summary of the literature argued that ‘social relationships, or the relative lack thereof, constitute a major risk factor for health—rivaling the effects of well-established risk factors such as cigarette smoking, blood pressure, blood lipids, obesity and physical activity’ (House et al. 1988, p. 541).

It is now becoming clear that social support may also be implicated in the relief of affliction. Two studies of the survival rates of women with breast cancer report that social support is an important variable (Mansell et al. 1995; Waxler-Mansion et al. 1991), and David Ornish, an American physician, uses social support (along with diet and exercise) in a regimen that produces changes in the hearts of his patients, which are demonstrable in angiograms (Ornish 1990; Ornish et al. 1990).

A biomedical, rather than a sociological, explanation of these effects is provided by psychoneuroimmunology (pni) (see Vijoen et al. 2003). What the theory of pni does is to reduce the social to the

**placebo/placebo effect**
Any therapeutic practice that has no clear clinical effect. In practice it usually means giving patients an inert substance to take as a medication. When a patient reacts to a placebo in a way that is not clinically explicable, this is called the ‘placebo effect’.

**risk factors**
Conditions that are thought to increase an individual’s susceptibility to illness or disease such as abuse of alcohol, poor diet, and smoking.

**social support**
The support provided to an individual by being part of a network of kin, friends, or colleagues.
biological. Proponents of PNI argue that social effects cause changes in the immune system of individuals, and that these changes mean that people are less likely to become ill and more likely to recover when they are ill (see, for example, the study of HIV-positive men by Persson et al. 2002).

There have been very few scientific tests of alternative medicine. One reason for this is the different worldview held by many alternative practitioners. Many are not concerned with cure, but rather with healing, and thus do not accept the scientific criteria of cure. Further, their strong emphasis on the individual makes them resistant to treating groups of people in exactly the same way, so that a treatment group cannot be compared with a control group to test the efficacy of a treatment. However, the Research Council on Complementary Medicine in the United Kingdom has argued that conventional randomised control trial methodologies can be used to assess alternative therapies (Berman et al. 2000; Mason et al. 2002) and some such trials have been undertaken. The journal *Focus on Alternative and Complementary Therapies (FACT)* is using similar methods to the Cochrane collaboration to assess the clinical effectiveness of alternative therapies and medications.

**Conclusion: future directions**

An interesting feature of recent publications on the working of alternative treatment modalities is the increasing interest being shown in them by orthodox practitioners in many countries (Astin et al. 1998; Easthope et al. 2000a, b; Goldbeck-Wood et al. 1996; Pirotta et al. 2000).

Many orthodox doctors are incorporating alternative treatment modalities into their practice of medicine, and making judgments of their efficacy and safety (Easthope et al. 2000a,b). In Australia, one in seven GPs uses acupuncture (Easthope et al. 1999) and many doctors are using other complementary therapies or referring patients to other therapists, both medical and non-medical, for such treatments (Easthope et al. 2000b; Hall & Giles-Corti 2000; Pirotta et al. 2000). In Canada, England, Germany, New Zealand, Scotland, the USA, and the Netherlands, studies of GPs found widespread usage of alternative medical practices and referral to alternative practitioners (Astin et al. 1998; Schmidt et al. 2002; Thomas et al. 1991; Tuffs 2002). In response to this interest, most medical schools in the USA and over half of those in the United Kingdom now teach their trainee doctors about alternative medicine (Loveth 2000), as do many European medical schools (Barberis et al. 2001).

GPs in particular are looking to alternative practices to re-establish their role, which is being eroded by increased competition for patients among GPs and the development of corporate medicine backed by the state (Strasser 1992; White 2000). Alternative practices, with their emphasis on holism, are a tempting route for those wishing to avoid this fate. In the market-place for medical treatment, as in the commercial market-place, one way to deal with the opposition is to mount a takeover bid (Saks 1994). Nurses, too, have seen advantages in adopting alternative practices: the emphasis on care rather than cure, which is a major aspect of alternative medicine, is a means of extending their professional role (Adams & Tovey 2004).
The result is that alternative medicine is becoming less and less alternative. Some (Willis 1989a) have argued that there is a convergence between orthodox and alternative medicine but such convergence, if it is occurring in clinical medicine, is very weak (Bombardieri & Easthope 2000). Rather, for some practitioners, both orthodox and otherwise, it is being reclassified as complementary medicine—acting as a complement to orthodox medicine. A good example of this is the way complementary therapists are used in the Israeli hospital system, where they concentrate on patients’ subjective feelings and quality of life, leaving biology to the orthodox practitioners (Shuval et al. 2002; Shmueli & Shuval 2004).

Some therapies are being incorporated into orthodox medicine and becoming part of the orthodoxy. This incorporation can be achieved because of the concept of clinical judgment, which is an essential aspect of medicine as an art rather than as a science. Without the idea of clinical judgment, medicine could not lay claim to professional status, as the essence of professionalism is the ability to exercise professional judgment—judgment based on knowledge and experience. This concept allows the division between orthodox medicine and alternative medicine to become blurred if doctors, in their clinical judgment, see some alternative therapies as efficacious. Some doctors are choosing to blur this division by incorporating some alternative therapies into their practice as they become disenchanted with modern medicine as a means of treating some chronic illnesses, although they retain scientific diagnosis (Eastwood 2000).

However, if convergence is weak in clinical practice it is very strong in the area of alternative medicines. Here, where the market is the primary driving force, there has been considerable convergence, with most alternative medicines now produced by orthodox pharmaceutical companies (Collyer 2004). The pressure of the market has also led many hospitals and clinics, especially in the USA, to begin to advertise ‘integrative medicine’ (Coulter 2004). The precise meaning of the term is unclear and there have been few empirical studies of integrative clinics or hospitals (see Frank 2002; May & Sirur 1998; Peace & Manasse 2002).

Despite the use of terms such as ‘complementary’ and ‘integrative’, it is unlikely that the demarcation between the orthodox and the alternative will ever disappear completely. However, there is no longer a clear battle-front in which doctors are pitted against ‘quacks’, but rather an emerging era of cooperation, in which orthodoxy gradually shades into alternative practice.

Summary of main points

- Orthodox medicine dominates because, historically, it has been better organised politically than other forms of medicine.
- Alternative medicine is increasingly popular because it provides an explanation of illness, more people now distrust scientific expertise, healers appear to cope with chronic and terminal illness better than orthodox medicine, and

convergence
The process, which may or may not be occurring, whereby orthodox medicine adopts many of the practices of alternative medicine, and alternative medicine acts to become more orthodox by, for example, seeking to license practitioners and make them subject to training.
healers provide more personalised attention. It also helps people to believe that they are in control of their illness.

- Users of alternative medicine commonly also use orthodox medicine.
- Alternative medicine ‘works’ by changing the relationship of people to their illnesses through the placebo effect (which is also important in orthodox medicine), through the provision of social support, and through other means that are not yet clear (Lewith 1999).
- There have been few scientific tests of the efficacy of alternative medicine, but neither has most orthodox medical practice been subject to scientific testing.
- Many orthodox doctors, especially general practitioners, are incorporating alternative treatment methods into their practices and referring patients to alternative practitioners. Many alternative medicines are produced by pharmaceutical companies. Such changes have led to the abandonment of the term ‘alternative medicine’ and to the increasing use of the terms ‘complementary medicine’ and ‘integrative medicine’.

Sociological reflection: Alternative or complementary?

Three health clinics are operating in your suburb. One is an alternative medicine centre that offers the full range of alternative therapies delivered by qualified alternative practitioners. The second is a medical clinic, where doctors practise a number of alternative therapies such as spinal manipulation, acupuncture, and naturopathy. The third is a health clinic at which both orthodox and alternative health professionals practise side by side.

- If you were to use an alternative therapy, which clinic would you visit? Why?
- Have you used alternative therapies? Why or why not?
- Is the process of convergence between orthodox and alternative medicine an example of social closure to protect medical dominance or an indication of a more patient-focused medical practice?

Discussion questions

1. Which alternative medical practices are most likely to be accepted into orthodox medicine? Why?
2. Alternative therapies are mainly used by people who have good incomes and can afford to pay the fees. Should the government subsidise some alternative
practices so that people on low incomes can use them? If so, which practices should be subsidised?

3 Placebos work even when people know that they are placebos. What are the implications of this for orthodox medical practice and for alternative medical practices?

4 What are the main features of healer–client or doctor–patient interaction that would convince afflicted individuals that they are being treated on a personal level?

5 Does alternative medicine provide therapies that could be adopted by nurses or other health workers to improve their practice? If so, which alternative therapies would be most useful?

6 What alternative therapies (or medicines) would be attractive to different types of people?

Further investigation

1 Compare any one alternative/complementary medical therapy (e.g. acupuncture) with any one orthodox therapy (e.g. fixing a broken wrist). In making your comparison, you should examine the mode of diagnosis, the role of technology in treatment, the types of therapists involved in treatment, and the institutions in which treatment occurs.

2 Compare and contrast the way orthodox medicine and alternative/complementary medicine are portrayed in the media. Make comparisons in only one type of media (television, radio, newspapers, or magazines).

3 Using the Yellow Pages for your area, examine all the alternative/complementary therapists listed. Which are the most common and which the least common? Consider why some are more common than others. (An alternative would be to compare two areas that are very different in their social or ethnic composition and speculate why there are (or are not) differences in the therapies offered.)

Further reading and web resources

What is alternative about alternative medicine?

**Why is alternative medicine increasingly popular?**


**Does alternative medicine work?**


'**Complementary’ not ‘alternative’ medicine**


**Web sites**

Guild of Complementary Practitioners (UK): <http://www.gcpnet.com/>

Society of Homeopaths: <http://www.homeopathy-soh.org/>