

Explaining the growth of complementary and alternative medicine

ABSTRACT

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sociology,
complementary
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In this analytic review, the authors consider the 'boom' in demand for the services of practitioners of modalities of complementary and alternative medicine (CAM). The evidence for the increase in demand for these services is reviewed and explanations for this phenomenon considered and evaluated. Two particular explanations are considered: the postmodern thesis and the gendered spirituality thesis, as well as more general changes in society. Finally the paper considers the role of the social sciences in the legitimation and increasing use of CAM. The paper concludes that the trend is likely to continue, as will the role of social scientists in observing and documenting CAM.

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scientific method is generally accepted as a major foundation for health professions, and where scientific evidence has become the basis of western medicine. In these same countries, 'evidence based practice' has become the dominant health paradigm for the treatment of disease and trauma. At a time when the claim to be scientific by medicine has never been stronger, when medicine is witnessing an explosion in its knowledge base, and when genomic medicine is opening a new approach to medical care, we are witnessing the rapid growth and expansion of a branch of health care in which the claim to be scientific, so far at least, is tenuous at best and problematic at worst.

Introduction

The increasing use of complementary and alternative medicine (CAM) within the industrialised, 'advanced' nations in the west, presents itself as something of a curious enigma. As a social phenomenon it is not well understood or indeed much researched. This article offers an analytical review in the form of observations and tentative explanations, some of a speculative nature. It is curious that growth is occurring in those nations in which western

The problem of definition: What's in a name?

An immediate, and serious issue in understanding this area is that there is no agreed upon, or uniform definition of what constitutes CAM. The definition of CAM used by the *National Center of Complementary and Alternative Medicine* in the United States refers to those:

... healthcare practices that are not an integral part of conventional medicine. As diverse and abundant as the peoples of the world, these practices may be grouped within five major domains: alternative medical systems; mind-body interventions; biologically-based treatments; manipulative and body-based methods; and energy therapies

(NCCAM 2000:65).

However, as CAM is increasingly included in the teaching programs in medical schools and within medical practice, this distinction is becoming problematic. Further, the diversity and range of practices included under the rubric of CAM lessens its usefulness as a definition. These range from very focused therapy modalities such as reflexology, to whole medical systems, such as Ayurvedic Medicine and Traditional Chinese Medicine.

The lack of definitional clarity of the CAM group is not just an academic issue. There are important social and political ramifications. To term the group of modalities *alternative* may be to claim too much for their role in health care, but to term them *complementary* may make their role seem secondary to primary medical care. To call them *integrative* implies some ongoing historical process in which integration - in the sense of convergence - will eventually occur or has occurred. But overall, to define CAM in terms of 'otherness', that is, by what it is *not* (as in 'not taught in medical schools' or 'not practised by conventional medicine'), is arguably somewhat useless in defining what CAM actually is. We do not define allopathic medicine by what it is not. It is difficult to see what all these modalities have in common, and what would, at the same time, set them apart from allopathic medicine. Arguably there is little in common between a short, sharp, chiropractic adjustment when practised in the 'straight' mode, and for instance, a lengthy aromatherapy session; except that both are outside the orthodox medical system. Problems of definition remain substantial and indeed something of an obstacle in the process of growing legitimacy that sociologists and others have been observing and analysing now for several decades.

In sociological terms, the issue is one of commensurability of paradigms. Orthodox, allopathic medicine represents a relatively unified paradigm of knowledge about illness and health as well as treatments based on that knowledge. To a considerable extent, internal rules have emerged for resolving debates about treatments relying on the tenets of evidence based medicine, the Cochrane collaboration and so on. Yet the same cannot be said of CAM. The modalities together do not represent one relatively unified paradigm of disease causation and treatments, but several, each relying on its own paradigm. To argue for complementarity or integrativeness of the paradigms within CAM (let alone between CAM and orthodox medicine), implies the knowledge basis of the paradigms is commensurable; that is, they are not logically inconsistent. The Ayurvedic paradigm from this point of view is incommensurable with that on which Traditional Chinese medicine is based. Even closely related modalities have quite different paradigms; chiropractic and osteopathy being good examples.

This incommensurability issue is even more acute in the light of recent attempts to redefine the whole area as *Integrative Medicine*. To take one example, in the traditional allopathic paradigm - which has evolved into what we now call conventional western scientific medicine (biomedicine) - diluting a therapeutic substance weakens its potency. In the homeopathic paradigm however, dilution, (even on multiple occasions so that few molecules of the original chemical remain), actually increases its potency. Presumably it cannot do both. The paradigms are incommensurable and therefore the possibilities are limited for combining the explanations into one coherent modality. Of course CAM providers can combine therapies of incommensurable paradigms and indeed do it all the time. Many use homeopathic remedies without ever subscribing to the theory, but at their heart, the treatments are based upon incommensurable intellectual/theoretical paradigms. For these reasons, to our sceptical sociological gaze, the use of the term 'integrative' may bear more relation euphemistically to the

term 'takeover' in much the same way as in the business world; for there the term 'merger' conceals the reality of takeover between two companies (and on occasions, a hostile takeover).

Our answer to the question of definition, and indeed a way forward in terms of analysis, is to argue that there is one principal defining difference between orthodox and CAM treatments beyond the fact of 'otherness'. All the CAM group subscribe in one way or another to the principle of *Vitalism*: the acceptance of all living organisms as sustained by a vital force that is both different from, and greater than, physical and chemical forces (see also Goldstein 1999). In CAM there are numerous ways of expressing this Vitalism (*Qi*, life force, yin-yang, *prana*, universal intelligence, innate etc.). In the extreme form the vital force is supernatural. In a more moderate form, it holds a position called *vis medicatrix naturae* (the healing power of nature). This implies the natural order is for the body to heal itself. Under this approach, the physician merely facilitates the body's healing powers. Such a position contrasts with materialism, where disease is explained entirely in terms of materialistic factors (usually biological ones in the case of biomedicine), and where there is no need to invoke Vitalistic forces. It should be noted that Vitalism leads to a different philosophy about health, about health care and the role of the health provider. This is the basis of the claim that biomedicine (allopathic medicine) and CAM are distinct paradigms.

The CAM 'boom'

In most countries for which utilisation data exists, there is not much doubt that CAM has become a widely used form of health care. Indeed it has been characterised as 'booming worldwide' (Goldbeck-Wood *et al* 1996). An attempt at a systematic review of the prevalence literature in different countries by Harris and Rees (2000) concluded that although differences in definitions of CAM, as well as study design, make it difficult to compare prevalence estimates; CAM is used by a substantial and growing proportion of the population in most first world countries. In the United States, a 1997 follow-up national survey by Eisenberg and

associates (1998) of complementary and alternative medicine prevalence, costs, and patterns of use, found that in the period 1990-1997, CAM use increased by 25% from 33.8% in 1990, to 42.1% in 1997; while Herbal remedy use increased by a massive 380%. Moreover, the total number of visits to CAM providers increased by 47% from 427 million in 1990 to 629 million in 1997, with estimated expenditures for CAM professional services at \$21.2 billion dollars (an increase of 45%). In Great Britain, by the end of the 20th century, Thomas *et al* (2001:2) estimated that on an annual basis, 28.3% of the English adult population were making use of the most popular forms of CAM, whilst the number of people utilising CAM services at some point during their lives was estimated at 46.6%. In other European states, Cant and Sharma (1999) have estimated that similar numbers of people try CAM practices when ill health strikes. The evidence of increasing CAM use in the Australian context is provided mainly by MacLennan and associates (1996, 2002). Extrapolating from a South Australian study, they found that in 2000, Australians spent \$2.3 billion on alternative therapies, a 62% increase since 1993 (MacLennan *et al* 2002). These authors have shown not only extensive use of CAM by the population, but also that the number using CAM is increasing. Bensoussan (1999) cites government surveys indicating that 42% of Australians admit to using CAM treatments. In Canada, similar trends have been shown. In 1995 it was estimated that 15% of the population visited a CAM practitioner in the previous twelve months (Millar 1997; see also Verhoef *et al* 1994); and a study by the Fraser Institute (1999) in 1997, reported that 73% of Canadians had used at least one CAM treatment during their lives.

With increasing utilisation has also come institutionalisation. In the United States for instance, with the establishment of the *Office of Alternative Medicine* (OAM), now called the *National Center for Complementary and Alternative Medicine* (NCCAM), this major social shift has been reflected in the nation's most prestigious research institution, the *National Institutes for Health* (NIH) (Murray and Shepard

1993), of which NCCAM is a section. The current budget for the NCCAM is over \$100 million, and by 1997 this institution had funded ten university-based centres for research on alternative/complementary medicine. Directories of Databases now exists for CAM research (see Neimark 1997). At least one evidence based practice centre for CAM has been funded in the US by the NIH and is located at RAND as part of the Southern California *Evidenced Based Practice Center* (see EBPC for web address). In summary, what appears to be occurring, in sociological terms, is a social movement featuring the increasing legitimacy of CAM within the health services of many nations.

At the same time though, a small note of caution might be struck about these utilisation figures. While the evidence of booming utilisation is most likely real enough, the only slight reservation with this otherwise solid evidence is that perhaps there is at least a certain extent to which the public have *always* been using CAM type treatments (then called 'home' or 'folk' remedies). What may have changed is the social acceptability of admitting to researchers or medial practitioners that they have been doing so. No data exists on this, although MacLennan *et al* (2002) found in their 2000 survey that 57% of users would admit to interviewers that they still did not tell their conventional doctor they were using CAM treatments. Additionally, as the UK House of Lords report (2002) found, a large proportion of CAM treatments take place outside conventional medical settings, on an ad hoc basis and through individual providers rather than through an established or coordinated strategy. Likewise, in 'developing' countries, the bulk of health treatments, especially amongst the large poorer sections of their populations, have been (and have always been), folk remedies, probably because of the cost of conventional treatments (see also Bakx 1991). In other words, to use the traditional medical sociological notion of the 'iceberg phenomenon' (see Duncan 1988), it may just be an effect of respondents being more willing to answer truthfully to interviewers standing on their doorsteps, resulting in more of the iceberg of CAM treatments becoming visible.

Is this a passing fashion or craze? Our argument, outlined below, is that it is unlikely to be a temporary phenomenon; largely because of general societal changes and their impact in health care. One important area is the impact of evidence based methodologies. Whilst there is considerable variety in responses amongst the CAM group, some are coming to embrace these methodologies after initial doubts. One central feature of evidence based medicine (EBM), insofar as it affects CAM modalities, is an emphasis on outcomes; that is, on whether the treatment is effective, and more effective than control, other treatment or placebo groups. What is less important is the adequacy of the underlying explanation for why treatments might work; which is the traditional basis for objection from western scientific medicine. So for instance, chiropractic has struggled throughout its history to produce any defining evidence acceptable to orthodox practitioners of the existence of its core paradigmatic element: the *subluxation* of the vertebrae. This is claimed to be the cause of musculoskeletal, if not all, ill health, and treatable by (chiropractic) manipulation. But the strategic benefit of EBM is that demonstrating (under a microscope), the existence of such a misalignment, is now less important in terms of legitimacy than demonstrating by appropriate RCT technology that chiropractic spinal manipulation is as effective as other forms of treatment; especially with regard to problems of a musculoskeletal nature (see Coulter 1998).

The causes

The causes of the rise in demand for CAM are largely unknown and little researched (see Goldstein 1999). In this section of the paper some of the explanations that have been put forward to explain this phenomenon are reviewed and evaluated. Clearly an adequate explanation involves a number of factors; some general, some specific. However one perhaps rather obvious explanation can be ruled out. The characterisation of the trend towards utilisation of CAM treatments as a social movement reflects a view that whatever the reasons for this trend, the availability of a large corpus of evidence that

CAM treatments are effective or as effective as other treatments, is not amongst them. Evidence for the efficacy of CAM treatments does exist to a certain degree (for a review of manipulation see Coulter 1998), but overall it cannot be a clearly demonstrated efficacy that is leading to the growth in demand. Other social processes are at work.

It is perhaps worth considering what *would* be an acceptable explanation for the phenomenon of the growing utilisation of CAM. Such an account must explain not only for why patients are choosing CAM in greater numbers (and so likely to focus on changing patient and individual values), but also why patients are increasingly *able* to exercise this choice and have it met by the availability of CAM providers (and in some instances paid for by the State and insurance plans).

Amongst general societal issues firstly are those associated with the ageing of the population, with a concomitant growth in the prevalence of chronic illness, and lifestyle related morbidity rather than acute ill health. In this context of managing health problems that are at the less serious, non life-threatening end of the continuum of ill health (and where conventional medicine appears less successful), CAM may be perceived to have a lot to offer in alternatives. For the most part, CAM does not have serious side effects, and although the substances used are not inert, they seldom have the same interactive effects as pharmaceuticals. In the case of homeopathy the dilutions are so strong (in the sense of being numerous), that the critics doubt they could have any effect. In their study of acupuncture in Australia for instance, Easthope *et al* (1999) found acupuncture was used for chronic pain as an alternative to conventional treatment.

Two broad social changes appear to be implicated here. The first is the consumer movement. While initially this was about traditional consumer products, it later came to treat health and health care in the same way. Consumer factors have also been significant in the growth of CAM. In addition to those identified as postmodernist (values about nature, science,

technology, health, authority, individual responsibility, and consumerism), Astin (1998) found higher education, poorer health status, a transformational experience that changed the person's worldview, health problems (e.g. anxiety, chronic pain, back problems, urinary tract problems), and values (such as a commitment to the environment, to feminism, and an interest in spirituality and personal growth psychology), were all predictors of use of alternative health care. Astin (1998:1552) concluded that:

... the majority of alternative medicine users appear to be doing so not so much as a result of being dissatisfied with conventional medicine, but largely because they find their health care alternatives to be more congruent with their own values, beliefs and philosophical orientation towards health and life.

Allied closely with this has been the politicisation of health. The clearest example here has been feminism, but it can also be seen in the gay movement, particularly around issues to do with HIV, and the aforementioned green movement. Politicisation of health has to do with returning control of one's health back to the individual and the control of the health system to the community. It seems significant that the growth of CAM has coincided both in the United States and elsewhere (including Australia), with a weakening of medicine's political power and a lessening of medical dominance (See Willis 1989). For much of its history, medicine has successfully contained CAM by ensuring that it was not taught in medical schools; not university-based (even when not in medical schools); did not have access to funding for research; did not get access to hospitals, laboratories and infrastructure which might have enhanced services to patients; was not covered by Government and private insurances; did not obtain state licensure and/or registration; and did not receive funding for the private educational institutions created by CAM providers. All of these significantly impeded the legitimacy of CAM (see Saks 2003; Baer 2006). Much of it

was made possible by medicine claiming to be acting on the public's behalf and in the public interest. As the consumer movement gained strength and health became politicised, this defence to restrict competition lost its legitimacy and legality. Consumers demanded to act in their own interest, and such legislation as anti-trust law made restraint of trade illegal, even for medicine. Under anti-trust law, acting in the public interest is not a permitted defence for restricting competition.

A second explanation might be the so-called postmodern thesis, argued amongst others by Siahpush (1999a, 1999b; also Eastwood 2000). This suggests that as general processes of social change (also globalisation) have accelerated, we live in a substantively new stage of human history known as the postmodern era. Relevant features of this epoch include a decline in faith in the ability of science and technology (including medicine) to solve the problems of living (see Crook *et al* 1992). An example of these processes may be falling rates of immunisation against the traditional infectious diseases in first world countries: declines which have alarmed health authorities and been accompanied by attempts by some parents to provide similar levels of protection by other means such as homeopathy. Related to this change are general social 'green' movements around the environment with a preference for organic/non-chemical solutions to problems, including those of health, and reflected in movements in many countries against genetically modified food.

In addition, general societal trends in the growth of individualism (see Beck and Beck-Gersheim 2002), seem to have impacted upon health care as individuals are less prepared to accept traditional authority (including their doctor's instructions), and seek greater levels of control and empowerment over their lives: a trend fueled by the Internet. Instead, individuals exercise their own risk management regimes. Overall, the post modern thesis is an interesting one, but the difficulty is making the transition analytically from the broad conceptual level to the concrete and empirical. Most often, cross-sectional survey data is used, showing that those using CAM have post

modernist beliefs or opinions. What is difficult is making causal inferences from this type of data.

A third line of explanation, which might be termed the gendered spirituality thesis, has recently been proposed by the Finnish-born sociologist Eeva Sointu (2005a, 2005b). Most commentators agree that the clients of CAM practitioners are disproportionately female (Eisenberg *et al* 1998; Kelner and Wellman 1997; Millar 1997). Indeed Bayton (2005) has argued, in a study of reflexology practitioners, that 95% of their patients were women. For women, as Sointu has theorised, the search for wellbeing has a spiritual component in subjectively expressed personhood. Based upon her thematic analysis of newspapers, Sointu suggests the:

... discourses of wellbeing have changed considerably during the past twenty years. Whereas wellbeing tended to be a term utilised in relation to the body politic in the mid-1980s, wellbeing has now emerged as a significant attribute being sought through a variety of personal wellbeing practices that often have a consumerist character. Underneath the search for wellbeing lie changes in subjectivity; contemporary discourses of wellbeing reproduce subjects equipped with the faculties of self-mastery to deal with a social context addressing these very individuals as choosing consumers
(Sointu 2005a:272).

So the growth in utilisation of CAM practitioners may reflect a search for spiritual meaning in individualist and secular aspirations of personal wellness, especially for women. It is a secular, particularly female response, as the 'spiritual vacuum' left by established religion's decline in many western countries is reflected in the growth of a concern with wellness expressed in Vitalistic terms. This point is reinforced by Kelner and Wellman (1997), who found CAM users were more likely than non-users to respond that they consider spirituality to be an important factor in their lives: even if they had no formal religious affiliation. The resonance with Vitalism as the unifying feature of CAM is particularly relevant here.

There are other specific causes that have more to do with the political economy of health which may have contributed to CAM growth and will probably do so in the future. One is the changes to the structure of primary orthodox health care. In metropolitan areas at least, independent primary care practitioners are increasingly practicing out of corporately-owned premises, where rightly or wrongly, practitioners may be perceived to be employees maximising their companies profitability; especially when pathology laboratories are co-located (see Collyer 2004; Goldstein 1999). The second reason is the lessening of perceived economic advantage to patronising conventional practitioners as government reimbursement of primary medical practitioner fees declines in many countries; either by government policy or by primary practitioners voluntarily opting out because of perceived poorer remuneration than charging the patient directly. The services of CAM have never been cheap, but as the competitive advantage enjoyed by conventional practitioners declines (and will continue to do so), patients may be more willing to try alternatives; especially given the change in ratio of acute to chronic conditions in the nature of many complaints. Furthermore, as internet usage grows, patients may find more and more useful information about CAM treatments (however problematic some of that information might be).

The role of the social sciences

One of the most interesting questions that can be posed about the 'boom' concerns the role the social sciences have played in the legitimisation, and therefore increasing use, of CAM. There are two important areas of social science scholarship to consider. The first is the substantive critique of medical dominance mounted by sociologists and the other social scientists. In sociology the earlier work on the helping professions leads to recognition by Parsons (1964) and others of the role of medicine in social control. This perspective was further expanded by the critique of professions as a means of pursuing the class interest of the professions and not the interest necessarily of the patient. Professionalism came to be seen as a

highly ideological and political process that had more to do with economic dominance and protection than with acting in the public interest (Friedson 1970). This view culminated in the study of the medical profession as an extension of the capitalist class (Larson 1977). In the area of CAM, the work of Willis (1989), and Coburn and Biggs (1986), extended the work on medical dominance to look at the attacks mounted by medicine to contain CAM. Although the critique of professionalisation and medicalisation in particular, have been important for confronting medical dominance and have probably contributed directly to challenges to this dominance, the sociological contribution to other substantive critiques have also been important. In both, the consumerisation of health and the politicisation of health, sociologists have played important roles. This can be seen particularly in feminism and the consumer movement. As much as probably any other group, sociologists have contributed to the politicisation of health, providing much of the intellectual underpinning of the movement. Gender based analyses have clearly contributed significantly to gender based political movements.

The second contribution from the social sciences comes from the expanding interest in describing and analysing the various CAM groups. Within anthropology this has led to numerous ethnographic studies (e.g. Cowie and Roebuck 1975) and within sociology, CAM has provided a fruitful area for investigation. As this type of grounded work expanded, these CAM groups have gradually come to be seen within their own terms and not simply as oddities within western society. While a full analysis of this phenomenon is beyond the scope of this paper, we can illustrate how all the trends coalesce by focusing on the case study of sociological writings on chiropractic.

The seminal sociological work on chiropractors was that of Walter Wardwell's classic studies on the *marginal role* of chiropractors (Wardwell 1952, 1955, 1962); a term he coined to describe both the role, and later, the profession. As with most work during this period, the gold standard for the comparison of any 'profession' was medicine, and hence

chiropractic was deemed marginal. Wardwell's work introduced an era when the major interest in chiropractic by social scientists was in its marginality, its 'deviant' status, and the responses to this status. The focus was on the assumed marginality of chiropractic, its cultism, its professionalism (or lack of it), and its 'deviant' theory of disease. Both the terms used to describe chiropractic and the actual titles during this era are instructive. Among the terms were *deviant* (McCorkle 1961; Cowie and Roebuck 1975), *stigmatised* (Sternberg 1969); *heterodox*, as opposed to orthodox (Hewitt and Wood 1975; Baer 1984); *caste* (Anderson 1981); and *outcasts* (Weisner 1983). Also viewing chiropractic within the perspective of anthropology, Cobb (1977:2) continued the same tradition of negative characterisation by asserting 'writers of every persuasion are unanimous in their contention that the chiropractic theory of disease causation has no *scientific validity*': which in itself is an interesting comment for an anthropologist to make. The titles of these works continue the deviance discourse: *A Deviant Theory Of Disease And Treatment In Contemporary Western Culture* (McCorkle 1961); *An Ethnography of a Chiropractic Clinic: Definitions of a Deviant Situation* (Cowie and Roebuck 1975); *Medicine, Chiropractic and Caste* (Anderson 1981); *Boys in Plight. A Case Study of Chiropractic Students Confronting a Medically Oriented Society* (Sternberg 1969); and *A Caste and Outcasts System in Medicine* (Weisner 1983).

The first indication that this was beginning to change within social science occurred with the publication of a *Sociological Symposium* (1978), where for the first time, sociologists pondered whether the earlier conceptualisation might not have been empirically based. Three important changes were signaled in this publication. First, early theories about chiropractic were examined with regard to utilisation data (Schmidt 1978). Secondly, questions were posed about whether the marginality of CAM was not in fact a political marginality (Wild 1978), and if it was still an appropriate term. Thirdly, writers suggested, for the first time, that chiropractic might actually

represent a distinct, alternative paradigm (Nofz 1978).

By 1991, a special edition on the Sociology of Chiropractic in the *Journal of Manipulation and Physiologic Therapeutics* reflected how far this change amongst social scientists had come. Almost without exception, authors in this issue departed significantly from the earlier perspective of Wardwell. This new perspective is clearly seen in the work by Willis (1989) on medical dominance. His work also avoids labeling chiropractic, and focuses on the political attempts by medicine (including its use of the deviance discourse) to exclude chiropractic. In focus and method, Willis's study represents a break with earlier sociological writings. This perspective has been expanded in the work by Coulter (1991), which focuses specifically on ideology and hegemony, and by Coburn and Biggs (1986), Biggs (1991), and Coburn (1993), all of which examine various aspects of chiropractic legitimacy and the state.

The period covered by these writings, of course, also covers the era when chiropractors went from being persecuted and jailed for practicing medicine without a licence, to gaining legislative recognition in every state and province in North America. So in one sense, the sociological literature increasingly reflects that. But in another, it represents something entirely different. The actual paradigm of chiropractic did not alter over that time, yet the way in which sociologists conceptualised and presented it changed radically. This raises the question of the extent to which sociological writings themselves became an important part of the legitimization of chiropractic.

What is clear, is that from the 1950s until the 1970s, Wardwell's work was the primary source for those teaching about chiropractic: not only in sociology but also in medical schools and departments of community and public health. It had a tremendous influence on how chiropractic was viewed. In Naegele's (1970:105) work on the health care system, he states 'my justification for concentrating on chiropractors is that Walter Wardwell's excellent study of this group is available'. This was a study which by then was

over 30 years out of date; especially as Wardwell's data had been collected from the late 1940s. By the 1970s the situation of chiropractic, in terms of social acceptability, had undergone a major transformation as it began to be analysed more according to the discourse of professionalism and legitimacy.

Conclusion

It is very unlikely that the trend towards CAM will be reversed in the immediate future. It seems equally unlikely that medicine will be able to prevent this trend continuing. It is occurring in the context of broad societal changes which produced a political climate in which CAM practitioners could increasingly challenge medicine and seek their own power. To be clear, our argument is that this growth in CAM was not a major cause of the decline of medical dominance. Both related to trends in the provision of health care along with the related growth of a consumer movement that stressed increased choice and having those choices recognised as legitimate, and both were the result of broader social change.

Understanding the direction of this trend requires of sociologists that they understand how we got to this point. As we have noted, there is a lot of speculation but little rigorous analysis. It might also require that sociologists pay attention to the way in which the work in the social sciences is an integral part of the process of social change.

The case of the chiropractors suggests that sociologists and anthropologists were not simply 'inert' in the increasing popularity of CAM. On the one side their critiques of medicine probably contributed directly to the undermining of medical dominance, an undermining that increasing allowed CAM to challenge biomedicine. On the other, their increasing portrayal of CAM groups as legitimate alternative paradigms, also contributed directly to the process of legitimating CAM in the minds of the public and patients. In the process, the question might be asked of whether sociologists now err in the opposite direction. It is clear that to date they have not yet turned the same critique that

was applied to medicine to the CAM group. The overwhelming sense one gets to date from reading this literature is that the CAM group is seen as a victim by social scientists. One article has accused scientists of giving CAM a free ride (Angell and Kassirer 1998). A similar challenge may be laid in the future at the door of sociologists and other social scientists. This poses a further challenge. By and large, sociologists and anthropologists have gained access to CAM providers on the basis of trust. To the extent that the social scientists did not side with biomedicine, in recent years they have been seen as much more sympathetic to the causes of these groups. As they begin the process of turning the sociological critique back on these same groups, access for research purposes may become much more problematic.

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