Cogent Social Sciences

ISSN: (Print) (Online) Journal homepage: informahealthcare.com/journals/oass20

# The alternativisation of healthcare: A sociological framework for analysis

Ayodeji Bayo Ogunrotifa |

**To cite this article:** Ayodeji Bayo Ogunrotifa | (2020) The alternativisation of healthcare: A sociological framework for analysis, Cogent Social Sciences, 6:1, 1776463, DOI: 10.1080/23311886.2020.1776463

**To link to this article:** https://doi.org/10.1080/23311886.2020.1776463



Published online: 16 Jun 2020.

Ogunrotifa, *Cogent Social Sciences* (2020), 6: 1776463
**https://doi.org/10.1080/23311886.2020.1776463**

cogent social sciences

SOCIOLOGY | REVIEW ARTICLE

# The alternativisation of healthcare: A sociological framework for analysis

Ayodeji Bayo Ogunrotifa[1]*

Received: 23 March 2020
Accepted: 27 May 2020

*Corresponding author: Ayodeji Bayo Ogunrotifa, Medical Sociology at the School of Law and Social Sciences, Royal Holloway, University of London, London, UK
Email: Ayodeji.Ogunrotifa.2008@live.rhul.ac.uk

Reviewing editor:
Kar-wai Tong, City University of Hong Kong, Hong Kong

Additional information is available at the end of the article

**Abstract:** The use of alternative medicine (AM) outside mainstream healthcare has witnessed an increasing upsurge across western societies in recent decades. The theoretical tool articulated to capture this growing uptake of AM coalesced around the framework of alternativisation. Drawing from the perspectives in medical sociology, this article maps out the dimensions through which alternativisation and the expansion of AM in society. The key questions of what is alternativisation, how useful is alternativisation as a sociological concept, what is the nexus between alternativisation, medicalisation and pharmaceutisation and what are the future sociological agendas in this new domain are addressed in this article. It is posited that alternativisation occurs in society because AM practitioners contest therapeutic space with orthodox medical professionals and pharmaceutical companies and further extend their sphere of competence and expertise to the production of medicinal products for every day and personal problems that are outside the purview of medicalisation and pharmaceutisation. The article concludes by fleshing out empirical issues that are likely to impact the domain of AM as a form of healthcare and enriches the conceptual value of alternativisation in future sociological research.

**Subjects: Sociology & Social Policy; Medical Sociology; Public Health - Medical Sociology**

**Keywords: alternativisation; alternative medicine; medicalisation; pharmaceutisation and AM practitioners/users**

## 1. Introduction

As alternative medicine remains widespread in developing societies, the use of alternative medicine (AM) has witnessed a rapid increase in the UK and other western countries in recent years

Ayodeji Bayo Ogunrotifa

ABOUT THE AUTHOR

Ayodeji BayoOgunrotifa, is a PhD candidate in Medical Sociology at the School of Law and Social Sciences, Royal Holloway, University of London. His current research is on sociology of HIV management, with emphasis on healthwork, biographical disruption, embodiment, self and Identity. His research interest includes: Sociology of health and illness, sociology of complementary and alternative medicine, sociology of the body, evidence-based policy, and Qualitative methodology. All correspondence to the author should be sent to Centre for Criminology and Sociology, School of Law, Royal Holloway, University of London. Email: Ayodeji.Ogunrotifa.2008@live.rhul.ac.uk

PUBLIC INTEREST STATEMENT

The study of alternative medicine has been relegated to the margin of medical sociological discourse for more than three decades. Whenever alternative medicine is studied in sociology, it is usually regarded as something to complement or integrate with orthodox/western medicine rather than being considered as a system of medicine in its own right. This article attempts to bring alternative medicine into the frontline of medical sociology through the articulation of a new perspective called alternativisation, which sociologists and social scientists can deploy to reimagining alternative treatment.

(Barry, 2006; Bishop et al., 2007; Cant et al., 2011; Kelner et al., 2006; Saks, 2015). This growing upsurge in the use of AM has intensified a renewed call towards paying sociological attention to the domain of alternative medicine (Coulter & Willis, 2007; McQuaide, 2005; Stratton & McGivern-Snofsky, 2008). Sociologists have studied the use of alternative medicine (AM) both in western and developing country contexts for more than 30 years (Taylor, 1988; Baer, et al. 1998; Bakx, 1991; Fulder & Monro, 1982; Gale, 2014; Ning, 2012; Saks, 2001; Sointu, 2006), but the emphasis on the importance of AM to healthcare has been consigned to the margins of medical sociological discourse. Despite this marginalisation, consumer use of alternative medicine in western countries has expanded in the last three decades. In the UK, the House of Lords Select Committee on Science and Technology reported that 15 million people were estimated to be taking AM in the late 1990s (House of Lords, 2000). The report also indicated that there were "approximately 50,000 CAM practitioners in the United Kingdom, that there are approximately 10,000 statutory registered health professionals who practise some form of CAM in the United Kingdom and that up to 5 million patients have consulted a CAM practitioner in the last year" (House of Lords, 2000). Subsequently, WHO (2002) reported that almost 40% of physicians make referrals to alternative treatment in the UK who purchase it online or over the counter. Other studies in the United States and other western countries revealed that more than 10% of the population seek alternative treatment for chronic conditions such as back pain, arthritis, allergies, anxiety, depression, headaches and serious illnesses such as cancer (Eisenberg et al., 1998).

Following the widespread upsurge in the use of alternative medicine, sociologists have observed the increasing role that alternative medicine plays in people's lives (Coulter & Willis, 2004; Kelner & Wellman, 1997; Sharma, 1992). Much of the current scholarship, however, centres around usage of AM as something to complement or integrate with orthodox medicine (Baer & Coulter, 2008; Cant, 2004; Coulter et al., 2008). As stated elsewhere (Ogunrotifa, 2019), the complementary aspects of alternative medicine that were incorporated into orthodox medicine are of small scale and occurred within the limit which ontology and epistemology of orthodox medicine can permit (for example, acupuncture and homoeopathy). The adventure into alternative medicine was one of the strategies utilised by biomedicine/orthodox medicine to mitigate the crisis or inadequacies of its ontology and epistemology and therefore recognised the role that alternative medicine can play in treatment of illness, particularly in cases where disease entities are either intractable or difficult to identify or where there appears to be no obvious physiological basis for the complaint (Igun, 1988; Ogunrotifa, 2019).

Alternative medicine was therefore utilised to complement orthodox medicine in solving the problems of its epistemology and ontology. The aspects of alternative medicine that was appropriated into orthodox medicine are regarded as "complementary medicine", while other forms of AM that are considered incompatible with orthodox medicine were neglected and regarded as fringe. The notions of complementary and alternative medicine (CAM) or integrative medicine are purely western derivatives that obscure other forms of alternative treatments that are useful and contribute to the health and illness in developing countries but are considered as fringe and unconventional within the framework of orthodox medicine. For instance, Sams (2017) observed the use of kohl (a Hausa traditional medicine) for the treatment of eye problem in Niger. Other studies on AM include the use of shamanism for the treatment of depression and mental health in China (Winkelman, 1992, 2000, 2004) and the use of indigenous spiritism for the treatment of alcoholism in Puerto Rico (Singer & Borrero, 1984).

What will then happen to kohl, shamanism, spiritism and other forms of alternative treatment that do not complement orthodox medicine in any way or that would never be accepted or incorporated into orthodox medicine due to contrasting ontologies and epistemologies? The notion of complementary and alternative medicine (CAM) or integrative medicine is limited and cannot be applied globally or in a different context outside western countries. This paper, therefore, makes a case for AM that is utilised in both western and non-western contexts. Given the rising popularity of AM in western countries, a notable concept of "alternativisation" has been articulated

(Macdonald, 2002; Ogunrotifa, 2019) to capture this growing use of alternative medicine for health and human conditions. What seemed problematic is that the dimensions and processes that underpinned the framework of alternativisation have been largely obscured.

Drawing on perspectives in medical sociology, this article seeks to flesh out the processes and dimensions of alternativisation in the society. Delving into these dimensions will help to provide further sociological elucidation of this notion of alternativisation, with a view to espousing the key questions that underpin it: what is alternativisation? How useful is alternativisation as a sociological concept? What is the nexus between alternativisation, medicalisation and pharmaceutisation? What are the future sociological agendas in this new domain? The exploration of these questions helps to foreground the alternativisation of healthcare in the global context.

## 2. What is alternativisation?

The concept of medicalisation, which has its historical trajectory in the medical sociological discourse (Zola, 1972), has been utilised to analyse the incursion of medical jurisdiction into a wide range of everyday human and social problems. Medicalisation as "the process by which nonmedical problems become defined and treated as medical problems" (Conrad, 2005, p. vii), usually in the form of disorders or diseases, has enabled medical practitioners to frame human problems such as alcoholism and menopause as a medical problem with medical terminology and treatment within medical frameworks. Over the years, the inabilities of orthodox medicine (biomedicine) to deal with vast range of chronic medical conditions has represented a problem for medicalisation. This has led to patients resorting to the use of AM due to the perceived inadequacy of medicalisation (Macdonald, 2002).

Alternativisation as a new concept was introduced to articulate the processes through which AM use has become rapidly popular in the western context. In studies on alternativisation to date, what really constitutes the concept and its sociological credentials have not been adequately espoused. This article, therefore, starts by defining alternativisation. To be simply put, alternativisation *is the process through which health, bodily and social conditions are considered as requiring alternative medicinal solutions and are such treated within the framework of alternative medicine*. Alternativisation captures not only the rising trend in the use of AM in the western setting but also the continuous use of AM in non-western societies for health and human purposes, despite the dominance of orthodox medicine and pharmaceutical products (Baghdadi, 2005; Stephens et al., 2013; Wagner et al., 2013) in both contexts.

Alternative medicine is a form of medicine whose diagnostic method and therapeutic practices exist outside the institutions of orthodox/conventional medicine and healthcare. Alternative medicine includes acupuncture, aromatherapy, the Alexander technique, Ayurvedic medicine, chiropractic, diet therapy, herbalism, homoeopathy, naturopathy, massage therapy, nutritional therapy, reflexology, mind-body techniques and faith/spiritual healing, that may usually be in forms of herbs, oil, powder, water or cream.

The process of alternativisation is majorly driven by AM practitioners who utilised their expertise in alternative medical knowledge/healing methods in the diagnosis, treatment and care of health and human conditions, with the active involvement of the users whose lay involvement ushered the increasing popularity of AM use in the recent epoch. There is a great variation in AM practices, as alternative healing methods are developed in both western (Alexander techniques) and non-western contexts. In non-western societies, AM is an oldest form of the healthcare system, whose alternative healing methods have evolved over the centuries in different societies, and are captured under the broad concept of traditional medicine (Abdullahi, 2011, p. 115) with examples of African, Chinese and Indian traditional medicines. With the advent of colonialism, imperialism and globalisation, orthodox medicine made inroads into non-western countries and later became the dominant form of the healthcare system. The negative aspect of colonialism, as Abdullahi (2011) noted, was that AM and the knowledge underpinning its development was stifled, subjugated and

stigmatised as backward, superstitious and unscientific. Consequently, AM practitioners were only given limited freedom to operate and practise outside the formal institution of the healthcare system, which is orthodox medicine (Abdullahi, 2011). Both AM and orthodox medicine co-exist in some parts of non-western countries, but with the former being relegated to the margins of the formal healthcare system as far as the regulation and legislation governing the administration of health is concerned.

In western countries, AM was popular especially in the Anglo-American context until the middle of the twentieth century. It was the growth of scientific knowledge that shifted the appeal towards orthodox/modern medicine, a system of healthcare that later framed and dominated the language of health and healing (Saks, 2001, p. 122).

In western and non-western contexts, alternativisation is encouraged by the loss of medical authority and expertise (Sharma, 1996; Siahpush, 1999a), the loss of faith in biomedical science in alleviating pains of chronic conditions (Siahpush, 1999b), the rising/huge cost of accessing biomedical treatment (Passarelli, 2008), the rise of postmodern and consumerist attitudes to health (Rayner & Easthope, 2001), cultural/social understanding of health and illness (Hopwood, 1997), and the rise of consumerism accompanied by an attendant quest for individual control and decisions over health (Bakx, 1991; Easthope, 1993; Riessman, 1994) and the desire to have a holistic approach to health and healthcare (Low, 1999).

With increased resort to AM, the number of AM practitioners has increased in the last three decades. In the UK, the number of practitioners of AM has increased from about 30,000 in the 1980s (Fulder & Monro, 1982) to more than 60,000 in 2001 (Saks, 2001), operating and practising outside the formal structure of the healthcare system. This increased proportion of AM practitioners can be seen among the three groups. The first group is the remnants of British AM practitioners that had been excluded since the advent of biomedicine. In the UK, both AM and orthodox medicine were competing in the therapeutic space until 1858 when the Medical Act in England was introduced (Saks, 1995; Wiese et al., 2010). This regulation gave rise to the establishment of biomedicine/orthodox medicine as the dominant form of the healthcare system in western countries (Turner, 2005; Willis, 1989) while alternative medical practitioners were excluded (Willis, 1994). The excluded group of traditional medical practitioners later "maintained their system's existence in private practice outside of the mainstream healthcare system under the common law right of individuals to seek their own medical treatment" (Wiese et al., 2010, p. 327) till today, under the auspices of the National Institute of Medical Herbalists. The second group is the UK citizens (with African and Asian ancestry) who have chosen AM, especially Ayurvedic, acupuncture and homoeopathy as a profession. This group might have studied or learned about these aspects of AM either through informal training or as part of their medical degrees. The prime example of an individual in this group is Geeta Vara, who founded the Geeta Vara Ayurveda in Central London (https://www.geetavara.co.uk/about-geeta-vara), a Briton of Indian descent.

The third category is AM practitioners who had migrated to the UK in the last 30 years. African/Chinese traditional medicine and Indian's ayurvedic medicine became more widespread following the influx of African, Chinese and Indian immigrants into the UK in the last 40 years (Green et al., 2006). With the influx of these immigrants, the use of African, Chinese and Indian traditional medicine became commonplace among African and Asian communities, who became the initial customer/consumer base that constitutes the market for AM in western countries, until recently when its widespread uptake was also found among other nationalities in the UK.

The expansion of the customer base from African and Asian communities to other nationalities in the UK stemmed from the meaning that AM users assigned to the therapeutic efficacy of the medications, and such meaning is a dynamic process that underlies trust in the ability of the therapy to relieve the suffering of the patients from prevailing health problems (Low, 1999) and constitutes a new regime of healthcare to them. The meaning of AM has profound implications for

the users in terms of how they constantly engage in interpretation and re-interpretation of the meaning of their health and human conditions. The understanding of alternativisation through the context of how the users define themselves and their situations has structural imprimatur in relation to the interaction with others, despite being individualistic. For instance, Low (1999) further observed that people resorted to the use of AM following encounters and recommendations "from friends, family and the media" (Low, 1999, p. iii). This demonstrates that the engagement of people with AM has structural elements that encompass social interaction, where individuals' reflexivity and their responses to others and themselves are broadly connected to the interactions in which they engage.

As for AM practitioners, the meaning of alternativisation is the ability to meet the health needs of their users, with respect to the alleviation of chronic health suffering of the patients despite limited state autonomy. This symbolic form of meaning that shapes and reshapes the growing use of AM on the part of AM practitioners and the users, provides a pathway to explore the key sociological dimensions that underpin the trends and dynamics of alternativisation in society.

## 3. Key trends, dimensions and processes of alternativisation

One of the major shortcomings associated with most studies on AM till date stems from the inability to flesh out the key processes and dimensions in which alternativisation occurs across the global society. Nevertheless, the insights drawn from these studies have helped to trace the pattern and trend of alternativisation. Following the review of evidence in these studies, alternativisation is constituted through four key sociological dimensions and processes in the global society. These dimensions are contestation; de-medicalisation; de-pharmaceutisation and redefinition of health, bodily and social conditions as a metaphysical problem. These processes would now be discussed in turn.

- *Contestation of the therapeutic space*

The first dimension in which an expansion of the regime of AM occurs stems from the "dissatisfaction with the health outcome of orthodox medicine" (Gale, 2014, p. 807). AM practitioners capitalised on this shortcoming of orthodox medicine and defined existing medical problems as having alternative treatment solutions with a view to attracting customers (patients), consumers and lay groups who are disillusioned and dissatisfied with orthodox medicine. AM practitioners are not just operating in the domain and jurisdiction of orthodox medicine, they are contesting the therapeutic space with them. The first process of contestation is the appropriation of medical names for diseases and illnesses (developed by orthodox medicine), but such diseases and illnesses are treated within the AM framework and with alternative treatment intervention by AM practitioners. For instance, a critical look at six AM practitioners in the UK and Ireland demonstrates how medical names are not only appropriate in the therapeutic practice of AM but becomes the basis through which online marketing and sales of alternative therapeutic products are undertaken. These six AM practitioners comprise African, Chinese and Indian AM practitioners. The African AM practitioners are Esabod Herbs and Roots (https://www.esabodspiritualherbs.com/) and Magical Herbs and Roots (https://www.magicalherbs.co.uk/). The Chinese AM practitioners are Bristol Chinese Medicine Centre (http://www.bristolchinesemedicine.co.uk/) and Dr Damin Wan (http://dr-wan.co.uk/). The Indian AM practitioners are Geeta Vara (https://www.geetavara.co.uk/) and Dr Wade's Ayurvedic Clinic (https://www.drwakde.com/clinic).

In the websites of these practitioners, alternative treatments for back pain, hypertension, stomach pain and ulcer, diarrhoea, anorexia, rheumatism, arthritis, asthma, psoriasis, diabetes, stroke management, autism, depression, ear and eye problems, Parkinson's disease, migraine, epilepsy and multiple sclerosis are marketed. The provision of alternative treatments for these conditions depicts that AM practitioners are adopting the existing medical terminologies and treating it within the AM framework, making incursions into the jurisdiction of orthodox medicine and contesting the therapeutic space with medical authority. Despite adopting or

appropriating the medical names/terminologies for diseases (like cancer and diabetes), the second process of contestation is that AM practitioners reject the causation, diagnosis and treatment procedures and method associated with orthodox medicine. AM shares medical names for diseases/illnesses but utilises different treatment frameworks and interventions. The information on these websites revealed that the method used by these AM practitioners with respect to causation, diagnosis and treatment is fundamentally different from orthodox medicine, despite sharing the same medical names. This can be demonstrated by several studies that observed the efficacy of alternative treatment for diabetes (Dey et al., 2002; Yeh et al., 2002), chronic pain (Haetzman et al., 2003; Rosenberg et al., 2008), hypertension (Bell et al., 2006; Wang & Xiong, 2013) and rheumatism (Ernst, 2000; Ramos-Remus et al., 1998) and treatment of fallopian tube (Wurn et al. 2008).

The appropriation of medical names by AM practitioners is part of modern ways of re-inventing alternative medical practices. Most diseases/illnesses and conditions have local names they were called by prior to the outset of biomedicine, with the alternative treatments for such conditions already existing and predating biomedicine, as the observation of Edgerton on mental illness depicts:

> Traditional healers throughout Africa continue to be the primary caregivers for most psychiatric patients. Also, even Western-trained psychiatrists and other physicians have come to accept the view that these traditional psychiatric practices can be highly efficacious. (Edgerton, 1980, p. 168)

The adoption of medical names to replace local names for different conditions is influenced by the advent of modernity (Hollenberg, 2006, p. 731). This contestation of the therapeutic space with orthodox medicine could be part of demarginalisation strategy to gain status and recognition for alternative medicine. Despite this contestation, orthodox medicine has overwhelming superiority over AM in terms of expertise, professionalisation and training, research and innovation, funding, quality and safety, techniques and technologies as far as the delivery of healthcare is concerned (Fuller, 2017; Michael & Rosengarten, 2013). Therefore, if a person wholly rejects orthodox medicine as a treatment for mental illness, despite its dominance and superiority, because of perceived failure, and that person then utilises AM to solve the problem posed by mental illness, then alternativisation has ensued.

- *De-medicalisation: redefinition of existing medical problems as having an alternative treatment solution*

The last 40 years have witnessed increasing trend of medicalisation, where non-medical problems are categorised with medical names/terminologies and treated within medical parlance (Conrad, 2005, 2007). Many non-health problems such as alcoholism and infertility have been defined as medical problems and treated within the framework of medicine. The centrality of medicalisation as Conrad (2007, p. 5) noted, hinges on definition. That is, the definition of human problems such as alcoholism and menopause as a medical problem with a medical terminology to conceptualise it within the existing medical framework, and then treats it with medical intervention. The medicalisation of these non-health issues has been challenged by AM practitioners who de-medicalise such conditions and treat them within the AM framework.

As a corollary to medicalisation, the process of alternativisation hinges on definition. The definition is couched in treating non-health problems as requiring alternative treatment solutions. With alternativisation, health conditions are categorised and framed with existing medical names but treated within the AM framework and with alternative treatment interventions by AM practitioners. In this regard, the AM practitioners assume jurisdiction over certain aspects of non-health problems that have been medicalised by the medical profession and exercise their expertise towards finding alternative treatment solutions to them.

The extension of the therapeutic jurisdiction of AM practitioners into the arena of orthodox medicine can also be seen in the context of how the six aforementioned practitioners expanded their treatment jurisdiction into areas of anti-bald cures, acne cures, anti-ageing treatment, fertility problems, reversing menopause, sexual impotence cure, obesity solutions, sleeping problems, miscarriage, overdue labour, drug addiction and alcoholism. The alternative treatments for all these conditions can be found on the websites of these AM practitioners. By contesting the therapeutic space with orthodox medicine, AM practitioners are not only competing for market shares (Baer et al., 1998) and status; they are also eliminating the problem of lack of options occasioned by the monopoly of orthodox medicine for patients/users, by providing a competing set of alternative solutions to health problems. The engagement of these AM practitioners in this jurisdiction of medicalisation has been espoused in the growing veins of social scientific studies that have explored the use of AM for infertility (Gerhar & Wallis, 2002; Levitas et al., 2006; Read et al., 2014; Smith et al., 2010), alcoholism (Shin et al., 2017; Singer & Borrero, 1984; Sivertsen et al., 2018), menopause (Brett & Keenan, 2007; Gollschewskia et al., 2007; Posadzki et al., 2013) and childbirth (Adams et al., 2009; Kalder et al., 2011; Zeng et al., 2014). Alternativisation has occurred if a person uses AM products to treat menopause and fertility problems instead of orthodox medicine.

In conclusion, AM practitioners facilitate alternativisation by de-medicalising health conditions and offering alternative treatment solutions to clients suffering from such conditions, and therefore attract new consumers and expand their customer base and market. By extending their therapeutic landscape to the domain where orthodox medicine exercises hegemonic domination, AM practitioners have thus broadened the scope of their jurisdictional competence, appeal and knowledge to the realm where medicalisation operates.

●*De-pharmaceutisation: redefinition of bodily, behavioural and social conditions as having an alternative medicinal solution*

Recent sociological studies on pharmaceutisation have demonstrated how pharmaceutical companies have displaced physicians as the key drivers of medicalisation (Williams et al., 2009, 2011). In this sense, the definition of bodily, behavioural and social conditions is no longer the exclusive preserve or domain of biomedicine, but at the disposal of pharmaceutical companies (Conrad, 2007). With pharmaceutisation, pharmaceutical companies are said to be manufacturing new diseases (Moynihan et al., 2002); defining non-medical problems as requiring pharmaceutical interventions; bypassing medical authority through over-the-counter drug sale and direct-to-consumer advertising; and engaging in the production of drugs beyond treatment purposes or for enhancement and lifestyle purposes to healthy people (Abraham, 2010; Gabe et al., 2015; Williams et al., 2017, 2011). The consequences of pharmaceutisation can be seen in the increasing upsurge of healthy people taking pharmaceutical drugs for the treatment of anxiety (Williams et al., 2011), cholesterol reduction (Will & Weiner, 2015), weight loss, sexual dysfunction (Fox et al., 2005), cognitive enhancement (C.M Coveney et al., 2011) and sleeplessness (C Coveney et al., 2019).

Despite this increasing pharmaceutisation of society, patients and healthy people are still resorting to alternative treatments in growing proportions (Almeida, 2012). With the rise of the post-modernist regime that prioritises individual control over their health, patients are not only bypassing medical authority by visiting AM practitioners and taking AM products, they are also mounting resistance on the wave of the pharmaceutical regime that seeks to colonise their everyday lives (Chamberlain et al., 2011; Norris et al., 2013).

With alternativisation, AM practitioners are known to have identified medicinal plants and developed a unique method of diagnosis over centuries (Ramakrishnan et al., 2015) that are suitable for the treatment of illnesses or conditions. Through this method, AM practitioners have expanded their sphere of competence towards the production of medicinal products that challenged the dominance of pharmaceutical companies in the configuration of bodily, behavioural

and social conditions for pharmaceutical interventions. For instance, the websites of the six AM practitioners enumerated earlier revealed the online sale and marketing of AM products for conditions that are in the domain of pharmaceutisation. These non-medical conditions include miscarriage and premature birth, hair loss/anti-bald, bedwetting, attention deficit hyperactivity disorder (ADHD), sleeplessness, ageing (anti-ageing treatment), cholesterol reduction, weight loss, sexual enhancement, acne treatment and body/stretch mark removal.

The extension of AM treatment to the domain of non-health issues like infertility, menopause, sleeplessness and alcoholism has demonstrated that alternativisation has ushered in the de-pharmaceutisation of these conditions, and then colonised and redefined it within the AM framework as requiring alternative treatment solutions. According to social scientific literature, AM has been deployed in the treatment of sleeping problems (Gooneratne, 2008; Pearson et al., 2006), anti-ageing (Barbosa & Kalaaji, 2014; Cohen et al., 2002; Fries, 2014) and addiction to drugs and substance abuse (Manheimer et al., 2003; Lu et al., 2009; Behere et al. 2009). Therefore, alternativisation has also ensued when a person uses AM to resolve sleeplessness or cholesterol reduction/weight loss, instead of pharmaceutical interventions.

With de-pharmaceutisation, AM practitioners decolonise the health, bodily, behavioural and social conditions from the grip of pharmaceutical companies, and then recolonise it with AM solutions. These AM practitioners are contesting for therapeutic space with pharmaceutical companies in the context of providing alternative medications for enhancement and non-medical purposes such as curing anxiety, preventing hair loss, curing sexual impotence, inducing menstruation and reversing menopause. The incursion into the domain of pharmaceutisation demonstrates the expanding base of AM practitioners in creating new consumer markets for their medicinal products. By providing alternative treatment solutions, AM practitioners have furthered the appeal of AM to numerous users with different personal conditions like body/stretch marks, study and memorisation problems and so on.

●*Beyond the ordinary: redefinition of health, bodily and social conditions as a metaphysical problem*

The boundary of alternativisation further stretches into the realm of the metaphysical where that of medicalisation and pharmaceutisation end. AM practice seems to have a comparative advantage over the medical profession and pharmaceutical companies by virtue of delving into the realm of the metaphysical as part of healthcare delivery. This is because the ontology and epistemology of AM allow it to operate and practise in the metaphysical realm of engagement. The remit of metaphysical engagement of AM practice hinges on two grounds. First, some health, bodily and social conditions are culturally and socially defined as metaphysical problems requiring alternative treatment solutions, especially in non-western societies. Within the metaphysical frame, illnesses or conditions are believed to be caused by unseen factors or spiritual/supernatural forces that cannot be diagnosed within the biomedical framework (Kahissay et al., 2017; Razali et al., 1996; Samuel, 2007). For instance, Abdullahi (2011) reported that certain conditions are hereditary and AM practitioners would use their AM framework to metaphysically trace its cause to family history to examine whether the condition is caused by the evil atrocities of the patient's ancestors, inherited curse of the lineage or by witchcraft. The treatment and possible cure of such conditions will be undertaken within the AM framework. Odejide et al. (1978), Kurihara et al. (2006) and Avasthi et al. (2013) have reported how mental health patients in Indonesia, India and Nigeria had attributed their mental disorders to supernatural forces and had preferred to be treated by traditional healers in the early phase of intervention rather than orthodox medicine.

Second, illnesses or conditions are usually defined as "ordinary" or "metaphysical" within the AM framework (Igun, 1988). The term "ordinary" here means conditions that are caused by natural factors, environmental factors, poverty, personal hygiene, biological and psychological factors (Kahissay et al., 2017). AM practitioners will first diagnose any condition within the AM framework

by examining whether the illness or condition is ordinary or metaphysical. If it is ordinary, medical/pharmacological interventions or alternative treatment can be used to treat the condition. If the ordinary conditions of patients are not within the competence of AM practitioners, especially surgery, such patients would be referred to orthodox medical practitioners for biomedical intervention. The categorisation and diagnosis of illnesses and conditions into ordinary and metaphysical are important components of the AM framework for treatment.

However, whenever an illness does not respond to medical treatment or pharmacological interventions, metaphysical diagnosis is usually undertaken to unpack illness causation (Igun, 1988). If it is proven within the AM framework that such illnesses or conditions are metaphysical, then biomedical and pharmaceutical interventions are not suitable for treating such conditions (Fadare & Jemilohun, 2012). The illness or condition will be redefined as a metaphysical problem requiring alternative treatment solutions. The term "metaphysical" here means conditions that are deemed as "not ordinary" and cannot be treated with either medical or pharmaceutical interventions because of its spiritual/supernatural underpinning. In the African context, health conditions are widely believed to be caused by metaphysical/supernatural forces (Izugbara et al., 2005) and, in that context, AM practitioners act as "an intermediary between the visible and invisible worlds; between the living and the dead or ancestors, sometimes to determine which spirits are at work and how to bring the sick person back into harmony with the ancestors" (Abdullahi, 2011, p. 116).

The engagement in the metaphysical domain where medicalisation and pharmaceutisation cannot operate has led to accusations against AM practitioners of venturing into magic, voodoo, quackery and snake oil peddling in western parlance (Bausell, 2007; Shapiro, 2009). Information on the websites of both Esabod and Magical Herbs and Roots revealed the avalanche of spiritual products (herbs and others) that are advertised for health and healing purposes.

The involvement of these practitioners in spiritual aspects of healing demonstrates their engagement in the metaphysical domain of health and illness. The redefinition of bodily, health and social conditions as metaphysical has been observed in a wide range of studies. A survey of AM users in the United States undertaken by Eisenberg et al. (1998) revealed that 7% of Americans resorted to AM for spiritual healing. In a similar vein, Low (1999) observed that some Canadians used alternative therapies because they believed biomedicine was not suitable for the treatment of their conditions.

Other contexts where illnesses or health conditions are defined as a metaphysical problem are Tibet (Samuel, 2007), North and South America (Caplan et al., 2013; Foster, 1976; Greenway, 1998; Maduro, 1983; Rodgers, 1944) and among Turkish immigrants in Australia (Minas et al., 2007). In these studies, alternativisation would have taken place if a person's condition (health and non-health problems) was considered as a metaphysical problem and resolved with alternative treatment solutions. The holistic approach to treatment/healthcare (in mediating between the physical and metaphysical aspects of a patient's illness or condition) is what led to the rising patronage of AM by patients in western context especially among African, Asian and South American communities, and further reinforced the expansion of alternativisation in a non-western context.

## 4. Discussion and future direction for research

This paper has revealed two important insights. First, the increasing alternativisation in the health delivery sector stems from aggressive de-medicalisation and de-pharmaceutisation of health, bodily and social conditions away from the grip of the medical profession and pharmaceutical companies, and the recolonisation of these conditions within the AM framework by AM practitioners. The contestations of therapeutic space of medicalisation and pharmaceutisation with the medical profession and pharmaceutical companies enable the AM practitioners to attract new consumers and expand their customer base and market for alternative treatment. The symbolic meaning that AM users attach to the therapy is the faith in AM practitioners and belief in the efficacious power and value of the therapy in resolving and relieving pains associated with their

chronic conditions. Second, the increasing trend of alternativisation hinges on AM practice's engagement beyond the reach of medicalisation and pharmaceutisation into the realm of the metaphysical; users resort to AM because they feel their conditions cannot be treated within the context of orthodox medicine or pharmaceuticals. This expansion of AM therapeutic space to the realm of the metaphysical enables practitioners to expand their appeal and visibility.

Unlike pharmaceutisation that was encouraged by the deregulatory state regime (Abraham, 2010) with the medical profession sometimes acts as a gatekeeper (Williams et al., 2011), alternativisation is being resisted by medical professionals, pharmaceutical companies, the state as well as the media due to the concern about the efficacy of the medication produced by AM practitioners (Cant & Sharma, 1999; Perkin et al., 1994; Winnick, 2005). In contrast to Almeida's (2016) argument that the medical profession and the state promote AM use, it is only aspects of AM like acupuncture, homeopathy and others whose method and practise aligned with the epistemological and ontological lens of orthodox medicine that is promoted, while other aspects of AM that operate outside this perspective are rejected. For instance, among the six AM practitioners cited in this study, Dr Damin Wan was the only practitioner integrated into the formal healthcare system of the National Health Service (NHS). This stems from the fact that Dr Wan has had training in both the Chinese and Western Medicine, having qualified as a medical doctor, acupuncturist, Chinese herbalist and lecturer in Chinese medicine, and has worked with physicians and specialists in the NHS. Many AM practitioners were not integrated into the NHS because most of the medical products and services they offer, are incompatible with the ontology and epistemology of orthodox medicine which the NHS represents. Since AM practitioners are excluded from the formal healthcare system, they operate mostly as small businesses, whose accessibility to users/consumers is forged through lay networks, consumer groups and online marketing/sales.

Having accounted for what is alternativisation as well as its dimensions and processes, it is important to return to the remaining questions posed at the beginning of this article, which are as follows: How useful is alternativisation as a sociological concept? What are the future sociological agendas in this new domain? Addressing these questions will enable us to assess the validity of alternativisation as a sociological term.

Alternativisation, as posited in this paper, is a socially mediated process that is co-produced by both AM practitioners and the users to create a new regime of healthcare. The activities of these two actors create a market for AM that has accelerated the increasing trend of alternativisation in global society. However, the use of AM and its expansion have been dialectically occurring for more than two decades. The strict state regulation against AM in both western and non-western contexts has been responsible for the structural constraint on its operation outside the formal institution of healthcare. Due to this reason, over-estimating the scope of alternativisation may be wrong. The scope of alternativisation, therefore, remains open to empirical investigation, as the extent of its occurrence varies from context to context, case to case, and the kind of illnesses or conditions involved.

Unlike pharmaceutisation whose appeal and applicability in the non-western context is still being contested and debated (Bell & Figert, 2012), the analytical utility of alternativisation as a viable sociological concept is useful in both western and non-western contexts and provides a framework for theoretical and empirical research. This will help to push the boundary of sociological knowledge further by enriching the conceptual value of alternativisation and removing the marginality imposed on AM in mainstream medical sociological discourse.

In this regard, alternativisation requires a critical sociological engagement, particularly with theory-driven empirical work, that will not only investigate the widespread uptake of AM especially in western countries but unpack how these dimensions of alternativisation ensued in a non-western context. Moving forwards, future sociological research on alternativisation might require investigations into several issues that are pertinent to the centrality of AM as a form of healthcare.

These issues include the exploration of the extent, forms and circumstances in which alternative therapy is used in both western and non-western contexts; understanding the activities of AM practitioners (including those not-recognised) with respect to their knowledge claim and knowledge production associated with alternative therapy; how diagnosis is framed and understood by the AM practitioners, and the exploration of how AM practitioners and users construct safety and efficacy of the alternative medicinal products. The exploration of these questions will help to strengthen sociological engagements, in mapping out key policy issues that are likely to impact the domain of alternative medicine as a form of healthcare.

## 5. Conclusion

Sociologists have engaged with AM in recent time using a wide range of theoretical approaches including post-modernism (Siahpush, 1998; 1999a; 1999b; O'Callaghan & Jordan, 2003).,but the articulation of AM within the framework of alternativisation will help to refigure ways in which AM has traditionally been understood. Following Geertz (1980), the refiguration of AM vis-à-vis alternativisation is not about redrawing the intellectual map or tampering with disputed borders but altering the principle by which AM is understood, analysed and interpreted. Therefore, the articulation of alternativisation in this paper provides a framework for sociologists to reimagine alternative treatment and integrate it into the mainstream of medical sociological thought.

**Funding**
The author received no direct funding for this research.

**Author details**
Ayodeji Bayo Ogunrotifa[1]
E-mail: Ayodeji.Ogunrotifa.2008@live.rhul.ac.uk
[1] Medical Sociology at the School of Law and Social Sciences, Royal Holloway, University of London, London, UK.

**Citation information**
Cite this article as: The alternativisation of healthcare: A sociological framework for analysis, Ayodeji Bayo Ogunrotifa, *Cogent Social Sciences* (2020), 6: 1776463.

**References**

Abdullahi, A. A. (2011). Trends and challenges of traditional medicine in Africa. *African Journal of Traditional, Complementary & Alternative Medicine*, *8* (5 Suppl), 115–123. https://doi.org/10.4314/ajtcam.v8i5S.5

Abraham, J. (2010). Pharmaceuticalisation of society in context. Theoretical, empirical and health dimensions. *Sociology*, *44*(4), 603–622. https://doi.org/10.1177/0038038510369368

Adams, J., Lui, C. W., Sibbritt, D., Broom, A., Wardle, J., Homer, C., & Beck, S. (2009). Women's use of complementary and alternative medicine during pregnancy: A critical review of the literature. *Birth*, *36*(3), 237–245. https://doi.org/10.1111/j.1523-536X.2009.00328.x

Almeida, J. (2012) *Towards the CAMisation of health? The countervailing power of CAM in relation to the Portuguese Mainstream healthcare system* [Doctoral thesis]. University of London, Egham.

Almeida, J. (2016). Complementary and alternative medicine's occupational closure in Portuguese healthcare: Contradictions and challenges. *Health*, *20*(5), 447–464. https://doi.org/10.1177/1363459316660857

Avasthi, A., Kate, N., & Grover, S. (2013). Indianization of psychiatry utilizing Indian mental concepts. *Indian Journal of Psychiatry*, *55*(Suppl 2), S136–S144. https://doi.org/10.4103/0019-5545.105508

Baer, H., & Coulter, I. (2008). Introduction – Taking stock of integrative medicine: Broadening biomedicine or co-option of complementary and alternative medicine. *Health Sociology Review*, *17*(4), 331–341. https://doi.org/10.5172/hesr.451.17.4.331

Baer, H. A., Jen, C., Tanassi, L. M., Tsia, C., & Wahbeh, H. (1998). The drive for professionalization in acupuncture: A preliminary view from the San Francisco Bay area. *Social Science & Medicine*, *46*(4–5), 533–537. https://doi.org/10.1016/S0277-9536(97)00196-2

Baghdadi, G. (2005). Gender and medicines: An international public health perspective. *Journal of Women's Health*, *14*(1), 82–86. https://doi.org/10.1089/jwh.2005.14.82

Bakx, K. (1991). The 'eclipse' of folk medicine in western society. *Sociology of Health & Illness*, *13*(1), 20–38. https://doi.org/10.1111/1467-9566.ep11340307

Barbosa, N. S., & Kalaaji, A. N. (2014). CAM use in dermatology. Is there a potential role for honey, green tea, and vitamin C? *Complement Therapy in Clinical Practice*, *20*(1), 11–15. https://doi.org/10.1016/j.ctcp.2013.11.003

Barry, C. A. (2006). The role of evidence in alternative medicine: Contrasting biomedical and anthropological approaches. *Social Science & Medicine*, *62*(11), 2646–2657. https://doi.org/10.1016/j.socscimed.2005.11.025

Bausell, R. B. (2007). *Snake oil science: The truth about complementary and alternative medicine*. Oxford University Press.

Behere, R. V., Muralidharan, K., & Benegal, V. (2009). Complementary and alternative medicine in the treatment of substance use disorders: A review of evidence.*Drug and Alcohol Review*, 28(3), 292-300.

Bell, R. A., Suerken, C. K., Grzywacz, J. G., Lang, W., Quandt, S. A., & Arcury, T. A. (2006). CAM use among older adults age 65 or older with hypertension in the United States: General use and disease treatment. *Journal of Alternative & Complementary Medicine*, *12*(9), 903–909. https://doi.org/10.1089/acm.2006.12.903

Bell, S. E., & Figert, A. E. (2012). Medicalization and pharmaceuticalization at the intersections: Looking backward, sideways and forward. *Social Science & Medicine*, *75*(5), 775–783. https://doi.org/10.1016/j.socscimed.2012.04.002

Bishop, F. L., Yardley, L., & Lewith, G. T. (2007). A systematic review of beliefs involved in the use of complementary and alternative medicine. *Journal of Health Psychology*, *12*(6), 851–867. https://doi.org/10.1177/1359105307082447

Brett, K. M., & Keenan, N. L. (2007). Complementary and alternative medicine use among midlife women for reasons including menopause in the United States. *Menopause*, *14*(2), 300–307. https://doi.org/10.1097/01.gme.0000232031.84788.57

Cant, S. (2004). *A new medical pluralism. Alternative medicine, doctors, patients and the state*. UCL Press.

Cant, S., & Sharma, U. (1999). *A new medical pluralism: Alternative medicine, doctors, patients and the state*. Routledge.

Cant, S., Watts, P., & Ruston, A. (2011). Negotiating competency, professionalism and risk: The integration of complementary and alternative medicine by nurses and midwives in NHS hospitals. *Social Science & Medicine*, *72*(4), 529–536. https://doi.org/10.1016/j.socscimed.2010.11.034

Caplan, S., Escobar, J., Paris, M., Alvidrez, J., Dixon, J. K., Desai, M. M., Scahill, L. D., & Whittemore, R. (2013). Cultural influence on causal beliefs about depression among Latino Immigrants. *Journal of Transcultural Nursing*, *24*(1), 68–77. https://doi.org/10.1177/1043659612453745

Chamberlain, K., Madden, H., Gabe, J., Dew, K., & Norris, P. (2011). Forms of resistance to medications within New Zealand households. *Medische Antropologie*, *23*(2), 299–308.

Cohen, R. J., Ek, K., & Pan, C. X. (2002). Complementary and Alternative Medicine (CAM) use by older adults: A comparison of self-report and physician chart documentation. *The Journals of Gerontology*, *57*(4), 223–227. https://doi.org/10.1093/gerona/57.4.M223

Conrad, P. (2005). The shifting engines of medicalization. *Journal of Health and Social Behaviour*, *46*(1), 3–14. https://doi.org/10.1177/002214650504600102

Conrad, P. (2007). *The medicalization of society. On the transformation of human conditions into treatable disorders*. Johns Hopkins University Press.

Coulter, I., Hilton, L., Ryan, G., Ellison, M., & Rhodes, H. (2008). Trials and tribulations on the road to implementing integrative medicine in a hospital setting. *Health Sociology Review*, *17*(4), 368–383. https://doi.org/10.5172/hesr.451.17.4.368

Coulter, I., & Willis, E. (2004). The rise and rise of complementary and alternative medicine: A sociological perspective. *Medical Journal of Australia*, *180*(11), 587–589. https://doi.org/10.5694/j.1326-5377.2004.tb06099.x

Coulter, I., & Willis, E. (2007). Explaining the growth of complementary and alternative medicine. *Health Sociology Review*, *16*(3–4), 214–225. https://doi.org/10.5172/hesr.2007.16.3–4.214

Coveney, C., Williams, S., & Gabe, J. (2019). Medicalisation, Pharmaceutisation, or both? Exploring the medical management of sleeplessness as insomnia. *Sociology of Health & Illness*, *41*(2), 266–284. https://doi.org/10.1111/1467-9566.12820

Coveney, C. M., Gabe, J., & Williams, S. (2011). The sociology of cognitive enhancement: Medicalisation and beyond. *Health Sociology Review*, *20*(4), 381–393. https://doi.org/10.5172/hesr.2011.20.4.381

Dey, L., Attele, A. S., & Yuan, C. S. (2002). Alternative therapies for type 2 diabetes. *Alternative Medicine Review*, *7*(1), 45–58. http://altmedrev.com/archive/publications/7/1/45.pdf

Easthope, G. (1993). The response of orthodox medicine to the challenge of alternative medicine in Australia. *Australian and New Zealand Journal of Sociology*, *29*(3), 289–301. https://doi.org/10.1177/144078339302900301

Edgerton, R. B. (1980). Traditional treatment for mental illness in Africa: A review. *Culture, Medicine and Psychiatry*, *4*(2), 167–189. https://doi.org/10.1007/BF00051433

Eisenberg, D. M., Davis, R. B., Ettner, S. L., Appel, S., Wilkey, S., Van Rompay, M., & Kessler, R. C. (1998). Trends in alternative medicine use in the United States, 1990–1997: Results of a follow-up national survey. *Journal of the American Medical Association*, *280*(18), 1569–1575. https://doi.org/10.1001/jama.280.18.1569

Ernst, E. (2000). Complementary and alternative medicine in rheumatology. *Best Practice & Research. Clinical Rheumatology*, *14*(4), 731–749. https://doi.org/10.1053/berh.2000.0110

Fadare, J. O., & Jemilohun, A. C. (2012). Discharge against medical advice: Ethico-legal implications from an African perspective. *South African Journal of Bioethics and Law*, *5*(2), 98–101. https://doi.org/10.7196/sajbl.230

Foster, G. M. (1976). Disease aetiologies in non-Western medical systems. *American Anthropologist*, *78*(4), 773–781. https://doi.org/10.1525/aa.1976.78.4.02a00030

Fox, N. J., Ward, K. J., & O'Rourke, A. J. (2005). The 'expert patient': Empowerment or medical dominance? The case of weight loss, pharmaceutical drugs and the Internet. *Social Science & Medicine*, *60*(6), 1299–1309. https://doi.org/10.1016/j.socscimed.2004.07.005

Fries, C. J. (2014). Older adults' use of complementary and alternative medical therapies to resist biomedicalization of aging. *Journal of Aging Studies*, *28*, 1–10. https://doi.org/10.1016/j.jaging.2013.11.001

Fulder, S. J., & Monro, R. E. (1982). The status of complimentary medicine in the United Kingdom. London: The Threshold foundation.

Fuller, J. (2017). The new medical model: A renewed challenge for biomedicine. *CMAJ: Canadian Medical Association Journal*, *189*(17), E640–E641. https://doi.org/10.1503/cmaj.160627

Gabe, J., Williams, S. W., Martin, P., & Coveney, C. (2015). Pharmaceuticals and society: Power, promises and prospects. *Social Science & Medicine*, *131*, 193–198. https://doi.org/10.1016/j.socscimed.2015.02.031

Gale, N. (2014). The sociology of traditional, complementary and alternative medicine. *Sociology Compass*, *8*(6), 805–822. https://doi.org/10.1111/soc4.12182

Geertz, C. (1980). Blurred genres: The refiguration of social thought. *American Scholar*, *49*(2), 165–179. https://www.jstor.org/stable/41210607

Gerhar, I., & Wallis, E. (2002). Individualized homeopathic therapy for male infertility. *Homeopathy*, *91*(3), 133–144. https://doi.org/10.1054/homp.2002.0024

Gollschewskia, S., Kitto, S., Anderson, T., & Lyons-Wall, P. (2007). Women's perceptions and beliefs about the use of complementary and alternative medicines during menopause. *Complement Therapy in Medicine*, *16*(3), 163–168. https://doi.org/10.1016/j.ctim.2007.06.001

Gooneratne, N. S. (2008). Complementary and alternative medicine for sleep disturbances in older adults. *Clinics in Geriatric Medicine*, *24*(1), 121–138. https://doi.org/10.1016/j.cger.2007.08.002

Green, G., Bradby, H., Chan, A., & Lee, M. (2006). "We are not completely westernised": Dual medical systems and pathways to health care among Chinese migrant women in England. *Social Science & Medicine*, *62*(6),

1498–1509. https://doi.org/10.1016/j.socscimed.2005.08.014

Greenway, C. (1998). Hungry earth and vengeful stars: Soul loss and identity in the Peruvian Andes. *Social Science & Medicine*, *47*(8), 993–1004. https://doi.org/10.1016/S0277-9536(98)00163-4

Haetzman, M., Elliott, A. M., Smith, B. H., Hannaford, P., & Chambers, W. (2003). Chronic pain and the use of conventional and alternative therapy. *Family Practice*, *20*(2), 147–154. https://doi.org/10.1093/fampra/20.2.147

Hollenberg, D. (2006). Uncharted Ground: Patterns of professional interaction among complementary/alternative and biomedical practitioners in integrative health care settings. *Social Science & Medicine*, *62*(3), 731–744. https://doi.org/10.1016/j.socscimed.2005.06.030

Hopwood, A. L. (1997). The social construction of illness and its implications for complementary and alternative medicine. *Complementary Therapies in Medicine*, *5*(3), 152–155. https://doi.org/10.1016/S0965-2299(97)80058-1

House of Lords. (2000) *House of lords select committee on science and technology, 6th report on complementary and alternative medicine 1999–2000*. Retrieved March, 2019, from http://www.parliament.the-stationery-office.co.uk/pa/ld199900/ldselect/ldsctech/123/12301.htm

Igun, U. A. (1988). *Medical sociology: An introduction*. Shaneson C. I. Press.

Izugbara, C. O., Etukudoh, I. W., & Brown, A. S. (2005). Transethnic Itineraries for ethnomedical therapies in Nigeria: Igbo women seeking ibibio cures. *Health & Place*, *11*(1), 1–14. https://doi.org/10.1016/j.healthplace.2003.12.001

Kahissay, M. H., Fenta, T. G., & Boon, H. (2017). Beliefs and perception of ill-health causation: A socio-cultural qualitative study in rural North-Eastern Ethiopia. *BMC Public Health*,*17*(124), 1–10. https://doi.org/10.1186/s12889-017-4052-y

Kalder, M., Knoblauch, K., Hrgovic, I., & Münstedt, K. (2011). Use of complementary and alternative medicine during pregnancy and delivery. *Archives of Gynaecology & Obstetrics*, *283*(3), 475. https://doi.org/10.1007/s00404-010-1388-2

Kelner, M., & Wellman, B. (1997). Health care and consumer choice: Medical and alternative therapies. *Social Science & Medicine*, *45*(2), 203–212. https://doi.org/10.1016/S0277-9536(96)00334-6

Kelner, M., Wellman, B., Welsh, S., & Boon, H. (2006). How far can complementary and alternative medicine go? The case of chiropractic and homeopathy. *Social Science & Medicine*, *63*(10), 2617–2627. https://doi.org/10.1016/j.socscimed.2006.07.005

Kurihara, T., Kato, M., Reverger, R., & Tirta, I. G. R. (2006). Pathway to psychiatric care in Bali. *Psychiatry and Clinical Neurosciences*, *60*(2), 204–210. https://doi.org/10.1111/j.1440-1819.2006.01487.x

Levitas, E., Parmet, A., Lunenfeld, E., Bentov, Y., Burstein, E., Friger, M., & Potashnik, G. (2006). Impact of hypnosis during embryo transfer on the outcome of in vitro fertilization–embryo transfer: A case-control study. *Fertility and Sterility*, *85*(5), 1404–1408. https://doi.org/10.1016/j.fertnstert.2005.10.035

Low, J. (1999) *The experiences of people who use alternative therapies: A symbolic interactionist analysis* [Doctoral thesis]. McMaster University.

Lu, L., Liu, Y., Zhu, W., Shi, J., Liu, Y., Ling, W., & Kosten, T. R. (2009). Traditional medicine in the treatment of drug addiction. *American Journal of Drug & Alcohol Abuse*, *35*(1), 1–11. https://doi.org/10.1080/00952990802455469

Macdonald, C. (2002). Out of the frying pan and into the fire? The alternativization of women's health. *Annals of the Royal College of Physicians and Surgeons of Canada*, *35*(1), 1–3. http://www.ethicsweb.ca/papers/Alternativization2002.pdf

Maduro, R. (1983). Curanderismo and Latino views of disease and curing. *Western Journal of Medicine*, *139*(6), 858–874. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1011018/

Manheimer, E., Anderson, B. J., & Stein, M. D. (2003). Use and assessment of complementary and alternative therapies by intravenous drug users. *American Journal of Drug Alcohol Abuse*, *29*(2), 401–413. https://doi.org/10.1081/ADA-120020522

McQuaide, M. M. (2005). The rise of alternative health care: A sociological account. *Social Theory & Health*, *3*(4), 286–301. https://doi.org/10.1057/palgrave.sth.8700061

Michael, M., & Rosengarten, M. (2013). *Innovation and biomedicine: Ethics, evidence and expectation in HIV*. Palgrave.

Minas, H., Klimidis, S., & Tuncer, C. (2007). Illness causal beliefs in Turkish immigrants. *BMC Psychiatry*, *7*(34), 65–81. https://doi.org/10.1186/1471-244X-7-34

Moynihan, R., Health, I., & Henry, D. (2002). Selling sickness: The pharmaceutical industry and disease-mongering. *British Medical Journal*, *324*(7342), 886–891. https://doi.org/10.1136/bmj.324.7342.886

Ning, A. M. (2012). How 'alternative' is CAM? Rethinking conventional dichotomies between biomedicine and complementary/alternative medicine. *Health*, *17*(2), 135–158. https://doi.org/10.1177/1363459312447252

Norris, P., Chamberlain, K., Dew, K., Gabe, J., Hodgetts, D., & Madden, H. (2013). Public beliefs about antibiotics, infection and resistance: A qualitative study. *Antibiotics*, *2*(4), 465–476. https://doi.org/10.3390/antibiotics2040465

O'Callaghan, F. V., & Jordan, N. (2003). Postmodern values, attitudes and the use of complementary and alternative medicine. *Complementary Therapies in Medicine*, *11*(1), 28–32. https://doi.org/10.1016/S0965-2299(02)00109-7

Odejide, A. O., Olatawura, M. O., Sanda, O., & Oyeneye, A. O. (1978). Traditional healers and mental illness in the City of Ibadan. *Journal of Black Studies*, *9*(2), 195–205. https://doi.org/10.1177/002193477800900207

Ogunrotifa, A. B. (2019). Towards the alternativisation of health? A commentary on Joana Almeida's notion of Camisation. *International Journal of Complementary & Alternative Medicine*, *12*(1), 27–29. https://doi.org/10.15406/ijcam.2019.12.00444

Passarelli, T. (2008). *Complementary and alternative medicine in the United States*. http://www.cwru.edu/med/epidbio/mphp439/complimentary_meds.pdf

Pearson, N. J., Johnson, L. L., & Nahin, R. L. (2006). Insomnia, trouble sleeping, and complementary and alternative medicine: Analysis of the 2002 national health interview survey data. *Archives of Internal Medicine*, *166*(16), 1775–1782. https://doi.org/10.1001/archinte.166.16.1775

Perkin, M. R., Pearcy, R. M., & Fraser, J. S. (1994). A comparison of the attitudes shown by general practitioners, hospital doctors and medical students towards alternative medicine. *Journal of the Royal Society of Medicine*, *87*(9), 523–525. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1294769/

Posadzki, P., Lee, M. S., Moon, T. W., Choi, T. Y., Park, T. Y., & Ernst, E. (2013). Prevalence of complementary and alternative medicine (CAM) use by menopausal women: A systematic review of surveys. *Maturitas*, *75*(1), 34–43. https://doi.org/10.1016/j.maturitas.2013.02.005

Ramakrishnan, P., Karimah, A., Kuntaman, K., Shukla, A., Ansari, B. K. M., Rao, P. H., Ahmed, M., Tribulato, A., Agarwal, A. K., Koenig, H. G., & Murthy, P. (2015). Religious/spiritual characteristics of indian and Indonesian physicians and their acceptance of spirituality in health care: A cross-cultural comparison. *Journal of Religious Health*, *54*(2), 649–663. https://doi.org/10.1007/s10943-014-9906-3

Ramos-Remus, C., Gamez-Nava, J. I., Gonzalez-Lopez, L., Skeith, K. J., Perla-Navarro, A. V., Galvan-Villegas, F., & Suarez-Almazor, M. E. (1998). Use of alternative therapies by patients with rheumatic disease in Guadalajara, Mexico: Prevalence, beliefs, and expectations. *Arthritis & Rheumatology*, *11*(5), 411–418. https://doi.org/10.1002/art.1790110513

Rayner, L., & Easthope, G. (2001). Postmodern consumption and alternative medications. *Journal of Sociology*, *37*(2), 157–176. https://doi.org/10.1177/144078301128756274

Razali, S. M., Khan, U. A., & Hasanah, C. I. (1996). Belief in supernatural causes of mental illness among Malay patients: Impact on treatment. *Acta psychiatrica Scandinavica*, *94*(4), 229–233. https://doi.org/10.1111/j.1600-0447.1996.tb09854.x

Read, S. C., Carrier, M., Whitley, R., Gold, I., Tulandi, T., & Zelkowitz, P. (2014). Complementary and alternative medicine use in infertility: Cultural and religious influences in a multicultural Canadian setting. *Journal of Alternative and Complementary Medicine*, *20*(9), 686–692. https://doi.org/10.1089/acm.2013.0329

Riessman, F. (1994). Alternative health movements. *Social Policy*, *24*(3), 53–57. https://scholar.google.com/scholar_lookup?title=Alternative%20health%20movements.&author=F%20Riesmann&publication_year=&journal=Soc%20Policy.&volume=&pages=

Rodgers, S. L. (1944). Disease concept in North America. *American Anthropologist*, *46*(4), 559–564. https://doi.org/10.1525/aa.1944.46.4.02a00230

Rosenberg, E. I., Genao, I., Chen, I., Mechaber, A. J., Wood, J. A., Faselis, C. J., Kurz, J., Menon, M., O'Rorke, J., Panda, M., Pasanen, M., Staton, L., Calleson, D., & Cykert, S. (2008). Complementary and alter-native medicine use by primary care patients with chronic pain. *Pain Medicine*, *9*(8), 1065–1072. https://doi.org/10.1111/j.1526-4637.2008.00477.x

Saks, M. (1995). *Professions and the public interest: Medical power, altruism, and alternative medicine*. Routledge.

Saks, M. (2001). Alternative medicine and the health care division of labour: Present trends and future prospects. *Current Sociology*, *49*(3), 119–134. https://doi.org/10.1177/0011392101049003008

Saks, M. (2015). 'Power and professionalisation in CAM: A sociological approach'. In N. K. Gale & J. V. McHale (Eds.), *Routledge handbook of complementary and alternative medicine: Perspectives from social science and law* (pp. 30-40). Routledge.

Sams, K. (2017). Engaging conceptions of identity in a context of medical pluralism: Explaining treatment choices for everyday illness in Niger. *Sociology of Health & Illness*, *39*(7), 1100–1116. https://doi.org/10.1111/1467-9566.12564

Samuel, G. (2007). Spirit causation and illness in Tibetan medicine. In Schrempf, M (Ed.), *Soundings in Tibetan medicine* (pp. 213–224). Brill.

Shapiro, R. (2009). *Suckers: How alternative medicine makes fool of us all*. Vintage books.

Sharma, U. (1992) Complementary Medicine today: Practitioners and Patients. London: Tavistock/Routledge.

Sharma, U. (1996). 'Using complementary therapies: A challenge to orthodox medicine? In S. J. Williams & M. Calnan (Eds.), *Modern medicine: Lay perspectives and experiences* (pp. 230–55). UCL Press.

Shin, N. Y., Lim, Y. J., Yang, C., & Kim, C. (2017). Acupuncture for alcohol use disorder: A meta-analysis. *Evidence-Based Complementary and Alternative Medicine*, *4*(1), 1–6. https://doi.org/10.1155/2017/7823278

Siahpush, M. (1998). Postmodern values, dissatisfaction with conventional medicine and popularity of alternative therapies. *Journal of Sociology*, *34*(1), 58–70. https://doi.org/10.1177/144078339803400106

Siahpush, M. (1999a). Why do people favour alternative therapies? *Australian and New Zealand Journal of Public Health*, *23*(3), 266–271. https://doi.org/10.1111/j.1467-842X.1999.tb01254.x

Siahpush, M. (1999b). A critical review of the sociology of alternative medicine: Research on users, practitioners and the orthodoxy. *Health*, *4*(2), 159–178. https://doi.org/10.1177/136345930000400201

Singer, M., & Borrero, M. G. (1984). Indigenous treatment for alcoholism: The case of Puerto Rican spiritism. *Medical Anthropology*, *8*(4), 246–273. https://doi.org/10.1080/01459740.1984.9965908

Sivertsen, K., Lukic, M., & Kristoffersen, A. E. (2018). Gender specific association between the use of complementary and alternative medicine (CAM) and alcohol consumption and injuries caused by drinking in the sixth Tromsø study. *BMC Complementary and Alternative Medicine*, *18*(1), 239. https://doi.org/10.1186/s12906-018-2301-y

Smith, J. F., Eisenberg, M. L., Millstein, S. G., Nachtigall, R. D., Shindel, A. W., Wing, H., Cedars, M., Pasch, L., & Katz, P. P. (2010). The use of complementary and alternative fertility treatment in couples seeking fertility care: Data from a prospective cohort in the United States. *Fertility and Sterility*, *93*(7), 2169–2174. https://doi.org/10.1016/j.fertnstert.2010.02.054

Sointu, E. (2006). The search for wellbeing in alternative and complementary health practices. *Sociology of Health & Illness*, *28*(3), 330–349. https://doi.org/10.1111/j.1467-9566.2006.00495.x

Stephens, P., Ross-Degnan, D., & Wagner, A. K. (2013). Does access to medicines differ by gender? Evidence from 15 low- and middle-income countries. *Health Policy (Amsterdam, Netherlands)*, *110*(1), 60–66. https://doi.org/10.1016/j.healthpol.2013.01.016

Stratton, T. D., & McGivern-Snofsky, J. L. (2008). Toward a sociological understanding of complementary and alternative medicine use. *Journal of Alternative Complementary Medicine*, *14*(6), 777–783. https://doi.org/10.1089/acm.2007.7006

Taylor, R. C. (1984). Alternative medicine and the medical encounter in Britain and the United States. In J. W. Salmon (Ed.), *Alternative medicines: Popular and policy perspectives* (pp. 191–228). Tavistock.

Turner, B. S. (2005). Foreword: The end of scientific medicine? In P. Tovey, G. Easthope, & J. Adams (Eds.), *The Mainstreaming of complementary and alternative medicine* (pp. xiii–xx). Routledge.

Wagner, A. K., Graves, A. J., Fan, Z., Walker, S., Zhang, F., & Ross-Degnan, D. (2013). Need for and access to health care and medicines: Are there gender inequities? *PloS One*, *8*(3), 1–10. https://doi.org/10.1371/journal.pone.0057228

Wang, J., & Xiong, X. (2013). Evidence-based Chinese medicine for hypertension. *Evidence-based Complementary and Alternative Medicine*, *9*(7), 22–35. https://doi.org/10.1155/2013/978398

WHO. (2002). *WHO traditional medicine strategy 2002–2005*. World Health Organisation.

Wiese, M., Oster, C., & Pincombe, J. (2010). Understanding the emerging relationship between complementary medicine and mainstream health care: A review of the literature. *Health*, *14*(3), 326–342. https://doi.org/10.1177/1363459309358594

Will, C. M., & Weiner, K. (2015). The drugs don't sell: DIY heart health and the over-the-counter statin experience. *Social Science & Medicine*, *131*, 280–288. https://doi.org/10.1016/j.socscimed.2014.04.033

Williams, S., Coveney, C., & Gabe, J. (2017). The concept of medicalisation reassessed: A response to Joan Busfield. *Sociology of Health & Illness*, *39*(5), 775–780. https://doi.org/10.1111/1467-9566.12576

Williams, S., Martin, P., & Gabe, J. (2011). The pharmaceuticalisation of society? A framework for analysis. *Sociology of Health & Illness*, *33*(5), 710–725. https://doi.org/10.1111/j.1467-9566.2011.01320.x

Williams, S. J., Gabe, J., & Davis, P. (Eds.). (2009). *Pharmaceuticals and society: Critical discourses and debates*. Blackwell.

Willis, E. (1989). *Medical dominance*. Allen and Unwin.

Willis, E. (1994). *Illness and social relations*. Allen and Unwin.

Winkelman, M. (1992). *Shamans, priests, and witches: A cross-cultural study of magico-religious practitioners*. Arizona State University Press.

Winkelman, M. (2000). *Shamanism: A natural ecology of consciousness and healing*. Bergin and Garvey.

Winkelman, M. (2004). Shamanism as the original neurotheology. *Zygon*, *39*(1), 193–217. https://doi.org/10.1111/j.1467-9744.2004.00566.x

Winnick, T. A. (2005). From quackery to "complementary" medicine: The American medical profession confronts alternative therapies. *Social Problems*, *52*(1), 38–61. https://doi.org/10.1525/sp.2005.52.1.38

Wurn, B. F., Wurn, L. J., King, C. R., Heuer, M. A., Roscow, A. S., Hornberger, K., & Scharf, E. S. (2008). Treating fallopian tube occlusion with a manual pelvic physical therapy. *Alternative Therapies*, *14*(1), 18–23. https://pubmed.ncbi.nlm.nih.gov/18251317/

Yeh, G. Y., Eisenbery, D. M., Davis, R. B., & Phillips, R. S. (2002). Use of complementary and alternative medicine among persons with diabetes mellitus: Results of a national survey. *American Journal of Public Health*, *92*(10), 1648–1652. https://doi.org/10.2105/AJPH.92.10.1648

Zeng, Y., Zhou, Y., Chen, P., Luo, T., & Huang, M. (2014). Use of complementary and alternative medicine across the childbirth spectrum in China. *Complementary Therapy in Medicine*, *22*(6), 1047–1052. https://doi.org/10.1016/j.ctim.2014.10.009

Zola, I. K. (1972). Medicine as an institution of social control. *Sociological Review*, *20*(4), 487–504. https://doi.org/10.1111/j.1467-954X.1972.tb00220.x