Introduction

This chapter analyzes the markets of medicine at a macro level through a neo-Weberian perspective which is fundamentally based on the notion of competition between occupational groups in the market in which goods and services are exchanged (Saks 2010). This competition has been mediated in the contemporary era by a number of parties, including the professions and the state, on which we focus here. A key driver for change for neo-Weberian theorists is the self-interests of professionalizing groups based on the enhancement of their income, status, and power. In medicine and elsewhere, occupations successful in advancing their interests have gained exclusionary social closure in the market, underwritten by the state. This means that a limited group of eligible actors are able to establish legal barriers to entry to outsiders (Parkin 1979). The neo-Weberian perspective itself is centred on a novel interpretation of the original work of Max Weber (1968), rooted in his concept of social closure, whereby social groups aim to maximize their own advantage by restricting external parties’ access to social rewards.

For neo-Weberians, exclusionary social closure underpins professionalization in the market and is associated with a restricted register of practitioners, legitimated forms of educational credentialism, codes of ethics, and a disciplinary framework. The case of medicine in Britain specifically is used as the primary illustration here to highlight the way in which the market, and the position of religion within it, has changed with the emergence and consolidation of professionalization and ever-growing secularization from early industrial to modern times. Despite previous more limited forms of monopoly based on royal charters and other mechanisms from the feudal guild system, such closure was first achieved in medicine on a national basis in Britain through the Medical Act in the mid-nineteenth century (Roche 2018).

A parallel state licensing system emerged across the United States by the beginning of the twentieth century (Horowitz 2018). Its form was shaped by the experience of the British Puritans who settled in Colonial America in the early seventeenth century (Jenkins 2012). In part because of their frontier spirit and general resistance to monopolies in the Jacksonian period and beyond, when the medical profession finally emerged in the early twentieth century through state-by-state licensing, it was centred on a de jure rather than the de facto type of exclusionary closure in Britain (Berlant 1975). This meant that competitors to doctors were...
legally excluded from practising in the United States unless they themselves were licensed and were not subject to the more open provisions of the Common Law as in Britain. Thus, with greater corporatization and resistance to state-funded national health provision, the market for healthcare took a different shape to Britain, with a varying play of interests involved (Saks 2015c).

This account is centred on the specific development in Britain of a sphere of complementary and alternative medicine (CAM), including religious practices, in the wake of a more pluralistic medical marketplace prior to the mid-nineteenth century. As we shall see, the position of CAM was eroded by its growing disadvantaged position in the market with the legislative enactment of exclusionary social closure by the medical profession. CAM, though, underwent a resurgence following the 1960s/70s counter-culture with escalating numbers of practitioners and users of what had become defined as unorthodox therapies. However, it is claimed in this chapter that, in an era in which both CAM and orthodox medicine have been challenged, religion remains important in the market for healthcare. While increasing secularization in a largely Christian culture has arguably occurred, CAM therapies have become ever more popular—not least in relation to Eastern religious philosophies. But before we look at these trends and their implications in detail, it is first necessary to consider some bounding issues in a neo-Weberian analysis.

**Bounding issues in a neo-Weberian approach**

It should be noted that, for all its insights into the relationship between professions and the state in the markets of medicine, there are some pitfalls in adopting a neo-Weberian approach. One issue is that the Anglo-American model of professionalization does not universally apply in modern societies—especially in continental Europe where professions lack the same level of regulatory independence and are more closely incorporated into the state (Saks 2012). Moreover, neo-Weberianism has sometimes been operationalized in practice in an unduly critical manner, without sufficient evidence for the conclusions reached. However, this is not intrinsic to the approach, which can and does provide a platform for arriving at balanced and empirically sustainable arguments on professional dynamics in healthcare and other areas in Britain, the United States, and beyond (Saks 2016).

It must be said, though, that there is not, and never has been, a completely free market based on supply and demand as sought by the followers of economists like Friedman (1962). The notion of a ‘free market’ is simply a Weberian ‘ideal type’ employed in different contexts by various social theorists (Swedberg and Agevall 2016). However, the extent to which it exists in reality varies along a spectrum. This is exemplified by the range from the more *laissez-faire* model of the United States, through greater state welfare interventionism in Britain, to the more state-regulated framework of Russia. This can be demonstrated by the case of medicine in these three societies, each of which has a different contemporary configuration of the professions, state, and the market—from the largely fee-based, corporatized provision in the United States through the free at the point of access National Health Service (NHS) in Britain to the even more heavily state-run healthcare apparatus in Russia, deriving from Soviet times (Saks 2015c).

In the contemporary period there has generally been greater marketization and managerialism of health and welfare services in neo-liberal societies in the West, with the growth of decentralized commissioning, privatization, and private sub-contracting, alongside the rising implementation of the new public management which aims to make public sector organizations more efficient and business-like (Klenke and Pavolini 2015). Russia in the East meanwhile
in its primarily state-based medical system for official healthcare continues to have one of the largest ‘black markets.’ These black markets often operate illegally and beyond formal institutional rules—with gifts and money frequently being traded by users for treatment from doctors and other health personnel (Field 2000). Interestingly here, unlike in the British and American cases, the independent professionalization of medicine failed to take root following the disestablishment of the embryonic medical profession after the Bolshevik Revolution and the subsequent socialist abrogation of the market in the early twentieth century (Saks 2018).

One of the best illustrations of the shift in the markets of medicine in a single society, though, is the state-endorsed professionalization of healthcare in Britain following the seventeenth and eighteenth centuries. As will be seen, this shift was also linked to religion, especially as regards the evolving division between medical orthodoxy and CAM (Saks 2002). Although there is a lack of consensus about the term ‘religion,’ this is broadly defined here in terms of its association with beliefs about the supernatural (Holloway 2016). To understand the importance of the division between mainstream and alternative therapies and the associated organizing infrastructures of medicine and religion in Britain, we need to return to neo-Weberianism which emphasizes the fluidly shifting boundaries between professions and other occupational groups.

It was the mid-nineteenth century professionalization of medicine in the market that created the diverse sphere of CAM in Britain. CAM, including its frequent religious underpinning whereby healing is attributed to supernatural forces, is accordingly seen as not so much defined by its content—be this acupuncture, naturopathy, or such like—as its political marginalization and lack of state legitimation related to exclusionary social closure, with sporadic links to the black market (Saks 2015b). This relativistic definition avoids classifying CAM therapies in a restricted way by, for example, having long traditions or being holistic—neither of which fully captures their heterogeneity. It also allows variations in the division between medical orthodoxy and CAM to be interpreted historically and between societies. Thus, although this was not always the case, an orthodoxy centred on biomedicine is now dominant in the modern Anglo-American context. However, the contemporary nature of orthodox healthcare is not so clear cut in Asian countries like China and India where indigenous therapies, including those with a religious base, have been more prevalent in the market (Adams et al. 2012). Nonetheless, our focus is on changes in British medicine in the market over recent centuries—to which we now turn.

The healthcare market in early industrial Britain

In the seventeenth and eighteenth centuries, the healthcare landscape in Britain can be defined as pluralistic without self-evident patterns of market control by a medical profession. In the absence of a nationally enforceable legal monopoly of medicine in the market, healthcare was a relatively undifferentiated field up to the mid-nineteenth century from a neo-Weberian perspective (Saks 2015b). As Porter (1995) notes—despite such formal designations as membership of the Royal College of Physicians, Royal College of Surgeons and Society of Apothecaries—it was far from easy to differentiate those delivering healthcare. While a varied range of health practitioners entrepreneurially employed a wide range of treatments, from secret over-the-counter remedies to heroic medicine, their training was very often based on apprenticeship, with little formalized education available. There was also scant understanding, if any, of the modus operandi of the treatments they employed, in a largely gender-based division of labour. Crucially, the many practitioners involved were not distinguishable either in terms of scientific repute, at a time when there was no central reference point against which to judge best practice.
Indeed, as Porter (2002) notes, even the developing hospital system in a society on the cusp of industrialization was mainly concerned to classify rather than cure diseases and in the nineteenth century was widely seen as a ‘gateway to death,’ with little user confidence in its effectiveness. Given that the distinctions between practitioners were ‘blurred to the point of irrelevance’ (Jenner and Wallis 2007), the widely-used invective of ‘quackery’ could be viewed as applicable to both what would now be seen as ‘regular’ and ‘irregular’ groups involved in healthcare. Thus, the cut-and-thrust attribution of this and related terms such as ‘charlatanism’ by groups like apothecaries, physicians, and surgeons—who together were to become legitimated members of the medical profession—was little more than an occupational ideology to discredit competitors and increase income, status, and power in a chaotic marketplace. Here hucksters and mountebanks vied for business with higher class, but not necessarily more reliable, practitioners in their homes and offices (Porter 2001).

In this market of medicine in Britain, in which protagonists advertised and sold their wares, many of their therapies were empirical and not religiously based—except on the loosest definition of the term, going beyond belief in superhuman powers (Holloway 2016). Aside from the longstanding pragmatic use of well-known heroic therapies like bleeding, cupping, and purging to promote self-healing that continued to be employed (Duffin 2010), there was a vogue in Britain in the first half of the nineteenth century among more affluent upper class clientele for homeopathy (Nicholls 1988) and mesmerism (Parssinen 1979). An improvised, rudimentary form of acupuncture was also used by some practitioners before the mid-nineteenth century without understanding its ancient theoretical roots (Saks 1995). Other empirically-based practices employed in the nineteenth century included bone setting (Cooter 1987) and herbalism stripped of its spiritual underpinnings (Griggs 1997), alongside technical devices and remedies for treating ailments—from powders and pills to eyeglasses (Spary 2013). These provided distinctive pathways for their proponents to thrive financially in a crowded marketplace. Moreover, great numbers of therapies were administered unpaid by friends, family members, and neighbours—centrally including women in the home—in an age when self-help was fashionable (Porter 1995).

The role of religion in healthcare in the early industrial period

The early industrial period from Tudor times onwards was distinctly religious in Britain in Christian spiritual terms, notwithstanding internal divisions up to the Victorian era—including Anglicanism, Methodism, and Roman Catholicism (Gilley and Sheils 1994). It should not be surprising, therefore, that some therapies had strong religious associations. As Larner (1992) relates, the use of amulets, employment of charms, recitation of mystical incantations, and saying of prayers to excise evil were all commonly based on the language of religion in the sixteenth and seventeenth centuries. Typical aspects included imploring Jesus Christ to take away the pain of toothache and curing scalds and burns with reference to the Father, Son, and Holy Ghost. In addition, there was a belief in the divine nature of kingship such that Kings and Queens regularly touched the sick in endeavouring to cure conditions such as scrofula. In a less mainstream manner, astrology—centred on the precept that planetary activity affected health states—gained considerable sway among higher status physicians as late as the seventeenth century (Wright 1992).

Despite the dissolution of Roman Catholic monasteries in the Tudor period, they too continued to play a part in healing in the charitable sector in the seventeenth and eighteenth centuries, along with the Christian hospitals with which they were associated—following the even larger role that was fulfilled in the medieval period through the ministrations of monks.
Alongside this, the sick and infirm continued to visit shrines and use saintly relics (Horden 2011). In addition, the involvement of religion in healing was apparent in the persecution of folk practitioners using the Witchcraft Acts of 1548 and 1563, largely against women who claimed special powers linked to the devil or his agents. Lay female midwife-healers were particularly attacked in this way, arguably because of the challenge they posed to the standing of male medical attendants (male midwives) and the Church in a patriarchal society (Oakley 1992). Witchcraft persecutions in Britain, frequently leading to trials and hangings, remained an important part of the landscape until the eighteenth century (Elmer 2016).

By the eighteenth and nineteenth centuries the British medical marketplace was one in which judgements about the choice of therapy in a predominantly private market were made by users according to factors like perceived cost and effectiveness (Jenner and Wallis 2007). This was shaped significantly by religion. Here the churches had a role in founding hospitals, medical and nursing schools, and sending out medical missionaries, even if the direct intervention of the Church in healing per se was in decline by the mid-nineteenth century (Webster 1995). Smith (1987) has also identified a ‘physical Puritanism’ connection to therapies ranging from vegetarianism to hydropathy, related to ascetic beliefs in cleanliness and hygiene—in which the right to manage the body for personal salvation was linked to Christian philosophical traditions. This was overlaid by such specific religious beliefs as those embodied in the temperance movement and ritualistically revered icons like holy wells. The depth of this influence is underlined by religious allusions in the cut-throat, financially driven patent medicine industry to preparations such as Friar’s Balsam and the Golden Vatican Pill (Porter 1989).

The entrepreneurial medical market that emerged by the early nineteenth century with religious overtones coalesced with the rise of a consumer-led, monetized, and commercialized economy with the development of capitalism in Britain and the expansion of empire through missionary and other activities in its colonies (Jenner and Wallis 2007). This built on the shifting Christian legacy that preceded it in Tudor and Stuart times in Britain (Gilley and Sheils 1994). However, paradoxically—despite the rise of a more liberal economy and the growth of wealth and consumerism—such a relatively open, pluralistic medical marketplace increasingly unravelled with state-endorsed medical professionalization based on exclusionary social closure in the mid-nineteenth century. This trend was accelerated by growing secularization—a contested term that can be seen to be related to declining public affinity with Christian churches—and the subsequent reduction in charitable, community, and domestic healthcare (Paley 2009). In parallel, state intervention expanded ever more into previously private domains (Smith 2009).

**Medical professionalization and CAM from the mid-nineteenth century**

At this time, a self-regulating medical profession was created in Britain through the 1858 Medical Act, after several legislative attempts. This and subsequent legislation formalized a new health pecking order—with the now unified, independent medical body of apothecaries, physicians, and surgeons at the apex and CAM therapists at the margins. The former group had lobbied hard in its own interests from a neo-Weberian perspective for the state-sanctioned formation of the General Medical Council in the first half of the nineteenth century through the Provincial Medical and Surgical Association, which later became the British Medical Association. The General Medical Council incorporated a register of qualified medical practitioners with a monopoly of title, code of ethics, and disciplinary
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procedures (Waddington 1984). Although this did not prevent CAM rivals like herbalists and homeopaths from practising under the Common Law (Bivins 2015), such exclusionary social closure meant medical doctors had greater legitimacy and—through subsequent legislation—secured privileged access to state employment and the exclusive right to claim to treat particular types of disease in the market, with consequent benefits for their income, status, and power.

This strike against the comparatively free market in medicine through an increasingly strengthened state market shelter was achieved, among other things, by vitriolic attacks on the dangers posed by their main competitors outside the profession. This took place as the wages of consumers rose and the new middle class emerged with greater purchasing power for medical care, as the capitalist economy developed (Johnson 2016). In this newly configured market, criticisms in the medical journals and elsewhere proliferated against ‘quack’ outliers for unscrupulously fleecing gullible clients while building up personal fortunes and prejudicing the public interest by endangering their health (Bivins 2015). Such attacks against marginalized practices were complemented by medical elites blocking access to official medical training posts for CAM practitioners, sidelining various forms of CAM in the orthodox medical curriculum, discrediting and striking off doctors who engaged in heretical practices, impeding selected moves of CAM therapists to professionalize and, more recently, restricting state funds for doctors researching unorthodox subjects (Saks 1996).

The position of the medical profession in the market was consolidated from a neo-Weberian standpoint after 1858 by further state underwriting of its financial position—when some doctors in poor and remote areas were still living in poverty. The main shifts occurred first through the 1911 National Health Insurance Act and then the 1946 National Health Service Act, based on the alliance that developed between the medical profession and the Department of Health between the two World Wars (Saks 2015a). It was reinforced by the creation, from the early twentieth century, of a range of mainly female subordinated orthodox health professions such as nursing, midwifery, and allied groups like occupational therapists and physiotherapists (Allsop and Saks 2002). In addition, the marginalization of CAM therapists was underwritten by legislation in the first half of the century restricting their practice in fields ranging from cancer and diabetes to epilepsy and glaucoma. These were defined as beyond the sphere that non-qualified doctors could claim to treat (Larkin 1995). The effect was to condemn CAM practitioners to a limited part of the private market outside the public sector—typically greatly diminishing not only their incomes, status, and power compared to doctors but also their numbers by the mid-twentieth century in Britain (Saks 1995).

One reason why medicine achieved professionalization in Britain from the mid-nineteenth century some fifty years ahead of the United States was because of public belief in the promise, rather than actual benefit, of biomedicine. It is otherwise difficult to understand why medicine should have professionalized at a time when there was little evidence that medicine was effective—before aseptic techniques and anaesthesia had been widely introduced (Saks 2015b). The increasing medical unity around biomedicine, which served doctors well in lobbying for the 1858 legislation, stemmed from the eighteenth-century Enlightenment. Here the growing secular emphasis was on individuals to accept responsibility for their own health through reason and scientific rationality—a philosophy that also filtered through to the colonies which often became sites for experimentation, not least through the work of medical missionaries (Spary 2013). In Britain, it resulted in the transition of orthodox medical work from eighteenth century ‘bedside medicine,’ in which affluent clients were actively engaged in their treatment in a patronage system, to nineteenth century ‘hospital medicine’ based on disease classification. This progressed to twentieth century ‘laboratory medicine,’ centred on
laboratory diagnosis in which the individual patient was depersonalized by being seen simply as a cell-based entity (Jewson 1976).

**Orthodox biomedicine, science, and religion up to the mid-twentieth century**

As such, the growing medical focus on the new biomedical paradigm, increasing scientific understanding, and burgeoning medical specialism tended to drive out religion from medicine up to the mid-twentieth century as tensions between the two increased from the Victorian era onwards (St. Aubyn 2009). Although there are arguments that Christianity and medicine co-constituted their authority through a collusive approach at this time, evidence for this claim derives primarily from North American rather than British sources (see, for instance, Barnes and Sered 2005). While recognizing the complexity of the interrelationship between medicine and religion, the direction of this change in Britain is perhaps understandable at a time of declining church attendance, even if this is only one indicator of secularization and religion remained pervasive in everyday life up to the first half of the twentieth century (Strange 2013).

In this environment, though, religion did not entirely disappear from view in medical orthodoxy. It was still represented in hospitals, including in the NHS, where prayer rooms were located in hospitals and chaplains ministered to the sick on the wards (Swift 2016). Meanwhile charitable homes were established for the dying, offering religious sustenance, which helped to mitigate the shifting medical emphasis on cure rather than care in the first half of the twentieth century (Strange 2013). Interestingly, as part of this changing relationship, the Churches’ Council for Health and Healing, which was founded in the 1940s to further the healing ministry, included all the major church denominations, hospital chaplaincy organizations and other healing groups, as well as the Royal Colleges representing the medical profession (Fulder 1996). The dominance of the scientific medical profession over this area was indicated by the committee of doctors who decided which cures might be seen as divine miracles by the Church following British pilgrimages of the sick and dying to Lourdes (Inglis 1980).

This epitomizes the retreat of the CAM sector in the marketplace period from the mid-nineteenth to the mid-twentieth century. This retreat was particularly accentuated by the growing vulnerability of elements of CAM based on the Christian religion. As Saks (1999) documents, its frailty particularly arose because of attacks by the biomedically-oriented medical profession on religious aspects of CAM for being linked to ‘sorcery’ and ‘superstition.’ The medical attack on CAM was intended to associate it with earlier primitive healthcare practices in its interest-driven crusade against ‘unscientific’ approaches to health and suffering. This firmly differentiated it from the rising wave of orthodox biomedicine that adopted the ideology of scientific rationality in face of heretics who were seen to be involved on a ‘flight from science and reason’ (Gross et al. 1996).

Christian Science certainly fell into this category. It developed in Britain from the latter part of the nineteenth century following its arrival from the United States (Schoepflin 1988). Its practitioners believed that pain, disease, and death were illusions based on erroneous thoughts resulting from ‘malicious animal magnetism’—which would persist unless overcome with the help of authorized Christian Science practitioners. Faith and spiritual healers by contrast did not dispute the existence of pain and suffering objectified by medical science, but felt that these could only be averted by divine intervention (Lee 1976). However, it was revealing that Harry Edwards, the best known of Britain’s spiritual healers, saw his spirit guides as Lister and Pasteur (Saks 1999), no doubt adding to his legitimacy in a scientific age. Such marginal practitioners were normally funded by donations in the CAM market as they lay outside the
state-supported medical sector. The relationship between medicine, religion, and the market was to change further, though, with the 1960s/70s counter-culture.

The rise of the 1960s/70s medical counter-culture

By the 1950s and 1960s there was much optimism about the progress of biomedicine in Britain with the development of antibiotics and other drugs, alongside surgical innovations such as open-heart surgery and hip replacements (Le Fanu 2011). Moreover, CAM continued to be subjected to negative invective from medical orthodoxy and collaboration with doctors remained blocked by the threat of disciplinary action by the General Medical Council. CAM use too was almost entirely confined to the private sector and its employment in the newly founded NHS was mainly restricted to orthodox health practitioners (Fulder 1996). The religious dimension of CAM also took a hit when a postwar British Medical Association report on spiritual healing refused to accept its role except in functional disorders originating from psychiatric causes, with successes outside this domain characteristically being attributed to spontaneous remission (Saks 1999).

However, from the mid-1960s in the Western world public faith in scientific progress was eroded—including in orthodox biomedicine—in large part as a result of frustration with its limited achievements and sometimes unhelpful consequences. This was the time of the counter-culture which opposed technocratic solutions to problems and sought alternative ways of living—including those drawing on Eastern philosophies (Roszak 1995). This had repercussions for many fields, from fashion to hallucinogenic drug taking. In medicine the effects of the counter-culture were very pervasive, translating into the questioning of doctors and a range of other professional groups who were previously deferentially put on a pedestal by many members of the community (Saks 2000). A central contributor to this debate, interestingly, was a former Roman Catholic priest, Ivan Illich.

Illich criticized many aspects of so-called industrial progress as counterproductive, from education to transport. He also attacked orthodox medicine, which he felt had expropriated health and resulted in nemesis—whereby our attempts to be immortal destroyed the goal of health enhancement (Illich 1976). Drawing on Catholic beliefs, he claimed this led to clinical, social, and cultural iatrogenesis. Clinical iatrogenesis is the direct harm done to people as a result of medical treatment, such as adverse drug side effects and hospital-acquired infections. Social iatrogenesis involves the medicalization of life, whereby hospitalization removes individuals from families and friends and unhelpfully extends sick life. Finally, cultural iatrogenesis refers to the disempowerment of individuals and communities in response to pain, illness, and death in face of organized medicine. The argument by Illich was not without flaws—particularly concerning where the appropriate balance of intervention lies—but his counter-cultural critique helped to prompt a shift in the relationship between orthodox medicine and the many forms of CAM in the market in contemporary Britain.

The impact of the counter-culture on CAM

This shift was apparent from fast-rising consumer demand for CAM from the 1960s and 1970s—through self-help and treatment from non-medical practitioners as well as the growing numbers of doctors and other health professionals who incorporated CAM into their repertoire. As Saks (2015b) notes, by 2000 about 15 per cent of the population annually were visiting some 60,000 CAM therapists in private practice. Meanwhile, CAM was increasingly employed by medical and non-medical personnel in the NHS—thereby improving access by
users seeking a wider span of state services in this area, free at the point of provision. The
General Medical Council also relaxed restrictions on referrals to CAM practitioners and the
state became more receptive to lobbying on their behalf.

Nonetheless, this did not blunt elite medical interests in maintaining dominance by attack-
ing CAM—as, for example, in a report by the British Medical Association (1986) which con-
demned ‘alternative therapy’ for its association with primordial superstition, religious cults,
and witchcraft, while extolling the march of science. However, this stance was soon revised
in a British Medical Association (1993) publication calling for greater absorption of ‘com-
plementary medicine’ into the orthodox medical curriculum. This was followed by the posi-
tive report on CAM by the House of Lords Select Committee on Science and Technology
(2000), which recommended the establishment of centres of research excellence in this area.
This paved the way for extensive ring-fenced, albeit time-limited, financial support from the
Department of Health for CAM research.

Such government funding provided momentum for selected areas of CAM to professional-
ize in neo-Weberian terms. Both chiropractic and osteopathy gained exclusionary social clo-
sure, based on registers underpinned by formal higher education qualifications in the final
decade of the twentieth century. Meanwhile other groups like acupuncturists and homeopaths
engaged in voluntary self-regulation (Saks 2002). The largely non-religious nature of CAM
occupational groups that achieved market benefits from statutory regulation can be seen to
reflect an increasingly secular modern age. This is also manifested in the way in which sick-
ness and death is now addressed in the medical mainstream, albeit with hospital chaplaincies
and others in support (Swift 2016).

Secureization and the medical response to CAM

There are, of course, other dimensions to the professionalization of chiropractic and oste-
opathy, such as gender given their predominantly male practitioner constituencies (Cant
and Watts 2012). But secularism is also mirrored in the diverse forms of CAM that have
flourished in twenty-first century Britain, from biofeedback to reflexology, which have
only a limited association with religions such as Christianity. This is to be expected at a
time when less than 10 per cent of the population regularly attend church or claim to be
‘very’ or ‘extremely’ religious (Field 1998). Such secularization is relevant too in ana-
lyzing the types of CAM practices that have been drawn into medical orthodoxy, in part
because of the lure of increased private income to doctors, especially where there is insur-
ance coverage. Even when CAM therapies have historic links to religion, as in the case of
hypnotherapy—with its magico-religious and mesmeric roots in healing from the seven-
teenth century onwards (Parssinen 1979)—they have normally been explained in medical
circles in biomedical terms.

As Saks (1992) has documented, this has been particularly so in the case of acupuncture—
one of the most widely incorporated CAM therapies in Britain, especially in primary care
inside and outside the NHS. It is usually now employed in orthodox medicine on the basis
of a neurophysiological modus operandi, centred on the release of endorphins. This form of
incorporation not only tends to limit its application to pain—as it is used more as a panacea in
traditional Chinese medicine—but also contrasts with the Taoist belief that its broader effects
are based on harmonizing Chi (the life force) flowing along the meridians through acupunc-
ture points. From a neo-Weberian perspective, medical acceptance of this spiritually-linked
theory would undermine the income, status, and power of orthodox doctors in the market
and legitimate their classically-trained, external CAM competitors, who can practise under
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the Common Law and are usually much better versed in the yin-yang philosophy underlying classical acupuncture.

Parallel arguments can also be made in the case of another holistic Asian practice—that of Ayurveda, which is comprised of a mixture of diet, massage, and meditation pivoted primarily on Indian Hindu philosophy. Although it has not yet had the medical take up or insurance-based funding available for acupuncture in the market, Ayurveda has become increasingly popular among CAM practitioners of late in Britain. However, it has largely been felt by doctors to be outside their comfort zone, except in pockets of Asian settlement offering greater opportunities for private practice (Saks 2008). The fate of acupuncture and Ayurveda are indicative of a range of remedies, including certain strains of herbalism and shiatsu, which have been imported to the West in the wake of the counter-culture.

Religion, CAM, and the medical market

Nonetheless, it should not be assumed, from a religious viewpoint, that in the more plural CAM healthcare marketplace therapies with a Christian underpinning have been completely overtaken by more exotic Eastern religious practices (Saks 1997). Some CAM therapies related to Christianity still prevail in the market, even if they are less prominent than in earlier times, as illustrated by the continued survival of bodies like the National Federation of Spiritual Healers and the Confederation of Healing Organisations (Saks 1999). Prayer also remains an important part of the territory. This is underlined by the classic study of the Assemblies of God in Scotland by Allen and Wallis (1976), who found that many of the Pentecostalist congregation believed that disease could be instigated by the devil and that God may send illness as a punishment. In this context, although lodged within a self-fulfilling frame of reference and standing outside conventional financial markets, divine healing by prayer was felt to be a key way to assist recovery—a path reinforced more recently by Gray (2018) who highlights how prayer can harness the help of heaven to create miracles.

However, in looking at the markets of medicine in Britain, change is afoot. Other new Western religious therapies have emerged, such as Scientology, which first appeared in the 1950s. Despite differences, Wallis (1977) claims that this is like Christian Science in so far as it is based on the idea that the mind is reincarnated and most human ailments are psychosomatic. He argues that in Scientology the ‘engrams’ of painful experience in the mind parallel the ‘malicious animal magnetism’ of Christian Scientists and are similarly amenable to being addressed by trained auditors in a manipulative social movement. At the same time, CAM therapies more generally—including those that are religiously based—have recently suffered renewed attacks by orthodox scientists for being non-scientific. This is embodied in what they see as the counter-intuitive practice of homeopathy, centred on the assumption that the more dilute a preparation the greater its potency. This has resulted in support for CAM in the NHS being reduced, as well as targeted research funding and the involvement of orthodox health professionals (Saks 2015b).

This setback has affected the market position of CAM in Britain, although—against this—orthodox medicine has also come under intense government scrutiny over the past fifteen years following high profile scandals. The greatest has been that of the mass murdering doctor, Harold Shipman, who practised undetected for some thirty years. This led the government to introduce the ‘regulated self-regulation’ of the medical profession involving regular peer appraisals, reaccreditation, independent adjudication of disciplinary cases, and the meta-regulator, the Professional Standards Authority for Health and Social Care (Chamberlain 2015). This policy is now being cascaded into other health professions such as nursing, which
has also had its share of scandals (see, for instance, Parris 2017). In addition, change through the re stratification of the medical profession has occurred as a result of government decisions about healthcare commissioning. This has put general practitioners in primary care at the helm, with the consequent growth of their income, status, and power against that of specialist hospital consultants (Saks 2015c).

Conclusion

The illustrative case of Britain highlights at a macro level the shifting market of medicine, including in the crucial infrastructural division between orthodox medicine and CAM, which is particularly relevant in understanding religiously based aspects of this market. The analysis here accentuates the importance of exclusionary social closure in medicine, facilitated by the state and group interests, in shaping the market from a neo-Weberian viewpoint. As a result, one form of pluralism in the contemporary era has in part replaced another (Cant and Sharma 1999), based on the increased secularization of Christian belief and the greater prominence of Eastern religious philosophies in healthcare. This underlines that Britain is not an island, but has been subject to extraneous global influences as much as it has reciprocally exported its own brand of religion and scientific medicine to markets elsewhere. This has taken place through missionaries, itinerant doctors, and other agents of the colonial empire not only, as has been seen, to the United States, but also to the Far East (Saks 1997).

In all this, it must be recognized that the way that religions are competitively configured in the markets of orthodox and unorthodox medicine is not simply of academic interest. It also has profound implications for the users of services. Here, in view of judgements about their relative effectiveness through placebo or other more systemic mechanisms, access may literally be a matter of life and death. It is hoped, therefore, that the illustrative case study of Britain, focusing on the division between conventional medicine and CAM, sheds helpful light not only on the shifting relationship between health professions, the state, and the market but also on the ramifications of the dynamic configuration of these elements for consumers who pick up its various consequences down the line.

Bibliography


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