

# **Medical Pluralism, Mainstream Marginality or Subaltern Therapeutics?**

## ***Globalisation and the Integration of 'Asian' Medicines and Biomedicine in the UK***

**Sarah Cant**  
**Principal Lecturer,**  
**School of Psychology, Politics and Sociology**  
**Canterbury Christ Church University, UK**  
**Email:** [sarah.cant@canterbury.ac.uk](mailto:sarah.cant@canterbury.ac.uk)

**Phone:** +44 01227 922145

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#### **Abstract**

*Medical Pluralism refers to the co-existence of differing medical traditions and practices grounded in divergent epistemological positions and based on distinctive worldviews. From the 1970s, a globalised health market, underpinned by new consumer and practitioner interest, spawned the importation of 'non-Western' therapeutics to the UK. Since then, these various modalities have co-existed alongside, and sometimes within, biomedical clinics. Sociologists have charted the emergence of this 'new' medical pluralism in the UK, to establish how complementary and alternative medicines (CAM) have fared in both the private and public health sectors and to consider explanations for the attraction of these modalities. The current positioning of CAM can be described as one of 'mainstream marginality' (Cant 2009): popular with users, but garnering little statutory support. Much sociological analysis has explained this marginal positioning of non-orthodox medicine by recourse to theories of professionalisation and has shown how biomedicine has been able, with the support of the state, to subordinate, co-opt and limit its competitors. Whilst insightful, this work has largely neglected to situate medical pluralism in its historical, global and colonial context. By drawing on post-colonial thinking, the paper suggests how we might differently theorise and research the appropriation, alteration and reimagining of 'Asian' therapeutic knowledges in the UK.*

**Keywords:** Complementary and Alternative Medicine, Globalisation, Medical Pluralism, Subaltern Therapeutics

## **Introduction**

In principle, the processes of both globalisation and medical pluralism — defined respectively as the interchange of worldviews, products and ideas, and as the co-existence of multiple health knowledges and practices — should be mutually reinforcing. In practice, flows of capital, labour and knowledge have served to establish and strengthen biomedicine's structural dominance across the globe and, simultaneously, major biomedical drug companies have coalesced into global firms with global markets. However, globalisation has not simply produced biomedical homogeneity; rather, it has also fostered opportunities for dialogic exchanges between traditional, non-orthodox and biomedical health knowledges. Put differently, globalisation has had two seemingly contradictory effects in the health arena: it has facilitated the homogenising of Western biomedical dominance and has concurrently encouraged medical pluralism.

In this paper, I examine the impact of globalisation upon the positioning of biomedicine and the pluralisation of health knowledges in the UK, through the renaissance of complementary and alternative medicines (CAM). The global dominance of biomedicine is far-reaching, underscored by evidence of efficacy and claims to objectivity and science, and shaped by epistemological and ontological premises that visualise the body as an anatomical atlas: a mechanical, objective and measurable entity/reality (Armstrong 1983; Jayasundar 2012). This discursive formation has served to eschew understandings of the body as animated through, and by, vitalism and energy. Whilst plural healing modalities have (re)positioned themselves in the global marketplace, I show that biomedicine continues to shape the delivery and practice of health care, and to define what counts as legitimate knowledge.

As such, medical pluralism has had limited impact on the epistemological and economic dominance of biomedicine which remains anchored by neoliberalism, capitalism and, importantly, the legacies of colonialism.

Globalisation has undoubtedly enabled connectivity, diversity and transformation: a stretching of social, political and economic activities across space, an interconnectedness in flows of trade, finance, migration and culture, a diffusion of ideas, goods, capital and people. In turn, global capitalist processes operate to transform the local and bring tensions and contradictions alongside opportunities (Robertson 1995). As such, exchange, interdependence and migration may all be global trends, but they map out differently across time and space and are shaped by contextual, economic and political allegiances: globalised biomedicine necessarily produces local adaptations and negotiations (Naraindas et al. 2014).

The transmission and exchange of ideas and knowledges provides a context in which medical pluralism might emerge. However, such pluralism does not necessarily signify an 'equal but different' positioning of voices, ideas and knowledges: on the contrary, pluralistic practice is rarely non-hierarchical or devoid of power relations. Indeed, even where traditional medicines are the affordable or available option, biomedical knowledge tends to wield authority and prestige (Leslie and Young 1992).

The growth of CAM in the UK, since the late 1970s, can be regarded as a new variant of medical pluralism. CAM is a short-hand to cover the huge array of knowledges and practices that range from herbalism, homeopathy, acupuncture, and ayurvedic medicine to reflexology, iridology, faith healing, etc. It is important to acknowledge that this nomenclature both reflects and reproduces 'Western' biomedical dominance. To be defined as

complementary, alternative or nonorthodox is to be understood in relation to something (biomedicine) and necessarily creates a binary and, implicitly, a hierarchy. Similarly, biomedicine is not usually required to justify its scientific credentials: in contrast, the scientificity and efficacy of other therapies are subject to interrogation. Indeed, problematic dichotomies beleaguer the study of this field and I reluctantly use the terms Western and Eastern medicines to explore the rise of medical pluralism and the exchange of health knowledges. This divide is not simply artificial, many forms of CAM originated in the West as well as the East (e.g. osteopathy in America; homeopathy originated in Germany, but is practiced widely in India), but it additionally evokes judgements about customs and ideas, about what stands as the norm, and what stands as a deviation. The terms necessarily reflect a history of colonisation (Anderson 1991; Said 1979): so whilst 'West' and 'East' provide a convenient spatial demarcation, they are a politically charged way to carve up the world.

Finally, the term 'Asian' medicine should not assume homogeneity or invariability. Using this umbrella term brings together a huge array of healing traditions and practices, all with complex histories. As Ernst (2002: 6) argues:

'any one tradition or medical system is inherently heterogeneous and represented by different groups of people with diverse views on how practice ought to be adapted (or not) to changing circumstances... medical traditions are intrinsically plural – both in terms of the variety of ways in which any one tradition has been interpreted and codified by learned authorities, and in terms of the great variety of their practical applications'.

Moreover, whilst I concentrate on the reimagining of 'Asian' medicine in the UK, this is not to suggest that these modalities have remained unaltered in their countries of origin (Sujatha and Abraham 2012: 5). 'Asian' medicine

has not been insulated from global influences and has interacted with biomedicine (Bode, 2002; Leslie 1976; Leslie and Young 1992). Therefore, I acknowledge that *all* health knowledges are dynamic and any discussion about the importation of 'Asian' medicine must be cognisant that this is not a static or homogeneous entity. The same caveat is just as applicable to biomedicine, the history of its development being similarly complex and shaped by contact with other health knowledges (Porter 1992).

### **Biomedicine: A Global Paradigm**

Any discussion of globalisation and health must acknowledge the global dominance of biomedicine. This position cannot simply be explained by scientific advancement. It is underscored by social, cultural, economic and political (including patriarchal) conditions of biomedical knowledge construction (see, for instance, Doyal 1979; Duden 1991; Freidson 1970; Foucault 1973) and, I suggest, our understanding can be usefully extended through mapping the influence of globalisation and colonialism.

In Robertson's (1992) historiography, there are five phases of globalisation which offer a heuristic device through which to examine the rise to global dominance of biomedicine. This periodization though is itself rooted in an occidental and colonial view of globalisation; serving to construct a temporalized and spatialized reading of global exchange and difference and the reproduction of 'progressive linearity'. In this way, the vocabulary of the social sciences constructs and reproduces a particular historical record and a particular worldview. The history depicted here is also necessarily broad-brush and partial and cannot, therefore, purport to capture the complexity and nuance of global/glocal biomedical development.

Recognising these limits, the first ‘germinal’ phase of globalisation, (which, for Robertson, spanned the fifteenth to the mid-eighteenth centuries), witnesses the growth of national communities, colonialism, the accentuation of concepts such as the individual, and the spread of the Church. Biomedicine is literally in its germinal phase at this time, characterised by the slow replacement of the humoral system, the decline of holistic links between the bodily and cosmic orders, to be superseded by a conceptualisation of the mechanical body — a corporeal paradigm that brackets out connections between the body and emotions, the mind or soul.

The ‘incipient’ phase spans 1750-1875 and sees, for Robertson, the crystallisation of the nation state and consolidation of international relations. The nation state was important for its endorsement of biomedicine as *the* legitimate medical knowledge system. In Britain, the 1858 Medical Act effectively authorised biomedicine and provided it with the epistemological and ideological high ground to discredit or absorb competitors. Worboys (1997: 250) suggests that this period is also characterised by the exchange of medical ideas through settlement: ‘a passive or even accidental introduction of Western medicine as an adjunct to European settlement, exploration and colonial rule’. Lock and Nguyan (2010: 148) provide a more critical analysis viewing biomedicine as a ‘tool of empire’, the exportation of biomedical ideas to the Americas, Asia, Australasia and Southern Africa designed to protect the health of settlers and soldiers. During this period, both homeopathy (from the 1830s) and allopathy (‘English medicine’) were imported to India (Das 2014; Waisse 2014), the former flourishing throughout the 20<sup>th</sup> century, in contrast to the decline in its popularity in the UK (Manchanda et al. 2014).

The 'take-off' phase, where the globalising tendencies of previous periods 'give way to an inexorable form... (and) increasing global conceptions of the 'correct outline' of an 'acceptable' national society' (Robertson 1992: 591), is mirrored by the ascendancy of biomedical practices. For Worboys, the spread of Western biomedicine becomes deliberate at this time, part of wider, political, economic and social policies associated with imperialism and missionary work:

'derived in part from new medical ideas and in part from wider political policies that demanded the imposition of Western language, culture and technology on subject people. The result in medicine was that Western practitioners moved from tacit acceptance of pluralism to a position where they sought a dominant, if not monopolistic, position' (1997: 256).

This included the development of specialities within biomedicine to deal with the particular health 'problems' of the colonised countries (*cf* tropical medicine).

During the 'struggle for hegemony' (1925-69), which Robertson describes as marked by disputes over the fragile terms of the dominant globalisation process (albeit when the United Nations is formed), biomedicine has a more stable phase and its dominance is secured. It is during this period that the World Health Organisation (WHO) is formed and many countries, (e.g. China and Japan), begin to freely adopt Western medical practices. Western biomedicine achieves a position of dominance in probably every country of the world by the 1970s, a product not just of its efficacy, but also its political and economic might: both appropriating as well as devaluing indigenous knowledge (Hollenberg and Muzzin 2010), with the implications for traditional medicines being stark. For example, in Africa, colonisers outlawed traditional medicine (Airhihenbuwa 1995), at least until the 1950s when



anthropologists recognised the benefits for social cohesion, if not the healing qualities. For a time then the dominance of biomedicine served to strangulate diversity in health practices and knowledges. However, from the 1970s, the WHO began to recognise that effective health care must resonate with national cultural traditions, a temporal chime with Robertson's fifth phase, and it was also recognised that, despite the global spread of biomedicine, millions of people were unable to access medical care (Stiglitz 2013).

Indeed, the globalisation of biomedicine did not signal absolute improvements to global health: on the contrary, the divergence between the increasingly wealthy and the desperately poor was concretised (Marmot 2015). These differences not simply a reflection of local environmental conditions, cultural differences and varying levels of GDP, but emanated from global decisions such as: permits on life-saving drugs; low incentives for pharmaceutical companies to invest in the development of drugs for the poor; and the impact of recruitment and migration of health workers from 'developing' countries (Lenard and Straehle 2012).

Nor can economic or accessibility reasons simply explain the continued existence of indigenous and traditional medicines alongside biomedical approaches during this time. People often preferred their local healers, and governments encouraged indigenous healers, sometimes for nationalistic reasons (Lock and Nguyen 2010; Khan 2006). In Japan, for instance, where a comprehensive and socialised health care system had been in place since the 1930s, continued access to acupuncturists and herbalists was also established (Lock 1980). In India, in Mysore, Beals (1976: 184) shows how a complex range of alternatives flourished during this period with choices

between them determined by ontological and folk beliefs, the economic and social status of the patient, and the range of advice available.

Robertson uses the descriptor of ‘uncertainty’ for the most recent phase of globalisation. A sharp acceleration in global communications and movement ushered in multi-culturality, poly-ethnicity and, in consequence, contestation and contradictions around ideas and identity. Perhaps there is no better term than ‘uncertainty’ to describe the position of biomedicine from the 1970s. Notwithstanding the global reach of biomedicine and the undeniable fact that biomedicine remains the prime means to battle the global burden of disease, the period since the 1970s is also characterised by de-professionalisation, contestation, scepticism and well-publicised biomedical risks. These shifts set the stage for the re-emergence of medical pluralism in the UK and a new dialogue between competing medical knowledges. In other words, whilst the global dominance of biomedicine led to a ‘Westernisation’ of world health practices, this latest phase provided the context in which a renaissance of medical pluralism was rendered possible.

### **A ‘New’ Medical Pluralism: CAM and Mainstream Marginality**

The spiralling costs of biomedicine, the persistence of chronic and degenerative diseases, the reluctance of a pharmaceutical industry to invest except where profits were secure, the recognition of the iatrogenic effects of some biomedical interventions, and opportunities to (re)learn about alternatives and explore different conceptions of self and well-being all provided the context for a new variant of medical pluralism to emerge.

The global recognition of the importance of supporting both traditional and biomedical practices was made first in 1977, when the WHO urged governments to promote integration in the face of unmet need and population growth (Leslie 1980). Concurrently, both global migration and interest from western Indophiles fostered a freer exchange of ideas, and the importation of therapies and practices to the UK was facilitated (Sujatha this volume; Wujastyk and Smith 2008). The passion of a number of key teachers (known as Gurus) ensured that knowledges were shared (Newcombe 2009). In turn, these knowledges were subsequently re-imported, in altered forms, back to South East Asia for a largely urban and cosmopolitan elite (Ernst 2002; Newcombe 2009). The softening of political relations with China fostered dialogue between acupuncturists, Chinese herbalists and biomedical practitioners (Saks 1992). Whilst the interest in CAM in the West was also underpinned by counter-revolutionary, feminist and green movements (Goldstein 2004), migration facilitated the transmission of ideas. Moreover, global capitalistic and neo-liberal imperatives, those that emphasised choice, individuality and profit, played their role in the expansion of a new plural medical marketplace (Han 2002).

Once therapies were made available, the market for CAM in the UK quickly and significantly expanded, and using CAM became a mainstream rather than a minority activity (Harris et al. 2012). Whilst there are over 200 therapeutic modalities available within the UK, there operates a distinct hierarchy. The most popular and well established 'big five' (Acupuncture, Chiropractic, Herbalism, Homeopathy and Osteopathy) categorised as 'Principal' and 'professionally organised' by the House of Lords (2000), with Shiatsu and Yoga defined as complementary without diagnostic capacity, and Ayurvedic

medicine, Traditional Chinese Medicine and Eastern Medicine (Tibb) acknowledged as being long-established, but indifferent to scientific principles of conventional medicine. As such, there has been little support for the latter in gaining access to the NHS. These differences map onto variances in availability – for instance, Svoboda (2008) notes the dearth of well-trained Ayurvedic physicians in the UK, estimating that as few as 20 college-trained *vaidyas* are practicing.

The attractions of CAM to users can help explain the renaissance of CAM, and also gives insights about its limits. It should be noted that users, in the main: come from a discrete demographic (middle class, middle aged and women); continue to use biomedicine; tend to turn to CAM for limited and more usually intractable conditions, those where biomedicine is deemed less effective (Cant 2009). Research also suggests that around half of users do not actively engage with the spiritual claims of the therapies that they use (Heelas et al. 2000): it is the minority, termed ‘holistics’ (Newcombe 2012) who fully embrace the metaphysical beliefs. Overall, users appreciate the lengthier, holistic, personalised and equitable health encounters that often characterise CAM consultations and the perceived alignment with less invasive, ‘natural’ interventions, and they report ‘experiential’ evidence of efficacy. The strong correlation between use and gross socio-economic indicators such as class, gender and ethnicity are suggestive of other attractions.

Some authors (Brenton and Elliott 2014; Flesch 2007, 2010; Scott 1998) have made an association between CAM and feminist campaigns, seeing the former as an alternative space to develop gender-sensitive health care. Certainly, whilst the majority of users are women (Adams et al. 2003; Bishop et al. 2010; Harris et al. 2012) it must be remembered that women are also the

primary consumers of conventional medicine, and male use is not insignificant (Cant and Watts 2019). Research suggests that CAM is experienced by women as empowering, affording personal control over health and health care. Women practitioners are also drawn to CAM for similar reasons (Cant et al. 2011; Flesch, 2007). However, it would be simplistic to see CAM as unequivocally empowering: women's use of CAM may serve to reinforce dominant ideologies that emphasise individual responsibility, and is contained through access to marginalised therapeutic modalities that do not have state support. Moreover, these analyses tend to be ethnocentric, focussed on privileged, middle class women users in the West and so are by no means universal. For instance, in India, Broom and colleagues (2009) found that women with cancer were likely to employ traditional medicines because their lack of status in the family meant they were denied access to biomedical treatment (c.f Sen and Chakraborty 2016; Shih et al. 2008). Nevertheless, in the UK, and the West more generally, CAM can be understood as delivering gender-sensitive care and providing spaces for self-realisation (Sointu 2011).

There is nascent work looking at the use of traditional healing by migrant populations in the UK. Aslam (1979) and Healey and Aslam (1990) found that traditional healing was commonly used by British Asians in Bradford, especially the recourse to the *Hakim*, to assert cultural identity. Green and colleagues (2006) found that migrant Chinese women in the UK turned to CAM when their access to biomedicine was blocked due to discrimination or communication difficulties (cf Rochelle and Marks 2010). Others have shown that CAM provides the means to assert a strong sense of cultural identity and to resist biomedical constructions of risk (Keval 2009; Reed 2003). Medical

pluralism can then be regarded as a powerful resource through which to construct ethnic and gendered identities, albeit for specific groups of users.

These examples give insight into the experiential effects of medical pluralism but do not tell us about the organisation and delivery of health care in the UK. Globalisation may have encouraged pluralism, but it is a pluralistic system that is shaped decisively by biomedicine. CAM is 'judged' in terms of scientific criteria, placing biomedical rules of thought as the basis of arbitration, legislation and definition. Globalisation, then, provided a context for CAM to flourish, but also set parameters by which it might develop.

We can see the impact of biomedicine on CAM in the UK. In the case of acupuncture, the practices have largely been delivered by biomedical practitioners who have emphasized the analgesic qualities of the techniques. Non-medical acupuncture, homeopathy, herbalism etc. had a popular following from the 1970s and initially practitioners were focused on developing and sharing their practices, often defining themselves as a radical movement that eschewed all things biomedical (Cant 1996). However, from the 1980s, pressure from the state and the medical profession resulted in accelerated professional projects that mimicked the organisation and training of biomedicine. There were also clear attempts to temper knowledge claims. In homeopathy, for instance, advice to avoid vaccinations was withdrawn. Overall, CAM has tended to imitate biomedicine, but has not succeeded in securing the same economic status, power or market share. This is most clearly evidenced in access to state support and funding. Whilst the last two decades have seen a shift in the disposition of biomedicine towards CAM — from a position of hostility to cooperation, with calls for integrative medicine — CAM practice remains predominantly situated in the private sector. The

delivery of integrative medicine tends to be piecemeal and *ad hoc*, often focussed on more residual medical arenas, those with lower status and where biomedical intervention has had little success or where there are limited curative opportunities (e.g. end of life care). To date only two therapeutic modalities – chiropractic and osteopathy – have secured statutory registration and the remainder are dependent on voluntary self-regulation and support from private clients. This leaves much CAM practice vulnerable to shifts in the market and wider health policy, as seen in the recent exclusion of homeopathic remedies from National Health Service (NHS) prescription.

Overall, there is a dearth of empirical studies that have examined integration in practice in the UK. One recent study (Cant et al. 2011) examined the integration of CAM by nurses and midwives into NHS hospitals and showed that whilst this enabled the enhancement of occupational jurisdiction and quality of work experience, practitioners were acutely sensitive to the boundaries of practice *delegated* to them by the medical profession. This research mirrors findings of integrative medicine elsewhere in the West where complementary therapies are always shown to be symbolically, structurally, epistemologically and economically marginalised (Hollenberg 2006; Hollenberg and Bourgeault 2011; Mizrahi et al. 2005; Shuval 2006; Shuval et al. 2002, 2004). In sum, the research evidence points to an appropriation of practices and techniques by biomedicine, and not to a situation of epistemological or philosophical realignment.

In the UK, CAM is situated in the ambiguous position of ‘mainstream marginality’ (Cant 2009): popular, but not state sanctioned or funded. Moreover, where CAM has been integrated with conventional health care, biomedicine has maintained its epistemological superiority and medical

pluralism is powerfully dominated by allopathy and defined in its terms. Considering that CAM use in the UK is higher amongst social groups who themselves feel disempowered by biomedicine (experienced as patriarchal, ethnocentric or ineffective), there appears to be a mutually reinforcing relationship in which marginalised therapeutic practices are supported by interest from relatively marginalised users. However, whether this is sufficient to explain the precarious positioning of CAM in the UK is debatable.

### **Subaltern Therapeutics: A Post-Colonial Interpretation of Medical Pluralism**

Whilst the global dominance of biomedicine was tied closely to colonialism, medical sociology has largely ignored the impact of this legacy for understanding the shape of contemporary health knowledges and practices in the UK. Rather, the social history of medicine has tended to focus on the transfer and dissemination of the Western model of medicine to the East. There is a dearth of research focussed on the transfer and dissemination of Asian therapeutic modalities to the West and how these might be understood in terms of post-colonial theory, with an appreciation of the impact of colonial power and history.

An optimistic reading of existing work could focus on syncretism and hybridity, providing a conceptual space by which to see CAM as a mode of resistance as well as appropriation. Johnston (2002) makes such a case in her study of native American traditions in the USA:

‘Indigenous medicine provides a vehicle through which to express individual and cultural identities and to take a stance in relation to a history of colonization and ongoing power relationships with the dominant society. Outmoded concepts like a simple dichotomy



between traditional and modern get resoundingly upended by the realities in native communities' (2002: 209).

This type of analysis prompts Penkala and Rajtar (2016: 129) to suggest that the term medical pluralism should be replaced by more fluid alternatives such as 'medioscapes', to enable reflection on the 'distinct results of ongoing globalised entanglements in the international medical arena' or 'medical diversity', 'super-diversity' or 'hyper-diversity', which in turn allow for the acknowledgment of complex and mutual borrowing between medical traditions.

There is support for such renaming in Campbell's detailed examination of the Easternisation of the West (2007) and where he conceives *Yogaization*: the importation of value systems which deeply affect and transform Western civilisation. In his view, globalisation focusses too heavily on the dominance of Western civilisation, with a relative neglect of what is happening to the West itself. He sees the acceptance of acupressure, acupuncture, moxibustion, shiatsu, etc. as indicative of a seismic shift in the Western worldview with the search for Eastern wisdom producing concomitant changes to Western practices and the Western psyche:

'for there exists an enthusiasm for things Eastern in the countries of the West...paradoxically, it is possible that just at the point when the rest of the world seems intent on imitating the Western way of life, the West itself is actually turning away from its own historic roots and embracing an Eastern outlook' (2007: 19 -20).

This, he argues, is as significant a shaping of the West as was the Renaissance, the Reformation and the Enlightenment, and it indicates a shift away from a materialistic, mechanistic, positivist, deterministic and reductionist (Newtonian style) worldview; a rejection of the dualisms between the mind and the body, mankind and nature, body and soul. Instead, holistic beliefs,

with an appeal to self-determination and self-knowledge, are embraced: reason is balanced with intuition; calculation is supplemented with contemplation; and individuals are regarded as imbued with a vitality, a life force.

Such an ontological shift can be seen to be accompanied by epistemological change. In her examination of CAM, Almeida (2012) focusses on the changes made to biomedical organisation and practice and makes the case that a process of *camisation* now sits alongside medicalisation: a situation where health problems can be treated in CAM terms and within a CAM framework.

There are a number of problems with these theses, not least because they produce a homogenised view of 'Eastern' traditions (Hamilton 2002). There are also empirical difficulties in asserting seismic change: we have seen that CAM practitioners engaged in professional projects that mimicked biomedicine, and that the power balance in integrated clinics is firmly skewed in favour of the biomedical profession. CAM is situated in a precarious and vulnerable position, largely unregulated and dependant on private clients. Moreover, the majority of users are from a discrete demographic and have limited engagement with the 'Eastern' worldviews that underpin many of the therapies they access,

Notwithstanding all the caveats made thus far in the paper that are careful to note that biomedicine and CAM are dynamic knowledges and far from homogeneous, there is a deeper issue to consider. While the focus on professionalisation tells us much about occupational strategies, territorial and jurisdictional battles, it does not reveal the deep, cultural, knowledge wars that are also enacted in, and through, medical pluralism. The West's adoption of 'Asian' therapeutics might be regarded instead as a restrained and partial

appeal to a romantic *idealisation* of ‘Eastern’ knowledges. This idealisation serves to conflate lots of differing traditions and reduces them to a singular worldview: ‘a perspective based on an idealistic holistic assumption rather than an engagement with the sociological and historical reality of the tradition that they practice’ (Newcombe 2012: 208). Indeed, Campbell (2007:40) too makes this important qualification, while ‘the turn to the East is neither superficial nor insignificant’ ...’ it is the West’s’ *image* of the East that ‘exerts a powerful influence over the West’.

It is this idea of cultural re-imagining that I want to emphasise. The discursive juxtaposition of the West from the East, the Occident from the Orient is steeped in history, trade, and a need to assert difference through boundary construction and nationalism. Where Anderson (1983) details how ‘imagined’ communities are socially constructed, Said (1979) shows how cultural representations of the differences between East and West are exaggerated and assume hierarchical difference: otherness, in turn, is equated with subjugation. In the process of colonialism and globalisation, what counts as knowledge is shaped by Western modes of thinking and the continued ascendance of a rationalist, positivist and scientific paradigm with a consequent destruction of rival forms of knowledge — a process of epistemicide (Santos 2014). Other ways of thinking and knowing are starved of funding, rejected or altered to become a more ‘acceptable shape’, and to fit with the dominant categories and rules of thought (Bhambra and Santos 2017). In so doing, non-Western forms of knowing, and for the purposes of this paper, ‘Asian’ therapeutic knowledges and wisdom, can be understood as necessarily re-imagined and relegated to the margins.

Postcolonial theorising permits us to view this dynamic not through Western conceptions of efficacy, progress and professional power, but in terms of history, enslavement, and appropriation. It demands that the sociology of CAM becomes 'connected' to colonial history (Bhambra 2007, 2014), and that medical pluralism in the UK be understood as constituted by broader colonial processes. It requires that medical social theory not simply engage with postcolonial thought, but also assess how its own dominant constructs are a product of colonial modernity.

Spivak's use of the concept of 'subaltern' is useful here. The term is widely used in post-colonial studies to refer to persons and groups who are radically marginalised because they are positioned outside colonial hegemonic discourse: those who are written out of colonial narratives, or written into them only in terms that belong to the colonial powers. As such, subaltern status is more than a matter of simple oppression: post-colonial power relations, both material and discursive, leave the subaltern without agency. For Spivak (1988), to be heard and known the 'subaltern' can only adopt Western ways of knowing, of thought, reasoning and language. She is very critical of many Western intellectuals for their tendency to reify and romanticise the oppressed colonial Other. Empowerment for subaltern peoples will not come through seeking to gift an authentic voice to othered peoples, but through challenging the post-colonial systems that position people outside discourse in the first place.

Viewing the uptake of Eastern therapeutic modalities through this lens is insightful. The subaltern status of such knowledges is immediately apparent in its naming: CAM implies that Western colonial biomedicine is normal, the yardstick to be judged against. Biomedical epistemologies and standards of

evidence still determine the legitimacy of CAM. Integration into Western medical practice involves CAM being reduced to specific interventions, delivered in specific circumstances. To apply this thinking still further: if the subaltern can only be heard by the oppressors by speaking the language of the rulers, 'Asian' therapeutics can only be understood and known by, and through, a Western medical discourse.

Hollenberg and Muzzin (2010) powerfully argue that in integrative medicine the privileging of the biomedical paradigm is unquestioned and stands as 'an extension of Euroscience: a paradigm with a long history of appropriation and assimilation of Indigenous knowledges' (2010: 25). Biomedicine, rooted in a Cartesian, mechanistic and reductionist worldview, looks for cures and preventions, and studies diseases not people. When coming into contact with other ways of knowing, it tends to dismiss that deemed to be non-objective and non-empirical and cannot reconcile non-materialist conceptions of vitality, that characterise nearly every other medical system. A number of empirical studies support this view. In Israel, Fadlon (2004: 72) uses the concept of 'domestication' to describe the process by which the 'foreign' is 'rendered familiar and palatable to local taste'. Similarly, Unschuld (1987) describes the practice of 'so-called' Chinese medicine in the USA and Europe as appearing to mirror Western ideas of what 'alternative' medicine should be like, rather than original Chinese thought. Banerjee (2004) details the downgrading of Ayurvedic medicine to a more rudimentary form through importation, and Warriar (2014) shows how the processes of systemisation and standardisation have served to marginalise the informal networks that have historically vitalised Ayurvedic practice as well as enabling the exchange of ideas.

My aim here is not to speak on behalf of formally colonised knowledges and people, but to foreground the pluralisms inherent in medical pluralism. This paper by no means intends to be a closing voice on the topic of medical pluralism from a point of view that either, privileges the Western voice in speaking for the Other, or assumes a homogenous other for whom one is speaking. It may, however, be helpful to think of medical pluralism as *subaltern therapeutics* in three ways. First, to capture and acknowledge the ways in which our talk of CAM is shaped by binary constructions, and so foster a more critical discussion of the descriptors that we use. To date, our thinking about ‘other’ medicines/therapeutics has been restricted by, and through, the application of hegemonic vocabulary. Second, it is to acknowledge that ‘Asian’ therapeutics in the UK have been constructed as historically subjugated healing practices, defined by and through colonial relations, and are ‘known’ through a dominant biomedical lens. Subaltern therapeutics are ‘translated’ by the language of biomedical science and are institutionally configured on a biomedical template of delivery and practice. Third, to support and foster new historical and contemporary research: Mukharji (2016), for instance, argues that too little attention has been given to the scientific study of those rich seams of health knowledge that had been vibrant until colonialism. Too often, he suggests, ‘the majority of studies look at how non-Western knowledge is transformed into globalized intelligence useful to the ‘West’’ (2016: 23).

## **Conclusion**

Globalisation has encouraged a new variant of medical pluralism to take root in the UK with opportunities to explore different conceptions of health and creatively combine contrary healing traditions. However, an

asymmetry prevails and involves a very specific imagining of CAM, which cannot be reduced simply to efficacy. In the first place, limited sponsorship from the state places CAM in a marginalised position, despite mainstream consumer support. Second, this mainstream support has, nevertheless, key characteristics and there is an association between CAM use and biomedical marginalisation— that is, users are those who tend to feel disempowered by biomedicine but their decision to seek alternative health care does not unsettle its hegemonic status. Third, the prioritisation of biomedical evidence and science has produced a limited engagement with the philosophies, ideas, worldviews and vocabulary of CAM knowledges; a form of engagement replicated in users' accounts. In these ways, the plural market in the UK does not serve to challenge the dominant rules of thought: rather, Western, biomedical epistemological dominance appears secure.

To date, medical sociology, in documenting the dominance of biomedical epistemology, has not drawn strong enough connections to colonialism and historical therapeutic epistemicide. More than this, medical sociologists in the UK have been working with a very small part of the extensive knowledge systems that pertain to CAM, and thereby themselves contribute to such epistemicide. Post-colonial theory challenges us to recognise that theories, concepts and frameworks within medical sociology are shaped by, and were constitutive of, colonial modernity, and this requires us to critically evaluate our own suppositions (Go 2016). Therefore, terms such as 'integrative' medicine and 'medical pluralism' are problematic descriptors of global health changes because they are themselves implicated in the resilience and dominance of biomedical and Western worldviews, even as they cast light on those phenomena. The challenge and opportunity posed for medical sociology

by post-colonial theory is twofold. First, to render visible the durable colonial power relations that continue to shape health knowledges and practices, and our own research concepts and studies. Second, to reconstitute research practice to be globally interdisciplinary, comparative, ethnographic and historical. Drawing together the research of global southern and northern scholars would enable a fuller examination of the relations of power that run through medical, therapeutic and sociological practices, facilitate a deeper appreciation of the ways in which medical pluralisms variously map out across the globe, and give room for other knowledges and histories to be articulated.

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