Royal London Homoeopathic Hospital

A medical anthropological look at complementary medicine in public health care

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Abstract:

This thesis deals with alternative medicine (referred to as *CAM*) in public health care. Fieldwork was conducted at the *Royal London Homeopathic Hospital* (RLHH) in London, England, in the fall of 2004. The goal of the thesis is two-fold. First, I have wanted to show how alternative medicine (in this case mainly homeopathy and acupuncture) is offered in public health care in Britain. Secondly, I have briefly discussed this from a Norwegian context and looked into the possibilities of CAM in public health care in Norway.

I have in this thesis made use of theories ranging from Stoner (1986) on medical pluralism; Eisenberg (1977) on the illness-disease distinction; Scheper-Hughes & Lock (1987) on the three bodies; Barth's (2000) theory of knowledge systems; Gramsci and his concept of hegemony, as well as Foucault (2000) on British biomedicine. I have argued that biomedicine is a system of knowledge which is not exempt from cultural analysis, and I have wanted to show how biomedicine holds hegemony over CAM. Simultaneously, using Gramsci's definition of hegemony, I have argued that in Britain this hegemony is neither static nor complete; rather it is dynamic and based on process.

The reasons for RLHH's existence in Britain are to be found, I have argued, in specific British socio-political and historical traits; a specific form of British biomedicine; in the British homeopathic history and the two main homeopathic organizations; the Royal and elite patronage of homeopathy, as well as RLHH being a hospital where the doctors are initially trained as biomedical doctors. This, together with the hospital focusing on biomedical research on homeopathy, makes the homeopathy practiced there in many ways biomedical in its approach.

Finally, from a Norwegian point of view, I have argued that the chances of having homeopathic hospitals like RLHH in Norway at present are limited. It will in many respects depend – as will future acceptance of CAM – on the future doctors', policy makers' and researchers' willingness to accept CAM, even if no scientific proving of it is found.

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Introduction:

The use of, and interest in, alternative medicine is on the rise in Norway, as it is in most European countries, and has been so for many years already (Alternativ medisin 1998). In general, the trend today seems to be a steadily rising amount of people using one or several alternative forms of treatment, either on their own, or as a supplement/complementary to biomedicine, the dominant medial system. [1] There are many reasons for this. The most well known includes on the one hand a growing "green wave"/New Age movement - a rising interest in spirituality as opposed to the focus in biomedicine on technology. People in general seem increasingly concerned with their health, the body, food, diets and food additives. Moreover, there is an increasing desire to gain greater control over our own health and well being (Saks 2003:144). On the other hand, from the biomedical point of view, many patients are experiencing a lack of time with the doctors at consultations as well as being sceptical to the side effects of chemically produced medicines in conventional care. Many are also seeking alternative treatment because biomedicine currently is unable to treat some of the new and chronic illnesses. Simultaneously, the alternative medical movement, as it has grown in momentum and popularity over the last few decades, in itself produces an accelerating effect; - accessibility to alternative medicine leads to greater knowledge and a heightened interest in and use of it (Alternativ medisin 1998:39).

In Norway, as in other complex, nation states in comtemporary Europe, there are many different medical systems available. Biomedicine is one of these. Homeopathy, acupuncture, aromatherapy, and healing are examples of some other well known ones. These medical systems constitutes

[1] I refer in this thesis to a medical system as a separate system of healing consisting of a) a disease theory system (to explain how sickness works and how to cure it) and b) a health care system (the relationship between the patient and the healer, in for example a hospital) (Foster and Anderson 1978 in Baer et. al. 1997)

what by many has been labelled *medical pluralism* (see e.g. Stoner 1986, Welsh 1983, Baer et.al. 1997), in that there is a multitude of different medical systems available to choose from.

Anthropological studies have shown that people move with ease between these different medical systems (Stoner 1986, Welsh 1983, Janzen 1978). They choose biomedical treatment one day; homeopathy, acupuncture or other forms of alternative medicine the next (even for the same type of disease/illness).[2] They even do this in spite of e.g. biomedicine and homeopathy being two very different medical systems indeed.

It has been argued that the reason for this simply is that the sick person – as a *user* of any given form of healing/therapy – is *pragmatic* in his/her choice of treatment (see Stoner 1986, Welsh 1983).[3] Welsh argues that the major factor when deciding on types of healing is *accessibility* and *convenience* (1983:51).

Alternative medicine is easily accessible on the private market, but the accessibility of it in public health care is, however, virtually non-existing. The reason for this, it has been argued, is the fact that biomedicine – the dominant medical system in Europe today – is sceptical to most of the alternative medicine being offered, especially homeopathy. This scepticism is primarily based on the fact that biomedicine believes there is a lack of any given scientifically proven effect in most alternative medical treatments.

This leads to alternative medicine not being offered in public health care, at least only on a very

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[2] The distinction between illness and disease was originally introduced by Eisenberg (1977). I will elaborate on this in chapter 3. Throughout this thesis I will use the term *illness*.

[3] Also referred to as "*committed users"* (see Barry 2003).

small scale.[4] In Norway, as in most European countries today, the idea of biomedicine and for example homeopathy working together in public health care in any complementary shape or form has always been somewhat impossible to imagine. There are, of course, exceptions: there are biomedically trained doctors practicing alternative medicine; there are homeopaths who later train as doctors; there are doctors who have abandoned their biomedical training and career altogether to work only with alternative medicine, etc.[5] However, the vital point here is that this is, with few exceptions, not the case *in public health care*.

The biomedical scepticism towards alternative medicine keeps, in effect, the different forms of alternative medicine out of the public health care sector, giving people no choice but to seek out private practitioners to obtain the desired treatment. Due to the often high cost of private homeopathic and acupunctural treatment, this could - taken to its extreme - result in sick people not being able to afford treatment that could have benefited them and offered to them in public health care, either for a small fee or for free. In this respect, biomedicine holds, as Sharma points out, a privileged position "*vis-à-vis other systems* [...] *being the form of medicine recognised, funded and given priority by the state*" (Sharma 1992:28).

Field of inquiry:

In the beginning of 2004 I learned of five hospitals throughout Britain that were offering alternative medicine (primarily homeopathy and acupuncture) whilst at the same time being public hospitals under the British public health service (called *NHS – National Health Service)*. The

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[4] The most apparent exception is acupuncture, which is used at a few hospitals in Norway, primarily in relation to births. See Alternativ Medisin 1998, chapter 9.

[5] For an overview of Norway, see Alternativ Medisin 1998, especially chapter 9.

largest of these is the *Royal London Homeopathic Hospital*.[6] I was very surprised by this, and my initial response was that this simply did not make any sense. With the British health care system being quite similar to the Norwegian – or so I have always thought – how could these five hospitals, under control of the public health authorities, co-exist and work in a medical culture based, like Norway, on an alleged biomedical hegemony? [7]

This thesis is based on fieldwork conducted at the Royal London Homeopathic Hospital (abbreviated throughout as *RLHH*) in the fall of 2004. My aim with the thesis is two-fold: I wish to answer the above question of why these homeopathic hospitals exists in Britain, as well as exploring the possibility of having hospitals like these in Norwegian public health care.

I wish in this thesis, following Scheper-Hughes & Lock's (1987) theory of the three bodies (written from a *critical medical anthropological point of view*, see below), to argue that there is a biomedical hegemony that exerts power and control over alternative medicine. I will show that there indeed *is* a biomedical hegemony in Britain (as well as in Norway) and I will show in what ways biomedicine is able to hold this hegemony. Yet at the same time I wish to argue that the reasons why RLHH is able to exist within a biomedical framework are based on very specific British medical, historical and socio-political traits, both present and historically.[8] These traits can

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[6] Britain is the only European Union country who has homeopathic hospitals in public sector. The other four hospitals are: Glasgow Homeopathic Hospital, United Bristol NHS Trust, Kent & Sussex Weald NHS Trust Homeopathic Hospital and Dept. of homeopathic medicine, Liverpool.

[7] For a general discussion on the topic of alternative medicine vs. biomedicine, see for example Sharma 1992 and Saks 1992.

[8] Countries constitute a "national medical culture". The term is adopted from Last (in Sargent/Johnson 1996:37). It refers to a national arena where competition between medical systems takes place.

not be adapted to a Norwegian context, which is the reason why, I will argue, there at present are no homeopathic hospitals in Norway.

I will answer the above by making use of Stoner (1986) and his theory of medical pluralism, as well as Eisenberg's (1977) theory on the distinction between illness and disease, and show how RLHH (and homeopathy in general) in many ways can be said to bridge the gap between illness and disease. I will also argue, following Barth's (2000) theory of systems of knowledge, that biomedicine is a system of knowledge which is not exempt from cultural analysis (cf. Brown 1997). Further, following Gramsci's definition of hegemony, I wish to argue that the biomedical hegemony (in Britain and Norway) is not a static structure; it is a social *process* which changes our understanding of medicine and treatment over time, just like the biomedical community and the doctors' views on alternative medicine does.

During my fieldwork it became clear to me that there were a few very evident reasons for RLHH's existence. In Britain, homeopathy, as it was developed by the German doctor Samuel Hahnemann in the beginning of the 19th century, was introduced almost from the very beginning,[9] which led homeopathy and biomedicine to develop both in their own right but also in accordance with each other. This was primarily due to the fact that the people who trained as homeopaths were almost exclusively doctors (e.g. already biomedically trained) who for various reasons turned to homeopathy. This has affected the way homeopathy is being practiced in the UK, even up to today. The homeopathic history and tradition is, in short, longer in the UK than in Norway.

Another important reason is that the homeopathy practiced at my place of fieldwork is not necessarily as far detached from biomedicine as one would first imagine. The core philosophy of

[9] I will elaborate on the homeopathic history of Britain in chapter 4.

homeopathy is based on medical principles quite the opposite of the biomedical ones.[10] This should, ideally, mean that viewed as two separate medical systems, it would seemingly be difficult for them to cooperate. This did not seem to be the case at RLHH, because the homeopathy practised there is, put simply, more biomedical in its approach. To such a degree, I will argue in this thesis, that it can be viewed almost as a form of *biomedical homeopathy*. This has implications both on how homeopathy is used at RLHH and how the hospital actually works, both in its own right and in relation to NHS and to the biomedical community. The homeopaths at RLHH are all trained doctors, which means that the homeopathy offered there in practice also draws on biomedical ideas.[11]

The third main reason is British class-structure and elitist thinking. The British Royal family, as well as the wealthy elite, have been keen advocates of homeopathy from its very introduction in the UK. The Queen is Patron of RLHH, the Clinical Director of RLHH is the Queen's homeopathic doctor, and Prince Charles is the founder of the Prince Charles' Foundation for Integrated Health. The Royal Family all the way back to Queen Victoria has been users and advocates of alternative medicine (especially homeopathy), a fact that could clearly be seen as important in the development of the British homeopathic tradition. Homeopathy was also, it should be noted, first introduced and spread itself among the elite, with the lay practitioners and public health care catching on only at a later stage. The homeopathic hospitals and dispensaries were also funded by them.

I will discuss and elaborate on all of the above at length in the thesis. What I want to show is that homeopathy and biomedicine are indeed two very different and theoretically almost mutually exclusive medical systems, but this – rather paradoxically – does not mean that they can not

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[10] See chapter 1.

[11] I will outline on consultations and the doctor's views on homeopathy in chapter 3

cooperate or work alongside each other. Quite on the contrary, from my fieldwork at RLHH I intend to show that the two systems even to some degree can become dependant of each other, with homeopathy – the system one would think is the most vulnerable in this context – still being able to carve out a niche for itself within a public health care founded on biomedical principles.[12]

Before I move on, I will first turn to the important question of terminology. I will then briefly provide an outline of medical anthropology. I will then outline on the methodology used, before finally outlining the thesis and its different chapters.

The question of terminology:

I will in the following spend some time on terminology, and I do this for two reasons. First, there are many different terms used in the often heated debate between alternative medicine and biomedicine. The terms are also, to complicate matters, used differently by different groups. Secondly, the term *biomedicine* is but one of many terms used both within the biomedical community as well as within the alternative medical one. To avoid confusion I therefore believe it is imperative to have the terminology in order before we can analyze the empirical material.

Biomedicine:

A glance through some of the works in the field of medical anthropology displays a huge diversity in terminology (see e.g. Sharma 1992:1-8). Biomedicine (or, rather, *biological medicine*) is but one of many terms used. Other terms include *western medicine* (which is not very "western" anymore anyway since it is practiced throughout the world), *allopathic medicine*, *conventional medicine*,

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[12] Saks argues that Britain has one of the most liberal politics in the world concerning alternative medicine, since non-medically trained therapists in general have been allowed to practice under the Common Law (Saks in Scambler et. al. 1998). See chapter 1 for statistics on practitioners and so on.

cosmopolitan medicine, *school medicine* (or "skolemedisin*" in Norwegian*), *orthodox medicine*, *modern medicine*, *evidence-based medicine* and *natural medicine* to name the perhaps most well-known.

A convincing argument could probably be given for choosing any of the above terms. My argument for using *biomedicine* is as follows: This thesis deals, in effect, with the differences between biomedicine and homeopathy. The biggest difference between the two is, as noted above, that while homeopathy treats patients with medicine that produces similar symptoms to those the patient manifested in the first place (what in homeopathy is termed "*like cures like*"), biomedicine is founded on the principle that disease is treated with medicine that are held to have the opposite effect (in other words "counter-like"). Viewed this way homeopathy and biomedicine are two genuinely alternative systems with "[...] *mutually incompatible views of the human body and the way in which it can be cured of illness*" (Sharma 1992:5). This does not mean that homeopathy is not biologically orientated in its treatment, but in biomedicine disease is, primarily, a *biological* phenomenon.[13] Homeopathy, on the other hand, puts a greater emphasis on the connection between the biological and psychological dimension of disease and illness. The term biomedicine is therefore, I believe, superior when comparing these two medical systems.

A note on the term "*orthodox medicine*": I find this term a bit tricky, because it to me connotes a certain moral value; i.e. that alternative medical systems like homeopathy and acupuncture are somewhat "unorthodox" and "unconventional" in relation to biomedicine, implying that biomedicine is the "correct" form of treatment and that the other systems are - from the biomedical point of view, this is - somewhat "wrong". That they are *unconventional* either in their

[13] One of the biggest critiques of modern biomedicine deals exactly with this problem: the biomedical lack of interest in more psychologically orientated ways of explaining disease (see e.g. Brown 1998). I will discuss this later in the thesis.

ways of treatment or their aetiologies[14] is probably a compliment to many alternative practitioners, especially the ones most eager to show that their form of medicine is exactly what the term implies: something *different* from biomedicine. It is difficult to imagine, however, that the many practitioners genuinely interesting in bridging the gap between biomedicine and alternative medicine finds this term fruitful (e.g. some believe that *their* medical system is as equally orthodox as biomedicine). I will for these reasons use the term biomedicine.

I will in this thesis refer to what I label the *biomedical community*. With this term I refer to doctors, researchers and public health care authorities employed in health care work which is founded on biomedical premises. Primarily I use the term to illustrate the interaction between biomedicine, NHS and the doctors, both the GP's and the doctors working at RLHH.

Alternative medicine:

Concerning alternative medicine, this thesis deals as noted primarily with homeopathy. However, when discussing alternative medicine in general, I will use the term *CAM* - short for *Complementary and Alternative Medicine*. CAM refers in this thesis to two things: a) alternative medicines used solely as a *substitute* for biomedicine, and b) as a *supplement to* biomedicine – i.e. people using biomedical and CAM treatment interchangeably. I use this term because most of the doctors at RLHH seemed to prefer this term over others. The term is also used both by the CAM research community and practitioners in Norway.

Finally, it is important to note that the terminology within this field is not static but rather dynamic and it changes over time, as the Norwegian Parliament's Report on Alternative Medicine (Alternativ medisin 1998) clearly shows. Both the CAM practitioners and the public prefer different terms, even within their own community. Some prefer alternative medicine with emphasis on *medicine* and some prefer emphasis on the *alternative* aspect. Furthermore, some

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[14] Aetiology: the different medical systems' explanations for the causes of sickness/illness/disease.

prefer alternative *treatment*, others *complementary medicine*, all depending, it seems, on each individual's own stance and degree of acceptance for either biomedicine and/or alternative medicine. The only distinction may be that in general, it seems that those in favour of alternative medicine prefer emphasis on *medicine* and the sceptics on *treatment* (ibid.:1998:25).

The biomedical community usually prefers terminology that emphasises the scientific and biological nature of biomedicine[15], while those in favour of the word *treatment* uses this to avoid connotations to the word *medicine,* implying different sorts of medication.

I will now move to a brief outline on medical anthropology; its history and theoretical framework.

Medical anthropology:

"(...) medical anthropology is simply the application of anthropological theories and methods to questions of health, illness, medicine, and healing. As such, it may be more correct to refer to a variety of medical anthropologies" [my emphasis] (Brown 1998: 10).

Medical anthropology is a relatively new subfield within anthropology, with the term "medical anthropology" first being introduced and used sometime in the 60's (Barnard/Spencer 2003:358). The British doctor and psychiatrist W.H.R. Rivers (1864-1922) is generally acknowledged as the first to study medicine in a cultural context, but his works did not establish medical anthropology as a subfield. Rivers argued that ""*primitive medicine" could be studied as a social institution employing the same principles and methods that are used to study other social and cultural phenomena"* (ibid.). Compared to the above quote by Brown, Rivers' argument can definitely be seen as ahead of his time.

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[15] The Norwegian Medical Association (*Den Norske Lægeforening)* decided in 1998 to use the term alternative *treatment* instead of *medicine*, on the grounds that they wanted exclusive rights to the term *medicine*.

Medical anthropology has changed much over the last few decades. In the 1960's and -70's the sub-field was concerned with producing ethnography of non-Western medical concepts and traditions. Today, the biggest difference, however, is that medical anthropology is more concerned not only with the medicine of indigenous, non-Western societies (what can be labelled *ethno-medicine*[16]) but also with the growing paradigm of modern biomedicine (ibid.). Biomedicine, some medical anthropologist argue, is just as socially constructed and historically situated as any other medical system (see below, see also Good 1994).

There has also been a rising interest in the *medical pluralism* mentioned above; the coexisting of different medical systems and traditions within different cultural contexts, as well as greater focus on *applied anthropology* in public health care and clinical medicine. This, in effect, also means that more anthropology has become concerned with taking a critical, and more subjective, stance on different issues of health (Singer in Brown 1998:226).

Finally, and most interesting regarding this thesis, is the growing anthropological interest in alternative types of therapies within Western industrial societies (as this thesis explores) – this perhaps due to the growing anthropological interest in the study of our own culture.

Today medical anthropology, it seems, has developed into a giant sub-discipline with studies ranging from applied work to topics of mainstream anthropology. This, Barnard/Spencer argues, means that medical anthropology has a massive diversity to it, but that, at the same time, "*the sub-discipline lacks the character of a truly coherent field*" (2003:361). Whether this is to be regarded as a disadvantage or not remains to be seen.

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[16] Biomedicine is also, note, an ethno-medical system similar to e.g. homeopathy or acupuncture (Brown 1998), even though it does not originate from one separate nation or culture.

Critical Medical Anthropology:

Brown argues that medical anthropology has "*witnessed a significant break from its disciplinary past*" (1998:15). Today, he argues, medical anthropology has been influenced by the growing interest in "critical theories" (postmodernism, Neo-Marxism etc.) which emphasises that society is socially constructed and can be used to conceal complex political, economic and social relationships (ibid.). From here what is called *critical medical anthropology* emerged. [17] It is not one coherent theory, but rather a collection of different theoretical viewpoints. Merrill Singer's definition may serve as a starting point:

"Critical medical anthropology can be defined as a theoretical and practical effort to understand and respond to issues and problems of health, illness, and treatment in terms of the interaction between the macro-level of political economy, the national level of political and class structure, the institutional level of the health care system [and] the micro-level of illness experience" (Singer, in Brown 1998:225).

Critical medical anthropology is concerned with at least three major recurring themes in medicine and health: First, it recognizes that health is a political issue; second, that power is an important variable in health research, policy and decision-making, and third – and this is its strongest critique of medical anthropology in general - medical anthropology has not been concerned with bridging the gap between the local (micro-) and the wider political-economic (macro-) context (ibid:226).

One of the critiques offered by critical medical anthropology is based on a debate on the nature of biomedicine. For many decades, some anthropologists claim, medical anthropology in general have assumed that biomedicine is an empirical science which is unbiased by its own cultural premises and exempt from cultural analysis (Brown 1998:16). If we regard, as noted above,

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[17] Critical medical anthropology is often abbreviated *CMA*, but to avoid any mix-up with CAM I will in this thesis use its full name.

biomedicine as just one of many different medical systems operating together (harmoniously or not) we do get, as critical medical anthropology claims, a clearer view on biomedicine. We also see clearer to what degree it exerts control and power over other medical systems, like for example homeopathy and acupuncture.

I will write this thesis with the critical medical anthropology in mind, in the sense that it is occupied with the important question of power and control in relation to issues of health and medical systems. Theoretically, however, I will only make use of Scheper-Hughes & Lock's (1987) theory of the three bodies from this sub-field. As I will argue later, critical medical anthropology is a somewhat neo-Marxist approach where the concept of hegemony is too narrowly defined, with too much emphasis on structure rather than on process, which I believe makes it difficult to grasp the *dynamics* of the interaction between the medical systems.

Anthropology and history:

As will become clear both in the thesis in general and in the methodology section below, I will base some of my argumentation on the historic development of homeopathy and biomedicine in Britain to understand how RLHH currently works and exists. I will make use of this historic element for two reasons. First, because it is an important part of critical medical anthropology in its pursuit to understand how issues of health changes over time. Second, I believe it helps us to explain both how RLHH, homeopathy and biomedicine has developed over time and how they today are intertwined as a consequence of their respective historic developments.[18] Especially, I will make use of Foucault's (2000) theory of British medicine as *labour force medicine* to show how British medicine is a distinct form of medicine compared to e.g. German or French medicine.

[18] For a discussion of medical anthropology, biomedicine and historical contextualisation, see Sargent and Johnson (1996).

Applied anthropology?

This thesis is not written on behalf of any health organization or policy agency or otherwise, as much of (critical) medical anthropology is (see Brown 1998). In the strictest sense of the word, then, this is not applied anthropology. However, even though I have only once tried a homeopathic remedy myself (but no homeopathic treatment), as well as being sceptical to many of its alleged medical effects, I want to make it clear from the very beginning that my aim with this thesis is to explore the possibility of a form of CAM in Norway like the one I have seen in Britain. Critical medical anthropology is, in a way, founded on the premise that "*no anthropologists can escape involvement*" (Singer, in Brown 1998:235) and, as noted above, it is - or at least *can* be - political. This means, as Singer argues (ibid; 226), that critical medical anthropology aims not only at understanding, but also at changing.

Primarily, my own intention with this thesis is aimed at understanding, not changing anything in itself. I do believe, however, that the hegemony and power biomedicine holds over CAM in general not only limits CAM and its way of working and explaining illness. It also limits the public in accessing different forms of medicine that could benefit them. Hopefully the ethnographic example I use in this thesis from RLHH in the UK will answer some of the questions posed above; not only how, and to what degree the hospital itself works, but also why this is not so in Norway.

Methodology:

I will in this paragraph outline on the methodology used for my fieldwork. As noted above, I learned in the beginning of 2004 of five homeopathic hospitals in United Kingdom, with RLHH being the biggest and oldest of these. I contacted NAFKAM (the Norwegian Institute for research on alternative and complementary medicine) in Tromsø. They told me that they had visited the hospital in 2003, and suggested that it would be an appropriate place for my fieldwork. I contacted the hospital's Deputy Director of Research, Dr. Robbert van Haselen, and described

my project, my interest in the hospital and the possibility of me doing my fieldwork there.

It is to the hospital's credit that they on principle approved of this immediately, but from there on things became trickier. Since RLHH is part of the UCLH (*University College London Hospitals*) I was asked to fill out two standard applications, the same as for all research conducted at any UCLH Hospital. One was for the formal registration of my project, and the other for the ethical part of the research (over 50 pages to fill in). The project then needed to be approved by a UCLH Committee, who only met a specific number of times every year. The forms were handed in mid-February 2004.

As it turned out, the Committee did not initially approve of my project, and via RLHH I was informed that the forms needed more work in order to be approved. I later talked to the hospital's Clinical Governance Manager (the link between the Committee and RLHH, and also my key informant for much of the fieldwork), who said that the Committee at first seemed unsure about the qualitative aspect of the project. I re-filled the forms, and they were approved in June 2004. Hence, the project was delayed almost five months. Fieldwork was conducted between July and September 2004.

Concerning methodology I was initially a bit unsure as to how I was going to conduct the fieldwork. RLHH is a hospital, and as an institution it is in most respects clearly spatially and physically defined. In that sense the job of narrowing and defining the place of fieldwork was very easy. I was, however, unsure if the technique of participant-observation (for a discussion, see e.g. Pelto & Pelto 1978, or Wadel 1991) would be possible. I am neither a trained doctor nor a homeopath, and participating in the daily activities of the hospital (treatment, consultations) would be more difficult than in more "classical" types of fieldwork. The emphasis has therefore been on observation, interviews with the staff/doctors, and informal talks.

Barnard and Spencer (2003:366) argues that a researcher's methodological approach is influenced by his/hers vision of the goals or the objective of (social) anthropology in itself. They make a

distinction between two types of objectives, the "humanistic" and the "scientific", with the humanistic goal being the understanding of people's (social) lives (i.e. Geertz (1973) and "thick description"), while the scientific is more concerned with descriptive generalizations and explanatory laws about the way society and culture works (Barnard & Spencer 2003:366). Methodologically, the difference between the two could be summarized as follows: the "humanistic" methodology is concerned with empathy, participation in and observation of everyday life, collecting conversation and life-stories, interviews and so on. The "scientific" methodology, on the other hand, favours general surveys, observations of behaviour patterns, structured interviews etc (ibid.:366). These two categories are not, of course, mutually exclusive, and for my own fieldwork the initial thought was that I would be studying not only the people working at RLHH (the staff and doctors), but also RLHH as an *institution*, which means that both methodologies were needed. Methodologically I have, perhaps, opted for a more "scientific" approach. This became clear very early, since I realised that RLHH in no way is an "island to itself" – i.e. I could not study the hospital without seeing it as part of a wider context.

Furthermore, in terms of budgets, treatments and so on, RLHH is under constant influence from NHS; in other words my focus needed to be on the *interaction* between the hospital, NHS, the biomedical community and the CAM community (mainly homeopathy). Methodologically, this meant that I needed to alternate focus between observation in the classical sense of the word (who worked at RLHH, who did what and where, who made the decisions) and, simultaneously, focus on the historical element of the development of the hospital, NHS and British homeopathy and how they are intertwined. This necessitated the collection of historical data, archival documents and so forth.

My main sources of data have therefore been observation, informal talks and structured interviews with the staff and the doctors. I attended group clinics and a few staff meetings, and for two weeks I sat in on doctor-patient consultations. I did this primarily to get a sense of "participation" and of understanding how the doctors worked and how they treated (also in the

literate sense of the word) the patients. I also wanted to understand a bit about how homeopaths worked, and finally how the doctors used their combined training in biomedicine and homeopathy (and, for some, acupuncture) in practice.

Besides this I have studied the history of RLHH, NHS and British homeopathy while on fieldwork and interviewed (structured/unstructured) the staff/doctors to get their opinion on these subjects. Also, I have studied the hospital's own qualitative and quantitative research, ranging from the effectiveness of their treatments to patient satisfactory surveys.

Concerning the length of the fieldwork Wikan, (lecture, autumn 2003) argued that anywhere between 4 and 6 months would suffice, especially with fieldwork being conducted in one's own culture (or at least culture's quite similar to one's own). I was given a deadline by the Committee to terminate the project by September 27. 2004, and I did not re-apply, as I felt that I had collected the data I needed.

RLHH's Clinical Director Peter Fisher formally became my *Principle Investigator,* but van Haselen became my initial key informant. However, he resigned from his position at the hospital a few weeks into my fieldwork, and for the rest of my project the hospital's Clinical Governance Officer became my key informant. Much of the data collected at the hospital in terms of informal talks about the daily workings of the hospital and its relation to NHS were given to me by her.

I was well received at the hospital, and both the staff and the doctors were virtually without exception kind, polite and interested in my project. The only exception was one doctor who did not want me to sit in on his consultations.[19] My role at the hospital was very clear-cut, and I was

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[19] Attending these consultations took quite a lot of preparation, as the clerk at the reception desk had to ask every new patient to read through a sheet with a summary of my project I was asked to prepare. After this they had to sign two copies of a letter of consent where I would be allowed to attend the consultation – one for me and one for the patient.

given an ID-card to wear at all times. In the beginning both staff and doctors were curious about what I was actually doing there, in the sense that no anthropologist had been doing this sort of research there before, but they understood when I told them that my role was to be a sort of "fly on the wall".

Regarding my empirical findings, I do not feel in retrospect that there were things left out for me by the hospital staff and doctors. The exception, perhaps understandably, was when touching upon the subject of the funding of the hospital, as some of the doctors and staff I interviewed briefly mentioned in the interviews. As will be clear later, RLHH have several times over the years been under threat of being closed down, and when I asked questions about this it was by some only vaguely hinted at.

However, most of the doctors at the hospital were very busy and they did not, understandably, have the time to sit down and be interviewed by me as much as I would ideally have liked. With a few exceptions I had to interview the doctor's in-between patients at consultations or in the rare cases when patients did not show up for their appointments. Also, I did not study the decision-making process of the hospital (who made the administrative decisions, who allowed what to be done and how etc.). As I will make clear in the concluding chapter concerning the limitations to my fieldwork, a closer study of these two elements of the hospital would, I believe, have benefited the thesis greatly.

Fieldwork in one's own culture:

Conduction fieldwork in a culture not very different from one's own is, one can argue, both a blessing and a curse. Wadel argues that, in theory at least, it should be easier to conduct fieldwork in your own culture due to lack of language barriers, practical and logistical reasons etc. Yet at the same time the obvious danger is to take elements of that culture for granted (Wadel 1991:18-21). His own suggestion is, first, to look at the study of a given culture as the study of a *part of* that culture (sub-culture), and second, to be curious and constantly confront the things in other sub-cultures that separates them from one's own (ibid.). This is, I believe, for my own fieldwork at

least, a good way of avoiding the trap of taking cultural elements for granted.

It is also important to note that this fieldwork was conducted in a place – a hospital – that to most people, I would argue, is a place that seems both very familiar and at the same time exotic. Most of us have been to one in our lifetime, yet at the same time very few know anything about the daily routines, the activities and the administration of a hospital. In this sense, a hospital can be regarded as both something strange and familiar at the same time. Since RLHH is a homeopathic hospital as well as a hospital under NHS administration it certainly felt very exotic to me both during my fieldwork.

A final note: when I quote people at the hospital I will use the terms "doctor" or "staff". Answers given to me in interviews/informal talks with doctors refers to the doctors working at RLHH. A member of staff refers to any one employed at RLHH who is not a doctor, primarily this is the staff employed at the Academic Unit of the hospital, where I spent most of my time. If someone else besides this is quoted, this will be specified.

Outline of the thesis:

Chapter 1 focuses on the ethnographic context of CAM in the UK (and briefly in Norway). Who uses it; what is being used, why people use it, as well as how the biomedical community views CAM. I will also in this chapter outline on the history of the British public health service (NHS) and how it is currently working and administrated.

Chapter 2 focuses on RLHH itself: its physical surroundings, how it is administrated and so forth. I will also elaborate on the Academic Unit of RLHH where I spent most of my time during fieldwork, as well as showing what types of CAM treatments are being used at RLHH. Finally I will outline on the doctors and the patients.

Chapter3 focuses on the patient, the doctor and the consultations at RLHH. I will describe what homeopathy is, as well as a "typical" consultation. I will then outline on some of the views of the doctors at RLHH I interviewed. Finally I will discuss RLHH and its way of working with

reference to Eisenberg's illness/disease-distinction.

Chapter 4 focuses on the homeopathic and biomedical history in Britain. Here I will show how the two medical systems have developed both on their own as well as in relation to each other. I will also, following Foucault, show how the biomedicine developed in Britain is different from biomedicine in e.g. Germany and France. I will here also look at the Royal Family and aristocratic influence on RLHH.

Chapter 5 focuses on how homeopathy is being practiced at RLHH as well as how it is organized in the UK. I will here also focus on the two homeopathic organizations in the UK and show how this has shaped homeopathy and RLHH both present and historically.

Chapter 6 focuses on biomedicine – in its own right and in relation to RLHH; what are its main features. Also, following Scheper-Hughes & Lock's theory on the three bodies, what means does biomedicine have to hold the alleged power and hegemony over CAM. I will also look at how RLHH works within NHS. I will here make use of Barth's theory of different systems of knowledge and discuss hegemony in relation to Gramsci's definition of the term, where hegemony is viewed as a dynamic rather than a static process.

Conclusions. Concluding remarks, limitations to the fieldwork conducted/topics for further research, as well as a brief discussion of the future of CAM in the UK and Norway.

Chapter 1: Ethnographic context. NHS and complementary medicine in the UK:

I will in this chapter outline the ethnographical context of this thesis. I will describe CAM and its current position in the United Kingdom (and, for the sake of comparison, briefly in Norway) - what is being offered, where and to whom. I will then look at the NHS; a brief outline of its history, and how it is currently working. Then I will look at what and to what degree CAM is offered within NHS. Finally, I will look at how RLHH became part of NHS.

CAM in Norway:

As noted in the introduction, the use of and interest – both private and public – in CAM has been steadily rising throughout most of the Western world for many years. This is also the case in Norway. In 1997, at the request of the Norwegian Parliament, the Department of Health commissioned a report to account for the status of alternative medicine in Norway today. The report written by the Committee was published in 1998 (Alternativ medisin 1998).

The Report's own survey from 1997 shows that 33% of the Norwegian population had at least once in their life used some form of CAM. This number has been steadily rising since 1977, where a survey concluded the percentage to be 19%. The Report also shows that people's attitude towards CAM were positive: 75% of those who had never used it said they were positive towards using it at some point in the future (1998; chapter 7).

There have traditionally been a difference in gender (more women than men) and socio-economic factors like where one is born, place of residence, income etc. These differences do not seem as evident today. The only constant factor seems to be age, with older people being more sceptical than younger or middle-aged people (ibid.).

The reasons why people try CAM seems to be two-fold: the first is that people simply want to try something new when biomedicine is unable to do something with their illness (this is especially

the case with cancer, as well as chronic diseases), and the second is some form of dissatisfaction with what the public health care offers them as patients (either because of the doctor or the treatment in itself or both) (ibid., chapter 7).

Concerning the usage of the different forms of alternative medicine, homeopathy and acupuncture is by far the most widely used (ibid.:1998, pp. 95-96). In past years, people using CAM have consulted a doctor for biomedical treatment first. Today there is, simultaneously, a trend where people consult CAM first and a doctor second, or in some cases not consulting a doctor at all.

The doctors and CAM knowledge:

When asked about their homeopathic knowledge, 95, 9% of the doctors in a Norwegian survey said their knowledge was "average" or "bad" (as opposed to 3,5% stating their knowledge was "good") (Aasland et. al. 1997). 75% of the doctors said that they did not agree at all when asked whether homeopathy should be part of public health care. I will return to this lack of knowledge about CAM with the doctors and the implications this may have,[20] but it is interesting to note the conclusions the survey draws: this lack of knowledge may lead to a categorical denial of CAM, as well as the doctors being unable to give advice to patients when they ask about it (ibid 1997:2467).

CAM and public health care:

The NOU-Report is at time of writing almost 10 years old, but little has changed regarding CAM and what is being offered in public health care in Norway. Most of the CAM treatments are only offered by private practitioners. In public health care, however, some of the major hospitals,[21] of

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[20] This lack of knowledge has also been found with British doctors (Aasland et.al.1997:2467)

[21] *Aker* and *Ullevål sykehus* in Oslo, *Regionsykehuset* in Trondheim, *Haukeland sykehus* in Bergen, amongst others.

which some are University Hospitals, have hired acupunctural practitioners on a part-time basis, especially at birth- and pain-clinics. Some of these are nurses who are trained in acupuncture. Investigation by the NOU-Committee found almost no use of homeopathy at these hospitals, as well as few other ways of alternative treatment. This is not surprising, since the doctors in general are more positive towards acupuncture than homeopathy (Alternativ medisin 1998).

I will later in the thesis discuss the reasons for the biomedical scepticism towards homeopathy from a British point of view, and this is also consistent with the view taken by the Norwegian biomedical community (doctors, researchers, policy makers etc.). I will now turn to CAM in the UK.

CAM in the United Kingdom:

The British equivalent to the NOU Report is the report from the *House of Lords Select Committee on Science and Technology* (abbreviated throughout as HoLR[22]) on CAM published in 2000. It estimates there to be about 50,000 CAM practitioners in the United Kingdom as well as approximately 10,000 statutory registered health professionals who practise some form of CAM.

Approximately 5 million people had consulted a CAM practitioner in 1998 (HoLR 2000).The Report also shows that in the United Kingdom in 1999 20% of the population had used some form of CAM in the past twelve months. This number, it is suggested, has been rising for quite some time. The Report is cautious in being too categorical, though, especially since there has been no surveys conducted on people using self-medication (over-the-counter drugs such as vitamins which also, broadly defined, can be described as alternative medicine).

As is the case in Norway, there are many different reasons why people use CAM. The House of Lords Report states reasons that does not seem to be as clear as the conclusions of the NOU

[22] Version of report used in this thesis is available on the Web, see bibliography.

Report. In Norway, as noted above, the primary reasons seems to be a dissatisfaction either with the doctor or with the biomedical treatment, but the HoLR also says something quite different: "*Some evidence we have received has suggested reasons for CAM use that are neither to do with patient satisfaction with CAM, nor dissatisfaction with conventional medicine*" (HoLR 2000). The reasons given here have more to do, the Report argues, with a more "philosophical" approach to the use of CAM. These ranges from a renewed interest in the paranormal, a flight from the scientific basis of biomedicine and from science in general, to one doctor interviewed by the Committee arguing that CAM today was simply something fashionable (ibid.:2000).

There seems to be some truth to this: only 7% of the respondents in a BBC survey on CAM answered that they used CAM because they couldn't get treatment on the NHS or under conventional care.

On the other hand, the NOU Report outlines findings from a British survey[23] suggesting that 4 out of 5 people in the United Kingdom who used homeopathy were doing so because they were unhappy with the "*established*" medicine and what it had to offer (I take it here that NOU is referring to biomedicine/public health care) (Alternativ medisin 1998:96). Another important point HoLR makes, is that people's satisfaction with CAM must to some extent account for its popularity, i.e. why do people use it and spend money on something that supposedly does not work for them?

A survey comparing satisfaction levels for CAM with conventional care suggests that the patients, in this case with arthritis, felt that many CAM therapists were friendlier, that they spent more time with the patient and were more forthcoming with information on the treatment and the sickness than in conventional care (HoLR 2000). Yet another survey concludes that people tried

[23] No reference to this survey given in Alternativ medisin 1998.

CAM treatment due to lack of effective biomedical treatment and the risk of potential side-effects (Sharples, F. et al, 2003).

Sharma (1992:55) argues that the reasons why people use CAM can be divided in two categories: ideological and practical. She argues that there is no hard evidence for the claim that people using CAM have lost all faith in conventional care. Quite on the contrary, the trend both in Norway and Britain seems to be that people with ease alternate between several medical systems, taking the advantage of the best from both worlds.

I will now turn to the British public health service (NHS). I will briefly outline it historically, how it is currently administrated, and finally show CAM's place in public health care.

National Health Service (NHS):

History:

The NHS (*National Health Service*) was founded in 1948.[24] Today it is one of the biggest as well as leading health organizations in Europe, with an estimated budget of approx. £42 billion. The socialist movement had long argued that medical treatment should be free (paid for by taxation). In the beginning the idea was to create a service that would primarily work on the eradication of illness and disease, and then later to become "*a national* health *service, with prevention of sickness as its primary function*" (Inglis in Saks 1992:125).

The basic principles behind NHS are in most respects similar to the Norwegian public health care system, which is also one of the reasons why the comparison between the two are so relevant. All British citizens are, like the Norwegian, entitled to their own local doctor (called *GP* - General

[24] This paragraph is an abstract of a historical overview at www.nhs.uk, no writer credited. See also Inglis in Saks 1992.

Practitioner).[25] The biggest difference between the to public health services is probably that in the UK all consultations are, in principle, free of charge (including surgery and treatment in hospitals), whereas in Norway the patients can obtain treatment from their GP (which is a private doctor; the patient must pay for the services) or from a communal casualty clinic (for a small fee, cheaper than the GP). The GP has the medical and clinical responsibility of the patient while in the doctor's care.

The biggest difference prior to the creation of the NHS and now is that before poor people could not afford treatment, and instead many of them went to dubious doctors and quacks. Access to a doctor was free to workers - who were on lower pay - but this didn't necessarily cover their wives or children. The hospitals, on the other hand, charged for services. The need for free health care was widely recognized, but it was impossible to achieve without the support or resources of the state.

In the beginning the Government did not know how NHS should be run properly or how to finance it. Soon it became evident that all consultations and treatments could not be given free of charge, as was first intended. Legislation by recent governments has introduced a system of partial payments for drugs obtained by prescriptions.

NHS established *Family doctors* (or GP's) and *Community health centres* (were different practitioners could work together in the same place, for example doctors and dentists). The majority of the GP's today work exclusively in public health care, but some of them also maintain private practices. A very important factor – that I will return to – is that the GP functions as the *gatekeeper* to the NHS and its different specialized medical treatments. Patients have no right to be referred to specialists – this is a matter of judgement of the GP - and since specialists are not

[25] In Norwegian called "*fastlege*".

allowed to advertise, even self-referral to private consultants can be difficult if a GP disapproves of this (Giddens 1997:129).

Organization:

The United Kingdom is divided into 10 *Strategic Health Authorities* (SHA), which are the key link between the Department of Health and the NHS. Each of these are composed of local government nominees, members of the medical profession and lay people (interest group etc.).

Within each SHA, the NHS is split up into various types of *Trusts* that take responsibility for running the different NHS services on a local level. The different Trusts are:

Acute Trusts (e.g. hospitals). These Trusts employ most of the NHS workforce, including nurses, doctors, dentists etc. There is also many non-medical staff). Besides this there are *Ambulance Trusts*, *Care Trusts* and *Mental Health Trusts*. and *Primary Care Trusts*.

In Britain there is a difference between *Primary Care* and *Secondary Care*. Primary Care is the practitioners the patients meet when they seek treatment. Secondary Care is the NHS hospitals – the place the patients are being referred to if there is need for acute treatment, or if Primary Care can't treat the patient.

After a report on the NHS was produced by the Conservative government in 1989, the stress was put on competition and efficiency within NHS, with emphasis on local government and the option of the hospital to become self-governing trusts, which meant that the hospitals were encouraged to be autonomous in their funding (Giddens 1997). The first NHS Trusts were founded in 1991; the UCLH NHS Trusts were founded in 1994. RLHH joined in 2002.

Over the years an enormous amount of money has been spent on constantly trying to improve the NHS, and it has not been an easy enterprise. The election of the new Labour Government in 1997, however, brought about a new approach. Since then there has been a series of initiatives, both financial and organizational as well as changes in policy to try to modernize the NHS for the

new century, but little research exists that can point to any results (ibid.:1997).

The NHS and CAM:

The doctor's opinions in many European countries today is that they believe that if there are CAM treatments that have any proven effect they should be practiced, but by *medically trained personnel* (Alternativ medisin 1998:133). Concerning CAM and what is being offered in public health care in the UK, the majority of CAM is, just as in Norway, being practised in the private sector. HoLR identified about 80 cases (except for the 5 homeopathic hospitals) of integration both with primary and hospital services (HoLR 2000). The patient access to these services depends to a large degree on the attitude of their particular *Primary Care Trust*, and the British Foundation of Integrated Medicine describes this access as "*patchy*" (ibid.).

The year after the foundation of the NHS in 1948, the Minister of Health gave an absolute guarantee that homeopathy would continue within the NHS if this was a public demand. Some of the reason for this seems to be pressure from The Faculty of Homeopathy and the British Homeopathic Association (Sharma 1992:183).[26]

The Government has not been willing to restrict peoples choice of treatment – e.g. whether they prefer the public or private practitioners – and alternative medicine has always, as noted above, had its friends among the elite and aristocracy who have used and promoted it. However, when different alternative groups have tried to obtain registration, they have encountered the one problem more heatedly debated than any between the alternative and conventionalist side of medicine; that the different forms of CAM will get this registration when - and only when - they can prove their medicine's scientific efficacy. Or, in other words, when homeopathy is, as Sharma writes, "(...) *on terms which the orthodox medical profession approves and understands*" (Sharma 1992:98). I will discuss this in chapter 5.

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[26] I will elaborate on this and the homeopathic organizations in chapter 5.

HoLR argues that its investigation into CAM and NHS has showed that NHS is more inclined to move towards an integrated form of medicine where CAM is more easily accessible within public health care, and this is already to some extent happening today. As I will argue in this thesis, this is positive for RLHH.

Summary:

I have in this chapter outlined the ethnographical context of CAM in the United Kingdom as well as in Norway – who uses it, what and why it is being used, as well as the doctors' and the biomedical community's view on CAM in general. We have also seen that the doctor's knowledge of CAM in their own view is limited, which partly can explain why not more CAM is offered in public health care.

Furthermore, I have outlined on the history of NHS, as well as how it currently is administrated. Finally, I have shown to what degree CAM is being offered within NHS. Homeopathy was, interestingly enough, incorporated in NHS from the very beginning, perhaps, amongst other things, due to pressure from the Faculty of Homeopathy (of which more later). I will later in the thesis show how the homeopathic organizations have shaped homeopathy in Britain as well as at RLHH.

In the next chapter I will turn to the Royal London Homeopathic Hospital itself and describe how it is administrated and outline on the staff and doctors working there

Chapter 2: The Royal London Homeopathic Hospital

I will in this chapter outline on the Royal London Homeopathic Hospital - its physical surroundings, its administration and how the hospital is organized. I will then describe the Academic Unit of RLHH where I spent most of my time during fieldwork, as well as the doctors and the patients.

Physical surroundings:

RLHH is not a hospital in the biomedical sense of the word, but is nonetheless referred to as one both by RLHH itself and NHS. At the time of fieldwork the hospital had moved out of its original location in Great Ormond street in Central London[27] to a temporary site in Greenwell street. This site is situated next to Regents Park and Great Portland street, about 10 minutes walk from Oxford street. RLHH moved back to Great Ormond street in the spring of 2005, when the hospital had been undergoing a £20 million refurbishment. The following description is thus based on the hospital's temporary site in Greenwell street.

The hospital is a relatively small two-storey building with two entrances, both of them on the ground floor: the main entrance, and a second entrance on the back of the building which is accessed primarily by the staff and doctors.

The ground floor consists of the reception area, the hospital's own pharmacy (see below) and some of the consultation rooms. Also, a separate wing of the floor consists of offices for much of the administrative posts: finance, medical records clerks, housekeeping, clerks/receptionists, medical secretaries, superintendents and so on.

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[27] This is the original site of the hospital, from 1845.

The first floor houses another reception area for patients, more consultation rooms, staff offices, as well as the Academic Unit (see below).

The consultation rooms (about 15 in total) did not differ greatly in size. The rooms were sparsely furnished, with only a desk for the doctors, and usually one or two chairs, for the patient. A few of the biggest rooms also had a bench for patients undergoing acupunctural treatment. The rooms were reserved for one specific doctor each day (length depending of number of patients). Apart from pictures/paintings/posters on the wall, plants, a few books on a shelf etc., the rooms rarely had any personal touches to them since they were divided and used by many doctors each week. Also, homeopaths do not use the same amount of medical equipment as biomedical doctors, hence there were not much medical equipment in the rooms. In that sense, not much would remind you of a "typical" doctoral consultation room.

The hospital was at time of fieldwork open daytime Monday to Friday, with little or no activity in the weekends, apart from homeopathic coursing.

Pharmacy:

The hospital has its own retail pharmacy. Here the homeopathic remedies for the patients are made. To my understanding, all remedies prescribed by the doctors at consultations could be purchased there. The pharmacy is open to the general public as well, but it only sells acute medicine to the public, not chronic.[28] The pharmacy can recommend a GP for a referral if necessary. The average price of homeopathic remedies I was told were approx. £5 per consultation. All homeopathic remedies are free for people on benefit, children under 16 and people over 60 years.

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[28] I even bought some flu medicine there myself. Some members of staff said they bought remedies there on a regular basis.

Several people are employed there, including superintendents, a Principle Pharmacist, Managers and Pharmacy Technicians. All the pharmacists were at time of fieldwork undergoing training to become homeopaths.

Administration:

RLHH has, since 2002, become one of eight University hospitals in London (UCLH – *University College London Hospitals*). These hospitals conduct research in co-operation with the University, which is similar to what is being done at for example *Aker* and *Ullevål* hospitals in Norway.[29]

The other seven University Hospitals are: 1) *UCH – University College London*: accident, emergency and medical services both for local people and visitors to London; 2) *Middelsex Hospital* - medical, surgical and paediatric services; 3) *Hospital for Tropical Diseases* (which is also National centre for diagnosis and treatment of tropical diseases); 4) *National Hospital for Neurology and Neurosurgery* - centre for diagnosis, treatment and care of patients with MS, epilepsy, Alzheimer's, strokes, head injuries etc.; 5) *Elizabeth Garret Anderson & Obstetric Hospital* - gynaecology and maternity services; 6) *Eastman Dental Hospital* - dental advice/treatment, and 7) *The Heart Hospital* - cardiac services.

At the time of fieldwork over a hundred people were employed at RLHH. It was administrated as follows: Professor David Fish is "*Medical Director – Specialist Hospital UCLH*". He is the link between the RLHH and UCLH. He does not hold office at RLHH, and I did not see him there during my fieldwork. Under him is a *General Manager* (the overall manager of RLHH, finances etc.). There is also a *Clinical Director of Research* as well as a *Clinical Director*; Dr. Peter Fisher.

The hospital also has a *Service Development & Marketing Manager*, a *Patient Services Manager* and a *Nurse Manager*, all of which are situated and have offices in the Academic Unit part of the hospital.

[29] In Norwegian called *Universitetssykehus*.

Academic Unit:

RLHH has its own Academic Unit which is conducting research, educating homeopathic doctors as well as overseeing audit (overseeing the safety of the patients at RLHH). The Academic Unit was established in 1995. It has a *Director of Education* and a *Deputy Director of Education*. Furthermore, The Unit consists of an *Academic Unit Manager* (manages educational courses, background checks, conferences, funding for research etc.), an *Academic Administrator* (the Academic Unit Managers assistant) as well as a *Clinical Governance Manager* (in charge of the audit and safety of health). Some of them had separate offices and other shared offices. Personally, I divided my time between three different offices during fieldwork.

The main purpose of the Academic Unit is to produce research evidence for its treatments as well as to evaluate its services. This research, both quantitative and qualitative, is published either externally (in medical journals like *Lancet* or *Homeopath*) or by the hospital itself. Amongst other things, a summary of much of their research, both on efficacy, safety and cost-effectiveness, is published in a portfolio called "*The Evidence Base of Complementary Medicine*" (in collaboration with RCCM – Research Council for Complementary Medicine). The second edition of this portfolio was published in 1999.[30]

I will elaborate further on the research conducted at the hospital in chapter 6, since the way it is conducted is of relevance in the analysis of the hospital and its relationship with biomedicine/NHS.

Several different courses and demonstrations of CAM therapies were regularly held at the hospital/Academic Unit. At these demonstrations the staff and the doctors could attend to learn about different new forms of complementary treatments and so on. As an example, out of curiosity, I attended one of these meetings. A therapy developed in America by psychologist

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[30] See bibliography.

Roger Callahan called TFT (*Thought Field Therapy*) was introduced to the staff/doctors by a British TFT Trainer named Robin Ellis. I volunteered as a guinea pig to try to cure my life-long arachnophobia. It actually seems to have helped somewhat, too.[31]

Treatments offered:

RLHH offers several forms of CAM. Homeopathy, obviously, is the main type, alongside acupuncture, autogenic training,[32] nutritional medicine, physiotherapy, aromatherapy etc. These were used either separately or combined at the doctor's discretion.

Usually, the doctors did not treat patients with conventional biomedical medicine, but they were allowed to, and sometimes did, prescribe antibiotics and other biomedical remedies. This varied from doctor to doctor.

The doctors:

At time of fieldwork, some 25 doctors worked at RLHH.[33] With a few exceptions most of these worked only part-time. All of the doctors were, surprisingly to me at first, initially bio-medically

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[31] This therapy has been introduced on a few talk-shows on TV both in Britain and Norway in past years. It is used for the treatment of phobias, anxiety, chronic pain and many other things. The therapy is centred around using the fingers to tap certain points on the upper body and head, addressing the body's Meridian System. The therapy itself lasts only a few minutes and can be repeated by the "patient" later, without a trainer present. Callahan himself claims the success-rate to be over 98% independent of condition (brochures/leaflets given at the demonstration).

[32] A way of treating chronic fatigue patients.

[33] I will in the following use the term *doctor*, even though this a *homeopathic* hospital and they are not doctors as such. I use the term for two reasons: they are all biomedically *trained* as doctors, and the hospital itself referred to them as doctors in papers, research material, when speaking to patients etc.

trained. This is not, it should be noted, a prerequisite in order for them to work at RLHH, but as will be clearer later in the thesis; in practice it seems to be of importance anyway.

In addition, the doctors had supplementary training in homeopathy and/or other forms of alternative medicine (primarily acupuncture), either from the medical homeopathic courses at RLHH itself (of which more later) or other schools in the UK or abroad, depending on the nationality of the doctor.

The doctors were of many different nationalities: English, Dutch, German and Indian. They were almost equally divided between the sexes.

The doctors were divided in four different *Clinical teams*: A, B, C and D, with each team having one of the doctors as a Team Leader. *Team A* specialized in the treatment of allergy and environmental medicine; *Team B* musculoskeletal and skin diseases; *Team C* cancer, as well as running the women's clinics and autogenic training, and *Team D* children. The teams met quarterly to discuss treatments, patients etc.

I was told that the clinical teams were mostly for the *doctors* rather than for administrational purposes, as a way of organizing and knowing how to alternate between the groups when there were patients with multiple illnesses and so forth.

Concerning the doctors as *colleagues*, I did not ask specifically about this. In a public (biomedical) hospital most of the doctors, at least if they have worked together for some time, are entwined in a different way than at RLHH because they see each other more, perhaps eat lunch together and so forth. At RLHH most of the doctors worked, as noted, part-time, and because of their lack of time I got the impression that they rarely did see each other or talk much to each other except when in meetings etc.

In-patients and Out-patients:

In the UK there is a difference between what is called *Out-patients* and *In-patients.* Out-patients are

patients who are treated instantly, on the day of their appointment. In-patients are patients in need of longer treatment, who needs to spend time at the hospital for this treatment (for example surgery). There are mostly out-patients at RLHH today (even though they have a small in-patient facility outside the hospital): historically there have also been in-patients at the hospital.

All services at RLHH are consultant-led, and all clinical staff is registered health professionals. Treatment is on standard NHS terms, i.e. the consultations are free of charge (except for any homeopathic remedies needed, on average £5 per visit).

In order for patients to obtain an appointment at RLHH they need to be referred by their GP (General Practitioner), of which more later.

Who are the patients?

Concerning the patients and who they were - their age, sex, nationality and background and so forth, I did not get any specific impression of this.[34] I did, however, spend much time walking in the hallways between offices during my fieldwork. This included the two reception areas for the patients. Furthermore, I attended the consultations. From this I got the impression that in *general*, the patients who came to RLHH seemed to be from all walks of life regarding class, age nationality and so on. Historically, homeopathy was once referred to as a "rich man's therapy" (see chapter 4 for the homeopathic history), but this was at a time when patients had to pay for homeopathic treatment. Today this is not the case, with the lay practitioners and the general public using homeopathy too, not just the elite. Statistically, Sharma (Sharma 1992, pp. 18-24) has shown that in Britain, concerning usage of homeopathy, there are relatively more female than

[34] cf. HoLR 2000 and chapter 1 on the users of CAM.

men, relatively more people in the age of 35-60 than other groups, as well as relatively more people from higher and middle socio-economic groups than others. [35]

RLHH is a public hospital where the patients are being referred by their GP, and it that sense there may be discrepancies between the patients at RLHH (who get the treatment for free) and the patients seeking private homeopathic treatment (who have to pay for it).

Summary:

I have in this chapter described RLHH and its physical surroundings. I have shown how the hospital is administrated, both in terms of staff and doctors. I have also outlined on who the patients at RLHH are. In the next chapter I will elaborate on the above by describing a "typical" consultation at RLHH. I will also present empirical data from interviews with some of the doctors. I will then, using Eisenberg's (1977) distinction between *illness* and *disease*, discuss RLHH's way of working concerning the patient and treatment, as well as the patient's views on homeopathic treatment.

[35] Note that Sharma's book is from 1992, and parts of it may be outdated.

Chapter 3: Illness/disease – the patient at RLHH:

In this chapter I will focus on the patient and the doctor at RLHH. I will first describe a "typical" consultation at RLHH regarding use of time, treatments used, physical contact, conversations between the doctor and patient and so on. I will then present empirical data from the interviews I conducted with some of the doctors at RLHH. Finally I will, using Eisenberg's distinction between illness and disease, discuss in what ways RLHH could be viewed as unique in their way of treating the patients.[36] First, though, to understand how homeopathy is offered at RLHH, we must look at what it actually is.

What is homeopathy?

The term homeopathy is derived from the Greek words *homoeo* (meaning similar) and *pathos* (meaning suffering). [37] It is a system of medicine based on treating what is known as "like with like". This basically means that the illness will manifest itself as a set of symptoms in your body. These symptoms are unique to each individual person, and they are the body's attempt to cure itself. For example, from a homeopathic point of view, a common cold caused by the same virus will exhibit different symptoms in different people. This means that each patient must be assessed individually and the treatment will be based upon that particular patient's way of displaying the symptoms.

Homeopathy is holistic, implying that the aim is to treat the *whole* person, not just the illness in itself. This means that on the first homeopathic consultation, which typically lasts 45-60 minutes on average, the patient will be asked many questions, regarding not only physical health and the illness itself, but also on topics such as mental health, general well-being, sexuality, social

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[36] Unless otherwise stated, I will throughout this chapter use the term *illness* over *disease*, cf. my argument below.

[37] The following is an abstract taken from the webpage www.abchomeopathy.com

network, family, friends etc. Or, as one of the doctors at RLHH said when he described homeopathy to me: "*...and so we ask all these funny questions that some people find a bit odd*".

Based on the information gathered, the homeopath will then suggest a remedy for the patient. The remedy can be taken either as pills or in fluid form. The remedy is taken in an extremely diluted form (normally one part of the remedy to around 1,000,000,000,000 parts of water), and the idea behind homeopathy is that the more diluted (the process is done in water), the more potent and effective the remedy.[38] To such a degree that the homeopathic critics argue that when the remedy is being given to the patient, no actual trace of the original substance is left in the water, hence the treatment will have no effect and one is left with only a placebo-effect.[39]

Finding the right remedy is not easy, since there are literally thousands of homeopathic remedies currently available. The homeopath must also at the same time consider the patient's individual way of displaying symptoms, which means that one remedy may work for one person but not on another. Finding the right remedy can therefore be very time-consuming.

Concerning what illnesses can be cured with homeopathy, it has been suggested that homeopathy works best on symptomatic diseases, whereas biomedicine works best when there is a known cause for the illness in question (Castro 1990:9, see also Hepburn 1998).

By glancing through a handful of homeopathic magazines, journals, books and websites, one clearly gets the impression that they have a few things in common: First, it is interesting to see how much time is spent on contrasting homeopathy with biomedicine, e.g. what is "wrong" with biomedical treatment compared to homeopathy and to what extent this way of treating sickness can harm a person. Second, much time and space is spent on showing homeopathy's efficiency in

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[38] There is, note, debate within the homeopathic community on the question of potency strength.

[39] I will not discuss the *medical effects* of homeopathy in this thesis.

treating patients holistically, naturally and virtually without side-effects, meaning that it is a very safe way of treatment.

Homeopathy has developed much over the years, and it is practised in many different ways. Many homeopaths today, for example, do not follow Hahnemann's original ideas on diluting, potency etc, and homeopathy - in the UK - has split up in two camps were one is occupied with a more biomedical approach to homeopathy whilst the other focuses on homeopathy's distinctive character as opposed to biomedicine. I will discuss this in chapter 6.

Consultations:

For a couple of weeks (on and off) in the middle of fieldwork I sat in on doctor-patient consultations at the hospital. I did not do this primarily as part of the project as such, but more because I was curious as to how the doctors interacted with their patients compared to the biomedical way of treatment. This was a way for me to understand how homeopaths worked, as well as seeing the interaction between CAM (primarily homeopathy and acupuncture) and biomedicine first-hand. As noted in the introductory chapter, my initial understanding of homeopathy (compared to biomedicine) dictated that using biomedicine would exclude homeopathy and vice verse. Since I saw early on that this was not the case at RLHH, I wanted to explore it further.

RLHH has anywhere between 1500 and 2500 consultations per month (on average some 25000 consultations a year) - most of these are patients from either London or the south-east of England, although patients from all over the UK can be referred if needed.

At the beginning of each day, the doctors would arrive at the office designated for them, and the medical clerks would put the files of the patients of the day on the doctor's desk before he/she arrived. Sometimes the doctors came earlier to read through the journals, and sometimes they arrived at the same time as the patient. It did not seem that they had much time preparing for each patient. Some of the doctors started reading the patient's files only after the patient had

entered the doctor's office, but in general they spent a few minutes looking through the files before the patient entered.

Much of the day was occupied with *follow-up* patients – some having been to the same doctor or at RLHH in general for several years. On average the doctors seemed to have only one or two new patients each day. Very few patients did not show up for their appointment during the consultations I sat in on, but I did not ask how this was in general.

The patients reported their arrival at the reception desk either on the ground floor or the first floor, and the doctors then walked out of their office and asked the patient to enter. Because of my presence there, the doctor first introduced me by my full name and my purpose in being there before the consultation started. Then they asked if it was okay with them for me to sit in on the consultation.[40]

After the patient had sat down, the doctor read through the files and then asked how the patient was doing. The patient then typically responded by saying something about how well the homeopathic remedy had worked or not, as well as talking about any physical/mental pain they might have had since the last consultation. The doctor then acted upon this information to suggest a new remedy or to continue with what the patient was already using.

Homeopathy is, compared to biomedicine, a very non-intrusive treatment. Thus it seemed to me that there was little physical contact between the doctor and the patient at the consultations. The exception was when the patient complained about any specific physical pain (for example in the hands or feet). The doctor would then examine that part of the body and explain to the patient why the pain was there and/or what could be done to make it disappear or not. The doctors would sometimes ask if he/she could examine a part of the patient's body, but either way this did

[40] During the period I sat in on consultations only one patient declined to have me there.

not take much time. Many patients at RLHH had chronic pain (especially arthritis) in the joints, hands and feet, so the doctors often examined these for flexibility, pain and so on.

The patients were sometimes asked to undress, especially on the upper body. Typically this happened when the doctor suggested acupuncture in addition to the homeopathic remedies (for example in the back region). A few times the patient asked for acupuncture himself/herself and the doctor then either recommended it or explained why it did not work for this or that type of sickness.

Homeopathy in general puts greater emphasis on the interaction between the physical and psychological elements of sickness, as well as the subjective element of the patient in treatment.[41] Consequently, most of the time in consultations was spent talking, about what had happened since the last consultation and how the patient himself/herself had responded to the remedies. If the prescribed remedy at the time had not worked, some time was spent discussing and explaining what other remedies could be used, or how specific remedies worked. The doctors explained the ingredients in the remedies or how the remedies actually worked only if the patients asked specifically about this.[42] If the patient reported that a given remedy had worked, the doctors seemed okay with this, and did in these cases not ask any follow-up questions. Instead they usually asked the patient if they wanted to continue with the remedy. This may be due to the subjective element in homeopathy: if the patient himself/herself feels an improvement in their health, there is, perhaps, no need to question this on the doctor's part, as some of the doctors also noted in interviews.

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[41] See the next chapter for the doctor's views on this.

[42] One doctor said to me that she rarely explained the ingredients because certain homeopathic remedies contained traces of bacteria's from different venereal diseases as part of the treatment. Understandably, she said she didn't want to upset her patients.

Regarding the time spent talking in consultations, it seemed that some doctors talked more than others. Some told the patient directly what was wrong and what sort of remedy should be used, and the patients were more "passive" in this respect. Others seemed to listen more to the patient than talk themselves. In general, though, the patients seemed to speak more than the doctors, which, given the nature of the homeopathic consultation, is not surprising.

As noted above, the doctors could prescribe antibiotics if needed, and I observed a few things regarding the homeopathic remedies and treatments – as well as combining different alternative medicines. First of all, the doctors did not only prescribe homeopathic remedies, they also recommended other over-the-counter drugs and vitamins (e.g. Omega-3, oils and herbs for patients with arthritis). Another example was if the patient had tried several homeopathic remedies and nothing had worked, the doctors would often ask the patient if they wanted to try other therapies or courses available at RLHH. The autogenic training described above, for example, was recommended many times, as well as acupuncture.

Concerning the time used, the consultations with new patients lasted on average 45 minutes to an hour. I was told that this was standard consultation time in homeopathy in general. Follow-up patients lasted on average 15 minutes. However, the time spent on each patient varied greatly between the doctors. A German doctor I sat with for two days spent almost two hours on a new patient, but this was rare. When this particular patient had left, the doctor said that spending time explaining the homeopathic remedies and how they worked to the patient could have a therapeutic effect in itself. In general it was not uncommon for the patients to be 15-30 minutes overdue. In my opinion, though I have no data to compare it to a "typical" biomedical consultation, I got the impression that the patients were allowed to talk quite freely, which may account for the patients being overdue. This was especially the case towards the end of the day.

Either way, the homeopathic consultation takes longer time, and I will discuss this element both below and later in the thesis.[43]

When the right remedy was found, the doctors would update the journal (by hand in the medical journal, no computers were present in the offices) and sign a prescription for a remedy.[44] Then the doctor set up a new appointment and the consultation ended.

The doctor's views on RLHH and homeopathy:

It was imperative to interview as many of the doctors as possible, to get a feel of their opinions of the hospital, NHS and CAM. These interviews were formal and structured. I had written down a set of questions I wanted to ask all doctors. However, few of the doctors had the time to be interviewed for a long period of time, let alone answer all of my questions at once, so many of the answers were given in more informal talks, when patients did not show up for their appointments and so forth. Some doctors were later asked follow-up questions when they were available.

After interviewing most of the doctors at RLHH, it struck me how much they seemingly differed in their views on what constituted both a doctor and a homeopath, as well as how the two could be combined in a hospital like RLHH. At the same time they seemed to be almost in unison regarding the patient and his/her subjective view on the homeopathic treatment. One of the first questions that appeared most interesting to ask was what they felt most like: a doctor, a homeopath or both. Interestingly enough I got very different answers, ranging from one doctor

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[43] For use of time at biomedical consultations, national differences and so on, see e.g. Worsley 1997.

[44] A few of the doctors had a personal laptop with them at the office. There are software programs available for looking up homeopathic remedies.

saying he was primarily a doctor, via one who said she was "*probably both*", to another saying he felt more like a homeopath than a doctor.[45]

The reasons for the doctor's different answers become a bit clearer if we compare them to their views on the patients and homeopathic treatment. Almost without exception the doctors said that they knew that homeopathy did not work on everybody. It could take months, even years, before a homeopathic remedy that had any effect was found.

Another view expressed by the doctors was that some of them said that it really didn't matter if the homeopathic treatment "worked" in the purely scientific sense of the word, as long as the patient himself/herself felt the difference. One doctor said that it was important to have an open mind and be open to alternatives (i.e. alternatives to biomedicine), to avoid becoming dependant on one type of doctor, "*whether orthodox or CAM*". The same doctor said that he felt almost like a regular GP to his patients.

The doctor who felt she was equally as much doctor as a homeopath expressed some interesting views on the homeopathic treatment. She said that in biomedicine the treatment is related primarily to the disease in itself, not to the human being having the disease. In homeopathy, on the other hand, she felt that "*the patient suddenly becomes important* [again]". What she sought was trying to heal whatever they - the patients themselves – wanted. The subjective element and opinions of the patient were important to her. As long as results were seen, it actually didn't matter if homeopathy worked. "*Otherwise*", she said, "*I wouldn't be working here*". Interestingly, she said that she thought it was an "*artistic side*" to medicine as well, not only the scientific, which she thought had been lost in biomedicine.

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[45] Just for fun, to see their reaction, I told a few doctors about the answers given by other doctors (anonymously, of course), and some of them were surprised when they learned of the other doctors' answers.

Concerning the time used on the part of the doctor, many of the doctors complained about this, saying that they rarely had the time they needed with each patient. One doctor said that she did not see her patients as often as she hoped to – her own feeling was that in homeopathy, ideally, there should be a consultation every month. At RLHH it could take several months before she saw some of her patients again.

The above views expressed by the doctors about whether homeopathy works or not, seems to be a general trend in homeopathy (see e.g. Fernholt 2003). The most important factor for many in the homeopathic treatment seems to be the *patient*, and the answers the doctors gave me in the interviews are in that sense, it should be noted, not unique for RLHH as such. However, as will become clear later, RLHH is constantly working to improve the scientific base of homeopathy. One would think that the doctors themselves were interested in the actual medical effects of homeopathy from a biomedical point of view – as trained doctors – especially with the biomedical community being so hostile towards any alleged homeopathic effect. When asked about this they replied differently. One said that treatment should ideally be evidence-based, but this was only interesting "*in conversations with colleagues*". Another said that "*the evidence base is not for me primarily, but for NHS*" – meaning to prove and to get sufficient funding for the hospital. A third doctor, the one who said he was more a doctor than a homeopath, said that he always suggested to his patients that if a given treatment was evidence-based (meaning scientifically proven) they should opt for this first.

Simultaneously, his idea of homeopathic treatment was that the body was not allowed to heal itself of illness because of too much antibiotics, paracetamol and so on. Orthodox medicine (the doctor's own term) had too many side-effects, he said. The homeopathy was therefore a means of trying to get the patient to *withdraw* from orthodox medicine. Biomedicine, he said, was "*too over the top*" and he was also afraid that orthodox medicine in itself created new diseases.

Another doctor had a very interesting view on homeopathy vs. biomedicine: in-between patients one day I asked him about his opinion on differences between the two, and he replied that many

of the illnesses people suffer today are difficult to diagnose because the symptoms varies so much between each patient. He said that homeopathy was much easier to use for diagnosing, simply because diagnoses are "*phenomenons*". He explained that he believed homeopathic treatment instead of conventional treatment for e.g. osteoarthritis (one of the most common illnesses in Britain today) was much better, while at the same time acknowledging that homeopathy worked for some, not all.

Some of the explanation as to why the doctor's differed so much in their views on homeopathy, RLHH and the patient can perhaps be found it the fact that the doctors, as noted in chapter 2, originate from many different countries, and the way they were trained in both homeopathy and biomedicine will have an effect on how they use it at RLHH (cf. Worsley 1997, p. 208-214 on the national/cultural differences among doctors).

For example, the doctors at RLHH expressed different views on the question of the importance of homeopathy's evidence-base, though this did not seem to have any effect on the treatment in itself. One German doctor at RLHH, for example, had biomedical training from the University of Vienna - a university, the doctor said, very interested in CAM in general.

The training there will bring with him knowledge of medicine, treatment and illness and so on that a British trained doctor will not and vice versa. [46] None of the doctors expressed any negativity towards this, on the contrary, as far as I could see this did not represent a problem.[47] I

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[46] It is important to note that in e.g. France and Germany the use of homeopathy is higher than in the UK, and especially in Germany there is emphasis on CAM in biomedical training in general (Alternativ Medisin, 1998:21). The German doctor pointed to Germany, India, England and France as the four biggest countries in terms of homeopathic use.

[47] Some of the doctors also said that RLHH was a very popular place to work and one doctor said it was "*high up on my wish-list*" when he applied.

did not ask specifically about whether the doctors' nationality and training in homeopathy made the homeopathic treatment differ with the doctors on a practical level at the hospital. On the other hand, none of the doctors or staff explicitly expressed any problems with this in interviews.

The doctors also differed in their views on what was best: private CAM or public CAM (as represented by RLHH). One doctor (British) said that he didn't like private CAM because of too many compromises and financial restraints, while another doctor (also British) said the exact opposite: at RLHH one had to cover too much and had too little time, and as a result she felt she had to make compromises a lot of the time.

Stress was a major factor for many doctors, but it seemed to me that they used it differently: by some it was defined as the cause of illness, by others more as a "side-effect" from other illnesses. I did not find any similarities when comparing the nationalities of the doctors at RLHH, but it is consisting with Worsley's argument on cultures emphasising different aspects of illness.[48]

If we sum up the above; consultations and the doctor's views, the differences and similarities between the homeopathic and biomedical way of treating clearly emerge. I am not medically trained myself, nor do I have any empirical data from biomedical consultations. However, what I believe emerge from the consultations and from interviews is that the doctors made use of their biomedical training both when explaining illnesses as well as when they physically examined their patients. For example, when the doctor physically examined a patient and explained something to him/her that had to do with physiology or how the human body worked, I suddenly had the feeling that it was the *doctor*, not the *homeopath* that emerged. For the rest of the consultation, on

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[48] Worsley 1997. For a telling example, see his comparison between German and British doctors' divergent emphasis on high/low blood pressure (pp. 207-208)

the other hand, the emphasis was on homeopathy; - the homeopathic remedy in question and how homeopathy works. [49]

Illness and disease:

What we see from the above is that the doctors at RLHH differ in their views on homeopathic treatment at RLHH, as well as on homeopathy compared to biomedicine. I will now discuss how the homeopathy practised at RLHH can be said to represent a very unique way of treating patients. Biomedicine has been criticised, by the sick person and homeopaths alike (see e.g. Sharma 1992, especially chapter 3), for not being able to treat holistically and not taking into account psychological causes of illness. I will in the following, using Eisenberg's distinction between illness and disease, argue that the homeopathy practiced at RLHH – where the homeopaths are biomedically trained - in many ways can be said to bridge the gap between illness and disease.

As noted in the introductory chapter, Eisenberg (1977) has proposed a view of sickness as separated in two: *illness* and *disease*.[50] Put short, illness refers to what the patient/sick person suffers – i.e. subjectively experienced by the sick person. Disease, on the other hand, refers to what the physicians diagnose and treat from a scientific point of view – "*an* [abnormality] *in the structure and function of body organs and systems*" as it is conceptualized by the physician (ibid. p.11).

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[49] It must be noted here that this may just be me being biased since I knew that the doctors were biomedically trained. In Norway, for example, when training for homeopathy, the students learn physiology and anatomy at the level of physiotherapy, so it is no surprise. It is interesting, though, to see this in relation to the doctors at RLHH and their views on the interaction between homeopathy and biomedical treatment.

[50] See e.g. Good (1994), Worsley (1997) and Young (1982) for more on illness/disease and illness experience. Due to lingual differences, in Norwegian illness and disease are usually named by the same term: *sykdom*. *Lidelse* and *plage* are also used.

Eisenberg's argument is that medicine is based on *models*, and these models are a way of constructing reality. The danger, he argues, is that the models may be mistaken for reality in itself. The models available to physicians have effect on medical behaviour – in short how the patients are treated.

Eisenberg's way of defining illness and disease stresses that the two do not stand in a "*one-to-one relationship*" with each other (1977:11). They are in other words not mutually exclusive, in the sense that there can be (but not always *is*) illness present when a person experience disease.

Following Eisenberg's argument it is interesting to see how some of the patients responded to the homeopathic treatment, as well as on the context in which the homeopathic treatment is situated. A recurring comment by many of the patients at RLHH was on two topics: time available at the consultations, and the possibility of talking/discussing with the doctor.[51] As noted, the doctors usually allowed their patients to talk freely (cf. above). This meant that they sometimes were overdue, but some of the patients told me either during or after the consultations that they felt that at RLHH they were treated with respect (some of them were clearly unhappy with their GP).

Some patients who had only been to RLHH a few times seemed surprised when they told their doctor that the homeopathic remedy had worked for them. This is understandable since many of them had never tried homeopathy before. Here it must be noted that many of the patients at RLHH have been diagnosed for years without any successful biomedical treatment. Some of the patients may have tried other types of CAM without me knowing of it, so homeopathy in itself may not account for the patient's level of satisfaction in this respect.

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[51] As noted above the doctors in general stressed this, though it must be noted that after an older lady who had been to RLHH for many years had left his office, the doctor commented on her often talking too much and that she never seemed to stop!

There were also some patients who approached me during consultations (since they beforehand had been told that I was a "social scientist" of sorts who was there to study the hospital) who commented on how different homeopathy and homeopathic treatment was compared to biomedicine. An older woman (she seemed to want to compliment her doctor in my presence, which she had had for several years) said to me that she felt that her condition was not taken seriously by her GP, but she always felt welcome at RLHH.

The Deputy Director of Research at RLHH pointed out very early in my fieldwork that there at times was a distinct gap between what the patients *wanted* and what they, from a medical point of view, actually *needed*. This point is very relevant to this analysis, since it affects many factors: how much time is spent on the patients, if the right treatment is actually given, and most of all: how much money is spent. This is, obviously, a problem biomedical doctors (e.g. GP's) face in their own clinical setting as well.

Another aspect of this, as several doctors pointed out in interviews, is that many of the patients at RLHH had been there for years and some of them were very difficult to discharge. One of the reasons for this is that a lot of patients at RLHH have chronic illnesses which are difficult to treat, let alone diagnose. In this sense it could be argued that for some patients RLHH becomes a sort of "last resort" – a place they end up because they in a many ways are *given up* or discharged by their GP. The problem is, in some cases, that RLHH simultaneously is unable - or only partially able - to treat the patient with homeopathy or other types of CAM. This is consistent with the research on why people choose CAM in the first place (their GP is unable to cure their illness, see chapter 1). One of the doctors told me that this was the case with some patients – they had an illness which made them circle between RLHH, their GP and other specialists for years without finding the right treatment.

Here it can be argued that our society is becoming increasingly *medicalized*, in the sense that more illness is being diagnosed and labelled for the first time (Scheper-Hughes & Lock 1987). Some of these are difficult to treat properly precisely because they are often chronic diseases. Scheper-

Hughes/Lock argues that this medicalization leads doctors, amongst others, to end up as "*agents of social consensus*", since this constantly restricts our cultural definitions of the concept of "normal" (ibid.:26). One of the doctors said something interesting in a brief interview I had with him during consultations. He pointed out that many patients have several diagnoses, not just one, and he wondered aloud how this could he handled, not just from the patient's perspective, but also from RLHH's.

With the empirical data presented in mind I will argue that RLHH is a hospital where the gap between illness and disease in many respects is bridged. From the consultations we have seen that the doctors in general emphasised communication with the patients, allowing them to talk. They also emphasised the subjective element in medicine – as we have seen, some of the doctors ignored any scientifically proven effect of homeopathy as long as the patient themselves experienced improvement in their own health. This benefits the patients, since they are allowed to communicate the subjective elements of their illness. This is especially interesting, I believe, if we follow Eisenberg's definition of illness as what the patient himself/herself experience, not just what the doctor perceives or diagnose as illness.

It is important here not to dichotomize – biomedical doctors treat illness as well, of course, but I will argue that it is precisely herein that RLHH's biggest advantage lies. The homeopaths at RLHH are trained doctors as well as homeopaths, which mean that they can make use of two complementary medical systems for the benefit of the patient, offering what a member of staff referred to as "*the best of both worlds*". Consequently, I will argue that RLLH in many ways can be said to base itself on genuinely *complementary* medicine – biomedicine and homeopathy complementing each other.

Summary:

I have in this chapter described the homeopathic consultation between doctor-patient and outlined on the doctors' views on topics concerning RLHH, NHS, CAM and the patients. What we have seen is that the doctors' opinions differ on many of these topics, which is not surprising

since it is important to note that neither the biomedical or CAM community is a homogenous group with a unified view. This is also consisting with Barry's findings (2003) that the GP's have very different views on many things related to CAM. Many are, for example, neither positive nor negative to CAM and its medical effects as such.

Furthermore, I have discussed Eisenberg's illness/disease-distinction and argued that RLHH, precisely because of the doctors being both biomedical doctors and homeopaths, is a hospital where genuinely *complementary* medicine is being used, which benefits the patients greatly.

In the next chapter I will outline on the German doctor Samuel Hahnemann, the founder of homeopathy, as well as the founder of RLHH, Dr. Fredric Quin. Then I will look at homeopathy and biomedicine historically, both together and in their own right. Concerning homeopathy, I want to show that it developed in Britain in a very special way, which is part of the explanation why RLHH exists today, as well as how it was so easily incorporated into NHS in 1948. Concerning biomedicine I want to show, following Foucault's argument of *labour force medicine*, how British biomedicine can be viewed as a distinct form of biomedicine different from e.g. the French and German. Finally, I will show how homeopathy was introduced among the aristocracy and the royals in Britain and how this royal patronage has its influence on RLHH even today, due to the Royal's use of and interest in homeopathy.

Chapter 4: Homeopathy and biomedicine: history & practice in Britain:

I will in this chapter focus on the homeopathic and biomedical history and practice in Britain. I do this because the history of the founder of homeopathy, Samuel Hahnemann, and the founder of RLHH, Dr. F. Quin, is intertwined. I believe this can be better understood when put in a historical context. I will, amongst other things, focus on Foucault and his view of British biomedicine as *labour force medicine*, and show how this type of biomedicine is different from the German or French type of biomedicine. Further, I will outline on Samuel Hahnemann, Dr. Quin and the homeopathic history of the United Kingdom. Finally in this chapter I will look at the royal and aristocratic influence on RLHH past and present.

Samuel Hahnemann:[52]

Samuel Hahnemann (1755-1843) was born in Germany, and began medical training at the University of Leipzig in 1775. He never actually finished his training, though, and instead he got a job practising medicine for a rich patron in Transylvania. He registered for the degree of MD in 1779 after only one term's study. He obtained several different medical posts during the next year, and apparently during these years he became dissatisfied with the inefficacy of the medical profession. Instead he spent more time working on translating books and articles, among them medical texts.

Over the next decade he obtained evidence for radically new medical concepts and methods, and he started work on what was to become homeopathy. He sought to develop a medical system that relied solely on single drugs in harmless doses based upon pure observation, empiricism and experiment.

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[52] The following is an abstract of an essay by Peter Morell (1999).

Hahnemann started in the beginning of the 1800's to write essays were he critiqued what we today label biomedicine.[53] In these essays he tried to explain why he thought his new form of medicine were superior to the leading medical establishment.

In 1812, Hahnemann moved back to Leipzig, were he obtained a teaching post at the University's medical school. His lectures soon became unpopular amongst the students, however, as Hahnemann attacked the medical mainstream at every possibility. Soon his lectures were attended by only a handful, which weakened his position at the University.

By 1820 he left the city and moved to Coethen with his wife and daughters were he lived for fourteen years. In this period he continued to publish essays and books. In 1834, Melanie D'Hervilly Gohier, a well-connected French artist, became first his patient and later his new wife, after the death of Hahnemann's first wife four years earlier

In terms of what became of homeopathy after Hahnemann's death, partly through attracting great controversy, and partly through impressive clinical results, homeopathy spread rapidly in Europe, Russia, India and America, where it found the sympathy of the rich and the aristocracy as a safer, some argued, alternative to biomedical treatment.

Dr. Fredrick F. H. Quin.[54]

When studying the history of both RLHH and homeopathy in England one man stands out – the hospital's founder: Dr. Fredrick Foster Harvey Quin. He was born in either 1798 or 1799 and qualified in medicine in 1820. Due to moving in high circles he was appointed physician to Napoleon Bonaparte, but Napoleon died before Quin could take up his appointment. Instead he

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[53] Biomedicine was at the time, we must not forget, very different from what it is today. See below.

[54] The following is an abstract of an article in the *British Homeopathic Journal*, Number 4, volume 78, Oct. 1989.

became physician to Prince Leopold of Saxe Coburg (who later became King of Belgium), who was also a favourite Uncle of Queen Victoria.

Quin discovered homeopathy while travelling in Italy with Leopold, and at about the same time Quin's wife was cured from a disease with homeopathy. Quin sought out Samuel Hahnemann in Germany in 1826 and studied with him for a year in Paris. He had practice in Naples as a homeopath, before he returned to London in 1832 and set up practice as a homeopathic doctor there.

In 1844 he founded the *Homeopathic Society* and opened London Homeopathic Hospital the same year (the hospital did not have royal patronage back then). It accommodated 25 patients and had over 1500 out-patients in the first year alone.

There seems to be two main reasons why Quin was able to introduce homeopathy and build LHH. First, his social position (he was part of the aristocracy and friends with many people of importance in England, including the Royal Family). Second, his intention was to bring homeopathy to the general public. Many of the aristocracy were also his patients (Charles Dickens, the Duke and Duchess of Westminster among others). It has been suggested that Quin was a very good and popular doctor, but that his real contribution was more on the social side - he knew many people and were able to interest them in homeopathy. This way he also secured funding for building LHH:

"Without Quin there would have been no peers to rush to the aid of homeopathy whenever it was threatened. [...] Without him there could be no registered doctors practising homeopathy and the method would probably have disappeared." (British Homeopathic Journal 1989: 209).

In 1854 an infamous cholera epidemic broke out in London due to contaminated water from a water pump in Westminster. All beds at LHH were used to treat the cholera cases, and the hospital had enormous success treating them with homeopathy: Only 16,4% of the patients died, compared to 53, 2% at the Middlesex Hospital were the patients were treated with conventional

medicine. This gave the hospital its first major reputation and publicity, and homeopathy gained support from the general public.[55]

In 1859 LHH moved due to lack of beds, and again in 1908, when the hospital moved to its present location: Great Ormond Street in London. By the turn of the century homeopathic hospitals had also been established in several other places across the country. In 1920 the Hospital first received Royal Patronage from HRH the Duke of York, who also became President of the Hospital in 1924.

The public health service (NHS - *National Health Service*) was established in 1948, and RLHH, including the other four homeopathic hospitals, were taken over by NHS and homeopathy was recognized by the Government as part of the NHS, with each hospital having its own management committee. In 1943 the Homeopathic Society formed by Quin became the Faculty of Homeopathy, and in 1950 the Faculty of Homeopathy Act was passed by Parliament. In this Act the Minister assured that the homeopathic institutions would be enabled to provide their own form of treatment.

In 1948 the hospital changed its name to Royal London Homeopathic Hospital (RLHH) and in 1952 Her Majesty the Queen became Patron of the Hospital.

The hospital has been forced to close different wards over the years: surgery, geriatric and so on, but despite this the hospital has survived for over 150 years.

[55] The case of the "Broad street pump" (as it is referred to today) is an interesting example. See also Worsley (1997, p. 170). It has been suggested elsewhere that RLHH was so successful in their treatment of the epidemic simply because they had better hygiene than the other hospitals in London at the time.

The homeopathic history in United Kingdom:

With the history of RLHH and Quin in mind, it is interesting to note that ten years later, 178 doctors in Britain and Ireland had publicly declared allegiance to homeopathy. By 1867, the number had grown to 251 (Nicholls, in Saks 1992:77). New hospitals and dispensaries were built, and by the same year RLHH had received almost 60000 out- and in-patients over a 20 year period. In other words, homeopathy became popular very fast, both with many doctors and with the general public. The reasons for this seem to be both the public popularity, but also a clerical sympathy and the aristocratic patronage (ibid.).

The then *Provincial Medical and Surgical Association* held a meeting in 1856 where a resolution stated that homeopathy was absurd and that no member of the Association should have anything to do with it. Moreover, new members had to give a written statement were they made it clear that they did not practice homeopathy or that they never would intend to use it (1992:80). The reason for this "homeopathic fear" seems to be, as Nicholls writes: *"The success of "professionalism" as a strategy [...] depended on control over medical personnel and institutions, over the content of practice itself, and over the remuneration merited by professional status"* (1992:78).

The first 30 years of 1900's showed a general decline and interest in homeopathy, to a point where it almost died out. Some doctors used it, but the general consensus amongst the medical profession was that they did not want anything to do with neither homeopathy nor herbalism (Morell 1999). Homeopathy was at this point more or less handed over to lay practitioners, which seemed to suit the doctors just fine (ibid.).

The historical trend since 1930 has been for doctors to abandon homeopathy, and for the movement to be gradually taken over by and controlled by lay practitioners. Homeopathy did not gather any new strength until the 1970's. The reason for this decline, Morell argues (ibid.), is partly because of WW2, and then later that homeopathy in the next decades moved from being controlled by the doctors to being controlled by lay practitioners, a place were homeopathy had

never been before. There was also a boom in lay practitioners in the 40's.[56]

For now, let us leave homeopathy and move to biomedicine and see how it has developed historically. After that I will discuss the two combined.

Biomedicine in the UK:

Historically, when talking about an emergence of a medical profession in Britain on can, as a starting point, go back to 1518 where the state awarded monopolistic powers to a newly formed *College of Physicians*. This helped control entry and training within the profession (Worsley 1997:185). The physicians were few and far between (due to, amongst other things, a very costly training), because the College wanted to keep the number of physicians down. This, in effect, meant that the patients were wealthy people, since the poor could not afford the physician's services. At the same time this "medical profession", however, was not a biomedical profession like the one we know today. Treatment of illness was centred on different kinds of healing, and was not as scientifically based as today, though it was expected that sickness could somehow be explained by other means than magic and witchcraft. The concept of placebo and mind over matter were known at the time, but during the 15- and 1600's the knowledge of the body, disease and treatment were still very limited. The King was, for example, believed to have healing abilities only by being touched upon, and astrology was still a major part of treatment.

In 1542, a Witchcraft Act was passed. This essentially made healing by local people dangerous, since no one could claim to have special powers anymore without being sanctified by the Church (Larner in Saks 1992:25). This certainly helped the medical profession claim more legitimacy.

There were official, licensed medical practitioners at the time, but the concept of "doctor" as we know it today was very different. One example of this is one of the most famous astrologers of

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[56] See chapter 5 for the membership numbers of the two British homeopathic organizations.

this time, William Lilly (1602-81), who was granted license to practice medicine in 1670 without having any formal medical training at all (Wright in Saks 1992:48).

Moving along to the first half of the 1800's, Foucault (2000) argues that it was the *Poor Law* that made British medicine a social medicine. The *Poor Law*, instituted in 1834, was meant as an aid to the poor, giving public benefits for sickness and treatment. This law, Foucault argues, made way for the idea of a tax-supported welfare system where the poorest would be helped to "*meet their health needs* [...]" (ibid.;153). This made it possible for the wealthy classes to control and protect themselves from sickness and e.g. epidemics. This was especially relevant in a society being increasingly urbanized, where diseases did not recognizing any class-boundaries (Worsley 1997:194).

Worsley argues that the development of "scientific medicine" (or biomedicine) came with breakthroughs in biology and chemistry in the 19th century. With the increasing knowledge of the body and sickness/spreading of disease, medicine moved from doctors practicing for their patrons at their homes to the laboratory and, most importantly, to the *hospital*. In other words an institutionalization of medicine (ibid.). From here on the concept of the *general practitioner* also arose.

In the middle of the 1800's, the physicians and surgeons began petitioning Parliament to reform its own profession. They wanted a single medical organization to register all medical practitioners, standardization of medical education, and being able to sanction against unlicensed practitioners. In 1858, The Parliament passed what today is known as the *Medical Act*, where only qualified practitioners would have the exclusive right to the term "medical practitioner" (Sharma 1992:2). Non-conventionalist practitioners were allowed to treat patients as long as they did not claim to be qualified doctors. The General Medical Council was also from that year responsible for defining medical qualifications and overseeing educational standards. Furthermore, the *British Medical Association* (BMA), as it is still known today, was established in 1856 (see chapter 6 for an outline on BMA). It is interesting to note here that this Act was passed not long after

homeopathy began to spread among the (biomedical) doctors, in other words it could be argued that homeopathy was seen as a threat. By the end of the 1800's, Worsley argues, biomedicine had won the "*decisive backing of the state*" (Worsley 1997:198).

A point of note here is the use of statistics in questions of health. In Britain, as in France, there was a desire to understand social change and to "*establish a scientific basis for social policy*" (Porter 1986:30). As a consequence, statistical offices and later a General Register Office were set up (in the 1830's), both in London and Manchester. Most of the leading figures in these offices were industrialists, and the basic idea behind this statistical investigation was, Porter argues, to "improve" the workers, i.e. the labour force, by exploring effects of crime, education and for example death rates in relation to sanitary conditions (Porter 1986, pp.18-39). It is interesting to see this rise in the use of statistics in relation to the rise of biomedicine from a *scientific* point of view, its process towards greater institutionalisation, especially when compared to Foucault's argument on British social medicine.

If we move to the 20th century, we see that biomedicine and the doctors were given an additional advantage over alternative practitioners. In 1911 The Parliament passed the *National Insurance Act* and the 1946 *National Health Service Act*, which has further extended the state monopoly of orthodox medicine (Saks 2003:143).

Medical care was still not for everyone, however, covering only 40% of the population in 1938 (Worsley 1997:202). The next step was to make it available to everyone and from here the idea of a national health service - NHS - emerged (see chapter 1).

What we see from Foucault's argument is that the labour force medicine established in Britain was a means for the wealthy classes to protect themselves against diseases, but it also helped them *control* the health of the labour force, in order to make the labour force more "*fit for labour*" (Foucault 2000). This also helped to increase productivity, i.e. increase profits for the ruling classes. Foucault argues that this type of medicine was based on authority (ibid.).

Homeopathy and biomedicine:

If we follow Foucault and Worsley, we see that the medicine developed in Britain was based around the labour force, i.e. the poor, whereas the historical overview of homeopathy above shows us that homeopathy in the first part of its existence in Britain has been a medicine mostly for the wealthy. It is only since the 1970's that homeopathy specifically has become "lay" – lay practitioners and an increased use by the general public. In other words there is also a class aspect to homeopathy as well.

As homeopathy moved into the 20th century, both homeopathy and biomedicine had changed. It is important to note that homeopathy is not *one* unified theoretical school, not even today. Conventional medicine, perhaps as a response to the homeopathic popularity, Nicholls (1992) argues, started in the last decades of the 19th century to change, even to the degree that it began to adopt some of the homeopathic principals (see discussion below). This, Nicholls claims, more than the professional and institutional reactions to homeopathy, was responsible for the homeopathic decline from then on (1992:89). The *Cancer Act* passed in 1939 stated that only registered medical practitioners were allowed to treat cancer, and in 1941 the *Pharmacy and Medicines Act* was passed on stating the same for a series of serious diseases, including diabetes, tuberculosis, epilepsy and so on.

Acupuncture, for example, even as late as the 1960's, had very few practitioners, and the method was widely dismissed by the established medicine, amongst other things due to its clash with the main principles of biomedicine (Saks 1992:191). Still, today, despite not being taught in medical schools and with limited funding for research on the medical effects of acupuncture, it is by and large more "approved" of by the biomedical community than homeopathy (Saks 1992:183-198).

Morell argues (2000) that the decline of homeopathy in the period from 1880 to 1940 can be tied to the decline in wealth and power of the aristocrats, who, after all, very largely formed its client-

base. [57] The resurgence of homeopathy in the 1970's in the UK were due to the lay homeopaths gaining strength, not the Royals having any real power in their advocating of homeopathy or complementary medicine in general. I did not ask specifically about any royal impact on RLHH when conducing fieldwork, but as noted above, it became clear from the interviews with some of the doctors and staff that it none the less seemed an important factor.

Concerning homeopathy and biomedicine today, one would perhaps think that both the professional and lay practitioners would be interested in seeing the two medical systems complement each other and work harmoniously together. It is not that simple. Not all CAM practitioners are interested in being a part of the NHS, being statutorily registered or "controlled" in any way. The reason is quite simple: many homeopaths emphasize the *alternative* aspects of homeopathy, meaning that too much interfering from the state could take away this alternative aspect of CAM, making it too similar to biomedicine.[58]

Homeopathic influence on biomedicine:

When discussing homeopathy and the way it works at RLHH, it is also important to note that not only has biomedicine shaped homeopathy, it has also been the other way around, especially in the mid-1800's. In the period from 1850 to 1890 homeopathy had impact upon regular medicine, inspiring it to reduce its doses and the complexity of drugs in use. Biomedicine was also forced to reconsider its use of practices like bloodletting (Morell 2000). There was also the backfiring of biomedicine's own critique of homeopathic efficacy based upon 'trusting in nature' and 'self-limiting diseases'. This meant that leaving the disease to heal itself not only explained away the

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[57] The dominance of biomedicine from around the beginning of 1900 has also been linked to a "*mortality revolution"*, in that biomedicine became increasingly successful in preventing diseases and epidemics (see e.g. Flikke 2003, also Foucault 2000, and Armstrong 1995 on "*surveillance medicine*".)

[58] See Sharma 1992, especially chapter 6 & 8.

'efficacy' of the small doses of homeopathy, but also tended to undermine any underpinning justification for the dangerous heroic practices of the regulars. The ideological discomfort within regular medicine forced it to reconsider its philosophy and methods (ibid.). Nicholls (1988) argues that biomedicine both rejected homeopathy and at the same time incorporated some of its work. The biomedical response to homeopathy was *dialectic* - at the same time as homeopathy was officially rejected there was a covert assimilation of its remedies and lessons regarding dosage and drug proving (1988:104).

The Royal Family and the aristocratic patronage of homeopathy and RLHH.[59]

As we have seen above, Dr. Quin was part of the British aristocracy and it was also within this circle of people that homeopathy was introduced. It is impossible to think of RLHH, let alone homeopathy in Britain in general, without this aristocratic element of British culture. Thus I will now turn to discuss the aristocratic and royal influence on homeopathy and RLHH, both past and present.

Dr. Quin, the founder of RLHH, was as noted above a member of the aristocracy, and this way he, amongst other things, secured funding for the building of what would become RLHH. This, however, is only the beginning. The British elite - the Royal Family, the aristocracy - were surprisingly united in their advocacy of homeopathy from the very beginning, and it has changed little over the years. When I started the fieldwork, I obviously noticed the word "Royal" in the hospital's name. When I interviewed the first doctor after only a few weeks at the hospital, I asked him for reasons why the hospital existed and why it was incorporated into the NHS. He smiled and said: "*...we have friends in high places"*. The answer made me realise that the Royal Family still had its influence on RLHH. I will in this section, based on the historical overview given

[59] These paragraphs are an abstract of an essay by Peter Morell (1998). See also Sharma 1992, especially chapter. 8.

above, show how homeopathy spread among the British elite, and how this could be said to have an effect on RLHH today.

First of all, with homeopathy being developed in Germany, how did the British Royals gain access to it? Dr. Quin studied under Hahnemann and brought homeopathy to Britain. The British Royals were closely related to the German Royals, who were keen users of homeopathy, so it is assumed that homeopathy also spread to Britain this way. Apparently, there is an anecdote about one of the German Kings who came to Queen Victoria's Coronation in 1837 and was taken ill due to “overindulgence”. The whole entourage had to rush back to the continent to get homeopathic treatment. Soon after that the British Royals all became users of homeopathy (Morell 2000). Queen Victoria herself did not use homeopathy at all, though many of her relatives did. According to Morell, the British doctor Sir John Weir was apparently homeopathic doctor to the King of Norway, King Edward VII, George V, Edward VIII, George VI and Queen Elizabeth II.

On the question of why the Royals started using homeopathy, Morell argues that before it was spread out to the public it simply became fashionable – due to it being exclusive. Queen Victoria was married to Prince Albert, who was German. The Belgian Royals derive from the same lineage as Prince Albert, and Dr Quin, as noted before, was doctor to Prince Leopold before Leopold became King of Belgium.

Much of the early expansion of homeopathy only became possible through rich patrons. Quin himself was the son of the Duchess of Devonshire (c.1765-1824), and when he began to practise homeopathy in London he mainly treated members of his own class and other members of the nobility. This was very common at the time, as poor people could not afford treatment from doctors and instead were forced to use the services of amateur herbalists and apothecaries for their medical needs.

That the Royals turned into loyal patrons of the emerging homeopathic hospitals and

dispensaries made it easier for homeopathy to gain access as a new therapy in the UK, legitimising it and making it fashionable. There were dozens of these rich patrons of homeopathy throughout Britain at the turn of the century, and homeopathy was referred to as the "rich-man's therapy". Not only RLHH was built by aristocratic money, also the Liverpool and Bristol homeopathic hospitals were paid for and build by aristocratic funding. It is also worth noting here that the aristocratic influence did pay off even politically: when the Medical Act was passed in 1858 it came, originally, with a clause forbidding doctors from practicing other types of treatment than the conventional, but this clause was removed due to pressure from Lord Grosvenor (Sharma 1992:183). [60]

Another important point, Morell argues, is the amount of time and money rich people had compared to lower-class people. Working people could not afford doctors nor could they afford to spend an hour or more talking to a doctor about their symptoms, which is what visiting a homeopath often necessitated.

The Royal Family and RLHH today:

The homeopathic patronage continues to this very day, from King Edward VII via his son King George V (1865-1936), his sons Edward VIII (1894-1972) and George VI (1895-1952), and so into today's Royals. The late Queen Mother (who were also Patron of the then *British Homeopathic Association*), HRH the Queen, Princess Anne and Prince Charles are all homeopathic users on a regular basis. The Queen has visited RLHH two times, in the 50's and again in the late 1990's. When RLHH re-opened in 2005, Prince Charles visited the hospital. RLHH's Clinical Director, Dr. Peter Fisher, was at the time of fieldwork appointed homeopathic doctor to the Queen.

[60] Lord Grosvenor was at the time one of Britain's richest men, and he was also the first chairman of RLHH's hospital board.

A further point should be made on Prince Charles, by the way, because he is a keen advocate of complementary medicine and founded the Prince of Wales's Foundation for Integrated Health in 1997 to promote and fund complementary medicine and treatment. In 2004 the Prince commissioned a large report on alternative medicine, where RLHH's Clinical Director Dr. Fisher was interviewed.[61] The Prince was also President of the British Medical Association in the 1980's and instigated several inquiries into alternative therapies (Saks in Gabe et.al.1994).

The question of any royal influence on homeopathy and RLHH today is difficult to answer precisely, and was not part of my fieldwork. Obviously, however, it goes without saying that a Royal patronage does not do RLHH (or any other institution) any harm, as many people at RLHH pointed out to me in interviews. RLHH is not the only institution to gain this patronage. For example, the Ainsworth's Homeopathic pharmacy has three Royal Warrants, from the late Queen Mother, the Prince of Wales and the Queen.

A quick glance on the internet shows that the Prince's and royal influence in general is not to be underestimated in this respect, especially given the Queen's popularity in the Britain.[62] In 2004, the Prince's Foundation was given nearly £1m by the Government to work on developing regulation systems for complementary health care professionals.[63] Also in 2004, the British Health Minister agreed to back plans for a pilot project offering homeopathy to NHS Wales on

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[61] Known as the Smallwood-Report (2004)

[62] In articles, reviews and interviews on the internet, for example, it is interesting in to see how often Dr. Fisher is actually referred to as the Queen's homeopathic doctor.

[63] The Guardian, Dec. 23rd, 2004.

the advice of Prince Charles himself; an important step since patients then could get homeopathic treatment for free.[64]

This goes some way to show that the royal influence on homeopathy (and to some degree CAM in general) has far from died out, however weak it may or may not be compared to its influence in the 19th century. It is difficult, however, to draw any firm conclusions from my own empirical material.

Summary:

I have in this chapter outlined the history of homeopathy and biomedicine in the UK, as well as on Hahnemann and Dr. Quin. What we have seen is that homeopathy for much of the 19th century battled with biomedicine in an attempt to legitimize itself. Many biomedically trained doctors practiced and were trained in homeopathy, but from about 1900 homeopathy declined and were left out mostly to lay practitioners without any medical training. The lay movement resurrected homeopathy in the 1970's due to a boom in homeopaths, most of the doctor's losing interest in it as well as a heightened interest in alternative medicine amongst the public.

We have also seen that the history of homeopathy is closely related to the upper-class of British society, and that Dr. Quin, the founder of RLHH, introduced homeopathy to the aristocracy before it spread out to the public. This has had historical implications on securing funding for homeopathic hospitals as well as today, with royal homeopathic patronage and at least partially royal influence.

I will in the next chapter look at the two homeopathic organizations in Britain, and outline on how they have developed and how this currently affects RLHH.

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[64] ibid.

Chapter 5 – RLHH and the homeopathic organizations:

I will in this chapter describe the way homeopathy is practiced and researched at RLHH. This has to a large extent to do with the way homeopathy is organised in Britain. Almost from the very inclusion of homeopathy in Britain there have been two major homeopathic organizations: *The Faculty of Homeopaths* and the *Society of Homeopaths*. Philosophically and practically these two organizations differ greatly, with the first being more biomedical in its approach and the latter closer to the original "classic" homeopathy as developed by Hahnemann. At RLHH the Faculty of Homeopathy has a strong position, and I will in the following argue that this is a very important element in an analysis of RLHH and how it is working.

I will first outline on the history of the homeopathic organisations and show why and how they became separate entities. I will then show how they are working today, both in general and at RLHH, with emphasis on the *Faculty of Homeopaths*.

Homeopathy and its organizations:

Faculty of homeopathy:

As Barry points out (Barry 2003), it is striking to see how the two homeopathic movements have been different from the very beginning, as well as how relatively unchanged they are even today. The first homeopathic organization in Britain was the *British Homeopathic Society* (BHS), which was founded by the RLHH's founding father: Dr. Fredric Quin. For quite a long time it was the only institution where training on homeopathy could be obtained.

What is interesting to see is how BHS was organized. In order to obtain the training, you had to be trained as a medical doctor first. In other words, BHS was organized around the doctors (i.e. the medically qualified homeopaths), not the lay practitioners. BHS was made up entirely of doctors, and it was an elitist and hierarchical organisation modelled on the Royal Colleges of Surgeons and Physicians (Rankin, in Cooter 1988). To obtain membership you had to meet

certain demands. You had to practice homeopathy exclusively, but could stay in general practice.

BHS did not follow Hahnemann's original ideas - instead they integrating them with (bio)medical ideas and tried to make homeopathy more scientific, ignoring the spiritual and idealist elements of Hahnemann's thinking. In this sense they were in many ways contrary to Hahnemann's doctrines. The involvement of patients in their own health was also minimised, and the role of the patient was reduced to that of the traditional "passive" biomedical patient (Barry 2003).

BHS changed its name to *The Faculty of Homeopathy* in 1943. It is worth noting here that the Faculty was actually incorporated by an Act of Parliament in 1950 to train and examine doctors in homeopathy, in other words as an officially recognised postgraduate medical teaching facility.

In 1902 the *British Homeopathic Association* (BHA) was founded by Dr. Edwin Neatby. It was basically an organization set up for the funding of doctors so they could afford to study homeopathy. It still exists today, supporting the Faculty, incorporating the *Homeopathic Trust* (a registered charity body responsible for administering funds for education and research), as well as publishing a magazine called "*Health & Homeopathy*".

The Faculty publishes the journal called "*Homeopathy – British Journal of Homeopathy*", where RLHH's Clinical Director Peter Fisher is editor. It is also the only homeopathic journal which is indexed/abstracted in MEDLINE.

Regarding the number of members, the Faculty had 11 members in 1844 (Quin and ten of his colleagues). From the mid-1850's to the mid-1970's the number has been ranging between 200 and 300 members. Since the resurgence of homeopathy in the 70's the number has been rising considerably, and in 1999 the Faculty had 1600 members (Morell 1998).

Society of Homeopaths/EHA:

Dr. John Epps (1805-1869) was one of the doctors working at the then London Homeopathic Hospital, and was loosely associated with Quin. Epps was a medical radical and apparently he did

not approve of Quin and some of the other doctor's way of teaching and using homeopathy (Morell 1999). As a consequence he joined a few other homeopathic doctors in the founding of the breakaway *English Homeopathic Association* (EHA) in 1845, which before long stood in direct opposition to BHS.

A few notes on Epps are relevant to grasp the difference between him, Quin and BHS. Epps' philosophy was that state interference to protect vested interests was an evil to be resisted at all costs – the only true form of government was democracy. Neither did he believe in any privilege or patronage; in medicine, religion or otherwise (Rankin in Cooter 1998). Epps believed in God, and homeopathy (as an ability to cure a sick person) was a gift given by God to Hahnemann. Based on this, Epps sought to emphasize the more spiritual aspects of homeopathy. In terms of religion, Rankin (ibid.) argues that BHS and EHA's religious attitudes were quite different: for the members of BHS there was a difference between the sacred and the profane, but for Epps and EHA all were created equal under God, in other words there should be no social distinction between men.

The EHA is the forerunner to the *Society of Homeopaths* (SoH). SoH was initially founded in 1970, and then re-founded in 1978. In the first year they had 15 members, growing to 595 in 1999. The Society of Homeopaths was founded by lay practitioners, and it is also meant for the lay branch of homeopaths. The idea was to "*give professional unity to non-medical*[ly] *qualified practitioners.*" (Sharma 1992:185). It has a Register, an educational College (The London College of Homeopathy), its own Journal "*The Homeopath*" and Code of Ethics. The founding of the Society resulted in the rapid expansion of homeopathy in the UK and its growing success in the 1970's, and more Colleges becoming established during the 1980's and 1990's. The success of this is such that the lay movement within homeopathy is now a semi-legitimised profession with its own mode of registration, unified teaching syllabuses, training procedures and self-regulation (Morell 1998). Just as the Faculty has the BHA, there is an organisation called *Friends of Homeopathy*, which supports the Society.

The Faculty and homeopathic training:

What is the most interesting about the Faculty for the sake of this thesis, is their training and education of homeopathic doctors. In the first decades of the 1900's, Nicholls argues (1988:219) that the problem for homeopathy was not being recognised by biomedicine – the problem was education. There was thus a call for research and the proving of homeopathic efficacy. Obtaining a place for homeopathy on the medical curriculum for undergraduates seemed unrealistic, so the homeopaths had to rely on post-graduate instruction. The main objective was to obtain a fair recognition by the State - the right to educate. In 1943 the Faculty obtained recognition from the Board of Trade as a corporate body and thus acquired the right to set the standard for post-graduate educational courses and examinations. The Faculty of Homeopathy Act was as noted secured in 1950, which also ensured the continuation of facilities at the RLHH for research and education (ibid.:220).

The Faculty has today a very extensive training programme for those who wish to become homeopaths. However, to obtain this training the Faculty approves as members only medical practitioners registered with the General Medical Council. These include doctors, veterinarians, dentists, pharmacists and podiatrists. Other health care professionals are welcome as long as they are statutorily registered (e.g. midwives, nurses and so on).

The training consists of either part-time, full-time or distance learning courses. Prices range from £120 a day for modular part-time courses to £3000 for a full time course.[65] The training is held at the teaching centres at the homeopathic hospitals in Glasgow, London and Bristol, as well as in Oxford. The examination is called *Primary Health Care Examination*, and marks the basic skill levels within standards of safety, quality of practice and professional competence. This training leads to one of three titles: *Member of Faculty of Homeopathy* (MFHom); *Fellow of the Faculty of Homeopathy*

[65] Prices listed in 1999, in the Faculty's own research portfolio I obtained at RLHH.

(FFHom), or LFHom, which is a licensed Associate of the Faculty, meaning they have passed the examination.

The Faculty at RLHH:

What we can see from the above is that there are two very different homeopathic organizations in Britain today. There are the medically qualified doctors using homeopathy (represented by the *Faculty*) and then there's the lay practitioners (represented by the *Society*). Just to give some idea as to how the two differ, a member of the Faculty can join the Society if he/she wishes to do so, but do not have voting rights. This, allegedly, was an arrangement instituted to prevent any doctoral take-over of the organisation (Sharma 1992:186).

Regarding RLHH, The Faculty is very closely linked to the hospital (the two have also earlier shared premises at RLHH). At RLHH I counted at least 17 out of 25 doctors as being members of the Faculty. I did not interview and ask all of the doctors at RLHH, but from what I could see there were no members of the Society there. This is hardly surprising, considering the hospital's history, Quin being the founder of the Faculty and the fact that RLHH is one of the Faculty's national training centres for homeopathy.

The Faculty and its members are in many respects very biomedical in its approach to homeopathy, as well as the Faculty being very restrictive regarding who can join as members. Put simply, I would argue that RLHH can be viewed as a sort of Faculty *stronghold*, and it is on these premises I wish to argue that the homeopathy at RLHH is not as far detached from biomedicine as one would think.

In this argument, we must make the distinction between two things: a) homeopathy in clinical practice at RLHH and b) the research. Even though the doctors themselves said in interviews that the two medical systems complemented each other and they made use of both, it is difficult to say exactly to what extent this happens at RLHH on a *practical* level. This is especially so since I have no medical training myself and only theoretical knowledge about homeopathy. Whichever

way it is practiced, though, it seems that it is not necessarily the *type of* homeopathy in itself that is the most important factor.

The GP's, as noted before, functions as *gate-keepers* to CAM services within NHS, and we have seen that they in this respect have quite an amount of power to control CAM services available to patients (even though this power may be declining due to NHS being more consumer/market-driven). It seems the trend is that GP's are more inclined to refer patients to medically qualified homeopaths. [66] This could imply that the GP's simply feels more at ease with homeopaths (i.e. Faculty-members) they know have training in the GP's "own" medical system rather than the lay homeopaths (Society-members) with usually no medical training at all.[67]

What we are left with more than anything is, I believe, not only the biomedical homeopathy in clinical settings as such, but also the homeopathic *research*, of which type the Faculty represents. As Barry has pointed out (Barry 2003) one needs only to look at the two homeopathic organisations' journals to see the striking difference between them and the emphasis put on research. The Society's journal, for example, emphasises the more spiritual aspects of homeopathy and is more in line with the original homeopathic ideas as developed by Hahnemann. This does not mean that the Society is negligent of research, but the Faculty's journal, on the other hand, is much more "scientific" in its approach, both regarding layout and subject matter. The articles emphasises clinical trials (RCT's), proving of homeopathic efficacy, cost-effectiveness of CAM, literature review and so on.

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[66] See Akhtar's study in the next chapter.

[67] It is, however, important, to note that the GP's are heterogeneous groups, and the GP's different referral patterns and motivation for referring does not apply to every GP. It is therefore important not to generalize too much from Akhtar's study, see next chapter.

The GP as a *gate-keeper* for the patients is one thing. At the same time, I believe that NHS can be viewed as a *gate-keeper* in its own right, especially in relation to funding of the hospital. The subject of research is important for RLHH and the Academic Unit. This was not communicated to me explicitly when I interviewed staff as such, but many of them said that evidence-based research on CAM and homeopathy was important to prove its effectiveness. RLHH's own Evidence-based Portfolio (see bibliography) states that "*we are aware that commissioners are under increasing pressure to justify expenditure*", in others words the question of cost-effectiveness and which therapies should be used and not, as was stated many times in interviews I conducted (see chapter 2).

I did not ask about this at the hospital, but I would argue from my empirical data that this would be very different indeed if the Society had any major standing at RLHH. The hospital will in this way explicitly communicate that it is interested in co-operation with the biomedical community, as some of the doctors also pointed out in interviews. I believe this would be very different if any given research by the hospital constantly concluded that "homeopathy works, but we don't quite now *how*", or "homeopathy works anyway, research is not interesting to us".

The research referred to in this thesis may indicate that the most important factors for the doctors and the biomedical community (and NHS) is an interest in research of CAM. The priority, it seems, is first and foremost with *patient safety*. This is, of course, increasingly important in a more consumer-led NHS where patients can end up suing hospitals and doctors for negligence if they do something wrong. Priority is also given to cost-effectiveness rather than on the efficacy on homeopathy. Either way: to be able to legitimise its own ways of treatment, the RLHH is dependant on the research they conduct, and the question is then if they (or other CAM research in general) are given the opportunity – i.e. being secured funding - to do so. Proving that CAM is effective in treatment and cost-effective enough to save NHS money is, therefore, imperative for RLHH. As noted in RLHH's own research (Sharples et.al.), the cost-effectiveness of CAM is actually one of RLHH's weightiest arguments, as well as one of the areas

which has most potential for the benefit of the patients (ibid.:13).

Being on good terms with the biomedical community (as the Faculty aims at) is, it seems, an advantage the hospital would perhaps not have if the Society's homeopathic philosophy were RLHH's common view, due to the biomedical community trusting RLHH more because of its biomedical basis.

When I asked the Clinical Governance Manager about NHS and any control over RLHH, she said that part of this control of RLHH is based around a growing "suing-culture" adopted from USA. If RLHH (or, in effect, NHS) does something wrong during treatment of a patient, they can be sued, i.e. sued for malpractice. NHS is, understandably, afraid of this. This coincides well with what a member of staff said about RLHH having to be conservative and threading middle-ground in relation to NHS - the emphasis of the hospital is on the safety of the patients and the safety of any given new treatments.

Concerning the two homeopathic organizations and their different view on homeopathy, in what way and to what extent homeopathy will be offered in NHS in the future depends to a certain degree on the relationship between them. The House of Lords Report (HoLR 2000) advices the homeopaths in Britain to form a single professional statutory body to regulate the profession, and homeopathy is at present the only alternative medical profession who has not yet done this. With the differences between the two homeopathic organizations in mind this may not happen anytime soon. RLHH's Clinical Director, Peter Fisher, has said that he is in favour of this type of body himself (see Smallwood 2004:48), but this has not happened yet due to inter-professional disagreements between the two bodies.

Summary:

I have in this chapter looked at the two homeopathic organizations in Britain, The Faculty and the Society. I have argued that homeopathy is organised around two philosophically different homeopathic organizations in the UK, and the Faculty has a strong standing at RLHH. I have

argued that the hospital's emphasis on scientific research on CAM (which the Faculty is in favour of), as well as allowing only doctors and medically trained personnel to become members, are weighty arguments in the understanding of RLHH's standing within NHS, both past and present. I have not studied either of the two organizations in-depth, but I have argued that the GP's level of trust towards RLHH to some degree seems to depend on the hospital having medical homeopaths employed, and it is difficult to imagine the Society of Homeopaths and their stance on homeopathy and scientific research as the dominant view at RLHH.

With the previous chapters in mind, I will in the last chapter discuss all of the above in relation to biomedicine and its alleged power and hegemony over CAM. I will argue, following Barth and Scheper-Hughes & Lock, that biomedicine (as a medical system) is a *system of knowledge* which is culturally created, as well as a system that must not be exempt from cultural analysis. In doing this I will make use of Gramsci's definition of hegemony, to emphasise the *dynamic* element of the biomedical hegemony. I will show what means are available to biomedicine to hold hegemony, while simultaneously show how RLHH responds to this. One important factor in this is the patient and a currently heightened patient autonomy regarding choosing treatments.

Chapter 6: Biomedicine – power and hegemony:

On one of the first days of fieldwork I had a talk with the hospital's Clinical Director Dr. Peter Fisher at the Academic Unit. Here I clarified the intentions of the fieldwork and what I was going to do there. I explained that I was very intrigued by the hospital and the fact that it is placed under NHS (in other words public health care), and that there were no hospitals like these in Norway. I stated that my purpose in being there basically was to understand how the hospital "*was working*". The Clinical Director joked something to the effect of :"*...or if it* is *working?*" while giving me a wry smile. He was, it turned out, not the only one to respond to my question this way at the hospital, and I think his answer is quite telling with regards both to the hospital's past, present and future.

As noted in the Introduction, Baer et. al. (1997, see also Stoner 1986) argues that complex modern capitalist societies (like Britain and Norway) exhibits medical pluralism. Biomedicine is but one of the many medical systems that make up this pluralism (1997:30). Simultaneously, it has been argued that there is a biomedical hegemony over these other medical systems, a claim that is generally well accepted within anthropology (see e.g. Sharma 1992, Saks 1992, Baer et. al. 1997, Worsley 1997, Foucault 2000, Scheper-Hughes & Lock 1987). The question is then *how* this hegemony can be said to express itself.

With the historical overview in the previous chapter and Stoner's argument about medical pluralism in mind, I will in this chapter discuss biomedicine and its alleged power and hegemony over CAM. I will argue, following Barth and Scheper-Hughes & Lock, that biomedicine, as a medical system, is a system of *knowledge* that can – and must be - be culturally analysed like any other system of knowledge. I will then situate this within a British context and look at to what degree biomedicine can be said to have hegemony in relation to RLHH. I will do this by using Gramsci's definition of hegemony, which emphasises the dynamic element of hegemony, meaning that the hegemonic structures are not static. I will do this as follows:

First I will present the critical medical anthropological view posed by Scheper-Hughes & Lock (1987) on the body and politics, which is an elaboration on the critical medical anthropological concept of power. I will then look at Barth (2000) and his "anthropology of knowledge". Then I will outline on what I believe are the most important means available for biomedicine to have hegemony and in turn how RLHH responds to them. By doing this I hope to show that there are indeed hegemonic structures present that affect RLHH, but these are not as clear-cut as one would initially think.

Biomedicine as a system of knowledge:

"*Part of the goal of* [critical medical anthropology]", Brown writes (1998:208), "*is to attempt to understand and describe the hidden cultural models of biomedical thinking*". Scheper-Hughes & Lock have elaborated on this in "The Mindful Body: A Prolegomenon to Future Work in Medical Anthropology" (1987). In this essay they outline three types of bodies; the individual, the social and the body politic (bodies being controlled through power), and how they represent three separate units of analysis.

The very important point they make is that what we label biomedicine is a medical system that should not be exempt from cultural analysis. It is, alongside other medical systems such as homeopathy, a system that is not to be taken for granted. Or, as Brown writes, it is not a system that is unbiased by its own cultural premises (Brown 1998:16).

Scheper-Hughes & Lock argue that while biomedicine can be traced all the way back to Hippocrates, it is Rene Descartes who "most clearly formulated the ideas that are the immediate precursors of contemporary biomedical co*nceptions of the human organism.*" (Scheper-Hughes & Lock 1987:9). This in the sense that the Cartesian division between body and soul is what biomedicine is founded on today. This, they argue, made the mind (or soul) disappear into the

background for several hundred years, and it did not re-appear until the development of psychosomatic medicine in the 20th century.[68]

What is interesting is that this mind-body division has, Scheper-Hughes & Lock argue, made it impossible to "*conceptualize a "mindful" causation of somatic states*" (ibid.) which has, in short, made it difficult for medical anthropology to successfully grasp the interaction between mind, body and society. [69] From an anthropological perspective the solution to this problem is to develop a theory that incorporates concepts of power and control, or what they call the third type of body: the body politic.

Scheper-Hughes & Lock, citing Mary Douglas and Michel Foucault, argues that in times of crisis society will try to control bodies (individually or/and collectively) and it this way "*reproduce and socialize the kind of bodies they need*" (ibid.). One of the reasons why this is so, they argue, is due to the disappearance of traditional cultural idioms through which expression of individual/collective discontent can be made, and this has "*allowed medicine* [...] *to assume a hegemonic role in shaping and responding to human distress*" (ibid.). Furthermore, with regards to biomedicine, Scheper-Hughes & Lock show, again citing Foucault,[70] how biomedicine, serving the interest of the state, traditionally have had the power to control even the most basic of human activities, such as reproduction and sexuality.

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[68] This coincides well, I believe, with chapter 3 and Eisenberg's illness/disease-distinction.

[69] The medical students in Norway are today being educated within a framework of a *bio-psycho-social* model, referred to as the "Oslo 96-Reform". I will discuss the implications of this in the concluding chapter. See also Hepburn 1988, pp. 61-62. British medical training has also changed over the last few years, see e.g. www.nhshistory.net.

[70] See Foucault 1980 for a further discussion on the topic of the body and power.

Barth (2000), very much in line with Scheper-Hughes & Lock's argument on biomedicine as a cultural system available for analysis, has written about knowledge and how traditions of knowledge are in a constant state of configuration and change. He argues that knowledge, as it is distributed in a population, "*provides people with both materials for reflection and premises for action*" (2000:1). Barth sees three aspects of knowledge (ideas/assertions about the world, communication of knowledge, and distribution of knowledge) and these mutually determine each other. This is done in terms of *agency*: people "*hold, learn, produce and apply knowledge in* [...] *various activities*" (ibid:3). In short, Barth argues that if one takes this perspective on knowledge it can be adapted to modern (academic) knowledge as well as on other forms of knowledge (e.g. his own ethnographic material from Baktaman rituals and Bali Hinduism).[71]

Further, Barth elaborates on academic knowledge at British universities. Here he argues that the British social democratic (hence political) concern with the question of the usefulness in universities' services has created an "audit culture" which shapes the anthropological knowledge and production of it in terms of research and so on. This is, I believe, an apt analogue to viewing biomedicine as a system of knowledge that shapes both thought and action in relation to other medical systems.

Barth's definition of knowledge secures, he argues, space for agency and action, which in my view is very important, since it puts focus on the actual people holding and distributing (medical) knowledge, rather than on knowledge solely as structure/system. Moreover it puts focus on how knowledge production and distribution is a social process. I will now contextualize the views posed by Barth and Scheper-Hughes & Lock above in relation to my own fieldwork and the

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[71] Here Barth has an interesting example of treatment of sick people and how different systems of healing (healers, priests, teachers and biomedical doctors) are being used. These constitute different traditions of knowledge ranging from Hinduism to biomedical science (2000:6).

question of biomedical hegemony – in short, how this hegemony is expressed in practice. Before we do this, however, I will present a definition of hegemony[72] developed by the Italian writer Antonio Gramsci (1891-1937).

Gramsci's definition of hegemony, as well as much of his other writings, is heavily influenced by Machiavelli. It is primarily written from a communistic political point of view, but still fits well with Barth and an anthropological analysis of knowledge and power. This is especially so precisely because both of them focus on *agency*.

Hegemony is conceived by Gramsci as the "*vehicle whereby the dominant social groups establish a system of "permanent consent" that legitimises a prevailing social order* [...]" (Fontana 1993:141).[73] This social order is, in line with Barth's argument, based on knowledge (via institutions, like education). This knowledge, Gramsci argues (following Machiavelli), is not a static body of knowledge unchanged over time. Rather, the knowledge is "*"open" to the people*" (ibid.:151). In short, knowledge is a product of conversation and, most importantly, interaction; hence the relation to knowledge as something *dynamic*. According to Bellamy (Bellamy (ed.) 1994) Gramsci used the term in two ways: first, hegemony refers to the leadership the proletariat had to seek to make the allied classes identify with its interests. Second, hegemony refers to the "*consent of the population to the prevailing political and economic system through the institutions of civil society* [...]" (ibid.).

When situating knowledge in relation to this thesis and hegemony, we must take the view that biomedical knowledge, as well as homeopathic knowledge, is a product of a social process. Knowledge is thus acquired, distributed and even withheld from actors. I will in the following

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72 Also referred to as "*ideological power*" (Fontana 1993).

73 Note: Gramsci's theories cited in this thesis are based on Gramsci readers, not his actual writings. See bibliography.

argue that there are at least four specific means available to biomedicine in their attempt to hold hegemony over CAM. These are statutorily regulation of medical training; the GP and CAM referrals; the biomedical research, and finally the funding of RLHH/research. I will look at these in turn, describe how RLHH answers to them, and finally discuss the question of hegemony in relation to the *patient* and rising patient autonomy. [74]

Statutorily regulation of biomedical education:

Worsley argues that after the founding of NHS organized medicine was stronger than ever. In such a way, in fact, that it has been argued that their position could be "*matched [only] by the Church and the Law*" (Worsley 1997:203). With the historical overview in chapter 4 in mind, we see that what has historically developed into biomedicine has become the dominant form of medicine in the UK partly because of statutorily regulation of the medical education of doctors - i.e. the Royal Colleges having control over the training.

This institutionalization of education gives biomedicine a high degree of autonomy. Friedson argues that there are three reasons for this autonomy (1988:137). First, that biomedical knowledge is so "special" that lay people are not able to evaluate or regulate it. Second, biomedicine is given the *responsibility* to work with and manage this knowledge, an third; biomedicine is given the power to sanction against its own members and outline codes of conduct.

Further, Friedson argues that biomedical control is based on the fact that it is *political* (ibid.:23): it is the state which sanctions the degree of security and autonomy of a medical profession (Sharma

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[74] This argument is my own. It is written from a British context, but is also, I believe, partly adaptable to e.g. a Norwegian context or other countries where biomedicine is the leading medical system. See the concluding chapter.

1992:119).[75] Concerning education, Sharma argues that raising educational levels and prolonging the training "[enhances] *the credibility of the group's claims to esteem and expertise*" (ibid.1992:117). The dominant status of biomedicine is, Baer et. al. argues, legitimized by laws that gives it monopoly over "*certain medical practices* [that] *limits or prohibit the practice of other types of healing*" (1997:29). Wright (in Saks 1992:49) argues that there is social power invested in licensed practitioners because they are "*members of organized professional groups with the legal authority* [...] *to exclude others*" (ibid:1992:49). This, in short, puts them in a privileged position in the labour-market.

Institutionalisation also leads to another thing. As I showed in the previous chapter, homeopathy has never enjoyed a single organizational body, which has lead to much debate between the homeopathic practitioners. This is not as problematic for biomedicine. The *British Medical Association* (BMA), founded in 1856, have at present almost 140 000 members, as well as overseas members and medical students (20 000),[76] and their considerable influential power is not to be taken for granted.[77]

With regards to BMA's stance on CAM, in 1986 they published in its Report on alternative medicine, where they "*depicted alternative medicine as superstitious dogma.*" (Saks in Gabe et. al.1994:87-88). This approach, Saks argues, has led to two things: CAM – especially homeopathy – being criticised for its lack of any scientific evidence in their medicine, and secondly, it is not being allocated enough official research funds (see below).

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[75] It should be noted here that Friedson simultaneously questions how genuinely autonomous biomedicine can be when being governed by the state (1988:24).

[76] Statistics from www.bma.org.uk (2006).

[77] For a discussion on lobbyism and how the Norwegian Medical Association works, see Arum 2006.

Concerning RLHH, the statutorily regulation of the medical profession has no direct implications on the hospital as such, but it has for CAM in general - especially with regards to training of CAM therapists. This training is left out to privately funded (and expensive) schools/colleges which must be paid for by each individual student.[78] Moreover, by enjoying the privilege of

occupational self-government from the state, biomedicine is to a higher degree able to marginalize competitors - CAM occupations and practitioners that are mostly organized voluntarily often remain vulnerable to this competition (Larkin, in Saks 1992:112).

Referrals/the GP as gate-keeper to CAM services:

The General Practitioner (GP) holds considerable power over the types of (free) CAM being offered to the patient within NHS. In the UK the GP acts as a *gate-keeper* to many of the CAM services being offered within NHS, which in practice means that when a patient requests CAM within NHS he/she needs a referral from the GP to obtain this.

Being referred by the GP can be done in many ways. When the patient sees a GP, the GP can do the following:

- Provide CAM himself/herself, or refer to a CAM practitioner at the GP's own health centre (private).

- Refer to a member of an on-site multi-disciplinary team (as in the case of *Marylebone Health Centre* in London, which provides both CAM *and* biomedical care).

- Refer to a specialist CAM centre within an NHS Acute Trust (for example RLHH).

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[78] It is sometimes easy to forget that medical training (via the public universities) is for free, except for the modest tuition fees.

- Refer to a specialist CAM centre contracted by the District Health Authority (for example *Centre for Complementary Health Studies in Southampton*).

- Refer to an individual, off-site, CAM practitioner contracted by the Primary Care Group or Primary Care Trust.

- Refer to a secondary care service within the NHS Acute Trust that uses CAM (as in some physiotherapy and orthopaedic clinics).

- If patient is terminally ill refer to a palliative care unit which provides CAM.

- Take advantage of District Health Authority Initiatives that may be piloting CAM projects.

Here two questions must be answered when discussing the GP and referrals. The first is to what degree the GP actually provides this. A study cited in HoLR (2000) shows that 40% of GP partnerships in England provide access to CAM for NHS patients.

The second questions concerns the reasons *why* the GP's choose to refer or not. A survey on referrals conducted by RLHH itself (Sharples, F.M.C., et. al. 2003) concluded that concerning who initiated the referral, 79% of the patients asked for a referral first (in other words, before the GP recommended it), while only 15% of the GP's initiated referrals (80% of this was homeopathic treatment and 20% acupuncture). The survey concludes that the doctor's negative attitude towards CAM has fallen over the last two years (2001-2003), due to greater acceptance of CAM's medical effects.

I did not ask any staff or doctor about their views on the GP's and their referral patterns, but research on this I obtained at RLHH (Akhtar 2000) gives us an idea of the GP's attitude towards both RLHH and CAM in general. Interviews with 12 GP's showed that 8 of them referred the patient if he/she wished so, the rest would not. Three factors were examined: Efficacy, cost and safety. Concerning efficacy of CAM, the GP's were divided in their opinion: some had doubts whereas others felt they could not interfere in the patient's right to choose their own course of

treatment (2000:14). On the topic of cost-effectiveness the GP's knew little about this, but most of them assumed overall that it was cheaper than conventional care (ibid.:15). Moreover, the GP's seemed to prefer referring patients to doctors that had training in homeopathy.

6 of the GP's said that RLHH was one of the few places, for some also the only one, they would refer to. The reasons stated was that they either knew of no other place, or they trusted the hospital (because it was a public NHS hospital), or because they wanted only medically qualified homeopaths.

From the study by Akthar we also see that the GP's are not united in their views neither concerning homeopathy nor referral patterns. This could mean that GP's in the future are more inclined to let the patients decide on treatments themselves. The question remains if the BMA - representing the doctors - would agree, especially if this means a loss of the power invested in the doctor.

Biomedical research – RCT:

Beside the GP's power in referring patients to CAM, I believe the perhaps most important factor in an analysis of biomedical hegemony is on the subject of biomedical research and its negativity towards homeopathic efficacy.

In biomedicine, the standard of research on medicine is based on what is known as RCT: *Randomised Control Trials* (or *Randomised, Placebo-Controlled Trials*). The basic idea behind this is, in short, to employ two groups of patients when testing new treatments. One group is tested only with a *placebo* medicine (meaning medicine with no medical effect). The other group, known as the *control group*, uses the medicine that is being researched. Then the two groups are compared to check for any given effect. Since the beginning of the 20th century medical science has focused on the biological component of disease, and has evolved together with the development in the other sciences: physics, anatomy, biology and chemistry (Saks 1992:212). This scientific way of conducting medical research is today approved of as the most valid way of conducting research

within biomedicine, and it is here that we find the biggest argument posed by biomedicine against homeopathy.

If it currently is impossible to conduct research on homeopathy using RCT, what follows is that it is difficult to prove any medical effects above or beyond placebo (Saks 1992). In homeopathy conducting research in the "scientific" manner is not as easy, due to what some homeopaths believe are methodological and practical problems. The treatments given vary greatly from patient to patient (the subjective element of illness) which makes it difficult, some homeopaths argue, to generalise from the research results ("*Evidence base*" 1999:8-11).[79]

In relation to RLHH, the hospital focuses heavily on research to prove CAM's medical effects, which is why the Academic Unit was set up in the first place. Based on the interviews I did and from the emphasis put on presenting the research in terms of journals, conferences and so on, the hospital seemed very explicit in communicating this research.

The research conducted at the hospital aims at being as scientific in its approach as possible, which means that the research is designed to follow the (biomedical) RCT standard. This is, I believe, a very important point in this discussion, and has implications on RLHH's way of working.

First, the research conducted at RLHH helps the hospital to avoid what they believe are ineffective treatments – for example did research on acupunctural treatment of tinnitus show little or no effect. In these cases the hospital discourages patients from being referred to RLHH by the GP's (*Evidence base* 1999). The hospital states that therapies will only be made available on the NHS once there is convincing evidence of its effectiveness (ibid.).

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[79] Some believe homeopathic research is downright impossible, due to psychological factors in illness that cannot be measured quantitatively (cf. Smallwood 2004).

Second, the hospital itself is aware of the methodological difficulties involved in research on CAM and proving of any effectiveness entirely beyond doubt. The idea, the hospital states, is rather to act upon the best possible evidence ("*Evidence base*" 1999:24).

Third, the hospital emphasises the aspect of *cost-effectiveness* of CAM. This refers to the question of how much money CAM treatment actually costs and, consequently, if money can be saved using CAM rather than conventional care in treatment. The cost-effectiveness of CAM was stressed both by the Deputy Clinical Director, by the staff and some of the doctors in interviews with them, and the hospital regularly produces research that they argue shows how CAM in many cases can save money on public health care.[80]

To give an example of this, 665 patients were enrolled in a study at homeopathic and conventional primary care settings in Germany and Austria.[81] 70% suffered from chronic diseases - asthma, bronchitis, migraine and so on – which also are the diseases most frequent at RLHH. Two findings emerged from this study. First, 24% of patients treated with homeopathy reported complete recovery compared to 10% treated with conventional medicine. Secondly, a cost-effectiveness analysis revealed that in order to obtain a complete recovery, one had to spend 86 Euros for homeopathic treatment, compared to 173 Euro for conventional treatment within the first six months.

Concerning NHS's own stance on the efficacy of CAM, in the House of Lords Report the Department of Health explained their position as one of safety before anything else, even before scientific plausibility. Their opinion on homeopathy and safety was that homeopathy seemed safe

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[80] See e.g. van Haselen 1999, 2000.

[81] Haidvogel, M. et. al.

and unharmful, and their approach was "*fairly pragmatic*: *If homeopathy does not harm then it is less important to have an in-depth understanding of its mechanism for effectiveness*" (HoLR 2000).

This pragmatism seems to be consisting with the view of the doctors I elaborated on in chapter 3 (i.e. the doctors in general not especially concerned with homeopathic efficacy as long as the patient himself/herself experienced improvement in their health).

RLHH and funding:

When interviewing the doctors and staff, observing the daily life of the hospital, reading the hospital's history and so on, what was most striking was the subject of funding and financing of the hospital. As already noted, RLHH's history is filled to the brim with threats of being closed down. The current situation is definitively more promising (according to a member of staff the budget, amongst other things, had been doubled in the last few years), but nothing is taken for granted. The most interesting question in this respect is how *autonomous* RLHH is, both past and present. This will become clearer if we elaborate a little on the historical overview I gave in chapter 4.

RLHH was an independent hospital within NHS with its own management board until 1974. Then, after a re-organization of NHS, the hospital was incorporated in the South Camden Health District, which made the hospital lose much of its independence. The theatres and surgical beds were closed in 1981, the geriatric ward in 1983, and later also the children's ward.

In 1989 RLHH obtained NHS Trust status, which meant that it became autonomous again, but a bad relationship with the local health authorities threatened to close down the hospital – a date in march 1992 was actually set for the hospital to be closed down. Things took a turn for the better, however, and in 1993 it received *full* NHS Trust status. In 2002 RLHH joined what is called UCLH NHS Trust, meaning that the hospital was now also part of the *UCLH - University College of London*.

That the hospital was granted the before-mentioned £20 million to refurbish the original hospital

in Great Ormond street is, obviously, a sign of the hospital's current standing within NHS. Even though I have spent some time in this thesis arguing that it seems the hospital is under constant threat of being closed down, the £20 million make-over of the original hospital means that it is secured further existence.

Concerning RLHH and funding of research, this involves many things: time, patients and money. The hospital does not get enough money for this from NHS. According to the British Medical Journal only 0.08% of funding for research in NHS goes to CAM in general (*Evidence base* 1999). The hospital is thus raising money for research from a variety of other sources like charities, industry and official bodies such as the European Commission. Moreover, the RLHH relationship (and full partnership) with UCLH since 2002 also helps the hospital to fund the research. Simultaneously, funding for research at RLHH was, for example, increased by 35% by NHS in 1998 (ibid.:8)

From conducting the fieldwork at RLHH I would argue that the opinions expressed by both the doctors and staff regarding the future of the hospital seemed to be one of concern, yet at the same time they seemed fairly optimistic. A member of the staff, who was also partially working with treatment, said that in almost 10 years working there he felt there had become a greater acceptance for CAM in general, both from the GP's and from the general public. When asked about NHS and its relationship with the hospital, he remarked that NHS now had become more consumer-led, which meant that the public – the patient - had a much more realistic choice in terms of choosing different kinds of treatments. The member of staff regarded NHS both as a "*strength and a limitation*" – a point of view many others at the hospital, staff and doctors alike, expressed as well. He said that the hospital had to "*thread middle-ground*" in relation to NHS. The hospital had to be very conservative when looking at new treatments, simply because it was difficult to get funding for them. He said that it after all was important for the hospital to be professional, since it is using public money.

Concerning funding, I did not during my fieldwork look into budgets and financial figures of the

hospital, nor did I ask about this from a historical point of view. It should, however, be obvious from what I have written in the previous chapters, that the member of staff mentioned above is right when he said in an interview that it was NHS's goal to make RLHH be on budget, preferably with a surplus. RLHH, as any other public hospital, obviously has to justify their use of money.

He emphasized two additional points: First, RLHH stood in danger of being marginalized if the PCT's (*Primary Care Trusts*, see chapter 1) in the future decided to give less money, or if the hospital did not generate enough money. Second, if too many patients were treated without positive results this could mean that the patients started telling their GP's about this, which, in effect, could mean less patients being referred to the hospital by the GP's (cf. the GP and referrals above). The member of staff interviewed did not, however, see this as a threat since he personally thought that there were "*fairly good*" evidences for many of the treatments being offered at the hospital.

In relation to funding there is a recently added element in the NHS of what is called "*performance funding*" in resource allocation to health care (see Newdick 2001 for a general discussion). Additional sums may be given if, for example, a given hospital achieves specific targets (completion of projects and objectives, performing its functions etc.). Hospitals and Trusts are rated via a star rating system, so the public can see which hospitals perform well or not. A low star rating does not necessarily mean that the hospital offers bad clinical service or that the staff is not working well enough, but rather that performances must be improved in certain areas (Newdick 2001:71). RLHH and its Trust had at time of fieldwork a high star rating, which in general means that it is given greater autonomy, less regular monitoring and additional funding.

The patient and power/autonomy:

What we see from the above, is that the statutorily regulation and, in short, the professionalisation of biomedicine via a united professional body has given it an advantage CAM, which is mainly voluntarily organized, does not have. Homeopathy in Britain is also as noted

divided in two organizations with much inter-professional disagreement. Furthermore, we have seen that it is the GP who decides whether patients obtain CAM treatment within NHS or not. We also saw that research indicates that the patients themselves initiated the request for a referral rather than the GP. Further research has suggested that at least some of the GP's preferred RLHH because the homeopaths working there are biomedically trained.

Further, we have seen that funding is crucial to conduct research, both in general and at RLHH. NHS has acknowledged this and rewarded RLHH with increased funding for research. One of the reasons for this may be growing patient power/autonomy.

Hahn has argued that we in many ways have moved from the *era of the doctor* to the *era of the patient*, where the experiences of the patients to a higher degree than before shapes and contests the nature of medical practice and institutions (Hahn 1995:266). This also coincides with Baer et al's (1997:215) argument that biomedicine never will be able to establish *complete* hegemony, simply because the patients now and again for various reasons seek alternatives to biomedicine.

Moreover, this coincides well with chapter 3 and its focus on RLHH as a place were the illness and illness *experience* of the patient seems to be emphasised on the part of the doctors. It could be argued that RLHH here, in short, gains credibility with the patients that many doctors (most importantly GP's) does not get, due to lack of time, prescription of too many drugs, patients not feeling they are being taken seriously and so forth.

The patients are a rising force. Today, more than ever, people in general have a higher level of medical knowledge than previous generations. Courses, literature, the internet and a growing

interest in health has made it easier to gain knowledge about our own health, body, diseases, treatment and alternative medical systems (see for example Hepburn 1988 and Sharma 1992).[82]

This heightened medical knowledge affects the way people choose and *what* we choose – for example homeopathy over biomedicine. Or in other words, as Sharma argues, even though any "*scientificity*" may help a professional group to gain credibility, this scientific knowledge does not amount to much if a patient does not think a given treatment works (Sharma 1992:123). NHS, it seems, has recognised this, in the sense that they today are emphasising the patient as a *consumer* that have the power to choose the treatments he/she wants; - we "*shop for health*", as Sharma puts it (Sharma 1992).

For people to actually obtain treatment at RLHH, they must *know* of the homeopathic hospitals. I did not ask the doctors about this, but members of staff pointed out that the hospital was not widely known to all - neither patients nor doctors - especially outside the London area.[83] With only four other homeopathic hospitals like RLHH available via NHS this could mean that many patients in need of treatment would have to seek help from private practitioners instead. On the other hand, it did not seem to me that RLHH had any trouble obtaining enough patients, and during the consultations I sat in on, the doctors did not appear to have many free slots in their schedule each day.

If the research presented in chapter 1 is correct, this would mean that people, both patients and doctors, have a higher acceptance for CAM in general than previous years. I did not ask

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[82] A crucial aspect regarding the patients and power in obtaining CAM is self-help/advocacy groups. As a social movement they can be said to represent considerable power. I did not look into what effect this may have had on RLHH and the patients there. The internet is, not surprisingly, full of these sort of sites.

[83] The hospital is, on the other hand, well known within the CAM research community.

specifically about this, but it could be argued that due to NHS' acknowledgement of the patient as a consumer, RLHH's standing is reflected in the additional funding of research as well as allocation of the hospital's resources.

Finally, it is important to remember two very crucial aspects of CAM in Britain. First, with the homeopathic history in chapter 4 in mind, due to the elite and royals introducing homeopathy from the very beginning, CAM has been put, one must remember, in a privileged position in Britain (compared to e.g. Norway). Second, the state has never restricted private practitioners, which has affected the number of practitioners as well as how CAM is viewed. As an example, two other medical systems, osteopathy and chiropractics, are in Norway regarded primarily as CAM. In Britain they are now statutorily regulated (1993/1994 respectively) and have become professional bodies with guidelines on education set by their regulatory councils: GOsC and GCC.

Another example is acupuncture. The British Acupuncture Council has been forming an Independent Accreditation Board for Educational Standards to ensure that no college or course would be advocated by the Council without being scrutinised by an independent board (HoLR 2000). Acupuncture was rejected by biomedicine for many decades, but since the 1970's acupuncture has enjoyed a rise in interest, both from the public and from a rising number of doctors practicing it (ibid.).

When trying to identify any biomedical hegemony over CAM and RLHH, we see that the biomedical research on CAM is a very important element, in the sense that the research being conducted on CAM is based on the strongest knowledge of them all – hard science. In setting up the Academic Unit, and by being a Faculty of Homeopathy-based hospital, RLHH answers to this the only way they can: by emphasising science and conducting and publishing their own research, in other words they make their voice heard. I have not looked into to what extent this makes the biomedical community (NHS/the GP's/researchers and so on) more inclined to accept homeopathy, but I will argue that by emphasising scientific research on CAM

(homeopathy and acupuncture in particular) RLHH *legitimises* the hospital's standing and use of (public) money.

In the end, from Scheper-Hughes & Lock, via Barth to Gramsci, what we see from the above is that biomedicine is a system of knowledge; a *cultural product*, which must be analysed and not taken for granted. Simultaneously, this system of knowledge is not static; - neither is its hegemony over CAM, due to CAM (and especially homeopathy) being introduced in Britain from the very beginning, which has shaped and moulded its historical development alongside biomedicine. This historical development and its implications on biomedicine and CAM are important to keep in mind. The Royal and elite patronage of homeopathy have also favoured it in a very special way. This has resulted in homeopathy and CAM being put in a special position on the medical market in Britain, where the two have interacted.

Biomedicine is constantly trying to uphold its hegemony, and indeed there *is* hegemony present in Britain. But what we see from the above is that due to CAM being put in a privileged position – as well as being able to put *itself* in this position, the biomedical hegemony is not as strong as in e.g. Norway, as I will discuss in the concluding chapter. Finally, another thing we see from the above is that what this in many respects ultimately boils down to, is not only biomedicine and CAM as knowledge systems, but also the patients as *users* of these systems of knowledge. The power of the patients (cf. Hahn and "the era of the patient") is therefore a very important element in this discussion; hence Gramsci and the idea of hegemony as a dynamic process, since the patients and their experiences with CAM and biomedicine inevitably will change the relationship between the two over time, just as biomedicine and CAM have. As I have argued above, it seems that NHS has acknowledged this and partly changed its politics and goals as a consequence of this.

The above mentioned historical, socio-economic and human factors are, to conclude, elements in a dynamic relationship of knowledge, and Gramsci's definition of hegemony helps us to understand what Barth is saying: that biomedical and CAM knowledge is *accumulated* knowledge.

It is also *distributed* as well as discussed among people - agents - and this process is structurally anything but stable, rather it is dynamic. What this means in relation to medical systems, effectively, is that the biomedical and CAM knowledge is discussed and contested openly by the various parties – biomedicine, NHS, CAM, homeopathy and the patients alike, on a medical arena where each of them have their own agenda. This discussion, which changes and shapes everybody involved in it, is happening right here, right now - not in the past, and it will affect the involved parties' knowledge in the future. This, inevitably, includes the possibilities for CAM in public health care, which I will turn to in the concluding chapter.

Summary:

I have in this chapter outlined on the critical medical anthropological view posed by Scheper-Hughes & Lock on the three bodies, as well as on Barth and his theory of knowledge systems. By doing this I have shown that biomedicine – as a medical system of knowledge – must be analysed like other systems of knowledge. I have in this chapter tried to show that there is a biomedical hegemony over CAM/other medical systems, and I have shown in what ways I believe this hegemony can be said to present itself (statutorily regulation of education, the GP's and their power in referrals for CAM, research and finally funding). From my empirical material we see that this hegemony is not as clear as in other countries (e.g. Norway), and I have used Gramsci's definition of hegemony to show the instability of the hegemonic structures. This is due to CAM historically being put in a privileged position in Britain by the elite/royalty, as well as RLHH focusing on scientific research on CAM, which I have argued legitimises the hospital's standing. Further, I have discussed this in relation to the patient and the rising power invested in the patient as a *consumer*, which NHS seems to have recognised. With the budgets at RLHH being doubled and additional funding being given to research, this could be seen as higher recognition of RLHH on NHS's part.

Conclusions:

Using Royal London Homeopathic Hospital in the United Kingdom as an ethnographic example, my aim with this thesis has been two-fold. First, I have wanted to show how and to what degree CAM can exist within a public health care system which is situated within a biomedical framework. Second, I have wanted to explore the possibilities of hospitals like RLHH in Norway. I will in this concluding chapter sum up my findings, and with my second aim in mind I will at the end of the chapter briefly discuss the future of CAM in public health care in Britain and Norway. I will also present possibilities for future research on this topic and the limitations to my fieldwork.[84]

When thinking of biomedical power and its hegemony over CAM, in whatever shape or form it may come, it is sometimes all to tempting for some people, it seems, to think of biomedicine as the "bad guy" and CAM the "good guy" – with a David and Goliath metaphor thrown in for argument's sake. It is, of course, not that simple. The point of this thesis has not been to criticise biomedicine as such - its medical effects, the development of medication, eradication and cure of diseases/illnesses or anything else – a development and progress, we must remember, unprecedented in medical history. Rather, I have wanted to answer what I believe is a very fundamental question: why are there hospitals like RLHH in the UK when biomedicine in general so strongly seem to reject every facet of what homeopathy is supposed to represent? I will in the following sum up my findings, which I believe answers this question.

[84] The summary of the findings in this chapter is meant to address both readers of the whole thesis as well as those who read only the conclusions.

Findings:

First, I have argued that the historic development of homeopathy is one of the most important reasons for its current standing in Britain. Homeopathy was introduced from the very beginning, as it was developed by the German doctor Samuel Hahnemann in the beginning of the 19th century. Here we must remember that homeopathy was developed at a time when biomedicine was gradually being institutionalised as well as professionalized. The homeopaths practicing in the first years of its inclusion in Britain were biomedical doctors, which meant that homeopathy developed alongside and was susceptible to biomedical influence from the very start (as well as the other way around). This has shaped how homeopathy is practiced as well as *who* is practicing it.

On biomedicine's part, it developed in the 19th century in Britain into what Foucault has termed *labour force medicine*, which amongst other things meant that the social medicine in Britain developed in a different direction than in e.g. France and Germany (or Norway). The idea behind this type of medicine was for the wealthy classes to protect themselves against diseases, to control the health of the workers, increase their productivity, meaning they would make more money.

Historically in Britain, homeopathy was referred to as a "rich man's medicine", which meant that it was an expensive treatment that the average member of the working class could not afford. It is only in the latter half of the 20th century that homeopathy became *lay* homeopathy, with e.g. RLHH being included in NHS as a public hospital, even though most of the homeopathic treatment is still offered only in private healthcare.

Second, I have looked at how homeopathy is organized in Britain. We have seen from this that homeopathy was, and still is, divided in two camps: the *Society of Homeopaths*, which is the lay branch of the homeopaths, and the *Faculty of Homeopathy*, which emphasises a more scientific approach to homeopathy, as well as only allowing statutorily regulated health care professionals as members. The Faculty has a high standing at RLHH, and I have in this thesis argued that this standing has helped the hospital in its struggle to exist within NHS. I have also argued that this

biomedical approach to homeopathy and emphasis on CAM research makes the hospital legitimize its standing as well as making the GP's more willing to refer patients to RLHH. Research has also suggested that at least some of the GP's feel more at ease with homeopaths who are medically trained.

Third, historically and present I have shown the royal and aristocratic influence on homeopathy. Homeopathy became popular with the elite and only spread out to the lay practitioners at a later stage. Homeopathic hospitals and dispensaries were paid for by the rich and wealthy, and homeopathy was, and still is, advocated by the Royal Family. For RLHH this is important in explaining its standing – the hospital still enjoys royal patronage by HRH Queen Elizabeth II. The members of the Royal Family are keen advocates of alternative medicine, and RLHH's Clinical Director was at time of fieldwork the Queen's homeopathic doctor. Moreover, the Prince of Wales's Foundation for Integrated Health, founded in 1997, helps secure funding for CAM service, research and projects nation-wide which, I have argued, lends CAM much-needed prestige.

Fourth, I have argued that RLHH's focus on specific targets helps the hospital to legitimize its standing. Some years ago RLHH set up its own Academic Unit which focuses on CAM research. Further, RLHH focuses on *cost-effectiveness*. The hospital emphasises that its treatments in many cases are more cost-effective that conventional treatment. It is important for RLHH, I have argued, to make this point heard in NHS, which is under-funded and therefore needs strong focus on saving money in public health care.

Fifth, I have shown how the doctors working at RLHH are all trained biomedically, and I have argued that this makes RLHH a hospital offering a sort of biomedically orientated homeopathy. I have used Eisenberg's illness/disease-distinction and argued that RLHH is a place where this distinction in many ways can be said to be bridged, in the sense that homeopathy is a treatment where the subjective element of illness is addressed. Further, by interviewing some of the doctors, I have shown that they have divergent views on homeopathic effect, on research, on the

debate between RLHH vs. private CAM and so forth, however they do agree that the patient is the most important. Besides this, the doctor's work in clinical teams, and RLHH offers many types of CAM, which means that the patients can alternate between these if so desired. This, I have argued, in many ways makes RLHH a hospital for genuinely *complementary* medicine.

Sixth, I have argued that the NHS and GP's, as well as the biomedical community, seem more inclined to accept homeopathy today, and I have pointed to what I believe is a rising patient autonomy and power in choosing different treatments. This is especially important since NHS over the years have become more consumer-led. Another point here is that NHS is currently focusing on "performance funding", where the hospitals can benefit from additional funding if they perform specific targets. RLHH seems to do well in this respect, as well as having a high standing amongst medical homeopaths, patients and researchers, both nation-wide and internationally.

Finally, and overall, I have argued that there is a biomedical hegemony over CAM, and I have shown some of the ways in which this hegemony presents itself. The most important are in my view statutorily regulation of biomedical education (herein also the institutionalisation of biomedicine in general); the GP and referrals and the power invested in the GP to decide who to refer), as well as the biomedical research on homeopathy being negative to any homeopathic medical effect beyond placebo.

This hegemony is as noted well accepted in medical anthropological theory/ethnography, and I believe this thesis shows how at least some of these hegemonic structures are displayed. However, by adopting Gramsci's definition of hegemony as dynamic, what my fieldwork has hopefully also shown is that this hegemony is not as clear-cut as one would think. Quite to the contrary, following what I have written on Stoner and medical systems, the doctor's views on CAM, as well as on the biomedical/homeopathic history in Britain culturally, I have argued that the hegemonic structures present are actually changeable over time. The patients and their rising autonomy in choosing treatments, and NHS seemingly understanding this in focusing on the

patients as consumers, in my view reflects this point well.

Before moving to a discussion of the future of CAM in Britain and Norway I will discuss the possibilities of further research from an anthropological point of view, as well as the limitations to my fieldwork.

Further research/limitations to the fieldwork:

My fieldwork is – as are they all – not without its limitations. First of all, to fully grasp the *interaction* between RLHH and NHS, a deeper exploration of NHS would be needed. NHS policies and thoughts regarding both RLHH and CAM in general are easily obtainable in the form of written material (reports, statures etc.), and I have used some of it in this thesis. However, research into NHS would give us a clearer idea on its thoughts both on the current as well as on the future situation of CAM in public health care. From an anthropological point of view a study of NHS as a formal organization – the critical medical anthropological point of view notwithstanding – would also, I believe, make for an interesting read.

Furthermore, I noted in the introductory chapter that there are five homeopathic hospitals in the United Kingdom. Even though I have focused solely on RLHH in this thesis (since it is the biggest and most well known one), a study of all these five hospitals and how they differ would give a better understanding of the status of the homeopathic hospitals in Britain. Within the time, scope and range of this thesis I did not have the possibility of doing any of the above.

CAM and its future in public health care in the UK and Norway:

To begin from a British point of view, it is obviously difficult to say - as well as being a different discussion altogether - to what extent NHS, the British Medical Association and the doctors and biomedical community in general will accept any major loss of their power, especially if this means that it denies the GP his/her right to function as the *gate-keeper* to CAM services. For RLHH the heightened sense of patient autonomy discussed above can definitely be regarded as a good thing. However, it does not amount to much unless the GP's – as well as the public – are

actually *aware* of CAM services available within NHS and the GP's are willing to refer the patients to those services. Making the homeopathic hospitals known both within NHS and in the public is therefore imperative.

The *accessibility* of CAM in public health care is one of the most important elements in this discussion. From a British point of view, Leckridge (2004) discusses models in which patients can access various forms of treatment. These models, he argues, can produce different systems of health, and this is interesting concerning RLHH and the hospital's future.

The first model is what I have already pointed at; the market/consumer model, where the patients are free to choose whatever products and services they want. In this model the involvement of the state is minimal. The advantage of this is complete freedom of choice; the disadvantage is that the responsibility of ensuring that the products are safe is with the patients, due to absence of regulation. The second model is the regulated model, where the patients are still free to choose, but all products and services are regulated by the government. The problem here is that the patients still has to choose and be responsible for the outcome of treatments. The third model is what Leckridge calls the "Assimilated Model": Here CAM therapies and medication become increasingly used by biomedical practitioners. Products receive licenses and they will be available on prescriptions. The problem with this model is that no GP can ever learn everything the patient need. This means focus mainly on the providers rather than the patients.

The fourth model, which is the one Leckridge opts for, is the patient-centred model. This model focuses on how the patient in question can be treated for their specific illness. The distinctions between CAM and biomedicine are here irrelevant. This model demands a shift in the power-balance from the practitioners to the patients, through informed choice. This ensures safety, good quality products and it accepts CAM treatment by the biomedical establishment. It forces the different groups to co-operate and work together, with firm focus on the patient. This model is already mostly at work in health care, since most health care workers are regulated as

individuals.

Leckridge argues that the current CAM vs. biomedicine debate is profession and manufacturer centred, and that this is not in the best interest of the patients (Leckridge 2004:416). For RLHH, the future of the hospital will in many respects, it seems, lie in this discussion. With NHS being more consumer-led – i.e. the patients being given a greater degree of autonomy in choosing treatment – NHS is to a higher degree "forced" to adhere to the patient's wishes. Or are they? The questions still remains how much freedom is given; will the patients be able to refer themselves to places like RLHH or other public CAM services in the future, or will this be the responsibility of the GP's as it is today?

We must remember that not only RLHH but the GP's as well are forced to think of the cost/benefit of treatments and their patients. As I have shown, RLHH is well aware of this themselves - if a given treatment is not working they will ask GP's not to refer patients to them for that sort of illness. The GP's, from their own biomedical point of view, have to think about this too: which patients benefits the most from which treatments?

Newdick argues (2005:51) that in previous years the patients were more inclined to accept the GP's word in cases where no additional treatments were possible. Today, where public health service is more focused on the patient's own choice, this may not be the case due to rising patient autonomy.

Finally, discussing this from a Norwegian point of view, The Norwegian Medical Association ("*Den Norske Lægeforening*") said in 1998 that on principle all alternative medicine should be approved of *if*, and only if, it becomes scientifically proven to have any given effect. Acupuncture, the Association said, had been scientifically proven for some diseases/illnesses and should therefore be statutorily regulated and be taken in as part of "official" medicine. Homeopathy, on the other hand, had only limited effect and further research were, the Association argued, needed. On the other hand patient autonomy and the freedom to choose

different treatments were emphasised by the Association as well. [85]

After conducting the fieldwork for this thesis, the above statement strikes me as something of a paradox. It seems impossible, on the one hand, to reject homeopathy on scientific grounds and then, on the other hand, to emphasize the patients and any alleged freedom being given to choose medical treatments.

In the meantime, biomedicine and the different CAM practitioners both in Norway and the UK argues, not only over what is possible to prove scientifically, but also to what extent it is actually any *need* for this. After doing fieldwork at RLHH it may seem that if the British (as well as the Norwegian) homeopaths united and somehow announced that they would follow RCT as the only way of testing and proving homeopathy, the biomedical community would, in all probability, be much more inclined to co-operate. Not because this would mean that proof of homeopathic efficacy would finally be found, but because it would signal a willingness to find a standard for research that all could agree on. The only problem with this is that not everyone is willing to do this, just as every homeopath does not want to adhere to biomedical regulations/standards. Then, some homeopaths argue, they would lose the *alternative* aspect of homeopathy, and then what would be the point?

What actually happens if CAM becomes part of mainstream/conventional health care? Will CAM lose much of its appeal as a genuinely *alternative* way of treatment if it in any way is incorporated? Wolpe (1999) argues, from an American point of view, that acupuncture (and other types of CAM) will lose much of its symbolism if it is being taught in medical schools. He argues that CAM is becoming corporate and yet another service on the market, which will make it lose much

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[85] Simultaneously, the Association claimed sole right to the term *medicine*, arguing that alternative medicine should be labelled *alternative treatment*.

of what made it so desirable in the first place. It is not difficult to grasp his point, and obviously this could easily happen in e.g. Norway and Britain too.

As this fieldwork has hopefully shown, the century old differences between the medical and the lay homeopaths in the UK makes it difficult to think that homeopathy at present is ready to be incorporated into biomedicine anytime soon, however much willingness there seems to be. Either way, it will certainly take time. Because if there was an integration, would homeopathy then be allowed to be practiced the way it should be, and are the lay homeopaths willing to *be* incorporated? Will homeopaths agree on what is "right" and what is "wrong" in the proving of homeopathy from a scientific point of view? And will biomedicine only approve of homeopaths that are medically trained?

It is tempting to think of the biomedical community as an entity consisting of researchers, policy-makers and doctors whose sole job is to rule out anything that smacks of anything remotely *alternative*, on the grounds that it does not comply with any biomedical standard, scientific way of research or philosophical train of thought. What I believe strikes us as another paradox is that medical anthropological research has shown that in other parts of the world, where biomedicine has been introduced in cultures based on radically different indigenous and ethno-medical ways of treatment, this introduction – not to say incorporation – have more often than not run very smoothly indeed (see e.g. Janzen 1978 and Welsh 1983). It turns out that people are using several medical systems at once, just like people in Britain or Norway choose CAM one day and biomedicine the other. Why, then, and especially in Norway, does it seem to be so difficult for CAM to gain access within a biomedical framework; - in other words in a medical culture where biomedicine is the leading medical system and not the other way around?

As far as I can see it seems difficult to imagine a homeopathic hospital like RLHH becoming a reality in Norway in the near future. The reasons for RLHH existing in the UK are simply, I have argued in this thesis, too embedded in British medical culture and history. However, if CAM is to

be offered for free in public health care in Norway, at least four factors must be addressed.

First, the patient and their lay knowledge/power. More power given to the patient in choosing different treatments is imperative. The patient – the public – must be given a higher degree of freedom in choosing treatments than is the case today. This could mean a loss of power for the GP, and as in the UK, the question remains if the Norwegian Medical Association are willing to accept this.

Second, the CAM practitioners. In the future, CAM practitioners *may* have to be more willing to accept biomedicine as the basis of medical treatment, in that biomedicine is the dominant medical system. The homeopathic training in Norway today is split in different institutions and schools with divergent views, but there is currently talk of uniting them in a foundation. Willingness on both biomedicine and CAM's part in terms of cooperation and sharing information/research is imperative, but considering the heated debate so far, the question of whether this is possible in practice remains unanswered. Either way, the doctors at RLHH certainly proves that it is possible, with the two medical systems complementing each other, as well as showing that doctors too can become keen adverts to homeopathy. However, how the homeopathic practitioners most negative to biomedicine, as well as the doctors most negative to CAM, responds to this is another matter.

Third, the medical profession. More doctors positive towards CAM will result in for example more GP's being willing to recommend and inform patients of different CAM practitioners when biomedical treatment fails. This can only be done if the doctors, as early as medical school, are being given basic training in different CAM treatments, something they at present are not.[86] More

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[86] At the University in Oslo, for example, the students are only given a few hours of CAM tuition throughout their whole 6-year long medical training.

doctoral knowledge of CAM is either way crucial, especially for GP's when patients ask for advice on CAM treatments.

The medical training in Norway has been changed over the last ten years. *Oslo-96 reformen*, as is it called, was established with especially two things in mind: a more active role on the student's part in terms of their examination requirements, which has resulted in a different construction of the syllabus, an idea inspired by medical training at Harvard University (Larsen 2002, see also Good 1994: chapter 3). Second, the students would have more patient-doctor contact at an earlier stage in the training than before (from the third semester). Regarding CAM and illness and the experience of the patient this early patient-doctor relation is, I believe, positive. The reform has not, however, increased the amount of CAM tuition, and it remains to be seen how new generations of doctors responds to CAM.[87]

Finally, the Government/policy makers. The NOU-Report, as well as the establishment of NAFKAM, the Norwegian research institute on CAM, has shown that the Norwegian Parliament is willing to look at the status of alternative medicine in Norway and outline on what can be done. We have also seen that the same applies for the British Government with the House of Lords Report. This heightened political interest in CAM could mean more funding for CAM research, pilot projects and so on.

The influence of the British Medical Association is, as I noted in chapter 6, formidable. Its Norwegian counterpart is no exception. Arum (2006) has shown how the Norwegian Medical Association works in terms of lobbyism and in getting their views heard by the politicians and the Norwegian Parliament. Karin Andersen, member of the Parliament, sums it up well when she

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[87] The first students under the 96-reform graduated in 2002. The incorporation of the reform seems to have been successful (Larsen 2002). For a historical outline on the medical student and training in Norway and on the Oslo-96 reform, see Larsen (2002).

discusses the power that lies in the doctoral knowledge: [my translation] "*A politician can never compete with a doctor in being "the one who knows".* [...]*When a doctor presents a solution to a problem the politician is unable to review it* [...] *My experience was that the Association came* [to me]*, put "the patient on the table" and said: "Are we getting money or are we not? Otherwise this patient will die". You don't stand a chance. You have to raise your hands and say "here you are!*" (Arum 2006:pp. 52-53).

The American physiatrist and anthropologist Arthur Kleinmann argues that the institutionalisation of medicine leads to treatment and medicine being something that does not affect us as human beings – rather it becomes a question of politics and economics. Moreover, he argues that biomedicine (at least in the Western context) is based on monotheism: one religion and one culture, which makes it unable to incorporate dialectic ways of thinking (Kleinmann 1992). From a (critical) medical anthropological way of seeing things I certainly believe that there is truth to this. What the ethnographic example from RLHH may show us, however, is that alternative medical systems like homeopathy are well able to exist within a biomedical framework, albeit under specific conditions. For now, in Norway at least, the question seems to be who is willing to pay the biggest price for this to happen.

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