The alternativisation of healthcare: A sociological framework for analysis
Ayodeji Bayo Ogunrotifa

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

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

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

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

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

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

What will then happen to kohl, shamanism, spiritism and other forms of alternative treatment that do not complement orthodox medicine in any way or that would never be accepted or incorporated into orthodox medicine due to contrasting ontologies and epistemologies? The notion of complementary and alternative medicine (CAM) or integrative medicine is limited and cannot be applied globally or in a different context outside western countries. This paper, therefore, makes a case for AM that is utilised in both western and non-western contexts. Given the rising popularity of AM in western countries, a notable concept of “alternativisation” has been articulated...
(Macdonald, 2002; Ogunrotifa, 2019) to capture this growing use of alternative medicine for health and human conditions. What seemed problematic is that the dimensions and processes that underpinned the framework of alternativisation have been largely obscured.

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

2. What is alternativisation?

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

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

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

The process of alternativisation is majorly driven by AM practitioners who utilised their expertise in alternative medical knowledge/healing methods in the diagnosis, treatment and care of health and human conditions, with the active involvement of the users whose lay involvement ushered the increasing popularity of AM use in the recent epoch. There is a great variation in AM practices, as alternative healing methods are developed in both western (Alexander techniques) and non-western contexts. In non-western societies, AM is an oldest form of the healthcare system, whose alternative healing methods have evolved over the centuries in different societies, and are captured under the broad concept of traditional medicine (Abdullahi, 2011, p. 115) with examples of African, Chinese and Indian traditional medicines. With the advent of colonialism, imperialism and globalisation, orthodox medicine made inroads into non-western countries and later became the dominant form of the healthcare system. The negative aspect of colonialism, as Abdullahi (2011) noted, was that AM and the knowledge underpinning its development was stifled, subjugated and
stigmatised as backward, superstitious and unscientific. Consequently, AM practitioners were only
given limited freedom to operate and practise outside the formal institution of the healthcare
system, which is orthodox medicine (Abdullahi, 2011). Both AM and orthodox medicine co-exist in
some parts of non-western countries, but with the former being relegated to the margins of the
formal healthcare system as far as the regulation and legislation governing the administration of
health is concerned.

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

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

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

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

The expansion of the customer base from African and Asian communities to other nationalities
in the UK stemmed from the meaning that AM users assigned to the therapeutic efficacy of the
medications, and such meaning is a dynamic process that underlies trust in the ability of the
therapy to relieve the suffering of the patients from prevailing health problems (Low, 1999) and
constitutes a new regime of healthcare to them. The meaning of AM has profound implications for
the users in terms of how they constantly engage in interpretation and re-interpretation of the meaning of their health and human conditions. The understanding of alternativisation through the context of how the users define themselves and their situations has structural imprimatur in relation to the interaction with others, despite being individualistic. For instance, Low (1999) further observed that people resorted to the use of AM following encounters and recommendations “from friends, family and the media” (Low, 1999, p. iii). This demonstrates that the engagement of people with AM has structural elements that encompass social interaction, where individuals' reflexivity and their responses to others and themselves are broadly connected to the interactions in which they engage.

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

3. Key trends, dimensions and processes of alternativisation

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

● Contestation of the therapeutic space

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

In the websites of these practitioners, alternative treatments for back pain, hypertension, stomach pain and ulcer, diarrhea, anorexia, rheumatism, arthritis, asthma, psoriasis, diabetes, stroke management, autism, depression, ear and eye problems, Parkinson’s disease, migraine, epilepsy and multiple sclerosis are marketed. The provision of alternative treatments for these conditions depicts that AM practitioners are adopting the existing medical terminologies and treating it within the AM framework, making incursions into the jurisdiction of orthodox medicine and contesting the therapeutic space with medical authority. Despite adopting or
appropriating the medical names/terminologies for diseases (like cancer and diabetes),
the second process of contestation is that AM practitioners reject the causation, diagnosis
and treatment procedures and method associated with orthodox medicine. AM shares medical
names for diseases/illnesses but utilises different treatment frameworks and interventions. The
information on these websites revealed that the method used by these AM practitioners with
respect to causation, diagnosis and treatment is fundamentally different from orthodox med-
icine, despite sharing the same medical names. This can be demonstrated by several studies
that observed the efficacy of alternative treatment for diabetes (Dey et al., 2002; Yeh et al.,
2002), chronic pain (Haetzman et al., 2003; Rosenberg et al., 2008), hypertension (Bell et al.,
2006; Wang & Xiong, 2013) and rheumatism (Ernst, 2000; Ramos-Remus et al., 1998) and
treatment of fallopian tube (Wun et al. 2008).

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

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

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

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

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

As a corollary to medicalisation, the process of alternativisation hinges on definition. The
definition is couched in treating non-health problems as requiring alternative treatment solutions.
With alternativisation, health conditions are categorised and framed with existing medical names
but treated within the AM framework and with alternative treatment interventions by AM practi-
tioners. In this regard, the AM practitioners assume jurisdiction over certain aspects of non-health
problems that have been medicalised by the medical profession and exercise their expertise
towards finding alternative treatment solutions to them.
The extension of the therapeutic jurisdiction of AM practitioners into the arena of orthodox medicine can also be seen in the context of how the six aforementioned practitioners expanded their treatment jurisdiction into areas of anti-bald cures, acne cures, anti-ageing treatment, fertility problems, reversing menopause, sexual impotence cure, obesity solutions, sleeping problems, miscarriage, overdue labour, drug addiction and alcoholism. The alternative treatments for all these conditions can be found on the websites of these AM practitioners. By contesting the therapeutic space with orthodox medicine, AM practitioners are not only competing for market shares (Baer et al., 1998) and status; they are also eliminating the problem of lack of options occasioned by the monopoly of orthodox medicine for patients/users, by providing a competing set of alternative solutions to health problems. The engagement of these AM practitioners in this jurisdiction of medicalisation has been espoused in the growing veins of social scientific studies that have explored the use of AM for infertility (Gerhar & Wallis, 2002; Levitas et al., 2006; Read et al., 2014; Smith et al., 2010), alcoholism (Shin et al., 2017; Singer & Borrero, 1984; Sivertsen et al., 2018), menopause (Brett & Keenan, 2007; Golischewskia et al., 2007; Posadzki et al., 2013) and childbirth (Adams et al., 2009; Kalder et al., 2011; Zeng et al., 2014). Alternativisation has occurred if a person uses AM products to treat menopause and fertility problems instead of orthodox medicine.

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

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

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

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

With alternativisation, AM practitioners are known to have identified medicinal plants and developed a unique method of diagnosis over centuries (Ramakrishnan et al., 2015) that are suitable for the treatment of illnesses or conditions. Through this method, AM practitioners have expanded their sphere of competence towards the production of medicinal products that challenged the dominance of pharmaceutical companies in the configuration of bodily, behavioural
and social conditions for pharmaceutical interventions. For instance, the websites of the six AM practitioners enumerated earlier revealed the online sale and marketing of AM products for conditions that are in the domain of pharmaceutisation. These non-medical conditions include miscarriage and premature birth, hair loss/anti-bald, bedwetting, attention deficit hyperactivity disorder (ADHD), sleeplessness, ageing (anti-ageing treatment), cholesterol reduction, weight loss, sexual enhancement, acne treatment and body/stretch mark removal.

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

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

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

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

Second, illnesses or conditions are usually defined as “ordinary” or “metaphysical” within the AM framework (Igun, 1988). The term “ordinary” here means conditions that are caused by natural factors, environmental factors, poverty, personal hygiene, biological and psychological factors (Kahissay et al., 2017). AM practitioners will first diagnose any condition within the AM framework
by examining whether the illness or condition is ordinary or metaphysical. If it is ordinary, medical/pharmacological interventions or alternative treatment can be used to treat the condition. If the ordinary conditions of patients are not within the competence of AM practitioners, especially surgery, such patients would be referred to orthodox medical practitioners for biomedical intervention. The categorisation and diagnosis of illnesses and conditions into ordinary and metaphysical are important components of the AM framework for treatment.

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

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

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

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

4. Discussion and future direction for research

This paper has revealed two important insights. First, the increasing alternativisation in the health delivery sector stems from aggressive de-medicalisation and de-pharmaceutisation of health, bodily and social conditions away from the grip of the medical profession and pharmaceutical companies, and the recolonisation of these conditions within the AM framework by AM practitioners. The contestations of therapeutic space of medicalisation and pharmaceutisation with the medical profession and pharmaceutical companies enable the AM practitioners to attract new consumers and expand their customer base and market for alternative treatment. The symbolic meaning that AM users attach to the therapy is the faith in AM practitioners and belief in the efficacious power and value of the therapy in resolving and relieving pains associated with their
chronic conditions. Second, the increasing trend of alternativisation hinges on AM practice’s engagement beyond the reach of medicalisation and pharmaceutisation into the realm of the metaphysical; users resort to AM because they feel their conditions cannot be treated within the context of orthodox medicine or pharmaceuticals. This expansion of AM therapeutic space to the realm of the metaphysical enables practitioners to expand their appeal and visibility.

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

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

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

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

In this regard, alternativisation requires a critical sociological engagement, particularly with theory-driven empirical work, that will not only investigate the widespread uptake of AM especially in western countries but unpack how these dimensions of alternativisation ensued in a non-western context. Moving forwards, future sociological research on alternativisation might require investigations into several issues that are pertinent to the centrality of AM as a form of healthcare.
These issues include the exploration of the extent, forms and circumstances in which alternative therapy is used in both western and non-western contexts; understanding the activities of AM practitioners (including those not-recognised) with respect to their knowledge claim and knowledge production associated with alternative therapy; how diagnosis is framed and understood by the AM practitioners, and the exploration of how AM practitioners and users construct safety and efficacy of the alternative medicinal products. The exploration of these questions will help to strengthen sociological engagements, in mapping out key policy issues that are likely to impact the domain of alternative medicine as a form of healthcare.

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

Funding
The author received no direct funding for this research.

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

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

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