

# Legitimizing complementary therapies in the NHS: Campaigning, care and epistemic labour

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## Abstract

Questions of legitimacy loom large in debates about the funding and regulation of complementary and alternative medicine (CAM) in contemporary health systems. CAM's growth in popularity is often portrayed as a potential clash between clinical, state and scientific legitimacies and legitimacy derived from the broader public. CAM's 'publics', however, are often backgrounded in studies of the legitimacy of CAM and present only as a barometer of the legitimating efforts of others. This article foregrounds the epistemic work of one public's effort to legitimate CAM within the UK's National Health Service: the campaign to 'save' Glasgow's Centre for Integrative Care (CIC). Campaigners skilfully intertwined 'experiential' knowledge of the value of CIC care with 'credentialed' knowledge regarding best clinical and managerial practice. They did so in ways that were pragmatic as well as purist, reformist as well as oppositional. We argue for legitimization as negotiated practice over legitimacy as a stable state, and as labour borne by various publics as they insert themselves into matrices of knowledge production and decision-making within wider health care governance.

## Keywords

complementary and alternative medicine (CAM), health activism, legitimation, NHS, public participation

## Introduction

Increasing use of Complementary and Alternative Medicine (CAM) in the UK has been well-documented but remains a site of contestation, with the question of statutory

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funding at its nub (Stone, 2015). There is a proclivity to set CAM *against* the biomedical orthodoxy: a fundamental ‘conflict over turf’ (Derkatch, 2016: 5). When framed as their ‘ideal types’, CAM and mainstream biomedical science draw on conflicting systems of knowledge and belief, practice and care, power and authority and, ultimately, legitimation. Debates can become polarised and, at times, sensationalised. This obscures the considerable work undertaken to reconcile and assimilate CAM with existing biomedical and managerial rationalities within shared spaces. This work is undertaken by both CAM and biomedical practitioners and is – we explore – an established area of research. It is also, crucially, undertaken by CAM’s various ‘publics’, often backgrounded as unseen consumers in studies of CAM legitimation rather than active protagonists.

The epistemic work of campaigners in legitimating CAM within the UK’s National Health Service (NHS) is the focus of this article. It centres on Glasgow’s Centre for Integrative Care (CIC, formerly Glasgow Homeopathic Hospital), a highly modern, custom-built centre with in-patient facilities providing extensive CAM services. One of only two remaining dedicated hospitals in the UK (at the time of writing) offering CAM services within the NHS, the CIC has faced increased scrutiny as to its NHS funding and status, with the erosion of services over time. This has triggered waves of coordinated campaigns by patients, carers and clinicians, with varying degrees of success. One might hypothesize, given the perceived incompatibility of CAM with orthodox medicine, CIC campaigners to have assumed a strongly oppositional, outsider stance vis-à-vis established medical and managerial knowledge. We argue that the situation was more nuanced. Campaigners were, at the height of their success, reformers from the inside as well as outside, drawing on managerial and clinical repertoires: ‘credentialed’ as well as ‘experiential’ knowledge (Rabeharisoa et al., 2014).<sup>1</sup>

In order to examine the work of CIC campaigners in legitimating NHS-funded CAM, the article first revisits the sociology of CAM, embracing recent work that moves away from polar positions to reveal CAM (and its legitimation) as a dynamic assemblage of practices. Second, we survey existing work on the legitimacy/legitimation of CAM, which focuses on the actions of practitioners. We bring the CAM ‘consumer’ into the frame, actively shaping the trajectory of *their* NHS (Stewart, 2016, 2019). The third empirical section examines campaigners’ work in legitimating CAM, drawing on both experiential knowledge and that credentialed by experts. We detail shifts between oppositional and reformist positions. Drawing on post-Weberian accounts of legitimacy, the article concludes that the legitimation of CAM is situational and pragmatic as well as principled and confrontational. Furthermore, legitimation practices are not simply the work of professional groups, put out for public consumption. They are reinterpreted and negotiated via publics’ own epistemic work within various political arenas.

### *CAM and biomedicine*

As Brosnan et al. detail, CAM has become a ‘staple research area’ in the sociology of health (2018: 2; also Gale, 2014), reflecting a fascination with its shift in status and its broader implications. Some influential literature associates CAM and its use with fundamental challenges to state power and authority (e.g. Cant and Sharma, 1999; Saks, 1996, 2003; Wahlberg, 2007) – including biomedicine (Broom and Tovey, 2007; Eastwood,

2000; Goldner, 2000; Stratton and McGivern-Snofsky, 2008). CAM and biomedicine are oppositional where CAM is defined as that which falls outside the ‘dominant health care system’ (WHO 2013, cited in Gale and McHale, 2015). Certainly, the relationship can be antagonistic. Sointu examines how CAM and its users draw on different philosophical understandings of the body and healing, which can and must ‘unseat’ biomedical interpretations of illness (2013: 538). On this reading, CAM entails a distinct and challenging understanding of knowledge and, crucially, evidence (Barry, 2006; Broom and Tovey, 2007; Cant and Sharma, 1999; Heirs, 2015; Hirschhorn, 2006; Hollenberg and Muzzin, 2010; Jackson and Scambler, 2007; Keshet, 2009; Pedersen and Baarts, 2010).

Recent literature seeks to circumvent dichotomous understandings of CAM versus biomedicine (Brosnan et al., 2018; Ning, 2013). Different professions *within* mainstream medicine, for instance, vary in willingness to work within CAM paradigms (Broom and Tovey, 2007; Gale, 2014). Some biomedical communities also aspire to ‘holism’ (Ning, 2013; Stone, 2015), elsewhere identified as distinguishing CAM (Cant and Sharma, 1996a: 2; Hirschhorn, 2006). CAM epistemologies are ‘hybridised’, drawing on both scientific domains (Brosnan et al., 2018: 6) and alternative ‘ways of knowing’ (Keshet, 2009: 148). Some CAM practitioners are themselves biomedical professionals (Cant and Sharma, 1996b; Hess, 2004). Boundaries between CAM and biomedicine are thus difficult to maintain in practice (Gale, 2014; Ning, 2013), even ‘untenable’ (Keshet, 2009), despite the considerable ‘boundary work’ that goes into distancing biomedicine from CAM (Derkatch, 2016; Mizrachi et al., 2005).

To translate this discussion to the CAM-user turned campaigner, dichotomised understandings of CAM/biomedicine would suggest users to be intrinsically oppositional to conventional medicine and its supporting epistemologies. As studies show, however, CAM users are pragmatic in their use of both CAM and orthodox medicine (Gale, 2014; Tovey and Broom, 2008). CAM users ‘do not reflect the polarities evident in the public debate’ (Segar, 2011: 366) but entertain ‘pragmatic pluralism’ (*ibid.*). CAM campaigners are thus ‘evidence-based activists’ as any other, interweaving ‘experiential’ with ‘credentialed’ knowledge (Rabeharisoa et al., 2014). Brosnan et al.’s move towards ‘epistemic hybridity’ (2018: 19; also Gale, 2014) is, therefore, helpful in understanding campaigners’ roles in legitimating CAM.

### *Legitimizing CAM: bringing campaigners into view*

A significant body of work examines the professionalization efforts of CAM practitioners, documenting the move from marginality to ‘enhanced legitimacy’ (Cant and Sharma, 1996b: 579) since the 1980s. Practitioner groups have sought statutory regulation, recognition and, ultimately, funding in a bid to increase credibility (Baer, 1984; Brosnan, 2017; Clarke et al., 2004; Kelner et al., 2004; Saks, 2003; Sharma, 1996; Stone, 2015; Welsh et al., 2004; Wiese and Oster, 2010). Other studies examine practitioners’ subtler ‘microprocess’ legitimation in constructing and maintaining professional expertise, drawing on heterogeneous forms of knowledge (Givati, 2015; Keshet, 2009; Hess, 2004; Pedersen and Baarts, 2010). Legitimation involves inter- and intra-sectoral claim-making, as practitioners communicate with each other, other practitioner communities (Broom and Tovey, 2007; Tovey, 1997) and the outside ‘public’ (Hirschhorn, 2006).

The legitimization of CAM emerged from the late 1990s as a key concern within the CAM literature. Legitimation is not coextensive with professionalization efforts and ultimately invokes some rendering of the ‘public’. Key journal articles, substantively centring the legitimacy/legitimization/legitimation of CAM, were prominent within *Social Science and Medicine*, *Sociology of Health and Illness* and this journal. The majority explored familiar, attributive forms of legitimacy, most prominently ‘scientific’, ‘state’, ‘public’, ‘professional’ and ‘clinical’ (see Almeida and Gabe, 2016; Baer, 2006; Broom and Tovey, 2007; Brosnan, 2017; Connor, 2004; Goldner, 2004; Hirschhorn, 2006; Jackson and Scambler, 2007; Lewis, 2019; Pedersen and Baarts, 2010; Tovey, 1997; Welsh et al., 2004; Wiese and Oster, 2010). Some moved to challenge these orthodox forms of legitimacy by including socio-cultural forms argued to be more pertinent to CAM, including ‘charismatic’ (Jackson and Scambler, 2007; Keshet, 2009), ‘traditional’ (Eastwood, 2000; Wiese and Oster, 2010), ‘therapeutic’ (Broom, 2009) and ‘cultural’ legitimacy (Ho, 2007).

Despite being mentioned in many of these studies, public legitimacy proves the least determinate (defined only once and somewhat circularly as ‘public perception. . . as legitimate’ in Wiese and Oster, 2010: 424). Substantively for our research, *all* forms of legitimacy rely on some kind of public, yet publics are not visible as active participants in its making or contestation. Rather this literature privileges the (de)legitimation efforts of professional groups within CAM and/or biomedicine. One exception is Goldner (2004), describing the interface between mainstream professionals and CAM activists in the US marketplace. Here, the prior legitimization practices of activists are acknowledged but not central to the analysis. A recent addition analyses the discursive practices of online publics in (de)legitimizing CAM (Gibson, 2018), which resonates strongly with our methodological and analytical position. We attend more closely however to the interface between practitioners, policy-makers and publics, as publics insert themselves into matrices of knowledge production *and* decision-making. This article makes visible the epistemic work of campaigners in skilfully enacting and defending CAM within Scotland’s NHS. Centring this work challenges default understandings of legitimacy as an attributive state, but rather subject to ongoing labour, negotiation and contestation.

## Study background and methods

Founded by homeopathic practitioners and funded by philanthropists, the Glasgow Homeopathic Hospital dates from the mid-19<sup>th</sup> century (Crawford, 2016: 88) but was incorporated into the new NHS in 1948. The hospital moved from its bequeathed building to custom-built premises in 1999, privately funded at a cost of almost £2.8 million. Following relocation, the hospital renamed itself the Centre for Integrative Care (CIC) and continued to be operated by NHS Greater Glasgow. Despite its history of private philanthropy, the CIC operated within ‘the field of publicly funded healthcare in Scotland’, underpinned by NHS principles (Crawford, 2016: 89). It had been financially dependent on referrals from the 14 regional health boards in Scotland, the majority since ceasing referrals. The hospital offered a wide range of CAM services alongside orthodox medicine.

The CIC uniquely (in the UK) offered in-patient care, with the provision of 15 beds Monday–Thursday, and 7 weekend beds, serving around 350 patients per year. Against the backdrop of increased scrutiny of specifically homeopathy by UK Parliament (HoL,

2000; HoC, 2010), these beds were earmarked for cuts by NHS Greater Glasgow following a major funding review in 2004. The result was a 15-month campaign which, rather unusually for hospitals earmarked for downgrade or closure, was successful. However, in 2010–2011, subsequent cuts reduced the number of weekday beds to 7 and ceased weekend beds. In-patient treatment was finally closed in 2017.

This article reports data drawn from in-depth interviews with 10 campaigners who fought CIC closure at different times, with a focus on the 2004–2005 campaign. Interview data are supplemented with analysis of official board documents, CIC empirical studies (published and unpublished), emails and written correspondence. These data were collected between February 2018 and July 2019, as part of a broader 4 year interpretive study of four ‘change projects’ in the Scottish NHS (Stewart, 2019). Ethical approval for the study was received from the University of Edinburgh’s Usher Institute Research Ethics G. The CIC case was added ‘asymmetrically’: first as an atypical example where patients come from all over Scotland but which is not designated a national service and, second, because our reading of the sociology of CAM indicated that the case might yield a clash of ‘knowledges’ at the fringes of mainstream healthcare.

Initial interviewees were identified via campaign media coverage and recruited via email. Thereafter, snowballing techniques were used within key campaigners’ networks. While this had drawbacks in possible selection bias, snowballing allowed the authors to overcome recruitment challenges associated with the time passed, especially because the 2004 campaign was less documented online. Of the 10 campaigners interviewed, the majority were female (8) and white (9). The age range was 45–72 with the majority not working. Nine became involved in the campaign through their experience as patients, and one through their former professional role within the CIC. The resulting purposive sample is small, reflecting the small population under study, but we are aware of no significant campaigners who were missed.

Interviews were conducted by Dodworth in person or by telephone, using a semi-structured interview schedule which covered their experiences of the hospital, how they came to be involved in the campaign and how the campaign developed and operated. We were careful to position our research as exploratory and non-activist, but our interviewees’ passion, commitment and in some cases distressing descriptions of suffering in conventional medical care demanded a degree of commitment. Dodworth, for example, drew on her own experience of chronic illness, including hospitalization, in understanding respondents’ points of view. The resulting interviews were long and very rich (with prominent campaigners averaging 90 minutes), reflecting the prominence of the hospital within interviewees’ lives. Interviews were audio-recorded and we undertook a reflexive thematic analysis of the transcripts in Nvivo. Following Braun et al., we developed codes iteratively and through our discussions (2018). Our initial focus was on specific tactics, motivations and obstacles faced by campaigners, and as the legitimation problematic crystallized, codes were further developed to capture the forms of ‘knowledge’ and ‘legitimation’ work undertaken by campaigners.

In order to provide context for the interview data, we searched publicly available documents relating to the Centre for Integrative Care and/or the Glasgow Homeopathic Hospital on the websites of NHS Greater Glasgow & Clyde and the Scottish Health Council (the statutory agency which assures the quality of public involvement in changes

to NHS services in Scotland). Having identified documents relating to the 2004 and 2016 service changes, we did not locate documents relating to 2010 online and received these via a Freedom of Information request. These were supplemented by documents shared by interviewees (e.g. unpublished CIC studies). All documents were thoroughly read and catalogued by the authors, but were not included in the thematic analysis of interview data. They supplement our interviewees' accounts of the campaigns – providing some triangulation (Pope and Mays, 2020) – but do not constitute a fully analysed account of organisational change processes, which is beyond the remit of this article.

## Findings

The campaign group was formed in 2004 on the day information was received about the proposed closure of beds. According to the clinical campaigner, they were approached by a large staff delegation to lead the campaign (Interview 2). On the patient side, a lead patient campaigner recruited others from the 'apolitical' Friends of the CIC fundraising body to form a small, independent grouping (Interview 1). They and one other took the lead in running an effective media campaign, in lodging a petition with the Scottish Parliament to request national funding, and mobilising patients and carers for meetings, protests and letter-writing. All campaigners undertook extensive epistemic work in various forms. While interviewees gave differing accounts of labour division and responsibilities, it was clear that a collective formed forged in common experiences and 'paths' navigating the NHS (Interview 5) and in defending CAM.

As Table 1 shows, organisational justifications for the change proposals made in 2004, 2010 and 2016 pointed to UK-wide trends in homeopathic service models, and a backdrop of financial constraint, but were never explicitly critical of the CIC's 'holistic, person-centred' model.

In 2020, the centre retains its distinctive and impressive building, complete with 'NHS' logo and located on a major hospital site. However, it has no inpatient beds, no homeopathic pharmacy and there have been proposals to partially integrate the space into mainstream provision.<sup>2</sup> In totality, the CIC is a story of fluctuating legitimacy within the highly centralised Scottish NHS. In the following sections we explicate how CIC campaigners defended the CIC, with the data demonstrating two interlinked approaches. The first is the articulation of positive patient experience in opposition to prevailing biomedical accounts and the second the reformist positioning of campaigners, intertwining experiential and credentialed knowledge from the inside.

## Making patient experience count: the experiential as oppositional knowledge work

Work to promote experiential, 'embodied' knowledge of care was strongly visible in the CIC campaign. Campaigners shared a collective identity which, contra Brown et al.'s oft-cited work on health social movements (2004), was not based on a single disease but forged on experiential knowledge of disparate conditions. Patients reported high levels of (multi)morbidity prior to admission, with around 97% having seen a hospital specialist of some kind (Mercer et al., 1998) and two thirds previously hospitalized (GGHB, 2005).

**Table 1.** Board rationales for CIC service changes 2004–16.

Year	Proposal	Board rationale	Outcome
2004	Removal of inpatient beds	<ul style="list-style-type: none"> <li>• Financial review of all spending</li> <li>• Other UK homeopathic services (and 95% of CIC) provided on outpatient basis</li> <li>• 70% of patients with psychiatric distress; 41% uncontrolled pain: other NHS facilities available</li> <li>• Excessive waiting times</li> </ul> <p>(GGHB, 2005)</p>	Proposal voted down at board level
2010	Reduction of beds and removal of weekend inpatient care	<ul style="list-style-type: none"> <li>• Not all therapies provided at weekend due to staff working patterns</li> <li>• Financial review of spending: need for efficiencies</li> <li>• Other UK homeopathic facilities moved to outpatient only, meaning Glasgow ‘less well developed’</li> <li>• ‘Well recognised’ that chronic conditions better managed at home or in community</li> </ul> <p><i>Document also states: ‘current political scrutiny on the provision of homeopathic services’ necessitate further redesign.</i></p> <p>(GGCHB, 2010)</p>	Proposal agreed
2016	Removal of remaining inpatient beds	<ul style="list-style-type: none"> <li>• Previous reduction in beds</li> <li>• All services already available on ambulatory basis and majority of service use outpatient</li> <li>• Inpatient capacity ‘underutilised’</li> <li>• Enable development of new Scottish National Residential Pain Management Programme in ‘released capacity’</li> </ul> <p>(GGCHB, 2016)</p>	Proposal agreed

The mainstay of this collective identity was that certain conditions were not served by conventional approaches. Biomedical hierarchies rest on verticalized interactions, moving between primary, secondary and tertiary services following expertise vis-à-vis individual diseases. One respondent termed this the ‘medical merry-go-round’ (Interview 1, patient campaigner, 40s) and connected to feelings of inequality and injustice:

When you become a ‘chronic’, in inverted commas, patient, because the medical profession can’t heal you, you tend to be a kind of embarrassment to the service, so it’s as if you’re being brushed under the carpet. . . [I]f you’ve got cancer, . . . there’s different services [. . .] but there’s nothing for people who just have multiple chronic health problems [. . .] So, from as long as I’ve known the CIC and the Homeopathic before it, they tended to gather these patients that didn’t fit, who had been effectively binned by acute services; they gathered these patients and still tried to work with them.

Interview 5, patient campaigner, 60s

For these campaigners, there was ‘no other place. . .to go’ (Interview 8, patient campaigner, 50s), stoking impassioned responses. The medical merry-go-round contrasted with patients’ positive experiential knowledge of the centre’s holistic approach, reinforcing the incompatibility of conventional medicine and CAM:

I was referred and I met up with Dr [. . .] and it was the best thing that ever happened to me. . .because listening, listening to the whole story. . .it’s just. . .the homeopathic consensus, you know, is to treat the whole person, right, and not just that artery or that valve.

Interview 4, patient campaigner

This experience of care was described as contesting biomedicine’s aetiology, unsettling established relations of authority and expertise:

They ask you first. You know? You’re the most important person. I think in any other health field, in my experience, you’re not. It’s the doctor just telling you all the time.

Interview 5, patient campaigner, 60s

Weaving these life-changing experiential narratives into a collective challenge to the efficacy of dominant medical orthodoxies was a key part of campaigners’ early activism. Such oppositional stances translated into oppositional protest politics, manifest in ‘confrontational’ tactics of meetings, marches and protests (Stewart, 2016: 92). In addition, the promotion of patient experiences translated into an effective media campaign, generating considerable interest in the local and Scottish press. One interviewee recalled a clinical campaigner stating that experiential knowledge constituted *indisputable* knowledge that could be given separate, indeed greater standing than that of clinical knowledge:

[Clinical campaigner] always said that, it was much better coming as a patient campaigner. Because [they], as a clinician, could be challenged for [their] treatments by a sceptic, but it’s very difficult to argue with a patient. . .and it was the right thing to do, because it was the way to win it.

Interview 1, patient campaigner, 40s

Mobilising experiential knowledge also shaped the assumption of the ‘political route’ (Interview 1, patient campaigner, 40s), which bypassed NHS decision-making processes. Lead campaigners engaged Members of Parliament face-to-face and encouraged campaigners to write to their representatives. This was in addition to more ‘disruptive tactics’ (Stewart, 2016: 92) of door-stopping Scottish ministers and other figures entering buildings and events and the deliberate derailing of health board meetings (Interviews 1 and 5). The decision to take the political route was taken early. In the words of one interviewee:



That was the start, when we started becoming quite visible, that we were gonna take it politically.

Interview 1, patient campaigner, 40s

The campaign also lodged a petition with the Scottish Parliament, requesting that parliament review how ‘national specialist services’ were funded and claiming the funding process ‘neither transparent nor effective’. The petition sought both to frame the CIC as a national service as well as challenge the (public) legitimacy of existing health board decision-making. This petition triggered the involvement of both the Scottish Minister for Health and the Chief Medical Officer for Scotland, although to no satisfactory outcome for campaigners. The political route as a whole, however, bolstered by effective mobilisation of experiential knowledge, ‘boomeranged’ considerable pressure onto board decision-makers around the proposed closure in 2004–5. This led, as we will explore, to unusual access to board decision-making; one informant said a condition of this access was to ‘quieten down’ the public campaign (Interview 5, patient campaigner).

In sum, promulgating experiential knowledge, as a separate onto-epistemological domain, was a key part of how campaigners legitimated the centre, challenging biomedical expertise as might be predicted. However, highlighting the importance of this work should not erase the considerable knowledge work undertaken by campaigners that drew upon and engaged with specific clinical and managerial claims. The campaign was therefore not purely oppositional (in an onto-epistemological sense), as campaigners skilfully worked the ‘insider/outsider’ divide.

## **Pragmatic pluralism: working credentialed knowledge on the inside**

CIC campaigners, at the height of their success in 2005, were reformers from the inside, drawing on managerial and medical repertoires. Central to this was framing the centre’s model as ‘conventional medicine plus’, with campaigners emphasising that all staff were qualified medical practitioners. All clinical staff were fully trained in conventional medicine but had also, apart from senior house officers, completed post-graduate training in homeopathy, with many having formal accreditation (GGHB, 2005).<sup>3</sup> One campaigner, who also trained as a nurse, stressed the ‘integrative’ approach of the centre as its defining characteristic, rather than commitment to any particular treatment:

All the doctors at the Centre for Integrative Care are obviously, you know, qualified medical practitioners; every single nurse, doctor, everybody is qualified [. . .]

First and foremost, it’s conventional. The very first thing [doctor] said to me was, ‘if you need steroids, you’ll get steroids’ [. . .] So yes, I did have homeopathy, although lots and lots of patients go there and don’t. . . It might be just tweaking your conventional meds, it might be just giving you dietary advice, you know, it can take all sorts of shapes [. . .] My petition is about integrated medicine. . . I have never been fixated on any one treatment to do with the CIC either, and I never would be, because it’s all about the patient and the individual, and you know, maybe that’s because I come from a health professional background.

Interview 1, patient campaigner, 40s

Other campaigners emphasised the quality of the CIC's more conventional services, such as intensive physiotherapy, which supplemented deficient services elsewhere and rendered the CIC and conventional medicine directly compatible:

I realised it was the only facility available to me, as a person suffering chronic pain. And because of that I had been cancelled by the pain clinic service, because I was attending for intensive physiotherapy and other treatments, that they felt that that was a better avenue.

Interview 5, patient campaigner, 60s

Staff too explicitly emphasised their credentials in conventional medicine prior to CAM:

I say that as someone fully trained as a consultant physician, and a Fellow of the Royal College of Physicians, and a Member of the Royal College of GPs, with decades of experience, and having worked for over a decade in the Pain Relief Clinic, for example, at The Royal Infirmary.

Interview 2, clinical campaigner, 50s

In a previous analysis of the then-Glasgow Homeopathic Hospital, the growing emphasis on 'integrative medicine' – including the name change – was described as a disingenuous tactic to legitimate the (illegitimate) centre to the wider public (Crawford, 2016: 94).<sup>4</sup> Certainly, integrative care formed an important part of legitimisation work to wider audiences. It was central, for example, to the language of the petition lodged with the Scottish Parliament and was crafted and materially fixed within board papers, academic literature and even policy debates at a national level. Crawford argued that such language was a means to direct attention away from homeopathy specifically (*ibid.*). The administration of homeopathy was indeed downplayed as a treatment choice within legitimisation scripts of campaigners when remarkably, on the basis of one in-patient survey, 95% of patients had received it (IDCCIM, 2004).

Nonetheless, the hallmarks of integrative medicine formed a key part of reported care experience at the centre. The aforementioned in-patient survey, conducted by hospital clinicians via questionnaire to 200 patients and cited in the 2005 board paper, found that 88% of in-patients received 'perceived benefits of value in overall wellbeing' (IDCCIM, 2004). Published qualitative studies exploring consultations at the hospital cited empathy, being listened to and a relationship of equality as crucial to the success of this encounter (Bikker et al., 2004; Mercer et al., 2002; Mercer and Reilly, 2004). Moreover, the fact that the CIC remained an NHS facility was key to patients' perceptions of credibility and safety (Mercer and Reilly, 2004: 15). These studies, interweaving experiential and credentialed knowledge, were successfully inserted into the debate by campaigners.

Epistemic work from inside the process was not, therefore, a battle once won but an ongoing negotiation. Board papers from the time can be read as a dialogue between two sharply opposing positions on the value of the CIC. The following excerpt sets out the position of unnamed 'senior doctors', with the position of CIC staff as an addendum:

Within this challenging environment, where NHS Greater Glasgow has to make choices about service priorities, some senior doctors are questioning why investment should continue to be made in the homoeopathy service where in their view there is little systematic evidence of efficacy rather than supporting those services where objective scientific evidence has shown benefits to patients. (It should be noted that staff of the Glasgow Homoeopathic Hospital counter that there have been over 200 controlled trials and four meta-analyses showing on balance efficacy of homoeopathy, that much of acute care lacks explicit evidence of value and homoeopathy is only one modality within the hospital.) (GGHB, 2005)

Further efforts by the centre to credential its own evidence base included the creation of 'ADHOM Academic Departments' (a subsidiary of registered charity 'Ad Hominem'). This department, not affiliated to any university, conducted research on the CIC. It emphasised its wide-ranging methods, again including controlled trials, aiming to 'improve clinical care and standards' (Ad Hominem Accounts, 2005: 2). The department was commissioned to research clinical outcomes from the CIC's new Chronic Fatigue service by NHS Greater Glasgow in 2004 (*ibid.*). Thus the centre was positioning itself within debates around clinical best practice.

Beyond clinical efficacy, campaigners also engaged directly with managerial discourses around changes to the CIC. Change proposals had been concerned with costs in a period when NHS Glasgow was in financial difficulties. CIC campaigners undertook knowledge work around the posited cost savings of changing the CIC. First, campaigners strongly disputed the potential savings claimed by GGHB from closing in-patient care in the draft board papers. The original figure of £420,000 (perhaps erroneously still present in the final papers' breakdown) was revised downwards to £250,000 (as cited in the paper's summary), apparently following campaigners' interventions (Interview 1). This undermined the managerial case for closure.

Second, calculating precise savings proved challenging due to a lack of capacity to track patients through NHS services over time. Campaigners nonetheless consistently cited a reduction in demand of this particularly complex population of in-patients for conventional services following discharge. The campaign team pointed to declared reductions in patient demand for GP consultations (41%), use of drugs (41%), outpatient visits (39%) and hospital admissions (53%) (GGHB, 2005 Attachment 1; drawing on Mercer et al., 1998), presenting similar figures to the Petitions Committee in December 2004. Questions have been asked as to the accuracy of self-reported patient data in this politically-charged field (HoC, 2010). Nevertheless, campaigners gathered and packaged such data to speak to the sensibilities of GGHB's managers as well as clinical leaders.

As the campaign increasingly oriented itself 'inside' the process, the most crucial development came in 2005. After disputing the draft board papers in 2004, interviewees reported that a private working group was established in 2005 comprising key board members and three members of the campaign group to debate and negotiate the final version of papers to be presented to the board. Campaigners reported success in getting the papers amended, claiming 'the original papers did not represent what the unit did' (Interview 1). The group reworked the depiction of the centre, which was included within the main board paper as well as annexed in its entirety (GGHB, 2005). While advocacy

for CAM practices are obviously central to the message of these papers, an explicitly integrative approach is evident: ‘fully inclusive of orthodox model – no competition or fragmentation’. In these documents, the CIC’s aims have been acknowledged and to some extent endorsed by the health board that was seeking to downgrade services. Opposing positions were ultimately reconciled, albeit temporarily.

This process of rewriting the board papers was described as iterative and dialogical, over several meetings. One campaigner described the criticality of this ‘insidership’:

Well to engage in the meetings with the board, the private meetings with the board members. . . rather than campaign publicly. . . it was a route for negotiations as such and it meant that we could influence the board paper and *question*; you never get a chance to do something like that I don’t think.

Interview 6, patient campaigner, 50s.

Lastly, an additional area of work situated the CIC as not ‘in parallel’ to mainstream biomedicine but rather ‘moving ahead’ at the forefront of contemporary thinking in healthcare. The CIC projected itself as innovative, pushing rather than threatening mainstream thinking. Core to such work was first the building itself. The building was constructed using a highly modern design, integrating green spaces, works of art and curved, fluid design features in a bid to construct ‘a place of beauty and healing’.<sup>5</sup> The construction brought teams of clinicians, architects and artists together, becoming a finalist for the Scottish Dynamic Place Award (GGHB, 2005). While the building was unusual for NHS construction, it was promoted not as exceptional but as pioneering, influencing hospital design elsewhere (GGHB, 2005 Attachment 1).

Beyond its physical space, the centre was further legitimated as an ‘innovative’ care assemblage, positioned within cutting edge thinking about a ‘fifth wave’ of public health thinking in Scotland (Hanlon et al., 2011) that continues to resonate.

And increasingly, the public at least, and to some measure, the government, is now, and we’re now speaking 15 years later, that’s come on people’s radars. People are getting it that the medical model, and the ‘drugs fix it’ model, is not adequate for these challenges. So, what the building was about, and what was going on inside the building, was a pioneering process of developing new models of care, to address these epidemics.

Interview 2, clinical campaigner

This face of the CIC, interacting with (and claiming influence of) contemporary debates in public health, was central to its ongoing advocacy:

[It’s about] co-creation, between the practitioner and the patients. It’s about empowering and enabling the patients. It’s about de-medicalising, it’s about us moving away from a drug based model. Do we or don’t we want that? And, hand on heart, if it’s felt that this is not helpful or needed, then just shut this unit. ‘Cause I’m not here to defend beds. And I meant it; I’m not there even to defend the hospital. My role was about what sort of care do we want, on a bigger

scale. . .the hospital to me. . .it was a seedling. It was a demonstration model. It was a temporary inspiration of something.

Interview 2, clinical campaigner.

## Discussion

Over 15 years, campaigns to ‘save’ the CIC demanded considerable epistemic work to legitimate non-mainstream therapies in an era of straitened budgets and evidence-based medicine. We have explored two threads of epistemic labour within campaigns: on the one hand proclaiming experiential knowledge as a rejection of biomedical and managerial stances and, on the other, subtly weaving their narratives into an enhanced vision of those credentialed stances. These, we propose, are intertwined in generating and promulgating a vision of CAM as legitimate healthcare. As we identify above, the concept of legitimacy has been a central, if under-explicated, concern of the sociology of CAM. This article seeks to advance this debate in two directions. Firstly, as a constant background presence, legitimacy has been inadequately specified. Recent conceptual developments emphasise legitimation as a multifaceted practice over a binary ‘yes/no’ conception of legitimacy as a stable, attributive state. Weber’s work (1968 [1919]) has been central to prising legitimacy’s normative and often elusive content from the empirical ‘facticity of *legitimation*’ (Von Haldenvang, 2017: 270) and this legacy has undergone a useful revival (Barker, 2001: 13; Dodworth, 2018). We build on these insights through our case study at the ‘fringes’ of UK healthcare where CAM faces a ‘double’ legitimation bind: overcoming managerial thinking around bed numbers but also CAM as medical practice. This case demonstrates that the legitimacy of a healthcare facility is not a stable attribute but subject to ongoing labour, negotiation and contestation (also Stewart, 2019).

Second, the burden of establishing and defending the legitimacy of CAM has been primarily portrayed as borne by CAM practitioners and, in some cases, their biomedical counterparts. Patients and wider publics are largely reactive audiences or heuristic devices (what would a ‘reasonable person’ expect (Sorbie, 2019)). This tendency reflects weaknesses in conceptualising legitimation across social and political enquiry more broadly and is, we argue, a legacy of Weber that has proven more limiting. Legitimacy/legitimation is dependably drawn by late-modern thinkers as the codification and transmission of norms, beliefs and/or symbols on the part of (state) elites, ultimately to lay publics (Dodworth, 2018). Publics are thus a barometer of the legitimation efforts of others, rather than active protagonists. Weber’s renowned sources of legitimation (1970 [1919]) – charismatic, traditional and rational-legal – have directly influenced some CAM studies (e.g. Cant, 1996; Jackson and Scambler, 2007; Keshet, 2009). His more indirect legacy, however, in legitimacy as belief transmission, is latent in most studies of CAM, which posit legitimation as diffusion rather than negotiation. By contrast, in this study, such negotiations were central to the work of campaigners.

In this article, therefore, we challenge the practitioner/public dichotomy to insert particular publics in legitimating CAM. We draw on detailed interviews with campaigners

to reveal the epistemic work of their campaign, which skilfully enacted and defended a particular rendering of CAM. Unlike previous studies (Crawford, 2016), we resist interpreting the organised and strategic mobilisation of a group of affected patients as cynical. Too often, patient and public ‘voice’ must be naïve or un-organised in order to be seen as authentic (Newman, 2008). In an environment populated by highly-formalised groups (including health professions, healthcare managers and policymakers, and corporate pharmaceutical companies), strategic action is the only option for publics keen to be heard. This is the lesson of a host of social movements in the healthcare field, from mental health, HIV/Aids and harmed patient campaigns (Brown et al., 2004). Legitimation, however, is not purely instrumental (Suchman, 1995). Campaigners intertwined their embodied, lived experience of the value of the CIC, often predicated on the failures of conventional medicine, with pragmatic arguments that this distinctive model of care was compatible with both biomedical best practice *and* managerial definitions of acceptable costs. This generated an epistemic ‘tightrope’ as campaigners both insisted on the distinctiveness of the CIC while also declaring it coherent (‘no competition or fragmentation’) with mainstream models of care. This portrayal of the centre as ‘conventional care plus’ shaped the emerging face of the CIC.

CAM has provided a fruitful point of departure for debates on how positivistic models of evidence-for-decision-making can acknowledge experiential expertise, but our analysis also yields wider insights for societal processes of valuation and prioritisation of non-mainstream (whether novel or traditional) healthcare. Firstly, moving beyond legitimacy as a binary state avoids the temptation to take snapshots of how state bodies or public opinion view a form of care. Taking a wider historical lens demonstrates that practices of legitimation are ongoing, subject to setbacks and surprising victories, but are never statically settled. This approach highlights the ‘greyzone’ of legitimacy-as-process, which is not captured by straightforward questions regarding the presence of public funding. Explicitly centring questions of legitimation as negotiated practice also forces us to recognise empirically the presence of the public beyond imagined audience or arbiter. Publics are not mere ‘barometers of legitimacy’ and studying legitimation through the narratives of campaigners has allowed us to question the kinds of epistemic labour, and labourers, our research makes visible.

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## Notes

1. Rabeharisoa et al. detail how patient groups translate 'experience into the language of science and medicine and vice-versa', marrying experiential and credentialed knowledge (2014: 117).
2. According to Greater Glasgow's website, homeopathy is no longer available through the hospital, though it does not exclude NHS provision via GPs: <https://www.nhsggc.org.uk/patients-and-visitors/main-hospital-sites/gartnavel-campus/nhs-centre-for-integrative-care/nhs-centre-for-integrative-care-therapies/> [accessed 21 February 2020].
3. Information on accreditation via the Faculty of Homeopathy available here: <https://facultyof-homeopathy.org/membership/levels-of-membership-and-costs/> [accessed 3 March 2020].
4. The London Homeopathic Hospital followed suit in 2007, renaming itself the Royal London Hospital for Integrative Medicine: <https://www.uclh.nhs.uk/OurServices/OurHospitals/RLHIM/Pages/historyofrlhim.aspx> [accessed 1 March 2020].
5. Information on the building design is available at <http://ghh.info/welcome.htm> [accessed 30 October 2019].

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