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Religion, Values and Knowledge-power in Contemporary Secular Spaces

The Case of an English Medical Centre

The aim of this article is to examine the way in which knowledge-power is exercised in contemporary controversies in healthcare, and what this flexing of discursive muscles shows about the nature of secularity and its relationship to religion. The discussion is focused on two controversial issues at the heart of general medical practice in the UK: the doctor–patient relationship and complementary and alternative medicine. As will become clear, participation in these debates is not restricted to doctors alone, but increasingly to government departments, professional medical and scientific bodies, therapists beyond the medical mainstream, and patients themselves. What is interesting for scholars of religion is the way in which the debates (which are not confined only to discourse, but are also reflected in physical and social spaces) reveal deep-seated but dynamic values. The debates themselves, and many of the values and opinions expressed in association with them, are ostensibly ‘secular’, but, as we shall see, ‘religion’ has an interesting place within them. It variously enters the scene as a critical tool, the butt of jokes, the enemy or a potentially fruitful partner (particularly in its nascent guise as ‘spirituality’). I would suggest that there are two important outcomes of this examination: first, the opening up of a secular organisation and exposure of the heterogeneity of value and knowledge positions within it, and, secondly, the recognition that methodological tools from within the study of religions (in this case a spatial analysis for locating religion) can be put to use in such an examination, in pursuit of a fuller understanding of secularity.

Introduction: Context and Controversy

I shall begin with a controversy which illustrates the way in which deep-seated interests concerning the religious and the secular are roused by the

subject of contemporary medicine. Between May 2004 and April 2005, I directed a research project entitled 'Locating religion in the fabric of the secular: an experiment in two public sector organisations' (a high school and a medical centre). The research was funded by the Arts and Humanities Research Council in the UK, and my co-worker was Dr Myfanwy Franks – she undertook the ethnographic work, and assisted in its analysis and writing up.¹ The aims of the project were, first, to test the feasibility of the spatial approach described in my book, *The Location of Religion: A Spatial Analysis* (2005) for analysing data on religion and secularity collected in public sector organizations, and, secondly, to yield new insights on the relationship between the religious and the secular in domains associated primarily with a modernist secular agenda.

Although we aimed to investigate 'the location of religion' in secular organizations, we could not guarantee in advance that we would find it (except in so far as such organisations probably retained formal historical, legal or institutional links with particular Christian denominations). Our project proposal – for which we were given 'Innovation funding' for use in speculative research – allowed us to experiment. It presupposed that we would use an innovative methodology to attempt to break open 'the secular' (that body of discourse and values that has become second nature to us in modern Britain) and that, in doing so, we might fail to find any trace of 'religion' as such. Of course, as we know this depends on how one defines these terms and I will come on to that a little later.

Let me turn now to the controversy. During the later stages of the project the research fellow and I were interviewed by our university press office and an article was published in the University of Leeds newsletter, *The Reporter*, entitled 'Looking for God in public places' (21.3.05). The article was illustrated with a picture of the two of us standing in front of the motto of the University's Old Medical School. The caption for the photo read:

Religion in evidence – Professor Kim Knott (left) and Myfanwy Franks in the entrance to the old medical school where a Latin inscription reads: "Heal the sick, cleanse the lepers; freely you have received, freely

1 I am grateful to the Arts and Humanities Research Board (now Council) for funding this project (B/IA/AN5276/APN17687), and to Myfanwy Franks for her contribution to the research for this article. Both of us extend our gratitude to those in the medical centre who gave their time and insights during the fieldwork and ensuing workshop.

give." Absent from this edited passage from Matthew 10:8 is "raise the dead and cast out evils" which, of course, are found today in emergency resuscitation and psychiatry. (*The Reporter* 21.03.05.)

Following its publication, *The Reporter* received several letters pointing out their typographical mistake: the missing passage from Matthew 10:8 should of course have read 'Raise the dead and cast out *devils*.' One of the letters came from a Professor of Psychiatry. He was clearly upset, as he said,

by the allusion to psychiatry in the caption. For only a short time in the long history of medicine has mental disorder been attributed to devils, possession or inherent evil, and it certainly isn't in modern medicine. Your joke about psychiatry trades on a metaphor about troubled people, but more strongly than that it plays to a certain sort of prejudice about mental illness ... (*The Reporter* 03.05.05.)

I need not go into the details of our reply to him, which was published along with his letter in the May issue of the magazine, suffice it to say that we denied it was a joke. What he perhaps did not realise was that his response confirmed the very point that we had made in the original article,

Religion can also be found in opposition, or controversy, as Professor Knott explains: "Where you have two world views in opposition you begin to see strong moral positions revealing those things that people hold [to be] sacred" (*The Reporter* 21.03.05).

His strong reaction against equating mental illness with demonic possession and against bringing supernatural explanations into modern medicine exposed the nerve-endings surrounding the religious/secular boundary. His reaction confirmed the closeness of the very things he wished to keep apart. There is a genealogical relationship between religion and modern medicine (including the treatment of mental illness). It has been usefully discussed by Michel Foucault (1973), Talcott Parsons (1951, 1985) and Bryan Turner (1992, 1996) among others. It is more than just a historical relationship of succession, of medicine superseding religion; it is a past and present relationship, both discursive and practical, which rotates around conceptions of life, health, destiny, healing and what it is to be 'normal'. Who authorises, governs and participates in the debate and practice of these issues is what is at stake here.

Our correspondent, the Professor of Psychiatry, would evidently like religion to be kept well out of what he sees to be secular territory. Its presence on the edge of that territory he finds disturbing and dangerous. From his perspective on religion – which would undoubtedly be contested by many religious people themselves – religious ideas and practices run counter to contemporary views about the nature of persons, health and ill-health, equality and difference. Such a contemporary perspective, despite being institutionalised and empowered by the medical mainstream, must still be argued for and defended when under attack from other positions, not least of all religion.

Returning now to the research project itself, what a spatial approach based on controversies enabled us to do was to look beneath the surface of secular public organisations, and to reflect in depth on differing ideological, professional and moral perspectives (such as those we have just seen). We identified two areas of anxiety or controversy in our examination of the medical centre, these being the doctor–patient relationship and complementary and alternative medicine or ‘CAM’. We interpreted these controversies as physical, social and mental sites, and considered the ways in which they were extended historically and co-existed simultaneously with other related spaces (Knott and Franks, in press). We looked at them as sites of struggle in which various knowledge-power positions were in contention, and reflected on how they were produced and reproduced.

Occasionally, aspects of conventional religion came to the fore in our observations and interviews, such as ideas about healing and vocation in the medical profession; the religious allegiance of patients and medical staff; the proximity of the medical centre to a Catholic church. However, even where no explicit religious concerns were evident, our approach allowed us to identify competing moral discourses which touched on vital matters. Furthermore, we could see that the ‘secular’ itself was constituted by a variety of positions and values, and it is these and their implications for issues of moral authority and knowledge-power on which I intend to focus here.

It is my aim then to consider discursive controversies in an English medical centre, an organisation at the frontline of national public health provision. As a starting point I take it for granted that such an organisation is ‘non-religious’ in our conventional use of that term, and suggest that it is a secular body, part of the public services provided by the state, ‘free at the point of delivery’, overseen by a government department and regulated by laws, government policy and National Health Service (NHS) directives. However, as Sophie Gilliat-Ray has suggested, ‘some of the richest insights

into contemporary religious life are to be found outside formal congregations, away from religious buildings and in perhaps the most “unlikely” secular institutions’ (2005, cf. Beckford 1999). What does a spatial approach to two controversies in a medical centre reveal about the ideological and moral struggles currently taking place in public health in the UK? What was the nature of the values exposed in such struggles? What were we able to learn about the nature of secular knowledge-power? And, how, if at all, did this relate to religion?

In what follows I shall first consider the following key terms – the ‘religious’ and the ‘secular’, ‘controversy’ and ‘power’ – before going on to introduce the space of the medical centre, and then to examine the two controversies of the doctor–patient relationship and complementary and alternative medicine and what they reveal about the struggle for moral authority and knowledge-power in contemporary general medical practice.

Definitions: Religion, Secularity and Knowledge-power

In my recent book I rejected the idea of settling for either an existing definition of religion (or secularity) or of inventing one of my own, either before or after the research process. Instead I opted for a nominal definition of religion (Comstock 1984, Anttonen 2005a) in which the meaning or contents of ‘religion’ is not determined by any single property, substance or function, but where ‘the range of possible meanings ... is derived from the discourse in which [the term “religion”] is used’ (Anttonen 2005a).

In *Social Theory and Religion*, James Beckford states that, ‘religion is ... a particularly interesting ‘site’ where boundary disputes are endemic and where well-entrenched interest groups are prepared to defend their definition of religion against opponents’ (2003: 13). It is a similar perspective that underpins the approach I have taken. With Beckford, I assert that ‘definitions have a broadly political significance in the sense of relating to struggles for power’ (1999: 23) and look at contested spaces or ‘boundary disputes’ to see what they reveal about interests, but, unlike him, I do not depend upon ‘religion’ being the subject of contestation. Instead, I assume that in all knowledge-power struggles people do not just fight for the sake of it; rather they argue about things which are important to them and which arise from values they hold that are non-negotiable – or ‘sacred’ (Anttonen 1996, 2005b) – and beliefs about which they have conviction or that they want to test.

In my book, for the purpose of considering ‘the location of religion’, I

devised a field of religious/secular knowledge-power relations based on the following assumptions: First, that in the modern West the religious and the secular may be said to be 'two sides of a single coin' – what Grace Jantzen (1998: 8) has called 'a binary constitutive of modernity' – and, second, that, as Charles Taylor (1998, 2002) and Talal Asad (2003) have argued, European Christianity and secularity are historically enmeshed, and philosophically, legally and ethically intertwined despite often appearing to be radically dissimilar and in opposition. I suggest that such ideological distance and contestation can be explained historically and dialectically. This knowledge-power field – which of course is a scholarly construct for analysing contemporary struggles about beliefs and values – provides a frame for deliberating upon notions of the 'religious' and the 'secular' and on discourse about them. It does not provide hard and fast definitions of either. Neither does it resolve the difficulty of how to distinguish between them. This is with good reason, as there exists no static boundary between them (Beckford 2003: 21). The 'secular' and the 'religious' are within the same force-field, in a categorical relationship predicated upon a constantly negotiated boundary. What the field does do is provide a context for sorting the 'religious' and the 'secular' according to the way subjects use such notions; furthermore, it makes space for competing 'religious' notions, or competing 'secular' ones: it acknowledges the heterogeneity of discursive positions. It is precisely the heterogeneity of such positions within the field's 'secular' camp that is of importance in this article, though I shall also consider how 'religion' is viewed and used to authorise and critique various secular value positions.

So, for the purposes of this article the 'religious' and the 'secular' – and a third post-secular position (which is often expressed in terms of 'spirituality' rather than 'religion' or 'religiosity') – form a field of knowledge-power relations (Foucault in Gordon 1980; Carrette 1999, 2000). In referring to such relationships in terms of knowledge-power I am following Foucault in drawing attention to the role of discursive formations in modern institutional struggles, though, like Foucault, I do not intend 'to isolate discourse from the social practices that surround it' (Rabinow 1991: 10). More generally, by 'power' I mean both social- and knowledge-power that may be used coercively or subversively, for discipline, survival or liberation, in struggles for empowerment, identity or mastery whether large or small scale. In stating that all ideas and groups need to acquire a morphology if they are to be successful and lasting, Henri Lefebvre (1991: 417) reminds us that, in focusing on a multi-dimensional space, in this case a medical centre, we need to be aware of the social and knowledge struggles

that have taken place to bring it about as well as those that contribute to its maintenance and future development.

The Space of an English Medical Centre

The medical centre in which our research was conducted was situated in a seaside town in the south of England, serving a largely white population with a high percentage of elderly people. It was not selected for reasons of representativeness – no single medical centre could provide that – but because of its clientele and its ease of access (through a personal connection). The fieldworker, Myfanwy Franks, and I had previous experience of research with people and organisations which were predominantly minority ethnic and minority religious in character (Franks 2001, Franks and Medforth 2005, Knott and Khokher 1993), and decided it was important for us to select an organisation in which religion and ethnicity were less prominent and secularity arguably more so. As our research project was small scale and experimental and we had no comparative ambitions, we selected only one medical centre (and one school – which I shall not discuss here). We know that we would probably have learnt other things and encountered other spaces if our choice of medical centre had differed.

The ethnographic process entailed Myfanwy spending time in the waiting room, observing the various physical and social spaces, taking field notes, and interviewing practitioners in their habitats.² No patients were interviewed for ethical reasons. Attention was paid to the spatial nature of the medical centre, its history and context, and to its internal character (architecture and layout, open and closed spaces, boundaries and directions, doctor–patient spaces, sites of information, etc.), and these sometimes generated questions and discussion points in the interviews.

The medical centre, a new building on former church land owned by a Cambridge University college (though many miles from Cambridge), was situated in a greenfield site near to houses and opposite a Catholic church, the large cross of which could easily be seen from the waiting room. The historical power of Christianity in England, its symbolic pres-

2 Full- and part-time staff at the medical centre included six doctors (five of whom were partners), three nurses, a practice manager, six receptionists and several clerical staff. Community nurses also made use of the premises. Multiple in-depth interviews and discussions were conducted with five staff members, in addition to observations on 29 and 30 June 2004.

ence in churches, and continued provision of pastoral and civic as well as religious services, is all too easy to overlook. In fact, in the planning stage of the medical centre, the Catholic priest had organised a public meeting to discuss the suitability and use of the site and the plans for its development. Of course, a few of the centre's patients and staff attended his church and some frequented other places of worship, whilst others – including most of the doctors – deliberately eschewed religious belief and practice.³ Moving inside the medical centre, it was impossible not to be impressed by its large 'waiting room' with high ceiling and roof beams. As a time-space of waiting and dwelling on matters of health, healing and destiny, it resembled the interior of a church or cathedral, a point noted by one of the doctors.⁴

There is much more that could be said about spatial methodology (Knott 2005), the nature of the space of the medical centre and what it revealed, but these are not my intentions here. The discussion that follows derives from the application of a spatial approach, one in which, following Henri Lefebvre (1991), I treat the medical centre as a physical, mental and social space; I use the properties of space – of configuration, extension, simultaneity and power, developed from concepts used by Foucault (1986) – to think about the place of the medical centre, its relationships and discourses. The geography of the body, and ideas about the production and reproduction of space are used to think about how moral and ideological struggles are enacted in this medical context. This approach is discussed and applied in Knott and Franks (in press).

In the remainder of the article I shall consider two controversies which illustrate the way in which knowledge-power is exercised and contested and secular values are expressed before returning to the subject of the relationship between religion and secularity in the space of a contemporary medical centre.

3 Interviews with staff, 18.05., 29.06. and 30.06.04.

4 Interview with GP1 (male), 30.06.04. Resemblance and metaphor may have no scientific or formal evidential status in a discussion about the relationship between two separate institutions, worldviews or discourses, but their significance in the process of representation makes them worthy of note. Architects draw on a variety of influences, memories and resources in designing buildings, and users have these in mind too in inhabiting them.

Controversies I: The Doctor–Patient Relationship

An interesting entry point for a discussion of the social and mental space of the doctor–patient relationship is the physical space of the shield, or crest, of the Royal College of Physicians, a flourishing organisation, first established in 1518, which aims to support doctors in improving health-care for patients.⁵ A right hand descends vertically from a sunburst at the top of the shield and takes the pulse of another hand placed horizontally beneath it. The pomegranate, a traditional symbol of life and regeneration associated with the goddess Persephone, is below. The image suggests a confidential relationship between two parties that is also hierarchical and religious: the sunburst from which the healer’s hand emerges implies that (s)he is acting under divine inspiration and/or has some knowledge or power that is extramundane. The historical doctor–patient relationship, articulated in the physical space of this shield and in its many reproductions, suggests a top–down specialist/client, active/passive relationship. But to what extent is this traditional relationship borne out by other spatial clues revealed in our examination of the medical centre?

In its modern, spacious consulting rooms the arrangement of the seating is generally such that the desk does not come between doctor and patient. The presence of chairs of similar size and height for both parties suggests a professional awareness of both the way in which power relations may be reproduced in design and furniture, and the discourses of equality and co-agency that are particularly evident in contemporary health care and counselling.

Increasing pressures on what was once the confidential and hierarchical social space of the doctor–patient relationship mean that, although there may be only two people facing one another in the consulting room, the space of the relationship is now filled with power relations and gazes many of which originate outside the encounter, whether in law, public policy or popular culture. The ‘medical gaze’, a concept founded particularly upon Foucault’s conception of the historical development of the scope and

5 The Arms of the Royal College of Physicians were granted in 1546, and a modern version of the shield which forms part of those arms can be viewed in the top left hand corner of the College website (<http://www.rcplondon.ac.uk/college/>). I am indebted to Myfanwy Franks for this account of the arms and for much of what follows in this and the next section. Though the methodology and final presentation are mine, the fieldwork and its analysis are hers.

status of medical knowledge and power (1973), is no longer monolithic but has been disrupted by the governmental gaze, and by the changing expectations of the role of the patient.⁶ For instance, as a result of the conviction in 2000 of the general practitioner (GP) Harold Shipman for the murder of fifteen patients and the subsequent inquiry, doctors have lost some autonomy and are now subjected to increased surveillance.⁷ Further, as part of their new contract, GPs are expected to achieve specific targets according to which they are paid.⁸ More than ever before, the patient is being invited, indeed expected, to participate actively in their health care, and this new approach goes hand in hand with a conception of 'the informed patient', irrespective of their ability or willingness to take on this role.⁹ This inevitably leads to conflicts between 'lay and expert medical knowledges' (Henwood *et al.* 2003: 598) and to the new consumerist patient making demands that cannot always be met within existing financial and clinical constraints. Information technology has also entered the social and physical space of the encounter giving increased power to both sides, with GPs routinely using computers during consultations and with many patients, as 'online self helpers' (Ferguson 1997), making use of the Internet in order to seek advice and become better informed (Shilling 2002).

The controversy between technological intervention, surveillance and quantification, on the one hand, and the qualitative role of carer and healer on the other is being played out within the limited time-space¹⁰ of the doctor-patient consultation.¹¹ But, there are also historical assumptions about the nature of the doctor-patient relationship that are carried into a consul-

6 See UK Department of Health website, <http://www.dh.gov.uk/PolicyAndGuidance/fs/en>.

7 The number of Shipman's victims is thought to be as high as 250. The Shipman Inquiry recommended changes in the licensing and revalidation of GPs. A new system and guidelines on 'fitness to practise' were introduced by the General Medical Council in April 2005. Its guidelines on *Good Medical Practice* were being revised (2006).

8 For the new General Medical Services Contract, 2003 'Investing in General Practice', see [http://www.bma.org.uk/ap.nsf/Content/NewGMScontract/\\$file/gpcont.pdf](http://www.bma.org.uk/ap.nsf/Content/NewGMScontract/$file/gpcont.pdf).

9 On doctor-patient partnerships, see *Developing Patient Partnerships*, <http://dpp.org.uk/>.

10 A ten-minute consultation is now the norm arising from the 2003 General Medical Services Contract and the Carr-Hill allocation formula, [http://www.bma.org.uk/ap.nsf/Content/NewGMScontract/\\$file/gpcont.pdf](http://www.bma.org.uk/ap.nsf/Content/NewGMScontract/$file/gpcont.pdf).

11 This was borne out in the interview with GP3 (female), 30.06.04.

tation: it is linked by chains of memory to previous confidential and hierarchical relationships such as those centred round a priest, confessor, analyst or counsellor. One GP at interview, referring to the traditional response of patients to the authority of the doctor, ironically used religious imagery, saying, 'Here is the fount of all wisdom. And I'm going to the shrine and saying "Please help"'.¹² And, of course, there are also social power issues, associated with gender, class, ethnicity, etc, affecting this complex relationship.

Another area of contestation is the importance of science and an evidence-based approach to treatment. According to its exponents, 'Evidence-based medicine is the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients' (Sackett *et al.* 1996: 71). It focuses on the use of randomised controlled trials, as well as systematic reviews and meta-analysis. There is an emphasis on linking published research to clinical practice, with GPs then being alerted to findings so that they can engage their practice with the evidence.¹³ Here we see the shift of power from the individual doctor, authorised by his or her training, experience and membership of professional bodies, to the GP as front-line representative of a highly scientific and academic approach to medical treatment.

Of the GPs we interviewed, all of whom acknowledged the contribution of evidence-based medicine (EBM), one emphasised the importance of medicine as an art as well as a science.¹⁴ Another, more secularist in outlook, conceded that one could go too far. He said,

I think you can be the 'Citadel' doctor who *only* wants science ... You do have to take into consideration people's psychological state, their social concerns and you've got to take in their belief systems to an extent. Sometimes I find that difficult – taking in other people's belief systems.¹⁵

A third recognised the importance of EBM but felt confined by it.

12 Interview with GP2 (female), 29.06.04.

13 It is closely linked to the Cochrane Collaboration, a worldwide network of centres whose aim is to foster this approach (<http://www.cochrane.org>).

14 Interview with GP2, 29.06.04.

15 Interview with GP1, 29.06.04. The 'Citadel' is the term used for the medical establishment by the jaded and disillusioned doctor, Andrew Manson, in A. J. Cronin's novel *The Citadel* (1937).

You're not supposed to do anything unless there's been some paper showing that it has been effective. But it doesn't always work like that. There may be a study showing that 75 per cent of people *in this study* responded well to such and such but you can't always extrapolate [from] that to real life ... in real life people don't just come in with one problem – a lot of them have co-existing disease ... it's quite difficult and sometimes you just get a hunch you would like to try doing something.¹⁶

Although they recognised its importance, these doctors expressed concern that EBM fails to accommodate other sorts of evidence amenable through experience, that it restricts their autonomy and knowledge, and prioritises evidence over patients' accounts, beliefs and co-existing problems.

The medical literature is even more robust on this matter. One commentator (Sinclair 2004) suggested that EBM functions as a 'new ritual' in medical teaching; several others referred to it satirically as a 'new religion' (including a group known humorously as CRAP, Clinicians for the Restoration of Autonomous Practice). Although science has traditionally been opposed to religion by secularists on the grounds of religion's otherworldliness, so-called blind faith and lack of an evidence-base – as EBM, science is here mocked for the faith its own exponents place on evidence. To quote one critic,

EBM has become the new religion – the new authority, with priests, acolytes, followers and a rigid dogma. The practising doctor cannot interact with it, cannot judge for himself or herself and cannot make his or her own decisions ... It has created its own system of belief to which we have to practise faith-based medicine. (Rosenfeld 2004: 155.)

In the article entitled 'EBM: unmasking the ugly truth' (a parody published in the *British Medical Journal*) the authors claim to provide 'irrefutable proof that EBM is, indeed, a full-blown religious movement, complete with a priesthood, catechisms, a liturgy, religious symbols, and sacraments' (CRAP 2002: 1496). This satirical perspective is interesting for what it tells us about secular views of religion. Secular medical exponents who favour a more democratic and less scientific approach to treatment see EBM – like religion – as a rigid, unquestioning and authoritarian system.

So, within a controversy about the best way to practise medicine and treat patients we see the old struggle of secularism vs. religion raising its

16 Interview with GP3, 30.06.04.

head, albeit in metaphorical form. But moving from the metaphor to the real issues at the heart of this struggle, what we see is that, *within* the secular system of contemporary medical practice, there are things deemed to be worth fighting about. The secular value system is not homogeneous. Different values – of the importance of the scientific method and the evidence that it can provide, and of the autonomy and judgement of the medical practitioner – are vigorously contended within the social space of the doctor–patient relationship and the time-space of their consultation. Furthermore, within a heterogeneous secular medical context, religion may be used pejoratively by advocates of one or another position to devalue the views of their opponents.

Controversies II: Complementary and Alternative Medicine (CAM)

As this last case has shown, the names and labels given to things can be revealing for understanding how they are conceived and contested. We may note then that, before the opening of the medical centre, the name ‘*Health Centre*’ was rejected by the senior doctor because he feared that people would think it offered alternative as well as conventional treatments. That this was an area of controversy was reinforced when he said to the researcher that he hoped they would not fall out with one another over the issue of CAM.¹⁷

The reasons for the popularity of CAM have been summarised by D. B. Clarke, M. A. Doel and J. Segrott as ‘dissatisfaction with orthodox medicine, a desire for holistic treatments that value patient experience, the emergence of “smart consumers” seeking self-empowerment through active healthcare decision-making, or ... symptomatic of an age of cultivated anxiety’ (Clarke *et al.* 2004: 329; see also Sharples *et al.* 2003).¹⁸ Defined by Nikki Bradford (1996) as including five types of therapies – Eastern, manipulative, natural, active, and therapies involving external power – CAM is a further example of an ideological struggle within contemporary healthcare. The very appellation of complementary and alternative therapies as ‘alternative’ marks them out as different to mainstream medicine, though it also implies that they fulfil similar functions or goals; the term

17 Whether because he thought her interest in religion or her gender and age would incline her to be sympathetic to CAM is not known. Interview with GP1, 29.06.04.

18 Authors’ citations not included.

'complementary' suggests that they add a further dimension or perspective to allopathic medicine.¹⁹ The scholar of religion, Dominic Corrywright (2004), states that there is a continuum of views about CAM among orthodox medical practitioners ranging from acceptance to non-acceptance, with some specific therapeutic forms generally held to be anathema, particularly those involving spiritual healing, psychic medicine, *reiki* and crystal healing, incidentally all forms that do not involve physical contact between therapist and patient, that appear to be the least rational and evidence-based, and that imply external, extramundane powers. The more overtly spiritual or religious, the less well accepted by GPs, it would appear.

Staff at the centre were articulate about this controversy with the general attitude of doctors being summed up by one as 'Prove it first and then we'll use it!'²⁰ Another also related CAM to the issue of scientific evidence.

I have fairly strongly held views and other people have strongly held views in the opposite direction and they usually can produce loads of anecdotes about people who've been helped by homeopathy, copper bracelets, acupuncture and various other treatments and I think that the evidence base is not rigid enough for medicine. What I do accept is that there is a holistic element in medicine. And I think there are things which some people get a lot of benefit from. But they're not necessarily curative. They are things that help people's emotions and help people's bodily tensions and [to some] extent that's what people often need. When they come and see a GP people do not necessarily have a physical illness. But I find some of the claims made by some of the alternative therapists are exaggerated and there doesn't seem to be a scientific basis for them and that worries me.²¹

Despite his focus on scientific reason as normative for general medical practice, this doctor did acknowledge the concept at the heart of the alternative ideological agenda: holism. And with some regret another made the following point:

19 The Department of Health in its 2001 report and Whitehouse Commission (2002) has laid the way for CAM to play a role in national health provision (Corrywright 2004). See also Saks (2003) on the developing relationship between orthodox and alternative healthcare.

20 GP2 in discussion, 29.06.04.

21 GP1 in discussion, 29.06.04.

Because doctors haven't got time to treat the whole patient and to listen, then these other therapies are going to become much more popular. You go and see a homeopathic practitioner and they will give you an hour taking your history. Well, of course you're going to feel better and cared for when you come out. Rather than ten minutes [and] 'Right take that!'²²

This allusion to the treatment of the whole patient as a practice beyond the remit and time of the GP is interesting. It recognises the presence of simultaneous but different health systems with alternative geographies of the body. The presence of other systems with holistic views of the body (such as homeopathy and Chinese medicine) invites us to consider the geography of the body that operates within conventional medical discourse. In *The Birth of the Clinic* (1973) Foucault examined the way in which the person was constituted as an object of the scientific medical gaze, as a body in pieces. This spatial understanding of the body, its gender, parts and systems, is fundamental to conventional medical practice. Conceptions of disease and medical research concentrate on these arrangements. Modern hospitals reflect them in their organisation and architecture. But complementary and alternative therapies operate with different, often spiritual or theological conceptions of the body.

Discussion with staff at the medical centre brought other assumptions to the fore as well, particularly about who and what is best served by CAM. One nurse, who placed CAM in the context of health promotion rather than treatment, said: 'You know a lot of ladies are looking toward these things now, acupuncture ... aromatherapy. And you know all these things are very much in vogue and ladies are thinking "Well, I don't know if I want to take that tablet anymore. I want to think about something else".'²³ One doctor, reflecting on the use of alternative therapies in her previous place of work, said,

[In a hospice] they really do try looking at the whole thing. They are not just looking at the fact that you're feeling sick or just the social ... Yes, people died ... but on the whole it was a lovely atmosphere not mournful, not depressing. You have people coming in to entertain you, have a reflexologist going round, you have a music therapist. It's great and it's a beautiful place where I used to work.²⁴

22 GP2 in discussion, 29.06.04.

23 Interview with PN (female), 30.06.04.

24 Interview with GP3, 30.06.04.

In these quotations it is women and the dying who are associated with the use of CAM. In describing a women's health evening organised at the medical centre that had attracted some 200 women, the nurse mentioned that there had been a Pilates instructor and someone to talk about complementary therapies, particularly in relation to the menopause. Not only would men have been unlikely to attend such a health evening – unless it was held in a pub, she said – they would have been less likely than women to be interested in such therapies in the first place.²⁵ Women were more ready to be 'informed patients' and active as partners in the health care process. This nurse, like the doctors from whom we have heard, linked the application of CAM to those conditions for which cures were felt to be inappropriate or ineffective. They also associated it with liminal states – such as the menopause and incurable illness leading to death – in which assistance in making a transition between the stages of life or life and death was required and where the role of evidence-based medicine might be limited or unnecessary. Furthermore, we see medical staff making space for CAM, sometimes reluctantly, alongside mainstream medicine by relating it to a different class of conditions, those requiring therapy not cure.

Secular Values, Knowledge-power and the Location of 'Religion'

The aim here has been to investigate those discourses and values at work within an English medical centre. The focus has been on controversies surrounding the doctor–patient relationship and complementary and alternative medicine in order to examine religious/secular knowledge-power relations, particularly those occurring *within* contemporary secularity.

First I looked at the doctor–patient relationship as a multi-dimensional space that was principally social, but played out in and imprinted upon the physical space of the doctor's surgery. As a mental space, it comprised a complex configuration of interwoven gazes, many of which have invaded the relationship as a result of recent government policy, contractual change, professional surveillance, scientific testing and technological innovation. For some staff maintaining the integrity of the social relationship depended chiefly on diagnosis and treatment based on scientific evidence; for others it depended on the recognition of the practice of medicine as an

25 Interview with PN, 30.06.04. We note also that CAM made its appearance in the centre outside normal working hours, in the temporal, if not spatial margins.

art as well as a science, and of hearing from and responding to patients as whole people rather than body parts.

The doctors themselves raised the issue of CAM as a site of contention, both social and ideological. The place of the body was central to the debate, being the focus of different geographies as well as different curative and therapeutic procedures. I noted also the way in which a time-space was made for CAM in the medical centre by limiting its application to women, to particular life-stages, to therapy rather than cure, and, incidentally, to the work of some staff and not others. CAM provided an interesting case because its various therapies reflected simultaneous alternative health systems, which in the past were offered to clients in separate physical locations, but which now contend for space within the domain of state medical provision. Changing public conceptions of the informed and responsible patient and holistic healthcare in particular have made it hard for staff to exclude CAM entirely from the medical centre. Making appropriate time and space for some but not all CAM therapies, especially not those involving supernatural powers, has been a knowledge-power struggle between staff (and also with CAM practitioners outside the centre).

A key factor running through these controversies has been the Enlightenment-inspired secularist preoccupation with proof or evidence. None of the medical staff we spoke to denied its importance, but they variously tempered their acceptance of it with reference to other values, such as holism, personal well-being, professional judgement and autonomy, patient (or consumer) agency, and the art of medical practice. I suggest that some of these values conform more closely to a secular modernist perspective (the importance of evidence, autonomy and professional judgement) whilst others emerge as *post*-secular values (holism, well-being, patient-agency, the art of medicine) allied with late-modern 'spiritual' as opposed to either wholly secular or wholly religious concerns.²⁶

To what extent has religion been unearthed in this study? Traces of it have been observed in the physical and social spaces of the medical centre, and its parallel geographical and ideological presence has been noted. We have seen it used metaphorically within a secular controversy to parody those who hold alternative – some might say systematic and rather fixed –

26 Such late-modern concerns have variously been associated with the 'spiritual revolution' (Heelas *et al.* 2004), neo-liberal capitalism (Carrette and King 2005) and post-secularity (Knott 2005), which are related trends with rather different conceptual and historical reference points.

opinions. After all, religious terms and ideas are chief among the resources in our linguistic armoury for mounting arguments about moral matters. Further, we have sensed rather than closely examined its location at the heart of some alternative therapies, and have noted that those that are more closely associated with the non-natural and the lack of an evidence base are unlikely to gain acceptance or space in the medical centre. However, it has not been religious beliefs and perspectives that have emerged as controversial but rather secular ones.²⁷ The heterogeneity of positions within contemporary secularity has been revealed, positions which are distinguishable on the basis of their association with either modernist values or post-secular 'spiritual' ones related to the whole person, intuition and experience, art and agency.

Medical controversies throw up issues that are of importance; they reveal the values that are at stake when it comes to debating and negotiating the vocation of the doctor, the relationship with patients and the treatment of disease, ill-health and the management of the some of life's liminal stages. In the examples we have examined, 'religion' has been projected and shaped as dangerous and disturbing, as the archetypal regime of blind faith and authoritarianism, and – through its relationship with the least acceptable of complementary and alternative therapies – as being out of place in a publicly funded medical centre where reason and evidence are the measures of good practice. The 'secular', however, has not been mentioned overtly – rather, it is formed by default; we get a sense of it through its contending positions and their relationship to one another, and the way in which they distance themselves from religion.

27 We might say that it is the 'secular sacred' rather than the 'religious sacred' that is at stake in debates about the doctor–patient relationship, CAM and – cutting across the two – evidence-based medicine. Describing secularity and its values in this way requires a fuller argument and more evidence than there is space for here. For a discussion of the 'sacred' as a secular as well as religious category boundary, see Knott (2005: 215–28).

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