2012

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Publication details

Postprint of: Nissen, N & Evans, S 2012, 'Exploring the practice and use of Western herbal medicine: perspectives from the social science literature', *Journal of Herbal Medicine,* vol. 2, no. 1, pp. 6-15.
Published version available from:
http://dx.doi.org/10.1016/j.hermed.2012.02.001

Title:

Exploring the practice and use of Western herbal medicine: Perspectives from the social science literature

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Abstract

The literature which concerns Western herbal medicine (WHM) overwhelmingly provides clinical and pharmacological perspectives on the utilisation of herbs as medicine. Research which examines WHM as a social practice and the theoretical concepts associated with it, or the manner in which the knowledge base of WHM is developing and changing is less often discussed. This article provides an overview of the social science literature concerning WHM, as it pertains to practice in Europe, North America and Australasia. One theme emerging from this literature is the mapping of the practice, patients and practitioners of WHM, and another theme addresses more theoretical issues that consider the development of herbal knowledge and the social factors which impact on herbal practice. This article, based on a small but diverse body of literature, sketches the current breadth of enquiry and debate surrounding WHM and points towards the importance of further social science research in the area.

Keywords

Western herbal medicine, patient-practitioner relationship, knowledge base, practitioners, patients, clinical practice

1. Introduction

Explorations of academic work in herbal medicine reveal an established body of research in clinical studies and pharmacology that aims at determining the safety and efficacy of medicinal plant use (for example Ernst 2000; Mills and Bone 2000; Linde ter Riet, Gerben et al. 2001; Mills 2002) . In addition, practitioners of Western herbal medicine (WHM) testify to the effectiveness of professional herbal practice (for example Green, Denham et al. 2007). Claims of the effectiveness of herbal medicine/s are grounded in a long history of the traditional use of plants in the prevention and cure of ill-health (Griggs 1997; Mills 2002). Underlying these areas of enquiry are questions such as 'Does herbal medicine work?'; 'How does it work?' and 'Why does it work?' Closely related debates address how the efficacy, safety and effectiveness of medicinal plants and the practice of herbal medicine can be established (Whitelegg 1996; Mills 2002; 2007). These issues are familiar to many herbalists and have dominated and shaped herbal research for many years.

By contrast, explorations of WHM that draw on research traditions originating in the social sciences, such as sociology, anthropology, cultural studies and politics, are far less frequent and less visible. Included here are examinations of the social practices and processes, and the ideas, concepts, and knowledge that underpin and inform the practice and use of WHM. These enquiries pose questions such as: Who are practitioners of WHM? Who are their patients? What social practices and processes guide the work of WHM practitioners? and What core beliefs, values and concepts do WHM practitioners draw on in their practice?

The term WHM is of fairly recent coinage (Wahlberg 2010) and no agreed-upon understanding exists. Some describe WHM as a 'therapy to treat disease' and equate it with phytotherapy (Walker 2006), or as based on an Anglo-American heritage with roots in early eclectic and physiomedical traditions (Casey, Adams et al. 2007). Others highlight the centrality of vitalism to the practice of herbal medicine, including WHM in Australia (Evans 2009; Singer and Fisher 2007), whereas diverse notions of holism are identified as critical to the plurality of practices of WHM in the UK (Nissen 2011). In the context of this paper, WHM is understood as the practice of herbal medicine that uses plants largely native to Europe, within philosophical traditions arising from European thought.

Our aim in this article is to bring together and examine literature that explores the field of WHM and its practice and use from a social science perspective. To this end, we gather a small but important body of literature and highlight the key themes that it allows us to identify. That is, we explore a subset of the available literature concerning WHM. Readers may therefore identify what they consider to be omissions and they are referred to the Methods section for details about our literature search strategy.

The article is limited to the practice of WHM in English-speaking countries, and the articles located through a systematic search of literature (see below) refer to WHM in the UK, Canada, and Australia. This geographical spread raises a number of challenges. Most importantly, variations in the practice of WHM have arisen in response to specific political, social and cultural contexts. For example, each country (and often also regions within countries) has distinct legal and regulatory frameworks which circumscribe the practice of WHM and influence its local development. In addition, and cutting across these differences, wider socio- cultural developments characteristic of the 20th and 21st century also have implications for WHM.

2. Methods

This article is based on a systematic search of literature. A search strategy was developed to address the question 'What can social science literature tell us about the practice and use of WHM?' Peer-reviewed articles identified through a search of academic databases, complemented by additional scholarly publications, provide the basis for the explorations presented here.

2.1 Literature search

To identify relevant peer-reviewed articles the following databases were used: Web of Science, one of the most encompassing social science databases; Academic Search Premier a leading multidisciplinary database; and AMED and CINHAL, databases specific for publications concerning complementary and alternative medicine (CAM) and allied health professions. A number of key search terms and synonyms were identified to reflect the research question posed (see Box 1), and these were chosen by consulting published articles in the field. The searches were limited from 1 Jan 1985 to 31 Dec 2010, and the following

exclusion criteria were adopted: no abstract; abstract not in English; presentation as abstract only; editorials, letters, opinion pieces; outside Europe, USA, Canada, Australia, New Zealand; articles reporting on clinical studies or the evaluation of treatment; pharmacological studies. Given the explicit focus on peer-reviewed literature concerning WHM, so-called grey literature was also excluded, such as Master dissertations, government reports, public opinion polls, and articles in professional newsletters of herbal organisations. Also excluded were articles which do not address the research question we examine, such as articles specifically on the history of herbal medicine. Both authors read all the included publications and jointly identified broad themes as emerging from the publications.

Insert Box 1 here

Box 1: Search terms and synonyms				
Key search term	**WHM**	**Professionalisation**	**Knowledge**	**Practice**
Synonyms	-Herbal medicine -Phytotherapy -Botanical medicine -Medical herbalism -Herbalism	-Biomedical co-option -Integration -Education -Regulation	-World views -Professional knowledge -Science -Scientific knowledge -Traditional knowledge -Vitalism -Evidence-based medicine	-Practitioner-patient relationship* -Therapeutic relationship* -Clinical relationship* -Therapeutic encounter -Clinical encounter -Therapeutics

The search of Web of Science produced 2.735 hits. After reading titles and abstracts, 36 papers met criteria for inclusion. The combined search of CINAHL, AMED, and Academic Search Premier produced 77 hits, 46 of which met our inclusion criteria. Duplicates between the searches were removed. The full articles were obtained and detailed examination of them led to further exclusions; twelve articles remained. To ensure that the field of WHM social science research was covered as well as possible, name searches of scholars engaged in researching WHM known to us through our work were carried out, yielding an additional five articles. Where available to us, PhD studies of WHM are included

(five) as are chapters in academic anthologies (three). We thus consider a total of 25 publications as the basis for this review of literature (see flow chart).

Insert flow chart here (see end of document)

2.2 Analysis

A thematic approach was used to analyse the included publications. This involved the close re/reading of each publication, leading to basic and advanced coding and the identification of emerging categories, themes and sub-themes (Miles and Huberman 1994). Both authors analysed each publication, followed by discussion and verification of emerging themes and sub-themes.

The analysis highlights two main themes. The first theme concerns practitioners of WHM and their practice. It provides a broad 'map' of contemporary WHM and examines some of its social practices. The second theme focuses on the development of herbal knowledge and the ways in which it is being modified and developed in response to contemporary issues and pressures. These themes and related publications are presented and discussed in the following sections.

3. Mapping WHM: Practitioners of WHM and their practice

In this section we examine the literature which provides an overview of contemporary WHM. Topics include: how practitioners describe their profession; demographic details about practitioners and business aspects relating to their practice; and explorations of practitioners' clinical practice. These issues are predominantly examined through large-scale surveys and questionnaires. In addition, qualitative studies examine the patient-practitioner relationship in WHM and explore issues relating to WHM patients. See Box 2, for authors and year of publication arising from the literature search examined in this section.

Insert Box 2 here

Box 2: Authors and year of publication arising from the literature searches examined in section 3	
Bensoussan, Myers et al (2004)	Little (2009)
Birch and Nissen (2012, forthcoming)	Nissen (2010)
Casey, Adams et al (2008)	Nissen (2008)
Casey, Adams et al (2007)	Stewart (2010)
Denham (2005)	Walker (2006)
Evans (2009)	Vickers, Jolly et al (2006)
Hirschkorn (2005)	Zick, Schwabl et al (2009)

3.1. What do practitioners call themselves?

Several terms are used by practitioners (and others) to describe themselves and their profession. The usage of the different terms reflects the legal and socio-cultural influences in different countries.

Australian practitioners largely use the title 'herbalist' [1](Bensoussan, Myers et al's 2004). This contrasts with their UK counterparts: 76% use the term 'medical herbalist' and 24% the term 'herbalist'; both these terms are preferred to the term 'phytotherapist' which was not used by any participant in this study (Nissen 2010). In Australia however, in contrast to the UK and Canada, the descriptor 'medical' has, in some legislation at least, been a proscribed term and is only available to those who have biomedical qualifications. These differences can also be noted in the names of the main professional organisations in the UK (National Institute of Medical Herbalists) and Australia (National Herbalist Association of Australia).

In Canada, the term 'clinical herbalist' is often used interchangeably with the term 'medical herbalist', which is considered to refer to a more 'rational' from of herbal practice (Hirschkorn 2005). In addition, the term 'registered herbal consultant' is used by the Canadian Herbalist Association and denotes shorter training, compared to a 'clinical herbal therapist' (ibid).

[1] In Australia, herbal medicine is practiced both as a stand-alone profession and as a modality within naturopathy. Therefore the boundary between the two professions is less clear cut than e.g. in the UK and the US, where herbal medicine and naturopathy may indicate more distinct practices and professions.

3.2 Who are the practitioners?

Two surveys have aimed to establish demographic details about practitioners of WHM: a national survey in Australia (Bensoussan, Myers et al. 2004), and a survey of a sample of UK practitioners (Nissen 2010). Both surveys note that women play a central role in WHM.

In the Australian study, women make up 76% of herbalists/naturopaths; practitioners are on average 44 years old; and have diverse herbal training and education, and clinical practice and experience. Participants claim to spend about 24 hours in clinical practice/week, and on average undertake 22 herbal or naturopathic consultations/week. Almost half of the practitioners feel that they are fully employed in their practice, though for many participants the income generated through their practice does not represent the total of their earnings. Approx 30% of practitioners work in a multi-disciplinary clinic and almost a third in a number of different clinic settings[2]; many practise in predominantly urban areas. The majority of their patients heard about their practice by word-of-mouth.

A similar picture emerges from the UK. A typical UK practitioner is a woman (in 2004/5, 81 % of practising members of the NIMH were women[3], and 78% of registered College of Practitioners of Phytotherapy members in England were women); between 41 and 50 years of age; white; and works part-time in herbal practice (Nissen 2010). More women than men work part-time in herbal practice (83% and 57%, respectively) (ibid) and referral by word-of mouth is common (Nissen 2008; Little 2009). Women and men supplement their income from herbal practice with unrelated income and more than half (53%) of the participants in Nissen's (2010) study mention difficulties in establishing a financially viable herbal practice. This suggests that some UK practitioners who currently work part-time would prefer to work full-time.

3.3 The clinical practice of WHM

Several studies have explored the clinical practice of WHM, with a focus on the use of herbal medicines, dispensing, length of consultation, and general therapeutic strategies. Both Bensoussan, Myers et al (2004) and Nissen (2010) asked practitioners which tradition of herbal medicine they practise or practise most regularly.

[2] For details of Australian practitioners working in community pharmacies, see Braun et al 2011

[3] This figure rose to 85% in 2011/12

The Australian participants emphasised their WHM training, though some have undertaken additional training and practise Chinese and Ayurvedic medicine (19% and 18%, respectively). Casey et al (2007) find that most prescriptions by WHM practitioners are individualised liquid formulae for internal consumption, which are dispensed following a consultation. The dominant dosage is that of pharmacologically active doses of highly concentrated fluid extracts. Topical preparations are also used, including creams, pessaries, douches, and eyebath (ibid).

The majority (78%) of respondents in Nissen's (2010) UK sample characterise their practice as 'traditional herbal medicine', 'Western European' or 'Western herbal medicine'. Despite perceiving of themselves as grounded in a 'Western tradition' the increasing globalisation of accessing and sourcing herbal medicines is prominent: almost three quarters (71%) also use herbs native to North America, 25% regularly use Chinese herbs and 16% also use Ayurvedic herbs.

In both Australia and the UK, most initial consultations last 60 mins and follow-up consultations last between 30 and 60 mins (Bensoussan, Myers et al. 2004; Casey, Adams et al. 2008; Nissen 2008). A wide range of activities take place during consultations: the taking of the medical history, including the recording of diet, exercise and lifestyle; diagnosis, comprising, for example, physical examination and diagnostic testing; the development of therapeutic strategies which combine the use of herbs with nutritional, exercise and lifestyle advice; the formulation and dispensing of herbal medicines (Casey, Adams et al. 2008; Evans 2009; Nissen 2008). The range of activities identified by these authors also points towards the therapeutic approach of WHM as comprising the use of herbs, dietary advice and lifestyle suggestions (Evans 2009; Nissen 2008; Walker 2006). One UK practitioner notes:

> We don't just give herbs. Herbal medicine is actually not the full story, so in terms of a holistic practice, i.e. using lots of tools to treat that whole person, it's not enough to have herbs alone. It's about food and it's about lifestyle and about practical things. Maybe it's simply encouraging someone to go dancing again. And that could be the way in which that person releases or finds fulfilment or finds wholeness, actually. So it might not be the medicine at all. [...] I think we are not just practicing herbal medicine, we are practicing good medicine, where herbs are [...] the face of the medicine perhaps, [...] they are the symbol of the practitioner (Nissen 2008, p.165-6).

The notion of herbs as a symbol of the WHM practitioner that connects intrinsically with a broad notion of herbal health and healing contrasts somewhat with Zick, Schwable et al's (2009) proposition to define a herbalist as someone 'who uses herbs as "the" primary modality to treat patients or clients' and draws on diet or other therapeutic strategies as a complement to herbal treatment'.

Despite a broad understanding of health and healing most Australian practitioners (95%) accept the importance of a biomedical diagnosis when providing herbal treatment (Casey, Adams et al (2008). The use of diagnostic testing or the referral for such testing as a means of making treatment decisions range from 38% to 56% of respondents (Bensoussan, Myers et al. 2004; Casey, Adams et al. 2008). This integration of biomedical knowledge into herbal practice, Casey, Adams et al (2008, p 231) suggest, 'may be the result of the increasing number of herbalists with university qualification'.

Educational requirements for practitioners are strongly influenced by the aspirations for statutory regulation (see for example Hirschkorn 2005). A priority for professional associations and herbal medicine educators has been to maintain the status of herbalists as prime-contact practitioners, rather than working on referral from another health professional. This involves maintaining the right to diagnose patients, both for the treatment herbalists prescribe themselves, and to ensure recognition of situations which are appropriately referred to other practitioners, in both emergency and non-emergency situations (Denham 2005).

3.4 The users of WHM

In the literature identified for this article, little attention is paid to the users of WHM. One study which examines the use of CAM in England indicates that women predominate in CAM use, including in WHM (Thomas, Nicholl et al. 2001). This finding resonates with Nissen's (2010) survey of WHM practitioners who report a high proportion of women patients (67%)[4]. These practitioners further report that 35% of their women patients

[4] A similar situation is noted in Australia, where a government report on the workforce of naturopathy and WHM reports a figure of 68% of women patients amongst the participating practitioners (Lin, Bensoussan et al 2006, p.239).

consult them for gynaecological complaints, 24% for more general women's health issues, and 5% for obstetric complaints. Thus, typically a user of WHM in the UK is a woman who consults a practitioner with a broad spectrum of women's health needs (ibid).

Patients' motivations to consult a WHM practitioner are also under-researched, though indications are that few people specifically aim to consult a WHM practitioner but are referred by word-of-mouth through their social networks (Bensoussan, Myers et al. 2004; Birch and Nissen forthcoming; Little 2009). For instance, the majority of the 19 patient participants in Little's (2009) study had not set out to specifically consult a WHM practitioner. Rather, they were seeking 'an alternative' to biomedical care and decided accidentally on WHM. Others may do so as a last resort (Vickers, Jolly et al. 2006). Despite multiple motivations for using WHM, shared between the patients in Little's (2009) study is a search for 'more effective healthcare'. Little's patient participants were initially seeking treatment for a chronic complaint, and over time WHM became 'used as a first-line treatment for everyday illness' (p.303).

How then do these users of WHM assess the effectiveness of WHM? Little's (2009) analysis identifies six criteria on which patients judge healthcare effectiveness: symptomatic relief; repair and recovery at physical, emotional and psychological levels; absence of side-effects; collaborative patient-practitioner relationship; and minimal disruption to daily life. The 'central constituent' of effective healthcare though relates 'to the extent to which health care corroborated with participants' personal perspectives'; that is, 'health care needed to be understandable in a personalised rather than theoretical way' (p. 304).

3.5 The patient-practitioner relationship in WHM

In the literature identified by us, few studies examine the character of the WHM consultation and the practitioner-patient relationship, and these have mostly been carried out by herbalist-researchers (see, Evans 2009; Nissen 2008; Stewart 2010). In these studies interviews with practitioners and/or patients predominate as data collection method (see Evans 2009; Little 2009), though Stewart (2010) additionally utilises an online diary facility with patients, and Nissen (2008) observed herbal consultations.

These studies point towards the complexity of herbal practice and the practitioner-patient relationship. In addition, they draw attention to the importance of patients' stories in the context of herbal consultations[5]. In both Evans' (2009) and Nissen's (2008) studies, herbalists emphasise that herbal practice involves 'something more' than biomedicine – something not fully explained by the use of herbs rather than pharmaceuticals. This is also reflected in Little's (2009, p.5) study where patients note that WHM performs 'beyond science'. Detailed information from patients is required by practitioners because, as one practitioner in Evans' study (2009, p176) stated: 'I'm trying to get a picture of the person and the way they feel about their life, and how they approach their life and how all that is impacting on their health'. Similarly, Stewart (2010) describes the process of case-taking in her study as involving 'the hermeneutic interpretation of the patient's lived experience' (p. 205).

The practitioners in Nissen's (2008) study further emphasise the importance of facilitating and 'listening' to patients' stories as an integral part of how practitioners support their patients. For patients on the other hand, the process of 'telling one's story' and being listened to is a much valued aspect of consultations. The importance of 'chatting' was also emphasised by the patients in Little's (2009) study.

Little (2009, p.304) notes that 'a genuinely collaborative [practitioner-patient] relationship' in WHM 'strive[s] for consensus.' Nissen (2008) both confirms and challenges Little's (2009) conclusion. Based on observations of herbal consultations, Nissen (2008) illustrates how practitioners and patients jointly construct stories, a process which constitutes the basis for developing an ongoing collaborative relationship. In this 'partnership of healing', she suggests, knowledge sharing and the building of consensus about a suitable therapeutic approach and shared understandings are facilitated, and differences and disagreement about how to approach and interpret health problems accommodated.

[5] For a WHM practitioner's perspective on the consultation, see Conway 2010.

4. Exploring the herbal knowledge base: theoretical issues

In this section we examine the literature which addresses broad theoretical aspects of herbal practice. A key theme concerns the development of herbal knowledge and the ways in which it is being modified and developed in response to contemporary issues and pressures.

A subset of the literature discussed here explores the relationship between practitioners of WHM and herbal medicines. The emerging debates highlight the ways in which historical, social, and cultural contexts impact on the knowledge base and the practice of WHM, indicating the importance of considering herbal practice, education, regulation and research 'in dialogue' with wider contexts (see also O'Sullivan 2005). See Box 3, for authors and year of publication arising from the literature searches examined in this section.

Insert Box 3 here

Box 3: Authors and year of publication arising from the literature searches examined in section 4	
Conway (2005) Evans (2008) Jagtenberg and Evans (2003) Singer and Fisher (2007) VanMarie (2002) Wahlberg (2010)	Wahlberg (2008a) Wahlberg (2008b) Wahlberg (2007) Whitelegg (2003) Whitelegg (1996)

4.1 Construction of knowledge and methodological concerns

A number of studies have explored the ways in which knowledge in WHM is constructed and used in both herbal practice and research. Tensions which impact on this development include the role of science and the contemporary context of the regulation of the herbal profession.

The work by Whitelegg (1996; 2003) is concerned with the philosophy of science and focuses on the choice of paradigms which is used to consider herbal medicine. In her work on comfrey (*Symphytum spp*) Whitelegg (1996) critiques decisions taken with regard to its safety and suggests that there are serious flaws in the scientific arguments used to justify limiting its medicinal use. She raises issues that are broadly applicable in considering the

safety of specific herbal medicines and argues for consideration of the limitations of the scientific paradigm as a 'lens' through which to consider herbalism. She suggests that herbal medicine is 'incommensurate' with science, that an analytical approach that isolates constituents from the whole plant and which does not allow for dimensions of experience outside these narrow confines is inappropriate. To our knowledge, this discussion has not been significantly developed in relation to herbal medicine, though discussions have occurred in the broader work on CAM (see for example Coulter 2004; Di Stefano 2006). This, we suggest, makes Whitelegg's (1996) early engagement with the philosophy of science in the context of WHM particularly important.

In later work Whitelegg (2003) develops her interest in paradigmatic and methodological issues and how knowledge about plants is produced. She argues for the development of inquiry into herbal medicine from perspectives which emphasise qualitative rather than quantitative approaches, and for a clear emphasis on holism rather than reductionism. She suggests the application of Goethean science to herbal medicine, as it incorporates a phenomenological approach, which allows for consideration of the living plant in its complexity, employing both sensory and imaginative facilities.

Evans (2008) is also concerned with the construction of knowledge in WHM, though her interest is in the changes which have occurred to the knowledge base of WHM. She compares of two herbal texts - Grieve's (1931) *A Modern Herbal* and Braun and Cohen's (2007) *Herbs and natural supplements, an evidence-based guide,* and through an analysis of the language used and information communicated, illustrates the differences between traditional herbal knowledge and more recent evidence-based and scientific knowledge. Grieve gathers information and describes each plant as an individual entity, while Braun and Cohen describe herbal products using data largely obtained from clinical trials and phytochemistry. Grieve's (1931) discussion centres on the less common, but more serious 'dangers' of individual plants, whereas Braun and Cohen's (2007) work emphasises potential risk, toxicity and herb-drug interactions. Evans argues that these differences reflect changes in the ways in which WHM practitioners are coming to understand the medicines which are their tools of trade.

Some authors (e.g. Conway 2005; Singer and Fisher 2007; VanMarie 2002) consider the influence of the changing knowledge base on the practice of WHM in the UK and Australia, and come to different conclusions. VanMarie (2002) suggests that the adoption of a science base to WHM in the UK, and the reinterpretation of herbal practice to include a strong emphasis on biomedicine, was a tactic consciously adopted by leaders of the herbal profession. In so doing, they were seeking to strengthen the legitimacy of WHM and to facilitate its professionalization with the aim to reposition WHM within a competitive healthcare market. VanMarie suggests that these changes had not yet (2002) affected practice in any significant way, nor had they been they universally welcomed by UK practitioners. Three years later, Conway (2005) argued strongly both for the reinterpretation of WHM to incorporate scientific explanations and for the statutory regulation of practitioners, thus providing an example which is consistent with VanMarie's (2002) argument that these two factors are connected.

Conway (2005) also claims that resistance by sections of the herbal practitioner community to science and to statutory regulation is evidence of these practitioners subscribing to a 'wilful cultivation of a countercultural stance' (Conway 2005 p195). He suggests that concerns that the increasing science-orientation of WHM will destroy the essence of herbal practice are misplaced, and posits that 'countercultural' attitudes will be challenged as increasing numbers of practitioners become university-educated. This view concerning the increasing prominence of science in WHM is consistent with Casey, Adams et al (2008) mentioned above and Evans (2008). Evans (ibid) analyses articles published in the Australian Journal of Herbal Medicine between 1989 and 2008, and identifies a decrease in references to herbal philosophy in clinical articles written by herbal practitioners, and an increase of references to phytochemistry and clinical trials in the articles published.

Singer and Fisher (2007) provide a further Australian perspective on these issues and suggest an 'epistemological bifurcation' (p22-3) has taken place which has split the WHM community into two groups: One group supports the increased science-orientation of WHM, and the other describes itself as 'traditional herbalists' who practise according to a vitalist, holistic and health-enhancing approach.

4.2 Incorporation of WHM into mainstream healthcare

Closely related to the above debates about the construction of knowledge and the changing knowledge base in WHM are issues concerning the legitimacy and incorporation of WHM into mainstream healthcare. Wahlberg (2007; 2008a; 2008b; 2010) has identified particular societal changes which have facilitated the acceptance of WHM. Wahlberg terms this acceptance the 'normalisation' of WHM, a process by which, he argues, WHM has been accepted as a legitimate form of healing. Taking a historical perspective, he considers specific criticisms which have been levelled at herbal practice, and discusses how changes in these concepts have allowed more sympathetic assessment of herbal practice.

In discussing the role of placebo in WHM, Wahlberg (2008a) draws on the work of early 20th century medical anthropologists on 'symbolic efficacy' and the role of 'suggestion' in the West , and describes how 'the "sham" was taken out of placebo', as the term ceased being a synonym for fraud in medical treatment. As the role of the mind has been shown to play a significant role in any medical treatment, the placebo effect can no longer be seen as the province only of the trickster but is part of all medical treatment. Through reference to *Hypericum perforatum*, Wahlberg argues that WHM 'works' in collaboration with placebo, and that to separate out 'drug effects' from 'symbolic effects' is not possible.

In a similar vein, Wahlberg (2010) discusses how the resurgence of the practice of WHM in the latter years of the 20th century involved not only the industrialisation of herbal products, but also the revaluing of folk or domestic medicine. The latter was once seen by some as obsolete 'old wives tales', and is now understood and appreciated as 'oral history' that can make valuable contributions to our knowledge and understanding of the use of herbs.

4.3 Herbal manufacture and the industrialisation of WHM

Herbal medicines are essential 'tools of trade' for herbalists (see Casey 2007), though they are also often consumed without the involvement of a herbal practitioner. Much of the discussion about herbal products in the literature refers to those herbs which are produced for the over-the-counter market, the following articles are of particular interest with regard to the relationship between WHM practitioners and herbal products. Of central importance in this debate is both the role of science in the production of herbal products and the

philosophical and environmental implications to the practice of WHM that these changes in the preparation of herbal medicines entail.

Wahlberg (2008b) and Jagtenberg and Evans (2003) take differing positions on the developments with regard to herbal products. Wahlberg (2008b) suggests that the 'revival and reinvention' of WHM entails its industrialisation and science-orientation, which often involves 'innovative collaborations between herbal practitioners, phytochemists and pharmacologists when it comes to standardizing and industrializing herbal remedies' (p.40). He sees such changes as part of a process of 'normalization', whereby products are modified to better provide standardised herbal products, with minimal batch-to-batch variations. He argues that the movement from quality assessment based on the senses of smell, taste, touch and sight to laboratory confirmed quality assurance, such as high performance liquid and gas chromatography , facilitates the integration of herbal products into mainstream healthcare.

Jagtenberg and Evans (2003), by contrast, describe a complex picture where the increasing regulation of herbal medicines has encouraged the development of phytopharmaceuticals at the expense of simple herbal products. They suggest that these changes come at a cost to traditional herbal philosophy and bring new ecological challenges. Their views are supported by Singer and Fisher (2007), who describe herbal practitioners 'in overt rebellion to the commodification of their medicines' (p.24) and who return to manufacture their own herbal medicines for use in their practices.

5. Concluding remarks

In this exploration of social science perspectives on the practice and use of WHM we have identified literature that firstly gives us information about the field of enquiry – herbal practice and use - and secondly that facilitates analysis and debate of the factors which are affecting its development. While some mapping of herbal practice has occurred, we have noted significant gaps, particularly regarding the patients of WHM and the practitioner-patient relationship. We have also highlighted subtle but significant differences between the practice of WHM in the UK, Australia and Canada, particularly in terms of nomenclature.

Further, we have noted that the literature illustrates critical engagement with underpinning philosophies and ideas that shape WHM within social, cultural and political contexts.

The regulation of herbal practitioners, herbal medicines and the herbal profession form the implicit or explicit context to many of these publications. Practitioner regulation has been an important aspiration for the major herbal associations in the UK, Australia and Canada, who understood it to demonstrate the acceptance and legitimacy of the herbal profession; in other words, a badge of professional inclusion. As outlined in the literature discussed here, it is clear that the context in which mainstreaming of WHM occurs today is very different to the one in which herbalists were marginalised a century ago. This resonates with O'Sullivan's (2005) observation that the professions in the 21st century, including WHM, have undergone dramatic change, becoming less autonomous and more constrained than they were a century ago. The literature discussed here further identifies tensions within WHM regarding the current direction of the profession.

Various strands to this broader social and cultural context in which the mainstreaming of WHM is taking place can be identified. Some of these are directly linked with healthcare, others with people's personal world views and philosophical orientations, and others again with cultural developments characteristic of the 20th and 21st century. For example, some authors (e.g. Melucci 1989; Bakx 1991; Cant and Sharma 1999) have suggested that the general increase in popularity of 'alternative' medicine arose due to dissatisfaction with science and disappointment with aspects of biomedical practice. Others draw attention to the pervasive emphasis on assessing and managing risk throughout society (Beck, Giddens et al. 1994). This has implications for both WHM practitioners and their medicines, since governments would be considered irresponsible if they were to disregard healthcare practices utilised by large sectors of the population, and which involve a lucrative manufacturing sector.

It is within this very broad social and cultural context and associated theoretical work that the studies examined here have been carried out. They thus provide insights into the practice of WHM and practitioners' 'tools of trade' from different yet complementary perspectives and methodological and theoretical positions. Taken together, these studies highlight the importance of considering the practice of WHM, as well as the changes

affecting herbal practice, education, regulation and research in contexts beyond WHM per se. In doing so, we can appreciate and interrogate, for example, practitioners' diverse attempts to straddle the demands of appropriately developing and maintaining their professional identity and clinical skills; the ways in which changes occurring within contemporary herbal practice implicate the nature of herbal practice and the patient-practitioner relationship; or how WHM came to be 're-invented', 'revitalised' and 'normalised'. More work of a similar nature is needed to understand the diversity and richness of practices, changes and challenges encountered by WHM practitioners and patients alike.

Invariably there are some limitations to this review of literature. Foremost is our focus on peer-reviewed literature which we predominantly identified through academic databases. Academic databases however only list selected journals, thus imposing a limit on the range of articles to be identified in this way. Furthermore, we excluded 'grey literature' which would have contributed other data and perspectives from practitioners, patients and also the general public. In addition, the wider field of social science research in WHM is characterised by a great diversity of studies originating from different academic disciplines, such as sociology, anthropology, health and social care, and politics. This leads to a lack of commonality of search terms. We have aimed to counteract this by carrying out author searches and including chapters in anthologies and PhD theses.

Literature reviews do not reflect an entire field of enquiry but are inevitably partial and limited. Nevertheless, this review of social science literature concerning the practice and use of WHM sketches the breadth of enquiry and debate surrounding WHM and indicates new avenues for understanding. We hope that it may inspire the use of such literature in further explorations of the profession of WHM and its users and stimulate discussion and debate.

Acknowledgments

We would like to thank the reviewers for their helpful and stimulating comments on a previous version of this article.

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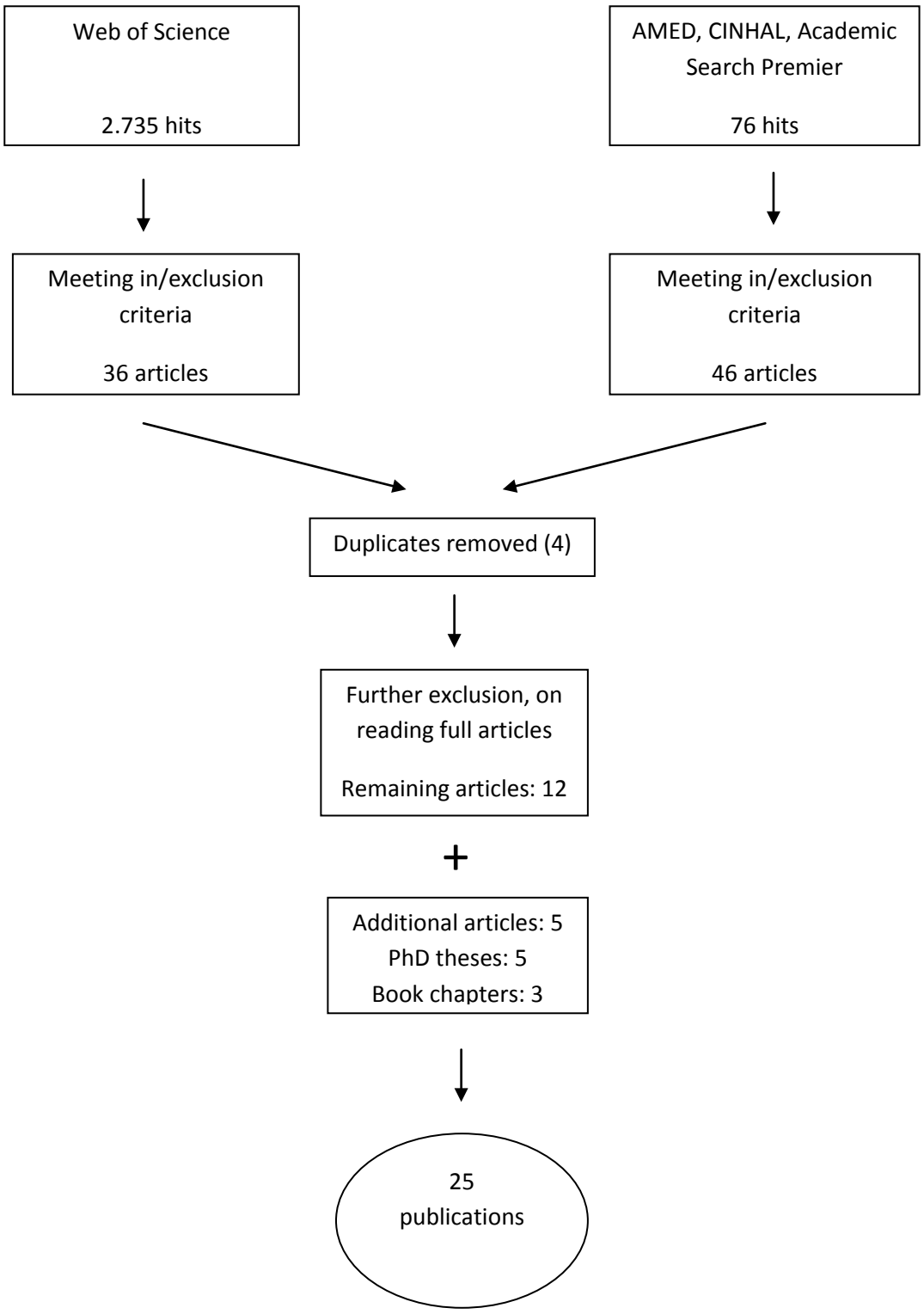

Flow chart: Literature search