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Secular values and the location of religion: a spatial analysis of an English medical centre

Kim Knott and Myfanwy Franks

Abstract

What do contemporary controversies in healthcare reveal about secular values and the location of religion within an English medical centre? Using a socio-spatial methodology designed to break open ideological perspectives and normative values, we analyse the doctor-patient relationship, complementary and alternative medicine, and an issue that bridges the two, evidence-based medicine. In the physical, social and mental spaces of the medical centre we uncover the traces of religious activity and roles and of alternative therapeutic regimes often informed by spiritual or religious systems. Furthermore we disclose the heterogeneity of values that comprise the secular worldview of one group of contemporary general practitioners.

Article

In this article we look at the nature of values and the location of religion within an ostensibly non-religious or secular organisation, a medical centre, an example of frontline public health provision in the UK. Using a spatial methodology, informed by the socio-spatial theories of Henri Lefebvre and Michel Foucault, we analyse ethnographic data in order to raise questions about the values and discourses at work in contemporary general medical practice. Our approach is broadly inductive, insofar as we do not start by presupposing or hypothesizing the emergence of any particular values or discourses. Nevertheless, our work is contextualised by a perspective on religious/secular relations outlined by Knott (2005) which argues that, in the modern West, the religious and the secular are two sides of a single coin – 'a binary constitutive of modernity' (Jantzen, 1998, p. 8) – and that European

Christianity and secularity are historically enmeshed, and philosophically, legally and ethically intertwined (Taylor, 1998, 2002; Asad, 2003) despite often appearing to be radically dissimilar and in opposition. Ideological distance and contestation can be explained historically and dialectically. According to Knott (2005), the religious and the secular – and a third post-secular position (which often makes use of the notion of 'spirituality' rather than 'religion' or 'religiosity') – form a field of knowledge-power relations (Foucault in Gordon, 1980; Carrette, 1999, 2000). Debates and contests on this field are the means by which ideological positions are articulated, tested and authorised, boundaries between various positions are maintained, and new positions and values begin to emerge.

Looking for the religious and the secular in a modern medical context

Why is a medical centre an appropriate and interesting setting for such a study? What is the relevance of the religious and the secular for health and medical practice? In 2004, the Arts and Humanities Research Board funded research under its Innovation Scheme on 'Locating religion in the fabric of the secular: an experiment in two public sector organisations'.[1] The two organisations chosen for this experimental study were a high school and a medical centre. Two of the priorities of modernity, Western education and medicine are rational institutions based on expert systems of knowledge and bureaucratic organisation (Weber, 1970). Schools, medical centres and hospitals are agents of secular government policy, though they continue to be affected by various legal and contractual requirements concerning religion,[2] and, as such, could be said to reflect the progressive separation of religion from the world. They are precisely the types of disenchanted public institutions from which, according to theorists of secularization such as Wilson (1982) and Bruce (2002), religion is said to have retreated in terms of its social and political significance. But is this really the case? Denying that the

process of institutional differentiation (whereby religion becomes increasingly separated from education, health, law and government) constitutes secularization, Talcott Parsons (1960; Beckford, 1989, pp. 56-63) argued that the social system continued to be informed by values that were rooted in religion, albeit that the mechanisms for the transmission of such values were now secular rather than religious. More recently, Gilliat-Ray stated that '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, p. 368; cf. Beckford, 1999). In what ways do such institutions manifest these insights? In the case of healthcare, is this just a question of the replacement of religion with an empty rhetoric of 'spirituality' – the content and definition of which is much contested by health as well as religious professionals and academics (Orchard, 2001; Gilliat-Ray, 2003; Carrette and King, 2005) – or, as Parsons suggested, do secular discourses and values themselves tell us something about the location of religion and those things that are now held to be sacred?

We propose that a spatial methodology – described in the next section – enables *the secular* (or any other ideological system) to be broken open. Our objective here is not to criticise the exponents of secularism as such or to replace a secular worldview with a religious one (or vice versa). Rather, our principal aim is to take a good look at what constitutes *the secular*, to uncover some of its values and principles, and to consider in what ways they are informed by religion, particularly by western Christianity but also by other religious traditions and new spiritual movements. The case of health and the place of a medical centre operate as a focus for such an investigation.

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). We had experience of research with people and organisations that were predominantly minority ethnic and minority religious in character (e.g. Franks, 2001; Franks and Medforth, 2005; Knott and Khokher, 1993), and preferred to select an organisation in which religion and ethnicity were less prominent and secularity arguably more so. As we had no comparative ambitions, and our aim was not primarily a study of contemporary healthcare or general practice but the application of a spatial methodology to secular discourse and values, we selected only one medical centre. We are aware that we would have learnt other things, witnessed different controversies, and encountered other spaces if our choice of medical centre had differed.

Our ethnographic process entailed spending time in the waiting room, observing the various physical and social spaces, taking field notes, and interviewing practitioners in their habitats.[3] No patients were interviewed for ethical reasons. Attention was paid to the nature of the medical centre as a place with a 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 at interview.

Back at the university we reviewed the data for cases of controversy and debate.[4] The two that stood out for greater exploration were the doctor-patient relationship, and complementary and alternative medicine (CAM), and we discuss these below. We were interested to see what controversies around these issues might reveal about the principles, beliefs and values associated with the secular and what light they might shed on religious and secular force-relations. We did not expect to see neat battle lines drawn between exponents of religious, secular or post-secular

positions; neither did we expect to see conventional religious viewpoints strongly or clearly articulated. Rather, we hoped we might begin to get a sense of the way in which the secular is comprised of a variety of value positions, some more hospitable to religion or spirituality than others.

The spatial methodology

A spatial methodology allows us to look closely at a place, however large or small, simple or complex, in terms of its spatial dimensions, properties and dynamics. This particular approach is not a set of practical methods, but an analytical process applied once data has been collected. It is particularly suited to examining places as sites of contestation – and thus for controversies regarding the religious and the secular – because, as Lefebvre (1991) made clear, all ideological positions and views must acquire a morphology if they are to be successful and lasting, and all struggles between such positions are spatially enacted, whether in physical, social or mental space. The spatial approach used in this research is described in detail in Knott (2005). The key elements of relevance to our analysis of the medical centre are *the body as the source of space*, *the dimensions of space*, *the properties of space* and *spatial dynamics*. These will be introduced here and their relevance to the case of the medical centre explained.

Bodies are central to any discussion of health and medicine, and important for analysing the physical and social spaces of organisations that prioritise these matters. They are also to the fore in the historical relationship between religion and medicine. As Foucault argued, not only did commitment to the health of bodies correspond to the salvation of souls, but the medicalization of society and 'the establishment of a therapeutic clergy' or medical profession (1973, p. 32) was based on an earlier clerical model. It was a 'lay carbon copy' of the spiritual vocation of the

church (p. 32). Furthermore, there was 'a *prima facie* parallel between the idea of the medical regimen and religious rules of ascetic discipline, in that both [were] addressed to the government of the body (Turner, 1996, p. 96). These historical and disciplinary relationships between religious and secular approaches to health and the treatment of the body are important for understanding the operation of values and practices in a medical centre.

It is not difficult to see the role that the body has played in the production of these different but related discourses. Lefebvre goes further, however, in asserting that, 'the whole of (social) space proceeds from the body, even though it so metamorphoses the body that it may forget it altogether' (1991, p. 405). Despite the fact that we may not recognise the role that the body has played in defining and constituting a space – whether social, physical or discursive – it is nevertheless the case that 'the genesis of a far-away order can be accounted for only on the basis of the order that is nearest to us – namely the order of the body' (p. 405).[5] Grasping this process, seeing the contribution of bodies to organisational spaces, and uncovering these bodies – in terms of their size, shape, gender, age and sexuality (Franks and Knott, 2005) – is an important part of spatial thinking, but so is the recognition that the relationship between organisations and bodies works the other way too. These bodies are subject to strategies of coercion and discipline. In writing about docile bodies, Foucault spoke of,

> A policy of coercions that act upon the body, a calculated manipulation of its elements, its gestures, its behaviour. The human body was entering a machinery of power that explores it, breaks it down, and rearranges it… Thus, discipline produces subjected and practised bodies, "docile" bodies. (Foucault, 1977, p. 138)

The first stage in this spatial analysis then is the recognition that bodies have this double role vis-à-vis space in being both the source of larger and more far-away

spaces, and the spatial outcome of bio-power (Foucault, 1998, p. 140-44). Later we shall see how this operates in the medical centre through the doctor-patient relationship and CAM.

Bodies, like other spaces, may be physical, social and/or cultural ('mental', as Lefebvre has it). Space is multidimensional and, when employed methodologically, offers the possibility of reuniting disparate perspectives and disciplines (Lefebvre, 1991, pp. 11-12). In thinking spatially, we are not obliged to focus solely on one area of human activity or the natural environment, but may think in terms of any body, object, or community as gathering all these dimensions together within a single 'place'. When we investigate a medical centre, then, whether the waiting room, the surgery or the doctor-patient relationship, we may think about them as having these three interconnected dimensions, of physical space, socially constituted space, and imagined, mentally conceived space – hardly a single space, rather a cluster of heterogeneous, contested and overlapping spaces.

This multi-dimensionality is one aspect of the first of four 'properties' of space (Knott, 2005), this first being 'configuration', the capacity of spaces to gather or hold things together (Heidegger, 1993). 'Space', as a linguistic construct, is often used to signify containment – an arena in which various things are placed or events happen: even when it is used to signal 'open' or 'outer' space, it is constituted by elements in the landscape, natural features, constellations or astrophysical bodies. Any particular space, or 'place', is the sum of smaller units – objects, relationships and representations. The computer on the desk of a general practitioner (GP), for example, is comprised of numerous separate, manufactured components. It is connected to the PCs of other doctors, to relevant programmes and websites. Yet it is also personalised, with a screensaver reflecting the tastes of its owner, with e-mail contacts and favourite websites. Furthermore, it gives access to the personal

records, the medical biographies of patients. In sum, it is a technological representation of the medical relationship between a doctor and his or her patients, and the administration that supports and constrains it (a drug database, forms on which to log targets, to prescribe treatments and to record symptoms, and a programme which flags up contra-indications).

Configuration is one of four properties first noted by Foucault in his 1967 lecture on space, *Des espaces autres* (Foucault, 1986), the others being extension, simultaneity and power, the last of which runs throughout Foucault's deliberations on space (1991). Extension and simultaneity represent the diachronic and synchronic properties of space (Massey, 1993; Knott, 2005). They reveal its dynamism. By 'extension' we mean the way in which a space is more than its present face and configuration, but is also its past (and future), both in terms of the earlier things and events that took place in that location, and the previous forms of that space. Both de Certeau and Lefebvre comment on this, the former as 'stratified places' (de Certeau, 1984, p. 200) and the latter as an 'etymology of locations' (Lefebvre, 1991, p. 37). De Certeau, who writes of place as 'palimpsest' (p. 201), a manuscript on which ideas are written, overwritten, erased and annotated, notes that, 'the revolutions of history, economic mutations, demographic mixtures lie in layers within it, and remain there, hidden in customs, rites, and spatial practices (p. 201).

Take the medical pharmacy as a case in point. What culture and ideology does it currently express, and what previous ones does it refer to or replace? To what earlier pharmaceutical, therapeutic, homeopathic or herbal healing regimes does the pharmacy point? What previously occupied the physical space? A car park, or sheep in a field? And are their traces still visible, whether in the form of tangible evidence, memories or oral testimonies?

In addition to their diachronic connections, spaces exist simultaneously. The pharmacy at one medical centre co-exists with innumerable such pharmacies in the UK and beyond, some of which may be similar physical, social and mental spaces, whilst others are different, in their expression of alternative medical and pharmaceutical cultures and chemist-client relations. The link between different spaces of the same type may be either an active social one or a passive categorical one. But there are other types of connections too that may be still further an expression of the localising and globalising ties that bind. For example, the late-modern western pharmacy is regulated and shaped by national laws and codes of practice as well as by local market forces: staff at the medical practice at the centre of this research debated whether to incorporate a pharmacy into what would have become a 'one-stop shop', fearing that in doing so they would have put the local family pharmacy out of business. At a global level the pharmacy is also the sum of the flow of drugs from multinational companies that meet – and to some extent shape – the prescribed needs of local patients with their particular disorders.

Attentiveness to the way in which spaces of all kinds are infused with and generated and transformed by power – the fourth of the spatial properties – is essential to understanding the dynamism of an organisation like a medical centre. By 'power' we mean here 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. As with extension and simultaneity, the spatial property of power is fundamental to what Lefebvre has referred to as 'the production of space'. In distinguishing between the study of 'things in space' to its process of production and reproduction (1991, p. 37), he recognised the dynamism of space and the role of both knowledge-power and social struggle in its formation and manipulation whilst conceding that neither producers nor users of space could

be fully conscious of the process of cause and effect.[6] Thus, in the case of the medical centre, we suggest that a variety of forces and disciplines have been at work in forming it as a present space that exceeds the understanding – however well informed – of those who work there and use its services and facilities. Our spatial analysis, then, is intended to uncover some of these forces and disciplines – though there will be others that we cannot yet see or name – and to learn more about both product (the present space of the centre) and production process (Lefebvre, 1991, p. 37) with specific reference to the religious and the secular.

The doctor-patient relationship

In addressing the question of the location of religion in the doctor's role and relationship with patients and their bodies, it is important to note the genealogy of medical practice, and the correspondence with and historical dependency on its clerical and monastic forebears (Foucault, 1973). This link was also made by Parsons (1951, 1985) who saw the roles of physician – particularly the psychiatrist – and minister as comparable in enabling social and moral equilibrium. A striking entry point for an examination of the social space of the contemporary doctor-patient relationship is the physical space of the shield of the Royal College of Physicians, an organisation, first established in 1518, which supports doctors in providing high quality healthcare for patients.[7] 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 the shield

and its many reproductions, is top-down, specialist/client, active/passive in kind. Such an image conforms to more recent ideas about the relationship. Parsons, in his sociological account of the sick person and the physician (1951), refers to the helplessness, technical incompetence and disqualification of the one, and the control, skill, knowledge and professionalism of the other. As he notes, however, the uncertainty, hopes and expectations bound up with ill-health and the medical process mean that both roles are susceptible to what Parsons refers to as 'ir- and non-rational beliefs and practices' (1951, p. 446, pp. 450-1; cf. Shilling, 2002, p. 628, pp. 632-3).

Before we examine further the doctor-patient relationship and the values located within it, we must introduce the space in which it operates. The medical centre, a new building on former church land owned by a Cambridge University college, is situated in a green field site near to houses and opposite a Catholic church, the large cross of which is easily visible from the waiting room. The historical power of Christianity in England, its symbolic presence in churches, and continued provision of pastoral and civic as well as religious services are easy to overlook. Yet, at the planning stage of the medical centre, the Catholic priest had organised a public meeting to discuss the suitability of the site vis-à-vis its planned usage. Furthermore, some of the centre's patients and staff attended his church, some favoured other places of worship, whilst others eschewed religious belief and practice altogether.[8]

Internally, the centre's large waiting room with its high ceiling and roof beams – with its time-space of waiting and dwelling on matters of health, healing and destiny – resembles meditative, monastic space or the interior of a church or cathedral, a point noted by one of the doctors.[9] 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.[10]

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 status of medical knowledge and power (1973, p. 89), is no longer uncontested but has been disrupted by the governmental gaze, and by the changing expectations regarding both doctors and patients, as interviews and policy documents confirmed.[11] For instance, post-Shipman, GPs have lost some autonomy and are subjected to increased surveillance.[12] Further, as part of their new contract, they are expected to achieve specific targets according to which they are paid.[13] 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.[14] This may lead to 'conflict between lay and expert medical knowledges' (Henwood et al, 2003, p. 598), as well as to the possibility of the new consumerist patient making demands that cannot 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 making use of the Internet – as 'online self helpers' (Ferguson, 1997; Shilling, 2002, pp. 628-31) – in order to become better informed.

In addition to such current pressures, there are historical assumptions about the nature of the doctor-patient relationship that are carried into a consultation: it is linked by chains of memory to previous confidential and hierarchical relationships with priests, confessors, analysts or counsellors. One GP, referring to patients' traditional response to the authority of the doctor, said 'Here is the fount of all wisdom. And I'm going to the shrine and saying "Please help"'.[15] There are also power issues associated with gender, class and other differences within the doctor-patient consultation which nuance those power relations already mentioned. The normal ten minute time-space of the consultation, then, is informed by various forces.[16] One GP, reflecting on the impact of new targets and IT on the consultation (her computer was pushed to the back of the desk out of the sight-line between herself and the patient) had this to say:

> I think generally I do have quite a good rapport with patients. You know, we do a lot of talking. What's happening now though is that with the new contract we've got lots and lots of targets to meet which is fine 'cause I mean generally ultimately it is going to help the patient. Just at the minute there's something being installed on the computer so basically when someone comes in …it comes up what you need to fill in, the boxes that haven't been ticked basically. Which is fine but, if I know this person hasn't got blood pressure and hasn't got this that and the other, it may take me four or five minutes to do that and I've only got ten minutes for a consultation. They may have come in about something completely different. …They might say well actually my husband has just died. The last thing they want to do is talk about all this sort of stuff. You may need 15-20 minutes with that person. I mean it really is important but I think its going to muck up our consultations.[17]

The controversy between technological intervention and quantification on the one hand, and the qualitative role of carer and healer on the other is now played out within the space of the doctor-patient consultation.

Another area of contestation pertaining to the role of the doctor and his or her relations with patients is the importance of science and an evidence-based approach to treatment. Of two other GPs, both of whom acknowledged the contribution of evidence-based medicine (EBM), one emphasised the importance of medicine as an art as well as a science,[18] and the other suggested that it was possible to go too far,

> I think you can be the 'Citadel' doctor who only wants science. He only wants to deal with things in a scientific manner...I do believe that … 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.[19]

On the one hand, then, there are those pressures which further democratise the doctor-patient relationship and shift the balance towards informed, active patients with their own beliefs and values. There are also those that secure knowledge-power in the hands of professionals, the trend towards EBM being a current example. At first sight the latter seems more consistent with the traditional role of the physician as depicted by Parsons (1951), whilst the former is suggestive of changing late-modern roles (Shilling, 2002), characterised by choice (of therapies, medicines and practitioners), access to information, and the recognition of cultural diversity, all of which may challenge established doctor-patient power relations. As Shilling suggests, however, Parsons' focus on the authority and competence of the doctor should not be read simply as evidence of patient passivity, but within his

analysis of the way in which 'ultimately religious values helped create a culture which associated illness with the capacity for instrumental action' (2002, p. 624). Doctor and patient are in a 'complementary role structure' (Parsons, 1951, p. 437) informed by cultural values.

According to Sackett et al, 'Evidence-based medicine is the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients' (1996, p. 71). Typically, it focuses on the use of randomised controlled trials, systematic reviews and meta-analysis. The Cochrane Collaboration, an international network of centres, aims to foster such an approach in which the emphasis is on linking evidence, via published research, to clinical practice.[20] Despite its scientific orientation, the move to EBM is in some ways no more traditional than that focused on the informed patient. Both signal the shift of power away from the individual GP, authorised by his or her training, professional membership and regulation by the General Medical Council, but here the shift is towards GPs as front-line representatives of a powerful, global research agency. Responding to the issue of EBM, one doctor we interviewed insisted on the importance of professional judgement, albeit informed by evidence;[21] another said,

> They are trying to move much more towards EBM which is obviously very important. 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% of people *in this study* responded well to such and such but you can't always extrapolate 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.[22]

In summary, concern was expressed in the medical centre that EBM does not accommodate the variety of relevant types of evidence, that it challenges doctors' vocation and training, and prioritises evidence over patients and their own accounts.

Writing critically, one scholar suggests that EBM functions as a 'new ritual' in medical teaching (Sinclair, 2004); others refer to it with more or less seriousness as a 'new religion' (Clinicians for the Restoration of Autonomous Practice Writing Group (CRAP), 2002; Rosenfeld, 2004). Science in the form of EBM – traditionally opposed to religion with its other-worldliness, blind faith and lack of an evidence-base – is mocked for the faith its own exponents place on evidence.

> 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 become the antithesis of populism. It has created its own system of belief to which we have to practise faith-based medicine. (Rosenfeld, 2004, p. 155)

A secular approach is here referred to pejoratively as 'a religion'. We see this again in the parody entitled 'EBM: unmasking the ugly truth' in which 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, p. 1496). This ironic commentary is interesting for what it tells us about secular views of religion. Those secular medical exponents who favour a more democratic and mixed approach to treatment see EBM – and religion – as rigid, faith-based, autocratic and not open to question. Within a controversy about the best way to practise medicine and treat patients we see the old struggle of secularism v. religion raising its 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 held 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 contended within the social space of the doctor-patient relationship and the time-space of their consultation. Furthermore, as we shall see again in the next section, 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.

Complementary and alternative medicine (CAM)

As this last case has shown, the names and labels given to things can be informative for how those things are conceived and contested. It is instructive to note then that, at its inception, the name 'health centre' had been rejected as inappropriate by one of the doctors who had feared that people might think the medical practice offered alternative therapies. His recognition that this was an area of controversy was further highlighted by his comment to the fieldworker that he hoped discussion of CAM would not cause them to fall out with one another.[23]

The 'burgeoning demand for CAM' is noted by Clarke, Doel and Segrott (2004, p. 329). They summarise the reasons for it 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' (p. 329),[24] several of which echo issues raised in our earlier discussion of the doctor-patient relationship (see also Luff and Thomas, 2000, and Sharples et al, 2003, on patient perspectives on CAM, and Shilling, 2002, on CAM and instrumentalism). Defined by one source (Bradford, 1996) as including five types of therapies – Eastern, manipulative, natural, active, and therapies involving external power – CAM, like EBM, is an

example of an ideological struggle within contemporary healthcare. The very appellation of CAM therapies as 'alternative' marks them out as different to mainstream medicine, though it also implies that they fulfil some of the same functions or have similar goals; the term 'complementary' suggests that they add a dimension or perspective which allopathic medicine does not offer.[25] Their emergence within contemporary healthcare may reflect the uncertainty and non-rationality associated with illness (Parsons, 1951) as much as a critique of Western medicine per se.

Corrywright (2004) states that there is a continuum of views among orthodox medical practitioners regarding CAM ranging from acceptance to non-acceptance, with some specific therapeutic forms generally held to be anathema, notably spiritual healing, psychic medicine, *reiki* and crystal healing, 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 accepted by GPs, it would appear. This was partially borne out in a discussion about how notice-boards were used at the medical centre, with one GP saying 'If you allow osteopaths (to advertise)' – which he thought would be useful – 'do you allow reflexologists?' 'Nice and relaxing', said another, but with 'very little scientific backing'.[26]

Staff at the centre were articulate about this controversy and the reasons for CAM's recent popularity. The general attitude of the doctors was summed up by one as 'Prove it first and then we'll use it!' (suggesting a somewhat contradictory approach to the role of evidence given their fears about EBM).[27]

> 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 a lot of 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. I think that a medical practice should be a place where at least you can look at something and say "I think this works this way".[28]

His focus on scientific reason as normative for general practice did not stop this GP from acknowledging the concept at the heart of the alternative ideological agenda: holism. With some regret, another doctor made the following point:

> 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!"[29]

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 other simultaneous health systems which stress and make time for a whole person approach, systems with alternative geographies of the body. Such a presence – of simultaneous mental spaces some of which are based on spiritual or religious beliefs about corporality – invites us to consider the geography of the body operating within

conventional medical discourse. In *The Birth of the Clinic* Foucault (1973) examined the way in which the person was constituted as an object of the clinician's gaze: 'In this medical regime we find the 'spatialisation' of the body in medical pathology…and the illumination of disease in opening the corps.' (Carrette, 2000, p. 13) The medicalised body is a body in pieces. Conventional medicine, then, works according to a particular spatial understanding of the body, its gender, parts and systems. Conceptions of disease and research on disease concentrate on these arrangements (Foucault, 1973, pp. 152-4). Hospitals reflect them in their organisation and architecture. CAM therapies operate with different conceptions of the body, many – though not all – with a holistic perspective: homeopathy and Chinese medicine being principal examples.

A rather different type of classification was also at work among GPs reflecting on the use and value of CAM. It is hinted at by the GP who said that not all therapies are curative and 'not all patients have a physical illness', and became clear in interviews with a practice nurse and one of the other doctors. The former, 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". So that's what it's all about really. I think women generally are more open to things. More want to talk about their conditions, their problems than men.[30]

The doctor, reflecting on the use of therapies in a hospice, said,

> 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 - that's what they do… Yes, people died and I got upset when people died… It was very calm

> 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.[31]

Women and the dying are linked here with the use of CAM. In describing a women's health evening organised at the medical centre that attracted some 200 women, a practice 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 – but also they would be less likely to be interested in alternative therapies. Gender, as she saw it, was an important factor affecting the acceptance of CAM within the medical centre.[32] Like the doctor reminiscing about the rather different space of a hospice, the nurse linked the application of CAM both with conditions for which cures are inappropriate or ineffective, and with liminal periods – such as childbirth, menopause and incurable illness leading to death – in which assistance in making a transition between stages of life and death is required and where the role of evidence-based science is limited or unnecessary. Although it might appear that the bodies of women and the dying were being relegated to treatment by CAM by medics who did not approve of it on ideological grounds, the practice nurse suggested something rather different, that women – as informed and active participants in the doctor-patient relationship – sought additions and/or alternatives to drug-based treatments plus a measure of collaboration, discipline and control in dealing with physical problems associated with the life cycle. Furthermore, we see medical staff making mental space for CAM by relating it to a different class of conditions –

those requiring therapy not cure – and to different times and places, namely women's health evenings and the hospice.

Conclusions

In this paper we have used a spatial approach to investigate those discourses and values at work within an English public-sector organisation. We have focused on areas of contestation in relation to the doctor-patient relationship and CAM in order to examine religious/secular knowledge-power relations, particularly those occurring *within* contemporary secularity.

Several elements of Knott's spatial methodology have been used to analyse Franks' observations and interviews with staff at the centre. We looked at the doctor-patient relationship as a multi-dimensional space that was first and foremost social, being informed by gender, class, age and other variables, 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. Competing expert knowledges have emerged to challenge the status and autonomy of the GP. Conceived as 'lay' interventions, they reinforce the idea of the doctor as a privileged knower, the priest of the body (Foucault, 1973, p. 32). In addition to the configuration of dimensions and gazes, the spatial properties of extension and power also enabled us to appreciate the way in which earlier religious and therapeutic relationships, as well as the professional formation of the doctor-patient hierarchy and the move to the informed patient, have had an impact. 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 art as well as a science, and of hearing from and responding to patients as whole people rather than body parts or parcels of symptoms.

The doctors themselves brought CAM to our attention 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. We noted also the way in which a time-space was made for CAM in the medical practice by limiting its application to women, to particular life-stages, to therapy rather than cure, and to the work of some staff and not others. Furthermore, distinctions were made between different types of CAM, principally according to their evidence-base. CAM provided an interesting case because its various therapies represented 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 public medicine. Changing conceptions of the informed and responsible patient and holistic healthcare in particular 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 was a knowledge-power struggle *between* staff (and also *with* anonymous CAM practitioners) argued on the basis of such issues as evidence, complementarity, choice, gender, and the length and nature of the consultation. The extent to which therapies were based on extra-mundane powers and spiritual ideas may have been a contributing factor but it was not one voiced by doctors.

These same controversies could, of course, have been examined using different approaches, but a spatial methodology based on Lefebvre's notion of

reuniting previous separated fields of enquiry by focusing on the physical, social and mental dimensions of space has enabled us, we hope, to be comprehensive in our analysis. The inclusion of mental space in this process necessarily opened up the possibility of examining discourse and values which we also found underscored in physical arrangements and social relationships.

We have seen that a key factor running through these controversies is 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, autonomy, well-being, professional judgement, patient (or consumer) agency, and the art of medical practice. We suggest that some of these values conform more closely to a secular modernist perspective (the importance of evidence, autonomy and professional judgement, cf. Parsons on the physician's role 1951, 1957); others – which were offered as both an insider critique and an alternative to a conventional medical approach – emerge rather as *post*-secular values (holism, well-being, patient-agency, the art of medicine) allied with late-modern 'spirituality' (Carrette and King, 2005) as opposed to either wholly secular or wholly religious interests.[33]

To what extent has religion been unearthed in this study? We have recognised its normative and genealogical relationship to modern medicine (Parsons, Foucault), witnessed traces of it in the physical and social spaces of the medical centre, and have noted its parallel geographical and ideological presence. We have seen it used metaphorically within a secular controversy to parody those with an extreme position. Because it was not referred to directly at interview, we have sensed rather than examined its location at the heart of some alternative therapies (cf. Corrywright). Significantly, it has not

been religious beliefs and perspectives *per se* that have emerged as controversial, but secular ones.[34] Our spatial analysis has revealed a heterogeneity of positions within contemporary secularity. We have distinguished between them on the basis of their adherence to either modernist values or post-secular 'spiritual' ones, but even this distinction is crude. The individual medical staff we spoke to had nuanced, well informed secular views that belied easy classification, demonstrating an ability to negotiate and make judgements on the basis of differing opinions and demands.

How one assesses the relationship between these secular values and those of contemporary religions or their forebears depends on the way one understands both the dynamic relationship between religion and the world and the process of secularisation. If secular values of various kinds are to the fore in modern medical practice, is this evidence of the retreat of their religious counterparts from the public domain, or is their expression itself an attempt by individual medical practitioners to make sense of deep-seated cultural and moral issues which in the West have their roots in Christianity – the pursuit of truth, uncertainty about the future, faith and knowledge, body and spirit, health and destiny, human frailty and the life-course? We would argue that what we have here is a *continuity* of concerns – though often expressed in oppositional terms vis-à-vis the secular and religious, or science and art – in the changing context of social and institutional differentiation. How one identifies the cultural values operating in a contemporary medical practice – as avowedly secular, implicitly religious, or post-Christian – is arguably of less significance than the fact that it continues to be in controversies, like those concerning the doctor-patient relationship, EBM or CAM, that they are unearthed. The norms and values that are held by particular medical practitioners to be sacred and

non-negotiable – whether this is their professional integrity, vocation, commitment to evidence, democratic principles, belief in extramundane forces or obligation to the counselling relationship – come to light when they are challenged and put under pressure.[35]

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[1] This project (B/IA/AN5276/APN17687) ran from 1 May 2004 to 30 April 2005 with Kim Knott as Principal Investigator and Myfanwy Franks as Senior Research Fellow. The spatial methodology discussed in this article is attributable to Kim Knott; the ethnographic data to Myfanwy Franks. They both contributed to the analysis and writing.

[2] For example, the Education Act 1988 requires schools to hold a daily act of collective worship (with a right of withdrawal) and to teach a basic curriculum including not only National Curriculum subjects but also RE; public organisations, like all other employers, are bound by the terms of the Employment Equality Regulations 2003 (Religion and Belief). In recent years, the Department of Health has issued guidelines on 'NHS Chaplaincy: Meeting the religious and spiritual needs of patients and staff' and reviewed chaplaincy funding arrangements.

[3] Full- and part-time staff at the medical centre included six doctors (five or 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.

[4] Five months after the fieldwork took place, two staff members from the medical centre attended a day-workshop at the university at which they presented their place of work and participated in discussions about the spatial approach, religion and secularity within contemporary medicine.

[5] See Knott (2005) for a study of the space of the left hand.

[6] It is at this point in his book that Lefebvre describes his dialectical triad which Knott refers to as the 'aspects of space' (2005, p. 36). Despite their potential value for an analysis of the religious and the secular in a medical setting, the authors decided to focus here on other elements of the spatial methodology.

[7] 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/).

[8] Interviews with staff, 18/05/04, 29/06/04, 30/06/04.

[9] 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. However, 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.

[10] Interviewees noted that this was not the case in patient reception where receptionists sometimes felt undermined because their seating placed them below the level of patients (29/06/04, 30/06/04).

[11] Information on Government policy initiatives was frequently updated in 2004-05 on the UK Department of Health website, http://www.dh.gov.uk/PolicyAndGuidance/fs/en.

[12] 'Post-Shipman' refers to the period since the conviction in 2000 of GP Harold Shipman for the murder of fifteen patients in his care (though the number is thought to be as high as 250). The Shipman Inquiry which followed 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.

[13] 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.

[14] On new patient role, see Developing Patient Partnerships, http://dpp.org.uk/. This is in tension with the sick role described by Parsons (1951), but see Shilling (2002).

[15] Interview with GP2 (female), 29/06/04.

[16] 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.

[17] Interview with GP3 (female), 30/06/04.

[18] Interview with GP2, 29/06/04.

[19] 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).

[20] On the Cochrane Collaboration, see http://www.cochrane.org.

[21] Interview with GP2, 29/06/04.

[22] Interview with GP3, 30/06/04.

[23] Whether because he thought her interest in religion or her gender and age would incline her to be sympathetic to CAM is not known.

[24] Authors' citations not included.

[25] 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 on the developing relationship between orthodox and alternative healthcare (2003).

[26] Discussion between GP1 and GP2, 29/06/04. On the relationship between CAM and EBM, see Adams (2000).

[27] GP2 in discussion, 29/06/04.

[28] GP1 in discussion, 29/06/04.

[29] GP2 in discussion, 29/06/04.

[30] Interview with PN (female), 30/06/04.

[31] Interview with GP3, 30/06/04.

[32] 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.

[33] Such late-modern concerns have variously been associated with the 'spiritual revolution' (Heelas et al, 2004), neoliberal capitalism (Carrette and King, 2005) and post-secularity (Knott, 2005), which are related trends with rather different conceptual and historical reference points. We recognise that the notion of 'spirituality' begs greater consideration in a discussion of late-modern medicine (e.g. Gilliat-Ray, 2003) but space forbids it here.

[34] 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, pp. 215-28).

[35] For further discussion of the role of controversies for exposing 'sacred' values – whether secular or religious – see Beckford (1999) and Knott (2005, pp. 84-5, 124-26, 216-28).

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